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**AGENCY  
AND  
DISCOURSE ON DISTRESS**

**by**

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A thesis submitted to the University of Bristol in accordance with the requirements of Doctor of Philosophy in the Faculty of Medicine

## **Abstract**

This thesis is about social suffering in developed English-speaking societies such as Britain and the British Overseas Territory of St. Helena. A principal aim of this research was to develop a social theory about social suffering in such societies. Cultural processes and relational settings mediate the impact of social structure on personal agency and this partly accounts for how distress becomes socially distributed in such societies. The experience, expression, and meaning of distress depend upon how the self is partly constituted in a cultural discourse on the self. Two case studies are presented to develop these theoretical ideas. A critical-realist and interpretive methodology and an ethnographic approach to social research were used in a study of the social experience of distress in two developed English-speaking societies: the English city of Bristol and the south Atlantic Island of St. Helena. Accounts of personal distress (principally depression) were obtained from interviews with thirty-six informants in south Bristol and with forty informants on St. Helena. On St. Helena, interviews with informants were supplemented with ethnographic data collected from a range of sources. The data was interpreted using a discourse-analytic framework, paying close attention to narrativity, trope, intertextuality, ideology, and the constitutive force of discourse. Social suffering in developed English-speaking societies is commonly produced by life events and relational settings that involve a disruption of agency or a breach in social relations. How distress is expressed, experienced, and interpreted in such societies depends on how social identity and agency are constituted through diverse cultural and symbolic processes. Lay discourse on distress employs metaphor, metonymy, and low levels of narrativity to depict distress as a socio-moral response to social adversity and as a breakdown in agency. Expert discourses on distress transform social suffering into an individual disorder organised around an illness metaphor.

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### **Author's declaration**

I declare that the work in this dissertation was carried out in accordance with the Regulations of the University of Bristol. The work is original except where indicated by special reference in the text and no part of the dissertation has been submitted for any other degree.

Any views expressed in the dissertation are those of the author and in no way represent those of the University of Bristol.

The dissertation has not been presented to any other University for examination either in the United Kingdom or overseas.

SIGNED:

DATE:



# TABLE OF CONTENTS

<b>INTRODUCTION</b>	<b>1</b>
<b>CHAPTER 1 SOCIAL SUFFERING AND THE ANTHROPOLOGY OF AFFLICTION</b>	<b>5</b>
1.1 Culture and the social aetiology of depression	5
1.2 Social suffering and the anthropology of affliction	8
<b>CHAPTER 2 SOMA AND PSYCHE</b>	<b>15</b>
2.1 Culture and distress	15
2.2 Idioms of distress	22
2.3 The self in distress	30
<b>CHAPTER 3 DISCOURSE, NARRATIVITY, AND ETHNOGRAPHY</b>	<b>37</b>
3.1 A discourse-based approach to interpretation	37
3.2 Research methods	45
3.3 Case Study 1: Bristol	48
3.4 Case Study 2: St. Helena	49
<b>CHAPTER 4 ‘THE USUAL CLASSIC SYMPTOMS’</b>	<b>54</b>
4.1 English metaphors of distress	55
4.2 Loss of agency and human behavioural breakdown	63
4.3 The illness metaphor: loss of agency and social disconnection	76
4.4 Contingency and indeterminacy in English discourse on distress	82
<b>CHAPTER 5 SOCIAL SUFFERING AND THE ST. HELENIAN PREDICAMENT</b>	<b>91</b>
5.1 The Communion of Saints	92
5.2 The ‘St. Helenian Predicament’	102
5.3 “It’s just one thing over and over”	110
5.4 The social regulation of affliction	132
<b>CHAPTER 6 AGENCY AND METONYMS OF ADVERSITY</b>	<b>139</b>
6.1 Metonyms of adversity: ‘worry’, ‘stress’, and ‘pressure’	140
6.2 Illness-like distress: ‘depression’ and ‘getting depressed’	145
6.3 Public discourse and personal distress	153

<b>6.4 ‘Headaches’ as dramatic mask</b>	<b>156</b>
<b>6.5 ‘High blood pressure’ as a metonym of distress</b>	<b>166</b>
<b>CHAPTER 7 AGENCY AND DISCOURSE ON DISTRESS</b>	<b>170</b>
<b>7.1 English discourse on distress</b>	<b>170</b>
<b>7.2 St. Helenian discourse on distress</b>	<b>172</b>
<b>7.3 A dialectical relationship between expert and lay discourses on distress</b>	<b>175</b>
<b>7.4 Agency, social relations, and affliction</b>	<b>180</b>
<b>APPENDICES TO CHAPTER 3</b>	<b>184</b>
<b>A3.1 Methods of interpretation: qualitative analysis</b>	<b>184</b>
<b>A3.2 Narrative analysis and a prototype concept of narrative</b>	<b>184</b>
<b>A3.3 Rhetorical analysis: drama and trope</b>	<b>187</b>
<b>A3.4 Interpretive framework for discourse analysis</b>	<b>192</b>
<b>A3.5 Topic guide</b>	<b>198</b>
<b>A3.6 Interpretation of the Bristol data</b>	<b>199</b>
<b>A3.7 Interpretation of the St. Helena data</b>	<b>201</b>
<b>A3.8 A small-scale community survey of an outlying district of St. Helena</b>	<b>202</b>
<b>APPENDICES TO CHAPTER 6</b>	<b>204</b>
<b>A6.1 Mental health on St. Helena</b>	<b>204</b>
<b>A6.2 St. Helenian discourse on ‘mental illness’</b>	<b>206</b>
<b>A6.3 Public health and mental-health service provision on St. Helena</b>	<b>208</b>
<b>NOTES</b>	<b>213</b>
<b>BIBLIOGRAPHY</b>	<b>220</b>

## Introduction

This thesis is about the social experience of distress<sup>1</sup> and social suffering in developed English-speaking societies such as Britain. In *Britain on the Couch*, Oliver James expressed alarm at the rising rates of psychiatric morbidity that have been seen in the UK since the 1950s, culminating in what he describes as an ‘angst epidemic’ (1998: 59). Whether they have risen or not, levels of personal distress in Britain do appear to be very high. For instance, in 1993, the first *British Psychiatric Morbidity Survey* (BPMS) found that around 14% (one in six) of adults (aged 16-64) in Britain and living in private households had a ‘neurotic health problem’ (Jenkins *et al*, 1997, 1998).<sup>2</sup> These findings were replicated in the second BPMS in 2000; around one in six adults living in Britain were reported to have a ‘neurotic disorder’ (ONS, 2001). Moreover, around one in four respondents reported ‘hazardous drinking patterns’.

Are these epidemiological symptoms of a sick social body? What do these findings say about British society? James believes that ‘the modern malaise’ has been partly caused by an increasing tendency to engage in maladaptive psychological processes of social comparison that result in lowered self-esteem and increased risk of depression. Karp (1996), on the other hand, has argued that the proliferation of depression in North American society is due to a complex combination of cultural factors and macro socio-economic processes. For instance, in his qualitative study of depression among white Americans, Karp concluded that:

A necessary condition for widespread depressive illness is a culturally induced readiness to view emotional pain as a disease requiring medical intervention. The grounds for treating pain as an abnormal medical condition have been largely established through increasing incursion of medical and other therapeutic experts into literally every aspect of our lives. Doctors in particular have become explorers, discovering every conceivable aspect of the human condition as potentially problematic and warranting their intervention. Such a ‘medicalisation’ process has dramatically increased the number of uncomfortable or disliked feelings and behaviors that we now see as illnesses.

Karp, 1996: 172-173

Accounting for a putative historical increase in levels of personal distress and explaining the social distribution of suffering in late capitalist societies such as Britain requires the development of a social theory of social suffering and what Fabrega described as a ‘social theory of the psychiatric’ (1992: 91). According to Bourdieu, the challenge for contemporary social science is to develop an understanding of:



The true causes of the malaise that is expressed only through social signs that are difficult to interpret precisely because they seem so obvious. I am thinking of the outbreaks of senseless violence at sports events or elsewhere, about racist crimes, about the electoral success of the prophets of doom, eager to exploit and magnify the most primitive expressions of moral suffering that – as much as and more than by the poverty and the ‘passive violence’ of economic and social structures – are produced by the small privations and muted violence of everyday life.

Bourdieu, 1999: 628-629 (Postscript)

Anthropologists and cultural psychiatrists have produced a rich body of ethnographic evidence on social suffering across cultures. Despite the ‘thickness’ of these ethnographic accounts, the social theory of social suffering remains underdeveloped (Kleinman, 1996). Kleinman points out that without social theory ‘it is uncertain how different ethnographies of the violence of everyday living can construct an ethnographic subject that differs from that of psychologists or novelists’ (1996: 241).

The purpose of the research reported in this thesis is to contribute to the development of a social theory of social suffering by drawing together theory and research in medical anthropology and sociology. Kleinman *et al* point out that research on social suffering requires an interdisciplinary approach: ‘The most interesting questions for theory and practice concerning social suffering are in the cracks between our categories and in the discursive processes that traverse our disciplines’ (1996: XIII). By adopting an interdisciplinary approach, the research reported here set out to explore the interplay between cultural and symbolic processes, social structure, individual agency, and experiences of personal distress. The aims of the research were:

- (a) To investigate the processes through which ‘social structure’ and social adversity produce experiences of personal distress in developed English-speaking societies. As I will show, this requires the development of a social theory of social suffering in such societies.
- (b) To explore how cultural and symbolic processes partly constitute the experience of personal distress.<sup>3</sup> This involves forming an interpretation of the cultural discourses that are used to describe and interpret such experience. How do such processes shape the experience of distress and enter into its aetiology?
- (c) To examine how ‘the self’ and ‘social identity’ mediate the relationship between adversity and distress and how they influence the experience, expression, and response to such distress. How do experiences of distress rely on the provision of a cultural discourse on the self, body, and society?
- (d) To assess the relevance of the analytical concepts of ‘agency’<sup>4</sup>, ‘narrativity’, and ‘trope’<sup>5</sup> for the interpretation of expert and lay discourse on distress. How can an interpretive focus on discourse facilitate an understanding of the relationship between culture and distress? What are the most effective ways of researching the relationship between cultural processes, social structure, and social suffering in late capitalist societies such as Britain?

## **Structure of the thesis**

This thesis is divided into seven chapters. The first two chapters present a critical overview of how medical anthropologists and sociologists have sought to understand the relationship between personal distress and social suffering. They describe the theoretical framework employed in later chapters. Chapter 1 discusses the role of cultural and symbolic processes in ‘social origin’ explanations of distress in developed, English-speaking societies such as Britain. The chapter goes onto describe how contemporary medical anthropologists have sought to incorporate macro social, political, and economic forces into their cultural interpretations of illness and distress.

Chapter 2 reviews some of the ways that medical anthropologists and cross-cultural psychiatrists have developed their thinking about the relationship between culture and distress. It draws on a range of examples to illustrate how cultural and symbolic processes influence the experience, expression, and meaning of distress. This includes a discussion of the anthropological concept of an ‘idiom of distress’ and its relevance to an interpretation of distress in developed English-speaking societies. The final part of the chapter introduces the idea of a cultural discourse on the self and argues that the communication, meaning, and social response to personal distress in such societies is partly contingent on such a discourse.

Chapter 3 describes the methodological framework, research methods, and interpretive framework used in the empirical phase of the research. It includes a critical discussion of how medical anthropologists and sociologists have applied the concept of narrative in their research on illness and sickness. This is followed by the presentation of a discourse-based concept of narrative. The second part of the chapter presents an account of the research methods used and data-collection in both fieldwork settings: St. Helena and Bristol.

Chapter 4 presents an interpretation of English discourse on distress among two samples of white English informants living in the English city of Bristol. The first section of the chapter presents an interpretation of informants’ descriptions of their experiences of distress. The second part discusses how sufferers and former sufferers of distress evaluate, interpret, and represent their experiences in highly contextualised accounts of social experience that can be more or less coherent and more or less narrative-like. This chapter argues that, while such discourse may not always have a clear explanatory logic, it functions to articulate speakers’ sense of moral agency.

Chapters 5 and 6 present the findings from the second ethnographic case study (St. Helena). They present an ethnographically informed interpretation of discourse on distress among St. Helenians. Chapter 5 presents an ethnographic account of how cultural processes and macro socio-economic forces interact to produce a particular configuration of social suffering in St. Helenian society. Chapter 6 presents an interpretation of St. Helenian discourse on distress. St. Helenians’ accounts



of distress and illness are used to explore how the socio-cultural context in which distress takes place constrains its discursive representation.

Chapter 7 presents a synthesis of learning from the case studies and from the theoretical discussion of earlier chapters. The chapter presents an account of the dialectical relationship between expert and lay discourses on distress in such societies. The final part of the chapter re-engages with the theoretical themes discussed in the first two chapters, and describes how the interplay between socio-economic forces and cultural processes produce particular configurations of social suffering in developed English-speaking societies.

# Chapter 1

## Social Suffering and the Anthropology of Affliction

Those who have only empty space above them are almost inevitably lost in it, if no force restrains them.

Emile Durkheim (1975: 257)

This chapter is about personal affliction and social suffering. It describes some of the ways that medical anthropologists and sociologists have sought to understand such phenomena. The first part of the chapter describes how, over the past few decades, medical sociologists and social psychiatrists have sought to develop 'social origin' aetiological accounts of the 'neurotic disorders' and their social distribution within British society. These aetiological accounts draw upon a versatile vulnerability-stress explanatory system and form part of a broader expert discourse on distress.

Using 'depression' as an example, it is argued that such aetiological models have neglected to take into account cultural and symbolic processes and the sociomoral dimensions of affliction and distress. A range of examples is used to argue that such processes are internal to the social aetiology of distress. Cultural processes and social structure interact to produce particular configurations of affliction in developed English-speaking societies such as Britain. This interaction partly accounts for how social suffering becomes socially distributed in such societies.

Conversely, the second part of this chapter describes some of the ways that medical anthropologists have sought to take into account macro social, political settings, and economic processes in their cultural interpretations of suffering and affliction. It is argued that cultural processes and relational settings mediate agency and social structure in the production of affliction and personal distress. The concepts of social suffering, anomie, the social drama, and rituals of affliction facilitate an understanding of such processes.

### 1.1 Culture and the social aetiology of depression

In contemporary expert discourse on distress, at least four explanatory systems have been developed to account for the onset of depression and its social distribution among western populations: biological; psychological or cognitive; sociological; and composite explanatory systems (e.g. 'bio-cognitive', 'psychosocial' or 'biopsychosocial'). The ethnopsychiatric concept of stress and an expert explanatory system organised around the relationship between social 'diathesis' and 'stress' underlies contemporary sociological and social-psychiatric explanations for depression (e.g. Monroe and Simons, 1991). This explanatory system depends on a particular interpretation of the ethnopsychiatric concept of stress. Kirmayer (1988) has pointed out that the

concept of 'stress' is the 'organising metaphor' for 'behavioural medicine'. Within this discourse, stress 'stands for the inexorable demands of the environment that can, at times, exceed the human capacity for mastery' (Kirmayer, 1988: 74). Contemporary psychiatric discourse on stress is organised around a bifurcation between an objective source of stress (e.g. 'stressor' or 'provoking factors') and its effect on the body or in the mind of the sufferer ('the stress reaction'). This 'stress reaction' can take either a physical (e.g. an increase in blood pressure) or a psychological form (e.g. 'the feeling of being keyed up') (Gelder *et al*, 2003: 76). Gelder *et al* advise that these two meanings of stress should be distinguished in aetiological research:

First, it [stress] is applied to events or situations, such as working for an examination, which may have an adverse effect on someone. Second, it is applied to the adverse effects that are induced, which may be psychological or physiological change. In considering aetiology it is advisable to separate these components.

Gelder *et al*, 2003: 76

In 'social origin' accounts of depression, distress is explained as a consequence of an interaction between: a vulnerability or predisposition to develop a particular disorder; an environmental stress (e.g. a difficult or traumatic life event that precedes onset); and ongoing 'perpetuating factors' (e.g. factors that prolong the course of disorder) (Gelder *et al*, 2003: 75-76). Over the past few decades researchers in medical sociology and social psychiatry have identified a variety of social 'stressors' and 'vulnerability' factors that partly account for depression and, therefore, its social distribution (Brown, 2003).<sup>6</sup>

Nonetheless, cultural processes mediate the aetiological gap between vulnerability factor (the 'diatheses'), adverse life event (the 'stress'), and personal distress. The aetiological significance of life events depends on their meaning. For example, in narrative analyses of personal accounts of infidelity and divorce, Riessman showed how the way that negative relationship events are interpreted mediate their emotional impact. She drew some general implications for social-science research on stress:

Investigators have not given sufficient attention to the meanings imputed by the social actor, that is, how individuals themselves interpret the stressors in their lives [...] It is in the interpretation of an event by the social actor that the significance may lie and, consequently, the potential for distress and disorder.

Riessman, 1989: 749

In addition, the impact of negative life events is partly contingent on social identity<sup>7</sup> and how agency has been constituted in relation to social setting. This is highlighted in attempts to explain why, in societies such as Britain, the prevalence of depression among women is greater than that among men. In recent British psychiatric morbidity surveys, women in Britain have been reported to be around one and a half times more likely as men to suffer from 'depressive disorder' and almost twice as likely to suffer from 'mixed anxiety and depression' (Jenkins *et al*, 1997;



Bebbington *et al*, 1998). Do such differences mean that women experience more adversity? Alternatively, do men articulate and respond to their experiences of distress differently? Some researchers have argued that women are more likely to be exposed to the kinds of adversity that result in depression because of the kinds of gender-typed social roles that they perform. For instance, in one British study, Nazroo *et al* (1987) explained gender differences in depression as the result of differences in the social roles of men and women. They found, for instance, that women were only at greater risk of depression compared with men when they had experienced a negative life event that involved children, reproduction, or housing. The correlations between gender and patterns of personal distress are partly a social and cultural construction. Schwartz (1991), for instance, pointed to a familiar picture of higher rates of 'acting out, anti-social' behaviour, alcohol and drug use among men and higher rates of depression among women. Based on survey data collected from a small sample of Jewish women in New York, she explained the difference in terms of culturally shaped 'sex-role norms' that govern how distress is experienced and expressed by men and women: 'The lives of men and women are both accompanied by stress which may engender psychopathological responses. But differences in the social context of their lives support different patterned responses to such stress' (1991: 138). In a community-based epidemiological survey of depression among Anglo-Jewry in the UK, Loewenthal *et al* (1995) found an equal prevalence of case depression between men and women, but no difference in the risk of exposure to provoking agents or economic adversity. There were, however, other differences in their social roles. Women, for instance, were more likely to occupy a homemaker and carer role in the family, and were less likely to be earning. They were also more likely to report difficulties in concentrating and to experiencing self-deprecating thoughts. Loewenthal *et al* explained this apparent contradiction with reference to cultural and religious factors. The cultural value attached to a woman's role in family management buffered them from adversity:

Amongst the Jews interviewed, the culturally-associated pattern of occupational characteristics, interacting with economic conditions, appeared to have resulted in economic stress which was an important factor contributing to depression among those interviewed.

Loewenthal *et al*, 1995: 1061

These explanations for observed differences in rates of depression between men and women point to the relevance of cultural and social processes in constituting identity, the experience of adversity, its meaning or significance, and the response taken to such adversity. A comparative study conducted by Brown and Prudo (1981) further illustrates the limits of mechanical 'diathesis-stress' aetiological models and highlights the importance of taking into account the local socio-cultural contexts in which distress takes place. Brown and Prudo (1981) set out to test the validity of the aetiological developed by Brown and Harris (1978) in their original study of depression among working-class women living in Camberwell, south London. They chose the rural population living on the Hebridean islands of North Uist and Lewis as the subjects of a sociological comparison with the women included in the Camberwell study. Like in Camberwell, Brown and Prudo found that

depression was the most common psychiatric syndrome in women living on these islands. Nonetheless, compared with working-class women living in Camberwell, social class accounted for less of the variation in depression among Hebridean women. Rates of depression were highest among those who were least 'integrated' into a traditional way of life. In both rural and urban populations, the onset of depression typically followed an adverse life event. Nonetheless, the types of events that resulted in depression differed between the two populations. Prudo *et al* (1981), for instance, reported that depression was more likely to follow a death or imminent death of a close relative among women living in the Outer Hebrides compared with women in the urban sample. The experience of depression was also more likely to take a 'chronic course' and have a 'strong anxiety component' among the Hebridean women (1981: 610). Prudo *et al* cited an array of 'socio-cultural differences' in order to account for these differences between the two populations (e.g. family structure, marital position, degree of contact with relatives).

One of the tasks for a social theory of social suffering is to form a theoretical account of how social structure and adversity become embodied in personal distress and how such distress becomes distributed across social categories. Cultural and symbolic processes are likely to be at least partly responsible for how distress is distributed in developed English-speaking societies. An understanding of these processes is likely to be important in deciding how to respond to such suffering. Good (1977) has points out, for example, that:

Our understanding of the way in which psychosocial and cultural factors affect the incidence, course, experience, and outcome of disease is crucial for clinical medicine, both in the determination of the what data is clinically relevant and where the therapeutic intervention should occur.

Good, 1977: 25

A small but growing body of sociological, psychiatric, and anthropological research has sought to explore the role of social and cultural processes in the experience and understanding of psychiatric illness in developed English-speaking societies.<sup>8</sup> In addition, critical medical anthropologists have sought to incorporate macro social and political factors into their interpretations of illness, distress, and social suffering.

## **1.2 Social suffering and the anthropology of affliction**

The last section argued that medical sociological and social psychiatric explanations for psychosocial distress and their social distribution in societies such as Britain have taken insufficient account of cultural and symbolic processes. Conversely, during the 1980s, critical medical anthropologists mounted a critique of mainstream medical anthropology for marginalizing social relations and issues of power and for having become too 'medicalised' with the consequence that medicalisation had become a marginal concern as an area of research (Singer, 1989). Interpretive medical anthropology attracted criticism for paying too much attention to ideographic and micro-cultural processes and for neglecting to take into account social structure, power relations, and the



broader political and economic contexts in which cultural practices are embedded (Lock and Scheper-Hughes, 1996; Jenkins, 1996). For instance, writing over two decades ago, Frankenburg (1980) recommended that medical anthropology go beyond the analysis of custom, social relations, and cultural practices at the local level and contextualise them in relation to broader social and economic processes and national and international political contexts. More recently, Jenkins (1996) has argued that anthropological studies of distress need to broaden their outlook from a focus on local intra-psychic analyses to consider the role of the state in constructing emotional experience.

Critical medical anthropologists have sought to foreground social, economic, political, and 'macro level structures' in their interpretations of illness and distress (Singer, 1989; Singer and Baer, 1995). They have developed sophisticated critiques of biomedical knowledge and practice, and have pointed to some of its social and ideological functions within late capitalist societies.<sup>9</sup> Moreover, some have sought to understand how socio-political processes interact with cultural and symbolic practices to produce particular configurations of illness, suffering, and distress (Lock and Scheper-Hughes, 1996; Jenkins, 1996; Kleinman, 1996). For instance, Lock (1986) interpreted school refusal syndrome among Japanese children in relation to broad national concerns (e.g. nationalisation, cultural identity) as well as a culturally patterned response to local relational contexts (e.g. relationships between parents and children, the school system). Good (1977), for instance, has written about the 'state construction of affect' in Iran and investigated the nation state's role in the production of sentiments among Iranians. Within a Salvadoran context, Jenkins (1991) highlighted the role of the state in the construction and regulation of affect. She investigated the mental-health consequences of life in El Salvador among a group of Salvadoran refugees living in the United States, a group whose 'life worlds are framed by chronic political violence, extreme poverty, unrelenting trauma and loss' (1991: 141). Jenkins argued that the state in El Salvador has played a covert and overt role in promoting and legitimating particular kinds of emotional discourse, shaping how political events and situations are perceived and evaluated. During the 1980s, the state in El Salvador engendered dysphoric emotional reactions among the Salvadoran population through 'a system of affective interaction, generalised emotional atmosphere, and social control' (1991: 157). In El Salvador, the refugees in her study lived under a 'pervasive dysthymic ethos and a cultural of terror' that partly explained the high levels of emotional distress that was observed among them (1991: 149).

Lock and Scheper-Hughes have argued that in oppressive political or social settings illness is regularly used 'to portray opposition – an institutionalised space from which to communicate fear, anxiety, and anger' and often represents 'a form of protest against oppressive social roles and ideologies' (1996: 64-67). In ethnographic research in a Brazilian shantytown, for example, Scheper-Hughes showed how an ethnomedical illness category of 'nerves' (*nervoso*) was used by the poor and oppressed cane-cutters to express their hunger and 'as a collective and embodied response to the nervous political system' (1993: 186). As an ethnomedical illness category and a

metaphor for social suffering, *nervoso* represented a coded form of criticism of the prevailing political and economic where other means for the expression of dissent and discontent were unavailable. While *nervoso* expressed 'nervous hunger', it was also an 'embodied metaphor' for intractable social and economic difficulties and so represented 'an act of refusal, an oblique form of protest' (1993: 213). However, Scheper-Hughes found that *nervoso* had become medically appropriated (or medicalised) and was treated as a biomedical illness thereby disguising its socio-political origins and neutralising the 'hungry body' as a symbol of resistance.

Kleinman (1980; 1986) investigated the ways that cultural processes, social structure, and political contexts interact to produce neurasthenia<sup>10</sup> and chronic pain among the Chinese. He found that most of the Chinese patients he interviewed had experienced social or personal difficulties shortly before the onset of their symptoms of neurasthenia. Otherwise, they had experienced 'ongoing difficulties'. He described how the Chinese share a sociocentric view of the self and an ideological view of social harmony. Emotional expression is used evaluatively to articulate a moral perspective on events and circumstances. The expression of depressive emotion therefore had political implications for Chinese patients and represented a challenge to the dominant ideological discourse in Chinese society; the expression of dysphoria was interpreted as 'disaffiliation, alienation, potential opposition' (Kleinman and Kleinman, 1985: 468). The expression of dysphoric emotion was therefore considered 'shameful' and was socially stigmatised in Chinese society. Moreover, it was associated with highly stigmatised 'mental illness'. Kleinman and Kleinman maintained that 'mental illness' and the psychological expression of distress were strongly discouraged during the Cultural Revolution. With the collusion of clinicians, 'frustration', 'demoralisation', and political disenchantment were canalised into more socially acceptable public idioms of distress: symptoms of bodily pain, clinically constellated into the ethnomedical category of neurasthenia. Patients used a somatic idiom to communicate 'otherwise unsanctioned personal or social distress in a legitimised bodily idiom' (Kleinman and Kleinman, 1985: 439).

Medical anthropologists have employed the concept of 'social suffering' to describe the negative impact that macro political, social, or economic forces can have on individual bodies (e.g. war, revolution, dictatorship, economic depression). For example, Kleinman *et al* describe social suffering as:

An assemblage of human problems that have their origins and consequences in the devastating injuries that social force inflicts on human experience. Social suffering results from what political, economic, and institutional power does to people, and, reciprocally, from how these forms of power themselves influence responses to social problems.

Kleinman *et al*, 1996: XI

So, what makes suffering social? Kleinman has defined the social experience of suffering as 'a universal aspect of human experience in which individuals and groups have to undergo or bear



certain burdens, troubles, and serious wounds to the body and the spirit that can be grouped into a variety of forms' (1996: 101). Kleinman and Kleinman point to two ways in which suffering is a 'social experience'. First, 'collective modes of expression' partly constitute experiences of suffering and shape how it is communicated. Second, social relations are part of the experience of illness and distress (1996: 2). Suffering is social in at least two other ways. Experiences of individual distress are partly produced by macro social, economic, and political forces. In addition, experiences of personal distress transform social relations and so influence how societies are organised.

Bourdieu characterises 'social suffering' as the distress and pain that results from 'socio-structural violence'. Social suffering takes place along fissures in the social structure, suffering shared by many individuals or families because of their shared socio-economic circumstances. It involves subjugation; 'a being done to' as Monks (2000) puts it. Individual lives are structured in ways that cause them to suffer. In late capitalist societies such as Britain, a multiplicity of macro social and economic processes systematically generates social suffering in individual bodies. These processes include, for instance, inequalities in power or access to material and non-material resources; the role of state and commercial institutions in sustaining and reproducing social structure and in exploiting populations; political oppression; social and economic practices that systematically exclude some while including others.

The impact of macro social and economic forces on individual bodies is conveyed by the local social contexts and personalised worlds that individuals inhabit. Somers (1994) advocates the use of the metaphorical concept of a 'relational setting' for thinking about this intermediate social space between structure and agency. A 'relational setting' refers to 'a pattern of relationships between institutions, public narratives, and social practices. As such, it is a relational matrix, a social network' (1994: 626). These settings are generated by macro political, economic, and social forces, and partly constitute individual agency and identity.

Social structure<sup>11</sup> (e.g. race, class, and gender) systematically positions individuals in a way that places them at increased risk of personal distress. Kleinman *et al* describe how social suffering takes place in 'nested contexts of embodiment: collective, intersubjective, individual' (1996: XVII). For example, in the context of a discussion about the socio-political production of distress among the Chinese, Kleinman and Kleinman describe these local contexts of power that determine how 'risk, stress, and resources are configured': 'The local context itself can be thought of as a nested hierarchy of family, network, work, and community settings. This local cultural system systematically relates person to social structure, bridging physiological processes and social relations' (1985: 468). Psychosocial distress (e.g. depression, chronic pain, neurasthenia) therefore expresses the relationship between society and individual. These local contexts convey the impact

of large-scale social, political forces to individual bodies. Symbolic meanings mediate self and local context, body and self-connecting body and society (Kleinman and Kleinman, 1985).

The term 'positional suffering' refers to the suffering associated with the experience of disadvantaged social position (Bourdieu, 1999). It is partly produced by 'the directly experienced effects of social interaction within these social microcosms (office, workshop, business, neighbourhood, in the extended family)' (1999: 4). Bourdieu points out that the suffering of those occupying an 'inferior, obscure position in a prestigious and privileged universe' is 'all the more painful when the universe in which they participate just enough to feel their relatively low standing is higher in social space overall' (1999: 4). While visible levels of material suffering (e.g. absolute poverty) may have been reduced in late capitalist societies, the experience of 'ordinary' social suffering is distributed throughout the social field:

This positional suffering, experienced from inside the microcosm, will appear, as the saying goes 'entirely relative', meaning completely unreal, if we take the point of view of the macrocosm and compare it to the 'real' suffering of material poverty (*la grande misere*) [...] Using material poverty as the sole measure of all suffering keeps us from seeing and understanding a whole side of the suffering characteristic of a social order which, although it has undoubtedly reduced poverty overall (though less than often claimed) has also multiplied the social spaces (specialised fields and subfields) and set up the conditions for an unprecedented development of all kinds of ordinary suffering (*la petite misere*).

Bourdieu, 1999: 4

It is through adverse 'nested contexts' and 'positional suffering' that social structure becomes embodied as personal distress. Kleinman and Kleinman have said, for instance, that 'social structures and social relations are deeply affective, thus embodied in the individual and his disorders' (1985: 427). Within late capitalist societies such as Britain, relational settings of subjugation, social disconnection, powerlessness, and entrapment<sup>12</sup> are systematically produced and inhabited by a large proportion of the population. Such adverse settings erode the agency of those who inhabit them, thereby placing them at risk of distress and, in some cases, more severe psychiatric illness.

Durkheim analysed suicide data from several European societies and concluded that: 'Whenever serious adjustments take place in the social order, whether or not due to a sudden growth or to an unexpected catastrophe, men are more inclined to self-destruction' (1975: 246). He used the concept of 'anomie' to explain this association between such change and higher rates of suicide. Durkheim maintained that anomie is produced large-scale, industrialised societies by "society's insufficient presence in the individual." It results from a breakdown in a society's capacity to 'temper', regulate, or control individuals and their appetites and desires (1975: 248). The 'moral limits' set by society fail to be enforced so that individuals become 'unsocialised'. Anomie is generated by 'disturbances in the collective order', 'disturbances of equilibrium', or breaches in social relations (1975: 246). Durkheim described two sources of anomie in his account of suicide;



first, where there is a breakdown in social relations (e.g. marital relationships); second, economic change (e.g. increasing prosperity) that ‘disrupts social regulation and exalts the individual’ (1975: 253).

Durkheim therefore characterised anomie as a delimitation of moral agency and as the sense of dissatisfaction and disillusionment that accompanies the ‘futility of an endless pursuit’ (1975: 256). In some cases, such ‘futility’ results in ‘anomic suicide’. Merton (1957) further developed the concept of anomie to mean a disjunction between collectively shared values and the ‘socially structured capacities of members of the group to act in accord with them’ (Merton, 1957; cited in Deflem, 1989: 631). High levels of anomie in late capitalist societies such as Britain may account for much of the social suffering recorded in such societies so that anomie becomes individually embodied as anomic suffering. This anomic form of social suffering arises out of a disruption in personal agency, social disconnection, and breaches in social relations. Deflem (1989), for example, has argued that ‘anomie’ (in Merton’s sense) is a source of ‘depression’ (‘anomic depression’) in such societies.

Personal distress as social suffering is produced out of particular types of interaction between agency, social structure, and symbolic processes. Victor Turner’s concept of the social drama provides a rich metaphor for understanding these relationships (Turner, 1975, 1981) (the social drama is discussed in more detail in Appendix A3.3). For example, Turner (1967, 1968) described how, in small-scale societies (e.g. among the Ndembu of Ghana), ‘rituals of affliction’ are commonly employed as a symbolic means of redressing social conflicts and breaches in the social order.

Durkheim’s theory of anomie reverberates through an editorial published in the *Journal of Psychosomatic Research*, written in 1966 by the medical anthropologist Joseph Loudon. Loudon maintained, for instance, that high levels of social stability, integration, and the presence of ‘traditional customs and institutions’ promote the mental well being of the members of such societies (1966: 101). Conversely, he maintained that rapid social change and modernisation could result in social disintegration, which he linked with heightened levels of psychiatric disorder. Rituals of affliction<sup>13</sup> provide a symbolic means of adjusting to the stresses that emanate from contradictions deep within society’s social structure (Turner, 1968, 1981; Loudon, 1966). According to Loudon, their principal function is to redress breaches in the social order and to resolve social conflict. Social conflict and breaches in social relations are often experienced as powerful negative emotions such as rage or anger. Rituals of affliction provide a safe cultural form within which strong disruptive emotions arising out of such conflict can be vented. They originate at the individual level and become institutionalised and standardized as an acceptable way of expressing distress: ‘Ritual gives controlled expression to personal emotions that demand some formal outlet as well as to the conflicts to which any particular set of social relations gives rise’



(Loudon, 1966: 103). These ritual displays of powerful negative emotions have a 'safety-valve function' in small-scale societies, acting out the stresses in the social system:

Although there may be no exact correspondence, the links and the cleavages in the social system are often experienced in the individual personality system as friendship and hostility, love and hate. If we mean by cleavage a social relationship with a more or less distinctly hostile component [...] then rituals [...] may be said to act the links and stresses of the social system as well as to act out the positive and negative feelings of individuals.

Loudon, 1966: 103-4

The performance of such rituals therefore has a positive and negative function: to promote social unity and continuity and to prevent social 'schism' or a more permanent breakdown in the social order occurring (Turner, 1968, 1981; Loudon, 1966). Loudon claimed that rituals of affliction provide a means of discharging powerful and 'potentially dangerous internal forces' through 'controlled expression' (1966: 104). This reduces their potency and neutralizes any threat they might have to the social order. For example, in research among the Zulu, Loudon argued that conflicts in the social structure and tensions produced by power relations resonate in the individual psyche and these find cathartic 'release' in socially approved 'abreactive rituals'. Moreover, the 'tensions' produced by the repression of women find 'release' in 'rituals of rebellion' through which fundamental conflicts in the community are acted out (1959: 367). Where no sanctioned modes of release are available, social tensions or difficulties are canalised into an illness called *ufufanyana*, an illness without biological cause and where the symptoms are precipitated by and amplified by social difficulties.

The research described in this chapter suggests that instead of viewing personal distress as a discrete psychological event or as a response to a de-contextualised stimulus (e.g. 'a stressor'), such experiences can be interpreted as a type of social suffering that occur within the context of a society's 'overall functioning' (Littlewood, 1990: 321). It is clear from the anthropological and sociological evidence that cultural and symbolic processes play an important constitutive role in the social aetiology of depression. Such processes are therefore bound to influence how depression becomes socially distributed within developed English-speaking societies such as Britain. In such societies, macro social, political, and economic forces systematically produce the kinds of adverse relational settings that are associated with personal distress. These settings produce distress by undermining agency, disrupting relationships, increasing exposure to adversity, eroding resilience, and narrowing down the range of options available for coping and responding to adversity. Cultural and symbolic processes mediate between such toxic relational settings, adverse life events, and their embodied impact as personal distress. While cultural processes partly constitute agency, in their ideological mode, they also contribute to the reproduction of the power relations and socio-economic forces that produce these local settings. The relationship between these cultural and symbolic processes and distress is the central concern of the next chapter.

## Chapter 2

### Soma and Psyche

All we have is a disposition to use the language of our ancestors, to worship the corpses of their metaphors.

Rorty (1986) *The Contingency of Language*

This chapter is about the relationship between culture and affliction. It builds on the last chapter in discussing how cultural and symbolic processes partly constitute the experience, communication, meaning, and social response to personal distress and psychiatric illness. Keeping with the example of depression, the first section describes how affliction and personal distress are re-worked in biomedical discourse in terms of a theory of disorder. Biomedical discourse on distress forms the basis for the response of an 'old cross-cultural psychiatry' to the existence of manifest variations in the experience, expression, and meaning of depression across different socio-cultural settings. The chapter goes on to review how medical anthropology and a 'new cross-cultural psychiatry' have sought to understand the relationship between culture and distress. The second section discusses how the idiom of distress concept has been developed by medical anthropologists to explore this relationship. The discussion centres on how the expression and experience of depression and emotional distress are influenced by cultural and symbolic processes. This includes a critical discussion of how a dualistic distinction between psychological and somatic idioms of distress has been used to characterise western/non-western differences in depression and dysphoria.

In the final part of the chapter it is argued that how psychiatric illness and emotional distress are configured in any particular society is contingent on the cultural availability of an indigenous psychology and a local ethnopsychology of emotion. It is argued how personal distress and private affliction are experienced, communicated, interpreted, and responded to in developed English-speaking societies is contingent on a Euro-American discourse on the self and body. This implies that how social suffering is socially distributed across the populations of such societies is partly a function of how agency is constituted differently across the social field.

#### 2.1 Culture and distress

The biomedical discourse that organises and provides the rationale for clinical practice and research depends on a view of diseases as: 'Universal biological or psychophysiological entities, resulting from somatic lesions or dysfunctions' (Good, 1994: 8). According to Gelder *et al* (2003), the biomedical concept of disease refers to an underlying biological or psychological malfunction. Within biomedical discourse, diseases are understood to produce observable physiological abnormalities as well as symptoms 'communicated as an ordered set of complaints' (Good, 1994:



8). It is the clinician's task to decode the patient's subjective or symbolic expressions of distress in terms of 'underlying somatic referents' (1994: 8).

Biomedical discourse on distress is grounded in what Canguilhem (1989) has described as the 'positivist view of disease' and an analogy between the concept of mental disorder and that of a disease entity. Personal distress is configured as disorder, as qualitatively distinct from normal experience. For instance, in the *Diagnostic and Statistical Manual of Mental Disorders* (4<sup>th</sup> ed)<sup>14</sup>, the concept of mental disorder depends on a distinction between normal and abnormal psychological or behavioural functioning. 'Disorder' is defined in functional terms as:

A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful syndrome) or disability (i.e. , impairment in one or more important areas of functioning) or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom.

APA, 1994: XXI

Mental disorders (incorporating the 'neurotic disorders') are defined in terms of dysfunction or deviation at any of three levels of individual ontology: 'Syndrome or pattern must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual' (APA, 1994: XXI). As kinds of mental disorder, the 'emotional pathologies' are depicted as though they were an objective manifestation of an underlying biological or psychological disease-like dysfunction. 'Depression', for instance, refers to a syndrome, prototypically defined as a cluster of symptoms (APA, 1994; Hammen, 1998).

The disease metaphor provides the rationale for cross-cultural psychiatric thinking about culture and distress. Psychiatric illnesses in western and non-western societies are assumed to have the same underlying biological cause (Littlewood, 1998). Cheng (2001), for instance, adopts as his starting point the canonical biomedical distinction between 'subjective complaint' and 'objective symptom'. He then proceeds to argue that, while the idiom used to express 'psychological disorder' may be free to vary across societies, the underlying disorder (the objective symptoms) is not. Such assertions rely on a distinction between the universal (biological) 'form' of disorder and their particular 'content' (Kleinman, 1988; Littlewood, 1990). This distinction between objective disorder and subjective illness means that socio-cultural variations in the incidence and manifestation of distress are treated as surface variations that are believed to mask deep-seated, biological or psychological processes (Kleinman, 1988; Good, 1994). Cross-cultural psychiatrists have therefore interpreted depression as a biological disorder surrounded by 'a series of cultural encrustations' (Littlewood, 1998). Cultural processes and subjective meanings are thought to influence disorder only insofar as they configure the subjective experience of illness. The underlying disease-like disorder, on the other hand, the objective pathology and its aetiology, escape cultural contamination. Cultural differences are bracketed off, while underlying similarities

in symptomatology become the central focus of research (Kleinman, 1987). According to Kleinman, this view of the 'pathogenicity/pathoplasticity' of distress 'comes fairly close to being a professional orthodoxy' and represents an 'interpretive bias' in such research (1987: 450).

Kleinman (1977) presented a powerful critique of what he described as the 'old cross-cultural psychiatry' in response to a review of cross-cultural studies on depressive illness (Singer, 1975). Research within this paradigm has been characterised by a search for universal psychiatric disease entities and an attempt to validate ethnopsychiatric concepts designed for use in western clinical practice (Kleinman, 1977; Marsella *et al*, 1980). For example, in a World Health Organisation study of depression<sup>15</sup> across several western and non-western societies, Sartorius *et al* report 'a remarkable absence of culture-specific symptoms, i.e. manifestations that would not fit the classical phenomenology of depressive disorders' (1983: 92-93). They claimed that 'although prevalence figures vary from study to study, from one investigator to another, there is at present little doubt that depressive disorders occur in all parts of the world' (Sartorius *et al*, 1983: 89).

Cross-cultural differences in depression challenge biomedical assumptions about its universality and biological aetiology. Biomedically-oriented researchers must either modify these assumptions and their theory of disease-like disorder; else, they are constrained to attribute the cause of these cultural differences to measurement error or methodological irregularities. Cheng, for instance, has argued that differences in rates of mental disorders across societies are due to differences in 'case finding', measurement, and sampling. Without fully demonstrating exactly how such irregularities might have generated observed cross-cultural differences, he concludes that 'there is no sound evidence at present to support a real difference in major psychiatric disorders across cultures and societies' (2001: 2). Similarly, at the end of Marsella *et al*'s (1980) review of the cross-cultural literature on depression, the authors concluded that no clear conclusions could be made about differences in incidence rates because of 'variations in conceptualisation'. Culture is washed out through thick epidemiological re-description.

The emergence of a 'new cross-cultural psychiatry' dates back to Kleinman's challenge of the orthodox psychiatric view that there are universal depressive reactions (Kleinman, 1977). It dovetailed with the development of an interpretive paradigm in medical anthropology<sup>16</sup> grounded in American cultural anthropology. This interpretive paradigm was strongly influenced by Kleinman's research on Asian medical systems and somatisation in China (Kleinman, 1980). 'New cross-cultural psychiatry' is closely associated with and, in places, indistinguishable from medical anthropology, particularly in its allegiance to an ethnographic approach and its employment of an anthropological theoretical perspective (Littlewood, 1990, 1998). Unlike medical anthropology, new cross-cultural psychiatry combines the ethnographic approach with clinical, case-based methods (Littlewood, 1990).



New cross-cultural psychiatrists and medical anthropologists have produced a sustained critique of western expert psychiatric discourse on distress. A positive and a negative strategy have been employed. The negative critique points to the cultural contingency of psychiatric discourse and practice and involves a cultural deconstruction of biomedical discourse on psychiatric illness and distress (e.g. Littlewood, 1990, 1998; Gaines, 1992a, 1992b; Jadhav, 1996; Luhrmann, 2000). Littlewood (1990), for example, characterises the 'new cross-cultural psychiatry' as a 'set of related approaches which uses a variety of recent interpretative developments in the humanities and social sciences to examine psychiatry's claim to be a biological or psychological discipline, constantly pointing out the origins of psychiatric categories, theories, and practice in wider political and historical contexts' (1990: 308).

Comparative epidemiological studies of depressive disorder operationalise psychiatric constructs grounded in western symptom configurations (e.g. Sartorius *et al*, 1983). Kleinman (1977) challenged the view that psychiatric diagnostic categories are objective and non-contingent and criticized the 'old cross-cultural psychiatry' for committing a 'category fallacy'; the superimposition of 'their own cultural categories on some sample of deviant behavior in other cultures as if their own categories were culture-free' (1977: 4). In contrast to this, Kleinman has characterised the 'depression syndrome' as 'a cultural category constructed by psychiatrists in the west to yield a homogeneous group of patients' (1977: 3). Moreover, the operationalisation of western psychiatric categories in research within western societies is not immune from such 'category fallacies'.<sup>17</sup>

The positive critique, on the other hand, involves the thesis that cultural and symbolic processes partly constitute experiences of psychiatric illness in ways that problematise the disease-entity view and the assumption that western psychiatric diagnostic categories have universal generalisability. This critique has involved a deconstruction of the form versus content distinction upon which the psychiatric concept of a mental disorder and the universality thesis both rest (e.g. Littlewood, 1990; Fabrega, 1992). Fabrega has asserted, for instance, that: "Culture is not only responsible for the 'surface' content of behavior but also for part of its structure" (1992: 99).

Over the past three decades, medical anthropologists and new cross-cultural psychiatrists have investigated the ways that cultural and symbolic processes influence the expression and meaning of distress and the therapeutic and social response to it.<sup>18</sup> This research on the relationship of culture and distress has been facilitated by the conceptual distinction made by Eisenberg (1977) between disease and illness, categories that the 'old cross-cultural psychiatry' had confused (Kleinman, 1977). Kleinman has characterised disease as 'malfunctioning or maladaptation of biological or psychological processes' (1977: 9). 'Illness', on the other hand, is viewed as the subjective and cultural response to 'disease'. Kirmayer has emphasised that both categories are infused with culture when he describes disease as 'the physician's biomedical interpretation of disorder' and



illness as 'the patient's personal experience of distress' (1988: 59). This distinction has made it possible to differentiate between, on the one hand, the study of the relationship between culture and biomedical discourse and practice, and, on the other hand, the study of how experiences of illness and distress are configured by cultural and symbolic processes.

An understanding of the relationship between culture and distress in medical anthropology relies on an understanding of how cultural symbols relate to somatic experience (Good, 1994). In this meaning-centred approach to medical anthropology, Good characterises illness experience as 'a syndrome of meaning and experience' (1994: 54) or as 'a set of words, experiences, and feelings which typically 'run together' for members of a society' (1977: 27). Symbolic processes are believed to mediate the relationship between society and the phenomenological world of illness. Good, for instance, describes how illness is produced out of the interplay between soma, psyche, and social reality: 'Meaning and interpretive practices interact with social, psychological, and physiological processes to produce distinctive forms of illness and illness trajectories' (Good, 1994: 54-65). Similarly, Kleinman says how a 'symbolic pathway of words, feelings, values, expectations, beliefs and the like' connects 'affective and physiological processes and cultural events' (Kleinman, 1973: 209; cited in Good, 1977: 52). The meaning and expression of physical pain is patterned by this 'symbolic reality' so that physiological, psychological, and social processes interact to generate a 'complaint'. As Kleinman puts it: 'We learn how to identify and react to pain, how to label and communicate dysfunction [...] Illness idioms crystallize out of a dialectic between bodily processes and cultural categories, between experience and meaning' (1988: 13-14).

Cultural and symbolic processes strongly influence how psychiatric illness is expressed and the social and therapeutic response taken to it. According to Littlewood, psychiatric illness occurs within the context of 'a web of economic constraints, social relations and beliefs' whose impact is 'mediated' by symbols (1998: 1). Good *et al* characterise depression as 'a disorder of the interpretive process, a disorder of 'perception and interpretation' and not just 'a result of culturally influenced interpretations of an underlying disease' (1985: 381). They point out that cultural representations and interpretations 'provide the means for responding to and interpreting 'reality'' (1985: 382). Cultural or symbolic processes determine which events or stimuli count as 'stressors'. In a North American cultural context, depression has been characterised as a tendency to experience automatic, unintended, and negative thoughts about the self, world, and future (Beck, 1976, 1987). 'Dysfunctional' cognitive schemas or beliefs that shape how events and circumstances are interpreted generate such depressive thinking. The interaction of such a cognitive 'diathesis' and environmental 'stressors' is believed to cause 'non-endogenous unipolar depression' (Kovacs and Beck, 1978). Moreover, the power of events or circumstances to trigger depression depends on their subjective significance or meaning and the personality of the sufferer (e.g. whether they are 'relationship' or 'autonomy-oriented') (Beck, 1983). The emotions engendered by how the

environment is interpreted are partly constituted in a symbolic process of labelling, perception, categorization, explanation, and interpretation. In this way, again, symbolic processes are internal to the social aetiology of depression. Furthermore, as Rack pointed out, how sufferers interpret their experience of depression 'alters the quality of the experience itself' (1982: 106).

The meaning and interpretation of illness symptoms are based on shared cultural understandings (Kleinman, 1980; Kleinman and Kleinman, 1985). Society provides its members with a set of cultural symbols through which suffering can be articulated. Littlewood describes how 'public symbols' mediate the relationship between the public domain and individual embodied experience. The verbalisation of feelings 'draws upon certain stock expressions which are familiar to our audience' (1998: 239). Such symbols are used to express personal distress and partly constitute the form that it takes (1998: 219).

Interpretive and critical medical anthropologists have identified at least six ways that cultural and symbolic processes constitute experiences of personal distress:<sup>19</sup>

- (a) Experiences of personal distress are categorised and typologised in local ethnomedical or ethnopsychiatric discourses.
- (b) The public expression or communication of personal distress depends on the cultural availability of idioms of distress and embodied metaphors.
- (c) Personal distress is represented, explained, and interpreted in 'explanatory models' or 'illness narratives'.
- (d) The experience, expression, and meaning of personal distress are contingent on cultural discourses on the self and the body, and on an ethnopsychology of emotion.
- (e) Cultural processes constitute the phenomenological experience of suffering and distress and how it becomes embodied.
- (f) Cultural and symbolic processes influence the social and therapeutic response to distress, and how suffering is interpreted, evaluated, and responded to (e.g. Kirmayer, 1989; Csordas and Kleinman, 1996).

One way that culture influences illness experience is through 'the cultural construction of illness categories' (Kleinman, 1980: 78). By analogy, many societies have their own 'ethnopsychiatry' or folk model of psychiatric illness, their own distinctive ways of categorising, classifying, and describing abnormal and deviant behaviour, bodily or social experience in accordance with local moral concerns (Gaines, 1992a, 1992b; Kleinman, 1990). In a bid to circumvent cultural relativism while taking into account the cultural contingency of psychiatric illnesses, Fabrega sought to re-conceptualise them as 'human behavioural breakdowns'. Such breakdowns represent 'culturally distinctive psychopathological structures' defined in relation to local cultural norms of experience and behaviour. They represent 'impairments in emotional well-being' or 'irregularities in social



identity and conduct' that tend to 'render work and relationships unproductive' and 'disrupt the social life of persons and their immediate co-members' (1992: 92-93).

As Littlewood (1990) has argued, illness categories and representations are not 'pure cognitions'. Their use is often figurative rather than literal and they are embedded in local social practices in which they are rhetorically deployed by speakers to achieve diverse social ends. Like ethnomedical categories, ethnopsychiatric terms only make sense as part of a wider 'field of signs' (Good, 1994). For instance, among Iranians, 'heart distress' represents an ethnopsychiatric disease category that refers to 'a complex of physical sensations associated with particular feelings of anxiety' (Good, 1977: 33). Good points out that such 'dis-ease' is experienced on a continuum from 'mild excitation' to 'chronic sensations of heart irregularities'. The image of 'heart distress' is a 'particular configuration of stress' that draws together stresses, feelings, values, symbols, and social relationships. Its meaning partly resides in its rhetorical use in social situations as a way of communicating distress and obtaining treatment and relief (1977: 49).

In western ethnopsychiatric discourse, depression as symptom (e.g. dysphoric affect) can be distinguished from depression as mental disorder or psychiatric syndrome (Kleinman and Good, 1985). The latter can be distinguished from the employment of the term 'depression' in lay discourse on distress in which it is commonly used to signify a mood or emotion (Littlewood, 1990). It is possible that the somatic symptoms associated with depressive illness are universal. Nonetheless, these symptoms are interpreted and responded to in very different ways in different societies (Kleinman and Kleinman, 1985; Kirmayer and Young, 1998). Fabrega, for instance, says how members of small-scale societies 'select out, label, and amplify depressive reactions for social purposes' (Fabrega, 1974; quoted in Littlewood, 1998: 114). In non-western societies, the etic category of 'depression' is rarely used as an ethnomedical illness category. Nor is it used as a label for a particular kind of emotion (Littlewood, 1998; Singer, 1975). Jenkins has argued that the relationship culture and distress can be understood within the context of a society's full range of emotional experience. 'Cultural styles of dysphoria', for example, can be usefully interpreted as elements of an 'ethnopsychological model of emotion' rather than as different versions of a western illness category of depression (1996: 84). In Trinidad, for instance, the term *tabanka* refers to a form of emotional distress experienced by men in response to desertion or loss of a spouse (Littlewood, 1988, 1998). However, it is not regarded as an illness even though its 'vegetative symptoms' are similar to those of depression (Littlewood, 1998: 122). Obeyesekere (1985) has argued that the view of depressive affect (dysphoria) as a symptom of a psychiatric illness is not shared by Buddhists in Sri Lanka. In Buddhism, he says, suffering, sorrow, and pain are accepted as a part of what it is to live 'in the world' and, in Sri Lanka, such suffering is expressed in meditation and the religious practice of *sil*. Obeyesekere argues that Buddhist discourse on suffering, loss, and hopelessness can only be understood in relation to its wider context in Buddhist religious practices. Depressive affect is interpreted in existential terms rather than as a symptom of

illness. In an anthropological study of emotions among the Kuali of Papua New Guinea, Schieffelin (1985) reports that 'depression' (as an emotion) is not recognised and there is no label for it. He shows how the social and cultural context within which emotional distress (e.g. anger, grief) takes place among the Kuali shapes its expression. Distress is experienced and articulated as part of an 'expressive order of emotion' so that what are interpreted as symptoms of 'depression' in western societies have a different meaning among the Kuali. The social and cultural order, he says, is implicated in 'the way people experience emotions, and in the symptomatology and structure of the types of depression they experience' (Schieffelin, 1985: 127).

## **2.2 Idioms of distress**

Medical anthropologists have developed the concept of an idiom of distress to describe culture-specific ways of symbolising and expressing distress (Nichter, 1981; Parsons and Wakeley, 1991; Kirmayer and Young, 1998). For instance, in the context of an ethnographic study of psychosocial conflict among Havik Brahmin women, Nichter (1981) argued that ethnopsychiatric phenomena could be usefully conceptualised as idioms of distress. Such idioms refer to the 'modes' available in a particular socio-cultural setting for the expression and communication of distress. The meaning of such idioms derives from the context of their use, the social consequences of their employment, and their 'communicative force', and the social and cultural availability of alternative means of articulating distress (1981: 382, 402). Good (1994) points out that the meaning of such idioms partly derives from their context within shared semantic networks or 'meaning complexes'. Kleinman (1986) has shown how such cultural modes of expression provide the means for articulating personal distress in socially sanctioned ways. Within medical anthropology and cross-cultural psychiatry, discussion about idioms of distress has been organised around a distinction between somatic and psychological idioms of distress.<sup>20</sup>

### **Somatisation**

Medical anthropologists, sociologists, and medical researchers have found that somatic idioms of distress are common across non-western and western settings as a way of articulating distress and social adversity. Such an idiom is commonly used to articulate distress that has its roots in interpersonal, social, and economic difficulties (Raguram *et al*, 2001). Much of the discussion about somatic idioms of distress has constellated around the polysemous concept of 'somatisation'. 'Somatisation' refers to a pattern of illness behaviour in which personal or social distress is expressed in 'an idiom of bodily complaints and medical help seeking' (Kleinman and Kleinman, 1985: 430). According to a review of the literature on 'somatisation' by Kirmayer and Young (1998), the current evidence suggests that 'somatisation' is 'ubiquitous' and is probably the most common means of articulating distress and adversity in both western and non-western settings. They argue that the high prevalence of 'somatisation' across societies challenges the view that it is a separate form of psychopathology (i.e. 'somatoform disorders'). Nonetheless, there remain some marked differences across different sociocultural groups in the extent to which they employ a somatic idiom of distress to articulate distress, as well as the kinds of somatic idiom that are used.



The form that such idioms take, how they are used, and in what circumstances, are grounded in the local socio-cultural contexts of their production. They can be used figuratively and strategically to communicate a range of meanings: somatic, social, moral, and emotional (Kirmayer and Young, 1998). For example, Good (1994) showed how Iranians make use of an idiom of 'heart distress' to communicate their personal difficulties and concerns.

Among Asian populations, distress is commonly expressed in a somatic idiom, rather than a psychological discourse on mood or emotion.<sup>21</sup> Krause (1989) found that Punjabi patients living in England drew on a somatic metaphor of the 'sinking heart' to express personal and social distress. Nichter found that multiple cultural idioms were available to Havik Brahmin women for expressing their distress and experiences of social affliction. These included, for instance, a 'food idiom'; a somatic idiom of 'dizziness' and 'weakness'; a socio-moral idiom of purity and devotion; and a magical idiom of 'evil eye' and spirit possession (1981: 382). Nichter found that public expressions of emotion within the family were discouraged and social mobility and autonomy outside of the family tightly restricted. There were few opportunities to express distress in a public setting (1981: 398). Nichter interpreted somatic idioms of distress as forms of 'somatization', as somatic symptoms of distress produced in response to social conflict, powerlessness, and feelings of vulnerability. He argued that such somatic idioms of distress articulated core values and norms within the Havik Brahmin community. For instance, metaphors of 'loss of balance' or 'overheat' were used to signify an infringement of the communal expectation that emotions be kept under control. In the recent EMPIRIC study in the UK, Nazroo and O'Connor (2002) explored the idioms used to express mental distress across different ethnic groups.<sup>22</sup> In comparison with other ethnic groups, they found that South Asian respondents were less likely to use a vocabulary of self-esteem, guilt, shame, or loss of confidence. A somatic idiom of 'pressure' was commonly used to describe their experiences of distress. For example, migrants from South Asia reported 'pressure in the head' or 'rising blood pressure' and described a range of other physical symptoms to communicate social affliction.

While medical anthropologists have interpreted somatic expressive modes as idioms of distress, cross-cultural psychiatrists and biomedically-oriented researchers have interpreted somatic expressions of distress as symptoms of mental disorder (Kirmayer and Young, 1998). The focus here has been on 'somatisation' as a form of psychopathology.<sup>23</sup> For instance, in a review of the cross-cultural psychiatric literature on depression, Marsella *et al* (1980) concluded that depressive disorder in non-western societies is typically presented somatically. Psychological and mood idioms (e.g. guilt, self-deprecation, dysphoria) were reported to be rare. In a comparative study that explored the experience of distress among British and Indian patients, Jadav *et al* (2001) found that Indian patients spontaneously described distress using a somatic discourse. They surmised that these findings 'are consistent with widely accepted views of 'somatisation' outside of Euro-American cultures' (2001: 60), challenging the view of depression as a psychological entity

indicated by mood symptoms. Nonetheless, many patients also expressed their distress in psychological terms. This, they argued, challenges the distinction in DSM-IV and ICD-10 between somatoform and depressive disorders. In recent comparative psychiatric research in Zimbabwe, Patel *et al* (2001) found that no concept of depression or anxiety exists in Shona culture. Distress is expressed in a somatic idiom of headache and fatigue, rather than in a psychological idiom of emotion and mood. Nonetheless, Patel *et al* believed that such somatic idioms masked underlying psychological distress (e.g. 'depression') among Shona people:

On inquiry, however, most patients freely admit to cognitive and emotional symptoms. Many somatic symptoms, especially those related to the heart and the head, are cultural metaphors for fear or grief. Most depressed individuals attribute their symptoms to 'thinking too much', to a supernatural cause, and to social stressors.

Patel *et al*, 2001: 483

Kleinman found that the ethnomedical category of 'neurasthenia' was commonly used by Chinese psychiatrists to diagnose patients who presented with headaches, insomnia, dizziness, and chronic pain. Chinese sufferers construed their distress as chronic or persistent pain and presented their problems in a somatic idiom. Chinese clinicians viewed their patients' illnesses as having a biological aetiology. 'Somatisation', then, was co-constructed by patient and doctor in a way that sanctioned "the patient's bodily idiom of distress" (Kleinman and Kleinman, 1985: 439). Kleinman (1986) reported that, among a sample of Chinese neurasthenic patients, the majority met criteria for diagnosis of 'major depressive disorder'. Only a small minority complained of depression. He believed that dysphoric emotion was 'suppressed' among these neurasthenic patients. Moreover, these patients rejected the label 'depression' when it was applied to them. Kleinman (1986) also investigated chronic pain (e.g. headaches and insomnia) in a Chinese primary-care setting, but among patients without a medical diagnosis. A significant minority of these patients did not meet criteria for psychiatric disorder (using western diagnostic schemes). Nonetheless, chronic pain was commonly linked to social difficulties and Kleinman interpreted it as a form of 'somatisation'.

Are depressive disorders presented in a somatic idiom of distress the same as depressive disorders articulated in a psychological idiom? Kleinman and Kleinman maintained that 'neurasthenia' and 'depression' represent 'distinctive cultural construals of the same psychobiological state', and that these 'labels are not creating out of nothing the difficult social reality patients face, though they are organizing that exigent reality in different (sometimes greatly different) ways' (1985: 438). The somatisation and psychologisation of depression refer to different illness experiences. Nonetheless, according to Kleinman, both are articulated upon a universal 'psychobiological and social' foundation of human experience.

While personal distress and the response to adversity are principally articulated in a somatic idiom in non-western societies, the somatization of affective and anxiety disorders is also common among



the majority populations of developed English-speaking societies (Kirmayer and Young, 1998). Rack, for instance, observed that the 'somatisation of emotional distress applies to depression (whether endogenous or reactive) and to anxiety. It is by no means unknown among the indigenous British, especially the less articulate and the elderly' (1982: 101-2). A somatic idiom of distress is commonly used by North Americans and Europeans to express emotional distress (Kleinman and Kleinman, 1985; Kirmayer and Young, 1998). For example, in the EMPIRIC study, a somatic idiom of distress was common among all ethnic groups (including white Britons) (Nazroo and O'Connor, 2002). Across ethnic groups, respondents complained of difficulties sleeping, feeling tired, loss of interest or poor concentration, loss of motivation, headache, backache, and a loss of appetite. The *World Health Organisation Cross-National Study of Mental Disorders in Primary Care* showed that personal distress is clinically presented somatically in primary-settings across the world (Ustun & Sartorius, 1995). In secondary analysis of data from the *World Health Organisation* study, Simon *et al* (1999) found that somatic symptoms were associated with anxiety and depression in many of the 14 countries included in the *World Health Organisation* study with half of the patients diagnosed with depression reporting 'multiple unexplained somatic symptoms' and around one in ten denying that they had psychological symptoms of depression. They also report significant cultural variation across study sites in the frequency with which somatic symptoms were associated with depression. There were no differences, however, between western and non-western sites in the degree to which distress was reported exclusively with somatic symptoms.

Kirmayer and Young (1998) point out that patterns of somatisation of emotional distress across societies may reflect familiarity with and the degree of access to (western) healthcare provision. Contact with clinicians trained in biomedicine may work to amplify somatic idioms even where other idioms ('sociomoral' or other) are used in everyday life. Stigma may also explain why some patients articulate their distress somatically, rather than in other ways. Raguram *et al* (1996) found that among a sample of Indian patients suffering from depression, even though they experienced a high degree of psychological distress, most focused on their somatic symptoms. The latter carried a lower degree of stigma, while depressive symptoms were perceived as 'private and dangerous' and 'socially disadvantageous' and so attracted a higher degree of stigma. This partly explained patients' tendency to present their distress somatically.

Kirmayer (1988) has argued that emotional or social distress articulated in a somatic idiom challenges the rational order of biomedicine. It conflicts with a dominant Euro-American ethnopsychology that constructs emotion as deep psychological experience, as 'interpersonal or intrapsychic conflict' (1988: 329). Biomedical discourse is organised around a set of metaphysical dualisms that make it difficult to rationalise such phenomena. As Kirmayer puts it: 'Psychosomatic medicine, despite its aspirations toward wholeness, reproduces the same Cartesian split. Attributing symptoms to psychological causes attaches blame to patients or diminishes trust in their rationality'

(1988: 83). Even where a patient conforms to the norms of illness behaviour, Kirmayer points out that 'if medicine cannot explain or alleviate the illness, the patient may be blamed for its failure. These manoeuvres act to maintain the rationality and coherence of the biomedical world view even while they disqualify the patient's suffering or moral agency' (1988: 58). 'Somatisation' represents an expert interpretation of lay discourse on distress where affliction is articulated in the language of the body, in feeling and sensation. This interpretation implies that depression is really a psychological or social phenomenon, rather than principally a biological one.

### **Psychologisation**

Kirmayer defines psychological idioms of distress as 'modes of expression that explicitly refer to indigenous theories of mind, self and emotion' (1989: 330). Psychologisation is 'the obverse of somatization: patients with physical or social origins of distress focus on the emotional aspects of experience and attribute their symptoms to intrapsychic conflict' (Kirmayer, 1989: 330). Such idioms are more common among the majority populations of developed English-speaking societies and are grounded in a Euro-American ethnopsychology articulated in a cultural discourse on emotion and mood. For instance, Nazroo and O'Connor (2002) found that only White and Black Caribbean respondents spoke of 'mood swings' in their descriptions of personal distress. These informants also deployed a metaphorical discourse on 'stress', 'anxiety levels', and 'pressure' to describe the emotional impact of adversity. Idioms of 'nervousness', 'fear', and 'panic attacks' were also common among White respondents and they deployed an array of other metaphors to articulate their distress (e.g. 'feeling lost'). Nonetheless, Nazroo and O'Connor (2002) found that all ethnic groups used both psychological and somatic idioms of distress; across all groups, a vocabulary of 'stress', 'worry', 'hopelessness', 'depression', and 'anxiety' were used to describe mental distress. Discourse expressing low self-esteem (e.g. 'feeling worthless') or a loss of confidence was also common across all groups. All ethnic groups spoke about depression, anxiety and stress as short-lived or 'periodic' affective states, rather than as prolonged experiences. Many respondents differentiated between ordinary distress (e.g. 'worries', 'anxiety') and more severe experiences of distress. Metaphors of 'feeling down' or 'feeling low' were common.

Another example comes from an Australian study that compared idioms of distress employed among two small samples, one drawn from the general population and the other drawn from among a sample of individuals seeking professional counselling support (Parsons and Wakeley, 1991). Although both groups reported physical symptoms, such symptoms did not figure centrally in their accounts. Moreover, most informants did not connect their somatic experiences with their experiences of personal distress. Nonetheless, informants experiencing more severe distress were more likely to describe it using a somatic idiom. In some cases though, even where a high degree of physical suffering was present, distress was still described and explained in 'psycho-emotional' terms. Parsons and Wakeley partly explained this in terms of an 'Australian Anglo-Celtic' cultural discourse on the self that includes 'the pervasive belief that distress is a psychoemotional phenomena somehow bereft of physiological manifestations' (1991: 127). This is combined with a



moral expectation that emotions be constrained or expressed in a 'rational/pseudo-rational manner' lest one appears 'weak'. Parsons and Wakeley suggested that the dualism that underlies lay discourse on distress maps onto biomedical and therapeutic responses where distress is conceived psychologically and illness is constructed as a somatic experience. In the Australian context, distress therefore becomes somatised partly as a consequence of the clinical encounter where 'patient and doctor collude in the presentation of disorder in bodily narrative' (1991: 127).

