

RECEIVED
CL. No. TR 07 - 120
DATE

**MAKING SENSE OF THE LIVED AND TOLD
EXPERIENCE OF THE 'ILL' BODY**

A Phenomenological Exploration into the Storied and Embodied Nature of
Somatic or Medically Unexplained Symptoms

A thesis submitted in partial fulfilment of the requirements for the degree of
MASTER OF ARTS IN CLINICAL PSYCHOLOGY
of Rhodes University, Grahamstown

by
CLAIRE LOUISE HAGGARD

December 2006

TABLE OF CONTENTS

Table of Contents.....	i
Acknowledgements.....	ii
Abstract.....	ii
CHAPTER ONE	
General Introduction.....	1
Overview of Relevant Chapters.....	4
CHAPTER TWO	
Introduction.....	6
Somatization: An Epistemologically Complex Concept.....	7
An Overview of the Aetiology of Somatization.....	10
Somatic Epistemology and Contemporary Theoretical Dialogues	18
The Mona Lisa Smile: The Disembodied Psyche and Literalised Soma	20
Somatization and the Absent Body.....	23
Conclusion.....	27
CHAPTER THREE	
Introduction.....	29
An Absence of Patient Perspectives: Suffering the Professional's View of the Corpse.....	31
Social Constructionism and the Body as a Renewed Theme of Exploration.....	34
Critiques of Social Constructionist Articulations of the Body.....	37
The Foregrounding of Embodiment Principles in the Radicalisation of the Role of the Body.....	39
Conclusion.....	48
CHAPTER FOUR	
Introduction	51
A Crisis of Representation: The Danger of a Unitary Concept of Somatic Distress....	52
Narrative Research: A Phenomenologically Attuned Means of Accessing Bodily Experience and Expression.....	55
Giving Voice to Experiences that Medicine Cannot Describe.....	61
Participant Selection.....	62
Gathering Information: The Narrative Life Story Interview.....	64
Narrative Analysis	68
Conclusion	70

CHAPTER FIVE

Introduction 71
Sarah: Present-Absences..... 71
Jenna: Absent-Presences..... 86

CHAPTER SIX

Concluding Discussion..... 97

REFERENCES..... 102

APPENDICES

Appendix A: Participant Information Letter and Consent Form..... 110
Appendix B: Life Story Transcripts..... 115
 Sarah’s Life Story..... 116
 Jenna’s Life Story..... 146

ACKNOWLEDGEMENTS

- ❖ To Sarah and Jenna. Without your willing, open and trusting participation, this study would not have been possible. Thank you.

I also wish to thank:

- ❖ Desmond – for your unconditional support and love throughout.
- ❖ My parents, Ray and Belinda – for fostering and nurturing my capacity to question; for persevering alongside me during some of the most challenging moments in the last two years; and for bodying forth my being-in-the-world.
- ❖ Jan Knoetze – for supervising this thesis.
- ❖ Friends both far and wide – thank you for sharing, laughing, and crying along with me. I am indebted to all of you.

ABSTRACT

Despite a wealth of literature on the aetiology of somatic distress or somatization, somatic theory has failed to expand beyond a dualistic epistemology of causation. Within the primary health context where medically unexplained symptoms are characteristically articulated as literal, symbolic gestures of internal psychological processes, individuals' subjective accounts of somatic distress are reduced to objective phenomena and thus articulated on the grounds of absence. Within this context, the body as a lived, meaningful, perceiving subjectivity is silenced in favour of the corpse, thus rendering the somatizing individual's lived and subjective experience, expression and knowledge of somatic distress inaccessible. Instead, the somatizing individual is positioned within a domain of perturbed silence – a domain in which the professional's turning away or retreat from engaging somatization on the grounds of unique, subjective and corporeal experience, positions the patient/client as a passive, silent recipient whose somatic expressions as lived are overlooked. This study attempts to initiate a theoretical focus of departure from existing articulations of somatic distress through the development of a theoretical and epistemological framework that addresses some of the tensions inherent to contemporary somatic theory. In so doing, it employs embodiment philosophy and narrative methodology as a basis for a preliminary and critical investigation into a relatively neglected area of somatization research.

CHAPTER ONE

General Introduction

Epistemologically, it could be argued that both the medical and clinical approaches to understanding, articulating and dealing with illness phenomena are deeply entrenched within an extensive history of dualistic philosophical and cultural meta-narratives (e.g. Cartesian Dualism) around the self, mind and body. Within this context, the mind and body have been culturally constructed as distinct and non-overlapping entities, such that bodily experience has come to be articulated as literal, self-contained and explainable on the grounds of the physical and thus the objective. In this sense the body is characteristically constructed as a discrete, physical entity that is external to a self that has, in turn, been rendered a singular and interiorised domain or landscape of being.

Kozłowska (2003) argues that it is within this philosophical or theoretically divided context that the mind is afforded the position of subject, where distinctions such as conscious and unconscious; subjective and objective; the physical and psychological have become the predominant and necessary vehicles for making sense of human experience – particularly human experience that appears to make present a territory to which literal and universal expressions of bodily phenomena cannot gain access (i.e. somatic distress, somatization, somatic symptoms or medically unexplained symptoms – all of which are used interchangeably throughout this study to refer to physical symptoms that lack a definitive physiological basis of explanation).

Rubin (2005) suggests that despite a wealth of literature and studies on the aetiology of somatic distress (some of which attempt to critique or challenge dualistic constructions of illness experience), somatic aetiological theory and mental health professionals alike, continue to subscribe to either/or assumptions and thus dualistic epistemologies regarding the manifestation and presentation of somatic distress. In this sense, the interpretation and understanding of somatic symptoms is chiefly informed by two distinct (and mutually exclusive) schools of thought: i) the scientific-empirical perspective where empirical events (i.e. symptom presentation) are typically afforded the distinction of the 'real', such that 'real' illness is that which has an identifiable

physical cause, and ii) the psychodynamic tradition, in which bodily expressions are afforded the distinction of guiding us towards interior psychological mechanisms (i.e. repression, dissociation, etc.) which are, in turn, considered central to the causation of the phenomena of somatic distress (Kozłowska, 2003; Swartz, 1998; Fabrega, 1991).

In this regard, the body of theoretical literature informing our understandings of the complex and elusive phenomenon and experience of somatization, is one which has failed to expand beyond a dualistic epistemology that attempts to reduce individual's physical expressions to an objective image of presenting signs and symptoms. Within this context, the body as a lived, meaningful, perceiving subjectivity is silenced in favour of the corpse, thus rendering the somatizing body-subject's lived and subjective experience, expression and knowledge of somatic distress inaccessible (Leder, 1990).

Swartz (1998) argues that our current views of the aetiology and manifestation of somatic symptoms articulate somatizing individuals' experiences on the grounds of absence, such that the professional's turning away or retreat from engaging somatization on the grounds of unique, subjective and corporeal experience (in favour of interiorised, theoretical 'knowing' or 'not knowing'), positions the patient/client as a passive, silent recipient whose somatic expressions as lived within a particular life context are overlooked. Within this context, illness experience (and thus somatization) is regarded as something that happens *to* or *within* individuals rather than an act or performance in which the body-subject is actively and agent-ically involved (Burkitt, 1999; Martin, 1989).

Both Swartz (1998) and Kozłowska (2003) express concern about the relative absence of theoretical accounts that challenge the continued perpetuation of disengaged, agnostic and egocentric explanations and classifications of body-self expression. They argue that the relative lack of subjective accounts of somatic distress and thus the absence of embedded articulations of the *lived* meaning attributed to somatic symptoms by those who suffer from them has served to heighten existing frustration on the part of patients who frequently feel misunderstood and ignored (Simon, 1991).

Swartz (1998) argues that the theoretical challenge lies not so much in operationalising somatic distress in the form of specific symptoms and syndromes (that are underscored by broad assumptions entrenched within an extensive history of psychoanalytic abstraction and thus the substitution of the body for an image or phantasy of the body), but in exploring somatic distress as a basic way of being-in-the-world, thus allowing for the understanding and interpreting of different forms of somatic distress in more depth (Swartz, 1998; Lewis-Fernández & Kleinman, 1995). In this sense, several authors have argued that contemporary research into somatization should endeavour to discover alternative ways in which to envision and articulate somatic distress, such that research or theoretical emphasis is placed on the *acquiring* of an understanding of how each individual *experiences, embodies and communicates* his or her experience of illness (Cardo, 1999).

This study is thus concerned with returning to the *lived*, subjective world of individuals suffering from somatic distress, where the body is no longer constructed as an object dislocated from the world and separate from the theatre of the mind, but is rather conceptualised as the context and form through which the body-subject/self/mind is able to have a relation with other individuals, objects and the external environment (Grosz, 1994; Leder, 1990). In this regard, the experience of somatic distress is one that is hypothesised as unfolding within an embodied horizon of meaning, where bodily expressions are articulated as extensions of what Merleau-Ponty (1968) and Leder (1990) refer to as the lived body (or lived anatomy). In this sense, this study subscribes to the notion of the body as a *living* body that is deeply embedded in, and an integral and active part of, lived experience, such that knowledge and meaning is received and generated through one's corporeal involvement with one's life world over time (Burkitt, 1999; Grosz, 1994). Furthermore, this study draws heavily on embodiment philosophy in order to construct a phenomenological anatomy with which to position somatic distress as an expression or story of an embodied way-of-being in the world.

In-keeping with Leder's (1990) suggestion that the body is by nature a storytelling body and thus has the ability to construe itself as lived through stories or narratives of itself, this study employs narrative methodology as a phenomenologically attuned means of accessing and enacting the world of bodily and thus somatic experience. The use of narrative methodology is significant within the context of researching somatization phenomena, particularly as a central tenet of

narrative research is the notion that the human subject (as an embodied body-subject) is reinstated as the central character in his or her subjective tellings of illness experience. By shifting the focus away from the 'pathology', 'syndrome' or 'symptoms' of participants' respective experiences of somatization towards an exploration into how participant's story their experiences of the 'ill' body, this study attempts to theoretically situate the individual as a body that remembers – a body that is at once object *and* subject – and thus a body that is recognised as the kinaesthetic sight for the performance and communication of somatic meaning.

It should be noted that this study is exploratory in nature (as opposed to empirical) and is thus concerned with making preliminary theoretical investigations into a relatively neglected area of somatization research: i.e. the subjective, unique and lived experience of somatic distress as told through the narrative accounts of individuals' experiences of somatic distress. In this sense, findings are interpreted in relation to both the manner in which individuals share their accounts of somatic distress and the manner in which these accounts may support or refute central theoretical arguments within this study.

Overview of Relevant Chapters

This study begins with a critical overview of the phenomenon of somatization in a chapter entitled Somatization: 'Medicine's unsolved problem' – a title that captures the epistemologically complex and ambiguous nature of a phenomenon that continues to elude existing theoretical models of aetiology. Chapter Three is entitled A Return to the Lived Body and is chiefly concerned with developing a theoretical and epistemological framework that addresses some of the tensions inherent to contemporary somatic theory (and thus the study of somatization as a bodily phenomenon) whilst simultaneously forging a theoretical (and critical) point of departure from existing articulations of somatic distress. Chapter Four, entitled Enacting Somatic Distress, alludes to arguments from previous chapters in a delineation of a methodological approach that aims to capture and address some of the central theoretical concerns outlined in chapter two. Chapter Five presents findings from participants' subjective accounts of the experience of somatic distress, in such a way that prominent themes are explored in direct relation to theoretical arguments outlined in the previous chapters. Chapter Six provides a concluding discussion that offers a broad synthesis of the interpretive findings in Chapter Five. It should be noted that due to the limited

scope of this study, attention is focused specifically on the findings and the manner in which they may support or refute central theoretical arguments within this study.

CHAPTER TWO

Somatization: 'Medicine's unsolved problem'¹

Introduction

This chapter provides an overview of the phenomenon of somatization, including an exploration of some of the main tensions and trends inherent to contemporary theoretical dialogues around the definition of somatic distress. Prominent models of somatic aetiology are also outlined, with particular emphasis placed on psychoanalytic theories and their historical and informative role in the development of somatic theory. It is argued that theoretical discourse around somatic distress has emerged (and continues to emerge) within a historically embedded dualistic context that articulates the very vehicle of somatic expression as a literal phenomenon. This has, in turn, allowed for a psychogenic form of reductionism where somatic distress is articulated as the expression and manifestation of strictly internal or psychological processes.

Despite attempts to define somatization in manners that recognise or reinstate the contextual and lived quality of somatic distress, contemporary somatic theory continues to be informed by a philosophical and theoretical tradition that is deeply entrenched within a conceptual framework that draws its epistemological underpinnings from the basic tenets of Cartesian dualism. In this regard, it is argued that the body and its expressions continue to assume a dislocated or absent position within aetiological theories regarding somatic distress.

The chapter ends with the suggestion that in order to explore somatic distress on the grounds of its manifestation (i.e. on the grounds of the corporeal), somatic theories need to return to the lived, subjective world of individuals suffering from somatic distress and to the notion of the body as an expression of a way of being in the world and thus the surface from which one first engages the lived world.

¹ Lipowski (1987)

Somatization: An Epistemologically Complex Concept

Despite the extensive body of research that has accumulated over several decades, and the prevalence of somatic manifestations of psychological distress within primary care and general medical/mental health settings, somatization remains an epistemologically complex and ambiguous concept (De Gucht & Fischler, 2001). In recent years, the term 'somatization' has come to refer generically to "a tendency to experience and communicate somatic [i.e. physical] distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness, and to seek medical help for them" (Lipowski, 1988 in Bass & Cawley, 1990, pp. 2-3). Thus, rather than embodying a psychiatric diagnosis comprising of distinct diagnostic hierarchies or criteria, 'somatization' is a term used to cover a broad range of clinical situations, all of which are characterised by the presence of symptoms suggesting (or alluding to) an underlying medical condition, in which the condition is not found (Lock & Giammona, 1999).

Underlying these different situations is a broad assumption that overt, unexplained somatic distress exemplifies the manifestation of an underlying or latent psychological process and thus a pathological response to psychosocial stressors that results in significant functional impairment in a variety of life contexts (Kellner, 1990; Kirmayer & Robbins, 1991; McWhinney, Epstein, & Freeman, 1997).

However, Avila (2006) suggests that such a broad description does not provide an adequate framework for understanding the aetiology of the presentation of somatic distress and thus fails to establish satisfactory classification principles that would enable the effective and successful implementation of psychiatric/psychological/medical and theoretical interventions. Central to the broad nature of this definition is a lack of clarity in defining the parameters of what constitutes somatic distress or somatization: i.e. the term somatization is "neither a discrete clinical entity, nor the result of a single pathological process" (Kirmayer & Robbins, 1991) and thus subsumes several diagnostic categories, spanning a continuum of varying degrees of categorical (both psychiatric and pathophysiological) precision. For example, somatization is commonly associated with (and intimately linked to) psychiatric disorders, including major depressive disorder, anxiety disorders, substance-related disorders and personality disorders, in which case it would be defined as a

'masked' presentation of the above. Similarly, somatization is afforded more loosely defined labels of 'neurovegetative disorders', 'stress', 'burnout syndrome', 'chronic fatigue syndrome', 'psychosomatic illness' and 'medically unexplained symptoms' (Avila, 2006). Included within this continuum of somatization phenomena are mental health organizations' attempts (for the purposes of effective clinical practice and intervention) to arrange medically unexplained somatic phenomena within broad descriptive and diagnostic categories: e.g. the DSM-IV-TR and ICD-10's category of 'somatoform disorders'. This category includes: the presentation of exclusively physical symptoms in gross excess of what would be expected from appropriate physiological examination (i.e. somatization disorder); deficits affecting voluntary motor or sensory function suggestive of a neurological or other general medical condition (i.e. conversion disorder); preoccupations or fears relating to either the conviction that one is physically ill without objective evidence of disease (i.e. hypochondriasis) or the belief that one's appearance is marred by an imagined defect (i.e. body dysmorphic disorder); pain in one or more anatomical sites (i.e. pain disorder); and a pervasive pattern of frequent medically unexplained or psychologically determined symptoms (e.g. vocal chord dysfunction, reflex sympathetic dystrophy, etc.,) that prompt help-seeking behaviour and cause disability (i.e. undifferentiated somatoform disorder, and somatoform disorder not otherwise specified) (Lock & Giammona, 1999; Kaplan & Sadock, 2003).

Although the DSM-IV-TR and ICD-10's attempts at diagnostic classification appear to contradict Avila's (2006) hypothesis that current somatization taxonomies possess an inherent lack of clarity (in that there appears to be a descriptive difference between the established somatoform disorder categories), several authors argue that there is a significant degree of similarity between, and mutability of, symptom constellations of somatic distress (Avila, 2006; Dubovsky, 1997; Kirmayer & Robbins, 1991; Bass & Cawley, 1990). Furthermore, they suggest that there is a paucity of empirical evidence pointing to distinct boundaries between the clinical syndromes articulated as 'somatoform disorders'. For example: the distinction between somatization disorder proper and undifferentiated somatoform disorder appears superfluous, particularly as the majority of individuals with chronic somatization fail to satisfy the restrictive criteria for somatization disorder and are thus diagnosed with the former. Furthermore, patients diagnosed with either one of these categories often display significant levels of hypochondria (i.e. central to both somatization

disorder and hypochondriasis is preoccupation – whether it be made manifest through a set of beliefs, attitudes and fears (disease conviction) or through an extensive medical history, in which case the preoccupation would lie with past neglect or mistreatment by various health professionals) (Bass & Cawley, 1990). The definition of ‘body dysmorphic disorder’ (i.e. “a pervasive subjective feeling of ugliness of some aspect of [one’s] appearance despite a normal or nearly normal appearance” (Kaplan & Sadock, 2003, p. 653)) adds further emphasis to the complexities inherent in clearly defining the criteria of somatic distress: i.e. this definition relies heavily on a value judgement, which in turn relies on social constructions of what ‘normal’ means (Bass & Cawley, 1990).

Adding further complexity to an apparent lack of conceptual clarity or distinction, is the recognition (and fear of) numerous professionals that a tendency towards ‘somatization’ does not necessarily rule out the possibility of the existence of very real comorbid illnesses (e.g. eczema or a peptic ulcer) in which differentiating between the influence of extraorganic or ‘medically unexplained’ factors (e.g. psychological, familial, social, cultural, etc.) versus the influence of possible organic factors is frequently challenging (Avila, 2006; Dubovsky, 1997). Rubin (2005) and Bass & Cawley (1990) suggest that further compounding this issue is a relative lack of attention (in the form of alternative avenues of research and intervention) afforded to somatization phenomena within the context of mental health, in which despite a wealth of literature and studies on somatic distress, mental health professionals continue to fail to develop or agree on a satisfactory classification of the phenomenon of somatization, thus establishing a significant barrier to constructive research within this field. In this regard, the evaluation and treatment of somatic distress is frequently frustrating and intimidating for professionals and clients alike, where the primary health care setting is fraught with a pervasive ‘dislike’ of problems that are biomedically ‘unexplainable’; a relative sense of discomfort or lack of familiarity with various treatment options, and a sense of overwhelm, on the part of health professionals, in relation to the wide array of symptoms exhibited by patients (Rubin, 2005).

An Overview of the Aetiology of Somatization: A Variety of Mainstream Theoretical Models

This recognition of the complexity of the experience of somatic distress has resulted in the generation of a variety of theoretical possibilities in order to attempt to explain somatization, and establish a possible root cause. These explanations have ranged from postulating the existence of potential neurological deficits; to defining somatization as a syndrome or feature of illness, a mechanism of defense and expression of unconscious conflict, a manifestation of family dysfunction, a personality style, a disorder of learning, a condition of deception, a strategy or device of attention seeking and thus a form of wish fulfilment (Rubin, 2005; Dubovsky, 1997; Simon, 1991; Bass & Cawley, 1990). From this list of hypothesised aetiologies, it becomes possible to ascertain that central to a variety of definitions of somatization is an emphasis on psychological factors both as causing disorders, and in an ontological sense, as constituting the phenomena of somatic distress (Fabrega, 1991; Swartz, 1998).

This emphasis can be attributed to somatization's deeply entrenched history within the psychodynamic tradition². Freud's articulation of, and elaboration on, conversion hysteria (in which repressed and socially unacceptable needs seeking fulfilment, are converted into symptoms that covertly fulfil these needs, whilst keeping them safely compartmentalised from conscious awareness) is generally considered the first formal formulation of psychosomatic theory. Historically, this complex, hypothetical process has prompted subsequent psychoanalytic writers to develop a somatic discourse in which the manifestation of medically unexplained physical symptoms have been constructed as signs of more significant underlying psychological disturbance (Simon, 1991; Dubovsky, 1997). Within this context, medically unexplained symptoms continue to perform a defensive function in which the body translates the mental or emotional troubles of an individual into a symbolic physiological language. In this regard, somatic distress is a method of communication often of symbolic significance, an "organ of speech of the mind" (Steckel, 1943, p.580).

² Reflected not only in the wealth of analytical theory around the concept of 'psychosomatic symptoms', but also in our contemporary diagnostic manuals, in which the analytic notion of 'conversion' is maintained as a diagnostic category.

A Symbolic Physiological Language

The metaphorical role afforded to somatic distress within psychoanalytic literature mirrors psychodynamic discourses around ego development (and the consequences of arrested psychical development): i.e. the body is positioned as the essential “surface...from which both internal and external perceptions may spring” (Freud, 1923, p. 26). Thus, according to Freud, every psychical phenomenon develops in constant reference and in intimate connection to, bodily experience – i.e. the ego derives anaclitically³ from the bodily surface (Malcom, 1994). In this sense somatization is intimately linked to the process of interiorization of a sense of self/ego and thus the infant’s development of an independent psychological and physical life.

Several prominent psychoanalytical theorists have contributed significantly to the body of literature exploring the phenomenon of somatic distress, including Winnicott, McDougall and Anzieu. Central to their definitions of ‘psychosomatic symptoms’ is the notion of the self as a psychical, interiorized representation of the infant’s experience and perception of his/her body and the other’s responses to his/her physical needs. Winnicott (1965, 1971) articulates the development of self and thus psychic life as inextricably related to the body: i.e. the body is the site that allows for the internalisation and development of internal/mental representations of objects (including somatic elements, feelings and functions, such as the mother’s physical and emotional presence to the child and vice versa), and thus the acquiring of a sense of a developing distinction between self and other. In this regard, the infant’s “first bodily experiences begin to build up the first memories, and external realities are progressively woven into the texture of phantasy” (Isaacs, 1983, p. 93), such that the process of building a self is a process of natural co-ordination between the soma and psyche – a process in which the developing psyche and continuously experiencing soma are in continual dialogue (Clarke, 1996). Winnicott (1956) maintains that this tendency towards a psycho-somatic union is either facilitated by the infant’s interaction with his/her environment or thwarted by it. Thus, central to the development of a healthy self is the mother’s ‘good-enough’ ability to communicate sensuously with her child, and in turn, the infant’s ability to introject or receive this communication and thus establish not only a self, but an internalised sense of his or her bodily boundaries (i.e. a ‘psychosomatic container’ or body ego).

³ Where anaclitical refers to a relationship that is characterised by the strong dependence of one person or object on another.

Anzieu (1989) conceptualises this internalised sense of bodily boundaries as the 'Skin Ego': i.e. a psychological membrane or mental surface between inner and outer that is grounded within the sensory experience of the body and thus embodies a primary means of communicating with others and filtering experience. In this regard, the Skin Ego plays the role of mediating between the inner and outer, self and other (i.e. a psychic container) and develops (as Winnicott and McDougall suggest) through the interiorization of maternal holding. The Skin Ego represents an 'inscribing surface' (Malcolm, 1994) upon which parts of the mother or parental object are etched and utilised by the child to develop a sense of an ego/self that contains internal psychic contents (Malcolm, 1994).

Thus, if during childhood, one does not experience soothing, reciprocal bodily or sensuous contact with one's parental figure, or this is interrupted or withdrawn in some way, McDougall (1989), Winnicott (1956) and Anzieu (1989) maintain that the infant is robbed of the opportunity to mediate between the bodily experience of affects (as communicated from self to other and other to self) and thus develop a mental or psychological vocabulary in relation to these affects. In this sense, the child perceives the maternal soma as threatening (thus internalising a mental or psychic representation of a persecuting soma and a distorted, uncontained surface or boundary formation between self and other), in which case "the unmediated physical and emotional distress becomes so great that the psyche dissociates from the persecuting soma in order to protect the precious core from the intolerable pain [of affective and physical withdrawal/absence/rejection]" (Clarke, 1996, p. 356). In this sense, the infant is unable to develop a sense of possessing the phantasy of a somatic psychical container and thus a boundary between his/her internal experiences and that of the potentially annihilatory external environment (Anzieu, 1989; Malcolm, 1994). The mother's failure to act as a protective shield against overwhelming stimuli (from without and within) compels the infant to defensively split and repress early, affectively and intrapsychically overwhelming experiences from conscious awareness and thus project these preverbal experiences upon or into the body (a preverbal signifier) in the form of 'somatic explosions' (McDougall, 1989). The phenomenon of somatic distress is thus articulated by psychoanalytic theorists as embodying a symbolic or metaphorical expression of a profound split between psyche and soma,

where infantile ways of experiencing ‘mental pain’ (McDougall, 1989; Malcom, 1994) find their expression “in and on the surface of the lived-body. The body becomes the inscribing surface for these unspoken thing-presentations” (Malcolm, 1994, p, 65).

A Mind-Body Deception

In-keeping with psychoanalytic notions of the aetiology of somatization, Dubovsky (1997) suggests that central to the experience of somatization is the conversion and relocation of emotional problems that are intolerable to the mind into the realm of the physical, “where symptoms seem more deserving of sympathy and care, and where interventions feel less threatening to the person’s self-esteem” (p.46). In this regard, somatic distress is articulated as a ‘mind-body deception’ or ‘mental process’ (Dubovsky, 1997), where the mind’s refusal to acknowledge conflictual emotion through mechanisms of repression or denial deceives the body into assuming the role of indirect communicator of internal psychological states. Individuals who present with somatic distress are thus articulated as “unaware of the ebb and flow of their subjective inner states” (Dubovsky, 1997, p. 91) to the extent that the body is afforded the status of the primary means of self-expression. Here, physical sensations and changes replace emotional response: i.e. “the apparent mental vacuum that seems to accompany a barrage of bodily complaints hides a secret core of terror, rage, and loss of boundary between fantasy and reality, thought and action” (Dubovsky, 1997, p. 109).

A Mechanism of Secondary Gain/Wish Fulfilment

Dubovsky’s (1997) description of the process of somatization alludes to another hypothesised root cause: that of gain. Several authors have suggested that somatization embodies an unconscious attention and validation-seeking device, maintained and reinforced by several factors, including that of wish fulfilment, emotional gain (e.g. expatiating guilt) and financial gain (Rubin, 2005).

A Pervasive Cognitive Style or Disorder of Appraisal

Other psychological theories concerning aetiology suggest that the tendency to somatize may relate to a pervasive cognitive style or learned pattern of coping that has its origins in an individual’s

family's' response (e.g. dismissive, hypervigilant, etc.) to the expression of his/her needs, be they emotional or physical (i.e. illness). In this regard, early experiences will inform the manner in which a person thinks about, attends to, and behaves in relation to bodily sensations. For example, an individual whose relatives have responded to the most obscure bodily sensations with hypervigilance or preoccupation throughout their life, may internalise a core belief system that incorporates faulty mechanisms of information processing (e.g. catastrophising, overgeneralisation, etc.) and thus assumptions, such as "all symptoms indicate disease" Thus, if benign bodily sensations are informed by a deeply entrenched belief system and catastrophic self-talk such as the aforementioned, several consequences ensue: i) the individual will experience emotional distress, which may trigger further physical sensations; ii) increased attention will be paid to these sensations in the form of 'dysfunctional' behaviours that serve to further amplify the sensations (e.g. checking behaviour, incessant reading of medical literature and increased/more concentrated engagement in negative or anxious self-talk), and iii) this will serve to reinforce entrenched dysfunctional core beliefs and assumptions, as well as avoidant behaviours, thus increasing and perpetuating the individual's attention to bodily sensations and dysfunctional coping mechanisms. (Kellner, 1990; Simon, 1991; Kirmayer & Robbins, 1991). In this way, somatization is articulated as a 'disorder of appraisal' and thus the outcome of exaggerated processes of bodily awareness, symptom preoccupation and symptom attribution (Bass & Cawley, 1990). Within this theoretical context somatic distress is attributed to faulty percepts of physiological reactivity, including higher levels of perceptual sensitivity, and an amplificatory style. Here, the individual's capacity for accurately perceiving and reporting emotional distress is lowered, thus increasing the likelihood that they may attribute noxious bodily symptoms to undiagnosed disease (Simon, 1991).

A Personality Disposition or Trait

This cognitive model of somatic aetiology is intimately linked to the hypothesis that somatization may be attributed to certain personality dispositions or traits and thus the manner in which an individual cognitively appraises and copes (or doesn't cope) with significant life changes (Suls & Rittenhouse, 1987). Central to this model is the hypothesis that neurotic personality traits are a significant predictor of somatic distress, in that they are often coupled by high levels of emotional reactivity and a consistently negative reporting style (De Gucht, Fischler & Heiser, 2003). In this

regard, an individual with significant dependent traits, for example, may find it more difficult to negotiate events involving psychological loss (e.g. bereavement, relationship breakdown) or change in routine (e.g. relocating, job promotion). Such events would reinforce a self-perception of being unable to function adequately without the assistance of others, thus inciting such an individual to engage in mechanisms or behaviours that would elicit care giving on the parts of others. For example, medically unexplained symptoms may elicit care giving behaviour or consistent attention on the part of significant others, which may, in turn be reinforced by possible accompanying medical investigations and treatments. In this sense, the focus on the physical manifestation of the individual's narcissistic wound may be sanctioned, thus distracting attention away from attending to issues that may have precipitated the initial distress (e.g. impaired self esteem and sense of self adequacy) (American Psychiatric Association, 2004; Mayou, 1993).

Kirmayer & Robbins (1991) suggest that several authors have proposed, in more specific terms, significant personality trait predictors for each of the classified somatoform disorders: e.g. classic descriptions of conversion and somatization disorder relate both phenomena to the histrionic personality; somatization disorder has also been linked to avoidant, paranoid, self-defeating and obsessive compulsive traits, and more recently to antisocial personality disorder (Kirmayer & Robbins, 1994). Furthermore, hypochondriasis has been articulated as a narcissistic investment of interest and energy into one's own body as well as an attempt to acquire a sense of safety and control – traits that are considered characteristic of the obsessive-compulsive personality (Kirmayer & Robbins, 1994). Inherent to these suggestions, is the broad assumption that somatization reflects a maladaptive pattern of inner experience and behaviour, in which the manifestation of somatic symptoms bears testament to individuals' varying inability to draw on effective or sustainable coping mechanisms at a time of illness. In this regard, the angry, resentful, oppositional, sullen and mistrustful hypochondriac is articulated as embodying significant personality pathology and limited internal resources, whereas, the individual suffering from somatoform pain disorder is referred to in less pathological or disordered terms: i.e. the experience of pain is considered a reflection of hard-working individuals, who may characteristically attend selflessly to others to the detriment of themselves (Kirmayer & Robbins, 1994).

A Global Deficit in the Capacity to Articulate Emotion

The notion of alexithymia as a root cause of somatization is a construct that has been afforded a significant degree of prominence within psychosomatic literature (Kirmayer & Robbins, 1994; Bass & Cawley, 1990), possibly because it is a theoretical construct that subsumes several key concepts expressed within each of the aforementioned theories of somatic aetiology. Although psychodynamically oriented, this construct has been linked to several aspects, including childhood trauma, cognitive styles, personality styles, as well as familial and social factors. In broad terms, alexithymia refers to a global deficit in the capacity to articulate emotion - the absence of language for feelings - in which the inability to label one's affective states "leads to difficulty in discriminating emotional feelings and bodily sensations, a reluctance to expressing emotions, a lack of fantasy or emotion, and a tendency to think and problem solve in concretely, externally oriented terms" (Taylor, Bagby, Ryan & Parker, 1990 p. 292).

In this regard somatization relates to an individual's 'emotional illiteracy' (Dubovsky, 1997; Lynch, 1984) and lack of insight: i.e. "psychosomatic patients have so completely and successfully buried their emotional problems in their bodies that they no longer have the capacity for insight" (Lynch, 1984, p. 232). Thus, the 'psychosomatically prone' alexithymic individuals' 'elementary' affective vocabulary renders them inadequate in interpreting emotional arousal, and results in the displacement or transference of this arousal into physical forms of communication (Stephenson & Royce, 1999).

A Masked Affective Disorder

The notion of alexithymia also lends itself well to theories suggesting that somatization may embody a masked affective disorder. Although Kellner (1990) and Kirmayer & Robbins (1991) suggest that the assumption that somatizers have an underlying major psychiatric disorder that accounts for their physical distress, is more often wrong than right (and note that there is a relative lack of empirical evidence supporting the notion of somatization as a depressive or anxiety equivalent), Kirmayer & Robbins (1991) emphasise the prevalence of an exclusively somatic presentation of major depressive episodes within the medical and psychiatric context. Here, individuals who are unable to articulate significantly emotionally and psychologically distressing experiences, employ somatization as a mechanism of defense and thus indirect communication.

Similarly, individuals suffering from anxiety disorders (e.g. panic disorder) frequently present with somatic symptoms due to their inability to make the link between physical symptoms, fear and situations that trigger the anxiety symptoms (Bass & Cawley, 1990).

The apparent sense of disagreement between Kirmayer & Robbins' statements between 1991 and 1994 may serve to reflect the prevalence of numerous competing definitions of somatization and may thus contribute to current theoretical discourses around somatization as a 'problematic' and 'overwhelming' phenomenon.

A Neurological Deficit

In an attempt to afford psychological theories of causation, a physiological 'equivalent', several authors have attributed the alexithymic construct (and thus the hypothesised absence of affective vocabulary) to a possible neurological deficit (Kaplan & Sadock, 2003; Lynch, 1984). This hypothesis has a long-standing history within the biomedical tradition in which essential to the explanation of illness experiences is the assumption that signs or symptoms can be reduced to physiological mechanisms and thus separated from the psychological. The possibility that somatization may relate to "minor or as yet undetectable changes in neurochemistry, neurophysiology, and neuroimmunology" (Kaplan & Sadock, 2003, p.643) allows for the possibility that somatization may indeed have a physiological basis (i.e. disordered brain function). Lynch (1984) suggests that from as early as 1949, when Maclean posited a deficit model relating to potential deficits within the domain of language and thus verbal performance, authors have elaborated on this biomedical hypothesis and suggested that somatization may reflect "a neurological discontinuity between the emotional centers in the brain (the limbic system) and the thinking (cortical) brain centers" (Lynch, 1984, p. 239). Furthermore, bi-frontal abnormalities on the neuropsychological testing of somatizing individuals have been demonstrated, and several authors have suggested that somatization may result from a predominantly right-hemispheric style of information processing, thus accounting for the relative absence of 'feeling words' within somatizing individuals' reports (Lynch, 1984).

Somatic Epistemology and Contemporary Theoretical Dialogues: A Seemingly Irredeemable Either/Or Split

This brief overview of a number of core, mainstream aetiological theories regarding somatization appears to reinforce Avila's (2006) contention that the complexity inherent in accurately defining the phenomenon of somatization lies in the relative absence of a unitary classification system or taxonomy of causation that is able to coherently address and incorporate the numerous and competing definitions of somatization (and thus illustrate more clearly the mechanisms underlying somatization). Several authors (e.g. Kirmayer & Robbins, 1994; Swartz, 1998; Strassnig, Stowell, First & Pincus, 2006) have (historically and presently) argued that it may be more constructive to adopt a multi-dimensional aetiological model of somatization (i.e. one that would encourage the researcher/clinician/health professional to construct somatization as comprising multi-layers, *in addition* to the psychological and physiological). Within this context the phenomenon is afforded a polytheistic character that embodies a move away from normative attempts of classification that may dilute the central role that psychological, familial, psychosocial, historical and cultural factors play in informing somatic presentations (e.g. diagnostic reductionism; measuring scales etc).

However, despite this prominent trend, recent theoretical dialogues around the definition of somatic distress argue for more rigid, empirical (and normative) approaches towards improving effective clinical practice. For example, Rief, Henningsen, Hiller & Stein (2006) argue that the category of 'somatoform disorders' ought to be improved with empirically validated criteria for symptom lists (e.g. The Somatization Behaviour Scale (Rubin, 2005)) and cut-off scores, as opposed to subscribing to a broad category that may serve to further erode an already complex phenomenon. They suggest that such lists and cut-off scores may provide an important role in establishing highly specific characteristics relating to the symptom constellations of potentially somatizing individuals.

Others question the validity of an Axis I diagnosis of a somatoform disorder, but attempt to maintain the rubric of a classification system by suggesting that the somatoform disorders be classified as a new Axis III category (i.e. 'functional somatic symptoms and syndromes') (Mayou,

Kirmayer, Simon, Kroenke & Sharpe, 2005). Although such a suggestion points to an attempt to incorporate a broad range of medically unexplained symptoms into the definition of somatic distress, Rief et al. (2006) argue that such a category may only serve to add further complexity and heterogeneity to the process of classification: i.e. “What would be the chance of any clear finding? ... This mixing of diverse patients is a recipe to avoid finding anything clinically useful” (p. 747).

These theoretical dialogues appear to be characterised by an either/or split between those who subscribe to normative or objective epistemological principles and those who attempt to articulate somatization from a broader perspective that recognises the correlation between one’s contextual life experience and the manifestations of somatic distress. This either/or split is arguably central to the lack of agreement on a somatic epistemology and is mirrored in the frequent therapeutic impasses and client/patient frustrations that are evoked when their symptoms are articulated in a dualistic manner (i.e. mind vs. body): i.e. “When finally informed of the diagnosis by the [health professional], the patient is typically not prone to accept it. The patient is convinced of the physical origin of the undiagnosed distress and is equally convinced that the psyche plays no part in the disease process. Thus, when a patient has a somatoform disorder, a disconnect is initially established between patient and physician in the diagnostic process” (Guggenheim, 1999, p. 1504).

This dialectical tension between the somatizing individual’s ‘inability’ to recognise the underlying or repressed mechanisms informing his/her distress, the professional’s equal inability to recognise the significance that the body’s expressions play for the individual, and their shared inability to consider the central role that *both* body and mind may play in the manifestation of somatic symptoms, may be considered an expression of a historical and philosophical legacy that has informed (and continues to inform), our constructions of human experience and thus the subject/self and his/her body: i.e. Cartesian Dualism.

Mona Lisa Smile: The Disembodied Psyche and Literalised Soma

Romanyshyn (1982) employs the elusive character of Mona Lisa’s smile to refer to psychology’s historical treatment of the body and self: “in the midst of this landscape looms the figure of Mona

Lisa. She dominates the landscape even while she turns her back on it and faces us with her smile... The smile of Mona Lisa is and remains a secret smile, and nothing around her, nothing in the landscape reflects its meaning” (p. 25). Da Vinci’s elusive figures’ persona is one of secrecy and hidden, interiorised meaning and is described by Van den Berg (1975) as embodying the first representation of one who is estranged from the landscape and thus her lived reality. The force of the painting is one that turns the viewers eye towards the smile and away from the landscape: “We are not invited nor are we meant to see through it a world which is its reflection.... we are meant to see only the smile and behind it, in a world beyond time, ‘a *beauty wrought out from within* upon the flesh” (Romanyshyn, 1982, p. 25). In this regard, the Mona Lisa and her smile is possibly the first face that simultaneously invites one to look away from the world (constructed and characterised by qualities of neutrality and indifference) and to gaze within. Thus, in order to come to know the self, the Mona Lisa encourages us to retreat inside and turn a blind eye on the world: “Mona Lisa’s smile betrays a communion with herself and herself alone” (Romanyshyn, 1982, p. 25).

