Cultural aspects of stress

The nature of stress

The concept of 'stress' was first described by Hans Selye in 1936[1], and since then more than 110 000 papers have been published on it in the academic literature[2]. On the level of popular culture, however, 'stress' has also become one of the most pervasive metaphors for personal and collective suffering in the late twentieth century.

In Selye's original model, stress represents the generalized response of the organism to environmental demands. It is an inherent physiological mechanism which prepares the organism for action, and which comes into play when demands are placed on it. Not all stress is harmful to the organism; at a moderate level ('eustress') it has a protective and adaptive function. However, at a higher level ('dystress') the stress response can cause pathological changes and even death. The actual environmental influence – whether physical, psychological or socio-cultural – that produces stress is termed a *stressor*. Selye has described the sequence of events whereby an organism responds to a stressor as the General Adaptation Syndrome (GAS). This usually has three stages:

1. The *alarm* reaction, whereby the organism becomes aware of a specific noxious stimulus
2. The stage of resistance or *adaptation*, in which the organism recovers to a functional level superior to that before it was stressed
3. The stage of *exhaustion*, where the recovery processes, under the continuing assault of stressors, are no longer able to cope and to restore homeostasis.

In this final stage, the physiological changes that have taken place in the organism now become pathological to it, and disease or death results. From a physiological point of view, the GAS is said to be mediated via the adrenal medulla and the hypothalamic–pituitary–adrenocortical axis, and involves a wide range of physical changes[3].

Critiques of Selye's model

Selye's early model, although widely accepted as basic for all stress research, has been criticized on several counts -- in particular, for its rather mechanistic approach and its overemphasis on the physiological dimensions of the stress response. Psychologists such as Weinman[4] have pointed out the importance of the *psychological* responses or coping strategies of the individual confronted by a stressor. These range from an initial 'alarm and shock state', with feelings of anxiety or of being threatened, through attempts to cope with the subjectively unpleasant situation, to a range of more extreme psychological reactions such as depression, withdrawal, suicide or resort to 'chemical comforters'. These responses, as well as the *meanings* people give to their stressful experiences, are all influenced by the individual's personality, education, social environment, economic situation and cultural background. As such, they are of more interest to the social scientist than the purely physiological stress responses.

A further salient critique of Selye's model, and of much of the subsequent literature on stress, comes from the anthropologist Allan Young[5]. He argues that 'stressors' are often described in the

stress literature as if they were abstract 'things', separated from a particular social and political context, and a particular time and place. Sometimes they are described almost as if they were invisible pathogens or forces that cause illness or unhappiness to certain individuals. Furthermore, the focus on these decontextualized stressors and their physiological effects may lead to ignoring the larger economic and social forces acting upon the individual, which may also have an adverse effect on health.

Pollock[6], too, has criticized Selye's approach, pointing out that his original model of how stress acts physiologically was a mechanical one, taken from physics and engineering. However, since then stress theory has become heavily 'psychologized', with an increasing emphasis on the pathogenic role of emotions and perceptions, but 'it still relies for its validation on the physiological models with which it is fundamentally non-compatible'. In addition, the key link in stress theory – the postulated process by which stress is actually transformed into illness – 'remains unclear and unproven', and many of the studies carried out on this link have produced 'inconsistent, contradictory or inconclusive results'.

Another critique of the model is that it overemphasizes the *external* origin of stress, so that the individual often appears in the stress literature as a passive victim of circumstances. However, from a psychological point of view, many sources of stress may originate *within* the individual. Whatever their origin in early development, these intrapsychic factors – such as exaggerated fears, chronic anxiety, aggressiveness, insecurity, over-sensitivity or false expectations of life – may all contribute towards one individual having a much more stressful life than another.

Finally, the assumption that stress is always negative in its effect on the individual can also be challenged. McElroy and Townsend[7], for example, point out that in many cultures certain rituals can actually induce physical and emotional stress as part of a healing process. These rituals may include painful stimuli (such as fire-walking), physical exhaustion, sleep deprivation, extreme heat or cold, hyperventilation or altered states of consciousness – sometimes with the aid of hallucinogenic drugs (see Chapter 8). To members of these cultural groups, these stressful processes are an essential prerequisite to being healed. Furthermore, on a physical level, some of these culturally-induced stressors may cause the release of endorphins, or endogenous opiates, which induce feelings of wellbeing, reduce pain perception and have a variety of other positive physiological effects[7].

Despite these and many other criticisms, Selye's model of stressors and stress responses is useful as a starting point in understanding how human beings cope with the adversities of life. It can be used as an analytical tool, provided there is an awareness of its limitations and that the role of *context* – psychological, social, cultural and economic – is always included when trying to understand why one individual or group finds some situations stressful, while others do not.

Relation of stressors to stress response

By definition, a 'stressor'. according to Selye, is an environmental influence or agent that produces a stress response in the organism. The range of possible stressors is therefore extremely wide, and a list could include such events as severe illness or trauma, natural disasters, bereavement, divorce, marital conflict, unemployment, retirement, interpersonal tensions at work, religious or other persecution, financial difficulties, changes in occupation, migration, wartime combat, and excessive exposure to heat, cold, damp or noise. However, the relationship between stressors and their response is more complex than this list suggests. For example, the same event might cause stress in one individual but not in another. Also, as Parkes[8] points out, stress can arise from usually positive experiences such as promotion, engagement, the birth of a child or winning a great deal of money, all of which involve a change in lifestyle. Individuals vary in how they cope with and adapt to these life changes, and to more adverse circumstances such as bereavement. In both cases, as the World Health Organization[9] pointed out, stress (and the diseases that result from it) represents an unsuccessful attempt on the part of the body to deal with adverse factors in the environment'. Thus 'disease is the body's failure to become adapted to these adverse factors rather than the effect of the factors themselves'. There are many reasons for this failure of adaptation, including the physical, psychological and sociocultural characteristics of the individual. For example, elderly frail people are more likely to

experience cold or very humid weather as 'stressful' than younger, more robust people. Also, some situations (such as retirement) may cause a stress response in one person but not in another. Weinman notes that 'specific situations or objects are threatening to the individual because they are perceived as such rather than because of some inherent characteristic'[4]. Some of the social or cultural factors that apparently predispose to, or protect against, the stress response will be described later in the chapter.

According to Selye[2], the relationship between particular stressors and the response they elicit is marked by *non-specificity*. That is, it cannot be predicted what specific stress-related disease (such as peptic ulceration, psychiatric disorders, hypertension or coronary thrombosis) will result from a specific stressor (such as marital conflict, frustration at work, combat fatigue or burns). A stressor such as marital conflict may result in peptic ulceration in one individual, and bronchial asthma in another. In psychosomatic research (see Chapter 10) this is known as the problem of *organ choice*, and many theories have been put forward to explain why one organ is 'chosen' and not another[10]. In practical terms, therefore, a stressor and its effect can only be linked circumstantially, and to some extent only *post hoc*, though more experimental evidence is accumulating on the nature and prevalence of this link.

