

WORKING THROUGH THE BODY
Women, Pain and the Embodiment of Work

by

Leah Marie Shumka
B.A., University of Victoria, 2004

A Thesis Submitted in Partial Fulfillment of the
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ABSTRACT

Building on theoretical frameworks that conceptualize the body as a material and symbolic entity, this thesis examines how women use their bodies to mediate the conditions of their social and cultural environment. Canadian women who occupy social locations marked by their involvement in one of three socially and economically marginalized service occupations (hairdressing, sex trade and restaurant work) were interviewed using a body-mapping methodology. The purpose was to reveal how quotidian experiences such as feeling inadequate, incompetent, lonely, disenfranchised or dissatisfied are embodied as physical pain and illness. The research shows that women give meanings to these experiences by acting on and reflecting cultural beliefs about health, work, the body and the flexibility and potential for recreating the self. In particular, the Canadian women in the study are influenced by discursive ideas that they have the option (and indeed the personal responsibility) to ‘transform,’ ‘change,’ ‘control,’ and ‘reshape’ themselves.

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CHAPTER ONE: INTRODUCTION

Bodies are unstable entities. Regardless of what the word 'body' conjures in one's mind, it changes (sometimes dramatically) depending on the context and circumstances. If you imagine a physical lump of flesh, well, it changes size and shape depending on diet and lifestyle and whether one is in sickness or in health. If a body is a discursive object that reflects current cultural politics, it can take on almost any meaning: a sexual object, a military tool, a biomedical resource or a spiritual vessel. Women's bodies in particular may be wont to transform and change with cultural and social trends. Physiologically speaking women's bodies make minor adjustments throughout their month-long cycle and radically adjust for the development of a fetus. There are also unlimited ways to adorn, enhance, embellish and beautify a woman's body. Symbolically, women's bodies may alternately be sites for struggle and resistance or reflective of the status quo. The flexible and polysemic nature of the body may be why it mediates the world around us; it alone is able to reconcile an individual's competing wants, needs, behaviours and experiences with the political, social and cultural environment.

This thesis aims to reveal the way women use their bodies and the language of pain and illness to communicate their suffering. In other words, how are women embodying their distress. As will be revealed, Canadian women who occupy particular social locations, have many reasons to suffer. First, let us be clear on what is meant by "suffering." Suffering means to feel pain or distress; to tolerate or endure; undergo or sustain. Suffering may result from something as grievous as a traumatic event (physical, sexual or emotional abuse) or from something embedded in the minutia of an everyday experience. Many women in Canada suffer from feeling inadequate, incompetent, lonely,

self-conscious, disenfranchised or dissatisfied and they use their bodies to resolve¹ these experiences.

As will be argued, women cope with suffering by acting on and reflecting cultural beliefs about health, work, the body and the flexibility and potential for recreating the self. Women embody their suffering as physical pain and illness because cultural values imbue us with the notion that we have the power to 'transform,' 'change,' 'control,' 'process' and 'reshape' these experiences. The notion of a transformative body and self is, however, shaped by a woman's social location in Canadian society. The term "social location" defies clear explanation but refers to the multiple "roles" or "statuses" that one individual can occupy at any given time. It is, in large part, conditioned by an individual's age, gender, ethnicity, health-status and occupation. Individuals can move in and out of various social locations as the circumstances of their lives change. What shapes and coalesces the social location of these women is largely their engagement in one of three types of 'service' work, within which their bodies and emotions are intimately connected to performance. As such, the cultural discourses engaged by women working in the service industry will be examined.

Interactive Service Workers Project

This research project, *Working through the Body: Women, Pain and the Embodiment of Work*, was developed under the auspices of a larger, sociological project entitled *Interactive Service Workers Health and Access to Health Services Project* (ISW). This is a longitudinal study funded by the Canadian Institutes for Health Research (CIHR), and it is being conducted by Dr. Cecilia Benoit, Dr. Bill McCarthy, Dr. Mikael

Jansson and Dr. Bonnie Leadbeater. The purpose of this study is to investigate the health impact of providing “emotional labour” in frontline (i.e. face-to-face) service jobs, where a large part of the worker’s income is dependent on pleasing the customer enough so that he/she will tip the worker. A central objective of this study is to examine the health costs associated with providing emotional labour in working environments that are non-unionized, sexualized and, in the case of the sex trade, highly stigmatized. *Emotional labour* refers to the commercialization and commodification of human emotions in the workplace whereby workers are compelled to manage their emotions in order to be financially remunerated and/or deemed a ‘good’ or ‘successful’ worker (Hochschild 1983; Shumka, Benoit and Phillips 2006). This study focuses on three female-dominated service occupations that are socially and economically marginalized to greater and lesser degrees: hairstylists and barbers, food and beverage servers and sex trade workers.

A number of structural and workplace characteristics bring this seemingly disparate group of workers together. Beyond the consideration that these are all frontline service jobs, these occupations are highly gendered. Statistics Canada reports that in 2001, 81 percent of hairstylists and 77 percent of food and beverage servers in the study area were female (Statistics Canada 2005). It is estimated that between 70-80 percent of sex workers in most metropolitan areas of Canada, including Victoria, BC, are female (Benoit and Millar 2001; Benoit et al. 2005a; Benoit et al. 2005b; Hallgrimsdottir et al. 2005).

Secondly, these jobs have minimal educational requirement. Hairstylists in Victoria have, on average, a tenth grade education (Industry, Training and Apprenticeship Commission 2001). While recent deregulation of the industry has changed training

requirements, the majority of hairstylists and barbers have received specialized training at either a trade school or through an apprenticeship. Food and beverage servers are not required to have a minimum level of education. There are a number of short certificate programs recommended for servers to get (Food Safe, Serving-it-Right, etc.), yet these are not mandatory at most places. It is well-recognized within the industry in Victoria, however, that many individuals working as food and beverage servers do so to put themselves through post-secondary school². This is supported by ISW data which shows that 26 percent of servers have completed a post-secondary degree (and another 37 have started but have yet to complete a degree program). This is significantly higher than the 5.5 percent of hairstylists and 4.5 percent of sex trade workers who have completed a college or university degree. The sex industry has no formal educational entry requirement and in Victoria, the median level for sex trade workers (STWs) in a recent study is grade 10 (Benoit and Millar 2001).

Third, all three occupations are marked by unstable employment and high job turnover. Abiala (1999) for instance notes that hairstylists have short job tenures and tend to change workplaces often. Reiter (1996) and Leidner (1993) found the same for food and beverage servers. Likewise, Benoit and Millar (2001) found that the majority of STWs had worked in a variety of venues, including street prostitution, erotic massage, escort, exotic dancing, movies and phone sex (Benoit et al. 2005 a); Benoit et al. 2005 b); Hallgrimsdottir et al. 2005).

Fourth, the average yearly income for these workers is well below the national average. The average income for hairstylists and barbers in Victoria in 2001 was approximately \$18,000; for food and beverage workers it was even lower, at \$12,700 per

annum (Statistics Canada 2005). Tips, however, are not included in these reported earnings, which can be between 10-15 percent of the hairstylist or server's sales per shift (Industry Training and Apprenticeship Commissions 2001; Industry Training and Apprenticeship Commissions 2002). The median earnings of Victoria sex workers was \$18,000 (Benoit and Millar 2001).

The ISW study is comprised of four interviews or 'waves' that are (ideally) administered every four months. Each interview is made up of a series of closed and open-ended questions that cover a range of topics including: demographic variables (age, gender, ethnicity); family history; education (early education and on-going training or education); work history; description of current occupation (hours, schedule, satisfaction and description of working environment); income (monthly, yearly and household income); tipping (reliance on tipping, percentage of take-home wage); enacted and internalized stigma; occupational injuries (including perceived occupational risks); current physical and mental health; utilization of health care services and children's access to and use of health care services.

The information collected through the ISW project is important on a number of levels: 1) it provides future researchers with baseline information on what are three understudied occupations; 2) municipal, provincial and national labour and health organizations will be able to use this information to improve the working conditions and health care access of individuals working in these economically and socially marginalized occupations; 3) for the purposes of the *Working through the Body* project, the ISW investigation provides a framework to contextualize the research findings. The biographical and statistical data collected every four months over the course of a year

provides a series of snapshots that can be used to flesh out the experiences of women working in the service industry. In return, the ISW study will obtain a rich source of ethnographic data for interpreting and contextualizing their results. For example, clarification and insight will be given to statistical information that shows that women, in general, have high rates of job satisfaction despite the low occupational prestige of their jobs. In turn, the personal and occupational pathways to physical pain, stress and fatigue can be traced.

Working through the Body Project

This independent research project constitutes a fifth wave of interviews for a select group of women involved in the ISW project. The project focuses exclusively on the experiences of women for three reasons. As already noted, women make up the majority of workers involved in these occupations; of the 303 individuals involved in the ISW project, 77 percent of these are women. Beyond this pragmatic reason, my role as a Canadian female researcher who lives in the study area and has worked in the food and beverage industry for 10 years, made me ideally suited to investigate the experiences of women occupying similar social locations. Finally, research suggests that women are more likely than men to embody their suffering as physical pain and illness (this is a topic that will be considered in more depth in Chapter Two) (Lennon 1987; DelVecchio-Good 1992).

The larger ISW project was instrumental to the development and implementation of the *Working through the Body* project as it provides the quantitative springboard from which to understand how social distress becomes embodied as physical pain. The ISW

data reveals that women have been exposed to various forms of suffering throughout their lives. For instance, 17 percent of the women interviewed indicated that they had lived in a foster home or some other form of government care at some time in their childhood or adolescence. Another 48 percent of women indicated that they or their family has experienced “serious financial difficulty” in their lifetime. When asked if they had ever been a victim of abuse, 45 percent of women indicated that they had been physically abused, 44 percent said they had been sexually abused and 60 percent reported that they had been emotionally abused. Just under one-third of the women in this study specified that they had experienced all three forms of abuse. While these high numbers may be attributable to the fact that 40 percent of the women involved in the study have been involved in the sex trade, the numbers are, nonetheless, disturbingly high.

Focusing specifically on health, the ISW project’s preliminary findings indicate that, overall, one-quarter of the women rate their *physical* health as “fair” or “poor” and 23 percent consider their *mental* health to be “fair” or “poor.” When asked “How often do you experience body pain?” approximately one third of the women indicate that they “very often” or “always/chronically” experience body pain. Looking at the study population as a whole (male, female and transgendered), participants report significant levels of work-related pain, stress and fatigue; 67 percent of the participants report work-related *fatigue*; 64 percent experience workplace *stress* and 40 percent report experiencing work-related *pain*.

Study Location

The study was carried out in the Capital Regional District (CRD) of Victoria, the capital city of British Columbia. Victoria lies on the southern-most tip of Vancouver Island, which is located 69 km from Vancouver, BC one of Canada's largest urban centres. Victoria is a seaport city where approximately 325,754 people reside, either in the city proper or in one of the adjacent 13 municipalities that make up the CRD (Statistics Canada 2001). The metropolitan area has many attractions. In addition to the provincial government, it has one of the province's main research universities, a number of colleges and other educational institutions, and is a cultural centre for Northwest coast Aboriginal art and traditions (Benoit and Millar 2001; Benoit et al. 2005 a); Benoit et al. 2005 b); Phillips and Benoit 2005). With its mild climate and reputation as 'the garden city' of Canada, Victoria attracts tourists from around the world, but due to its close proximity to Washington State and the metropolitan area of Seattle, it is particularly popular among American tourists³. Travel brochures market Victoria as a quaint city where you can immerse yourself in British inspired gardens, double-decker buses, sweet shops and 'high tea' while being exposed to the "rugged" and "natural" beauty of the Pacific Northwest (i.e. killer whales, eagles and salmon) (Tourism Victoria accessed March 2006). Tourism is one of the most important industries in the metropolitan area and high growth is expected in the field throughout 2005/06 (Statistics Canada 2001). Hairstylists, food and beverage servers and sex workers are among the occupational groups affected by the burgeoning tourist industry. Estimates indicate that there are approximately 790 hairstylists, 3,010 food and beverage servers, and about 1500 sex

workers work in the CRD (Benoit and Millar 2001; Benoit et al. 2005a; Statistics Canada 2001).

What the moniker 'garden city' conveniently effaces are the social problems that trouble the city of Victoria. In particular, there are high rates of poverty, homelessness and drug addiction. While it is a common misconception that many of the city's homeless come from other places in Canada because of the temperate climate (and the option of staying outdoors year round), the Victoria Cool Aid non-profit organization that sponsors a city-wide yearly homeless count indicates that the majority of the city's homeless grew up in Victoria. The 2005 homeless count's estimate determines there are well over 700 homeless people living in Victoria (Victoria Cool Aid Society accessed April 2006). The average age of these homeless persons is 34 years, with ages ranging from 16 to 67 years. The most frequent reasons cited for being homeless are abuse, addiction, family conflict/breakdown, and eviction (Victoria Cool Aid Society accessed April 2006). In addition to the extreme shortage of affordable and low income housing in Victoria (Reitsma-Street and Prentice 2002)⁴, the city is fast becoming the area with the highest percentage of intravenous drug users (per capita) in Canada. In 1997, it was reported that there were "15,000 regular and frequent" intravenous drug users (IDU's) in BC, with many more "occasional users" (Millar 1998). Currently, downtown Victoria needle exchange groups estimate that there are 2,000 IDU's in Victoria city proper (population 74,000) (City of Victoria 2005). Due to a number of reasons, including the sharing of used needles, it is estimated that 80 percent of IDU's in Victoria have Hepatitis C and approximately 16 percent are HIV positive (Health Canada 2003). It is significant to point out that one of the primary reasons for the spread of infectious disease via IDU is

the lack of affordable housing. Persons who are addicted to illicit drugs (specifically cocaine, which requires more frequent injections) and who lack stable housing, are known to congregate in “shooting galleries,” whereby they are more likely to share “dirty” needles (Millar 1998).

In contextualizing the health concerns of women from the study population within the larger geographical area of British Columbia (BC), it is estimated that roughly 13 percent of women in BC between the ages 20-64 report moderate or severe pain or discomfort (Statistics Canada 2003). Nine percent of women (aged 20-64) consider their mental health to be “fair or poor” and 10 percent self-report “fair or poor” physical health. These numbers (percentage wise) fall well below those reported by women involved in the ISW project and the implication is that women involved in the three service occupations being studied are less healthy than the general provincial population. In terms of provincial and national statistics on the incidence of physical, sexual and emotional abuse, it is virtually impossible to assess the number of women who have suffered one or more of these traumas in their lives. These experiences are notoriously under-reported around the world, and BC is no different. What we do know, is that between the years 2000/01, over 14,000 women in BC were admitted into shelters for reasons of abuse (Statistics Canada 2005). However, this figure is by no means representative of the total number of women abused. It reflects only the number of women whose situations became so desperate that they felt compelled to leave their homes. Police records of sexual assault provide no more illumination. According to Statistics Canada (2001), sexual assaults comprise one percent of reported crimes, and

BC police believe this figure reflects only one-tenth of the sexual assaults that occur in the province.