In this regard, the embodied quality of self and of the lived world, as reflected in earlier, sixteenth century notions of the grotesque union of subject, body and lived world (in which the body was one that “extended out into other bodies or into the world, a body encroached on by other bodies and by the world” (Young, 1994, p. 713)), have been steadily displaced in favour of what Lightfoot & Lyra (2000) refer to as an age of the first person singular. In this sense, the self has traditionally been communicated and articulated – across various disciplines – as a product or aspect of personal authenticity (Lightfoot & Lyra, 2000), whereby “the new sense of self [seeks] singularity, interiority and distance from the commonplace” (p.100).

Looking at this development within its broader socio-historical context makes it possible to trace, from as early as the Renaissance, a transcendence or severing of self or personhood from its interwoven relations and dialogues with its spatial-bodily and temporal dimension (Burkitt, 1999). For example, the collective, communicative self/body of the early Renaissance was replaced by a privatized body in the Classical period – a body whose ‘instinctual’ acts such as sex, were no longer regarded as meaningful acts to be collectively celebrated, but rather became privatized acts

that one did not speak of in polite society (Burkitt, 1999). In this sense, the subject of classicism became one who was firmly encased in his or her closed bodily shell and thus removed from his/her connection to the concrete present (Lightfoot & Lyra, 2000). Within this context it becomes possible to argue that the subject/self has been discharged into a realm of the hypothetical, resulting in what Lightfoot and Lyra (2000) refer to as “a certain orphan and isolated existence” (p.101). One could therefore suggest that our sense of who we are is one that has been informed by a historical legacy that sets the very vehicle for our self-existence (i.e. our body) apart from the distinct characteristics that make us thinking, speaking and ultimately feeling beings.

Leder (1990) points out that our continued tendency to articulate self and body as distinct, either/or entities that establish internal and external boundaries governing ‘truths’ and our manners of being in the world, is intimately related to the mind-body split that thinkers such as Descartes, and later our own models of explanation (e.g. the biomedical model) have employed in their quest for the realisation of qualities such as objectivity and absolute truth. As Romanyshyn (1982) suggests, this distinction was evidently *necessary* in the development and evolution of medicine, for example, and for our scientific understanding of the world. Had Copernicus not had the capacity to ‘step outside’ of his bodily understanding of his lived environment in order to envisage an alternative explanation to the nature of the relation between the sun and the earth, we would possibly not have established as early as we did that the earth revolved around the sun. Similarly, Vesalius’ book on the structure of the human body marks the inauguration of the modern approach to anatomy and the human body, such that the literal, anatomical corpse (as opposed to the incarnate human body) was afforded significance. The Copernican Revolution and Vesalius’ new articulation of the body, represent an ‘act of the imagination’ and a process of articulating bodily expression in literal, physiological terms (Romanyshyn, 1982), thus marking the emergence of an era of discovery, particularly within the realm of science, where various great thinkers had to engage in a so-called objective distancing - a severing off from their subjectively experienced environment and thus a distancing from the ‘deceptive body’.

Within this epistemological framework of Cartesian dualism, bodily experience has been literalised and the body has come to be articulated as a self-contained, physical entity (understood in terms of physical mechanisms) existing in itself as an object and thus as an outsider to the lived,

experienced world (Burkitt, 1999; Leder, 1990). Similarly, psychological life has been rendered an interior domain, in which the mind has assumed the position of the subject (i.e. where self is articulated as the 'theatre of the mind') and distinctions such as conscious and unconscious being have become the predominant vehicles for making sense of human experience.

It is within this context (in which the body and mind have been culturally and philosophically constructed as distinct and non-overlapping entities) where 'real' illness is defined as that which has an identifiable physical cause and medically unexplained 'illness' is constructed as primarily psychological or emotional in nature and presentation (Swartz, 1998; Fabrega, 1991). In this regard, the bodily *communication* and *experience* of distress is reduced to something that is biomedically incorrect due to the relative absence of tangible physiological objects (i.e. signs or symptoms). This, in turn, allows for a 'psychogenic' form of reductionism in which somatic distress is informed by strictly internal or 'psychological' processes (Swartz, 1998).

Kirmayer (1992) argues that within a context in which 'illness' is traditionally reduced to biological disease and thus objective signs and symptoms, psychodynamic theory has had to assume a central role (particularly within the mental health context) in affording elusive illness phenomena such as somatization a degree of credibility (as emphasised by the pervasive influence of psychoanalytic concepts within mainstream psychological explanations of somatization). In this sense, that which *can* be explained (i.e. the mechanisms underlying illness experience) is placed at centre stage. However, despite psychoanalytical theorists' heavy reliance on the central role of the body in the development of self/ego, the body is afforded a transitional status, in which one's sense of having a body relies on the infant's ability to internalise a mental representation of his/her bodily boundaries and thus establish the phantasy of possessing a body (Csordas, 1994).

Psychodynamic theories have thus substituted "the image [or phantasy] of the body for the body" (Kirmayer, 1992, pp. 331-332) – and engaged in a dualistic split of the mind and body, in which the manifestation of somatic distress reflects one's relation to an internal or interiorised domain (referred to as the unconscious), as opposed to an embodied relationship with the very vehicle of one's being in the world. Burkitt (1999) and Kirmayer (1992) argue that it is within the context of this interiorised discourse that the body can be regarded as an irrational construct whose somatic

articulations or ‘explosions’ (McDougall, 1989) need to be understood, contained and classified as symbols that allude to universal themes or concepts of repressed or split-off inner conflict, maternal rejection, abandonment or withdrawal, unconscious attention and validation-seeking, emotional gain, and wish fulfilment. Within the context of other psychological theories of aetiology, these themes are similarly articulated as pervasive, hypervigilant cognitive styles, prominent dependent or histrionic personality traits, a mind-body deception or a limited affective vocabulary, which are in turn informed by universal psychodynamic principles. In this regard, it may be possible to suggest that “[p]sychoanalytic explanation reduces the variety, complexity and multivocality of the patient’s bodily experiences and expressions” (Kirmayer, 1992, p. 331) by articulating somatic distress as a mental phenomenon, thus re-enacting the very mechanisms with which they make sense of ‘psychosomatic phenomena’: i.e. a defensive splitting of the mind/self and body, conscious and unconscious, subject and object.

Somatization and the Absent Body

Thus, within the creation of dualistic boundaries between self and bodily expression, it may be possible to suggest, as Csordas (1994) does, that predominant theories of bodily expression, illness, etc. have rendered the body an absent and ultimately passive phenomenon. In so doing, the body’s embodied participation in an individual’s life world is excluded, and its expressions are considered surface representations of the unconscious seeking realisation or bulging out onto the bodily surface (Csordas, 1994). In this regard, theoretical articulations of bodily phenomena are informed by an epistemological distrust in the sensuous, experiential body (Burkitt, 1999; Leder, 1990), thus subscribing to the Cartesian premise that “[w]hat we know of the world is not based on the information gathered by touch, sight, smell or sound, but how this is classified and worked on by the intellect” (Burkitt, 1999, p. 10).

In this regard, it becomes possible to understand researchers’ continued attempts to apply objective diagnostic criteria to a phenomenon whose essential defining characteristic is one of elusivity and thus ‘epistemological deception’. Within this context, the *experienced* body, and the body’s capacity for agency or meaning-making is thwarted, to such an extent that the body is rendered an ‘object in the mind’. In so doing, ‘mindful intellectualism’ can continue to articulate somatization as a metaphor or reflection of the body as an acted upon entity rather than performing a disclosive

function of that *from* which one exists in the world (i.e. the surface with which one first engages the world) (Leder, 1990).

Several aetiological theories have attempted to define somatization in manners that recognise the contextual quality of bodily expression. In an attempt to move away from a Cartesian mode of thought (in which concrete physiological events are made sensible through a decontextualised or disembodied return to internal locations/articulations of self), theoretical articulations of somatic distress have begun to turn their attention towards the manner in which one's bodily engagement in external events (cultural, familial, etc.), both from the past as well as those that continue to occur in the immediate present, inform the manner in which an individual may communicate his/her illness experience (Cardo, 1999).

Systemic family theory offers the perspective that somatic manifestations of distress are frequently indicative of a crisis of interaction within a family system, whereby symptoms of somatic distress are articulated as the use of the body as "an unconscious means of coping with *other people's psyches*" (Dubovsky, 1997, p. 54). In this regard, the symptom serves to afford a degree of autonomy to a potentially dysfunctional system, by allowing individual members (and the family as a whole) to turn their attention away from interpersonal deficiencies and potentially explosive issues and focus on the physiological manifestations of illness as a means of coping and maintaining the 'status quo' (Dubovsky, 1997). In this regard, the body assumes a disclosive function in that somatic symptoms are not only indicative of a body being acted upon by external dynamics, but also indicative of a body making sense of those external dynamics: e.g. within a family unit characterized by parental neglect (on an affective level), somatic symptoms may serve the function of ensuring visibility within the family unit and may, in turn, serve other family members by enabling an indirect expression of transgenerational patterns of abandonment (Corey, 1996).

Somatization is also frequently articulated as performative in nature and thus representative or symbolic of a predominantly unconscious strategy for conducting social interaction and attaining help (Kleinman, 1995). Central to this definition is the notion that somatization is frequently a

pattern of reaction to psychosocial or ideological stressors, in which somatic symptoms may provide a safe, yet visible strategy for those in impoverished, disadvantaged contexts to protest social inequities. This hypothesis is reinforced by theorists writing from within the South African context (e.g. Swartz, 1998) – a context that has an extended history of inequality and ideological restriction. Kleinman (1995) argues that this aetiological theory constructs the body as a vehicle for the communication and experience of externally motivated distress, as opposed to a surface upon which *internal* psychological processes are projected. In this sense, the body is construed as a way of engaging the world (Lewis-Fernández & Kleinman, 1995).

This theory is extended into theories concerning an individual's exposure to significantly traumatic events (e.g. sexual abuse), in which case the body's response is a paradoxical one to an individual's chronic and ingrained pattern of hiding his/her feelings and reality. In this sense, the body engages the world in an act of attempting to make 'public' lifelong and invasive patterns of secrecy, by displacing the emotional and psychological trauma endured by the individual into a form that allows for acknowledgement of suffering (Rubin, 2005).

Central to these theories of causation is the argument that somatization is a phenomenon that not only incorporates physical and psychological components, but also a multitude of experiential components (e.g. interpersonal, cultural, economic), thus inciting the researcher or health professional to engage with the presenting problem within the contexts in which individuals live and find themselves (Swartz, 1998). Within this context, the body may be construed as a body 'in revolt' – an image which has been employed not only within broader social and ideological contexts, but also within the medical field in which theorists have (since the early 1980's) attempted to recapture and emphasise the inextricable relationship between mind, body and external events. Lynch (1984), for example speaks of the body's intimate and ongoing dialogue with a 'social membrane' that meshes with internal physiological and psychological events, such that one's dialogues with the external world can quite literally construct one's physiological reality (e.g. changes in blood pressure, heart rate, etc.). In this regard, somatic distress embodies a breakdown in effective communication or dialogue with one's external reality, which is, in turn, internalized defensively as a breakdown in one's communication with, and awareness of, the

changes occurring in one's body during interactions with one's external environment. Somatic symptoms are thus the body's way of informing one of a conscious turning away from the hidden physiological communications that underlie our external interpersonal communications. Lynch (1984) argues that the body's response to being acted upon by dysfunctional dialogues with one's external interpersonal environment, is one of revolt and thus one in which the "my whole body...turn[s] against me!" (Lynch, 1984, p. 20).

As highlighted by mainstream aetiological somatic theories, the aforementioned theories serve to further reinforce the argument that somatization is an extremely complex phenomenon that fails to 'slot' comfortably into a single, unitary definition or classification system (Swartz, 1998). However, these theories afford the study of somatization the *added* dimension of highlighting the importance of taking individuals' lived contexts into account and thus the manner in which the situated/contextual or lived body plays an integral role in the process of creating meaning.

However, although the intention may be to explore somatic distress as a way of being in the world and thus emphasise the performative and disclosive function of the body, both Stam (2003) and Gillies, Harden, Johnson, Reavey, Strange & Willig (2004) argue that the articulation of various human phenomena in 'non-Cartesian' terms within the context of contemporary psychology poses a challenging task, particularly when the culturally and historically ingrained nature of Cartesian dualism as a conceptual framework continues to inform and regulate (or 'restrict') the performance and generation of both individual meaning and experience. It may be possible to argue that the aforementioned contextual theories of aetiology serve to perpetuate a mind-body split and ironically continue to articulate individuals' illness experiences on the grounds of absence.

Although such theories articulate the body's somatic expressions as indicative of the body's engagement with its lived environment, the body continues to be positioned as an acted upon and thus passive phenomenon. In this sense, the continued employment of notions of somatic symptoms as symbolic of unconscious strategies or coping mechanisms, patterns of secrecy, a breakdown in one's connection to one's external interpersonal and internal or 'hidden' physiological dialogues serve to establish a distinction between the internal and external. In so

doing, the body is afforded a slate-like quality in which its expressions are not so much an act of 'presencing' the body, but rather an expression of the body as a passive theatre of both the internal and external (Griffith & Griffith, 1994; Gergen & Gergen, 1998).

Furthermore, such constructions are deeply entrenched within a Western philosophical framework and allow for the articulation of somatic distress as an expression of less developed or less sophisticated societies – a hypothesis that has been afforded prominence within somatic literature (Fabrega, 1991).

Conclusion

It may be possible to argue that the body and its expressions continue to assume a dislocated or absent position – a position amenable to objectification, discrimination and pathologising. From this position, the somatizing individual is encouraged to adopt the detached perspective of the scientist towards their own bodies, thus rendering the lived, subjective meaning that they attribute to their illness experience a silent, disempowering phenomenon – something which is perpetuated by the negative manner in which somatizers are frequently spoken about by health professionals.

In this sense, Swartz (1998) posits that the challenge lies not so much in operationalising somatic distress in the form of specific symptoms and syndromes, unconscious mechanisms (or as a reflection of the body's malleability in the face of prominent psychosocial, socioeconomic and ideological stressors), but in incorporating an *embedded* understanding of the *lived* meaning attributed to somatic symptoms by those who suffer from them: i.e. how do individuals experience, embody and communicate their experience of somatic distress as body-subjects?(Cardo, 1999).

Such an approach would require a return to the lived, subjective world of individuals suffering from somatic distress where the body is articulated as a co-participant and thus an expression of our way of being in the world. The theoretical thrust and unfolding of this study will be based on a broad phenomenological notion of the body as that *from* which one exists in the world – the surface from which one first engages in the world. In this sense, it is "via bodily means that I am

capable of responding” (Leder, 1990, p.1) and thus capable of generating meaning, and engaging in gestures that are not only a reflection of being a body-subject, but are also a reflection of one’s sense of who one is in relation to multiple planes or horizons of value and meaning (Bakhtin, 1990).

The proceeding chapter both initiates and develops this phenomenological notion within the context of illness and, more specifically, somatization research. It therefore attempts to address the relative absence of a corporeal and embodied theory of somatization through a development of a theoretical framework that arguably allows for the return to the somatizing body as the vehicle through which somatizing individuals make sense of their lived world.

CHAPTER THREE

A Return to the Lived Body

Introduction

By drawing on arguments from the previous chapter, this chapter attempts to develop an embodied theoretical landscape or corporeal framework with which to redirect attention towards the somatizing body as a focal entity and perceiving subjectivity in its own right. It is argued that the concept of the 'lived body' (i.e. a concept that is central to embodiment philosophy) is one that may serve to undermine the epistemological and ontological primacy of the decorporealized and interiorised self of Western philosophy, and more specifically, somatic aetiology.

Theoretical developments around the body as a contextual and lived phenomenon are explored, with particular reference to social constructionism as having played a significant role in redirecting our attention towards the body as a theme of exploration within somatic literature. However, a brief and by no means all-inclusive exploration of some of the basic tenets of social constructionist or discursive body discourse, reveals that despite the social constructionist claim that the body and its expressions are of central analytical concern, discursive accounts of somatic theory continue to pay little attention to the body as a generative source in its *own right*. In this sense, it is argued that the social constructionist understanding and articulation of the body as created *through* and *by* discourse, once again relegates the body into a realm of disengaged absence, whereby experience is constituted through the processes of language, rather than preobjective bodily knowledge.

Following Burkitt (1999) and Sparkes' (1999) expressed concern that contemporary body theory continues to champion disembodied epistemological principles, this chapter's theoretical focus turns towards the embodiment philosophies of Merleau-Ponty (1962; 1968) and Leder (1990) as possible mechanisms with which to capture the body's capacity for intentional action, agency and subjectivity and thus challenge dualistic partitionings of body and self, etc. Based on both theorists' notions of the lived body, a phenomenological anatomy is developed such that the body and its expressions (i.e. somatic distress) are positioned as the central vehicle through which to gain access to lived corporeal experience as a generative source in its own right.

Leder (1990) offers an alternative perspective to the mind-body dichotomy that continues to pervade contemporary body literature, and provides an effective rehabilitation and exploration of the experiential core of Cartesian dualism. This is significant within the context of both somatic and broader illness literature as it offers an alternative perspective to the apparent subscription to a mind-body split that contemporary authors have highlighted as characteristic of individual's attempts to negotiate the ill body. In contrast, Leder (1990) argues that what we regard (in participants' accounts) as a distancing of the self from the deceptive, somatizing body, is possibly better accounted for by the phenomenologically and experientially grounded experience of the body as lived. He argues that inherent to our embodied experience of the lived world is a gestalt-like experience of both absence and presence: i.e. the body tends to disappear when functioning unproblematically, but seizes our attention most strongly at times of dysfunction. In this sense, we experience the body as the very *absence* of a desired state and as a very present force that appears to stand in opposition to the self.

By employing Leder's (1990) notion of the body as a gestalt-like absent-presence and present-absence, it is argued that embodiment philosophy provides the researcher with valuable tools with which to explore a phenomenon that appears to elude Western theorist's attempts at problematising a seeming integrity between psyche and soma.

To conclude, this chapter ends with the suggestion that in order to enable somatic theory to become *enacted* by the body-subject, rather than the body-subject being enacted *through* and *by* discursive practices, one must approach somatic theorisation as a mode of being-in-the-world and thus as a reflection of an individual's social, interpersonal and cultural organization of their lived reality. Thus, of central concern is affording individuals who experience somatic distress as an integral part of their body-self expression, the opportunity to offer theoretically established absences around somatization, the *presence* of subjective experience.

An Absence of Patient Perspectives: Suffering the Professional's View of the Corpse

Swartz' (1998) suggestion that somatic literature begin to incorporate and pay attention to the lived and embedded meaning of somatic symptoms is echoed by Kozłowska (2003) in her argument that patient perspectives regarding somatization are remarkably absent within contemporary

literature. Kozłowska's (2003) hypotheses concerning this absence are reminiscent of the arguments outlined in the previous chapter: i.e. she speaks of a philosophical or theoretical divide inherent within our discourses of somatic aetiology and argues that the belief that somatization phenomena are genuine requires "an [either/or] acceptance of hypothetical constructs such as 'dissociation'...or 'repression and conversion'...or necessitates that the clinician adopt an agnostic position with regard to the subjective reality of the symptom" (p.74). According to her such a divide encourages an avoidance of comfortable dialogue and engagement with medically unexplained symptoms on the part of health professionals, and results in the adoption of a perturbed silence that "implicitly raises questions as to the authenticity of the [individual's] symptoms and the contribution of illness behaviour and negative emotional factors" (p. 77).

Kozłowska (2003) further argues that within the agnostic, biomedical context in which these symptoms frequently present, existing, prescriptive discourses of aetiological complexity, medical uncertainty, and psychical interiorization serve to maintain clients' experiences of shame and frustration, and thus "perpetuate client fears that their illness is seen as feigned, unreal and 'in the head'" (p. 78). Thus, within a context in which the body is characteristically articulated as a "discrete physicality external to the self" (Lyon & Barbalet, 1994, p. 84), which must be scrutinized, manipulated and corrected via medical expertise and imperatives, the elusive manifestations of the somatizing body are rendered literal transcriptions of interiorised, abstract and universal psychological principles. This positions the body as nothing more than the territory of, or backdrop to, "whatever psychological property is in question" (Stam, 1996, p. 555). Within this distinctly Cartesian mode of thought, clients' physical expressions are positioned as phenomena requiring empirical interpretation by an 'expert' as the vehicle through which an interiorised domain of lived experience is accessed. This in effect renders the immediacy of the body-subject's lived experience and subjective expressions and knowledge of his or her illness inaccessible. Within the context of somatic distress, where a patient's physiological expressions *cannot* be empirically articulated as anatomic or technological facts, and are thus rendered immaterial, such disregard for dialoguing with, and understanding somatic distress as articulated through the meaning individuals attribute to their illness experiences, reduces the authority of the lived, embodied world to silence. Diekama (1989) argues that inherent to the professional's turning away or retreat from an engagement of somatic distress on the grounds of unique, subjective

experience, rather than on the grounds of interiorised, theoretical ‘knowing’ or ‘not knowing’, positions the patient as a “passive, silent recipient who is distanced from the possibility that [their] own resources [are] as... valuable [as that of the medical/psychiatric or psychological professional]” (in Etherington, 2003, pp. 33-34).

Cardo (1999) argues that the biomedical framework’s lack of concern in, and inability to understand illness phenomena (as opposed to measurable disease phenomena) is largely due to the fact that it confronts a territory to which its decontextualised, literal and universal accounts of bodily phenomena cannot gain access. “[I]n its ability to forget differences in order to envision a neutral [and empirical] world” (Romanyshyn, 1982, p. 61) modern psychology’s traditionally scientific-empirical perspective has positioned the professional as distrustful of *experienced* appearance, thus favouring a narrow definition of the human being as an empirical person *only*, whereby empirical events or symptoms are afforded the distinction of guiding us inwards towards that which is deemed psychological or meaningful (Romanyshyn, 1982).

The physician’s lack of serious attention to the body as a meaningful, perceiving subjectivity (thus silencing the possibility that the presentation of somatic distress may relate *not only* to interior psychological mechanisms but to how individuals “body forth their world” (Cardo, 1999, p. 50)) relegates the professional-client relationship into a terrain of mutual, perturbed silence. Within this context, the client “suffers from his physician[/psychiatrist/psychologist’s] point of view” (Van den Berg, 1972, p. 85) – a point of view in which the patient’s own experience and subjective voice becomes inessential to the medical/psychiatric or psychological encounter: i.e. “The story told by the physician becomes the one against which others are ultimately judged true or false, useful or not” (Frank, 1995, p. 5). In this regard, the patient’s expressions of somatic distress are afforded an imaginary or phantasy body: i.e. in the absence of objective evidence, the professional will frequently turn to the psychological and thus an interiorised domain that incorporates the phantasy or psychic representation of the body as central to explaining the manifestation of somatic symptoms. In this regard, the lived body (although present) is rendered absent (i.e. an absent presence) such that the patient “as a living, suffering being” (Leder, 1990, pp. 147-148) is overlooked, giving way to medicalized or dualistic practices through which individuals experience themselves as disembodied and fragmented absent-presences (Leder, 1990). Within this context,

illness experience is regarded as something that happens *to* individuals rather than an act or a performance in which the body-subject is actively and agent-ically involved (Burkitt, 1999; Martin, 1989).

Leder (1990) suggests that the concealment of lived experience and the lived body within our theoretical discussions of the body (and more specifically somatic distress) as well as our attempts to develop strategies of intervention and management of bodily illness experience may be attributed to historical developments within the medical realm. In short, “The corpse – and not the living, experienced individual – became the paradigmatic figure of truth in medicine” (Leder, 1990, p. 47).

Within the context of somatization, in which current models of aetiology continue to subscribe to the historical legacy of Cartesian Dualism (i.e. a philosophical dualism between an isolated, rational self and a world external to that self) as well as the absent lived body or the corpse, it becomes possible to understand both Swartz’ (1998) and Kozłowska’s (2003) already mentioned concerns about the relative absence of accounts that incorporate an exploration of somatic symptoms on their own terms: as phenomena that appear to escape or elude the disengaged, agnostic and egocentric explanations and classifications of body-self expression that continue to pervade somatic literature. The prevalent reactions of frustration on the parts of patients who “often feel that we do not understand them at all” (Simon, 1991, p. 37) may attest to this, and may reflect an attempt to engage health professionals in the possibility “that more is involved in their [patient’s] experiences than the medical story can tell” (Frank, 1995, p. 6). In this regard, Frank (1995) argues that what is distinct in contemporary literature concerning the body and illness experience, is a re-awakening of “the need for a voice [that people] can recognize as their own” (p. 7).

Social Constructionism and the Body as a Renewed Theme of Exploration

A significant amount of contemporary literature and theory regarding the body and its expressions has redirected attention towards the body as “a focal entity of psychological life” (Radley, 1998, p.559). Burkitt (1999) argues that central to this paradigmatic shift is a recognition that, due to Western philosophy’s deeply entrenched history in a “foundation of profound somatophobia”

(Grosz, 1994, p. 5), the body has until recently been an almost invisible and passive object for both the social and psychological sciences. Stated differently, the body had remained a dislocated and disengaged object of knowledge and thus an instrument of the rational mind or self (Csordas, 1994). In an attempt to overcome dualistic articulations of the relation between the subject-self, body and world, and thus address the relative absence of subjective and embodied accounts of illness experience in body literature, psychological and social theorists have attempted to develop a corporeal framework that requires an analytic focus on 'lived experience' and thus displays a sensitivity to the embodied/corporeal and mutable nature of human selfhood (Gillies et al., 2004; Howson, 2004).

This shift in focus represents an attempt to direct attention away from the body as a reified, material object, and towards the body as lived - as "the *experiential*... [and] ... existential basis of our being-in-the-world" (Howson, 2004, pp. 9-10). Within this context the epistemological and ontological primacy of the decorporealized and thus interiorised self of Western philosophy (and more specifically, somatic aetiology), is undermined by a concept (i.e. the 'lived body') that provides a potential mode of escape from the conceptual dualisms that have restricted the development of adequate *and* experiential accounts of bodily expression. Unlike the "fundamental passivity and transparency of the [inanimate, medicalised] body" (Grosz, 1994, p. 9), the notion of the 'lived body' allows for a recognition of the body as an elusive, dynamic and disclosive entity capable of meaning-making (Leder, 1990; Howson, 1994).

O'Loughlin (1995) argues that social constructionism has been essential in emphasizing the 'intelligence' and agency of the body as lived and experienced. Central to the theoretical framework of social constructionism is the premise that one's knowledge and thus experience of the world is always situated and mediated discursively within a socio-historical context. In this sense, the unified, disembodied and isolated self of the enlightenment period and the metaphor of the body-as-biomedical-machine is challenged and displaced in favour of a recognition that human beings "cannot be wholly indifferent to the world around us. We must to an extent, continuously react and respond to it, spontaneously, whether we like it or not, and in so doing, we must of necessity, relate and connect ourselves to our surroundings in one way or another" (Shotter, 1994, p. 1). Social constructionist theorists thus endeavour to make explicit an awareness of the

'background' circumstances (i.e. intersubjective, historical, sociological, political) that add form to our actions as we emerge from, or act 'into' networks of meaning and social significance (Grosz, 1994). Within this context, the body is recognised as central to the lived status of the subject – whereby the human self's mode of insertion necessarily requires corporeal modes of interaction (i.e. bodily feeling, gesture and dialogue).

Within this broad theoretical framework, the self is constructed within a field of continuously interactive relationships and thus emerges in inextricable relation to the responses, actions and dialogues that take place within an intersubjective and linguistic community of self and other (Gergen, 1991; Shotter, 1994). Self is afforded a reality of relatedness that is negotiated through the performative, constructive and (frequently) prescriptive functions of speech, and thus through the linguistic processes or discourses that we utilise when referring to ourselves and others' selves (Gergen, 1991). Within social constructionist literature, language thus plays a central role in the formation and construction of the lived fabric of human reality, "where all meaning is textual and anything about which we have knowledge is constituted through discourse" (Edwards, Ashmore & Potter, 1995, p. 32).

It is within this core concept of self as 'lived discourse' that social constructionist theorists attempt to reinstate the body as lived and 'intelligent'; that is, the bodily production of language is an essential component to our insertion into and interaction with the vicissitudes of the lived socio-cultural world. The body is thus positioned as the corporeal or material location "from and through which the subject/self knows and speaks" (Howson, 2004, p. 10). Wittgenstein (1953) emphasises the central and intelligent role of the body in the linguistic or discursive construction of reality through his reference to language as an extension or 'prosthetic device' of the apparatus of bodily production (Burkitt, 1999; Shotter, 1994). In this regard discursive practices, dialogues, etc. are articulated, not as abstract units of grammar, but rather as representative of an individual's embodied location within a living, social and relational context.

Through our embodied-linguistic productions of our socially embedded interactions, the body "can be read as an agent, a labouring, exchanging being, [and] a subject of social contracts" (Grosz, 1994, p. 120), thus positioning it as the experiential site or grounding of knowledge, experience,

action and intention. In this regard, the body is neither private nor public, self nor other, natural nor cultural, psychical nor literal, but is rather perceived as a discursive object and a cultural product that is able to act and engage by virtue of our cultural, social, political, and personal “textualization[s] [inscriptions and markings] of ... [its]... contours and organic outlines” (Grosz, 1994, p. 119). Within this context, the body lives and [inter]acts, not because of essential, biological and natural givens but because of the power invested in it and through it by the symbolic order of discursive practices (Burkitt, 1999). The body’s expressions and manifestations are at once representational (or symbolic) and agentic. This means that they are the symbolic carriers, bearers or signifiers of social meaning and symbolism *and* active creators of meaning and thus vehicles of social action (Reischer & Koo, 2004). In line with this, Turner (1996) argues that within social constructionism, disease or illness categories (e.g. somatization) are articulated as products of changing social relations of power rather than inherently reflective of essential, agnostic scientific explanations and advances. As highlighted in the previous chapter, expressions of somatic distress are thus articulated as symbolic expressions, signifiers or replications of an individual’s engagement with his/her social situation, particularly in relation to mechanisms of social power and oppression (e.g. somatic distress may provide a safe, yet visible strategy for those in impoverished, disadvantaged contexts to protest social inequities) (Reischer & Koo, 2004).

Howson (2004) and Csordas (1994) argue that such an approach to the body serves to problematise monological or singular canons of ‘the body as object’. In so doing, it highlights the multiplicity of meaning and animation inherent in our corporeal-linguistic expressions of our inescapable relation to, and ideological, social and historical constitution of, other bodies. As an entity that is inextricably related to the order of signification and power (an entity that is able to engage in the production and appropriation of the materiality of language), the body is afforded a history and an “indeterminable position [that] enables it to be used as a particularly strategic term to upset the frameworks by which...primary [and thus dualistic] pairs are considered” (Grosz, 1994, pp. 23-24). Within this context, accounts of the body necessarily require the subject’s linguistic (or ‘fleshy’) accounts of his/her embedded position within his/her socio-cultural/historical context. Here, the body is not a mode of interiorised expression that allows for the projection, communication and mediation of essentially private or latent psychical processes. Instead, it is a meaningful, experientially grounded subjectivity upon which meaning and knowledge is inscribed

through its lived engagement and intralinguistic self-body interactions over time (Shotter, 1994). In this regard, the body can exist not only as the 'medicalised body', but also as the 'discursive body', the 'material body', the 'talking body', the 'individual or social body', the 'communicative body', the 'consumer body', the 'somatic body', the 'disciplined body' etc. thus challenging or problematising the notion of the body as a reified object (Howson, 2004).

Critiques of Social Constructionist Articulations of the Body

As was outlined in the previous section, theorists working from a social constructionist orientation argue that this perspective reinstates the body as a meaningful subjectivity, in which the self's intersubjective and intercorporeal dialogues or perspectives around bodily experience are afforded primacy in understanding the often-complex aetiology of bodily expression. In an attempt to make present the previously decorporealised, absent and natural or essential body, social constructionism not only emphasises the lack of finitude of any phenomenon, but also directs our theoretical focus towards paying attention to the body as a prerequisite for human action and an object of knowledge that is deeply embedded within the constantly shifting horizons of meaning and varying contexts in which an individual finds him/herself (Howson, 2004).

However, although social constructionism has played a significant role in redirecting our attention towards the body as a focal entity and thus theme of exploration within somatic literature, several contemporary theorists have also severely criticised the constructionist understanding of bodily experience and agency as constituted and animated through language and thus the symbolic realm. Csordas (1999), for example, argues that despite the social constructionist claim that the body and its transformations are of central analytical concern, somatic theory continues to pay little attention to the body as a generative source in its *own right*: i.e. the social constructionist understanding of the body as created through and by discourse once again relegates the body into a realm of disengaged absence, whereby experience is constituted (or afforded validity) only through the processes of language. In this sense, Csordas (1994) maintains that by establishing discourse as the precondition through which the body is constructed, communicated and inscribed upon, the phenomenological experience of *being* a body is submerged beneath the text and thus positioned as irrelevant. He argues that within a context in which the actual living body of flesh and blood has been replaced with "[a] discursivist and theoreticist bias" (Wacquant, 1995) that reduces the

phenomenology of experience to 'fleshy' but nevertheless semiotic and representational structures, the body as a function of being-in-the-world is rendered absent and positioned, once again, as an objectified abstraction: i.e. "the subjugation of the bodily to the semantic is empirically untenable ... meaning should not be reduced to a sign which, as it were, lies on a separate plane outside the immediate domain of an act" (Jackson, 1989, p. 122, cited in Csordas, 1994, p. 10).

Both Burkitt (1999) and Sparkes (1999) echo this concern by suggesting that although "the body may be back ... the new body theory is just as ... disembodied as it ever was" (Sparkes, 1999, p. 18). Both authors argue that lived reality is not based on purely discursive practices, as social constructionism would suggest, and highlight a parallel between the theoretical premises of social constructionism and those of Cartesian Dualism: i.e. in both paradigms "the mediated nature of experience ... separates people from the world because they have no direct access to reality" (Burkitt, 1999, p. 94). Thus, central to the critiques of social constructionism is the concern that the heavily theorized and discursively constituted body of constructionist approaches has remained as detached and distant as the literal body of Western Cartesian philosophy. In this regard, much of the existing theory concerning the study of the body continues to champion ideals of the disembodied Cartesian consciousness and thus "for the most part [lacks] intimate connection to the lived experiences of the corporeal beings who are the objects of analytical scrutiny" (Sparkes, 1999, p. 18).

Within the context of somatization or somatic distress, the recognition by body theorists that the lived body is as absent as it ever was suggests that a theoretical articulation of a non-Cartesian, lived body (and thus a non-Cartesian self) within the context of contemporary somatic theory poses a challenging task. This may be a relevant argument, particularly when the notion of self and body are deeply embedded within a tradition that has typically allowed for the discursive (abyss-like) separation of body and self, the external and internal, and the conscious and unconscious. In response to this theoretical challenge, authors such as Csordas (1994) and Turner (1996) suggest that somatic theory needs to incorporate a "more radical role for the body – a role that contrasts significantly with approaches that have typically treated the body as an object, or theme of analysis" (Csordas, 1994, p. 6). Inherent to their argument is the suggestion that the philosophical notion of *embodiment* may provide somatic or body theorists with a method of exploring "the

systematic contradictions and ambiguities of the body as corporeality, sensibility and objectivity” (Turner, 1996, p. 33).

The Foregrounding of Embodiment Principles in the Radicalisation of the Role of the Body

In keeping with Csordas (1994) and Turner’s (1996) arguments for the radicalisation of the role of the body, more recent critiques of the continued perpetuation of the unified subject (within the context of both philosophical and psychological writings on the body), have involved a foregrounding of embodiment as a central theme for exploration, and thus a means of exploring the multiple realities of self (O’Loughlin, 1995; Cardo, 1999; Burkitt, 1999). Within this context, embodiment is broadly defined as an existential immediacy and intimate connection to, or immersion in, the multiple dimensions of lived experience that individuals actively participate in (whether it be through gesture, dialogue, etc.). Such a definition allows for the incorporation of an individual’s “socio-economic positionings, intersubjective and social dimensions, as well as the temporal context which situates [an individual] in a personal and communal history” (O’Loughlin, 1995, p. 2).

Embodiment theorists suggest that although social constructionist approaches purport to capture and illuminate the embodied nature of the discursive mediation of one’s lived involvement with one’s socio-historical context over time, the foregrounding of embodiment as a philosophical principle requires that the theoretical focus turns toward the *pre-reflective* and *pre-objective* knowledge of the body (and the body’s capacity for intentional action, agency and subjectivity), as opposed to the linguistic and thus reflective constructions of the body as a readable text or *tabula rasa* (O’Loughlin, 1995, Csordas, 1994). In this regard, Hofmeister (2000) argues that the discursive conceptualisation of embodiment is unsatisfactory as “[d]iscursive approaches displace the question of materiality of the body by changing the status of the problem from ontological to epistemological” (p. 194). In this regard, the body is rendered a process of “performative materialization of discourses” (Hofmeister, 2000, p. 194) where the subject’s *fleshy* and *subjective* relation to his or her context dissipates into a realm of discourse.

Csordas (1999) suggests that Merleau-Ponty’s philosophy of embodiment may provide a means of collapsing our continued subscription to the dualities or distinctions of subject and object; literal

body and corporeal meaning, etc. For Merleau-Ponty (1962), the body is a “setting in relation to the world” (p. 303) and thus the condition and context through which the subject is able to have a relation to its lived world. In this regard, the body is *always* engaged (pre-objectively and immediately) in the constitution of one’s environment in that it provides the horizon through which the subject is able to relate and engage with some other (whether that other be the objects of one’s lived reality, another person, other parts of self or one’s social or cultural environment) (Csordas, 1999; Grosz, 1994; Bakhtin, 1990). Within this context, the subject’s ability to create or generate meaning and thus receive knowledge relies not on a contemplative or discursive withdrawal from the body as lived and experienced, but rather on the recognition that the self’s experience is “always and necessarily embodied, corporeally constituted [and] located in the subject’s incarnation” (Grosz, 1994, p. 95).

By situating the body as “the general instrument of my ‘comprehension’” (Merleau-Ponty, 1962, p. 235), Merleau-Ponty seeks to affirm and emphasise the interrelated nature of mind – as it is personified (or ‘made flesh’) – and the body. In this regard, self is always embodied and thus always engaged in the act of perceiving such that one’s sense of self is one of implicit connection and coherence with one’s lived bodily or physical boundaries (Grosz, 1994; Csordas, 1997). The integration of the subjective I with the physical body thus establishes the body as an intelligent being that is central in our ability to make sense (and thus make intelligible) our lived relation with the indeterminate nature of the lived world. In this regard, the Cartesian belief that the production of knowledge involves a solitary subject that grasps the world in a purely cognitive manner, and the constructionist production of self as a function of discursive theoretical thought, are rendered impossible in their inability to grasp the gestalt-like interchange between self, body and world: i.e. “I am not able to stand back from the body and its experiences to reflect on them; this withdrawal is unable to grasp my body-as-it-is-lived-by-me. I have access to knowledge of my body only by living it” (Grosz, 1994, p. 86).