Stress can also be viewed either as a causal factor in disease or as a contributory one, by reducing the individual's 'resistance' to disease processes such as viral infections[11] or rheumatoid arthritis[12]. The relatively new field of *psychoneuroimmunology* (PNI) (see Chapter 10) has tried to examine the relationships between psychological state, the endocrine system and the body's defences or immune system[13]. Although still characterized by non-specificity, there is evidence that depression and anxiety may adversely affect the immune system and thus increase susceptibility to infections and other illnesses[13]. In other cases, an individual with a pre-existing organic disease might have a relapse in response to stress, as described by Trimble and Wilson-Barnet[14] in the case of epileptic seizures. Finally, the physical disease itself may be a stressful experience which can delay recovery or cause other forms of ill health, especially if it involves loss of income or of job security or a change in personal relationships.

Stress and life changes

Many of the stressors mentioned above, such as bereavement, migration or the birth of a child, involve prolonged, major *changes* in the patterns of people's lives. In recent years, more attention has been paid to the possible negative effects of these changes on both mental and physical health. From this point of view, stress represents an inadequate adaptation to change, an unsuccessful attempt on the part of the individual to cope with and adapt to the changed circumstances of their lives – whether promotion at work or the loneliness of widowhood. Parkes[1] provides a useful way of viewing these changes, or psychosocial transitions. He points out that the change is likely to take place in that part of the world which impinges upon the self – the 'life space'. This consists of 'those parts of the environment with which the self interacts and in relation to which behaviour is organized; other persons, material possessions, the familiar world of home and place of work, and the individual's body and mind in so far as he can view these as separate from his self'. They also involve changes in the basic assumptions that people have made about their worlds, for these can no longer be taken for granted. In Parkes' view, the psychosocial transitions most likely to cause stress are those that are lasting in their effects, take place over a relatively short period of time and affect many of the assumptions that people make about their worlds. In that sense, the sudden unexpected loss of a spouse or job is likely to be more stressful than other slower transitions, such as those involved in growth and maturation. Changes such as bereavement, losing a job, or migration will involve many aspects of an individual's life space, such as social relationships, occupational status, financial security and living arrangements, and are more likely to provoke a stress response.

The effects of these changes on both mental and physical health have been studied by several investigators. In their study of bereavement, for example, Parkes and colleagues[15] examined the death rates of 4486 widowers aged 55 years or older for 9 years following the death of their wives. Of these, 213 died in the first 6 months of bereavement – 40 per cent above the expected death rate for married men of the same ages. The death rate from degenerative heart disease was 67 per cent higher than expected. The mortality rate dropped to that of married men after the

first year. The authors ascribed the increased death rate to 'the emotional effects of bereavement with the concomitant changes in psychoendocrine function'. Other studies have reached similar conclusions; in a significant number of cases ill health is preceded by a high level of psychosocial transitions or 'life events', especially if these events are perceived as negative.

The precise causal link between these life changes and the occurrence of ill health remains unclear, though various hypotheses have been advanced. Murphy and Brown[16], in examining the question 'whether stressful situations bring about episodes of illness associated with pathological structural changes occurring in a tissue, system or area of the body', point out that in most cases illness will *not* follow from an experience of stress, but where it does the link is likely to be a psychiatric disturbance. They cite evidence that individuals with psychiatric disorders have a significantly higher rate of organic illness, and hypothesize that 'stressful circumstances lead to organic illness by first producing a psychiatric disturbance'. In their study of 111 women in London, 81 had developed a new organic disease (from which they had previously not suffered) in the previous 6 months. Of this latter group, 30 per cent (24) had had at least one severe life event before the onset of ill health, compared with 17 per cent of a matched comparison group. However, this association applied only to women aged between 18 and 50 years, where 38 per cent had had at least one severe event compared with 15 per cent of a control group. In this age group, 30 per cent had experienced the onset of psychiatric disturbance in an average period of 7 weeks before the start of their illness, compared with an expected 2 per cent in the control group. The authors conclude that 'it is the onset of psychiatric disturbance rather than a severe event that is the immediate cause of organic disorder for those [women] under 50'. The events most likely to cause psychiatric disorders are those involving long-term threat to the 'life space', such as an unplanned pregnancy, or terminal illness in a relative. However, the exact physiological mechanism whereby life events, psychiatric disorder and organic illness are interlinked remains unclear. Engel[17] has also pointed out how sometimes illness and even death can be preceded by a period of psychological disturbance, during which the person feels 'unable to cope'. He termed this the 'giving-up–given-up

complex', and suggests that this state 'plays some significant role in modifying the capacity of the organism to cope with concurrent pathogenic factors'. It is characterized by: a feeling of psychological impotence or helplessness ('giving-up'); a lowered self-image as one who is no longer competent, in control or functioning in the usual manner; a loss of gratification from human relationships and social roles; a disruption of the sense of continuity between past, present and future; and reactivation of earlier memories of helplessness or giving-up. In this state, the person is less likely to deal with pathological processes, though the complex itself does not 'cause disease directly but rather contributes towards its emergence'. Once again, the precise physiological mechanism by which this occurs remains unclear. However, the three perspectives mentioned above – 'psychosocial transitions', 'life events' and the 'giving up–given-up' complex – all provide useful ways of viewing the effects on health and illness of such dramatic changes in life space as migration, urbanization, conquest, refugee status, rapid social or technological change and voodoo death.

Factors influencing the stress response

In Selye's original model, stress represented a pathological physical response to environmental demands. However, as noted earlier, this response is mediated by a number of other factors, including:

1. The characteristics of the individuals concerned
2. Their physical environment
3. The social support available to them
4. Their economic status
5. Their cultural background.

Individual characteristics

The individual's characteristics that influence response to stress are partly physical (such as age, weight, build, genetic make-up, state of nutrition and previous health) and partly psychological. Weinman[4] points out how differences in personality affect response to stress, from phlegmatic types to those whose response is primarily somatic –

such as the 'gastric responders' or 'cardiovascular responders'. Infantile and childhood experiences also play some part, as do the individuals' perception of whether they have control over their lives or not. In the work situation, for example, Karasek and colleagues[18] have related a low sense of personal control to high levels of stress response. To a variable degree, the individual's outlook on life, including his or her hopes, fears and ambitions, is conditioned by socio-cultural background as well as by early upbringing.

Physical environment

Physical sources of stress include extreme heat, cold, dryness and damp, and sources of tissue damage such as pathogenic organisms, burns or trauma. In all these cases, the nature and extent of the environmental stressor will influence the severity of the stress response.

