Chapter II

Theoretical Approaches and Key Concepts in Medical Anthropology

2.1 Introduction

This chapter presents theoretical approaches and concepts that will assist me in studying how migrants' health is affected by exclusion and discrimination from the host society. By discussing these theoretical approaches, I address the broader social, cultural, political and economic conditions which contextualise migrants' experiences of illness and distress. Throughout this discussion, I will emphasise the links between these individuals' experiences and the societal forces acting upon them, without losing the perspective of individuals' capacity for agency and resistance.

The first part of this chapter entitled: *'Developments in medical anthropology: In search of the middle ground',* discusses four theoretical perspectives. These are: the interpretive approach in medical anthropology, the political economy of health approach, the critical approach in medical anthropology and the social suffering approach. Contributions from these theoretical perspectives highlight various dimensions relevant in the analysis of my research problem and assist me in the construction of a middle ground perspective which brings macro societal forces and processes, as well as individuals' experiences together.

The discussion starts by introducing the interpretative approach which entails a relevant epistemological turn in medical anthropology, shifting from where various other approaches in medical anthropology have departed. In order to reach this middle ground approach I continue by discussing the political economy of health approach. The importance of this approach lays in its emphasis upon societal forces and their influence on health, introducing the dimension of the social production of sickness into the debate. This dimension is particularly relevant to my problem of study as it allows addressing the societal and macro structural factors that impact upon migrant workers' health.

The critical approach in medical anthropology integrates the macro perspective of the political economy approach, without losing sight of individual experiences and agency. This double focus is central to the analysis of migrants' illness experiences. The approach of social suffering continues the line of analysis proposed by the critical approach, integrating into its analysis a wider range of forms of human suffering including experiences of emotional distress. Also, it establishes links between experience and social practices, both relevant dimensions of my analyisis.

The second part of this chapter entitled: '*The self, embodiment and agency in the context of illness and suffering',* presents a conceptual approach which delves into a micro-level of analysis. This approach deals with the ways in which oppressive

structures of society and conflictive interactions affect individuals' subjectivities and bodies. It looks into people's shared experiences and notions of suffering and their capacity for agency over their own experiences of emotional distress. The concept of self as a cultural construct is discussed, vis-à-vis processes of social and personal displacement which results from migration. It is argued, that while Andean notions of identity – the self and body – emphasises interconnectedness, migration, exclusion and discrimination trigger feelings of loss, uprooted-ness and personal dislocation in migrants.

The concept of agency comes into play when migrants attempt to maintain control over their productive bodies; to be able to continue engaging in paid work. As it is argued, agency over bodies allows migrants to regain their sense of self and reinvest their bodies for work. This is a central dimension of their migration endeavours and self worth.

The third and final part of this chapter entitled: *'Making sense of suffering in shifting contexts'* discusses the use of various idioms to communicate experiences of distress. Idioms of distress used by migrants are hybrid and context related. They may be somatic and rooted in Andean conceptions of illness and the body. Alternatively, they are also framed within newly emerging experiences and meanings. Idioms take the form of discursive accounts, used by migrants to rework the self and their identities. In the use of these idioms, migrants reveal their own efforts to make sense of a disrupted world in a foreign society.

2.2 Developments in medical anthropology: In search of the middle ground

2.2.1 Changes in the conceptualisation of illness in medical anthropology: Towards an interpretive approach

Recent approaches in medical anthropology have departed from the epistemological turn proposed by the interpretive approach. This approach moved the debate from the previous rationalist epistemological stand, to one that conceptualises disease as belonging to the cultural domain. This claim has since been the source of much recent theoretical and empirical work in the field. To better understand the epistemological turn of the interpretive approach I will first introduce the trajectory of the concepts of illness and disease in medical anthropology.

Illness and its relation with disease has been conceptualised in medical anthropology in various ways. Initially, illness – the subjective experience – was understood as a domain separate from disease – the biological dimension. This particular understanding of illness (which did not differ from the biomedical view) prevailed especially during the 1950s and 60s when medical anthropology had a strong applied emphasis.

Medical anthropology – then an emerging field – played a role in facilitating medical science's understanding of 'other cultures'. Indeed, the main aim of medical anthropology was, then, to contribute to and improve the efficiency of public health campaigns implemented in third world countries, following the Second World War.

Disease under this scope was understood and treated as 'paradigmatically biological', and unchallenged by the anthropological inquiry. The anthropological knowledge remained at the time in the terrain of culture and culture was understood in this tradition as separate from the biological dimension of disease.

An example of this theoretical stand can be found in the ecological approach, which sees illness representations as 'cultural beliefs'. Culture in this perspective plays an adaptive role in relation to disease. Medical systems within the ecological approach are understood as the sum of cumulative socio-cultural adaptive strategies while culture was conceived as 'a set of adaptive responses to diseases'. Under the ecological approach, the division between disease and illness became separated realms and continues to exist as such.

Subsequent perspectives in medical anthropology, such as the cognitive approach, maintained the distinction between disease and illness. Illness representations in this perspective are seen as perceptions; as a domain structured by language and culture which convey "the apparent order in the natural and social world" (Good 1994, quoted by Meyer 2003). Culture would explain illness conceptions and beliefs around health and illness, which in turn, explain human behaviour. However, disease was still considered to belong to the medical domain.

In the 1960s, cognitive influences of the psychological sciences in medical anthropology were expressed as 'ethnosciences' and 'ethnosemantics'. Both anthropological projects dealt with disease classification, 'ethnotheories' of illness and the structure of illness narratives.

2.2.2 The interpretive approach in medical anthropology

The interpretive approach, which emerged with Arthur Kleinman's foundational work (1980), departs from an epistemological stand that differs from earlier approaches such as the ecological and cognitive. The concept of explanatory models of illness proposed by Kleinman (1978:187) to elicit what he referred to as the 'native's point of view', introduced a radical change of perspective in the understanding of the relation between the cultural domain and the domain of disease. Kleinman's explanatory model also pertains to the domain of disease. He argued that *disease is not an entity but an explanatory model* (Kleinman 1973 quoted by Good 1994:53). Disease, in this perspective, belongs to culture in particular to "the specialized culture of medicine. And culture is not only a means of representing disease but is essential to its very constitution as a human reality*"* (idem).

Kleinman unveils the 'category fallacy' present in the currently dominant view of disease as belonging to the order of nature and asserts: "it is the mistaken belief that our categories belong to nature and that disease as we know is natural and therefore above or beyond (or deeper than) culture…" (Keinman 1977 quoted by Good 1994:53).