Merleau-Ponty’s philosophy of embodiment is one that actively attempts to destabilise the dualistic philosophies that have dominated much of Western thought. Through his emphasis on the importance of the lived world or perceptual reality, he encourages us to engage in an “ontological rehabilitation of the sensible” (Gardiner, 1998, p. 133) – to pay attention to the manner in which

our body-selves author our lived realities (through their actions, their symptoms, etc.). Within this context, the lived world is articulated as “a living and complexly interacting medium in which we as body-subjects are enmeshed” (Gardiner, 1998, p. 133) and thus positioned as engaged in a complex and reflexive interplay between the experience of simultaneously constituting and being constituted by the “flesh”⁴ of the world. Within this dynamic context, the body-subject is at once object and subject, where dualistic partitionings of conscious and unconscious, the external and internal, mind/self and body become problematic and are rather embraced by the ambiguity which is inherent in the unfinished, indeterminate nature of the pre-objective and actively perceived environment, where body and self are intimately connected.

It is possible to argue that Merleau-Ponty’s notion of embodiment (in which body, self and world exist in chiasmatic relation to one another), makes it possible to understand how the perceiving body becomes the supposed absent component within Cartesian, constructionist, *and* biomedical models of thought and thus within our dualistic theories regarding the experience and articulation of somatic distress on the part of somatizing individuals. The body *can* be rendered absent, precisely because it is the point from which the perceptual or lived field radiates (Leder, 1990): i.e. the body must *necessarily* remain ‘absent’ in the midst of the perceived. The disclosive function of the body is premised on the embodied individual experiencing an *absence* of the body from his/her self-awareness: “The body always has a determinate stance – it is that whereby we are located and defined. But the very nature of the body is to project outward from its place of standing The body conceals itself precisely in the act of revealing what is other. The very presencing of the world and of the body as an object within it is always correlative with this primordial absence” (Leder, 1990, pp. 21-22).

These ideas can be illustrated with the following example. The act of writing about the body is one in which the walking, active-in-the-world body is largely pushed into background awareness – thoughts, fingers and eyes alone are in motion. However, in terms of bodily or physical self-awareness there is a focal disappearance of one’s fingers, one’s eyes and ultimately one’s brain

⁴ Where “flesh” is a notion or basic term utilised by Merleau-Ponty (1968) to refer to the indeterminate nature of so-called boundaries between object and subject, the visible and invisible and thus self and body, body and world, etc. In this regard, flesh could be described as a circular or reversible union between lived world and lived body: “it [flesh] is at once world and body, at once internal and exterior, at once absent and present” (Merleau-Ponty, 1968, p. 152).

(the experientially absent anatomical centre that influences our thought production, bodily movement, etc. – a centre that fails to register in our physical world (Leder, 1990)). Similarly, the rest of one's body – one's legs, torso, etc. - are engaged in a background disappearance. In both instances, there is a seemingly apparent absence of the lived, experienced body; in that it is not *obviously* engaged in any action that could possibly render a disclosive property to one's lived reality. In other words, although my fingers, eyes and brain are the aspects of my body that are engaged in 'object interaction' (such as the computer keyboard and screen), I am not particularly aware of my actions, except perhaps for my current process of thought whilst sitting at the computer. In this sense, my body, by virtue of its obvious physiological presence and thus its inescapable presence in my lived world, is at *once* both absent *and* present – a functional gestalt that is informed by two modes of bodily absence or disappearance: i) *focal disappearance*: the self 'deletion' of bodily organs that as a result of their engagement with our perceptual and 'actional' field and thus the disclosure of our experienced, lived world, 'disappear' from conscious awareness, and ii) *background disappearance*: where one's awareness is withdrawn from a particular bodily-region when it does not partake in the focal origin of one's corporeal engagement with one's lived environment. Such bodily regions are thus relegated to a supportive role within the bodily gestalt and thus 'put out of play' (Leder, 1990).

These modes of disappearance are used to account, phenomenologically, for our ability to exist at once as a grounded physicality (a grounded presence) *and* as an intimately interrelated and involved 'absence' – that is, to exist continuously 'outside' oneself and thus to apprehend one's sense of embodiment through one's relation to other embodied human absence-presences. As Leder (1990) points out, my body is therefore experienced as "a tacit and self-concealing structure" (p. 108) allowing for the 'mind' (or that part of the human being in the world, e.g. self, that does not form a [self]-evident part of one's bodily armour) to *seem* disembodied. In this sense, the mind/thought/self could be construed in the moment of writing and thinking as anatomically *nowhere* (Leder, 1990).

Anatomically, however, it is the 'disappearance' and seemingly disembodied quality of the brain (i.e. its lack of *visible* insertion into our lived reality) as well as the background disappearance of the body (in the above example) that provides a possible key to understanding the historical

emergence of the ‘orphan self’, and more presently, of the continued tendency to resort to hypothetical notions of bodily expression (e.g. somatic distress) that render both the body and self absent from the immediacy of the lived world. As the centre point from which our perceptual field radiates, “it is the body’s own tendency toward self-concealment” (Leder, 1990, p. 69) that has historically allowed individuals such as Copernicus, Descartes and later psychoanalytic writers such as Freud, Winnicott, etc. to identify self with an incorporeal mind and attribute a quality of deception to the physical body, thus allowing for the possibility of a neglect or deprecation of the corporeal/material (Leder, 1990). If one attempts to articulate a phenomenology of the lived body, Descartes’ incorporeal mind would necessarily have been embodied, i.e. one that emerged from within a phenomenological experience of his very own corporeal gestalt⁵ - an entity that is (at times of good health) rarely “the thematic object of experience” (Leder, 1990, p. 1). Similarly, when the body *does* draw Descartes’ philosophical attention, it is generally at times of injury, disease and fatigue – times in which the body is distinctly and painfully present, but as a piercing and demanding Other. Whilst both these modes of being in the world exhibit the characteristics of the body as functional gestalt (enabling one to simultaneously experience the contrasting positions of its absences and presences, of which some are more pronounced than others), it is this experience of the body as Other, as deceptive, that has essentially informed and sanctioned the Cartesian categorisation of the phenomenological ambivalence that is the body (Csordas, 1994).

Historically it therefore becomes evident that whilst the *experiential* basis from which Cartesianism emerged is one characterised by a constant shift between absence and presence, visibility and invisibility, objectivity and subjectivity, our philosophical and theoretical approaches towards the articulation of human being in the world have been formulated on the grounds of absence only, thus allowing for the discursive separation of body and self, unconscious and conscious, etc. In so doing, the Western philosophical and psychological tradition has cultivated and nurtured a narcissistic “fantasy [and epistemology] of total self-determination, total self-grounding” (Gardiner, 1998, p. 128) whereby the sense of one’s incarnate union and lived engagement or dialogue (i.e. intertwining of self-body-world) with one’s lived reality is positioned

⁵ “it is from the very immediacy of the life-world that this dualism is first brought forth and by which it is continually sanctioned” (Leder, 1990, p. 149).

as alien and supplanted with a solipsistic disincarnate self that interprets the world as a projection of its own cognitive faculties (Gardiner, 1998; O'Loughlin, 1995).

Although Merleau-Ponty's philosophy of embodiment affords body theorists with a perspective that attempts to enable us to "plunge into the world instead of surveying it[,] [to] descend towards it such as it is instead of working its way back up toward a prior possibility of thinking it – which would impose upon the world in advance the conditions for our control over it" (Merleau-Ponty, 1968, pp. 38-39), both Stam (2003) and Gillies et al. (2004) argue that whilst the intention may be to explore notions of self, bodily manifestations of distress, etc. as integral to an embodied, dialogical reality, "the language we use to convey our accounts [both personally and theoretically] is inevitably distilled from culturally ingrained, dualistic discourse" (Gillies et al., 2004, p. 111). For example, Gillies et al. (2004) recently published an article entitled "Women's Collective Constructions of Embodied Practices Through Memory Work: Cartesian Dualism in Memories of Sweating and Pain". In this they suggest that the articulation of embodied, non-Cartesian self and bodily-experience is constrained by an inherent dualistic split between self and body that exists not only in theoretical accounts of selfhood, but in participants' accounts of their lived experiences as well. Similarly, within literature concerning individuals' experiences of somatization or somatic distress, the body has frequently been positioned in manners that are reminiscent of the deceptive Other of Cartesian philosophy: i.e. patients frequently refer to their bodies as a body 'in revolt' (Lynch, 1984) or as 'an alien presence' (Csordas, 1994) – thus positioning the body or vehicle of being-in-the-world as a presence that "speak[s] a language of its own" (Etherington, 2003, p. 29) and is thus distinct from the experience of self. Gillies et al. argue that it is participants' accounts such as these that highlight the culturally and historically ingrained nature of Cartesian dualism as a conceptual framework that continues to inform and regulate (or 'restrict') the performance and generation of both meaning and experience. Adding to Gillies et al.'s argument, Stam (2003) questions whether the "recuperation of self as [embodied]" (p. 87) necessarily implies that psychology has effectively managed to articulate a self that truly partakes in a shared, embodied and pluralistic lived environment, and thus moves beyond reliance for its articulation on unconsciously Cartesian theoretical schemes of representation.

Central to both Gillies et al. and Stam's argument is the question of how *does* one methodologically capture a truly non-Cartesian body-subject (?), and thus how does one explore somatic phenomena from a framework that enables theories of aetiology to become *enacted* by the body as lived, rather than the body being enacted *through* and *by* discursive practices. Similarly, how does one capture the individual's experience of somatic distress and thus his/her body in such a way that the experience is not broken down or 'abstracted up' into rigid and thus disembodied diagnostic categories, or discursive practices that render the body as an object rather than subject of discourse?

With the finding that Cartesian dualism "accounts for, and also constitutes, embodied experience" Gillies et al.'s (2004, p. 110) article concerns itself not with an "attempt to formulate an outright rejection of Cartesian dualism that [has] become popular in some recent writings" (p. 110), but rather attempts to reveal "how this discourse can be utilized as a resource" (pp. 110-111). Whilst such an approach can be considered a constructive one in finding or developing alternative ways with which to articulate and challenge (and ultimately break away from) an extensive history of conceptual frameworks and discursive accounts (in which "notions such as the lived body, have been rendered creature[s] of representation" (Csordas, 1994, p. 12) rather than *functions* of being in the world), it still incorporates or utilizes Cartesianism on the grounds of *absence* in which the body as an ambiguous absence-presence remains negated.

Whilst "merely cit[ing] counterevidence to a previous philosophical position never really breaks its hold over our consciousness" (Leder, 1990, p. 107), it would be possible to argue, as Leder does, that a reconciliation with, and incorporation of, a philosophical position without an exploration into that philosophical position's own "domain of evidences" (p. 107) is equally problematic. Thus, when faced with the task of attempting to enact and articulate a non-Cartesian language and notion of the body and thus somatization or somatic distress as its lived expressions, a mere reconciliation with the *epistemological* embeddedness of Cartesianism is insufficient to understand, *experientially*, why our theories and accounts of self have typically been 'immaterial' and 'disembodied'.

Leder's extended critique of the mind/self duality from a phenomenological standpoint effectively enables the rehabilitation and exploration of the experiential core of Cartesian dualism as a philosophical position (Csordas, 1994). Furthermore, Leder's critique also enables us to begin to make sense of somatizing patients' apparent subscription to a mind-body split as indicative not of a Cartesian distancing of the self from the deceptive body, but as a phenomenologically and thus experientially grounded experience of the body as lived. In establishing the body as a functional gestalt that is at once a presence and absence, Leder is able to illustrate that the phenomenological experience of the body does not necessarily set the mind/self and body as separate or distinct entities. Furthermore, in his suggestion that there is an experiential Cartesianism inherent in our own embodied experiences of the lived world, he effectively points out that both historically and presently, our fundamental error has been one of attempting to (theoretically) segregate and ontologize or define contrasting classes of experience (i.e. absence and presence, self and other, physiologically real and physiologically unreal) that, in reality, stand in ceaseless interchange.

Leder's critique enables us to recognise that the so-called dualistic split between self and body in participants' accounts of their lived experiences has less to do with an unconscious subscription to a historically and culturally embedded or ingrained epistemology, than with a recognition and articulation of their own dynamic and ambivalent experience of the inherently dual nature of their lived or embodied reality. In this regard, it becomes possible to understand somatizing patients' references to their bodies as an 'alien presence' not as a splitting off of the self from bodily experience (such that unbearable traumatic experience is displaced or projected into the body, thus allowing for an avoidance of direct connection with the pain of repressed or dissociated trauma), but a recognition of the inherently gestalt-like experience of the body at times of dysfunction or illness: i.e. "Insofar as the body tends to disappear when functioning unproblematically, it often seizes our attention most strongly at times of dysfunction; we then experience the body as the very *absence* of a desired or ordinary state, and as a [very present] force that stands opposed to the self" (Leder, 1990, p. 4).

The aforementioned quotation highlights the ceaseless interchange of absences and presences individuals encounter as they experience *through* the bodily manifestations of both health and illness. In addition, it highlights the phenomenological experience of Cartesianism that Leder

refers to in his outlining of a phenomenological anatomy: i.e. at times of bodily dysfunction the relationship to one's body is frequently experienced as foreign, problematic or destructive in nature, precisely because the body's phenomenological positioning as a functional absence-presence requires that at times of dysfunction the body's predominant role as the 'taken-for-granted' (or absent) vehicle *from* which one engages the world is drastically transformed into one that "demands a direct and focal thematization" (Leder, 1990, p. 83). In this regard, the body is perceived not only as explicitly (and often painfully, or disturbingly) present, but also as embodying the absence of a desired or ordinary state, thus positioning the body as a force that "can come to appear 'Other' and opposed to the self" (Leder, 1990, p. 79). However, within this context, it is essential to highlight, as Leder does, that this position of Othering or distance arises from an opposition that is particular to the experience of one's body and "not between it [the body] and an ontologically separate thing [i.e. self]" (Leder, 1990, p. 88). The self, thus remains an embodied self: i.e. "As I look down on a paralyzed limb I may be struck by the alien nature of embodiment. But I still use my eyes in looking down, my nervous system in thought, my other limbs in compensation for the paralyzed one" (Leder, 1990, p. 88).

Thus, Leder's phenomenological anatomy of the lived body incorporates the experience of bodily illness as *integral*, rather than separate to the gestalt-like interplay of absences and presences that characterise the experience of embodiment and thus of the lived body. This may be relevant within the context of somatization, in which the body's position as a present absence, is arguably amplified by the complex layers of absent-presences and present-absences within the context of the individual's experience not only as a body-subject, but also as a body-subject that is informed by a theoretical and curative context that operates within a doctrine of absence (not only in relation to the body as lived, but also in relation to a phenomenon that is defined on the grounds of absence – i.e. physiological absence, the repression or absencing of traumatic experience, the projection of unconscious and thus absent material, etc.). In this regard, the importance of the phenomenological experience of illness is essential in addressing not only the history of the concept of the body, but also in addressing the relative absence of accounts of somatization that allow somatic phenomena to *speak for themselves*, such that the structure of the somatic experience is analysed and suffering individuals are afforded the space to make *present* the embodied or felt effects of their experience as lived in chiasmatic relation to their life world and thus their sense of self (Leder, 1990).

From within the context of both Merleau-Ponty's philosophy of embodiment (in which he encourages the researcher to return to the level of primordial experience and thus the existential beginnings of lived experience as a starting point for the analysis of knowledge, the body, etc.) and Leder's critique of the mind/body duality from a phenomenological standpoint, one could suggest that central to alternative explorations of somatic distress is the recognition that when articulating or attempting to understand somatic distress, a severing or segregation of the soma from the psyche (as somatic theory continues to do) is in fact impossible. Rather, it may be possible to suggest that in order to afford somatic literature an embedded, meaningful and thus embodied perspective it may be necessary to recognise somatic distress as an expression of a manner of being-in-the-world, and thus a bodily mode that situates the individual as a body that remembers and thus as a body that actively *re-members* its phenomenological context, as it negotiates and re-organizes the absences and presences in its existing relationships and dialogues with its lived dimension over time (Leder, 1990).

Conclusion

Although constructionist theorists may argue that both Leder and Merleau-Ponty's articulations of one's incarnate and thus pre-objective involvement in one's lived reality over time, implies that embodied existence is that which occurs outside of, or prior to, culture and one's socio-historical context, Csordas (1994) argues that such critiques miss the essential core of such philosophies. He argues that by beginning theoretical analyses with the pre-objective (i.e. with a "[c]onsciousness [that] projects itself into a cultural world" (Merleau-Ponty, 1962, p. 311), one begins with experience as *pre-abstract* rather than pre-cultural. In this regard, Merleau-Ponty's embodied philosophy merges well with Leder's phenomenology of the body to remind one of the unfinished, indeterminate and chiasmatic relation of body-self and lived world, thus allowing for discussions and exploration of bodily phenomena within a theoretical context that seeks to afford the body-subject's experiences of agency interpretive significance through an active attempt to undermine the solipsistic tendencies of existing body theory.

To return to Gillies et al.'s argument, it may be possible to suggest that the preceding argument alerts us to the possibility that attempts to reconcile one's theoretical articulation of an embodied

self with a doctrine that negates the ceaselessly fluid reality that essentially provided the grounds for its emergence, would be to ensure that we can only articulate a self (an ‘orphan self’) that is performable, ‘dialogical’, ‘lived’, etc. within the context of yet another representational epistemology. In recognising and reinstating the experiential core of Cartesianism (i.e. the present or grounded partner, to the more absence and transcendent Cartesian doctrine) through an exploration of a phenomenological anatomy of the body-subject, the experience (and thus the articulation) of the embodied subject (and his or her experiences), and of being-in-the-world must necessarily assume an ecstatic/recessive, incarnate/disincarnate, absent/present character.

One could argue that whilst both Merleau-Ponty and Leder’s philosophical arguments possibly serve to undermine the dichotomous structure of the self/body dualism that has been so prevalent in accounts of the body, self and more specifically, the experience of somatic distress, the fact that the articulation of self will always remain to some extent reliant on the use of language, will ensure that the body-subject as representation and thus as object is ever present (Csordas, 1994). However, as authors such as Leder (1990) (through his ability to bring to one’s awareness an inherent phenomenology in even the most, seemingly distanced actions, such as reading, writing and thinking), Burkitt (1999) (who explored the notion of language as artefact, i.e. as an embodied aspect of being in the world), and Merleau-Ponty (1968) (through his notion of “flesh” which affords philosophical or theoretical thought with the capacity for reflexivity⁶) point out, the use of language as a means and *act* of articulation is always and necessarily experienced and felt somatically as embodied gesture, and thus as a responsive interaction or dialogue with one’s lived reality: “Language always remains embodied” (Merleau-Ponty, 1968, p. 152).

Thus, in an endeavour to enable somatic theory to become *enacted* by the body-subject, rather than the body-subject being enacted *through* and *by* discursive practices, one must approach any form of somatic theorisation with the very premises upon which the existential experience thereof is arguably based (i.e. the indeterminate, lived, incarnate, chiasmatic and reflexive nature of somatization as a phenomenological mode of being-in-the-world and thus as a reflection of an individual’s social, interpersonal and cultural organization of their lived reality). In this regard, the theoretical goal is not to reach determinate categories or criteria of diagnosis or explicit

⁶ O’Loughlin, 1995.

conclusions about the specific aetiology of somatization – such efforts would only serve to subscribe to the particularism that is so characteristic of Cartesianism as a philosophical doctrine of absence.

This study is rather concerned with affording individuals who experience somatic distress as an integral part of their body-self-expression, the opportunity to offer theoretically established absences around somatization, the presence of subjective experience and thus multiple subjective accounts in the hopes that incarnate or corporeal accounts will afford health professionals with an opportunity to engage in the possible development of a “mutually meaningful language [that enables both practitioner and patient with the capacity to] arrive at a[n] [experiential and subjective] name for the illness [thus restoring faith in] the patient’s bodily experience of distress” (Epstein, Quill & McWhinney, 1999, p. 215).

In the proceeding chapter, narrative methodology is offered as an appropriate and phenomenologically attuned method to the collection of corporeal accounts of bodily distress – accounts that fail to adhere to taxonomical or categorical forms of representation. In this sense, narrative research is positioned as a methodology and philosophy that may afford somatic theorists (and professionals alike) a means with which to develop a mutually meaningful, subjective and experiential language around a phenomenon that is hypothesised to embody an individual’s lived engagement with their life world over time.

CHAPTER FOUR

Enacting Somatic Distress

Introduction

This chapter begins with the contention that somatic theory is currently faced with a crisis of representation and thus a crisis of finding alternative ways of articulating the complexity of a phenomenon that fails to comply to a unitary concept of what it means to somatize. Descriptive narrative accounts of the experience of somatic distress are identified as the most appropriate method of eliciting multiple and unique accounts of a phenomenon that continues to elude prescriptive narratives (e.g. the diagnostic story) - as supported by the variability in the cultural patterning and the storying of symptoms of somatic distress. In this sense, the body is positioned as a teller of stories, where somatic symptoms are afforded the capacity to generate an embodied (and somatic) language that points to individuals' ways of negotiating their world as lived.

Through an overview of narrative methodology and some of its basic premises, it is argued that narrative research or narrative methodology's focus on the body and the philosophical notion of embodiment, provides somatic theorists with a means with which to approach an exploration into the personally, culturally, socially, etc. embedded ways in which the body is used to experience and communicate somatic distress.

The structure or plot of this thesis (as an organic whole) is one that attempts to move away from partitioned chapters. In this sense, this study attempts to explore the phenomenon of somatization (and the individual's subjective and embodied experiences thereof) within the forward-backward grasp of both the theoretical argument and the participant's sharing of their illness experiences. Thus, although this chapter is not formally entitled 'Methodology Chapter' it does incorporate central themes that pertain to such a chapter: i.e. research question, research context, research paradigm, participant selection, interview protocol, issues of reflexivity and validity (or 'trustworthiness' in the case of narrative research), narrative ethics and the process of analysis (i.e. situating the analysis process and the model of narrative analysis utilised).



A Crisis of Representation: The Danger of a Unitary Concept of Somatic Distress

As suggested in the previous chapters, the relative absence of embodied and thus subjective accounts of somatic distress within the mental health context can be attributed to a continued theoretical allegiance to reductionist articulations of the patient's presenting narrative. In this regard, the diagnostic story is one that continues to assume a position of authority, whereby an individual's experience of somatic distress, his or her body, etc. is interpreted through the employment of pre-existing, culturally sanctioned systems of meaning. Within this context, the subject's story of distress (as he/she is confronted with the occurrence of an illness experience that appears to elude established diagnostic and theoretical criteria of interpretation), is condensed into a narrative that is dependent not on the client's lived or embodied knowledge of their experience (as an interactive cultural, social and personal phenomenon), but on the theoretical orientation of the professional and thus on an imposition of a cultural narrative that fails to acknowledge that "...the diagnostic story ... is just one way of [articulating and enacting] a person's story of distress" (Barker & Barker, 2004, p. 18).

Despite the growing recognition of the prescriptive nature of the biomedical model and its concomitant constructions of objective, third-person accounts (in which the pathology, rather than the subject, is situated as the central character in the professional-patient encounter), clinical and medical practitioners continue to adopt a "traditionally hostile [approach]...to connotative discourse" (Garro & Mattingly, 2000, p. 7) and thus towards approaches that afford the characteristically muted or silenced dialogue of embodied distress some prominence (Becker, 1999; Csordas 1994). Kleinman (1995) argues that this existing conflict is informed by a dangerous myth that "the [patient's subjective story or account] will entangle [the professional] in confusion, which may ... [make] diagnosis more difficult ..." (p. 96) or may interfere with the single-minded pursuit of a single ideal treatment or management plan. The danger inherent within this prominent myth, particularly within the context of somatic distress, is that "there is no such thing as [a unitary concept] of *the* [somatizing] patient" (Kleinman, 1995 p. 73).

Within the context of somatic theory, professionals and theorists alike are faced with a crisis of representation: i.e. a crisis of articulating phenomena that appear to embody a psychosomatic integrity or unity that Western philosophical models of explanation have endeavoured to problematise (Kleinman, 1995). The finding that different cultures vary in the manner in which they pattern, represent or make sense of somatic symptoms (e.g. within the South African context somatic distress is frequently articulated by suffering individuals as embodying a complex interplay between the personal, the collective and supernatural forces, including the ancestors, or the act of bewitchment (Helman, 2004)), serves to highlight not only the embodied nature of somatic distress, but also adds emphasis to Kleinman's contention that establishing set categories of somatization would fail to take the variety of representations of somatic distress into account, as they are made manifest within a lived context.

The variability in the cultural patterning of symptoms of somatic distress can be seen in the unique ways in which medically unexplained symptoms are made manifest by various different cultures: e.g. in Southeast Asia, somatic symptoms tend to relate specifically to the head area (e.g. headaches), whereas in Latino countries individuals tend to present with 'pseudoneurological' problems such as dizziness, numbness, weakness of extremities, etc. (Wiatzkin & Magaña, 1997). Fabrega (1991) suggests that the difference in somatic expression from one cultural group to another is informed by varying social, religious, cultural, etc. narratives that position the somatizing individual as engaged in an inextricable and embodied dialogue with his/her culture's cosmological practices: i.e. "The somatic concomitants of illness as well as its social role are linked to symbols with ecological, social and cultural significance within the society" (p. 183). In this regard, the "language of the body plays a central role in the cultural dynamics of illness and healing" (Fabrega, 1991, p. 183), whereby the body is positioned as the instrument through which the subject's inextricable relationship with his/her life world is communicated.

This conceptualization of somatization, where the body is positioned as an intelligent being that is simultaneously constituting and being constituted by the "flesh" of the world, is one that has characteristically and historically (within the context of somatic theory) pertained to 'elementary' and thus 'less sophisticated' societies (Fabrega, 1991). It has been suggested that within such societies, "individuals are not seen as discrete, wilful, autonomous agents comprised of minds and bodies that operate like (dualistic) machines" (Fabrega, 1991, p. 184). Instead, individuals and

their bodily manifestations of illness are regarded as “social affairs” (Fabrega, 1991, p. 184), in which the aetiology of illness experience is negotiated along social, moral and political lines as opposed to biomedical explanations. Within the Asian medical context, for example, somatic symptoms are storied employing themes of harmony, union and communion between body and world, where the ill body embodies a disruption of this union and thus a disruption of bodily harmony (a quality that is considered to constitute freedom from illness) (Fabrega, 1991).

It may be possible to suggest that the gradual shift, within psychological body theories towards employing philosophical notions such as embodiment, serves to problematise the notion that the aforementioned cultural narratives and understandings of somatic distress are indeed elementary or less sophisticated. Instead, the continued prevalence of such understandings (despite factors such as colonisation, urbanisation, etc.) appear to add emphasis to existing critiques of the biomedical model of somatic distress, in particular: i.e. by articulating somatic distress as the body’s way of ‘linguaging’ or storying an individual’s phenomenological and incarnate experience of their life world, such understandings serve to break down the dualistic (and often mutually exclusive) distinction between illness (as subjective experience) and disease (as an objectively verifiable organic disturbance – something which is frequently absent within the context of somatic distress presentations) (Fabrega, 1991; Helman, 2004).

Swartz (1998) argues that within the context of multicultural societies, such as South Africa, in which real discrepancies between class, gender and culture exist, the articulation, understanding and management of somatic distress cannot be one that ascribes to chiefly Western meta-narratives around illness experience. In this regard, he positions the suffering individual as essential to the development of alternative explanations of somatic distress, and argues that as researchers we need to pay attention to “how the body is being used to experience and communicate distress” (p. 138). In this regard, he encourages researchers to acknowledge the body’s position as a *teller of stories* – as possessing the capacity to generate an embodied language that points to individual’s ways of seeing and negotiating the world as lived.

Narrative Research: A Phenomenologically Attuned Means of Accessing Bodily Experience and Expression

Several prominent authors (e.g. Crossley, 2000; Garro & Mattingly, 2000; Becker, 1994, 1999; Frank, 1996, 1995 and Young, 1990) suggest that at a pragmatic level, narrative methodology is a phenomenologically attuned means of accessing (and enacting) the world of bodily experience and embodied gesture. Although narrative research is a broad area that draws on a number of theoretical paradigms (including the social constructivist, and interpretive phenomenological paradigms), the body and the philosophical notion of embodiment (e.g. Leder's phenomenological anatomy and Merleau-Ponty's intelligent body-subject) has been central in the development of some of the basic premises of narrative methodology (Becker, 1999).

Central to a narrative psychological approach is the development of a critical, phenomenological understanding of the manners in which individuals construct meaning within given contexts (i.e. social, cultural, political or personal). From this theoretical perspective, language or dialogue is positioned as performative in nature, where the act of telling one's story relies wholly on the body's role as the "kinaesthetic site of... performance" (Jung, 1998, pp. 96-97) and thus as central to the recovery or exploration of an individual's story: i.e. "[t]o recover the world of [activated word] ... is to recover the human body" (Brown, 1966, p. 265 in Jung, 1998, p. 97). In this regard, the body-subject or the lived body is articulated as inextricably linked to the unfolding of human drama, such that narrative is treated as "the enactment of bodily experience" (Becker, 1999, p. 194). Within this mode of research, the "creation of meaning begins with the body" (Becker, 1999, p. 93) – thus reflecting philosophical notions explored in the previous chapter: i.e. one's body is deeply embedded in, and highly communicative or receptive to the different contexts in which an individual lives. Within this context, narrative is positioned as the linguistic means through which individuals and researchers alike may gain "access to a world of experience insofar as experience is brought to language" (Becker, 1999, p. 14).

Narrative methodology therefore operates on the basic premise that human body-subjects are tellers of stories: i.e. it is through the telling of stories that the individual is able to make sense of, and give meaning to, their pre-objective and incarnate experience of a life world that is characteristically in flux (Bruner, 1986). In this sense, the telling of stories is possibly one of the

most significant ways in which an individual is able to achieve a “synthesis of the heterogeneous” (Ricoeur, 1984, p. 436) and thus a synthesis of his/her dialogical and embodied reality of self. The lived world of immediate (or pre-linguistic) everyday experience thus forms the central theoretical focus within narrative research, whereby the researcher concerns him/herself with the manners in which individuals perform the “telling of events” (Overcash, 2004, p. 15), as they attempt to actively locate, generate, integrate and interpret meaning within the chiasmatic and dynamic relation between self and other (whether that other be another person, other parts of self, or the individual’s society or cultural environment) (Casey & Long, 2002; Polkinghorne, 1995; Josselson, 1996).

By focusing on the embodied and lived nature of human experience, narrative research positions the subject and the human life space as intelligible within the forward-backward grasp of the narrative act, in which the gestalt-like interplay between “the presently understood past, experienced present and anticipated future” (Mishler, 1992, p. 25) affords the narrating individual, and researcher, the ability to reveal and explore structures or meanings that have previously remained implicit or unrecognised (Crossley, 2000). In this regard narrative has ontological status: it acts as an organizing principle for human action by affording a sense of order and meaning to everyday life, and also provides structure and coherence to our sense of self (Sarbin, 1986). Thus, as our lives are “told in being lived and lived in being told” (Carr, 1986), so we are able to recognise ourselves, begin defining ourselves, and, through the process of telling, become responsible (response – able) for our lives (Ricoeur, 1984).

In this regard self is a central organising principle in narrative methodology, and is, in comparison to the traditional and abstract phantasies or articulations of self⁷, one that attempts to problematise the traditional notion of the solitary subject as a bounded entity that interprets the world as “a projection of its own cognitive faculties” (Gardiner, 1998, pp. 128-129). Instead, by virtue of narrative theory’s recognition of the corporeal and embedded nature of self (and thus of one’s sense of identity), the self is articulated as coming into being through others and thus through the self’s engagement with its life world: “I am a self because I am simultaneously also an other, just as the other is simultaneously a self” (Romanyshyn, 1982, p. 63). In this sense, the narrative notion

⁷ Whereby the embodied connection between self and other has been defined on the basis of an “epistemological abyss” (Levin, 1991, p. 56) between the monadistic, self-determined and self-grounding subject of Cartesian dualism and his/her community or life world.

of self is one that positions the subject and his/her sense of identity as emerging through the creation and exchange of meaning as it is made intelligible through the body-subject's responsive interaction or dialogue with his/her lived reality. The location of self as intersubjective and inextricably related to its life world, establishes it as a reflexive phenomenon – a phenomenon that requires the absence-presence of the lived body *and* the embodied gesture of storied dialogue in order to come to know itself: i.e. our existence is too tightly weaved into the fabric of the world for us to know ourselves at the moment of our involvement, meaning that we require story to make present the manners in which we 'absently' construct our experience (e.g. illness experience) and thus our lives (Merleau-Ponty, 1962).

The ability of the self to engage in a perpetual adjustment of the past and present in the construction of a coherent and meaningful story points to another central premise of narrative research: the notion of reflexivity. Bruner (1986) describes reflexivity as the restoring of memory – an act that relies on the body-subject's capacity to make present the past, to reflect on that past and alter or refine the present or past in light of their respective counterparts. Within this context narrative methodology recognises that meaning is not permanent or fixed but rather changes through time. Freeman (1993) alerts the researcher to the fluidity of meaning within the narrative context by highlighting the provisional nature of narratives. He refers to storytelling as an act of recollection – an act of gathering together that which may have disappeared or been lost. In this sense, narratives are subject to change (as different dialogues of self become available for, or are integrated into the story), and thus reflect the indeterminate, multiple and unfinished nature of embodied reality: "The point is that all texts stand on moving ground; there is no master narrative" (Riessman, 1993, p. 15).

The act of researching story is one that attends to the unique, unrepeatable ways in which a person's embodied expressions unfold in lived time, meaning that the researcher is positioned not as an observer, but as a *co-participant* who has entered into embodied communion with the "actual eventness of the once occurrent act" (Bakhtin, 1993, p. 1). This approach requires the recognition that just as the narrator's story is a representation and interpretation of *a* truth unfolding within *a* specific spatial (i.e. personal, social and cultural dimensions) and temporal milieu, so the researcher's interpretations regarding the manner in which the story is conveyed, the prevalence of core themes, etc. are but *representations* of a presented reality – a reality that is, in addition,

informed by the researcher as an equally active agent who is embedded in certain kinds of social relationships that are, in turn, set against a particular cultural background (Parker, 2005). In this sense, narrative meaning “is fluid and contextual, not fixed and universal. All we have is talk and texts that represent reality partially, selectively, and imperfectly” (Riessman, 1993, p. 15).

Notions of truth and representation are thus central to narrative research. In this regard Parker (2005) argues that as researchers, we need to be aware that narrative research is not concerned with discovering empirical truths, but rather seeks to make sense of events as represented by the teller/s and thus as representative not of the Truth of a scientific ideal but as “the truths of our experiences” (Riessman, 1993, p. 22): “When talking about their lives, people lie sometimes, forget a lot, exaggerate, become confused, and get things wrong. Yet they *are* revealing truths. These truths don’t reveal the past ‘as it actually was,’ aspiring to a standard of objectivity” (Riessman, 1993, p. 22).

Narratives are interpretive and embody a performance that relies on several factors (including the nature of the researcher-participant relationship) that will influence the manner in which an individual tells his or her story. In turn, the dialogical character of the narrative act affords narrative tellings a multiplicity of meaning, where meaning is not only generated through the telling of the original ‘text’, but also through the engagement with that ‘text’ by teller, listener, reader and researcher (Bruner, 1986). Within the context of narrative methodology, the researcher is engaged in multiple canons or horizons of meaning where realist or monological assumptions regarding historical truths are not of primary concern. Instead, narrative methodology is concerned with elucidating the manner in which an individual makes sense of aspects of their experience (e.g. their experience of somatic distress) – aspects which are interpreted as emerging and undergoing continual transformation and negotiation within embodied “communities of persons, and within the context of social structures and institutions” (White, 1992, p. 124).

One may argue that narrative research’s focus on recovering or elucidating the storied and thus *bodily* enactment of an individual’s unique, embodied and culturally/socially embedded experience of their life world, is one that captures some of the central concerns within critical, contemporary somatic theory. By positioning the body as the kinaesthetic site of performance and thus as central to the act of telling one’s story, narrative research provides a means with which somatic theorists

can approach an exploration into the personally, culturally, socially, etc. embedded ways in which the body is used to experience and communicate somatic distress. Furthermore, the recognition that the human process of meaning-making is a dialogical and multiple phenomenon, problematises the monological diagnostic canon of Western biomedicine. In this regard, dominant cultural meta-narratives concerning the aetiology of somatic distress are recognised as forming but a *part* of a broader and more complex narrative of somatization, where the variability in the cultural patterning and storying of symptoms of somatic distress are afforded significance in the development of an understanding of how individuals bodily perform their lived union with their respective life world. Narrative research thus reinstates bodily experience, knowledge and expression as highly communicative and receptive characters in the languaged (and embodied) [re]enactment of somatic distress within a variety of different contexts (Kleinman, 1988; Becker, 1999).

By acknowledging that the body is a teller of stories, narrative methodology arguably establishes the experience of somatic distress as a narrative intentionality. In this regard, Frank (1996) suggests that there has been a significant shift within body and illness literature towards the narrative intentionality of the lived body, such that bodily symptoms are afforded a disclosive function: i.e. through the process of narrative telling of illness experience (and thus the experience of bodily symptoms), individuals are afforded the opportunity to connect to a reawakening of embodied knowledge, the capacity to integrate illness experience and the ability to shift between the absent presences inherent in their stories (e.g. the absence of the taken-for-granted body and the simultaneous presence of the 'alien', 'deceiving' or 'disruptive' body; the absence of bodily 'control' in the face of present, culturally sanctioned norms (i.e. Western norms) of control and self-autonomy, etc). The notion of affording the body (and its expressions) a dialogical space within contemporary health contexts, such that the innately human *experience* of the body-subject is afforded primacy rather than the pathology, is one that seems significant within the context of somatic distress and theoretical attempts to explore alternatives to the existing silence and retreat (on the part of both the patient and professional) from a phenomenon that eludes both literal and psychological explanations of aetiology.

Kleinman's (1995) contention that there is no such thing as a unitary concept of the somatizing patient serves to emphasise the significance of adopting a research approach, like narrative analysis,

that allows for a variety of voices and frameworks of understanding (e.g. personal, cultural, social) to contribute to making sense of medically unexplained bodily distress. Thus, within a context in which “sensation and bodily experience are undervalued [e.g. within the biomedical realm]” (Becker, 1999, p. 26) (the very mechanisms through which somatic distress commands the individual’s (and later, the professional’s) attention), narrative research could be considered our primary means through which to access bodily experience (Becker, 1999). In turn, such an approach may afford legitimacy to the body’s insistence on meaning, such that “[N]ormals and whitecoats” (Frank, 1995, p. 145) can begin to conceive of the embodied experience, knowledge and expression of somatic distress as a pedagogy worthy of trust and thus worthy of assuming “equal place alongside professional expertise... [where] ... the possibility for shifting between frameworks as required by *responding* to the ill ... afford[s] each [voice] full legitimacy in reaching a consensus that is ... workable” (Frank, 1995, p. 145-146).

Frank (1995) argues that on the premises of narrative research philosophy around the body-subject and his/her expressions (where narrative is the embodied enactment of bodily experience), the telling of stories allows for an interplay of mutual presence between the teller (the ‘patient’) and listener (e.g. health professional): “the listener must be present as a potentially suffering body to receive the testimony that is the suffering body of the teller” (p. 144). In this sense, the embodied self is one that cannot exist in isolation but rather unfolds within the mutual dialogues of self and other, where both patient/client and professional are phenomenologically intertwined into mutually inclusive dialogues informed by broad socio-cultural/political meta-narratives as well as more subjective dialogues or narratives around life and illness experience. As opposed to the patient suffering the physician/psychiatrist/psychologist’s point of view, narrative research encourages the professional to revere the client’s story such that the person’s indigenous knowledge systems require meaning within the patient-professional dialogue: i.e.” As professionals, our first important contribution ... should be to respect the awesome nature of th[e] story and to revere the story teller” (Barker & Barker, 2004, p. 19).