Social support

Social and cultural factors tend to overlap in practice, but will be considered separately. Several authors have noted the importance of social support, at all stages of life, in protecting against stress. Weinman[5] notes how 'insufficient early support can give rise to physical and behavioural abnormalities, including a reduced ability to withstand stress' later in life. Brown and Harris[19] have demonstrated that women who lost their mothers before the age of 11 years are more vulnerable to depression in adulthood, and a close and confiding relationship with another person helps protect against stress and psychiatric disorder. Kiritz and Moos[20] also pointed out the relationships of social environment to stress. In their view, social support and a sense of group cohesion protect against stress, while a sense of personal responsibility for others increases the physiological stress response. It is also increased by work pressure (to complete a large number of transactions per unit time), uncertainty (about the possibility of physical or psychological harm) and change in their psychosocial environments (such as job relocation or redundancy). Some social factors, such as violence – whether domestic, crime-related or political – can be important stressors, with a major impact on the mental and physical health of the individual.

Economic status

Economic factors are especially relevant to the stress response. Unemployment, deprivation and poverty (and the associated poor housing, diet, sanitation, clothing and exposure to crime and violence) are potent stressors in any community, as is loss of income and financial insecurity resulting from either physical or mental ill health. The competitiveness, high expectations, long hours and lack of job security associated with so many careers in the industrialized world today also leads to a heightening of the stress response.

Cultural background

Cultural factors play a complex role in the response to stress. In general, this role might considered to be either protective or pathogenic. Culture also helps to shape the *form* of the stress response into a recognizable language of distress. That is, different cultural groups exposed to similar stressors may display different types of stress response, as may men and women within the same cultural group. In their study of French, American, Filipino and Haitian college students, Guthrie and colleagues[21] found clustering of the different symptoms of stress in the four groups. The Americans, for example, reported more gastrointestinal symptoms, while the French reported more changes in mood or thought content. The Filipinos, especially the women, tended to emphasize cardiovascular symptoms, such as a rapid heartbeat and shortness of breath. Symptoms such as dizziness, headaches, nightmares and muscle twitches were more often mentioned by women in all four groups, and the authors suggest that 'in certain societies it may be less socially acceptable for males to admit and experience this constellation of symptoms'. The cultural values of a group may also *protect* against stress – for example, by strengthening social and family cohesion and mutual support, which enable the individual to cope better with the vicissitudes of life. A culture's world-view can also have this effect, by placing individual suffering in the wider context of misfortune in general. This is characteristic of religious world-views, especially those with a fatalistic view of misfortune as being an expression of divine will or fate. Membership of a group with such a shared conceptual system also helps give
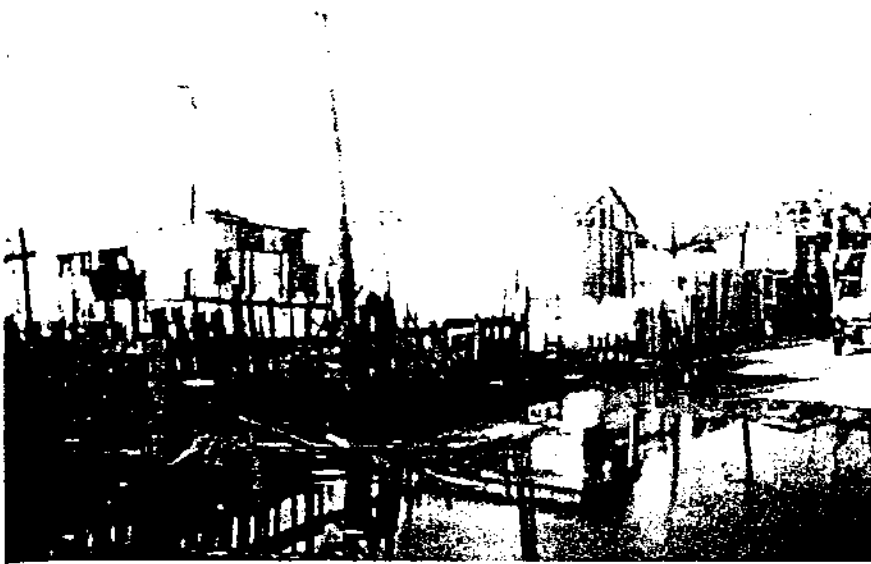
Figure 11.1 A *favela* or shanty town in Porto Alegre, Brazil. Poverty, unemployment, poor housing, and inadequate sanitation are all major sources of stress in many parts of the world (Source: Cecil Helman).

meaning and coherence to daily life, and reduces the stress of uncertainty. Cultures that value meditation and contemplation rather than competitiveness and material achievement are probably less stressful overall to their members. A further factor is that in many societies the rearing of children (and the stress that goes with it) is shared among several adults of an extended family as well as the parents, and this may also have a protective function. In looking at non-Western or pre-industrial societies, however, care should be taken to avoid what has been termed 'the myth of the stress-free "primitive" existence'[22]. Contrary to the WHO's contention[9] that stress as 'a traditional method of adaptation has become inadequate in the psychological, social and economic circumstances of modern society', the evidence is that traditional societies, too, have their full share of damaging stressors.

'Culturogenic' stress: the nocebo effect

While culture can protect against stress, it can also make it more likely. That is, certain cultural beliefs, values, expectations and practices are likely to *increase* the number of stressors that the individual is exposed to. For example, each culture defines what constitutes 'success' (as opposed to 'failure'), prestige (as opposed to loss of face), 'good' behaviour (as opposed to 'bad') and good news (as opposed to bad tidings), and there is considerable variation between these in different societies. In part of New Guinea, for example, failure to have enough pigs or yams to exchange with other tribal members on certain occasions may lead to a stressful loss of face; in the Western world, failure to 'keep up with the Joneses' in terms of consumer objects may also result in subjective stress. In each society, individuals try to reach the defined goals, levels of prestige and standards of behaviour that the cultural group expects of its members. Failure to reach these goals, even if the goals seem absurd to members of another society, may result in frustration, anxiety, depression and even the 'giving-up–given-up' complex described below. Some beliefs can be directly stressful, such as the belief that one has been 'cursed' or 'hexed' by a powerful person against whom there is little defence. In some cases, as in 'voodoo death', this may result in the victim's death after a short period of time. Other cultural values that may induce stress are an emphasis on warlike activities, or intense competition for marriage partners, money, goods or prestige. The unequal distribution of wealth in a society, based on its economic culture, is usually stressful to its poorer members, whose lives are a daily struggle for survival; however, economic privileges also sometimes involve high levels of stress, due to competitiveness and fear of the poor.

In its effect upon the health of the individual, therefore, there are both negative and positive sides to belief. As Hahn and Kleinman[23] put it, 'belief kills; belief heals'. Those beliefs and behaviours that contribute to stress, and are

acquired by growing up within a particular society, can therefore be regarded as a form of culturally induced or 'culturogenic' stress.

This type of stress is also an example of the nocebo phenomenon (from the Latin root *noceo*, I hurt), which is the negative effect on health of beliefs and expectations – and therefore the exact reverse of the placebo phenomenon (see Chapter 8).