Before moving onto a review of the literature, it is critical to point out that while the hairdressing, food & beverage and sex trade industries are characterized as socially and economically marginalized *occupations*, the individuals working in these positions are not necessarily ‘vulnerable’ or ‘marginalized.’ Instead, there is a hierarchy within each of these occupations whereby some are better off than others. For example, servers can work in high-end establishments where they enjoy considerable prestige based on their specialized knowledge of fine food and wine. These restaurants attract wealthier clientele and the server’s income (vis-à-vis tips) reflects this patronage. Conversely, there are those who work at low-end family-style restaurants or diners that offer a basic menu with low prices. These workers certainly do not enjoy the relative elevated prestige and income of their counterparts. As well, the individual women working in these occupations range in age, education, personal history and health status and these factors influence their social location. As a research assistant on the larger ISW project, I entered the homes of women who were deeply impoverished, living in squatter-style dwellings, but just as often I entered luxurious homes in upscale areas of the city. It is important to realize, then, that ‘vulnerable’ and ‘marginal’ are not rigid categories that encompass certain ‘types’ of persons. Instead, anyone in the course of their life can enter one of these categories and remain fixed or transform their “positionality” (Hall interviewed by Osbourne and Segal 1999). Hall defines *positionality* as the “positions offered by a social discourse in which you are willing for the moment to invest... It is both a point of enunciation and a point of agency, but it won’t be repeated, it won’t be the

same position that you will take up later on; or at least, it won't be the same position that you have in relation to another discourse" (Hall interviewed by Osbourne and Segal 1999:401).

As will be revealed, women who are or have been involved in one of these three service industries embody their social locations in ways that reflect dominant cultural discourses. Those discourses, primarily centered on biomedical perceptions of how the body should look, feel and function, are powerful, but not completely totalizing. Women exert considerable flexibility and agency within these discursive frameworks; they are able to negotiate meaning in their lives in ways that make 'cultural sense' while fitting within the shifting circumstances of women's everyday lived experience. As will become clear, women are engaged in a search for understanding their pain and suffering. In keeping with this spirit of 'discovery,' this thesis is laid out in such a way that the reader's understanding of the issues and concerns impacting the lives of these women will also evolve and take shape. In the end, the goal is not to reach a conclusion or definitive resolution; rather, the purpose is to illuminate and clarify.

End Notes: Chapter One

¹ That is not to suggest that women use their bodies to 'solve' their problems; rather, women are using their bodies to 'make sense' of the experiences that are causing them to suffer.

² This may not necessary be the case in other towns or cities. Victoria is a university town and many of these students take advantage of the thriving tourist industry.

³ Victoria is 35 km from Port Angeles, Washington and 247 km from Seattle, Washington.

⁴ Reitsma-Street and Prentice (2002) report that Victoria's high housing costs keep low income workers out of reasonable rental properties and out of home ownership all together. Since 2001, there has been virtually no new subsidized housing in Victoria except for senior and special needs housing.

CHAPTER TWO: LITERATURE REVIEW

The pertinent literature reviewed here covers a range of topics drawn from anthropology and sociology. This begins with a discussion of *social suffering* to situate the pain and illness experiences of individual women within a larger matrix of social and cultural meanings. Further, the notion that suffering is rooted within the social and political environment is foundational to all subsequent discussions of embodiment, pain, power, discourse and gender. Subsequently, the relationship between *women, pain and illness* is discussed to point out the pivotal role gender plays in any discussion of work and health and also to highlight the polysemic nature of pain. From there, a comprehensive review of the emotional labour literature is provided to give insight into how managing emotions in a commercial context may impact the health and well-being of service workers. The review of the literature culminates with a discussion of three perspectives: *embodiment, phenomenology* and *Foucault inspired theories of discourse*. These are complementary perspectives that focus on the subjective experience of individuals and how their body mediates the social world around them. Bodies are understood as material and symbolic entities capable of negotiating powerful cultural discourses that permeate Canadian society.

The perspectives of anthropology and sociology have been brought together in order to provide a more comprehensive and holistic understanding of the issues at hand. While both disciplines are concerned with taking a critical perspective on issues surrounding gender, health, inequality and power, they also differ in fundamental ways. Where sociology concerns itself with social organization and the location of individuals within society as a whole, anthropology looks closely at the *meaning* of social

phenomena to individuals and evokes what is deemed to be relevant and important to them and by them. Throughout the design, implementation and interpretive stages of this research the focus shifted back and forth between these perspectives, resulting in analytically rich insight into why some people, occupying particular social locations, attribute particular cultural meanings to their experiences of pain and suffering.

Social Suffering

The term *social suffering* is defined by anthropologists Arthur Kleinman, Veena Das and Margaret Lock (1997) as the pain and distress that can result from what is done to and by people through their involvement with processes of political, economic and institutional power. By this definition, pain and distress refers to all manner of “wound or injury to the [mind], body and spirit” (Kleinman and Kleinman 1991). This definition is broad but useful because it acknowledges an assemblage of different human experiences – including health, welfare, legal, moral, ethical, political and religious issues – that can shape individual suffering.

It is often remarked in the social science literature that suffering is a pan-human condition, or that “suffering is one of the existential grounds of human experience; it is a defining quality, a limiting experience in human conditions” (Kleinman and Kleinman 1997). Although anthropologists acknowledge that suffering can take many forms and afflict persons of any age, gender, socio-economic status and ethnicity, it is common for the notion of social suffering to be applied only to three areas of anthropological interest. There are the “contingent misfortunes” which refer to serious acute diseases such as cancer. This suffering can strike suddenly and affect anybody but is considered traumatic

because of the threat of imminent mortality. Less obvious, but more insidious are “routinized forms of suffering” that are attached to conditions like poverty and the attendant hunger, thirst, homelessness and infectious disease; this suffering afflicts “the poor, the vulnerable and the defeated” (Kleinman and Kleinman 1991). Finally, and well-documented in the anthropological literature, is the “suffering resulting from extreme conditions” such as war, famine, dispossession, rape and torture (which are often found in combination with one another). As may seem readily apparent, this suffering has a strong political dimension to it and is often tied to the oppression and rejection of economically, politically and socially marginalized groups of individuals. The political and economic strife in Rwanda, Afghanistan and Kosovo are ready reminders of the social suffering that can be inflicted on individuals through their involvement with political processes that extend far into the international arena.

Overlooked in the social suffering literature is a concern with everyday forms of suffering. *Everyday* is defined here as the ‘commonplace’ events that impact the lives of ‘ordinary’ individuals who do not necessarily fall within the category of vulnerable, oppressed, marginalized or downtrodden. These events are a quotidian experience, which is to say they are virtually normative. Scheper-Hughes (1992; 2000) does speak about the “violence of everyday life” in her work in Brazil on infant mortality and her investigation of the global trafficking of human organs; however, her use of the term “everyday” refers to the lives of those living under the unrelenting condition of extreme poverty. While this is important research, it could be argued that it loses much of its relevance¹ within a Canadian context where the majority of individuals have access to health care and social services that readily supply food, water and healthcare. This is not

to say that Canadians do not suffer from poverty and social inequality but that the Canadian experience is qualitatively different and some might argue, less extreme.

Kleinman (2000) also refers to the “everyday” practices that contribute to suffering under the rubric of *social violence*. A term that he contextualizes thus,

The ethnography of social violence implicates the social dynamics of everyday practices as the appropriate site to understand how larger orders of social force come together with micro-contexts of local power to shape human problems in ways that are resistant to the standard approaches of policies and intervention programs (Kleinman 2000:227).

Kleinman’s argument is closer to capturing the ‘commonplace’ suffering that concerns us here but his use of the term “violence” has a visceral impact that connotes an extraordinary event, even an aggressive or invasive assault. Instead, the focus of this investigation is the suffering that is caught up in the minutia of daily life. Specifically, it could be the distress and despair related to job dissatisfaction, loneliness in a marriage, feelings of inadequacy or an inability to reconcile disparate social roles (i.e. mother, wife, and employer). It is important, then, to expand the definition of social suffering to let in the common events that impact the lives of Canadians. By expanding the definition of social suffering, the intent is not to diminish the experiences of those who have endured severely traumatic events such as rape, torture and debilitating disease; rather, the purpose is to draw attention to the idea that there are many ways in which a person can suffer. Some individuals may suffer from a series of events that could include a severely traumatic incident, prolonged economic inequality and job dissatisfaction. In other words, some individuals are unfortunate enough to have to endure multiple forms of suffering.

The subsequent discussion will highlight the work that has been done that illustrates everyday social forms of suffering (although it is rarely called such in the sociological and anthropological literature). In particular, the focus will shift to the suffering that afflicts women. Premenstrual Syndrome, or PMS, is a medicalized condition common in North America and the United Kingdom (and other parts of Western Europe). While it is regularly confused with dysmenorrhea – painful menstrual cramping – which is reported cross-culturally, PMS is deemed to be a separate “medical disorder.” PMS is characterized as having up to 150 known symptoms which range from the somatic (lower back pain, cramping, bloating), to the emotional (irritability, anxiety, hostility), and the behavioral (crying, social withdrawal and being argumentative). According to Davis (1996), PMS only emerged in the medical literature in the 1980’s but it is estimated that up to 90 percent of all women in North America and the United Kingdom currently report one or more of these symptoms. Anthropologists theorize that PMS presents women with a medically sanctioned and consequently ‘legitimate’ way to communicate the anger, frustration, and helplessness that is associated with having to fulfill contradictory social expectations in our society (Davis 1996; Gottlieb 1988; Johnson 1987). Rapping (1996:7) calls this the “super woman complex” which comes about when women feel the pressure to be, at once, nurturing mothers, good housewives, supportive spouses and enthusiastic lovers while maintaining successful careers or part-time jobs. Others, like Mitchell (2003), suggest that PMS is mired in a particular set of cultural meanings surrounding reproduction, contraception and sex. It could also be suggested that PMS is a culturally shaped way for women to communicate aspects of their everyday suffering.

Salient to this research is that suffering is known to be embodied in culturally elaborated ways that have specific moral and political dimensions (Kleinman et al. 1997). In Canada, suffering is commonly categorized as a medical “condition” such as “stress,” “anxiety” and “depression.” There are a number of implications associated with the appropriation of suffering by institutions of power. First, the individual is made to feel personally responsible for his or her suffering and is consequently deflected from the structural circumstances that may be complicit in their suffering. Second, professional and political appropriation of suffering allows institutions to regulate individuals and their bodies (Kleinman et al.1997: xii); in the process, certain behaviours are deemed ‘normal’ and others ‘deviant.’ Third, government, institutions and businesses are able to profit from the commodification of suffering. Kleinman and Kleinman (1997:1) point out how images of famine and natural disaster victims are used to “appeal emotionally and morally both to global audiences and to local populations” as a means of mobilizing the flow of capital. Biomedicine profits largely from the medicalization of suffering, for those working in this field are able to create new sites for the administration of drugs and therapies. Particularly lucrative is the sale of pharmaceuticals such as pain relievers, anti-depressants and anti-anxiety medication, which mask, and often ignore, the deeper root causes of pain and suffering.

Women, Pain and Illness

It is critical to consider what people are communicating when they say they are in pain or when they convey a particular set of illness symptoms. Not only is pain, like suffering, a ubiquitous feature of human experience, but “it is the single most frequent

complaint brought to the offices of physicians in North America” (Kleinman, Brodwin, Good and DelVecchio-Good 1992). As Stephenson (2006) points out, pain is also the “existential symptom.” It is a normal, neurological response warning the body of imminent harm. It has an important function in the survival of the organism, and the constant attempt to avoid it is the hallmark of a particular culture and its relationship to pain.

From a biomedical perspective, pain is a physiological response to material/bodily disorder. Thus, an ear ache may be the body’s response to a viral infection, and an upset stomach may be the result of ingesting a harmful bacterium. On the other hand, medical anthropologists and sociologists have long looked outside the body to understand the complex and often ambiguous etiology of pain and illness. As Kleinman (1988:199) asserts,

The dominant conceptualization of pain has focused on sensation, with the subsequent inference that it is able to be rationally and objectively measured. Yet as well as being a medical ‘problem’, as we have emphasized, pain is also very much an everyday experience: one rooted in the lived structures of embodiment and the emotional modes of being and selfhood this involves. It is culture which provides the symbolic bridge between the brute materiality of disordered physiological processes and the meaning-laden character of human significance.

The problem with pain and the symptoms associated with illness is these are subjective experiences that resist and challenge all forms of objective measurement. As one researcher explains, this is because “unlike most psychic, somatic or perpetual states, pain has no object [in the external world] . . . it is not focused on anything but itself” (Scarry 1985:4). In other words, pain does not have a stable reference point that can be used to compare one person’s pain to another’s. Medical professionals have sought to

quantify the experience of pain with measures that test for “intensity,” “acuity” and “duration,” but ultimately, pain is only knowable to the sufferer (Scarry 1985). Even for the individual, pain may be a poorly understood phenomenon in that it is often non-localized and unstable, making it difficult to articulate. Scarry (1985:4) writes that pain “does not simply resist language but actively destroys it, bringing about an immediate reversion to a state anterior to language, to the sounds and cries a human being makes before language is learned.”

Conversely, pain may be the only language that an individual can use to communicate a deeper, and more complex, set of meanings. When a person is suffering, and the etiology is poorly understood – in the sense that it may be sub-conscious or inchoate – the experience may be rendered graspable through the reification of a more immediate experience such as pain (Herzfeld 1986). Brodwin (1992) picks up on this point when he characterizes pain, specifically chronic pain, as resembling a human language. His case study of one woman’s experience with a vast array of mutable and uncontrollable pain symptoms explains what he means,

. . . the pain symptoms themselves represent both a performance and a protest against the demand to perform she feels within virtually all her relationships. Diane thus uses her body (and its sufferings) to communicate with and influence her social world. Her pain symptoms function like a language. Indeed, her bodily messages can speak with the authenticity and power that her verbal messages often lack” (Brodwin 1992: 80).