This claim has been the basis for much of the theorising and empirical research in this interpretive tradition. For Good, understanding disease as an explanatory model

"was not an idealist counter to biological reductionism, but a constructivist argument that sickness is constituted and only knowable through interpretive activities" (idem).[32]

The interpretive activities according to Good involve interaction of biology, social practices and culturally constituted frames of meanings, through which "clinical realities" are constructed" (idem). According to Baer (1997), interpretive medical anthropology has verified how various biomedical subspecialties reach different conclusions about the same clinical episode. The interpretive tradition examines the construction of interpretations in different social contexts. That is: "how meaning and interpretive practices interact with social, psychological, and physiological processes to produce distinctive forms of illness and illness trajectories" (Good 1994:54). Good's work is part of this tradition. Together with Mary-Jo Delvecchio-Good, he conducted an analysis of semantic networks associated with 'heart distress' in Iran and America (Good 1977). Through this study, they achieved an understanding of how meanings and symbols attached to symptoms compress a reflection and, at the same time, both motivate experiences of illness and social relations.

Good's semantic network analysis has "provided a means of systematically recording the domains of meaning associated with core symbols and symptoms in a medical lexicon. These are domains which reflect and provoke forms of experience and social relations, and which constitute illness as a 'syndrome of meaning and experience"(1994:54).

Within the interpretive theoretical orientation emerges the perspective of embodied experiences. The departure point of this perspective is that sickness is present in the human body as 'traces of history and social relations'. From a phenomenological perspective these traces constitute 'memoirs' to interpret distress, illness and suffering (ibid:55). Efforts to achieve experience-near accounts have used the phenomenological approach to study the medium and structure of experience. Here, the body is conceived as "subject of knowledge and meaning and experience as prior to representation" (idem).

The interpretive approach has been dealing with problems of adequately representing illness, suffering and experience in ethnographic accounts. It also deals with the problematic relation of experience to cultural forms such as narratives and the grounding of such experience in local moral worlds (Kleinman 1991). However, the main shortcoming of the interpretive approach has been its failure to provide a critical stance.

Critical views of the interpretive approach – which later resulted into the formulation of the 'critical approach' – pointed to a central flaw: the lack of attention to the role of asymmetrical power relations in the construction of the same clinical realities which this perspective has contributed to disclose. Indeed, those realities constituted through interpretation and representational processes have largely been treated as consensual by the interpretive approach, while usually, in reality, they are not.

[32] In this assertion, Good uses the concept of sickness as encompassing illness and disease. Sickness is here used as a neutral term. The concept of sickness is used differently in approaches such as the political economy of health, discussed further in this chapter.

The interpretive perspective, Baer (1997) asserted, lacks attention to societal structural determinations of the experience and its interpretations. This problem was also found in Good's account, Baer maintains that:

> The role of political economy (e.g., class relations) in shaping the formative activities through which illness is constituted, made the object of knowledge, and embedded in experience, for example, is largely ignored in Good's account (ibid:25).

Hence illness from the perspective of the interpretive approach provides a better understanding of illness as an inter-subjectively interpreted experience. However critical views of the interpretive approach point to its overemphasising illness individual experiences as well as to its lack of attention to the role of societal forces and structural determinations. Economic migration to Chile from neighbouring countries, responds to global economic trends and changing economic/social structures forcing people to search for low skilled jobs beyond the national frontiers. Consequently, related problems such as structural forms of exclusion and societal discrimination against migrants in Chile ought to be understood in the light of the analysis of the political economy of health, an approach to be discussed next.

2.2.3 Political economy of health approach

Concerned with the macro societal determinants impacting health, the political economy of health approach places its attention on the economic and political structures lying at the base of the social production of morbidity or the rate of disease incidence in a population group.

Morgan defines the political economy of health approach as a "macro-analytic, critical, and historical perspective for analysing disease distribution and health services under a variety of economic systems, with particular emphasis on the effects of stratified social, political, and economic relations within the world economic system" (Morgan 1984:132).

Although concerned with a variety of economic systems, centrally, the political economy of health addresses the process of development and expansion of the capitalist world-system and the way biomedicine operates within this context. Both systems, capitalism and biomedicine, are seen as having concomitant logics: "(T)he profit-making orientation caused biomedicine to evolve into a capital-intensive endeavour heavily oriented to high technology, the massive use of drugs, and the concentration of services in medical complexes" (Baer 1997:28). This perspective takes into account the economic and political interests involved in administration and provision of health services under the capitalist system.

Indeed, the expansion of the capitalist system is recognised by the political economy of health approach as the most significant, transcending contemporary process and increasingly shaping and reshaping social life. Moreover macro-economic transformations create economic and social exclusion of large social groups, manifested in their marginal access to economic and social resources, security, housing and health.

In this particular case of study, the economic migration of Peruvian workers into Chile is a consequence of the expansion of capitalism and the emergence of new forms

of labour such as labour provided by transnational migrant workers. Such workers' increasing vulnerability is the result of the weakening of the laws and structures that protect workers' well-being (e.g. labour legislation, social security provisions) and new labour-flexible schemes in tune with the changing needs of the capitalist system for expansion. These factors have increased the precarious work/economic conditions of migrant workers and ultimately impact upon their health.

Although very influential, the perspective of political economy of health showed some shortcomings when used within the anthropological analysis. Its emphasis on societal macro forces has resulted in a tendency to "depersonalise the subject matter and the content of medical anthropology by focusing on the analysis of social system and *things*, and by neglecting the particular, the subjective content of illness, suffering and healing as lived events and experiences" (ibid:32).

Not only particular and subjective experiences need to be addressed but also, the different identities existing among worker groups must be considered when scrutinising the way in which a subordinated position impacts their health. These differences often become visible along lines of gender, ethnicity and national identities.

In general, factors that impact upon migrant workers' health are forms of exclusion and societal discrimination which should be understood in the light of political economy of health. This, as stated before, is because this phenomenon responds to global economic trends and changing economic/social structures. While this is true, recently, the possibility to apprehend empirically and conceptually the world system or global perspective has been debated by anthropologists.

Moore (2004) for instance, discusses how the world system has become an elusive dimension when anthropologists call for its examination in concrete terms. Although Moore does not discard the global perspective, she defines it as a concept-metaphor; as "a space of theoretical abstraction and processes, experiences and connections in the world, important not only to social scientists but now part of most people imagined and experienced worlds" (2004:71).