Culturogenic stress: some examples

The most extreme form of culturogenic stress and the nocebo effect described by anthropologists is known as 'voodoo death', 'hex death' or 'magical death', which Landy[24] prefers to term *socio-cultural death*. This phenomenon has been reported from various parts of the world, including Latin America, Africa, the Caribbean and Australia, and is usually found in traditional, pre-industrial societies. In magical death, people who believe they have been marked out for death by sorcery sicken and die within a short period, apparently of natural causes. Once victims and those around them believe that a fatal curse has been placed upon them, then all concerned regard them as doomed. As Landy puts it, a 'process is set in motion, usually by a supposed religious or social transgression that results in the transgressor being marked out for death by a sorcerer acting on behalf of society through a ritual of accusation and condemnation; then death occurs within a brief span, usually 24 to 48 hours'. The anthropologist Claude Levi-Strauss[25] has provided a graphic account of this process, beginning with the individual's awareness that he is doomed, according to the traditions of his culture. His family and friends share this belief, and gradually the community withdraws from him. Often they remind the unfortunate victim that he is doomed, and virtually dead. Then:

> Shortly thereafter, sacred rites are held to dispatch him to the realm of shadows. First brutally torn from all of his family and social ties and excluded from all functions and activities through which he experienced self-awareness, then banished by the same forces from the world of the living, the victim yields to the combined terror, the sudden total withdrawal of the multiple reference systems provided by the support of the group, and, finally, to the group's decisive reversal in proclaiming him – once a living man, with rights and obligations – dead and an object of fear, ritual, and taboo'.

This situation is a classic example of Engel's 'giving-up–given-up' complex, which he sees as a life setting conducive both to illness and to sudden death. He has analysed the reports of 170 cases of sudden death[26], and finds certain common themes in most of them:

- they involve events that are impossible for the victim to ignore
- the individual experiences or is threatened with overwhelming emotional excitation
- the person believes he or she no longer has control over the situation.

Ten of the cases involved sudden death during loss of status or self-esteem; for example, two men who were confidently expecting promotion to important positions dropped dead when their expectations were unexpectedly dashed. Various hypotheses have been advanced to explain the mechanism of culturogenic sudden death. Cannon[27] believed it was due to overactivity of the sympathetic nervous system – the 'fight or flight' response – in a situation where the victim is (culturally) immobilized and can do neither. According to Engel[28], it is due to vasovagal syncope and cardiac arrhythmias in a patient with pre-existing cardiovascular disease. This occurs in cases of emotional arousal and psychological uncertainty, where both the sympathetic ('fight–flight') and parasympathetic ('conservation–withdrawal') systems are simultaneously activated. In Lex's[29] view this simultaneous activation takes place in the settings characteristic of magical death. In this state the nervous system is 'tuned' or over-sensitized, and the individual is more vulnerable to suggestions that he will die by magical means; he is also vulnerable to acute parasympathetic hyper-reactivity, or vagal death.

'Magical death' is an extreme and dramatic form of the culturogenic stress response. It represents the reverse of Hertz's[30] model of bereavement (see Chapter 9), for here social death *precedes* biological death by a variable period of time. In a Western setting, long-term admission to a psychiatric institution, old age home, geriatric ward or prison can also be seen (in some circumstances) as a form of socio-cultural death. It involves a major change in life space, and a new set of stressors for the inmates of these institutions, and has been well described by Erving Goffman[31] in his work on the impact of these 'total environments' on their inmates.

A modern form of social death was commonly seen among the victims of the acquired immuno-

deficiency syndrome (AIDS), especially in the first years of the epidemic. Cassens[32] described the many stressful social consequences that occurred for homosexual men who had been diagnosed as having this condition. As well as the physical illness itself, they had to cope with guilt, anxiety and the fear of certain death, and the prejudices of other people (see Chapter 5). There was also a loss of privacy about their sexuality, possible loss of employment and rejection by family and friends, and constant exposure to lurid stories in the media with their 'tones of sin and retribution' – which could only enhance their sense of social isolation and rejection.

Another, though much less extreme, example of culturogenic stress is the damaging effect on health and behaviour of certain *diagnostic labels* – for example, patients told by their doctor 'you've got cancer', 'you've got a weak heart' or 'you've got hypertension'. In Waxler's[33] view, certain diagnostic labels can affect patients' symptoms, behaviour, social relationships, prognosis and self-perception, as well as the attitudes of others towards them. This may even occur in the absence of physical disease. In this case, the nocebo phenomenon results from lay beliefs about the origin, significance, severity and prognosis of 'a weak heart' or 'hypertension', and about the behaviour appropriate to sufferers from that condition. Patients may see themselves as ill or disabled, while family and friends may begin treating them in a particular way – encouraging them to change their diet or behaviour, or to take special precautions. Like the patient, the relatives' attitudes are shaped by cultural beliefs about the significance of certain diseases. In the case of children, this might have lifelong effects; parents of a child labelled 'asthmatic' may, based on their own childhood memories of what asthma entailed, prohibit the child from a wide range of social or sporting activities. A diagnostic label can thus become a form of self-fulfilling prophecy. Some individuals who are labelled as 'ill' may become enmeshed within certain institutions that sustain the label rather than encourage its disappearance. Waxler notes how organizations such as Alcoholics Anonymous, for example, may inadvertently prolong an individual's label of 'illness' because 'a large percentage of AA members' social lives centers on the organization and other members, thus isolating them from normal relationships and further strengthening their role as "alcoholics"'.

She quotes another study of a group of American farmers who had no evidence of cardiac disease, but who labelled themselves as having 'heart disease', due to misunderstanding their doctors' diagnosis. As a result they took more heart-related precautions, and generally acted like cardiac invalids. As Waxler points out, the label itself – what the farmer or his family *believed* to be the case – had an important effect upon his behaviour, even when he had no symptoms and no disease. Another example of how labelling can affect everyday behaviour is described by Haynes and colleagues[34], who screened factory workers for hypertension. In those (asymptomatic) patients who were told they had 'hypertension', absenteeism from work rose by 80 per cent, greatly exceeding the 9 per cent rise in absenteeism in the general employee population during the same period. Certain diagnostic labels, therefore, if they provoke anxiety and foreboding (such as 'cancer'), are likely to act as additional stressors, especially if the person is already physically ill.

Similarly, certain settings (such as a hospital clinic or doctor's office) can also induce so much anxiety that it causes a physiological response, which can be misdiagnosed as disease. The two best-known examples of this phenomenon are 'white coat hypertension'[35] and 'white coat hyperglycaemia'[36]. In the former, higher blood pressure readings are found when taken in a medical setting, compared to measurements taken in the patient's home. In the latter, it is the blood glucose level that is higher when measured in the clinic, compared with a similar test carried out in the home.