Among the majority populations of developed English-speaking societies, emotional, and social distress is commonly expressed in a psychological idiom of mood and emotion (Jenkins, 1996; Kleinman, 1986, 1988; Marsella *et al*, 1980). Jadhav *et al* (2001) explored discourse on depression among White Britons. Informants included a mixture of in-patients and outpatients. They were questioned about patterns of distress, perceived causes, help seeking, and their beliefs on 'mind-body-soul' (2001: 54). The majority of patients mentioned 'sadness' spontaneously (i.e. without further probing). Around two-fifths of their informants reported 'anxiety'. Only one in ten spontaneously described their distress in terms of 'somatic symptoms' (2001: 56). On further probing, however, most White British patients mentioned somatic symptoms. Moreover, in their narratives of distress, emotional and somatic descriptions of distress were closely juxtaposed. Jadhav *et al* argued that such accounts challenge the etic distinction between somatic and psychological symptoms. They concluded that: 'An emic analysis of narrative accounts of illness shows the complexity of patterns of distress and how the components overlap and interrelate' (2001: 61). Nonetheless, in a society where psychological modes of emotional expression are socially encouraged and 'amplified' in clinical encounters, it is more likely that depression will be expressed in such a form.

There is some evidence that idioms of distress vary within the majority populations of developed English-speaking societies such as Britain. The psychologisation of distress is believed to be particularly common among the educated and middle-class members of such societies (Kleinman, 1986; Jadhav *et al*, 2001). Kleinman says, for instance, that in contemporary western societies, affect is "culturally shaped as 'deep' psychological experience and rationalised into discretely labelled emotions (depression, anxiety, anger) that were previously categorized and felt primarily as bodily experiences" (Kleinman, 1986: 56). This understanding of emotion is rooted in a dominant Euro-American ethnopsychology and a psychologised cultural discourse on the self. Conversely, the use of a somatic idiom of distress has been associated with lower socio-economic status and poor levels of education (Kleinman, 1986).<sup>24</sup>

A clear message emerges from this body of research: somatisation and psychogisation are not mutually exclusive. For example, the populations of developed English-speaking societies employ both a somatic and a psychological idiom to express their experiences of distress. Nonetheless, there is significant variation in the type, frequency, and use of idioms of distress across

sociocultural groups (Kirmayer and Young, 1998). A psychological idiom of distress, for instance, is rarely deployed among the majority populations of non-western societies. While western and non-western societies have the body in common, an individualised psyche is constituted within a western cultural discourse on the self. This, in turn, influences how distress is expressed, communicated, and interpreted in societies such as Britain. If the accumulated evidence on somatisation and psychologisation point to anything, it is to the cultural and historical contingency of western expert discourses on the self, body, and distress. Where a sociocentric cultural discourse on the self predominates and where the expression of personal distress and social adversity are discouraged or attract a social stigma, a somatic idiom of distress may be the only socially sanctioned pathway left open for the expression of social suffering. Conversely, a psychological idiom of distress may be more likely among sociocultural groups and in speech situations where the physical expression of emotional or social distress is de-emphasised and devalued.

### **Embodied metaphors of distress**

There has been a recent methodological and theoretical shift in medical anthropology from a concern with symbolism, meaning, and interpretation to an interest in phenomenology and how selves are embodied in different socio-cultural settings (Lock, 1993; Monks, 1996; Csordas, 1990, 1994). The shift to a cultural phenomenology of illness and suffering signals a shift of emphasis in medical anthropology from cognitive or interpretive processes to symbolically mediated embodied experience. Lock and Scheper-Hughes, for instance, argue for an anthropological conception of the body that pays more attention to the existential, lived experience of the subject; what they describe as the ‘the phenomenological sense of the lived experience of the body self’ (1996: 45). On this view, the task for medical anthropology is to explore ‘the relationship of cultural beliefs and practices in connection with health and illness to the sentient human body’ (Lock and Scheper-Hughes, 1996: 44). This shift of emphasis away from symbolic processes to embodiment has involved a cultural deconstruction of the mind/body and psychological/somatic dualisms that organise both biomedical and medical-anthropological knowledge about illness and distress. Moreover, the distinction between psychological and somatic idioms of distress is grounded in this dualism. Lock and Scheper-Hughes rightly argue that “if mind and body are truly one, as even the most conventional medical anthropologists assert, then *all* diseases and bodily distress, without exception, are and must be psychosomatic because all are ‘somatized’ as well as ‘mentalized’” (1996: 65). The goal for research is therefore to uncover the relationships between illness experiences, idioms of distress, moments of refusal, resistance, and the broader political and social order. Within this methodological paradigm, somatisation is re-interpreted as ‘a dominant metaphor expressing [both] individual and social complaint’ (Lock and Scheper-Hughes, 1996: 65).

The discourse on somatisation described above remains caught within the biomedical antinomies described by Kirmayer (1988). For instance, Scheper-Hughes points out that anthropologists have tended to interpret *nervoso* (‘nerves’) as somatisation of emotional distress originating in social or economic adversity. Within the somatisation model, she says, ‘illnesses are understood as the



subjective, transparently psychological manifestation of real, identified physical diseases, else they are nothing at all' (1993: 65). Scheper-Hughes interpreted *nervoso* among the residents of a Brazilian shantytown as a 'polysemic folk concept', an 'expansive diagnostic category of distress', a generative metaphor for expressing both social and physical distress, and as a 'folk conceptual scheme for describing relations among mind, body and social body' (1993: 173-186). The cane cutters of the Brazilian shantytown expressed hunger, poverty, anxiety, and other afflictions in an embodied metaphor of *nervoso*. This took the form of trembling, fainting, seizures, and paralysis. *Nervoso*, she argued, represented a 'metaphor and metonym for the socio-political system and for the weak position of the rural worker' (1993: 186).

One way of interpreting somatic idioms of distress is to view them as discursive acts (e.g. 'acts of positioning') and as embodied metaphors of experience (Kirmayer and Young, 1998). On this view, idioms of distress are not necessarily literal 'presentations' of experience. Rather, they are discursive constructions that employ rhetoric and trope and only have meaning in relation to the sociocultural contexts of their production. Low, for instance, advocates a shift of emphasis from an interpretive-hermeneutic focus on idioms of distress, vocabularies, and symptoms, to lived experience as embodied metaphor. A defining property of such metaphors is that they articulate bodily sensations, while simultaneously conveying social and political meaning. As embodied symbolic processes, they work back onto the body to partly constitute the bodily sensations and feelings out of which they originate. Medicalisation, for instance, refers to an ideological, symbolic process through which medical metaphors are imposed on embodied experience, partly constituting such experience in a way that conforms with biomedical knowledge and practice (Low, 1994; Kirmayer, 1988). For instance, an embodied metaphor of nerves is common among some Central and Latin American populations as a 'way in which distress is embodied' (1994: 142). Figurative language and 'graphic and vivid bodily terms' are used to express nervous physical and emotional sensations including: fear, trembling, crying, headaches, upset stomach, insomnia, loss of appetite, dizziness, and a pounding heart (1994: 142-6). According to Low, the phenomenon of 'nerves' (*nervios*) also articulates social and political adversity and is used to express 'the lived experience of daily life as a metaphor of social, psychological, political or economic distress' (1994: 142). Among urban Costa Ricans, for instance, Low interprets *nervios* as an 'embodied metaphor of the self and the self's relation to the social system [...] It embodies the breakdown of the individual's relations in the social system' (1994: 159). *Nervios* ('nerves') embodies the broken family ties and fractured social relations that form the basis of identity and selfhood and is simultaneously emotional, social, and embodied. It is metaphorically employed to symbolise 'the disintegration and breakdown of the self/society contract in explicitly bodily terms' (1994: 157).

The ideational or referential meaning of discourse on distress is only one dimension of its meaning. Discourse on distress is constituted by its context in a wider conversation. It takes its meaning from its location in a cultural discourse on the self and body organised around an array of tropes and

idioms, ontological, and explanatory systems, a stock of stories, and an assortment of symbols. While discourse on distress is partly grounded in the phenomenology of the body, it is also grounded in a cultural discourse on the self and society and in social institutions, practices, and structures. Moreover, while metaphors may be embodied, they are also discursive acts deployed by speakers to accomplish a range of social ends; they have social force.

## **2.3 The self in distress**

### **The self as an embodied symbolic process**

Medical anthropologists and cultural psychiatrists have applied the concept of 'the self' in their interpretations of illness and suffering across cultures as well as in western societies (Gaines, 1992b; Kirmayer, 1989). Some anthropologists have suggested that 'the self' is universal (Cohen, 1992, 1994; Lock and Scheper-Hughes, 1996). Cohen, for instance, has argued that the concept of 'the self' should play an axiomatic role in anthropological analysis and that such analysis is somehow contingent on such a concept. On this view, the self is essentially characterised by self-consciousness, autonomy, and creativity. Similarly, Lock and Scheper-Hughes define 'the self' in terms of its capacity for self-consciousness, its separateness, and independence. They also emphasise the embodied nature of 'the self'. This is captured in the concept of the 'body-self' described above (1996: 52). However, an entity metaphor underlies this concept, so that 'the self' collapses into the body. Instead of reifying the self as a thing in this way, it is more useful to view the self as partly constituted out of its own self-interpretations (e.g. Taylor, 1985). 'The self' might be usefully conceived as an embodied, symbolic process, an ongoing social accomplishment, rather than as a thing or entity. As Bruner puts it, selves are 'always in production' (1986a: 12). If selves are universal at all, then it is only because embodiment, symbolic processes, and the social relations through which bodies are constituted as selves are also universal. Such a concept of 'the self' provides a heuristic interpretive tool that facilitates social-scientific understanding of experience and action.

As an interpretive process, the self mediates the relationship between society and somatic experience and is constituted through engagement in discursive and symbolic practices in social relations with other selves. For instance, social psychologists Potter and Wetherell maintain that 'the very possibility of a self concept, is inextricably dependent on the linguistic practices used in everyday life to make sense of our own and others' actions' (1987: 95). In what Berger and Luckmann describe as 'primary socialisation', self-formation occurs through an ongoing 'societal dialectic' between the emerging self and others. This dialectic facilitates the internalisation of collective meanings (1971: 149). Rapport says, for instance, that individuals 'routinely dip' into 'a fund of clichés' and 'consume cultural artefacts [...] in order to create and develop themselves' (1992: 203). Cultural or symbolic processes do not so much 'mediate' the relationship between body and self. This is because they are part of the same process. Rather, symbolic and cultural practices bridge the gap between body and society through the configuration of agency. They work



through social relations to socialise the body, so that the self is the process through which the body is made social.

Even if the self is a universal feature of every society, how selves are constituted and conceptualised is not universal. For instance, individuals come to define themselves in relation to the dominant cultural model of the self in the society to which they belong (Rosaldo, 1984; Heelas, 1981). Heelas, for instance, defines an ‘indigenous psychology’ as ‘the cultural views, theories, conjectures, classifications, assumptions and metaphors – together with notions embedded in social institutions – which bear on psychological topics. These psychologies are statements about the nature of the person and his relations with the world’ (1981: 3). Along similar lines, Jenkins defined an ‘ethnopsychology’ as an ‘indigenous emotional categories, notions of the self and body, the relations between emotions and the contexts in which they occur; and the kinds of accounts that are given for emotional experiences’ (1996: 74).

Indigenous psychologies provide guidance on how to live and a framework for interpreting social action and for communicating experience. For instance, Shweder and Bourne say that a society’s self-conceptions are the ‘ideas, premises by which people guide their lives, and only to the extent a person lives by them do they have force’ (1982: 193). Heelas says that indigenous psychologies ‘enable participants to make sense of what they are about, how they should judge others, how they can live up to their roles, how deviants should be handled, how, in general, the individual should operate in society’ (1981: 15). As a prototypical cultural process, language is the principal medium in this hermeneutic process. Indigenous psychologies or ethnopsychologies are articulated in cultural or public discourses on the self, body, and society. Selves reflexively interpret and partly constitute themselves out of such discourses (Appendix A3.4 includes a discussion on the constitutive power of discourse in relation to experience, selfhood, and social relations).

### **Ethnopsychology of distress**

Indigenous notions of the person, body, and society partly constitute the experience, expression, and meaning of personal distress and psychiatric illness (Marsella *et al*, 1985; Littlewood, 1990; Fabrega, 1992). Indigenous psychologies or ethnopsychologies mediate the relationship between social relations and phenomenological experience. The provision of a cultural discourse on the self is therefore a central way that culture shapes the experience and expression of emotional distress. Differences in how emotions are identified, interpreted, experienced, and expressed are grounded in different conceptions of the self and body (Jenkins, 1996; Rosaldo, 1984). Heelas, for instance, emphasises how cultural meanings partly constitute emotion experiences. How events are interpreted determines their emotional impact:

How we respond [to events] depends on how we use our knowledge of our emotional life, interpreting an episode as shaming, for example, because it accords with our understanding of the episode as being bound up with what we take shame to mean [...] Meanings are necessary for the construction of emotions.

Heelas, 1981: 235

Cultural understandings of body and self organise the interpretation and social response to illness experience (Good, 1994; Lock and Scheper-Hughes, 1996). Gordon has shown, for instance, how a cultural discourse on illness among the Fulani is informed by their cultural identity. Their thinking on illness is fashioned by 'who the Fulani think they are' (2000: 297). Similarly, ethnopsychiatry, embodied metaphors, and idioms of distress are embedded in wider cultural discourses about the self, body, and society.<sup>25</sup> According to Fabrega, for instance, 'human behavioural breakdowns' (HBBs) are breakdowns in what it is to be a person in relation to a particular cultural context and this is expressed in terms of the locally dominant discourse on the self and society. Fabrega, for instance, has argued that cultural and symbolic processes shape 'the experience and organisation of the self and social behaviour, and by extension, HBB and HBB illness' (1992: 100). On this view, 'psychiatric illnesses' are 'disturbances of the self', deviations from what are collectively understood as normal behaviour or experience. These standards of normality are rooted in cultural understandings of what it is to be a person as articulated<sup>26</sup> in a cultural discourse on the self. Similarly, Marsella has argued that definitions of disorder depend on cultural understandings of the self and that 'the concept of the self offers a mediating link for relating cultural variables to mental disorder' (1985: 297).

Cultural beliefs about body, self, and emotion mediate the relationship between culture and distress, and pattern social and therapeutic response. As Kirmayer says, for instance, 'the same ethnopsychological theories of mind, self and emotion that shape the expression of distress influence the social response to both psychiatric disorders and everyday forms of distress' (1989: 328). Raguram *et al* (2001) have shown how the meaning of somatic symptoms of distress among Indian patients attending a psychiatric outpatient clinic in Bangalore depend upon cultural beliefs and values relating to illness and the body, including cultural conceptions of the healthy body. Krause showed that, among the Punjabi population living in the UK, 'sinking heart' is linked to a model of the emotional self in which the 'the heart is identified with the most private and individual aspects of the self' (1989: 568). Heart symptoms express the distress experienced in circumstances where the individual feels a loss of social or emotional control. Good *et al* interpreted the cultural meaning and experience of depression, sadness, loss, and melancholy (or 'heart distress') among Iranians in terms of local understandings of the self, symbolized in the figure of the heart (1985: 385). Research carried out by Jenkins (1991, 1996) on distress and social suffering among Salvadoran refugees in the United States showed that how they experienced and articulated their affliction was contingent on a sociocentric and kinship-oriented Salvadoran indigenous psychology. She described how cultural meanings mediated the impact of terror and traumatic events on bodily experience: 'Distress is a particular stance toward the situation; a consequence of the construal of terror as terror' (1991: 154). The way that Salvadoran refugees expressed their suffering was shaped by a 'Salvadoran ethnopsychology of emotion', a 'collective ideology of affect' (1991: 149). They drew on a 'lexicon of emotions', including an idiom of 'nervios', 'sadness', 'sorrow', and a metaphor of life as tragedy, to express their distress. Jenkins



interpreted somatic symptoms such as insomnia, loss of appetite, and 'psychomotor agitation' as expressions of loss and mourning. *Nervios* was the principal idiom of distress used by the Salvadoran refugees and, according to Jenkins, it represented a mental, physical, and spiritual response to poverty and violence.

### **Agency and Euro-American discourse on distress**

A hegemonic Euro-American folk psychology is organised in line with other dualisms of Modernism. From one perspective, the self is conceived as a body-object, a passive centre of experience, constrained, and determined by (depending on theoretical predilection) social, biological, or psychological forces that are outside its control and beyond its conscious awareness. From another perspective, the self is idealised as an agent; as an autonomous, individualised centre of consciousness and originator of action who is in control of his or her own destiny. Kirmayer articulates this dualism when he distinguishes between two 'cultural templates, prototypes and meta-narratives of what it is to be a person and how the self should function' (2002: 726). He calls these the 'adamantine self' and the 'transactional self'. The former is characterised by its 'integrity, coherence, autonomy, self-definition, self-determination and self-control', the latter by 'its fluidity, responsiveness to context, heteronomy, multi-vocality, deference and yielding to or accommodating others' (Kirmayer, 2002: 726). These prototypes map directly onto stereotypical conceptions of masculinity ('adamantine') and femininity ('transactional') that define traditional gender roles in Euro-American societies. More generally, this dualism is rooted in relations of power; these different prototypical selves correspond with polarised social positions of subjugation and domination.

Kirmayer's 'adamantine self' closely resembles Taylor's notion of the 'disengaged self' and a view of human agency that emphasises independence, control, freedom, autonomy, and the rational pursuit of self-defined goals (Taylor, 1985). This modern, liberal view of agency is manifest in Berlin's concept of liberty as freedom from constraints or impediments, rather than freedom to (Berlin, 1969). Taylor distinguishes this dominant view of a disengaged human agency from a humanistic view that has its roots in European idealist thinking. On the latter view, selves are partly constituted hermeneutically out of their self-interpretations or self-understandings. Human beings are 'beings for whom things matter'; they come to understand themselves in a 'space defined by distinctions of worth' (Taylor 1985: 3).

Cultural psychologists and anthropologists have distinguished western from non-western models of the self and have emphasised the individualism of the former and the sociocentricity of the latter (Heelas, 1981; Shweder and Bourne, 1982). According to Sampson, the indigenous psychology of western societies is characterised by an ideology of 'self-contained individualism' in which the self is conceived as an autonomous, self-determining agent with an emphasis on personal control and with rigid self/non-self boundaries (1988: 19). Similarly, Marsella (1985) characterises the dominant western concept of the self as individuated, separate, detached, self-sufficient, and

autonomous. Shweder and Bourne have argued that the modern western view of the self is as an 'autonomous distinctive individual living-in-society [...] free to choose and mind his own business'. Western individualism implies an 'egocentric contractual' relationship with society, the institution of privacy, and a sense of 'personal inviolability' (1982: 191-4).

'The self' articulated in the ethnopsychologies of non-western societies has been characterised in terms of its sociability, 'social interdependency', and its 'diffuse' or 'un-individuated' nature (Marsella, 1985: 290). Sampson depicts such a prototypical (non-western) self as relationship-oriented, with fluid boundaries between self and other, and an external loci of control (1988: 16). Shweder and Bourne (1982) maintain that a socio-centric conception of 'the person' is more common in the 'holistic cultures' of non-western societies where there is a 'socio-centric organic' relationship between individual and society and high levels of interdependency.

Nonetheless, the contemporary discourse on the self in developed English-speaking societies is composed of a plurality of discourses. While subordinate to the disengaged, individualised view of human agency, a socio-centric view of the self has a long tradition in European thought and culture. The social sciences are, after all, historically contingent on such a discourse. Moreover, the possibility of forming statements about cultural or historical differences about the self (the kinds of statements that cultural psychologists make) is premised on the self's sociability. Such a discourse depends on a social, hermeneutic view of the self as partly constituted linguistically and symbolically. Indeed, Taylor's preferred hermeneutic view of agency itself is grounded in such a Euro-American cultural discourse on the self, albeit a historically subjugated one.

Rose has argued that the very notion of the self articulates a western concept of the person as an individualised psychological entity, as 'a naturally unique and discrete entity, the boundaries of the body enclosing, as if by definition, an inner life of the psyche, in which are inscribed the experiences of an individual biography' (1998: 22). This notion of the self implies an ethnopsychology in which emotions are constructed as distinct from thought or cognition and as reified psychological objects that occur somewhere deep in the privacy of the individual mind. This psychological or cognitive model of emotion contrasts with a view of emotions as fundamentally evaluative and as centrally located in social rather than psychological space. On this view, emotion talk provides speakers with a means of communicating core concerns and of making evaluations or judgements (Lutz, 1982, 1988).

As the discussion above on somatisation and psychologisation made clear, lay discourse on distress (including idioms of distress) in western cultural settings is contingent on a dominant western cultural discourse on the self, body, and emotion (e.g. Kleinman, 1986; Parsons and Wakeley, 1991). In North America, for instance, a psychological idiom of distress relies on a psychologised self-discourse that locates the origins of suffering in 'inner moods and conflicting desires of the



individual' (Kirmayer, 1989: 330). Jadhav has shown how English discourse on distress depends on a view of the self as an entity that generates emotions or thoughts 'from inside a metaphorical three-dimensional space enclosed within firm boundaries and containing a substance' (1996: 5). The 'emotional pathologies' or 'neurotic disorders' form part of an 'ethnopsychiatry' grounded in this local ethnopsychology. Similarly, Littlewood maintains that, given a western ideology of the self and society, 'the locus of psychopathology is thus within the individual body, in its constitution, personality and history, and this is then the appropriate focus for psychiatric intervention' (1990: 316). If cultural identity and selfhood are at least partly expressed and constituted in terms of a dominant Euro-American cultural discourse on the self, then so must experiences of personal distress. An individualised psychological discourse that prescribes rational self-control has implications for how distress becomes embodied, and how it is interpreted and responded to. For example, such a discourse is internal to the 'psychopathological process' associated with depression in that it influences how self and body are experienced and represented, and regulates the social response to dysphoria (Kirmayer, 1989).

Cultural processes constitute personal distress in developed English-speaking societies through a double hermeneutic. First, symbolic processes and cultural practices contribute to the generation of suffering through partly constituting the agency of the sufferer. Second, the dominant cultural discourse on the self and body determines the social response to 'deviant behaviour or mental illness', including personal distress. This is because this discourse defines standards of normal (socially acceptable) behaviour and experience. As Kirmayer says: 'Where a person is defined in terms of an autonomous rational agency, as in the West, stigma may be less a shared social problem and various forms of marginality, short of complete extrusion, can evolve' (1989: 334). A stigmatising or negative social response to distress works to magnify such suffering and influences how distress is expressed and communicated.

The experience, expression, and response to personal distress and psychiatric illness are contingent on cultural understandings about the self and agency. Psychiatric illnesses represent deviations from standards of normal behaviour and experience as defined in this dominant discourse (Fabrega, 1992). In Euro-American cultural contexts, the dominant way that personal distress is articulated and conceptualised is in psychological terms and as a disruption of human agency. The breakdown in agency and functioning that often accompanies personal distress provides the grounds for an illness metaphor. This breakdown often makes it necessary for sufferers to seek medical help and entry into the sick role.

Chapter 7 discusses how expert discourses on distress are constituted within this cultural discourse on the self and body. For example, expert discourse on depression has its genealogical origins in an English ethnopsychology of emotion. According to Jadhav (1996), the 'emotional pathologies' are grounded in four emotions: depression, elation, anxiety, and fear. These underlie British expert and

lay discourse on emotional distress centred on notions of guilt, energy, stress, and depression. “Depression”, says Jadhav, “is primarily a ‘disorder of mood’ that rests upon a pathology of key emotions considered to arise within the ‘mind’” (1996: 6). This ethnopsychology of emotional distress is bound to a ‘white British and Western European’ cultural and historical context and is ‘enshrined’ in western psychiatric diagnostic systems (i.e. as the ‘affective disorders’).

The first two chapters of this thesis have drawn on contemporary theory and research in medical anthropology and sociology in order to critically examine current understanding about the relationship between cultural processes, social structure, and distress in developed English-speaking societies. Macro social and economic factors generate the adverse relational settings that produce embodied distress. These relational settings commonly involve the disruption of social ties, social disconnection, loss of agency, powerlessness, and entrapment. While cultural processes and ideological practices partly constitute the individual experience of distress, they also mediate the relationship between local relational settings and individual bodies. One way in which they do so is through the provision of a cultural discourse on the self out of which individuals partly constitute themselves. The ideologically dominant discourse on the self in developed English-speaking societies is grounded in a view of human agency that emphasises autonomy, freedom from external constraint, disengagement, self-control, and independence. In such societies, personal distress and psychiatric illness involve a disruption of agency and therefore present a threat to this dominant ideological discourse on the self.



## Chapter 3

### Discourse, Narrativity, and Ethnography

The previous two chapters developed a critical theoretical understanding of the ways that cultural and discursive processes mediate the relationship between social setting, affliction, and distress. The next four chapters draw on two ethnographic case studies in order to explore these theoretical themes and questions in more depth. Fieldwork was conducted in two different English-speaking sociocultural settings: the English city of Bristol and the South Atlantic Island of St. Helena. This chapter presents an overview of the methodology, the research methods, and the interpretive strategies used in this empirical phase of the research.

The chapter has four sections. It begins with an account of the methodology employed in the research. This includes a description of the approach taken to interpretation. A discourse-based interpretive framework is described and an account is presented of how this interpretive framework evolved as the research proceeded. Close attention is paid to the discursive concept of narrative. This includes a discussion of some of the ways that medical anthropologists and sociologists have employed the concept of an 'illness narrative'. The second section summarises the social-research methods used in the fieldwork (e.g. an ethnographic and case-study based approach and extensive use of in-depth interviewing). The third and fourth sections present an account of the fieldwork in both settings.

#### 3.1 A discourse-based approach to interpretation

The theoretical discussion in Chapters 1 and 2 pointed to the relevance of both an interpretive-hermeneutic and a critical realist approach to social science (Bhaskar, 1989; Keat and Urry, 1975). Keat and Urry characterise a realist social science as the 'science of social life and social formations' (1975: 228). Its aim is to develop the theoretical 'description of structures and mechanisms which causally generate the observable phenomena, a description which enables us to explain them' (1975: 5). A longstanding theme in social theory has been the relationship between social structure and subjective experience. According to Keat and Urry, this constitutes the central problem for social theory:

At the level of substantive theory, the primary problem is how to develop theories that satisfactorily synthesize the structural analysis of social formations, and the explanation of human action in terms of subjective states and meanings.

Keat and Urry, 1975: 228

In *Truth and Method*, Gadamer (1989) presented a non-positivist perspective on social-scientific investigation grounded in hermeneutics, the interpretive procedure deployed in historical research.

The principal method of interpretive social science is *verstehen*, the hermeneutic understanding of cultural products, lived experience, and its expressions (Dilthey, 1986; Outhwaite, 1975). According to Dilthey (1986), the central aim of hermeneutics is to understand subjective experience through interpreting its 'life-expressions', e.g. stories, performances, symbols, and texts. In ethnographic research, the interpretation of these life expressions occurs at two levels (Bruner, 1986a: 10). First, individuals interpret their own experience using culturally available expressive forms. Second, the ethnographer sets out to interpret these expressions. Instead of drawing a sharp line between some objective reality and its symbolic representation or subjective experience, it is perhaps more useful to view both as part of the same encompassing reality. A realist perspective would require that subjective states and meanings be granted the same reality status as material social and economic structures. This attention to both meaning and personal experience, on the one hand, and social processes and structures, on the other, warrants a multi-disciplinary and an interpretive or hermeneutic approach to social research (Gadamer, 1988, 1989; Ricoeur, 1981a, 1991).

### **Explanatory models and illness narratives**

Medical anthropologists and sociologists grounded in the 'sociology of health and illness' tradition<sup>27</sup> have developed an interpretive repertoire<sup>28</sup> of discursive concepts to facilitate their interpretation of illness experience. These include, for instance: vocabulary and lexicon; idiom and metaphor; grammar and rhetoric; explanatory model; illness narrative.

The idea of an explanatory model, for instance, has been developed as a means of interpreting how patients make sense of illness experience and its consequences (Kleinman, 1980, 1988); these models depict the patients' understandings of cause, course, prognosis, onset, treatment, coping strategies, consequences, diagnosis (Garro, 1994; Kleinman, 1988).<sup>29</sup> The experience and meaning of illness and patients' help-seeking are partly constituted by these 'lay explanatory models' (Good, 1977; Kleinman, 1988: 49). However, this explanatory model interpretive framework has been criticised for being too narrowly tied to clinical settings, for being too 'medically orientated', and for focusing on illness, cause, process, and treatment to the 'exclusion of broader contextual meanings' (Garro, 1994: 776). This approach has also been criticized for overemphasising the degree of rationality present in lay discourse on illness and sickness. Writing at the beginning of the 1980s, Young criticized the explanatory-model approach in medical anthropology for reproducing an ideological view of the subject as a 'rational man', as a kind of lay scientist (1981). The construct of an explanatory model focuses attention on informants' statements of causality to the exclusion of other (often less coherent) features of their discourse. Young used Piaget's distinction between operational and pre-operational thinking to make his case against medical anthropology's 'rational men'.<sup>30</sup> Medical anthropologists, he argued, commonly assume that their informants think 'operationally'. Young pointed out, however, that the thought processes and theoretical knowledge of 'a large proportion of people living in industrialised societies' are characterised by a mixture of operational and pre-operational processes (1981: 329). He also



criticised the 'embedded theoretical knowledge' of medical anthropology: this knowledge consists, for example, of assumptions about the relationship between thought or belief and its linguistic representation. For instance, he claimed that medical anthropologists tend to reduce informants' discourse on illness or sickness to cognitive structures (e.g. explanatory models).

Medical anthropologists and sociologists have turned to the concept of narrative as a framework for interpreting talk about illness, distress, and suffering.<sup>31</sup> A narrative-based approach provides a means of exploring the relationship between illness or distress and the biographical or social contexts in which they take place. Narrative is a common discursive form used by patients to describe, account for, and interpret illness experience. Illness narratives describe what happened during an illness, the actions taken in response to it, and they provide an account for how illness has affected the speaker's life (Garro, 1994). Narratives are thought to bring coherence, form, and meaning to the experiences of illness and distress:

Narrative is a form in which experience is represented and recounted as having a meaningful and coherent order in which activities and events are described along with the experiences associated with them and the significance that lends them their sense for the persons involved.

Good, 1994: 139

For instance, according to Hyden, narrative provides a way to make sense of 'the illness disruption' by fitting it into 'a temporal framework' and by situating such experience into 'a context that encompasses both the illness event and surrounding life events and recreates a sense of interrelatedness' (1997: 53). In this way, illness narratives facilitate the reconstruction of biography in response to a disruptive illness event (e.g. Williams, 1984; Hyden, 1997). For instance, Bury says how narratives provide a means of making sense of the disruptive experience of chronic illness 'in terms of past social experience and to reaffirm the impression that life has a course and the self has a purpose or telos' (1984: 179). Similarly, Good emphasises how narratives 'reflect and rework' illness experience and how they are one of the 'primary reciprocal processes of both personal and social efforts to counter this dissolution and to reconstitute the world' (1994: 188). Williams (1984) has argued that explanatory models need to be re-conceptualised as narrative reconstructions and showed how those who suffer from chronic illnesses employ narrative as a means of making their life intelligible again, of reconstructing their biography in response to the disruption caused by the illness:

Narrative reconstruction is an attempt to reconstitute and repair ruptures between body, self, and world by linking-up and interpreting different aspects of biography in order to realign present and past and self with society. In this context, the identification of 'causes' creates important reference points in the interface between self and society.

Williams, 1984: 197-198

Some anthropologists and sociologists of health and illness have emphasised how narratives partly constitute illness experience and the response to illness. Since narratives inscribe 'cultural scripts', they are an important way that illness-related experience and behaviour are brought into line with collective norms and values (Mattingly, 1998; Kleinman, 1988; Good and Good, 1994). Finally, a few researchers have emphasised the rhetorical function and social force of illness narratives (e.g. Riessman, 1990a; Monks, 1996; Hyden, 1995a, 1995b). These researchers have demonstrated how illness narratives are used by sufferers to present themselves in some ways rather than in others and as a way of making moral claims. Bury (2001), for instance, has shown how illness narratives are used to express a patient's moral viewpoint on their illness in terms of a relationship between self, body, and society.

Examining 'narrative reconstructions' of biographies ruptured by illness also provides researchers with a means of investigating how culture influences the experience of illness and distress (Good, 1994; Kleinman, 1988). Good and Good, for instance, have emphasised how 'illness narratives' are 'one of the specific (discursive) forms through which culture mediates experience' (1994: 841). Garro (1994) has pointed out that illness narratives are grounded in cultural knowledge. For instance, in order to explain or account for illness, patients construct their stories around 'explanatory' or 'cultural models' of illness (Garro, 1994; Kleinman, 1988). Moreover, illness narratives draw on culturally available genres, metaphors, and rhetorical forms in order to communicate suffering and its personal or social significance.<sup>32</sup> For instance, Good *et al* point out that: 'Explanatory logics, available therapies, narrative forms, and the norms governing the telling of such narratives vary across cultures' (1985: 837).

Two difficulties are associated with the concept of an 'illness narrative' as it has been used in such social-science research. First, the implied rationality underlying the concept of an explanatory model re-appears in the concept of the illness narrative. The function of illness narratives may not always be to explain illness experience, even though an explanatory logic may sometimes run through them. Good (1994), for instance, has warned against treating illness narratives as 'beliefs' or 'explanations for illness'. As Chapter 4 will argue, discourse on illness and distress can be more or less coherent, more or less narrative-like (Parsons and Wakeley, 1991; Spicer, 1998). In some cases, a lack of coherence and a low level of narrativity may signify something important about the nature of disruptive experiences where rationality has been momentarily suspended. The second difficulty is that the concept of narrative is sometimes used as an analogue for cultural model or explanatory scheme; in this way, narrative becomes reified as a cognitive entity. This makes it difficult to interpret discourse about illness or distress that varies in its degree of narrativity. A possible antidote to this is to view narrative as a kind of discourse unit, as a form of talk, rather than as a latent cognitive structure. Similarly, explanation is also a discourse unit; for instance, explanations are produced in discursive acts of explaining. Such explanatory acts are used to



accomplish a range of social tasks: accounting, justifying, legitimising, and making moral claims (Antaki, 1988; Heritage, 1988).

### **Discourse and narrative**

Linde defines a 'discourse unit' as a 'segment of spoken language, longer than a single sentence, with socially recognised initial and final boundaries, and a formally definable internal structure' (1984: 186). A 'text' is discourse that has been fixed in writing (Fairclough, 1992). For example, a transcript generated from a research interview is a text. Narrative and explanation, for example, are discourse units. Discourse can have a variety of levels. Linde defines the 'discourse level' as the 'linguistic level at which social action and exchange take place' (1986: 184). Discourse units are embedded and produced in social practices that involve language use, in what Fairclough (1992) calls 'discursive practices'. Linde extends Hymes' notion of a speech event<sup>33</sup> to include 'discontinuous contexts' in which discourse units are produced. She distinguishes between two kinds: 'units consisting of all interactions by a participant on a particular topic, and units consisting of the history of interactions between specified participants' (1986: 184). An example of the latter type of discourse unit includes extended public conversations on a particular topic or theme produced in 'discontinuous contexts'. For instance, Linde maintains that expert social-science discourse is a type of public discourse, an 'extended and discontinuous conversation, carried on by experts' (1986: 196). Other examples of such public discourse include the discourse produced in countless social interactions and 'discontinuous contexts' by members of a particular society around the themes of selfhood, the body, gender, illness, or emotion.

According to Linde, narrative is the 'prototypical discourse unit' (1986: 184). Narrativity provides English speakers with a means of interpreting experience and action by relating it to agency, biography, and social setting. Somers, for instance, says that: 'Narrativity demands that we discern the meaning of any single event only in temporal and spatial relationship to other events' (1994: 616). Riessman describes three ways that the analytic concept of narrative has been employed in the social sciences: as discrete narrative excerpt; as personal narrative; and as biography (2002: 698). Four levels of narrative discourse can be distinguished. The first three levels broadly correspond to Riessman's tripartite categorisation. Each of these levels of narrative deploy narrativity in different ways.

First, narrative can refer to a discrete unit of discourse embedded in a speech event. For instance, Watson loosely characterises narrative as 'an account of an event or series of events' (1973: 243). Linde depicts Labov's formal definition of a discrete narrative discourse unit as 'a recapitulation of past experience and its meaning using a sequence of past tense main clauses whose order is taken to mirror the order of events' (Linde, 1986: 186; Labov, 1976). According to Riessman, in this restricted (socio-linguistic) sense, narrative refers to a 'brief, topically specific stories organised

around characters, settings, and plot. These are discrete stories told in response to single questions; they recapitulate specific events the narrator witnessed or experienced' (2002: 697).

This formal Labovian definition of narrative depends on a theory of meaning that foregrounds the referential function of language. Events in the narrative proceed according to narrative time while the events being related occur in real time. The temporal relation between them involves a compression of temporality and maintenance of chronological order. Meaning is reduced to a homological relationship between narrative discourse and the events it depicts. However, narrative discourse can have a variety of meanings depending on its social, expressive, or constitutive function. Labov (1982) has corrected for this in later models where he has placed more emphasis on discourse and narrative as speech acts.

Second, over the course of a conversation, another narrative unfolds. Here, narrative refers to discourse units at a higher level than the discrete narrative excerpt. These are presented in extended stretches of talk so that narrativity is co-constructed with the interlocutor dialogically facilitating the process of narration. Riessman characterises personal narrative as a series of stories (e.g. episodes) that emerge over the course of a conversation(s): 'Large sections of talk and interview exchanges - extended accounts of lives that develop over the course of interviews [...] an evolving series of stories that are framed in and through interaction' (2002: 698). Narrative episodes, bursts of narrative discourse, typically pepper such dialogue and are used by speakers to accomplish a range of social tasks within them. Moreover, the audience employs narrative as a framework for interpreting what is being recounted.

Third, a self-narrative or life story is a discontinuous discourse unit composed of all the narratives that an individual produces about their life during the course of their life. Linde (1986) notes that it is possible to form an understanding of an individual's life story by attending to a small subset of such discourse. Life stories, biography, or biographical segments have been routinely used in ethnographic and social-historical accounts in anthropology and oral history (e.g. Tonkin, 1992; Thompson, 1978; Riessman, 2002). Biography and life history have become a central concern of sociologists (e.g. Josselson & Lieblich, 1993). Life events or more discrete narrative episodes are contextualised within biographical or life narratives.<sup>34</sup>

Fourth, at an even higher level of discourse, public narratives or what Linde calls 'group stories' refer to 'discontinuous' discourse units that are told by a group or a society. According to Linde, such stories of group life are 'built up both by the public discourse of history books, civic texts, articles about sociology, political speeches, etc., as well as by private oral narratives' (1986: 199). Such stories articulate the cultural identity of individuals who are party to the conversation.



Narrative discourse units are often organised around an explanatory system (Linde, 1986). Following Linde, explanation as a discrete discourse unit can be distinguished from an explanatory system, 'the assumptions about the world which the speaker uses to make events and evaluations coherent' (1986: 188). In addition, Linde distinguishes between 'common-sense' or 'popular' explanatory systems and 'expert explanatory systems'. Explanatory systems are one of the principal ways that coherence is achieved in discourse. Personal and public narratives, for instance, are often organised around an explanatory system. While narrative and explanation are both types of discourse unit, narratives can be built-up around explanatory systems and theories.

The explanatory systems used in lay discourse are often popular versions of formal theories and expert systems. For instance, expert explanatory systems historically evolve out of common-sense or lay theories as well as pre-existing expert theories and explanatory systems. Through a process of diffusion, these feed back into popular discourse forming 'semi-expert explanatory systems' (Linde, 1986: 194). In the final stage of this process, these expert systems can sometimes become part of 'common sense', a society's view of reality: 'As a given explanatory system becomes better known and more widely held, it begins to move closer to common sense, and may eventually come to form part of common sense' (1986: 195). Expert discourses are discontinuous discourse units that encompass the 'extended conversations' of experts, academics, and professionals on a particular topic, theme, or set of practices. For instance, biomedicine and anthropology are expert discourses and are partly characterised by their distinctive explanatory systems or modes of rationality.

Four features of the relationship between agency and narrative are worth highlighting. First, a speaker's agency drives the discursive processes of narrativisation (See Appendix A3.3). This also applies to the listener who must follow the story and re-construct the narrative logic embodied in the plot in order to make sense of it. The meaning of personal experience is articulated in the process of narrativisation and the reflexive interpretation of experience is an expression of agency in Taylor's hermeneutic sense. Second, narrating is a speech act and, as such, has social force.<sup>35</sup> For instance, narrative is used to perform a variety of social functions: it can explain, legitimise, justify, convince, or facilitate understanding. Third, narratives depict agency. Narrative is used to portray action, its relationship with events and the settings in which they take place. Plot carries the action in narrative so that it is through plot that the dynamic relationship between context and agency is played out. Fourth, narrative discourse plays a constitutive role in relation to agency, social identity, and selfhood.

### **Interpretive framework**

The chapters that follow draw on a variety of different approaches to discourse analysis including thematic, narrative, and rhetorical approaches. Each of these is described in more detail in Appendices A3.1 to A3.4. The interpretive framework used in this thesis evolved during the course of the research. Later approaches came to encompass or build on earlier ones without erasing them.

The evolution of this repertoire of interpretive concepts is traced out in the Appendices. They represent the background detail or scaffolding for the discussion presented in the body of the text. This methodological development represents one of the central themes of the thesis.

In the early stages of the research, a combination of qualitative analysis and narrative analysis was planned (See Appendices A3.1 and A3.2). As the research progressed, other features of discourse and forms of rhetoric (particularly metaphor and dramatisation) became more prominent (See Appendix A3.3). The prominence given to certain features of discourse was determined by the disciplinary context of the research. The discursive categories of narrative, explanation, idiom, metaphor, account, and the dramatic metaphor have become a central part of the interpretive repertoire of medical anthropologists and sociologists. Thematic coherence, narrativity, and rhetoric (e.g. trope, explanation, positioning, and dramatisation) were selected for detailed interpretation partly because of their relevance to theory and research in medical anthropology and sociology. Finally, discourse analysis provided a way of exploring these different features of texts under a common interpretive framework (See Appendix A3.4).

According to Riessman, the aim of narrative analysis is to identify ‘forms of telling about experience, not simply the content to which language refers’ (2001: 697). It is therefore useful in the interpretation of texts produced in in-depth interviews. It represents a systematic approach to achieving what Bruner (1986, 1990) described as narrative understanding. In this thesis, narrative analysis is viewed as a kind of discourse analysis that provides a conceptual framework for the systematic interpretation of the structure and content of discrete narrative discourse units and personal narratives (Labov, 1976; Riessman, 1993, 2002; Mishler, 1986a). As such, the interpretation of narrative discourse can be combined with the interpretation of other features of discourse, including discourse without a narrative structure (See Appendix A3.2 for the interpretive framework used in the analysis of narrative and a definition of the prototype concept of ‘narrativity’).

Narrative analysis can also be used as a kind of social analysis. According to Somers (1994), social analysis involves the systematic analysis of the relationships between four domains of social reality: lived experience or an individual’s ‘ontological narrative’; the ‘public narratives’ or cultural scripts that partly constitute individual lived experience; the local ‘relational settings’ that individuals inhabit; and the macro social forces that constrain the lives of individuals and partly determine these relational settings. A central argument of Chapters 1 and 2 was that these relationships are mediated or are partly constituted by symbolic processes and cultural practices. Narrative analysis can be used to examine such relationships as they appear in informants’ discourse. Riessman, for instance, has employed narrative analysis to achieve an understanding of the relationships between disruptive life events and macro-level social processes (1993, 2002).



A central aim in the interpretation presented in Chapters 4 to 7 is to examine the relationship between personal accounts of distress and public discourses on distress (e.g. expert, common-sense), what Fairclough (1992) refers to as 'intertextuality'. Particular attention is paid to the social force of discourse, its interpersonal function, and its constitutive power.<sup>36</sup> Symbolic and cultural practices are assumed to have a formative function such that multiple, often irreconcilable 'worlds' become possible (Goodman, 1978). Discourse is conceived as a symbolic social practice with the power to partly constitute worlds: objects, subjectivities, selfhood, social identity, social relations, institutions, experiences, actions, and lives. Appendix A3.4 discusses the constitutive power of discourse in more detail; how discourse partly constitutes experience, self, and social relations; and how ideological discourse contributes to the reproduction of social structure and helps to distribute power unequally throughout the social field. These theoretical assumptions about the constitutive force of discourse underpin the argument presented in Section 2.3 about the constitutive power of cultural discourses on the self and body.

### **3.2 Research methods**

Qualitative methods provide a means of researching the relationship between illness, distress, and the sociocultural settings that partly constitute these experiences. The theoretical perspective described in Chapter 2 and the interpretive approach described in Section 3.1 is compatible with the following research methods:

- An ethnographic approach to social research
- Person-centred or experience-centred ethnography
- A case-study approach
- In-depth interviewing
- An analytic focus on discourse and narrative

#### **An ethnographic approach to social research**

Ethnography typically employs multiple methods and data collected from a range of different sources including: participant observation; informal and in-depth interviewing; documentary research, and a range of other data-collection techniques.<sup>37</sup> Its aim is to form an understanding of how people in different social and cultural settings make sense of action and experience, or, as Geertz maintains, ethnography aims to form an account of the 'formulae they use to define their experience' (1993: 15). According to Geertz, the thick ethnographic description of cultural and social practices partly involves the social analysis of symbolic action: 'In the study of culture the signifiers are not symptoms or clusters of symptoms, but symbolic acts or clusters of symbolic acts, and the aim is not therapy but the analysis of social discourse' (1993: 20).

The social research reported in this thesis draws on both sociology and anthropology to develop a theoretical understanding of social suffering in developed English-speaking societies. Social theory and ethnography are central to both disciplines. As a strategy for collecting social and cultural data, participant observation and a prolonged period of field work abroad has defined the

anthropological project from the outset and is a way that anthropologists have differentiated their work from other social scientists (La Fontaine, 1999; Peirano, 1998). Sociologists, on the other hand, have typically studied large-scale, developed societies using the social survey as the principal research instrument. Anthropologists have avoided conducting research at home partly because of the difficulties associated with applying participant observation and ethnographic research in such societies. This has meant that sociologists have traditionally studied us, while anthropologists have studied them.

Goody (1966) challenged this division of labour when he criticized the division between the sociological study of complex developed societies and the social anthropological study of exotic, small-scale societies. Moreover, the idea that an extended period of fieldwork abroad is a necessary condition for anthropological research has been challenged by anthropologists who have conducted ethnographic research in their countries of origin (Peirano, 1998). Such research has come to be known as ‘anthropology at home’ or, in medical anthropology, ‘medical anthropology at home’ (Peirano, 1998; Van Dongen and Fainzang, 1998). Peirano (1998) points out that the degree of emphasis placed on home-based anthropological research varies from country to country. In addition, medical sociologists working within the ‘sociology of health and illness’ paradigm have also conducted in-depth qualitative studies of illness and suffering within western social settings, often with methods, concerns and research questions that overlap with those of medical anthropologists (e.g. Bury, 1991, 2001; Conrad, 1990).<sup>38</sup>

The empirical social research reported in this thesis has aimed to strike a balance between the theoretical and the empirical. The empirical dimension of the research involved two small-scale ethnographic case studies of social suffering in two developed English-speaking societies. In neither case was the aim to conduct a traditional ethnography (in the anthropological sense). Rather, the purpose of this social research was chiefly theoretical: it was intended to facilitate an exploration of the theoretical issues presented in the first two chapters of this thesis.

### **Person-centred ethnography and the anthropology of experience**

An empirical exploration of the theoretical questions and themes around which this thesis is organised requires a research methodology that foregrounds personal experience and close attention to ‘experience-near concepts’ (Geertz, 1983). Bruner maintained that the possibility of hermeneutical understanding of ‘life expressions’ presupposed lived experience. He grounds an ‘anthropology of experience’ in Dilthey’s notion of *erlebrnis* or ‘lived through’ experience, a primary reality of ‘thought and feeling, as word and image’ (1986a: 5). Cohen has argued that the anthropological interpretation of experience is bound to ‘proceed from the premise of the self’ (1992: 237). He argues that this is because individuals everywhere come to understand themselves as selves and such self-conceptions run through all experience and action (1992: 230-232). Person-centred ethnography is grounded in such a methodological perspective and is concerned with the production of ‘thick descriptions’ of subjective experience grounded in detailed interpretation of



individual case studies (Hollan, 1997). The analytic focus is on 'experience-near concepts', rather than reified abstract concepts such as society or culture. This involves developing 'experience-near ways of describing and analysing human beings', so that ethnographic analysis aims to generate interpretive categories that are grounded in the experiential lives of subjects (LeVine, 1982: 219). A person-centred approach to ethnography is well adapted for research in the field of cross-cultural psychiatry, where the central aim is to explore the relationship between cultural processes psychiatric illness and distress (Hollan, 1997).

### **In-depth interviewing**

In what has been described as 'New British Ethnography', in-depth interviews have tended to take precedence over participant observation as the principal means of collecting social data (Hockey, 1999). In-depth interviewing is the preferred and sometimes the only available means of conducting ethnographic research in large-scale, developed societies (La Fontaine, 1999; Hockey, 1999). The social research reported in this thesis involved the collection of data on personal experiences of distress and illness using in-depth, informal, and semi-structured interviewing.<sup>39</sup> The use of in-depth interviewing and a case-study approach has a natural affinity with an analytic focus on narrative (e.g. Mishler, 1986b, 1991; Riessman, 2002). The approach to interviewing was influenced by the biographical-interpretive method of in-depth interviewing that has been used to collect life stories in European settings (Holloway and Jefferson, 1997). This approach can be summarised as follows: the use of open-ended questions; the elicitation of narratives; attentive listening; identification of themes and their ordering; following up responses using respondents' own phrasing and ordering; avoiding asking 'why' questions; beginning the interview with a single, open question (Holloway and Jefferson, 1997). In listening to narratives, narrativity works as an interpretive principle, facilitating an understanding of the connections between events.

### **A case-study approach**

Case-study methods were used in the social research reported in this thesis. Case-study methods are commonly used in qualitative sociology and anthropology as a way of exploring the relationships between social practices, cultural processes, action, and experience.<sup>40</sup> In qualitative social research, field sites and samples are rarely selected with the aim of forming generalisable conclusions about a population. Theoretical or judgemental sampling is typically used to select locations, cases, and data.<sup>41</sup> Selection of case material took place at three levels. Selection of case material at all three levels was 'purposive' and was driven by theoretical questions and categories. First, two different social settings were selected as 'cases'. Second, within these settings individual cases were selected for in-depth interview. The case-study approach applied at this level involved a reliance on detailed transcripts of discourse recorded during in-depth or open-ended interviews, detailed interpretation of individual cases, and the examination of similarities and differences between informants' stories (Riessman, 2002). Third, in the chapters that follow narratives and instances of discourse were selected for detailed interpretation and to illustrate core themes.

### 3.3 Case Study 1: Bristol

The initial phase of the fieldwork aimed to investigate the experience of distress and the discourse used to articulate it among a small sample drawn from among the white English population living in the English city of Bristol. No assumption was made about the representativeness of this sample in relation to the English population of the city as a whole. This fieldwork was exploratory and did not aim to make broad empirical generalisations about social suffering among the English population as a whole. Nonetheless, the research did aim to facilitate the development of theoretical generalisations about the social experience of personal distress and the discourse used by sufferers and former sufferers to express it. The aim of the fieldwork was also methodological: to develop innovative ways of interpreting discourse on illness and distress.

The initial problem was to identify a small sample of English informants living in a defined geographical area who had experienced psychosocial distress. Two different selection strategies were used in order to cover a wide range of experience. One sample of informants was selected directly from the community. A second sample was selected through a general practice situated in an area of south Bristol serving a predominantly white English population.

The initial phase of the fieldwork began with recruitment of a small sample of self-selected volunteers. Advertisements were placed in a newsletter of a local mental-health charity. These advertisements explained the purpose of the research and used the word depression in the text. Eleven informants responded. Four were male, seven female and they ranged in age from 29 to 45 years. Most of these informants lived in the south and central areas of Bristol. All informants believed that they had experienced at least one episode of depression in the past, although two informants had not received any formal diagnosis of their complaint. In-depth, exploratory interviews using the 'biographic-interpretive' method were conducted with each of the informants using an interview schedule (the topic guide used in these interviews is presented in Appendix A3.5). This guide was grounded in the research questions (see Introduction) and covered the following themes: the experience of distress; the meanings associated with this experience; social and biographical context; social and personal consequences; encounters with healthcare practitioners; experience of treatment and recovery. All informants were interviewed about their experience of personal distress (typically 'depression') at least twice and on no more than four occasions. Most of these interviews took place at the informants' homes. Where this proved inconvenient, a few of the interviews were conducted at the researcher's office. Each interview lasted around an hour and, in most cases, was tape-recorded. All interviews were fully transcribed verbatim.<sup>42</sup> Two informants requested that the interviews not be recorded so that notes were taken instead.

The second, larger sample was selected through a general practice situated in an inner city area of south Bristol. All registered patients who had been identified by a doctor as showing signs of



depression were identified by one of the practice doctors. This list of several hundred patients was stratified by age and sex and 120 patients were selected randomly from this list. The list was then filtered by a practice doctor who removed the names of patients whom he felt should not be contacted as part of the research. A letter was then sent to each patient explaining the nature and purpose of the research and inviting them to participate. Twenty-five patients consented to take part in the research and interviews were arranged. All informants were white English, predominantly female (17 female, 8 male) and aged between 24 and 55. Interviews were conducted using the interview schedule used to interview informants in the first sample (See Appendix A3.5). Informants were interviewed on a single occasion either at the clinic or at their own homes. Again, each interview lasted around an hour and in all cases they were tape-recorded and transcribed verbatim. Appendix A3.6 gives presents an account of how this qualitative data was analysed.

Given the way in which informants were selected, it was anticipated that patients would vary widely in their experience of distress. In many cases, informants had experienced a minor, brief episode of distress in response to a difficult life event. In a few cases, informants reported more severe and prolonged experiences of distress. It was clear from their accounts that all had experienced a period of severe personal distress at some point in the recent past. Most informants described an episode of 'depression' or of 'feeling depressed' in combination with 'anxiety', 'panic', or 'stress'. Some had not fully recovered, so that their experience of distress remained a central feature of their lives. A few informants did not believe that they had experienced 'depression' at all, even though they reported 'feeling depressed'. One informant, for instance, reported experiencing 'panic attacks' without any mention of 'depression'. Another informant reported a variety of distressing feelings including 'anxiety', but without any mention of depression.

### **3.4 Case Study 2: St. Helena**

As the Bristol fieldwork proceeded, the limits of an ethnographic approach relying solely on in-depth interviews became clear. A purely interview-based study conducted in an urban western setting would not make it possible to explore some of the central theoretical themes guiding the research; for instance, how personal distress is partly constituted through the dynamic relationship between agency, cultural processes, and social structure. A broader ethnographic approach would be required to explore the central questions guiding the research. Another field-site was sought.

One of my supervisors suggested Tristan da Cunha<sup>43</sup> as a possible field site for this purpose. Her own doctoral supervisor, Dr Joseph Loudon, had undertaken a cultural epidemiological study of psychosocial distress among the inhabitants of the island in the 1960s (Rawnsley and Loudon, 1964). The possibility of conducting fieldwork on Tristan da Cunha was explored, but I developed reservations about the remoteness of the island and the practicability of conducting such research in

such a setting without having prior links with the island population and without the degree of access that Dr. Loudon's clinical status may have afforded him.

However, background research on Tristan da Cunha had brought the south Atlantic island of St. Helena to my attention. St. Helena is an island situated in the mid-Atlantic (16° South, 5°45' west), 1,600 km from the west coast of Africa and 2,700 km northwest of Cape Town. The island measures 10 by 6 miles with a land area of 47 square miles. According to the 1998 Census of St. Helena, there were around 5,000 St. Helenians resident on the island.<sup>44</sup> St. Helena has no indigenous population and the resident population originated from Africa, Britain, China, and India, as well as having Malagasy and Huguenot ancestry (Evans, 1994). At the time the fieldwork was conducted, however, St. Helenians did not possess full British Citizenship. Since then, British Citizenship has been restored to the Islanders. St. Helena is a British Overseas Territory and, although the language spoken is English, St. Helenians (or 'Saints') speak with a distinctive St. Helenian dialect. The island is hilly and difficult to access from the ocean, with the highest peak (Diana's peak) at 820m. Temperatures vary between 16-27°C in the winter and 21-31°C in the summer. There is no airport, and access is only possible by sea.

Like Tristan da Cunha, St. Helena is also very remote. Nonetheless, it has a much larger population. After some initial exploratory research about the Island, I decided to write to the Governor of St. Helena and St. Helena's Public Health Department with a tentative proposal for conducting research on the island focusing on the role of social and cultural factors in St. Helenians' experience of psychosocial distress. On receiving a positive response to the proposed research, I then proceeded to make contact and meet with a few individuals linked with St. Helena and who were based in Britain in order to find out more about the island. For instance, I met with the island's Chief Medical Officer, Dr David Bagley, while he was on leave from duty and discussed my proposed research in more detail. After this meeting, a decision was made to proceed with a period of fieldwork on St. Helena.

Six months were spent on St. Helena conducting fieldwork commencing in January 2000. The principal aim of the fieldwork was to explore the role of cultural, social, and economic factors in the experience of psychosocial distress on the island. Another aim at the outset was to document and develop an ethnographic understanding of St. Helenians' discourse on distress. It was anticipated that such research would also need to encompass St. Helenians' interpretations of illness experience as well. The research questions that guided this fieldwork therefore included:

- How do St. Helenians articulate and express experiences of distress and illness?
- How do local cultural discourses on the self, body, and society influence the experience and expression of distress among St. Helenians?
- How do St. Helenians interpret, evaluate, and respond to distress and illness?



- What role does St. Helena's remoteness and its socio-economic difficulties play in experiences of personal distress?
- What kinds of adversity do St. Helenians experience and how do these relate to macro social and economic forces?
- How do macro social and economic processes generate social suffering through their impact on the lives of individuals?
- How do St. Helenians express their core concerns and how is their sense of agency constituted by the relational settings within which they live their lives?

A variety of data-collection methods were used within a general ethnographic approach: these included participant observation, informal interviewing, and documentary research. Such methods were used to learn about the general social and cultural context of life on St. Helena and the local cultural meanings and understandings associated with personal distress, illness, and 'mental illness'. They included: in-depth interviews; a community survey; observation and listening; documentary research. Each of these is discussed in turn below.

### **In-depth interviews**

No formal criteria were used to select informants for in-depth interview. Selection took place through local healthcare and social-welfare services, informal social connections, and through a small-scale screening survey conducted in one of St. Helena's outlying districts. In-depth interviews were conducted with 40 St. Helenians who had experienced or who were experiencing personal or social distress (10 male; 30 female; aged between 29 and 70 years). Most informants linked their experience of distress to social adversity. In a minority of cases, the experience of social distress was compounded by chronic illness. Informants were interviewed on more than one occasion where a single interview was insufficient to cover all of the themes listed on the schedule. The maximum number of interviews with any single informant was five. The topic schedule used in these interviews was based on the interview schedule used in the Bristol interviews. This was extended in an ongoing fashion as new themes emerged during the course of fieldwork (See Appendix A3.7). Where consent was granted, interviews were tape-recorded. Where consent was not granted, notes were taken. Interviews were usually conducted in informants' homes or at their place of work. In a few cases, interviews were arranged at an outlying clinic and, in a few cases, interviews took place at the General Hospital in Jamestown.

St. Helenian informants used either a sociomoral idiom of 'worry' or they deployed a somatic idiom and an illness metaphor to express their feelings of distress and their social concerns. This made it necessary to develop an understanding of both social and economic adversity on St. Helena and St. Helenian illness discourse. For example, I interviewed ten St. Helenians about their experience of chronic illness. I conducted informal interviews with St. Helenians who had experienced social or economic adversity or who were socially excluded in some other way.<sup>45</sup> I also

conducted life-history interviews with some of the residents of the Island's nursing home for the elderly as well as elderly people living in outlying areas. The aim of these interviews was to learn more about the life course among St. Helenians and about the island's recent history, for which few documentary sources are available. I also interviewed or consulted with many key figures on the island on a range of issues including illness and distress, the island way of life, and St. Helenians' socio-economic difficulties. These informants included religious figures, government officials, healthcare staff, development consultants, researchers, lay people, and community-based workers. A few St. Helenians became 'key informants'. I met with these informants regularly during the six-month period of fieldwork and discussed a range of themes with them relating to island life.

### **A small-scale community survey**

However, the fieldwork on St. Helena was not without its challenges. Difficulties associated with the fieldwork included, for example, the close-knit nature of the community and a high degree of reticence and a pervasive suspicion of outsiders. This was compounded by the island's remoteness and a high level of stigma attached to social adversity, the public expression of distress, and anything to do with 'mental illness'. There were also difficulties in identifying and recruiting informants. For instance, one way of selecting informants that was attempted was to contact them through the doctors and the community nursing team. I composed information sheets for the doctors, community nurses, and developed criteria for selecting patients. However, this approach was not successful partly because the doctors failed to inform patients about the research and because many of the community nurses were not engaged in the research. St. Helenian society was found to consist of a network of villages or settlements in different geographical areas. Mid-way into the fieldwork, I was therefore forced to narrow down my focus to a smaller, more bounded geographical district.

In order to identify a small sample of individuals who were experiencing distress, I undertook a community survey of all the adults in one outlying district of the island. The district was chosen for the survey partly on the advice of the CMO, partly because of its size<sup>46</sup>, its remoteness from Jamestown, and because it was one of the more disadvantaged areas of the island. Details of the screening instrument used and the survey response can be found in Appendix A3.8. The results of the survey are reported in Appendix A6.1. Of the 70 cases who responded in this survey, around 22 indicated the presence of distress. The majority of these informants were followed up for interview and some were interviewed on multiple occasions.

### **Observation/listening**

Apart from ongoing dialogues with key informants, I learned about island life by participating in the island's social life. Everyday conversations with St. Helenians were a rich source of learning. I also spent much time talking with St. Helenian families, particularly in the outlying districts. I attended events of historical or social importance (e.g. attended traditional dances, fishing with



local fishermen, participated in community social events, attended various religious services and meetings, and so on).

More focused observation was also undertaken. For instance, I spent time shadowing the island's community psychiatric nurse, the island's social welfare officer, and a community-work supervisor. I visited and spoke with staff at the island's hospital for adults experiencing mental-health difficulties (*Sundale*), a nursing home for the elderly (*The Haven*), and visited community clinics in outlying areas. Fieldnotes consisted of notes from unrecorded interviews and informal conversations, notes from observation, interpretive comments, and notes on primary documentary material.

### **Documentary research**

Documentary material both on the island and in the UK was collected from a variety of historical, socio-economic and health-related sources: the St. Helena Government's Archives; the UK Government's Foreign and Commonwealth Office Library; the British Library; private collections. A separate set of notes was kept on primary documentary material.

Appendix A3.7 presents an account of how this ethnographic data was interpreted and includes a description of the framework used to interpret informants' discourse on distress.

The next three chapters present two sets of interpretations. First, Chapter 4 presents the interpretation of discourse on distress among the samples of English informants. Second, Chapters 5 and 6 present an interpretation of the data collected in the St. Helena fieldwork.

## Chapter 4

### ‘The Usual Classic Symptoms’

This chapter presents an interpretation of the discourse on distress employed among a sample of white English informants living in the English city of Bristol. The interpretation of this discourse is approached from two angles. The first section presents an interpretation of informants’ descriptions of their experience of distress. While the central focus is on informants’ discourse on depression, the interpretation also explores other features of informants’ descriptions; for instance, how narrativity and metaphor are used to depict experiences of distress where agency has been disrupted. The second section is concerned with how informants sought to interpret and account for these experiences. It examines how they contextualised their experiences of affliction within personal narratives and how trope and narrativity were used to depict the relationship between self, distress, and relational settings.

Section 3.3 and Appendix A3.6 present an account of how this data was collected and analysed. The qualitative analysis of the data collected in in-depth interviews with informants yielded seven core sub-themes under the broad thematic domain: ‘Experience and expression of distress’. Most informants described a single experience of personal distress (e.g. a prolonged period of ‘feeling depressed’, ‘low’ or ‘down’). A few informants labelled their experience of distress as ‘panic attack’ or ‘anxiety’, but not ‘depression’. Informants’ descriptive discourse on distress was organised into the following thematic categories (i.e. recurring domains of content):

- Metaphors of mood (e.g. ‘feeling low’, ‘feeling depressed’)
- A vocabulary of emotional distress (e.g. sadness, hopelessness, emptiness)
- Idioms of distress (e.g. ‘anxiety’, ‘panic’, ‘fright’, ‘stress’, ‘worry’)
- The loss of agency and human behavioural breakdown
- The embodiment of personal distress
- Social disconnection and biographical disruption
- Ethnopsychiatric categories (e.g. ‘depression’, ‘panic attacks’, ‘stress’, ‘mania’, ‘nerves’, ‘neurosis’, ‘psychosis’).

Each of these discursive domains was organised around a set of ‘root metaphors’<sup>47</sup>, ontological concepts, and symbolic associations. The material presented below was selected in terms of how well it illustrates these core themes. I have parsed narrativised discourse into clauses for presentation and referencing purposes. Some detail in the accounts has been changed to protect the privacy of the informants.



#### 4.1 English metaphors of distress

Personal narratives of illness or distress are commonly composed of a mixture of both descriptive and explanatory discourse. Where the speaker's purpose is explanatory, then descriptive discourse is employed in the service of explanation. In this section, the discussion centres on how speakers described their experiences of personal distress and the metaphors they used to articulate it, rather than on how informants explained or accounted for such experiences. The analytic focus is therefore on discrete units of discourse that depict, describe, and that partly constitute experiences of personal distress.

The creative deployment of metaphor gives form to what is ambiguous and inchoate in terms of what is already familiar (Fernandez, 1982). Fairclough points to the constitutive power of metaphor when he says that 'metaphors structure the way we think and the way we act, and our systems of knowledge and belief in a pervasive and fundamental way' (1992: 194). Culturally available metaphors amplify some features of experience, just while they silence others. For instance, the metaphors employed by sufferers in their discourse on illness and distress have the power to constitute experiences of personal distress in some ways and not in others (See Appendix A3.3 for definitions of 'metaphor' and the other 'tropes').

Metaphors of mood are a central feature of English discourse on distress. 'Mood' here is taken to mean a prolonged, embodied emotional state (Keyes, 1985), what one informant described as 'happy, sad, sort of grumpy, the way I feel'. Metaphor makes it possible for creative language users to articulate experiences where existing linguistic resources are unavailable. Given the ineffability of suffering, metaphor and what Fernandez (1986) describes as the 'play of tropes' make it possible for sufferers and former sufferers to communicate their embodied experiences. Low, for instance, points to how metaphor 'allows for the communication of otherwise senseless and unspeakable suffering' and 'provide flexible, creative, and strategic language for the expression of suffering' (1994: 142).

Informants distinguished between two kinds of personal distress in their accounts. First, 'ordinary suffering' refers to everyday experiences of feeling 'down', 'low', 'depressed', 'anxious', 'stressed', 'up and down'. Second, 'illness-like suffering' refers to more severe personal distress that involves a breakdown in personal agency (e.g. depicted as a 'loss of control' or 'inability to cope') or a disruption in everyday functioning and the fulfillment of usual social roles. Within informants' accounts, the latter kind of distress was commonly depicted with a strong somatic component and was described using a cluster of quasi-expert and ethnopsychiatric terms such as 'panic attacks', 'anxiety attacks', 'nerves', 'mania', and 'depression'. Informants distinguished illness-like suffering from ordinary suffering both dimensionally and categorically. As I will show, the underlying 'root metaphor' used to depict more severe experiences of personal distress was that of chronic illness.

Informants described their embodied experiences of both ordinary and illness-like suffering using the embodied metaphors of 'height', 'depth', 'weight', 'energy', and 'pressure'. This metaphorical discourse provides English speakers with a kind of physics of experience; a set of symbolic tools for configuring embodied experience in a wide range of ways. The most common ways that informants articulated their experiences of ordinary suffering (using terms such as 'low', 'down', or 'depressed') were grounded in these metaphors. Their discourse on distress was structured around an orientation metaphor that mapped out a spectrum of mood states that ranged between 'high' and 'low', 'up' and 'down'. This 'root metaphor' of 'mood' provided speakers with a dynamic means for communicating fluctuations in motivation and emotional experience.

The language of personal experience (e.g. 'thought', 'feeling', 'action') in developed English-speaking societies is organised around set of dualisms and 'root metaphors'. The latter also constitutes Anglo-American discourses on health, illness, and distress. Writing within a North American context, Lakoff and Johnson point out, for instance, that orientation metaphors (e.g. the 'root metaphor' of 'verticality') are grounded in bodily experience. They cite the example of space metaphors that are used by English speakers to articulate emotions (1980: 14). For instance, 'happiness', 'control', 'rationality', 'consciousness', 'health', high social status, and positive emotional states are 'up'. Conversely, 'down' is associated with 'illness', negative emotional states, 'unconsciousness', 'loss of control', 'irrationality', and low social status. Lakoff and Johnson argue that the embodied experience of emotion has 'systematic correlates' with 'sensory-motor experiences' so that 'up' becomes associated with 'happy'. Such metaphors provide a language for articulating mood and emotion; they 'allow us to conceptualise our emotions in more sharply defined terms and also to relate them to other concepts having to do with general well being (e.g. health, life, control, etc.)' (1980: 58). While such metaphors are grounded in bodily experience, they are also constructive; they provide a way of 'partially structuring one experience in terms of another' (1980: 77).