As Moore points out, one of the problems anthropologists face when dealing with the global perspective is that often the processes, experiences and connections encompassing it "do not involve face-to-face interactions, and are extended over space and time; flows of capital and financial transactions" (ibid:75). As a general consensus in the social sciences, the global perspective exists in contra-distinction and interrelation with the local perspective. However, for the anthropologic inquiry, it represents a less debatable scale of analysis.

This general critic also encompasses anthropological efforts to analyse illness and health from the perspective of political economy and led to the development of a new middle range theoretical approach. The development of a middle ground perspective has been expressed by Lindenbaum (2005) as follows:

> Anthropological theories, once split between models of change based either on political–economic determinism or on changing beliefs and cultural values, have given away to an emphasis on an approach that brings the two sides together. Attention now focuses on the productive middle ground, on the analysis of material forces as well as economic and political factors in relation to cultural and subjective orientations (2005:752).

In summary, from an anthropological stand, shortcomings of the political economy of health specifically are divided into three areas. Its emphasis focuses upon the overarching social system. It pays little attention to individual-subjective experiences. And it does not take culture into account. Acknowledgement of these gaps contributed to the development of the critical approach in medical anthropology; middle ground approach that is discussed next.

2.2.4 The critical approach in medical anthropology

The critical approach in medical anthropology emerged as a distinctive theoretical conceptualisation, mainly for two reasons. Firstly, as a criticism against the interpretive approach, and secondly, as an attempt to redirect the analysis of the medical anthropology towards broader societal and economic dimensions, much in the line proposed by the political economy of health.

Indeed, what of late is called the critical approach in medical anthropology was introduced by Soheir Morsy in 1979 in a paper titled "The missing link in medical anthropology: the political economy of health" (Morsy 1979). This was an early effort to bring the analysis of political economy of health into the anthropological perspective. This theoretical endeavour aimed to overcome the inherent shortcomings of the one sided and macro perspective of the political economy of health.

Ten years later, Morsy (1990) gave an account of the developments of the critical medical anthropology, stressing its particularities and differences with the political economy of health.

The critical medical anthropology retained emphasis on the connection of health related issues with the economic order and social forces. However, this concern has gone beyond merely focusing upon 'grand' and modern capitalist orders to address the nature of health-related issues in indigenous and pre-capitalist societies, as well as socialist oriented-state societies.

The emphasis on individuals and the place culture has come to signify within the critical analysis, had not been present either in political economy of health. The focus on linkages between individual actions and social/structural determination is based upon the understanding of individual actions as "culturally informed interactions between social actors and political economic relationships as dialectically related" (Morsy 1990:22).

The centrality of culture is also manifested in the relation with 'the Other' seen as "different but connected; a product of a particular history that is itself intertwined with a larger set of economic, political, social and cultural process" (idem). Culture is seen in the critical approach as a system of symbols of an institutional order. The interpretation of these symbols, Morsy argues, involves simultaneous consideration of the political context where these symbols are inscribed. Culture is, therefore, understood in connection with issues of "power, control, resistance and defiance surrounding health, sickness, and healing" (ibid:23).

The critical approach also distinguishes itself from conventional medical anthropological studies as its analysis goes beyond the classic depiction of ethnomedical conceptions as historically free conceptions. The critical approach sees them both – ethnomedical and biomedical constructs – as historically situated social products.

The perspective of the local – as discussed before, more in tune with the anthropological view – has been a relevant and productive field of the critical analysis. Empirically less problematic, in a critical account, the local is usually contextualised within the broader political setting an often situated within an imaginary global paradigm.

The priority to the local context becomes especially important when conducting ethnography. Indeed, Lindenbaum has acknowledged the development of a critical ethnographic engagement with concepts of 'health' and 'human rights'. Such commitment has been embraced by the critical approach since it "provides a powerful entry point for understanding and confronting inequalities at home and abroad" (2005:753).

The value of the local has been also demonstrated by the critical approach in terms of creative powers of its analysis, reformulation and resistance. Agency and resistance are key concepts of the critical approach. In the critical analysis, recognising the powerful role of economic and social forces "does not imply that individuals are passive or impersonal objects but rather, they respond to the material conditions they face in light of the possibility created by the existing configuration of social relations"(Baer 1997:32).

Particularly important is the attention the critical approach pays to the agency of those whose experiences have been alienated by dominant biomedical discourse. Within the critical approach, the term 'resistance' has served to bring attention to cultural forms and activities which resist the increasing medicalisation of lives (Good 1994).

Studies in the critical approach have also emphasised the need to maintain close attention to sufferers' experience which is not seen as isolated from the social and economic forces which determine this same experience. "…Sufferer experience is a social product, one that is constructed and reconstructed in the action arena between socially constituted categories of meaning and the political-economic forces that shape the context of daily life" (Baer 1997:187).

In summary, as a middle ground perspective, the critical approach departs from the political economy of health approach to address shortcomings as well as critical views of the interpretive approach. As a result, the critical approach developed a more encompassing understanding of illness. Indeed, the epistemological stand of the critical approach holds an interpretive understanding of illness, but its analysis goes beyond that framework. It points to power relations and social interactions in which illness experiences are embedded. These dimensions are also central to my own analysis.

A pivotal element of the problem under study is the connection between macro-societal determinations and an individual's subjective experiences. This is a connection to which the critical approach also adheres. The critical approach also addresses the

importance of understanding the experience of the sufferer in social contexts which is a central dimension of my own problem.

In the next section I discuss the social suffering approach, which not only focuses on illness but also includes in its analysis, various forms of human suffering. This includes emotional suffering and sees these various forms as embedded in broader societal relations. In this approach, illnesses as well as other forms of human suffering are seen as a consequence of existent structural inequality and various other forms of violence. Hence, in this approach, migrants' emotional distress is placed within the framework of various forms of suffering which results from structural, economic and political violence.

2.2.5 The social suffering approach

A call to explore the ways in which social relations and ideologies encourage diverse experiences of suffering was articulated by various authors in the field. Kleinman (1991, 1997) and Farmer (1989, 1990) have explored the ways in which structural violence and social suffering construct the social relations of everyday life. According to them, social suffering is understood as resulting 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 1997:ix). However, suffering in this approach is a more all-encompassing concept. It can also take the form of grieving, frustration, desperation, impotence, desolation as well as other forms of human suffering.