This does not mean that individuals are *unconsciously* using their bodies and the language of pain and illness to communicate their suffering. In many cases, individuals are well aware that verbal communication often lacks the clarity, authenticity and power of a bodily message (Brodwin 1992:96). Illness and pain experiences may be used

performatively to negotiate the difficult and challenging aspects of particular social situations (White and Marsella 1982:3).

It is instructive to consider why women are more commonly linked to the expression of pain and illness. Das Gupta (1997) indicates that women may be more likely to embody their experiences of suffering because they lack the power and autonomy to negotiate their circumstances in other, more overt, ways. As highlighted in the discussion of PMS, it may be that women feel overwhelmed by the need to fulfill contradictory social roles. Significant here are the large number of “culture-specific illnesses” (CSI) that afflict women. Davis (1996:61) defines CSI’s as a “constellation of symptoms categorized as a disease where the etiology symbolizes core meanings and reflects the preoccupations of a culture and where diagnosis and treatment are dependent on a culturally specific technology and ideology.” While there are numerous examples of CSI’s that affect women, the focus will shift, briefly, to anorexia nervosa. While men are increasingly being diagnosed and treated for anorexia, approximately 90 percent of diagnosed sufferers are women (Gremillion 2003).

Within Canada and other Westernized countries where eating disorders among women proliferate, anorexia is considered a psychiatric illness. However, the notorious difficulty of treating anorexia with medication, psychotherapy and behavior modification seems to support the notion that it is deeply rooted within the social world (Gremillion 2003). Social scientists from across a range of disciplines have noted a connection between anorexia, late capitalism and idealized notions of femininity within Western cultures (Bordo 1993). In her book, *Feeding Anorexia: Gender and Power at a Treatment Center*, Gremillion (2003) states that in the 1970/80’s anorexia increased by

up to 50 percent. This was at a time when mainstream American society was promoting the idea that women should achieve autonomy, self control, and bodily fitness through dieting and exercise. For women, particularly white, middle-class women, the size and shape of the body became a communication about the self (Reischer and Koo 2004)². Specifically, in a consumer culture that simultaneously promotes indulgence in food and alcohol while glorifying constraint (in the form of beautiful, young and thin female bodies that appear in magazines and on billboards), the ability to maintain an ideal body weight signals one's "internal capacity for commitment" and moral superiority (Bordo 1993; Reischer and Koo 2004:300). Anorexia, then, is the embodiment of a complex and contradictory set of social meanings directed toward women.

Turning now to a discussion of the role of gender in the communication of work-related pain and illness, Bendelow and Williams (1998:201) report that women in the United States demonstrate a higher incidence of temporary, persistent and chronic pain than men. However, they contextualize these findings with a discussion of the cultural appropriateness of expressing pain. For example, these researchers point to cross-cultural studies in westernized contexts which show that there is an overwhelming perception among both men and women that women are more able to cope with pain than are men" (Bendelow and Williams 1998:201). This is partly credited to women's experience of childbirth, and thus it is hypothesized that they have a higher pain threshold than men. More intriguing is the argument that women are socialized to believe it is culturally acceptable to communicate that they are in pain, whereas men are encouraged to exhibit stoicism and fortitude. Bendelow and Williams (1998:209) also report that there is a perceived hierarchy to pain whereby physical pain is considered more "real" and

“legitimate” than emotional pain or anguish and that physical pain is more “deserving of sympathy and respect.”

Numerous studies have also shown that women are more likely to experience work-related stress and or psychological *distress* than men (Jick and Mitz 1985; Haw 1982; Lennon 1987). It is not clear from these reports why women may be more vulnerable to work-related psycho-social stress. One suggestion is that women are more likely to work in jobs that are known to be stressful³, and thus it is an issue of exposure (Lennon 1987; Sprout and Yassi 1995). For example, service-oriented occupations are commonly characterized as high-stress jobs and women make up over three-quarters of the workers. Perhaps more intriguing is the idea that women are not necessarily more vulnerable to distress, but more likely to embody the effects (Lennon 1987). In her article *Work as a Haven from Pain*, DelVecchio-Good (1992:51) indicates that it is well-documented that women have “higher physical and psychiatric morbidity than do men and are more likely to seek health care for their symptoms.” Waldren (1991:20) indicates that while men are more likely to suffer occupational health injuries because they are more likely to work in “dangerous” or “hazardous” jobs (i.e. logging, mining and construction), women in the United States “report more symptoms, more acute conditions, more days of restricted activity due to illness, and more doctor visits than do men.” While overall the work/health/gender literature is inconclusive as to whether men or women suffer more as a result of work, a close reading of this research suggests that men are more likely to suffer work-related ill health and accidental injury but women are more likely to communicate pain and illness and engage in self-help seeking behaviours.

It terms of the personal and idiosyncratic illness narratives of women who work in service-oriented occupations; it may be that the women are telling a moral story about social suffering. According to Brodwin (1992), workers may do this consciously to legitimize job loss or sick leave, or they may do it unconsciously because the etiology of their pain does not bear thinking about directly.

Emotional Labour

Within anthropology, there is little information on emotional labour; what it is, how it affects health and how it is embodied remains open for anthropological investigation. Research done in sociology, however, provides a useful beginning framework for understanding what emotional labour is and why it might be important within medical anthropology. A wider question exists about whether all labour cannot be understood as “emotional” in some way. Certainly “alienated” factory labour, and the entire area of workplace (“occupational”) injury are related (and widely studied in medical anthropology and epidemiology). However, those studies are generally done in the context of organized labour – not in the marginalized context of stigmatized work.

Arlie Hochschild (1983:7) coined the term “emotional labour” in the early eighties to refer to “the management of feeling to create a publicly observable facial and bodily display.” Her observation was that while people regularly manage their emotions in their personal lives, dramatic changes in Western labour markets toward interactive service jobs has led to the commercialization of human feelings. Hochschild’s (1983) case study of an airline company found that the success of this industry depends on its frontline service providers (i.e. flight attendants) embodying a warm, friendly and caring

persona that customers can trust. Hochschild's contention was that the management of emotions has potential negative psychological consequences for the worker that can result in serious physical health concerns.

In the 20 or so years since this seminal work, there has been considerable debate about whether or not emotional labour actually leads to negative health outcomes. While opinions vary, perhaps the most constructive criticism is that Hochschild's model is unidimensional. Emotional labour can have both positive and negative repercussions for people engaged in 'people work,' and it varies according to the social position of the worker and working environment (Sharma and Black 2001; Wharton 1993). However, much of the work/health literature indicates that a worker's "level of occupational control" is a key component for job satisfaction (Link et al. 1993; Sauter et al. 1989). For example, those who are able to exercise a high level of autonomy and control over their schedule, duties and responsibilities are less likely to become emotionally "burned-out" (exhausted, or drained and experiencing severely diminished capability for continued emotional response) from working face-to-face with the public (Erickson and Ritter 2001). Consequently, an integral part of understanding emotional labour requires that we learn how much control people have in their jobs.

Recently, sociologists have redefined emotional labour as "the effort, planning and control needed to express organizationally desired emotions during interpersonal transactions" (Morris and Feldman 1996:986). Morris and Feldman believe that emotional labour can be broken down into four dimensions: 1) the "frequency and duration of appropriate emotional display" which refers to the number of customers a person must respond to in a given period of time; 2) attentiveness to display rules, which

concerns the appropriateness of the employee's emotions in regard to social rules or norms⁴; 3) variety of emotions to be displayed, which concerns the diversity of emotions that are expected over the course of an exchange. Service providers are expected to alter their moods to fit that of their client; consequently, conscious monitoring of emotions and active planning are required; and 4) emotional dissonance, which refers to the conflict between the felt emotions of the service provider and the emotions that are required to be displayed (Morris and Feldman 1996). This final dimension of emotional labour is arguably the most costly and it is explicitly linked to "burn-out" because it has been argued that it "impairs one's sense of authentic self" (Ashforth and Humphrey 1993:89). Emotional dissonance requires the greatest level of control by the worker and usually leads to the highest level of job dissatisfaction (Morris and Feldman 1996:992).

According to many researchers, the increasing competition among service providers and the overall growth of service industries has created a competitive environment, which demands that employers pay closer attention to the nature and quality of the services they provide to their customers (Ashforth and Humphrey 1993; Morris and Feldman 1996; Wharton 1993). In addition, the increased expectation by customers and clients to be treated in emotionally pleasing ways has increased the level of emotional labour required from those who work for tips and gratuities. Consequently, more demand is put on employees to please their customers.

Ethnographic investigation into the concept of emotional labour has been done with flight attendants, nurses, midwives, call-center workers, food & beverage servers, chefs, models and teachers. Nowhere in the sociological literature has there been a comparative study involving servers, hairdressers and sex trade workers. However, there

have been a number of noteworthy studies that focus independently on the experiences of hairdressers and servers.

Sharma and Black (2001) and Gimlin (1996) both touch on the issue of emotional labour within the context of beauty salons. Their research suggests that women working in beauty salons are often keenly aware of the emotional labour they perform. Both case studies note that hair stylists and or/beauty “therapists” stress the level of emotional labour they perform as a means of gaining social recognition and legitimacy for their work as a “profession” (akin to naturopathy or chiropractics). While it is clear that there is a certain level of skill and ability for emotionally managing their clients (and themselves), these workers admit that they do not receive any kind of specialized training in regards to emotional labour, instead, they believe that managing emotions is an innate skill common among women. Sharma and Black (2001) point out, however, that claims for legitimacy are undermined by the reality that hairdressers and beauty consultants receive low pay and work in what is a highly gendered and socially invisible occupation (Sharma and Black 2001)⁵. Furthermore, while stylists “may use their attachment to beauty culture to nullify status differences between themselves and their clientele and to imagine themselves their customers’ friends and social equals,” it is exactly this kind of emotional work that forces stylists to accommodate the wishes of a client over their “professional” judgment (Gimlin 1996:505).

Data collected on food and beverage workers is primarily focused on the so-called “McJob” end of the restaurant industry, that is, unskilled, entry level positions in fast-food style restaurants which are often either shift work or part-time (or both)(Leidner 1993; Lindsay and McQuaid 2004; Mayhey and Quinlan 2002). While research of this

type is valuable for its insights into frontline service work, arguably fast-food providers are distinct from restaurant workers who are required to engage with their customers for a longer, more intense period of time and be more attentive to their wants and desires. However, Robin Leidner's (1993) book *Fast food, Fast talk* does speak to the psychologically damaging effect of performing emotional labour in what are highly routinized and standardized work environments. Employees are coached on how to talk, smile, stand and respond to customers while simultaneously given the impossible task of treating each customer "as an individual in sixty seconds or less" (Leidner 1993:178). In this tightly controlled environment, where employees are often verbally assaulted by customers who feel morally superior to them, people learn to distance themselves from their emotions. The result can be a loss of the sense of authenticity and personal identity. Owings (2002) picks up on this idea in her book *Hey Waitress!* in which she notes the façade that waitresses have long been forced to wear while attending to their customers. In her book, Owings provides a brief history of waitressing (going as far back as the 19th Century) which she characterizes as servile and demeaning work. She also points out the close association waitressing has had to prostitution⁶. This correlation comes from the notion that serving was almost exclusively a female-oriented occupation whereby women were employed to serve the needs of men. These women often served alcohol, which encouraged lascivious behaviour from their patrons, behaviour which the waitresses were directly and indirectly encouraged to tolerate in order to receive money from customers who especially appreciated or enjoyed their services (Owings 2002).

One problem with these descriptions of "docile workers offering (de)personalized care" is that it ignores the agency of both the worker and the customer (Bolton and

Houlihan 2005:686). Bolton and Houlihan (2005:686) suggest that an analysis of service work requires that we reinterpret “customer service interaction as a social act and a human relationship.” For instance, not all customers are demanding and rude. Many exhibit empathy for the serving staff and attempt to make their job as easy as possible. Furthermore, servers may genuinely like the customers they serve and enjoy their presence in the restaurant. Qualitative data from the ISW project shows that servers report enjoying their interactions with customers for a number of reasons that include the potential for relieving the stress associated with their personal lives. From this perspective, we start to see the potential positive effects of working with ‘the public.’

Another important aspect of the work servers do is that they are more likely to be directly employed under either a manager and an owner/operator (or both). This differs from most hairstylists and sex trade workers who either work independently or have a supervisor who does not directly check up on their work performance. The result is that servers are regularly monitored through management programs like “secret shoppers” to ensure that servers are adhering to acceptable levels of emotional labour. This is in addition to the knowledge that servers working in corporate-styled restaurants often have “serving scripts” that they are required to adhere to (Hall 1993). Likely this lower level of occupational control exacerbates the potential negative affects of emotional labour.

In terms of sex trade workers and emotional labour, there are a wealth of studies that focus on issues surrounding sexually transmitted infections (HIV in particular), transnational trade of women for sexual labour, violence and the worker’s use of drugs and alcohol. To date, there is little written about the emotional labour inherent to their profession and the embodied effects of working in highly sexualized, stressful, and

marginalized environments⁷. However, as Owings' brief history of waitressing points, many of the issues faced by servers are undoubtedly shared by sex trade workers (although sex trade workers are likely negatively affected to a more significant degree). Sprout and Yassi (1995) also make this observation when looking at the occupational health concerns of women who work in the public sphere. They note that sex workers share, along with food and beverage servers, sales clerks, and barbers and hairdressers, a vulnerability to psycho-social related stress, violence, and unsafe working environments. While informative, this article, along with all the previously mentioned studies, has not made the connection between poor health outcomes and providing emotional labour in marginalized social situations. Consequently, an in-depth investigation is needed to situate personal suffering, occupational and emotional labour within a broader social context.

From an anthropological perspective, the emotional labour of women working in stigmatized and socially and economically marginalized occupations is entrenched within a complex and often contradictory set of cultural meanings (Mitchell 2005). Women working in the serving, hairdressing and sex trade industries are expected to provide 'pleasure' in the form of food, beauty and sex. To be successful, they must navigate a fine balance between getting paid for providing a 'professional' service while satisfying a customer's need for 'intimacy' and personal pleasure (Mitchell 2005). This is supported anecdotally by sex trade workers involved in the ISW project who report men's desire for a "girlfriend experience" in which the worker is expected to behave in an affectionate and loving manner that makes the customers feel desired and special. Moreover, women are expected to conform to a highly idealized vision of femininity, which, in many instances,

is in direct contradiction to the reality of women working in these jobs. The inherent difficulty of fulfilling cultural and societal expectations while maintaining personal integrity in jobs that are poorly compensated, potentially dangerous and physically demanding cannot be underestimated. Under these circumstances, the suppression of “real”⁸ emotions for commercially managed ones may exacerbate the physical and emotional distress of individual workers. For, as Lupton (1998:82) explains,

At a time in which people in western societies are both encouraged to ‘display’ and ‘confess’ their emotions but also to ‘manage’ their emotions carefully by conforming to expectations about the expression of emotional states in specific social settings, the emotions are integral to the conduct of social life and relationships with others. So too, the emotions are integral to notions of embodiment, or the ways in which people live and experience their bodies.