This metaphorical system was employed by English informants to articulate the distinction between ordinary suffering and illness-like suffering. Many informants' discourse on distress articulated a spectrum of suffering ranging from 'severe' or 'deep' ('feeling very depressed') to 'mild' or 'low' ('feeling a bit fed-up'). In this discourse, they distinguished normal fluctuations in mood (e.g. 'ups and downs') from more severe distress (e.g. 'depression') in terms of the depth, prolonged duration, and degree of intractability associated with the latter.

Informants commonly distinguished 'feeling depressed' from 'depression', with the latter being used as an ethnopsychiatric illness term. It was therefore possible to 'feel depressed' either within the context of a depressive episode/illness or outside of that context, within the context of everyday fluctuations in mood. This distinction mimics (and is mimicked by) the clinical distinction between



dysphoria and depressive disorder described in Section 2.2. For example, some informants used the phrase ‘feeling depressed’ to refer to ordinary suffering. In line with the underlying root metaphor, synonyms for ‘feeling depressed’ included ‘feeling down’ or ‘low’. One informant described her experience of ‘feeling depressed’ as being ‘on a downer’. A woman in her 50s depicted ‘feeling low’ as an ongoing experience of emotional vulnerability: “So, I’m not feeling as low. No, I can’t say I’m feeling : yeh, I could cry at the drop of a hat. But, I feel more fed-up, than low”. In Text 1, a woman in her 20s uses the term ‘depressed’ as a metonym for a prolonged feeling of ‘unhappiness’, rather than as an illness term:

**Text 1**

I just sort of say ‘depressed’. I just use it like a word. I just say I’m depressed. I don’t think deep down think that I am. I haven’t had anyone confirm that I’m depressed. I just sort of see it as just sort of being unhappy all the time.

Similarly, in Text 2 a middle-aged woman uses a mood metaphor of ‘feeling down’ as a synonym for ‘feeling fed up’:

**Text 2**

Down is to be fed-up with life [...] Just sort of fed up really. Your husband gets on your nerves and you don’t want to bother with ‘im. Again, I just feel like just shut the door. Find somewhere to run out of the way of it all, y’know. But, I think everybody gets like that.

Some informants sought to make a categorical or qualitative distinction between ordinary suffering and more severe forms of distress. One informant referred to her experience of ordinary suffering as ‘the downers’ and categorically distinguished it from depression. In Text 3, for example, a man in his 30s distinguishes between ‘feeling depressed’ from ‘feeling cheesed-off’. The former is associated with more severe distress and illness-like suffering (e.g. ‘depression’) and is differentiated from ordinary suffering:

**Text 3**

I think there’s a fine line between saying, ‘I’m depressed’, or you’re actually feeling low. I think there’s a big difference [...] If you’re feeling low, I mean somebody can say: ‘Erm, fancy a pint, fancy a chat, or you need a good night out’. You’re just cheesed-off basically.

The dimensionality underling the English metaphors of mood described above made it possible for informants to characterise illness-like suffering (‘depression’, ‘feeling very low’, ‘being at rock bottom’) as a more extreme form of ordinary suffering (e.g. ‘feeling a bit low’, ‘being on a bit of a downer’, ‘up and down’). For instance, one female informant said that to ‘feel depressed’ meant to ‘feel very low’. Another informant equated ‘depression’ with ‘feeling really low in yourself’. A man in his 50s defined ‘depression’ as ‘being as fed-up as you can imagine’. A man in his 20s described his experience of ‘depression’ as ‘feeling really low, just feeling really unhappy about things’. One informant said that during her experience of ‘depression’ she felt ‘very, very low’. Another informant differentiated ‘low ones’ from ‘really low ones’. A middle-aged woman said

about her experience of 'depression': 'You just get very low. Your moods get very low and it's very hard to pick it up because you're totally engulfed by your own emotions and problems'. Another man in his 50s equated 'depression' with 'feeling really low in yourself'. A woman in her 40s described her experience of 'depression' as 'mood swings. I was just feeling very down'. Other informants described their experience of 'depression' as being 'at the bottom', 'at rock bottom', or 'in a deep depression'. For example, a woman in her 50s used such metaphors to characterise feelings of hopelessness associated with 'depression' (Text 4):

**Text 4**

Depression to me is : I'm gonna sound : I feel really really down, rock bottom. I can't get no further. And you think: 'Is this what life is all about? It's gotta be better.' Erm, you don't necessarily feel physically ill : but you're just so, so : you can't imagine smiling again, being happy again.

In these examples, the metaphors of ordinary suffering ('feeling low' or 'down') were not categorically distinguished from 'depression'. They were used as synonyms for 'feeling depressed'. As ordinary suffering became deeper, it became more illness-like; it became more like 'depression'.

These metaphors were not the only ways that informants depicted the severity of their distress. The intractability and prolonged duration of distress was also used to form a qualitative distinction between ordinary, everyday experiences of personal distress and more severe illness-like suffering. For example, a middle-aged woman in her 50s who had experienced several episodes of 'depression' distinguished the 'ups and downs', short-term and recurrent feelings of sadness or despondency, from "the depression that doesn't come and go [...] the kind that you can't shake off". A man in his 50s reported experiencing 'peaks and troughs', depressed feelings that 'come and go'. He differentiated this labile movement from a steady state of prolonged 'depression'. In Text 5, a woman in her 30s distinguishes between those individuals with a 'depressive' disposition who are prone to ordinary suffering, from those 'with depression' who are 'down all the time':

**Text 5**

I seem to think if you're depressive you can go along for a while okay and then you go down, and then you go back up. Like you're on a zigzag line – you're up and down, up and down all the time. I suppose if you 'ad depression, you'd be down all the time, but whether : I seem to think if you're depressive you're up and down. That's what I seem to be is up and down.

Similarly, in Text 6, a middle-aged woman implicitly distinguishes between everyday or ordinary suffering ('a bit depressed') from a state of 'depression':

**Text 6**

And, if I did feel a bit depressed one day, it might not 'ave been depression. It might just've been a bit of a downer like everybody gets. It'd terrify me: 'Oh, I'm going down again. Oh, I'm going back again.' But, then, it would wear off. [...] I don't get the downers so much. I can cope with a lot more things. I feel better in meself. Some mornings I wakes up and I thinks: "Oh, I'm pissed off. I've gotta go a work. And I've got to listen to everybody moaning at me." Y'know. But, once I'm at work or at the first house, it goes.



In Text 6, 'depression' or 'the downers' is distinguished from a 'bit of a downer like everybody gets'. Being 'a bit depressed' is a transient experience that 'wears off'. For this speaker, everyday fluctuations in mood, 'ups and downs', signal a possible return of 'depression' and are hedged with fear. She metaphorically describes the transition from ordinary suffering to a more intractable experience of 'depression' as a downward movement. She then elaborates with narrative detail in order to contextualise these feelings of being 'a bit down'. Moreover, she normalises her experience of distress by situating it within the context of her everyday activity.

The embodied concepts of weight, depth, and verticality provide the metaphorical grounding for the ethnopsychiatric concept of depression. Some informants described the experience of 'depression' metaphorically as a downward journey, with pressure increasing the lower that they travelled. A metaphor of 'falling' or 'going downhill' was sometimes used to describe the process of becoming 'depressed': 'I suppose you find your own way to cope. You either spiral down, or you kind of : you bottom out and you get up and you start climbing back up'. In Text 7, a woman in her 50s emphasizes the intractability of her experience of 'depression' and describes the process of recovery using an extended metaphor of falling and climbing:

**Text 7**

The trouble is is if you go too far, it's gonna take you a hell of a lot longer to get out of it again because it's like climbing that bloody ladder – you get right to the top and you fall down a few more steps and then you gotta try it again. And that's just how it is.

Similarly, a woman in her 30s described the process of becoming 'depressed' using a metaphor of uncontrolled falling (Text 27). Conversely, some informants used a metaphor of ascent to describe the process of recovery. For example, a woman in her 40s who had experienced prolonged and recurrent experiences of depressive illness described the process of recovery as follows:

**Text 8**

It's superficially erm : it's getting you to slow yourself down to pick yourself back up, do you see what I mean? You've got to go down before you go back up again, before you can sort of feel more positive.

In Text 8, feeling 'down' is associated with negative agency and precipitates entry into the sick role. 'Up', on the other hand, is associated with recovery and the restoration of a positive sense of agency.

Feeling 'depressed' is more than just feeling 'low'. It is also to feel under a weight. For instance, one informant said that 'depression' was "some'ing being depressed, pushed down". Another informant described the state of 'depression' as 'unshakeable'. Similarly, another said that 'depression is that bloody cloud just above your head, it follows you everywhere'.

A container or entity metaphor was also common in informants' accounts. Like the orientation metaphors described above, Lakoff and Johnson argue that such metaphors are grounded in the embodied experience of everyday objects. The metaphorisation of 'the self' as an object or psychological entity opens up a diversity of ways for describing personal distress (e.g. metaphors of 'fragility', 'emptiness', 'cracked'). For instance, the ethnopsychiatric concept of 'depression' is partly constructed out of a container metaphor. This metaphor is generally employed in English ethnopsychological discourse as a way of describing emotion or mood states as something one 'is in' or as a substance or liquid that one 'sinks into'. For instance, a middle-aged woman used a container metaphor to express this feeling of intractability: "I 'ad depression terrible. And I really went down, and I thought: 'I'm not gonna get out of this'".

Informants did not represent their experience of 'depressive illness' as a tightly bounded event with a tidy beginning, middle, and end. Moreover, informants' experiences of personal distress commonly involved a process of experience, rather than a static one-off event. An analogy can be drawn here with Turner's re-description of social process as a 'social drama' (Turner, 1981). Among these informants, illness-like suffering took the form of a personal drama: a breach occurs in normal, everyday experience; a build-up follows culminating in a crisis; a fall or breakdown take place; redress is sought; if the measures taken to redress the situation are effective, there is a 'climbing back', a recovery; this restoration of agency is associated with an interpretive reconstruction of the suffering that has taken place and a search its meaning. The metaphors of mood afforded speakers with the linguistic resources to articulate this personal drama as a dynamic, embodied process. The rhythm of this process was sometimes depicted as fluctuations between 'up' and 'down' (e.g. Text 12). These vicissitudes of mood were captured in the metaphorical concept of a 'mood swing'. For example, one woman said: "I'm constantly up and down mood wise [...] I still feel low. I'm getting better. I'm learning how to deal with things better. I have my high and lows. I go through a lot more highs now". Similarly, a man in his 30s used this dynamic metaphor ('up and down') to describe his 'bad mood swings' (Text 9):

**Text 9**

I could be quite positive and a little bit up. And you kind of notice things about yourself [...] You could be quite hyper, and over-the-top happy. Erm, it wasn't a true happiness, don't get me wrong [...] I'd say over that period of time, I'd say, I suppose it was a bit erm : constant. But, I'd say it was probably up and down as well.

Some informants reported a cycle of 'depression and mania', of 'lows and highs', of 'flipping between the two'. Otherwise, they spoke of 'feeling high' after a prolonged period of 'feeling low' or 'feeling depressed'. Conversely, they described periods of illness-like suffering (e.g. depression) that was followed by feeling intensely 'high' or 'manic'. A woman in her 30s, for example, described how she 'gradually started to get better, but after two, three months of apparent normality, I just went to a higher state straight on. I suffered a manic state'. The dimensional



concept underlying informants' discourse on mood is clear in the following excerpt (Text 10) in which the speaker describes oscillations between 'depression' and 'mania' over time:

**Text 10**

It didn't stay the same. Like erm there's been periods where I've felt like it's got loads better. But these 'ave been quite small periods compared to the depression. It almost feels like it could be slightly manic. But, I mean, I definitely don't go off the other end of the scale. But, I do into these phases where I just feel really good.

For some informants, 'depression' or 'feeling down' was a continuous experience, sometimes becoming more severe than at other times. There was no clear differentiation between normal and abnormal, sickness and health in some informants' discourse. For example:

**Text 11**

Well, you think you're plodding along okay, and you're quite happy, and it can go on for like two months. And then som'it stupid'll just set you off [...] You think you're better and on an even keel and you go right back down again. I don't think I'll ever get that where I'm fine day-in, day-out for a long period. [...] I usually 'ave one bad day a week, and then, every two or three months, I'll 'ave a bad week. There'll be a whole week of it, and it really takes some picking up.

Others reported one-off experiences of 'depression' or other form of illness-like suffering such as 'panic attacks'. Again, these were clearly distinguished from ordinary suffering in terms of depth, duration, and the degree of disruption that they caused. Some informants reported experiencing recurrent episodes of 'depression' or 'anxiety' that took place over a longer period and, again, these experiences were articulated in terms of their duration, severity, depth, frequency, and lability (e.g. Text 12). For these informants, the experience of illness-like suffering could last for a few days or several years. For instance, a male informant reported experiencing repeated 'bouts' or 'spells' of 'mild depression'. A woman in her 30s said that her experience of 'depression' had begun continuously and then occurred in sporadic 'bursts'. Another informant used the term 'depression' as a synecdoche for his entire experience of illness-like suffering; he only ever felt 'better' against a 'background of depression'. Some of those who had experienced 'depression' on multiple occasions had become conscious of patterns or rhythms in their experience. In Text 12, for instance, a woman in her 30s depicts her experience of personal distress as if it were 'a cold' that she catches every now and then:

**Text 12**

They all take about a year. Yeh, it just seems like it's another illness. A cold is three days here, three days. To me, it just seems like depression: one year.

It's blips going down and then up, and down a bit further, then up, and then down a bit.

Each time it gets longer and deeper.

I sort of see that with every one I got worse. So. I'm sort of thinking: 'Oh the next time, what's it gonna be? How much worse can it get?'

In addition to a discourse on mood and illness, informants' discourse on distress employed the ethnopsychiatric categories of 'stress', 'anxiety', and 'panic' and a vocabulary of negative emotion. There is no space to present a full account of this discourse on distress. Nonetheless, a few key themes to emerge from the interpretation of this discourse are worth highlighting:

First, some informants used an idiom of 'stress' or 'worry' to articulate their moral concerns. Section 4.4 illustrates how these ethnopsychological categories played an important evaluative function in some informants' discourse on distress. 'Anxiety' and 'panic' were used to index highly physicalised experiences of distress that occurred in response to adversity. Although often linked, informants distinguished such distress from 'depression' or 'feeling depressed'. Like 'nerves' among Costa Ricans (e.g. Low, 1994), 'stress', 'anxiety', and 'panic' represent embodied metaphors of distress.

Second, while metaphors of mood frequently appeared in informants' discourse on distress, a psychological vocabulary on emotion was much less common. A vocabulary of 'guilt', for example, rarely appeared in informants' discourse on distress. A vocabulary of negative emotion peppered informants' discourse; e.g. a vocabulary of 'sadness', 'unhappiness', 'low self-esteem', 'worthlessness', 'hopelessness', 'disconnection', and 'loss of interest'. Some informants associated 'sadness', 'hopelessness', and 'unhappiness' with 'depression'. For example, a middle-aged woman reported feeling "hopeless because you don't see an end to it". Similarly, a woman in her 30s described her experience of 'depression' as: "No hope. Erm, a lack of hope [...] Everything is hopeless, pointless [...] I can't see any future."

Third, an ethnopsychological concept of 'low self-esteem' plays an explanatory role in both expert and lay discourse on distress. For instance, some informants reported feeling 'low self-worth' as part of their experience of suffering rather than its cause (Text 13):

**Text 13**

I'd failed, y'know. I didn't feel worth in myself. Basically, started to get very : I dunno. I just felt terrible.

I just felt worthless.

I just hated my life.

You don't give a shit about nothing, not even yourself.

That was how I understood depression: people who suddenly find themselves feeling worthless, bad, err, but without really understanding why.

A middle-aged woman who had been 'depressed' for several months used a metaphor of colour to communicate the emotional experience of 'depression' as 'that feeling where everything feels worthless and, erm, everything feels very black'.



Fourth, a few informants associated ‘depression’ or ‘feeling depressed’ with a generalised feeling of emotional disconnection and disinterest. For instance, a woman in her 30s said that she had felt ‘like an iceberg’ when she had been ‘depressed’. Similarly, a man in his 40s reported that, when he had been ‘very depressed’, at the ‘bottom of the pit’, he was incapable of expressing any emotion. A few informants reported a ‘loss of interest’ (e.g. ‘You get to that stage that you got interests’). For example, a middle-aged woman reported experiencing a generalised lack of positive feeling when she had been ‘depressed’:

**Text 14**

If somebody said to you - it’s hard to verbalise - if you : I’d say being depressed : if you won a lot of money on the lottery, or if you won a holiday that was going to take you abroad for two weeks, so what? You don’t feel great about it. You don’t feel great about anything yourself. Mentally, emotionally, spiritually, you’re low. You’re kind of zombified.

A metaphor of being ‘zombified’ (Text 14) expresses a dampening down of emotion and a loss of personal agency. ‘Feeling low’ is associated with a negative evaluation of the self and the world more generally.

#### **4.2 Loss of agency and human behavioural breakdown**

A society’s discourse on distress is formed in relation to its dominant discourses on the self, body, and society. Experiences of personal distress are articulated, evaluated, and interpreted in terms of a cultural discourse on distress. Personal distress is therefore partly constituted in terms of a society’s dominant cultural discourse on the self. In addition, if social identity and selfhood are at least partly constituted in terms of the latter, then so must experiences of personal distress.

Chapter 2 characterised a dominant Euro-American discourse on the self. This discourse prescribes a view of human ‘agency’ as ‘autonomy’, ‘self-control’, ‘independence’, ‘objectivity’, and ‘rationality’. According to Kirmayer, this view of agency is associated with a concept of the self ‘as a rational agent, which occupies a space within the body, which itself dwells within the social world [...] The person is identical with that rational agency that establishes its unique worth by promoting its own goals over those of others’ (1988: 79). Chapter 2 pointed to another subjugated view of agency in developed English-speaking societies. A sociomoral or hermeneutic view of ‘agency’ is associated with a view of ‘the self’ characterised by its sociality, its core concerns, and its distinctions of worth (Taylor, 1985). An implication of this view is that self-efficacy is partly contingent on a capacity to evaluate and interpret. The power to act (as opposed to merely behave) is contingent on the formation of positive evaluations about the self and world.

The discursive forms and genres that informants drew upon to describe and interpret their experiences of distress were rooted in these public discourses. While informants rarely interpreted their suffering as psychiatric illness, personal distress always involved some disruption in agency in their accounts. Embodied metaphors of mood and an idiom of agency were the principal figurative

devices used to depict such disruption. In some cases, a breakdown of agency provided the grounding for an illness metaphor that, in turn, warranted entry into the sick role. In many cases, if personal distress had not disrupted agency so profoundly, then there would be no need to visit a doctor. This disruption in agency had five dimensions. Each of these corresponded with a different dimension of agency (as defined within Euro-American discourses on the self and body):

- Moral agency: a breakdown of agency in the interpretive and evaluative sense;
- Embodied agency: a breakdown in the capacity to physically act, to move one's body into action;
- Volitional agency: a breakdown in motivation;
- Behavioural agency: a breakdown in functionality and in the capacity to act in a controlled or co-ordinated fashion;
- Social agency: a breakdown of sociality, social disconnection, and social exclusion.<sup>48</sup>

### **Demoralisation: the loss of moral agency**

The 'emotional pathologies' involve a disruption of a positive sense of agency. Within English ethnopsychology, a vocabulary of mood, emotion, and feeling are used to account for and interpret action and behaviour. Similarly, in English discourse on distress, a disruption of mood and emotion (a breakdown in agency in the interpretive or evaluative sense) was regularly used to account for a loss of behavioural control, a loss of functionality, or breakdown in sociality (e.g. Texts 28, 29, & 33). In some cases, feelings of emptiness, disconnection, or a negative evaluation of the self or future had negative implications for the capacity for action or the inclination to engage with others. For example, a man in his 20s reported feeling disconnected from his emotions and therefore lacked motivation (Text 15):

#### **Text 15**

It was more like I was cut off from all these nice feelings that really keep you going, that keep you doing. The things you like. So, I was almost acting out from memory of what I used to do, y'know [...] It felt like everything that I'd ever valued in life, y'know, the value that they had, had gone.

This speaker's capacity to form positive evaluations or distinctions of worth was disrupted. He uses the metaphor of an empty container to express this feeling of emptiness (Text 15). For instance, he described himself as 'an empty shell that's incapable of feeling'. This negativity was generalised leaving him without a positive grounding for action ('I suppose just every aspect of my life was tainted by how I felt').

A loss of a sense of agency was central to informants' experiences of illness-like distress. This can also involve a disruption of personal or social identity. For example, a woman in her 40s associated her experience of depression with a breakdown in her social identity and this was associated with withdrawal and social disconnection and the loss of a valued social role: 'I just seemed to lose my identity completely'. She went from being "quite a successful, articulate career person, to just somebody who just didn't do anything [...] I didn't go out with my friends. I just : I just didn't



want to. All I wanted to do was get into the safety of my home and stay there”. Similarly, in the low-narrativity, habitual narrative below (Text 16), a middle-aged woman describes the loss of identity that had accompanied her first experience of depression:

**Text 16**

When I experienced the first deep, very deep and very dangerous depression,  
I suddenly couldn't recognise the places that  
I : where I was.  
I was feeling very scared  
and I : suddenly :  
I just couldn't talk.  
Not because : not because I was de : de : deaf.  
If somebody asked my name,  
I didn't know.  
I didn't even know my name.  
And people who knew me asked:  
'How are you?'  
I couldn't even answer.  
I was just terrified.

This excerpt (Text 16) tells of a breakdown in the capacity to communicate or talk, symbolised by the forgetting of her own name. Again, the metaphor of 'depth' is used to articulate the severity of the distress.

### **A disruption of embodied agency**

Chapter 2 described how the distinction between 'somatisation' and 'psychologisation' is contingent on a dominant Euro-American folk psychology. This discourse is organised around a set of western metaphysical antinomies. Yet, these antinomies collapse in the face of embodied distress. Such distress starkly clashes with a dominant Euro-American discourse on the self and the institutions and practices grounded in this discourse. As Chapter 2 showed, somatic and psychological idioms of distress are commonly used to articulate personal distress among western populations. In fact, the dominant 'idiom of distress' employed in developed English-speaking societies is 'a discourse on agency'. English speakers (e.g. 'feeling low' or 'feeling depressed', 'anxiety', 'panic', 'mania') are constrained to articulate suffering as a disruption and, in more severe cases, a complete breakdown in embodied agency and behavioural functioning.<sup>49</sup>

English lay discourse on distress has assimilated a biomedical discourse on distress to a high degree. A poor degree of fit between this official discourse on psychological suffering and the embodied experience of distress forced the creative deployment of trope in informants' accounts. In some informants' discourse, the psychological and the somatic domains were depicted as though they were independent. As informants' stories unravelled, it became clear that their experiences of personal distress had had a strong somatic component. They therefore employed metaphor to physicalise their descriptions. These descriptions involved a metonymic reduction from intangible and inchoate feelings and sensations into concrete and tangible representations; bodily feelings were selected out and amplified in concrete metaphors and embodied symbols. Some informants described how their distress had involved a disruption in their appetites (e.g. 'eating not quite so

good'; 'I couldn't eat'; 'I lost half a stone'). Some disruption of sleeping patterns was also common. For instance, a woman in her 20s described how her experience of 'depression' had started with a disruption in her usual sleeping patterns and this had precipitated a visit to her doctor. In Text 17, another female informant describes how 'stress' had disrupted her sleep:

**Text 17**

I think that maybe once you are stressed and you are very wound up, maybe that, in my case, was altering my sleep pattern. Once you can't sleep, you feel pretty crap. I think you don't have time for yourself, you don't have time to sit, not necessarily think, 'cos, in my case, I think that makes me worse.

Many informants reported 'feeling tired' or 'lacking in energy' (e.g. Text 33). A woman in her 50s described how she 'would wake up in the morning and feel that I'd had no rest'. A man in his 50s said that his experience of 'mild depression' had involved difficulties in sleeping and had begun as a feeling of 'tiredness'. 'Feeling depressed' had left him without 'mental energy' and, therefore, 'physical energy'. Once he 'felt tired', he no longer had the energy to resolve his problems, so they began to 'build up'. He could see 'no way out'. Similarly, one middle-aged female informant described how she had 'just felt physically and mentally exhausted' when she had been 'depressed'. A man in his 20s used a psychological idiom of mood to describe his experience of 'depression' and then, at the end of his account, listed the somatic features of his illness as though they were independent of its psychologisation: "Physically, it's, y'know, no energy, losing weight, not sleeping properly, not much of a sex drive". A man in his 30s described his experience of 'depression' as 'my very bad illness' which left him in a 'a terrible, terrible state' so that he "couldn't coordinate", was unable to sleep ("I didn't sleep at night for six months. I used to sleep in the morning"). It had left him feeling 'completely drained', 'a physical wreck'.

Some informants used a vocabulary of 'pain' to depict their experiences of personal distress. For instance, a man in his 30s described his experience of 'depression' using an idiom of 'mental pain': 'All you've got is pain in your mind'. Similarly, a vocabulary of 'mental pain' was prominent in the account of a female informant in her 40s: "I don't know how anybody can think that anything in the mind is painful", she said, "but it is so painful. It's like pain : I've never experienced pain like it". Finally, a woman in her 50s who, while reflecting on her experience of 'depression' many years before, described how it had first manifested itself as a pain or tension in the head: "I had a bad head [...] Everything was in my head. So, my head was so, so tense".

Agency is embodied so that the physicalisation of distress had implications for informants' functionality and their capacity for action (e.g. Texts 27). In many cases, this precipitated an initial consultation with a doctor. For instance, a woman in her 40s said how, once she had become 'depressed': "I just couldn't do anything [...] I just couldn't function at all. Everything I was doing was on automatic pilot". Text 18 is taken from the personal narrative of a woman in her 40s. She was one of the few informants to describe her experience of 'depression' as a 'mental illness':



**Text 18**

It is very difficult to define your feelings about it all, because it's not a physical thing. Although it does have a physical bearing on your physical ability to do things [...] You're not moving around as quickly as you would do if you were positive. So, the debilitating thing about mental illness is that it slows our body down. [...] It disables you even to wanting to motivate yourself in the mornings, because, sometimes, you just feel so weak physically.

This informant went on to describe how her experience of depression also involved 'panic attacks' and how these further disrupted her agency. She said, for example, that she was 'not able to function on a daily basis - doing the normal routine things, being able to hold down a job - because I get panic attacks'. While her experience of distress is interpreted as a mental phenomenon (Text 18), it had physical consequences; it was associated with a breakdown in embodied functioning (as 'disabling' or 'debilitating'). This undermined her ability to carry out her usual social roles, to work, and to maintain social relations with others. This illustrates how the embodied and debilitating nature of depression provides the grounding for the illness metaphor configured in an ethnopsychiatric illness category 'depression'. Continuing with this theme of how distress becomes embodied, Text 19 presents the low-narrativity narrative of a man in his 50s:

**Text 19**

1. I was never shy about speaking to nobody
2. and I noticed
3. I was getting like erm :
4. I was going there [to the meetings]
5. and I was starting giving it this like
6. [gestures with shaking hands]
7. and I thought:
8. 'Oi up, what's going on 'ere?'
9. That's when it all started coming on,
10. and I started thinking about it.
11. Then when we started 'aving meetings [...]
12. and I started getting tight for breath,
13. a bit of heavy breathing like.
14. And I 'ad my heart checked out
15. and everything like that.
16. Nothing wrong with me 'eart. [...]
17. That's just how it started coming on.
18. It was like one thing after another.
19. Y'know, I thought :
20. I used to say to the missus:
21. "I'm sure blokes go through the same things as women,
22. like a menopause, or whatever they calls 'em -
23. I'm sure some blokes go through it."
24. I used to say:
25. "Well, what's the matter with you?"
26. I got nothing to worry about.
27. My house is paid for.
28. I've got plenty of money in the bank.

In this 'generic narrative', the speaker employs 'narrativity' to dramatize his experience of distress in relation to its social setting (Text 19). The meaning of distress is interpreted in terms of its consequences. Experience is presented in a way that is consistent with a masculine identity. The speaker's suffering presents a threat to the preferred version of himself. He symbolically associates emotional distress with women (lines 20-21). Discourse on emotion or mood is absent. His suffering is presented as a highly physicalised experience (e.g. as tightness of breath and shaking)

and it is presented as a medical mystery, as if it were an unexplained illness. The force of this discourse is to persuade the listener that these unexplained symptoms could not be psychogenic in origin. Since he symbolically associates ‘worry’ with financial difficulties, and given that he has no such difficulties, he cannot be worried (lines 25-27). Since he has no ‘worries’, his physical symptoms cannot therefore be psychogenic in origin.

As the last example showed, ‘depression’ is associated with a disruption in normal bodily experience and embodied agency that makes it appear illness-like and so distinguishes it from ordinary suffering. Like chronic illness, it involves a breach in normal bodily experience and in the ability to perform usual roles and routines. For instance, a woman in her 40s differentiated ‘depression’ as an illness from ‘feeling down’ in terms of its physical impact. In Text 32, for instance, she describes how ‘the whole body can shake’ when she is ‘depressed’. In a small number of cases, the early signs of personal distress had been somatic. Possibly as a consequence of medical encounters, these informants came to view these somatic signs as psychogenic in origin. Personal distress (e.g. ‘depression’) was interpreted as the underlying cause of these somatic symptoms because no organic cause could be found. For example, a man in his 40s described how the early signs of ‘depression’ had been embodied as a pain in his leg. The doctors could find no physical cause for this pain. On receiving a diagnosis of ‘depression’, he formed a psychogenic interpretation of this physical pain (e.g. ‘The pain in my leg was more of a symptom of being depressed’). In another case, a woman in her 40s initially experienced ‘a pain in the jaw’ for which her dentist could find no physical basis. On consulting a doctor about her pain, she described how she had ‘just burst into tears’. After this medical encounter, the pain in the jaw vanished. She therefore depicted her physical pain as a metonym for her personal distress.

### **A breakdown in motivation**

The experience of ‘depression’ often involved a loss of motivation, despondency, a loss of interest, and demoralisation (e.g. Texts 20 and 27). This was often embodied as ‘tiredness’ or a ‘lack of energy’. For instance, a female informant in her 40s said that when she had been ‘depressed’, she “didn’t wanna do anything”, “didn’t want to go out”, and “didn’t wanna talk to anyone”. Similarly, a female informant in her 30s said that when she felt ‘really unhappy’; she had ‘no motivation to do anything’. In Text 29, a man in his 20s describes a breakdown in motivation and a state of generalised despondency. The phrase, ‘staying in bed’, was used metonymically by some informants to describe this lack of motivation and loss of agency. For example, one woman described how ‘depression’ had taken control of her life to such an extent that she was unable to get out of bed and lost all motivation (Text 20):

#### **Text 20**

I think last week I felt really low. Some days it was an effort to get out of bed. And in retrospect, thinking back to how those days were [when she was depressed], every day was like that for me – every day from beginning to end. Because there were days when I didn’t go out at all. It was hard to get out of bed.



The lay metaphors of mood ('low', 'down', and 'depressed') can now be re-interpreted as being grounded in both psychological and somatic experience as embodied metaphors of agency. English discourse on mood depicts agency and its vicissitudes, the 'ups and downs' of motivation and inclination. The informants included in this study invoked these mood metaphors in order to depict how their agency had broken down. For example, a woman in her 30s used a metaphor of mood to describe her experience of recurrent 'depression' and emphasised how this feeling had been associated with feelings of disconnection: "I was just really : really low [...] I didn't wanna go out". For instance, the following excerpt (Text 21) was extracted from a narrative account of a woman in her 20s and describes the impact of 'depression' on her life:

**Text 21**

It [feeling depressed] restricts me from doing things that I would like to do because I haven't got the confidence to do them [...] I could just get up and do something. But I can't. [...] I get lower and lower. It stops when I might be in a particularly good mood and then I'll do some'ing that I wouldn't usually do. And that'll perk me up. And I'll start making more of an effort then, and doing things that I wouldn't usually do. But, then, if I get tired or something or if I 'ave a bad day at work, then I won't. And I won't do it again. And, then, it'll start all over again. So, I'm constantly up and down moodwise.

Text 21 illustrates how English discourse on mood provides way of symbolising the contingent relationship between action and embodied agency. A 'good mood' is to be 'up' and is associated with positive action. 'Feeling low' or 'down', on the other hand, is associated with tiredness, lethargy, inertia, a feeling that one's capacity for action has somehow become constrained. In English discourse on distress, disruptions in feeling or mood are used to account for breakdowns in action. Conversely, this breakdown in the capacity or inclination to act has implications for how a person feels and how they evaluate and interpret themselves and the world.

**Idioms of agency: 'coping' and 'control'**

Lutz has argued that a 'rhetoric of control' figures strongly in American discourse on the self and emotion. Emotions are constituted as 'something in need of control', to be coped with, dealt with and managed (1987: 71). In his characterisation of the dominant cultural discourse on 'the Western self', Kirmayer maintains that 'self-control' 'implies rationally guided behaviour'. 'Self-control' and independence are proscribed within the hegemonic discourse on the self within developed English-speaking societies. This proscription is gendered so that, as Kirmayer puts it, 'the claim to be out of control carries far more stigma for men in North American culture. While an out of control woman brings to mind someone weeping, an out of control man is likely to be imagined as aggressive or violent' (1988: 71). Not being able to 'cope' or not being 'in control' are therefore evaluated negatively and attract a social stigma. Moreover, as Lutz (1987) points out, the open expression of emotion is viewed as a sign of irrationality and weakness.

English informants in the study reported here regularly used a metaphor of 'control' and an idiom of 'coping' to describe their experiences of personal distress. The self was typically positioned in a passive mode relative to the events depicted in their accounts. For example, a middle-aged woman

described her experience of 'depression' as: 'The feeling of not being in control of things. Everything going on around you, and you're not in on it, you're not a part of it. Things out of control'. Similarly, a middle-aged man told how his experience of 'depression' involved 'a loss of control'. In order to recover, he 'had to control it. But for a while it did control me, because my life was terrible. I think it becomes so much you: it kind of takes your body over. Because I think it was such a deep, deep depression'. A man who had recovered from a prolonged experience of 'depression' used an idiom of 'control' to articulate how he had regained his sense of agency: "Now I've learnt to be able to control it and it's still there, but it's not controlling my life anymore". The following sequence of quotes (Text 22) illustrate the use of this idiom of 'coping' as a way of expressing this loss of a sense of agency and control:

**Text 22**

I couldn't deal with my life. I couldn't cope with things.

I just couldn't cope.

I just could not cope with other people. And I was finding it really difficult to cope with my own children.

You can't cope with your life. You just can't handle things that you would normally handle quite easily : it's sort of hopelessness. And, yeh, it's not : not able to carry on.

Text 22 illustrates how more severe experiences of personal distress sometimes undermined the performance of social roles that represent an important source of a positive social identity. Personal distress can disrupt the ability to 'cope' at work, in the home, in everyday life. What it means to 'cope' is relative to the roles and identities that an individual performs. For instance, in Text 23 a middle-aged woman uses an idiom of 'coping' to describe an experience of distress that occurred in response to a family crisis:

**Text 23**

I felt I was going really mad. I couldn't cope. I couldn't talk to anybody. I was crying. I was screaming. Totally strung up and totally : I felt that I had no support whatsoever and nobody understood. Nobody. Just totally on me own with a situation I knew very little about. I couldn't cope with it.

In this excerpt (Text 23), an idiom of 'coping' is used to express distress that was experienced as a 'loss of control'. In Text 24, a man in his 40s describes his experience of 'depression' as a breakdown in 'coping':

**Text 24**

The feeling that I couldn't really cope with everything [...] And, then, I talked it through, and stood back a little bit: 'No, I can normally cope with that job'. It's just that everything else sort of piled in on me.

This speaker's difficulties in coping meant that he had been forced to give up his job, precipitating a temporary social withdrawal (Text 24). In Text 25, the same speaker goes on to differentiate 'depression' (a breakdown in 'coping') from 'stress' (still trying to 'cope'):



**Text 25**

I tend to think of stress as being an agitated state; when things are eating away at you and you get very agitated, like you don't withdraw and stuff: 'I cannot cope with this'. You maybe try and cope with it. Things seem to be coming at you from all angles. But, you are in some way dealing with it. With depression, things maybe coming at you and you withdraw and think : go into a shell, if you like. You don't try and deal with them head on.

'Stress' and 'depression' disrupt personal agency in different ways and to different degrees (Text 25). 'Stress', for instance, is associated with difficulties in 'coping', but there is no complete breakdown of agency. With 'depression', on the other hand, there is a complete 'withdrawal' from the world associated with a breakdown in 'coping'. The latter is associated with a disruption of identity analogous to the 'loss of self' sometimes associated with the experience of chronic illness (Charmaz, 1983; Nochi, 1998).

Exactly how agency breaks down is partly a function of the sufferer's social identity. For example, Text 26 presents a generic, low-narrativity narrative of depression belonging to a woman in her 30s. The speaker is married and performs a gendered domestic role in the home, caring for her children and maintaining the family home. The text illustrates how social position and identity influence the way that personal distress is experienced and communicated:

**Text 26**

1. I was really, really tired.
2. I couldn't move my arms, my legs.
3. I just : to get out of bed in the morning
4. was such an effort.
5. It really was.
6. It is sometimes now.
7. But, back then, it was day-in day-out, every day.
8. Erm, that's the main thing
9. I can remember being really, really tired and miserable.
10. And I'd be shouting at the kids all day.
11. I'd just be shouting
12. an' whatever they was doing :
13. if they'd one toy out,
14. I'd go mad
15. because they were messing up the house.
16. And I just couldn't stand 'em
17. messing up the house.
18. And erm that would drive me mad,
19. and I'd be shouting at them [...]
20. I'd be like :
21. erm, I 'ad this compulsive need -
22. when he'd [her partner] come in from work,
23. I 'ad to 'ave the tea on the table for 'im.
24. No matter what the children were doing,
25. I'd make sure
26. I cooked 'im that meal,
27. and made 'im see I was coping,
28. and could do it,
29. that it wasn't bothering me.
30. I think it was mainly like the cleaning where :
31. I've never been one for housework anyway.
32. But, yeh, I think
33. that was the main thing: the cleaning and the tiredness.

In Text 26, narrative clauses depict the linkages between recurrent, generalised events that occurred at an unspecified point in the past. A central theme is the speaker's difficulty in coping with her usual social responsibilities as a mother and home keeper. It begins with a description of a breakdown in her embodied agency and a loss of motivation (lines 1-9). This became manifest as an overperformance of her domestic duties. This had negative implications for her relationships with other family members (lines 10-20). Her ability to cope in her domestic role was signified by the daily preparation of an evening meal for her partner (line 26-29). How her agency became disrupted was partly constituted by her social role and the social identity associated with it.

Discourse on illness and distress does not always conform to culturally defined narrative prototypes. In informants' discourse on distress, the self was often positioned in a passive role in relation to the action and the locus of control depicted exogenously, as external to the self. In 'dramatistic' terms, the agent-scene ratio was weighted towards the scene.<sup>50</sup> For example, in the following low-narrativity narrative (Text 27), a woman in her 30s tells of her struggle against falling into a state of 'depression':

**Text 27**

1. I tend to get really anxious
2. before I get a depression.
3. I'm really struggling not to get like that,
4. but, it's almost :
5. I'm like, erm, like a swan,
6. y'know, under the water,
7. with the legs going,
8. trying not to sort of slide into this depression.
9. And, I'll do everything
10. I can to try and make : y'know.
11. 'cos the minute I sort of go on this slidey slope
12. down to a deep depression,
13. I can't seem to get back up again.
14. It's like another year or so.
15. So, there's real, y'know, panic.
16. But erm : then I take,
17. I take : everything goes out,
18. completely out of co : completely out of :
19. what's the word I'm looking for - out of :
20. I dunno.
21. Everything small seems large.
22. It's like, y'know,
23. I get really worried.
24. I get really worried
25. that I can't, say, pay bills
26. or do normal things.
27. Then, I started having these, these stupid routines like
28. writing it down in my book
29. to forget :
30. to remember that -
31. normal things that I would do in my stride -
32. and I would be writing them down in a book, say,
33. and trying : y'know,
34. trying to keep tabs on :
35. 'cos everything just seemed out of control
36. and it was :
37. it was just awful.
38. And I just :
39. it was like, leading up to the depression,
40. everything's just like going out of control.
41. And, then, one day, it's like:



42. I can't cope.
43. And it's, y'know :
44. And I just slide.
45. And that's it.
46. Then, I just don't do anything.
47. And I just sit there like a vegetable.

In Text 27, the speaker portrays her embodied experience of distress as a breakdown in agency. The discourse deviates from the definition of a prototypical narrative; narrative clauses are rare (there are two - at lines 27 and 41) and a low level of narrativity is used to portray the disrupted nature of the experience being recounted. The description has a loose event structure and tells of generalised experiences that are repeated with unclear boundaries. The present tense and continuous aspect are used to emphasise the repeated and habitual nature of these experience. A loose plot line traces an inexorable slide into a depressive state. This contrasts with a struggle to maintain control and to prevent such a slide. There is a turning point at line 41 that marks the beginning of a descent to a point where agency has broken down altogether.

How does the speaker position herself and portray her agency in the text? On the one hand, she presents herself as someone who struggled to resist a descent into depression, desperately trying to maintain control. On the other hand, the self is presented as someone who is unable to 'cope', as 'out of control'; in this case, she depicts herself as a passive object of experience rather than as an agent of change. On another occasion, she used an idiom of 'coping' to depict the 'loss of control' associated with a fall into a solid state of 'depression': "I was struggling not to slide into this depression. Then, again, it happened. One day, I thought: "I just can't cope anymore'. I slid. And then it's almost like, once I've slid, I can't go back".

Gergen and Gergen's (1984) distinction between 'regressive' and 'progressive' plot lines is useful here. 'Regressive' plots arrange narrative events in relation to a negative end state while 'progressive' plot lines delineate a movement towards a positively valued ending. In this sense, narratives can be viewed as articulating distinctions of worth, the shared moral values of a community, and thus articulate human agency. Given the low level of 'narrativity' in Text 27, coherence is achieved through a regressive plot line that is configured out of the root metaphors of depth and descent towards a negatively valued end state. An inanimate object is used as a metaphor to figure the speaker's embodied experience of human behavioural breakdown. The speaker portrays herself as descending through a series of subject positions: from agent status, the experience of 'losing control', to being 'out of control', and ending in an inanimate position. Agency is located in an indefinite object *it* that drives the descent. This breakdown in agency foreshadows her subsequent hospitalisation and entry into the sick role. A dominant Euro-American cultural discourse on 'the self' is latent in the account, a discourse that associates the idealised (healthy) self with autonomy, self-control, and independence. Personal distress is presented as a breakdown of self and agency. If narrative depicts agency, then narrative incoherence and low narrativity are available to English speakers for depicting its break down.

## **Social disconnection**

A breakdown of agency was commonly associated with a disruption in social relationships in informants' discourse on distress. This was sometimes a function of a breakdown in sociality, in the disposition and capacity to engage in positive social relationships. For example, a few informants associated feelings of loneliness with 'depression'. One young woman said that the central feeling in her experience of 'depression' had been of feeling 'completely alone'. Similarly, a man in his 30s described his experience of 'depression' as 'an eternal feeling of loneliness [...] utter loneliness'. Metaphors of disconnection were common in informants' discourse on distress (feeling 'withdrawn', 'shut off', or 'cut off'). For example, one informant described 'feeling depressed' as 'a withdrawn, reclusive feeling'. A woman in her 40s who had suffered from depression said: 'I went to hide on my own, shut myself off from people'. For some informants, social withdrawal and self-exclusion had been a conscious strategy. For instance, a man in his 50s had retreated 'into a shell' because he felt unable to cope. A woman in her 30s described how she had felt "really tired, really withdrawn. I wouldn't go out. I never took 'em [her children] to playgroups of anything like that. I just wouldn't go out the house". A middle-aged woman described how she had cut herself off from the world completely when she had been depressed: "I used to just get up in the morning and sit in a chair, and I didn't go to see friends. I'd cut off all my friends then. Cut off the television. Cut off the news". She would avoid anything 'that would stir up what was already going on in my head'. 'Cutting off' was a way of coping with her vulnerability and a strategy for restoring the control she had lost. A woman in her 20s described how she had shut herself away in her bedroom and stopped doing 'normal chores' like shopping. Similarly, in Text 28, a woman in her 40s describes how she avoided others as a way of coping with her distress:

### **Text 28**

I had completely shut everybody out then. I thought that if I can cope with my own little world, in my own home, then I'll be fine. Nobody else can upset me [...] I was no good socially at all.

These accounts support Karp's interpretation of 'depression' as a 'disease of disconnection' (1996: 178). Based on qualitative research among a North American sample, he argued social disconnection is intrinsic to depression. It is also one of its chief consequences: 'The pain of depression arises in part because of the separation from others; from an inability to connect, even as one desperately yearns for just such connection' and 'the inability to remain socially connected is a chief consequence of the illness' (1996: 26-27). Karp also highlighted the close relationship between social disconnection and a breakdown in agency: 'The self loses its social foundation, begins to wither [...] It is in depression's vicious feedback loop – the downward spiral of hopelessness, withdrawal, the erosion of the self, the still more powerful feelings of hopelessness, the even greater impulse to withdraw, and so on – that we witness, in its most negative form, the dialectic of self and society' (1996: 16).



This negative dialectic was also an organising theme in discourse on distress among some English informants. For instance, in Text 28, a breakdown in agency coincided with a breakdown in sociality and a desire to avoid social contact. Similarly, in Text 29, a man in his 20s depicts his distress as a gradual process of social disengagement:

**Text 29**

I did just spend most of my time in bed  
'cos I did get a job.  
Well, it was very boring - mundane and boring.  
And, erm, I just started thinking  
it was all I've got  
to look forward to in life  
'cos I can't do anything else.  
Erm, y'know, so I was very negative then.  
Well, yeh, totally despondent.  
And, I think it was this time  
that I really lost contact  
with a lot of my friends [...]  
I started getting into  
where I was just really,  
I dunno,  
sort of going a bad way.  
I was just like watching TV,  
whatever was on.  
Just really shut off.

This generic, low-narrativity narrative (Text 29) depicts a generalised loss of interest. This resulted in a breakdown in embodied agency and sociality so that ongoing relationships became disrupted. The excerpt also describes part of the social context of his distress; the absence of a fulfilling, stimulating job further exacerbated his feelings of despondency.

'Human behavioural breakdowns' are also breakdowns in social agency. Like chronic illness, 'depression' and the other 'emotional pathologies' often disrupt biography. For instance, in a British survey of people who had experienced a mental-health difficulty at some point (Rogers *et al*, 1993), respondents were asked how such difficulties had affected their lives. The vast majority said that it had had a negative impact on their self-confidence, relationships, employment, and their financial situation. Similarly, in the research reported here, personal distress was commonly associated with social and sometimes economic exclusion in informants' accounts. In many cases, the loss of agency associated with distress further deepened the adversity that had produced their distress in the first place (e.g. Text 29). Social disconnection and exclusion meant that access to sources of support could become more limited.

A 'loss of control' or a breakdown in 'coping' meant that some informants had found it difficult to hold down a job or perform their usual social roles. For example, a female informant in her 30s used an idiom of 'coping' to depict the negative impact of her distress on her social relationships, particularly with her children: "I just could not cope with other people. And I was finding it really difficult to cope with my own children. If they questioned something, I would just scream at them or just cry: 'Go away'". A woman in her 40s described how a disruption in her embodied

functioning had undermined her capacity to engage socially: “Sometimes, I don’t know what to say to my friends or my family. You’re like in a world of your own sometimes [...] You’re totally engulfed by your own emotions and problems [...] You’re just disorientated. It just goes over your head – conversation – because you’re not there. You’re not functioning properly.” Other informants highlighted how a disruption in their sense of agency had had a negative impact on their employment status. For instance, a woman in her 30s described the effect of social anxiety on her social and work life: “I suffer from paranoia, anxiety [...] I’ve been unemployed for about ten years. I find situations when I’m around people very stressful [...] I found it hard to function in the outside world.” Similarly, a man in his 30s described how a prolonged experience of depression had disrupted his biography (‘absolutely turned my life completely upside-down’) so that he was unable to hold down a job (‘I didn’t work for about nine months’). In another case, a woman in her 50s described how the loss of control associated with her distress resulted in her losing her job: “Well, I lost everything, I lost my job. I lost my home [...] I just lost control of the whole situation then. I can’t : looking back now I can’t even remember it”.

#### **4.3 The illness metaphor: loss of agency and social disconnection**

Along with metaphors of mood and a discourse on agency, the illness metaphor was a common way that personal distress was articulated among these English informants. Bury’s distinction between ‘spectral’ and ‘categorical’ illness concepts<sup>51</sup> applied to the way that they conceptualised their experiences of personal distress. Section 4.1 showed how individual experiences of personal distress were located on a spectrum that stretched from ‘ordinary suffering’ at one pole through to more severe illness-like distress at the other. Informants applied a dimensional concept of distress to emphasise how it could have a more or less negative impact on agency, social engagement, and embodied functioning. More severe distress was characterised in terms of depth, duration, and intractability. In many cases, informants therefore drew a categorical or qualitative distinction between illness-like distress and ordinary suffering, although exactly where and how this line was drawn varied considerably.

What is the grounding for this illness metaphor? Section 4.2 drew on informants’ accounts to argue that the experience of personal distress in developed English-speaking societies typically involves a disruption or breakdown in agency and that this can take a variety of forms. Medical sociologists have shown how chronic illness in western settings commonly involves a breakdown in agency and a disruption in social relationships (Bury, 1982; Charmaz, 1983). Bury, for instance, has described how chronic illness is experienced as ‘a disruptive event’, ‘a critical situation’, and has characterised it as a ‘form of biographical disruption’ (1982: 169). Chronic illness can disrupt the ‘structures of everyday life’ and dislodge social relationships, challenging the sense of self, and forcing a re-examination of existing goals and projects. Social relationships and the ability ‘to mobilise material resources’ can become disrupted (Bury, 1982). Charmaz (1983) and Nochi (1998) have interpreted this breakdown in agency associated with chronic illness as a ‘loss of self’.



Charmaz describes how chronic illness results in a 'restricted life' and a withdrawal from usual social roles resulting in 'a diminished self-concept', a 'crumbling away' of 'former self-images without simultaneous development of equally valued new ones' (1983: 192).

Illness-like distress resembles chronic illness in that it disrupts everyday routines, personal agency, and social relationships. It is also associated with a more or less severe and stereotyped set of somatic symptoms that prototypically distinguish one ethnopsychiatric category from another. These symptoms can be more or less pronounced depending on the severity of the distress. Drawing on a prototypical concept of chronic illness (i.e. as a prolonged physical complaint that disrupts everyday functioning and requires biomedical intervention), many informants pointed to the somatic concomitants of personal distress in order to warrant its status as an illness and as a way of legitimising their suffering. Section 4.1 showed how an ethnopsychiatric illness category of 'depression' was regularly employed by these English informants to refer to more severe, intractable, and prolonged experiences of personal distress. They distinguished 'depression' as illness from ordinary suffering both dimensionally and categorically; 'depression' represents a severe form of ordinary suffering and is qualitatively distinct from such suffering. For example, a man in his 30s described his experience of 'depression' as 'those bad feelings [...] my very bad illness'. In Text 30, a man in his 50s characterizes 'depression' as an illness, but not a disease:

**Text 30**

I think I see it as a mental illness, but it can have physical effects, maybe in tiredness, en you actually feel that you've got no life in you. You can't do anything [...] I definitely consider it an illness. I see it as err quite a serious illness, although you can come of it [...] I wouldn't call it a disease. I suppose I make a distinction in my mind: an illness is a bit less serious than a disease. When you think of diseases you think of, erm, like sort of : plague's a disease or that type of thing [...] The word 'disease' to me has a far-reaching sort of connotation, with whole populations affected by it.

The prototypical concept of 'disease' employed here is that of a contagious germ. Depression, though, is not contagious and is less serious than a disease (Text 30). The illness metaphor is grounded in the embodied nature of the distress. Depression is believed to be serious in that it has a negative impact on embodied agency, thereby qualifying it for biomedical intervention. In the next example (Text 31), a woman in her 40s interprets her distress using the folk psychiatric noun-phrase, 'clinical depression', and seeks to categorically distinguish it from ordinary suffering:

**Text 31**

It was only because I've heard that mentioned so much. I mean people in everyday life say they are 'depressed' I think: 'You don't even know what the bloody word means I expect.' Because to me, what I imagine people mean by 'clinical depression': they treat it as an illness.

Text 31 distinguishes between the ordinary use of the term 'depressed' and 'depression' as illness or 'clinical depression'. The speaker went on to negotiate the meaning of her experience as an instance of 'clinical depression'. The reflexive medicalisation of her distress conferred moral

legitimacy upon her suffering. The rhetorical prefixing of the term 'depression' with the adjective, 'clinical', signals that her distress is a biomedical responsibility or concern. 'Clinical depression' is 'depression' as illness; it involves a physical 'breakdown', medical treatment, and can involve admission into hospital. In Text 32, she went on to characterise 'depression' as a 'mental illness', as qualitatively distinct from ordinary suffering:

**Text 32**

We can all say: 'We're depressed'. But there is such a difference in saying: 'Oh, I feel down. I feel depressed', when really you just feel down. You've had a hard day, a hard week, and you feel, y'know : it's not : whereas ours is clinical depression, because ours is something up here [gestures to her head]. So, it is : that [...] something up here [gestures to her head again] that's making us feel that we really have got something wrong with us [...] The whole body can shake, and so that has gotta be the clinical depression. Whereas, depression you just : I feel down in the mouth and everything's an effort, or it's an effort to get out of bed, and that you need to be motivated. But there is a hell of a difference.

Ordinary suffering is distinct from 'clinical depression' in that the latter has physical consequences ('the whole body can shake'), is associated with a breakdown in agency, and is ontologically located in the head (Text 32). The persuasive force of this discourse is to convince the listener that 'clinical depression' is an illness just like other chronic illnesses. The discourse works to position the speaker as someone who suffers from an illness: it portrays and partly constitutes an illness identity.

How does illness-like distress become socially recognised as an illness? How is personal distress re-constituted as an object of biomedical concern? What is the social process through which ordinary suffering is transformed into a sickness? On the one hand, the representation of personal distress as illness experience is symbolically and socially produced. On the other hand, the illness metaphor is grounded in the embodied nature of personal distress. Section 4.1 showed how a root metaphor of verticality organises English informants' descriptive discourse on distress. This root metaphor articulates dominant cultural concerns within English society. English metaphors of distress form part of a wider moral discourse that encodes collective concerns. For instance, Lakoff and Johnson (1980) have highlighted how orientational and spatialised metaphors have an evaluative component. 'Up', for instance, is symbolically associated with action, mind, reason, agency, and is positively evaluated. 'Down', on the other hand, is associated with passivity, irrationality, body, emotion, lack of self-control, and is evaluated negatively. Illness experience and personal distress are similarly located on the devalued side of this dualistic system (Kirmayer, 1988). They therefore become subject to a powerful conjunction of therapeutic and normalising practices. These antinomies organise biomedical discourse on distress and are institutionalised in the social roles of doctor and patient. 'Chronic illness' becomes a cultural template for expressing, experiencing, interpreting, and responding to personal distress. Psychiatric discourse fixes the somatic concomitants of personal distress and social suffering into an organising illness metaphor: that of a 'mental disorder'. On encountering such discourse, the sufferer is then placed under pressure to take on an illness identity in order to gain entry to the sick role and access scarce



palliative resources. In this social and symbolic process, personal distress is metaphorised into a sickness.

Personal distress represents a deviation from normative notions of the self as articulated in a dominant Euro-American discourse on the self. It is experienced, expressed, and interpreted as a breakdown in agency, a loss of control, an inability to cope, and a loss of dependence. The experience of 'depression', for instance, is represented both as a breakdown in functioning and as a disruption of social ties and usual roles. Such distress is the symbolic inverse of idealised notions of the self in western societies that partly explains its pathologisation. To feel 'down' (as opposed to feeling 'up') is symbolically associated with a breakdown in embodied agency, a 'loss of control', on the one hand, and with being a patient, with illness, on the other.

Kirmayer maintains that the concept of the 'sick role' is a 'prototype in both lay and professional thinking about illness' (1988: 62).<sup>52</sup> He describes how the disruption caused by chronic illness precipitates entry into the 'sick role' and the passage from social agent to medical patient. Illness becomes sickness. Analogously, the accounts of English informants above show how the severity of personal distress is partly indexed by the degree to which agency and functioning have become disrupted. On this view, the severity of distress is signified by the presence of somatic symptoms, the signs of bodily illness. A disruption or breakdown in agency and the somatic signs of distress place sufferers under pressure to seek: first, legitimate release from usual social roles which are likely to become increasingly difficult to maintain (e.g. entry into the 'sick role'); second, therapeutic redress. In developed English-speaking societies, access to the sick role is restricted to those who suffer from a medically recognised illness, disorder, or dysfunction. This is because medical doctors are the formal 'gate keepers' to the 'sick role'. They have the state-enforced authority to confer legitimacy upon individual suffering and to sanction the sufferer's release from usual social roles, duties, and expectations. They also control access to scarce therapeutic resources. Sufferers are therefore under pressure to articulate their suffering in a way that is consistent with biomedical meanings and definitions of distress as illness or disorder. An extension of this is that they are also under social pressure to conform to biomedical treatment regimes. The clinic is a social space in which a variety of social and symbolic practices work to transform embodied social misery into illness.

There were some indications in English informants' accounts that the categorical distinction between ordinary suffering and illness-like distress (e.g. 'depression') was partly configured in medical encounters. The biographical disruption and breakdown in agency associated with illness-like distress was a commonly cited reason for consulting a doctor. Contact with a medical practitioner often marked the transition from feeling unhappy to illness. Moreover, for some informants, this marked the first point of entry into the sick role and the taking up of an illness identity. For example, a woman in her 20s reported that 'feeling depressed' involved a prolonged

feeling of 'unhappiness', until she was eventually persuaded to visit her doctor by members of her family. 'I was just fed-up. I just couldn't go on feeling so miserable and so unhappy. So, erm, after lots of persuasion from my like parents, I decided to come and see him [the doctor]'. In Text 33, a woman in her 30s warrants her decision to visit the doctor:

**Text 33**

Erm, I was really, really tired. I was really lethargic with my arms. I was really tired, was really miserable. All I wanted to do is stay in bed all day. That's why I first came to the doctors with it [...] He said it was 'depression'.

In this excerpt, a breakdown in the speaker's embodied sense agency warranted a visit to the doctor. In the process, her embodied misery was reconstituted as an illness experience (i.e. 'depression').

Kirmayer depicts the predicament of 'the sick person' as follows: 'The sick person is a reminder to others of the limits of reason. Sickness is violent and capricious; it erodes the sense of self-control and threatens the exchanges that maintain family life and social structure' (1988: 60). This could equally well be said of 'the distressed person'. For instance, the English informants included in this study often performed their distress according to an illness script. They sought help from their doctor when they became conscious of a serious disruption in their agency, in their normal social or somatic functioning. The metaphorical reconfiguration of distress into illness experience sanctioned informants' occupancy of the sick role, socially legitimized their suffering, and granted them access to scarce therapeutic resources and sources of professional support. Moreover, the cultural provision of the illness metaphor provided the warrant for biomedical intervention as though personal distress were a disease to be cured. Through this social and symbolic process, a dimensional relationship between ordinary suffering and illness-like distress becomes concretised in a categorical division between the normal and the pathological; personal distress becomes an illness experience. The illness metaphor then comes fully into play, re-organising informants' interpretations of body and self. Once they have taken up the illness perspective (and they are under considerable pressure to do so), sufferers then amplify and select out particular features of their distress that conform with the illness prototype: personal distress is expressed as a breakdown in functioning with a strong somatic basis.

Yet, there is a gap between expert discourse and the lived experience of personal distress. The 'illness metaphor' does not quite fit. For example, in Text 6, a middle-aged woman implicitly distinguished between 'feeling down' ('a feeling that 'would wear off') and 'depression'. In Text 34, this same speaker portrays her distress using an illness metaphor:



#### Text 34

You do get mood swings. You can be quite all-right one minute, quite high, and then down the next minute. You never know. It's a very crafty illness, a very sly illness. You don't know what thoughts you're gonna get next. But if you know the nasty thoughts you're getting are part of depression, then you don't get so frightened [...] It's when you go to the doctor's and they say: 'Hmm, take these for six weeks'. And you thinks: "Oh, I got depression. What's bloody depression? But I got all these other feelings as well. What are they? Are they because I'm physically ill, or mentally ill?" [...] It's worse than a physical illness, it really is.

This speaker expresses a lack of clarity about exactly what 'depression' is (Text 34). On the one hand, she describes it in psychological terms (e.g. as involving unpredictable, labile moods and negative thinking); this brings it into conformity with a definition of 'mental illness'. On the other hand, she depicts 'depression' as a highly physicalised experience that involves a breakdown in embodied agency. This brings it closer to a prototypical concept of 'illness'. Moreover, the phenomenology of her 'depression' included many other somatic experiences apart from 'feeling depressed' or 'down', including 'fear', 'anxiety', and an array of unpleasant bodily sensations. Expert discourse on distress, and the antinomies that organise it, does not fit with how she experienced suffering: as embodied psychological experience.

Moreover, not all informants described their distress using illness terms or even believed that they had been ill. Almost all informants made a distinction between ordinary suffering and more severe, intractable distress, between 'feeling low' and 'depression', or, analogously, between 'worry' and 'anxiety', or 'panic attacks'. In most cases, 'the illness metaphor' organised informants' discourse on distress and so contrasted it with 'wellness'. Only a few informants articulated their distress as 'mental illness'. None considered themselves to have a disease and few accounted for their distress in biological or medical terminology. For instance, one informant expressed ambivalence about 'depression' as an illness term. A man in his 50s rejected the diagnostic label 'clinical depression' and the illness metaphor altogether: "When I say 'depressed', I think 'pissed-off' is a better word, 'cos 'depressed' is a clinical word." Rather, he saw 'depression' as part of life, as a natural response to life's difficulties. The term 'depression' was used as a metaphor for his lived experience, what he described as 'this sort of mundane existence'. Moreover, a minority of informants avoided using any medical or illness categories including the illness term 'depression'. They did not use the illness metaphor to interpret their suffering. A male informant in his 50s, for instance, denied that he was ill: "No, no I'm not ill. I don't know 'ow to define my health. Somebody with som' it with kidney problems, liver problems, heart problems, things of that nature, I call illness [...] But, quite often, I do feel quite low in meself."

Jadhav *et al* have pointed out that 'psychiatric illnesses differ from other medical disorders insofar as the social context and patients' beliefs shape the very pathology to a greater extent, and this tendency is particularly notable for minor psychiatric disorders' (2001: 47). Similarly, Kleinman emphasises that the way that distress is symbolised 'feed back to influence the experience of distress' (1988: 15). In his descriptive account of Buddhist beliefs about suffering, Obeyesekere

(1985) maintained that the disease/illness distinction breaks down in 'depressive illness' since the disease *is* the illness. The disruptions in agency, identity, and sociality that are commonly associated with the 'emotional pathologies' are more than just consequential to the illness; they are part of the illness itself. The 'emotional pathologies', including 'depression', are sicknesses based on a parody of illness. As such, they are social sicknesses. The illness metaphor articulates the somatic nature of personal distress and provides a socially sanctioned means for articulating social suffering, personal distress that is rooted in a breach in social relations or in a breakdown in personal agency. The contribution of social and symbolic processes to the production of such suffering are rendered invisible by its medicalisation.

#### **4.4 Contingency and indeterminacy in English discourse on distress**

Chronic illness often disrupts biography, destabilises usual social roles, and can therefore threaten to undermine the sense of self. This means that chronic illness calls for symbolic expression perhaps more so than other forms of experience. For instance, Williams has described how rheumatoid arthritis 'assaults the taken-for-granted world and requires explanation' (1984: 197). Monks has shown how a diagnosis of 'multiple sclerosis' brings 'into play meanings, practices, feelings which require new ways of interpreting the self' (1996: 2). Bury points out that 'the search for the cause of the illness [...] is at the one and the same time a search for its meaning' (1982: 179). Similarly, Littlewood says how individuals who have experienced a 'mental illness' 'are driven by a quest for meaning' (1998: 243). Karp describes how experiences of 'depression' represent 'critical turning points in identity' and so call forth 'special efforts to figure out how the past has shaped us and what our prospects for the future might be' (1996: 15).

Karp exaggerates the rationality implicit in personal narratives of 'depression' when he describes his North American informants as 'theorists' who sought to explain their experiences of 'depression': 'Efforts to come to grips with depression turn on its presumed causes [...] Everyone suffering from depression inevitably becomes a theorist as they try to give order and coherence to their situation' (1996: 166). His informants commonly attributed their experiences of 'depression' to either biographical or biological causes. Nonetheless, on occasions they presented contextualised interpretations of their suffering, depicting them 'as resulting from the subtle interplay of personal history, recent life events, and chemical imbalances' (1996: 166). Moreover, these interpretations rarely took into account the wider cultural or social milieu in which such suffering took place: 'Even those who name situational causes for their emotional problems typically restrict their conceptual vision to the immediate and local circumstances of their lives' (1996: 166).

However, experiences of personal distress are often indeterminate. Contingency and contextualisation are therefore more likely to appear in lay discourse on distress than quasi-scientific 'explanatory models'. Clear-cut causal relationships are difficult to decipher where experience is disorganised and inchoate. Instead, meaning is achieved by contextualising distress in



relation to biographical and social experience. For example, research within a British context has shown how experiences of personal distress are frequently contextualised in loose, fragmented, and partially narrativised discourse units organised around what are often contradictory popularized and expert explanatory systems. For example, Jadhav *et al* analysed the kinds of explanations employed in the depression narratives of a sample of white Britons. They found that explanations for distress were presented in a ‘highly contextual, overlapping, and dynamic fashion’ (2001: 64) and they identified fifty-five different types of explanation in these narratives. Contrary to Karp’s findings, only one in ten of the white Britons included in Jadhav *et al*’s study attributed a biological cause to their experience of ‘depression’. Instead, they incorporated a ‘wide range of diverse explanations, far removed from biomedical theories’ (2001: 65). Some informants blamed their distress on fate, chance, or on supernatural forces, and some cited early biographical experience as a possible causal factor. Nonetheless, a combination of social and psychological explanations was most common. In addition, ‘thoughts’, ‘worries’, and ‘stress’ were often cited as causes, usually in combination with other kinds of explanation. Similarly, in another recent British study, Fenton and Karlsen (2002) found that both white British and minority ethnic respondents accounted for their experiences of personal distress in terms of an array of interconnected personal and social difficulties:

Often, though, problems were discussed in a manner that suggested that they occurred in clusters of chains, with further problems arising because of earlier negative experiences, or operating to intensify the impact of the already difficult situation.

Fenton and Karlsen, 2002: 25

In an earlier British survey of individuals who had had some experience of in-patient psychiatric care, respondents were asked why they had first made contact with mental-health services (Rogers *et al*, 1993). Respondents cited a variety of different kinds of social and personal adversity in their response; these included, for example, relationship difficulties, work, study-related stress, bereavement, loss, and illness. Only one in ten respondents said that they had contacted services because of a ‘mental illness’. These responses reflected patients’ self-understandings; they expressed their agency and their core concerns. Rogers *et al* (1993) pointed out that:

Descriptions are merely given and perplexity remains about any pertinent antecedent events [...] Patients sometimes only described a series of events but at other times alluded to a variety of life circumstances surrounding their initial problem.

Rogers *et al*, 1993: 25

Rogers *et al* argued that these findings highlight a gap between ‘the basic way in which professionals and users of services construe the fundamental problem’ (1993: 22). These studies show that, at least within a British context, sufferers and former sufferers of personal distress commonly interpret such distress as a response to social or personal adversity. They also point to a gap between expert discourse (including social-science discourse) and lay discourse on distress.

Apart from the 'framework analysis' of informants' experiences of distress presented in Section 4.1, two other thematic 'framework charts' were produced. The second of these charts explored how informants interpreted and accounted for their experiences of distress either in explanatory or narrative discourse. Some key points to emerge from this analysis are summarised below. A third 'framework chart' was produced to examine informants' experiences of treatment, coping, experience of contact with healthcare professionals and their experience of recovery. The results of this analysis are not presented in this thesis.<sup>53</sup>

Sections 4.2 to 4.3 presented an interpretation of descriptions of personal distress among two small samples of white English informants. This discourse was more or less coherent and exhibited more or less narrativity. Such experiences were often repeated, generalised, overlapping, disruptive, and involved a breakdown in agency. Their quality constrained their discursive representation; their repeated, inchoate, and disorganised nature disrupted their temporalisation and emplotment. Informants depicted their experiences of personal distress in generic, habitual, and pseudo-narratives (Linde, 1992; Carranza, 1998). At this level of discourse, little explanatory or narrative logic was visible.