Perspectives on social suffering interrogate aspects of human experience that are usually considered separately, and bring together conditions that simultaneously involve health, welfare, legal, moral and religious issues. This approach necessarily challenges dichotomised approaches to the mental and physical, or the individual and the collective. It highlights, instead, the interconnections needed to grasp the political economic and social origin of illness as well as other forms of human suffering. As Kleinman asserted "we put in that category of social suffering every different kind of human problem that creates pain, distress, and other trials for people to undergo and endure. We do not, for example, separate illness from political violence or from other forms of misery…" (Kleinman 1995:15). This approach provides for a grouping of human problems which highlight the issue this study deals with. That is, how suffering derived from exclusion and discrimination is transformed into emotional distress, or through its embodiment, transformed into a physical experience.

Causes of suffering, as collectively rooted, make it a social experience which Kleinman defines as "the often close linkage of personal problems with societal problems. It reveals, too, the interpersonal grounds of suffering: in other words suffering is a social experience" (Kleinman 1997:ix).

Three themes are highlighted within the perspective of social suffering; the cultural representation of suffering; suffering as social – and changing – experience as well as the political and professional processes placed in motion to respond to suffering.

Firstly, cultural representations of suffering refer to "– images, prototypical tales, metaphors, models – can be (and frequently are) appropriated in the popular culture or by particular social institutions for political and moral purposes" (ibid:xi). In that sense it is possible to affirm that suffering has social and political use. Furthermore, collective suffering is a core component of the global political economy. Kleinman point out how in the modern, capitalist and interconnected world there is even a market for suffering. For instance, "victimhood becomes commodified" (idem), and global media campaigns are a case in point. The cultural representations of suffering shape different modes of suffering which, in turn, are authorised by a moral community and its institutions.

Secondly, the cultural representation of suffering shapes it as a form of social experience. As a social experience, suffering is understood in at least two ways:1) as collective modes of experience which shape individual perceptions and expression. Modes are visible in "collective patterns of how to undergo troubles and they are taught and learned, sometimes openly, often indirectly," (Kleinman 1997b:2) and (2) as social interactions that enter into an illness experience (idem).

Relationships and interactions are visible in the involvement of the social milieu in individual suffering. This means taking part in the experience of suffering. Suffering, the authors assert, although grounded in the human condition, may also undergo changes. These changes result from its connection with the moral symbolic system, with the political economy. Therefore, suffering is subject to societal transformations. Social experiences are viewed in the perspective of its transformation which, in turn, they impact upon the way individuals experience suffering "…Changing societal practices," Kleinman says, "transform individual lives and ways of being-in-the-world" (1997:xii). What is ultimately transformed is the way in which individuals experience suffering.

Thirdly, political and professional processes powerfully shape the responses to the many types of social suffering. In other words, institutional efforts directed toward managing and regulating suffering take on the form of medicalisation and public policies as well as programs tailored to respond to social suffering. According to Kleinman, these processes involve both authorised and contested appropriations of collective suffering. Appropriation refers to the representation on behalf of the victims assumed by leaders, organisations or institutional agents.

In summary, the approaches previously discussed provide an understanding of migrants' illness experiences. These can be described as being both an inter-subjective interpreted reality as well as resulting from social and economic structures and political forces.

Understanding illness as inter-subjective experience allows us to grasp changes in perceptions of illness resulting from migrants' interaction with members of the host society as well as with member of their own community. In addition, and equally central to my analysis, is the connection between illness – as well as emotional distress – with macro societal processes linked to economic structures. The social suffering approach ultimately discussed, has added a perspective to my analysis, which recognises various forms of human suffering. This includes emotional distress as engrained in the subordinated position migrants occupy within the host society.

The next section builds a micro level of analysis by means of various concepts; the self, embodiment and body-agency. These concepts lead to an understanding of the way in which societal forces ultimately impact upon individual's experiences – on their bodies and subjectivities.

2.3 The self, embodiment and agency in the context of illness and suffering

2.3.1 The self in the context of culture

One basic orientation of contemporary psychological anthropology – not excepted from controversy – is the dichotomy according to which a distinction is made in self constructs among those cultures which are individually centred and those which are socio-centric. The former cultures foster an independent, autonomic, egocentric construal of the self. The latter cultures favour an interdependent self.

Self constructs are therefore thought to be organised in two types – an independent self, characteristic of western societies and an interdependent self as characteristic of non-western societies. Markus and Kitayama (1991) explain this last construe in the following terms: "in some cultures, on certain occasions, the individual, in the sense of a set of significant inner attributes of the person, may cease to be a primary unit of consciousness. Instead, the sense of belongingness to a social relation may become so strong that it makes better sense to think of the relationship as the functional unit of conscious reflection" (ibid:5). Markus and Kitayama's understanding of connectedness and interdependence of the self, is "seeing oneself as part of an encompassing social relationship and recognising that ones' behaviour is determined, contingent on, and to a large extent organised by what the actor perceives to be thoughts, feelings and actions of others in the relationship" (1991:7).

The above definition has been criticised by Spiro (1993) who argues that the authors are confusing cultural conceptions of self with individual or actor 'self conceptions' or 'self representation'.[33] Spiro raises the critical question to Markus and Kitayama's perspective on the interdependent self by asking where are the others in the self? Spiro distinguishes the existence of an 'I' (a psychic structure, an ego, a soul) and its self representation as the 'me', which he calls the 'I' objectified. This distinction is related to what Hallowell described as a fundamental process of self-awareness. "One of the distinguishing features of human adjustment rests upon the fact that the human adult, in the course of ontogenetic development, has learned to discriminate himself as an object in a world of objects other than himself" (Hallowell 1955:75 quoted by Spiro 1993:110).

[33] Spiro refers to Hartman's distinction between two dimensions; the 'person' referred holistically to the psycho-socio-biological individual and 'self' referred to the individual's own person". Then Spiro asserts, that typically anthropologists (and comparative social psychologists) do not investigate the self or the individual's conception of his/her self (the self representation) but the cultural conception of the person (Spiro 1993:117) "Is the western conception of the self 'peculiar' within the context of the world cultures?" (ibid:153). I claim here that anthropologists are concerned with the individual's self representation to the extent in which this representation is influenced by culture.

Hallowell (1955) defined the self as a notion "people everywhere are likely to develop an understanding of themselves as physically distinct and separable from others" (Hallowell 1955:80 quoted by Spiro 1993:110). In Hallowell's understanding, the capacity of self-awareness, the ability to distinguish self from others (self-identity) and the concern of self continuity are essential for basic human and cultural functioning. For Hallowell the concept of the self – and not the self itself – is "in part culturally derived" (idem).