To consider the potential health implications of embodying emotions, a discussion of the theoretical perspectives on the body and embodiment will follow. From there, women’s embodied experiences will be considered in terms of how they reflect, and respond to, dominant cultural values and norms.

Theoretical Issues

The theoretical perspectives employed in this study overlap considerably. A discussion of embodiment is necessarily a conversation about the body and how it is conceptualized in Canadian society. As will be shown there are powerful discourses influencing Western perspectives of the body, biomedicine in particular is a part of a “system of dispersion” that influences the way Canadians think about and live through their bodies. Rose (2001:137) defines *system of dispersal* (i.e. discursive formation) as the connection of different discourses whereby “one can define a regularity (an order,

correlations, positions and functionings, transformations) between the separate parts of the whole.” For instance, biomedicine is implicated not only in the way Canadians think about their health, but also in how they conceptualize the interaction of their mind and body; biomedicine also has a powerful impact on what is considered ‘normal’ in terms of body weight and aesthetic beauty. An investigation of how the body mediates our social surroundings is also necessarily a discussion of phenomenology because our bodies represent the first frontier of subjectively knowing the social world.

The Body

At times, the body has been viewed by social scientists “uninterestingly as a prerequisite for human action” (Reischer and Koo 2004), and as the domain of the “natural” sciences, such as biology. More recently, however, the body has become a central concern of social theorists (Moss and Dyck 2002; Reischer and Koo 2004; Sharp 2000). Within anthropology, the body has always been “a favored site of interest,” partly due to early curiosity in the body’s: physiology, decoration, modification and even internment (Sharp 2000). However, the body has become increasingly important over time. Moss and Dyck (2002:19-20) attribute this increased interest to three primary reasons: 1) through the media, our capitalist society’s commoditization of the body, its appearance, modification, health, and sense of itself, has naturally moved the body to the fore of theoretical contemplation; 2) the fact that bodies appear to be everywhere (in terms of sheer numbers), in addition to advances in reproductive technologies (including cloning), has made bodies difficult to ignore; and 3) “the concomitant widespread turn to

subjectivity in social theory.” Arguably, the beginning of a well-defined anthropology of the body began with Scheper-Hughes and Lock’s (1987) article on the *Mindful Body*.

The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology reformulates the body as simultaneously an individual, social, cultural, historical and political entity (Scheper-Hughes and Lock 1987). This epistemological perspective views the body as three separate, yet overlapping units of analysis. The first ‘body,’ is the individual or phenomenological body, where the body is perceived, experienced, and sensed in the mind of the individual. Rather than accept a mind/body dualism, this body takes the position that the mind and body are inseparable and interactive, linked to create a holistic human experience. This unit of analysis also encompasses the relationship between the individual and society. In Western societies, these are often seen to be in opposition, where the innate desires, wishes, and needs of the individual are in direct opposition to larger societal values, laws, and rules.

The second body is the social body, and it links individual experience to more widely shared interpretations and to social relationships. Used metaphorically to talk about nature, society, and culture, this body makes associations between a healthy body and a healthy society, or a diseased body and a malfunctioning society. People equate an individual’s health status with that of the social body and vice versa. This body is also concerned with how societal forces, like capitalism, can influence how we perceive our bodies (as exemplified in the ‘body-as-machine’ and/or ‘body-as-commodity’ metaphors).

The third and final body is referred to as the “body politic.” This unit of analysis is more concerned with collective bodies and how they are regulated and controlled.

Essentially, this body moves beyond issues of individual and collective representation, and is primarily concerned with notions of power and control. Scheper-Hughes and Lock (1987) use the example of the proliferation of disease categories in medicine and psychiatry. The definition of what or who is normal is becoming increasingly restricted, and a deviant majority is rapidly growing. Doctors and psychiatrists have assumed a hegemonic role in society that allows them to control individual distress, discontent, or complaints through a process of medicalization.

What made/makes the *Mindful Body* such an important piece of work is not necessarily the innovation of the ideas; the works of Marx, Foucault, Bourdieu and Merleau-Ponty came before. Rather it is the way that epistemological and ontological frameworks were coalesced to bring together previously divergent theories; namely, embodiment, symbolism and political economic perspectives. More recent theorizations of the body reflect changing relationships between the 'self' and 'other' and between the individual and what Haraway (1997) calls the "New World Order" (i.e. global dynamics).

Within a Canadian/North American context, a pervasive and certainly the most authoritative perspective or account of the body is biomedical. This model views the body as a mere "thing" that can be broken apart and commodified; this divisible body has porous borders that can be transgressed and suppressed. According to Lock (1993), the biomedical body is, in part, a legacy of Descartes, but it also seems to be one of necessity. In order for medical doctors and those involved in many of the health sciences to justify what they do to bodies in the name of the "greater good" (i.e. saving lives), society as a whole has had to "reify, isolate, decontextualize, and abstract the body from real time, actual location, and social space" (Lock 1993:370-371). In other words, biomedicine has

had to demystify the body and make it, and its parts, ordinary “things.” As a result, individuals have been alienated from the personal, cultural, historical, social and political experiences that shape the body and its expressions of pain and illness.

Embodiment

Embodiment means, quite simply, to represent something in bodily form. In medical anthropology, embodiment is tied to Mauss, who said that “we all are and we all have a body” and, as such, it is the “best tool to think with” (in Csordas 1990; Lock 1993; Van Wolputte 2004). Therefore, bodies are much more than biological/organic entities. Bodies are also symbolic; they mediate our experience, orienting us in our world while simultaneously making political statements. When we use our bodies to unite both our subjective and objective realities, we are said to embody our experiences.

At its core, embodiment is about breaking down the conventional dualistic binary distinctions between mind/body, subject/object and nurture/nature. Our Cartesian legacy, which conditioned modern biomedicine, has taught us to create a division between what is related to our minds (cognition, intelligence and, some would argue, emotions) and what is in, and about, our body. It is only recently that Western science has begun to realize the intersubjectivity that occurs between our minds and bodies; that stress⁹, pain and fatigue can have a direct impact on our physical bodies and vice versa. It was philosophers such as Merleau-Ponty and Bourdieu, who became concerned with collapsing traditional mind/body, subject/object and practice/structure dualisms by way of an epistemology called embodiment. They theorized that the body is capable of

transmitting knowledge, receiving knowledge and subjectively creating knowledge through a combination of perception and practice (Csordas 1990).

This research is similarly committed to questioning mind/body dualisms. This stems from the understanding within medical anthropology that individuals sometimes use their bodies and the language of illness and disease to speak about human suffering. Often it is the socially disadvantaged and marginalized people in our society who are forced to speak through their bodies (Scheper-Hughes 1994). As such, it is not enough to simply listen to what people speak about; we must also watch and listen for what their bodies communicate. In many cases, the body may be “the most immediate, most proximate terrain where social truths are forged and social contradictions are played out” (Scheper-Hughes 1994:232). In this sense, our bodies are a surface upon which culture is carried out, *and* the fundamental tools with which that work is achieved (Csordas 1990). As Csordas (1990:11) succinctly articulates, the body “is at once the object of technique, a technical means and the subjective origin of technique.”

Phenomenology

Due to the clear focus of this study on the experience of the individual and the nature of their lived experience, this research is also grounded within a philosophical framework of phenomenology. Caelli (2001:274) defines phenomenology as a “hermeneutic philosophical perspective . . . which recognizes a need to return to the grounding of truths in human experience.” More specifically, phenomenology is the study of “phenomena,” or the “appearances of things, or things as they appear in our experience, or the ways we experience things, thus the meanings things have in our

experience. Phenomenology is the study of conscious experience as experienced from the subjective or first person point of view” (Smith 2003). Phenomenology is a human science that studies unique persons. It is a method of inquiry based on the premise that reality consists of objects and events as they are perceived or understood in human consciousness and not of anything independent of human consciousness. Van Manen (1990:7) describes it thus: “it is a philosophy of the personal, the individual, which we pursue against the background of an understanding of the evasive character of the *logos* or *other*, the *whole*, the *communal*, or the *social*”(emphasis his). He goes on to say that phenomenology is something that can be grasped intellectually, but that real awareness requires “understanding from the inside” which can only be gained by “actively doing it” (van Manen 1990:8). In this way, phenomenology is both a philosophy and a methodological tool. Fundamentally, the aim of this approach is to gain a deeper understanding of the nature or meaning of our everyday experience (van Manen 1990). From the perspective of this research, phenomenology is well suited because it asks “holistic questions of meaning that spring from experience; in particular, phenomena that are not well understood and that are central to the lived experience of human beings” (Levasseur 2003:409). This approach becomes particularly meaningful when studying the subjective experience of pain. Pain cannot be empirically measured, and because of its inchoate nature, an approach is needed that doesn’t categorize and classify. Instead, phenomenology offers “plausible insights that bring us into direct contact with the world” (van Manen 1990:9).

As Caelli (2001) points out in a recent article, phenomenological research is fraught with a number of challenges for new researchers that range from a

misunderstanding of its philosophical underpinnings to a lack of articulated methods. Caelli's concerns are 1) a reticence on the part of phenomenological scholars to provide transparent descriptions of their methods; and 2) the ability of new researchers to comprehend the intricacies of the underlying philosophy. As pointed out, this is "tough stuff, very abstract, and very conceptual" (Knafl 1994 quoted by Caelli 2001:273). As such, new researchers are often left floundering when confronted by the complexity of the approach.

Unfortunately, Caelli does not expand on her discussion of how the philosophical framework of phenomenology is a pitfall for new researchers. Perhaps the abstract and conceptual nature of it barred a more in-depth discussion. Her only suggestion is that the philosophy should be well studied as it imbues all aspects of the research from the methodology through to the specific methods. It could be suggested, that any researcher working within a specific theoretical framework would do well to study it carefully and thoroughly. However, the nature of this kind of research is emergent, and one could presume that a full understanding can be arrived at only through continual exposure and practice. Furthermore, it may be a limitation to adhere strictly to the directives of only one kind of paradigm. An ability to be flexible creates an opportunity to develop new theories and ideas.

Notions of Power, Discourse and the Body: Perspectives on Foucault

Embodiment and a discussion of human subjective experience leads naturally to a discussion of Foucault for it was his belief that human subjectivity is constructed through particular social processes. According to Foucault, there is nothing "natural" about the way we perceive ourselves and the world around us (Foucault 1980; Greenlee 1991).

Our thinking and behaviour is shaped by particular *discourses* by which Foucault was referring to ideas (in the form of words, objects and images) that are structured to influence the way they are thought about and acted upon. In other words, the study of discourse is an investigation of what things mean and how those meanings are created in association with one another across various sites. A discourse of violence for example could be examined in terms of literature, newspapers, advertising and TV dramas. To examine it in only one modality, would be to lose a sense of the way in which violence is both transpersonal and culturally embedded. Similarly, 'pain' exists in a discourse which spans many social contexts. Inherent to discourse are issues of power, particularly in terms of how it intersects and produces knowledge (Rose 2001). Dominant ideologies or institutions produce knowledge through the use of *apparatus* (the forms of power and knowledge which define a particular institution, i.e. regulations, mandates, morals and laws) and *technologies* (practical techniques used to implement and purvey power and knowledge, i.e. material items such as stethoscopes and operating equipment) to shape the way we think about and interact with our social, cultural and political environment (Rose 2001). The ability of ideologies and/or institutions to inform or produce specific forms of knowledge is made through claims and assumptions of 'truth telling,' what Foucault calls "regimes of truth" (Rose 2001).

There are a number of powerful discourses that operate in a Western cultural setting in relation to the body. Foucault (1980:170) took a special interest in the body, for it was his belief that "different power apparatuses are called upon to take charge of bodies." By this he did not mean that individual bodies were in the possession of certain individuals or groups who hold power, but rather that bodies are shaped by *processes* of

power that have “different origins and scattered locations” that are able to regulate and normalize the “most intimate and minute elements of the construction of time, space, desire and embodiment” (Bordo 1990:666). The classic example of this is Foucault’s notion of “docile” bodies, whereby institutions (he uses the example of prisons, hospitals and asylums) encourage individuals through various apparatus and technologies to discipline themselves, to “conform” the body’s “constraints and privations, obligations and prohibitions” (Gremillion 2005; Rose 2001:166). For other reasons, bodies “are constrained to ensure their own good health” by political apparatus to ensure that the social body is healthy as a whole (Foucault 1980:170). Foucault contends that the basis for the imposition of good health is utilitarian. Bodies must be preserved and maintained to ensure a productive labour force and as a means of keeping individuals subjected. This last point sheds light on Lock’s and Wakewich-Dunk (1990) contention that the bodily pain and stress of workers (specifically those engaged in low prestige, manual-labour occupations) can be viewed as a mode of resistance and protest at the idea of having a healthy and productive body.

Today, women living in a Canadian context are subject to a number of powerful discourses that shape the way they think about their bodies¹⁰. As already mentioned, the most pervasive and ubiquitous construction of the body is the biomedical body. This view of the body allows biomedical institutions to pathologize pain (i.e. fibromyalgia), fatigue (i.e. chronic fatigue syndrome) and illness (i.e. menopause), and through these processes, medical professionals are able to “desocialize illness experiences” and reify them as biological and physical processes (Greenlee 1991:79). However, biomedicine is also imbricated in other powerful discourses that permeate Canadian culture and impact

the lives of women. These discourses are the normalized constructs of an ideal feminine body.

Gremillion's (2005:14) article *The Cultural Politics of Body Size* reviews the literature of the body to find a host of "normalizing cultural beliefs about the body, hierarchies of power and exclusion that are supported by and help constitute these norms, and the cultural role of scientific discourse about the body." Biomedicine is again a key player in the discursive formations that promote a body weight that is based on "medico-actuarial weight and height standards" charts. These height/weight tables are, as Gremillion (2005:22) points out, "unstable, racialized, ageist, nationalist, gendered and consumer driven" constructs that drive people to conform for the sake of their "health." Being slim is also about conforming to core social values that are promulgated by the popular media (in the form of magazines, advertisements, internet, television and movies) and the consumer-driven fashion, fitness, life-style and plastic surgery industries. These mediums suggest that being thin, toned and well-proportioned is a "symbol of having the correct attitude"; in turn, women translate this as having the willpower, commitment, self-control and ability to transform their appearance and "shape their life" (Bordo 1993:195; Reischer and Koo 2004:300). Bordo (1990:653), in her critique of these various industries, theorizes that we are currently living in a "culture of plastic" that makes it possible to 'transform,' 'reshape,' 'rebuild' and 'correct' the body in order to defy "the historicity, the mortality, and indeed the very materiality of the body." The implications of this are troubling on a number of different levels. As Bordo (1990:660) writes,

The general tyranny of fashion – perpetual, elusive, and instructing the female body in a pedagogy of personal inadequacy and lack – is

a powerful discipline for the normalization of all women in this culture. But even as we are all normalized to the requirements of appropriate feminine insecurity and preoccupation with appearance, more specific requirements emerge in different cultural and historical contexts, and for different groups.