Crossley (2000) argues that such an approach to research around bodily manifestations of illness would require an incorporation of a narrative ethics: i.e. a theoretical and pragmatic approach where the biography becomes the “conduit through which embodied knowledge of the body-self/subject is presented to oneself and to others” (Becker, 1999, pp. 125-126). In this sense, the

role of the professional becomes one of engaging mutually and reciprocally in the narrative construction of the “effects of ... illness ... to [individuals’] ongoing lives” (Hunt, 2000, p. 100) and sense of self.

In this regard, it is hoped that an exploration into the storied accounts of two participants, both of whom have lived (and continue to live through) a relatively extensive history of medically unexplained bodily symptoms, may provide a medium through which somatic acts may reveal and enact embodied structures or meanings that have previously remained implicit or unrecognized within our dominant and dualistic theoretical articulations of somatic distress.

Giving Voice to Experiences that Medicine Cannot Describe

Situating the Study: Research Question and Research Context

The research question informing this study was a broad one that was concerned with exploring and making phenomenological sense of the lived and told experience of the ‘ill’ body (and thus of somatic distress or somatization). In this regard, the choice of participants was based on the purposeful selection of individuals who were experiencing (at the time of data collection) ‘somatic distress’.

Somatic theory suggests that a positive DSM-IV-TR diagnosis of a ‘somatoform disorder’ proper is relatively uncommon within the mental health context, despite the prevalence of the presentation of various ‘psychosomatic’ symptoms. For this reason, I chose to define somatic distress according to the generic definition of somatization and thus within the broad parameter of ‘medically unexplained symptoms’: i.e. the manifestation of physical distress and symptoms, which after appropriate investigation (e.g. medical examination) cannot be fully explained by a general medical condition. This definition also incorporates the recognition that these symptoms can cause significant emotional distress and impairment in personal, social and occupational functioning.

Additional criteria or parameters for the selection of research participants included: i) the participant has given free and informed consent to being interviewed and to the interview being audio-taped, and ii) she or he is comfortable with being interviewed in English.

The choice of a broad definition for somatization or somatic distress was in-keeping with the aim of this study, which was to explore alternative manners in which to articulate the *experience* of somatic distress. In this sense, this study was not concerned with establishing or developing a satisfactory taxonomy of empirical classification principles or a unitary theory of aetiology or causation – aims which would only serve to reinforce the monological and dualistic canon of biomedicine and its theoretical counterparts (e.g. psychoanalysis). Alternatively, this study was concerned with responding to a recognition within contemporary somatic theory that existing approaches to the presentation, articulation and management of somatic distress continues to perpetuate a detached, dichotomous perspective towards a phenomenon that appears to embody a ‘psychosomatic’ unity or integrity that eludes objective, Western criteria or parameters of definition. In this sense, the narratives that have been afforded prominence within existing somatic theory have rendered the lived, subjective meaning that individuals attribute to their illness experience a silent phenomenon – thus establishing it as a phenomenon that has been robbed of the capacity to tell its story on the very grounds of its manifestation, presentation and expression within a contextual life world.

In this regard, this study embodies a theoretical attempt to afford a phenomenon that continues to escape contemporary models of explanation a phenomenological anatomy and thus a presence to the vehicle through which it is communicated and experienced by the body-subject. The use of narrative accounts of individuals’ experiences of somatic distress form an integral role in the exploration of the subjective and lived experience of somatization, such that the absence of an embodied language that acknowledges the body’s position as *teller of stories* can be afforded a presence.

Participant Selection

Because this study is exploratory in nature and is concerned with making preliminary theoretical investigations into a relatively neglected area of somatization research, I chose to select only two participants. My rationale was informed by the inductive nature of my research question: i.e. in the hopes that I would be able to elicit new insights into the experience of somatization, the choice of a small sample group ensured that I would be able to collect information-rich and detailed accounts of individual’s experiences of somatic distress. My approach is in-keeping with the basic premises

of exploratory research: i.e. exploratory studies are characteristically open, flexible and in-depth in nature and are less concerned with the accurate description, classification or measuring of phenomena, than the generation of speculative insights, new questions and hypotheses (Terre Blanche & Durrheim, 1999).

The process of participant selection involved the distribution and circulation of both posters (put up on Rhodes University Campus and at a shopping centre in Grahamstown) and e-mail postings (on www.psychforums.com and the student forums on www.ru.ac.za/Studentzone) that briefly outlined the topic of research as well as proposed aims of the study.

The first participant, Sarah, was an individual with whom I was well-acquainted and who had expressed an interest in the research topic. She had been experiencing several somatic symptoms (for a period of six months) such as nausea, painful eyes, severe back pain, stomach ache, and a “spastic colon”. In addition, she reported a subjective experience of depressed mood and an accompanying experience of panic-like symptoms (e.g. shortness of breath, dizziness) which she attributed to a “bout of hypochondria” (ln. 669). Furthermore, she articulated her experience of “hypochondria” as informed by a preoccupation with the fear of having developed a serious disease. She noted that her fears were based on her experience and interpretation of the aforementioned symptoms as possible evidence of a serious disease (e.g. cancer, Mad Cows Disease, a brain tumour, etc.), despite having seen two medical specialists (a gynaecologist and urologist) and a general medical practitioner – all of whom conducted several blood tests and medical examinations that failed to reveal the presence of a physical/physiological disorder.

The second participant, Jenna responded via e-mail to a posting on www.psychforums.com. She currently lives in Canada and was formally diagnosed in 2003 with Conversion Disorder, following a referral by her general medical practitioner to a neurologist due to concerns about chronic, debilitating motor symptoms (e.g. staggering and involuntary shaking of hands) severe migraines and dizziness. Although several medical examinations were carried out (e.g. MRI and CT scans), medical professionals were unable to establish a neurological or physiological cause for the participant’s bodily symptoms. In addition, she continues to experience occasional motor symptoms (in the form of staggering and shaking hands).

In her e-mail contact with me, the second participant wrote that she had responded to my posting because she felt that telling her life story would “help, to make my experiences mean[ing]ful to me” (lns. 7-8). Furthermore, she noted that she has “always been a willing guinea pig. I guess that a part of me defines my worth in how much I can help other people, and this is just another way to do that” (lns. 10-12).

Both participants are white, English-speaking females. They have both received tertiary education: i.e. the first participant was completing a Masters Degree in Political Sciences at Rhodes University in Grahamstown (2003) at the time of the interview, whilst the second participant has completed her tertiary education in Animal Health Technology and is employed as a tutor for a distance education programme, teaching animal welfare. She is also currently involved as a rescue/disaster volunteer worker for the SPCA.

Gathering Information: The Narrative Life Story Interview

In an attempt to explore illness experience as a possible expression (and embodiment) of Sarah and Jenna’s involvement with their life world within a temporal and spatial dimension, the life-story interview was utilised. Atkinson (1998) suggests that the life story interview is the most extended and in-depth qualitative research method for gathering information on the subjective essence of an individual’s life: i.e.” Life stories are essential in gaining a full understanding of human life, especially the individual life in relation to others [i.e. other aspects of self, other individuals, various societal and cultural roles/narratives, etc.]” (Atkinson, 1998, pp. 19-20). The significance of the life story approach is that it allows the participant to situate their experience of the topic to be studied within a context that holds meaning and personal truth for them. In this sense, the phenomenon of interest (e.g. somatic distress) is afforded the space in which to assume character and meaning within a variety of life contexts: “[the life story interview] has become a central element of the burgeoning subfield of the narrative study of lives ... for its interdisciplinary applications in understanding single lives in detail and how the individual plays various roles [with]in [their lived contexts]” (Atkinson, 1998, p. 3).

Unlike a structured interview, the life story interview assumes a flexible, organic, open-ended and unstructured form. In this regard, the researcher is concerned with affording the participant the opportunity to tell their story in the form, shape and style that is most comfortable to them, such

that the researcher is positioned as a guide or facilitator (rather than an expert) who invites and encourages the participant to reflect on their life experience as a whole. In order to initiate this process of telling and reflection, the researcher can (as I did) suggest to the participant that they think of their life in terms of stages or the chapters of a book – and thus as a narrative that is afforded a sense of sequence and flow (Lieblich, Tuval-Mashiach & Zilber, 1998).

The aim of narrative research is to find an interviewing technique with which one's participants are comfortable and which allows the developing narrative account to convey stories that speak for, and about, the individual's unique sense of place within their life world. Although narrative methodology constructs the participant as a "co-researcher" (Parker, 2005, p. 54), where the participant is framed as an expert on his/her processes of meaning-making and knowledge construction, Mishler (1986) and Parker (2005) emphasise that the dialogical nature of the interviewing context requires that the researcher recognise his/her role, presence and form of involvement in the respondent's account.

The interview is in itself a relational context, in which the subjectivity that emerges within the dialectical relationship between the researcher and the researched (as embodied and contextual body-subjects) is one that is a function "of what we thought we would find and the position we try to make sense of it from" (Parker, 2005, p. 27). In this regard, the quality of the researcher-researched relationship has a significant impact on the manner in which a participant chooses to represent aspects of their life experience and may, in turn, impact on whether "what you get [is] in their authentic voice or ... a voice that he or she thinks you might be looking for" (Atkinson, 1998, p. 74).

Thus, the researcher, by virtue of their research question, purposes and aims (in addition to their own embodied reality), is entering into the dialogical research context with an agenda and thus a dialogue that has the potential to silence or elicit certain dynamics (Parker, 2005). Narrative ethics requires that the researcher pay particular attention to the manner in which they may unknowingly re-enact dominant Western meta-narratives around the role of the researcher (e.g. researcher as expert) through their attempts to elicit stories around their topic of interest. In this sense, although the researcher is concerned with situating the topic of interest (i.e. somatic distress) within an

embodied and lived context, the necessary use of probing or guiding questions that place more emphasis on particular experiences than others, may serve to limit “the widest possible range of responses” (Parker, 2005, p. 60).

With this in mind, I chose to provide my participants with an information letter (along with the consent form) that not only informed them of how the information gathering and research process may unfold, but attempted to afford them a sense of agency and primacy within the interview process (refer to Appendix A for an example of the letter): i.e.” participants are encouraged to share their life story with the researcher, in a manner that is comfortable and non-threatening to them. In this regard, it is the participant’s choice as to how they would like to structure their life story: i.e. you ... can decide what events you would like to include, and how – whether those events point directly to the topic of interest (which in this case would be your experience of somatic representation) or whether those events are seemingly unrelated. I am ... interested not only in your experience of somatic distress but also in the course that your life has followed from an early age to present time, which ... means that you do not necessarily have to make your experience of illness the central point of your story...” (Haggard, 2003, p. 1). In addition to this excerpt, I also incorporated a paragraph that recognised the participant’s “right and responsibility to decide how much you feel comfortable with disclosing and what you want to disclose” (p. 2).

The Embodied Landscape of Telling

Although Sarah was interviewed face-to-face, Jenna’s geographical distance required that she engage in a written process of sharing her life story – a discrepancy that had a significant impact on the voices, dialogues and roles assumed in the telling of the participant’s respective stories.

Sarah’s story is rich in emotive material and provides thick descriptions around, not only her experience of somatization, but her experience of her entire life thus far – something I interpreted as reflective of the sense of ease and comfort that characterised our relationship at the time of conducting the interview. In this sense, the interview was one that was informed by a relative sense of proximity, where the interviewing process appeared to unfold within a reciprocal and mutual space – one that enabled Sarah to choose the direction and flow of her narrative on her own terms.

In relation to our mutual engagement within the interviewing landscape, and thus my role within the interviewing process, I found that I had to remain acutely aware of the degree to which I assumed the role of friend and that of 'researcher' or facilitator: i.e. I had to remain cognisant of the possibility that my prior-knowledge of certain recounted events (and thus my responses to those events as told in the interview) did not limit Sarah's range of telling, but afforded her the opportunity to explore them in as comprehensive or limited a manner as she wished.

Jenna's narrative, on the other hand, appeared to adhere to prominent cultural meta-narratives around the nature of the relationship between the researcher and the researched: i.e. Jenna positioned herself as a "guinea pig" (ln. 10) - an agent to be acted upon and interpreted by the all-knowing, "expert" gaze of the researcher. On first reading, I became acutely aware of this dynamic - reflected most poignantly in my automatic subscription to a psychodynamic and thus 'absent' interpretation of her narrative (a form of interpretation that I have actively attempted to problematise in this study!). It appeared that Jenna's written story had established a distance between myself as the reader and her as the teller - a distance that seemed to situate our roles within a landscape of absence: i.e. Jenna as the absent, acted-upon body (i.e. the guinea pig) and myself as the all-seeing other. Thus, in our respective engagements with the embodied act and horizon of written, storied gesture both Jenna and I appeared to re-enact broader cultural narratives around the role of the participant and that of the researcher or 'expert'. Consequently, in order to remain 'true' to Jenna's embodied expression of her experience of somatization, I had to remain consistently aware of the degree to which both Jenna and I were/weren't unwittingly subscribing to dominant, absencing philosophical and cultural narratives.

In the case of Sarah, a full verbatim transcription of the interview was made, whereas Jenna's story has remained unchanged and has been retained exactly as she chose to represent and structure it (Appendix B). In this sense, I have chosen to represent each story in a way that attempts to capture a reality of telling as it unfolded within a particular moment. Similarly, my decision to retain the narratives in a medium that conveys the authenticity of the storied moment (in its inflexions and gestures), is an attempt to pay homage to (or recognise) my participants as "the first interpreters of the stories told" (Atkinson, 1998, p.5).

Within the context of narrative methodology, traditional notions of validity and reliability of data are radically reconceptualised or dialogued (Riessman, 1993). By moving the process of research into the lived world of the individual, narrative research concerns itself with the “trustworthiness” of the researcher’s interpretations. Crossley (2000) argues that an essential aspect to establishing the trustworthiness of a study is to invite participants to go through their transcribed and analysed interviews for comment on the degree of adequacy and accuracy. Unfortunately, due to the period of time that had elapsed (i.e. three years: 2003-2006) between conducting, collecting, transcribing and interpreting the interviews or narrative accounts this vital check for accuracy was not carried out. However, in the case of Sarah’s interview, the transcription was checked and rechecked in its entirety against the recorded interview.

Narrative Analysis

Situating the Analysis Process

Although the narrative researcher usually has a research question or general aims that inform decisions regarding participant selection and the method of data collection, the specific direction of a study usually emerges from engagement with the collected material. In this sense, hypotheses are characteristically generated in the course of the interpretive process as opposed to prior to that process (Lieblich et al., 1998). Given the dialogical nature of narrative research (where the researcher is frequently engaged in a *simultaneous* dialogue with a collection of interview texts *as well as* with a collection of theoretical texts around the topic of interest), the notion that narrative analysis begins within a landscape free of *a priori* hypotheses is arguably problematic and stands in contradiction to the narrative premise that human action occurs within an *embodied context*. The pragmatics of a research process (e.g. the drawing up of a research proposal) requires that the researcher has a broad sense of possible hypotheses that may emerge within the context of narrative enquiry (particularly within the context of an exploratory approach concerned with the generation of new *theoretical* insights). In this regard, this study has evolved and developed within the context of a *possibility* that somatizing individuals’ illness narratives may position the body as an active and embodied teller of stories, such that the experience of somatic distress may relate to an incarnate expression of one’s way of being-in-the-world.

Throughout the interpretive process, my dialogical engagement and “trustworthy” presence to the voice of the participants (as presented by the audio recording and the transcribed/written text), and the principles of narrative analysis required that I engaged reflexively with the knowledge that a theoretical landscape (no matter how vague or well structured) weaved itself through my interpretations as an absent-presence and thus as a present-absence. I felt that an attempt to consciously suspend, or make absent all theoretical assumptions (as narrative analysis suggests) would reinforce existing dichotomous meta narratives and thus fail to uphold the embodied and thus gestalt-like nature of human phenomena. This awareness can be likened to a narrative analysis premise that the researcher remains aware of the multiple contextual factors (i.e. self as researcher, participant, and potential theoretical bias) that can impact on the type of interpretations made (Lieblich et al., 1998). In this regard, it may be argued that this study embodies a dialogical and reciprocal interplay between participant narratives (and emergent themes), and a theoretical landscape – such that both the story and the theory have been afforded the space with which to constitute and be constituted by the other.

A Model for the Analysis of Somatization Narratives

In-keeping with the exploratory nature of this study, interview data was analysed and interpreted according to the Holistic-Content Perspective as posited by Lieblich et al. (1998) (a perspective that is better suited to small sample groups or individual cases). Within this mode of reading, the complete life story and its content is taken into consideration. In this sense, each part is interpreted and explored “in light of content that emerges from the rest of the narrative or in the context of the story in its entirety” (Lieblich et al., 1998, p. 13). This mode of analysis is suitable to the aims and purposes of this study as it characteristically concentrates on one major theme and the manner in which that theme may emerge, develop and transform within different contexts: e.g. somatizing individuals’ relationships to their bodies.

This approach is an inductive one that requires several readings of the text so as to allow a thick description of themes to emerge from within the data itself. In order to ensure an adequate and trustworthy reading of the texts, a critical engagement with, or enhancement of, the dialogical interaction between the text of the storyteller and potential theoretical ideas, I chose to employ a strategy of continual observation throughout the analysis or interpretation process (in the form of

notes made during and after every reading). These notes played a central role in encouraging me to continually pay attention to a range of different interpretations and possibilities – an approach that is essential within a research methodology that emphasises the multiple nature of meaning-making processes and thus the multiple nature of the interpretive process.

Conclusion

This chapter has provided an overview of narrative methodology and its value and place within the context of somatization research and existing theoretical tensions around the validity and efficacy of prescriptive and monological theoretical models. It has been argued that narrative methodology provides a phenomenologically attuned means of accessing bodily experience and thus the bodily enactment of somatic distress. In this regard, narrative methodology is framed as an epistemological response to the monological canons that continue to articulate a dialogical and disparate phenomenon on the grounds of consistency and uniformity.

In anticipation of the findings to follow, this chapter has also addressed central methodological issues, such as clarifying the aims and purposes of the study, the process of participant selection, etc.

CHAPTER FIVE

Findings

Introduction

The narrative interpretations that follow in this chapter are not intended to provide comprehensive accounts of somatic distress, nor are they attempting to provide definitive accounts of the participants' respective experiences of the phenomenon of somatization. Instead, the findings hope to explore prominent, organizing themes that situate the experience of somatic distress within the broader life contexts of two unique individuals. In this regard, interpretations regarding each participant's life story will be explored in direct relation to the theoretical arguments concerning the body and its expressions, as outlined in this study.

In presenting excerpts from the transcribed and written narratives, priority has been given to verbatim accounts as expressed by the participants. Grammatical accuracy has, in this regard, been overlooked in favour of word-for-word accounts as storied by the participants themselves. Very little editing of the transcribed and written texts was carried out, except in instances where speech utterances (in the face-to-face interview) were unclear or unintelligible. In addition, for ease of reading the excerpts used in the proceeding discussion have omitted continuation responses and probing/guiding questions on my part.

Sarah: Present-Absences

Sarah chose to structure her life story into several different life stages or phases, each of which rely heavily on corporeal language, bodily images and bodily gesture to convey incidents and events from her life as lived. Of interest is the degree of emphasis that Sarah places on her life *prior* to her experience of somatic distress – an experience that appears embedded within (and informed by) a rich tapestry of life events. In this regard, I have chosen to situate her experience of somatic symptoms within a broad (and by no means exhaustive) interpretation of her life story as a whole (and have done so using the narrative structure provided by Sarah).

It should be noted that Sarah's story of somatic distress is situated within a broader experience of what would be referred to clinically as "eating disordered behaviour". This historical information is relevant to this study, particularly as Sarah places significant emphasis on her perceptions of her body image and thus her sense of comfort within her life world. For the purposes of this study, I have chosen to incorporate an interpretation of Sarah's telling of her complex relationship with her body weight from an early age, in favour of preceding theoretical arguments regarding somatic distress: i.e. it has been hypothesised that somatic distress unfolds within a life context – a context that is continuously being made intelligible by the body as lived.

In the initial stages of the narrative interpretation, I became aware of the manner in which Sarah's story appeared to employ central ideas (communicated in the text as phrases that were afforded more emphasis and, at times, repetition) around which the themes of her life stages unfolded or developed. These central ideas or linguistic themes appear to afford each stage a sense of narrative coherence and thus a sense of a developing landscape of action in which her experience of somatic distress is afforded a sense of embodied and contextual placement. Of significance is the manner in which each of these phrases relies on body metaphors and corporeal language as a generative source and thus as an organising principle throughout the narrative process: i.e.

- School Years in Mafikeng – Sub. A to Standard Six: "a *knot* in my stomach the whole time"
- Standard Seven and a Move to Grahamstown: "standard seven ... the worst period ... of my life I *couldn't* run" and "I was ... a bit shaky [but] I came out of my shell a lot"
- Undergraduate and Fourth Years at Rhodes University: "And then I started running ... And, my whole body shape changed ..."
- Overseas Trip to the United Kingdom: "I completely lost myself ... I put on a *hell* of a lot of weight again"
- Return to South Africa: "I was terrified of my body"
- Somatic Distress: "I've always had that distant relationship ... to my body" and "I was *angry* with my body, *so angry* ..."

These aforementioned stages and central ideas are interesting given both Merleau-Ponty and Leder's reference to the phenomenological body as a functional gestalt that is simultaneously an absent presence and present absence and thus the very condition and context through which the self is able to have a relation to its lived world over time. In this regard, the first three phases of Sarah's narrative (and their corresponding linguistic themes) appear to position the body as inextricably present to the unfolding of her story, such that her body appears to allude to itself (through the use of 'physical' words, e.g. knot, shaky, run, fat) as the kinaesthetic site of her storied performance. Similarly, Sarah's use of description within the next three phases, once again make reference to the body – references that begin to establish a perceived sense of distance between Sarah's sense of self and her experienced body. Unlike, the previous phases, Sarah's use of words (within the central ideas) refer more literally to the body as a body that is distinctly and painfully present as an alien other. Most notably, her experience of somatic distress is one that appears to correlate to traditional notions of the body as distinct or separate from the experience of self (i.e. "I have always had that distant relationship ... to my body" (lns. 722-723). However, using Leder's notion of the body as an absent-presence it may be possible to suggest that her narrative plot embodies a shift or movement from the taken-for-granted, background disappearance of the body as lived to the experience of her body as the very *absence* of a desired or ordinary state.

This surface and potentially presumptuous reading of Sarah's ordering of events appears relevant to the body or content of her story: i.e. salient themes such as perceived lack of security, stability and agency; fear in relation to the other; a sense of imminent threat; pervasive feelings of inadequacy; control vs. lack of control, and importance of achievement vs. inability to achieve are consistently articulated on the grounds of the physical or corporeal. In this sense, these themes unfold within (and repeatedly refer back to) a broader, organising theme of physical integrity and the multiple registers and expressions of this theme as it is made manifest within her sense of embeddedness in various interpersonal, social and political contexts (i.e. the threat to...; the fragmentation of...; the absence of...; fear of survival; hatred of body, and fear of body).

Merleau-Ponty's notion of the body-subject as engaged in a complex and reflexive interplay between the experience of simultaneously constituting and being constituted by the "flesh" of the

world (such that the body is theoretically positioned as the preobjective and immediate horizon through which the subject is able to relate and engage with some other), appears to be reflected most poignantly in Sarah's descriptions of childhood experiences from the first two phases of her life story:

- i. ...when I got to school ... I found school ... very tense ... When my best friend of a long time left in standard one, I had a ... very hard time making new friends ... It made me feel sick to have to go to school everyday ... I felt very scared – very, very scared ... tense ... a knot in my stomach the whole time I just remember there were certain roses that used to grow in the gardens of the primary school and if I smell them now ... I get a knot in my stomach...(Ins. 22 -37).
- ii. I started getting victimised by this girl ... she turned against She used to come out of nowhere ... and pour coke over my head ... and issue vicious threats, like: If I waited outside school too long she was going to come and kill me... And ... she was going to beat me up... (Ins. 77-85).
- iii. [During the mid 1980's in Mafikeng] we had some terrible things with shooting and stuff like that ... I remember the one night ... the AWB [Afrikaner Weerstandsbeweging] came into ... town and started shooting everybody and there was like ... guns going off and stuff and we [Sarah and her brother] had to hide under my parent's bed ... cos it wasn't safe to be near windows and stuff I was fourteen the second time it happened, and I was seven ... the first time it happened ... The first time it happened we had to ... hide under our desks and stuff ...there'd been a whole period before where we weren't allowed to go to school in uniform cos they were targeting school kids ... and we had petrol bombs in our library ... it did unsettle me to think, that I could die, like ... a bullet could come through the window... (Ins. 152-166).

All three excerpts highlight Sarah's use of corporeal language, images and themes to articulate her early experiences. Within these brief acts of telling, one becomes aware of how Sarah's perception of her life world, as a threatening, dangerous place is one that is related to quite literal themes of threat to physical integrity and the survival thereof, a perceived lack of security, stability and agency, fear in relation to the other, and a pervasive sense of imminent threat (both at an interpersonal and socio-political level). In this regard, it may be hypothesised that each of the preceding excerpts establish Sarah's body as the vehicle through which her relation with her life world (and the dialogical re-enactment of that world) is made intelligible. This hypothesis is possibly emphasised, most strikingly, in Sarah's reference (in the first excerpt) to the power of

smell to make present her past experiences of physical sensations of fear and anxiety (experiences that she articulates on the grounds of the physical).

Sarah's descriptions of her relation to the other within her life context (in this case, a physically threatening school friend and political violence on the part of the AWB) also serve to highlight Grosz's (1994) notion of the self as "always and necessarily embodied, corporeally constituted [and] located in the subject's incarnation" (p. 95). In this sense, Sarah articulates her positioning within her life world in relation to (and thus in dialogue with) other physical bodies (or body-subjects) engaged in threatening physical acts towards her body and thus her sense of self (i.e. "your *person* ... your physical being was being threatened" (ln. 174)).

The philosophical notion of the body as "the general instrument of my comprehension" (Merleau-Ponty, 1962, p. 235) appears relevant to Sarah's narrative account: i.e. *throughout* Sarah's life story, Sarah shifts her attention from her relationship with others to her relationship with her body. In this sense, Sarah's descriptions appear to situate her body and life world as standing in inextricable, dialogical relationship with one another. In this regard, her sense of physical integrity and thus her relationship to her body appears to be informed by the various contexts in which she finds herself, which in turn inform the degree of comfort, security, and adequacy (frequently defined in direct relation to Sarah's perception of her body weight in relation to other bodies) that Sarah feels as a body-subject/self.

- iv. I remember getting to puberty ... and being very aware of my body and how much I hated it ... Because I was overweight by the time I got to Standard Five ... I was very chubby ... I had very *thin* friends, and that ... was a big problem ... I always thought they looked so *lovely* and that I could never look like that ... and that was a *big* aspect of my life one day ... I decided: "Okay, I'm going to restrict my eating this holiday" ... I came back [to school] and I lost a lot of weight ...and I felt really good ... for the first time in my life I felt thin ... like consciously that I *knew* about And I really enjoyed that feeling ... and that ... phase of early high school was great ... for about a year... (lns. 62-77).
- v. ...my mom got a job in Grahamstown ... when I was in standard seven ... and that was great, because ... the end of standard seven was probably the worst period ... of my life. I was *seriously* depressed, I think ... I put on all the weight that I'd put on again ... I felt like shutting myself off ... I *know* that from reading my diaries back then I was talking about *killing* myself ... this girl was *really* making my life ... a misery ... And ... I *couldn't* run from her, I *couldn't* escape from her ... (lns. 108-122).

- vi. For the first six months, I was ... a bit shaky, as to whether I was actually happy or not ... in Grahamstown ... but I *did* enjoy life a lot better ... I started playing sport ... and I lost a lot of weight ... I came out of my shell a lot ...(Ins. 133-140).

Prominent themes within the aforementioned excerpts include: control vs. lack of control (expressed through Sarah's attempts to control her body weight and restrict her intake of bodily nourishment); hatred of her body; inadequate sense of self (defined in a physical manner); perceived lack of physical security and physical agency (in relation to a threatening life world), and self-imposed threat to Sarah's sense of physical integrity (i.e. a desire to kill herself). Similarly these themes are contrasted with themes of a developing sense of agency and security as Sarah moves into the telling and enacting of her move to Grahamstown. Of significance is the central role that Sarah's body plays in her sense of self adequacy: i.e. when she is able to restrict her eating and lose significant amounts of body mass, she experiences a sense of self-agency and thus the capacity to "c[o]me out of [her] shell", whereas when she experiences a sense of physical threat and thus a lack of bodily agency (i.e. "I *couldn't* run from her"), she puts on weight and similarly experiences a desire to kill herself (and thus render a body that is painfully present, absent).

Here, the focus appears to turn towards a body that is experienced as painfully present in its inability to conform to the thin and thus adequate and 'secure' status of other body-subjects. Instead, Sarah's body is experienced as an absence of her perception of the ideal body-self. It may be possible to argue that Sarah's shift in attention towards her direct experience of her body (and thus her hatred of her body) serves to highlight the manner in which the body may be phenomenologically constituted by its lived world over time: i.e. Sarah's corporeal engagement with a threatening, erratic and unstable life world appears to be reflected in the contrasting position of Sarah's body as a threatening 'object' to be controlled and restricted and thus as an entity that seizes Sarah's attention. In this regard, the disclosive body of earlier excerpts (i.e. the centre point from which the perceptual or lived field radiates) begins to assume a contrasting position of a 'foreign' presence that demands direct and focal thematisation. Here, Sarah's sense of self relies on her ability to regulate her body mass (which in its unbearable weight possesses the qualities of a present absence – i.e. the absence of a desired body weight). Thus, the background disappearance

of the body as lived, (where the body communicates its presence to Sarah's life world through an earlier reliance (in the text) on corporeal images and language) is rendered absent in favour of a dysfunctional, hated presence that is afforded more literal translation within the context of Sarah's narrative.

Although Sarah's attempts to starve her body of nurturance and sustenance (the very aspects that have appeared absent within the socio-political and interpersonal contexts of her life world) could be interpreted psychodynamically as the displacement or projection of traumatic experience into the body, Sarah appears to position her body as a functional gestalt and thus as a phenomenon that is at once a present-absence: i.e. an absence from a desired way of being that is present to its life world such that it is able to reveal what is other by making present the felt effects as lived by Sarah in her chiasmatic relation to her life world and thus her sense of self. The positioning of her body as a force that has come to appear "other" and opposed to Sarah's sense of self, is in fact inextricably related not only to Sarah's life world, but her subjective experience of self. In this sense, the absence of a secure, stable, non-threatening and adequate social and interpersonal life world is embodied within the presence of bodily/physical attempts to reinstate or create a sense of order and control (and make present an embodied ideal of what it is to be physically adequate (i.e. thin) and thus corporeally secure). Within this absent-presence, the body is not positioned as a passive object, but rather as possessing the capacity to communicate its precarious engagement with its life world over time – thus positioning it as a *function* of its ongoing dialogue with its lived environment.

As Sarah's life story unfolds and moves into later stages, her body as an embodied 'object' of control and a simultaneous *subject* of embodied experience (i.e. her body is at once an object *and* subject) becomes evident. During her high school, and postgraduate years, Sarah continues to position her body as the object-subject of her landscape of action: e.g. Sarah relates the initial stages of her move to Grahamstown by reflecting on her experience of excessive weight loss, and connects this experience to her father's absence (i.e. he remained in Mafikeng for a period of time). In this sense, Sarah's reference to getting "very, very thin" (ln. 270) appears to embody a corporeal expression and sympathy with her subjective experience of difficulty in relation to her father's absence. Of interest is the manner in which Sarah's body made its presence known

throughout her sharing of her story of excessive (absenting) weight loss: i.e. as she shared her story, she began tapping on the table with her finger to the extent that each word was mirrored with a determined tap and thus a gesture that expressed her body's inescapable presence, within its stories of absence.

It may be possible to suggest that Sarah's story thus far, has positioned the body as a meaningful, perceiving subjectivity and thus as an ambiguous corporeality that is *always* engaged in the constitution of her environment and similarly, her sense of self. Within this dynamic context, her body's continuous assumption of absent-presences and present-absences serves to highlight Leder's articulation of the body and its lived world as inherently dual phenomena. Similarly, Sarah's articulation of the body also adds emphasis to Leder's notion of the dysfunctional body as integral, rather than separate to the gestalt-like interplay of absences and presences that characterise the experience of embodiment and thus of the lived body. This notion is afforded emphasis through excerpts (e.g. excerpt six) that highlight Sarah's continuous negotiation of her body as a reflection of the "flesh" of the world. For example, her reference to coming out of her shell in excerpt six points to the dynamic interaction between her life world and body, such that her sense of comfort, adequacy and agency in her body (expressed through a loss of weight and involvement in physical activity) reflects her gradual development of a sense of security, safety and order within her new environment (Grahamstown): "I think ... for once in my life, I *relaxed*" (ln. 251-252). Other examples that point to her body's return to a background disappearance and thus a position of embodied (and present) concealment as it reveals its life world over time include:

- vii. I felt more confident in second year [of university] and stopped throwing up ... (lns. 366-367).
- viii. And then I started running ... And, my whole body shape changed ..., like I lost a lot of weight ... I felt *so* much better ... about myself ... And halfway through third year, was when – like the fruits of that really came together ... [I] decided I needed a calling, or a purpose of something ... I'd always known, you know: 'Okay, I'm gonna do Human Kinetics and Ergonomics Honours ... But it wasn't that bigger deal, it felt right that I should be like questioning [her choice of degree], and it felt *good*. It actually felt like I was liberating myself...and I started forming my *philosophies* on life ... and what I believed in, and what I didn't believe in [And what *did* you believe in?] ... I believed in ... humans helping humans ... And so I wanted to be a part of that ... So that's why I decided to do [a postgraduate diploma in Political Studies]...(lns. 376-408).

This last excerpt is significant, particularly as Sarah describes her change in body shape as contributing to a new-found sense of liberation. With the emergence of a greater sense of physical coherence, physical integrity and structure/control (themes that embody the presence of that which has been historically absent in Sarah's life world), Sarah is able to begin questioning the 'structure' of her university degree. In this regard, it may be argued that Sarah no longer requires the presence of a *bodily* university degree to structure her keen sense of an absence of that which her initial degree of choice (Human Kinetics and Ergonomics) focuses on (i.e. the well-functioning and fit body).

Sarah's experience of somatic distress serves to recapitulate many of the aforementioned themes and hypotheses and is inextricably related to Sarah's life story as a whole. Through the course of telling her story, Sarah describes the emergence of 'psychosomatic' symptoms in direct relation to "*the most traumatic transition I've ever had...*" (Ins. 439). In this case, Sarah is referring to a move to the United Kingdom in March 2003 – a move which she described as characterised by extreme anxiety, in relation to leaving an established sense of security, and more importantly, in relation to her perception of the world as a dangerous, insecure and unstable place:

- ix. ... at *that* time the world was quite ... unstable ... I was ... thinking: "How can I trust the world – how do I trust these world leaders ... to protect me? ...I just felt really angry ... And ... just the week before I fly out Tony Blair puts his army around Heathrow Airport ... I'm like ...freaking out ... (Ins. 443-463).

Once again, Sarah refers to a life world that poses a potential threat to her physical integrity and thus her sense of occupying a secure place within her life world. Themes that are afforded prominence within the fourth phase of her life story, serve to reiterate and make present themes from the first two phases of Sarah's life: e.g. perceived lack of security, stability and agency; fear in relation to the other; imminent threat to Sarah's sense of physical integrity and fear of survival. The inextricable relation of Sarah's body to her engagement with her life world *and* to her sense of self is once again emphasised in the following excerpt:

- X. I guess I went over there to find myself and I *lost* myself ... very, very big time ... I completely lost myself ... I put on a hell of a lot of weight again ... As happens every time ... I felt ugly ... I felt inferior ... (Ins. 468-471).

In this regard, the fourth phase of Sarah's life positions the body as actively and corporeally involved in a reflexive dialogue with its life world, such that Sarah's perception of her life world as dangerous is reflexively re-enacted at the level of incarnate experience. In this sense, Sarah's emphasis on having *lost* herself, points (once again) to the loss or absence of a desired or ordinary state.

It is within this storied context where Sarah constructs her experience of both her life world and incarnate body-self as foreign, dangerous and destructive in nature, that she makes the decision to engage in care work for quadriplegic individuals. From an embodiment perspective, Sarah's decision is striking. As a body-subject who articulates her body as a corporeal reflection and expression of her lived environment (and thus as an absent-presence, present-absence, subjective-object and objective-subject), Sarah seeks out a state of embodiment that is arguably one of the most convincing illustrations of Leder's notion of the body as a functional gestalt: i.e. for individuals who are severely handicapped or chronically ill, the body as lived moves from the background to the foreground of the experienced world (Leder, 1990). In this regard, the body as taken-for-granted can become what Toombs (1992) refers to as a state of "inescapable embodiment" (p. 134) where self can come to seem separate or distant from the physiological. However, despite the "dysappearing" (Leder, 1990) nature of the body (i.e. the body's *appearance* as *dys*function as well as loss), and the seemingly alien nature of the paralysed body, the self still requires the body (e.g. eyes, nervous system in thought, etc.) in order to perceive the body as paralysed or embodiment as alien.

Although Sarah describes her experience of care work as meaningful and enriching, she also describes the powerful effect that working with quadriplegic individuals had on her sense of self and thus her sense of physical integrity within the broader context of her life world:

- xi. ...*incredible* feeling of being trapped ... and just being anxious all the time, like *actually* feeling I was going to *scream* if I couldn't get out, like about to *tear* the walls down, like I was gonna go *mad* ... any

moment ... And when I was working with him [James], that's when I felt that actually I wouldn't want to be a quadriplegic ever, I became ... really *scared* that I was ... I became scared of going in cars, cos ... all of them [the individual's Sarah cared for] ... had been in care accidents – I was like...: “No, we're going to have an accident and I don't wanna be a quadriplegic” ... And I came back [to South Africa] with that fear ... I was scared of *everything* when I came back: I didn't want to run by myself, made [my boyfriend] come running with me all the time ... I didn't want to *go* anywhere by myself ... I didn't want to stay at *home* by myself ... I was *terrified* of being raped ... It had been the reverse before I'd gone to England ... like I'd been terrified of dying in a terrorist attack ... or something ... And ... on coming back to South Africa, I was *terrified* again ...' (lns. 505-521).

As a carer Sarah is faced with the reality of the loss of physical agency, such that the quadriplegic individuals with whom she interacts and engages in dialogue, serve to mirror an organizing theme that has characterised her body-self engagement over time: i.e. physical integrity and its multiple registers or expression (i.e. the threat to...; the fragmentation of...; the absence of...; fear of survival; hatred of body, and fear of body). It could be argued that Sarah's engagement with the “dysappearing” body, serves to (once again) position her body as an objective-subject and subjective-object. Sarah's bodily engagement and relationship with bodies that serve to reflect the inescapable condition of embodiment is one that is *always* positioned as existing in an intimate and ambiguous relationship with the flesh of the world. In this sense, her own body is perceived *and* experienced as a reflection of what it is to be a body that has lost a significant degree of agency - a body that is literally paralysed and, thus a body that is physically helpless⁸ in relation to the dangers of the world as lived. In this sense, Sarah's reference to feeling trapped, anxious and feeling like she was going to scream or tear the walls down appears to embody a corporeal expression (i.e. through her use of physical images, e.g. tearing the walls down) and sympathy with her subjective involvement with disabled bodies. This hypothesis is afforded support through her description of an emergent fear in relation to becoming paraplegic (and accompanying fears of being raped, or dying): i.e. her body-self appears to articulate Merleau-Ponty's notion of the body-self as not only constituting its world, but being constituted by the world, such that Sarah's body-self resonates and dialogues in frequency with the body of the other (and more importantly with the threatened body of the other).