While these theoretical stands are, to some extent irreconcilable, I opt by the following perspective: While the subject's agency is acknowledged, it also must be assumed it depends on a relational dimension. The self-in-relation-to-the-others is central in individual experience in socio-centric cultures. This conception influences cognitive orientations, perceptions, motivations as well as the disposition to relate to others. It also influences individuals' definition of their personal goals.

Some anthropologists have argued as Ewing (1990) points out, that "even the functioning of the 'self (not just the representation of it) as well as an associated structure of emotional experience are culturally organised" (1990:229). The existence of an affective, culturally derived structure is also expressed by Raymond Williams as; "the affective elements of consciousness and relations are not reified as a permanent form of indeterminacy but are treated as structured formations that can 'exert palpable pressures and set effective limits on experience and actions'" (William 1977:132 quoted by McNay 2004:187).

Such conceptions gain strength as they are reinforced within the same individual's social environment. This is explained by Moore (1994) as follows: "…Since all psychic and developmental processes are relational, then the nature of the relationship between [the] self and other(s), and the matrix of social relations and symbolic systems within which that relationship is conducted, must play a role in the development of the self and the subjectivity. It appears pertinent therefore, that in many contexts people do not believe that selves and persons are bounded…" (Moore 1994:34).

In the Andean cultural tradition, human beings are viewed as closely linked to each other, as well as to the natural and supernatural world. Beings and worlds are connected through the same living force that flows through them and linked to one and another in a complex net of interrelationships, structured through premises of reciprocal obligations and duties (Greenway 1998).

In this tradition, individual, family and community are conceived as interrelated. Among Peruvian migrants – as it is among other Latin American cultures – interpersonal obligations and loyalties largely become connected to this socio-centric ideology. In this conception individual experiences of self-worth and self-fulfilment are nested in networks of social relations. Therefore, self expression requires an interpersonal idiom (Lewis-Fernandez 1994).

Concerns may be raised when considering the influence of these cultural conceptions, specifically regarding the extent to which persons who are not thought to be separated from other persons can be conceived as individuals (Moore 1994). Also, whether or not, those persons who are defined in relation to other persons can be said to have "appropriate capacities for agency and intention" (ibid:33).

As Moore asserts, one can be an individual and also bounded to a 'web of kinship'. These are phenomena that occur simultaneously. Indeed, this cultural self conception does not make the individuals concerned incapable of agency or intention as demonstrated in the context of the economic migration of Peruvians to Chile. In this case decisions to leave one's family to look for better economic opportunities is both the result of an individual capacity of agency and – at the same time – a socially accepted move responding to the cultural imperative to fulfil others' needs and goals.

However, the individual degree of response to culturally defined moral duties is variable. Ewing (1990), debates about the multiplicity of self representations operating at the individual level. The author questions aspects of consistency, unity and cohesiveness as permanent attributes of the self and argues that in an individual, self representations can be multiple. For Ewing, self-representations can shift, becoming inconsistent, as they are highly context related. "Self representations are embedded in a particular frame of reference, are culturally shaped, and highly contextual. Contexts themselves rapidly shift, as actors negotiate status and seek to achieve specific goals, implicitly redefining themselves and each other during the course of the interaction" (ibid:310).Thus, as a context-related notion, migration triggers changes in self conceptions.

Nevertheless, as it has been previously stated, intrinsic to the self and beyond each particular culture, there is also a need to experience some degree of continuity of the self across time and space. Such continuity, however, seems not to be a given but achieved, and this accomplishment is fundamental to the definition of personhood. "…Personhood is best understood in terms of people's chronic efforts to acquire and maintain possession of properties that they value: *continuity of the self is not given but achieved;* and ideal personhood involves a lasting form of self-possession or proprietorship in the self" (*my italics*) (Rouse 1995:358).

Ewing further argues that such continuity of the self is illusory. "When we consider the temporal flow of experience, we can observe that individuals are continuously reconstituting themselves into new selves in response to internal and external stimuli. They reconstruct these new selves from their available set of self–representations, which are based on cultural constructs" (Ewing 1990:300).

When people migrate, the context from which their sense of self is constructed becomes shifted. Such migration often affects individuals by *decentring* the attributes of their identity and selves. In relation to this process of decentring, Takeyuki maintains:

> The act of migration frequently disrupts and de-centres the ethnic identities of immigrants, who are thrust into a completely different socio-cultural environment and confronted by new ethnic groups. This can challenge their former identities; causing a profound transformation in ethnic self-consciousness (…) identity and self-formation involve a dynamic balance between centring and de-centring. During a period of de-centring, individuals detach themselves from their previous identities as they confront new experiences and incorporate and reintegrate new forms of identification (1999:147).

This disruption may be experienced even more strongly when the new social milieu is hostile to migrants, as is the case in Chile.

In summary, I have argued here that while the sense of self involves a perception of unity, continuity and separateness of one's own experience, certain cultural constructs of the self, emphasise the connection to others, exerting considerable influence on individuals' subjectivity and affects. Attending to cultural constructs of the self becomes particularly relevant in an understanding of the cultural embeddedness of migrants' experiences of emotional suffering.

Indeed, as I have stated before, Andean conceptions of self and identity emphasise the interconnectedness of individuals with their family and community. This particular migration with its associated social and cultural dislocation, involves a "de-centring of the self and uprootedness". This causes migrants emotional suffering and distress. Such a "taken for granted" state of being gets lost, along with the personal and social displacement produced by migration. Therefore, efforts should be made to maintain continuity in their own sense of self.

The next section highlights those linkages through which a disruption of the identity, resulting from the transformation of the social milieu and the confrontation of adverse social conditions, impact not only the self, but also the body.

2.3.2 Migrants' embodiment of adverse social conditions

From a phenomenological perspective, the sense of self is anchored in bodies; perception and lived experiences. This perspective of the self is described by Scheper-Hughes and Lock (1987) in terms of some intuitive sense people share "of the embodied self as existing apart from other individual bodies" (Lock 1993:135).

From this perspective, the de-centring of the self, triggered by migration is experienced as a disruption in the body. This is described by Jackson in the following terms: "…when our familiar environment is suddenly disrupted, we feel uprooted, we lose our footing, we are thrown, we collapse, we fall" (Jackson 1983:322). This falling, Jackson adds, is not metaphorical, but "it is a shock and disorientation which occurs simultaneously in body and mind and refers to a basic ontological structure of our Being-in-the world" (idem).

Implicit in the above perspective, is the possibility to approach the dimension of lived experiences through the body, which involves an understanding of the culture and self from the standpoint of embodiment. Embodiment can be defined as: "an existential condition in which the body is the subjective source or inter-subjective ground of experience" (Csordas 1999:182).