Two things are occurring through the perpetuation of an ideal feminine body. First, the ideal feminine body is highly racialized. The perfect body, beyond being slim with specific proportions, has light skin, hair and eyes. Based on population statistics, these features are not the 'norm' and are, consequently, impossible for most women to achieve. Likely, this racialized form of 'perfection' has heightened the sense of inadequacy and despair many women feel. Second, a preoccupation with trying to conform to the 'body beautiful' comes at "the detriment of more socially relevant projects." This ties into Rapping's (1996) discussion of how women have shifted their gaze from a concern with social problems in the 1960's to a heightened preoccupation with personal problems and concerns in the 1980's. Reischer and Koo (2004:301) see this shift as inherently political and a mechanism "for social power and control" over women.

A problem arises when we discover that these polemics of the body beautiful describe women as passive receptacles of culture or blank canvases waiting to be 'inscribed' – in the sense that their bodies are simply reflecting dominant ideologies. Instead, women have the power "to appropriate the symbolic nature of their bodies to their own ends" (Reischer and Koo 2004:299). Others criticize the view that individuals can be cast as "passive dupes of ideology" because, "it gives too much to dominant ideology, imagining it as seamless and univocal, overlooking the gaps which are continually allowing for eruption of 'difference' and the polysemous, unstable, open nature of all cultural texts" (Bordo 1990:654).

As Foucault also indicates, there are multiple points of resistance to any discourse (Rose 2001). Not all women subscribe to the idea that they *have* to apply make-up, maintain an ideal body weight or increase their breast size to be considered valuable and/or attractive. They can either resist or negotiate dominant cultural values in ways that suit their personal needs and values. Reischer and Koo (2004:298) call this the *agentic body* which is an active participant or agent in the social world.” This “body is endowed with the capacity to participate in the creation of social meaning” (Reischer and Koo 2004:307). The idea that the body is able to create rather than simply reflect the existential ground of culture moves us back to a discussion of embodiment and Csordas (1990), for a self that acts on the world does so necessarily through the processes of embodiment. Reischer and Koo (2004:307) put it well when they assert,

The self is ultimately an embodied self, and the symbolic capacity of material bodies can thus be “employed” by this self so embodied as one way to act on the world, That is, bodies are not only constitutive of subjectivity, but also mediate the relationship between persons and the world: We meet the world through our bodies.

Within the context of this research, women’s bodies are shown to be “employed” in a host of different ways. Their bodies are employed literally in that they are intimately connected to the performance, and success, of their occupations. Symbolically, women’s bodies are also the locus of a series of competing discourses. The embodied effect represents both a resistance to, and confirmation of suffering in a Canadian cultural context.

End Notes: Chapter Two

¹ This is not to imply that Canadians are not complicit in the suffering associated with global inequality; rather the purpose is to suggest that Canadians do not endure the widespread grinding poverty associated with famines, wars and displacement in ‘developing’ countries.

² Anorexia is commonly linked with privilege – i.e. white and upper or middle class – however, Gremillion (2003:157) points out that “since the mid-1980s, an increasing number of studies have cast doubt on this epidemiological portrait.” Women of various ethnic minority groups suffer from eating-disorders however they are deemed “atypical” within most clinical settings. It may be that the prohibitive cost of many treatment centers (particularly in the United States) has barred women from lower socio-economic groups (which often translates into ethnic minorities) and this has skewed the statistical reality of women living with anorexia.

³ There is a well established epidemiological link between stress and jobs that are characterized as high demand, low control, long hours and low complexity (Link et al. 1993; Sauter et al. 1989).

⁴ For example, a greeter at The Gap is expected to be cheerful and fun, in contrast to a funeral attendant who is expected to be suitably somber and composed. The duration and intensity of the required emotion is indicative of the level of emotional labour required. In terms of servers, hairdressers and sex workers, the emotional labour expended would be considerable due to the duration of the interactions and the level of intensity. Intensity becomes important when an employee is involved in an occupation that services repeat clients because persons who feel they have a personal relationship with a service provider expect a more personalized and attentive exchange (Morris and Feldman 1996). Presumably, working for tips and gratuities, which are in essence a reward given to the worker at the culmination of an exchange, would heighten the level of emotional exhaustion.

⁵ This is a highly contentious claim. Many of the men and women involved in the Victoria hairdressing industry believe that what they do is socially important and deeply meaningful to their clientele.

⁶ Clearly, this is a situation that has changed through the decades. Men now make up approximately 35% of food and beverage servers, tipping has become the norm within North America and serving is not usually explicitly linked to the sex trade.

⁷ The literature that does focus on the emotional work of sex trade workers is almost exclusively focused on the experiences of exotic dancers (“strippers”). See Murphy 2003, Reid, Epstein and Benson 1994 and Wesley 2003 for a more in-depth discussion.

⁸ The use of the term “real” is not to imply that some emotions are more “authentic” or “genuine” than others. What is vital to understand is that emotional labour represents a situation where individuals are expected to feign certain emotions which *may* not reflect their actually felt emotions. For instance, smiling and being friendly to a customer even though they have been rude and demanding.

⁹ The term “stress” is highly problematic in that it has numerous meanings and seemingly unlimited uses. Furthermore, the term is often used with a limited scope that fails to recognize the non-linear nature of stress. As well, discussions of stress commonly perpetuate a mind/body division in that medical practitioners and health-based researchers create a division between psychological stress (that cannot be accurately ‘measured’) and physiological stress (that presumably can be ‘measured’). A complete unpacking of the term, while a worthwhile endeavor, is inappropriate here considering the scope of the project and the limited use of the term. The term, however, is included for two reasons: 1) women were asked within the confines of the ISW project to self-report on how much stress they felt they were under and this was one of the criteria that made them eligible for this study; 2) women frequently invoke the term stress because it is a common concept used to discuss matters of health.

¹⁰ This is not to marginalize or ignore the parallel discourses that affect how men view their bodies. Clearly men are also impacted by the notion that there is an ‘ideal’ masculine body (increasingly so). However, my research is focused on the experiences of women and it could be argued that these discourses are affecting women, if not a deeper and more profound ways than men, then in a distinct manner.

CHAPTER THREE: METHODS AND METHODOLOGY

This project was conducted with a firm commitment to a qualitative epistemology. Throughout, the goal has been to adhere to an in-depth, exploratory style of research to gain a meaningful understanding of how individuals experience and live in and through their bodies. As such, both the methods and methodology reflect this approach. A purposeful distinction is made here between *methods*, which are the practical tools and techniques used to carry out a project, and the *methodology*, which refers to the theoretical principals and orientation guiding the methods (Guillemin 2004). This project was conducted with an understanding that people, when communicating about deeply personal issues and concerns, often do so by talking or creatively expressing themselves in a multitude of ways. Thus, conscientious researchers should incorporate a combination of these same modes of expression. As such, this research was carried out through the use of in-depth interviews and body mapping. The theories underlying these methods are founded in principals of reflexivity, subjectivity and the critical assessment of divergent ways of knowing.

A caveat before beginning. It is valuable to contextualize the everyday experiences of individuals within larger social trends (as was done in the introduction); at the same time, it is important to avoid reducing the women in this study to a set of statistics. I did not (and do not) want to diminish the richness of their experience with claims of uniformity. However, throughout the analysis, adjectives like “most,” “many” or “a few” are used to convey the pervasiveness of certain themes. This is not to suggest that these women are representative of all Canadian women. Nor, are these women likely to be representative of all of the women involved in the larger ISW project (as discussed

in Chapter One). Instead, the purpose of this study is to show how some women located in particular social, cultural and economic locations are using their bodies to communicate distress and suffering.

Overview

This project was carried out in Victoria, British Columbia between October, 2005 and January, 2006¹. Women were recruited into the study through their participation in the aforementioned ISW project. Four criteria were established for participants to be eligible for the *Working through the Body* project. Each woman must: 1) have completed all four ISW interviews; 2) be willing to participate in a fifth interview; 3) self-identify as female (as the larger project included both males, females and transgendered individuals); 4) indicate during previous interviews that they experienced significant levels of pain, stress or fatigue. In this context, *significant* was not defined as ‘important’ but as ‘considerable’ (i.e. participants needed to report that they “very often” or “always/chronically” experienced pain, stress or fatigue).

Once it was established that a participant was eligible, I contacted her via telephone to see if she was willing to participate. In several instances I had a difficult time reaching the participants, so messages were left at the downtown outreach centers they were known to frequent. Of the four women I contacted this way, two returned the call and were recruited into the project. During all the initial telephone conversations, the project’s purpose was explained and the style of interview (i.e. non-structured) was outlined (specifically in terms of how it differed from previous ISW interviews). Included in this discussion was a brief explanation of body mapping and what it entailed.

Everyone that was contacted agreed to participate. In the end, fourteen women were interviewed from one of the three occupational groups: hairstylists (N=5), food & beverage servers (N=4) and sex trade workers² (N=5). Each of these women was paid a modest honorarium of \$35 for her time. The sum of \$35 was chosen as this was the amount given at the time of the fourth ISW interview.

Women were specifically chosen for this project for three reasons. First, as has been mentioned, it is well-documented in the sociological literature that sex trade, hairdressing and serving are highly gendered, female-oriented occupations. Second, as the literature review indicates, women are more likely to *report* temporary and chronic pain and more likely to seek medical attention for these experiences (Bendelow and Williams 1998). In addition, some researchers report that women experience more work-related illness, stress and psychological *distress* than men (Bendelow and Williams 1998; Jick and Mitz 1985; Haw 1982; Lennon 1987). It is not the purpose of this study to comment on the accuracy of this prior research. However, it did strengthen the decision to focus solely on the experiences of women. Thirdly, as previously mentioned, it is my belief that my similar social location to these women gives me insight into their experiences.

As mentioned in Chapter One, the 14 women involved in this project occupy social locations that are shaped by a number of specific variables. For example, the women represent a range of ages, ethnic backgrounds, educational attainments and family and socio-economic statuses. While many of the women were born in Canada, three others were born outside Canada – Eastern Europe, England and New Zealand – and immigrated to Canada in their late adolescence or early twenties. Two women self-

identify as belonging to an ethnic minority – Aboriginal and African Canadian. The women's ages range from 22 to 57 with the average age being 41. In terms of education, the average level of school completion is grade eleven. Forty-three percent of the women are married or involved in a common-law relationship and while many have children, only 21 percent have dependant children (i.e. 18 years old or younger). The average yearly income of the women is approximately \$22,175; however, because many of these women are not currently working (43 percent of the women are unemployed³, and 21 percent reported that they work only part-time) the income they report may include the money received from social-service programs such as Income Assistance and/or Disability Benefits. While owning a home in Victoria is not necessarily an index of social security because of the notoriously high cost of housing, it is nonetheless significant to point that 29 percent of the women indicate that they own their own home, 57 percent rent a house or apartment and 14 percent indicate that they lack secure housing⁴.

It should be noted here that a number of issues arose due to my selection process. To begin with, the University of Victoria's Human Research Ethics Board (HREB) approval was based on the limitation that participants could only be recruited based on their responses to a select number of questions posed during their fourth ISW interview. This means that when the majority of the women were interviewed, very little was known about their personal and occupational backgrounds⁵. As such, it was not known if the women would still be working in a service job. As it turned out, a large number of women were not working in the service industry and had not worked for an extended period of time. The implication of this was that many of the women had to reflect back

to when they were working in order to answer work-related questions. This selection bias may explain why few of the women identified any specific work-related pain or illness.

Another situation arose in terms of a time delay between the participant's fourth interview with the ISW project (when they originally reported experiencing significant pain) and their fifth interview with the *Working through the Body* study. For instance, although the average time span between the fourth and fifth interviews was four months, in some instances women were interviewed nine months after their final ISW interview. This meant that, in a few cases, the women were no longer experiencing significant pain or illness at the time of their fifth interview. While initially this finding was met with concern, I came to realize that this actually strengthens one of the central tenets of the project: that individuals embody their economic and social locations. Thus, when a woman has made significant, positive changes in her life, her experience with pain and illness is also likely to change. In addition, body mapping the experiences of these "healthy/pain-free" women highlighted the potential for this method. Mapping women's bodies through periods of sickness *and* health is a rich area for future anthropological investigation.

A third concern arose in regard to the four previous health-related interviews in which each woman participated. These previous interviews likely influenced the depth and breadth of the responses given during the fifth interview. All of the women were open, approachable and willing to share intimate details about their personal lives and health concerns. When asked specific questions about health and their bodies, women were generally quick to respond with insightful comments. While this was a boon for the

neophyte researcher hoping to evoke rich narratives, I was cognizant that these responses may have differed with other, less prepared, participants.

Finally, what bring this diverse group of women together are their gender and their involvement in service work. While the notion of 'service work' is an integral part of my project, the women will not be explicitly identified by the work they do. The reason for this is two-fold. First, by *not* identifying what occupation these women work(ed) in, attention is drawn to the similarities between the conditions of each of the occupations. Second, and perhaps more importantly, this is done to avoid stereotyping the "type" of women who would be engaged in each of these occupations. In some cases, the women's occupation will become clear and in Chapter Four's section on *Unpacking the Meaning of Work* occupation is specifically discussed. Appendix 'A' has been provided to give descriptive details of each woman, including her occupation.

Methods

This section outlines, in detail, the specific methods chosen to collect information. Included are some definitions and some preliminary reasons why these techniques were implemented. In general, however, this represents the step-by-step process that led to the collection of *life/illness narratives* (Kleinman 1988) and *body maps* (Cornwall n.d.).

Life/Illness Narratives

At the outset it should be established what is meant by *life/illness narratives*. A life history approach was taken whereby participants were asked to speak about the life circumstances that led them to certain occupations and their subsequent experiences with

pain and *dis-ease* (i.e. feeling ill or not quite right with the world). This did not entail an exhaustive summary of each woman's life; instead the purpose was to trace individual women's pathways to pain and illness.