In Chapter 3, a number of different levels of narrative were distinguished. Discrete discourse units were differentiated from discontinuous discourse or personal narratives produced by speakers in extended stretches of talk (e.g. conversations, research interviews). Informants sought to portray the significance of their distress by contextualising them in higher-level or extended discourse units. While they depicted their experiences of distress in a discourse on agency, mood, and illness, they sought to depict its moral significance by situating it in relation to a variety of adverse social settings and biographical experiences. A mixture of common sense and expert explanatory systems were employed in two ways in these extended accounts. First, some informants accounted for their suffering in discrete explanatory statements.<sup>54</sup> These were rarely produced spontaneously, but were presented in response to questions about what had caused informants' experiences of distress. Biological or physiological explanatory statements were rare. Informants were more likely to attribute the causes of their distress to a mixture of biographical factors (e.g. childhood or early family relationships); character-based or dispositional factors; and social factors (e.g. social adversity; relationship difficulties and breakdown; distress related to the fulfilment of social roles). Second, informants' interpretations typically took the form of 'contingent narratives' (Bury, 2001).<sup>55</sup> Informants cited an array of contingent factors embedded in extended stretches of partially narrativised talk that emerged over the course of a conversation(s). These factors were typically adverse biographical events, breaches in social relations, and disruptions in agency. In these interpretations of distress, informants deployed the rhetorical strategies of positioning, narrative, trope, and explanation to depict the moral significance of their suffering and to present preferred versions of themselves. Varying degrees of 'narrativity' were used to portray temporal and



contingent relationships between personal distress, biographical events, and social setting. Nonetheless, the explanatory systems embedded in such talk were often incomplete, ambiguous, or incoherent.

Although it was clear that most informants were not distressed at the time that they were interviewed, a few were in the midst of their suffering or had recently recovered from a period of distress. Illness narratives are constructed retrospectively. They represent an application of a present perspective on past biographical experience. However, such narratives often lack an ending (Spicer, 1998; Good, 1994). Turner points out that: 'Meaning is apprehended by looking back over a temporal process' (1981: 153). It is difficult to make sense of ongoing experiences of suffering without an ending that has arrived, or an ending in sight, to frame their meaning. Indeterminacy surrounds the meaning of experiences that have yet to be concluded. Indeterminate experience is therefore represented in the 'subjunctive mode, since it is that which is not yet settled, concluded, and known' (1981: 153). Good (1994), for instance, found that Turkish epilepsy narratives were commonly presented in the 'subjunctive mode' so that narrative closure was not achieved and the future was left open-ended and indeterminate.<sup>56</sup> While in the midst of suffering, the construction of narrative discourse units is problematised because 'biographical reconstruction' has yet to take place and a point of view on what is taking place is more difficult to achieve. In addition, the production of narrative discourse depends on the speaker's agency in order to drive the plot forward. Where agency has become disrupted, discursive practices (including narrativisation) are also likely to become disrupted.

The root metaphor in most informants' extended stretches of talk was that of the 'drama of human relations' (see Appendix A3.3). This represents a culturally available rhetoric of agency that is commonly deployed by English speakers in their everyday moral accounting for action and experience. Informants' personal narratives of distress typically dramatised their suffering as the outcome of the interplay between agent qualities (e.g. 'vulnerability' to distress), actions, events, and the scene of these events (e.g. 'stress' or social adversity). In Burke's 'dramatistic' terminology, experiences of personal distress are 'motivated' by 'ratios' between agent, action, and scene (See Appendix A3.3 for an account of the 'dramatistic' framework). By seeking to dramatised their suffering, informants sought to communicate its moral significance. Nonetheless, this discourse rarely took a prototypical narrative form. The discursive representation of this interplay between individual, setting, event, and distress was often disorganised and fragmented. This signified the indeterminate and contingent nature of the suffering depicted. 'Motivation' in these accounts was typically represented as external to the self and was located in the social setting. Informants rhetorically positioned themselves passively, as vulnerable to distress. Distress responses were presented as inevitable and natural by emphasising their contingency on ambient social circumstances and events.

By situating their distress in 'contingent narratives', informants were able to interpret their suffering, despite its indeterminacy. Informants did this in two ways. In the first type of contingent narrative, they interpreted their distress by contextualising it in 'thick descriptions' of social experience that concatenated adverse situations and events one on top of the other. The rhetorical force of these descriptions was to warrant and naturalise suffering in relation to social adversity. In the second type of contingent narrative, informants accounted for their distress in relation to social and personal difficulties, but attributed efficacy to a particular event, or to features of their personal or social situation. These interpretations relied on a distinction between background and foreground. Biographical and broader social settings represented the background of distress in contrast to specific events or situations that were foregrounded and identified as having triggered a distress event, often within a broader context of social adversity. Social situations and life events that were threatening, humiliating, that disrupted core relationships, or that undermined agency in some way were identified as the local contexts of suffering. Informants evaluated the moral significance of their suffering in terms of their core concerns and distinctions of worth.

Medical sociologists and social psychiatrists have demonstrated that socio-economic disadvantage increases the risk of exposure to adversity: e.g., disruptions in valued social ties, social disconnection, humiliation, loss of agency, and powerlessness. In both types of 'contingent narrative' described above, a range of exogenous difficulties were metonymically associated with personal distress. These included, for example:

- Economic or financial difficulties
- Career or work-related difficulties
- Relationship or family difficulties
- Social disconnection and isolation
- Chronic illness (self or relative) and loss

Personal distress typically occurred as a response to adverse social and economic circumstances (e.g. unemployment; financial difficulties; social disconnection; constrained career opportunities; entrapment). Such adverse 'relational settings' produced distress by placing informants at an increased risk of adverse life events or difficulties and eroded the ability to cope with such events or difficulties when they did occur.

'The self' mediates the impact of these relational settings, life events, and their impact on the body. How distress is expressed, interpreted, and evaluated is a function of social identity and how the self is constituted. The kinds of difficulties that informants associated with their distress were partly a function of their social position and identity. For instance, some female informants emphasised the contingency of their distress on their identity and role as a carer. Nonetheless, male and female informants identified work and relationship difficulties as central sources of concern



and personal importance so that disruption in these domains was used to account for personal distress.

Social identity is partly constituted by the same social and cultural processes that play a role in the production of personal distress as well as its interpretation. This mediating role of the self and identity was illustrated in informants' moral or evaluative responses to adverse events and circumstances. Metonyms of 'stress' and 'worry' played a key role in some informants' accounts as a way of articulating their evaluations and moral concerns in relation to their circumstances. Where they featured in informants' accounts, they were used to account for how adverse life events and difficult relational settings had resulted in a breakdown in agency. 'Stress' had a double reference. On the one hand, the term 'stress' was used metonymically to stand for social or personal difficulties, as a way of articulating core concerns and distinctions of worth. On the other hand, 'stress' was used to signify the embodied response to adversity or to 'stressful' situations. For instance, a middle-aged woman reported that she 'was really stressed out. I just wanted to cry all the time'. A man in his 40s drew a categorical distinction between 'stress' and 'depression'. He used the term 'stress' to refer to an agitated physical state ('it eats away at you'), while 'feeling depressed' was characterised in terms of feelings of 'withdrawal'.

An idiom of 'worry' played an analogous accounting function to that of 'stress' in some informants' accounts. For instance, a middle-aged woman associated 'worrying' with 'feeling depressed' or 'down'. However, she also deployed an idiom of 'worry' to express her agency and her core concerns and described how her 'worrying' had made her vulnerable to more severe distress (Text 35):

**Text 35**

If I get depressed now, it's over certain things, and it's nearly always a worry over my children. And if I start worrying over them, if they've got a problem, and I worry over them, for three weeks I'm down, and then I know the anxiety's gonna hit me. And the anxiety attacks are horrendous.

In Text 35, 'worry' articulates the speaker's core concerns about her health and her children's welfare. She says that she gets 'depressed' 'over certain things' and that "it's nearly always a worry over my children". Another example comes from a man in his 50s for whom 'worrying' was described as part of his experience of 'feeling depressed'. He described 'worry' in psychological terms as a 'constant mulling it over', as 'obsessive thoughts'. Similarly, another man in his 50s used an idiom of 'worry' to articulate his core concerns, the same concerns that made him vulnerable to 'feeling depressed'. In Text 36, he reports:

**Text 36**

Feeling worried most of the time. Quite worried about a lot of different things. The major things, obviously I worry about more, like the wife, money. I mean she comes first, and the kids, before any money, or my health. Worrying a lot. I am quite a worrier. Erm, I don't worry about money myself, for me, and personal possessions. I got everything I needs. I got a TV. I got a lovely wife. I got nice kids. I got lovely grandkids. I got everything a man could need in that respect.

In Text 36, 'worry' metonymically links the speaker's distress to his core concerns and his problems of living. Moreover, these concerns express his social identity as a man, just at the point that it is denied.

Some informants made rhetorical use of 'stress' and 'worry' in their accounts of personal distress. For instance, a woman in her 40s said that when she gets 'stressed out', she experiences 'panic attacks'. Another woman identified her 'worries' as the source of her distress: 'Everyone has got their worries, their problems, ' she said, 'but nothing to make me as low as I felt'. In each of his episodes of 'depression', a man in his 40s identified a different source of 'stress' that had triggered each episode of 'depression'. These included, for instance, a broken relationship, a disruption in his career progression and work-related 'stress'. A woman in her 40s cited her doctor's explanation for her 'panic attacks' and 'depression' as being due to 'extreme stress'. She believed that 'stress' had been a response to her father's illness and subsequent death. A man in his 30s deployed a metaphor of 'stress' as a metonym for his adverse social circumstances and used it to account for his 'depression' (e.g. 'The stress of all that has told on me honestly'). Similarly, a woman in her 30s used 'stress' to account for her 'panic attacks' (e.g. 'It was just an enormous amount of stress that I was under'). In Text 37, a woman in her 50s uses 'worry' to account for her experience of 'anxiety attacks' and 'depression':

**Text 37**

A worry : oh it can be so stupid [...] That can bring on an anxiety attack. If I sit and think about it too long, then I can 'ave an anxiety attack.

They don't just come out of the blue for no reason. It's just over a worry. Stupid things. Stupid things.

But, sometimes, when I 'ave just an anxiety attack, it's because I 'aven't been worried for weeks. It's just I've 'ad a worry for a couple of days. And, then, bang! I'll 'ave an anxiety attack.

It would worry me, so I'd get depressed and down, and then the anxiety would start.

If I've been worried for three weeks, and I've been very down, and I think to myself: 'Oh, I've got a bit of depression 'ere'. Err, then I know I'm gonna get anxiety attacks.

The examples depicted in Text 37 demonstrate the close relationship between 'anxiety', 'feeling down', and 'worry'. 'Worry' triggered 'anxiety attacks', but its relationship with 'depression' is less clear. This informant would feel 'worried' or 'down' and then experience an 'anxiety attack'. 'Worry' fades into feeling 'down', and more prolonged 'worrying' eventually becomes 'depression'.

English lay discourse on distress (e.g. feeling 'depressed', 'down', 'low', 'fed up', 'worried', or 'stressed') provides an array of metaphors and tropes for articulating the embodied impact of sociomoral concerns and social adversity. This discourse forms a 'symbolic bridge' between the body and adverse relational settings. The discursive relationship between adversity and distress is



typically metonymic (rather than causal) and is mediated by subjective and moral meaning. Through a double reference, metonyms of distress index informants' evaluative responses to adverse life events and ongoing difficulties. 'Worry' and 'stress', for instance, stand for both adversity and the embodied response to adversity. Among the English informants included in this study, these metonyms of distress were used to represent the concerns of everyday life. To have such concerns is to have agency, and, to possess agency, is to be vulnerable to one or other of the 'emotional pathologies'. Personal distress expresses agency just as it depicts its breakdown.

This chapter has illustrated how English lay discourse on distress is commonly characterised by ambivalence, contradiction, diffuse event boundaries, and high levels of metaphorisation. Interpretations of suffering deploy an array of culturally available expert and lay explanatory systems that are embedded in overlapping, contextualised description. Overlapping and often competing half explanations, fragments of rationality, are cobbled together in personal narratives of distress often with a loose explanatory logic, varying degrees of narrativity, and more or less coherence. The incoherence, indeterminacy, and irrationality of suffering are suppressed in the rationality implicit in the analytic concepts of 'illness narrative' and 'explanatory model'. Researchers' projections of these 'modes of rationality' onto sufferers' discourse is likely to overestimate the degree of coherence that has been achieved.

Personal distress and psychiatric illness are experienced and expressed in terms of a society's cultural discourse on the self. A cultural discourse on the self, body and society articulates a society's indigenous psychology and the Euro-American folk discourse on 'the self' is organised around a set of metaphysical dualisms that generate two ideologically opposing views of human agency. The dominant ideological discourse in developed English-speaking societies partly constitutes agency in terms of independence, self-control, autonomy, and disengagement. A second, partly subjugated discourse on the self articulated agency in terms of distinctions of worth, sociality, as a centre of meaning and evaluation. In late capitalist English-speaking societies such as Britain, these features of emotional suffering partly account for its medicalisation. 'Human behavioural breakdowns', breakdowns in 'coping' and 'control', and deviations from prescribed roles and normal experience, often result in a medical encounter and entry into the sick role. The transformation of embodied social adversity into illness takes place because the sick role provides a legitimate social position open to individuals experiencing 'human behavioural breakdown'. Entry into the 'sick role' requires that a person be ill and this requires formal diagnosis by a medical practitioner. It is, therefore, no coincidence that chronic illness provides the 'root metaphor' for the expression, interpretation, and response to personal distress, whether this is expressed somatically or psychologically. Individuals who experience personal distress may partly take up an illness identity in order to access the sick role, the scarce medical resources, and the opportunity for recovery that it affords.

The next two chapters explores these questions about the social and moral significance of personal distress and the nature of the discourse used to articulate it within an altogether different social setting: the south Atlantic island of St. Helena.



## Chapter 5

### Social Suffering and the St. Helenian Predicament

It is certainly not outside the bounds of possibility that with victory [in World War II] St. Helena may again become the focal point of world interest as an Island Siberia, the most perfect natural fortress in the world, where those war criminals who escape death shall be held in exile.

Colonel Josiah Wedgwood MP (Cited in King, 1945: 105).

Just as millions of anthozoan polyps create, willy-nilly, a coral reef, so do thousands upon thousands of individual acts of insubordination and evasion create a political and economic barrier reef of their own.

Scott, 1985: 36

The next two chapters aim to develop the theoretical themes of the previous chapters by drawing on fieldwork conducted on the South Atlantic Island of St. Helena. They present an ethnographically informed interpretation of discourse on distress among St. Helenians (or *Saints* as St. Helenians call themselves).

The travel writer-journalist Simon Winchester has described St. Helena as ringed with cliffs and inhospitable mountains, giving it ‘a wild, prison-like aspect’ (1985: 153). In the centuries that followed its permanent settlement by the British in 1673, the island was used as a place of confinement (Gosse, 1938; Royle, 1998; Kauffman, 1999). The prison metaphor has been overplayed in representations of St. Helena. St. Helena is not a prison. Nor is it a place of exile. It is a home to an island community of more than 5,000 St. Helenians. Moreover, this community is spread over four islands. According to the 1998 Census, around four-fifths of St. Helenians were living on St. Helena (81%). Around 19% of the total St. Helenian resident population lived on Ascension Island (12%), the Falkland Islands (5%), and a small number were training or working in Britain (DEPD, 1999a).

This chapter is about social suffering on St. Helena. Its purpose is to explore how social adversity and cultural and symbolic processes interact to produce experiences of personal distress.<sup>57</sup> The chapter begins by describing St. Helena’s communal ideology and briefly presents an interpretation of St. Helenian cultural identity as articulated in a cultural discourse on the self and society. This discourse partly constitutes agency by forming a symbolic bridge between social and economic structure and the embodied self. The chapter goes on to highlight a stark contradiction between St. Helena’s dominant communal ideology and the lived experience of most St. Helenians creating the conditions for ‘anomic suffering’. This is followed by an exploration of the ways in which this contradiction is played out in the lives of individual Saints. Case studies and excerpts from informants’ accounts are used to illustrate these key themes. I have parsed narrativised discourse

into clauses for presentation and referencing purposes. Some detail in the accounts has been changed to protect the privacy of the informants. Section 3.4 and Appendix A3.7 present an account of how the data used in these two chapters was collected and interpreted. The framework used to interpret informants' discourse is described in Appendix A3.1 to A3.4.

## **5.1 The Communion of Saints**

### **St. Helena and its 'Britishness'**

Despite a history of migration, British colonial policies, social and political structures have dominated the historical development of St. Helenian society (Gosse, 1938). Yon points out, for instance, that wherever they came from, settlers to the island were 'submerged in a dominant sense of Englishness' (1998: 9). In the post-colonial era, partly because of St. Helena's economic dependency on Britain, the British Government (UKG) has continued to wield a high degree of control over St. Helenian affairs. St. Helena's current political status is as a British Overseas Territory. St. Helena's Governor and Chief Executive are appointed by UKG and sit at the apex of executive power within the St. Helenian Government (SHG). Many of the other key positions in SHG are filled by British expatriates. Britain provides considerable economic, developmental, and technical support to St. Helena (UNDP, 1999).

The political identity and affiliation of St. Helena has always been British (Turner, 1996, 1997). Indeed, many of the St. Helenians who I spoke with politically aligned themselves with the British flag and, when asked, claimed to hold a British 'citizenship identity'. In the early 1990s, Royle (1992) undertook a survey of St. Helenian school children and found that 70% described their nationality as British. Nonetheless, at the time of the fieldwork, St. Helenians were not British citizens.

Since 1659, St. Helena has been continuously settled by the British (Turner, 1997). The British East India Company controlled the island until an Act of Parliament in 1833 transferred responsibility for governance of St. Helena to the British. St. Helena was transferred to the Crown in 1838 (Gosse, 1938: 301). St. Helenians enjoyed British Citizenship and the right to live and work in the UK until the 1981 *British Nationality Act* removed their citizenship status (Turner, 1997). This Act specified that permanent residency in Britain was only available to individuals if they were born in the UK and a parent was a British Citizen at birth. St. Helenians became *British Dependent Territory Citizens* and received St. Helenian passports (Turner, 1997). In a travel guide to St. Helena, Phillips claims that: 'The effect on the island was devastating' (1998: 10). Saints could no longer work, live, or study in the UK, so that their rights and freedoms became severely restricted.

The 1981 *British Nationality Act* clashed with the view shared among many St. Helenians that they are British, both in terms of their political affiliation and in terms of their cultural identity and



historical heritage. It was therefore resented and bitterly contested by many St. Helenians. For instance, a middle-aged Saint woman said: “I believe that we are British. We had that right and they take that right away from us. ‘Cos, okay, we under British law and everything else. I see no reason why we shouldn’t be British”. In response to the removal of citizenship, the former Bishop of St. Helena, John Rushton, established *The Citizenship Commission* in 1992. Its principal aim was to restore British citizenship to St. Helenians through lobbying and research (Turner, 1996, 1997; George, 1999). Saints, they argued, should be restored British citizenship and St. Helena granted the status of a British island and not regarded as a ‘colony’.

At a conference of the Dependent Territories Association in 1998, the Foreign Secretary, Robin Cook, proposed a white paper on Britain’s relationship with its existing ‘Dependent Territories’. After a series of Commons debates, this white paper (UKG, 1999) was presented to the House of Commons on 17<sup>th</sup> March 1999. It granted full citizenship rights to those people living in Britain’s Overseas Territories. No conditions were attached to the restoration of citizenship. It specified that St. Helenians would be free to determine their constitutional relationship with the UK. The Overseas Territories Act came into force on 21<sup>st</sup> May 2002. British citizenship was fully restored to occupants of all 14 *British Overseas Territories*, including St. Helena and its dependencies.<sup>58</sup> Saints once again have the right to live and work in the UK.

The historically dominant public discourse on St. Helenian identity depicts Saints as both politically and culturally British, as possessing a British ‘root identity’<sup>59</sup> and a British ‘citizenship identity’. A view of Saints as British, however, does not preclude the possibility of having a St. Helenian identity as well. As Yon says, the localised identity is ‘being British and Saint’ (1998: 21). Nonetheless, in traditional representations of St. Helena, Saints are represented as principally British. This view is particularly common among older St. Helenians and in representations of St. Helenian society in the writing of British observers, visitors, and expatriates. For example, after a visit to the island in the 1950s, the British MP Cledwyn Hughes (1958) asserted that Saints have a British cultural identity:

These people are a British people in their upbringing, education, attitudes and everyday needs. Their language is English, they eat, dress and live, so far as they can, on a European Standard. Their small, clean and frequently overcrowded houses are furnished as British cottages would be. In the most meagre and drab shacks, [there are] several photographs of the British Royal family.

Cledwyn Hughes, 1958: 2

More recently, the authors of a UNDP report on St. Helena<sup>60</sup> claimed that ‘St. Helenians regard themselves as British’:

Indeed unlike most colonies which despite the influence of their colonisers retained their own identity, culture and way of life, on St. Helena the identity, culture and way of life is completely British adapted by local circumstances.

UNDP, 1999: 4

Similarly, in an SHG investment guide to St. Helena, Hoole asserted that ‘we hold to British cultural tradition’ (1990: 4). A former Chief Medical Officer of St. Helena observed that: ‘Island culture is essentially British’ (Aldridge, 1994: 790). Some writers have positioned St. Helena as a stronghold of ‘Britishness’. According to the writer and journalist, Simon Winchester, St. Helena is British ‘in every apparent way’ (1985: 164). An English medical researcher writing in the late 1970s compared St. Helena to a pre-War English village community: ‘The modern St. Helenians form a relatively uniform cultural group which socially resembles the more stable rural society that was common in the Western World prior to the World Wars’ (Moyes, 1978: 6). He went on to emphasise St. Helenians’ Englishness: ‘Despite the varied racial origins of the St. Helenians, the striking features of modern society are its uniformity and the absence of elements from cultures other than English’ (1978: 3). Similarly, Winchester muses: ‘This island has become a rock of exile for a British way of life – a way of life now only to be found in Britain’s isolated rural retreats [...] unwittingly the St. Helenians have preserved it’ (1985: 167).

It is true that in the past, and perhaps among older St. Helenians today, there was a strong loyalty to Queen and Crown. In official circles, the Queen’s birthday is still celebrated on St. Helena. In a St. Helena Day address, Mrs Lillian Crowie declared that ‘we still look to Britain as our Motherland, and have great love and loyalty for the British Crown’.<sup>61</sup> In an interview with a St. Helenian man in his 60s, I noticed the picture of the Queen hanging on the wall and two plastic Union Jacks. When I asked him about the picture on the wall, he explained: ‘That’s the tradition that the Saints live under’.

However, the traditional emphasis on a British cultural identity may have obstructed the emergence of a distinctive St. Helenian root identity and a distinctively St. Helenian voice. Moreover, this traditional view ideologically exploits the polysemy in the term ‘British’ by confounding citizenship identity with root identity. This identity discourse represents Saints as prototypically British, as ‘more British than the British’ and rhetorically works to deny Saints a cultural identity of their own. Timm, for instance, wrote that there is ‘a total lack of any culture roots’ (1977: 44) and ‘there is no indigenous culture on the island, the different races had to adjust to this small community environment’ (1977: 78). Culture is projected onto the outside, symbolically represented by England, while the inside is depicted as devoid of culture. In the context of a debate about whether or St. Helena has a culture of its own, a contributor to the *St. Helena News*<sup>62</sup> articulated this issue: ‘We on this island lack a true identity. We call ourselves British, yet we are not of Britain. We practice shallowly the British cultural beliefs and in the process deny our roots’ (Robertson, 1999). The contributor pointed out that this emphasis on a British cultural identity is partly the result of St. Helena’s dependency on Britain.

### **A St. Helenian root identity**

Nonetheless, among many St. Helenians, a strong affinity with a St. Helenian root identity<sup>63</sup> co-exists with a political and, in some cases, cultural alignment with Britain. It has been argued, for



instance, that the possession of a British national identity does not preclude the possession of a distinctive local identity within the context of a wider 'Britishness' (e.g. Turner, 1996, 1997). For instance, the Citizenship Commission's central argument for the restoration of citizenship depended on the view that St. Helenians are socially and culturally British and that, in the political sense, St. Helena has always been a British island: 'St. Helena is entirely British, and has never been settled by any other county. St. Helenians are British, and have never been anything else' and 'it is self-evident to all St. Helenians that they are British and always have been' (Turner, 1997: 13). This is demonstrated by the fact that they are 'unwaveringly loyal to the Queen' and that they share the same language, institutions, values, social and political practices, religious institutions and education system, 'the same culture and influence and interest. It is a British society' (1997: 12).

However, while emphasising St. Helenians' 'Britishness', Turner writes that 'St. Helenians are British, but this does not make them any less St. Helenian' (1997: 16). While Saints have an 'intense loyalty to their island', a strong local identity is consistent with the possession of a British national identity: 'To be St. Helenian *is* to be British' (1997: 16). For example, in a recent study of St. Helenians' 'spatial identity', Hogenstijn and van Middelkoop (2002) argue that a St. Helenian 'island identity' co-exists with a British 'national identity', and that, even without British citizenship, it is still possible for Saints to feel part of a wider 'Britishness'.

According to Yon, there is an ambivalence in St. Helenians' feelings of belonging towards their island home. On the one hand, many St. Helenians claim to 'follow England' and some express a view that 'we don't have a culture' (1998: 13). On the other hand, they recognize that their way of life is different from the British (1998: 11) and that 'St. Helenian history and cultural identity are unique' (1998: 9). This paradox is associated with ambivalence about belonging to both St. Helena and to the outside, symbolised by Britain and 'Britishness'. According to Yon, a desire to leave, to 'break away', co-exists with a desire to stay and a sense of belonging to their island home (1998: 11). There is a tension between coming and going, leaving and staying. Yon illustrates this 'ambivalence in belonging' with quotes from young St. Helenians. For example, one young Saint is quoted as saying: 'I'm bored here'. Yon contrasts this sentiment with a quote from another young Saint who said: 'Here is where I fit in' (1998: 22). "In these ambivalent ways", Yon argues, "one can identify with 'them' of the cultural representations that circulate through the television while at the same time affirming an identification with 'us' as 'Saints'" (1998: 22).

A third view on St. Helenian 'root identity' has become more common in recent years. There is an emerging sense of being 'a Saint' as distinct from being British. This shift in affiliation is particularly strong among younger St. Helenians (Yon, 1998). This view de-emphasises 'Britishness', and foregrounds a distinct St. Helenian 'root identity', that the Saints are somehow different from the English, while acknowledging that English culture, social practices, and political

structures have been a dominant influence on the St. Helenian way of life. For instance, some of Hogenstijn and van Middelkoop's British informants expressed this view of St. Helenian 'root identity': 'They are Saints first, and British second' and 'Feelings of Britishness can be a bit double edged' (2002: 6.1).

The removal of British citizenship in the early 1980s, globalisation, and de-colonialisation, and, more recently, greater economic independence from Britain have combined to produce this shift in affiliation and this has strengthened the local cultural identity. A distinctively St. Helenian voice is beginning to be heard. In this nascent identity discourse, England and the English are positioned as 'other' (as 'them'), while 'us' refers to the community of Saints tied by bonds of blood ('Saint blood') and ancestry and a strong symbolic identification with the Island of St. Helena. The criteria that need to be met to be classified as a Saint are partly set politically through a strict immigration policy (SHG, 1986). To be a Saint, one must be born and raised on St. Helena and at least one parent must be a Saint. It is almost impossible for an outsider to become a Saint and it is rare for individuals to settle permanently on St. Helena unless they marry an indigenous St. Helenian. For instance, Hogenstijn and van Middelkoop quote an expatriate UKG employee on St. Helena who observed that 'you will never be accepted as a Saint here, unless you are born and brought up here' (2002: 4.3). As one St. Helenian woman put it: "They've got this thing here: a Saint is a Saint".

It is possible that a strong 'Saint' identity will gradually work to weaken the sense of 'Britishness' described above. Indeed, some of the St. Helenians I spoke with on this theme only saw themselves as British in the citizenship sense, while they asserted a 'root identity' that was distinctively St. Helenian. When asked whether he thought himself as British or not, a St. Helenian man in his 40s replied: "Well, it's hard to say. I would see myself as a Saint in that way - not been off the island so far". Another St. Helenian woman said that although her religion is 'Church of England', she considered herself St. Helenian and not British. She warranted this identity claim by saying that she was born on St. Helena and that everything she owns is on the island. A St. Helenian man in his 40s said: "I don't really see myself as being British. I'm St. Helenian. I was born here". Nonetheless, when he fills in forms that request information about his nationality, he always states that he is 'British'. A St. Helenian man in his 30s was clear that he was not British and that he was St. Helenian. However, when I asked him what the difference was between being a Saint and being British, he replied:

**Text 1**

It's where you live, where you were born, where you live mainly. If it comes down to who feeds you, yeh, I'm British. Err, other dhan that, err, I don't think so. No. I mean : Okay. Fair enough. It's a : it's a British island. Err, still, it don't make it British. Erm, I'm all for a: I mean y'know : they'll get my vote for the : the erm, erm, the British passport. They would, y'know, err : I mean the erm : with a British passport I'd look to go somewhere else. Don't have to be in Britain. It should still be possible [...] [Referring to St. Helena] It's not much, err : but, I ain't seen it all yet. Why? Because there's some places I like to go twice, three times, and more. I've still got a lot to see of St. Helena, y'know, without takin' a boat to go on the outside.



In Text 1, the speaker makes a distinction between a British citizenship identity and a St. Helenian root identity grounded in a view of St. Helena as home, as a place imbued with sentiments of belonging. He understands himself to be British in the political sense and that he lives on an island that is dependent on and partly 'ruled by' Britain. On this view, there is a clear distinction between being a British citizen and the possession of a St. Helenian 'root identity'. While there is an emerging ambivalence about being British (in the cultural sense) among St. Helenians, there is no ambivalence about the possession of a British citizenship identity (See Section 5.2). In addition, Britain ('Overseas') and British citizenship are symbolically associated with a centrifugal pull away, to the outside, and away from home. This is offset by a centripetal pull inwards, back toward St. Helena; there is no ambivalence about being a St. Helenian and the attachment to their island home remains very strong indeed.

### **A St. Helenian public narrative**

Although the community of Saints are dispersed across a wide geographical area, they retain a strong connection to their island home (Hogenstijn and van Middelkoop, 2002). St. Helena's communal ideology plays an important role in maintaining this sense of cohesion. It articulates the values and distinctions of worth shared by most St. Helenians and it incorporates an idealized self-representation articulated in a variety of different public fora and media.<sup>64</sup> The communal ideology is the blueprint for the social structure, for how social and personal life should be conducted. It functions to legitimise the status quo and to maintain cohesion despite the challenges facing the island and the existence of deep-seated contradictions in the social structure. Social relations on St. Helena are partly constituted and legitimised by the provision of a dominant communal ideology and a cultural discourse on the self. This discourse prescribes what it is to be a St. Helenian, the proper social roles of men and women, articulates the relationship between individual and society, and includes a public narrative about St. Helenian society and its past.

St. Helena was uninhabited when it was discovered in the 16<sup>th</sup> Century by a Portuguese navigator (Gosse, 1938). The motif of an 'Atlantic paradise' has sometimes been deployed to represent the island. Writing in the 19<sup>th</sup> Century, Melliss deployed this motif when he wrote:

No human eye ever saw this rocky spot in its primeval grandeur until the 21st of May in the year 1502, when one of the earliest and bravest navigators, Commodore John de Nova Castella, commanding a Portuguese fleet on its return from India, discovered it. He found there no aborigines, nor was any trace of man's work to be seen. This celebrated voyager with his companions had, however, the satisfaction of seeing the Island in all the pristine beauty of its native vegetation.

Melliss, 1875: 1

On many occasions during the fieldwork, I heard the view expressed that St. Helena is somehow unique and that St. Helenians have a unique way of life. The preferred image of St. Helenian society is of idyllic island life and civility. The following description of St. Helena comes from an SHG investment guide and articulates the key features of this idealised view of island life:

Living on St. Helena is similar to living in any small rural community albeit accentuated by its isolated position. So, everyone knows who you are and what you do. The range of products and services available, while they have expanded considerably in recent years with well known UK supermarket brands available, is obviously less than in major urban centres. There are few laid on entertainments. It is impossible to get away for a short break and a large proportion of any time away from the island is spent travelling to and from it. The upside is that this creates a true community spirit and the vast majority of people who have come to work here have greatly enjoyed their stay. Saints are a very friendly and supportive people. The climate is pleasant; crime is relatively minimal; there is stunning countryside; the local produce is of excellent quality; and there is a surprisingly wide range of activities to keep one occupied.

SHG, 2000: 14<sup>65</sup>

In Section 2.3, 'the self' was characterised as an embodied process that mediates the relationship between social structure and somatic experience and symbolically constitutes the relationship between society and body. A central part of a communal ideology is a discourse on the self that specifies what it is to be a person (relative to social position and role). Heelas (1996) differentiates between the indigenous psychologies of traditional societies and contemporary western societies. The former are associated with a socio-centric discourse on the self in which individual expression is discouraged, the individual is subordinated to a wider whole, subjectivity is de-emphasised, and traditional duties and obligations move to the foreground. The cultural discourse on the self on St. Helena is 'traditional' in this sense. This discourse forms part of a broader traditional communal ideology that configures cultural identity and the proper relationship between individual and society and works to legitimise the prevailing social order and distribution of power. There is a strong sense of solidarity with the extended family and to the wider community of Saints. 'The self', for instance, is defined in socio-centric terms, in terms of social ties, role, and position (e.g. family ties, occupational role, gender, marital status), rather than in individualistic or psychological terms.

St. Helenian ideological discourse on self and society articulates both a shared St. Helenian cultural identity and a matrix of social identities attached to social positions and roles. Social identities on St. Helena are fixed within a matrix of traditional social roles and positions defined by the social structure: gender, familial affiliation, occupational position, social class, age, district, education. Agency, then, is forged out of a dialectical relationship between social position and a cultural discourse on the self. Family and individual identity are closely interwoven and Saints characterise themselves and other Saints in terms of their family of origin; personal qualities and attributes are attributed to individuals based on their family membership. Extended families in turn are associated with a particular geographical district of the island. Social identities are uniform and more clearly defined compared with the more hybrid social identities in late capitalist English-speaking societies such as Britain.



St. Helena is a socially conservative society and many Saints are mistrustful of change. One St. Helenian woman, for instance, expressed the belief that Saints dislike anything new or anything that ‘rocks the boat’. This partly has its origins in the sociocentric view of ‘the self’ described above. Public discourse on St. Helena depicts St. Helenian society as a homogeneous, harmonious, unified, and cohesive whole. For instance, in a public address on St. Helena, one prominent member of the community emphasises this unity:

One of the joys of believing in the Communion of Saints is that, never mind how far separated we may be from one another by time, distance, or even death, we know that, in praying for one another we are one in Christ, and that we have our Union in Him.

Mrs Lillian Crowie in a St. Helena Day address<sup>66</sup>

Homogeneity is prescribed; heterogeneity is proscribed. Hogenstijn and van Middelkoop point out that this conservatism is associated with a high level of social control so that it ‘is hard to be different’ (2002: 4.3). They observe that ‘the island has an image of social homogeneity: there are hardly any sub-cultures’ (2002: 4.3).

Moreover, as a community of Saints, St. Helenian society is rich in social capital.<sup>67</sup> For instance, a St. Helenian woman observed: ‘If you haven’t got something, then the neighbours will help you’. In the quote from an SHG investment guide cited above, Saints are described as a ‘very friendly and supportive people’ (SHG, 2000: 14). Timm describes St. Helenians as ‘a friendly, kind, hospitable, and trustworthy people. They in turn trust and believe in others’ (1977: 54). Similarly, the authors of a *United Nations Development Report* on St. Helena observed that the ‘population strikes all visitors as one that is friendly, welcoming and accommodating. They have a basic charity of spirit and sympathy for others. They would never see anyone going hungry and there is a willingness to share produce grown at home’ (1999: 35).

Perceptions of the outside shape how Saints view themselves and their way of life. England, ‘the outside world’, is perceived to proceed at a rapid pace. By contrast, many Saints expressed the view that life on St. Helena is ‘set back’ and has a slow, ‘relaxed’ pace of life. A St. Helenian woman said that in St. Helena one ‘can safely walk down the road and know you are safe’. She said that the way of life is different on St. Helena than Britain. The pace of life is slower, and ‘there’s no rushing around’. In informal conversations, Saints sometimes expressed the view that England is unsafe, that it is overrun with crime in comparison with St. Helena. Conversely, St. Helena was depicted as safe, secure, and free of more serious crime. Timm writes, for instance, that ‘crime is almost non-existent’ aside from ‘petty pilfering’ (1977: 54).

The public narrative that holds most sway is one of an integrated people free of social schism, without segmentation by class or race. For instance, Timm writes that there is ‘no recognized class distinction’ (1977: 44). In her public address, Mrs Lillian Crowie articulated this strand of the

dominant public narrative: 'We remain an island and a people free from racial or national prejudice and always willing to exercise our ministry of hospitality to anyone who finds us as they sail across the seas'. One visitor to the Island observed that 'there's complete racial harmony' (Phillips, 1998: 21). Similarly, in an investment guide to St. Helena, Hoole wrote that 'there are no racial divisions on the island' (1990: 4). In his research on the history of the Church on St. Helena, Ascension Island, and Tristan da Cunha, Edward Cannan, a former Bishop of St. Helena, observes that:

In the 18<sup>th</sup> and 19<sup>th</sup> centuries there were two social classes, the English settlers and the rest; today there are no remaining racial groups, all are St. Helenians of whatever shade of colour, and decidedly British.

Cannan, 1992: 16

Nonetheless, Yon points out that, while 'race thinking is absent on St. Helena', there is certainly 'colour-consciousness' (1998: 15). This is supported by the authors of the UNDP report who maintain, for instance, that "skin colour is a sensitive issue with examples of prejudice due to the colour of people's skin both because it is too light and because it is too dark" (1999: 43).

Instead of emphasising dependency, one facet of St. Helena's public narrative emphasises Saints' strengths and portrays a positive sense of masculine agency. On this story, Saints, particularly St. Helenian men, are positioned as resourceful, strong, adaptable, practical, resilient, and in control (e.g. George, 1994). In response to the contribution to the *St. Helena News* cited above, a prominent St. Helenian submitted a letter that was printed in a subsequent edition of the island newspaper. The letter pointed that St. Helenians 'already have a St. Helenian culture' which needs to be positively promoted; he pointed out, for instance, that permeating St. Helenian history is a relaxed 'philosophical approach to life' combined with a 'high degree of resiliency which enables us to continue smiling while struggling to survive in the face of adversity' (George, 1999: 4). George writes that 'resourcefulness is an island way of life', that 'one of the characteristics that identifies a Saint is his resourcefulness in dealing with practical problems', and that 'resourcefulness is at the centre of St. Helenian identity and culture. This is why today the St. Helenian values practical skills above academic knowledge' (1999: 4). Similarly, the authors of the UNDP report write, for instance, that 'the people have a capacity for resourcefulness and personal strength and an ability to bear hardship' (1999: 35). This represents a positive source of masculinity for many St. Helenian men. St. Helenian men pride themselves on their practical skills, rather than being strong on 'theory'. Adapting to life on such a remote island with scarce natural resources has meant that Saints have become highly resourceful; they live on whatever washes in from the sea and they make the most out of it. Saints are good at fixing things, making a part that fits, making do. Writing in the 1960s, for instance, Shine observed that 'most men were able to farm, fish, play the guitar, cut hair, make an efficient watering can from a margarine tin, mend shoes and build their houses' (1970: 21).



## **Diglossia on St. Helena**

Dialect is another important marker of St. Helenian 'root identity'. Some Saints have depicted St. Helenian society as having an 'oral' or 'verbal culture' (Timm, 1977; George, 1994). Although the only language spoken on St. Helena is English, most islanders speak in a dialect that is unique to St. Helena, what I have called 'St. Helenian English'.<sup>68</sup> The strength of a St. Helenian dialect is associated with the speaker's socio-economic position, district of origin, and the social context of the speech act.

'Diglossia' pertains where two varieties of the same language are used within the same speech community under different conditions by the same speakers or by different speakers according to their social status (Ferguson, 1959).<sup>69</sup> Diglossias typically have a 'high' and a 'low' variety.<sup>70</sup> In St. Helena, the superposed variety is Standard English. The low variety is 'St. Helenian English'. Public discourse is dominated by the 'high variety'. There is some specialisation of function; Standard English is more likely to be used in formal discourse or for conversing with outsiders. Saints often switch between a St. Helenian dialect and Standard English depending on the social context or on whom they are speaking with. According to Trevor Hearl, a British scholar of St. Helenian society, 'St. Helena speak' has two forms.<sup>71</sup> First, Saints use 'formal English' to communicate with outsiders. Second, Saints use an 'informal banter' among themselves and which outsiders strain to understand.

In speech communities characterised by diglossia, the 'higher form' of the language is typically regarded as superior and has a social function as a mark of education and distinction (Ferguson, 1959). The dominance of Standard English in British society has characterised the modern period (Leith, 1983; Fairclough, 1992). Fairclough (1992) points out that within British society, it is an overt marker of hierarchy and status, and expresses power asymmetries. This means that public or official discourse on St. Helena tends to be practiced in standard English and is commonly used among high-status and educated St. Helenians and among members of the civil service elite closely attached to the Castle. As in Britain, dialect is a marker of power and status on St. Helena. Moreover, the historical subjugation of St. Helenian identity and voice is reflected in the view that the way that Saints talk is somehow less correct than Standard English pronunciation. Timm acknowledges the existence of 'social differences' in how Saints talk with 'some speakers recognized as using the language better than others do' (1977: 44). This statement implies that Saints' way of talking is viewed as somehow less correct than Standard English. One St. Helenian woman believed, for instance, that: 'We [Saints] don't talk properly'. Timm says that Saints employ a limited vocabulary to express themselves and rely heavily on 'social expressions and gestures' to communicate with one another (1977: 54).

Where diglossia pertains, the 'higher form' of the language becomes standardized and it becomes the language of diction and grammar. There is typically no accepted orthography for the lower



variety (Ferguson, 1959). Indeed, George (1994) points out that St. Helenian children find it difficult to write in standard English given that the way that they speak is so different from standard English. Ferguson (1959) points out that diglossia comes about where literacy is limited to a small elite and then several centuries come to pass.

## **5.2 The ‘St. Helenian Predicament’**

There is no agreed view of the predicament St. Helena is in. Some blame the British. A few blame the island itself. Others do not see a predicament at all. Yon has pointed out that the Saints ‘occupy a social space and are parties to a local culture which in some sense is geographically isolated’ (1998: 22). St. Helena is geographically remote, with the postal ship (the RMS St. Helena) the only means of access save from occasional passing trade ships or yachts. One visitor to the island described St. Helena as a ‘pinpoint of inaccessibility, unbelievably remote’ (Winchester, 1985: 148). This remoteness has been a powerful determinant of St. Helena’s economic, political, social, and cultural development (Royle, 2001). The main features of St. Helena’s predicament and its social structure are as follows:

- Geographical remoteness.
- Economic fragility and economic dependency on Britain. In addition, there is a high degree of reliance on remittances from overseas work to fund local development.
- Limited training and employment opportunities, high levels of state employment and unemployment, and a highly gendered labour market. The private sector on St. Helena is very limited.
- Relative economic disadvantage and hardship.
- High levels of labour migration. Escalating rates of outward migration over the past decade, particularly among young people and skilled workers.
- The remnants of a colonial political structure and continued British political and economic control over some of the island’s affairs.
- A powerful state apparatus and bureaucracy with a large public sector; this is reinforced by the fact that the overwhelming majority of economically active St. Helenians resident on St. Helena are employed by SHG or SHG-controlled organisations and agencies.
- A social structure stratified along lines of social class, employment status, gender, extended family ties, and geographical district. The emergence of new economic and social inequalities.
- A traditional domestic division of labour.
- Rapid social, cultural, political, and technological change over the past decades.

Sources<sup>72</sup>: UNDP, 1999; DEPD, 1999a, 1999b; Royle, 1993, 2001; *St. Helena News*, 1990-1999; Hogenstijn & van Middelkoop, 2002; St. Helena Government reports and documentary material (see bibliography).



The remainder of this section aims to show how St. Helena's remoteness, its social and political structures, ongoing economic difficulties, and the policies of both UKG and SHG have contributed to producing St. Helena's current predicament (Appendix A6.3 describes public health and mental-health provision on St. Helena).

### **The Castle**

The dominant influence on the evolution of St. Helenian society and culture over the past century has been British colonialism (Gosse, 1938). Economic dependency translates into political dependency on Britain. Saints have little control over some of the key issues that affect their lives. An ossified colonial government apparatus tightly regulates island society and the governing hierarchy (including an elite of high-ranking St. Helenians) constitutes the backbone of St. Helenian social structure. Phillips depicted Government of St. Helena as 'an oligarchy where an unelected Governor, advised by unelected civil servants retain full power' (1998: 17). Executive power is concentrated in the office of the UKG appointed Governor and Chief Executive (Royle, 2001), although on key decisions the Governor is required to consult with an elected Legislative Council composed of St. Helenians. The authors of the UNDP report point out that UKG 'prescribes a number of policies as a condition for the level of aid provided and this is a matter of frustration and resentment for local politicians' (UNDP, 1999: 4). Turner, writing on behalf of the Citizenship Commission, describes the dependency on 'an aid programme' as 'demeaning' and 'alienating' (1997: 44). Decades of economic dependency and political disempowerment have undermined St. Helenians' sense of agency and autonomy.

The consequences of remoteness, economic underdevelopment, and dependency have affected the lives of every St. Helenian and have constrained the development of local community-based organisations, political, and social institutions. Because of the close relationship between St. Helenian statutory organisations and the wider society, UKG's changes in policy towards St. Helena had a far-reaching impact on St. Helenian society. These changes coincided with rapid technological development during the 1990s. These developments have been associated with the introduction of new communication and other technologies in recent years (e.g. television, videos, internet, telecommunications, internal communications, information technology) (UNDP, 1999; Yon, 1998).

### **Economic straits**

St. Helena's economic situation is weak and there are limited economic opportunities (Royle, 2001). Royle, for instance, has said that St. Helena's 'economic position is dire' (1997: 331). St. Helena has a static economy with a low GNP; low levels of productivity; the import-export ratio in 1994 was 43:1; the wages are very low relative to the cost of living, especially relative to food and transport costs<sup>73</sup>; St. Helena has a 'depressed labour market'<sup>74</sup> with high levels of unemployment (Royle, 1993; DEPD, 1999a, 1999b). There are several reasons for St. Helena's economic weakness: remoteness; limited natural or other resources; a small scale and highly regulated

internal market; a poorly developed infrastructure for business; a lack of skilled human resources partly because of labour migration of skilled and trained workers; high transport costs (Royle, 1993, 1997, 2001; DEPD, 1999b). Nonetheless, there is a small fishing industry and a sizable proportion of the island's income is generated by the sale of fishing licences. In addition, St. Helena produces of a range of foodstuffs principally for domestic consumption. Coffee is an exception and is principally produced for export, although production remains on a small scale. There is a limited tourist trade and a fledgling service industry dominated by *Solomon and Co.*<sup>75</sup> and a small number of family businesses (Royle, 2001; UNDP, 1999). Given the high cost of goods, there is a high degree of dependence on an informal market for home produce and the informal economy plays a vital role in the sustenance of many St. Helenian families. St. Helena has achieved a degree of self-sufficiency in the production of some foods (DEPD, 1999b; Agriculture and Natural Resources Department, 1999).

Moreover, such economic fragility has meant that St. Helena is economically dependent on the UK. In 1997/98, almost £6 million was allocated to St. Helena by UKG. In 2000, this contributed to around 30% of SHG's annual recurrent budget (UKG's 'grant in aid' to St. Helena). UK development assistance to St. Helena also includes support with large-scale capital investment and infrastructure projects; a technical assistance programme that includes provision of specialist skills and knowledge; provision of key administrative and technical posts; funds for improved governance; and a shipping subsidy (UKG, 1999: 7.5).

During the 1990s, St. Helena underwent rapid social, economic, and political change. This was partly driven by the political decisions of UKG. First, British citizenship was withdrawn in 1982. In the mid-1990s, UKG's Overseas Development Agency (ODA) came under pressure to reduce its budget. Because of St. Helena's dependency on economic assistance from the ODA, St. Helena would be disproportionately affected compared with other aid recipients.<sup>76</sup> UKG decided to progressively reduce the recurrent aid budget available to St. Helena without increasing its development budget so that aid to St. Helena declined in real terms by 20% during the 1990s (UNDP, 1999: 15). In the late 1990s, UKG's political and economic policy regarding the Overseas Dependent Territories was described in a UKG White Paper, *A Partnership for Progress and Prosperity*.<sup>77</sup> It stated that UKG would promote self-sufficiency, economic growth and sustainable development among the these Territories: 'The Government recognises its responsibility to provide necessary and appropriate development support to these territories, up to the stage when they can be said to have achieved economic self-sufficiency' (UKG, 1999: 7.5). This would be achieved through the promotion of 'sensible economic and financial management' and the development of 'efficient and well regulated markets'. This also marks a shift of emphasis from 'aid' to 'development' (UKG, 1999: 7.3).



The 'carrot and stick' policy of UKG towards St. Helena involved a reduction and restructuring of economic assistance during the 1990s followed by the re-granting of citizenship in 2002. In the mid 1990s, existing aid was tied to the implementation of far-reaching changes in its economic and social policies. Not only was UKG aid to St. Helena reduced in the 1990s, but SHG was also placed under pressure to undergo a process of 'structural adjustment' beginning in 1995.<sup>78</sup> The savings made in this process were presumably intended to offset the reduction in the UKG aid package. SHG undertook a review of the public sector and began implementation of a 'public sector reform programme' involving: a rationalisation of public services justified in a rhetoric of 'efficiency', 'value for money', and 'efficient pricing'; privatisation of UKG services; and a private-sector development programme<sup>79</sup> (Chief Secretary to St. Helena, 1996; UNDP, 1999). The thrust of this programme clearly came from UKG's desire to promote sustainable development on St. Helena. A statement by the Chief Secretary to St. Helena to SHG's Legislative Council<sup>80</sup> made it clear that this policy would involve 'voluntary redundancy' and 'redundancy', and would be combined with efforts to promote offshore employment: 'Offshore employment makes a significant contribution to the economy and hopefully this would continue'.

### **Social structure and labour market**

St. Helenian social structure consists a series of crosscutting and bivalent lines of stratification according to labour-market position, kinship, regional affiliation, and gender. The principal axis of 'schism' in St. Helenian society defining the social structure is that between an elite St. Helenian civil service class, St. Helenians with English ancestry, and British expatriate workers, on the one hand, and the remainder of St. Helenians on the other. St. Helena's political and economic elite are closely linked with the island's bureaucratic centre of power, the Castle in Jamestown and therefore with the British administration of the island. This constitutes the apex of the social structure. The backbone is constituted out of a set of employment positions and statuses. For instance, writing in the late 1970s, a medical researcher observed that: 'There is only a small managerial and clerical class, the vast majority being manual workers' (Moyes, 1978: 3). The labour market forms the principal structural basis for inequalities in income.<sup>81</sup> According to the 1998 Census, around two-thirds of St. Helenians in employment worked for SHG, SHG enterprises or para-statal organisations (DEPD, 1999a). Around three in every ten economically active St. Helenians worked for 'commercial organisations' including the island's largest company, *Solomon & Co*. An important line of stratification divides those Saints who are in full-time, permanent technical, or administrative government positions from those who are in low-paid, untenured, or unskilled manual jobs. The latter can be further distinguished from those Saints who are unemployed, who are on the SHG's workfare scheme (the 'three-day week'), or who depend on insecure and meagre social-security payments in order to survive. A determinant factor in generating the social structure is therefore the social and cultural processes through which individuals are allocated to these social positions. The socio-economic status of family of origin partly determines access to economic resources and employment opportunities. For example, the authors of the UNDP report observe that socio-economic position is associated with skin colour:

Historically, it seems as though darker skinned people have been poorer and less well educated. Also historically, the individuals and families who have had most power and money tend to be lighter skinned or white. Perhaps as a result, few darker skinned people have traditionally worked in shops or Government offices.

UNDP, 1999: 43

These observations suggest that the underlying social process that determines access to the economic resources on St. Helena and scarce high-status employment is partly influenced by family of origin.

### **Unemployment**

Due to St. Helena's economic predicament, levels of unemployment have historically been very high on St. Helena. The overall impact of the reduction in grant aid from UKG and SHG's reform programme was to reduce the number of employment opportunities available on the island (UNDP, 1999: 15). Between 1990/91 and 1999/00, expenditure on 'Public Works' dropped from 33% of Government (SHG) spending to 18% of its annual experience (UNDP, 1999: 16). As part of this reform program, relatively large numbers of St. Helenians (principally unskilled and semi-skilled men) faced redundancy or were made to retire early. However, St. Helena has a poorly developed private sector and there remain significant social and economic barriers to private sector development (Hogenstijn and van Middelkoop, 2002). The private sector was therefore unable to provide employment for these newly redundant workers and the unemployment rate shot up sharply in the mid-90s. According to the 1998 Census, around 18% of an economically active population of 2,386 were classified as 'unemployed'<sup>82</sup>, almost two-thirds of whom were men. The restructuring of the public sector had hit St. Helenian men particularly hard, as the former SHG policy had been to guarantee a job to all men, but not to women. Most of the jobs shed in the SHG's efficiency and reform programme were in unskilled and semi-skilled manual work. While men made up almost 70% of the unemployed in 1999, a decade before, around 70% of the unemployed had been women (UNDP, 1999). This meant that a high proportion of St. Helenians and their families were dependent on receipt of a basic income in the form of social-security payments. For adults who are able to work, receipt of such income is contingent on compulsory participation in the island's 'workfare' programme (locally known as the 'three-day week').<sup>83</sup>

### **Migration**

Given the limited economic opportunities and high levels of unemployment, migration has become a way of life for many St. Helenians. Over the past century, there have been several other waves of outward migration from St. Helena driven by poverty, hardship, and economic depression (Cross, 1980; Gosse, 1938; Hughes, 1958). Given the lack of economic opportunity and a high cost of living relative to incomes, many Saints seek work overseas: to Ascension Island<sup>84</sup>, the Falkland Islands and, to a lesser extent, Britain. It is frequently those Saints with training, education, scarce skills, and the most experience who are able to find overseas work that offers them far higher salaries than they can hope to attract on St. Helena (UNDP, 1999: 10)). For many Saints, the



alternative is to stay on the island in low-paid, insecure work on long-term dependency on unsustainable benefit incomes with the possibility of work on the 'three-day' week. Most normally go overseas for a few years 'most commonly while savings are gathered to pay for a house to be built' (UNDP, 1999: 37). Not all leave for economic reasons alone, or even as a principal motivation. Younger St. Helenians often leave because they desire to see what possibilities the 'outside' has to offer them. Others seek to escape the confines and social constraints of living in a small tight-knit community. Many do not return. Comparisons between the results of the most recent Census of St. Helena in 1999 and the Census of 1987 suggest that the rate of migration escalated during the 1990s (DEPD, 1988, 1999a). In 1998, there were 2,453 economically active adults living on St. Helena and over 1,200 worked overseas, so about one third of the economically active population were working abroad (UNDP, 1999). St. Helenians who opt to find jobs overseas are more likely to be male<sup>85</sup>, single, trained, or skilled workers (UNDP, 1999; CMO, 1999).

There was, therefore, a clear relationship between increased levels of migration, unemployment, and SHG's 'public sector reform program'. These changes were ultimately driven by shifts in UKG's policy towards St. Helena, the progressive reduction in the aid budget during the 1990s, and the imposition of a process of 'structural adjustment'.

### **Poverty, affluence, and new inequalities**

In a 1958 report,<sup>86</sup> the British MP Cledwyn Hughes said that St. Helena suffered a 'continued depression'. He reported observing 'poverty of the most distressing kind and amongst a large section of the community' (1958: 12). He noted that around 30% of the working population were unemployed (1958: 12). Moreover, 'poverty, low wages, and the lack of prospects have combined to produce a fairly universal desire to emigrate amongst young people' (1958: 24). In 1999, however, the authors of a UNDP report on St. Helena state that there are no 'real indications of poverty' on St. Helena. Somewhat paradoxically, they add, however, that 'there are of course poor people who struggle to make ends meet but there is no starvation and every one who wants it has access to adequate shelter and clothing' (1999: 39). In response to a request by the SHG Legislative Council, in 1999 an investigation was carried out by a United Nations Volunteer with the support of the Chief Development Officer and Social Security Officer (DEPD, 1999b).<sup>87</sup> Using existing evidence on St. Helena's labour market, incomes and expenditure on St. Helena, it concluded that there was some evidence of relative, but not absolute poverty, on St. Helena.<sup>88</sup> Anecdotal references to poverty on St. Helena can be found in some of the accounts of visitors to the island. For instance, in a recent account, Phillips observed that 'too many people are below the poverty line' (1998: 24). One St. Helenian man living in an outlying area confessed that most people on the island and including himself were living in a 'poverty situation'.

During the 1990s, wages in the public sector dropped by 16% implying that the improvements in many St. Helenians' material standard of living (e.g. house building and expenditure on consumer durables) was driven by the high rates of overseas employment (UNDP, 1999; DEPD, 1999b). The

remittances returning to the island from overseas work partly offset the reduction in aid available from UKG.<sup>89</sup> There have been positive material implications for many St. Helenians and their families. These remittances have enabled many St. Helenians to build new homes and reduce their dependence on SHG and, therefore, UKG. This source of income has brought increased levels of material prosperity to many St. Helenian families so that average living standards have risen (DEPD, 1999b: 10). For example, a St. Helenian man in his 50s maintained that a positive consequence of increased overseas employment to the Falkland Islands and Ascension Island had been increased levels of house ownership among Saints. For the first time, he said, many St. Helenians are beginning to support themselves and St. Helena is developing rapidly. The informant saw this as an example of Saints' resourcefulness, St. Helenians' capacity to adapt to adversity.

Nonetheless, while a minority of St. Helenian families have become newly affluent, many others continue to experience hardship. One St. Helenian man in his 50s expressed the frustration that goes along with such disparities when he complained about the high prices, the low wages, and the fact that there are 'big people' on St. Helena, 'business people' who 'get rich'. He was unhappy with the state of things and finds it hard to pay the bills. Yet, new inequalities are gradually supplanting old ones. The income generated by overseas employment and the 'rationalisation' of public services has generated new inequalities and fresh sources of relative deprivation (UNDP, 1999: 44; DEPD, 1999b). Not everyone has been able to share in the wealth generated by the increased employment opportunities in the Falkland Islands.

Some Saints expressed a concern about recent changes on St. Helena and had developed a sophisticated understanding of recent social change on St. Helena. For instance, one St. Helenian woman described how, in the past, the unity of the extended family prevented social exclusion. Relatives would provide financial and other forms of support where necessary. A quarter of a century ago, there had been full employment on St. Helena.<sup>90</sup> Back then, there had been enough to live on for everyone, and Saints lived in a state of sufficiency. Moreover, she believed that there had been a greater degree of material equality and the extended family was stronger than it is today. The local labour market was undermined by the collapse of St. Helena's flax industry in the 1950s and 1960s so that Saints were forced overseas to work. Work in the Falkland Islands became available at a time when routes to UK were being closed down through the withdrawal of British citizenship in the early 1980s. She believed that: 'The St. Helena economy would have collapsed if it wasn't for the Falklands'. Saints could command relatively high wages on the Falkland Islands and Ascension Island and could send back thousands of pounds. This was also because there was nothing to spend the money on and food and accommodation were often included. This brought increased wealth to many St. Helenian families at a time when aid from the UK was being cut back and possibilities of working in the UK curtailed.



She highlighted two main effects of this overseas work. First, St. Helenians have become less community orientated. In recent years, she said, the importance of the extended family, the security it once provided, and the support it had once offered has eroded. Second, this erosion of community values the extended family has partly been caused by the fact that St. Helenian society has become more materialistic. She described how the dominant values have shifted from an emphasis on community and reciprocity towards a concern with material consumption. She argued that those younger Saints who opt to go overseas rationalise these less socially acceptable materialistic aspirations by claiming to assist their families. She pointed out, however, that they often leave their families behind. She said that many of those who depart are already 'comfortable' before they leave. 'Why go?' she asked. She believed that one of the main reason why Saints go overseas to work is so that they can earn money so that they can build a new house, buy a new car, and go on holidays. Saints who have not gone overseas to work have seen these offshore workers returning with money and material possessions and so have become discontented with a way of life that Saints had previously accepted. She believes that this marked a cultural shift towards materialism: 'Everyone wanted more'. She said that remittances from overseas work have recently been declining<sup>91</sup> and used this to warrant her view that there has been a loosening of family ties and a turn to a set of more materialistic set of values.

The emergence of new inequalities and relative deprivation threatens social cohesion in a different way than migration. There was some evidence to suggest that income inequality in St. Helena may have increased during the 1990s with the gap between highest and lowest average earnings widening during this period.<sup>92</sup> While more earners moved into higher income bands during this period, this was offset by an increase in the number of lower earners generating a widening gap. While migration disrupted the lives of many families, the difficulties faced by those individuals (and their dependents) who have not been able to share in this new affluence deepened. While fewer opportunities were available on St. Helena due to a tightening up of SHG spending, many St. Helenians had no way of obtaining access to the employment opportunities available overseas and were placed in a vulnerable position, a position of 'entrapment'. This included individuals working in unskilled, manual, insecure, poorly paid jobs; older St. Helenians; lone parents with young dependants; those men who had been made redundant during the 1990s and who were living on social-security benefits.

It is likely that social and economic change on St. Helena has been matched by a shift in St. Helenians' core concerns. For instance, the authors of the UNDP report observed an 'increasing materialism and a disinclination to do something for nothing' and the presence of a 'more materialistic attitude' among St. Helenians (1999: 37).

## **Gender**

The structure of employment on St. Helena is highly gendered. Men were four times more likely to be self-employed, twice as likely to be unemployed and slightly more likely to be employed in full-

time positions (DEPD, 1999a). Men's employment is heavily concentrated in technical, manual (skilled and unskilled) and 'elementary' occupations, engineering, labouring, craftwork and production, fishing, or overseas work on Ascension Island or the Falkland Islands.<sup>93</sup> Going to work on these islands has become an integral part of St. Helenian masculinity, a 'rite of passage' through which young men acquire both social status and material security.

Women, on the other hand, tend to be concentrated in service and sales jobs, clerical and administrative work, health, teaching, and care work.<sup>94</sup> Women occupy many of the senior positions in SHG, although almost all St. Helena's elected councillors are men (UNDP, 1999; DEPD, 1999b). Many women go to work overseas, particularly to the UK and the Falkland Islands. Despite the fact that women have come to dominate certain areas of labour market-activity, the authors of the UNDP report point out that this co-exists with 'a high degree of sexism' on St. Helena. With many men working overseas and without qualifications, women increased their presence in the labour market during the 1990s.<sup>95</sup>

Traditional male and female roles in the home are rigidly defined. Men's typical domestic role involves house building, collecting firewood, gardening, informal economic production, and physical labour. Despite increased participation in the labour market (DEPD, 1999b: 7), women continue to perform a traditional domestic role in the home that includes caring for children and elderly relatives, cooking, cleaning, washing, and 'keeping home'. Almost all those classified as 'economically inactive' in 1998 Census were women (DEPD, 1999a). Nonetheless, many women are expected to carry out both domestic work and seek paid employment. This places some women under considerable strain.

Given an historical dependency on manual work, masculinity has come to be associated with physical work and a more practical orientation. According to the authors of the UNDP report on St. Helena, boys are not as motivated as girls to learn at school (1999: 54) and this may be partly because, in the past, men were guaranteed a job by SHG. Men are therefore less likely to obtain the qualifications required for the more secure and well-remunerated jobs in SHG (e.g. administration and clerical work, health, education).

### **5.3 "It's just one thing over and over"**

St. Helena's communal ideology emphasises family duty, harmony and homogeneity, strength and independence, social connectedness, and an absence of social schism or adversity. St. Helena's predicament during the second half of the 1990s was characterised by high levels of migration and unemployment; an erosion of the traditionally high levels of social capital; economic hardship and relative deprivation, entrapment; and an emerging communal ideology of materialism and individualism. This predicament was partly produced by the removal of British citizenship rights and a programme of SHG reform during the 1990s. These changes have placed the community of



Saints under considerable strain. The consequent breach in the received order of things directly conflicts with St. Helena's communal ideology. It therefore works to undermine an allegiance to a British root identity that partly depends on this ideology.

As a consequence of rapid social and economic change, St. Helena has become caught in a liminal space, somewhere between the modern and the traditional, between a St. Helenian future and a British colonial past. Moreover, such change has been associated with a nascent materialism and individualism. A liberal, individualistic ideology that emphasises the rights of the individual (e.g. to free expression, liberty, participation, and privacy) is not wholly consistent with St. Helena's public narrative and a traditional socio-centric discourse on the self. In conjunction with rising material expectations, this ideology sanctions the desire of younger Saints to exit from traditional social constraints and socio-economic adversity to seek their fortune overseas; it represents a release from the rigid social hierarchies that characterise St. Helenian society.

The remainder of this chapter explores how this predicament translates into anomic and social suffering among many St. Helenians. It highlights the mediating role of communal ideology and other cultural processes in constituting such suffering.

Macro socio-economic forces constitute the local relational settings inhabited by Saints and their families. Through adverse relational settings, social structure systematically impinges upon the lives of some individuals and families in ways that disrupt their social relationships, constrain their agency, or entrap them in situations of social and economic disadvantage. The examples that follow illustrate how such adversity can produce social and anomic suffering. They also show how the impact of such adversity on individual bodies is mediated by cultural processes and through the provision of a communal ideology.

St. Helenians' experiences of distress included contextualised descriptions of adverse life events and ongoing social and economic difficulties. In most cases, this discourse exhibited a low degree of narrativity. In a few cases, Saints' discourse on social suffering took the form of contingent narratives (See Chapter 4). A small number of informants situated their suffering in their biography as a whole or formed an interpretation of their suffering in terms of more general features of St. Helenian society. Three core categories of adversity emerged from informants' discourse on distress:

- A breach in social relations (e.g. social disconnection, social conflict)
- Economic adversity (e.g. 'financial worries', hardship)
- Disruption of agency (e.g. entrapment, anomie)

### **A breach in social relations**

Macro political and economic forces have forced rapid socio-cultural change on St. Helena. These changes were amplified by the introduction of new technologies and St. Helena's changing

geopolitical context.<sup>96</sup> The recent waves of emigration that took place during the 1980s and 1990s have been a mixed blessing for St. Helenians. While many Saints have become more prosperous and less dependent on SHG (and therefore UKG), large-scale outward migration has undermined social cohesion and has had a negative social impact on core relationships and social ties and has eroded traditional sources of social capital (e.g. UNDP, 1999). For instance, many households in St. Helena are missing 'significant individuals' because of overseas employment.<sup>97</sup> The authors of the UNDP report maintain that 'offshore employment may have contributed to the dislocation of families' and that 'the cohesion of the extended family is not as secure as it was in the fairly recent past' (UNDP, 1999: 37). Similarly, a middle-aged St. Helenian man believed that many Saints had been forced to go offshore during the 1990s to find work because of a lack of employment opportunities on the island and relationships and marriages had broken up as a result. In many cases, these men had left behind dependent children. This informant also expressed a concern about rising crime. Five years ago, he said, there had been an occasional theft from a shop. Nowadays, he protested, 'they are taking from their own'. He believed that the rising rate of crime was because increasing numbers of St. Helenian children are growing up without any parental control or authority.

It is likely that St. Helen's predicament, compounded by escalating levels of outward migration and unemployment in the second half of the 1990s, have had a negative impact on the public health and well being of St. Helenians.<sup>98</sup> Plummeting fertility rates on the island over the past two decades have been blamed on the social effects of migration.<sup>99</sup> For instance, the authors of the UNDP report claim that high levels of offshore employment:

Results in a severe strain being placed on family life. Children are often left in the care of grandparents and relatives while parents go away, there is a very high proportion of single people as marriage is not an attractive option when partners can be away for years at a time overseas and illegitimacy and divorce rates are higher than the United Kingdom despite the relative conservatism of the society.