To conceptualise embodiment, Csordas synthesises two perspectives. Firstly, the author establishes a metaphorical parallel between text and textuality, as well as body and embodiment. The body is seen as "a biological, material entity and embodiment is an indeterminate methodological field defined by perceptual experience and by mode of presence and engagement in the world" (ibid:182). The epistemological standpoint supporting this perspective is one that sees representation "not as denoting experience but as containing it" (idem). Although this perspective allows overcoming the dualism between experience and language, Csordas asserts it does so by "reducing experiences to language, or discourse or representation" (idem).

The second perspective of embodiment is in the phenomenological tradition which asserts the being-in-the-world as the key theoretical term. The work of Merleau-Ponty has been influential in establishing an understanding of experience as embodied immediacy. "… Perception is basic bodily experience, where the body is not an object but a subject, and where embodiment is the condition for us to have any objects – that is to objectify reality – in the first place" (ibid:183). For Csordas the work of Merleau Ponty suggests that culture does not reside only in objects and representations, but also in the bodily processes of perception by which those representations come into being" (idem).

Embodiment is therefore, about experience and subjectivity; an equation stemming from the two perspectives previously outlined and expressed by Csordas in the following terms: "… Semiotics gives us textuality in order to understand representation, phenomenology gives us embodiment in order to understand being-in the-world" (ibid:184). So, in this way, the body can be constructed "*both* as source of representation and as ground of being-in-the-world" (idem).

Within the Andean cultural tradition, the principle of embodiment of the natural and the social world is a fundamental one. This principle becomes clear in the Andean concepts of the body, illness and healing. Within this cultural matrix, body and mind are not conceived as two separated entities. Instead, they are perceived as deeply intertwined realms responding both to the environment and the social order. A central component of the body is an energetic foundation (*ánima*, animating power, breath of life) of the corporeal dimension. (Polia Meconi 1996).

Coexisting etiologies in illness are a distinct feature of Andean beliefs and practices and show how the principle of interrelatedness of the social the natural/supernatural world works. Furthermore, these etiological principles also illustrate the principle of embodiment of these realms in the view of any illness condition. Illnesses are attributed alternatively or simultaneously to: "(1) supernatural causes – devils, spirits, [the] stars, ghosts and dead persons; (2) natural/environmental causes – excessive heat, colds, and winds; (3) interpersonal issues or conflicts with family, community, or spirits (4) biological/biomedical explanations; and (5) socio-political accounts that may underline situations of poverty and lack of financial and material resources and/or social support" (Darghouth 2006:3-4).

These factors may be the cause of a variety of popular Andean illness categories. The popular illness, *susto* – fright illness or loss of soul – common among Andean cultures, exemplifies the functioning of the principle of an 'animating power' among contemporary Peruvians. *Susto* also assembles the Cartesian dichotomy of mind and body and shows the irreducibility of the physical to the mental or the mental to the physical state (Oths 1999). This popular illness also demonstrates how the body in the Andean world is lived as a dynamic and interrelated totality that incorporates without dissecting the psychological and corporeal dimensions. As Kirmayer (1988) observed, cultural variations in metaphors of the mind and the body are a reflection of the influence of social structure, to the extent that it can be stated that the 'intra-psychic world is a social creation' (Kirmayer 1988:78).

The popular Andean illness of *debilidad* (weakness) is in turn, an expression of "embodied exhaustion resulting from a lifelong accumulation of productive and

reproductive stresses" (Oths, 1999:286). *Debilidad* also demonstrates how it collapses "the western boundaries between mind and body" (ibid:287). *Sobreparto,* a chronic women's illness, following giving birth, embodies the hardships of their reproductive work-related roles (Leatherman 2005).

In this section, I have examined some of the continuities observed in the way these contemporary forms of suffering are experienced by Peruvian migrants and how they are linked to cultural representations of the self, body and illness. References made to various Andean popular illnesses aim to show the existence of a non-dichotomist relationship between mind and body, which prevails among the migrant population of my study. This relation is where migrants' conceptions of illness are founded and this relation shapes their bodily experiences. Furthermore, popular illnesses in the Andean tradition are understood as embodied effects of difficult material conditions and social relations. Illness also results from disruptions in the interaction between the body with the natural and supernatural world.

Attending to both cultural continuities and changes, exclusion, discrimination and uprooted-ness represent emergent forms of social suffering, associated with this economic migration. I have also shown that, congruent with Andean conceptions of illness, migrants' current experiences of loss, of personal dislocation and self-decentring have become embodied experiences. As effects of the disruption of the migrant's social world, these embodied experiences must be interpreted in relational terms and regarded in its somatic and socio-moral dimensions. However, before delving into these dimensions and having explored bodies as fields of lived experience, next I discuss how the body-self can be experienced as a means of resistance, and as such, as a source of agency and intentionality.

2.3.3 Agency: recentring the body and self

The concept of agency is placed in my analysis, in the midst of social forces, determining individual experiences of suffering. In this discussion, I draw the concept of agency from McNay's work. As the author rightly asserts, developing mediating concepts such as agency, allows that "the determining force of economic and cultural relations upon daily life can be made visible and, in this way, the issue of identity can be connected to that of social structure" (McNay 2004:175).

Agency refers to an individual capacity for action, which cannot be deduced from abstract structures. Crucial features of agency are intention and reflexivity. Agency can be defined therefore, as an individual capacity for self-reflection and self evaluation. This capacity however, is not only supported by rationality but by experience; an essential notion in an account of agency.

Based upon the notion of agency as generative experiences and situated discourses in lived relations, I specifically explore whether agency can be exerted by and through the body-self. The latter is understood as a unit of experience and support of lived relations. In this exploration, I take an opposite stand to the western dualism between body and mind that emphasises rational agency, individualism and psychologisation of experience. Kirmayer (1988) has rightly addressed the arbitrary nature of the western assumption about rationality and the mind as the locus of agency. He expressed this as:

"the nature of mind, as the interior world or agency of the person, and body, as a medium of sensation and action, [would then] depend on the way in which social structure shapes the development of the sense of self" (Kirmayer 1988:78)

McNay, following Scott (1992) draws from the analysis of historical processes a concept of experience which provides a generative account of agency. Experience as discursively constructed leads to examining "historical processes that, through discourse, position subjects and produce their experiences" (McNay 2004:179). However – as McNay observes – from this historical dimension, the notion of experience has been widely used as a discursive construction mainly in post-structuralism analysis. The problem with this use, McNay adds, is that it suggests a kind of linguistic determinism and as a result, the generative potential of experience in the historical analysis is to a large extent, lost.