A final example of how the cultural values of a society may contribute towards stress and disease in its members is seen in the case of coronary heart disease (CHD). This condition is believed to have a multifactorial aetiology, and a number of risk factors that predispose to its development have been described. These include a high dietary intake of saturated fats, lack of exercise, cigarette smoking, raised serum cholesterol and hypertension. However, the work of Friedman and Rosenman[37] suggests that psychosocial patterns, especially behaviour patterns and personality type, also play a role in its aetiology, particularly in susceptible individuals. They have described the characteristics of what they term the *Type A behaviour pattern* (TABP) – in particular, the chronic struggle to achieve an unlimited number of goals in as short

a time as possible. Those individuals displaying the TABP show marked aggressiveness, ambition and competitive drive; they are work-orientated and 'workaholic' people, preoccupied with deadlines and chronically impatient[37]. Their personal lives are emotionally parched and incomplete, and both family and leisure are less important to them than work and ambition. Long-term follow-up studies have shown that individuals with this behaviour pattern are about twice as likely to develop CHD as other adults of similar age without these traits (known as the *Type B* behaviour pattern)[38]. According to Friedman and Rosenman, modern Western industrial society encourages the development of Type A traits, and rewards them. Those who exhibit them often become successful executives, professionals, politicians, managers, technocrats and salesmen. However, these rewards often involve constant anxiety about failure, demotion or loss of control. Appels[39] saw this type of personality as one who cannot manage or handle the pressures of the industrialized, fast-moving and achievement-orientated society and who, by this very failure, shows the characteristics of this society in an excessive way. In his study of 22 societies he found that the mortality rate from CHD was positively correlated with a cultural emphasis in the societies on the need for achievement. Waldron[40] has examined the relationship of Type A behaviour and gender within the USA, where the risk of CHD is twice as great in men as in women. She suggests that while men's excess vulnerability may be partly due to hormonal factors, cultural factors also play a part. In particular, Type A behaviour can contribute to success in traditional male roles and professions, but not in the traditional female role in society. Accordingly, parents and other socializing institutions may promote Type A characteristics in boys but not in girls, and later in life this may protect a higher proportion of the women from the risk of CHD.

It is possible therefore to view the Type A behaviour pattern as a Western culture-bound syndrome (see Chapter 10), embodying many of the cultural values of an industrial, capitalist society, where competition, ambition, materialism and the time-urgency of rush hours and deadlines are all part of daily life. Furthermore, this model of stressful behaviour also encompasses some of the *contradictions* within the cultural values of Western society, and the Type A individual is the living embodiment of those

contradictions. On the one hand, for example, he conforms to the social values of his society — to what Weber[41] terms its 'philosophy of avarice' — and is rewarded for doing so, but on the other hand his hostile, competitive behaviour is also *anti*social, damaging to himself, his family, his friends and those he works with. It can be argued that this paradox of values – that some forms of antisocial behaviour are being constantly rewarded by society – is symbolically resolved (at least for a while) when he is 'punished' by suffering a heart attack, and emerges from the hospital as a chastened, fragile and less aggressive Type B[42].

Chapter 12 will include discussion of how some immigrants to the USA, such as the Japanese, seem to be partly protected by their cultural background against the risk of both Type A behaviour and CHD, provided they retain many of their traditional cultural values.

Stress and migration

Migration from one culture to another (or from one part of a country to another) is often a traumatic experience, involving major disruptions in the individual's 'life space'. As Eitinger[43] noted, new immigrants have to deal with isolation, helplessness and a feeling of insecurity in their surroundings, coupled with a flood of incomprehensible stimuli. Not only have they left family, friends and a familiar locality, but many of their assumptions about their world are no longer valid. They are often faced with language difficulties, with hostility or indifference from the host population, and with new cultural practices that may be at variance with their religious beliefs. Also, migration is often not only between cultures but also from a small village community to a big metropolis; from the life of a peasant on his own little plot of land to that of an unskilled labourer in the big city. While some of the migrant's cultural values, such as an emphasis on family cohesion, may be protective against stress, the experience of migration is usually a profound psychosocial transition – analogous in some ways to bereavement or disablement. Eisenbruch[44] has coined the term *cultural bereavement* for those groups of people who have suffered a permanent traumatic loss of their familiar land and culture. This applies especially to unwilling migrants such as exiles and refugees, suddenly uprooted

during war or persecution. The stressful changes that such a group may undergo in its collective grief are analogous to those suffered by individual mourners, and may include pathological and atypical grief reactions.

Actual physical migration is not the only cause of stress. One can also 'migrate' socially and economically, from one social class to another, without actually changing locality. For example, a person who was born poor but who then makes money (or wins a lottery or other prize) and rises rapidly in the social scale, even without actually leaving the home village, town, or neighbourhood, can be considered a type of social migrant. Often this rise in social status can be a major psychosocial transition, involving considerable stress; new insecurities, anxieties and pressures, possible alienation from family and friends, the fracturing of old relationships and so on. For example, Dressler[45] has described the types of stress response (such as a rise in blood pressure, or psychosomatic symptoms) that are often associated with modernization, economic development, social change and upward social mobility in some communities in the Caribbean and the USA. In many cases economic development raises expectations, fuels competitiveness, increases dissatisfaction and widens the gap between rich and poor. In this situation, both those who rise socially and those who fail to do so can suffer from considerable stress, although for different reasons and in very different ways.

Some of the stress responses (both physical and psychological) of immigrants to the UK and the USA have been examined in a number of studies outlined below, though the exact mechanism by which these relate to migration is complex and not yet fully understood.

Case study: Effects of migration on blood pressure

Cassell[46] has reviewed the research done on the effects of migration on blood pressure. In one study, the blood pressure of black migrants from the Southern USA to Chicago was compared with that of Chicago-born blacks. It was found that the longer the period of city life, the higher their blood pressure. In another study, the blood pressures of inhabitants of the Cape Verde Islands (off West Africa) were compared with those of Cape Verdeans who

had migrated to the eastern USA. The immigrants showed higher pressures at each age, and a sharper difference between young and old than did the islanders. Other studies showed higher rates of hypertension among Irish immigrants to the USA (32 per cent) when compared with their brothers living in Ireland (21 per cent). In Cassell's view, the findings of these studies are unlikely to be due to genetic differences between those who emigrate and those who stay behind, but possibly to genetic differences in the susceptibility to environmental influences among individual migrants. These influences include such physical factors as caloric intake, physical activity and salt intake, and the absence of certain parasites and diseases in the host country which, in the country of origin, usually cause wasting, anaemia and a fall in blood pressure. However, psychosocial factors also play a part, particularly the disappearance of a coherent value system and its replacement by different values and different situations, where the migrant's traditional way of coping with life is no longer effective.

Case study: Mental illness among immigrants in Manchester, UK

Carpenter and Brockington[47] examined the incidence of mental illness among Asian, West Indian and African immigrants living in Manchester. It was found that the migrant populations had about twice the first admission rate to mental hospitals that British-born subjects had, especially those migrants aged 35–44 years, and also Asian women. Schizophrenia was particularly common among the immigrants, especially with delusions of persecution, a phenomenon noted in many other studies of migrants. The authors hypothesized that 'social and lingual isolation ... insecurity and the attitudes of the milieu are the explanations for the development of persecutory delusions'.