⁸ A subject/self that, according to Toombs (1992) can come to experience their body as an object or an 'it' (i.e. an object-subject).

This excerpt is also significant in relation to Sarah's experience of somatic distress – chiefly because it serves to highlight the manner in which illness narratives frequently embody an attempt to afford a sense of coherence to the illness experience: i.e. it is within the forward-backward grasp of the narrative act (and of telling one's life story) that the incarnate body-self is able to afford meaning and context to the manifestation of illness symptoms and to the disruption (personal, social, cultural, etc.) that these symptoms frequently entail (Becker, 1999; Frank, 1996). In this regard, Sarah's telling of this excerpt and its situation within the body of the storied text, serves to highlight her body's role in the manifestation and expression of somatic or medically unexplained symptoms.

By framing her experience of caring for quadriplegic individuals in such a way that themes from events in her past are recapitulated and emphasised, Sarah affords a context to her telling of her experience of somatic distress: i.e. her description of somatic distress emerges from her telling of her experience of care work (which, in turn, refers back to previous prominent themes and experiences), suggesting that the told experience of somatic distress is one that is intimately linked to her body's historical *and* embodied involvement with her life world over time. In this regard, it may be possible to suggest that Sarah's experience of somatic symptoms reflects her lived and embodied relationship with a world that has consistently been experienced by her as threatening, erratic and insecure.

- xii. ...when I *did* actually get sick, physically sick [on her return to South Africa] ... I actually *really* got sick ... again and again [kidney infections] ... three times ... And then *bad* reactions to the antibiotics ... which *really* frightened me – like I'd *never* had reactions like ... that to ... *dizziness* and *sore* eyes and vomiting and ... that's frightening ... And then ... the doctor said: "Well, you don't have any infections anymore, you're fine" (lns. 526-579).
- xiii. I was too scared to exercise ... scared to use my body. I was terrified of my body ... I *actually* didn't want to use my body at *all* in any way ... any kind of exercise ... I just wanted to ... keep quiet – like not disturb it ... so that it didn't *do* anything horrible to me [Did you feel like you were separated from your body?] ... Ja, completely ... Like ... "Why is it making me feel so shit? ... (lns. 585-602).
- xiv. ...like usually if you're feeling sick you can *take* something ... to cure you ... There was an *unknown* thing happening to me, and that *frightened* the hell out of me – I was like...:"Well, if it's unknown it must be *really bad*, in fact it must be ... a *brain tumour* ... And that's the kind of thinking that ... took

me on to this ... *unbelievable* bought of hypochondria ... I don't know if it was hypochondria ... And I was *angry* with my body ... I felt *nauseas*, I felt *tired*, I had *headaches*, I had this *crushing* pressure ... On the *back* of my head and on the *top* of my head like it would *crush* me, I couldn't actually *talk* cos it was so crushing ... And that like ... immediately – I thought “brain tumour” ... I was *convinced*. I *mean* you don't get that crushing pressure in your head ... and its *nothing* ... I was *convinced* that there was no simple explanation to what I was feeling, and ... I *cried*, it was just like crying all the time ... just wanted to hide ... going to sleep was my favourite thing ... I just wanted *someone* to tell me what was wrong with me so that I could take a pill and it would go away. And I was *angry with my body*, so *angry* with my ... It was like ... “*Why* are you [her body] making me feel *so horrible*?” I'd have these *panic* attacks ... which brought on *dizziness* and shortness of *breath* ... I have no control over anything ... such a feeling of being distanced from people ... I wish I could just feel normal like they are [other people] right now” ... (Ins. 614-664).

Although Sarah refers to her experience of somatic distress as one that positions her body as a distant, alien entity and thus as a body in revolt (Lynch, 1984), she continues to articulate her experience on the grounds of the physical as inescapable. In this sense, her experience of medically unexplained somatic distress appears integral to her distressed, angry and panicked sense of self. This is possibly most strikingly emphasised in her description of experiencing panic attacks (a phenomenon that is informed and exacerbated by an individual's heightened sense of awareness to physical cues): i.e. despite her attempts to “keep quiet” and thus avoid disturbing her seemingly oppositional body, Sarah continues to experience her sense of self on the grounds of the physical (i.e. physical panic symptoms). In this regard, Sarah's reference to her body as an alien presence is not so much a splitting off of her self from bodily experience, but a recognition of the inherently (and frustratingly) gestalt-like experience of the body at times of dysfunction or illness.

In this sense, Sarah's description of her experience of somatic distress appears to add emphasis to Leder's notion of the “dysappearing” body: i.e. at times of bodily dysfunction the relationship to one's body is experienced as foreign or destructive in nature precisely because the body's phenomenological positioning as a functional absence-presence requires that at times of dysfunction the body's predominant role as the ‘taken-for-granted’ (or absent) vehicle *from* which one engages the world is drastically transformed into one that demands our direct attention (Leder, 1990).

Sarah's description of her experience of somatic symptoms serves to highlight prominent themes – particularly that of physical integrity (i.e. the threat to...; the fragmentation of...; the absence of...; fear of survival; hatred of body, and fear of body). Thus, it may be possible to argue that in her telling, Sarah once again positions her body as the vehicle through which her relation with her life world is made intelligible. In this case, Sarah's experience of the "dysappearing" body (made manifest through somatic symptoms) appears to be precipitated by her corporeal engagement and dialogue with other "dysappearing" bodies. In comparison to earlier excerpts (where Sarah's engagement with an erratic and threatening life world is articulated through a body that is experienced as painfully present in its inability to conform to the thin and thus adequate or 'secure' status of other body-subjects), Sarah articulates her body as one that escapes previous attempts at control and restriction: i.e. "I *actually* didn't want to use my body at *all* in any way ... any kind of exercise ..." (Ins. 597-598). Furthermore, unlike previous descriptions of Sarah's engagement with other body-subjects (in which her body appears to have been experienced as present in relation to some *ideal* other), Sarah's description of care work with disabled individuals (and thus other "dysappearing" bodies) positions her body as devastatingly and inescapably present in relation to (and in dialogue with) other inescapably present bodies. Thus, in the absence of the capacity to constitute a felt absence (e.g. bodily security and control) with an 'ideal' presence, Sarah's experience of her life world as unpredictable, dangerous and assaultive is mirrored in the unpredictable, "crushing" and potentially dangerous experience of somatic symptoms and thoughts (i.e. hypochondriacal thoughts around the possibility of having a brain tumour).

This hypothesis may be relevant given Sarah's account of her interaction with her general medical practitioner, following a series of medical examinations that revealed no physiological abnormalities:

- xv. The blood tests had tested for everything: cancer, any kind of serious disease ... there was nothing ... So ... the doctor said to me: "There's nothing wrong with you, go home, you're okay" ... and I said: "No ... I'm not. I'm feeling so terrible ... What's wrong with me?" ... and he said: "I think you ..." ... he referred me to a psychologist, he was like: "I really think that you're depressed" ... and prescribed antidepressants for me ...(Ins. 681-687).
- xvi. Although ... it didn't explain all the individual symptoms ... It felt like ... "Actually, that could be a plausible explanation" ... And ... it turned out ... it was *all* related to my mental processes basically ...

but I mean the fact was that these things were real things that were happening to my body ... I wasn't *imagining* them or anything like that ... but it all came from my mental state ... And I just couldn't believe that ... my *body* could actually feel so terrible ... I just felt that so hard to ... grasp ... *Until* I started ... physically, I mean ...*actively* taking my life back ... (Ins. 690-707).

These excerpts serve to highlight the biomedical and thus dualistic manner of articulating somatic symptoms: i.e. Sarah's general medical practitioner essentially articulates her somatic experience on the grounds of absence. Within this context, Sarah also appears to articulate her symptoms as a product of her mental processes, thus situating her illness experience as separate from her corporeal being. However, despite Sarah's attempts to define her experience of the "dysappearing" body on the grounds of biomedical absencing, her body makes itself present in the language with which she chooses to tell her story: i.e. she notes that the only manner in which she could "grasp" (i.e. defined by the Chambers Twentieth Century Dictionary (1974) as "the capacity to both physically *and* mentally seize and hold" (p.568)) the present-absence of a physiological disorder, was to attempt to actively and thus physically work towards affording her body the position of an absent-presence (i.e. what Leder refers to as the 'taken-for-granted' body).

Sarah's recognition that her general medical practitioner's diagnosis of depression enabled her to body forth her world and "...take control of my body again" (ln. 742-743), may suggest that his diagnosis provided her with the structure and control that she was unable to articulate through her dialogical engagement with other body-subjects and thus her own body-self. In this sense, Sarah was afforded a frame of reference (i.e. a biomedical diagnosis) that allowed for an absencing of the body as an embodied phenomenon and thus a literal presencing of the body as taken-for-granted (that which Sarah so desires). Although this appears to stand in contradiction to the notion of the self as inextricably related to the body and its incarnate experience of its lived world, Sarah's descriptions of the manners in which she continues to negotiate ongoing episodes of somatic distress are articulated on the grounds of the physical and on the grounds of the body as a functional gestalt: e.g. "[I] [m]ake sure I run four times a week ... make sure ... you only eat this much in a week, and you eat whatever you want on Saturday's and Sunday's.... Just having rigid ... sort of rigid patterns..." (Ins. 800-804). In this sense, Sarah's experience of both her body and life world as dangerously present informs her attempts to render her body a background

disappearance by making present her desire for coherence, control, corporeal adequacy and corporeal stability at the level of her body: i.e. she requires her body in order to experience a sense of self-coherence.

Jenna: Absent-Presences

It should be noted that the proceeding interpretations differ in structure and form from those pertaining to Sarah's life story. Unlike the face to face interview context in which Sarah's telling of her life emerged (thus allowing for the communication of several different themes and a presence – on my part - to the repetition of phrases and gestures that appeared integral to the interpretation of the whole), Jenna's story was one that was succinct in its written form and thus provoked a more global response on my part. In this sense, I interpreted it in a forward-backward manner such that parts from both present and past were simultaneously interpreted in relation to the whole.

Like Sarah, Jenna chose to structure her story into several life stages: i.e. School; Family; Jobs; Health, and Conversion Syndrome. However, in contrast to Sarah's heavy reliance on corporeal language, bodily images and bodily gesture throughout the telling of her life story, Jenna's body (and thus the presence of bodily images and bodily language) appears conspicuously absent (i.e. an absent-presence) for the greater part of her story. As mentioned in the previous chapter, Jenna's narrative evoked a response (on my part) that was informed by my predominantly psychodynamic training: i.e. I found myself automatically making sense of her story in terms of dualistic notions of the conscious and unconscious, and the absent versus the present. In this sense, I appeared to engage with Jenna's story on the grounds of absence and thus from a position that appeared to actively negate the absent-presence and present-absence that embodiment philosophy attributes to the incarnate experience of the body-subject.

Thus, Jenna's descriptions of her illness experience (within the broader context of her life story) appeared to lend themselves well to an interpretive dialogue incorporating psychodynamic concepts of repression; the internalisation of the phantasy of a withdrawing, abandoning, punitive and rejecting love-object, and thus the projection of unresolved unconscious trauma onto the bodily casing. In this sense, the seeming absence (or splitting-off) of her body as lived appeared to invite a psychodynamic interpretive gaze in relation to her experience of somatic distress.

The discrepancy between the interpretive response that Jenna's story evoked within me and the aims and purposes of my research question, prompted me to pay attention to what it was that I was experiencing in relation to my reading of, and connecting to, her story as told. In comparison to the process of reading Sarah's transcribed story (i.e. a process that quite literally came to life through her use of corporeal imagery and action/bodily-oriented language), my sense of the underlying tone of Jenna's story was one that appeared distant, apologetic and paralysed – to the extent that the body of the text elicited a distant and seemingly estranged response (on my part) to the landscape of Jenna's lived reality. This may be attributed to Jenna's sense of familiarity with the mental health context (i.e. she was formally diagnosed with Seasonal Affective Disorder at the age of 13, began experiencing medically unexplained physical symptoms in 1994, and, at the time of writing this story, was in psychotherapy) and thus a familiarity with a language and a professional way of being that serves to silence the body-subject, such that the body-subject suffers the professional's point of view like a "guinea-pig". Although I attempted to highlight the exploratory and phenomenological nature of this study in my e-mail contact with Jenna, this hypothesis may be relevant given my positioning of myself as a Psychology Masters Student at Rhodes University – a label that may have evoked the absent, acted-upon body-subject (and thus a *seeming* distinction between psyche and soma) that Jenna has so frequently experienced within medical and mental health contexts. With this in mind I chose to begin the interpretation of Jenna's life story with an excerpt that occurs at the very end of her story and thus an excerpt that appears to reflect the absenting aspects of the interpretive position that I had automatically and unthinkingly assumed:

- i In the spring of 2003 ... I went to a conference in reno [sic] ... I was happy, excited and confident. Plus I had a great time and learned a lot. When I was there, I experienced some dizziness, like the floor was moving or shaking. It was odd, and I even questioned a few people to see if they felt the same thing as we were on a floating floor, but it was only myself. When I got back the dizziness increased dramatically ... I assumed it was an inner ear thing and went to the Dr, as I not even drive at this time ... I found it extremely difficult to concentrate My hands started to shake as well. A few days later I suddenly began to stagger. It freaked me out, as I could barely walk. So when my husband came home we went to the walk in clinic. The doctor there was pretty perplexed, and referred me to a neurologist. When I went to the neurologist he examined me, and then booked an MRI. But he said that he didn't relay think that there was anything wrong as both my sides were equal in reacting. I went home, very frustrated. I could barely walk, couldn't drive or do many other things that I was used to doing The MRI (which originally was supposed to be a 2 week

wait) ended up not happening for 7 weeks. At about the 4 week mark I went to my regular doctor, as my quality of life right about then sucked, and begged for some help. He sent me for a CT which showed nothing. I was also having daily migraines, and was taking T3's to control the worst pain (usually one every other day) When I had the MRI I went back to the neurologists. He confronted me and my husband (he even kicked me out of the room) and asked what major trauma I had gone through in my childhood to cause this. I was perplexed, and he said that there was nothing wrong with me, just like he had thought. He sold me a book to read on the migraines (which helped me immensely, and I got them under control) and he placed me on PaxilI felt guilty for wasting so much time and having caused my loved ones to worry. I also felt anger at the way I had been brushed off....I still have problems with shaking hands and the occasional stagger, particularly when I am tired. I did see the therapist that I had seen after my son's birth, and she helped me get over some of my anger and frustration that I had with myself and the doctors. It is still there, but isn't as much of a wound anymore Its not that I don't want to be well, or that I want something wrong with me. I would dearly love to never have to see my doctor again except to bring the kids in for routine exams. But I hate that I have all these symptoms that end up to be "nothing". It makes me feel like I am wasting people's time, and taxpayer money. If it could just be something harmless, but less ambiguous (as in your breast lump is just a cyst, or just regular depression) then I would feel a lot better. For some reason I can't be "typical" and so they end up having to run tons of tests and then....nothing I feel like he views me as a whiner, or as a hypochondriac, and does not take me seriously (Ins. 322-369).

This excerpt truly emphasises Kozlowska's (2003) contention that within the agnostic, biomedical context in which somatic distress symptoms frequently present (as did Jenna's), existing prescriptive discourses of medical uncertainty, and psychical interiorization serve to maintain the client's experiences of shame, anger and frustration with regards to the manifestation of symptoms that are frequently articulated as feigned, unreal and 'in the head'. In this sense, it may be possible to suggest that Jenna's experience of somatic distress within the biomedical context has been one that has positioned her as the literal body or the "guinea pig" to be empirically interpreted by the 'expert' as the vehicle through which to gain access to an interiorised/psychological domain of lived experience.

Jenna articulates her experience of somatic symptoms and thus her experience of receiving a diagnosis of 'Conversion Disorder' as emerging within a horizon of absence/silence (where her body as a meaningful, perceiving and knowledgeable subjectivity is negated by relevant medical

professionals). However, it is interesting to note that in the absence of professional dialogue with Jenna's subjective experience of bodily instability, so Jenna's body (within the storied text) is able to direct the reader towards a corporeal wound that is *very* much present and *alive* with subjectivity: i.e. Jenna articulates her experience of anger and frustration towards the medical profession as constituting a "wound" (ln. 361). Within the broader context of Jenna's life story, her description of powerful subjective feelings on the grounds of the corporeal stands in stark contrast to previous narrative tellings, which are conveyed in an evasive and pragmatic tone (e.g. "I would calm down quickly and move on" (ln. 22-23)). Although this could be interpreted as a defensive engagement in the splitting off or denial of affective expression, it becomes apparent that the absence of significant expression of emotion relates to a pervasive sense, on the part of Jenna, of her sense of self being constructed through a consistent experience of incarnate exclusion and displacement (by others and self) within her life world: i.e.

- ii I became an easy target [during elementary school], and was soon excluded from most play and activities, though I had a few friends. This worsened over the years, and combined with self doubt and easy to trigger crying outbursts became a self perpetuating circle. I never really felt that I belonged, or was equal to my peers...(lns. 29-32).

In this sense, it may be hypothesised that my experience of the relative absence of her body as lived and articulated (in the storied text), relates inextricably to this experience of exclusion. Thus, although Jenna does not articulate her life through a heavy reliance on bodily language, corporeal metaphors, etc. she does relate several stories that position her corporeal being (from an early age: i.e. junior high school to college) as one that has been severely abused and bullied by other body-subjects within her life world and thus one that has been rendered absent or silent in some way:

- iii These were to become my worst years [junior high school], as several boys ganged together and would actively pursue me, kicking at me to make me trip when I wasn't looking, body checking me into lockers or walls and other physical as well as mental abuse. Some of the girls were verbally taunting as well, but mainly they just excluded me in that nasty way that girls do (lns. 36-40).
- iv Though I had a few friends [at junior high] I was not particularly close to any of them. One friend gained another friend who though nice to me in the beginning borrowed items and money from me

and then turned nasty when I refused to lend her anymore. Her and my friend ended up kicking me while I was sitting down reading one afternoon. I felt horribly betrayed and like I was the party at fault. I was quite the geek/nerd type, reading quite a lot and being nice to teachers ect [sic] – not the rebelling behavior which seemed to be the norm for that age group (Ins. 42-47).

- v In college I was more confident, but still didn't have a lot of skills for interacting with peers. I was never "cool". In the first week of school a guy approached me and I was again shocked and honored that someone could be interested in me, so again went into dating. This didn't jive so well as I was at a real low, having just broken up with my first boyfriend and I didn't feel very confident, and so was seeking outside support unknowingly. School went all right, and I did do well, but emotionally I was crumbling. He first started by some "harmless" comments as to that I wasn't so good at this, or could do that better. He wanted me with him always and didn't want me to hang around with my friends. This grew into outright verbal abuse, putting me down constantly, and eventually rape. Though I never fought him, I didn't want to participate and felt horribly violated but helpless On new years eve [following her second year in college] I went over to a friends home to celebrate and he came back from his parents home early to surprise me. I was horridly disappointed as I couldn't relax and enjoy my friends company – had to constantly be at his side. He insisted that I drive him home shortly after midnight and he wanted me to go into the house with him to have sex. When I refused he was very angry. The next day when I went over we had an argument and he ended up hitting me (it was the second time) I asked him if he could ever promise not to hit me again and he said no, that I made him so angry sometimes that was what happened (Ins. 66-88).

Although Jenna assumes a reporting style of narration that employs relatively little in the way of corporeal and strong affective language (as displayed by Sarah in the telling of her story), one could argue that Jenna's body is inextricably related to her excluded (and thus inadequate, worthless and displaced⁹) sense of self. In each of the preceding excerpts Jenna's accounts of bullying and physical abuse position her experience of her life world (and thus her relation with other body-subjects) as one that has been characterised by a corporeally violent and aggressive rejection (and silencing) of her body-self. Thus, in-keeping with Merleau-Ponty's notion of the body, self and world as existing in chiasmatic relation to one another, it may be possible to suggest that Jenna's experience of a physically aggressive and rejecting environment may have been articulated (by her) as a rejection or an attempt by other body-subjects to render her bodily

⁹ Sarah makes reference to these adjectives within the context of her written story.

knowledge and corporeal positioning within her life world as absent and thus insecure (an experience that is also highlighted in excerpt one).

In this regard, excerpts three, four and five appear to establish Jenna's body (as articulated by her dialogical engagement with other body-subjects) as an absent-presence and thus as a presence that Jenna herself attempts to make absent within (or remove from, i.e. a present-absence) a corporeally assaultive environment: e.g. "I ... spent a lot of time volunteering in the library and cafeteria. It was the only place that I fit, and was also free of the bullying [sic]" (lns. 40-42).

Although Jenna describes herself as having always been a shy child, she appears to articulate her inadequate, worthless, helpless and paralysed sense of self in direct relation to her experience of physical abuse: i.e. Jenna describes her sense of self as inextricably related to her lived experience of repeated threats to her physical integrity (e.g. "[I] was ... plagued by the feelings of unworthiness and whatnot that came with the bull[y]ing" (lns. 51-52)). In this sense, Jenna's fragile sense of self is articulated as an inescapable embodied reflection of her body as helpless and paralysed in preventing the physical assault of her lived environment (e.g. "Though I never fought him, I didn't want to participate and felt horribly violated but helpless" (lns. 74-75)). Jenna is thus positioned as actively and corporeally involved in a reflexive dialogue with her life world, such that her experience of her life world as punitive, rejecting and paralysing is reflexively re-enacted at the level of her incarnate experience of self.

Merleau-Ponty's notion of the body-subject as engaged in a complex and reflexive interplay between the experience of simultaneously constituting and being constituted by the "flesh" of the world is emphasised in Jenna's description of her first experience of depression in Grade eight:

- vi When I started grade 8 I was deeply troubled. I didn't want to leave my bed, or do anything. I was sad and crying all the time and ... had a very negative self image. My family Dr diagnosed me with depression and started me on medication. I had many low times where I considered or half heartedly attempted suicide, it was with me in every thought. I made a will of sorts and planned my death out many times. I never quite had the guts to pull it though [sic], took some pills a couple of times, but not enough to make me ill. I planned to go into the bush and starve slowly to death (lns. 163-169).

Jenna's reference to the experience of suicidal ideation and suicidal gestures (both of which appear to embody self-inflicted attempts to threaten her physical integrity) could be articulated as her attempt to make absent that which her dialogical engagement with other body-subjects consistently and punitively made present (i.e. the inadequate, passive and "geeky" body-self): e.g.

- vii I was an extremely gawky tall and thin young teen... I also had eye glasses, and was very clumsy. I was also one of the youngest in my class. All of this combined to make me feel physically unattractive (Ins. 142-145).

Similarly, Jenna's plan to "starve slowly to death" could be construed as indicative of a gestalt like interplay between the absent-presence and present-absence of the body: i.e. by planning to starve herself, Jenna generates an image or suicide plan that requires the enactment of the body as painfully and punitively acted upon through the absence of sustenance (which in turn would be rendered absent, by the presence of the rejecting and thus silencing act of starvation).

The allusion to the absence of bodily nurturance, sustenance and support in Jenna's accounts of her experience of severe depression is a theme that is afforded prominence within various different contexts of Jenna's life world (e.g. familial, scholastic, interpersonal, vocational, etc.). For example, her descriptions of her family environment as a child, point to a prominent theme of a perceived and actual lack of support and nurturance on the part of maternal figures:

- viii I remember my mother as not being precisely a bad mother, but not being there for us much either...(Ins. 105-106).
- ix When I was about 8 yrs old, a good friend of the family and her daughter moved in with us temporarily, as she was moving from Vancouver island and needed a place to stay... One day I came home from school and my parents asked my sister and I to sit down. They then told us that they were getting a divorce and that my mom would be leaving that day. I remember watching my mom load up the van with a feeling of disbelief. I did not see her for two years after she left. I can remember feeling guilty because I couldn't remember exactly what she looked like or sounded like.... So the family friend just stayed. She and my father married a year or so later (Ins. 114-124).

- x My step mom insisted that I was not depressed, that I was just trying to get attention. When she found out I was suicidal (a comment I made in school was brought to a teachers attention) she guilted me by saying how much I would hurt my father if I did that (Ins. 173-176).

Jenna's life story is thus one that has been characterised (even in later stages of her life) by the desire for nurturing support from other body-subjects - expressed by Jenna not only in her descriptions of the absence of support within her peer group, but also within her description of her need to please her parents and thus elicit their attention: i.e. "I have always been caught in the trap of wanting to please my parents so badly, and never feeling like I ever have completely pleased them, it is like a lock that I just can't find the right key for. My sisters have always seemed to be more the apple of their eye" (Ins. 183-185). In this regard, Jenna articulates her desire for support as a present-absence, and thus as a quality that she experiences as painfully present in its experienced absence. This may be relevant given Jenna's frequent references to the importance of "stand[ing] up for myself" (ln. 197), particularly within the context of relationships with other body-subjects: e.g. with reference to her first job at McDonald's she notes that "[i]t was frustrating as I was often mistreated by the customers... No one stood up for me, so I had to do it for myself" (Ins. 246-250).

The relative emphasis on the corporeal image of "standing up for myself" (a statement and image that Jenna frequently refers to throughout the telling of her life story) is interesting within the broader context of her life story, and thus her experience of somatic distress. In this sense, Jenna provides several descriptions in which she articulates her position within her embodied landscape of action as one of assuming a corporeal presence that positions her body as a present-absence: i.e. a present agency in a lived environment that has consistently provided a horizon of absence through dialogues of physical rejection and a lack of support - dialogues that have consistently attempted to make absent Jenna's inescapable corporeal engagement with her life world: e.g.

- xi The boys finally stopped hitting me when I started to fight back in grade 10. Kicked a few of them where it did the most good and eventually confronted one main aggressor with a threat in front of a large group of people to fight him fair and square so he would leave me alone. It felt good to stand up for myself, and I found myself doing it more often, but was still plagued by the feelings of unworthiness and whatnot that came with the bullying (Ins. 47-52).

- xii I was determined to stand up for myself in this relationship [with reference to her relationship with her current marital partner] ... Sometimes things that he say or do would be taken harder that [sic] what they were meant because of baggage from my previous abusive relationship... I was rather insecure with my feelings and so was quite needs and demanding for his affections (Ins. 197-206).

The theoretical recognition within embodiment philosophy of the self as corporeally constituted and located in the subject's incarnation appears to be emphasised in the aforementioned excerpts. Although Jenna attempts to story and describe an experience of bodily and thus self agency, she continues to articulate her sense of self (i.e. "still plagued by feelings of unworthiness" (ln. 51-52); "I was rather insecure with my feelings" (ln. 205)) as inextricably related to an embodied engagement with a life world that has been characterised by a theme of abusive exclusion, rejection and lack of support. In this regard, Jenna's perception of her self as inadequate, and her apparent apologetic tone towards affording herself a greater degree of corporeal presence within her life world (as emphasised by her reference to her perceived neediness and "demanding" approach towards her husband's display of affections and support – something she has not experienced consistently through her life) serves to reflect a body that has from the early stages of its lived engagement been experienced and articulated (by other body-subjects and by Jenna's body-subject) as undesirable (as kicked down when its standing up), and similarly as literally inescapable in its perceived undesirability.

Thus, despite attempting to make the corporeal present within the context of a written life story Jenna's body continues to remain silent and thus continues to articulate itself on the grounds of exclusion (in the storied phases or stages that lead up to Jenna's experience of somatic distress). This is possibly most poignantly emphasised through her reference, in excerpt eleven, to the carrying of emotional baggage – an image that appears to embody the gestalt-like interplay between the absences and presences that characterise the body as lived: i.e. this image is used to explain the difficulty of standing up for oneself (and thus of assuming corporeal agency), despite a present resolve to do so. Similarly, the *presence* of emotional baggage in relation to the hypothesised silence of Jenna's body appears to articulate a corporeal expression and empathy with Jenna's subjective experience of exclusion both within her familial and social context.

This hypothesis may be relevant, given Jenna's experience of predominantly motor symptoms such as staggering, loss of balance and thus a loss of physical agency within her lived environment. Thus, it may be possible to suggest that Jenna's experience of 'Conversion' symptoms (and thus a cluster of symptoms that render her unable to stand up for herself), position her body as the vehicle through which a life world characterised by experiences of exclusion, physical threat and violation and lack of support is made intelligible. In this sense, Jenna's body appears to embody an expression of a loss of the ability to bear or support the weight of a body-subject that has longed for the presence of support from other body-subjects.

Like Sarah, Jenna articulates her bodily expressions of somatic symptoms on the grounds of the "dysappearing" body and thus a body that is articulated as a seemingly attacking other that threatens Jenna's sense of physical integrity. However, in-keeping with embodiment theory regarding the "dysappearing body", Jenna positions her bodily experience of somatic distress within the forward-backward grasp of her life world as a lived and dialogical expression of the inherently dual nature of her lived and embodied reality. Thus, in the absence of the capacity to constitute a felt absence of embodied support and thus corporeal agency (e.g. "No one stood up for me") with an 'ideal' presence, so Jenna's body becomes overwhelmingly present in its dysfunction and thus its inability to support a secure placement (and thus stand up) within her life world.

The hypothesis that Jenna's experience of somatic distress positions her bodily dialogues as possessing the capacity to communicate a precarious engagement with a threatening and insecure life world (thus positioning the body as a *function* of its ongoing dialogue with its lived environment over time) is possibly most strikingly emphasised in Jenna's description of a loss of support at the age of ten from one individual upon whom she *could* rely for unconditional love and support: her father.

xiii My father was the one who I always sought for attention and love... He was always so loving and great to play with. Always a wonderful dad (Ins. 111-113).

xiv [However] [M]y father fell when I was about 10 yrs old, and struck his head against a metal train car in the middle of the night. As no one saw him do this he eventually got up on his own and went to bed. The next morning he was very ill and so they sent him to a hospital which misdiagnosed

him. No one realized he had [fallen]. So they sent him home on a plane. He went into hospital here [Canada] the next day at my step mother's [insistence] and spent a week there. He had fractured his skull nearly in half and had a lot of brain damage. The next year was spent in a lot of rehab, and with workman's compensation board trying to get a settlement. Eventually he received a pension, as he is unable to work as his balance is very unsteady, he has constant migraine headaches and cannot taste or smell. It was hard adjusting to the "new" dad, who was not as patient as he had been in the past and who we could not wrestle with like we once had (Ins. 132-141).

The striking resemblance of Jenna's somatic symptoms to those of her father's experienced symptoms following his head injury; seem significant (i.e. her experience of migraines and loss of balance appear to literally mirror her father's *continuing* experience of identical symptoms). In this sense, Jenna appears to position her father as a figure who simultaneously embodies the presence of a perceived sense of inclusion and support on the grounds of the physical (i.e. Jenna refers to wrestling as forming an integral part of her relationship with her father) *and* a powerful loss or absence of a sense of support and security within a predominantly threatening life world. Thus, it may be possible to argue that Jenna's profound sense of loss in relation to her father provides her with a powerful reference point from which to articulate her own corporeal experience of exclusion and insecurity.

This excerpt also serves to highlight the manner in which Jenna's incarnate body-self is able to afford meaning and context (through the forward-backward grasp of the narrative act and of telling one's life story) to the manifestation of her experience of illness symptoms and thus the significant level of disruption that these symptoms entail.

Thus, by situating Jenna's experience of somatic distress on the grounds of the corporeal and thus on the grounds of her subjectively experienced life world, her symptoms reveal themselves not as "nothing" or entities to be explored in relation to interiorised notions of repression, etc. but as dialogical and embodied expressions of the felt effects of her experience as lived in chiasmatic relation to her life world and thus her sense of self.

CHAPTER SIX

Concluding Discussion

The aim of this study is an exploratory one that endeavours to address a relatively neglected area of somatization research through a return to the lived, subjective world of individuals suffering from somatic distress. It has been hypothesised that the experience of somatic distress is one that unfolds within an embodied, contextual and spatial-temporal dimension, thus positioning the phenomenon as an embodied reflection of an individual's reflexive and dialogical engagement with other body-subjects over time. Chapter two argues that contemporary somatization literature continues to articulate the manifestation, expression and experience of somatic distress on the grounds of absence. In so doing, the expressions of somatic distress have been predominantly constructed as literal objects that are separate and dislocated from an interior psychical domain and thus represent symbolic manifestations of internal psychological processes. Chapter three extends this argument by suggesting that the continued perpetuation of disengaged, agnostic and egocentric explanations of body-self expressions allow for a turning away or retreat from engaging clients'/patients' somatic expressions as lived and meaningful in their own right. Patients are thus positioned as silent recipients who frequently feel misunderstood, shamed and frustrated within a professional-patient/client relationship that inhabits a horizon of perturbed silence where the patient's own experience and subjective voice is rendered inessential to the medical/psychiatric or psychological encounter.

Together, Sarah and Jenna's life stories serve to highlight and add support to some of the aforementioned theoretical arguments. Jenna's description of her extensive, historical engagement with various mental health and medical professionals positions her body as a "guinea pig" and thus a literal body to be empirically interpreted through the employment of prescriptive discourses of medical uncertainty and psychogenic reductionism. Similarly, Jenna's use of the metaphor of a "guinea pig" to position or explain her involvement in this study (a metaphor that refers directly to "a person used as the subject of an experiment" (Chambers Twentieth Century Dictionary, 1974, p. 579) draws attention to Kozłowska's (2003) argument that professional (medical/psychological/psychiatric, etc.) discourses around the bodily presentation and

manifestation of somatic symptoms relegates the professional-client relationship into a terrain of mutual, perturbed silence. In Chapter Five it is argued that Jenna's subjective, corporeal and lived experience of somatic distress is overlooked in favour of the professional's point of view - a point of view that silences Jenna's capacity for knowledge (as emphasised by her pervasive feelings of shame, anger and frustration in relation to her experience of very *real* bodily manifestations of distress). In this sense, the apparent absence (or absent-presence) of Jenna's body in the telling of her life story to another professional (i.e., myself as a Psychology Master's student) appears to add emphasis to Leder's (1990) argument that in the absence of objective evidence, the patient as a living, suffering being is overlooked - giving way to practices through which individuals experience themselves as disembodied absent-presences.

Sarah's recognition that her general medical practitioner's (G.P.) diagnosis of depression (or a 'masked affective disorder') enabled her to "take control of [her] body again" (ln. 742-743), appears to contradict Simon's (1991) suggestion that somatizing individuals often feel misunderstood and misheard when relating their experiences to health professionals. However, as argued in Chapter Five, Sarah's engagement with the health context and her account of the professional's explanation of her physical symptoms (as symbolic manifestations of her mental processes) nevertheless adds emphasis to the dualistic manner in which somatic symptoms are typically articulated. Although Sarah appears to endure her G.P.'s 'expert' and dichotomous narrative, the manner in which she continues to negotiate ongoing episodes of medically unexplained symptoms is articulated on the grounds of the physical and on the grounds of her body as a present absence: i.e. as embodying an absence of the 'healthy' body in the presence of somatic distress.

Both participants' accounts of their respective experiences of the presentation of somatic distress within different health contexts highlights the divide between contemporary narratives or theories regarding somatization and the silenced narratives or subjective realities of clients'/patients' experiences of somatic symptoms. It is this divide or mutually exclusive horizon of dialogue between the patient and professional that Chapter's Three and Four attempt to address.

Chapter Three develops a theoretical landscape or corporeal framework with which to redirect somatic theorists' attention towards the somatizing body as a focal entity and perceiving subjectivity in its own right. It is argued that the embodiment philosophies of Merleau-Ponty and Leder provide this landscape by highlighting the body's corporeal role in the enactment of subjective and lived experience. Merleau-Ponty's notion of the 'body-subject' as the instrument of the subject's comprehension and Leder's notion of the body as a functional gestalt (that can be rendered absent, precisely because it performs a role as the centre point from which the perceptual field radiates), serve to position the self as a corporeal subject (i.e. body-subject). Within this theoretical landscape of embodiment, the body and its physical expressions are thus articulated as reflexively engaged in chiasmatic relation with the "flesh" of the world.

In-keeping with the central premises of embodiment philosophy it is hypothesised that the body's incarnate role in the constitution of meaning allows for a theoretical departure from contemporary articulations of somatic distress. If the subject's ability to generate meaning and receive knowledge relies not on a contemplative or discursive withdrawal from the body as lived and experienced, but on the body's capacity to author and perform its dialogical engagement with a life world over time, it is hypothesised that somatic phenomena should be considered generative sources in their own right. In this sense, somatic experience embodies the body-subject's attempt as a functional gestalt to make *present* the felt effects of lived experience.

Narrative methodology mirrors some of the central concerns of embodiment philosophy, by suggesting that the act of telling one's story relies wholly on the body's role as the kinaesthetic site of performance: i.e. to recover the world as gesture or language is to recover the human body. It may be possible to suggest that each of the participants' storied accounts (as captured in selected excerpts in Chapter Five) establish a corporeal landscape of action which directs the reader's attention towards the 'intelligent' body as a focal entity and thus as a site of self-experience and performance (both within the broader context of their life histories and, more specifically, their experience of somatic distress).

Sarah's narrative positions her body as inextricably present to the unfolding of her story such that her body is established as the vehicle through which her relation with an erratic and physically

threatening interpersonal and social environment is made intelligible. Through her dialogical re-enactment of the history of her life world, her body communicates itself as an ambiguous function (i.e. present-absence/absent-presence) of its precarious engagement and ongoing dialogue with other body-subjects – a corporeality that is *always* engaged in the constitution of her environment and her sense of self.

Although Jenna does not articulate her life history through a heavy reliance on bodily language or corporeal metaphors (as Sarah does), she does relate several stories that articulate her corporeal being as one that is inextricably related, not only to her sense of self, but to her incarnate engagement with her life world over time. In this regard, Jenna positions herself as actively and corporeally involved in a reflexive dialogue with her life world, such that her phenomenological experience of her life world as punitive, rejecting, abusive and paralysing is re-enacted through the telling of a story that positions her body as a present-absence.

It may be argued that Sarah and Jenna's storied accounts add emphasis to both Leder (1990) and Merleau-Ponty's (1962; 1968) philosophical notions around the body, and in so doing, appear to develop a context out of which their bodies' expressions of somatic distress emerge as reflections of the body as lived in inextricable relation to an embodied (as opposed to an interiorised) landscape of action. Findings in Chapter Five successfully illustrate the manner in which both Sarah and Jenna's experiences of somatic distress are intimately linked to their bodies' historical and embodied involvements with their life worlds over time. Interestingly, both stories appear to convey similar aetiological themes: i.e. both Sarah and Jenna have historically experienced their engagement with their life world and other body-subjects as threatening in some way – experiences that are mirrored through their bodies' physical expressions of distress (i.e. somatic symptoms). For example, Sarah's prominent experience of fear and perceived threat in relation to the survival of her physical integrity is emphasised through her experience of "crushing" and potentially dangerous somatic symptoms and thoughts (e.g. frightening panic attacks, and hypochondriacal thoughts around the possibility of having a brain tumour). In the same way, Jenna's experience of significant motor symptoms (staggering, loss of balance, etc.) position her bodily dialogues as possessing the capacity to communicate a precarious engagement with a threatening and insecure

life world – a life world that has been characterised by a pervasive lack of support (as mirrored in her body's loss of balance and thus physical support).