Without loosing sight of the potential of discursive representation of experience, the author continues in her search for an approach to keep the generative capacity of experience and at the same time, overcome the dichotomy of material or subjective determination. As McNay proposes, agency must be understood in relational terms and experience, understood in a non reductive or essentialist form but as a notion that can animate other notions such as resistance and subversion.

In this search, McNay further develops a relational analysis of experience by drawing from Bourdieu's work on the phenomenology of social space. This concept introduces the idea of spatial distances as indicative of social distances where social space also functions as symbolic space. The inclusion of social space provides for a relational analysis of experience. At the same time, attending to space, it becomes a strategy to apprehend the effect of structures upon experience. McNay in this regard proposes that "by plotting social positions as spatial positions, the complex interaction between symbolic and material power relations, between immediate experience and invisible structures is elucidated" (ibid:184).

This perspective allows us to understand experience not as ontological but in its relational style, introducing the broader context where experience is situated. The contextualisation is central to agency, and it encompasses "tracing the links between the phenomenal immediacy of experience and abstract systems of power that operate at one remove from everyday activity" (idem). The use of the spatial metaphor to analyse experience completes the discursive analysis of experience previously traced in an historical frame of reference, as the author synthesises: "…discourse is a situated, rather than an abstract, medium where the situation itself is organised by invisible structures" (ibid:185).

In her analysis, McNay focuses on the conflicts inherent to the reproduction of normative forms of gender identity and the negotiations involved in such processes. I introduce this perspective into the examination of the effects of social suffering upon individual migrants in the following way. I take into account migrants' emotional distress as a result of the material determination of the subordinated position they occupy in the host society. Meanings attached to distress, to illness and the body are representations belonging to the cultural and symbolic realm.

Mediating between the two above dimensions is the migrants' agency upon their own body-self, a perspective which I aim to incorporate into the analysis of their emotional distress. Often, as it happens in Chile as well, this perspective has been absent from western healthcare systems, however in Kirmayer's view; this endeavour must be embraced by biomedicine if a change in perspective is to be introduced to better respond to people's emotional needs and distress. "…It is the fundamental experience of agency and accident, and their moral consequences that must be addressed if medical practice is to respond sensitively to the emotional needs of patients and the social implication of distress" (Kirmayer 1988:58).

While living as migrants in Chile, Peruvians experience the decentring of the self and identity – their own bodies are lived in as foreign bodies and their selves as others. Migrants resist this process of decentring as well as the framing of their emotional distress within pathologic medical categories. Agency comes into play in their struggle to regain control over their bodies. This must be done in order to be able to reengage and re-invest their body-self in the productive world, as this dimension is the central focus of their migration endeavours and self-identity. Agency is, therefore, manifest in migrants' attempts to re-centre their own bodies and selves; efforts which are not detached from their material determination.

In other words, the process of pathologisation of a socially produced distress can be understood as the "constraints that operate upon social actions" (ibid:177). Migrant's resistance to pathologisation and their agency – which comes into play in their attempts to maintain control over their bodies and selves – can be interpreted as "the possibility to overcome these constraints" (idem). Through agency over their bodies and self, migrants resist and contest societal attempts to discipline them; a struggle which underlies the competing interpretations of migrant's emotional distress.

An additional element taken from McNay's approach is the centrality of emotions in the analysis of experience. The author states: "by analysing emotions as a form of social interaction it is possible to see how they are both shaped by latent social structures and also the vehicle through which invisible power dynamics are made present within immediate everyday experience" (McNay 2004:187).

An analysis of experience, therefore, should look at emotions in the context where they emerge. The context under analysis is one of structural determination and power struggles over imposed notions of normality and attempts to redefine identities. This clashing of concepts will be discussed when analysing migrants' notions of normality vis-à-vis those held by members of the Chilean society with whom migrants interact on daily bases. Following McNay's argument, if structural forces only reveal themselves in the lived reality of social relations, then attention should be paid to emotions as they speak about these relationships. Conversely, when emotions are suppressed, subjects will speak out through the body about these relationships, demonstrating that such capacity can never be completely silenced.

In the next section I will explore various forms through which people communicate their experiences of suffering and emotional distress.

2.4 Making sense of suffering in alien contexts

This section deals with how to make sense of forms of suffering that emerge from the oppressive structures Peruvian migrants are subjected to in Chile. Idioms of distress are presented as means to communicate and represent personal and collective suffering among migrants.

2.4.1 Cultural idioms of distress

In anthropology the concept of cultural idioms allows an understanding of the role of culture in framing subjective experiences. Crapanzano has provided an approach into the web of interrelations between the person's subjective experience and the inscription of that experience into a field of discourse.

> The act of articulation is more than the passive representation of the event; it is in essence the creation of the event. It separates the event from the flow of experience ... gives the event structure, thus precipitating its context, relates it to other similarly constructed events, and evaluates the event along both idiosyncratic and (culturally) standardised lines. Once the experience is articulated, once it is rendered an event, it is cast within the word of meaning and may then provide a basis for action (Crapanzano 1977:10).

The standardised lines through which an experience is articulated is for Crapazano, a cultural idiom (Vanthuyne 2003:413). An idiom, however, as Crapanzano further observes, should be distinguished from its medium of articulation; which is not necessarily spoken language.

> The act of articulation requires a vehicle for articulation, an idiom, which must be distinguished from a medium of articulation such as spoken language, gesture, a behavioural sequence as in a ritual, or some endopsychic process.[34] (Crapanzano 1977:10-11)

Although the idiom is probably structured in a language it is clearly more than a language in the restricted sense of the term. In each culture, there exist a variety of idioms to express subjective experiences, including distress. Nichter (1981) studied the availability and social implication of the use of coexisting idioms to express distress among Havik women in South India. In Nichter's study, the term distress is used to refer to a wide range of feelings and anxiety states. If they are not expressed in existing and available cultural idioms, they may take the form of an unsustainable social conflict or upheaval (idem). These expressive modes are culturally constituted as "they initiate particular types of interaction and are associated with culturally pervasive values, generative themes, and health concerns" (ibid:379).

Somatisation has been studied as cultural idiom used in response to distress in everyday life. Initial studies in this area asserted that the tendency to somatise was predominant among the less educated and non-western societies whereas the opposite tendency – towards psychologisation of distress – was observed among the more

[34] By this term, Crapanzano describes "dreams, hallucinations, visions and body apperceptions, the shape of the past (and the future), its falling into some, usually chronological order, and the use of the past as explanation or justification of the present , if not as symbolic matrix for the articulation of the present and the future" (ibid:22).

educated and western societies.[35] Contrary to this initial understanding, Parson (1991) found severe and extended forms of somatisation among urban, white middle class, educated Australians they studied. In addition, it was found that somatisation and psychologisation were not two opposite ends in a continuum, but tended to occur simultaneously.