UNDP, 1999: 35

Divorce rates have increased in recent years (DEPD, 1999b) and a relatively high proportion of resident St. Helenians remain unmarried well into adulthood (DEPD, 1999a).

The evidence from the UK context indicates that personal distress is more likely when social relations have been disrupted and agency is constrained. It is possible that rapid socio-economic change and the 'St. Helenian predicament' have produced high levels of anomic and social suffering among St. Helenians. For example, in the CMO's annual report for 1998, a direct connection was made between emigration, social ('fragmented families') and personal distress ('stress-related syndromes'):



The number of fragmented families is increasing and set to increase further with the current situation in emigration. This is leading to a number of stress-related syndromes in both children and adults that we have no means of successfully managing.

CMO, 1999: 25

The social and health impact of these changes among St. Helenians is unknown. Evidence is scant and anecdotal.

The immediate relational setting of many St. Helenians' experiences of personal distress are characterised by (a) Social exclusion, social disconnection, and disrupted relationships; (b) Social conflict.

**(a) Disrupted relationships and social disconnection**

Relationship breakdowns were sometimes cited as a source of distress among female informants. For instance, one St. Helenian woman said that her personal distress had been caused by "the break-up of me an' my friend, aye. Many a time I here by myself, I sit down an' cry. Many a time". Some St. Helenian women cited the emigration of a partner as a reason for relationship breakdown and personal distress. For example, a woman in her 20s had a boyfriend who had left the island leaving her to live in poverty with two young children to care for. She had 'cracked up' in response to this experience of abandonment. According to one St. Helenian healthcare worker, many Saints who set out to work overseas are married or in a relationship at the time of their departure. Many women are left alone at home with young children. She believed that some of these women become socially isolated, receiving a phone call or a letter perhaps only once a month from their partners. She also believed that some of these women become 'depressed'. Others have affairs. At any rate, she believed that such relationships often break down.

According to one St. Helenian man, the public sector reform programme forced through by SHG and UKG during the 1990s meant that relatively large numbers of St. Helenian men were made redundant (See Section 5.2 for an account of this program). The avowed intention was that these workers would be re-employed in the private sector. However, he explained that whereas SHG would have employed ten workers to do a particular job, the private sector would only hire five. The other five became unemployed and ended up on the 'three-day week'. He said that men who could not find steady, paid work became 'fed up' with being on the 'three-day week' and went overseas. Husbands and fathers have been forced to leave their home in order to work leaving their families behind. In many cases, they had not wanted to leave. This, he explained, has had a negative effect on the cohesion of many families and, in some cases, has caused relationships and families to break up. He believed that it is common for a woman to find another partner while the man is overseas and the children 'stray' as well. He cited examples where St. Helenian men had returned from overseas to find that their partners had left the island to work overseas, leaving their children with another member of the family.

Although only a few St. Helenian men were interviewed about their experience of distress, in informal conversations with St. Helenians, relationship difficulties, breakdown, and difficulties in finding a partner or starting a family were often cited as a source of suffering among men. The expression of such suffering, however, is discouraged. For example, one elderly St. Helenian man said: ‘Say a woman leaves a husband [...] It build him up, aye. Under pressure. So he become weak’.

High levels of outward migration also disrupt other social relationships and erode extended family networks. This removes a pivotal source of social support and results in a sense of loss among some of those who remain. For instance, a woman in her 40s who had suffered from ‘headaches’ described how her children’s departure from St. Helena to find work had been a source of sadness for her (Text 2):

**Text 2**

I mean, he glad he go off the island. We miss ‘im. ‘I like my children’, I always say. It was all against me like [...] I miss that one, y’know [...] He most was at home all the time, ‘cos he didn’t have no work. So, he was jus’ gettin’ off the social service, y’know [...] It’s jus’ certain times when I by myself. But, I mean, he write, he phone, y’know. It’s alright.

An important consequence of the high levels of offshore employment is that the extended support networks that Saints have traditionally depended upon have come under threat. Many Saints are forced to face the consequences of the ‘St. Helenian predicament’ alone.

St. Helena’s geographical remoteness amplifies social processes that work to marginalize and exclude. Many individuals or families are victims of a double exclusion. Not only do they live on a remote island, but they also feel isolated and excluded because they have become socially marginalized. In a society where family is everything, the breakdown of family connections through conflict, exclusion, or migration can have profoundly negative personal, social, and economic implications. For example, a widow in her 60s reported ‘feeling depressed’. She expressed how much she valued social contact, yet most of her family had emigrated, and she lived on her own: ‘Down here by myself so far, I get bored sometimes been on my own.’

Similarly, a St. Helenian woman in her 60s reported feeling under ‘stress’ (e.g. “I’ve got a lot of problems to be under the stress that I am under today”). She had a chronic illness that severely constrained her embodied sense of agency (e.g. “I can’t light my stove or anything like that. I can’t strike a match”). St. Helena’s communal ideology prescribes a strong sense of belonging to an extended family, filial duty, and social support. Over the course of her life, this informant had come to invest her social identity in her social role as a mother. She emphasised the central importance of family relations in her life (e.g. ‘I gotta a lot of feelings for my children’) and equated ‘happiness’ with ‘a happy family’. However, she had been separated from her former partner for many years,



and, after a recent fall, she was unable to venture outdoors unassisted. She did not feel confident that, if she were ever sick, there would be someone there to support her. She felt alone, vulnerable, and unsupported by her grown-up children. A breach in filial duty and a lack of family support were the central sources of her distress. She felt that the care she had once provided to her children when they had been growing up had not been reciprocated now that she was in need of care herself. Her distress arose partly out of a discrepancy between her current social adversity and her core concerns; between her social disconnection and the value that she placed on reciprocity and family relations. She reported feeling unhappy in her own home: “All those things upset me [...] I don’t feel happy like what sort of love have I got”. If she were physically able to, she said that she would leave her current situation behind: “I would prefer to do it [to leave] because I would be myself again [...] I could be more happier, ‘cos I’m very unhappy, and I could feel better if I was away from here.” She was unable to travel on her own because of her chronic illness, so that it was difficult for her to leave the island: ‘I just stuck here now. Just stuck’. This informant felt entrapped in an adverse situation characterised by social disconnection and isolation, an infringement of her normative expectations about social reciprocity, chronic illness, and financial difficulties. These sources of adversity had systematically eroded her sense of agency, resulting in personal distress.

One group of informants shared a common pattern of social adversity and distress characterised by a dependency on meagre social-security benefits; the presence of one or more dependent children; low levels of family support; poor housing conditions; economic hardship; a lack of employment opportunities; social disconnection and ostracism; the experience of loss, abandonment, divorce, or separation. For instance, a lone parent in her 30s inhabited such a relational context. Living under such conditions had left her feeling devalued and excluded: “Most of the time,” she said, “you feel that you’re missing out on something – unwanted.” Another lone parent in her 30s lived in a similar set of adverse life circumstances. She felt entrapped by this adversity: ‘The same thing happens all the time [...] You never seem to be free of it’. She would like to work, but cannot find a job. She feels socially excluded: ‘When Saints at the top, they push you down as far as they can push it depending on who you is’. She reported receiving little support and that her voice had not been heard: “Sometimes, I feelin’ I want to cry. Like, there’s nobody there. Like, you’re fighting and fighting, trying to make people see what you’re trying to say. Crying for help”.

Similarly, another lone parent in her 30s reported several episodes of ‘depression’. She was not in paid employment, lived in a situation of economic hardship, and most of her days were spent shut up in her home taking care of her dependent children. She reported feeling ‘all cooped up’ and employed a prison metaphor to depict her predicament: “I sometimes feel like I’m in a prison system.” She expressed the desire to work, but could not get into Jamestown. She had no transport of her own and there is no public transport on St. Helena. Her image of happiness was of a ‘happy family’ - being married with children. Almost all of her immediate family had already left St. Helena and, partly because of this, she had lost contact with some of them. She reported that she

had few friends on the island and felt socially 'cut off'. Given such adversity, she described feeling highly vulnerable, portraying herself as a 'sitting duck'. Her exclusion translated into a feeling of being oppressed, that 'everyone is against her'. She reported feeling trapped on St. Helena and described how she often thought about leaving, but could see no way of getting off the island. Her responsibility for her dependent children limits her mobility; she has no career, nor the financial resources that would make exit possible. She described 'depression' as being "really unhappy about the situation you're in."

The next extended case study illustrates the relationships between these emergent themes of entrapment and social disconnection. Text 3 is an extract from a series of conversations with a St. Helenian woman in her 20s whom I call Ann. Ann is not in paid work and lives alone with her young child. In Text 3, she describes her domestic routine. Her daily activity, and so her identity, are tied up with her role as a mother and a carer:

**Text 3**

Well, get out of bed.  
Get [name of her child] ready for school.  
And after they go off to school,  
then, I start to clean up the house.  
So, erm, doing the clothes.  
And, after that's finish,  
then go out,  
and hang the clothes out.  
Go out to do the shopping.  
That's about it.  
And do the cooking [...]  
[In the evening] I jus' sit down.  
Jus' listen to the radio sometimes.  
I don't worry with telly much.  
That don't bother me.  
And, arm, I jus' sit down  
and jus' listen to the radio.  
Then go to bath,  
and go to bed after.

Most of Ann's immediate family have left St. Helena to work overseas. She is unsure whether any of her family will be returning home and her social network is limited (Text 4):

**Text 4**

They [her family overseas] hardly ever phone me. I feel quite down about that. They should call me up often. [name of relative] hasn't called me in two months. She hasn't called me and I feel quite down about that, 'cos she should call us and see how everything going' with me [...] Home is too much for me to handle [...] [name of relative] she's in [names place abroad] and she hasn't been home for a long time. She's putting all the strain on me. When I do go out, I do talk to friends and that there. But, it's not like friends who come in your house. I don't have many friends. I just have to go on living like that. There's nobody here. It's just me and [name of her child]. And, I do have a lot of work on my hands. There's no one else here to do the work.

What matters to her are positive social bonds, particularly with members of her family. However, Ann has little access to social support and sums up her social situation when she says 'there's



nobody here'. Text 5 portrays her experience of social disconnection. She recognises that her social circumstances have made her vulnerable to 'depression':

**Text 5**

I never go out there and enjoy myself like other girls do, although they got children. Other girls that got children go out and have a good time, aye. And people been tellin' me too: 'You got no life'. I don't go out and enjoy myself [...] Everybody tell me I should be out of the house and mixing with other people. And, then, probably I would come 'round and be alright and get out of this depression.

Another of her core concerns is employment. She expresses a desire to work, but believes that she would not have any chance of getting a job (Text 6):

**Text 6**

I would like to go out to work. The problem is : like : erm, somebody : like a person who said to me that I should go out and try to work. But, I think, erm, if I go out and try for work, that the person who picked the people [...] they won't choose me. [...] So far, I haven't had a good few jobs because I know I got a child there [...] I would like to go out to work.

In Text 6, Ann expresses the feeling of being trapped in an adverse social and economic situation that limits her autonomy and constrains her agency; her circumstances mean that it is impossible for her to travel, work, go out, enjoy herself, and form social bonds. She does have agency in the sense that things matter to her. What matters to her, her core concerns, express her social identity as a woman and articulate her sense of agency. However, a breach has opened up between these core concerns and her experience of social adversity. The personal impact of Ann's social circumstances is mediated by their meaning; how she evaluates this context is a function of her social identity and her agency. She therefore forms a negative evaluation of her life circumstances from the perspective of her core distinctions of worth. This discrepancy is the source of her 'worrying' which she believes is responsible for her 'depression'. Such 'worrying', for instance, is exacerbated by her experience of social isolation, tight constraints on her autonomy, and an adverse relational setting.

Ann's suffering can partly be understood in relation to the domestic and social division of labour between the sexes (See Section 5.2). Her experience of personal distress is situated in a relational setting that is systematically produced by macro social and economic forces that are outside of her control (e.g. migration, high levels of unemployment, social ostracism, social structure). As a metonym for her adversity, Ann's 'worrying' articulates her moral response to her social and economic circumstances. Moreover, her agency is partly constituted in a St. Helenian cultural discourse on the self, a discourse that sets out her core commitments. St. Helenians represent their society as a tight-knit community, characterised by relations of reciprocity and strong family bonds. Breaches in social relations, inequality, oppression, exclusion, and poverty are rarely acknowledged in public discourse because they challenge the preferred version of St. Helena's public narrative. Ann does not feel part of this narrative; her experience of adversity jars with the

preferred story and clashes with the sociocentric discourse on 'the self' that it depends upon. As such, her experience of 'depression' represents a form of anomic suffering, an individual embodied response to anomie.

Nonetheless, it is important to note that the majority of Helenians are socially included, particularly through their involvement in strong extended family networks. St. Helena may well be geographically remote, but, as Section 5.1 showed, the experience of many Saints is of involvement in a strong community life. For example, a St. Helenian woman in her 60s who had returned to the island after spending most of her adult life working in the UK said (Text 7):

**Text 7**

I, myself, don't find it isolated. But, not to me, because I was used to this, I was brought up to it [...] So, err : No! I would never : say thank you : even if you gave me a ticket now to go to the UK. Go anywhere in the world that I want to go, I wouldn't.

**(b) Social conflict**

Some female informants described situations of domestic conflict in their narratives of distress. Such conflict was typically between a woman and her partner, but, in a few cases, conflict between other family members was reported. Heavy drinking among men was sometimes associated with accounts of domestic conflict. For example, one St. Helenian woman cited domestic conflict as the source of her personal distress ('My husband upset me, aye'), eventuating in her admission to hospital (See Appendix A6.3). Another woman in her 20s explained that her experience of 'depression' had started because she "didn't get on so well" with her partner. She described how her partner would go out at the weekend. She felt trapped and resented the fact that he would go out drinking, leaving her alone with their young children to take care of. He would often come back late and there would be rows. Similarly, a woman in her 30s with young children depicted the relational context of her suffering as follows:

**Text 8**

Financial problems, but on top of that the children they up to mischief and stuff and ok sometimes my boyfriend [...] come drinks all night and he comes in and we have a row.

A woman in her 40s complained of chronic pain for which the doctors could find no medical cause. She believes that this pain was caused by 'stress'. This 'stress' is metonymically associated with her insecure employment situation. Marital conflict associated with her husband's drinking was cited as another source of her distress. Another woman in her 40s identified the relationship with her husband as a source of 'stress' ('Stress with the husband'). For instance, when her husband is drunk, she said, he can 'make trouble':



**Text 9**

Well, sometimes it [the headaches] can be due to stress with the husband, y'know, when he do go be drunk and make trouble. They do, if he gets drink. But, it's very seldom, and there.

Arguments with her husband and his persistent complaining make her feel 'down' at times (Text 10):

**Text 10**

There's times when I'm down sometimes [...] Might be things don't go right like or something like will go wrong. Y'know, we may have jus' a little argument sometimes. Don't be much, y'know. Most time he come from work, his work is finish, house clean, dinner cook, but he find somethin' to say. I suppos', sometimes [her husband] get angry o'er nothing [...] I tell him perhaps he have trouble with high blood pressure [...] The way the husband get at certain times o'er nothing, 'cos almost like a row in the house, you fancy. And, the noise get too much for you, that kind of way.

In some cases, social conflict was reported between family members other than husband and wife. For instance, a woman in her 20s reported that she had had not been sleeping properly and had been diagnosed as a 'bit depressed'. She explained her distress as the consequence of 'rows in the home' and described how a member of her family drinks heavily during the weekend and, when he returns home, arguments follow. These rows had caused her to 'worry' and this, in turn, had interfered with her sleeping.

In another example, a middle-aged St. Helenian woman reported experiencing 'panic attacks' and was keen to find out what they meant: 'What I cannot understand is where these panic attacks came from?' Nevertheless, as her narrative unfolded it became clear that her experience of 'panic' was associated with her domestic social position, a role that involved washing, cleaning, cooking, and ironing. She understood 'happiness' to mean the fulfilment of this role, as well as being adequately provided for materially. She often feels 'unhappy' or 'miserable'. Rehearsing the communal ideology, she questioned the legitimacy of her own suffering. Why, she asked, should she experience suffering in such a place as St. Helena, a place where 'you can walk free. Here on the island, we're free. The windows : I can go to sleep with the windows open and nobody will harm me?' She reasoned that, since she is materially provided for and feels secure, she has no cause for 'worry'; for example, she has 'nothing to worry over like where you gonna get the next meal from, nothing like that'. As a consequence of her household role, she has very few social contacts beyond her domestic setting and does not socialise very much. All of her direct family live abroad. Her first experience of 'panic' was depicted as a response to a breach in a relationship with a close relative: 'That is something that spark something off in me. It did build up in me'. Her 'panic attacks' have recurred ever since.

Another example comes from a woman in her 50s who reported suffering from 'headaches'. The main source of her personal distress was a breach in her relations with her son. She believed that the root cause of this breach was her son's excessive drinking. When he drinks, she said, "that's the

time he gets on worse [...] always arguments” and he causes ‘trouble in the home’. Although she believed that his disruptive behaviour was due to ‘too much drink’, she also linked it to the fact that he was unable to find full-time paid employment: ‘Sometimes he would up at something else, like his job. He not got a proper job. I can’t help it that he not got a proper job at the moment’. His behaviour in the home represents a breach in filial duty and reciprocity: ‘He still not the right kind of son to me’. In her view, this breach in social relations was the principal cause of her headaches: “It [the headaches] could be worries. It could be from, as I say : the boy is sometimes jus’ the opposite in the home”.

### **Economic adversity**

Alongside social adversity, economic adversity was also commonly portrayed as a setting or source of personal distress. These individual accounts drew on a widely held common-sense explanatory system that linked personal distress or ‘worry’ to social or economic adversity. In their discourse on distress, St. Helenians identified two kinds of economic adversity: (a) ‘Financial worries’ or everyday economic concerns; (b) More severe hardship, or, as one Saint described it, ‘poverty-stress’.

#### **(a) ‘Financial worries’**

Many St. Helenians cited ongoing financial difficulties as a common source of ‘worry’ or ‘stress’. For instance, one male informant explained:

**Text 11**

Well, maybe many a thing they like to have, but they can’t afford it. Maybe, some of those that get upset are on so much and they can’t afford it. They get maybe, well, uptight, because they can’t get what they want. They can’t afford it.

In Text 11, financial difficulties are interpreted as a source of ‘worry’ because they constrain agency, making it more difficult for a person to ‘get what they want’. Similarly, a middle-aged St. Helenian woman understood ‘worry’ as an individual response to financial difficulties (Text 12):

**Text 12**

To worry will be like, err, say, you got financial problems [...] Say, you got an account somewhere in the shop and, y’know : like at the end of the month, you have to pay. You will be worry how you gonna pay that.

In Text 13, a St. Helenian woman in her 70s identifies financial difficulties as a source of ‘worry’:

**Text 13**

Say you had bills to pay for and you couldn’t manage it, then it would be been in a lot of worry and stress, that type of thing, owing people money I wouldn’t be able to sleep at night.

Similarly, another St. Helenian woman associated ‘worries’ with financial difficulties and economic insecurity (Text 14):

**Text 14**

I’m sure people would [worry], because I cannot see how you can make one pound in money go further than I can make one pound in money go. Now some of these people, theirs husband is earning forty-eight pound, and they borrow money [to pay for a house], so they got to pay back fifteen pounds out of their forty-eight pounds. Whatever they got left to buy food and clothing, and they got children. I would imagine that it would be a lot of worries to them. I know it would be to me.



These examples illustrate how the common belief among Saints that financial difficulties are a common source of ‘worry’ and personal distress. Indeed, economic concerns are widespread among the population and the sociomoral idioms of ‘worry’ and ‘stress’ are commonly used to articulate such core concerns. For example, a woman in her 70s reported that her only source of income was ‘a bit of money off the dole’ and that ‘it is not enough, but there is nothing you can do about it’. Even though she and her partner budget carefully (i.e. they ‘work around’), their economic adversity is a source of ‘stress’ (Text 15):

**Text 15**

I fancy to myself that there is a bit of stress, because you gotta find this for this month. Next one, you gotta find something else. And the water is so expensive, you know what I mean [...] Bit of light. You gotta ‘ave a bit of electric.

Similarly, a woman in her 60s described financial difficulties as part of the context of her experience of personal distress. Since her husband’s death, she has had to struggle on her own on a small income to support herself and her home: ‘The house needs repairing and things like that and I think about it and err money is difficult’ and “sometimes you don’t have the money to do things with [...] to repair the house and things like that”.

**(b) Economic hardship (‘poverty-stress’)**

‘Financial worries’ expressed anything from more prolonged hardship to the everyday experience of not being able to pay a bill. Some informants believed that more severe economic hardship or poverty is a common source of personal distress among St. Helenians. For instance, a St. Helenian man in his 60s associated distress with economic disadvantage. He believed that poverty is a common cause of distress in his rural district (‘People living in stress-poverty, in need [...] They need to be maintained’). Moreover, he believed that some groups are more at risk of ‘poverty-stress’ than others. Women, for instance, belong to a different ‘class’ to men. Some ‘classes’ of people live in ‘poverty’ and are, therefore, vulnerable to ‘stress’ (Text 16):

**Text 16**

People in different classes will be in a different situation [...] They will have a different feeling and would be living in poverty-stress [...] Not everyone can overcome it [stress]. It depends on what does it occur from.

He maintained that households whose members are in full employment and receive a ‘fair wage’, or where both husband and wife have a job, are less likely to struggle financially. He compared the situation of working households with that of lone parents who are not in paid employment and who ‘live with problems and stress – in poverty’, what he described as ‘poverty-stress’. This, he said, was because such households were not been ‘maintained’. Moreover, he believed that, in comparison with men, women are more vulnerable to stress because of their domestic role. On his view, the male domestic role is to economically provide for the household. The woman’s role, on the other hand, is to clean the home and to raise the children. The occupation of these roles means that men and women experience different sets of pressures: ‘Women have different ideas and

feelings about certain things and women have the biggest burden.’ He gave the example of a lone parent: ‘She has children and not even a home of her own [...] so she is under strain’. He believed that such poverty had been partly caused by the withdrawal of British citizenship.

Indeed, the situation of some informants fitted with this description. Some were lone parents whose personal distress was partly constituted by their experience of economic hardship. Such hardship was often associated with relationship breakdown and limited access to social capital and social support. For instance, one lone parent described her situation as one of poverty and ongoing economic insecurity. The impact of economic adversity on her children further exacerbated her personal distress and was partly a consequence of divorce: “‘Cos of my financial problems - I been divorced - the children suffer. I mean everybody suffer through a divorce, but of late : like my children : because I can’t give them certain things’”. Such adversity figured strongly in her narrative of distress (Text 17):

**Text 17**

It’s just financial. I always look at it as financial problems because sometimes : like, err two weeks ago we didn’t have no money at all. So, I was worried the whole week, how we was to survive. I didn’t have anything to put on their plate, aye. And my [name of relative] tried to help ’em out, aye. I was just getting ’em up and I was just givin’ them bread and marg’ and the cups of tea. Like, I was going insane [...] It’s a vicious circle. If you got no electricity, you got no lighting, you can’t plug the kettle in for the baby’s milk. So, you pay for the electricity and you got no food.

While such hardship was partly the consequence of a relationship breakdown, inadequate levels of social and economic support available to lone parents also generated it. Moreover, she felt that she had received little support from the wider community: “You don’t get much support from the people y’know”.

Some informants described how economic adversity had caused difficulties in their relationships. For example, a woman in her 20s described how economic difficulties and problems accessing social-security benefits had put her relationship with her partner under pressure. She would grumble at her children for wasting anything and she cited a few occasions when they had completely run out of food. She was forced to borrow money in order to survive.

### **Disruption of agency**

The ‘St. Helenian predicament’ has negative implications for St. Helenians’ sense of personal agency and for their capacity to maintain a positive social identity in the face of social and economic circumstances that disrupt traditional sociocentric notions of agency and identity. Two ways in which adverse relational settings and events disrupt agency and produce anomic suffering are distinguished: (a) a disruption in social identity associated with positional suffering (e.g. Bourdieu, 1999); (b) the experience of entrapment (e.g. Brown *et al*, 1995).



### **(a) Positional suffering**

Some informants' experiences of personal distress were rooted in a breach between lived experience and a public discourse on gender roles and identity. The capacity to meet gendered social expectations was somehow disrupted. This kind of distress conformed to the definition of anomic suffering presented in Chapter 1.

What Saints 'worry' about depends on their core concerns and their distinctions of worth so that discourse on 'worry' expresses their moral agency. 'Worries', concerns, what matters, emanate from a St. Helenian discourse on the self and the communal ideology portrayed above. Social identity is anchored in social position and the performance of proscribed social roles. In St. Helenian society, a traditional gender division of labour in both the home and the labour market constitutes masculine and feminine social identities (See Section 5.2 for a discussion on gender roles on St. Helena). Men and women on St. Helena perform different social roles and act out a gendered public narrative. Embedded in these lived out stories are different sets of expectations, core concerns, and distinctions of worth. In this way, a gendered sense of agency emanates from social position. The way that men and women articulate and express their thoughts, feelings, and experiences of suffering are bound to be patterned by such differences. For example, a woman in her 50s who lived alone in an outlying district described how she had once occupied a traditional role as a 'home keeper' and had never engaged in paid employment until her husband had died. Unable to keep herself economically after her husband's death and unable to find paid employment, she was forced to claim a meagre social-security allowance in order to survive. Text 18 describes the source of her depressed feelings:

#### **Text 18**

Well if you got somethin' in the house like to do or a bit o' gardenin' or somethin'. So, okay, I gotta do all that myself. I got nobody to do it for me, so I got no other choice, but to do it myself, aye [...] When you got somethin' to do, aye : say that you got somethin' to do. I'm a woman. It come to man's job - I've gotta do it. So, you get depressed.

Her feelings of distress are partly a response to a disruption of her personal agency and social identity. The relational setting she inhabits is at odds with a gender discourse that prescribes clearly defined domestic roles for men and women. In Text 19, she uses the term 'boredom' to signify her evaluative response to the relational setting she inhabits:

#### **Text 19**

It gets boring in the house all the time, I would say [...] Bored to yourself and you don't feel right. You get, like, out o' way to yourself when you got somethin' to do and you can't do it.

A woman in her 60s associated her experience of depression with the circumstances that followed her husband's death. She lived alone in an isolated part of the island and most of her immediate family, including her children, had emigrated. For much of her life her domestic role had been to 'keep home' as her own mother had done. After her husband's death, she had continued to 'keep

home', but was also required to take over some of the tasks traditionally carried out by St. Helenian men (e.g. feeding animals, collecting wood, doing maintenance work on the home). She found it difficult adapting to the new situation ('I found it difficult to cope being on my own'). A breach in her usual social experience following the loss of her husband was articulated in a breakdown in her agency, in her ability to 'cope'. This difficulty in coping precipitated the onset of her 'depression' (Text 20):

**Text 20**

I suppose where I couldn't do things like I used to do [...] After my husband died, I had animals to look after and I had a place to look after. That's why I got depressed I suppose where I had too much to do. I had animals to look after, the house to look after [...] I had to do the things like getting wood and looking after the animals. You just had to do it, because nobody else to do it [...] At that time, things was difficult.

In Text 20 she articulates her moral response to this disruption using an illness idiom of 'depression'. She also uses an idiom of 'worry' to express her core concerns (Text 21). These concerns, in turn, are grounded in her social identity and express her difficulty in performing her domestic tasks.

**Text 21**

Sometimes I worry over things [...] I do worry about the house; I can't do things like I used to do [...] I had animals and I can't look after them like I used to and then I worry over them.

In Text 20, 'worry' is associated with a disruption in agency. Her agency, in turn, is partly constituted as her capacity to perform her domestic role. She 'worries' when she cannot 'cope': 'If something to get done, and you can't get it done'. These 'worries' were interpreted as the principal source of 'depression': "I suppose I worry because the things I couldn't do. I think that's what started it [her experience of depression]". This eventuated in a visit to the doctor and the symbolic transformation of social suffering into 'depression'. Her breakdown in coping became reconfigured as illness experience: 'I suppose when I had a lot to do and I got depressed'.

Similarly, a woman in her 70s described how she had been required to take on extra domestic tasks since her husband had taken up the sick role. As well as carrying out her usual (feminised) household role ('indoor work'), she had taken over some of her husband's former duties ('outside work') (Text 22):

**Text 22**

I fancy that, sometimes, the work gets the best of me. Well, sometimes, have the indoor work. I have the outside work to do. It's only occasionally, not all the time. Put it this way to you : at times, like where he got animals like. But although this gotta be done like [...] Well, then with my housework, at times, now, I feel now : I feel so: I can sit an' have a cry. But that's not all the time.

In Text 22, she expresses dramatises her distress as 'having a cry'. The force of this description is to express her evaluation of a situation that she finds difficult to cope with. In Text 23, she



describes her distress (i.e. 'out of passion') as a response to her difficulties in coping with these extra demands:

**Text 23**

I do this work e'eryday. But, of late, just occasionally, I get that way. I get that feelin' that I jus' want to cry. Sometimes, I don't do nothin'. I jus' let it happen. I get ill-tempered with myself, out of passion. Perhaps, I think that I can't get the jobs done.

The next example comes from a middle-aged woman who suffered from 'tiredness', 'headaches', and complained of 'feeling depressed'. These embodied experiences of personal distress were associated with her domestic role. She complained that she has no time for herself since she is expected to both maintain the home, to cook, wash, and clean, as well as take care of livestock and collect wood, domestic tasks traditionally carried out by men. Similarly, another married woman in her 40s accounted for 'headaches', 'stress', and 'feeling down' in terms of her domestic role. She has several grown-up children most of whom have left St. Helena to work abroad and occupies a traditional domestic role as a home keeper. She described an average day:

**Text 24**

Every day : work. I like err clean the house. I clean up the house. I house clean. I clean up.

This informant described how she had experienced 'headaches' since she was a teenager and how they had increased in severity after she had children (e.g. 'It got worse as I got older and had children'). In Text 25, she situates her 'worrying' in the context of her proscribed role as mother and home keeper:

**Text 25**

It's only the housework because he [her husband] do the woodwork. I don't have to go for wood. So I jus' clean the house and cook the dinner, that's all. But I mean it's no rush 'cos I got no babies now. But, when they were very young, it was more worrying, because was nappies to put out, clothes, the shop to do, y'know.

On St. Helena, the men traditionally collect the wood, fix the house, tend the animals, while the women clean, cook, shop, wash, and care (See Section 5.2). Text 26 expresses this informant's disillusionment with her domestic role:

**Text 26**

Like, err, they do the woodwork [son and husband]. I only got the housework to do. Just like: it's just one thing o'er and o'er. And you get tired with it. And, sometimes, certain things get too much for you.

She complained of 'tiredness', 'weariness', and that she sometimes finds her home environment 'stressful'. She performs a traditional female role in the household, but finds the domestic routine repetitive and mundane, feeling trapped by it. In Text 27, a vocabulary of 'down', 'stress', and 'tiredness' are used to express the embodied response to the misery of her social position and a breakdown in her sense of agency:

**Text 27**

Sometimes it is : I fancy like, with me, like, I feel down now. Perhaps, now, or tomorrow, he [her partner] go to work. [...] I think to myself: 'I gotta soak down a lot of clothes. I gotta get these out'. And, I settle down. And, I look at it. And, I don't feel like doin' this. I say to myself now: "I shouldn't of been soak all this down 'cos I don't feel like doin' it". But, sometimes, I sit down and wash them out. If I feel I got energy, then I will soak down more sometime. [...] I like washing clothes and cleanin' the house, but it's jus' that, at certain times, I don't feel like doin' it. But, it gotta be done, y'know. But, if I sick, I know it's different. [...] Like, perhaps, our bedding in the bath. I wash the clothes and I get tired, aye, that kind of way. Perhaps, I do leave the work. I put the clothes down to wash, but I leave them. I don't feel like washing them up. Like, it too much for me.

This speaker's lived experience of distress is articulated here as a breakdown in agency and in her motivation to perform her domestic role (Text 27). She went on to say that when she feels down or dull, "if I feel that kind of way, then I will save it [her domestic chores] for tomorrow, y'know". She went on to contrast the mundane activities associated with her domestic role with 'pleasure'. Her 'pleasure' is to go for walks and engage socially with others: 'When you talk to other people and go out you feel better [...] You can talk to them about all sorts of things and feel better like'. 'Happiness' is located outside of the domestic social space and is associated with social engagement:

**Text 28**

Happy is, like, err, to be : sometimes, I fancy it is : if you go out with the other people, like, and talk to them. An' enjoy yourself been out a little. An' then come in. That's the time when I feel happier.

Another example comes from a St. Helenian woman in her 60s, a widow who lives alone. She has several grown-up children, some of whom work overseas. Her social position as mother and home keeper set the parameters on her everyday lived experience: "Jus' everyday life, aye. Y'know, you got to do the homework, you got to care for the children, you got to care for the home, you got to do the shoppin'". Her personal distress was embodied as 'headaches'. In Text 29, she accounts for her experience of 'headaches' as a response to her 'worries':

**Text 29**

Well, as the family increased,  
then you would find it more difficult.  
So, then, that would give you headaches,  
because you trying your best  
to cope every sort of thing,  
to keep the home,  
to keep the children clean. [...]  
In those years,  
I had a family to care for, aye,  
because I got married early.  
There was all homework  
to be done, shopping, caring for the children, aye.  
And wages wasn't so big at that time.  
And, erm, I mean,  
you had [to buy] every little thing out of this bit of money.  
We had to find things for the home.  
We had to find clothing for the children.  
And, I mean, you have to find a second or third lot [of  
clothing] because of weather conditions.



Sometimes, all this worry -  
You got to sort it out  
And see how you can cope with it.

In this generic, habitual narrative, the speaker uses a low degree of narrativity to describe an ongoing recurrent experience of positional suffering that occurred at some unspecified point in the past (Text 29). The text depicts the speaker's ongoing difficulties ('all this worry') and articulates her core concerns. These concerns emanate from her social role as 'home keeper', wife, and mother. Her use of the term, 'worry', partly expresses her experience of economic hardship and so articulates her family's position within St. Helena's social structure. The 'worry' associated with the performance of her role as a mother while living in a situation of economic adversity finds its embodiment in 'headaches'.

The economic changes of the 1990s and high levels of outward migration have tended to disrupt the gendered organisation of labour, thereby challenging the gender identities that depend on them. A gap has emerged between the lived experience of many Saints and the traditional social scripts that they hitherto have been expected to perform and conform to. Even though many women are now actively engaged in the labour market, there is still an expectation that they will continue to perform traditional domestic duties. By becoming more work-orientated, and, in some cases, taking up more secure, better paid work than their male partners, women's traditional role as home keeper and mother becomes challenged. The traditional masculine role as the economic provider has similarly been challenged by St. Helena's economic difficulties. Since the performance of such scripts form the basis for a positive social identity and a sense of agency, their disruption can present a threat to personal identity and can potentially precipitate a breakdown in agency. The traditional domestic division of labour becomes disrupted where men are unable to perform a provider role within the household because of chronic depression in the local labour market. In such circumstances, a fundamental source of a positive masculine identity moves out of many men's reach; limited employment possibilities on St. Helena in combination with the constraints placed upon access to overseas employment implies that many St. Helenian men are unable to achieve a culturally valued social identity. A generalised situation of anomie prevails; where men's agency is socially disrupted in this way, the social suffering that results can be described as 'anomic'.

Given a proscription against the expression of distress, adversity, problems, or emotion amongst men, there are few outlets for such suffering. This may explain the high levels of drinking on St. Helena (See Chapter 6 and Appendix A6.1). In such circumstances, alcoholism or uncontrolled alcohol consumption represents a parody or symbolic inverse of a positive masculine identity. For example, a man in his 50s with dependants to support found that being out of paid employment left him feeling 'redundant'. Before describing his predicament, he presented an account of his working life in a short burst of narrative clauses (Text 30):

**Text 30**

I start off workin' sixteen years old workin' for [name of organisation].  
 By the time I eighteen,  
 I 'ad to wear orders again.  
 I had a couple o' years like that  
 And then I went to [names place of work] - like contract.  
 Only six months at a time.  
 Come home.  
 Work on the three-day.  
 Now, spent many years on that.

The reason why he had sought employment overseas was simply 'to try and get some money'. However, he went on to say that "it didn't help much" and hinted at his current economic plight when he said: "You can't buy e'erything that you want to buy, aye". He is therefore forced to support his family on a very low income received from 'social services'. He spends some of his time seeking out food (e.g. gardening): "Most of the thing I do everyday now is I came home, try : I go an' look for food [inaudible, whispering]". Nevertheless, without a job, he complained, "there's not'ing to do." His work had been an important source of his social identity as a man, but being out of paid employment has made him feel 'tired' (Text 31):

**Text 31**

Yes, sometimes I get fed-up-to-yourself goin' through the same ol' thing over an' over. Like, I that : I at home now. I mean, when I used to go to work, then I come home, I do the same thing as I doin' now. Now, I'm home all the time, an' you sort o' get tired and fed-up.

He went on to describe pain behind his eyes that he attributed to his drinking alcohol ("Probably the beer take the sugar out o' your blood or some'ing like that"). He sometimes experiences 'dizziness' and has problems sleeping, waking up in the middle of the night "when you can't go to sleep", he said, "you thinking about all things".

Gender is perhaps the dominant axis around which social identity is constructed on St. Helena so that the way that agency becomes disrupted is also gendered. Personal distress often follows a breach or inversion in the social order of things; for instance, where the play of gendered positions is disrupted by illness, death, migration, unemployment, or relationship breakdown. In turn, these breaches and the relational settings within which personal distress are situated are constituted by macro social, economic, and political forces that are usually outside of individual control. The 'St. Helenian predicament' is an important source of personal distress and social suffering among St. Helenians.

**(b) Entrapment**

A few Saints expressed feelings of being trapped on St. Helena. This relational setting of entrapment is constituted by limited access to economic resources or employment, low levels of social or political participation, remoteness, and practical or social barriers to exit. For example, an elderly St. Helenian man living in an outlying area said that, without citizenship rights, Saints are



trapped on St. Helena: 'Us are all prisoners on our own island'. A St. Helenian man in his 30s had only ever been to Ascension Island and expressed curiosity about the 'other side'. He would like to see more of the world but his responsibility to his family keeps him on the island. He said that he would not be able to afford to leave anyhow. In addition, he has no family connections 'out there' so that "there's nowhere to go. It's like a prison." He sometimes finds it difficult when friends leave because he wishes that he could join them.

The number of St. Helenians treated for 'high blood pressure' has rapidly accelerated over the past two decades (CMO, 1999).<sup>100</sup> A lay explanatory system that accounts for illness (e.g. high blood pressure) in terms of adversity and distress forms an important part of a St. Helenian discourse on illness and distress. One male informant, for instance, believed that these high rates of treatment symbolised high levels of distress among St. Helenians. He attributed increasing levels of distress to rising levels of relative deprivation and economic modernisation: 'St. Helena', he claimed, 'has changed and continues to change, and the financial situation is contributing to worry, anxiety, and everything'. He also believed that the introduction of a 'modern way of living' on St. Helena had involved a shift towards materialism. 'Saints', he said, 'are not as contented as our fathers and parents were'. This is partly because they perceive themselves as materially deprived in relation to others: 'We want to have the things like our neighbours and friends have'. Saints, he said, had been more content in the past than they are today. In recent years, they have been introduced to television and other media and they have become increasingly well educated. He maintained that their expectations have therefore risen. In addition, access to overseas employment over the past decade has meant that the incomes of many Saint families have increased and, again, this has raised material expectations even further. The problem, as he saw it, is that many Saints have not been able to meet these expectations or share in the new prosperity. He described children who 'nag their parents' for toys that their parents could not afford. He pointed out that many of the Saints who have been able build their own houses in recent years have worked on Ascension Island or the Falkland Islands or have a high-status job with SHG. In order to improve their economic situation, many Saints have been forced to leave their home and their families ('If I do want to try and build myself a home and so I need to go to the Falklands'). However, many St. Helenian men have not been able to gain access to overseas employment. He described how these men have watched on as their peers have gone overseas and have benefited economically. Naturally, they have come to ask themselves: 'Why them, and not me?' This informant believed that the Saints who have succeeded in accessing overseas work have often come from relatively advantaged families to begin with. Those who stay, he said, 'are stuck in the mud' and become "pee'd off because they can't get anywhere." He believed that one response to such adversity was to drink heavily: "What does a guy do when he can't get anywhere? He takes his ten pounds and blows his problems out of the window".

For some Saints, it is not entrapment *on*, but entrapment *in* St. Helena that is the difficulty. Many of the accounts described above involved an experience of entrapment in adverse social and economic situations that partly constituted their experiences of personal distress. Gender interacts with class structure and economic inequalities to generate a particular configuration of affliction and positional suffering across the social field. As the accounts above have shown, the experience of entrapment among some St. Helenian women is associated with economic hardship, lone parenthood, and the performance of traditional domestic roles. On the other hand, some St. Helenian men, for instance, are entrapped in unemployment, a 'three-day week', or insecure, low-paid jobs from which there is little prospect of escaping. A few informants' experiences of personal distress had been associated with feeling entrapped in adverse employment situations from which they could see no escape. For example, a St. Helenian man in his 40s depicted his experience of distress as a response to powerlessness. Text 32 depicts his frustration in his attempts to promote change:

**Text 32**

If you are a forward moving kind of person, you want to see things get done and you're always hitting the wall. Oh, my word [...] And, you get to the stage where you realise you can't go on forever fighting, and fighting, and fighting, pushing, pushing, pushing.

These feelings of frustration and powerlessness became embodied as 'stress' and 'headaches'. Moreover, he found living on St. Helena a 'little bit claustrophobic' and this amplified his feelings of distress:

**Text 33**

You can't get very far here. Even with work. I mean no matter where I go, somebody who was goin' to ask me something about work. You can't have a break from anything. It doesn't matter if it is Saturday, Sunday, or the evenings. You've got to go and check yourself out somewhere by yourself. And, then what happens? Somebody thinks you're loony. But that isn't the case. You need solitude sometimes. You cannot go anywhere on the island unless somebody will see [...] That's the problem. Maybe if you haven't experienced anything else, then it doesn't matter. We don't miss it. It isn't a problem.

The next case study is that of a St. Helenian man in his 30s (who I call Colin) who told a story about a prolonged experience of 'stress'. He accounted for this experience by contextualising his descriptions of 'stress' in relation to an array of social and biographical contexts and events. For instance, he depicted his affliction in his personal narrative by concatenating descriptions of these contexts and events one upon on top of the other. This discourse was characterised by a low level of narrativity and the locus of control was projected into the social environment so that he was positioned in a passive role in relation to the events depicted. He used the past conditional tense to describe repeated experiences and to express ambiguity about the sequencing and timing of events (e.g. 'it would have been' or 'you would have'). He rhetorically used the second person to normalise and distance himself from his experience of social adversity. This also signalled that



events were outside of his control and that anyone else would have become distressed under similar circumstances.

Social ostracism and teasing are examples of what Loudon (1970) described as forms of ‘canalised aggression’ on Tristan da Cunha. The theme of ostracism ran through one set of these contextualised descriptions. The close-knit nature of island life means that the power of ostracism is unusually strong on St. Helena. As Colin said: “You’re too well known. As you know, everybody knows everybody in St. Helena”. His experience of ostracism demonstrates its immense force as an informal social sanction in remote, ‘tight-knit’ communities (Text 34):

**Text 34**

We didn’t have helpful neighbours as everybody else had, y’know. Err, when you needed something, no one had it. And, erm, y’know, it’s like walkin’ in the town, y’know, and, err, you could count on your fingers how many people that actually said: ‘How your doin’?’, y’know. There was a lot : there would be a lot of: ‘Hellos’. There would be very few: ‘How you doings?’, or actually stoppin’ for an answer. Anybody can say: ‘Hello’.

In addition to social ostracism, his children were teased at school: “The kids would go to school and: ‘I had a hard time from so and so’. Why? The families are all so, so, so big here”. This shows how Colin’s experience of affliction had taken place in relational settings that were framed by the ‘St. Helenian predicament’. The macro factors that constituted Colin’s affliction included St. Helena’s remoteness, the limited employment opportunities available, and the tight-knit nature of St. Helenian society. This remoteness, for example, meant that Colin was trapped in an adverse relational setting. He could not escape from a situation that was causing him considerable distress. Given St. Helena’s size and economic situation, work opportunities are limited. During the 1980s and 1990s, this was reinforced by the removal of full British citizenship rights. The low pay and limits on the amount of time Colin could take off work meant that it was impossible for him to escape. The pressure just built up:

**Text 35**

I mean its [St. Helena’s] uniqueness is what hurts it so much. I couldn’t leave from: ‘cos where do I go? [...] I said: ‘Oh well, I’ll take some leave’, y’know. You take leave. An’ erm you spending the time at home because [laughs], where else do you go? I could’ve gotten to Cape Town an’ back again if I’d ‘ave pushed Martin Smith [Capt of the RMS St. Helena] a bit. No, but I mean, y’know, you couldn’t wind down, y’know.

The relationship between Colin’s experiences of distress and his social circumstances were mediated by his social and cultural identity. The relational settings of his affliction contradict a dominant communal ideology that celebrates social connectedness, reciprocity, and inclusion. This relates back to the earlier discussion about ‘ambivalence in belonging’ in Section 5.1. St. Helenian cultural identity underpins a sense of belonging to St. Helenian society. Affliction and social adversity can erode the sentiments of affiliation and belonging. Colin’s affliction challenges

preferred representations of both St. Helenian society and St. Helenian masculinity. His sentiments of belonging are therefore tempered by ambivalence:

**Text 36**

Although not many people would agree that people can get stressed on St. Helena, I think more so than anywhere else. [...] erm : it's erm [in terms of] stress, it's a bad place. You can't get away from it. It depends y'know. I mean, what the problem is, y'know. I mean everybody's got their problems, but you can't move. You've got a choice : either, stay an' deal with it, y'know, or leave an' try an' find a life. But, see, that : that's the thing - I don't think I could ever up an' go an' sail away [...] That's my home.

The dominant communal ideology has the function of maintaining the social order. Yet, the coherence of this ideology is undermined by the presence of affliction, adversity, and social suffering. Such suffering therefore contributes to the 'ambivalence in belonging' depicted in Section 5.1; adversity and affliction point to exit and departure. Some Saints are practically unable to escape from the sources of their affliction. Nonetheless, despite the 'predicament' that St. Helena is in, it is probable that the majority of Saints who are still resident on the island have no overwhelming desire to exit. The Island of St. Helena, after all, remains their Atlantic home and a touchstone for a unique Saint identity.

#### **5.4 The social regulation of affliction**

At the end of a collection of studies on the theme of communal ideology, Falk Moore (1975) asked: 'When discrepancies exist between ideology and social reality, what do people do? [...] What happens when a community that idealises communal harmony is faced with internal conflicts and contradictions?' (1975: 210). How, for instance, does St. Helenian society respond to the threat presented to the coherence of its dominant communal ideology by breaches in social relations, economic adversity, anomie, by the 'St. Helenian predicament'?

Apart from its grammatical meaning, there are at least two other meanings of the term 'voice'. First and most obviously, 'voice' is that which is spoken with. Second, 'voice' is a person's power or capacity to articulate their thoughts and feelings, evaluations and concerns. In this way, 'voice' both articulates and emanates from a sense of personal agency. It is often said (particularly among non-St. Helenians) that Saints do not speak up, that they do not express themselves openly in public settings, and that they have no 'voice' in this second sense. Writing in the 1970s, Edith Timm, a St. Helenian, claimed that Saints do not speak up because of a 'lack of confidence': "The lack of confidence in today's islander often causes a psychological inferiority, especially in language and communication" (1977: 69). She believed that the source of this 'lack of confidence' lay in St. Helena's trouble history: 'This weakness seemed to have spilt over and has been handed down from the humble lives of our grandfathers. Many of whom were discouraged from voicing opinions. Punishments involved being whipped, disembowelled, hung and quartered' (1977: 69). In a report<sup>101</sup> written in 1958 by the British MP, Cledwyn Hughes, a number of factors were cited to explain why St. Helenians were reticent to voice their suffering and express their dissatisfaction:



Several factors have combined to produce a subservience and shyness in their nature and tardiness to complain or to appeal for help [...] The great majority suffer distress in silence and really outspoken St. Helenians can be numbered on the fingers of one hand. This quality in their nature is due to the tenuous memories of the days of slavery which die hard in an isolated community; to the very real fear of victimization in work; to the virtual monopoly in business enjoyed over generations by one private company and to the aloof and often unimaginative rule of the Colonial Administration over the years. The Islanders have never been encouraged to take a responsible part in Government, which has appeared in a greater or lesser degree to be indifferent to their sufferings and aspirations.

Cledwyn Hughes, 1958: 2

There may be a residue of truth in these historical accounts. Yet, there is more to the silence of St. Helenian voices than St. Helena's silent past.

Saints lack control of their own affairs in two principal ways. First, Section 5.2 describes how UKG's political power over St. Helenian society partly depends on St. Helena's economic fragility and its dependency on aid from UKG. This is a source of frustration for many St. Helenians because it means that they are not fully in control of their own affairs and how life on their island is organised. Indeed, opportunities for political participation and community engagement are limited. The second principal way that Saints lack control over their own affairs is rooted in the fact that most Saints are dependent on SHG for their economic and social livelihood. SHG is the centre of power in a highly taut social field. Island society is characterised by a high degree of economic and political centralisation.<sup>102</sup> Society and government interpenetrate one another in complex ways; for instance, SHG is the chief progenitor of St. Helena's dominant communal ideology so that informal social regulation and formal political and economic controls reinforce one another. SHG is by far the main employer on the island. The fact that over 80% of the economically active population work for a single employer<sup>103</sup> means that there is a high degree of overlap between social exclusion in St. Helenian society and exclusion from government employment. In such circumstances, it becomes difficult to express political dissent or socially critical views; there is a risk that one's social position and employment prospects may be damaged as a result.

'Voice' is also subjugated through powerful normalising practices and an array of informal social controls. In a study of ostracism in a Kibbutz during early 1970s, Evens showed how Kibbutz ideology worked to 'eliminate the contradiction between the individual and society' (1975: 186). In the Kibbutz, there were 'neither police nor courts to enforce the rules. Its chief means is public opinion' (1975: 187). Through exhorting self-control and moral virtue, Kibbutz society aspires to become a 'society of saints' (1975: 205).

St. Helena's dominant communal ideology also depicts St. Helena as a 'society of Saints'. This ideology and a St. Helenian discourse on 'the self' are partly enforced through powerful normalising practices that pervade the social field. These are deployed in order to minimize the gap

between the preferred version of things (as depicted in the dominant public narrative) and the organisation of social and economic life. Moreover, they function to maintain cohesion despite the island's considerable social and economic difficulties. They include, for instance:

- A sociocentric discourse on the self that brokers the relationship between body and society and that emphasises independence, strength, resilience, and social harmony;
- A set of informal normalising social practices that preserve the dominant communal ideology and work to maintain the existing social structure (e.g. public opinion, denial of voice, gossip, informal ostracism, surveillance, stigmatisation, gossip, social surveillance, ostracism);
- A mixture of formal and informal social, economic and political controls that block freedom of expression, limit freedom, and ensure that St. Helenian voices remain unheard;
- Migration and exit.

Everything, including emotional experience, is evaluated from the perspective of the dominant communal ideology since it upholds the social order. Individual behaviour or characteristics that deviate from a normative discourse on the self are therefore bound to attract a social stigma and a negative social response.<sup>104</sup> Once stigmatised, an individual or family becomes subject to normalising practices that seek to reduce the threat their deviation represents to the existing order of things. These practices include, for instance, gossip and teasing, surveillance, exclusion, social ostracism, and, ultimately, expulsion. Normalising practices also work through configuring affective responses in ways that are consistent with the dominant communal ideology (e.g. by inducing shame or embarrassment as an internalised affective response to a perceived deviation from the normative script).<sup>105</sup>

St. Helenian society is composed of a tight network of village-like communities that are nestled into valleys and stitched across ridges and plateaus around the island. Given the remoteness and the rigidity of its social structure, informal social surveillance and a lack of privacy ensure that St. Helenians' behaviour remains tightly controlled. This ensures that St. Helenians publicly conform to the communal ideology and the dominant discourse on the self.<sup>106</sup> Public life blends into private life so that there are few secrets on St. Helena. For example, the authors of the UNDP report wrote that 'St. Helena is a small island where everyone knows everyone else and hence privacy is almost non-existent' and that 'because it is a very small place, all relationships and their complexities tend to be general knowledge, placing personal and family lives under greater scrutiny than elsewhere' (1999: 33). One St. Helenian woman advised: 'Anything you can keep private, you keep, you hold on to'. A St. Helenian man observed that:



**Text 37**

There's a lot of things that people here avoid. Unfortunately, in St. Helena, you talk too long to the wrong person an' they draw conclusions from what they see. They see two people together. They think: "Oh, they're havin' an affair." It's ridiculous [...] They categorize you, an' that's it.

Among the population of Tristan da Cunha, Loudon (1966) interpreted gossip and teasing in functional terms as an acceptable response to social conflict or a breach in social relations. He contrasted a public domain of outward appearances with a private, hidden world that lay 'under the surface'; a world of conflict, tension, and potentially disruptive emotions. Loudon believed that gossip and teasing provided a sanctioned outlet for this hidden world of socially unacceptable private feelings and emotions. In this way, they contributed to social cohesion and the maintenance of a public narrative of solidarity:

The people are outwardly most docile and law-abiding, and place great emphasis on their unity: under the surface, aggression seems to be canalised into a continuous process of gossip, scandalizing, and teasing, which maintains the solidarity, morals and values of the community and enables the community to control the competing cliques and aspiring individuals within it.

Loudon, 1966: 104

St. Helena also requires ways of ensuring that adversity, social conflict, and breaches in social relations do not spill over into the public realm. Like Tristan da Cunha, they are partly channelled into the normalising practices of gossip and teasing.

Gossip and stigma are closely related. The subject of gossip is typically an infringement of community norms or a breach in social relations resulting in stigmatisation of the afflicted and some degree of ostracism. While gossip has a profoundly negative social impact in that it erodes bonds of trust and reciprocity, it binds together those who are party to it. For example, a St. Helenian woman who suffered from a chronic illness described how she had received little social support; that nobody visited her, and that, when she did meet up with friends, she was careful not to talk about her problems 'because they have friends too, and probably their friends may not be my friends'. The account of a St. Helenian woman in her 30s demonstrates the potentially destructive social force of gossip (Text 38):

**Text 38**

To be acceptable on the island, you gotta be talkative and minding everybody else's business, I suppose. [...] Nosey and mouth type [...] If you don't happen to have : if I can't go out there, down to the shop, and say: 'Do you know, this happen today?' and: 'Do you know that?' You don't [...] conversation so you're not a part of them. And they can say really hurtful things. Sometimes, what they say and how they say it can sting you up for a life-time [...] Really hurtful things about your personal appearance, the way you live [...] There are some really hurtful people out there.

The normalising force of gossip, stigma, teasing, lack of privacy, and the threat of social ostracism combine to produce a high degree of conformity, homogeneity, and social conservatism in St.

Helenian society. In addition, it is likely that these normalising forces have a negative impact on healthcare provision and influence how St. Helenians make use of healthcare services.<sup>107</sup>

'Voice' and self-expression are also regulated through the provision of a cultural discourse on the self that prescribes self-control. This discourse de-emphasises individual self-expression and subjectivity and emphasises conformity. This may be a cultural solution to the problem of remoteness, a high degree of social interdependence, and the necessity of getting along with one another in a tight-knit community. For instance, the public display of emotional distress conflicts with a discourse on the self that prescribes strength and resilience. The expression of personal distress and the vocalisation of affliction are therefore stigmatised. They are perceived as a sign of 'weakness'. A St. Helenian healthcare worker maintained that *Saints* share a belief that one should be able to cope with one's personal difficulties, that one should be strong, 'keep it in', and 'not let on'. Both men and women are expected to keep their suffering to themselves. To illustrate how *Saints* 'hold things in', she observed that St. Helenian women are less vocal in expressing their pain when they are in labour compared with English women who tend to 'go through the roof'. While *Saints* are expected to put up with their suffering, she believed that 'Europeans' expect a solution, something that might help relieve the pain.<sup>108</sup>

On the one hand, St. Helena is represented as a friendly, idyllic island. On the other hand, many *Saints* feel entrapped in a situation constituted by powerful social forces and where there is little toleration of free expression. 'Voice' is subjugated for the sake of maintaining social order and public harmony. For instance, in her account of St. Helenian language and culture, Timm emphasised this high level of social connectedness among *Saints* and this is associated with an intolerance of individual 'outspokenness':

Although the younger generation differs from the older people who in a sense lack moral courage, (reluctant to let a blunt outspokenness interfere with social amenities or with friendly relations with other people); yet many customs which preserve relationships, bind and unite families and friends, are not only observed, but genuinely practiced by the young and old alike. This oneness, being of the one mind, promotes communication and confidence.

Timm, 1978: 69

As Turner (1981) has argued, a breach in social relations can threaten to become a more deep-seated schism if redressive action is not undertaken to remedy the breach. Where social order or cohesion are threatened, where a gulf appears between the preferred story and lived experience, then normalising practices are brought into play.

Ostracism is a powerful sanction against individuals who deviate from prescribed norms and can eventuate in exit or expulsion. As Hogenstijn & van Middelkoop put it: 'If your personal identity falls outside the social boundaries that come with being a Saint on St. Helena, you leave' (2002: 4.3.6). Migration has another function. A uniquely St. Helenian voice is subdued by the high levels



of outward migration. This is partly because migration provides a kind of pressure valve that allows for a steady release and controlled diffusion of tension and discontent away from the Island. In an essay on 'voice' in the German Democratic Republic (GDR), Hirschman argued that 'exit' and outward migration worked to undermine 'voice' and that the authorities in the GDR used 'forced exit to reduce voice' (1993: 185). He gave the meaning of 'voice' a political twist when he defined it as an 'act of complaining or of organising to complain or to protest, with the intent of achieving directly a recuperation of the quality that has been impaired' (1993: 176). The pressure generated by discontent and oppression in the former GDR was relieved through exit and migration: 'Deterioration generates the pressure of discontent, which will be channelled into voice or exit; the more pressure escapes through exit, the less is available to foment voice' (Hirschman, 1993: 178). Exit functioned to silent dissenting voices producing an 'exit-induced vacuum of leadership' (Hirschman, 1993: 185). Similarly, on St. Helena, exit and migration function to silence St. Helenian voices. This contributes to the reproduction of the existing social structure, the maintenance of the existing political order, and the power relations that organise St. Helenian society. Dissenting voices are subdued and any pressure for social or political change is channelled away.

On St. Helena social suffering takes many forms: entrapment, subjugation, hardship, oppression, social disconnection, a disruption in agency, social exclusion, ostracism, inequality, and breaches in social relations. Moreover, during the second half of the 1990s, there was some evidence that St. Helena's predicament<sup>109</sup> had produced a state of anomie and therefore the conditions for anomic suffering. A distinctive St. Helenian identity, dissenting voices, and the public expression of social suffering are subjugated through a combination of bureaucratic power, a rigid social structure, poverty and unemployment, exit and migration, and normalising practices. These practices work to enforce the prescriptions and proscriptions contained in a dominant communal ideology and a sociocentric discourse on the self. This dominant discourse prescribes self-control, resourcefulness, strength, social harmony, homogeneity, 'Britishness', and loyalty to Britain.

A restricted agency and an arrested voice combine to produce an ethos<sup>110</sup> of disillusionment. One afternoon whilst I travelling through an outlying district of the island, I met two men in their 50s sitting in a shelter upon a ridge. One of the men said how he spent his days collecting litter in black bags along the country roads. The other man looked fixed in misery and incapable of smiling. He complained that nothing ever works on St. Helena and presented examples of developments that had begun with potential, but which had soon come to nothing. A former Bishop of St. Helena, Edward Cannan observed that: "Successive Governors endeavoured to find some way to help the economy, but none were successful. St. Helena has well been called 'an Island of lost causes'" (1992: 17). One visitor to the Island observed 'a despair about opportunity, and the lack of stimulation found in a larger community' (Phillips, 1998: 24). A St. Helenian man described a pervasive feeling of disinterest among St. Helenians: "I think a lot of people have lost interest in a

lot of things. Take like even council an' that sort of stuff, people have lost interest in it y'know". A senior religious figure on St. Helena concluded that Saints' attitude to their predicament is one of 'hopelessness'.<sup>111</sup>

Chapter 6 explores the relationship between agency and how Saints articulate their experiences of personal distress and social suffering in a St. Helenian discourse on distress. Where the expression of voice and agency are arrested, personal affliction and social suffering is canalised into individual experiences of personal distress expressed in a sociomoral discourse on 'worry' and 'stress', an illness metaphor of 'depression' and a somatic idiom of 'headaches'.



## Chapter 6

### Agency and Metonyms of Adversity

Suggestion: what we deprecate more than everything else is the creation of an atmosphere and suggestion; and the killing of faith and confidence; for the psyche (soul or mind) undoubtedly reacts on the body and when depressed provides a favourable soil for the virus weed to flourish in where otherwise it would have perished. Mens sana in corpore sano. Don't forget the Mens Sana!

Anonymous, St. Helena Magazine, 1946: 7-8<sup>112</sup>

The last chapter explored how cultural processes and macro socio-economic forces interact to produce a particular configuration of social suffering in St. Helenian society. Three principal ways that the 'St. Helenian predicament' constitutes social suffering were highlighted: the systematic production of social and economic adversity; the provision of a communal ideology, including a cultural discourse on the self; the enforcement of a powerful set of normalising practices that enforce the dominant public narrative. It was argued that the relational settings that provoke personal distress commonly involved a breach in the social order of things or an infringement of personal agency.

This chapter continues with ongoing theoretical discussion from previous chapters and explores how St. Helenians articulate distress in response to the social, economic, and political settings depicted in Chapter 5. It argues that a St. Helenian discourse on distress articulates Saints' core concerns and their sense of moral agency. This discourse therefore emanates from a St. Helenian discourse on the self and society. The following questions are addressed in this chapter:

- What kinds of discourse do Saints use to describe, articulate, and interpret personal distress?
- What is the relationship between discourse on distress and other local discourses (e.g. cultural and social identity, illness, public narratives)?
- How do St. Helenians interpret and account for personal distress? How do they differentiate distress from illness and sickness?
- How is St. Helenian discourse on distress influenced by communal ideology, cultural discourse on the self, and the operation of powerful normalising practices?

It should be noted that the focus of this chapter is on St. Helenian discourse on distress and social suffering, and not on psychiatric illness. Appendix A6.1 includes a description of what little is known about psychiatric illness on St. Helena and Appendix A6.2 presents a brief account of St. Helenian discourse on 'mental illness'.

## 6.1 Metonyms of adversity: ‘worry’, ‘stress’, and ‘pressure’

### ‘Worry’

A psychological discourse on mood and emotion does not figure strongly in St. Helenian discourse on distress. This is partly because the public expression of emotion and self-expression more generally are socially discouraged. It is also because most St. Helenian discourse on the self and body does not include a highly differentiated vocabulary of emotion and mood. Nonetheless, a sociomoral idiom of ‘worry’ provides St. Helenians with a versatile medium for expressing what concerns them. ‘Worry’ is a polysemous term. In St. Helenians’ discourse on distress, it signifies:

- A particular kind of thinking activity
- A source of concern or difficulty
- An evaluative response to social adversity
- A form of distress that can become physicalised as tiredness, sleeplessness, and can potentially cause chronic illness, ‘depression’, or ‘mental illness’

### ‘Worry’ as ‘thinking’

An idiom of ‘worry’ was commonly used to describe a particular kind of ‘thinking’ - evaluative ‘thinking’ that expresses ‘core concerns’. To ‘study’ or ‘think’ are synonyms of to ‘worry’. Writing around 20 years after Shine, Aldridge (a former Chief Medical Officer of St. Helena) observed that many of his patients would use an idiom of ‘study’ interchangeably with ‘worry’ (1984: 19). For example, a St. Helenian woman in her 30s said that: “When people study, they sit there and think. You might say, for instance: ‘You sit there studying nonsense again.’” With reference to her experience of divorce, an elderly St. Helenian woman said: ‘I don’t bother to study the thing.’ In Text 1, a St. Helenian man in his 40s uses the term ‘thinking’ to account for the negative impact of his work difficulties and his ability to carry out his usual social role:

#### **Text 1**

Somedays, when you’re working, some days, you can do a good day’s work. But, somedays, when these things happen, you can’t do a good day’s work because your mind is thinking about things.

A female informant in her 50s associated ‘thinking’ with ‘feeling depressed’: ‘At times you feel depressed. Just comes on its own. Just thinking about something’. A woman in her 60s described her experience of distress as ‘unhappiness’, feeling ‘downhearted and thinking all those sorts of things’. Her experience of being unhappy involved being haunted by negative thoughts: ‘I would say when you err : if you’re not happy, you get a lot of funny things go through your mind. Weird things sometimes, I would say’. In Text 2, she uses a metaphor of being ‘haunted’ to describe an experience that, in turn, disrupted her sleep:



### **Text 2**

I can't sleep an' that. I say: 'Well, I jus' like a haunted person'. It doesn't mean that I done something or that I see ghosts, or anything like that [...] I get restless. I get haunted that I've done something and I am haunted, y'know. I always say: 'I haven't kill anybody in my time'. But, I feel like I'm haunted. That's what we Saints usually say: 'We get haunted'. You done something now, and, err it must be err come to you, or something like that.

In Text 2, the speaker draws on a metaphor grounded in a popular St. Helenian discourse on ghosts to describe her distress. She is haunted by thoughts about the past and these disrupt her sleep. They make her 'restless'.

### **'Worry' as a moral idiom**

An idiom of 'worry' is commonly used by St. Helenians to articulate their core concerns, distinctions of worth, and articulates a particular kind of relationship between self, action, and social setting. It expresses a gap between what is considered important and valuable, on the one hand, and social reality, on the other.

The objects of 'worry' are problems and concerns, what a person cares about. For example, a St. Helenian woman in her 60s defined 'worries' as 'problems to cope with'. What Saints 'worry' about depends on their social identity. This, in turn, depends on their social position(s) and the role(s) they perform. For instance, in informants' discourse on distress, 'worry' was commonly associated with financial difficulties (See Section 5.3). For instance, a few informants who were mothers cited their children as a common source of 'worry'. A woman in her 60s said that she 'worries' 'if you got something to pay, and you thinking not like to pay or whatever or if the children done anything and you know they not in the wrong or anything like that'. Similarly, a St. Helenian woman denied having any 'financial worries', but she did admit to 'worrying' about her children and her domestic work; for her, 'worry' was associated with a feeling of being 'burdened'. In the case of a St. Helenian woman in her 40s, 'worry' was a function of her role as mother and housekeeper: 'When they were very young, it was more worrying because was nappies to put out, clothes, the shop to do'. A woman expressed 'worry' about the welfare of her livestock and the housework: 'I do worry about the house; I can't do things like I used to do [...] I had animals and I can't look after them like I used to and then I worry over them'. Conversely, a sociomoral idiom of 'worry' can express a lack of concern or disinterest in something (e.g. "I jus' listen to the radio sometimes. I don't worry with telly much").

Informants commonly used an idiom of 'worry' to describe an embodied feeling that accompanies the difficulty in achieving a desired goal. In this sense, 'worry' articulated a subjective response to a disruption in agency. For instance, a man in his 40s said that he 'worries' when he "gonna do something that is on your mind. I gonna do something, so I gonna think about how I'm gonna do it". A woman in her 30s said that she 'worries' when she is unable to do something that she needs to do; for instance, when there is 'something to get done and you can't get it done'. A woman in her 70s portrayed her personal distress as a breakdown in her sense of agency. This had been

associated with 'worrying', eventuating in a visit to the doctor; 'worry' articulated her concerns about her situation and her difficulty in maintaining a valued social role (e.g. "I suppose I worry because the things I couldn't do").

### **'Worry' as embodied**

Writing in the 1960s, a former medical officer of St. Helena, Ian Shine, observed that St. Helenians used the term 'worry' to mean physical discomfort or exertion. In a brief account of St. Helenian illness representations, he presented an anecdote in which he asked one of his patients whether they ever 'worried'. The patient replied: 'Yes, I worry a bit against the hill when I fetch water' (1970: 35). In his role as doctor, Shine described how he would often inquire about his patients' 'exercise tolerance' by asking them: 'Can you worry against the hill?' (1970: 35). A few informants used an idiom of 'worry' in this way, to refer to a kind of physical exertion. For instance, a St. Helenian man in his 70s used the phrase 'got to worry' to refer to an agitated activity that meant: 'Got to do it in time, do it quick'. His 'worrying' would start if he 'work hard, walk too quick'.