Case study: Psychiatric admissions to hospitals of foreign-born people in Bradford, UK

Hitch and Rack[48] studied the rates of first admission to psychiatric hospitals in Bradford, and found that foreign-born people had substantially higher mental illness rates than British-

born people. The rates of psychiatric breakdown of a sample of Polish and Russian refugees in Bradford were measured 25 years after they had settled in the UK. While both had higher rates of mental illness (especially schizophrenia and paranoia) than the UK-born population, the Poles had a higher rate than the Russians. The most vulnerable group was the Polish females. The authors suggest that the difference between the immigrant groups was due partly to minimal cohesion among the Poles, and also to a strong sense of national, ethnic identity among the Russians (many of whom were Ukrainians). This ethnic social support not only afforded a protection against environmental stress, it also bestowed identity, though the Russians appeared to have maintained this identity more than the Poles. Many years after migration, though, both immigrant groups were especially vulnerable to first-time mental illness. The authors suggested that 'the combination of wartime experiences and culture shock may have been met with adequate coping mechanisms, but nevertheless rendered the personality vulnerable to later stress'. In middle age, when children have moved away from home and spouses or relatives have died, an immigrant who still speaks broken English and has no English friends will become particularly vulnerable to environmental stressors, with the consequent danger of mental or physical illness.

Case study: Attempted suicide among immigrants in Birmingham, UK

Burke, in three studies published in 1976, examined the rate of attempted suicide among Irish[49], Asian[50] and West Indian[51] immigrants in Birmingham. His findings indicate that immigrants have a higher rate of attempted suicide than the populations in their countries of origin, and this applies particularly to female immigrants. In Birmingham, those born in Northern Ireland or the Irish Republic had about a 30 per cent higher rate than the native population (as measured in Edinburgh), and higher rates than both Belfast and Dublin. Other indices of stress, such as the rates of alcoholism, drug addiction or mental illness, were also raised in this immigrant group. Asian immigrants (from India, Pakistan and Bangladesh) had a lower rate of attempted suicide than the native-born population, but their rate was higher than that of their countries of origin, especially among females. Burke

points out that language difficulties for women may play a major part in this, since Asian men have usually migrated several years earlier and have had a greater opportunity to learn the language and familiarize themselves with English culture. Female immigrants are often expected to remain at home, and there is also some culture conflict for younger Asian women and girls between the values of home and those of school or workplace. Among West Indians, too, attempted suicide was less common than in the native-born population, but West Indian women had a higher rate than women in the Caribbean; that is, the 'stresses that follow immigration and contribute to attempted suicide are more likely to affect women than men'. Part of the stress on young West Indians arises from the insecurity of low paid jobs, fear of not being able to cope financially and emotionally, housing difficulties, and the absence of the extended family in an urban setting. All of these 'may effectively reduce the tolerance of immigrants in withstanding these stresses'.

Case study: Suicide levels among immigrants in England and Wales

Raleigh and Balarajan[52] analysed national suicide rates among 17 immigrant groups in England and Wales for the years 1979–1983. Using mortality data on male and female immigrants aged 20–69 years, they found that many immigrant groups, especially Poles, Russians, French, Germans, South Africans, Scots and Irish, had much higher rates of suicide than the native population of England and Wales. The rates among Scottish and Irish immigrants aged between 20 and 29 years were particularly high. Other groups, such as migrants from the Caribbean, the Indian subcontinent, Italy, Spain and Portugal, had much lower rates than the national average. However, when the suicide rates of these various communities were compared to those of their countries of origin, they were found to be very similar. This was particularly true of male immigrants, but less true of females, especially from Ireland and Poland. The authors thus concluded that, as suicide levels in the immigrant groups differed less from levels in their home countries than from levels in England and Wales, 'the findings do not suggest that migration increases the risk of suicide'. Although they agreed that 'the economic and social changes associated with

migration can often be stressful', they suggested that 'reaction to such stress is conditioned by the social and cultural attitudes inculcated in the country of origin'.

It should be emphasized that these four studies dealt predominantly with the *first* generation of immigrants to the UK, people who were born outside the country. They do not necessarily apply to those born and raised in the UK, whose experiences and degree of acculturation are likely to be different from those of their parents. Some of the evidence of stress among the second generation, born in Britain, has already been described in Chapter 10. In addition, while all the studies seem to indicate higher levels of certain physical, emotional and social problems ('stress responses') among first-generation immigrants, there are some inconsistencies among them. Burke's studies[49,50,51], for example, indicate higher levels of *attempted* suicides among immigrants to the UK, while Raleigh and Balarajan[52] found *actual* suicide levels no higher among the immigrant population – although they did note that from 1970 to 1983 in England and Wales, suicide rates did significantly increase among some immigrant groups, especially those born in Russia, Ireland and South Africa. Furthermore, there are apparently wide variations in how different groups respond to the experience of migration. While these studies are useful in illustrating the high level of stress among immigrants, they do not provide enough data on *how* the cultural practices and world-view of immigrants – and of the host community itself – interact in the migrant situation. For example, which cultural traits in immigrant communities protect them from stress or predispose towards it? Do some cultural groups migrate less 'stressfully' than others? Is the status of temporary migrants (such as *gastarbeiters*) less or more stressful than that of permanent migrants, exiles or refugees? What are the effects of racial discrimination and racial prejudice, both individual and institutional, on immigrants' mental and physical health? Are some host cultures more 'stressful' to immigrants than others?

Another factor, mentioned in Chapter 10, is that the medical and other authorities in the host community determine whether deviant behaviour among immigrants is regarded as 'mad' or 'bad', and this can significantly affect the morbidity statistics among immigrant populations.

Collective stress and social suffering

Under some conditions, an entire population may be said to be 'under stress'. This form of social suffering is particularly common in conditions of war, civil unrest, natural disasters, population movements, political oppression, economic insecurity and extreme poverty. In some cases, several of these factors may operate at the same time and in the same place.

In the sense of collective suffering, the twentieth century may be seen as one of the most stressful in human history. In addition to two world wars, there have been numerous civil wars, inter-ethnic strife and widespread political repression. There has been genocide and ethnic cleansing, including the Armenian massacres of World War One, the Nazi holocaust of World War Two, the genocides of Cambodia and Rwanda, and the mass killings in Bosnia, Kosovo and elsewhere. In addition, Desjarlais and colleagues[53], in the *World Mental Health* report, cited the numerous low-intensity wars – such as those that have ravaged parts of Africa, Latin America, and Asia for many years – as a particular cause of considerable stress and tension at the population level. In these conflicts the aim is usually control over populations rather than territory and, as a result, violence often takes take place anywhere within the country, and can affect civilians as well as soldiers. As with other conflicts this century, these low-intensity wars have left large numbers of people with the *post-traumatic stress disorder* (PTSD) – suffering long-term symptoms of anxiety, depression, psychosomatic disorders and social dysfunction, and 'flashbacks' to traumatic events – even long after the conflict is over and the 'stress' of it has receded[53,54]. Because many of these conflicts have taken place in poorer countries, at the margins of the world economy, the access of millions of victims to medical and mental health facilities is often very limited.