The use of somatic idioms of distress in connection with gender identities and the place individuals occupy in the social structure has been also studied. Somatic idioms can be found among various generations within families and used according to gender. For example, it has been found to be evident among women who occupy similar social positions within their families. Somatisation as an idiom to express distress has been studied in the case of *nervios* suffered among women with excessive social and familial responsibilities in highland Ecuador (Finerman 1989). Having been conducted among similar cultural groups, these studies highlight the embeddedness of individual distress in social contexts.

Headache, a common symptom, has been studied by Darghout (2006) among women in Peru. Headache in this context is a term in the accepted social language of pain which articulates individual and shared notions of suffering (ibid). The authors propose the use of 'psychosomatic families', a concept derived from 'psychosomatic systems' coined by Minuchin and colleagues (Minuchin 1978 quoted by Darghout 2006). They apply this concept to explain the recurrence of headaches among women within a family in the following manner "…If psychosomatic families' form a well-geared system whereby one member of the family (usually one with less power such as a child) expresses discord shared by all members, the groups of women in this study may be analogously represented". The authors draw the parallel. These women occupy a central position relative to other members of the family. Therefore "they are concurrently, perhaps most likely, to exhibit interpersonal tension and communicative difficulties" (ibid:15).

Either in a somatic form or by means of other modes of expression, the way idioms are used to articulate subjective experiences including those of mental illness and emotional distress – are never free from consideration of their political or pragmatic uses (Vanthuyne 2003). The need to locate idioms of distress historically; this is, with respect to changing social conditions, has been stressed by Nichter (1981). For this author it is not enough to describe how a particular idiom is used; "it is also important to study how often this idiom is employed, in what circumstances and with what repercussions" (ibid:399).

The interpretation of idioms should also attend to the power relations involved in social interactions in which these idioms are inscribed. As Morris (1998) observes, idioms can be used as mediums through which individuals can rework their own identity. Certainly, the choice of an idiom is not independent from the interlocutor with whom the idiom is used, nor is it independent from consideration on the effect its use produces.

[35] Psychologisation and somatisation are both idioms of distress. Psychologisation refers to "the Western construal of the mind as being capable of dealing with affect separate from the body … The psychological process includes, therefore, the cognitive response to dissonance, the attempt to interpret the environment and social relations in meaningful narratives, cause-effect associations, and coping strategies" (Parsons 1991:116). Somatisation in turn, is defined as the expression of personal and social distress in an idiom of bodily complaint and medical help seeking. (Kleinman et. al 1985)

> …Different cultural idioms coexist in a society and are hierarchically positioned within a field of power relationships. Hence when people attempt to rework their identity through the use of one or more idioms, they engage in a field of contested truth claims and power struggles. The choice of a language situates them vis-à-vis their symbolic or actual interlocutors and manifests their more or less conscious desire to enter into a dialogue with certain individuals, and/or to signal their intention to distance themselves from others (Morris 1998 quoted by Vanthuye 2003:414).

The use of idioms of distress and its relation with the self and identity has been studied among patients with psychosomatic problems and also among patients with severe mental illness. These studies highlight the relationship between illness and identity and provide a scope to understand such relations in my own problem of study. This is so, since a diagnosis of mental illness often challenges the individuals' perception of their own self. Helman (1985) studied how patients make sense of their physiological experiences, of the diagnostic label of 'psychosomatic,' and of 'stress,' 'tension' or 'emotions' said by clinicians to exacerbate their disorders.

The use of a psychological idiom to explain psychosomatic complaints was negotiated between clinicians and patients in the medical setting, who by means of this idiom, jointly addressed the psychosomatic problem 'out there.' This was done in such a way that dealing with problematic dimensions of the patients' self-perception was avoided.

It was found that, in response to "psychologisation" and socially objectionable parts of the self ("bad emotions"), patients tended to "reify concepts of pathogenic (or "weak") personality, emotion and bodily parts, and separate them from the idealised concept of the self" (ibid:117). This allowed patients – in agreement with physicians – to shift the responsibility to outside forces which exert control over the emotions and body parts identified as problematic. In that way, "parts of the body and the personality are seen as "non-self," either part of other people or of the natural environment" (ibid:118).

Other studies have looked at how the self is reworked in cases of mental illness. Estroff (1991) analyse how illness and self are interdependent processes and domains, present in discursive accounts of patients with severe mental illness. The authors developed the concepts of 'illness-identity work' and 'illness-identity talks.'

"Illness-identity work," according to the authors, "produces the words, ideas, images, actions, and sentiments with which persons with disabling conditions reconstrue and get on with their lives. Elicited illness accounts and self-labelling discourse are a type of illness-identity work we call "illness-identity talk" (ibid:336).

Estroff and colleagues' study revealed that illness-identity work produced two main types of talks about the self and illness: "*normalising statements* and *illness-identity statements"* (ibid:337, cursives in the original). '*Normalising statements'* may focus on the condition or diagnosis, on the individual, or both. The authors see the main aims of these types of statements are "to dispute the assignation of illness and to recategorise either the condition as commonly occurring or the person as non-pathological" (idem). '*Illness identity statements,*' in turn, the authors add, consist of "self representation that encompass symptoms or illness, descriptions of symptoms as objects and separate from

self, labelling statements made by self and others, and “I am” or “I have” statements about illness” (idem).

I claim these concepts can be applied to the analysis of other – less severe but everyday hindering forms of emotional distress. Such an analogy is indeed plausible, considering the severity of the experiences accounted for through illness-identity talks are not sourced in individual’s mental illness but in the disruption of a social world. As such, illness-identity talks provide a means to speak about an equally destabilised self.

In summary, I have discussed here how often psychic or emotional distress expressed in the body or somatisation, is seen by western biomedicine as an incapacity to symbolise the affective experience. Never is somatisation seen as a non-dichotomist relationship between mind and body. I argue that if cultural traditions are to be taken into account, somatisation – as well as other bodily experiences of emotional distress – should be seen as comprising an idiom of distress where the body is experienced as a metaphor of the social world as well as their interrelations existing in this realm. Alternatively, idioms of distress can also comprise forms of illness-identity-talk through which identity and the self are constructed.