A few informants emphasised that 'worry' could become embodied in a variety of ways. For instance, a middle-aged St. Helenian woman who expressed 'worry' about her domestic situation articulated her experience in somatic terms (e.g. 'In your body it just come up on you'). Some informants described how 'worry' had affected their sleep, had made them 'tired', or had been associated with 'headaches'. For example, one elderly St. Helenian woman said that when she was 'worried', she "wouldn't be able to sleep at night". Similarly, another St. Helenian woman in her 70s described how her worrying had affected her sleep: "If I worry, y'know, I can't get much sleep". Another elderly St. Helenian woman linked sleeplessness and 'headaches' with 'worries' (Text 3):

#### **Text 3**

Lots of people think that you must have lots of worries if you can't sleep. [...] You go to work. You unhappy. You come home. You can't sleep. You may buy a lot of stuff. You can't afford to pay. You lose sleep over things.

In Text 3, she attributes her sleeping difficulties to 'worry'. She believed that 'worrying' had caused her experience of weight loss: "It was the worry. And, I think like: I think that's why I was losing weight".

### **'Worry' as personal distress**

Idioms of 'stress' and 'feeling depressed' were closely associated with 'worry' in St. Helenian discourse on distress. For instance, one St. Helenian woman said that 'worry' was 'what is depressed'. Similarly, an elderly St. Helenian woman described 'worry' as 'stress. Like, it means that you worried, aye. Sometimes, when you doing something and it get too much for you, you get quite stressed-to-yourself'. Conversely, an elderly St. Helenian woman said that, when she had 'got depressed', she 'could feel that kinda way - quite worried'.



Within St. Helenian discourse on distress, ‘worry’ is partly autonomous from a local discourse on ‘mental illness’ (See Appendix 6.2 for a description of this discourse). Nonetheless, a part of the meaning of ‘worry’ relies on its context within a lay explanatory system that Saints draw upon to explain or account for illness (e.g. ‘high blood pressure’), illness-like distress (e.g. headaches or depression), and ‘mental illness’. For example, a woman in her 70s explained why she had become ‘depressed’: “I suppose I worry because the things I couldn’t do. I think that’s what started it”. Similarly, a woman in her 20s accounted for her experience of ‘depression’ as a consequence of prolonged period of ‘worrying’: “It’s like : I worry myself too much, aye. In the house, jus’ worryin’ and worryin’ and worryin’ all the time. An’ don’t go out nowheres. An’ that brings on depression”. In this way, a sociomoral discourse on ‘worry’ forms a symbolic relationship between the social world (adversity) and the phenomenological world of the body (somatic complaint). As such, ‘worry’ appears at the intersection of discourses on the self, society, illness, and distress.

### **‘Worry’ as metonym of adversity**

‘Worry’ is commonly used by St. Helenians as a metonym of adversity and points to breaches and dislocations in the social and economic domain. Since social adversity and other sources of distress are metonymically signified in experiences of distress, the idioms of distress (e.g. worry, stress) are used to symbolise such adversity. ‘Worry’ can also signal powerlessness in the face of adversity and express a breach in the relationship between the individual and the collective. The public expression of ‘worry’ is therefore interpretable as a form of social critique. In this way, an idiom of worry articulates Saints’ deepest concerns and so expresses their cultural identity. ‘Worries’, then, articulate agency just at the point that it comes under threat from adverse relational settings.

### **‘Stress’, ‘strain’, and ‘pressure’**

The physical metaphors of ‘stress’, ‘strain’, and ‘pressure’ form part of St. Helenian discourse on distress. ‘Stress’ refers to a quasi-technical ethnopsychological concept that has slowly diffused into St. Helenian discourse on illness and distress, joining a lay idiom of ‘worry’. Nonetheless, some informants were unfamiliar with the term ‘stress’. Those who were familiar with the term closely identified it with ‘worry’. For example, a St. Helenian woman in her 60s said: ‘It is stress like it means that you worried, aye [...] Sometimes when you doing something and it get too much for you, you get quite stressed-to-yourself’. Medical encounters are probably the most likely pathway for the diffusion of a discourse on ‘stress’ and an illness model of distress into St. Helenian lay discourse. Doctor-patient consultations act as a catalyst for the medicalisation and psychologisation of social suffering partly by shaping how patients interpret their embodied experiences and somatic complaints (e.g. ‘worry’ becomes ‘depression’; ‘headaches’ becomes ‘stress’). For example, one St. Helenian woman described how her doctor had told her that she suffered from ‘stress’: “I asked him [the doctor] what the tablets were for and he said: ‘Stress. You have stress’.” She was prescribed medication and was told by a different doctor that it had been prescribed to treat ‘stress’. Before this consultation, she said that she had never heard of ‘stress’, which she described as: ‘Worries or problems to cope with’ or “if you have problems an’ worries

or something”. From her point of view, medication had been prescribed to treat her ‘worries’. Through a displacement of reference, these ‘worries’, her difficulties and concerns, became medicalised as ‘stress’. Since ‘worry’, like ‘stress’ also indexes social adversity, the medicalisation of ‘worry’ opens up everyday moral experience and social adversity to biomedical intervention.

Like ‘worry’, ‘stress’ metonymically stands for both social adversity and its embodied impact. It expresses a negative moral response to personal and social difficulties. For example, an elderly St. Helenian man described ‘stress’ as ‘a feeling, a pressure’, as a response to ‘what you are confronted with; what you are faced with’. Like ‘worry’, ‘stress’ was often associated with financial and economic difficulties. For example, a St. Helenian woman in her 60s remarked:

**Text 4**

Yes, I fancy to myself that there is a bit of stress, because you gotta find this for this month. Next one, you gotta find something else. And, the water is so expensive, y’know what I mean. [...] Bit of light - you gotta ‘ave a bit of electric.

Again, like ‘worry’, ‘stress’ was sometimes used to describe an impediment encountered in the achievement of a goal, as a disruption in agency. For instance, one man said that he felt ‘stressed’ ‘when trying to do something, but cannot do it right’. Some informants described ‘stress’ as an embodied experience (e.g. ‘feeling tired’): “You gotta do this, do that, do the other, like that kind of way. I can’t do nothing now see that kind of way [...] Get tired out, get tired out like. If I go down that hill an’ come back again, I tired out. I gotta sit down an’ rest”. In other cases, ‘stress’ was embodied as ‘headaches’ or was physicalised in other ways. For example, a middle-aged St. Helenian man said how he would get ‘headaches’ when ‘under stress’. Another St. Helenian man in his 40s described how his doctor had noticed that he was ‘stressed’ and prescribed him some ‘pills to relax the muscles’. He depicted ‘stress’ in his account as a form of embodied distress: ‘I think mentally you feel tired, worn out, sometimes there can be tension in the muscles, and the neck, maybe some headaches. Shows as frowns on your face’.

In this discourse on distress, ‘stress’ and ‘strain’ are used as synonyms for one another and both are associated with a gaseous metaphor of ‘pressure’. Like ‘stress’, ‘strain’ is metonymically associated with ‘worry’ and an idiom of ‘thinking’. For instance, a St. Helenian man in his 30s defined ‘strain’ as ‘pressure on you; like, worried about things’. Another St. Helenian man in his 60s identified ‘strain’ with ‘thinking’ about a practical problem: “When you think about something or something like that, aye - doing something. When you under strain, you find it more difficult to do that”. Similarly, an elderly St. Helenian woman said that ‘strain’ was ‘when you think about anything’.

Like ‘worry’ and ‘stress’, ‘strain’ and ‘pressure’ are also used to index social or personal concerns. For instance, in an evaluative response to her social problems, a St. Helenian woman in her 30s said: ‘I still feel a bit under pressure’. A middle-aged St. Helenian woman referred to her children



as a source of 'strain': 'At times they give you a strain too sometimes'. A St. Helenian man in his 70s defined 'strain' using a metaphor of physical pressure (e.g. 'strain' is 'when your body come under pressure'). A middle-aged St. Helenian man who worked as a labourer said how he felt overworked and 'under strain' because he felt as though he was doing 'the work of three men'. Finally, an elderly man said that he felt 'under strain' when there was a problem that he could not solve.

St. Helenian discourse on 'worry' and 'stress' articulates Saints' core concerns and distinctions of worth, and provides a vocabulary for registering personal and social difficulties (e.g. financial difficulties, social conflict or breaches in social relations, or disruptions in agency). Such adverse relational settings are metonymically signified in experiences of distress so that the idioms of 'worry' and 'stress' come to stand for such adversity. In this way, these idioms articulate St. Helenians' moral agency relative to their social position and the performance of prescribed social scripts. As such, St. Helenian discourse on distress forms part of a discourse on the self and society that partly constitutes agency.

'Worry' and 'stress' are metonymically displaced across two semantic fields. On the one hand, they signify embodied experience. On the other, they point to an adverse relational situation or event. They are, therefore, used to forge symbolic relationships between the body and the social field and to articulate disruptions of personal agency that occur in both these domains of experience.

## **6.2 Illness-like distress: 'depression' and 'getting depressed'**

### **'Depression' as illness metaphor**

Among St. Helenian informants, an idiom of 'depression' or 'getting depressed' was almost exclusively used as an illness metaphor that situated it within a St. Helenian discourse on chronic illness. An idiom of 'depression' was not salient in St. Helenians' everyday discourse on distress (e.g. 'worry', 'stress', 'thinking', 'headaches', being 'out of passion with oneself'). The term 'depressed' was rarely ever used to signify dysphoria or to refer to a distinctive form of emotional experience independent of its deployment as an illness term. Informants spoke about 'getting depressed' rather than 'feeling depressed'. In some informants' accounts, it was clear that their experience of personal distress had been reconfigured as 'depression' only through contact with a medical practitioner (e.g. see Text 10). An illness discourse on 'depression' had little currency beyond this context. Nonetheless, informants who had been told that they were 'depressed' or believed that they had had 'depression' expressed uncertainty about what it meant. In a few cases, the use of the ethnopsychiatric term 'depression' could be traced back to its origins in a medical consultation. For example, a St. Helenian woman in her 30s described how she had visited her doctor complaining of feeling 'nervous', 'shaky', and 'trembling'. He had responded by telling her that she was 'a bit depressed'. Similarly, an elderly woman in her 60s used an idiom of 'unhappiness' to describe her personal distress. She described how she had visited her doctor about

her arthritis. She had been ‘happy for somebody to talk to’ and, instead of talking about her arthritis, she found herself ‘crying’ and ‘talking’. She said how the doctor had prescribed her tablets for her distress. Through the transmission of an illness discourse on ‘depression’ grounded in the illness metaphor, personal distress becomes reconfigured as illness and in a way that is consistent with biomedical knowledge and practice. For instance, a woman in her 30s reported symptoms of sleeplessness and tiredness and these were re-configured as ‘depression’ through the medical encounter. After this consultation, she came to speak about her distress as ‘depression’ (e.g. ‘I do trouble with depression’). In this process, her ‘worries’ were reconfigured as the cause of an illness called ‘depression’. Similarly, a woman in her 60s described how her ‘worrying’ became reconfigured as ‘depression’ in dialogue with her doctor. Her doctor had ‘found out’ that she was ‘depressed’ by asking some questions (Text 5):

**Text 5**

I didn’t used to feel well sometimes and then I used to go to the doctors for check-ups. And, he found out that I, y’know, I used to get depressed [...] He asked me a few questions; he asked me how I feel, and I explained that I, y’know, didn’t feel like I should. Like, I couldn’t do my work like I used to; that I didn’t have mind to do things like I used to.

She had not visited her doctor because she had ‘got depressed’. Her doctor interpreted her ‘worrying’ and a breakdown in functioning (e.g. ‘feeling tired’, ‘not being able to things’) as ‘depression’. She therefore described her experience of ‘getting depressed’ as though it were an illness. The medicalisation of personal distress and social suffering re-configures it as illness. As it is brought under the control of biomedicine and its regime of treatment, personal distress is rendered legitimate.

In the following case study, a woman in her 30s describes how her experience of ‘depression’ involved a loss of sociality, social disconnection, and a breakdown in her sense of agency: “I depressed. I was sort of withdrawn first. I didn’t say much to anybody [...] I was cracking up. I just couldn’t cope”. She went on to say that on her ‘really hard days’ she “can’t handle to talk, to brush my hair, or how I dress”. Text 6 describes the social sources of her distress and her feelings of hopelessness:

**Text 6**

I don’t see a future. Everything is just deteriorating in front of me. I’m getting on more medication, less money, more problems coming in, the children doing everything wrong, no control over things.

Her medication increases as her social problems mount up (Text 6). In this excerpt, she uses an idiom of ‘control’ to depict a breakdown in her agency. A consequence of her ‘depression’ is that she never leaves her home (e.g. “ ‘cos I is depressed. I can’t get out, aye”). Like many of the English informants in Chapter 4, she uses an idiom of ‘withdrawal’ to describe a breakdown in sociality, in her disposition to form and maintain social relationships (Text 7):



**Text 7**

Sometimes, I is so withdrawn myself [...] Sometimes, people knock on the door. I ignore the knock, 'cos I don't want to see nobody. That's when I'm really down.

This breakdown is rooted in a deep distrust of others and this is part of the context of her distress:

**Text 8**

I can't handle to see people around me. Plus, I don't feel like talking most of the time. Sometimes, I is jus' lookin' at myself : I wonder if they are genuine enough to help? Or, they just there to help me, and then criticize me or expose me? I don't know [...] I, sometimes, is doubt people.

As Chapter 5 showed, social disconnection and exclusion are central features of those relational settings that foster personal distress among St. Helenians. In Text 8, feelings of withdrawal and disconnection represent an internalisation of her experience of being ostracised from the wider community. Adverse relational settings become embodied as personal distress. Such distress then comes to symbolise this adversity.

**'Depression' as a breakdown in embodied agency**

In accordance with the illness metaphor, informants' experiences of 'getting depressed' or 'depression' were embodied as tiredness or difficulties in sleeping. For example, a St. Helenian woman in her 50s described how she 'became depressed' following the death of her husband. This was embodied as a loss of appetite so that her weight had dropped. She was still not completely free of her distress: 'Sometimes, as weeks and days go by, sometimes, you feel yourself a bit depressed-to-yourself. At night time, you get no rest'. Similarly, a St. Helenian woman said how a one of her relatives would get 'depressed with himself' and this was articulated in an idiom of 'tiredness' ('I suppose he get tired out with the usual work. He come home tired'). Another informant, a St. Helenian woman in her 60s, used an idiom of 'tiredness' to describe a breakdown in embodied agency associated with 'getting depressed' (Text 9):

**Text 9**

I haven't feeling perfectly well and in good health sometimes. I get tired. I don't feel like doing anything.

You get depressed. You don't feel like doing things.

I don't fancy I been doing things like I used to. [...] Sometimes, I hardly do anything.

Distress was dramatised as 'crying' in a few women's accounts of personal distress (e.g. "Sometimes, I feelin' I want to cry. [...] y'know, like, sometimes, you cry for no reason"). One informant's experience of 'getting depressed' involved all of the somatic symptoms mentioned above: "I feel sick. I couldn't eat and I couldn't sleep. I cry a lot, aye. It wouldn't go away [...] I lost all my flesh". In the following generic narrative (Text 10), a woman in her 30s depicts her experience of 'depression' as an illness experience:

**Text 10**

Sometimes, I don't sleep well.  
I can be up for the whole night [...]

At certain times, I get very, very depressed.  
Like when I was here,  
I couldn't eat my food for three days.  
I was so weak.  
And, like, it tense-up inside [...]

I do trouble with depression  
and that I do have a lot of work on my hands.  
There's no one else here to do the work [...]

Well, I been suffer from depression for a couple of :  
Sometime, last year  
or the year before that,  
I suffer from that there.  
I been had depression before.  
An' [name of doctor] said it was depression.  
He said this time,  
'cos I said to 'im, aye:  
'I think I suffer from too much depression'.  
So. he say: 'Yes',  
he say:  
'That looks like the case' [...]

It's like,  
I worry myself too much, aye;  
in the house jus' worryin'  
an' worryin'  
an' worryin', all the time.  
An' don't go out nowheres.  
An' that brings on depression [...]

I feel like  
I don't wanna eat no food.  
I jus' wanna lay down  
an' don't do nothing;  
don't want the children to worry me.  
And I get so weak after.  
I can't walk or  
do anything.

In this speaker's personal narrative, suffering is portrayed as an embodied illness and the sufferer positions herself as passive patient (Text 10). A low level of narrativity is employed to represent the unbounded, repeated nature of her experiences of distress. This example illustrates how social suffering becomes physicalised as a breakdown in embodied agency, as 'human behavioural breakdown'. This breakdown precipitates a medical encounter in which she is diagnosed with 'depression' and her personal distress is re-configured in terms of the illness metaphor. The take-up of an illness identity sanctions her suffering and provides the rationale for biomedical intervention. The configuration of her distress on the basis of the illness metaphor partly explains the pattern of discourse presented in Text 10. In conformity with the illness metaphor, the speaker strongly emphasises the somatic nature of her distress; her experience of 'depression' involves tiredness, disruption of sleep, and a loss of appetite. The term 'weak' is used to depict a breakdown in her embodied agency.<sup>113</sup> A psychological discourse on distress (e.g. a vocabulary of mood or emotion) is almost entirely absent. Instead, the speaker physicalises her distress (e.g. she felt 'tense-up inside').



As I have shown above, Saints make metonymic use of an idiom of ‘worry’ to articulate both a moral response to social adversity and the embodied response to such adversity. The speaker in Text 10 attributes the cause of her illness to excessive ‘worrying’. Through this symbolic connection with ‘worry’, the embodied experience of ‘depression’ is re-moralised as both a mask and metaphor for social adversity.

### **‘Depression’ as ‘mental illness’**

St. Helenian discourse on ‘mental illness’ is a sociomoral discourse that defines ‘mental illness’ as a deviation from what is collectively considered to be normal behaviour, as being ‘out of control’ or ‘out of order’ (See Appendix A6.2). Moreover, ‘mental illness’ is highly stigmatised on St. Helena. Appendix A6.3 shows how St. Helenians’ perceptions of ‘mental illness’ are symbolically associated with the island’s psychiatric hospital. The relationship between a discourse on ‘mental illness’ and personal distress was ambiguous and ambivalent. St. Helenian informants were unlikely to frame their experiences of distress (whether depression or some other form of distress) in a discourse on mental illness. As Appendix A6.2 also makes clear, some resisted any linkage between their suffering and ‘mental illness’. Nonetheless, some non-sufferers, however, classified ‘depression’ as a ‘mental illness’. For instance, one St. Helenian woman said: ‘They call it [depression], like, a mental illness’. A nursing assistant at St. Helena’s psychiatric hospital expressed the belief that ‘anxiety’ and ‘depression’ were both forms of ‘mental illness’, although she was not able to distinguish between them. One St. Helenian woman interpreted a relative’s experience of ‘depression’ as a ‘mental illness’: ‘She was under a little bit of mental illness, I would say, because she used to say she see people and see things. All this is like: is depressed: or depression’.

### **‘Depression’ and ordinary suffering**

A few Saints used the terms ‘depressed’ or ‘depression’ as metonyms for ‘feeling down’, ‘thinking’, or ‘worry’. For example, a St. Helenian woman in her 30s interpreted the term ‘depressed’ to mean ‘worrying over something’. A man in his 60s used the term ‘depressed’ to mean “when you’re thinking about something”. A middle-aged St. Helenian woman associated ‘depression’ with ‘worry’: “When you so worried ‘bout the children, y’know, at home like”. Other informants associated ‘depression’ with ‘unhappiness’. For instance, a woman in her 30s said that ‘depression’ meant being “really unhappy about the situation you’re in”. One informant, a woman in her 30s, portrayed ‘worry’ as part of the experience of ‘depression’, alongside other somatic symptoms: ‘You start crying and it creeps up on you and builds up gradually from not sleeping, worry, not eating’. Other Saints, however, sought to distinguish ordinary suffering (e.g. ‘worry’ or ‘unhappiness’) from ‘depression’. For instance, one informant distinguished ‘depression’ from ‘stress’ (e.g. “It’s not stress, it’s more depression than anything”). A woman in her 60s pointed out that she had been ‘unhappy’, but not ‘depressed’. A St. Helenian man rejected the term, ‘depressed’, as a way of depicting his distress. He preferred the ordinary distress term ‘thinking’: “I wouldn’t say depressed. Sometimes something happen, an’ you jus’ thinking ‘bout it”.

Chapter 4 showed how English informants' discourse on distress was organised around an orientational metaphor of verticality ('up' and 'down'; 'high' and 'low'). For instance, they often used a vocabulary of mood (e.g. 'low', 'down', or 'depressed') to describe their experience of ordinary suffering. However, a vocabulary of mood and emotion was less prominent among St. Helenians than it was among English informants. A few Saints employed the orientational metaphor to depict their suffering. For example, a woman in her 40s who had spent much of her life in the UK was one of the few informants to articulate her experience of personal distress using the mood idiom 'feeling low'. She was also the only informant to employ a psychological concept of 'low self-esteem' to portray her distress. Similarly, a woman in her 30s who said that she had suffered from 'depression' used the orientational metaphors of 'down' and 'low' to describe how she felt: "Down feelings, low feelings. There don't have to be no reason. Be upset or angry. You just get that low feeling. [...] Sometimes, I get it : just blue in the afternoon. I get that down feeling". A St. Helenian woman in her 70s equated feeling 'depressed' with feeling 'down': 'If I was depressed, I would feel down sort of thing'. A female informant expressed puzzlement about the meaning of the term 'depressed', but went on to relate her meaning anecdotally. She equating 'depressed' with 'feeling down':

**Text 11**

Say, if somebody say to me: 'I'm ugly'. I going to feel down, because this person had the guts to tell me in my face: 'I'm ugly'. It will make me feel down, like upset to think that person for the guts to tell you.

Some informants used a metaphor of 'down' to articulate their distress without any mention of 'depression'. For instance, one informant used it to express her evaluative response to the fact that most of her family live overseas (e.g. 'I feel quite down about that'). A St. Helenian woman in her 40s distinguished 'a bit of strain, a bit of stress' from the 'ups and downs' that made her feel tired.

The following case study illustrates how the metaphor of 'down' represents an embodied metaphor of distress and communicates social suffering. The ethnopsychiatric terms 'depressed' and 'depression' are altogether absent from this account; it therefore illustrates the independence of an idiom of 'down' from the illness discourse on 'depression'. A St. Helenian woman in her 40s (who I call Jane) performs a traditional domestic role that she reports finding 'stressful' at times. She uses the terms 'stress' and 'fed-up' to describe her evaluative response to domestic adversity. Her social adversity is embodied as 'tiredness', a loss of energy, and disrupted sleep (Text 12):

**Text 12**

You get err tired. Tired and fed-up, that kind of way, I fancy. Fed-up like over nothing, sometimes. And, then you get tired.

I fancy it's like de energy. I get weak.

Some nights, I sleep right through well. And, some nights, like : erm I toss and turn. I can't lay to over one side, like. This, my leg, up here, sometimes gets pain. The weight might be, y'know.



Jane gets 'tired' when she has to do the housework. Domestic adversity erodes her sense of agency, culminating in a breakdown in her capacity to perform her proscribed social role. These somatic referents and a sociomoral idiom of 'stress' are used to communicate her evaluation of the social world that she inhabits. She goes on to say that she often feels 'dull'. Feeling 'dull' involves social withdrawal and a breakdown in her motivation to do anything:

**Text 13**

Dull, that kind of way. Like, err, I dunno : like everything is quiet. And sometimes I think, lookin' 'round, I say to myself: "I don't feel like goin' nowheres". I jus' stay here, that kind of way.

'Feeling dull' and being on her own are associated with periods of time spent 'thinking': "Like I think 'bout lot of things sometimes. Certain times, when I by myself, and err erm I just think about certain things". The metaphors of 'down' and 'dull' are used to express her feelings of lethargy, inertia, and a loss of agency: 'Some days, I feel very fresh and bright. And, some days, I feel down, and sleepy, like tired'. On her 'dull days', she does not feel motivated to do anything: "I don't feel like goin' out nowheres. Then, I feel like I wearified". After a period of feeling 'down', Jane feels 'up' again: "Somedays, I don't feel like goin' out like, and, somedays, I feel fresh, lot of energy". A root metaphor organises both Jane's discourse on distress and her lived experience of adversity. On the one hand, 'down' is symbolically associated with dark ('feeling dull'); lethargy and inertia ('tiredness' and 'feeling wearified'); the inside; social withdrawal; 'thinking'; and inactivity. On the other hand, 'up' is symbolically associated with light ('feeling bright'); energy; the outside; social engagement; action; and agency.

The habitual narrative portrayed in Text 14 illustrates this relationship between 'feeling down' and Jane's her capacity and motivation to perform her domestic role:

**Text 14**

Sometimes it is :  
I fancy like :  
with me, like,  
I feel down, now. [...]  
I think to myself:  
"I gotta soak down a lot of clothes.  
I gotta get these out".  
And I settle down,  
and I look at it,  
and I don't feel like doin' this.  
I say to myself, now,  
"I shouldn' of been soak all this down  
'cos I don't feel like doin' it."  
But, sometimes, I sit down  
and wash them out.  
If I feel I got energy,  
then I will soak down more. [...]  
I like washing clothes  
and cleanin' the house.  
But, it's jus' that, at certain times,  
I don't feel like doin' it.  
But, it gotta be done, y'know.

In Text 14, repetition and a low degree of narrativity are used to portray the inertia and the mundane nature of Jane's domestic work. It also dramatises how this domestic performance is disrupted by a breakdown in both her motivation and in her capacity to perform this role. The metaphor of 'down' articulates both Jane's social position and her body's revolt against it.

Nevertheless, the term 'depressed' was principally used among St. Helenian informants as an illness term (in conjunction with 'depression'), rather than as an idiom of mood. 'Depression' was portrayed as a kind of illness, analogous to a chronic illness. Otherwise, personal distress was described in somatic terms or in a sociomoral discourse on 'worry', 'stress', or 'thinking'.

As Sections 6.4 and 6.5 go on to show, the explanatory and symbolic relationships between personal distress and chronic illness form a central organising principle in St. Helenian discourse on illness and distress. It is commonly believed, for instance, that personal distress has the power to cause illness. As an extension of this explanatory system, Saints also cited 'worry', 'stress', and social adversity as possible causes of 'depression' and 'mental illness'. For example, in Text 9, the speaker claims that 'worrying' brought on her experience of 'depression'. Similarly, a St. Helenian woman believed that 'worry' was a cause of 'depression': "Worry about things, and all the sort of things I would imagine would make you depressed". A St. Helenian woman in her 60s believed that too much 'worry' could result in 'mental illness': "When you build your mind on something all the time, an' worry your mind or something an' then err it get too much for you. And then err your brain will get out o' balance".

St. Helenian discourse on 'depression' forms a semantic bridge between three discursive domains: (a) a sociomoral discourse on distress (e.g. 'worry', 'stress'); (b) an illness discourse (e.g. 'high blood pressure', 'headaches'); and (c) a discourse on 'mental illness'. Sociomoral idioms of distress relates to 'depression' in two ways: as metonym and as possible cause. 'Worry' is metonymically associated with being 'depressed' that, through its translation into an expert discourse on 'stress', provides a semantic bridging point between lay and expert discourse on suffering.

Discourse on 'depression' provides a way of expressing social distress in an illness idiom that diffuses the political or social significance of suffering. The medicalisation of depression de-socialises social suffering through an illness metaphor and so sanctions medical intervention grounded in biomedical aetiologies. The term 'depression' itself was almost exclusively used by informants as an illness category and was rarely used except by those St. Helenians who had been to see a doctor with somatic complaints and who had been told that they were 'depressed' or that they suffer from 'depression'. It is through this encounter that medical discourse on distress gains its principal foothold in lay discourse.



In addition, an illness discourse on 'depression' forms an intertextual bridge between ordinary suffering and psychiatric illness. The interpretation of personal distress as 'depressive illness' does not necessarily work to remove the stigma associated with such distress. There is a danger that as personal distress becomes increasingly medicalised and de-socialised, the stigma associated with distress and social adversity is doubled by bringing it into closer proximity to a discourse on 'mental illness'. Moreover, the reconfiguration of personal distress into an illness metaphor of 'depression' is associated with the diffusion of an individualised, psychological discourse on the self and a discourse on mood, a new way of talking about the self. This discourse forms a symbolic link between the social domain (e.g. social adversity) and the body (e.g. somatic symptoms). This constitutes an intermediate psychological zone between body and society is partly woven by an expert discourse on distress.

### **6.3 Public discourse and personal distress**

Littlewood interprets symptoms of distress as public symbols, claiming that 'culture-bound reactions appear to occur where major points of political and cultural opposition are represented in a particular situation' and represent dramatic, public 'representations in an individual whose personal situation demonstrates these oppositions, and they thus occur in certain well-defined situations' (1998: 243). Chapter 5 showed how some experiences of personal distress among St. Helenians are produced by particular kinds adversity; situations where agency is disrupted or where some breach in social relations has taken place. How such social suffering is expressed and experienced is partly determined by the social response and the cultural significance of distress. For instance, Kleinman and Kleinman point out that the 'dialectical relationship between depression (or for that matter any disorder) and society is mediated by the meanings and legitimacies that symptoms take on in local systems of power' (1985: 429). In an edition of *Daedalus* devoted to the theme of social suffering, they wrote that: 'There are communities in which suffering is devalued and others in which it is endowed with the utmost significance' (1996: 2).

The existence of adversity and distress contravenes the preferred image of St. Helenian society as depicted in the dominant public narrative. The public expression of distress contravenes a cultural discourse on the self that exhorts self-control, resourcefulness, and social connectedness and that depicts Saints as independent, adaptable, happy, and friendly. It therefore attracts a social stigma and a negative social response. As one informant put it in the Chapter 5 (Text 36): 'Not many people would agree that people can get stressed on St. Helena'. In addition, St. Helenian discourse on distress can be distinguished from a medico-moral discourse on 'mental illness'. 'Mental illness' is constructed as a deviation from normal functioning, as a breakdown in normal behaviour, as a loss of control and agency (See Appendix A6.2). As such, it is highly stigmatised. In Section 6.2, it was suggested that 'depression' bridges a discursive gap between a discourse on 'mental illness' and ordinary suffering. This overlap means that 'depression' picks up some of the stigma associated with 'mental illness'.

In a situation where individual St. Helenian voices are subjugated and the public display of emotion is proscribed against, the expression of private distress is also bound to attract a stigmatising response. Since such distress deviates from proscribed public scripts, it becomes subject to normalising practices that channel the way it is expressed into some forms rather than others. Some informants believed that personal distress was partly the consequence of a weakness of character. For example, one St. Helenian woman in her 30s believed that unemployment was a principal cause of ‘depression’ on St. Helena and that individual ‘weakness’ accounted for why some unemployed people experience distress while others do not: ‘Some people have weaker minds. Some are stronger than others’. A St. Helenian man contrasted the ‘stress’ of individuals living in ‘poverty’ (‘the problem is not their fault’) with those who ‘bring their problems on themselves’. ‘Stress’ is a sign of ‘weakness’. He explained why some people become distressed while others do not: “People have got different ideas. People don’t face their problems in the same ways [...] Depends on their own self [...] Some people are complacent, some are not”. He believed that men who become distressed in response to economic adversity ‘are weaker’; they ‘have got a different feeling in their self [...] Everyone’s got problems, but some people toughen to it. Others can’t live with their burdens. Some will put up with their hardship’ while others ‘are too weak to stand the stress [...] Some people’s minds build-up. They get tense’. One informant believed that a combination of excessive drinking and ‘weakness’ accounted for a breakdown in her ‘depression’ (Text 15):

**Text 15**

That is where my nerves went. That’s what ruined my nerves in the first place; like from the weakness in the family and the drinking. [...] Maybe, depression runs through our family. Maybe, there is a weakness. And, like I say, the problems I had in life, like it sort of break your nervous system down.

The way that personal distress is expressed is grounded in gender identity. Given a masculine identity that prescribes self-control, physical strength, independence, and that proscribes against the expression of emotion or self-expression, men were much less likely to talk about their experiences of distress, illness, or adversity. The following case study is used to illustrate these points. It is drawn from the personal narrative of a St. Helenian man in his 30s. In Texts 16 and 17, ‘stress’ is configured as a ‘loss of control’:

**Text 16**

Stress is : you’re in a situation that you can’t control, that you can’t handle, or any situation, y’know. It’s jus’ gotten on top o’ you or you allow yourself to be run down by this, that, and the other. Erm, that’s what I think stress is.

‘Stress’ is described as a relationship between an adverse situation and its embodied impact, a situation in which agency has been compromised. In Burke’s ‘dramatistic’ terminology, the ‘motivation’ for the ‘stress’ is expressed in a ‘scene-agent ratio’<sup>114</sup> weighted towards the scene. Elsewhere in this informant’s account, his experience of ‘stress’ is dramatised in a series of scenarios (Text 17):



**Text 17**

When the children's misbehaving [...]  
I'd be bouncin' off the ceilin'.  
I'd be really shouting [...]  
All I knew was,  
that any little thing would jus' :  
you would explode.

Tired:

I remember coming to the doctor  
always tired an' run down.  
Erm, my head felt so heavy, y'know.  
Sometimes, you sort of in a world o' your own.

But, err : start drinkin' more. [...]  
Nothin' was never the same.

Erm, [sighs] healthwise :  
I think I put on a stack of weight.

An' then it got to the point  
where you didn't say  
you didn't wanna go [to work],  
you jus' didn't want to go [laughs].

In Text 17, the speaker dramatises 'stress' as a 'loss of control', as a breakdown in agency. A psychological discourse on mood or emotion is absent in his description. 'Stress' is physicalised in a concatenation of behavioural and bodily signs of distress such as excessive drinking, an unbalanced diet, lack of self-care, disruption of family relationships, social withdrawal, and a lack of interest in work. The speaker presents himself as someone who has lost control. In Texts 16 and 17, for example, the informant's experience of 'stress' is depicted as a deviation from a cultural discourse on the self that constitutes men as independent, strong, and in control. 'Stress' is used as a metonym for such disruption; it expresses his agency just as he depicts its breakdown. In the following narrativised excerpt (Text 18), he explains how he first became aware that he was suffering from 'stress':

**Text 18**

Anybody that I know  
who [laughs] : who would be subjected to stress  
wouldn't want to know  
it existed, y'know what I mean.  
They [the doctors] said:  
'Well, y'know you been erm  
[whispering] stress'.  
'I'm fine.  
I'm not stress', y'know.  
That'd be the first thing, y'know,  
I think any of us would say.

His initial response to the doctor's suggestion that he might be 'stressed', that something might be wrong, was denial. In Text 18, this denial is depicted normatively (e.g. 'any of us would' and 'anybody that I know'). An implication of his denial was that he took no action to redress his difficulties. The severity of the 'stress' escalated until it reached a crisis point in the form of a chronic illness. This legitimised entry into the sick role and removed Colin from the socially toxic

situation that was producing his 'stress'. Social adversity produced a disruption in agency. His distress was only redressed once it had erupted into a physical illness.

Hogenstijn & Van Middelkoop observed that social difficulties are 'kept within the family and hardly ever communicated outsiders. But one problem that is very visible is alcoholism' (2002: 4.3). Chapter 5 hinted at a possible link between social suffering and excessive alcohol consumption among men. For example, a female informant said how her husband had 'a weakness', 'a non-resistance to drink'. Drinking alcohol, she said, was 'one way in which men feel really masculine'. Nonetheless, excessive drinking is not restricted to men. For example, a woman in her 30s described how she had begun drinking heavily in response to feelings of isolation: "I started drinking because I had nobody to talk to and, like, I'd drink just 'cos it was wearing me down".

Kleinman and Kleinman showed how depressive affect among the Chinese is 'socially and culturally unsanctioned and therefore suppressed' (1985: 478). This is partly because it symbolises a breach of social harmony and 'poses a threat to social arrangements and symbolic meanings [...] Demoralisation, despondency, hopelessness, withdrawal, loss of interest in the social environment are asocial. They call basic norms and relations and institutions into question' (1985: 478). Therefore, the most disempowered and disadvantaged members of Chinese society are also most likely to articulate personal distress in a somatic idiom. As Littlewood (1990) points out, Kleinman's Chinese research shows that, in socio-political contexts that demand a high degree of consensus, a somatic idiom of distress may be more socially acceptable than other ways of communicating distress.

Sections 6.1 and 6.2 showed that personal distress among St. Helenians is often expressed in a sociomoral discourse on 'worry', 'stress', 'thinking', and 'down'. Else, it is expressed in a discourse organised around an illness metaphor (e.g. 'depression'). The next section argues that the subjugation of voice and the stigma associated with social adversity and personal distress means that social suffering is 'canalised' into a more socially acceptable form: a somatic idiom of 'headaches' and a discourse on chronic illness.

#### **6.4 'Headaches' as dramatic mask**

Chapter 2 showed that in situations where 'voice' is suppressed, moral concerns, and social suffering are canalised into embodied metaphors, somatic idioms of distress, and chronic illness.<sup>115</sup> Partly because personal distress is tainted by its social origins, it regularly comes into direct conflict with hegemonic discourses on self and society.

During the 1960s, Rawnsley and Loudon (1964) investigated the social and cultural production of headaches among the adult population of the remote South Atlantic island of Tristan da Cunha



(pop.300). In an epidemiological survey of the island's population, they found that six out of ten of adults reported frequent headaches. Their informants attributed these headaches to a range of causes including 'strong winds', or 'sunshine', 'worry', or menses. Following their informants' cue, Rawnsley and Loudon also claimed that the islanders' 'headaches' were partly 'psychogenic' in origin. This view was warranted by the fact that 'respondents themselves said either spontaneously or in answer to enquiry that worry and anxiety were among the principal causes' (1964: 835). They estimated that around one quarter of the adult population suffered from what they described as 'psychogenic headaches'. In addition, they found that women were more likely to report 'headaches' than men and they were more likely than men to attribute their headaches to psychological causes (e.g. 'worry'). Nonetheless, many of those who complained of headaches 'stoutly denied' that 'emotional causes' were to blame. Where informants denied such an association, Rawnsley and Loudon interpreted such headaches as 'non-psychogenic'. They speculated that these headaches might have been caused by emotional causes, but that 'the sufferers do not choose to admit the emotional precipitants' (1964: 838).

These 'psychogenic headaches' were presented in a 'stereotyped manner'. For instance, they were: 'bi-frontal in distribution, the position often being indicated by a characteristic gesture'; were not associated with any other physical symptoms; were relieved by aspirin; occurred weekly or fortnightly; and, in most cases, did not 'interfere with life activities' (1964: 835). Rawnsley and Loudon applied the anthropological concept of a ritual of affliction in the context of a functionalist explanation of these 'headaches'. They claimed that the 'prophylactic ritual of psychogenic headaches' among women on Tristan da Cunha could be understood partly as a function of the island's social structure. For instance, women who suffered from 'psychogenic headaches' were much more likely to be married to a 'community leader'. Rawnsley and Loudon maintained that the 'anxiety' associated with such social positions was partly to blame for their increased risk of 'headaches'. The homogenous and tight-knit nature of the community accounted for why 'anxiety' was commonly 'canalised' into a somatic idiom of 'headaches':

The social factor which may be singled out as of cardinal importance in relation to psychiatric disorder is the high degree to which important life experiences are shared exclusively by members of the community. This is promoted by the small size of the population; by the physical proximity of the houses; by the universal inter-relatedness of individuals and of families through blood or marriage, and by the nature of the economy which requires a good deal of co-operation in certain processes.

Rawnsley and Loudon, 1964: 832

Like St. Helena, this feature of the island community produced a high degree of 'homogeneity' and 'a very low tolerance for departures from generally accepted standards of behaviour' (1964: 832). They argued that, given the 'extreme homogeneity' and the close-knit nature of the society, 'the headache response' to 'anxiety' represented a 'convenient, socially acceptable, common-place symbolic reaction' (1964: 838). Similarly, in a later article, Loudon wrote that psychogenic

'headaches' 'constitute a form of standardized socially prescribed behaviour which seems to be particularly prevalent among those women who are particularly liable to the stresses arising from latent conflicts within a most remarkably close-knit homogeneous community' (1966: 106).

As part of a screening strategy, a small-scale survey was carried out in one of St. Helena's smaller districts. Around four in ten out of those who responded reported that they experienced 'headaches' (See Appendices A3.8 and A6.1 for a fuller account). Women were three times more likely to report that they experience 'headaches' compared with men. The limited size of the sample, a low response rate, and other features of this screening exercise mean that the results of the survey cannot be reliably generalised to any wider population. Nonetheless, the results are suggestive. One of the Island's doctors said that 'headaches' were a common complaint among his patients.<sup>116</sup> A somatic idiom of 'headaches' figured strongly in informants' discourse on distress alongside the metonyms of adversity ('worry' and 'stress'). Informants portrayed their 'headaches' using a vocabulary of 'pain', 'tension', 'pressure', and 'strain'. For instance, a former CMO of St. Helena, Ian Shine (1970) reported that his patients commonly used the phrase 'a pain in the brains' as a synonym for 'headaches'. Similarly, a St. Helenian woman in her 60s described her husband's 'headaches' as 'pains in the head'. A St. Helenian man in his 70s described his 'headaches' using a vocabulary of 'pain': 'I get a headache through the night like I feel the pain come from my back up on my head [...] It start from the back of the head, and then start from the front over years'. In Text 19, a woman in her 30s draws on this somatic vocabulary to depict the 'head pain' associated with her experience of 'panic attacks':

**Text 19**

When I do have a panic attack, when I do start, I get a pain in my head and that head pain is extreme. It feel like my blood don't circulate, like if my brain tubes is blocked like. Something like that. And it extremely the pain.

In Text 19, 'pain' is symbolically associated with 'blockage'. Some informants used the embodied metaphors of 'strain' or 'pressure' to portray their 'headaches'. For instance, a St. Helenian woman in her 40s described her 'headaches' as a 'strain' that occurred at the front of her head. A St. Helenian man in his 30s claimed to have a 'heavy head'. Reports of feeling 'strained', 'tense', or 'tied-up' were commonly associated with 'headaches' in Saints' discourse on distress. Other informants described their 'headaches' using a vocabulary of 'dizziness' or a metaphor of 'balance'. For example, a man in his 60s described his experience of 'headaches' as 'getting dizzy'. Similarly, a St. Helenian woman described how she would experience 'headaches' when she got 'out of balance' or felt 'dizzy'.

Some informants' made a distinction between ordinary headaches and more intense, recurrent, and prolonged illness-like headaches. The latter were frequently associated with 'pressure', 'stress', and 'worry'. Informants were able to use such a discourse to signify the sociogenic (as opposed to psychogenic) origin of their headaches. For example, a man in his early 50s linked his 'head pains'



to 'pressure': 'Sometimes I got nasty head pains so I take paracetamols and it just wear away sometimes. I think sometimes it from pressure'. 'Pressure' is a polysemous term. On the one hand, it describes a somatic feeling of 'pressure' in the blood or body and is often centrally located in the head. On the other hand, it is metonymically associated with the social adversity and the relational settings in which such embodied 'pressure' is felt. For instance, a St. Helenian man in his 30s said that 'headaches' are caused by: "Worrying 'bout things and high blood pressure". A middle-aged woman said that her 'headaches' would worsen in response to the 'pressure' associated with her childcare responsibilities (Text 20):

**Text 20**

Oh, I used to have trouble with the headaches. [...] As the years go by, the children was growing up and givin' me a little bit more pressure, y'know. [...] When I think a little bit of pressure in there, they come worse y'know.

A St. Helenian woman in her 40s differentiated between ordinary headaches and more severe sociogenic headaches that were associated with 'pressure' in the blood. Ordinary headaches were brief, not usually very painful, and were caused by diet (e.g. eating cheese or drinking alcohol) or they would just happen 'sometimes when I wake mornings'. These were distinguished from the kind of headaches associated with illness experience (e.g. 'headaches' that 'come from flu pains' and 'If you feel sick, you get this headaches at the back of your eyes'). These were different again from sociogenic headaches that were characterised by their relatively long duration: 'Sometimes, I feel out of balance. After a while, you click back again [...] It be in there, just in one place. It don't stay there length of days. Just one or two days'. She used a hydraulic metaphor of 'pressure' to link such 'headaches' to a breach in social relations. They were produced by a build up of 'pressure' in the 'blood' associated with social situations that 'gets your temper up': 'If you get into a lot of arguments, then that can boost you up'. The speaker draws on an illness discourse on 'blood pressure' in order to articulate a set of metonymic connections between 'headaches', 'high blood pressure', and social conflict. Such conflict can make a person 'tense-up inside' and "push your blood up. Like ravings. Get your temper up. Get your pressure up. The blood'll go up in your eyes". Similarly, a woman in her 60s described 'headaches' as a 'pressure' behind her eyes that she gets when she is 'worried' about something. A middle-aged St. Helenian woman said that her grown-up children work overseas and that she sometimes 'worries' about them. This 'worry' brings on 'migraines'. Similarly, a man in his 50s complained of 'headaches' and believed that they were caused by 'tension':

**Text 21**

Sometimes, I get a little bit, like I would say, tied-up-fied, tense-up and things, y'know, wondering what the next move could be and things, y'know. And, then, you have your own problems to tend to, your work problems. All different problems we face.

In Text 21, these feelings of being 'tense-up' are depicted as an embodied response to the speaker's social difficulties. They articulate his core concerns: "Sometimes, you go to work and things don't

work for you like, that kind of way. Work problems, y'know". This social 'tension' is also identified as the source of his 'headaches'. In this way, an implicit connection is made between work-related difficulties and his 'headaches'.

In some cases, the severity, duration, or frequency of illness-like 'headaches' warranted a visit to the doctor. For instance, a St. Helenian man in his 60s explained: "I had to go to the doctors because it [his headaches] was gettin' grand, aye." In Text 22, a middle-aged St. Helenian woman dramatises a medical consultation that involved the diagnosis and treatment of her 'headaches':

**Text 22**

Jus' pains just getting' me top o' the head like that [...] like there's a press on top o' my head.  
I explained to the doctor 'bout it.  
I said:  
"Shouldn't be like that, aye".  
So, he give me these tablets to take and they :  
when I get that kind o' way.  
He say:  
"Jus' take the tablets", aye. [...]  
He didn't tell me what it was, but I told him that it was :  
I said:  
"It was the headaches that was pressin' down on top of my head like".  
And he say:  
"Oh" : give me some strong tablets that I had to take.  
I used to take the Panadols, aye.  
But, like the pains jus' keep greater, aye.  
So, he give me these strong tablets [...]  
Well, after I take 'em,  
I was okay afterwards.

In this partly narrativised account (Text 22), the speaker presents her 'headaches' as an illness, as an object of medical concern. Running through the discourse is a distinction between ordinary 'headaches' (for which 'Panadols' are taken) and more severe, illness-like 'headaches' that warrant a visit to the doctor. She positions herself as a patient in a dramatisation of the palliative ritual of the medical consultation in which 'headaches' come to mean something different; through acting out the patient role, her 'headaches' are re-described and socially sanctioned as illness.

The next example is drawn from an account of a St. Helenian woman in her 60s who reported suffering from 'headaches'. She distinguished between more severe, sociogenic 'headaches' and ordinary 'headaches'. The latter started when she was much younger and are characterized in terms their cause (Text 23):

**Text 23**

I know I used to get headaches when I was younger, but I think that they were just ordinary headaches. Probably due to the kind of food we used to eat, due to the weather, or anything like that.



'Ordinary headaches' are caused by dietary factors or vicissitudes in the weather (Text 23). Elsewhere in her account, she remarked that such 'headaches' could come from the 'heat of the day' or 'from a cold'. Her experience of 'hot flushes and tight head', the 'bad headaches', began more recently and are embodied as 'aches down the neck', a 'splitting head', and 'tiredness'. She uses a heat metaphor to articulate these pain sensations: "Sometimes, I get a bit flarey-up, fiery-up, but I tend to put up with it. I jus' try to put it out of my mind". She goes on to use a physicalised metaphor of a pressurized container ('tight', 'burst', "crackin'") to describe how her head feels during a 'headache' episode:

**Text 24**

Well, as I say, like, my head used to get that tight, like. I feel it : feel it want to burst, like it feel like crackin' or something. And, sometimes, I get quite sick in the body as well, but I didn't mention anything 'bout body feeling like flop : I just feel flop down.

These 'headaches' are illness-like in that they are associated with the feeling of being 'sick in the body', with a breakdown in embodied agency (Text 24). She presented her 'headaches' to her doctor as 'hot flushes', as repercussive through her body and not just located in her head: 'I told him I used to get hot flushes. I get tight head. Get up my head or neck sometimes. If it's in my head, it's in my chest'. Text 25 presents a narrative of how this informant first came to visit the doctor about her 'headaches'. The force of this discourse is to warrant her claim that her 'headaches' were caused by 'stress':

**Text 25**

It was two or three years ago  
when I did first go  
and see the doctor because,  
as I said,  
I had this splitting headaches.  
Head used to get really tight  
when I travel against the hill  
or get fast.  
Even if I on the level,  
I used to get tired.  
I used to get pains down my neck and shoulder.  
That's why I went to see the doctor.  
I thought it would bin blood pressure.  
And that was [Name of first doctor].  
Then, I saw [Name of second doctor].  
I asked him:  
'What the tablets were for?'  
And, he said:  
'Stress. You have stress'.

This tale of diagnosis (Text 25) warrants her view that her 'splitting headaches' were caused by social adversity, metonymically signified by the ethnopsychological term, 'stress'. The doctors on St. Helena proffered a psychogenic explanation for her 'headaches' and gave her some tablets. These medical encounters transformed the meaning of her distress. She went on to explain how she would 'all hot, flush-up, and head used to tighten, due to stress'. 'Stress' here means 'worries or problems to cope with'. Elsewhere in her account, she described the source of these 'worries' as

domestic conflict. Through a displacement of meaning from 'stress' to 'worry', 'headaches' become symbolically associated with domestic adversity. More abnormal, severe illness-like 'headaches' become a metonym for social adversity through their symbolic association with 'stress' and 'worry'.

A St. Helenian woman in her 40s said that she had 'trouble about headaches' which she distinguished from 'ordinary headaches' (e.g. 'migraine'). In Text 26, she describes how these more severe, painful, illness-like headaches are embodied:

**Text 26**

Ordinary headaches like just come in the forehead part. A slight pain. Might be take tablets. Might not. But, if it 'comes too great, if I get it here or here [pointing to her head], then if it gets too great for me, then I take the tablets. Sometimes, it take it away. Sometimes, it don't take it away 'til I lie down. [...] It like a tightening pain in the head, a tightening pain *here* [gesturing across to the left side of her face]. And, sometimes, I get it across the eyes like and down here [gesturing]. [...] It comes up here sometimes [gesturing again] and down the eye. That make me sick, y'know. I take the pain killers, and lay down and rest. Besides, I got the cold cloth there for easement. Sometimes, the cloth take it away. [...] The pain come first. And, once or twice, I been giddy with it too, with these pains and there. [...] It don't be every day. It jus' certain times that it come at me. And, then, I get this pain in the head. I get tired with it. And, sleepy sometimes. I not got no sugar 'cos they test. No sugar. Tired. Sleepy sometimes. Sittin' down like. [...] It jus' come sometimes when the pain come. Then I get giddy, and I have to sit down and lay down.

In Text 26, the speaker uses a highly physicalised language to describe her headaches, rich in metaphor. Yet, there is little evaluative commentary on her experience. Instead, her distress itself represents an evaluation of her adverse social circumstances. She distinguishes between two kinds of 'headache'. The first kind is associated with her 'monthlies' (i.e. 'blood'). The second kind is more severe and is associated with 'weariness', 'tiredness', and feeling 'dizzy'. She uses a vocabulary of 'pain' to describe the phenomenology of these 'headaches'; they are described as 'a pain' centred around her eyes, 'a pain' that makes her feel 'sick'. She has to stop her usual domestic work, 'take rest' and seek medical advice. The doctor said that her 'headaches' were caused by the 'sinuses' or 'monthlies' ('blood'): 'He, erm, says it infections. Sometimes, it could be the blood. Mostly, from the sinus'. Following her doctor's cue, she believed that 'the blood' might be a source of her more severe 'headaches' (as opposed to 'ordinary headaches'). Yet, 'headaches' caused by the 'monthlies' are 'ordinary'. Their intensity and phenomenology mean that they are unlikely to be caused by 'blood' or 'monthlies' (Text 27):

**Text 27**

Most stop here [gesturing to her head]. Sometimes, like the main part is down the eye, the side of the face, down thro' the jaw. Sometimes, it goes down through the neck, aye. But, I thought like it was the blood problem, monthlies, or something. But, it too great a pain sometimes. And, err tiredness like, weary and weak, y'know. And, sometimes, can be stressful.

Compared with 'ordinary headaches', more severe, illness-like 'headaches' are associated with greater pain and feelings of being 'weak and weary'. They are different in kind and so must have a



different causes. The semantic link between 'stress' and 'headaches' makes it possible for her to articulate her feelings of distress and unhappiness. 'Headaches' simultaneously mask and embody her social adversity; they make it possible for her to express her dissatisfaction with her domestic situation in a socially sanctioned way, that is, in a somatic idiom of illness. This symbolic effect is made possible by the ambiguity that surrounds the causes of her 'headaches':

**Text 28**

I think it might be the blood sometimes y'know. [...] I mean, like every month, y'know, a woman or a girl like be unwell, and have her monthlies and, then that's the problem like. But, I think, sometimes stress too.

In Text 28, the connection between 'stress' and 'headaches' is presented as indeterminate; her 'headaches' occur 'at certain times, certain days', on 'sad days', when she feels 'down'.

These accounts illustrate that social adversity (signified by the metonyms of adversity: 'stress', 'pressure', and 'worries') were not the only source of 'headaches' mentioned in informants' accounts. A variety of other causes were cited, all of which were associated with the body (e.g. high blood pressure, diet, or drinking alcohol, flu, or 'monthlies'). For example, one middle-aged informant said that she experienced 'headaches' that disrupted her sleep roughly about once every week. She distinguished such 'headaches' from those that she gets when she has 'the flu'. A woman in her 50s believed that her 'headaches' were caused by high blood pressure. She maintained that since she had started taking treatment for high blood pressure, her 'headaches' had become less frequent. A man in his 70s believed that his 'headaches' might be caused by the 'blood' (i.e. high blood pressure): "It could be the blood or something like that. I think : I can't tell you what. The doctor don't tell you what really do it". The indeterminacy surrounding the causes of 'headaches', makes them available for symbolising core concerns and 'worries'; 'headaches' provide Saints with a flexible somatic idiom for articulating social adversity in a socially safe way.

A patient brings a complaint of 'headaches' to their doctor. No biomedical explanation can be found. Treatment fails. The doctor tells the patient that the 'headaches' are caused by 'stress'. Medical treatment may be provided to redress the situation. In the examples described above, some informants collaborated in their doctor's psychogenic interpretation; that their 'headaches' were due to 'worries' or 'stress' (and, therefore, social adversity). What happens, then, when a patient presents with 'headaches' to a doctor, but no social adversity, no source of 'stress' or 'worry' is present? A St. Helenian man in his 30s (who I call Frank) said that he had experienced the same recurrent 'headaches' for many years. He described them in an idiom of 'dizziness' and 'weakness' (Text 29):

**Text 29**

Feelin' dizzy. Feelin' dizzy. It like : it always something to do with the head. It will : my flesh will get sweaty. It all goes to the head feelin'. It is silly for me to say, but it is like a pain in the head. Err, a agitatin' pain. Feelin' dizzy. And, then, I will probably feel weak like.

These ‘headaches’ do not involve severe pain, but are experienced as an ‘agitating pain’, so that one ‘must take notice to it’ (Text 29). Although this pain is situated ‘at the back of the eyes’, it is associated with a variety of other somatic symptoms including feeling ‘sweaty’, ‘dizzy’, ‘weak’, and ‘faintness’. After an hour or so, the ‘pain’ goes away so he feels relieved. Nonetheless, he says that he ‘never feels right for a week’ and “when it leave me, still not feelin’ normal. Still feelin’ dizzy. But, I don’t get the sweaty skin - faintness”. Text 30 presents a brief genesis narrative that depicts how his ‘headaches’ began with a breach in his everyday phenomenological experience; something was “out o’ order”. This warranted a visit to the doctor:

**Text 30**

When it first happen,  
 I remember it was in January.  
 What year it was now,  
 I’m not sure.  
 But, I was at the [names place].  
 An’ I was jus’ feelin’ out o’ order.  
 Come home.  
 Take a little rest on the bed.  
 I say: ‘It’ll probably go’.  
 Later, got up.  
 No, it didn’t went.  
 An’ from that stage onwards,  
 it jus’ lead  
 from jus’ one thing to the next.  
 I seen jus’ about every doctor.  
 Not actually no cure.  
 I always get a relief at somedays.  
 I’m feelin’ good.  
 Somedays, just the opposite.  
 And the [name of doctor] tell me  
 what I’m suffering from.  
 He : his tellin’ me :  
 I ask him:  
 ‘What what stress will do?  
 What costaphobia?’  
 He said: ‘Carry on talking  
 an’ tell me how your feel’.  
 An’ he say  
 that’s what I got:  
 ‘Stress. Costaphobia’.

The psychogenic interpretation of his ‘headaches’ caused by ‘stress’ originates in his consultation with the doctor (Text 30). This interpretation is warranted by the absence of any organic cause and the fact that all the treatments so far prescribed have failed to cure his ‘headaches’. Frank has ‘no idea’ what the distress terms ‘stress’ or ‘costaphobia’ mean. Nonetheless, he loosely associated ‘stress’ with ‘depression’. However, he denies that he is ‘depressed’: “Err, people tell me that, err, erm, stress come from depression, but I don’t think that I been feelin’ bin depressed”. As illustrated in section 6.2, in the explanatory system that forms part of St. Helenian discourse on distress, ‘worries’ are believed to a cause of ‘depression’. Similarly, Frank maintained that: “Worries make you depressed dependin’ on what kinds of worries you got”. Like some of the speakers in Section 6.1, he defined ‘worries’ as a concomitant of acting or doing. ‘Worry’ meant: ‘I gonna do something that is on your mind. I gonna do something. So, I gonna think about how I’m gonna do



it, or something like that'. In Text 31, he reasons that, since he has no such 'worries', he cannot be 'depressed':

**Text 31**

It is something, for instance - now, I don't feel this way - is, for instance, something you want, but you can't get. For instance, like owing to moneywise. [...] Like, okay, for instance, err there was somethin' I did need, I want, but I not got the money. I need it. I not got the money.

Moreover, 'depression' is caused by particular kinds of 'worries'. In Text 32, Frank draws on a prototypical understanding of 'worry' as a response to financial difficulties. He is keen to resist any interpretation that might stigmatise him. Since he has no such financial difficulties, he cannot therefore be 'worried':

**Text 32**

But I don't have a problem, a real problem with moneywise. I think : I think people wherever you go will have a problem with money, but I don't have that problem. What I get, I make do.

Other St. Helenians collaborate in the psychogenic interpretation of Frank's 'headaches' (Text 32). An indeterminate aetiology and a failure of medical treatment point to a cause 'in the mind'. Social or economic adversity is commonly believed to produce such mental distress. Frank does not believe he has such difficulties. He, therefore, resolutely rejects any 'diagnosis' to do with his 'mind'. He said that his illness is 'on his mind', not 'in his mind'.

Rawnsley and Loudon's psychogenic interpretation of 'worry' is worth re-visiting.<sup>117</sup> 'Worry' in St. Helena does not necessarily indicate psychological disorder (e.g. 'anxiety' or 'depression'). It articulates St. Helenians' sociomoral concerns and their distinctions of worth. It does not represent a psychologisation of distress. Rather, 'worry' expresses a perceived breach in the relationship between an individual and the social world that they inhabit. Moreover, the sociomoral idioms of 'worry', 'pressure', and 'stress' form a discursive bridge between social adversity and its embodiment as 'pain in the head'. Through this symbolic process, 'headaches' become a metonym for social adversity. However, the causes of 'headaches' are also indeterminate. Unlike 'worry', 'headaches' are not necessarily tied to the social field. Their indeterminacy makes it possible to express personal distress without publicly admitting to social adversity and this reduces the risk of attracting a negative social response; a somatic idiom of 'headaches' provides a relatively safe means for communicating distress. They can be interpreted as a dramatic mask for social suffering and the expression of core concerns. The threat presented by social adversity and personal distress to the existing social order of things is partly neutralised through their symbolic canalisation into illness-like 'headaches'; social suffering and anomic distress are channelled into the clinic. In this way, biomedicine comes to play an important role in social regulation and in the maintenance of the social order.

## 6.5 'High blood pressure' as a metonym of distress

Towards the end of my fieldwork on St. Helena, I received a letter from an American woman who was seeking information an ancestor on St. Helena. In response to this query, I searched the Castle's archives and looked up the record of Thomas Woodman in the Parish Records. I discovered that Mr Woodman had been buried in the cemetery of Anglican St. Pauls East in 1901. The record in the archive also included the inscription on his gravestone. It read: 'Thomas Woodman, died 17 Oct 1901, 30 years', with a short epitaph. His infant daughter had died not long after. Her epitaph read: 'Edith Elizabeth Woodman, born 18 July 1901, died 24 March 1902'. In the *St. Helena Guardian*, 24<sup>th</sup> Oct 1901, the obituary read:

Thomas Woodman died at the Civil Hospital after a long illness. He recently had some family troubles that brought on brain fever. He seemed to be on the mend, but took a relapse and died in a couple of days from heart failure. Being a private in the St. Helena Volunteer Sharp Shooters, the deceased was buried the following day with Military Honours. Many members of the Corps were present, His Excellency the Governor, the Colonel Commanding, who followed the body to the grave, and Captain Deason. Private Woodman was a good shot and in the last Annual Course Of the Corps made the next highest score. He was also a member of the St. Helena Band.

What is interesting about this account is not whether Thomas Woodman's 'family problems' were actually responsible for his 'brain fever', but rather the belief that a family death could trigger a 'brain fever' resulting in 'heart failure'. Did Thomas Woodman die of a broken heart? Does personal distress have the power to cause illness, disease, and even death? Many St. Helenians think so. For example, an elderly St. Helenian man believed that 'stress' was a source of 'minor ailments'. He associated such 'ailments' with a 'delicate' physical constitution. 'Stress' was correspondingly associated with personal 'weakness'. In addition, 'stress' could produce minor 'ailments'; he said that 'more delicate ones' become ill because they 'can't handle stress'. Complaining to a doctor with a minor 'ailment' was therefore interpreted as a sign of personal 'weakness'. He would only consult with a doctor when he felt 'a very severe pain' and not for the flu or 'something minor'. 'You get certain ailments', he said, 'but you have be toughen to it'. Other informants claimed that 'worry' or 'stress' could cause 'heart attacks'. For example, a retired man who had experienced a string of 'heart attacks' believed that they might have been caused by: 'Worry, worry the heart or something like that'. Similarly, in a middle-aged St. Helenian man said that 'stress' could kill a person; it could 'bring up other things in your body – it can bring on such things as a heart attack'. He believed that 'a lot of people lately been dying of heart attacks'. A St. Helenian woman in her 30s complained of chest pain that she described as 'a grip, a pricking pain that comes and goes'. She said that this 'pain' had been caused by a family death. She believed that 'heart burn' could be brought on by 'worry, if you worry too much'. A St. Helenian man in his 70s believed that 'worry' could bring about 'angina': 'If I worry, if I work hard, walk too quick', he said, 'then the angina comes'. Finally, a middle-aged St. Helenian man said that 'some people get 'emotionally worked up' and, in extreme cases, this could lead to death. He warranted this belief with an anecdote about a man who had caught some boys throwing stones. He had become angry and chased them away. During the chase, he had a heart attack. The informant rounded his story off



with two quotes which he said had come from the Bible: 'An answer when said turns away rage, but a word causing pain makes anger to come up' and 'a calm heart is the life of a fleshly organism, but jealousy is rottenness to the bones'.

The availability of an illness metaphor as a means of symbolising adversity partly depends on a symbolic connection between the metonyms of adversity (e.g. 'stress', 'worry', and 'pressure') and somatic experience. For instance, a St. Helenian nurse observed that her patients would often present their feelings of personal distress using a somatic or illness idiom; they would say, for instance, they would say that they 'do not feel good' or would complain of 'high blood pressure' as a way of expressing their distress. Moreover, as the examples above showed, some informants accounted for illness experience and somatic symptoms in terms of a lay discourse on distress. This was particularly the case for illnesses for which the doctor could find no biomedical cause or where treatment had failed. The explanatory discourse on 'high blood pressure' presents an example of this symbolic relationship between St. Helenian discourse on distress and illness. Some informants believed that 'worry' and 'stress' were a source of 'high blood pressure'. Sociomoral idioms of distress (e.g. 'worries', 'stress', 'thinking') form part of a lay explanatory system in which social and economic adversity is used to account for chronic illness (such as 'high blood pressure'). For instance, an elderly St. Helenian woman believed that 'worries' are common on St. Helena. She warranted this belief by citing the high rates of 'high blood pressure' or 'blood': 'I would imagine there must be a lot of worries, because I mean there's a lot of people that got blood'. A woman in her 60s believed that high blood pressure could be caused by 'the worries, if you worry over anything like that'. A St. Helenian woman in her 70s said blamed her high blood pressure on her domestic difficulties: 'I suppose the house needs repairing and things like that and I think about it and err money is difficult'. Another St. Helenian informant used a metaphor of 'pressure' in a container (i.e. the body) to articulate her belief that 'high blood pressure' was caused by 'holding in' feelings or 'bottling up' of 'anger'. This increased the level of 'inner tension' and could bring on 'high blood pressure'. This explanatory discourse is grounded in a St. Helenian cultural discourse on 'the self' that proscribes against the expression of feeling or pain (as 'weakness') and that prescribes 'holding things in' and being 'toughen to it'. For example, a woman in her 30s told how she suffers from 'stomach pains', how her stomach 'goes into spasms'. Her doctor had told her that her that these 'stomach pains' were caused by 'stress'. Following her doctor's cue, she believed that 'stress' disrupted the digestion of certain foods resulting in 'stomach pain'. Nonetheless, later on in her account she said that she did not really know what had caused these pains because the sources of her 'stress' (e.g. relationship and work-related difficulties) were no longer present, yet she still experienced 'stomach pain'. This gap in the logic of her account was filled with 'a weak stomach': 'I have always had a weak stomach. It's genetic'. Nonetheless, she subsequently went on to describe herself as someone who had never felt the need to 'kick out' or 'get out at anybody'. Instead, she said that she 'bundles up', 'bundles things up inside'.

Within St. Helenian discourse on distress, 'worry', 'stress', and 'pressure' are perceived to be a source of 'high blood pressure' so that, the latter comes to stand for private distress and, therefore, the adversity it represents. This explanatory system then becomes available as a way of accounting for putatively high rates of hypertension on St. Helena in terms of social and economic adversity (CMO, 1999; UNDP, 1999). Nonetheless, 'worry' and 'stress' are not the only perceived sources of high blood pressure. Like 'headaches', the causes of high blood pressure are indeterminate so that it can be used discursively to convey a range of meanings. For example, a few informants believed that diet could cause 'high blood pressure'. Indeed, St. Helena's CMO (1999) also identified dietary factors as a possible reason for the high levels of hypertension on the island. For example, a middle-aged woman believed that either 'worry' or her diet could cause her blood pressure to increase: "It's like worries, must be. Sometimes, the food that do it. If I eat curry, that does it. It could be biteness". A woman in her 50s believed that it was caused by 'what you eat, your diet, and everything'. Similarly, a St. Helenian woman in her 60s who suffered from high blood pressure believed that 'eating a little salt causes it'. A man in his 40s blamed it on 'stress' ('I think it was stress'). Nonetheless, elsewhere in his account, he proposed a different explanation ('I think I inherited it').

Why do some Saints employ metonyms of adversity (e.g. 'worry' and 'stress') to account for high blood pressure and somatic complaints such as headaches? How do they come to symbolize distress and adversity in this way? Personal distress and affliction points to the existence of socio-economic adversity. They symbolise a breach in the social order of things. They therefore contravene the dominant communal ideology; the public presentation of affliction or distress clashes with the normative expectations enshrined in a St. Helenian discourse on the self. Moreover, a breach between normative expectations and lived experience can produce anomic suffering; for example, where an individual is systematically prevented from realising a culturally valued social identity, or where an individual's biographical experience deviates from the preferred image of things as depicted in a society's public narratives.

Public displays of adversity, affliction, and distress therefore attract a social stigma. For example, the expression of distress risks a provoking a perception that one is 'weak'. Afflicted individuals and those experiencing adversity are, therefore, more likely to become subject to powerful normalising practices (See Chapter 5 for an account of these). A central function of these practices is to contain and neutralise the threat presented by social suffering and adversity to social stability and cohesion. In this way, social suffering is rendered private and unspoken.

Nonetheless, without the availability of some form of redress, distress threatens to produce a more deep-seated social schism. Like every society, St. Helena must provide alternative means of providing redress for distress and affliction. For some, migration and exit provide a means of redress and an escape route from adversity. For others, it is a way of expressing discontent. As



Chapter 5 argued, migration and exit functions to maintain homogeneity, cohesion, and the existing social structure by cleansing society of potential sources of change, resistance, creativity, and leadership.