Interviews lasted 1½ to 2 ½ hours and all were audio recorded and conducted in English. Questions were asked based on a number of broad themes (see Appendix 'C'): *general life history* (childhood, relationship with family and friends, education); *health and well-being* (definition of health, current health status, impact of stress on health); *work* (description of work, likes and dislikes, issues of control, impact of stigma, health impact); *the body* (general perception of body); *the body-in-pain* (locate specific locations and feeling of pain, stress and fatigue).

I began the interview by meeting the participant outside the interview space, located in a downtown Victoria heritage building. In two cases, the interviews were conducted elsewhere. One interview was done at a woman's house as she was unable to make the trip into town; the other interview was conducted at the University of Victoria because this was more convenient for the woman. For those that met me downtown, I would invite them into the space, introduce myself, and offer bottled water, juice or a light snack. One goal regarding the interview space was to make it a non-clinical setting. The room was casual and it had a number of plants, lamps and pictures on the walls, giving it a friendly, relaxed atmosphere. Once the participant settled in, the consent form (see Appendix 'D') was read and explained. All of the women were told that if answering any of the questions upset them, I would be more than willing to make an appointment with a qualified counsellor, free of charge. As the consent form was similar in style and format to those presented at previous interviews, all participants were

comfortable and signed without question. At this point I clarified that I would be turning on the tape-recorder and taking notes throughout the interview. Once the woman felt comfortable, the first general life-history question was posed, asking what her life was like growing up. Then, taking my cue from Paget (1983), the questions were “continually informed by the evolving conversation” (Mishler 1986:97). While the interview schedule was followed in broad strokes, the focus was on giving the participant as much control over the direction and flow of the interview as possible. As a result, there is considerable variety between the interviews in terms of what the women chose to focus their attention on. For example, women who were not working tended to focus on their childhood experiences or other aspects of their lives that they felt were relevant to their current health status.

This style of life-history approach was meant to focus on the conditions and consequences that have shaped each woman’s experience with pain and illness. In the end, this approach did not necessarily produce neatly packaged “illness narratives.” Women spoke about what was important to them. Sometimes their responses revealed a clear pathway to physical, emotional and mental pain and illness; other times, answers were ambiguous and contradictory and the pathway was less clear.

At the end of the illness/narrative portion of the interview, women were given the option of taking a break before the body mapping portion commenced. Of the 14 women interviewed, only two felt uncomfortable participating in the full-scale body mapping exercise (described below). One of these women was also the person who chose to be interviewed at the University. Unfortunately, this space was somewhat cramped and not conducive to body mapping, which requires a considerable amount of space. In addition,

this woman was wearing a skirt and felt uncomfortable lying on the floor. The second woman had arrived 45 minutes late for our interview and after talking for an hour and a half (which took us relatively late into the evening) we decided to forego the body mapping so that she could return home to care for her critically ill husband. A second interview was not rescheduled because this woman did not report *any* health concerns⁶. As she had a busy schedule and had participated in five interviews already, I made the decision to not call her back for a sixth interview.

Body Mapping

Body mapping is relatively new to the social sciences. In the past, it was used by psychiatrists and psychologists to study children. Anthropologists and sociologists have incorporated body mapping into their research in a number of ways, yet few studies provide well-articulated methods and concrete modes of analysis. Despite this problem, body mapping was incorporated into the project for a multitude of reasons. First of all, I felt it would be the most evocative way to uncover the deeply felt experience of pain. A tool is needed that can creatively access the inchoate and often contradictory experience of pain; because pain can be a difficult experience to articulate into words, it was felt that more could be revealed with a drawing.

Secondly, I wanted the participants to think about pain and illness in a way that contradicts our traditional assumptions. People commonly associate pain with corporeality, but as this research is based on the assumption that pain and illness have a complex etiology that defies the physicality of the body, a method was required that encouraged participants to think ‘outside the box.’

Finally, the theoretical backbone of this project requires methods that integrate both mind and body. The physical act of drawing and mapping our bodies incorporates a material physicality to the project that requires another level of awareness of how we experience life in and through our bodies. As Cornwall (n.d) indicates, “. . . body maps offer a way of opening up and entering into people’s experiences of living in their bodies, bridging gaps between knowledges, experiences and expectations, between the biological and the social.”

A unique style of body mapping was developed that drew on (and elaborated upon) two discrete methods⁷. The first style of body mapping was done by Karen Messing (2002), a Québécois researcher who has done research with sex trade workers in Montreal. She asked the women in her study to draw a generic outline of a body and then mark an “X” on the places where they felt pain. The result, while intriguing, did not provide any explanation of how sex trade workers in Montreal live with, understand, or manage what appear to be significant levels of pain.

Conversely, Marilys Guillemain (2004), who has worked with women dealing with menopause, took a more creative approach to body mapping and asked her participants to draw how their “condition” made them feel. These instructions elicited compelling and diverse responses. For example, some women drew their menopause as a series of platforms or life stages; others drew chaotic black scribbles which connoted their confusion. While this certainly illuminated the impact that their health concerns had in their lives, the drawings were decontextualized from their bodies. The women did not draw the outline or shape of their bodies; they were simply given 20x24 pieces of blank paper and asked to draw how they felt.

The body mapping portion of the interview began with each woman lying on the floor on a large piece of white paper⁸. In two instances, the paper was taped to a wall so the woman could lean against the wall rather than lie down. However, this method was quickly dispensed, as it resulted in body maps that were missing feet⁹. At this point, I drew an outline of the woman's entire body in a black felt marker. The women were not asked to reposition themselves or change their body position in any way; each woman was drawn exactly as she was because I did not want to signal or give the impression that there was a 'right' or 'wrong' way to do body mapping. From there, the woman got up and was given eight different coloured felt tipped markers¹⁰. Then, each woman was asked to personalize her body map by drawing her favourite and least favourite aspects of herself; the women were also asked to draw what she felt was the strongest and weakest areas of her body. The purpose of this was to encourage women to see the drawing as their own or as a space to visually depict *their* lived experiences and sensations (Mitchell 2006). Objectifying the process would have likely limited the women's expression and compounded any feeling that there was a proper way to do body mapping. Despite this, women frequently asked questions such as "Is this right?" or "How should I do that?" Invariably I answered that they could draw anything they wanted in any way they chose. This often led to long pauses while the woman thought about what she wanted to express and how she was going to draw it.

Once a woman had personalized her drawing, she was asked to mark all the places where she experienced a) 'general' and b) 'work-related' pain, stress and fatigue. The goal throughout was to move beyond a strictly physical understanding of pain to a wider mental, emotional and even spiritual conception. This had varying degrees of

success. Initially, the participants marked all the locations where they felt physical pain. For example, they would locate where arthritis affected their hips or the burning sensation felt in their feet at the end of a long day at work. At this point, many of the women reflected on how they had been feeling, and added emotions to their drawings (i.e. sadness in the heart, anxiety in stomach or chest). Other women were unsure about what 'should' or 'should not' be included on their body map or they were simply less forthcoming. For instance, some women made comments like "Oh, well, that's in my head, so should I still add that?" In many cases, when the women were unsure of what to do, they were reminded of the pain they discussed earlier in the interview. This was generally greeted with comments such as, "Oh yeah" or "I forgot about that." After the women were finished, they were asked to describe what they had drawn and if there were any reasons behind their colour choices.

Colour choice was often arbitrary. However, some women consciously chose colours to express specific kinds of pain. For instance, red and orange were chosen by some women to represent sharp or intense pain because of the connection to "blood," "heat" and "intensity." In other cases, women used colours they disliked for negative feelings – one woman chose brown and yellow to represent the "yuck" feeling she had in her stomach – and others used their favourite colours to represent the thing they most liked about themselves. One woman had extensive knowledge of colour theory and she employed this in her drawing. For example, she used green to indicate strength in her leg muscles because "green is the colour of trust," and she felt she could "trust in those muscles."

The final thing the women were asked to draw was the impact pain or illness had in their lives. For example each woman was asked “Is there something you could draw to help me understand how that feels?” or some variation of this question. Overall, the women found this to be the most difficult question to answer. Their first response was *always* to articulate in words how the pain felt. When asked, “Now, if you couldn’t use words, how would you draw it?” the women generally responded with either a long silence, nervous laugh or by repeating the question. A number of women didn’t draw anything at all. For those that did, the result was a wide variety of abstract and/or organic shapes. Equally common was a generic drawing of a ‘happy face’ with either the mouth turned down or the eyes closed to connote unhappiness or fatigue. Although the women had a hard time drawing the impact that pain has in their lives, this question prompted another level of introspection and engaged the women in a search for understanding their experiences with pain, stress, fatigue and illness.

Theories of method and discovery

The theoretical and practical concerns of analyzing the verbal and visual data elicited from these interviews are of equal importance to the methods themselves. What is integral is that the methodologies are flexible and complement a mixed-methods approach. In terms of the visual data, flexibility was required because the body maps are highly original (even ambiguous at times), and the method itself is viewed by many researchers as unorthodox. Similarly, there was a significant degree of variability between the transcripts; as already mentioned, some women focused on specific subjects (i.e. childhood or work) and had little to say about others.

Correspondingly, a methodology was needed that could be molded to the project while still revealing critical insights.

What is clear is that both the narratives and the body maps need to be considered together; in part to assess whether there is contradiction or agreement between the two methods of communication, and because it was difficult to separate one from the other. The women threaded their illness narratives through the body mapping exercise, and it is often crucial to reference the verbal text to contextualize the drawings.

Visual

The visual images gathered vis-à-vis body mapping will be interpreted using Rose's (2001) critical visual methodology as it is outlined in *Visual Methodologies: An Introduction to the Interpretation of Visual Materials*. Rose provides a theoretical base for thinking about 'what' and 'how' images mean, as well, she reviews the analytic tools she believes are best suited to the interpretation of visual images. Foremost among Rose's criteria of a critical visual methodology is to take image seriously. Too often, images are used as window dressing to give research findings an element of intertextuality rather than as important documents in their own right. Here, images are fully incorporated into the analysis and given equal weight.

When thinking about what an image might mean, it is important to look beyond the content or composition of the image itself (Guillemin 2004; Rose 2001). Whether it is a photograph, silkscreen, pencil sketch, painting or illustration, Rose recommends we consider the three sites where the meaning of an image is made; specifically, "the site of production," "the site of the image itself" and "the site where it is seen by an audience"

(Rose 2001:16-17) ¹¹. In terms of the body maps that were collected, what needs to be taken into consideration is that these images were produced in a non-clinical, non-judgemental space where the women were encouraged to draw anything they wanted in whatever manner they wanted. If the body maps were conducted in a clinical, sterile environment, the content, elaboration and creativity might have been inhibited. As well, the images were produced on a horizontal plane and as such, for their full effect, need to be considered from this same perspective (i.e. rather than hanging them on a wall to look at them it is best to view them laid on a floor).

In terms of the images themselves, there is a high degree of variability. Thus, beyond the images content (i.e. stomachs, legs, hands, etc), the colour, style and dimensions require careful thought. For instance, details I considered included the scale of the body maps. Taking into consideration that the bodies represented on the paper were life size I considered the size of the component parts (i.e. how large or small is the heart, the eyes, the stomach). As well, are the lines carefully measured and drawn? Is there an attention to detail? Or, are the lines loose and wavy or scribbled onto the page?

Finally, these body maps were created by a woman for another woman. No one else was present during their production and the images were created only at the researcher's behest. While the women were aware, in abstract terms, that the images could be used in the writing and dissemination of a thesis, and possibly shown to a wider audience, this audience was unknown to the women. Consequently, to understand what the images might mean culturally and socially, it is integral to understand that these images were produced in the context of a conversation where the women were able to describe, in words, *what* they were drawing *while* they were drawing. Under different

circumstances, if the audience was known and anticipated by the women, the maps may have been more explicit (i.e. instead of drawing a simple line to indicate the general arm 'area,' a more detailed wrist or arm may have been drawn) or less personal (i.e. one woman would not have drawn her breasts). As it is, the women often employed hand gestures to indicate the flow or movement of certain bodily processes or they punctuated how they felt by repeatedly redrawing a line or specific area of the body. Again, if a wider audience was anticipated, this likely would have been made more explicit in the actual drawings.

After careful consideration of the various modes of analysis Rose (2001) outlines (i.e. semiotics, psychoanalysis, etc.), I decided to incorporate both a content and discourse analysis¹², as they are complementary methods that can, when brought together, underscore images as socially and culturally valuable artefacts. Content analysis was used first to establish themes and patterns and discourse analysis was incorporated later to consider the wider social significance of the images.

A content analysis systematically draws attention to the various (independent and interrelated) elements that comprise an image. It is methodologically explicit in its adherence to 'scientific' principles of 'rigor,' 'reliability' and 'replicability' which is important for research aimed at an interdisciplinary audience that values both quantitative and qualitative approaches to discovery (Rose 2001). More importantly, content analysis is invaluable for the discovery of patterns and themes. While these are generally found by counting the presence/absence of certain variables (presumably to come up with percentages), the process also gives the researcher an opportunity to think carefully about the size, shape, colour, positioning and context of each of the composite parts.

For the purpose of this investigation, content analysis has been useful yet methodologically challenging. Because body maps rely on the cultural repertoire, imagination and drawing ability of each participant, they presented a wide variety of disparate images; consequently it was difficult to establish a rigorous and replicable coding system. As a result, codes were arrived at both deductively and inductively. While this is not the ideal way to approach content analysis, the uniqueness of the images required methodological flexibility. A strict inductive coding technique would have resulted in a vast number of variables that far outstripped their usefulness. For instance, the women as a group used a variety of techniques to indicate specific parts and locations on their bodies. These ranged from: 'X's to 'mark the spot,' straight lines, dashes, concentric circles, dots or, in some cases, 'realistic' renderings of particular body parts. On the other hand, a deductive set of codes would have likely missed the most interesting or unusual aspects of the images (i.e. one woman drew a large bubble around her head to indicate the "disassociation" she experiences). Therefore, to create unambiguous codes, I worked from my first-hand knowledge of the images (as the researcher present during their production) and combined this knowledge with the project's larger theoretical concerns about the body and embodiment. Thus, some of the variables coded for were the presence of a heart, liver, stomach, intestines and neck. Variables were also created for the use of written words, multiple colours and small circles/dots to indicate localized pain vs. long wavy lines to indicate diffuse pain. By no means were all possible variables accounted for; despite this, a number of interesting findings emerged. For example, a pattern became apparent where the women were drawing and labeling their 'mind' rather than something they labeled their 'brain' (a point that will be discussed in-depth in

Chapter Five). Similarly, it was striking how often women made references to their stomachs (externally and internally), their intestinal tracts and hearts (valentine shaped).