In circumstances where a similar level of stress is shared by many others in the population, what is the effect of this on the individual? Does it help make their own experience less stressful in some way, or more so? And how can communities who have collectively suffered social stress heal themselves in a collective way?

According to Desjarlais and colleagues[53], a collective healing process almost always involves people talking openly about their pain and suffering. Often the authorities have imposed a 'wall of silence' that has to be breached before healing can take place. Expressing these narratives or trauma stories, either in public or to a therapist, is one way that people can give meaning to their experience, enabling them to leave the past behind them (see Chapter 5). In South Africa, for example, Swartz[54] has described the situation of the many millions of non-white people who lived under the oppressive racist system of *apartheid*. Over almost 50 years, many of them were subject to constant humiliation, social and economic discrimination, the break-up of families, arbitrary arrest, forced relocation, and sometimes torture, extra-judicial killings and 'disappearances'. Although the effects of this system on the health of the population are difficult to quantify, it has left behind a considerable legacy of social, psychological and economic problems, including poverty, violence, crime and substance abuse. In order to heal itself on a collective level, post-*apartheid* South Africa has tried to achieve a shared 'national healing' of this stressful period by setting up a Truth and Reconciliation Commission (TRC). Its main slogan is: 'Truth: The Road to Freedom'. To a large extent, this model is based on psychoanalytic approaches to individual psychotherapy – 'finding the truth as a basis for healing'. The TRC has encouraged both perpetrators and victims to describe publicly the traumatic events that actually occurred under *apartheid*, and their role in it, in order to get either amnesty or compensation. However, Swartz points out that national healing, although essential, may not necessarily heal individual victims. In some cases the revelations at the TRC may prove cathartic to those who partake in them, but in others they have the opposite effect – reminding people of distressing events, and making them feel even worse as a result. In either case, an individual's response both to suffering ('stress') and to national healing, even if it is part of a more collective experience, is often idiosyncratic, difficult to predict and, like other forms of stress response, marked by non-specificity.

Refugees and stress

Today, the most common form of collective stress is probably to be found among *refugees*. In 1993 it was estimated that there were between 15 million and 50 million of them world-wide, from wars, civil unrest and natural disasters. Another estimate in 1995[56] assessed that there were 20 million 'official' refugees world-wide, and another 20 million people internally displaced within their own countries. The United Nations High Commission for Refugees has estimated that about 80 per cent of refugees are women and children[56]. Many refugees will have witnessed or personally experienced acts of extreme violence, sometimes including sexual abuse. As well as loss of home, property and possibly loved ones, they will also have experienced a major psychosocial transition. Many of them will be suffering from what Eisenbruch terms 'cultural bereavement'; grieving for the loss of all the familiar cultural reference points that defined who they were and how they were to live their lives. They will also have lost their livelihood, their sense of security and continuity, and even their sense of self. Many will encounter hostility among their host populations. Others will experience outbreaks of infectious diseases and other health problems. There may also be alcohol or drug abuse, or different forms of antisocial behaviour – especially among the youth. Overall, flight from one's home under these circumstances is likely to lead to major physical, emotional and cognitive distress, and often long-term PTSD[54], among refugee populations. To a certain extent, some protection for the refugees may arise from the social support available to them, especially if this comes from family, friends, people from their own community or voluntary workers. Religious figures and traditional healers may also play a positive role. In some cases, religious faith or ideological conviction can also help ameliorate the stress of their situation. Given the vast scale of many refugee situations today, both individual and collective healing may only be possible on a relatively small scale. For many individual refugees, true healing can only begin when they return home safely or when they become reconciled to a new life, in a new country.

Lay models of stress and suffering

In the past few decades the concept of 'stress' outlined above has increasingly entered popular discourse, and is now commonly used in books,

magazines, radio and television programmes. Lay concepts of stress are often those of a diffuse and invisible force, somehow mediating between individuals (and their mental and physical state) and the social environment in which they live and work.

The lay concept of stress can be regarded as one of the most pervasive and multidimensional folk illnesses of contemporary Western society. More importantly, in the modern age it is also one of the most widely used *metaphors* for human suffering, and especially one that places responsibility for that suffering outside the individual. Like 'heart distress' and 'sinking heart' (see Chapter 5), lay notions of stress blend together into a single image, a cluster of negative feelings, emotions and physical sensations, as well as certain social, cultural and economic circumstances. In doing so, it has absorbed older, more traditional models of misfortune and unhappiness, especially where they originate outside the individual. It has become a secularized version of more supernatural concepts, such as witchcraft, sorcery and other forms of interpersonal malevolence, as well as of fate, divine punishment and possession by malign spirits. Modern images of stress provide a fascinating illustration of how Selye's original concept has entered popular culture and blended with older models of misfortune, becoming a point of overlap between popular, medical and religious explanations for human suffering.

In the author's study[10] performed in Massachusetts, USA, 95 per cent of a sample of patients with psychosomatic disorders blamed their condition and personal suffering on 'stress', though they varied widely on what they meant by this term. It was variously described as:

- an invisible force in the environment, pressing down on the individual (to be 'under acute stress')
- an invisible and malevolent force, usually produced by other people, that enters your body and then causes disease ('stress can cause my bronchi to spasm', 'stress goes to the weakest organ. I let it get to me and eat me away')
- something that 'builds up' inside you unless you can get it out ('a good relationship can make you stay healthy, because you can ventilate a lot of stress').

'Stress' explanations are just as common in Britain, too. In one study[57] of 406 patients in an English general practice, 53 per cent of them blamed their illnesses on different types of stress – which they thought could be relieved by medical explanations of their condition and by discussion of their symptoms.

In English-speaking countries, a number of recurrent images or metaphors associated with the word 'stress' can therefore be identified. Each is a metaphor for a sense of personal suffering, and often of helplessness. Many of them overlap with lay concepts of 'nerves' (see below). Most of these metaphors, though not all, are drawn from the artefacts and technology of everyday life; heavy objects, machines, cars, batteries, electrical wires, strings, rubber bands, kettles, crockery and pottery. Some of them refer to the stress itself, others to reactions to the stress. Among the most common of these metaphors are the following:

1. Stress as a heavy *weight*. In this image, stress is conceived of as a heavy invisible weight, burden or force that somehow 'presses down' on the individuals from above – especially onto their chest, head or shoulders – and which they have difficulty in carrying. Examples include 'to be under a lot of stress', 'to be under pressure', 'to be under tension', to 'have things piling up on top of me', 'to have a lot on one's mind' (or 'on one's plate').

2. Stress as a *wire* or line. In this image, the nerves are described as if they were a series of wires, lines, rubber bands, or strings (similar to violin or guitar strings). For example, some people are 'highly strung', 'taut', 'tense', 'tightly wired' or 'at the end of their tether', while others have nerves that 'snap', or have become 'frayed' or 'jangled'.