For those who remain, a somatic idiom of distress and the illness metaphor provide a mask for expressing social suffering in a way that is socially acceptable in a close tight-knit community. The (biomedical) healthcare system is relatively well developed on St. Helena. Social care and mental healthcare provision, for instance, have been historically neglected and chronically under resourced in comparison with mainstream healthcare provision (See Appendix A6.1-3 for a description of public health, social care, and mental healthcare provision on St. Helena). Saints who experience adversity and distress are likely to seek out medical help, particularly when other sources of social support are unavailable. Personal distress is commonly physicalised in a somatic complaint of 'headaches' (caused by 'pressure', 'worry', and 'stress'). In other cases, it is experienced as a breakdown in embodied agency and as an illness-like affliction (e.g. 'depression').

The metonyms of adversity (e.g. 'stress', 'worry', 'pressure', 'thinking', 'tense-up', 'out of passion') are commonly employed to account for chronic illness (e.g. 'high blood pressure') and 'headaches'. Nonetheless, the source of the latter remains indeterminate; 'headaches', for instance, can be caused by anything from diet to the weather. The ambiguity surrounding their origins makes them symbolically available for the masked communication of personal distress; they offer Saints a symbolic way to voice discontent and private affliction by minimizing the social risk involved in doing so. As Section 1.2 showed, the body becomes an important source of resistance when other avenues of redress are unavailable. Consequently, adversity is bound to present itself in the clinic. When agency breaks down and the voice has been silenced, the body falls sick.

## Chapter 7

### Agency and Discourse on Distress

In an essay on experience, Bruner (1986a) pointed to a gulf between embodied experience and its symbolic manifestation in language. This gulf has been a central theme in this thesis. 'Some experiences', Bruner says, 'are inchoate, in that we simply do not understand what we are experiencing, either because the experiences are not storyable, or because we lack the performative and narrative resources, or because the vocabulary is lacking' (1986a: 6-7). This thesis has examined some of the ways that 'inchoate' experiences of personal distress are signified in English discourse. It has shown how discourse on distress articulates agency whilst it depicts its breakdown and has pointed to how suffering often remains unexpressed where the symbolic resources are unavailable for expressing it or because the agency upon which 'voice' depends has been radically disrupted. This thesis has also explored the ways that cultural processes partly constitute the social experience, expression, and meaning of personal distress, and has examined the relevance of the concept of agency for a social theory of social suffering. The discussion has been grounded in two case studies (Bristol and St. Helena) and in contemporary medical anthropological and sociological theory and evidence. This final chapter draws together what has been learned.

#### 7.1 English discourse on distress

English informants' descriptions of distress were composed of a mixture of lay and expert categories and metaphors of illness, agency, mood, emotion, and feeling. Informants' experiences of distress were interpreted in half-explanations, evaluative discourse, fragments of narrative, and thick contextualised accounts. Their accounts commonly depicted the drama of personal distress as an interplay between, self, agency, and social adversity. The organisation and grammatical structure of informants' discourse on distress conveyed traces of their experiences. Some accounts, for instance, were characterised by a low level of narrativity, mimicking the disruptive and disorganised nature of their experiences of distress. The kinds of adversity highlighted in informants' accounts were contingent on social position, role, and identity.

Four interlocking discursive domains were differentiated in informants' discourse on distress. First, illness provided a metaphor around which many informants constructed their representations and interpretations of distress (e.g. 'panic attacks', 'depression', 'anxiety', 'stress'). Dominant expert discourses on distress transform the moral and social dimensions of personal suffering into a disorder of mood, behaviour or functioning based on an illness metaphor. In some cases, informants' accounts depicted a social transition from active agent to passive patient. In this transformation, suffering is naturalised and its social significance neutralised. The illness metaphor is part of the symbolic process through which sickness is made out of social adversity. Second,



English informants employed a psychological idiom of distress, metaphors of mood (e.g. 'feeling low' or 'down') and an ethnopsychology of emotion (e.g. 'sadness', 'anxiety', 'hopelessness') to articulate their experiences of personal distress. Third, personal distress was commonly depicted as a breakdown in embodied agency and was often associated with social disconnection, 'withdrawal', and a disruption of usual social roles and relationships. An idiom of agency was commonly used to depict the experience of 'human behavioural breakdown' (e.g. 'unable to cope', 'loss of control'). In addition, some informants depicted the recovering self in terms of a recovery of control, a restoration of personal agency, and social engagement. These accounts demonstrate that 'depression' is more than just an 'interpretive disorder' or a disorder of cognitive process. It is also a social illness: a disorder of agency and of sociality. Fourth, sociomoral idioms of distress ('stress', 'worry', and 'pressure') were used metonymically to signify both the embodied experience of personal distress and the social adversity that produced it, thereby forming a symbolic bridge between the two. These metonyms of adversity were also used to express negative evaluations of such adversity and, in this way, articulated informants' core concerns, and their sense of moral agency.

The personal distress (e.g. 'stress', 'anxiety', 'panic', and 'depression') involves an erosion of agency. In some cases, agency can break down altogether. Experiences of personal distress are commonly inchoate, disorganised, generalised, repeated, and indeterminate. They therefore resist narrativisation so that the discourse depicting such distress is characterised by a low degree of narrativity. It rarely conforms to cultural definitions of a well-rounded, emplotted story, with a clear beginning, middle, and an end. Moreover, 'the self' is regularly positioned in a passive mode, as having lost control, rather than as an active agent, in control of events, and driving the plot forward. For those in the midst of their suffering, it is likely to be more difficult to arrange ongoing experience into a temporal sequence and to create a plot that renders it coherent. A more fluid concept of 'narrativity' is therefore required to cope with the contingency and indeterminacy that characterise lay discourse on distress and the broken language of suffering.

Clear-cut explanations for private distress were rare in English informants' accounts. Personal distress was rarely represented in seamless, flowing narratives. Instead, informants' discourse consisted of highly contextualised descriptions of repeated, habitual, and overlapping events and experiences. Contingent narratives provided informants with a flexible discursive form for depicting and interpreting their experiences of distress by loosely contextualising them in relation to biographical and relational contexts. Within such accounts, a multiplicity of contextual factors were symbolically or causally linked with informants' past and present suffering. This discourse often depicted a negative dialectic between self and society, involving a downward spiral of social disconnection and a breakdown in agency. In many cases, this breakdown precipitated entry into the sick role.

Expert discourses on distress (e.g. biomedical, psychological, psychoanalytic) were found to enter informants' discourse on distress in three ways. First, some informants employed expert vocabulary, categories, and metaphors in their descriptions of distress. Second, expert discourses partly constituted the experience of personal distress; how it was symbolised, expressed, evaluated, and responded to (e.g. the illness metaphor). Third, English informants drew eclectically from a wide range of expert explanatory systems in order to account for their suffering. These systems were often implicit in informants' contextualised accounts and were rarely presented spontaneously in the form of precise explanatory statements.

Ethnographic approaches to social research that depend on in-depth interviews alone restrict the kinds of theoretical questions that can be asked. The employment of a broader range of ethnographic methods is required in order to explore the relationship between macro social and economic processes, personal affliction, and the local relational settings in which such affliction takes place. The second case study (St. Helena) made use of a wider range of social research methods, including in-depth interviews, in order to explore this relationship in more depth in the context of a small-scale, developed English-speaking society.

## **7.2 St. Helenian discourse on distress**

On St. Helena, cultural processes and macro social and economic forces interact to produce a particular pattern of affliction and personal distress. It was argued in Chapter 5 that a St. Helenian discourse on the self and society works to legitimise and reproduce the existing social and economic order. This discourse specifies what it is to be a St. Helenian and articulates an array of social identities linked with social roles and positions (e.g. in relation to the domestic division of labour or labour-market position). Individual conformity with this communal ideology is ensured through the operation of powerful normalising practices (e.g. gossip, social surveillance, denial of voice, ostracism, and migration). Yet, this dominant public discourse clashes with the lived experience of many St. Helenians. In many cases, personal distress was depicted as sociogenic in origin and represented an evaluative response to adversity. Informants linked their experiences of personal distress to a limited range of relational contexts: poverty, breaches in social relations, social disconnection, exclusion, ostracism, loss, illness, entrapment and a loss of agency. Saints' discourse on distress therefore articulated their core concerns and their distinctions of worth. For instance, reports of financial difficulties and economic adversity were common in their accounts. Saints rarely cited individual or dispositional factors as the source of their distress, although some non-sufferers viewed personal distress as a sign of 'weakness'. This may have reflected a high degree of stigma associated with the presence of personal distress and social adversity. Some informants' distress took the form of anomic suffering produced by a breach in social relations or a contradiction between lived experience and the social expectations or norms implicit in the dominant communal ideology. To the extent that some St. Helenians are prevented from realising a



positive social or cultural identity (as Saints, as British citizens, as men or as women), anomic suffering becomes more likely.

The ‘St. Helenian predicament’ was characterised in Chapter 5. To use a Saint phrase, St. Helena is ‘in between’; it is situated somewhere between the traditional and the modern, between an English past and a globalised future, and between two continents. This predicament is a function of the island’s remoteness, social and economic policies, unusually high levels outward migration, a rigid social structure, economic fragility, the presence of a powerful state apparatus, and rapid socio-economic change. It was argued that this ‘predicament’ systematically generates the local relational contexts within which personal distress and private affliction occur. As St. Helena modernizes, a cleavage opens up between ideological representations of St. Helenian society and social and economic reality. In addition, there are signs that increased outward migration, new inequalities, globalisation, and a growing culture of individualism and materialism are contributing to an erosion of traditional social ties and sources of social connection.

St. Helenian discourse on distress consists of a semantic web of related terms organised around a cluster of root metaphors, ontologies, symbolic associations, and explanatory systems. Narrativity was not prominent in St. Helenians’ discourse on illness and distress. This discourse was composed of four overlapping discursive domains:

- Metonyms of adversity (e.g. ‘worry’, ‘stress’, ‘pressure’, ‘down’, ‘thinking’)
- A somatic idioms of distress (e.g. ‘tiredness’, ‘tense-up’, ‘headaches’)
- Discourse on illness (e.g. ‘depression’, ‘stress’, ‘heart attack’, ‘high blood pressure’, ‘headaches’)
- A discourse on ‘mental illness’ (e.g. ‘depression’, ‘stress’, ‘crack’, “out o’ order”, “out o’ balance”)

A sociomoral idiom of ‘worry’ and a quasi-expert discourse on ‘stress’ were common ways that St. Helenians articulated their experience of social adversity. The idioms of ‘worry’ and ‘stress’ have both an external (the object of ‘worry’) and an internal (the embodied experience of ‘worry’) referent. They link the body to social (dis)order by articulating core concerns and by metonymically representing adverse relational settings.

Such idioms of distress articulate distinctions of worth grounded in a socio-centric discourse on the self and a St. Helenian communal ideology. By articulating social concerns, discourse on distress points to disruptions and dislocations in the social order. It therefore threatens the coherence of St. Helena’s dominant communal ideology and presents a challenge to the existing order of things. The embodied experience of distress represents an inversion of St. Helena’s preferred public narrative. It contradicts the preferred story of self-control, independence, resilience, resourcefulness,

happiness, friendliness, and reciprocity. The display of private distress is therefore perceived as a sign of 'weakness'. It therefore attracts a negative social response and so becomes subject to regulation by normalising forces. The stigma attached to private distress and individual self-expression is a way of marginalizing difference, of denying versions of the self and society that clash with the preferred story.

A somatic idiom is used to articulate social suffering (e.g. 'headaches' or a metaphor of chronic illness). This is partly explained by the power of such normalising or homogenising forces and a proscription against social critique (i.e. 'doing down St. Helena') or expressing private distress (e.g. 'weakness'). Social or economic adversity is sometimes embodied in a way that disrupts everyday social and behavioural functioning. Such disruption sometimes results in a visit to a doctor. It is at this point that social adversity and personal distress are reconfigured as illness experience and, in more severe cases, as depressive illness. As healthcare provision develops and expands on the Island, an expert discourse on distress is likely to become more prevalent, gradually displacing sociomoral idioms of affliction.

St. Helenian discourse on distress relies on a dialectical relationship between the social and the somatic in a way that bypasses the psychological. Many St. Helenian informants believed that 'worry' or 'stress' can cause 'headaches' and chronic illness. 'Worry' and 'stress' link social adversity, on the one hand, and the experience of embodied suffering in the form of 'headaches' and chronic illness, on the other. There was some evidence that this way of interpreting somatic experience had originated in dialogues with the island's doctors. Doctors who, being unable to explain a patient's symptoms within a biomedical framework, collaborate in the patient's view that 'worry' and 'stress' can cause illness and produce somatic complaints. A somatic idiom and the illness metaphor then become culturally available as a means of symbolising social adversity. 'Headaches', for instance, become available as a way of signifying personal and social distress. The ambiguity surrounding the causes of 'headaches' and some forms of chronic illness makes them available for expressing private distress and social adversity in a coded way, thereby avoiding a negative social response.

Nonetheless, the reconfiguration of social suffering as illness means that the individual's body becomes the target for intervention rather than the social body. This denies agency while it simultaneously works to restore it. Moreover, this reconfiguration works to preserve social cohesion and stability. This is partly achieved by reducing the threat posed by individual distress and social adversity to the communal ideology. The enforcement of this ideology sustains the political and socio-economic order, the same order that systematically produces social and anomic suffering in the first place.



The medicalisation of social suffering takes place as part of a wider process of de-traditionalisation and socio-economic modernisation on St. Helena. As well as fostering the diffusion of an ideology of individualism and materialism, social and economic modernisation brings with it a psychologised discourse on the self and, therefore, a new way of talking about suffering. Moreover, the cultural diffusion of expert discourses on distress into St. Helenian lay discourse carries with it a particular interpretation of human agency, a view of the self as an autonomous, self-determining, disengaged individual.

### **7.3 A dialectical relationship between expert and lay discourses on distress**

#### **(a) The experience and expression of personal distress is partly constituted in a cultural discourse on the self, body, and society.**

A discourse-based approach to the social analysis of personal distress and affliction foregrounds the constitutive power of language as a social practice and as a form of symbolic activity. Discourse on distress has been interpreted from three main perspectives in this thesis: first, as a means of representing and expressing embodied experiences of social suffering and human behavioural breakdown; second, as a cultural performance enacted to achieve a diversity of interpretive and social ends; third, as a means of interpreting and evaluating experience.

As Chapter 2 showed, symbolic or discursive processes pattern the phenomenology of distress. Personal distress is produced out of a dialectical relationship between bodily feelings or sensations and their symbolisation. These processes determine how emotions and somatic processes are identified, bound, categorized, articulated, expressed, and interpreted. Symbolic processes themselves are embodied; they are as real as the somatic experiences that they represent and constitute.

This thesis has highlighted the relevance of the analytic concepts of agency, metaphor, and narrativity in research on social suffering and distress. Narrativisation and the use of trope are fundamental discursive strategies through which English speakers depict, articulate, and interpret their embodied experiences of suffering. Attention to narrativity facilitates an understanding of how embodied experiences of distress are produced out of the interplay between agency, social setting, biography and social structure. Narrativity and trope also provide a means of expressing the contingency and indeterminacy of personal distress and affliction.

#### **(b) Lay discourse on distress is part of and emanates from a society's lay discourse on the self and body.**

Discourses on the self, body, and society are among the principal mechanisms through which culture influences the experience, expression, and meaning of personal distress. Such a discourse articulates an indigenous psychology or ethnopsychology. Individuals and communities interpret and partly constitute themselves in terms of such a discourse. Self and agency mediate the impact of adverse relational settings and life events onto the body. In developed English-speaking

societies, for instance, how distress is embodied is contingent upon a Euro-American discourse on the self; distress is articulated as both a breakdown in agency and sociality, as a disruption of both embodied and social functioning.

**(c) Biomedical discourse on distress is culturally contingent.**

Critical medical anthropologists and a new cross-cultural psychiatry have demonstrated the cultural contingency of biomedical or psychiatric discourse on distress and the therapeutic practices for which this discourse provides the rationale.<sup>118</sup> The 'emotional pathologies' or 'neurotic disorders' represent a culturally and historically contingent set of interpretive categories that organise the interpretation and therapeutic response to personal distress and affliction in developed English-speaking societies (Kleinman, 1977; Kleinman and Good, 1985; Gaines, 1992a, 1992b). Psychiatric diagnostic categories cluster together sets of cultural idioms of distress (symptoms) into syndromes or cultural scripts for the expression of personal distress. For instance, a somatic idiom of 'melancholia' was common in English society up until the seventeenth century (Littlewood and Lipsedge, 1982; Jadhav, 1996). With the ascent of Modernism, this discourse was displaced by the current psychological category of 'depression' (Littlewood, 1985). Jadhav, for instance, has traced the etymology of the term 'depression' to the 17<sup>th</sup> Century, where it was originally used as a spatial metaphor. It subsequently acquired a gravitational dimension, making it possible to articulate mood states that move up and down along a vertical axis (1996: 18). Similarly, Jackson (1986) has traced the genealogy of 'depression' to its lay origins in a metaphor of being weighed down by sadness or sorrow. What began as an embodied metaphor became re-constituted in expert discourse on distress as a 'syndrome', prototypically defined as cluster of 'symptoms'. Taylor, for instance, has suggested that the most common forms of psychopathology in western societies reflect the state of the modern self. According to Taylor, this self lives in constant fear of losing a sense of meaning or significance, of 'a fracturing of world and body space' in which 'nothing is worth doing' (1989: 18). This predicament of the western self is reflected in a recent historical shift from an expert discourse on hysteria, phobia, and fixation in the early part of the 20<sup>th</sup> Century, to a contemporary discourse on ego loss, low self-esteem, futility, and depression.

Anthropologists and cross-cultural psychiatrists have demonstrated that the experience, expression, and social response to psychiatric illness and the ethnopsychiatric categories used to interpret them vary considerably across different socio-cultural settings (e.g. see Chapters 1 and 2). Since biomedical categories and explanatory systems for mental well being and psychiatric illness are contingent on English and North American cultural understandings, social practices, and lay discourses (on the self, body, and society), they cannot be reliably generalised to other socio-cultural settings. For instance, Jadhav point out that in non-western societies 'depression' provides: "A consensus taxonomy amongst health professionals who share a common (western medical) epistemology, and this is not the same as being culturally 'valid' among the general population" (1995: 24).<sup>119</sup>



**(d) Expert discourses on distress are contingent on a dominant cultural discourse on the self and body that articulates a Euro-American indigenous psychology or ethnopsychology.**

Biomedical discourse is grounded in a dominant Euro-American discourse on human nature, the self, and society.<sup>120</sup> Gordon (1988), for instance, has shown how biomedical knowledge and practice are deeply rooted in an ideological discourse on Individualism, the dominant discourse on the self and society in late capitalist societies such as United States and Britain.<sup>121</sup> According to Kirmayer, dualistic thinking about the self grounds the practice of biomedicine where, on the one hand, the patient is conceptualised as a body-object, as a ‘biochemical machine’ and as the ‘passive known’, while, on the other hand, the physician is positioned as agent, as ‘active knower’ (1988: 59). Such dualistic thinking is grounded in systems of dyadic power relations around which developed English-speaking societies are organised and which partly constitutes both expert and lay discourse in such societies.

Cultural assumptions about the nature of the self and body are also implicit in concepts of psychiatric illness and the biomedical concept of the ‘psychiatrically diseased person’ (Fabrega, 1992: 98).<sup>122</sup> Western schemes of psychiatric diagnosis and classification are contingent on a Euro-American cultural discourse on the self grounded in an ideology of individualism and organised around a Cartesian dualism of mind and body (Gaines, 1992b). For example, Kirmayer has argued that experiences of trauma, loss, and violence among Canadian refugees are evaluated and interpreted in terms of the ‘adamantine self’ (2002: 726).

**(e) Social-scientific explanatory systems of distress are grounded in lay explanatory systems (e.g. ‘interpretive repertoires’, cultural genres of accounting for action and experience).**

Social-scientific explanatory discourse on distress (see Chapter 1) is grounded in a broader Euro-American cultural discourse on the self and society. As Young (1980) showed with the psychological discourse on stress, this discourse appropriates and formalises common-sense explanatory systems and reflects them back as objective and scientific. The ‘common-sense’ explanatory systems of English speakers draw on a dramatic metaphor and a vocabulary of agency in order to depict and account for action and experience. Lived-out social dramas are depicted and interpreted in a vocabulary of act, action, actor, character, scene, setting, situation, circumstance, purpose, and motivation. This ‘interpretive repertoire’ provides the members of such societies with a shared language for making sense of action and for communicating experience. The interpretive frameworks and explanatory systems developed by social scientists in order to account for affliction and distress are inescapably grounded in lay explanatory systems. The narratives, metaphors, and rhetoric that make up lay explanatory systems are transformed into highly determinate explanatory frameworks that are presented in a way that render their social contingency invisible. Once lay explanatory systems have been re-constituted into an expert discourse, they can then be used to organise expert practices and interventions (diagnosing, planning, implementing, intervening, reviewing, studying, investigating, etc.). Moreover, the

interpretive repertoires of medical anthropology and sociology ultimately originate in lay discourse on the self and society. The principle of reflexivity requires an acknowledgement of the cultural contingency and indeterminacy of the interpretations of social scientists in the same way that they have pointed to the cultural contingency and indeterminacy of lay knowledge and explanatory systems.

**(f) Expert discourse on distress (root metaphors, explanatory systems, ontologies, narratives, and accounting frameworks) gradually diffuses into lay discourse on distress.**

The relationship between expert and lay discourse on distress is dialectical. Psychiatric discourse, for instance, is organised around metaphors of disease and disorder and is echoed by and reconfigured in lay discourse on distress and mental illness. The medicalisation of personal distress and affliction (and, therefore, social adversity) involves the displacement of a sociomoral discourse on distress that reflects personal and social concerns. Expert discourse on distress partly constitutes the experience and expression of distress in developed English-speaking societies through the provision of an illness metaphor. The root metaphors of illness and sickness organise the experience and meaning of distress in such societies. Both lay and expert discourse on 'depression', for example, are grounded in an illness metaphor that transforms suffering into something a person 'has', recovers from, and for which they seek and are expected to conform to medical treatment. This metaphor organises the therapeutic response to 'depression' as well as its modes of presentation. It is grounded in an analogy between the experience of chronic illness and personal distress; both involve a breakdown in agency, social disconnection, and biographical disruption. Moreover, both can involve entry into the sick role and temporary withdrawal from usual social roles and responsibilities.

This symbolic and social process of medicalisation through the illness metaphor (e.g. the 'emotional pathologies': 'depression', 'panic attacks', 'anxiety', 'stress') underpins and is functionally related to the support available. This metaphor legitimises biomedical intervention and treatment (both for the patient and the healer) and bridges the gap between a lay discourse on mood and agency and a biomedical discourse on psychiatric disorder. Illness talk is something that both doctor and patient can understand. However, with more severe distress such as depressive illness, entry into the sick role is more than just a consequence of the illness; the sickness is also part of the illness.

Expert and lay discourse on distress are not wholly commensurable. Kirmayer (1988) has pointed out that biomedical discourse is concerned with diagnosis, explanation, and is less concerned with the moral and social importance of illness and disease. He argues that the lay perspective on illness and disease is principally a moral one, characterised by a concern with issues of blame and responsibility rather than aetiology (1988: 80). This difference is grounded in two competing views of human agency. Lay discourse on distress is rooted in a view of agency as evaluative, moral, and



social, while expert discourse relies on a view of human agency as disengaged, autonomous, rational, and individualised. Instead of reproducing conventional notions about self and society, expert discourse on distress sometimes conflicts with lay representations.

Yet, the meaning of expert discourses on distress is transformed as they are selectively re-appropriated and assimilated back into lay discourse. The vocabulary of mental pathology becomes re-grounded in everyday social experience and ordinary talk and comes to take on a range of social functions (e.g. justifying, explaining, legitimising, labelling). Expert categories of distress become transformed into embodied metaphors and metonyms of adversity and are employed to express core concerns or evaluations of social experience. The examples presented in this thesis have shown how speakers creatively make use of the expert categories of 'depression' and 'stress' in order to express their moral response to social affliction and adversity. As it enters into lay conversations, expert discourse on distress becomes reconstituted as a sociomoral discourse. In this way, lay discourse on distress articulates core concerns and so articulates agency, just at the point that agency has become disrupted.

**(g) Expert interpretive and explanatory systems diffuse into lay conversations and are assimilated into common-sense explanatory systems and interpretive repertoires.**

Common-sense explanatory systems in contemporary western societies often take the form of what Linde describes as 'popularised versions of formal theories' or 'popularised expert systems' (1986: 189). While expert explanatory systems are grounded in popular explanatory systems, expert explanatory systems re-enter lay discourse, eventually becoming part of common-sense understanding (Linde, 1986: 194-5). In this way, they re-constitute the meaning of distress. Moreover, as they become assimilated into lay discourse, these explanatory systems function to re-constitute the experience, expression, meaning, and therapeutic response to distress and affliction, bringing common-sense understanding into line with dominant therapeutic practices. For instance, in St. Helenians' accounts of medical encounters, sufferers assimilated the stress-based psychogenic interpretations made by doctors and came to interpret their somatic symptoms in a different way.

**(h) Expert discourses on distress partly constitute and legitimise a dominant cultural discourse on the self, body, and society.**

Expert discourses on distress (e.g. psychiatric or psychological) deploy an array of metaphors, idioms, tropes, ontological categories, and explanatory systems for making sense of action and experience. As these discourses diffuse into lay discourse, they transform how people talk about and make sense of themselves and others. As they enter into lay conversations, they re-work subjectivity to fit in with their own metaphors. Section 3.3 discussed how these discourses reproduce a dominant cultural discourse on human agency and reinforces a particular view of the self, body, and society. For instance, in his genealogical study of multiple personality disorder, Hacking argued that expert knowledge in psychiatry 'affects the way in which individual human beings come to conceive of themselves' (1995: 68). Similarly, Rose maintained that expert

psychological knowledge has played a critical role in the development of the current western 'regime of the self' (1998: 39). Young (1980) has shown how expert 'discourse on stress' functions to reproduce and legitimise conventional knowledge about human nature and society, and the relationship between them. Similarly, expert biomedical and psychological discourse on distress are contingent upon and reinforce a culturally dominant Euro-American view of human agency as individualised, autonomous, disengaged, psychologised, rational, de-socialised, separate, and detached.

#### **7.4 Agency, social relations, and affliction**

An understanding of the social distribution of social suffering among the populations of developed English-speaking societies requires understanding how symbolic and cultural processes partly constitute the relationship between social adversity, affliction, and distress, and how distress is articulated and responded to. How do social structure, agency, and cultural processes combine to generate particular configurations of social suffering in developed English-speaking societies such as Britain or St. Helena? How social suffering become distributed throughout the social field depends on a range social and cultural processes. These include:

- The provision of a communal ideology and a cultural discourse on the self, body, and society. The latter articulates a society's indigenous psychology or ethnopsychology.
- The operation of 'normalising practices' (e.g. social stigma, ostracism, gossip, social exclusion)
- The social circulation of lay and expert discourses on distress that dialectically shape one another and which are employed by sufferers to symbolise and interpret their experiences.
- The interpretation, evaluation, and social response to adversity.
- The cultural, personal, and social significance of distress (e.g. evaluation, explanation, consequences, biographical and social context, symbolic significance).
- Local patterns of social and therapeutic response.
- A structure of hierarchically arranged social positions to which are attached identities and roles.
- The production of adversity as a consequence of macro social and economic processes. The local relational settings that produce private distress are themselves generated and reproduced through a diversity of cultural processes and social practices.

The material and symbolic relationships between society and the self are bridged by local relational settings. Two kinds of relational settings stand out in the anthropological, sociological, and epidemiological literature on distress and affliction: first, those settings that involve social disconnection and a significant breach or a disruption in core social relationships; second, relational settings that systematically disrupt personal agency and erode the conditions for meaningful action. Kleinman and Kleinman, for instance, characterise the circumstances that commonly produce 'depression as affect' across societies as 'something to do with loss of crucial social relationships,



withdrawal from established social structural positions, and undermining of cultural norms guiding the self' (1985: 478). British medical sociology and social psychiatry have documented how social-economic settings and life events that undermine agency or disrupt valued social relationships play a central aetiological role in depression. Similarly, in developed English-speaking societies such as Britain and St. Helena, personal distress is associated with breakdowns or disruptions in personal relationships, interpersonal conflict, loss, powerlessness, entrapment, chronic illness, social exclusion, isolation, and in the performance of valued social roles.

Social structure partly constitutes biography, experience, and agency through its impact on local relational settings. These relational settings systematically convey the destructive (and constructive) force of macro social and economic structures to individual bodies. Social suffering in developed English-speaking societies refers to the systematic ways that individual lives and relationships become disrupted and undermined by destructive economic forces, social inequalities, and relations of power that pervade the social field. The risk of adversity and the form that affliction takes is influenced by the sufferer's social position and the social roles that they perform. Adversity resonates in individual bodies as personal distress and becomes embodied as a breakdown in human agency. Where location in the social structure is associated with adverse relational settings and increased exposure to negative life events, then 'human behavioural breakdown', and a disruption in the capacity to perform usual social roles becomes more likely.

Littlewood says that 'depression' provides a 'flexible way of articulating specific difficulties' (1998: 239). How adversity becomes embodied is contingent on how agency is constituted. The self mediates the relationship between phenomenological and social experience. The embodied impact of life events and relational settings is contingent on how they are interpreted and evaluated. The latter depends on an individual's social identity and their sense of agency, their core concerns, affiliations, interests, and distinctions of worth as articulated in a Euro-American discourse on the self. The social structures of developed English-speaking societies provide the conditions for the performance of a diversity of social roles and social identities. Identities, commitments, and core concerns are therefore socially distributed according to social position along lines of social structure; for instance, according to gender, age, social class, and ethnicity. Where social and economic circumstances erode the conditions for the accomplishment of a positively valued social identity, then personal distress becomes more likely.

In biomedical discourse on distress, cultural and symbolic processes are not restricted to shaping illness experience or for causing variation in its expression. Cultural and symbolic processes are responsible for more than the surface or 'pathoplastic' manifestations of personal distress. They are also part of its social aetiology and influence its phenomenology. For instance, both local relational settings and cultural processes mediate the impact of macro social and economic forces on the body. Without taking such processes into account, it is not possible to make sense of how social

suffering becomes unequally distributed throughout the social field in developed English-speaking societies.

Personal distress occurs as a breakdown in personal agency in developed English-speaking societies. How agency breaks down depends on how agency is constituted; the way that personal distress is experienced, articulated, interpreted, and responded to is contingent on a western cultural discourse on the self. In such societies, social identities (e.g. gender, class, ethnicity) constitute distress differently and this partly explains how social suffering becomes socially distributed. Lay discourse on distress is a moral discourse in that it articulates core concerns, judgements, and evaluations; it communicates agency while depicting its breakdown. Personal distress often involves a loss of independence, difficulties in coping or control, disruptions in social ties and employment, and a breakdown in embodied agency. A person in distress therefore deviates from a proscribed public narrative on the self that exhorts self-control. Finally, in developed English-speaking societies, personal distress becomes medically reconfigured in a discourse organised around the illness metaphor.

The ‘neurotic disorders’ and the ‘emotional pathologies’ of developed English-speaking societies commonly originate in breaches in social relations or ruptures in the social order of things: in such cases, they can be interpreted as ‘rituals of affliction’ (see Section 1.2). Loudon pointed out that such rituals make it possible to articulate private stress in public settings without attracting a negative social response. They represent an ‘acceptable standardized mode of public behaviour that can be used symbolically by individuals in circumstances of psychic stress’ (1966: 104). Although individuals enact them, they are performed in a socially controlled and formalised fashion and are both ‘a means of saying something about the state of affairs both within the social system and within the personality system’ (1966: 104). Both expert and lay discourse on distress in developed English-speaking societies have become organised around an illness metaphor. This metaphor rationalises and legitimises the enactment of private distress as an illness experience. Social suffering and the affliction that arises out of breaches in the social order are redressed through the restorative ritual of the medical encounter, followed by entry into the sick role, treatment, recovery, and biographical reconstruction. Yet by constituting the person as the passive bodily object of biomedical intervention, the medicalisation of social affliction denies agency just at the moment that it hopes to restore it.

Social cohesion in developed English-speaking societies is partly sustained by ameliorating the disorder that arises in individual bodies in response to social and economic adversity. While often contributing to the relief of affliction and distress, biomedical discourse and treatment also work to bring sufferers back into conformity with normative expectations and to maintain individual functioning. The medicalisation of social suffering has just this function: to cleanse such societies of sources of instability in the social body and to maintain its smooth internal social and economic



functioning. Partly through the medicalisation of social suffering and affliction achieved through the illness metaphor, the biomedical-dominated healthcare system comes to play a crucial maintenance role in such societies.

## Appendices to Chapter 3

The interpretive framework used in this thesis evolved during the course of the research. How this framework evolved is traced out in the appendices that follow. Later interpretive frameworks came to encompass and build upon earlier ones without completely replacing them. In the early stages of the research, it was anticipated that the interpretation would involve a combination of qualitative analysis (A3.1) and narrative analysis (A3.2). As the research progressed, other features of discourse and forms of rhetoric (particularly metaphor and dramatisation) became more prominent (A3.3). Finally, discourse analysis came to provide a way of drawing together these different approaches to interpretation under a common interpretive framework (A3.4).

### **A3.1 Methods of interpretation: qualitative analysis**

The first and most mechanical of the interpretive frameworks used in this thesis was that of qualitative analysis. This describes a family of techniques for classifying, categorising, condensing, and representing large amounts of textual data. Qualitative analysis is a minimal form of textual analysis that involves a range of systematic procedures for summarising and describing the content of qualitative data (e.g. interview transcripts; fieldnotes) (e.g. Bryman & Burgess, 1994; Coffey and Atkinson, 1995). This involves the identification of core categories, patterns, themes, and regularities across large amounts of data, collected from a range of different sources (e.g. individual cases). Typically, core themes or categories are identified through multiple readings of the textualised data. The data are then coded or indexed according to these themes and categories and then re-organised according to these categories. This facilitates comparison across cases and the production of theoretically informed description. In ethnography and qualitative research, interpretation moves from the unique case or event to a description of general processes in order to produce theoretically informed description. Data are collected from an emic perspective and are then interpreted from an etic point of view (e.g. in relation to social or cultural theory). On this view, the overall aim of qualitative analysis is to develop theory.

### **A3.2 Narrative analysis and a prototype concept of narrative**

Narrative analysis was the second interpretive framework that has been drawn upon in this thesis. In his description of the 'experience of illness' approach in medical sociology, Conrad (1990) expressed a preference for narrative over categorical analysis. On his view, the latter 'shatters' the data whilst narrative analysis stresses the importance of the sufferer's story, attending to form as well as content. In addition, a narrative-based approach provides a way of exploring the relationship between biographical events, social context, and the experiences of illness and distress. The concept of narrative and the narrative-based approach to discourse and social analysis were discussed in detail in Chapter 3. Here, the concept of narrativity is defined and a prototype definition of narrative is characterised.



## Narrativity

Carrithers (1990) has characterised 'narrativity' as the capacity for generating narratives, a special kind of cognition that is 'embodied in narratives' involving the representation of 'complex nets of actions'. Still, 'narrativity' is only a property of the mind because it is a property of discourse. One way of thinking about narrative is as the function of a discursive process of narrativisation. 'Narrativisation' involves the temporalisation and emplotment of events and happenings. 'Temporalisation' refers to the active process of arranging representations of events and experiences into a temporal sequence or in a chronological order. 'Plot' specifies the logic of a narrative and involves the specification of causality. Ricoeur, for instance, defines 'plot' as 'the intelligible whole that governs a succession of events in any story' so that 'a story *is made out* of events to the extent that plot *makes* events into a story' (1981b: 167). 'Emplotment' is a discursive process that specifies the causal relations between chronologised, organising them into a configuration of events. For instance, Somers has defined 'narrative' as: 'Constellations of relationships (connected parts) embedded in time and space constituted by causal emplotment' (1994: 616). Ricoeur describes the function of 'emplotment' as 'to compose a story' by deriving 'a configuration from a succession' (1991: 427). Embodied experiences and events take place in chronological time. Experiences are encoded in the body and discursive processes such as narrativisation symbolically re-configure them in order to generate new meanings. 'A narrative', then, is unit of discourse that has been narrativised. In narrative discourse, clauses, episodes, scenes, and events are ordered chronologically and emplotted in order to create an intelligible whole.

Discourse units can be more or less narrativised and narratives can be more or less emplotted. For example, Chapters 3 and 4 discussed how discourse on illness and distress often exhibits narrative incoherence. Discrete stretches of narrativised talk often fall short of Labov's formal definition; oral narratives do not always re-capitulate discrete events in a temporal sequence or in the past tense. Narratives defined according to the formal definition differ from other kinds of narrative discourse units. For instance, 'generic narratives' deploy indefinite past tenses (e.g. would, used to) to describe how things happened in the past (Linde, 1986). Another type of narrative is the 'pseudonarrative', a temporally ordered encoding [...] of an essentially non-temporal structure' (Linde, 1986: 186). Moreover, narrativised discourse is often hypothetical, counterfactual, habitual, or 'low in narrativity' (Linde, 1992; Carranza, 1998).<sup>123</sup> For instance, in a study of American divorce stories, speakers made use of a variety of narrative genres to account for their experiences, including 'narratives' that told of habitual, repeated events or events that were difficult to locate temporally (Riessman, 1989).

Experiences of illness and distress are commonly depicted as disruptive and disordered, with events that are overlapping, undefined, and recurrent. The discourse depicting such events regularly deviates from formal linguistic definitions of 'narrative'. This does not mean that narrativity is

absent. A more flexible notion of 'narrative' is required to facilitate the interpretation of such discourse.

Conceptual resources for this task are available in the field of narratology (Bal, 1985; Prince, 1982). Prince has developed a prototypical view of 'narrative' in which discourse is characterised as having more or less narrativity. 'Narrativity' is the property that narratives have in common, so that a prototypical narrative is a discursive construction that has a high degree of narrativity. Prince (1982) characterises a 'prototypical narrative' in terms of a set of properties including: a beginning-middle-end structure; a representation of discrete and positive events; temporalisation and the presence of a sequence of narrative clauses; the presence of a conflict situation; audience recognition that what is being told is a narrative.

A stretch of discourse that is low in narrativity (i.e. a 'low-narrativity narrative') shares in these features, but not all of them (Carranza, 1998). For instance, the experiences being recounted may not involve discrete, neatly time-bounded events and, as such, may resist narrativisation. Causality often remains implicit or unspecified in such narratives. Instead, contextualised descriptions of events and experiences are presented.

### **Interpretive framework for narrative analysis**

The approach to narrative analysis applied in the research reported here was adapted from Riessman's approach to the analysis of personal narratives and discrete narrative discourse units (Riessman, 1993, 2002). Narrative analysis represents a distinctive interpretive genre in social science and has been used to conduct both social and discourse analysis of narrative accounts across a range of disciplines (including medical sociology and anthropology). Nonetheless, narrative analysis can be usefully situated within a broader discourse-analytic approach. After all, narrative is one among many symbolic forms available to speakers for expressing meaning and producing coherence in discourse. On this view, narrative analysis involves an explication of: how a narrative is organised; its ideational meaning; its social force and rhetorical function; the social context of its production; its constitutive power; the intertextual relations between personal narrative and public discourse. The framework used for the interpretation of narrativised discourse units has the following features:

- Detailed transcription of in-depth interviews.
- Identification of the point or function of the narrative. What is the social force of the narrativised discourse? How is the speaker using narrativity?
- Selection of a sample of narrative segments or extended stretches of talk for detailed interpretation. Discourse is selected only within certain thematic domains. These domains are determined by the theoretical or research interests and questions of the interpreter.
- Extraction of the narrative segment(s).



- Parsing into paragraphs (grouped by theme) and presentation of the excerpt(s) in numbered clauses.<sup>124</sup>
- Identification of themes (i.e. recurring content) that contributes to the narrative's thematic coherence (i.e. What is the story about?). Monks (1996) emphasises how these themes are related to notions of personhood in western cultural settings. They point to the speaker's core concerns.
- Textual description in terms of structure<sup>125</sup> and genre<sup>126</sup>. How does the discourse achieve narrative coherence? What degree of narrativity is present in the text?
- Identification of plot, major sub-plots, and root metaphors.
- Analysis of narrative rhetoric with particular attention to positioning and performance of self in personal narratives and the identification of 'narrative positions' and the different perspectives on experience that each affords (Monks, 1996; Riessman, 2001, 2002; Hyden, 1995a).<sup>127</sup>
- A comparative approach exploring similarities and differences among informants' narratives.
- Intertextuality. How does the speaker's narrative draw upon other cultural discourses? What public narratives do speakers employ in their self-presentations?

Riessman (2002) points out that the boundaries of narrative discourse are rarely clearly defined. Where the boundaries of a particular narrative segment are set is partly by theoretical concerns. Some speakers mark out a story with exit and entry talk. According to Bruner (1990), the act of story telling has a number of features that differentiate it from other speech acts. A signal is made before a speech act is initiated which informs the listener that what is about to be said is a story; a preamble indicates whether or not it is a true story or a fictional one; the genre within which the narrative falls is usually indicated.

This scheme represents a flexible analytic framework for analysis of both discrete narrative discourse units and personal narratives that typically unfold over the course of a conversation (See Chapter 3 for a definition of different levels of discourse). It is not a 'step-by-step' guide for how to do narrative analysis and particular features may be foregrounded over others depending on the interpretive aims of the researcher.

### **A3.3 Rhetorical analysis: drama and trope**

There is a danger that a narrow focus on narrative in discourse and social analysis means that many important forms of symbolic activity become neglected. Discourse on health and illness is wrought out of metaphor and an array of figurative and discursive processes. Discourse on illness or distress are rhetorically employed by both sufferers and non-sufferers to achieve a range of social ends.

Burke conceives of language as 'a species of action, symbolic action [...] and its nature is such that it can be used as a tool' (1966: 248). Ricouer characterises 'rhetoric' as the art of 'saying it well'

(1986: 10). The employment of rhetorical discourse partly aims at persuasion. According to Burke (1969), for instance, 'rhetoric' refers to the use of language that aims to manipulate the response of the audience through symbolic means.

Chapters 2 and 3 described some of the discursive concepts that make up the interpretive repertoire of medical anthropologists. These can be viewed as different kinds of rhetoric that speakers use to perform a variety of social tasks and include, for instance: trope (e.g. metaphor and metonymy); explanation; dramatisation; and subject positioning. Narratives can also be interpreted as a form of rhetoric.<sup>128</sup>

### **Trope**

'Trope' refers to the figurative use of language. 'Figures of speech', for instance, are examples of tropes. A 'figure of speech' is language that deviates from ordinary language to achieve some special meaning (Abrams, 1981). Three of the most common tropes are discussed here: 'metaphor', 'synecdoche', and 'metonym'.

Burke defines 'metaphor' as a point of view on something, as a 'device for seeing one thing in terms of another', or as a way of looking at something in terms of something else with which there is a resemblance (1969: 503). 'Metaphors' convey non-literal meaning. They provide speakers with a symbolic means of constructing new meanings in terms of existing ones. In this way, 'metaphor' represents an opportunity for individual creation. New, uncertain, or unfamiliar experiences trigger what Fernandez (1986) calls the 'play of tropes'. Metaphor symbolically mediates the relationship between body and consciousness, and provides a creative means of representing inchoate experiences and situations (Fernandez, 1982, 1996). The provision of a stock of metaphors for articulating and organising experience is one of the principal symbolic pathways through which culture constitutes illness experience and personal distress.

Lakoff and Johnson characterise metaphor as a mode of representation, a mode of understanding, and as a psychological construct or entity. They argue that the 'primary function' of metaphor is as a mode of understanding in which one thing is conceived in terms of another (1980: 36). Nonetheless, according to Lakoff and Johnson (1980), metaphor and metonymy are more than mere figments of discourse, or modes of understanding. They are figurative concepts that structure experience (thought, feeling, and action). Lakoff and Johnson say how metaphor involves experiencing 'one thing in terms of another'. However, they reify metaphorical discourse as a 'construct' or an 'entity' that has partial independence from language: 'metaphor' becomes a cognitive scheme rather than a figure of speech. On this psychological view of metaphor, metaphorical discourse merely signifies extra-linguistic metaphorical concepts and cognitive processes.



Ricoeur, on the other hand, interprets metaphor as a discursive event. He emphasises the creative function of metaphor when he calls it 'a momentary creation in language' or 'a semantic innovation'. It is both 'a strategy of discourse' and a 'rhetorical process by which discourse unleashes the power that certain fictions have to re-describe reality' (1986: 7). Metaphor as a discursive event centres on the 'metaphorical word'; yet the meaning of metaphor is conveyed by the 'metaphorical statement' within which this word is embedded (Ricoeur, 1991: 305).

A 'metonym' is a figure of speech where one thing is used to stand for another and where they have been closely related together in experience (Abrams, 1981). Lakoff and Johnson present an entity-based definition of 'metonymy' as the use of 'one entity to refer to another that is related to it' (1980: 35). They also depict it as a mode of representation. On this view, 'metonymy' 'has primarily a referential function' in that it 'allows us to use one entity to stand for another' (1980: 36). Burke, on the other hand, characterises 'metonymy' as a special kind of synecdoche that involves a reduction. 'Metonymy', he says, is unidirectional, and moves 'from a quality to a quantity', mind to matter, incorporeal to corporeal, intangible to tangible, abstract to concrete (1969: 509).

'Synecdoche' is a form of representation in which one thing is used to stand for another thing, for instance, where the part is figuratively used to stand for the whole (Abrams, 1981). Lakoff and Johnson (1980), on the other hand, interpret 'synecdoche' as a special form of metonymy in which the part stands for the whole. Burke (1969) gives the example of a cause standing for an effect, an effect for a cause, or an equation where the equivalence is bi-directional. For instance, a symptom that signifies an underlying disease process is a kind of synecdoche. Burke describes the 'noblest synecdoche' as the identity of microcosm and macrocosm (1969: 508).

### **The drama of social relations**

According to Turner, processes of social experience are composed of sequences of events and the internal responses to them (1986: 35). These events and processes are driven by social structure (i.e. 'relations which are relatively constant and consistent' (Turner, 1981: 147)). The 'social drama' is a spontaneous 'structure of experience', a 'protoaesthetic' form that patterns social processes and a community's movement through time (Turner, 1981, 1986). It has four stages: breach; crisis; redress; schism or reintegration. The social drama begins with 'a breach' in the 'customary order of group life' (1986: 39) in which 'a person or subgroup breaks a rule, deliberately or by inward compulsion, in a public settings. Conflicts between individuals, and factions follow the original breach, revealing hidden clashes of character, interest, and ambition' (1986: 35). As this breach in the social order grows, it comes to threaten the unity and continuity of the group; the crisis phase involves a 'juncture in relations, resulting in conflict'. It is in this phase that the underlying structural contradictions that generated the breach become 'slowly visible'. In order to limit the spread of the breach, redressive mechanisms or adjustments are implemented (e.g. redressive rituals, prophylactic life-crisis ceremonies, or rituals of affliction). Like initiatory rites,

these redressive rituals contain within them a 'liminal phase' in which the individual is detached from everyday life and ordinary pre-occupations: 'a no-man's land betwixt and between the structural past and the structural future' (1986: 41). The nature of these redressive mechanisms varies according to the nature of the crisis. They can include, for instance, personal advice, arbitration, legal proceedings, and the performance of public rituals (1981: 147). Fourth, if these redressive measures are successful, then the endpoint of the process is re-integration. If these measures to redress the situation fail or are absent, then this increases the chance that a more deep-seated social schism or breakdown in group life will occur.

Turner argued that there is a dialectical relationship between the real social dramas as they are lived (as described above) and 'genres of cultural performance' (e.g. the aesthetic form of the stage drama) (1981: 149). Stage drama, for instance, is rooted in social processes and 'recurrent forms of social experience – social dramas'. Conversely, Turner maintained that 'the aesthetic form of the theatre is inherent in the sociocultural' (1986: 42). The lived-out social drama relies on an 'implicit rhetorical structure' that draws on 'theatrical and fictional models' (1981: 150).

Burke's 'dramatism' articulates the structure of an Anglo-American discourse on agency grounded in the root metaphors of narrative and drama. 'Dramatism' is a technique for analysing language not in terms of the information it conveys, its signification, but as modes of action. Burke asks, for instance: 'What is involved, when we say what people are doing and why they are doing it?' 'Dramatism' has two functions in social analysis. On the one hand, it provides a conceptual framework for a social theory about human relations (Ruekert, 1982) and for interpreting discourse as a social practice (Watson, 1973). Burke's 'dramatistic' framework provides a way of describing this dynamic aspect of narrative discourse in terms of the motivation of an action or experience. An account of the motive of an act or event involves specifying each of the following:

- 'Act' refers to 'what happened in thought or deed' (Burke, 1969: XV).
- 'Scene' refers to 'the background to the act; the situation in which it occurred'; 'the scene contains the act'. 'Scene', for example, includes proximate social setting, social structure, communal ideology and cultural practices (1969: 3).
- 'Agent' refers to the person who 'performed the act' (1996: XV) and "embraces not only all words general or specific for person, actor, character, individual, hero, villain, father, doctor, engineer, but also any words, moral or functional, for patient, and words for the motivational properties of agents, such as 'drives,' 'instincts,' 'states of mind'." (1969: 20).
- 'Agency' refers to the 'means or instruments used' to achieve a particular purpose (1969: XV).
- 'Purpose' refers to 'why the act/event took place'. For instance, it refers to the goals of the person performing an action (1969: XV).



The relations between terms of this 'pentad' are specified in Burke's theory of rhetoric. He describes the relationships between the elements of the pentad as 'principles of determination' or 'ratios'. These make up the 'motive' of the event, act, or experience and can be located in the agent, in a quality of an agent, or in some aspect of the scene or setting.

The 'scene-act ratio' articulates the interdependency of act and scene. Either the 'scene contains the act', or the ratio can be reversed and the act can modify or change some feature of the scene or setting. In Burke's scheme, the scene-agent ratio is the relationship of person to place, the correlation between the qualities inherent in the scene and the qualities of those agents who are cast into it. Burke gives the example of brutalizing situations that yield brutalised characters. Here 'scene' becomes the 'motive-force' behind the qualities of the person or agent. The concept of 'a role' articulates this relationship. Burke says that 'a role' is 'summed up in slogans [...] that characterise the agent's situation or strategy [...] The 'role' involves properties both intrinsic to the agent and developed with relation to the scene and other agents' (Burke, 1969: 511). 'A role', then, incorporates both the agent's characteristics and the agent's relationships with others.

Another ratio is relevant here, particularly as a way of conceptualising how life events form the agent and how biographical experience constitutes selfhood. The 'act-agent ratio', the ratio of self-determination, is the relationship between the action and the agent, the relation here being temporal or consequential where the 'agent is the author of his acts'. Where there is a high degree of 'consistency' between act and agent, action takes place in accordance with the qualities of the agent, rather than in response to features of the scene or setting.

### **Positioning**

In their discourse on illness or suffering, speakers actively perform and position themselves and their experience. Some contemporary narrative analysts have turned their attention to the performative function of narrative and the active production of meaning and the presentation of the self (e.g. Monks, 1996; Riessman, 2001, 2002). English speakers use a variety of grammatical devices and discursive forms to position themselves in their accounts and to represent their agency in relation to what is being recounted. I have emphasised the role of narrativity in this respect. For instance, narrators may position themselves: in relation to the audience; as persons occupying a social role; as agents in control of the action depicted; as passive receivers of such action; and they often position themselves in their discourse in ways that present a 'preferred self' or in ways that are consistent with their social identity (Riessman, 2001). Harré and Van Langenhove define 'positioning' as 'the assignment of fluid 'parts' or 'roles' to speakers in the discursive construction of personal stories' (1991: 7). For instance, the way that speakers position themselves in their talk about illness or suffering expresses their moral viewpoint on what has taken place (Hyden, 1995a, 1995b; Riessman, 1990).

### **A3.4 Interpretive framework for discourse analysis**

The final interpretive framework drawn upon in this research was that of discourse analysis. The aim of discourse analysis is the systematic interpretation of discourse typically fixed in texts. This involves a description of central features of such texts, how coherence and meaning are achieved and an account of how the text was produced. Fairclough's approach to discourse analysis was adapted for use in this research (Fairclough, 1992). For other approaches to discourse analysis see Burman and Parker (1993), Van Dijk (1985), and Gee (1990).

Language has many functions and so discourse can convey multiple meanings. For instance, language can be viewed as a system of signs (de Saussure, 1993); as text (Barthes, 1977); as a means of expression (Taylor, 1985); as speech act (Austin, 1962); as 'symbolic action' (Burke, 1966); as tool (Wittgenstein, 1978); as an acquired linguistic competence determined by an innate cognitive language faculty (Chomsky, 1976: 40-43); as cultural practice (Duranti, 1997); as social practice (Fairclough, 1992). These multiple functions of language means that discourse can be interpreted from a range of different perspectives. As Fairclough says: 'Texts are usually highly ambivalent and open to multiple interpretations' (1992: 75). Broadly speaking, three types of linguistic meaning can be usefully distinguished: sense, reference, and social force. Similarly, following Halliday (1978), Fairclough points to three interdependent functions of language: textual, ideational or referential, and interpersonal. Sense can be distinguished from reference. What is said (text) is distinct from about what it is said (ideational meaning) (Ricoeur, 1991). The sense of discourse (e.g. a word, a sentence, or a text) refers to its 'immanent design', the architecture of the text and its semantic context within a broader discourse. The meaning of discourse also depends on its relationship with the extra-linguistic. As Ricoeur has said, reference points in two directions: outwards, towards the world; and inwards, reflectively towards the self. Fairclough (1992) calls this the 'ideational function' of discourse - what it is being used to express or say about the world. This function of discourse also includes a constitutive function, the 'role of discourse in constituting, reproducing, challenging, and restructuring systems of knowledge and belief' (Fairclough, 1992: 169).

'Speech' is also a form of social action (Burke, 1969) and the meaning of any speech act is a matter of both convention and intention (Searle, 1965). On the one hand, 'speech' is produced by 'a being with intentions' in order to perform a range of illocutionary acts. On the other, 'speech acts' are governed by conventions and 'rules of use'. One function of language use is to produce an effect in the listener or audience. Austin (1962) called this the 'force' of the linguistic act. The linguistic act and the intention behind the act are distinct. As Ricoeur says: "What is said of the subject is one thing: what I 'do' *in* saying that is another thing: I may make a mere description, or give an order, or formulate a wish, or give a warning, etc. Hence the polarity between the locutionary act (the act of saying) and the illocutionary act (that which I do in saying)" (1991: 306). The interpretation of any speech act must therefore take into account the agency of the speaker. To say that speakers use



discourse (e.g. narratives and explanations) to perform a range of social tasks is to say that discursive acts are partly a function of such agency and that the interpretation of discourse is therefore contingent on a view about human agency. In the end, the interpretation of lay and expert, popular and biomedical discourse on illness and distress is fundamentally indeterminate. This is partly because the meaning of a discourse unit is contingent on the agency and creativity of producers and receivers of discourse.

Moreover, discourse partly constitutes identities and the social relations upon which they depend. Fairclough distinguishes between two interpersonal functions of language: an 'identity' and a 'relational' function (1992: 64) (See section on 'discourse as social practice' below for a more detailed account of this).

### **Discourse analysis applied to ethnographic texts**

The first scheme of discourse analysis employed in this thesis was that of Agar and Hobbs (1982). They tailored a discourse-analytic approach to the interpretation of ethnographic data centred on an analysis of three types of coherence: thematic, global, and local. 'Thematic coherence' refers to the threads of thematic unity or chunks of content that recur producing coherence in the text. Themes might also include the use of particular discursive devices or narrative strategies. Within Agar and Hobbs' interpretive scheme, the 'local coherence' of discourse refers to the coherence relations or 'relations of continuation' between utterances and larger discursive segments. These include relations of elaboration, narrative, logical relations, relations of reversal, contrast, association, temporality, explanation, and so on. Narrative relations between clauses or utterances are therefore only one of the many ways that speakers achieve coherence in discourse. 'Global coherence' refers to the relation of individual utterances or sequences of utterances to the overall global goals of the speaker, what the speaker is doing with his/her speech. The speaker is assumed to develop a 'conversational or narrative plan' or strategy (Agar and Hobbes, 1982: 5) with sub-goals so that the speech is regulated by this plan as well as by the social context in which the speech is produced (e.g. the responses of the audience or listener).

Agar and Hobbes' ethnographic approach to discourse analysis, however, was found to have many limitations. First, it ignores the social and constitutive functions of discourse and the relationship between a discourse unit and wider public discourses. Second, this approach places too much emphasis on the concept of 'coherence' so that sense, reference, and force become confused. Third, this framework ignores the social context of discourse production. Fourth, its account of textual analysis (e.g. in terms thematic, local, and global coherence) is limited; it is unclear how the three types of coherence systematically relate in the production of a text. A broader framework is therefore required, a framework grounded in a social theory of discourse.

## **A framework for interpreting discourse**

According to Ricouer, the hermeneutic interpretation of discourse hinges on the relationship between 'sense' (what is said and its internal organisation) and 'reference' (what it is said about, 'a power to refer to reality outside of language' (1986: 6)). Similarly, discourse analysis aims to trace the explanatory connections between: the sense of a text, how it is constructed; its referential or ideational meaning; its social force; how it is produced, distributed, and consumed; the social practices that it forms part of (e.g. its constitutive power) (Fairclough, 1992). Fairclough's approach to discourse analysis has three dimensions: (a) textual analysis; (b) discursive practice; (c) social practice. Textual analysis is descriptive, while interpretation involves an account of the discursive and social functions of the text.

### **(a) Textual analysis**

'A text' refers to a unit of either spoken or written language (Halliday, 1978). The first dimension of Fairclough's scheme for discourse analysis (textual analysis) involves a description of 'what elements and episodes are combined in what ways and what order' (Fairclough, 1992: 75). Textual analysis involves a description of a text's structure, how it achieves cohesion, grammar, and vocabulary. For instance, textual analysis involves describing how sentences are linked together to form larger units; that is, how cohesion is achieved using a variety of semantic and syntactic devices (e.g. themes, repetition, synonyms, metaphors). Textual analysis involves an explication of text structure. The units of textual analysis range from an entire manuscript, paragraphs, sentences, and words. These elements may include for instance units of text at different levels: narratives, explanations, idiomatic phrases, wording, lexicalisation, and so on. Textual analysis also involves describing the vocabulary used in the text (e.g. metaphor, idiom, classification, etc.). 'Idiom', for instance, has become a central analytic term in interpretive medical anthropology. Everyday English talk in is full of idiomatic terms and phrases that do not always comply with the strict grammar of the language. From a grammatical point of view, an 'idiom' is 'a compound word or phrase whose meaning is not deducible from the meaning of the words of which it is composed' (Davidson, 1996: 27). Because of their non-literal meaning, idiomatic phrases depend for their comprehension on shared local meanings.

### **(b) Discursive practice**

According to Fairclough, the interpretation of texts takes place at two levels. At the first level, interpretation aims to elucidate the 'processes of text production'. Fairclough highlights three features of discursive practice: force, coherence, and intertextuality. The 'force of a text' is its 'action component', what it is used to do socially (Fairclough, 1992). A 'coherent text' is one in which the parts are related in such a way that the whole makes sense (1992: 83). According to Fairclough, 'coherence' is a feature of interpretation rather than of texts and so can be distinguished from relations of 'cohesion' within a text. 'Intertextuality' refers to the relationships between texts: 'The property texts have of being full of snatches of other texts, which may be explicitly demarcated or merged in, and which the text may assimilate, contradict, ironically echo, and so



forth' (1992: 84). An analysis of a text's intertextuality involves an account of the relationships between the discourse represented in the text and the resources that are drawn upon to produce the text. For example, this might involve accounting for a particular text in terms of public narratives about gender or illness.

### **(c) Social practice**

Discursive events are represented linguistically in texts, but they are also a form of social practice. At this level of interpretation, discourse analysis aims to account for texts in terms of their role in 'wider social practices' (Fairclough, 1992: 198). The production and interpretation of discourse is determined by the kinds of social practices that they form part of. Fairclough says, for instance, that 'texts are produced in specific ways in specific social contexts' (1992: 78). 'Discursive practices' are contingent on more than just the social context of language use. They are contingent on social structure.

Moreover, viewing discourse as a 'social practice' means foregrounding its constitutive power. Discourse more than just represents or signifies the world. It constitutes it. Fairclough points to three ways in which it is 'socially' constitutive, distinguishing between the relational and the ideational functions of discourse. First, discourse as a social practice constructs social identities and subject positions. Second, it contributes to the production and reproduction of social relations and social structure (class, norms, conventions, class) (1992: 64). Third, discourse as social practice has an 'ideational' function in that it contributes to the production of belief and knowledge. The constitutive power and the ideological function of discourse are discussed in more detail in the next section.

### **The constitutive force of discourse**

Following Dilthey, Bruner distinguishes between 'reality', 'experience', and its 'expression'. The relationship between experience and its symbolic expression is dialectical; while 'experience structures expressions', 'expressions also structure experience' (Bruner, 1986a: 6). A society's indigenous psychology is articulated in a cultural discourse on the self and body. Through the dialectical process of 'socialisation', emerging 'selves' come to interpret themselves and others in terms of such a discourse. Agency and experience are partly constituted hermeneutically and, therefore, discursively. Taylor emphasises the constitutive function of language when he says that it 'not only serve to depict the world and ourselves, it also helps to constitute our lives. Certain ways of being, of feeling, of relating to each other are only possible given certain linguistic resources' (1985: 10-11). Moreover, Taylor points out that since languages and patterns of social relations vary cross-culturally, the ways that 'selves' are constituted and how they articulate their distinctions of worth are also bound to vary across cultures.

In developed English-speaking societies such as Britain, selves are partly constituted in a dominant Euro-American discourse on the self, body, and society.<sup>129</sup> This discourse articulates a Euro-

American folk psychology. Chapter 2 pointed out that the dominant discourse on the self in developed English-speaking societies depicts a disengaged view of agency and an individualised, psychological concept of the self. This fails to take into account the social contingency of agency, that 'an individual is constituted by the language and culture which can only be maintained and renewed in the communities he is part of' (Taylor, 1985: 8).

'Agency' is articulated in English discourse using a variety of grammatical and figurative devices and discursive forms. The English language furnishes members of English speech communities with the linguistic resources, and interpretive frameworks for making sense of, classifying, expressing, accounting for, and explaining action and experience. English speakers make strategic use of pronouns, case, voice, and subject positioning to represent the person and to partly constitute their agency. Harré and Muhlhausler (1990), for instance, have argued that, in English-speaking societies, a dualistic, bifurcated concept of 'the person' is constituted by English grammatical constructions. They characterise English pronominal usage by a double indexicality in which the first person pronoun 'I' indexes and positions a speaker-subject whilst indexing the body of the speaker as object, as a passive centre of experience.

Narrative discourse partly constitutes action and experience (Mattingly, 1998; Gergen and Gergen, 1983; MacIntyre, 1984). Riessman says that narratives 'construct experience by telling about it' (1993: 40). As with metaphor, the strategic language user draws on the stock of scripts available in the speech community<sup>130</sup> to which they belong to create new story lines out of existing materials to achieve a variety of social ends. Since the discursive process of narrating is creative and is a function of the narrator's agency, how the story will end can never be predicted in advance.

Through narrativisation, autobiographical memories are reorganised into a 'narrative of the self' (Neisser and Fivush, 1994) or experience is configured into a 'self-narrative' (Gergen and Gergen, 1983). This narrativisation process draws on cultural discourses on the self. These cultural discourses depict and articulate agency and embody a society's core values, its distinctions of worth. For instance, in late capitalist English-speaking societies such as Britain, 'the self' is commonly conceived as an individual life project, a personal narrative that bridges the gap between cradle and grave. The idea of 'biography' itself has become a popularised cultural template for identity production within highly individualised western societies.

According to Bruner, such narratives of the self have constitutive power; they form 'recipes for structuring experience' (1987: 31). Speakers draw on the collective narratives of the speech community to which they belong in order to perform their own self-stories (Somers, 1994; Linde, 1996; Skultans, 1997). Somers, for instance, maintains that 'people are guided to act in certain ways, and not others, on the basis of projections, expectations, and memories from a multiplicity but ultimately limited repertoire of available social, public, and cultural narratives'. Such narratives



are ‘attached to cultural and institutional formations larger than the single individual’, for example, ‘the narratives of one’s family’ or ‘those of the workplace (organisational myths), church, government and nation’ (1994: 619). These relational settings and the social practices that take place within them are the pathways through which culturally available narratives are assimilated and accommodated by individuals. In addition, macro social and economic forces (systemic properties of societies) impinge and partly constitute these processes of self-making through their impact on the local social spaces that individuals inhabit:

People’s experiences as workers, for example, are inextricably interconnected with the larger matrix of relations that shaped their lives – their regional locations, the practical workings of the legal system, family patterns – as well as the particular stories (of honour, of ethnicity, of gender, of local community, of greed, etc.) used to account for the events that happening to them [...] Identity-formation takes shape within these relational settings of contested but patterned relations among narratives, people, and institutions.

Somers, 1994: 625-6

Discursive practices both express and constitute social position. Different social identities are associated with different ways of talking and differences in how feeling and thought are symbolised. In addition, it is through participation in discursive practices that people come to constitute and interpret themselves relative to their social position(s). As Fairclough says, “discourse contributes first of all to the construction of what are variously referred to as ‘social identities’ and ‘subject positions’ for social ‘subjects’ and types of ‘self’ “ (1992: 64). Similarly, Kirmayer maintains that ‘narratives of the self act to position the person in place and time vis-à-vis family, community, larger social and political institutions’ (2002: 126). In late capitalist societies, these cultural discourses partly constitute identity in relation to a structure of social positions defined by relations of class, power, race, marriage, and kinship.

Wittgenstein (1978) maintained that ‘language’ is a fundamentally public phenomenon, that the idea of a ‘private language’ is incoherent. Moreover, ‘discourse’ is partly constituted by the social context of its production, the social identity of speakers, and the linguistic resources available to them as members of a speech community. In this sense, communities are formed through dialogue and conversation. Language mediates between person and society and is the principal ‘symbolic process’ through which social relations are constituted. Ingold (1986), for instance, says that the primary process in talk is the unfolding of social relations. Speaking and talking are primary sources of sociality and personhood and ‘facilitate forms of social action in a field of constitutive social relations which are themselves the sources of meaning’ (1986: 25). Discursive practices articulate the relationship between body and society and partly constitute the relational settings that mediate the impact of social structures on the individual.

The concept of ‘ideology’ plays a central role in critical social theory. For Keat and Urry, for instance, the critical analysis of ‘ideology’ involves forming an account of how social formations

and structural processes generate and sustain subjective beliefs. Such analysis involves ‘an examination of the ways in which people perceive, and act in, the situations located within these structures’ (1975: 278). Instead of viewing ‘ideology’ as a reified set of ideas<sup>131</sup>, it can be usefully viewed as a property of discourse. Fairclough has shown how language is penetrated by power and social structure. On this view, ‘discourse’ represents ‘a mode of political and ideological practice’ (1992: 67). Ideological discourse, for example, represents ‘internalised social structures, norms and conventions’ (1992: 187). Discourse is ideological to the extent that it reproduces or legitimises power relations and incorporates ‘significations which contribute to sustaining or restructuring power relations’ (Fairclough, 1992: 91). On this view, discourse as an ideological practice contributes to the production and reproduction of existing power relations and social structure. Fairclough says, for instance, that ‘discourse as a political practice establishes, sustains and changes power relations, and the collective entities (classes, blocs, communities, groups) between which power relations entertain’ (1992: 67).

‘Social structure’, in turn, conditions the relational settings inhabited by individuals, constraining the possibilities of action and experience. For instance, Lock and Scheper-Hughes point to the ‘codes and social scripts’ that work to support social structures partly by configuring selves in a way that makes them vulnerable to illness and distress:

Whenever inequalities and hierarchy are institutionalised, they will of necessity be imposed by means of a dominant cultural ideology, which is likely to inflict a negative self-image, distress, and often ill health on the underprivileged and disenfranchised.

Lock and Scheper-Hughes, 1996: 44

Nonetheless, it is important not to overstate the case for the constitutive power of discourse. For instance, the relationship between discourse and embodied experience is dialectical. While speakers creatively use linguistic symbols to express their bodily and social experiences, in the last instance, their talk is constrained by the embodied nature of such experience. For instance, while narratives partly constitute lives, they simultaneously encode the speakers’ agency and mimic the structure of human action (Mattingly, 1998).