There are several drawbacks to engaging with a content analysis. As Rose (2001) explains, counting variables does not account for the visceral impact or “mood” of an image. It is a rather one-dimensional way of looking at any visual representation, whether it is a photograph, painting, drawing or illustration. This is certainly the case for the body maps presented here. In certain images, it is the play between colour, positioning, shape, line width and size that creates the impression of confusion, despair, confidence, etc. In other words, content analysis is incapable of capturing the interconnectedness of the parts that make up the whole. As well, this methodology looks at the images in isolation only, not taking into consideration their production and audiencing (Rose 2001).

Discourse analysis takes the themes or patterns that emerged from a content analysis and considers their wider cultural, social and political significance. More specifically, discourse analysis is focused on understanding *what* things mean and *how* a particular meaning is created. Drawn from Foucauldian theories about power and knowledge, this methodology looks at how knowledge intersects with power to produce knowledge and its effects (Rose 2001). This includes identifying the ideologies and/or institutions that have informed and contributed to the production of an image, text or object through claims and assumptions of ‘truth telling’ (Rose 2001).

For the purposes of this project, discourse analysis helped uncover the reasons why women draw and talk about their bodies in particular ways. For instance, three themes picked up through an analysis of interview transcripts revealed that women

communicate about an ‘anatomical body’ (i.e. what the interior of the body looks like from a biomedical perspective) ‘body beautiful’ (i.e. an idealized vision of an aesthetically pleasing [female] body) and ‘unmindful body’ (i.e. a body that is separate from the mind). Greenlee (1991) indicates that Foucault helps us see these as normalized constructions of the body that have been socially and culturally created through disciplinary techniques and networks of power and knowledge.

In terms of this research project, discourse analysis complements one of the project’s primary aims: to uncover the social significance of pain and suffering. For the medical anthropologist trying to understand how cultural meanings and social positions are embodied, it is critically important to understand how processes and institutions of power create and influence cultural modes of expression, because these discourses infiltrate all aspects of our lives.

An important contribution of discourse analysis to the analysis of body maps (particularly in contrast to content analysis), is that it enables the researcher to draw on multiple sources of information, bringing together images, objects, conversations and observations for an analysis that has both breadth and depth. As will be highlighted, it is the combination of visual and verbal data that provided the most comprehensive insights into women’s experiences. So, while the images need to be taken seriously in their own right, it would be short-sighted not to consider them intertextually.

Discourse analysis as it is applied here, also allows researchers to explore what is *not* shown in an image or talked about in a text. Content analysis drew attention to the finding that faces were missing from the body maps, but discourse analysis provided some explanation for this omission. It should be noted, however, that a

discourse analysis does not always provide the 'right' answer or argument for why something is missing. For example, the body maps this group of women drew did not, in large part, contain any reference to their sexual organs/body parts and this was surprising, considering that sex trade workers were a part of this study. An argument could be made that missing sexual organs among sex trade workers portrays alienation from work and, by extension the body, because it is intimately connected to the work. Yet, body mapping done with sex trade workers in other studies (Messing 2002) has elicited explicit reference to sexual body parts. The answer may be that Messing made the body mapping an objective exercise¹³ and by doing this she created representational distance between the women and their body maps. Whereas, this study was purposefully subjective and, at times, profoundly revealing; as a result, some women may have not wanted to make themselves more vulnerable than they already felt by drawing their bodies in such an intimate way. The point being, while a discourse analysis is potentially revealing and insightful it does not always yield the most satisfactory explanation. A researcher needs to entertain all possible explanations and theories.

As a final comment, Rose (2001) points out that a discourse analysis must necessarily consider what was mentioned in Chapter Two and that is, apparatus (i.e. institutional regulations, laws, statements) and technologies (i.e. material equipment: batons, police cars) of power. These are tools used in the efficient means of producing compliance with particular ways of knowing. At the outset, thinking about the body maps in terms of their sites of production and audiencing seemed irrelevant because there were no institutional apparatuses or technologies at play. On reflection, my

presence as a researcher associated with an institution like the University of Victoria gave me a position of power and likely influenced the body maps that were produced. While I made every effort to create a comfortable, non-institutional space, my presence may have shaped a discourse about the 'right' and 'wrong' way to create body maps. Furthermore, the consent forms each participant was *required* to sign could have been viewed as an institutional apparatus, and, in turn, affected the production of the images.

Textual

To begin the task of analyzing transcripts taken from in-depth, qualitative interviews, it is necessary to speak about some of the criticisms levied against open-ended interviews, and engage with the principles that underlie this method of gathering information. To begin, one of the primary critiques of qualitative research is that "the interview" is treated naively, as if it is the only source of information that exists about human experience. Sandelowski (2002:105) contends that this naiveté leads researchers to believe that the interview, "gives 'voice' to persons who may never have been heard before and offers privileged access to the authentic experience, private worlds, and true selves." Of concern is that researchers using this method are not being critical about how they engage with their participants and they are not analytical enough about the data they collect. In her words,

As evident in many qualitative studies, researchers seem to have forgotten the constructed nature of interview data, their status as products of a particular social interaction. They seem to have forgotten that people use interviews strategically to present, account for, and even justify themselves and their actions. Interviews are not only social constructed products, but also cultural products that combine memory, learned conventions, and narrative models for

telling one's story, with selected life events and conscious or unconscious motivations (Sandelowski 2002:106).

Sandelowski's critique is fair but only relevant to those researchers who believe they are collecting an objective account of 'reality.' I make no pretension in my research that I am gathering 'the truth.' Indeed, relatively few researchers who use this method are likely to make such a pretense, so to a certain extent, Sandelowski's critique is, in effect, attacking a "straw man." Throughout, my concern has been to understand how women use their bodies and the language of pain and illness to communicate suffering. As such, the way people "present, account for, and even justify themselves" is precisely what I am interested in exploring. Gathering subjective perspectives is not, in my view, a short-coming. Rather, it is intrinsically important information in its own right. Furthermore, I consider the interviews I participated in to be "joint productions" whereby the interviewer plays a crucial part in constructing the narrative (Mishler 1986). The information collected during these face-to-face encounters is subject to the social, cultural, historical and temporal embeddedness of the interviewer and interviewee as well as their exchange with each other (Kirby and McKenna 1989).

Another concern raised by Sandelowski (2002) is that interviewing, along with the interpretation and deconstruction that goes along with it, elevates the cerebral over the corporeal. This criticism has direct application to my project's larger phenomenological approach because investigating the individual lived experience is, in large part, focused on the individual's mental engagement with the social world (Miczo 2003). Sandelowski contends that qualitative researchers give primacy to what people think and emotionally feel, and do not pay attention to the body and its sensations of touching, hearing, smelling, tasting and seeing. Sandelowski (2002:108) articulates that,

The human experience we hope to evoke is “messy” not just because it is often ambiguous and contradictory but also because it is redolent and visceral; we can smell it and feel it in our guts. The Western cultural tendency to separate body from mind, and to elevate the mental over the corporeal, has trivialized the extent to which the body is the most obvious point of departure for any process of knowing.

This is a justified criticism and mirrors my own impetus for incorporating body mapping into my methodology. One of the strengths of this research is the combination of methods, which aim to integrate the everyday lived experience of individuals (as it is understood from a phenomenological point of view), with a focus on the body as the nexus of those encounters. This perspective mirrors Sandelowski’s but it is drawn from Csordas (1990:5) who takes a phenomenological approach to embodiment when he says “the body is not an *object* to be studied in relation to culture, but is to be considered as the *subject* of culture, or in other words the existential ground of culture.

Having established some of the underlying principles that shaped my approach to interviewing, I will now clarify the methods used to analyze my transcripts. A thematic analysis was chosen to capture the words, metaphors, schemata and ideas that people use to organize and interpret the sensations and events of their lives. After all, the discovery of themes is, in many ways, the basis of social science research (Ryan and Bernard 2003). Without it, “investigators have nothing to describe, nothing to compare, and nothing to explain” (Ryan and Bernard 2003:86). To provide an element of rigor and reliability, I will explain in detail how the categories and themes that structure the analysis were discovered (see Chapter Five).

At the broadest and most inclusive level there are four broad *categories* that organize the data I’ve gathered. These categories – *health, the body, work* and

embodiment – were arrived at deductively through a review of the literature and relevant theoretical principles. As these categories also guided the formation of the interview schedule, all four topics are clearly reflected in the women’s narratives. However, these categories do more in that they provide women with a coherent way to talk about what is important and meaningful in their lives. Embedded within each of these four categories are a number of *themes* that are more exclusive than the categories. These themes were arrived at both inductively (meaning that they emerged from the interview transcripts and body maps) and deductively (in that they came from a review of the literature and an understanding of the issues that impact women involved in service work).

Themes are defined here as, “abstract (and often fuzzy) constructs that link not only expressions found in texts but also expressions found in images, sounds, and objects” (Ryan and Bernard 2003:87). Deductively, I was aware of possible themes even before the interviews began. For example, my experience as a research assistant on the ISW project made me aware that ‘control’ is an important determinant of job satisfaction among servers, hairstylists and sex trade workers. What was not realized, until a full immersion in the data, was that ‘control’ is a theme that permeates almost all aspects of women’s lives. Overall, most themes were arrived at inductively through my prolonged engagement with the women’s words and drawings.

As I was concurrently the sole interviewer, transcriber, editor and analyst on this project, I was able to immerse myself in the data and get a “larger, more holistic understanding” of the data; I found that eventually “patterns/ arrangements behind the totality of what’s being studied” emerged (Carney 1983:58). While immersed in the data, a combination of techniques was employed to clarify what were the key themes being

discussed. Based on Ryan and Bernard (2003:89-91) article *Techniques to Identify Themes*, themes were found using, what they rather loosely term, "repetition," "similarities and differences" and "metaphors and analogies."

Repetition refers to the idea that if something is mentioned frequently enough then it must be an organizing principle in a person's life. To identify repetition, the transcripts were read and reread to come up with a list of topics that reoccurred. According to D'Andrade (1991:287), "Anyone who has listened to long stretches of talk knows how frequently people circle through the same network of ideas." Once a list was compiled, I simply counted the number of times a word or idea was mentioned. Through this technique it was discovered that 'change,' 'transformation,' 'self-realization,' 'body-as-communicator' and 'personal growth' are key organizing principles of women's lives.

Next, Ryan and Bernard's (2003) technique of finding *similarities and differences* was utilized. In many ways this is similar to the idea of looking for repetition, however, they suggest comparing excerpts of transcripts on the same question or topic and looking to see what are the similarities and differences. For instance, by focusing on each woman's discussion of childhood and adolescence it was discovered that there were two ideas that came up repeatedly. First, many of the women have suffered from low self-esteem throughout their lives and second, a large majority of women have endured some form of physical, sexual and/or emotional abuse (what many of the women called "a trauma"). Consequently, 'trauma' and 'self-esteem' became themes for my analysis. In the same way, by comparing the texts that accompanied the body mapping, major similarities in the way women talk about and draw their bodies was revealed; specifically,

the 'anatomical body' and the 'unmindful body' in which women were drawing their bodies but leaving their heads blank.

The final method, labeled by Ryan and Bernard as, *metaphors and analogies* involved a careful reading of the transcripts with the specific aim of documenting metaphors and/or analogies. After a careful reading, it was discovered that women rarely use analogies to describe their experiences. The exception was when women would talk about their bodily pain and illness. For example, to describe her feelings one woman evoked the image of sitting in a corner with a dunce cap on her head to indicate her feelings of shame and embarrassment. Another woman talked about the way stress felt like "horns" (sharp and hard) inside her body. Overall, the women's analogies were idiosyncratic and unique. There were two metaphors, however, that did come up repeatedly and that is, the notion of being on a "journey" to refer to the idea that they were moving forward in their lives. As well, the metaphor of "work" was used as in "I am working through my issues" or "I need to work on that" to indicate that effort is involved in their own self-improvement. As these metaphors were used repeatedly, they became themes and important focal points for my analysis.

Ryan and Bernard (2003) also recommend that researchers incorporate a number of labour intensive "processing techniques" to come up with a manageable number of themes. This generally involves counting the incidence of a certain word or doing a line-by-line analysis. However, these techniques were *not* employed in the context of this project for a number of reasons: 1) this was a small sample and I did not feel it was necessary to use techniques that are better suited to processing large quantities of data; 2) I was already intimately familiar with the details of each of the interviews and thus the

themes were, in large part, self-evident; 3) the process of counting words or phrases takes them out of their original context and renders them less meaningful for an in-depth analysis (Ryan and Bernard 2003). In other words, quantifying this kind of rich narrative may turn out be destructive to the intrinsic meanings underlying the information collected.

The number of themes for my analysis was limited by discarding those that stood alone and/or were tenuously linked to the larger categories that structured my discussion and analysis (health, embodiment, work and the body). For instance, women spoke frequently about their 'unusual intelligence.' While this is mentioned briefly in the analysis section, it is not a central organizing feature of my analysis. Instead, themes were focused on that complemented the practical and theoretical aims of my research. For example, there were countless similarities in the way women characterized their childhood and adolescence. While I focused on trauma and low self-esteem because they fit into my analysis of women's perceptions of their bodies and social suffering, a multitude of other themes emerged regarding women's relationships with their parents and siblings. For example, it was common for the woman to discuss their parents in terms of one being 'good' (patient, loving and attentive) and the other as 'bad' (selfish, neglectful or unbalanced). While important, these themes were not the project's primary concern.

As a final point, "there is no single set of categories [themes] waiting to be discovered. There are as many ways of 'seeing' the data as one can invent" (Dey 1993:110-111). This observation ties into Hall's (1980) point regarding the "preferred meaning" of images. While all "cultural texts" (images, sounds and words) are encoded

in their production with a preferred meaning (by which Hall meant the “imprint of the ideology of the dominant cultural order”), this meaning can be decoded in a multitude of different ways depending on the audience (Rose 2001:192). Similarly, there are a large number of themes that *could* have been established from these transcripts; however, my reading of the data was unabashedly influenced by my interest in women’s experiences, my exposure to the larger ISW project, my own research goals and by the applied and theory-based literature I based my research on. Consequently I had a heightened awareness of the issues that surround women and service workers and I was alert to any references to suffering, distress and embodiment.