Furthermore, Sarah and Jenna's descriptions of their experience of somatic symptoms as well as their respective relationships with their somatizing bodies appear to support Leder's (1990) hypothesis of the "dysappearing" body. Although both participants appear to articulate their somatizing bodies as attacking or malevolent others (and thus as separate to their senses of self), their storied accounts reveal the inescapable nature of embodiment and thus the phenomenological experience of the body as an ambiguous entity that continuously shifts between absent-presences and present-absences. In this sense, both participants position their somatizing bodies as making present an absence of an 'ideal' presence (present-absence/absence-presence). Similarly, both accounts serve to highlight a basic premise of narrative research (particularly within the context of illness experience): it is within the forward-backward grasp of the narrative act that the incarnate body-self is able to afford meaning and context to the manifestation of illness symptoms and to the disruption that these symptoms frequently entail.

To conclude, it may be possible to suggest that the generated findings appear to offer support to the theoretical hypotheses and arguments developed in this study: i.e. by situating two individuals' experiences of somatic distress on the grounds of the corporeal and thus on the grounds of their dialogical, subjective and embodied engagement with their life world, their symptoms reveal themselves as embodied expressions of the body-subject's gestalt-like and chiasmatic relation to the flesh of the world.

REFERENCES

- American Psychiatric Association (APA). (2004). *Diagnostic and statistical manual of mental disorders: Text revision* (4th ed.) (DSM-IV-TR). Washington, DC: American Psychiatric Association.
- Anzieu, D. (1989). *The skin ego*. (Trans. C. Turner). London: Yale University Press.
- Atkinson, R. (1998). *The life story interview*. Thousand Oaks, CA: SAGE Publications.
- Avila, L. A. (2006). Somatization or psychosomatic symptoms? *Psychosomatics*, 47, 163-166.
- Bakhtin, M.M. (1993). *Toward a philosophy of the act*. (Trans. V. Liapunov). Austin, TX: University of Texas Press.
- Bakhtin, M.M. (1990). *Art and answerability: Early philosophical essays by M.M. Bakhtin*. (Trans. V. Liapunov). Austin, TX: University of Texas Press.
- Barker, P., & Barker, P.B. (2004). Beyond empowerment: Revering the story teller. *Mental Health Practice*, 7(5), 18-20.
- Bass, C.M., & Cawley, R.H. (1990). *Somatization: Physical symptoms and psychological illness*. London: Blackwell Scientific Publications.
- Becker, G. (1999). *Disrupted lives: How people create meaning in a chaotic world*. London: University of California Press.
- Becker, G. (1994). Metaphors in disrupted lives: Infertility and cultural constructions of continuity. *Medical Anthropology Quarterly*, 8(4), 383-410.
- Brown, N.O. (1966). *Love's body*. New York: Alfred A. Knopf.
- Bruner, J (1986). *Actual minds, possible worlds*. Cambridge, MA: Harvard University Press.
- Burkitt, I. (1999). *Bodies of thought: Embodiment, identity and modernity*. London: SAGE Publications.
- Cardo, J. (1999). *HIV and metaphor: An imaginative response to illness*. Unpublished Master's Thesis, Rhodes University, Grahamstown.
- Carr, D. (1986). *Time, narrative and history*. Bloomington: Indiana University Press.
- Casey, B., & Long, A. (2002). Reconciling voices. *Journal of Psychiatric and Mental Health Nursing*, 9, 603-610.
- Clarke, G. (1996). The animating body: Psychoid substance as a mutual experience of psychosomatic disorder. *Journal of Analytical Psychology*, 41, 353-368.

- Corey, G. (1996). *Theory and practice of counselling and psychotherapy* (5th ed.). London: Brooks/Cole Publishing Company.
- Crossley, M.L. (2000). *Introducing narrative psychology: Self, trauma and the construction of meaning*.
- Csordas, T.J. (1999). Embodiment and cultural phenomenology. In G. Weiss & H.F. Haber (Eds.), *Perspectives on embodiment* (pp. 143-162). London: Routledge.
- Csordas, T.J. (1997). *The sacred self: A cultural phenomenology of charismatic healing*. Berkeley: University of California Press.
- Csordas, T.J. (1994). (Ed.). *Embodiment and experience: The existential ground of culture and self*. New York: Cambridge University Press.
- De Gucht, V., Fischler, B., & Heiser, W. (2003). Job stress, personality, and psychological distress as determinants of somatization and functional somatic syndromes in a population of nurses. *Stress and Health, 19*(4), 195-204.
- De Gucht, V., & Fischler, M.D. (2001). Somatization: A critical review of conceptual and methodological issues. *Psychosomatic Medicine, 52*(6), 653-672.
- Diekama, D. (1989). Introduction. In K. Etherington (Ed.), *Trauma, the body and transformation: A narrative inquiry* (pp. 9-21). London: Jessica Kingsley Publishers.
- Dubovsky, S.T. (1997). *Mind-body deceptions: The psychosomatics of everyday life*. New York: W.W. Norton & Company, Inc.
- Edwards, D., Ashmore, M., & Potter, J. (1995). Death and furniture: The rhetoric, politics and theology of bottom line arguments against relativism. *History of the Human Sciences, 8*(2), 25-49.
- Epstein, R.M., Quill, T.E., & McWhinney, I.R. (1999). Somatization reconsidered: Incorporating the patient's experience of illness. *Archives of Internal Medicine, 159* (3), 215-222.
- Etherington, K. (2003). (Ed.). *Trauma, the body and transformation: A narrative enquiry*. London: Jessica Kingsley Publishers.
- Fabrega, H. (1991). Somatization in cultural and historical perspective. In L.J. Kirmayer, & J.M. Robbins (Eds.), *Current concepts of somatization: Research and clinical perspectives* (pp. 181-199). Washington, DC: American Psychiatric Press.
- Frank, A.W. (1996). Essay review: From disappearance to hyperappearance: Sliding boundaries of illness and bodies. *Theory and Psychology, 6*(4), 733-760.

- Frank, A.W. (1995). *The wounded storyteller: Body, illness, and ethics*.
- Freeman, M. (1993). *Rewriting the self: Memory, history, narrative*. London: Routledge.
- Freud, S. (1923). *The Ego and the Id*. (ed. 19). London: Hogarth Press.
- Gardiner, M. (1998). The incomparable monster of solipsism: Bakhtin and Merleau-Ponty. In M. Mayerfield Bell, & M. Gardiner (Eds.), *Bakhtin and the human sciences* (pp. 128-144). London: Sage.
- Garro, L.C., & Mattingly, C. (2000) Narrative as construct and construction. In L.C. Garro, & C. Mattingly (Eds.), *Narrative and the cultural construction of illness and healing* (pp. 1-49). California, Berkeley: University of California Press.
- Garro, L.C. (2000). Cultural knowledge as resource in illness narratives. In L.C. Garro, & C. Mattingly (Eds.), *Narrative and the cultural construction of illness and healing* (pp. 70-87). California, Berkeley: University of California Press.
- Gergen, K.J., & Gergen, M. (1998). Narrative and the self relationship. *Advances in Experimental Social Psychology*, 21, 17-55.
- Gergen, K. J. (1991). *The saturated self: Dilemmas of identity in contemporary life*. New York: Basic Books.
- Gillies, V., Harden, A., Johnson, K., Reavey, P., Strange, V., & Willig, C. (2004). Women's collective constructions of embodied practices through memory work: Cartesian dualism in memories of sweating and pain. *British Journal of Social Psychology*, 43, 99-112.
- Griffith, J.L., & Griffith, M.E. (1994). *The body speaks: Therapeutic dialogues for mind-body problems*. New York: Basic Books.
- Grosz, E. (1994). *Volatile bodies: Toward a corporeal feminism*. Bloomington: Indiana University Press.
- Guggenheim, F.G. (1999). Somatoform disorders. In B.J. Sadock, & V.A. Sadock (Eds.), *Comprehensive textbook of psychiatry* (7th ed.) (pp. 1504-1532). Philadelphia, PA: Lippincott Williams & Wilkins.
- Helman, C. (2004). *Suburban shaman: A journey through medicine*. Cape Town: Double Storey.
- Hofmeister, A. (2000). Rethinking embodiment, subjectivity and agency. In N. Stephenson, H. Lorraine Radtke, R. Jorna, & H.J. Stam (Eds.), *Theoretical psychology: Critical contributions* (pp. 192-200). Calgary: Captus University Publications.
- Howson, A. (2004). *The body in society: An introduction*. Oxford: Oxford University Press.

- Hunt, L.M. (2000). Strategic suffering: Illness narratives as social empowerment among Mexican cancer patients. In L.C. Garro, & C. Mattingly (Eds.), *Narrative and the cultural construction of illness and healing* (pp. 83-107). California, Berkeley: University of California Press.
- Isaacs, S. (1983). The nature and function of phantasy. In M. Klein et al., *Developments in Psycho-Analysis*. London: Hogarth Press.
- Jackson, M. (1989). *Paths toward a clearing: Radical empiricism and ethnographic inquiry*. Bloomington: Indiana University Press.
- Josselson, R. (1996). Introduction. In R. Josselson (Ed.), *The narrative study of lives: Vol. 4*. Thousand Oaks, CA: Sage.
- Jung, H.J. (1998). Bakhtin's dialogical body politics. In M. Mayerfield Bell & M. Gardiner (Eds.), *Bakhtin and the human sciences* (pp. 95-111). London: Sage.
- Kellner, R. (1990). Somatization: Theories and research. *The Journal of Nervous and Mental Disease*, 178 (3), 150-160.
- Kirmayer, L.J., & Robbins, J.M. (1994). Symptom attribution in cultural perspective. *Canadian Journal of Psychiatry*, 39, 584-595.
- Kirmayer, L.J. (1992). The body's insistence on meaning: Metaphor as presentation and representation in illness experience. *Medical Anthropology Quarterly*, 6, 323-346.
- Kirmayer, L.J., & Robbins, J.M. (1991). Introduction: Concepts of somatization. In L.J. Kirmayer, & J.M. Robbins (Eds.), *Current concepts of somatization: Research and clinical perspectives* (pp. 1-19). Washington, DC: American Psychiatric Press.
- Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. New York: Basic Books.
- Kleinman, A. (1995). Do psychiatric disorders differ in different cultures? The methodological questions. In N.R. Goldberger & J.B. Veroff (Eds.), *The culture and psychology reader* (pp. 631 – 651). New York: New York University Press.
- Kozłowska, K. (2003). Good children with conversion disorder: Breaking the silence. *Clinical Child Psychology and Psychiatry*, 8(1), 73-90.
- Leder, D. (1990). *The absent body*. Chicago: University of Chicago Press.
- Levin, D.M. (1991). Visions of narcissism: intersubjectivity and the reversals of reflection. In M. Dillon (Ed.), *Merleau-Ponty vivant*. Albany, NY: Stanford University Press.

- Lewis-Fernández, R., & Kleinman, A. (1995). Cultural psychology: Theoretical, clinical, and research issues. *The Psychiatric Clinics of North America*, 18, 433-445.
- Lieblich, A., Tuval-Maschiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis and interpretation*. London: Sage.
- Lightfoot, C., & Lyra, M. (2000). Culture, self and time: Prospects for the new millennium. *Culture & Psychology*, 6(2), 1-11.
- Lipowski, Z.J. (1988). Somatization: The concept and its clinical application. *American Journal of Psychiatry*, 145, 1358-1368.
- Lipowski, Z.J. (1987). Editorial: Somatization: Medicine's unsolved problems. *Psychosomatics*, 28, 294-297.
- Lock, J., & Giammona, A. (1999). Severe somatoform disorder in adolescence: A case series using a rehabilitation model for intervention. *Clinical Child Psychology & Psychiatry*, 4(3), 341-351.
- Lynch, J.J. (1984). *The language of the heart: The body's response to human dialogue*. New York: Basic Books, Inc.
- Lyon, M.L., & Barbalet, J.M. (1994). Society's body: emotion and the "somatization" of social theory. In T.J. Csordas (Ed.), *Embodiment and experience: The existential ground of culture and self*. New York: Cambridge University Press.
- Macdonald, A.M. (1974). *Chambers twentieth century dictionary*. Edinburgh: W & R Chambers Ltd.
- Malcolm, C.F. (1994). *Torn between skinship and kinship: The phenomenology of self-mutilation*. Doctor of Philosophy in Psychotherapy Thesis, Rhodes University, Grahamstown.
- Martin, E. (1989). *The woman in the body: A cultural analysis of reproduction*. Buckingham: Open Press University.
- Mayou, R., Kirmayer, L.J., Simon, G., Kroenke, K., & Sharpe, M. (2005). Somatoform disorders: Time for a new approach in DSM-V. *American Journal of Psychiatry*, 162, 847-855.
- Mayou, R. (1993). Somatization. *Psychotherapy & Psychosomatics*, 59, 69-83.
- McDougall, J. (1989). *Theaters of the body: A psychoanalytic approach to psychosomatic illness*. New York: W.W. Norton & Co.
- McWhinney, I.R., Epstein, M.D., & Freeman, T.R. (1997). Lingua Medica: Rethinking Somatization. *Medical Writings*, 126(9), 747-750.

- Merleau-Ponty, M. (1968). *The visible and the invisible*. (Trans. A. Lingis). Evanston: Northwestern University Press.
- Merleau-Ponty, M. (1962). *Phenomenology of perception*. (Trans. C. Smith). New York: Humanities Press.
- Mishler, E.G. (1992). *Narrative accounts in clinical and research interviews*. Paper presented at conference on Discourse and the Professions, Swedish Association for Applied Linguistics, Uppsala University, Sweden.
- Mishler, E.G. (1986). *Research interviewing: Context and narrative*. Cambridge, MA: Harvard University Press.
- O'Loughlin, M. (1995). Intelligent bodies and ecological subjectivities: Merleau-Ponty's corrective to postmodernism's "subjects" of education. *Philosophy of Education*. Retrieved April 16, 2003, from http://www.ed.uiuc.edu/EPS/PES-Yearbook/95_docs/o'loughlin.html.
- Overcash, J.A. (2004). Narrative research: A viable methodology for clinical nursing. *Nursing Forum*, 39 (1), 15-22.
- Parker, I. (2005). *Qualitative psychology: Introducing radical research*. New York: Open University Press.
- Polkinghorne, D.P. (1995). Narrative configuration in qualitative analysis. In J. Hatch & R. Wisniewski (Eds.), *Life history and narrative* (pp. 5-23). Bristol, PA: Falmer.
- Radley, A. (1998). Displays and fragments: Embodiment and the configuration of social worlds. *Theory & Psychology*, 6, 559-576.
- Reischer, E., & Koo, K.S. (2004). The body beautiful: Symbolism and agency in the social world. *Annual Review of Anthropology*, 33, 297-317.
- Ricoeur, P. (1984). *Time and narrative*. (Trans. K. McLaughlin & D. Pellauer). Chicago: University of Chicago Press.
- Rief, W., Henningsen, P., Hiller, W., & Stein, E. (2006). Classification of somatoform disorders. .
- Riessman, C.K. (1993). *Narrative analysis*. Newbury Park, CA: Sage.
- Romanyshyn, R. (1982). *Psychological life: From science to metaphor*. Texas: University of Texas Press.
- Rubin, J.J. (2005). Psychosomatic pain: New insights and management strategies. *Southern Medical Journal*, 98 (11), 1099-1110.

- Sadock, B.J., & Sadock, V.A. (Eds.). (2003). *Kaplan and Sadock's synopsis of psychiatry* (9th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Sarbin, T.R. (Ed.). (1986). *Narrative psychology: The storied nature of human conduct*. New York: Praeger.
- Shotter, J. (1994). *Talk of saying, showing, gesturing, and feeling in Wittgenstein and Vygotsky*. Retrieved March 17, 2005, from <http://www.massey.ac.nz/~alock/virtual/wittvyg.html>.
- Simon, G.E. (1991). Somatization and psychiatric disorders. In L.J. Kirmayer, & J.M. Robbins (Eds.), *Current concepts of somatization: Research and clinical perspectives* (pp. 37-62). Washington, DC: American Psychiatric Press.
- Sparkes, A.C. (1999). Exploring body narratives. *Sport, Education & Society*, 4(1), 17-30.
- Stam, H.J. (2003). Addressing oneself as another: Dialogue and the self in Habermas and Butler. To appear in C.B. Grant (Ed.), *Rethinking communicative interaction: New interdisciplinary horizons*.
- Stam, H.J. (1996). Introduction: The body's psychology and psychology's body. *Theory & Psychology*, 6(4), 555-557.
- Steckel, W. (1943). *The interpretation of dreams*. New York: Liveright.
- Strassnig, M., Stowell, K.R., First, M.B., & Pincus, H.A. (2006). *Current opinion in psychiatry*. Philadelphia, PA: Lippincott Williams & Wilkins.
- Suls, J., & Rittenshouse, J.D. (1987). Personality and physical health: An introduction. *Journal of Personality*, 55(2), 156-167.
- Swartz, L. (1998). *Culture and mental health: A Southern African view*. Cape Town: Oxford University Press.
- Taylor, G.J., Bagby, R.M., Ryan, D.P., & Parker, J.D.A. (1990). Validation of the alexithymia construct: A measurement-based approach. *Canadian Journal of Psychiatry*, 35, 290-297.
- Terre Blanche, M., & Durrheim, K. (Eds.). (1999). *Research in practices: Applies methods for the social sciences*. Cape Town: UCT Press.
- Toombs, S.K. (1992). The body in multiple sclerosis: A patient's perspective. In D. Leder (Ed.), *The body in medical thought and practice* (pp. 233-249). London: Kluwer Academic Publishers.
- Turner, B.S. (1996). *The body and society* (2nd ed.). London: Sage.

- Van den Berg, J.H. (1975). *The changing nature of man: Introduction to a historical psychology*. New York: Dell Publishing Co.
- Van den Berg, J.H. (1972). *A different existence: Principles of phenomenological psychopathology*. Pittsburgh: Duquesne University Press.
- Wacquant, L. (1995). Pugs at work: bodily capital and bodily labour among professional boxers. *Body Society*, 11, 65-93.
- Waitzkin, H., & Magaña, H. (1997). The black box in somatization: Unexplained physical symptoms, culture, and narratives of trauma. *Social Science Medicine*, 45 (6), 811-825.
- White, M. (1992) Deconstruction and therapy. In D. Epston & M. White (Eds.), *Experience, contradiction, narrative, and imagination* (pp. 109-147). South Australia: Dulwich Centre.
- Winnicott, D. (1971). *Playing and reality*. London: Tavistock.
- Winnicott, D. (1965). *The maturational process and the facilitating environment*. London: Hogarth.
- Winnicott, D. (1956). *Through paediatrics to psycho-analysis*. New York: Basic Books.
- Wittgenstein, L. (1953). *Philosophical investigations*, trans. G.E.M. Anscombe. Oxford: Blackwell.
- Young, I.M. (1994). Gender as seriality: Thinking about women as a social collective. *Signs: Journal of Women in Culture and Society*, 19(3), 713-738.
- Young, I.M. (1990). *Throwing like a girl and other essays in feminist philosophy and social theory*. Bloomington, Ind.: Indiana University Press.

APPENDIX A

PARTICIPANT INFORMATION LETTER AND CONSENT FORM

Dear Participant,

I am currently carrying out a research project (as a Psychology Masters student at Rhodes University, Grahamstown) that aims to explore how one can make sense of somatic or medically unexplained symptoms (i.e., the manifestation of physical symptoms that have no known physiological cause, or cannot be entirely explained by a general medical condition) as lived and told through the 'ill' body. In this regard, I am concerned with the manner in which *you*, the participant, subjectively experiences and negotiates somatic representation as a part of your lived identity or sense of self.

Literature suggests that the explanatory models informing our current views of somatic representation do not comprehensively serve to explain (and thus effectively deal with) the physical and emotional distress that individual's presenting with somatic symptoms experience. This particular study, is thus chiefly concerned with attempting to discover (or contribute to finding) alternative ways in which to envision and deal with somatic distress and the experience thereof – where an emphasis will be placed on acquiring an understanding of how you experience, embody and communicate your experience of illness.

I hope to acquire this understanding through an approach referred to as 'Life Story' or Narrative Research, in which, participants are encouraged to share their life story with the researcher, in a manner that is comfortable and non-threatening to them. In this regard, it is the participant's choice as to how they would like to structure their life story: i.e., you as the participant can decide what events you would like to include, and how – whether those events point directly to the topic of interest (which in this case would be your experience of somatic representation) or whether those events are seemingly unrelated. I am therefore interested not only in your experience of somatic distress but also in the course that your life has followed from an early age to present time, which ultimately means that you do not necessarily have to make your experience of illness the central point of your story, but that you can relate your life in any way that you deem fit.

Your participation will take the form of: i) one pre-meeting, in which you will have the opportunity to give both written and informed consent and clarify any points that you may feel unsure about, ii) an in-depth (as in-depth as possible), written account of your medical history: i.e., when did your symptoms start, what were the nature of your symptoms, what action did you take with regards to these symptoms (e.g., did you go to a medical doctor, have you had any medical tests done with regards to your symptoms, have you been referred to a psychologist or any other practitioner?, etc.), iii) a single, audio-taped interview for the duration of about an hour (which will be transcribed verbatim), and iv) a follow-up interview in which you, as the participant, will have an opportunity to provide any further information that you feel may be of use to the researcher.

Please bear in mind that because you will be talking about your life, you have the right and the responsibility to decide how much you feel comfortable with disclosing and what you want to disclose. You therefore have the right to decide whether certain statements remain 'on' or 'off-the-record' and do not end up in the transcript. Similarly, you have the right to withdraw from the research project at any time. At no point will you be pressured or coerced into providing details that you may find emotionally threatening or uncomfortable. In addition, it may be helpful to know that all information gathered will be kept entirely confidential and will only be discussed with my supervisor. To further ensure confidentiality, your name will be replaced with a pseudonym, and any identifying information will be altered in any subsequent publishing of the research findings. You may decide what ought to be done with the tapes at the end of completion of the research: i.e., you may decide that you want to keep them, or you may feel more comfortable if I destroyed them at completion.

In keeping with the fact that you will be sharing highly meaningful experiences, I would like to ensure that you are comfortable with the findings and interpretations of my research. You will therefore, have a final say in any changes, deletions or additions made to any draft of the story (e.g., the transcript) and any interpretations that I may make about your story. Any feedback regarding the major findings of the study will be made available to you on request.

Your participation and help in this research study will be greatly appreciated, and could contribute significantly to developing a more embedded and sensitive understanding of somatic representation as subjectively experienced by individuals who are in a similar predicament as you.

If you are willing to participate in this study, please complete the following:

I agree to voluntarily participate in your life story research study	
I understand that my life story will be audio-taped	
I am well aware that I have the right to withdraw from the study at any time	
I understand that my life story will be reported in an anonymous manner	
I would feel more comfortable if the recording of the interview was:	
✓ Destroyed at completion of the research study	
✓ Given to me, the participant	

Name (in print):

Signature:

Date:

Should you have any queries at any time, you can contact me at:

E-mail: g99h1810@campus.ru.ac.za

Tel: 0466227941

Cell Phone: 0731505078

Thank you for your assistance,

Yours sincerely,

Claire Haggard (Researcher)

Jan Knoetze (Supervisor)

APPENDIX B

LIFE STORY TRANSCRIPTS

SARAH'S LIFE STORY

1 Claire: So...the whole idea before starting this interview, is thinking of your life as though it
2 were... - sort of, almost like a book...with chapters or significant events....And um...the
3 way in which you choose to structure that , and the way in which you choose to – or the
4 things you choose to focus on, are entirely up to you...um...so...you can start where you
5 want, you can end where you want, and obviously there are times where you can say you
6 want things off the record....And there are times where you can...ask that...um...I don't
7 know...like if you feel uncomfortable, you don't have to address that full thing, or
8 whatever...

9 Sarah: Okay...

10 Claire: Okay?

11 Sarah: I've thought about it in terms of like, stages of my life, like

12 Claire: Okay...

13 Sarah: ...in a kind of chronological order [mm]...I don't know if that's okay?...Okay

14 Claire: It's perfect...

15 Sarah: Um...[pauses and lets out a sigh that sounds almost tired, almost as if the thought of
16 recounting an entire life could be daunting or a challenging task] I think I had, I had a
17 very happy childhood, I think...um...I...never felt I was...[pauses] ...I was never tense,
18 or anything like that, I don't think...um...[pauses] I played a lot with my
19 brother...um...had a lot of contact with my parents, was taken around with them a
20 lot...um [clears throat]...Always had a kind of, um...looking after role with my brother [,
21 in a way. I always had to look after him and stuff...um...And that kind of changed when
22 I got to school...I found school very – a very tense...um...place [mm]...I didn't make
23 friends very easily [mm], I was very shy ...um...When my best friend of a long time left
24 in standard one, I had a – a very hard time making new friends after that...[pauses]
25 um...I...[sighs and pauses]...didn't enjoy primary school at all, it made me feel sick to
26 have to go to school... everyday...a lot of the time [just check this...a lot of noise in
27 background and a little distorted]...

28 Claire: And what about primary school made you feel sick?

29 Sarah: Um...it was just the whole atmosphere of the place...I felt...re-repressed
30 [mmhmm]...and that I wasn't going to be near my mother, I think – a lot of the time,

31 like, I *needed* that...I often used to ask, you know “Where’s my mother?; Where’s my
32 mom?” ...um...

33 Claire: And how did you feel in those situations (?) ... I mean...

34 Sarah: I felt really scared – very, very scared – tense...ja...a *knot* in my stomach the whole time
35 [mm] ...um...I just remember there were certain roses that used to grow in the gardens of
36 the primary school and if I smell them now...[mm?]?...I get that knot in my
37 stomach...there’s just...[jeeppers]...or if there’s a certain light...like you always used to
38 be very sunny in Mafikeng...so...a certain type of light and I just feel like I ‘m back
39 there...It’s quite strange...

40 Claire: And how does that feel. Being back..?

41 Sarah: It’s just an automatic, tense...response, it’s like...you know

42 Claire: And could that be attributed to oth – other things besides, maybe being separated from
43 your mother...or....?

44 Sarah: I think, um...I was scared of my teachers, I was scared of not performing...I was very
45 worried about... that I didn’t know enough to be at school, an all that [mm]...um...I
46 wasn’t going to do well...and that people were going to shout at me – I was terrified of
47 being shouted at ...I had shouting...[Was there any – was there anything that created
48 that? I mean, do you remember an event, or...?] I [...a point where...] only remember in
49 Grade One coming home and crying because...I’d been at school for a day and I couldn’t
50 read yet...and...my mom saying to me: “It’s okay, you’re supposed to go to school so
51 you can *learn* to read...And I was devastated by the fact that I *couldn’t*
52 read...um...and...I think th – maybe like the first day that I was in Grade One I *did* get
53 shouted at...by, by the teacher...for not going to the reading books [okay]...cos I wasn’t
54 sure what was going on...And feeling very scared of her from then...[mm]...I was
55 very...uh...sensitive to any kind of harsh reactions...I’d crumble [mhmm]...into tears,
56 so...um...[pause] Primary school...But at the same time I was motivated by this
57 *desperate* need to achieve things, like I *had* to get good marks for things...I *had* to be the
58 teacher’s pet, the teacher *had* to like me...Specially like round standard three and
59 standard four [hmm]...um...Ja [said with a real sense of clarity]...I just wanted to be the
60 best at things and...and...it was quite sad, cos our school didn’t really give you any
61 recognition for that [mm] so...[smiles and laughs at self]...I was just like achieving for

62 myself [we both laugh a little], I suppose...um...And then...[pause] I was very...I
63 remember getting to about puberty, I suppose, and being very aware of my body and how
64 much I hated it...um...Because I was quite overweight by the time I got to...standard
65 five...[mhmm]...I was very chubby...and...um...I had very *thin* friends, and that used
66 to...that to me was a big problem...was that my...I always thought they looked so *lovely*,
67 and that I could never look like that...and...that used to really make me...get me very
68 down. And that – like especially happened when I went to high school in [and?] standard
69 five...and that was a *big* aspect of my life, and...then one day...we went on holiday and I
70 decided: “Okay, I’m going to restrict my eating this
71 holiday...”...And...I...um...[pauses] I went on a diet, not, not a *hectic* diet...But I came
72 back and I lost a lot of weight, and people were like: “Oh wow, you look so
73 nice...”...um...And I felt really good...I was like: “Wow” – for the first time in my life I
74 felt thin...like *consciously*...that I *knew* about [mm]...I felt thin...And I *really* enjoyed
75 that feeling, I loved it...and I, like started wearing short dresses, and short skirts and
76 stuff, and [mhm] ...um...And then [sigh]...that kind of phase of early high school was
77 great for - when I was thin for a bit...for about a year...And...then...I started getting
78 victimized by this girl, who...felt that...she – we were very good friends for a bit and
79 ...and then um... she turned against me, telling me that I lived in a bubble...That I had
80 such a perfect little life and that that bubble was going to pop *really* badly, *really*
81 soon...And...she started *hating* me, like with this *vicious* hatred that I didn’t
82 understand...um...[So it just came [She used to come [out of nowhere] pour coke over
83 my head...[jeepers]...and like...issue, like *vicious* threats, like ... If I waited outside
84 school too long she was going to come and kill me...And...she was going to beat me
85 up...and *fuck* me up...and all this kind of stuff, ja...And got all her friends and cahonies,
86 like...into the whole thing [jeepers]...And I – I *never* understood what I’d done to, kind
87 of...[pauses] make her so angry at me?...Because we’d *been* really good friends...And I
88 *know* she came from a very broken home, and stuff, so I don’t know if it was the fact that
89 I had, like quite a solid family life [mm]...Because that’s one thing that’s always...been
90 very good for me, is that my family are very...close in a strange kind of
91 way...[mm]...and we get on very well, [mm] and they’re a source of happiness to me
92 [mm]...And they obviously weren’t for her...and I- I don’t know...It seemed to be based

93 on my perfect little life – bubble of a life...All the [hmm] hatred and stuff, so...I think it
 94 must have been related to that...And *that* [this is said with emphasis and volume] started
 95 another fear:...of school...Of going to school... I just obviously didn't want to go to
 96 school, because I knew this [mm] girl was waiting for me, basically...to come an' like
 97 [this is said in an almost 'inward' manner – quiet and withdrawn almost]...be horrible
 98 and nasty, and she accused me of cheating in *tests* and I had to go and sit before a
 99 disciplinary committee's 'nd...She was just...dreadful, she made my life
 100 miserable...I...*really*...used to-I used to sit in my cupboard and *cry*...cos [sjoe]...and
 101 she- she started to polarize my friends against me too, that was the other thing...she went
 102 and told them, like things *I'd* been saying about them, 'nd...Which left me with a *really*
 103 empty, *really* sad feeling, because I do tend to treasure my friends, like quite a [mm]lot,
 104 and I...*you* know, I like to have a solid base of close [mm] friends [definitely]...and...to
 105 have tho- those girls who I'd been friends with since, you know...*primary* school...to
 106 have this *silly* girl come and tell them these things and for them to, kind of *play* on
 107 that...[pause] was [pause – these pauses serve to emphasise the horridness of the
 108 situation]...*horrible*...um...and then, my mom got a job in Grahamstown...when I was at
 109 the end of standard seven...and that was great, because tha-the end of standard seven was
 110 probably the worst period...of my life, I was...*seriously* depressed, I think...um...I put
 111 on all the weight that I'd put on again, I...we-just wasn't happy...I [sigh] just wanted to
 112 live a normal life and I felt like I wasn't living it...in Mafikeng...um...

113 Claire: And within yourself, like um... you said you felt very depressed and stuff like
 114 that...[mm]...um...How did you, I mean...Just within yourself, like a sense of, you
 115 know, your presence in the world. *How* did you *feel*, like before you came, I mean what
 116 was the sort of over-riding thing, I mean, did you – feel like you just...I don't know...

117 Sarah: I felt like sitting in a cupboard...I felt like shutting myself off...I...um...[goodness]...at –
 118 *I know* that from reading my diaries back then I was talking about *killing* myself...um...I
 119 know I- I *wouldn't* have done it, I don't think- I don't think I was *that* desperate then,
 120 but...the *thought* didn't sound so bad to me...at that stage [so it really was quite a
 121 desperate stage...]...this girl was *really* making my life...a misery...And um...I *couldn't*
 122 run from her, I *couldn't* escape from her, I *had* to go to school...and she was there, all the
 123 time...and um...it was a *really* desperate feeling, and - and I think that the only thing

124 that saved me was th't my mom got this job in Grahamstown... 'nd then I *knew* I was
 125 *leaving* and I didn't have to put up with this for much longer, and I could just *go away*
 126 and *leave* her behind [mm], and *never have* to see her again... [hmh] I had like a *real*
 127 feeling of escape... And... so we moved here... and that was very intimidating for me,
 128 because I'd al-been in one of those places where I'd gone to pre primary school, primary
 129 school and high school... with the same people... [mm]... you know, I hadn't
 130 left... And... to *suddenly* arrive in Grahamstown, which is also very tight-knit kind of
 131 place... Having had that kind of history myself, but *not* fitting into th-the Grahamstown
 132 [here Sarah is actually referring to Mafikeng] one... [mm]... was quite hard for me [mm]
 133 when I first got here... [mm]... um... For the first six months, I was, kind of... a bit shaky,
 134 as to whether I was actually happy or not... in Grahamstown... um... but, I – I *did* enjoy
 135 life a lot better, you know... I st-started playing sport [mm] and I lost a lot of weight
 136 [mm]... again... and... I w's just a lot happier... And... then I met [name omitted] and
 137 [name omitted]... um... and then, like... my life took after – off after that really... I just- I
 138 had the most brilliant time [mm]... at school... [mm]...

139 Claire: And tha...

140 Sarah: I came out of my shell a lot...

141 Claire: The sense of shakiness before that... for the sort of, first six months of just
 142 feeling, like shaky... [Sarah sighs]... [um...

143 Sarah: ...just not sure who I was... where I was... um... Also coming out of a school where I was
 144 probably in the minority of whites... [mm]... like *very* much so – like twenty out of a [ja]
 145 thousand [ja], and then going to a kind of, like... very... white-centred model C
 146 schools... um... Things that I'd always heard about, but never [laughs] gone to... was quite
 147 strange for me, and also like, I felt like I had to compromise some of my beliefs in
 148 like... listening to white girls bitching about black girls... [okay]... listening to... but, you
 149 know... and the other way round... [okay so...]... I'd never really [okay]...

150 Claire: Cos you... okay so you came from Mafikeng right? So... [ja] that was quite – also - that
 151 time... wasn't that quite a hotspot as well [ja], in terms of politics and stuff?

152 Sarah: Ja... we had some terrible things with shooting and stuff like that... um... [long pause]
 153 um... I remember the one night... it was the night before my birthday... and... they're
 154 that's when the AWB came into to town and started shooting everybody and there was

155 like...guns going off and stuff and we had to hide under my parents bed, 'nd...cos it
 156 wasn't safe to be near windows and stuff...um...And just the looting and stuff...Kind of
 157 shook my world a bit...suddenly there was...I don't know, it had happened in grade two
 158 though, grade two...so I was kind of like no- [so you were...].*...totally* shaken by that...

159 Claire: How old were you?

160 Sarah: [Pauses]...I was fourteen the second time it happened, and I wass...seven...the first time
 161 it happened...so...The first time it happened we had to like, hide under our desks [mm]
 162 and stuff...there'd been a whole period before where we weren't allowed to go to school
 163 in uniform cos they were targeting school kids...and we had petrol bombs in our library,
 164 'nd...stuff like that, so it wasn't, like totally unexpected that this unrest was coming – but
 165 it did unsettle me to think that, I could die, like... you know [mm]...a bullet could come
 166 through the window...

167 Claire: So it was a *real* threat, I mean it was really...

168 Sarah: Ja [real]...it was a real threat...and the next day, we like left *really* early...um...for
 169 Jo'Burg...But we were worried that there'd be...um...roadblocks at Ventersdorp...the
 170 AWB...thing, and that they might cause trouble, but luckily there weren't...um...it was
 171 quite scary...But as we were going out, the SADF were coming into
 172 town...[mm]...um...ja

173 Claire: So then, coming from *that* environment...which...in a funny sense, your, kind of, like
 174 your *person*...your physical being was being threatened...[mm]...um...then coming to
 175 *Grahamstown*...which was quite different, and probably...obviously it is quite politically
 176 kind of aware, in the sense that it's an academic town... 'nd [ja]...people are quite
 177 liberal, in a way...um...but was that – was that quite a shift for you, at all?...In any way?
 178 [mm] Like, you said about the model C schools, so obviously...

179 Sarah: um...I think coming to a town where there were like... [pauses] academics...like a very
 180 academic town, like this – but I'd always been surrounded by that, cos [ja] my parents
 181 have always worked in a university [ja] environment...so I felt quite comfortable [mm]
 182 with that...um...I think for *me* [this is said with volume], in a way, like...I found it hard
 183 to accept, like – like the kind of...you know, I think my parents had tried so *hard* to give
 184 me a different education, it was quite hard coming in...to just fit in – slot in...but in a way
 185 I *really* enjoyed it...I *enjoyed* having a school tie, I *enjoyed* having a *uniform* with a

186 blazer – I [okay...] enjoyed [...so you didn't have that beforehand?...]No...we had this
 187 very *liberal* school where we were allowed to do [okay] anything we wanted to...and that
 188 used to drive me nuts...I just wanted structure in my life...[okay]...I wanted...[pause]
 189 structure [said in a very definite tone of voice]...I didn't – just when I got sent six pages
 190 of rules by V.G. before I arrived, I was like: “*Wow*, at [oh...[*last*” okay]...[We both
 191 laugh]...”At *last*. I'm going to a *proper* school” [laughs again]...um...[pause] which,
 192 ja...I think I regretted the six pages of rules later at V.G. [Claire laughs]...but, at that
 193 stage I was – No [here her voice raises in volume again], I mean I was *very* happy to be
 194 coming to Grahamstown, and I was very happy to be in Grahamstown, even if I did feel a
 195 bit shaky, I think it was more to do with friends...um, I was friends with a very
 196 depressive girl [laughs] for the first six months [okay]...and...ja-she didn't want to be
 197 here, she wanted to be back in Pietermaritzburg [okay] which was where she was from,
 198 [okay] and she was just *negative* the whole time, ‘nd...that kind of got to me a bit. But
 199 then, ja – like halfway through I started to be *really* good friends with [name omitted] and
 200 [name omitted], and after that...ja...I think was *really, really* happy [mm] ...at V.G.
 201 [mm]...You know – and I didn't have any boyfriends or things like that, which is what –
 202 I *did* want a boyfriend...but...that didn't really matter that much, I was like...was just
 203 really, really happy...at V.G.

204 Claire: You had *one* boyfriend though at V.G...

205 Sarah: Tom...

206 Claire: Ja...[Sarah laughs] [Then we both laugh]

207 Sarah: No, that was at the end [We both laugh]...No [drawn out ‘Nooo’]...I guess, like – I did
 208 have a few messed up things towards boys, because I didn't really – I was quite shy
 209 [okay]...And...I was scared of boys, *very* scared of boys...

210 Claire: Why were you so scared of boys?

211 Sarah: I don't know – I don't know, because I did have *boy friends* when I was in Mafi [...and
 212 you had a brother] keng...And I had a brother...I think [sighs]...I don't
 213 know...um...[long pause]...I just used to feel revolted at the-at the thought of having a
 214 boyfriend...for a long time when I was younger [mm]...But, I don't know – I thought
 215 that was normal...was like: I *really* wouldn't want a boy near me...I was like *that* kind of
 216 thirteen year old, like [okay]...