### **A3.5 Topic guide**

The following themes were covered in the in-depth interviews with informants in the two Bristol samples:

- Personal and social characteristics (e.g. age, employment status, occupation, marital status, family type)
- The experience of personal distress (e.g. stress, fear, panic, depression, anxiety, etc.)
- The meaning and causes of discourse on distress
- Biographical context of distress
- Coping



- Social support
- Social response to distress and mental-health difficulties
- Help seeking and contact with professionals
- Consequences of distress (e.g. impact of distress on work, relationships, social identity)
- Experience of recovery
- Experience of treatment and diagnosis

In-depth interviews with St. Helenians who had experienced personal distress or illness covered these same themes. However, informal interviews meetings in St. Helena also covered a broad range of social themes and issues. In addition to the above, the following themes were appended to the topic guide in-depth interviews with St. Helenian informants. This list evolved as the fieldwork proceeded and indexes some of the core themes to emerge in discussions with St. Helenians. To some extent, the remainder of the topic guide therefore represents some of the core concerns of St. Helenians:

- Experience of living on St. Helena
- St. Helenian identity; Britishness and British citizenship
- Family and social roles
- Employment and unemployment
- Social and economic adversity
- Migration
- Normalising practices (e.g. gossip, ostracism, and stigma)
- Life history and biography
- Experience and beliefs relating to health and illness
- Understandings about emotions and mental health
- Social response to distress and mental health difficulties

### **A3.6 Interpretation of the Bristol data**

A ‘framework approach’ to qualitative analysis was used in the thematic analysis of the data from the combined samples (Ritchie & Spencer, 1994).<sup>132</sup> The first step was a ‘familiarisation’ process through which core themes were identified. Some of these themes were pre-specified in the research questions and in the central theoretical concepts guiding the research. Others were grounded in the data. These categories were organised under three overarching domains of content: the experience of distress and its consequences; the meaning of distress (e.g. explanation, narration); and the experience of social support, coping, social response, treatment, and recovery. This yielded a coding frame that was then systematically applied to the transcripts (See below).<sup>133</sup>

Three charts were constructed, one for each content domain. The columns of each chart corresponded with the core categories identified within each domain, while the rows represented individual cases.<sup>134</sup> The data was then coded<sup>135</sup> using this framework of categories. Text

corresponding with these categories was then lifted from their original context in the transcripts and arranged according to thematic category in three sets of tables. Instances of each category were indexed in the table with a key word or 'emergent code', a distilled summary of the textual data phrase and illustrative quotes with a textual reference (i.e. line number). Emergent codes close to the data were recorded in the charts in repeated readings of the data and interpretive notes were taken examining relationships and patterns in the texts developing theoretical concepts grounded in the data. The use of trope, idiomatic phrases, and explanations were also noted in these charts. During this familiarisation phase, discrete narrative excerpts and extended stretches of narrativised discourse were marked out for more detailed interpretation later and these were categorised according to the core themes running through them.

The Bristol fieldwork was limited in a variety of ways. The urban setting in which the fieldwork was conducted limited the kinds of theoretical questions that could be asked. In addition, the recruitment strategies were only partially successful. This was partly a question of access and resources, but also the reflected the sensitivity surrounding the topic of the research. Ideally, a community survey would have been conducted in order to select a small sample of informants in defined geographical area. Although such a survey was considered at the outset, the logistical resources that would have been required to carry out such a survey were not available. The two methods described were therefore deployed.

### **Thematic framework used to interpret the Bristol data**

#### **Content domain 1: Experience and expression of distress**

- Personal distress as illness
- The vicissitudes of mood
- Emotional distress and vocabularies of emotion
- Idioms of distress
- Embodiment of distress
- Loss of agency and human behavioural breakdown
- Social disconnection and biographical disruption

#### **Content domain 2: The meaning of distress**

- Biographical explanations (e.g. childhood; relationships; loss; work-related; etc.)
- Biomedical explanations
- Psychological or character-based explanations
- Contingent narratives; contextualised accounts of personal distress

#### **Content domain 3: Experience of support, coping, treatment, and recovery**

- Ways of coping



- Social support and social response
- Doctor-patient encounter and diagnosis
- Experience of treatment
- Non-medical professional ‘help’
- Experience of recovery

### **A3.7 Interpretation of the St. Helena data**

Fieldwork on St. Helena was followed by an extended period of transcription, classification, and collation preceding analysis and interpretation. All interviews were fully transcribed verbatim. Data from St. Helena included field notes, interview transcripts, correspondence, primary documents, notes from documentary sources, demographic, social and economic data; information about health and social care on the island. A different approach was therefore needed to interpret this data than was applied to the Bristol data. In a series of readings of this material (‘familiarisation’), the data was indexed and organising concepts and themes were identified. These were organised into the thematic framework presented in the following section. Burke’s ‘dramatistic’ framework was used as a broad overarching framework for interpreting the fieldwork data.<sup>136</sup> The data were organised into these broad thematic categories and relationships were systematically explored between them. The theoretical interpretation of the data was refined through multiple readings in a cyclical process. Detailed interpretive notes were taken elucidating these theoretical concepts (e.g. ‘stigma’ or ‘worry’) and their relationships. Moreover, this process of interpretation continued into the writing up phase; this represented the final stage in the overall interpretation of the data in terms of its interplay with theory.

### **Thematic framework used to interpret the St. Helena data**

#### **(1) ‘Scene’**

##### **(a) ‘Relational setting’**

- Financial or economic adversity
- Work/employment and relationships
- Social capital and social support
- Social roles and social position
- Stigma, ostracism, isolation, disconnection, exclusion
- Migration

##### **(b) ‘Distal setting’**

- Economy (e.g. unemployment, labour migration, low pay)
- Political institutions and statutory services (e.g. the organisation of healthcare and social welfare - interaction of social welfare/health-care systems; social security system; housing)
- Religious institutions and practices
- Social structure

- Geographical/environmental setting (e.g. remoteness, scarcity)
- Normalising practices

## (2) 'Action' and 'experience'

- Social adversity/negative life events
- Experience of personal distress
- Experience of chronic illness
- Consequences of distress and illness (e.g. impact on relationships, work)
- Therapeutic process (e.g. encounter with doctor or other healer; treatment; diagnosis)
- Recovery

## (3) 'Agent'

- Personal and social characteristics (e.g. social and cultural, marital status, age, gender, socio-economic position)
- Knowledge and belief (e.g. discourse on self, body, illness, distress, society)
- Biography

## (4) 'Agency'

In Burke's scheme, 'agency' is defined as the purpose of the action moving the drama forward. I use the term 'agency' polysemously to mean: an agent's sense of purpose; the capacity or power for action; a property of the self; and the conditions that make meaningful action possible (including discursive action).

### A3.8 A small-scale community survey

The self-administered, 12-item General Health Questionnaire (GHQ-12) is a screening instrument designed to identify 'common mental disorders' and to differentiate psychiatric from non-psychiatric cases in community samples (Goldberg, 1978; Goldberg and Williams, 1988). It has been used widely in community-based epidemiological surveys of psychological distress (e.g. Weich *et al*, 2001). The GHQ-12 forms a composite scale that aims to indicate changes in mental state and breaks in normal functioning (i.e. in the previous few weeks). The items of the scale ask about the presence or absence of common signs of mental distress (e.g. difficulties sleeping or concentrating). A high score on the scale indicates the possible presence of psychological ill health. The GHQ-12 was developed for use within the UK and is grounded in an expert view of what constitutes English lay discourse on distress (for example, it uses the term 'tonic'). The underlying assumption is that the discourse used to articulate distress across all English-speaking societies and across different social categories is the same. As fieldwork on St. Helena proceeded, it became clear that 'headaches' were a common idiom of distress among St. Helenians. Partly in response to a suggestion from St. Helena's CMO, the GHQ-12 was supplemented with an additional question asking respondents whether they had suffered from 'headaches'. The questionnaire was then



piloted in interviews with a few St. Helenian informants. Based on these responses, the wording of the GHQ-12 was modified so that St. Helenians could more readily understand it.

Each item on the scale was scored positively or negatively yielding a score out of 12 (excluding the 'headaches' item). A recent British study used a score of three as a threshold in order to identify cases of 'common mental disorder' in a community-based survey (Weich *et al*, 2001). In the screening exercise reported here, a much lower threshold was applied; if any (at least one) of the items were scored positively, then this was taken to indicate the possible presence of psychological ill health or mental distress.

The questionnaire was sent with a covering letter explaining the nature of the research to all the adults in the chosen district. A combination of St. Helena's telephone directory and the 1998 electoral register (SHG, 1998) was used to compile a sampling list of all those resident in the outlying district. A number of adults living in the district were not listed on either. Of the approximately 232 adults living in this outlying district, around one in ten had left the island since the last census and some had relocated to another part of the island. This highlighted the degree to which the district was 'closed' or 'bounded'. There were therefore 194 valid cases (excluding those who had migrated). Of those listed, 84% were still resident in the outlying district. Only 71 (around 37% of valid cases) returned the self-administered GHQ-12. In some cases, the questionnaire was administered by telephone or face-to-face interview.

The average age of respondents was 49 and over 60% of respondents were over 45. This high representation of older people may have been partly because a high proportion of St. Helenian young people were working overseas at the time of the fieldwork. In addition, there were slightly more men than women listed in the sampling frame (56% of the 232 adults listed were men). However, female residents of the district were more likely to respond than male residents (47% of the 71 respondents were men). The results of this survey are reported in Appendix A6.1.

## Appendices to Chapter 6

### A6.1 Mental health on St. Helena

There is little documentation or research available on the health of the St. Helenian population and little is known about illness experience among Saints. Even less is known about mental health or psychiatric illness among St. Helenians. There is no epidemiological or administrative data available on mental health. Nevertheless, what anecdotal evidence exists points to a concern about levels of distress on St. Helena, and the lack of provision of services for individuals who experience such distress.

As long ago as 1955, St. Helena's Senior Medical Officer wrote in an annual report wrote that: 'The anxiety state is as could be expected on a small island - fairly prevalent'. Similarly, in the following year, the Social Work Officer of St. Helena described 'mothers sunk in apathy, engendered by financial strain, ill-health, and sometimes mental disharmony'.<sup>137</sup> During the 1960s, a former Senior Medical Officer of St. Helena, Dr Ian Shine conducted a study of local disease patterns (e.g. diabetes) in order to test the hypothesis that such patterns were due to 'genetical abnormalities' associated with the island's physical isolation (1970: 2). In his account of this medical research, he commented on the mental health of the inhabitants. 'Hysteria', he said, 'is a common neurotic manifestation (generally attributed to the evil eye by the islanders), although anxiety and depressive states are seen more frequently' (1970: 32).

There is no evidence on the mental health and well being of the St. Helenian population except a review of mental-health service provision conducted by a former medical officer on St. Helena, Dr Stephen Aldridge, in the early 1980s (1984, 1994). This review included a needs assessment of mental-health difficulties on the island. Aldridge claimed that "there is no shortage of severe mental illness on St. Helena" and he argued that this placed a pressure on mainstream healthcare provision: 'Severe mental illness (psychosis) constitutes the largest single continuing care problem facing the health care services on St. Helena. More persons are resident in institutions suffering from psychosis than the bed occupancy rate at the General Hospital for all other problems combined' (1984: 25-26).

Aldridge applied ICD-9 diagnostic criteria to St. Helenian patients who were admitted into hospital for mental-health related difficulties during 1982 and 1983. He found that there were at least 59 individuals with 'functional psychosis'<sup>138</sup> and, of those with affective psychosis (N=19), 14 were female, three times the number of men. The median age of onset was in the early 50s (Aldridge, 1984: 25). Aside from cases of 'psychosis', he reported 18 cases of 'neurotic depression' and 7 cases of 'hysteria', and 2 suicides (one of which was linked to psychosis). In a later paper, Aldridge (1994) estimated there were around 50 cases of individuals suffering from schizophrenia with a population prevalence of 1.1%.<sup>139</sup>



In his original report, Aldridge (1984) also highlighted the ‘increasing medical, psychiatric and social problems relating to alcohol consumption’, with 14 reported cases of ‘chronic alcoholism’. In addition, there was one alcohol-related suicide, a case of ‘delirium tremens’, and a death from cirrhosis. He also highlighted ‘episodic uncontrolled overindulgence’ of alcohol as a health-related problem, but noted that there was no way of knowing how widespread this was: ‘On the island of St. Helena’, he reported, ‘alcoholism not only exists, but there is every indication that it is a growing problem’ (1984: 27). Aldridge pointed out that ‘problem drinking’ was predominantly a male preoccupation and hypothesised that heavy drinking habits may have been learned during periods of time working on Ascension Island.

More recently, the CMO expressed a concern about excessive alcohol consumption on the island. Although no evidence is presented to support this claim, the CMO’s report argued that: ‘There is known to be a significant alcohol abuse problem on the island’ (1999: 25). Similarly, the authors of the UNDP report maintained that ‘substance abuse is a problem especially in relation to alcohol and tobacco where consumption per capita is high’ (1999: 32). They linked the occurrence of domestic violence on St. Helena with ‘problem drinking’: ‘Alcoholism and its associated crime and domestic violence is one of the island’s major social problems’ (1999: 35). They claim that ‘domestic violence especially against female partners is still regarded in some quarters as acceptable behaviour although attitudes are beginning to change. Most domestic violence revolves around alcohol abuse’ (1999: 38). They report that many of the referrals made to the social-care officer are for marital and family conflict and, in many cases, such adversity is associated with alcohol abuse (UNDP, 1999).<sup>140</sup>

The CMO estimated that, in 1998, just over 7% of the island’s overall drugs budget was spent on anti-depressants (1999: 15). In his annual report for 1998, the CMO described the community nursing team as a ‘surrogate psychology service’ (1999: 25).<sup>141</sup> This suggested the need for the employment of a psychologist to support the mental well being of those suffering from mental distress on the island.

Limited evidence about levels of distress comes from a small-scale screening survey that was conducted in an outlying district of St. Helena. A description of the context and methods used in this survey is described in Appendix A3.8. Around three out of every ten respondents (N=22) indicated the possible presence of mental distress (scored highly on at least one of the twelve items of the modified GHQ-12), even though it was sometimes unclear whether this was a result of a physical illness (See Table A6.1). The questionnaire also asked respondents whether they had experienced any ‘headaches’. More respondents complained of headaches (i.e. around four in ten respondents) than indicated the presence of possible ‘distress’. Conversely, 7 out of 10 of those who reported headaches also reported positively on at least one indicator of ‘distress’. Table A6.1

shows this positive relationship between the likelihood of reporting headaches and the likelihood of scoring positively on at least one item of the modified version of the GHQ-12.

**Table A6.1 Percentage of respondents in a small-scale community survey reporting ‘headaches’ and ‘mental distress’**

	No ‘headaches’ Row %	‘Headaches’* Row %	Total %	Total N
No distress	67	33	100	49
Distress**	45	55	100	22
All	61	39	100	71

\* Gave a positive response to a question asking whether respondents experience headaches

\*\* Reported experience of distress on at least one item of the modified GHQ-12

Over half of those who responded (53%, N=38) indicated that they either experience headaches or scored positively on one of the other twelve indicators of ‘mental distress’ (See Table A6.2).

**Table A6.2 Percentage of respondents in a small-scale community survey reporting ‘headaches’ and ‘mental distress’ by sex**

	‘Headaches’ Row%	Distress Row%	Total Col %	Total N
Male	18	21	46	33
Female	58	40	54	38
Total			100	71

Although the numbers are small, three times as many of the female respondents reported ‘headaches’ and twice as many women as men scored positively on the GHQ-12 (on at least one item) (See Table A6.2).

### **A6.2 St. Helenian discourse on ‘mental illness’**

Among St. Helenians, the term ‘mental’ is a pejorative term and is used to express a judgement about someone’s character, rather than to describe someone who is ill. It is used to describe someone who, in his or her overt behaviour, deviates from what is considered normal functioning. According to Aldridge, St. Helenians use the term ‘mental’ to describe:

Persons exhibiting behaviour which is clearly abnormal and unacceptable. In general terms this means excitable behaviour often accompanied by speech that fails to make complete sense and in a situation which is exposed to the public. A man who locks himself away and withdraws would not qualify for this adjective; it is more likely to be the person who goes round upsetting all the neighbours who would be described as ‘mental’.

Aldridge, 1984: 19-20

‘Mental illness’ is attributed to a person who behaves abnormally or who exhibits behaviour that is ‘disorderly’, ‘not normal’, or ‘insensible’. One St. Helenian woman, for example, described someone with a mental-health difficulty as “not well in his mind” and that he was ‘doing things that he wasn’t supposed to be doing’. According to a middle-aged St. Helenian man, a man who is



'mental' "don't know what he doing properly [...] doin' the things he not suppos'd to be doing". One informant who had experienced an episode of prolonged and severe distress in the past reported: "I had mental problems and all that. I was doing all the wrong things and stuff like that." A St. Helenian man in his 60s described people who have a 'mental illness' as 'not sure of themselves', 'their mind is not regulated properly', and 'their mind is affected'. A St. Helenian man in his 30s thought that 'mental' meant, "talking insensible, delirious-like. [...] Part of your memory is gone. A part of your senses is missing 'cos you won't do the things that me and you do". Some St. Helenians depicted 'mental illness' using a metaphor of balance. A man in his 50s said that the term 'mental' meant 'off-sided, off-balance'. A middle-aged man described another man's treatment for a 'mental illness' as the 'only thing that will keep him in balance'. One St. Helenian described how another man had been admitted to the Island's hospital for adults with psychiatric difficulties because he had 'got frustrated [...] mental, mental, mental, disturbed [...] a little bit off balance'. A St. Helenian man in his 60s described a relative as swearing, arguing, as not behaving in an 'orderly way' and that 'mental illness' was when "your brain get out o' balance".

These remarks from St. Helenians illustrate how 'mental illness' is conceived as a breakdown in usual behaviour and as a breakdown in agency. It implies a deviation from behavioural expectations and from what it is to be a person as articulated in the dominant St. Helenian discourse on the self (See Chapter 5). Such deviation therefore attracts a high degree of stigma and places the sufferer at risk of social ostracism. Aldridge, for example, observed that a physical explanation for an individual's abnormal behaviour was therefore more acceptable than a psychiatric interpretation. He used the example of 'nerves' to illustrate the point: "The family will agree that the person has a problem and that it may be due to 'nerves', but in no way will they accept that he is 'mental'" (1984: 19).

Given the existence of a sociocentric discourse on the self, 'mental illness' blights entire families. Stigma is conveyed from one person to another through close association extending to the sufferer's family. Aldridge observed that family members therefore resist admission to St. Helena's mental hospital. Similarly, one St. Helenian healthcare worker expressed the belief that an individual is more likely to be perceived as having a mental-health difficulty if another family member had experienced a mental-health difficulty in the past.

The high degree of stigma associated with anything to do with psychiatric illness affects the social response to personal and social distress (See Chapter 6). For example, one female informant who had experienced 'depression' said that she had received little social support or understanding from other Saints. It is likely that Saints would be reticent to admit personal or social distress to the island's doctors. This may be one of the reasons why such suffering is articulated using a somatic idiom (See Chapter 6).

### **A6.3 Public health and mental-health service provision on St. Helena**

The provision of support for individuals experiencing personal distress or 'mental illness' cannot be understood without a preliminary description of the structure of St. Helena's healthcare system. St. Helena has a well-developed healthcare system with 'comprehensive health services' available to all St. Helenians. The Public Health Department is one of SHG's executive departments. In 1998, public expenditure on health constituted around 10% of St. Helena's GNP and around 17% of SHG's recurrent budget is spent on public health (UNDP, 1999). St. Helena's healthcare system has been developed in partnership with the UK's National Health Service and consists of:

- A 42-bed UK National Health Service-style general hospital for acute medical and surgical care.
- Three medical doctors and a dentist employed from overseas.
- A network of seven outpatient clinics distributed around the island where people living in outlying areas who might find it difficult accessing services in Jamestown can consult with a doctor or community nurse.
- A hospital-based nursing team; a community nursing team; auxiliary healthcare workers including physiotherapist; an expatriate nurse tutor. The community nursing service provides home visits, injections, bathing and RX, vaccination, family planning, cervical smears (CMO, 1999). In 1998, two-thirds of the nurses had not formal nursing qualifications.
- Ancillary services such as a laboratory, radiology service, and a dispensary.
- A residential unit for adults who suffer from psychiatric illness.
- A residential unit for people with a physical disability or learning difficulty.

Source: Chief Medical Officer of St. Helena (1999)

At the time of the research, there was a limited social-care service. SHG's Social Service Department was responsible for the provision of financial support, personal, social care, community services, and government housing (UNDP, 1999: 39). In 2000, a St. Helenian social-welfare officer co-ordinated a limited social care service on the Island. His role involved adjudicating in domestic conflicts, needs assessments, providing advice, and support to more disadvantaged members of the community. In 2000, a consultant was employed from a social-work organisation in the UK to evaluate St. Helena's social-service provision (Evans, 1999). He reported that SHG provides a basic social-care service and expressed 'serious concerns' about both the quality and level of provision for both children and adults. Spending on social care was considered a low priority with £15 per capita in 1999/2000 being spent on social care compared with £89 per annum being spent on the Police Service (Evans, 1999: 3). He made the point that the Social Services Department's core work was not social work, but employment schemes, provision of benefits, and housing. Most referrals to the Social Services Department were for financial help rather than for social support. However, Evans described requests for financial support as 'the presenting problem'. Indeed, it is possible that, in many cases, an array of social and personal difficulties lie behind such requests for economic aid.



Evans' report recommended changes in the organisation of social care on St. Helena. For example, he recommended the secondment of a social-work manager and two qualified social workers to develop good practice in social care and to establish social work on St. Helena. The Social Services Department was dissolved in 2000. Responsibility for social care was taken over by the island's Public Health Department. In 2002, a social worker employed by the UKG's Department for International Development was appointed for an initial two-year period.

The fact that services to support poor families and individuals experiencing personal distress are poorly developed may partly be a consequence of the stigma associated with socio-economic adversity, personal distress, and 'mental illness'. Aldridge (1984) reviewed the services available to vulnerable adults on the island including the elderly, those experiencing a long-term mental-health difficulty, adults with a learning difficulty, and individuals with a physical disability. He was highly critical of the adequacy of the health and social service support available to patients suffering from 'mental illness': 'Mental health', he said, 'was the most neglected area of healthcare on St. Helena' (1984: 5). These inadequacies included negligence of certification and record keeping, and more generally 'a marked and serious lack of appreciation of 'mental illness' and its effective treatment' (1984: 6). In a later article, Aldridge maintained that existing mental-health facilities (prior to 1984) were underdeveloped in the early 1980s. In the first half of the century, adults with a mental-health difficulty lived in the poor house in Jamestown. This became dilapidated, so a new mental hospital was built up and this was opened in 1954 (called *Sundale*). The management of the mental hospital switched from the Poor Relief Board to the island's Medical Department. The new hospital had 20 beds, was gender segregated and there was accommodation for 'patients under restraint', a treatment room, dining area, and ward accommodation. In the Senior Medical Officer's report for 1954 reported that 'the grounds are all contained by a high wall and are laid out as lawns, flower-gardens and vegetable gardens' (1955: 4). Aldridge describes the mental hospital (prior to its re-development) as though it had the appearance of a prison:

Existence was stark and without any views behind 10 foot walls. Patients were clothed from a paltry pool of hospital clothing. Haircuts were convict-like. Patients were routinely locked into cells at 6pm because there was no night staff provision. There was no evidence that any patient had been medically examined since 1978. Disguised beneath a superficial tranquillity the mental hospital had all the hallmarks of a bad institution.

Aldridge, 1994: 790-1

In 1958, the new mental hospital had 13 patients. In 1982, there were still around that number with around 15 long-term 'inmates', five of whom were 'without the necessary certification' (Aldridge, 1994: 790). Between 1954 and 1983, there had been around 248 admissions to *Sundale*. Around one third of admissions had no 'valid legal certification to justify their admission' (Aldridge, 1984: 33). For those who had had medical records, there was inadequate information and insufficient

detail for identifying a diagnosis. Only around one fifth of records were adequate. Aldridge was highly critical of this lack of certification and inadequate record keeping. He was also critical of the fact that the *Mental Health Ordinance of 1956* (SHG, 1956) also covered the categories of ‘moral defective’ and ‘epileptic’ (the provisions of this Ordinance were still in effect at the time that Aldridge was writing). Based on an analysis of administrative data and the lack of any valid certification, he stated that: ‘It is obvious from the scanty records at the Mental Hospital that some patients have been admitted there in the past either because of immoral conduct or else because of inconvenient social behaviour’ (1984: 83). The Hospital had functioned as more than just a ‘receptacle for the mentally ill’. It was also used ‘as a threat to people who would best be described as social nuisances who were occasionally placed there for a few days as a lesson if they didn’t mend their ways they might be left there for all time’ (1984: 30).

In his original report, Aldridge made a series of recommendations for improving and modernising the support, treatment, and rehabilitation of individuals with severe ‘mental illness’. To the credit of SHG, many of his recommendations were implemented. In a follow-up article published in 1994, he described this process of modernisation in detail. It involved major structural changes to improve the image of *Sundale*, the mental hospital. Local staff were trained and all nurses attending local training programs were required to rotate through various mental health areas to broaden their experience. A *Mental Health Ordinance* based on the 1983 *Mental Health Amendment Act* of England and Wales became law in 1986.

St. Helena’s mental hospital has played a historically important role in the functioning of St. Helenian society. The fear and stigma associated with the mental hospital is metonymically associated with social ostracism and exclusion, so that it has contributed to the production of a high degree of conformity. Referring to the patients in *Sundale*, one middle-aged St. Helenian woman said: “They get up to things that they’re not suppos’d to”. Another informant described how, as a child, her Grandmother would threaten her if she misbehaved: “Behave, or I’ll send you to the *Sundale*,” she would say. She said that, as children, they would dare each other to go as close as possible to the high walls. Sometimes, she said, she could hear the screaming of the ‘inmates’ through the walls.

Perched high up on a cliff overlooking Jamestown, the Castle, and the sea, *Sundale* is still St. Helena’s psychiatric hospital. The Head of Nursing has overall managerial responsibility for *Sundale*’s nursing staff, but a nursing officer based at the hospital is responsible for its day-to-day management.<sup>142</sup> The CMO visits *Sundale* once a week. There were around twelve patients resident at the hospital, mostly elderly St. Helenians suffering from a long-term ‘mental illness’. Only two are men. On rare occasions, acute cases are admitted.<sup>143</sup> According to the island’s CPN, acute admissions usually consist of the same people being re-admitted periodically. Younger people suffering from a mental-health difficulty are more likely to be taken care of in the community.



The stigma associated with 'mental illness' finds its public and symbolic manifestation in Sundale. Aldridge noted that 'there has developed a strong and inappropriate degree of prejudice against the mental hospital itself and against patients who have been there' (1984: 19). St. Helena's community psychiatric nurse said that, because of this stigma, her clients in the community are hesitant to visit Sundale to meet with her. There is a fear of becoming tarnished by an association with Sundale and, therefore, with 'mental illness'.

The meaning of psychiatric illness ('mental' or 'crack') among St. Helenians is associated with admission to Sundale. As one informant said: 'People go to the mental hospital because they crack'). One woman in her 30s used an idiom of 'mental illness' to describe a woman whose behaviour is sometimes "out o' order". Being "out o' order", "off-balance" is symbolically linked with Sundale (Text 1):

**Text 1**

She nuts. Sometimes, she go into Sundale. [...] Sometimes, you'll walk in and you'll find her sitting there crying. And, sometimes, she can get really violent, but not with strangers. [...] If she in a bad mood and she want to screams at you, and, once she got that out, she a different person.

One woman in her 20s believed that once a person had been admitted to Sundale, other members of the community would brand them as 'nuts' and stop talking with them. Another informant maintained that once a person had been admitted to Sundale, they are treated differently by other St. Helenians. She said that Saints do not treat former patients at Sundale as if they had been ill, 'like you had diabetes'. Rather, she maintained that 'you are treated as if you are crack'. Any association with Sundale is highly stigmatising and results in ostracism (Text 2):

**Text 2**

They think you're crazy. They look at you as someone who is completely : it's hard to explain. You're classed differently. They look on you differently. They don't want to socialise with you. They think you was completely nuts.

Another woman spoke openly about the stigma associated with admission to Sundale. She said that people think of you as 'crazy' and that 'it carries on with you': "You can carry it around with you for the rest of your life. You're out of your mind". She believed that lack of understanding about about mental health difficulties is part of the problem ("They don't understand").

At the time of the fieldwork in 2000, St. Helena's CPN was attached to Sundale but was based within the community-nursing team. Many patients are taken care of in the community. In 2000, the CPN had a caseload of around 50 individuals living in the community. According to the CPN, the mental-health difficulties of many of these individuals remained undiagnosed, despite the fact that most received some form of medication. Writing in the early 1980s, Aldridge maintained that individuals experiencing mental-health difficulties would be taken care of in the community 'until

a crisis intervenes which may be a social problem, an illness or a behavioural problem' (1984: 7). In special or urgent cases, psychiatrists from the UK or Cape Town have been commissioned to conduct assessments on St. Helena. Members of the community nursing team also provide high levels of personal support to people living in the community (CMO, 1999: 25). In addition, a non-St. Helenian Salvation Army Captain was available for limited one-to-one counselling for those experiencing social adversity or personal distress. The island's doctors play a central role in treating individuals experiencing mental-health difficulties and personal distress. In 1998, the Public Health Department purchased an ECT machine for use at the General Hospital. The CMO reports that this would be used 'to control a variety of psychiatric disorders by the delivery of a carefully controlled electric shock to specific areas of the brain' (CMO, 1999: 11).



## Notes

<sup>1</sup> Within the context of a study of the idioms of distress used among Havik Brahmin women, Nichter defined 'distress' as 'a broad range of feeling states including vulnerability, apprehension, inadequacy, dissatisfaction, suppressed anger and other anxiety states' (1981: 403). Following Nichter (1981: 403), I use the term 'distress' to refer to an array of adverse feeling or emotion states and experiences. These are partly constituted by the socio-cultural context in which they occur. English lay discourse on distress, for instance, includes a rich vocabulary for describing such embodied experiences: for instance, anxiety and fear, panic, depression, stress, worry, guilt, low self esteem, hopelessness.

<sup>2</sup> The *British Psychiatric Morbidity Survey* operationalised the concept of 'mental disorder' using a revised version of CIS-R (ONS, 2001: 15). Neurotic disorders include depression and anxiety disorder, mixed depression and anxiety disorder. Disorder is defined in terms of functionality. 'Neurotic disorders' are 'characterised by a variety of symptoms such as fatigue and sleep problems, forgetfulness and concentration difficulties, irritability, worry, panic, hopelessness, and obsessions and compulsions, which are present to such a degree that they cause problems with daily activities and distress' (ONS, 2001: 15).

<sup>3</sup> The aims of this research were influenced at the outset by Good's suggestions on the kinds of questions that an interpretive study of illness and distress might focus on (Good, 1977: 53; Good *et al.*, 1985). In applying a broader theory of meaning to medical anthropology, Good outlined an agenda for research applying such a theory to the experience of illness (See Good, 1977: 53).

<sup>4</sup> The term 'agency' is used in this thesis to refer to the necessary conditions for action to take place. It is also used to mean the power or capacity to act and an agent's degree of consciousness of that capacity. 'Agency' also refers to the degree of external constraint that is placed upon action and is dialectically opposed to social structure. It represents the difference between behaviour and action or that motivational property of action that directs it towards the achievement of a desired or valued end-state.

<sup>5</sup> 'Trope' refers to figurative language use. Figures of speech, for instance, are examples of tropes. Burke (1969) characterised four master tropes in English language use including: metaphor, metonym, synecdoche, and irony. The interpretation of discourse on distress in this thesis makes use of extensive use of the concepts of metaphor and metonym. These are discussed in more detail in Appendix A3.3.

<sup>6</sup> For example, a diathesis-stress aetiological model underlies Brown and Harris's pioneering research on depression among working-class women in London (e.g. Brown and Harris, 1978). Other examples include: Brown *et al.*, 1995; Finlay-Jones & Brown, 1981; Bebbington *et al.*, 1991; Bifulco *et al.*, 1998; Brown *et al.*, 1987; Brown and Moran, 1997; Weich *et al.*, 2001.

<sup>7</sup> The take up of a social identity is relative to the social positions and roles that an individual inhabits; who people take themselves to be (or are taken to be by others) is partly a function of their social and economic position and the social relationships that they are engaged in (e.g. class, race, ethnicity, occupation, gender). Social identity has both an objective and subjective referent. Social structure is determinant and partly constitutes social identity and personal agency. As a socially differentiated set of positions and roles, it is partly independent of the individuals who inhabit them. Goffman (1963) defined 'social identity' as the social categories and attributes of an individual. Following Goffman, in this thesis social identity is used to refer to the internalisation of social positions and roles, and the social categories that are used to describe them.

<sup>8</sup> Such research includes, for example, ethnographic research of community or institution-based programs for individuals experiencing psychiatric illness (e.g. Estroff, 1985); cross-cultural psychiatric and medical anthropological research on psychosocial distress and psychiatric illness in developed English-speaking societies (e.g. Kleinman, 1986; Young & Kirmayer, 1995; Parsons and Wakeley, 1991; Jadhav *et al.*, 2001); qualitative sociological studies of depression and distress (e.g. Karp, 1996; O'Connor and Nazroo, 2002; Nairne & Smith, 1985; Becker, 1998; Rowe, 1978). In Britain, a few non-epidemiological surveys have been conducted of people who have experienced emotional distress and psychiatric illness asking them about their experiences of treatment, ways of coping, views on services (e.g. Mental Health Foundation, 1996; Rogers *et al.*, 1993). Anthropologists have also mounted critiques of Biomedicine and have conducted ethnographic studies of western psychiatry (e.g. Lindenbaum & Lock, 1993; Good, 1994; Kleinman, 1980; Luhrmann, 2000; Young, 1995; Lock and Gordon, 1988; Littlewood, 1998, 2000).

<sup>9</sup> Examples include: Baer *et al.* (1986), Young (1980), Lock and Gordon (1988), and Taussig (1980).

<sup>10</sup> 'Neurasthenia' is a physical disease characterised by exhaustion of the nervous system (Kleinman, 1986).

<sup>11</sup> 'Social structure' is used in the Durkheimian sense to refer to a relatively stable system of power relations that generate a set of social locations, roles, or positions (e.g. class, gender, race) within which social identities and biographies are forged. The ontology of structuralist sociology relies on Durkheim's splitting of the individual into a social ('a conscience collective') and psychological part ('individual consciousness') (Durkheim, 1953). The concept of society depends on the idea that the self has a social part (i.e. social identity) that is a function of a supra-individual whole. This social part of the self is configured through participation in society, through engagement in social relations. For Durkheim, 'psychology' is the science of the individual mind while the social part of the self bridges the gap between the individual and society. Society is emergent, is more than the sum of its part-individuals, and is the proper object of sociological investigation. Durkheim grounded this new autonomous science of sociology in an ontology of the individual and society and a positivist epistemology in which social phenomena are conceived as 'facts in nature'.

<sup>12</sup> Following Brown *et al.* (1995), entrapment is used here to mean the experience of powerlessness while living in an adverse social or economic situation that is difficult to escape from.

<sup>13</sup> Loudon defined ritual as symbolic or non-instrumental, prescribed and repetitive behaviour (1966: 103). Ritualistic action or behaviour is symbolic in that it says 'something about the state of affairs, particularly about the social condition of those taking part in the ritual' (1966: 103). Rituals do not necessarily change things. For example, Van Gennep (1960) distinguished between rituals that announce a change in social position (e.g. 'rites of passage') from those that reinforce and reaffirm belief and re-invigorate ideology.



<sup>14</sup> In the United States, the classification system most commonly used for statistical, clinical, and research purposes are the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (ASA, 1994) (also known as 'DSM IV').

<sup>15</sup> The *Collaborative Study on Standardised Assessment of Depressive Disorders* studied depression in Japan, Switzerland, Iran, and Canada in order to investigate cross-cultural similarities and differences in depression and to develop cross-culturally valid standardised instruments for identifying and diagnosing depression in research and clinical work (Sartorius *et al*, 1983).

<sup>16</sup> Medical anthropology's principal concern has been to apply ethnographic methods to develop an understanding of the relationship between culture and illness. Medical anthropology emerged as a distinct sub-field of anthropology during the 1950's. Good identified four 'orienting approaches' to illness representations in medical anthropology (1994: 36): an empiricist or 'folk-belief' model; a cognitive or ethnomedicine approach (e.g. Garro 1994; Lutz, 1988); a meaning-centred approach (e.g. Good, 1977; Kleinman, 1980, 1988); a critical approach (e.g. Singer, 1989; Scheper-Hughes, 1993). A fifth can be added: a functionalist, process-orientated approach that pre-dates most of these (e.g. Loudon, 1966; Turner, 1967, 1968). This older tradition links with a critical strain in current medical anthropology and provides a conceptual bridging point between structural sociology and medical anthropology.

<sup>17</sup> For instance, Nazroo and O'Connor point out that standardized research instruments 'perform inconsistently across different ethnic groups' (2002: 9). This may also apply to social-psychiatric epidemiology as well, where comparisons are made between different social groups in their experience of psychiatric illness or psychosocial distress.

<sup>18</sup> For example, see Jadhav *et al* (1996, 2001), Littlewood (1990), Fabrega (1992), and Kirmayer (1989).

<sup>19</sup> For example, see Kleinman and Good (1985), Kleinman (1980), Littlewood (1990), and Jenkins (1991).

<sup>20</sup> For example, see Kleinman (1986), Kirmayer (1989), Kirmayer and Young (1998), and Jadhav (1996). There are many other 'idioms of distress' of which the 'somatic' and the 'psychological' are just two. These include, for instance, cosmological, sociomoral, interpersonal, and political idioms of distress (Kleinman, 1986; Kirmayer and Young, 1998).

<sup>21</sup> For example, see Raguram *et al* (2001), Kleinman (1986), Nichter (1981), and Weiss *et al* (2001).

<sup>22</sup> The *Study of Ethnic Minority Psychiatric Illness in the Community* (EMPIRIC) had two parts: a quantitative survey of psychiatric illness across ethnic groups and a qualitative study exploring ethnic and cultural differences in mental health (Nazroo & O'Connor, 2002). The qualitative part of the EMPIRIC study was based on in-depth, exploratory qualitative interviews with a sample of respondents from different ethnic groups in England (Black Caribbean, Indian, Pakistani, Bangladeshi, Chinese, Irish, White British) and aimed to investigate ethnic and cultural differences in understanding and the context of mental distress among these groups and how these context shape their experience of distress (Nazroo and O'Connor, 2002).

<sup>23</sup> For example, in psychiatric discourse, 'somatisation' refers to either a 'somatic clinical presentations of affective, anxiety, or other psychiatric disorders' or it refers to a specific category of psychiatric disorder (e.g. 'the somatoform disorders'). (Kirmayer and Young, 1998: 420; APA, 1994). It is important to note that 'somatisation' has a more general reference than the 'somatisation' of distress. For example, Kleinman and Kleinman (1985) point out that 'somatisation' is not limited to depressive disorder and may not represent pathology at all.

<sup>24</sup> A psychological idiom of distress employed by white Britons has also been contrasted with the use of a somatic idiom of distress in the past (Jadhav, 1996; Nicholson, 1995). 'Melancholia', for instance, was expressed and articulated somatically and has only recently come to be replaced by the psychological idiom of depression.

<sup>25</sup> For example, see Raguram *et al* (2001), Parsons and Wakeley (1991), Kirmayer (1989), and Nichter (1981).

<sup>26</sup> The term 'articulates' is used in the linguistic sense, as de Saussure defined it as 'the division of a chain of speech into syllables, or to the division of the chain of meanings into meaningful units' (1993: 10).

<sup>27</sup> Eisenburg's distinction between illness and disease grounds the 'experience of illness' approach in British medical sociological research on chronic illness (Conrad, 1990). Following Eisenburg (1977), Conrad described 'disease' as the 'underlying physiological process' in contrast to 'illness', the 'social phenomena that may or may not rest on disease as a foundation' (1990: 1259). This tradition of social research is distinctive in that the knowledge it produces is grounded in illness experience and therefore in patient's accounts and narratives. Research within this paradigm has involved the ongoing development of an expert discourse on illness organised around a string of concepts, metaphors and explanatory systems: illness career, coping strategies, stigma, biographical disruption and reconstruction, illness narrative, experience of treatment and 'loss of self' (e.g. Charmaz, 1983; Williams, 1984; Bury, 1991).

<sup>28</sup> The social psychologists Potter and Wetherell developed the discourse-analytic concept of an 'interpretive repertoire' defined as 'a lexicon or register of terms and metaphors drawn upon to characterise and evaluate actions and events' (1987: 138).

<sup>29</sup> According to Garro (1994), 'explanatory models' have been applied in two principal ways in research on illness; first, as a clinical assessment tool; second, as a way of representing the cognitive basis of talk about illness at the individual level.

<sup>30</sup> 'Operational thinking' refers to thought that is abstract, rational, logical (consistent with syllogistic reasoning), and 'boundary maintaining' (Young, 1981: 332). In 'pre-operational thinking', 'theoretical knowledge' is typically organised around symbolic associations, clusters of prototypes, and concrete imagery rather than around causal relationships and chains of syllogistic reasoning; boundaries are fuzzy and a weak separation is made between concepts or representations and the objects or events that they organise (Young, 1981).

<sup>31</sup> For narrative-based approaches to research on illness experience in medical sociology and anthropology see, for example, Hyden (1997), Kleinman (1988), Brody (1987), and Frank (1995).

<sup>32</sup> For example, see Frank (1995), Robinson (1990), Williams (1984), Hyden (1997). 'Illness narratives' are constructed using literary and cultural conventions (Tonkin, 1992). Various classificatory schemes have been developed to categorize the genres of illness narrative. For instance, Frank (1995) identified three different genres of illness narrative: restitution, chaos, or quest narratives each with their own distinctive plot line. Robinson (1990) has distinguished between illness narratives that are progressive, chaotic, or restitutive.

<sup>33</sup> A 'speech event' refers to the social context in which discourse units are produced and exchanged (Hymes, 1964).



<sup>34</sup> Riessman (2002) characterises the interpretive strategy used in such research as 'textual interspersal'. She points out that it is typical in this approach for analyst's story to merge with interpretation.

<sup>35</sup> According to Fairclough, the 'force' of a text is its 'action component', what it is being used to do socially. This can be contrasted with the text's ideational meaning (1992: 82).

<sup>36</sup> According to Searle, such rules 'constitute' in that they generate new forms of behaviour or activity. 'Regulative rules', on the other hand, work to regulate activities that pre-exist or are independent of these rules (1965: 138-139).

<sup>37</sup> The following were used as sources of guidance on the ethnographic approach: Fetterman (1989), Bernard (1995), Duranti (1997), Burgess (1985), Hammersley and Atkinson (1986).

<sup>38</sup> There is a long tradition of comparative sociological research that has sought to investigate the similarities and differences between large-scale societies (Holy, 1987). The difference between comparative sociology and in-depth, qualitative research in a single social setting is analogous with the difference between the old cross-cultural psychiatry and medical anthropology.

<sup>39</sup> The approach to in-depth interviewing used in the research reported in this thesis relied on the approaches developed by Mishler (1986a, 1986b, 1991); Holloway and Jefferson (1997).

<sup>40</sup> For example, see the following on the case-study approach to social research: Mills (1959), Yin (1994), Mishler (1986a), Riessman (1990, 2002), Crapanzano (1985).

<sup>41</sup> Fetterman describes this way of selecting informants in ethnography as 'judgemental sampling' such that 'ethnographers rely on their judgement to select the most appropriate members of the subculture or unit, based on the research question' (1989: 43). Within the grounded-theory approach to qualitative research, this is known as 'theoretical sampling' (Strauss and Corbin, 1990).

<sup>42</sup> Standard orthography was used to transcribe the recorded interviews.

<sup>43</sup> Tristan da Cunha is a dependency of St. Helena, and is the smallest and remotest populated island in the world. It is situated in the South Atlantic (37°6'S, 12°20'W). Originating from Britain, Italy, St. Helena and America, there are around 300 people live on Tristan da Cunha (Evans, 1994).

<sup>44</sup> Of these, around 2% were visitors, 1% expatriate, and 97% were St. Helenians (DEPDa, 1999). The enumerated population of St. Helena, including Ascension Island, the Falkland Islands, and the UK is over 6,000. Of these, 712 (12%) were living on Ascension Island; 314 (5%) were living on the Falkland Islands; 2% (or 115) were resident elsewhere, principally the UK (DEPDa, 1999).

<sup>45</sup> For example, St. Helenians who were in receipt of social-security benefits, who were not in paid employment, or who had experienced social marginalization within the small island community.

<sup>46</sup> According to the 1998 Census, the size of the district's population was approximately 373 adults and children (DEPD, 1999a).

<sup>47</sup> See Turner (1975) and Ortner (1973) on the idea of a 'root metaphor'. A 'root metaphor' is a 'basic analogy' for understanding one domain of experience in terms of another (Turner, 1975: 26). According to Ortner, a 'root metaphor' is a kind of 'key symbol' that possesses a high degree of power to 'elaborate' upon and organise 'conceptual experience' (1973: 1342).

<sup>48</sup> I use the terms 'sociality' or 'social agency' to mean both the disposition and the capacity to initiate and maintain social relationships. Personal distress tends to undermines sociality in this sense.

<sup>49</sup> Some informants linked physical disruption with their use of anti-depressants. I have tried as much as possible in this account to restrict my focus on only those accounts where treatment was not mentioned.

<sup>50</sup> Within Burke's dramatisic framework, the agent-setting ratio is one way of representing the 'motivation' of the action. See Appendix A3.3 for a discussion of the dramatisic framework and the concept of 'motivation'.

<sup>51</sup> Bury (2001) distinguished between two concepts of illness. A 'categorical' concept of illness relies on a clear demarcation between 'normal' and 'pathological' experience. A 'spectral' concept of illness articulates the relationship between health and illness dimensionally; the line drawn between normal and pathological experience is partly socially produced. 'The occurrence of illness', says Bury, 'especially chronic illness, is here essentially emergent in character, depending strongly on social circumstance and societal reaction' (2001: 269).

<sup>52</sup> Parsons (1951) depicted the 'sick role' as a temporary social role that has the aim of restoring patients back to a state of health. It is characterised in terms of a set of expectations, obligations, and privileges. For instance, occupants of the 'sick role' are expected to seek and cooperate with medical advice and are required to abstain from usual social roles and the fulfilment of social responsibilities (e.g. employment and family obligations). Moreover, proto-patients must be considered to be in need of care or be unable to recover without support. The doctor's role is defined as the inverse of the patient's and this role is invested with considerable power and autonomy. This power is legitimised by the medical doctor's objectivity, disengagement, rationality, and command of expert knowledge gained in a protracted period of training.

<sup>53</sup> The thematic categories used in this analysis included: ways of coping; social response and social support; contact with healthcare workers; experience of medication; non-medical support; recovery (e.g. biographical reconstruction and recovery of agency).

<sup>54</sup> For the distinction between explanation and explanatory systems, see Section 3.1.

<sup>55</sup> What Bury describes as 'contingent narratives' refers to narratives that express beliefs about the origins of disease, the proximate causes of illness episodes and the impact of symptoms on everyday life. They 'describe events, their proximate causes, and their unfolding events' (2001: 274). Bury distinguishes 'contingent narratives' from 'moral' or 'core narratives'. 'Moral narratives' give an account of personal or social transformation, linking individual experience to social context, and involve the 'virtuous presentation of self'. Core narratives are 'deep cultural forms', genres, symbolic repertoires that speakers draw upon to tell their stories.

<sup>56</sup> Turner describes 'subjunctivity' as 'all that may be, might be, could be, perhaps even should be' (1981: 153).

<sup>57</sup> The approach taken is analogous to that taken by Jenkins (1991, 1996) in her research on emotional distress and social suffering among El Salvadorans (See Section 2.1)

<sup>58</sup> Browne, A. Banished Islanders are British Again. In *The Sunday Observer*, 12<sup>th</sup> May 2002.



<sup>59</sup> Globalisation has wrought what Bibeau (1997) calls a 'the creolisation of cultures' in contemporary western societies and has required a re-working of the concept of cultural identity. Corin *et al* distinguish between three levels of cultural identity within the context of Canadian society (cited in Bibeau, 1997:17). They associate 'root identity' with a person's culture of origin and the society within which they are socialised. 'Citizenship identity', on the other hand, is based on the attainment of civil rights and the right to participate in a host country to which a person has migrated. Finally, a 'reconstructed identity' refers to a hybrid identity developed within the cultural context of a host society (cited in Bibeau, 1997: 17).

<sup>60</sup> United Nations Development Programme, 1999

<sup>61</sup> St. Helena Day Address by Mrs Lillian Crowie quoted in *Wirebird* (1990: 18).

<sup>62</sup> The St. Helena News is the St. Helena's government-controlled newspaper and is the only newspaper on the island.

<sup>63</sup> Bibeau (1997)

<sup>64</sup> A number of themes were identified in an analysis of St. Helenian public discourse and ethnographic data, e.g. radio broadcasts, magazines, newspapers, newsletters, pamphlets; official discourse including SHG and UKG reports, briefing papers and policy documents; other public documents such as tourism or investment guides; interviews and discussions with St. Helenians and English expatriate workers or those with links to the island.

<sup>65</sup> Office of Chief Secretary's Office, 2000

<sup>66</sup> Quoted from St. Helena day address by Mrs Lillian Crowie reproduced in *Wirebird* (1990: 18).

<sup>67</sup> 'Social capital' is a property of communities characterised by high levels of civic engagement, strong community networks and by shared norms of trust and reciprocity (Putnam, 2001).

<sup>68</sup> Shelley Diaper, an undergraduate student of linguistics at the University of Wales Institute in Cardiff studied the St. Helenian dialect in 1999. In a personal communication with the author, she said that the St. Helenian dialect had undergone some degree of 'creolisation'; that is, there has been some simplification of the language although it remains very much like English. Some of these simplifications in grammar and phonology include: absent auxiliary verbs; the omission of part tense markers ('ed'); use participle forms of the verb 'to be' or 'to do'.

<sup>69</sup> Ferguson defines 'diglossia' as 'a particular kind of standardization where two varieties of a language exist side by side throughout a community, with each having a definite role to play' (1959: 237).

<sup>70</sup> The 'high' and 'low' varieties of 'diglossia' have different grammatical structures, with the 'low' variety being a simplified version of the 'high' variety. The bulk of the lexicon is shared, but the high variety includes terms and learned expressions that have no equivalent in the 'low' variety, and, conversely, the latter includes popular expressions and local names with no equivalent in the 'higher' variety (Ferguson, 1959).

<sup>71</sup> In a personal communication with the author (December 1999)

<sup>72</sup> The sources used in this description of the 'St. Helenian predicament' also included interviews/meetings with officials, experts, and workers employed by UKG or SHG.

<sup>73</sup> For instance, real food costs are much higher than in the UK; for instance, in the average St. Helenian household, almost one half of household incomes is spent on food (St. Helena Expenditure Surveys for the years 1980, 1987/1988, 1993).

<sup>74</sup> According to a UKG development advisor, 'a depressed labour market' on St. Helena was indicated by the high rate of unemployment; low numbers of self-employed; a low spread of employee incomes; low level of returns to education; lack of economic opportunities (cited in Development and Economic Planning Department (St. Helena Government), 1999b. *Poverty Assessment on St. Helena*).

<sup>75</sup> *Solomon & Co* are a principal retailer on the island and are also involved in insurance, farming, and insurance (SHG, 2000). The St. Helena Government are the dominant shareholders in *Solomon & Co*.

<sup>76</sup> Statement by Chief Secretary of St. Helena to St. Helena's Legislative Council on 15<sup>th</sup> March 1996. Reproduced in a supplement to *St. Helena News*, 10(38), 22<sup>nd</sup> March 1996.

<sup>77</sup> This White Paper applied to all of Britain's remaining 'Overseas Dependent Territories', now known as 'British Overseas Territories'.

<sup>78</sup> Appendix of the UKG's 1999 white paper, *A Partnership for Progress and Prosperity*

<sup>79</sup> This involved the establishment of a St. Helena Development Agency in 1995, a QUANGO set up to foster the development of a private sector on St. Helena (e.g. through the provision of loans and grants, and business advice). Private sector development during the second half of the 1990s also included a policy of capital investment and the switching of government resources from consumption to production (SHG, 2000: 7).

<sup>80</sup> Statement by Chief Secretary of St. Helena to St. Helena's Legislative Council

<sup>81</sup> Wages range from an average of £24 per week for individuals who are defined as 'unemployed'; to £40 to £60 per week for manual workers; average incomes then increase incrementally (depending on position) for those are 'salaried' workers within the Castle's bureaucracy; clerks and secretaries are at bottom of the pay scale, followed by middle managers, senior managers, skilled engineers and technicians; senior 'executives' head the pay scale and earn between £15,000 and £20,000 per annum (SHG, 2000). Similarly, income tax surveys during the 1990s showed that incomes were highest for legislators (councillors), senior officials, and managers, and lowest for unskilled 'elementary workers' (DEPD, 1999b).

<sup>82</sup> This unemployment rate reduces to around 14% of resident St. Helenians working overseas are included in the calculation.

<sup>83</sup> One third of those who were classified as 'unemployed' in the 1998 Census of St. Helena's population were employed on the 'three-day week' (DEPD, 1999a).

<sup>84</sup> St. Helenian men had already been migrating to Ascension Island since the 1960s. Most of these positions were unaccompanied, with few opportunities for women. Since 1982, the Falkland Islands have provided an important source of employment, offering much greater salaries than are available on St. Helena. Much of these jobs are to support the military presence on the Falkland Islands. They are primarily unskilled, semi-skilled manual, or service-sector jobs in catering and construction.



<sup>85</sup> The proportion of offshore workers who are male depends on the destination. Traditionally, most of the employment opportunities on Ascension Island have been 'unaccompanied' (i.e. no provision is made for dependants). In 1998, there were twice as many men working on Ascension Island as women (DEPD, 1999a). The more recent opportunities on the Falkland Islands, however, have attracted an even balance of male and female St. Helenians. The smaller number who head to the UK have tended to be women. Between 1994 and 1998, around one third of all offshore workers were female (UNDP, 1999).

<sup>86</sup> In 1958, the British MP Cledwyn Hughes was invited to St. Helena to assess the social and economic situation of the island and to produce a report for the British Labour Party.

<sup>87</sup> Reported in *St. Helena News*, 1(9), 19<sup>th</sup> November 1999.

<sup>88</sup> Nonetheless, much of the data upon which this *Poverty Assessment* was based are either unreliable or anecdotal, so it is difficult to form any generalisations about levels of poverty on the island. The author of the *Assessment* recommended further research.

<sup>89</sup> By the end of the 1990s, the income generated by offshore employment was at record levels at over £2m per annum (Royle, 2001; Hogenstijn and van Middelkoop, 2002).

<sup>90</sup> This refers to the situation before the recent growth in employment opportunities became available on Ascension Island and the Falkland Islands.

<sup>91</sup> This view is corroborated in the UNDP report. In the late 1990s, overseas remittances were still flowing back to St. Helena, but 'not to the same extent as in the past' (UNDP, 1999: 39).

<sup>92</sup> St. Helena Government Economist in a personal communication with the author (February, 2000)

<sup>93</sup> St. Helena Government, Income and Tax Surveys for the years 1987/88, 1990/91, and 1993-94 to 1997-98

<sup>94</sup> *Ibid.*

<sup>95</sup> The number of male workers decreased between 1990/91 and 1997/98 while the number of female workers on St. Helena increased (DEPD, 1999b: 7).

<sup>96</sup> For example, the Internet, information technology, telephone, and satellite television

<sup>97</sup> Most of the employment positions overseas are only available to those who are single or 'unaccompanied'. In 1998/99, more than 100 parents who had left St. Helena to work overseas left children with relatives or friends on the island (UNDP, 1999). The authors of the UNDP report suggest that there may be many more families where one parent (usually the mother) has remained, whilst the partner has left to work overseas. In addition, many elderly Saints are without the social support that the extended family once provided; in many cases, some or all of their children have migrated overseas, some never to return (1999: 37).

<sup>98</sup> It is possible that two of the most important public-health implications of socio-economic change on St. Helena include an increase in fertility rates and in levels of social and personal distress. Nonetheless, the true health impact of social and economic modernisation on St. Helena is currently unknown.

<sup>99</sup> Fertility rates on St. Helena dropped dramatically during the 1980s and 1990s (UNDP, 1999; CMO, 1999). Some observers have linked these plummeting fertility rates to recent economic change and high levels of outward migration (e.g. UNDP, 1999; CMO, 1999). One proposed explanation for this is that younger St. Helenians have been reluctant to begin a family when facing the prospect of several years of absence from the island and the impact of migration on relationships. For instance, the authors of the UNDP report speculate that 'the fall in the birth rate has almost certainly been sharper because of the amount of overseas working. Young people are reluctant to have children if they know there is a strong possibility that they will have to leave them in the care of relatives to go overseas for work' (1999: 37).

<sup>100</sup> This increase in rates of treatment does not indicate that the real, underlying rate of hypertension on St Helena has increased over the past two decades. This rise is likely to have been produced by the ongoing modernization and development of St. Helena's healthcare system over recent decades. As screening programs for hypertension have developed and become more extensive, this is bound to have increased the numbers of St. Helenians treated for hypertension. It is impossible to tell whether there has been a real increase in rates of hypertension or not, because there are no epidemiological data available.

<sup>101</sup> In 1958, the British MP Cledwyn Hughes was invited to St. Helena to assess the social and economic situation of the island and to produce a report for the British Labour Party.

<sup>102</sup> For instance, Hogenstijn and van Middelkoop point out that it is the 'political structure that organises society' on St. Helena (2002: 4.4.2).

<sup>103</sup> Including economic organisations that are controlled by SHG and para-statal organisations.

<sup>104</sup> 'Stigma' refers to a negative evaluation of an attribute or a social category (Goffman, 1963). Following Goffman, Evens defined 'stigma' as 'an attribute constituting a special discrepancy between the socially legitimised expectations of a person and actuality of a person' (1975: 168).

<sup>105</sup> In an ethnographic study of a Malaysian village, Scott described the social function of 'shame' as 'a concern for the good opinion of one's neighbors and friends, which circumscribes behavior within the moral boundaries created by shared values' (1985: 17). Writing within an American cultural context, Goffman depicts 'shame' as the personal response to the possession of a stigmatised attribute or of belonging to a stigmatised social category.

<sup>106</sup> For instance, Hogenstijn & van Middelkoop emphasised this high degree of social control in their account of St. Helenians' spatial identities. 'Social control', they point out, 'is so total that criminal offences are reported weekly in the newspaper with the person who committed the crime often written in full' (2002: 4.3). They observed that being placed under constant (social) observation can 'sometimes be felt physically: the eyes peering at you from the back' (2002: 4.3).

<sup>107</sup> The use of specialist services and the results of medical tests are difficult to keep confidential. For instance, the authors of the UNDP report observed that 'it is almost impossible to have a pregnancy termination in secret. This leads to some women preferring to go to the expense of travelling to the United Kingdom or South Africa for terminations' (UNDP, 1999: 33). He says how these breaches in confidentiality may prevent people seeking help who are experiencing a stigmatised health problem. The authors of the UNDP report cite the example of somebody who was rumoured to have contracted AIDS: 'This lack of confidentiality may also prevent individuals seeking medical attention for condition[s] which may have a social stigma attached to them in particular AIDS. The health department has already had to on one

occasion make a public declaration that to its knowledge no one on the island was HIV positive when rumours that someone had AIDS were rife due to a blood sample being sent to Cape Town for analysis' (UNDP, 1999: 33).

<sup>108</sup> This is reminiscent of Evens' observations made in a study of stigma and ostracism in a Kibbutz. He found that anything that deviated from an ideology of self-control and self-restraint became stigmatised or because a source of embarrassment. He found that women in the Kibbutz who 'cried out when giving birth were criticised'. Moreover, 'exhortation to self control had more comprehensive manifestations, as in the proscription on expressing ambition' and members of the Kibbutz were 'embarrassed about taking to bed for minor illness, or were unwilling to admit that they were ill' (1975: 187).

<sup>109</sup> For example, the 'St. Helenian predicament' is defined by economic and political dependency on Britain, a rigid social structure, the remoteness, undemocratic ex-colonial political institutions, a high level of dependency on government, the tight-knit nature of the society, the absence of citizenship rights, powerful normalising practices, high levels of migration, social disconnection, economic hardship.

<sup>110</sup> Gregory Bateson developed the notion of 'ethos' as a conceptual tool for understanding Iatmul culture and Balinese character (1987: 107). He defined 'ethos' as 'the expression of a culturally standardized system of organisation of the instincts and emotions of the individuals' (1987: 108). For example, a 'Balinese ethos' refers to the values, motives, and emotions that underlie the patterns underlying Balinese lives, the organisation of Balinese society, and its cultural practices (1987: 116). Jenkins (1991) applied an adapted version of this concept of 'ethos' in her interpretation of 'nerves' and 'depression' among Salvadorans as a response to an oppressive political ethos in El Salvador. Through 'long-term exposure to this political ethos,' she says, 'the experience of the 'lived body' is shot through with anxiety, terror, and despair' (1991: 149).

<sup>111</sup> In a personal communication with the author

<sup>112</sup> St. Helena Magazine. 'Varia', Jan. 1946, 520, 7-8.

<sup>113</sup> This use of the term 'weak' contrasts with its pejorative employment as an evaluative term that signifies a 'weakness' of character (see, for example, Section 6.3).

<sup>114</sup> See Appendix A3.3 for the definition of the 'scene-act ratio' and a description of Burke's 'dramatic' framework.

<sup>115</sup> See, for instance, Jenkins (1991), Scheper-Hughes (1992), and Loudon (1964) for examples.

<sup>116</sup> In a personal communication with the author

<sup>117</sup> An alternative interpretation of Rawnsley and Loudon's 'epidemiological data' is possible here. The prevalence rates that they report do not necessarily indicate the prevalence of 'psychogenic headaches' as a somatic expression of underlying emotional distress or disorder. Rather, they may signify that the frequency with which those who reported such headaches sought to account for them using a local explanatory system (e.g. 'worry' as a source of 'headaches'). Rawnsley and Loudon used an expert discourse on 'anxiety' to reframe their informants' discourse on 'worry'. High levels of 'anxiety' among certain groups were then used to explain the social distribution of 'headaches' on the Island even though their explanation appeared to have its origins in the lay explanatory system employed by their informants. Rawnsley and Loudon also used the expert term 'stress' as a gloss for the emic term 'worry'. Yet, it was unclear from their account whether 'stress' and 'anxiety' were used locally as a common idiom of distress. This re-interpretation of Rawnsley and Loudon's epidemiological survey of Tristan da Cunha points to a general difficulty with epidemiological surveys of the 'neurotic disorders'. The prevalence rates reported in such surveys partly signify the prevalence of socially structured and culturally mediated ways of expressing adversity; that is, how both ways of articulating distress and exposure to adversity are distributed within a population.

<sup>118</sup> For example, see Gaines (1992a, 1992b), Young (1980), Littlewood (1998), Scheper-Hughes (1993), and Fabrega (1992).

<sup>119</sup> The diagnostic categories of psychiatric discourse may even lack validity as a means of interpreting and classifying distress among some social groups within developed English-speaking societies. This is because such discourse is not systematically developed on the basis of lay understandings and so may not even have cultural validity within developed English-speaking societies.

<sup>120</sup> For example, see Gaines (1992), Good (1994), Kirmayer (1988), and Young (1980) for accounts of how expert knowledge and discourse on distress are contingent on Euro-American folk psychologies and discourse on the self and body.

<sup>121</sup> The term 'individualism' refers to an ideological discourse on the self and society that valorises the individual as the ultimate source of value. This discourse constitutes the individual as a rational, self-determining agency and defined in terms of set of rights (e.g. privacy, self-determination, etc) and freedoms (e.g. of speech, from non-interference, of movement, etc.) (Lukes, 1990). This ideology de-emphasises the self's social contingency and the importance of communal relationships as a source of value. This ideology is the dominant discourse on the self in late capitalist societies such as Britain or the United States.

<sup>122</sup> For example, see Littlewood (1990), Marsella *et al* (1985), Jadhav (1996), and Nichter (1981).

<sup>123</sup> Carranza (1998) describes 'habitual narratives' as 'low-narrativity' narratives because they deviate from definitions of a prototypical narrative.

<sup>124</sup> 'Clauses' are the most basic unit of meaning in discourse (Fairclough, 1992). They are grammatical constructions that minimally consist of a subject and a finite verb. Unlike clauses, utterances and spoken sentences do not always this subject-verb structure.

<sup>125</sup> In English-speaking societies, oral story-like accounts typically consist of the following components: (i) the scene is set; (ii) the characters are introduced; (iii) actions, events and happenings over time are described; (iv) the action involves a conflict; (v) this rises to a resolution; (vi) the story comes to an end. Labov's structural scheme for narrative analysis is relevant here. This involves parsing the narrative discourse unit into the following parts: abstract; orientation; complicating action; resolution; evaluation; coda (useful for interpreting narrative excerpts) (Labov, 1976).

<sup>126</sup> 'Oral genres' are discursive styles that speakers draw upon (as members of a particular speech community) to communicate experience. Many schemes have developed for the classification of narrative genre in developed English-



speaking societies: e.g. tragic versus comic; regressive versus progressive (Gergen and Gergen, 1984); 'low narrativity', 'pseudonarratives', hypothetical, counterfactual, and habitual narratives (Carranza, 1998; Linde, 1986, 1992).

<sup>127</sup> 'Narrative positions' are associated with a particular perspective on experience. For example, Monks describes them as 'structural positions which makes sense of a particular juxtaposition of statements by providing a reference point for a particular perspective' (1996: 457).

<sup>128</sup> Explanatory discourse and narrative are discussed in Chapter 3.

<sup>129</sup> For example, locally available explanatory systems, cultural scripts, public narratives, ontologies, and ideologies.

<sup>130</sup> Gumperz defined a 'speech community' as 'any human aggregate characterised by regular and frequent interaction by means of a shared body of verbal signs and set off from similar aggregates by similar differences in language usage' (1968: 219).

<sup>131</sup> For instance, an example of this can be found in a study of stigma and ostracism in a Kibbutz. Evens described 'ideology' as 'a systematic, self-reflective set of ideas' or as 'an institutionalised and highly sophisticated body of directive ideas' (1975: 205).

<sup>132</sup> This approach to qualitative analysis was also used in the EMPIRIC study described in Chapter 2 (O'Connor and Nazroo, 2002).

<sup>133</sup> The 'coding frame' used in this analysis is presented in Appendix A3.6.

<sup>134</sup> 'Charting' is an analytical device for rearranging qualitative data according to key themes and core concepts (Ritchie and Spencer, 1994). It facilitates comparison and generalisation across cases.

<sup>135</sup> 'A code' is a category or low-level concept. Coding involves moving through the data line-by-line matching units of discourse (e.g. words, utterances, phrases, narratives, explanations) with pre-existing or a priori categories or using them to produce newly emergent concepts. In the process of coding, codes representing concepts are linked to instances. These are then taken to indicate or instantiate the concept.

<sup>136</sup> For instance, 'scene' or 'setting' was distinguished from individual ('agent') characteristics, 'agency', and 'action' or 'experience'. See Appendix A3.4 for definitions of these categories and a description of Burke's 'dramatistic' framework (Burke, 1969).

<sup>137</sup> Annual report of St. Helena's Social Work Officer (1957).

<sup>138</sup> Including what Aldridge describes as 'affective, schizophrenic, paranoid psychosis' (1984: 25).

<sup>139</sup> This estimate was based on the contents of a mental-health register initiated in 1982. This register included all the 'active cases' 'brought to the attention of the medical services in whom there is substantial psychiatric disorder' (Aldridge, 1984: 18), e.g. psychosis as defined in ICD-9. 'Active cases' refers to those individuals 'with symptoms or on treatment' (Aldridge, 1984: 25). Aldridge made it clear that the Register excluded those patients with a minor psychiatric upset such as 'minor depressive symptoms' (1984: 23). The data used to estimate the extent of severe psychiatric illness on St. Helena was unlikely to provide a reliable basis for calculating population morbidity rates for psychiatric illness. Aldridge acknowledged the limits of the data upon which his estimates were based.

<sup>140</sup> However, no evidence is presented to support these claims about alcohol use and its putative relationship with violence and aggression.

<sup>141</sup> The activity of the community nursing team has increased dramatically in recent years. In 1995, there were 183 community visits made by this team. By 1998, this had increased to 299 visits. It is possible that the increased activity of the community nursing team during this period may have be partly due to increasing rates of social distress. It may also have been associated with expansion of the role of the community nursing team to encompass a broader set of public health concerns on the island.

<sup>142</sup> For instance, at the time of fieldwork, she managed a junior sister, a staff nurse, a senior nurse, and five nursing assistant.

<sup>143</sup> Personal communication with St Helena's community psychiatric nurse

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