3. Stress as *internal chaos*. Here the image is of some uncontrollable internal disorder, chaos, change or movement within the body. Examples include 'to be churned up', 'to be all mixed up', 'to be all shook up' or to have 'butterflies in the stomach'.

4. Stress as *fragmentation*. Here the image is of an object that fragments under stress, almost as if it were a plate or earthenware pot. Examples include 'to crack up', 'to fall apart', 'to break', 'to feel shattered' or 'to go to pieces'.

5. Stress as a *malfunctioning of a machine*. In this image, the body and self are seen as a machine or engine that can no longer

function. Examples include to 'have a nervous breakdown', 'to be burnt out', 'to grind to a halt', 'to crash' or to 'need one's batteries recharged'.

6. Stress as *depletion of a vital liquid*. Here the image is of the depleted level of some vital fluid, such as blood or breast milk, or – in an overlap with point (5) – of fuel or steam. Examples include 'to feel drained' or 'empty', to feel 'sucked dry', to 'run out of gas', to be 'running on empty', to 'run out of steam' to be 'at a low energy level'.

7. Stress as *inner explosion*. This image, drawn largely from the Age of Steam, conveys the idea of the build up of an internal force or pressure which, in the absence of some safety valve, suddenly and dramatically explodes. Examples include 'to get it off one's chest', 'to burst a boiler', 'to blow one's top' or 'to blow a gasket'.

8. Stress as *interpersonal force*. This image is similar to (1) above, but includes the idea of one person somehow causing (consciously or unconsciously) another person to feel stressed or to get ill. Examples include 'my boss gives me a lot of stress', 'I get a lot of stress from living with her', 'she gave him a nervous breakdown' or 'he broke his mother's heart'.

The frequent use of mechanical or machine metaphors to describe ideas of stress is also linked to another common contemporary image in both stress literature and popular discourse; the dangerous, disease-producing nature of 'modernity' itself. This idea of modernity as being pathogenic is not, in itself, modern. In 1897, for example, the famous physician Sir William Osler described 'arterial degeneration' as resulting from 'the worry and strain of modern life', and from 'the high pressure at which men live, and the habit of working the machine to its maximum capacity'[58]. Much of the contemporary New Age and other metaphysical movements also see modern life, modern diets and urban living as inherently stressful[59]. As one American woman put it to McGuire[60], stress 'has to do with some kind of thing that's very much a part of our Western culture – accomplishment-oriented, striving, being seen, having a big voice ... Making it, striving, getting ahead, that kind of thing. Really makes us crazy and makes us sick'. Often these ideas are associated with a sense of nostalgia for some more 'natural' way of living – for a

pre-industrial, more communal, non-competitive and notionally stress-free Garden of Eden.

'Nerves'

One of the commonest folk images of suffering, found in many different forms and in many different cultures, is the idea of 'nerves'. It seems to be particularly common among women, especially in Europe, North and South America and all the English-speaking countries, and usually overlaps with lay concepts of stress. Like stress, it incorporates physical, psychological and social experience into a single image. It also places the emphasis on an ostensibly physical phenomenon; the malfunctioning of a diffuse part of the body vaguely described as 'the nerves'. As illustrated earlier, these can be conceptualized in many different ways. However, unlike in the stress model there seems to be more emphasis on *internal reasons*, within the individual, for their emotional suffering or illness and their vulnerability to the stress of daily life. Thus some people are just born with 'weak nerves' or 'bad nerves', some inherit them from their parents, while others acquire them in childhood or adulthood – when their nerves were 'frayed', 'shattered', 'broken', or 'shot to ribbons' by some traumatic event. In each case, 'nerves' are blamed for predisposing the individual to ill health. As one 72-year-old asthmatic woman put it: 'A nervous person gets asthma. All through my life I never thought I was a nervous person, but I must have been. Behind it all there must have been a case of nerves'[10].

Anthropological studies of 'nerves' reveal that it is not a single image, folk category or culture-bound syndrome. Nor is there a clear and consistent set of symptoms associated with it. Rather, the concept of 'nerves' can only be understood in terms of the specific and local social *context* in which the word is used; as a way of explaining an individual's personality, for example, or their emotional, physical or social reactions to certain events. One problem is that physicians often misinterpret the significance of 'nerves' and the vague symptoms associated with it. As Finkler[61] points out, they often 'objectify and separate the disorder from the patient's experience in which the disorder is embedded', and assume that it is due to physiological malfunction. By concentrating on the 'disease' rather than the 'illness' dimension of

found that both men and women, of all ages and from all social classes, could be afflicted by 'nerves' (nervios). In a culture where family links and the *tranquilidad* (tranquillity) of family life are very important, it is often a symptom of family discord or disruption of the family structure. For example, a crisis of *nervios* may be precipitated when a son marries an undesirable woman, when a child is born illegitimately, or when a sudden bereavement occurs. People also blame their own *nervios* on a poverty-stricken childhood, an alcoholic father or a mother who was unwed when she gave birth to them. It can manifest by a variety of vague physical and emotional symptoms, including headache, insomnia, vomiting, lack of appetite, fatigue, anger, fear and disorientation. All of these indicate that the individual feels out of control, or separated from body or self. It is thus a culturally sanctioned way of signalling to others that something has gone wrong with family relationships, and that they need sympathy and attention. Overall, the belief in *nervios* is a way of 'encouraging culturally appropriate behaviour and an adherence to cultural norms', especially those that reinforce family relationships and thereby enhance family cohesion.

Dunk[63] described 'nerves' (*nevra*) among Greek immigrants in Montreal, a form of somatization found mainly among women. An attack of *nevra* manifests as a feeling of loss of control, of 'being grabbed by your nerves', which then 'burst' or 'break out'. At the same time there is often screaming, shouting, throwing things and hitting one's children. Often there are vague physical symptoms, such as headaches, neck pain, shoulder pain and dizziness. Sufferers from the condition commonly use the expression 'my nerves are broken!'. Its cause can be related to the specific conditions of the immigrants' lives, including: economic pressures, crowded living conditions, the effects of migration upon the family, gender-role conflicts and the women's double burden of running a home and going out to work. It is thus a culturally constituted metaphor for distress, and a cry for help; it can be viewed as a realistic way of coping when responded to positively by family members and others.

nerves', they may therefore miss its true significance and how it can be treated.

As these examples indicate, lay models of stress and 'nerves' are highly variable. They cannot be fully understood without taking into account the context in which these terms are used. Part of this context involves those traditional explanations for misfortune that have been absorbed into these modern models of stress or 'nerves'. In other cases – as with the *ataques de nervios* of Latino immigrants, described in the previous chapter – the wider picture must be taken into account, especially the social, political and economic context in which these immigrants find themselves. Overall, the concept of 'stress', although based originally on a limited, mechanistic model, has become one of the most pervasive images of human suffering of the modern world.

Recommended reading

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