217 Claire: So...ja...[we both laugh]

218 Sarah: um...

219 Claire: In terms of school. Anything that stood out, like any stories or any...[what at-at
220 V.G.?]...Ja...

221 Sarah: ...um...I think *mainly* like the fun things with [name omitted], especially...like...the
222 Brent fan club ...and like...going to the library and sticking horoscope stickers...like at
223 [Claire laughs] all the – on all the shelves [Claire laughs], and like: “You will meet a tall
224 dark, handsome man...Or maybe you won’t” [we both laugh]...Just things we found, like
225 *utterly* hilarious, that...[Sarah laughs] perhaps aren’t so funny now but we were like, in
226 stitches [we are both laughing]... [ja] in *pain* with laughter [ja] – at the time...um...I
227 think that’s...and I remember walking up to Art School one day after the standard eight
228 dance...ugh...the standard eight dance...[this is said with mock dread] and *that’s* a story
229 [Sarah laughs]...The standard eight dance, where [name omitted]’s cousin set us up with
230 two St. Andrew’s boys...who were... absolutely *appalling* [Claire laughs]...And we had
231 *nothing* to say to them the whole night, and it was just *dreadful* – the whole night was
232 just *so embarrassing* and dreadful...[Claire laughs]...Which did *nothing* to make me feel
233 better about boyfriends...[laughs] after that...

234 Claire: In what way was it embarrassing?

235 Sarah: ...um...we just had nothing to say to each other [Oh god...] [Sarah laughs]...They
236 weren’t very attractive either [both of us are laughing]...So we didn’t feel particularly
237 inclined to *try* and find something to talk about, so...we ended up ignoring them the
238 whole night...And then, *I* danced with [name omitted]’s partner, cos I decided that he
239 was *better* looking than *my* partner [Claire laughs], so I danced with him, and then the
240 next day at school there was this huge *scandal*...that I’d *stolen* [name omitted]’s
241 partner...[we both laugh] [Oh goodness...]...Which [name omitted] was like: “She could
242 have him if she wanted to”[we both laugh]...um...but anyway, we just found it hilarious
243 and also embarrassing. And one day me and [name omitted] were walking up to Art
244 [mm], and you know that middle field between...[yes]...where we – our digs [yes]
245 [referring to the digs in which both Sarah and I had lived during our third year of our
246 university degrees] and the top of the art school? [ja]...we were walking up there and we
247 were talking about the standard eight dance... and we...we actually – I had to sit down, I

248 collapsed with laughter, I was just like – I was *crying*...And I [Claire laughs] remember
 249 Nikki coming up behind us going: “What are you guys laughing about *now*?” [Sarah
 250 laughs] because like...I was actually unable to move, or talk, or anything [Claire
 251 laughs]...so I just remember school was a lot of laughter...I think, and...not taking them
 252 – for once in my life, I *relaxed*, I didn’t take things so seriously, I didn’t feel that if I
 253 didn’t work hard, you know [mm]...I actually adopted quite a – kind of...laid back
 254 attitude to work, like...[mm]...You know: “Whatever”. [name omitted] style... I think
 255 [name omitted] influenced me a lot in [mm] – how I thought...um...And, I think, only
 256 later did I realise that some of [name omitted]’s thinking perhaps isn’t like *so* great
 257 [Sarah laughs]...like, some of her attitudes to things aren’t like – shouldn’t particularly
 258 be copied. I don’t think I was consciously trying to copy her, I just *really* admired her
 259 [mm]...And found her really funny, and [ja]...attractive personality
 260 [ja...definitely]...and [name omitted] too, I enjoyed [name omitted] a lot...um...You
 261 know, we played squash together, I loved playing squash...um...Ja, I just had a brilliant
 262 time...

263 Claire: And um...in terms of, like loving playing squash, and then also, you know, you
 264 said about...previously you had weight issues, and stuff like that [Ja...]...um...

265 Sarah: I think the thing was that I did *so* much more exercise when I was in Grahamstown
 266 [okay]...I lost – I was *very, very* thin when I left school, I was like forty eight kilograms
 267 at one stage, which was far-far too thin...I a - o – yes, at the *beginning*, when [Sarah
 268 starts tapping the table with her fingers] I first arrived my [tapping] dad wasn’t living
 269 with us, cos [tapping occurring more often now, throughout] he stayed in Mafikeng [oh
 270 okay] for another year [tapping] [okay]...um...I got [tapping] *very, very* thin... I just
 271 wouldn’t eat, and ja...[tapping becomes more constant – almost like each tap articulates
 272 her words] that’s when I dropped to like forty eight kilograms [was that um...] I swear
 273 borderline...[...not wanting to eat? Or?]...It was just, *really* wanted to be thin, just
 274 needing to be thinner and thinner and thinner... I just...[and your behaviour around
 275 it?...] *loved* it... [I mean, did you actively, like – I mean, was it...like, were you kind
 276 of...doing everything you *possibly* could do to get thin...] ja [or...what *were* you doing,
 277 or...]... I was restricting my eating hectically. I would only eat fruit,
 278 basically...[okay]...and I’d eat supper, but only if I’d done like shit loads of

279 exercise...um...[okay...and did that make you, like a lot more aware of your
 280 body...and...].ja...I was – I’ve always been *very* aware of my body, ever since I kind
 281 of realised that I was overweight...[okay]...um...I...ja no, my - I mean my weight did
 282 fluctuate at school, even then – like the December holidays...I would tend to put on
 283 weight [mm], and I’d feel *terrible*...and I’d come back to school and start exercising and
 284 stuff, and I’d drop weight again, and then...[okay]...I *did* yo-yo a lot at school, and I
 285 did...have very bad eating patterns [okay]...um...starving – binging, starving-
 286 binging...I’ve always had those kind of problems...And I started throwing up at about
 287 the end of matric...um...[okay]...I don’t know why. At first I thought: “Well, I’m feeling
 288 *so* full, I just can’t handle this food [ja]...I’m *so* full [ja]. Let me just throw up because it
 289 will...” [ja]...”...make me feel better” [ja]. And then it just became, like an easy thing,
 290 like...But I – I kind of stopped that...um...at the end of matric...I felt that I didn’t need
 291 to do that [ja]...like, I thought: “No, okay – stop it, cos now you...you know...now it’s
 292 bulimia” [Sarah starts rubbing the table with her finger – quite hard] [okay] ...If you
 293 carry on with it [okay], then you’ve got a problem” [then wipes the table with her hand,
 294 as if wiping something off the table]...um...

295 Claire: And at that – like...around, sort of those eating habits, and stuff like that – like, I mean
 296 [draws in her breath]...um...[then sighs]...The emotions? I mean...

297 Sarah: [In a definite tone] Guilt...lots and lots of guilt...*Over-riding* sense of guilt that I couldn’t
 298 handle ... [Of what you were doing to yourself?]...um... No, of eating too
 299 much...[okay]...Every time I ate [alright] too much, I would feel *so* guilty [okay]...I’d
 300 be like: “Why can’t you control yourself?”...um...I think that’s what led to throwing
 301 up...cos I’d felt less guilty, at least if I got rid of some of it [ja]...um...just – ja...*intense*
 302 guilt...um...um...[long pause]...But also like, *so much* hunger [Sarah laughs]...like,
 303 [mm] I was just *so* hungry... *all* the time...It was just like...I’d sit there and talk about
 304 food, like...bar one’s and custard [this is said in ‘dreamy’ manner] [Claire
 305 laughs]...[name omitted] would be like: “Ja, ja, ja..” [Sarah laughs]...but...

306 Claire: And your mom and dad? Like family, were [they aware, or...

307 Sarah: They were *extremely* worried [okay]...um in standard eight, I remember...but, that was
 308 just for about a couple of months, that I was *so* bad [okay], and then I kind of levelled out
 309 again [okay]...um...decided I didn’t really need to be that thin – I was looking [ja]

310 terrible...and [ja]...you know, started like [laughs slightly]...on week-ends – say on
 311 week-ends: “You can eat whatever you want [okay], just control yourself in the week
 312 [okay]...and it will be fine” [ja]. So it - just a bit more balanced...[ja] and [ja], I put on a
 313 bit of weight, [okay] and I felt fine about it [mm]...um...And...I think my mom knew
 314 that I was ha-when I started throwing up, I think she knew, and she worried about it a
 315 lot...um...[pauses] At university too, cos in first year I did too... [mm]...um...I think she
 316 was *very, very* worried...I think um – Ja I felt very secure at the end of school, though. I
 317 felt like – you know how you do – [ja [you’re invincible...] ...definitely]...it’s like I felt
 318 a the end of fourth year [mm]...: “You’re invincible”, you know – like [takes a breath in]
 319 you did so well, you know. I ‘d done everything I wanted to be, I was a *prefect*, I was my
 320 squash captain, I’d made E.P. *squash*, I was in first team *swimming* [breathes in]... I’d
 321 got my academic *colours*, I was like [mm] – like: “You’ve done well” [ja]...okay...And
 322 then – ja, then I think getting to first year was [pauses] a shock...

323 Claire: A shock?

324 Sarah: I *loved* first year, in way, like I loved having the freedom to go out, and like get drunk
 325 [says this in a near whisper – a conspiratory tone, and laughs], ‘nd [we both
 326 laugh]...Party at the Union [Claire laughs at the manner in which Sarah says this
 327 statement – almost as if she is trying to convey how ‘cool’ we all thought it was at that
 328 time] – stuff like that. But I also found it extremely hard...[okay]...um...on an, kind of
 329 emotional level. I felt... I lost self confidence – *a lot* of self confidence I lost...um...

330 Claire: And where did that come from?

331 Sarah: [slight pause] Don’t know – I think...[pauses] ...Once again, I just – I felt...[pauses]
 332 inferior...um...And once again, also related to looks, in a lot of ways, which was so
 333 strange...[mm]...but just – you know, like obviously I had a lot of pretty friends, and I
 334 just felt that *I* wasn’t getting any attention...[okay]...and that that was quite hard for me,
 335 [mm] like – and then I thought: “Well, you’re fat, you’re ugly” [mm]...um...and then *not*
 336 doing particularly well academically in first year. Not really *trying* - but like...[mm]...
 337 not really doing that well. So kind of, relegating myself to the mediocre in every way,
 338 which...

339 Claire: And how did that feel?

340 Sarah: Well, it felt pretty shit [mm]. But I – you know, I thought: “Well, okay – that’s who I am.
 341 I’m average. So that’s fine”...But also, like just seeing all these, like, good looking guys
 342 and stuff, and [Claire laughs]...All these *girls*, and...like *really* looking up to the jocks,
 343 you know, like: “Wow...[Claire laughs], that’s *so* cool”. You know. And all these jocky
 344 chicks were so cool [mm]...Not realising that they were all the sluts, basically, you -
 345 [both of us laugh]...Getting *used*, [Claire laughs] but anyway...As you *don’t* in first
 346 year...So that was – and then, ja, like that... kind of thing with Kerr - like kissing lots of
 347 boys and stuff, it was kind of to try and make me feel better [okay]...but

348 Claire: And did it?

349 Sarah: No...not at all...[laughs] And that’s when I started like throwing up, as well...and always
 350 related in a way to...my self confidence [mm]...um...And then [sighs]...I think I found
 351 it very hard with [name omitted]...going off with Mark ja]...and kind of disappearing
 352 from my life [mm]...cos she’d been such a big part of it [mm]...that was [pauses] I felt
 353 like I’d lost something *big* ...you know, and there was nothing I could really do about
 354 it...as much as I tried...um...But I kind of got [here her voices raises slightly in volume]
 355 over that – in the end I was like...I was angry, but I was like: “Well...she’s made her
 356 choice, that’s fine. I still have other friends. I can still carry on” [mm]...and I felt stronger
 357 after that but that’s when my *admiration* of [name omitted] kind of came to an end - in
 358 certain ways. Not – no I still admire her, but...[no, no I...]...You know what I mean?
 359 [ja]...Like: “[name omitted] is totally ‘wow’, she is *perfect* in every respect”...*that’s*
 360 when it came to an end...

361 Claire: So I suppose you kind of realised – all of us have flaws...

362 Sarah: Ja... and I mean, because it was – I could *see* how [name omitted] was being exploited
 363 [here Sarah is referring to a friends relationship that had been particularly difficult and
 364 emotionally abusive] [mm]...And she wouldn’t help herself, and to me that was
 365 *weak*...and...I was angry at her about that...um...So second year
 366 [sighs]...[pause]...Second year was fun [slightly ‘tired’ tone of voice] as well ... I felt
 367 more confident in second year and stopped throwing up... uh ... [pause]... I felt a bit
 368 more *me*...Second and third year, I suppose – I’m lumping them to... [a bit more *me*?]
 369 ...gether [said almost under her breath]...[pause]...I felt like it was okay to be me, I
 370 didn’t have to be, like some stupid jock...[laughs]...You know, I could just be me...It

371 was fine [said rather absent mindedly]...And then, I think...halfway through third
 372 year...[pauses]...Oh, but tha – ja, the thing is I put on a lot of weight in second year...
 373 [okay] I got really, really big, like the biggest I'd been for a long time...and *that* didn't
 374 make me feel happy at all [mm]... I was very unhappy with that...[pause]...um...So, I
 375 think...first year up until the beginning of third year, was really like that [not completely
 376 clear of wording here], and then I started running ... with Maria [okay]...And, my whole
 377 body shape changed [mm], like I lost a lot of weight [mm]...I felt *so* much better [mm]
 378 about myself [mm]...And halfway through third year, was when – like the fruits of all of
 379 that really came together...And also, I'd done History 101, and found it really interesting
 380 [mm]...And kind of...decided I needed a calling, or a purpose, or something [here Sarah
 381 almost highlights or emphasises each word – from 'a calling...'in a staccato-like
 382 fashion]...and that the degree I was doing wasn't giving me any kind of [mm] sense of
 383 satisfaction [mm]...in any way...[ja]...So [she lingers on the word rather heavily – her
 384 voice picking up a little more volume], I kind of looked round a bit and – that was quite u
 385 - unsettling for me [suddenly her tone of voice changes, from being rather soft and
 386 steady, almost lazy, Sarah's voice suddenly shifts into a higher pitch – much louder now
 387 (almost like a crescendo in a piece of music) and almost excitable with great energy],
 388 because I'd always known, you know: 'Okay I'm gonna do HKE [Human Kinetics and
 389 Ergonomics] Honours, blah [ja] blah'. But it ...[pauses briefly] wasn't that bigger deal, it
 390 felt right that I should be, like questioning, and it felt *good*. It actually felt like I was
 391 liberating myself...

392 Claire: So, in a funny way, the first time – cos you were saying, like when you were younger,
 393 how that unsettling, sort of – that unsettledness – you were quite glad to come to
 394 Grahamstown, where it's more str [ja] uctured [ja]...And now, all of a sudden in third
 395 year – from going from structure, and then suddenly, kind of coming to a conscious
 396 decision of... going into *less* structure [ja]...And now *becoming* unsettled
 397 was...[that...[a] I felt [*good* thing for you] (this is said with emphasis and loudly) I felt
 398 great...]

399 Sarah: ...I felt absolutely wonderful [Sarah's tone of voice has now returned to a gentle, quieter
 400 tone] ...was like...I don't need to – and I felt *very, very* liberated, I was like: 'I don't

401 need to be like anybody, I can be [mm]...as'-and I started forming my *philosophies* on
 402 life...and what I believed in, and what I didn't believe in

403 Claire: And what *did* you believe in?

404 Sarah: [tone of voice becomes a little more energetic now – not as loud as previously] I believed
 405 in... humans helping humans, I believed that that is God...God is...people helping
 406 people [okay]...um...[pauses]...And I felt that that was a good thing to believe in
 407 [mm]...um... And so, I wanted to be part of that [mm]...So...that's why I decided to do
 408 Politics, it was like – 'Well it's that [here the words aren't quite clear – said under her
 409 breath] humanitarian aspect to it, so I'll do that'[mm]...[pauses] Which is great [said
 410 loudly and with emphasis, although there seems to be a hint of 'doubt']...um...I enjoyed
 411 my fourth year a lot, in terms of what I was learning – but I was a bit jealous of, like, you
 412 guys [referring to [name omitted], [name omitted] and myself – her close friends] doing
 413 Honours and stuff. I felt like I wasn't *quite*...[both laugh]...getting it, you know, like – I
 414 wasn't quite learning as much as you guys were learning, and... I wasn't quite stretching
 415 myself as much as I could of...um...and like you [referring to me, Claire] were – had
 416 really nice classes and you were tight and stuff – I didn't really get on with my class very
 417 [okay] well...And... [pauses] you know that was fine [once again said with emphasis and
 418 increased volume – the word 'fine'] – I had like lots of other friends [mm]...it wasn't
 419 such a big problem [mm]... But...[pauses]...I sometimes felt it would've been nice to
 420 have had an Honours [ja] kind of year [ja]...um...And that kind of led, to a kind of
 421 academic inferiority feeling, like I was – like ... a bit dumber, like I was a little bit of a
 422 dumb downpla – playing from everybody else [okay]...um...Which like [voice becomes
 423 louder once again], it was – it wasn't too bad [this returns back to a softer tone of
 424 voice]... And at the end of fourth year again, I felt like I was on top of the world
 425 [mhm]...like... like I'd conquered, you know, like...um...it was *such* a repetition of how
 426 I felt at the end of Matric...[pause]...you know, I felt like: 'I'm *me*'[mm], you know,
 427 'I'm strong...[mm] and...blah, blah, blah'

428 Claire: And that came with ... what – like, also you did quite well at the end of [I did quite well]

429 Sarah: ...and I met Martin [her current boyfriend], and he was like *very* complimentary about me
 430 and...just thought [okay] I was so wonderful [she says 'wonderful' very quietly, it almost
 431 seems as if she is pulling the word back into her mouth]... and... that really bolstered my

432 self confidence a lot ['a lot' also seems to be sucked back into her mouth], like *very*
 433 much... So...I was just brimming with it by the time I left [to go to the United Kingdom],
 434 you know, I was very, very happy [this is all said rather softly] [mm] ...[pauses] to go
 435 overseas...and then...[pauses]...I think the most important aspect for me...although each
 436 stage of...leaving and going onto something new, has been...*quite* traumatic for me
 437 [mm]...except for...the time I started my politics thing...[okay]... Like to me, that was
 438 *great*...but, every other time it's been *really* traumatic...[mm]...And I think going
 439 overseas was *the* most traumatic transition I've ever had...um...

440 Claire: How did that feel, I mean...when – before you left...were you quite excited about it?

441 Sarah: I was excited, I was extremely nervous, and I think that manifested in the fact that I
 442 thought my plane was going to crash...um...just *really, really*, nervous...um...

443 Claire: So once again, you have another kind of theme of instability again [ja], cos at *that* time
 444 [March 2003] the world was also quite [ja...] unstable [...I was also, like thinking: 'How
 445 can I trust the world – how do I trust these world leaders [mm] ... to protect me? [mm]
 446 When [laughs while saying 'When'] they're being such wankers [mm]...you know? ...
 447 um...[mm] Feeling very disappointed in the world order at the same time, thinking...
 448 Also thinking [here Sarah's voice picks up volume once again]: 'How can you have
 449 ideals?' You can't have ideals anymore, because...um...[pauses] ...everything gets
 450 crushed...[mm]...[Sarah sniffs – as if punctuating her point]...You can try and be a
 451 humanitarian, but you'll be actually - be playing into someone else's political cause, you
 452 know?...You can *never* just [takes a breath in] help someone else without it having, like a
 453 [... so everything's like, kind of...] motive [...political] and an agenda behind it –
 454 everything's political... And that depressed me...Well, it depressed me in a way [this is
 455 said almost as if she is now responding to her own statement – once again the volume
 456 picks up] – like, I wasn't like stricken down with grief [ja, ja] or anything [ja], but...kind
 457 of put a damper on things, 'nd it just got...[pauses and breathes in] *exaggerated* by the
 458 Iraq war [mm, mm]. It was like: 'I can't *believe* these people are actually doing this...
 459 [mm]...They're just undermining the *whole* kind of international world order
 460 that...[pauses]... was *specifically* set in place after World Ward Two to *prevent* that kind
 461 of thing...[sniffs]...And, ja...I just felt really angry ... And ja – like... you know, just the
 462 week before I fly out Tony Blair puts his army around Heathrow Airport, I'm like [mhm]

463 [Sarah laughs]... freaking out...um...[pauses briefly]...So...but uh – you know I was
 464 nervous, but... you know my family were there [in the UK] and like my aunts and uncles,
 465 so I was like: ‘No, it’ll be okay, it’ll be okay ...it’s fine’, you know...[mm]...I thought
 466 me and Martin were going to stay together, so...[sniffs]... You know, I just – and then:
 467 ‘I’m coming back in a year’ I kept telling – ‘I’m coming back in a year...there’s still –
 468 like something for me to do’[mm]...And...ahh I guess I went over there to find myself
 469 and I *lost* myself [said in such an incredulous tone of voice]... Very, very big time...[In
 470 what way? Said very quietly]...I completely lost myself...I put on a *hell* of a lot of
 471 weight again [okay]...As happens every time...um...I felt ugly...I felt inferior, I wasn’t
 472 using my brain...I felt *stupid* ...I couldn’t read – I couldn’t sit down and read [said in an
 473 ‘unbelieving’ yet slightly frustrated tone]...like – I *actually couldn’t read*...It was just,
 474 like [laughs incredulously] horrible...

475 Claire: And that was distressing for you...um

476 Sarah: It was *incredibly* distressing – the fact that I couldn’t feel comfortable enough just to sit
 477 down and read a book...um...The fact that I chose like the *worst* jobs available [worked
 478 for several months in a hotel in the Lake District. Sarah experienced this job as
 479 particularly isolatory and insular] [Claire laughs]... I don’t know if it was some kind of
 480 form of self inflicted *torture* [mm]...[pauses] ... Ja, I thought like – the reason I did the
 481 care work, was like: ‘*I’ll* be a better person because of it’ and I’m *glad* I did the care
 482 work [mm], because I think I am [mm] and I have an understanding now [mm] of people
 483 [mm]...that I didn’t have before [mm]...But... I mean it was *hard* [Sarah laughs]
 484 [mmm]...and mentally very [mm] draining – and emotionally very draining...And...

485 Claire: Was there anything from that kind of care work that you sort of ...have brought back with
 486 you that’s really, sort of – touched you, or...

487 Sarah: I think...[pauses]...When I first started the care work, I was like...actually being
 488 quadriplegic isn’t that *bad* ...you know. You can cope *pretty* well [mm] when you’re on
 489 your own...If you have a carer with you all the time [mm] and stuff [mm]...That was
 490 when I worked with Paul and Sandy...because they were such kind
 491 of...[pauses]...[clicks her tongue – it seems like a gesture of reinforcement of the thought
 492 that follows] I *liked* them as people, like we got on...

493 Claire: And they were both quadriplegic?

494 Sarah: Ja...[okay]...And Jonathan – the last guy I worked for – he was also really *nice* and *really*
 495 independent, and positive [mm] and all that kind of stuff [mm]...But...whereas with
 496 Sandy and - and Paul, I was *included* in their everyday life [okay], like I had to take them
 497 everywhere and do everything - with John, I was left at home, like all day – I basically
 498 had to get him up and put him to bed...which, you *may* think is good – because that’s like
 499 less work...[pauses]...but it was actually *really* frustrating [mm], cos I couldn’t
 500 read...[laughs]...[so there was nothing to do...we say this almost in unison] there was
 501 nothing else to do in the little town that he was in...I was stuck [mm] in a really [mm]
 502 horrible place [mm]...There wasn’t even like a Starbucks I could go and get a book and
 503 sit in, cos there was just like *nothing* – it was just this *horrible* little village [ja]...And
 504 [some words here which seem to flow into the other making it unclear what was said
 505 between ‘And’ and ‘*incredible*’] *incredible* feeling of being trapped [okay]...and just
 506 being anxious all the time, like *actually* feeling I was going to *scream* if I couldn’t get
 507 out, like about to *tear* the walls down, like I was gonna go *mad*...any moment [said a
 508 little softer]...And when I was working with him [John], that’s when I felt that actually I
 509 wouldn’t want to be a quadriplegic ever, and I became sc – really *scared* that I *was*
 510 ...like, I became to be scared of going in cars, cos I was like – all of them had been in car
 511 accidents - and I was like...:’No, we’re going to have an accident and I don’t wanna be a
 512 quadriplegic’...[mm]...um...[pauses]...And it wa - it was quite a positive feeling from
 513 the first two, but such a *negative*, like –And I came back with that fear, ‘nd like [breaths
 514 in]...[pauses] I was scared of *everything* when I came back: I didn’t want to run by
 515 myself, made Martin come running with me all the time, I um...And I only realized it
 516 when I look back now – when I came back – how depressed I actually was...umm...I
 517 made him, you know, run with me, I didn’t want to *go* anywhere by myself [mm]...I
 518 didn’t want to stay at *home* by myself [mm]...I was *terrified* of being raped...It had been
 519 the reverse before I’d gone to England...like I’d been terrified of dying in a terrorist
 520 attack...[mm] or something [mm]...And co - on coming back to South Africa, I was
 521 *terrified* again...

522 Claire: So it’s like, from broader kind of ...um...sources of possible, like...um...danger...you
 523 kind of became more focused on ... *real* sources of danger that could *really* impact you
 524 [ja] individually [ja]...Other person - by yourself...

525 Sarah: And I...ja...I just became terrified [here Sarah expresses the word terrified in a manner
 526 that suggests a sort of inward, sadness]...[pauses]...And I think that...[pauses]...when I
 527 *did* actually get sick, like physically sick...with the kidney infections [mm] that I had
 528 [mm]...um...I just never felt better after I had them...and I thought...I was gonna die
 529 [Sarah's tone of voice has a vulnerable, sad quality to it – a tone of voice that seemed to
 530 communicate the reality of 'I thought...I was gonna die']...like [here her voice fades
 531 away and the last two words are barely inaudible]

532 Claire: Okay...so just, just explore *that* one a bit...um [okay]...in terms of the, like, the kidney
 533 infections, and...[I think...]...how you felt [I - I felt that, like] about those...

534 Sarah: ...I hadn't felt...You know, when I got back, I slept for a week and a half [okay]...I think
 535 that was just – like, I just – I'd get up for like three hours and I'd have to go back to bed
 536 again...That's – I mean, that was how I emotionally exhausted I actually was, I think –
 537 like...I – I didn't realize that when I was in England, how *tired* I was...When I got back
 538 to South Africa, I couldn't keep my eyes open for over a week...

539 Claire: And the coming back to South Africa...like, the sort of, 'touch down'- the emotions
 540 associated with that, and then...

541 Sarah: I was *so* excited...[okay]...I was just – *all* I wanted to hear was: 'Ladies and gentleman
 542 we've arrived at Jo'burg International' [mm]... it was like – when he said that, I nearly
 543 cried, I was just like...[pauses]: 'I'm so happy'[okay]. I *actually* couldn't believe I
 544 was...[pauses]...in South Africa again...[pauses]...And then flying to P.E. [Port
 545 Elizabeth], I was [here she lingers on the s of 'was'] ...sitting next to this lady, and I was
 546 like [slight laugh]: 'I'm *so* happy I'm going home' [Here Sarah laughs]...

547 Claire: And Sarah, like in terms of ...um... you – okay - saying that you were so emotionally
 548 exhausted when you got back... and then, you sort of got kidney infections and [ja] stuff
 549 like that...

550 Sarah: Thing is, I *didn't* feel *well* [here Sarah really lingers on the emphasis of 'well'] the whole
 551 time I was back. After I slept for that week and a half I kid of woke up...And I *never* felt
 552 well...

553 Claire: And was there anything before you came *back* that you think could have *really* had an
 554 impact on...the way in which...you felt, like in your body, in your self...

555 Sarah: Um... I hadn't looked *after* myself particularly well...[okay]...um... I'd had a lot of
 556 constipation, I hadn't eaten lots of fruit and vegetables. I'd eaten [okay] badly basically
 557 [okay]...um...[pauses] I drank too much... [pauses] drank too much coffee, didn't do
 558 any exercise...Basically all the ingredients for feeling really
 559 rubbish...[okay]...um...[pauses]...So I thought that when I got back and I started
 560 running and stuff...you know, and eating properly [mm] and - but I found it hard to get
 561 into that, I just...didn't want to let myself [Sarah's voice sound almost incredulous, like
 562 she can't really believe that she could have found the very thing that has been central to
 563 her life, i.e., running, exercise, etc., difficult to do or 'get into']...I just wanted to slob in
 564 front of T.V. and eat chocolate and chips...[here both of us smile, both knowing what
 565 that feels like]...um...I had no kind of control over myself again...And I was, like I f -
 566 just felt *disgustingly* fat...I felt like a *blob* of note [mm]... I just *really* ... *hated* it...um...
 567 I just felt *uncomfortably big*...And...[pauses for a fairly long period]...I *never* felt
 568 well...[pauses – once again, for a fairly long time]...An' I - I don't know if it was from a
 569 year of eating nothing but rubbish [mm]...but ...um...I mean I wasn't actually ever sick
 570 [Here, Sarah raises her voice] in the UK – I was in perfect health [mm] the whole time
 571 while I was there [mm]...I never even felt remotely ill...didn't have to go to the doctor,
 572 or anything...[okay]...It was just after I – it was *when* I came back I just suddenly didn't
 573 feel well...Like, I didn't feel *good*...It was strange for me, because...I usually do feel
 574 fine...um...And then I actually *really* got sick [kidney infections]...again and
 575 again...three times [mm]...And then *bad* reactions to the antibiotics [mm], which *really*
 576 frightened me – like I'd *never* had reactions like [mm] that to [mm]... You know,
 577 *dizziness* and *sore* eyes and vomiting and...that's frightening [mm] when
 578 you...um...[takes a breath in] And then... the – then the doctor said: 'Well, you don't
 579 have any infections anymore, you're fine', you know? And I was ...[said almost under
 580 her breath – quietly]

581 Claire: So you went, you clearly had a problem, you went to him [ja], and he said [I went to him
 582 and...]

583 Sarah: ...and he said: 'Okay well, you've got – you've probably – because you're constipated
 584 and stuff, that's what's been causing the repeat infections, so you need to eat properly and
 585 exercise' [takes a breath in] I was too scared to exercise...[here Sarah's tone of voice

586 seems to indicate towards a frustrated, or disbelieving sadness towards something that
587 has been such an integral part of her life]

588 Claire: Why were you too scared to ex [I was] ercise?

589 Sarah: ...s-scared to use my body, I was terrified of my body, because I think of all the reactions
590 that I've been having [notice how Sarah shifts into the present
591 tense]...um...[pauses]...The [here Sarah lingers on the word]...[pauses for a fairly long
592 time]...The um [here Sarah's tone of voice seems pregnant with an over-riding sense of
593 sadness, as if she is about to cry]...Like I think I'd gone running the morning that I had
594 the bad reaction to the antibiotics [okay]...And I just felt *so* awful
595 afterwards...And...[pauses]...Then another time I'd gone running, but I'd been sick
596 [mm] – it was just before I'd had my kidney infection [mm], and I felt *so* dreadful
597 afterwards [mm] as well...I *actually* didn't want to use my body at *all*...in any way...any
598 kind of exercise...[mm]...I just s – wanted to...[pauses]...just keep quiet – like not
599 disturb it [her body] so that it didn't *do* anything horrible to me [here she smiles]...you
600 know...

601 Claire: Did you feel like you were separated from your [Ja...completely] body?

602 Sarah: Like... 'Why is it making me feel so shit [she laughs wryly as she says this]', you
603 know...like [So it's...]

604 Claire: ...kind of like this sort of distant relation... [Ja (said with force)] ...ship from it

605 Sarah: ...And like a *really horrible* one...Because...I've always had that distant relationship in a
606 way [here Sarah voice raises somewhat] [ja] to my body with like the eating problems
607 [ja] and stuff [her voice returns back to a softer tone of voice]. So it's always been like
608 [mm]: '*God*, it's so ugly', you know...[pauses]...'Do something about it'...um...And...

609 Claire: And in this situation – from what you've said before. You said how...when you felt that
610 you were too fat, you could go and you could restrict your eating and stuff like *that*, and
611 now you have these kind of reactions in your body...[mm]...Like the symptoms, like you
612 were saying [mm]...dizziness, and...nausea...and [ja] stuff like that...And people were
613 saying to you: 'Well...there *is* nothing...' [And...]...So then...

614 Sarah: Ja, there was nothing I could do to stop it. Because, like usually if you're feeling sick you
615 can *take* something [ja]...to cure you [ja]...There was an *unknown* thing happening to
616 me, and that *frightened* the hell out of me – I was like [okay]: 'Well, if it's unknown it

617 must be *bad*. It must be *really bad*, in fact it must be...*a brain tumour*' [here Sarah
 618 laughs. This is said in an exaggerated fashion in order to emphasise how 'exaggerated'
 619 Sarah's fears concerning this '*unknown thing*' were at the time], you know. And that's
 620 the kind of thinking that...took me on to this...like *unbelievable* bout of
 621 hypochondria...um...which, I don't know if it was hypochondria, because I *was* feeling
 622 *so* shit, I was feeling *terrible*...I felt...[Explain how you felt...]..And I was *angry* with
 623 my body [Sarah's tone of voice throughout is fairly loud and 'energetic' here] [okay]...I
 624 felt *nauseas*, I felt *tired*, I had *headaches*, I had this *crushing* pressure...[pauses] On the
 625 *back* of my head and on the *top* of my head, like it would just *crush* me, I couldn't
 626 actually *talk* cos it was so crushing [mm]...And that like...immediately I thought 'brain
 627 tumour', you know [here she laughs wryly again]...um...

628 Claire: And you – you didn't think that in jest, it was like seriously [No (said very definitely and
 629 with emphasis in an almost 'uptight' manner – an uptight manner that is directed towards
 630 the experience and her anger towards her body at the time)...for sure...] You thought...

631 Sarah: ...like I was *convinced*. I *mean* you don't get that crushing pressure in your head...and its
 632 *nothing*, you know [ja]...like...I was *convinced* that there was no simple explanation to
 633 what I was feeling, and – and then I had this *sore* back, and...*sore* stomach,
 634 and...um...[pauses]...Ja, I just felt – I *cried*, it was just crying all the time, like... just
 635 wanted to hide, like – going to sleep was my favourite thing – I just wanted to hide
 636 away...[mm]...um...I didn't want to *see* anybody, I just wanted *someone* to tell me what
 637 was wrong with me so that I could take a pill and it would go away. And I was *angry*
 638 with my body, *so* angry with my...[here she seems to swallow her words slightly, they
 639 almost seem to disappear as if being sucked back into her body]...It was like: '*Why*...[
 640 And just explore that one a bit] are you making...'

641 Sarah: No! [This does not refer to her not wanting to explore her anger or a resistance towards
 642 her interviewer – ultimately she immediately gets into or feels her anger towards her
 643 body with her explanation 'No!'] Just: '*Why* are you making me feel *so* horrible', you
 644 know [mm]...And especially as I was about to start my Masters with a *really exciting*
 645 project [mm], *really* wanting to get into things and I *just felt* [here she says 'just felt' in
 646 an almost staccato manner, which seems to highlight how tiring she found her 'illness'
 647 experience] *so* terrible...I *couldn't even move*, I didn't want to *see* [Sarah draws this word

648 out lingering on it for a while – emphasising it] anybody, I just *couldn't* do
 649 anything...[pauses] [Sarah clicks her tongue against her teeth]...And I was *afraid* [here
 650 she emphasises the word by saying it somewhat louder than the rest of the sentence on
 651 either side of the word] to move, because if I *moved* I'd feel *sick*...um...My *back* would
 652 start hurting [mm] and when my *back* started hurting I got all *panicked* ...I'd have these
 653 *panic* attacks, and...um...which brought on *dizziness* and shortness of *breath*...

654 Claire: And your thoughts around those panic attacks?

655 Sarah: 'I'm gonna *die*...like this – there is *something* here which is killing me 'nd I am in the
 656 process of dying' ...[pauses]...[okay]...um...

657 Claire: And you have no control over it...[I have...] ...or [...absolutely no con...]

658 Sarah: ...I have no control over anything... I... can do nothing...um... Obviously something
 659 really bad is happening to me [this becomes progressively less audible – i.e., 'is
 660 happening to me' – it seems to gradually evaporate until the words become like empty
 661 traces]...And I – it was just like the most... [pauses]...And I was so *jealous* of
 662 people...such a feeling of...being distanced from people, like going to the Rat [a local
 663 pub] and...like having a drink and looking at people, thinking: [takes a breath in] 'I wish
 664 I could just feel normal like they're feeling right now', [mm] you know...[Claire takes a
 665 very deep and long in breath here through her nose – this is fairly important, as this is
 666 something that Claire experiences in her own life at times]...'I *wish* I could just *feel* like
 667 them...[mm]...They all look *happy* and normal. Why am I so – in such a – Why am I so
 668 *unlucky* that I have to feel like this?' ...

669 Claire: And your relationships at the time...like...

670 Sarah: No, like...my parents were very good and my brother as well, you know I think they were
 671 very kind of like: 'We'll find out what's wrong with you, don't worry'. But they didn't
 672 *know* what was wrong with me either [here the wry laugh returns]...so...But my
 673 relationship with my boyfriend got quite bad...um...I go –became *very* suspicious and
 674 very *paranoid* about things, I was convinced he was going to leave me...I was convinced
 675 he didn't want anything to do with me...um...Convinced he was having an affairs behind
 676 my back [smiles]...um...Ja, just worried all the time, that he was gonna leave
 677 me...[okay]... um...Just to go with the- the whole self confidence issue, I
 678 think...[mm]...which was going down the tube [here Sarah's voice is fairly soft]...And

679 then [sighs]...I went to the doctor's office one day – I'd been to two
 680 specialists...Gynaecologist...um...a Urologist...I'd had two sets of blood
 681 tests...and...nothing had come up. The blood tests had tested for everything: cancer, any
 682 kind of serious disease...there was nothing...So [here she lingers on the word]...the
 683 doctor said to me: 'There's nothing wrong with you, go home, you're okay' ...and I said:
 684 'No, [here Sarah starts to laugh half heartedly] I'm not. I'm feeling so terrible' ...like:
 685 'What is wrong with me?'...And he said: 'I think you – I think...', you know, he referred
 686 me to a psychologist, he was like: 'I really think that you're depressed' [here Sarah's
 687 voice lowers]...and prescribed antidepressants for me...

688 Claire: And in that moment, how did that feel...With him prescri – saying to you: 'I think that
 689 this is *more* than just physical'...

690 Sarah: That felt...actually quite good...[okay]...um...because I felt that – Although [here her
 691 voice raises once again] it didn't explain all the individual symptoms, you know – the
 692 *pressure*, the *sore stomach*, the *aches* and *pains*. It felt like...'Actually that could be a
 693 plausible explanation' [okay]...And...[pauses]...you know, it turned out the nausea was
 694 like – I'd got myself into such a state that I had a spastic colon, which was just making
 695 me feel dreadful...[mm]...the only *plus* side was that was when I lost all the weight I put
 696 on overseas [laughs], so – which has left me feeling great now [this is said fairly loudly],
 697 but like [mm mm]... I felt really terrible then...[okay]...um...And...the pressure was
 698 from the fact that my *muscles* in my back had formed such tight... *knots*...that they...
 699 were actually fused into knots [mm] in my shoulders [mm] and that was all up my neck
 700 and causing...the pressure [sjo] feelings around my head [ja]...And...the *back* pain was
 701 the spastic colon, and...it was *all* related to my mental processes basically, every – but, I
 702 mean the fact was that these were real things that were happening to my body, you know,
 703 I wasn't *imagining* them or anything like that [mm]...And...[pauses] it ja – I mean – but
 704 it all came from my mental state...that...And I just couldn't believe that – cos of the
 705 way... I was feeling *mentally* that I could feel – my *body* could actually feel so
 706 terrible...I just felt that so hard to, kind of...*grasp*...Until I started actually,
 707 like...physically, I mean...*Actively* taking my life back to, like – back – in control of my
 708 life...um...

709 Claire: When you say: 'Taking your life back...?'

710 Sarah: I decided to do something [okay] cos now I felt – if it was *depression* or something like
 711 that, then I could actively go out and do something [mm], whereas before I'd been
 712 convinced it was like...[pauses]...deadly, you know. There was nothing I could
 713 do...[okay]...Um...And that made me feel a lot better, you know. Then I started,
 714 like...antidepressants, psychotherapy, and a whole lot of alternative therapies as
 715 well...And...[pauses]...

716 Claire: Did the symptoms clear up, or they still sort of, like...

717 Sarah: They still come back...um...I'm feeling a lot better *now* [okay]...But I still... feel
 718 nausea...[pauses]... um... [pauses and sighs deeply]...I still have that pressure feeling
 719 sometimes – my neck is still...[pauses]...And ja, sometimes I feel really
 720 overwhelmed...[pauses]...Still...[pauses]...But...[pauses]...Since I've – I kind of hit a
 721 ...[pauses]... turn in the road, a couple of weeks ago. I woke up one day feeling quite
 722 normal [mm]...which was the nicest feeling [laughs in a manner that conveys relief]...I
 723 hadn't felt normal, for like seven months [still a hint of a laugh]...[ja]...um...

724 Claire: And that feeling of – just define feeling normal...[I say something here which is
 725 inaudible amidst the sound of rustling paper]

726 Sarah: [Here the volume of her voice rises once again] Waking up being able to slob through to
 727 the kitchen and make a cup of coffee without the thought of a cup of coffee... *churning*
 728 my stomach [okay]...um...[pauses] Just enjoy the day, like look out my window and say:
 729 'Oh my god, what a *beautiful* day' [mm]...Like that was *such* an amazing thing for me,
 730 because usually I'd be like: 'Oh, mm whatever'...um... 'Not very interesting'
 731 [mm]...Nothing was very interesting...and...um...[pauses]...Actually, like interacting
 732 with people without having my mind being – with my - out my mind being a million
 733 miles away [ja]...as to like my next chemotherapy...You know like [here she laughs]
 734 [okay, alright]...when I was going to have to start chemotherapy [ja] or something like
 735 that [ja]...um...

736 Claire: So almost like just being *present*

737 Sarah: Ja [said very loudly]...just being in myself [smiles with a hint of a laugh], as opposed to
 738 being a million miles away [ja]...um...And its so funny, because two people have said to
 739 me: 'Wow, you're so much more in yourself than the last time I saw you'
 740 ...[pauses]... Which is true, like... I wasn't in myself at all [this is said with a laugh that

741 communicates a sense of wryness, or perhaps dryness]...it was, I was...*very* not part of
 742 myself...um...And through the process of actually doing things - like I'd taken control of
 743 my body again - the only thing was that the antidepressants... made me shake [this is
 744 said rather slowly, almost as if she is being cautious], and they still make me shaky a bit
 745 [okay]...And twitchy...um...which made me think I had Mad Cow Disease ...[Sarah
 746 laughs]...But ja, seriously, like *definitely* Mad Cow Disease, which [takes a breath
 747 in]...[pauses]...was really bad for a bit, because [ja] with *really* [ja] bad shakes [ja] I
 748 was: 'Oh my God, it's Mad Cow Disease'. But now, I've kind of...I'm feeling better and
 749 I *went* to the doctor the other day and he said: 'Shakes and twitches are...*very* much a
 750 part of being on antidepressants'...[okay]...um... 'Please don't worry. You're okay'...

751 Claire: And your experience of the doctors? Like – different ones...your exp...[um]...periences in
 752 the medical kind of field...

753 Sarah: I think the only... *doctor*, medical doctor who kind of knew the whole story was Dr. *
 754 ...[pauses]...um...The other doctors I went to were – they didn't know the whole mental
 755 – they just knew they had, like check me out [okay]...um...*He* [Dr. *] was very
 756 sympathetic actually...At one stage – I think after the third infection [kidney
 757 infection]...and I was still feeling so terrible [mm]...I came in and I basically broke
 758 down in his office, I was like: 'I just can't carry on like this'...And he was very, very
 759 sympathetic, and said: '*Don't* worry, we'll find what's wrong with you. We'll *turn* you
 760 inside out'...And he booked a *whole* lot of appointments for me *right* then and
 761 there...um...*Made sure* when my blood tests came back, he said – explained the *whole*
 762 thing to me...um...'There's *no* cancer, there's no serious disease...', you
 763 know...[mm]...'...this - *this* shows you this, *this* shows you that', you know...

764 Claire: And being shown those things, did that make [That made *me*...] feel better?

765 Sarah: ...feel better...ja...made me feel that [takes a quick breath in]...um...[pauses]... I think
 766 he was a good doctor, in that I think he realised I was depressed quite early on...um... He
 767 didn't *actually* say it to me...[pauses] I kind of went to him saying: 'Maybe it's a mental
 768 thing. I'm not sure'...He *mentioned* it to my mom. She kind of mentioned it to me and...
 769 [here one or two words are unclear]...*I* went to him and said: 'Well maybe it is'
 770 [mm]...um...[pauses]...And he was very sympathetic about the whole thing...um...Sat
 771 me down and gave me a good talk about – that the antidepressants were only forty

772 percent of the way, that the other sixty percent came from myself [mm] – sorting myself
 773 out [mm]...um...[pauses]...And I'm actually very grateful to him, cos he was very
 774 comforting...[that's good]...mm...[pauses]...I – I didn't come across – he didn't come
 775 across as like – [ja]... Writing me off...[pauses] at all...he was compassionate...[long
 776 pauses – almost like a 'therapeutic' silence]

777 Claire: Okay...Anything else that you want to say...

778 Sarah: No...I don't think so [this is said very quietly]...

779 Claire: There's just a few questions that I just saw on – there's a... list of questions that they
 780 [Qualitative methodology books, for e.g., Atkinson (1998) to be specific] give you, often,
 781 to ask [okay]. And I just thought there'd be a nice few ones that I could...look
 782 at...um...[pauses]...In terms of, like your – kind of, you know you've – you've
 783 experienced... a lot of your life you've had these moments of instability and often it's
 784 been surrounded around your kind of, like – your sense of self and parts of your - aspects
 785 of your self...[mm]...um...like...In what sort of areas...would you see yourself as being
 786 quite strong...I mean...

787 Sarah: Um...

788 Claire: As being able to, ja – as being strong...or

789 Sarah: What do you mean – what kind of areas?

790 Claire: Like...In amongst this kind of *feeling* of instability you've often had – you've had
 791 methods, obviously, of being able to restrict things, or ...[mm]...try and improve things
 792 [takes a breath]...um...

793

794 Sarah: I think that that is a strength in that I can pull myself up out of it [okay]...and that I
 795 *realise* [okay]...I – I always realise when I'm sinking...I always *know* when it's
 796 happening [mm]... I think *this* time was *different* because it was so intermingled with the
 797 physical... stuff that it was *hard* for me to realise [mm] that it was a mental thing, but
 798 *both* the other times...I *have* managed to pull myself up out of it and...um...by
 799 *narrowing* down things...By setting...timetables, by setting structure, putting structure in
 800 my life...[mm]...you know...Make sure I run four times a week... make
 801 sure...[pauses]...you only eat this much in a week, and you eat whatever you want on
 802 Saturday's and Sunday's...um...Just having rigid...[okay]...*certain* rigid [ja, ja]... You –

803 you can *only* drink on Friday's, you know...um...[pauses]...sort of rigid
 804 patterns...[okay]...um, which [pauses]...gave my life some kind of
 805 structure...[mm]...and meaning [mm] and things [this word is not entirely clear – sounds
 806 like 'things']...[pauses]...And also by thinking a lot...um...In terms of...what my life
 807 means...and where I fit in...um... and...through not having a religion or anything like
 808 that it's – it's been quite hard...um...but I *have* managed to do it...[takes a breath
 809 in]...And...I'm slowly regaining that now with the studies that I'm doing at the moment,
 810 which is *why* I love studying so much, because...[pauses]...It opens you up... to more
 811 kind of thoughts, which help *you* in the end...so...

812 Claire: And religion?

813 Sarah: I don't know about religion... um... I have a thing against any kind of institutionalized
 814 religion, that kind of trend...[okay]...But, I *am* drawn [here her voice raises in volume]
 815 to kind of like...more spiritual, Eastern religions, like...I would find those fascinating,
 816 but I don't know if I could believe in them fully [here her voice lowers once
 817 again]...[mm]...God [this is in response to the very loud chirping of a bird]...um... I
 818 remember I - having a very Christian library teacher in standard five, who I really liked
 819 though – she was very nice ... And the thought had just occurred to me in standard five:
 820 'What does my life mean? [laughs]', you know...'I don't believe in God', so what did
 821 my life mean... and... I asked her and she told me *not* to ask such questions, because...
 822 *those* kind of questions lead to *suicide* ...[takes a very definite sniff through her nose,
 823 almost as if she is punctuating her statement]...Your life is for *God* ...[laughs]... So I
 824 was like: 'Well, in that case what does my life *mean*?' [here we both laugh for a
 825 while]...[pauses]...So, I don't know – I find religion breeds narrowness [okay]...so
 826 many ways, ja... [okay]...

827 Claire: Um...[pauses]... So... just in terms of like...[pause] giving some sort of completion or
 828 coming to a sort of closure...*What* um...[pauses]...okay...What are some of the things
 829 that you hope that you would never forget, or that have been most kind of
 830 like...[pauses]...*Anything* about your life...

831 Sarah: I think...*especially* reaching...[pauses]... a stage of humility...and not reali – not
 832 thinking that you're just invincible...[okay]...um...[pauses]...Finding more empathy and
 833 compassion for people through it...you know, not just *writing* depressed people off as...

834 'loonies' who can't get it together [so it's like a kind of empathy as
 835 well...[ja]...through...]...I mean, that was... *kind* of my attitude – was like, well not
 836 *really*, but like [sniffs]...I *found* it *hard* to empathise with someone who was depressed
 837 [mm]...because it was like [laughs]: 'Well then sort yourself out', you know
 838 [mm]...'What's your problem' [mm mm]...[takes a breath in]...Which was *weird* for
 839 someone whose had depressive tendencies her whole life, but um...[pauses and smacks
 840 her tongue against her teeth]...Ja...just wanting to distance... you know, I'd like to feel
 841 that now that I've been through lots – a *really* horrible stage...that I've come out of it
 842 knowing how to deal with myself better...and...feeling stronger, and...*not* forgetting
 843 that...not forgetting how *awful* it feels...[pauses]...mm

844 Claire: And so then, along that train of thought: *What* would make you feel – like *what* makes
 845 you feel alive now, like sort of...What really gives you that sense of purpose in your life?

846 Sarah: I think... at the moment: studying [okay]...because *really*, you know like I've just done
 847 some amazing theories which I just find...[sighs quite deeply and pauses]...you know,
 848 like the resurgent of idealism in a way [mm]...which I think [mm] is so brilliant...And
 849 my *class* are like that as well. They're a bunch of bloody [laughs]...like *idealists*
 850 basically [here we both laugh] and ...We *sit* around [here her voice raises noticeably in
 851 volume], you know, going on about *revolutions* and [mm] *knowing* that...[sniffs], you
 852 know it's probably impossible [here her voice lowers again] 'nd... You know the one guy
 853 [her voice raises again in volume] who wants to go off and work in the *Congo* – he's
 854 doing this theses on child soldiers and he wants to go to Kinshasa [mm] and interview
 855 them [mm]...[smacks her tongue against her teeth]...And *he's a total* – like, he's the
 856 American boy - he's like *total* idealist, you know...and *Tracey** as well – we're all
 857 like...bring back idealism [laughs]...[takes a breath in]...Which makes me feel good, it
 858 makes me feel like people understand where I'm coming from
 859 and...um...[pauses]...Makes me feel like I can have ideals again...which I think I'd kind
 860 of thrown away, as in like: 'Well, the world's a pretty shitty place' [note her tone of voice
 861 here]

862 Claire: So *were* you an idealist beforehand, and then...

863 Sarah: I wanted to be...very much [okay]... I *was* an idealist for a bit... and then I kind of, like –
 864 realism hit in [okay]...It got really bad [mm]...and...I've just [the volume of Sarah's

865 voice raises once again] been reading theories now that have been like...[pauses]...You
866 know that there *are* actually people... who...still want to *fight* for something
867 [mm]...That's better [mm]...Even if it is hard...[mm]...it doesn't mean that you
868 shouldn't have them...[pauses]...So... I don't know [voice raises again] it just feels good
869 – that... at the moment...has given me...a *great* amount of oomph – 's just to think
870 that...[sniffs]...You know, that we can actually...have those kind of things...Made me
871 feel a *lot* better...[mm]...Which is great...um...ja...We're doing postmodernism at the
872 moment, but ...[sniffs again] [we both laugh]...

873 Claire: How does postmod – does postmodernism [laughs]...

874 Sarah: 'There's no reality' [said in an almost childlike voice] [here we both
875 laugh]...ja...Postmodernism depresses me...I like to think that there is some structure in
876 my life...[pauses and then laughs]...ja...I don't know...[pauses]...'s... quite funny, you
877 know that Sockal affair – that Allen Sockal? [no]...The American physicist? [no]...He
878 wrote a...thing called: 'Towards a transformative hermeneutics' – something about... the
879 theory of gravity [okay] and you submitted it to a postmodernist...journal [yes]...and
880 they accepted it, and published it...And it was a load of crap. He'd basically written –
881 just put together a whole lot of jargon [yes, I've heard about these]...and published it and
882 um...just to show that like, you know [Claire laughs]...whatever ... [here we both laugh]
883 and...I mean obviously it sparked off a war between like the postmodernists and the kind
884 of objective realists, and stuff [Sarah sniffs]...and he said ...um...:'If anybody thinks
885 reality is socially constructed they can come and jump out of my twelve storey office
886 [here we both laugh]'...Which I thought was quite funny [we
887 laugh]...hmm...um...ja...that's about [Thank you...] it...

888 Claire: Thanks very much...I really appreciate this...

JENNA'S LIFE STORY

1
2 Well, bet that you thought you'd never get this. Was hard to write some of
3 the parts of it, but was cleansing over all.
4 Sorry that I procrastinated so horribly over it, I am sure that something
5 subconscious was probably at work there.
6 To answer your questions.
7 I I wrote it because I wanted to help. I always want to help, to make my
8 experiences meanful to me. I had student nurses attend both of my
9 pregnancies so that they could get the exposure that they needed and have
10 always been a willing guinea pig. I guess that a part of me defines my worth
11 in how much I can help other people, and this is just another way to do
12 that.

13 2 Reflecting on it was a little eye opening, as it tends to be when I try
14 and explain things to people. It is really hard to summarize all the stuff I
15 have been through in a neat way. All of it intertwines in such a mess.
16 Looking over all of it is a bit validating, in the way that if I was reading
17 this about somebody else I would feel for them, so I should have a little
18 pity for myself too and stop beating myself over the head this much.
19

20 SCHOOL

21 My earliest years I remember being shy, but happy. I played well with other children, and
22 was generally a happy child, though I would easily burst into tears if my feelings were hurt, I
23 would calm down quickly and move on. When I started going to school things began to change
24 at about second grade. My mother was not very careful about making sure that I dressed
25 appropriately or brushed my hair before I went to school, and so if my father was away at work, I
26 often went in mismatched torn clothes. I had nice clothes – I guess those just happened to be the
27 first things that I laid eyes on so on they went. I was pretty tomboyish so practical clothes were
28 the thing.

29 Whatever the reason, I became an easy target, and was soon excluded from most play and
30 activities, though I had a few friends. This worsened over the years, and combined with self
31 doubt and easy to trigger crying outbursts became a self perpetuating circle. I never really felt

32 that I belonged, or was equal to my peers, and I put a lot of pressure on myself when placed in
33 group settings. Adults seemed to be my only outlet, but I was not supported totally by them
34 either, as it is impossible to have an equal relationship with such an age gap.

35 When I left elementary school for junior high I remember feeling quite excited, relieved that I
36 would be leaving the teasing and exclusion behind, eager for a fresh start. These were to become
37 my worst years, as several boys ganged together and would actively pursue me, kicking at me to
38 make me trip when I wasn't looking, body checking me into lockers or walls and other physical
39 as well as mental abuse. Some of the girls were verbally taunting as well, but mainly they just
40 excluded me in that nasty way that girls do. I felt desperate to fit in somewhere, and spent a lot of
41 time volunteering in the library and cafeteria. It was the only place that I fit, and was also free of
42 the bullying. Though I had a few friends I was not particularly close to any of them. One friend
43 gained another friend who though nice to me in the beginning borrowed items and money from
44 me and then turned nasty when I refused to lend her anymore. Her and my friend ended up
45 kicking me while I was sitting down reading one afternoon. I felt horribly betrayed and like I was
46 the party at fault. I was quite the geek/nerd type, reading quite a lot and being nice to teachers
47 ect – not the rebelling behavior which seemed to be the norm for that age group. The boys finally
48 stopped hitting me when I started to fight back in grade 10. Kicked a few of them where it did
49 the most good and eventually confronted one main aggressor with a threat in front of a large
50 group of people to fight him fair and square so he would leave me alone. It felt good to stand up
51 for myself, and I found myself doing it more often, but was still plagued by the feelings of
52 unworthiness and whatnot that came with the bullying.

53 I didn't hold out much hope for high school when I entered it, but to my surprise my peers
54 didn't tolerate bullying like they had at the junior high. Not that people usually stood up for me,
55 but that it was just quietly frowned upon as juvenile behavior. The bullying continued a bit, but
56 more with exclusion than with the in your face name-calling. I found a niche and a group of
57 friends that I fit in with and gained more confidence in myself and my abilities, though I still had
58 very low self esteem. I started to find my skill in areas that I enjoyed in school as well and ended
59 up graduating with honors. I had a boy express interest in me in grade 12, and was so amazed
60 that someone actually liked me, I wouldn't have dreamed of saying no to a date. Though he was
61 not my type, he was not a bad guy, but we didn't really have the same goals in life (he didn't
62 have any interest in ever marrying and having children and I did). We were also quite different in

63 interests and other things too, so after 7 months I ended the relationship. It was horrid hurting
64 him like that, and I still feel guilty after all these years as I don't think that he has ever totally
65 forgiven me.

66 In college I was more confident, but still didn't have a lot of skills for interacting with peers. I
67 was never "cool". In the first week of school a guy approached me and I was again shocked and
68 honored that someone could be interested in me, so again went into dating. This didn't jive so
69 well as I was at a real low, having just broken up with my first boyfriend and I didn't feel very
70 confident, and so was seeking outside support unknowingly. School went all right, and I did do
71 well, but emotionally I was crumbling. He first started by some "harmless" comments as to that I
72 wasn't so good at this, or could do that better. He wanted me with him always and didn't want
73 me to hang around with my friends. This grew into outright verbal abuse, putting me down
74 constantly, and eventually rape. Though I never fought him, I didn't want to participate and felt
75 horribly violated but helpless. When in the second year of college I entered into the program that
76 I had been striving for and was overjoyed he was not, as the program took a lot of my time. After
77 spending long hours in the program I then would go up to his place, and as he boarded at a home,
78 rarely ate supper as I didn't want to infringe on the ladies place by bringing meals that I could
79 prepare. So I often didn't eat until 10 or 11 at night. My parents were not supportive of the
80 relationship, but rather than feeling supported into ending it, it made me feel more like I was
81 failing. By the end of the first semester I had been seeking out my friends more and began to
82 think about ending the relationship. On new years eve I went over to a friends home to celebrate
83 and he came back from his parents home early to surprise me. I was horridly disappointed as I
84 couldn't relax and enjoy my friends company – had to constantly be at his side. He insisted that I
85 drive him home shortly after midnight and he wanted me to go into the house with him to have
86 sex. When I refused he was very angry. The next day when I went over we had an argument and
87 he ended up hitting me (it was the second time) I asked him if he could ever promise not to hit
88 me again and he said no, that I made him so angry sometimes that was what happened. It was the
89 excuse that I needed to leave him. The only thing that I regret was not speaking to the police or
90 to his parents (his dad was a physiologist) or something as I feel like I left other vulnerable
91 women unprotected against him.

92 The program continued on and I enjoyed it, but it was high stress and very demanding. I was
93 friendly with the people in it, but didn't socialize with any of them out of school. I still didn't

94 really feel accepted, though I tried hard. But it was a good functioning work relationship with
95 them. I became more confident and spent a lot more time with my friends, and did more things
96 that interested me. I felt so relieved after ending the relationship that I could make the decisions
97 for me. Though I didn't enjoy drinking, and very seldom had the odd drink, I went every
98 Saturday out to the bar with my friends to dance, which I loved to do. It was there that I met my
99 future husband, though I wasn't looking for a serious relationship at the time. I felt liberated and
100 the most confident that I had ever been, and as the successes in school continued and I was able
101 to realize my dream of becoming an Animal Health Tech I was quite happy.

102

103 FAMILY

104

105 What I remember of my childhood is more vague in spots where I had difficulties. I remember
106 my mother as not being precisely a bad mother, but not being there for us much either. I now
107 know that she had issues and problems of her own that she was trying to resolve. I had a younger
108 sister who in later years I ended up tormenting quite a bit. I would tease her by not letting her
109 past areas or tickling her or holding things out of reach. Nice sibling stuff. I guess that it was a
110 way of me trying to feel superior over someone as I felt so inadequate.

111 My father was the one who I always sought for attention and love. I would become despondent
112 if I discovered that he had left overnight for work for a week or more. He was always so loving
113 and great to play with. Always a wonderful Dad.

114 When I was about 8 yrs old, a good friend of the family and her daughter moved in with us
115 temporarily, as she was moving from Vancouver island and needed a place to stay. She was
116 much stricter than my mother, and at first we welcomed that support and guidance and structure
117 that she provided. The house was clean, the beds were to be made so on so forth. We were a
118 middle class family and now we looked the part.

119 One day I came home from school and my parents asked my sister and I to sit down. They then
120 told us that they were getting a divorce and that my mom would be leaving that day. I remember
121 watching my mom load up the van with a feeling of disbelief. I did not see her for two years after
122 she left. I can remember feeling guilty because I couldn't remember exactly what she looked like
123 or sounded like.

124 So the family friend just stayed. She and my father married a year or so later. I now had an
125 older sister who was extremely popular, pretty and talented. I was a little thorn in her butt of
126 embarrassment, though she didn't treat me all that badly, I embarrassed her with my presence.

127 At first it was wonderful having my new step mom. She was so put together and supportive.
128 Unfortunately we think completely different. When I did things a certain way she would correct
129 me to her way, even if they came to the same result, with the same amount of time or energy. In
130 puberty I began to resent her strictness (well what teen doesn't) and was resentful of my fathers
131 whole hearted support of her.

132 My father fell when I was about 10 yrs old, and struck his head against a metal train car in the
133 middle of the night. As no one saw him do this he eventually got up on his own and went to bed.
134 The next morning he was very ill and so they sent him to a hospital which misdiagnosed him. No
135 one realized he had fell. So they sent him home on a plane. He went into the hospital here the
136 next day at my step mothers instance and spent a week there. He had fractured his skull nearly in
137 half and had a lot of brain damage. The next year was spent in a lot of rehab, and with
138 workman's compensation board trying to get a settlement. Eventually he received a pension, as
139 he is unable to work as his balance is very unsteady, he has constant migraine grade headaches
140 and cannot taste or smell. It was hard adjusting to the "new" dad, who was not as patient as he
141 had been in the past and who we could not wrestle with like we once had.

142 I was an extremely gawky tall and thin young teen. Despite the fact that I ate like a horse all it
143 did was shoot me up taller. I wasn't consciously trying to gain weight, just had a big appetite. I
144 also had eye glasses, and was very clumsy. I was also one of the youngest in my class. All of this
145 combined to make me feel physically unattractive.

146 We had some wonderful family friends that were great. Among them were the Parkes, that
147 would take us to their cabin on the lake all the time. I have always felt wonderfully comforted by
148 this family.

149 As the years went on the tension between me and my step mother increased. We fought almost
150 daily. Though I was not a "problem child" – I did my chores, did well in school and did not do
151 "bad" things such as stay out late, destroy property, steal things or other typical naughty behavior
152 I was rebellious and would spend hours in my room by myself. I was pretty disrespectful in a
153 subtle way – for instance I would never dream of swearing at my parent, or near them for that
154 matter, I was not happy with her authority and I made that clear.

155 My step mom began telling me that I was to call my mom Barb and her mom. She said that my
156 mom didn't love me. I was scared to spend time with my mom as I felt that I was unloved, and
157 therefore clung to my step mom more, which is what she wanted, the security in knowing that
158 she was loved. I once was playing with a child that I didn't know and had just met on vacation
159 and when I referred to my step mom as "mom" she made a comment that she didn't look much
160 like me (I am nearly 6 feet tall, my step mom is 4' 9") and I said that she wasn't my real mom.
161 My step mom overheard and I got in big trouble for saying that. She was really insecure with
162 herself and had to always portray the perfect family, like everything was always perfect.

163 When I started grade 8 I was deeply troubled. I didn't want to leave my bed, or do anything. I
164 was sad and crying all the time and was had a very negative self image. My family Dr diagnosed
165 me with depression and started me on medication. I had many low times where I considered or
166 half heartedly attempted suicide, it was with me in every thought. I made a will of sorts and
167 planned my death out many times. I never quite had the guts to pull it though, took some pills a
168 couple of times, but not enough to make me ill. I planned to go into the bush and starve slowly to
169 death (quite the melodramatic and not so fun way to go) but my parents came home early and so
170 I had to unpack with them watching and thinking what the heck is going on. They tried then to
171 get me to see a psychiatrist, but I refused. So the Dr continued to monitor my drug dosages. Near
172 the end of Grade 10 I was able to stop medication.

173 My parents were at a loss to how to deal with me. My step mom insisted that I was not
174 depressed, that I was just trying to get attention. When she found out I was suicidal (a comment
175 I made in school was brought to a teachers attention) she guilted me by saying how much I
176 would hurt my father if I did that. As he was already pretty sick that was the last thing I wanted
177 to do. Hurtful, but effective nonetheless.

178 When I was a month away from completing my AHT training my step mom was expecting a
179 visit from a friend in England. She gave me the option of living on the fold out couch downstairs
180 so that the friend could have the room or I could move out. I think that it was a big shock for my
181 parents when I said that I would move in with my boyfriend, as I had always just sucked it up
182 with whatever they asked me to do. I may have been pouty, or grouchy, but I always did what
183 they wished. I have always been caught in the trap of wanting to please my parents so badly, and
184 never feeling like I ever have completely pleased them, it is like a lock that I just can't find the
185 right key for. My sisters have always seemed to be more the apple of their eye. My older, so

186 popular and well liked, a dancer who became a pageant runner up. My younger sister who was
187 extremely good in school, who needed my parents always (I was always independent and
188 wanted to figure out how to do things on my own without a lot of guidance from them). I felt like
189 the odd one out always, and was glad to leave the home at 19.

190 Out of the frying pan into the fire. Sonny and I had a lot to get used to in each other as we came
191 from pretty different backgrounds. The first month was pretty much non stop yelling at each
192 other. Nearly called it quits several times, but I realized that as big of a pain in the butt as he was
193 being, he was still behaving fairly. No belittling, no hitting, no forbidding. We hung out with my
194 group of friends often, and I could maintain my life outside the relationship. It was my first
195 really healthy, honest relationship, and it is far from perfect, but I don't know of anyone that has
196 the perfect relationship.

197 I was determined to stand up for myself in this relationship. Sometimes things that he would
198 say or do would be taken harder than what they were meant because of the baggage from my
199 previous abusive relationship. We hung in there and moved from our first apartment to a
200 basement suite. While living there he proposed on my 21st birthday. It was a safe bet – I was
201 eager to cement our relationship. We decided that it was a good time to move into buying rather
202 than renting so that summer we moved into our first home. The following spring we were
203 married (I was 22, he 26). We have had our share of fights over the years, once he locked me out
204 of the house because I made him walk home from the corner as he was a bit worse for drink and
205 was insulting a friend. And I was rather insecure with my feelings and so was quite needy and
206 demanding for his affections. Over the years we have learned that men and women have quite
207 different ways of communicating and just because the one isn't doing things the way you would
208 that it doesn't make it wrong. We have mellowed too, and instead of my short bursts of temper
209 resulting in a screaming fit and his slow burn keeping him from talking to me for day(s) we have
210 learned to talk it out better. It is a comfortable fit.

211 We decided to have a child and 2 months later I was pregnant.. Hormones are not my best
212 friend so that strained our relationship a bit, but we got through it. After giving birth to my son I
213 went through a bout of postpartum depression. On top of it my mother (barb) had just broken up
214 with her partner and moved in with us. She wasn't terrific at giving me space (much needed with
215 a month and half old baby) and ended up having a mental breakdown (turned out she has mild
216 manic depression) and being hospitalized.

217 Here I need to back track a little. My mother came out to me just before we got engaged. I had
218 already figured it out. I was, and still am, completely fine with the fact that she is gay. Heck, I
219 don't have problems with gay people period, and actually do a little minor advocating as well (it
220 is wise not to announce that your cat is pregnant or bash homosexuals in front of me). My
221 problem with my mother is that she is immature. She has a hard time with responsibility and
222 tends to launch herself full throttle into new relationships, that crash and burn 6 months to 5 yrs
223 afterwards. She has no savings, and so when relationships end she is impoverished and leans on
224 her mother for money. I was a little worried when she announced that she would be moving back
225 here just after I got engaged, and found that she tried to play up the "I was/am a great mother"
226 thing. Was really uncomfortable for me, but I swallowed it for years as I didn't want to hurt her
227 feelings.

228 After my mother got out of the hospital I avoided her. I still do. Its what I do when I am
229 uncomfortable to the point of "can't handle it anymore." Not a healthy way to deal with things,
230 but hey, I at least realize that and am working on it. I have since confronted her on the things that
231 she does that are stressful for me, but it is such an integral part of who she is that I don't know if
232 she will be able to change.

233 I did meet a wonderful therapist that worked me through my postpartum, and relieved the guilt
234 I had over "abandoning" my mother.

235 My daughter was born in 2001. I went back to work when she was 2 weeks old. Got really
236 good at breast feeding and typing at the same time. It was stressful trying to juggle a job, new
237 infant and toilet train a toddler, but I was blessed that the postpartum period was only baby blues,
238 and not a full blown depression.

239 I still find that I struggle with guilt over my mothering, and am scared that my kids will feel the
240 same towards me that I have felt towards both my mother and step mother. Teen years should
241 prove to be pretty challenging for me, I imagine.

242

243 JOBS

244

245 Other than babysitting my first job was at McDonalds. It was both frustrating and also
246 confidence building. I learned that I could manage busy times, multitask and do a good job. It
247 was frustrating as I often was mistreated by the customers (from being called a bitch because

248 there was pickles on their hamburger – which I had nothing to do with anyway) to being
249 propositioned (was once even offered to share a beer with a homeless man up in the bushes
250 behind the restaurant. No one stood up for me, so I had to do it for myself. I spent a year there
251 before leaving for the SPCA where I had started to volunteer.

252 The reason that I had started volunteering at the SPCA was because I wanted to get into the
253 Animal Health Tech program. I didn't have enough experience to be accepted the first time that I
254 applied, so this was a way to gain more to be hopefully accepted the next year. What I didn't
255 expect was the passion that I would find for it. I spent the winter volunteering and was hired for
256 the spring and summer. It was an extremely emotionally taxing job, and I was glad to be leaving
257 when I got into the AHT program. I was burnt out, dealing with the euthanasia of animals and
258 the realities of the public. I still kept volunteering during the time I was in school when I got
259 chances to, but it wasn't often as the program itself was very demanding.

260 While I was in the second year of the program I got hired at a local veterinary clinic to work
261 Sundays, which is the day that they are closed. This was a good job to teach me skills that I
262 needed for being an AHT, but was very hard to deal with, as my boss – the vet – would give me
263 one set of instructions, and the office manager would leave me a list with contrary instructions.
264 When I confronted either of them (separately) they would say that I was to follow their
265 instructions and ignore the others. I chose to follow the vets, as he was the owner after all. So I
266 got some negative feedback from others for that. When I graduated they kept me on more days to
267 help cover for holiday time and whatnot, but then suddenly the vet told me one day that he didn't
268 need my help anymore. I was crushed and asked to know why, and he just said that he had never
269 promised me a full time job. I later discovered that he was trying to save money as he was
270 building a new clinic and tried to cut almost everything to the bare bones. Unfortunately before
271 the new clinic was completed and only a couple of months after I left he hung himself.

272 So, left in a lurch I took a job as a telemarketer for a whole week. Couldn't stand the pushiness
273 of the business so I left that. Went by the SPCA to visit and help out and ironically a person had
274 just left so a position was open, and I took it. With my higher confidence level and a bit more
275 maturity I found that I was better equipped to deal with some of the stressors in the shelter, and
276 so managed myself better there than I had before. I became a cruelty officer and so had to learn
277 how to confront people. By default I also became the main media spokesperson so gained
278 confidence in speaking to larger numbers of people and dealing with on the spot situations. The

279 shelter was great for me in that it helped me gain even more self confidence and assurance. I
280 knew that I knew my stuff and could do it. I was also viewed fairly positively by the main body
281 of the public. It was damaging in that it is very emotionally exhausting and I encountered some
282 negative people through it that had a big influence on how I felt. It finally got to the point that I
283 was glad that I had to leave the shelter, as it meant I could avoid the power struggles going on at
284 a board level. I was 7 ½ months pregnant when I left.

285 When my son was about 1 ½ months old one of my teachers from the AHT program called me
286 and offered me a position doing marking and tutoring for a distance education program to teach
287 animal welfare. It has allowed me to stay home with my children and still retain some autonomy,
288 as well as bring in some additional income. I have been thrilled with this job, as it is extremely
289 flexible and I have a very easy going boss who I share a similar mindset and way of doing things
290 with. It has just been confidence building in realizing that I can do this, am good enough to have
291 this well esteemed of a job.

292 As the kids have gotten older, I have been able to volunteer more and more at the shelter. This
293 is very important to me, as I find it fulfils me in a way that I cannot find anyway else. August of
294 2003 was when I truly felt that I “re-entered” the SPCA as I spent over 150 hours there in one
295 month helping the animals affected by the fires that ravaged our area. Disaster work is stressful,
296 but I find it an absolute blast. I have since gone to another fire this past summer, and plan to be
297 available for future disasters. I do help in other areas, fundraising and the like, but my main
298 passion is for the disaster work. I am such an adrenaline junkie.

299

300

301 HEALTH

302

303 I have struggled with depression since I was 13. Not a whole lot of fun, but at least by now I
304 am fairly used to the routine and know generally when I need help. May come as a bit of a
305 belated realization (hey, life has been really sucking for the past couple of weeks, I need to see
306 the Dr.) but at least I catch things within the month. My depression tends to be SAD, so I try and
307 catch as much sun as I can.

308 In 1994 I was diagnosed with Irritable bowel syndrome. Over the years I have had just about
309 every test known to mankind, and they still have not found anything to counter that diagnosis.

310 However, it refuses to be just normal typical IBS, and so I now have to go back to the specialist
311 based on my most recent tests. (I have been having a lot more bleeding over the past couple of
312 years, and over the last 8 months have been having melena and other bleeding from higher up. I
313 have just had a blood test come back that shows that my red blood cell count is low.)

314 During the fires of 2003, my husband found a breast lump. It grew to about the size of a golf
315 ball in two weeks. Thankfully after a couple of biopsies it has come back as non-cancerous, but
316 they can't tell me what it is. It isn't a cyst or fibroadenoma, which are the two common non-
317 cancerous breast lumps, so for me it is again something that I obviously have, but they don't
318 know what the heck it is.

319

320 CONVERSION SYNDROME

321

322 In the spring of 2003 I was feeling pretty darn good. I went to a conference in Reno, taking a
323 journey by plane for the first time solo. I was happy, excited and confident. Plus I had a great
324 time and learned a lot. When I was there, I experienced some dizziness, like the floor was
325 moving or shaking. It was odd, and I even questioned a few people to see if they felt the same
326 thing as we were on a floating floor, but it was only myself. When I got back the dizziness
327 increased dramatically. I assumed it was an inner ear thing and went to the Dr, as I could not
328 even drive at this time. My Doctor prescribed some pills to help with the extreme dizziness. I
329 found it extremely difficult to concentrate and was misspelling words and reversing letters every
330 3 words or so when I typed. My hands started to shake as well.

331 A few days later I suddenly began to stagger. It freaked me out, as I could barely walk.
332 So when my husband came home we went to the walk-in clinic. The doctor there was pretty
333 perplexed, and referred me to a neurologist. When I went to the neurologist he examined me, and
334 then booked an MRI. But he said that he didn't really think that there was anything wrong as
335 both my sides were equal in reacting.

336 I went home, very frustrated. I could barely walk, couldn't drive or do many other things
337 that I was used to doing. I could barely type, couldn't do my crafts, and even had a hard time
338 writing. The MRI (which originally was supposed to be a 2-week wait) ended up not happening
339 for 7 weeks. At about the 4-week mark I went to my regular doctor, as my quality of life right
340 about then sucked, and begged for some help. He sent me for a CT which showed nothing. I was

341 also having daily migraines, and was taking T3's to control the worst pain (usually one every
342 other day)

343 Over time I began to slowly improve on my own, I got the hang of walking with the tremors,
344 and though still hard, could type and write. Driving was still out of the question. When I had the
345 MRI I went back to the neurologists. He confronted me and my husband (he even kicked me out
346 of the room) and asked what major trauma I had gone through in my childhood to cause this. I
347 was perplexed, and he said that there was nothing wrong with me, just like he had thought. He
348 sold me a book to read on the migraines (which helped me immensely, and I got them under
349 control) and he placed me on Paxil.

350 It took a good couple of months before I slowly recovered. There was no sudden improvement
351 with the paxil, things just continued to improve, as they had started to before I had the MRI. I felt
352 guilty for wasting so much time and having caused my loved ones to worry. I also felt anger at
353 the way I had been brushed off.

354 I stayed on the paxil for a year, increasing the dose to deal with my SAD over the winter,
355 which was really bad with the combo of me feeling guilty, nuts and stressed out from all the
356 action. Weaning off Paxil was hell. I ended up having horrible zaps and really bad suicidal
357 thoughts. I am glad to be off it.

358 I still have problems with shaking hands and the occasional stagger, particularly when I am
359 tired. I did see the therapist that I had seen after my son's birth, and she helped me get over some
360 of my anger and frustration that I had with myself and the doctors. It is still there, but isn't as
361 much of a wound anymore.

362 Its not that I don't want to be well, or that I want something wrong with me. I would dearly
363 love to never have to see my doctor again except to bring the kids in for routine exams. But I
364 hate that I have all these symptoms that end up to be "nothing". It makes me feel like I am
365 wasting people's time, and taxpayer money. If it could just be something harmless, but less
366 ambiguous (as in your breast lump is just a cyst, or just regular depression) then I would feel a
367 lot better. For some reason I can't be "typical" and so they end up having to run tons of tests and
368 then....nothing. I now hate going to the doctor, and delay going there as much as possible. I feel
369 like he views me as a whiner, or as a hypochondriac, and does not take me seriously. It took me
370 7 months before I called for an appointment about the melena. I just want to be healthy, or at
371 least be able to do something about the things that I do have.

372

373 Well, thanks for listening, quite the read eh?

374