Reflexivity

There is much to say under the rubric of *reflexivity* or, the critical assessment of one’s own assumptions, judgements and attitudes toward conducting research. I will begin by discussing the preconceived notions I had at the start of this project, specifically in terms of body mapping. Then the issue of ‘women’s voices’ and the ‘therapeutic potential’ of these interviews will be discussed. On reflection, it was my presumptions that led to some of the most profound moments of discovery. Perhaps foremost was my feeling that the participants in the study would either refuse or feel uncomfortable with the body mapping exercise. It was assumed that lying on a floor with a researcher crouching on the floor beside you, moving into your personal space with a black felt tip marker would make women feel awkward. To the contrary, this was one of the most intimate and comfortable moments of the interview, where I could either share a laugh or a personal thought with each of the women. While it was true that two of the women did

not create full-sized body maps, all of the other women were happy, even enthusiastic, to participate in this process, and it was during this time that I obtained a truly intimate portrait of each woman.

My biggest error in judgement came when designing the interview schedule. I felt it would be best to start the body mapping portion of the interview by asking women 'generic' and 'easy' questions about their bodies to ease them into the process. These were the "What is your favourite/least favourite aspect of yourself?" questions. As it turned out, these were the questions that evoked the most visceral responses. Women either felt embarrassed or immodest about praising one of their physical attributes; others were offended because, "It's like saying that one part of my body is better than another part of my body." The most troubling reactions came from those women who did not like *anything* about themselves. These were the reactions that, for me as a researcher, were the most difficult to respond to, for they showed the depths of some women's low self-esteem and despair. Through the process of drawing their body and then mapping out locations of pain, women's complicated and contested relationships with their bodies was revealed; it was at these moments that the women were, in many cases, at their most vulnerable. This realization highlighted for me just how serious my ethical and moral responsibilities as a researcher are. In response, I feel the need to create a representational distance between the images (which metaphorically are 'the women') and the audiencing of the images. As such, the original body maps will never be shown to an audience, and all papers and presentations resulting from this research will only show inadequate reproductions

(similar to those presented). The use of substandard images is purposeful for it is a way that I can disseminate my research while keeping the women, in some way, protected.

My final assumption was of a different kind, and it had to be brought to my attention. The purpose of this research has been, in large part, to deconstruct the mind/body dualism so prevalent, and commented upon, in Western cultures. One of my goals has been to show how individuals unconsciously (and, in many cases, consciously) integrate the mind and body in their conceptions of health and enactments of pain and illness. Despite this, I found that I was perpetuating this mind/body split in my preliminary interpretation and analysis. For example, I found myself (rather *unconsciously*) making a distinction between *physical* health concerns and *emotional* health concerns despite my intention of showing that this is an arbitrary and erroneous division. Extricating myself from this cultural legacy had been challenging but analytically rich. Through the process of identifying my own assumptions, it has been easier to identify other's unconscious separation of mind and body. This final point leads naturally to a discussion of how I have approached the question of women's "voice" and "agency."

My analysis will seek, in all ways possible, to let the women's voices be heard. Although the nature of the research project necessitates that I bring together and structure these women's experiences, I will give their words, explanations and interpretations equal footing. This means that the transcript excerpts that follow have received little editing. The purpose is to let the women's hesitations, pauses, laughter and general search for understanding speak for itself. As well, I have included notes to indicate what the women were doing at certain points in the interview (especially in the context of the

body mapping). For instance, I would indicate if the woman was drawing or making rapid hand gestures. According to Miczo (2003), the interview is highly indexical because there is so much non-verbal communication and yet researchers regularly interpret at the referential level alone. As well, throughout the body mapping, the women were invited to participate in the analysis. They were asked to describe what they had drawn, why they had drawn it and the reason for their colour choice. As such, their analysis will strengthen and, at times, contradict my own with the aim of reaching insightful conclusions. This is a strength of the project as, "I am working from a theoretical approach that questions singular truths and pre-existing meanings" (Guillemin 2004:286).

There is a final point to consider before moving on to Chapter Four and that is the therapeutic potential of the in-depth interview. According to Miczo (2003), giving people the opportunity to create a narrative out of an experience (particularly if there is a trauma involved), can be beneficial to the individual. Through the process of talking and "making-sense" of an experience, individuals can begin to integrate an event into the larger context of their lives. It also cannot be ignored that the one-on-one interview is, in many ways, constructed in similar ways to a therapeutic counseling session. The participant is able to come in and talk about what they feel is important in a non-threatening and non-judgmental environment. While it is, presumably, *not* the interviewer's usual practice to give advice, Miczo (2003) indicates that it is common for a researcher to offer (un)conscious social support in the form of reassurances, encouragement, understanding and sympathy. An example would be to nod while a participant is speaking or making an affirmative response such as "yes" or "right."

While the purpose of this is to build rapport and to facilitate a smooth exchange, Miczo warns that researchers need to be aware that participants may be looking for something more from the exchange.

In the course of the 14 conversations I participated in, women frequently made comments such as, “It feels good to talk about it,” “I feel better now that I’ve talked to you” or “I know I should get it out” and even “This is like free counseling!” While I was relieved that the women were not leaving the interview in distress¹⁴, the idea that the interview was therapeutic troubled me. At no point did I imply that I have any counseling background or expertise. On the other hand, I was empathetic and genuinely interested by each of these women’s stories. I frequently laughed with the women, and gave small reassurances and affirmations when it felt appropriate. I did this so the women would feel comfortable sharing the intimate and sometimes troubling moments of their lives, but it was not contrived. I was connecting with these women at a very interpersonal level that moved beyond my role as a researcher. As Miczo (2003:483) puts it,

The institutional position of research is that the interview is a data collection tool appropriate to certain types of research. Yet, the interview is also a communicative event between two human beings; it is a phenomenological experience for them both.

It should be noted that the majority of the women in this study explicitly mentioned that they had either attended lay counseling, crisis counseling or been to see a mental health professional (therapist, psychologist or psychiatrist). As such, I do not feel as though the women necessarily viewed me as a therapist or counselor, more, they were simply aware of the healing power of talk. This point will be returned to in Chapter Five.

End Notes: Chapter Three

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- ¹ Ethical approval was obtained for this project through the University of Victoria's HREB.
- ² It should be noted that these women refer to themselves by a variety of different terms: "prostitute," "escort" or "working girl." However, the term "sex trade worker" is used here because these women were recruited into the larger project by the term "sex trade worker" – referring to exotic dancers & masseuses, phone sex operators, escorts and street-level prostitutes.
- ³ The women were not working for a variety of reasons. Some felt they were too old to be working and another woman had recently quit her job to move to another country. One of the women included in this group did report working approximately one day per week (for an hour or two), but it was highly variable if she would work at all.
- ⁴ It is important to note that all four women who own their own home are married with spouses who have steady, dependable employment. Of the two women who lack secure housing, one of these women 'couch surf's' and the other woman has a permanent spot in a homeless shelter.
- ⁵ I interviewed five of the women involved in my study previously with the ISW project. As a research assistant on that project I participated in approximately 75 - 100 interviews and so it was not unforeseen that I would end up recruiting someone into my project that I had also had the opportunity to interview previously.
- ⁶ This woman not only had no physical health problems but she indicated to me that she has not had a single physical or mental health concern in the last twenty-five years. This finding was surprising considering she had been recruited into the project based on significant levels of pain, stress and fatigue.
- ⁷ I was also aided by Dr. Lisa Mitchell who has spent considerable time developing body mapping in her work with children in the Philippines (see Mitchell 2006).
- ⁸ The length of the paper was based on the height of the women but all pieces were .75 meters wide.
- ⁹ The lower part of the wall had an obtruding wooden baseboard that was difficult to draw over or work with; the result was that women's feet were either 'cut off' or added on afterwards.
- ¹⁰ There were actually 16 markers but only eight colours. Each colour had a thick-tip and thin-tip marker to give the women options in terms of line width and shape.
- ¹¹ Rose goes on to consider what she calls the three overlapping modalities that inhabit each 'site.' These are 'technology' (camera, paintbrush, etc.), 'composition' (content, colour, perspective) and the 'social.' Rose (2001:17) describes the social modality as "the range of economic, social and political relations, institutions and practices that surround an image and through which it is seen and used." While important, the body maps will only be considered from their site of production, content and audience.
- ¹² The term "discourse analysis" is used strictly in terms of how it is outlined in Rose's (2001) *Visual Methodologies* (i.e. it is a *critical* look at the role that power plays in the creation of meaning). This approach to a discourse analysis is not to be confused with a linguistic or psycholinguistic analysis of a discourse (i.e. a conversation between a minimum of two people) which is more properly understood as "pragmatics" which is "concerned with bridging the explanatory gap between sentence meaning and speaker's meaning" (Wikipedia Encyclopedia accessed May 2006).
- ¹³ Her body mapping exercise was done with pre-drawn, generic outlines of the body and women only had to mark an 'X' where they were experiencing pain.
- ¹⁴ No one chose the option of having a meeting with a qualified counselor free of charge.

CHAPTER FOUR: WOMEN'S WORDS AND IMAGES

In this chapter, the women who participated in the study are introduced and their words and images are shared. Women have been grouped into four broad categories that are loosely centered around notions of 'health,' 'embodiment,' 'work' and 'the body.' However, the chapter sections have been named after the women to highlight the importance of their voices in this project. For example, health is discussed under the heading *Sage, Tobi and Athena* and the important role that work plays in women's lives is covered in the section *Coral, Jane, Sam and Sparky*¹. These same four categories are also reflected (and elaborated upon) in Chapter Five under the headings, *Conceptions of Health, How Women Embody their Suffering, Unpacking the Meaning of Work* and *Women's Bodies: Symbolism or Agency?* A purposeful (and admittedly artificial) distinction was made between 'embodiment' and 'the body' for two reasons. First, there is a tremendous amount of information contained in the way women embody their social experiences; consequently an organization tool was needed to break the information into manageable sections. Second, although the two categories intersect and overlap in a number of ways, the category of 'embodiment' focuses on the way women are negotiating and even resisting a dominant biomedical ideology that separates mind and body. The section on 'the body' underscores the contradictory and contested relationships that women have with their bodies, its appearance and the way they grapple with powerful discourses about an 'ideal' female body.

The categories reflect both the theoretical and practical concerns of the project and the conceptual frameworks that women use to make sense of their lives. Embedded in each of these categories are a number of themes that were arrived at inductively

through a careful analysis of the visual and verbal data (i.e. 'transformation' and 'personal growth') and deductively through a review of the literature and my experience as a research assistant on the ISW project (i.e. 'control' and 'exposure'). Many of the themes discussed are threaded throughout all four categories. For instance, many women evoked notions of 'control,' 'change' and 'process' regardless of whether they were discussing their health or their work. All of the themes women use reflects the way they organize and interpret their experiences and sensations.

No single woman represents the group as a whole, nor can the women be pigeon-holed into only one of these four categories. Women have been placed in the categories where their words and drawings best reflect the range of thoughts and opinions expressed by all the women. Thus, within each category, divergent views on the same issue are shared to show the diversity within the group. For instance, Sage, Tobi and Athena have been brought together because Sage has a stable and multidimensional vision of health whereas Tobi's conception is more contested and likely to shift depending on the topic at hand. Conversely, Athena's definition of health is strongly shaped by her belief in her ability to control the way she feels through self-helping behaviour. In other words, a cross-section of experiences was needed in each category to cover the core issues being discussed among the women. Throughout, women's body maps are embedded within the body of the text. In some cases there is a marriage between a woman's words and her drawing, and in other cases they show a contradiction. Regardless, their body maps are important because they provide visual access into the subjective experience of living with pain and illness.

As a final caveat, I will end with a quote by Kleinman and Kleinman (1991) as a means of contextualizing my discussion and subsequent analysis within the slippery realm of anthropological investigation of human suffering,

Ethnographers enter the stream of social experience at a particular time and place, so that their description will be both a cross-sectional slice through the complexity of on-going priorities and a part of the temporal flow of changing structures of relevance. That such structures are contested, indeterminate, novel and changing means that the ethnographer's descriptions are always about a local moral world that can only be known incompletely, and for which the relative validity of observations must be regularly recalibrated. Moreover, what the ethnographer experiences matches how individuals encounter the flow of experience. They do not dominate it, or invent it, but rather are born or thrown into the stream of lived interaction (Kleinman and Kleinman 1991:277).

Sage, Tobi and Athena

All the women interviewed spoke about their health. Ostensibly, they did so because they were asked specific questions about their health and they felt compelled to answer. At another level, the concept of health gave the women access to a specific set of words, images and ideas that allowed them to communicate about their lives, to talk about what is meaningful and important to them. Consequently when women were asked to define health, their interpretations revealed the issues that were at the forefront of their minds. Many of these issues revolved around themes of 'control' – getting control, maintaining control or giving up control (i.e. "letting go"). However, it was just as common for women to discuss 'change,' 'growth' and an 'anatomical body.' The term anatomical body is used to reflect the prevailing biomedical discourse that shapes how these women think about and construct their bodies and health. What these discussions about health revealed was that women have highly nuanced conceptions of health that are

flexible and, at times, contradictory. Put another way, women's definitions of health are made up of a series of layers that shift and take prominence depending on the circumstances of their lives.

Sage is a woman who struggles daily with what she calls "terrible" pain. She has a number of lower back and hip injuries that she sustained earlier in her life doing strenuous physical labour in a long-term care home for elderly people. These injuries have been exacerbated over time by the physical abuse she endured from a boyfriend and an infection she acquired through the use of intravenous drugs (what Sage calls "dirty coke"). The infection, which was an antibiotic resistant strain, settled in Sage's "lower lumbar," and as a result she spent a period of several months in the hospital on two separate occasions. In Sage's own words,

I remember November 1996 I started the drug. By the summer of '98 I got a horrible bone marrow infection in my lumbar and SI [sacroiliac] joint. Horribly painful. I got hospitalized for three months in the [hospital] for this, I was on an IV drip of antibiotics and um, got out and went to [a rehabilitation] house. Sadly, I ended up, it didn't take long because of the environment and you're still like in the drug community . . . as long as you are in the drug community you end up using again! So there I was, didn't take long, I couldn't believe it. Here I was back to using again after all I'd been through and I still didn't learn a lesson. I still got addicted and would you believe now, less than four weeks and I just got out of the hospital and I've been there for seven weeks? Just this past month ago. And the same infection in the bone marrow, this time a lot more serious cause it was MRSA. That's um, um, um, Methicillin Resistant Staphylococcus Aureus and what I mean by that is antibiotic resistant bacteria has settled into my lumbar and my SI joint on my left side.

At the time of our interview, Sage had only been out of the hospital for four weeks so when asked, "How do you define health?" she responded,

Um for me, health is basically pain free. Yeah. Um, pain free and physically fit. To me, being not too skinny but not too fat.

Upon reflection, Sage added to this mainly physical definition of health by saying,

There's a mental reality to health, it's not just pain free. It's in my mind. My um . . . I, I, regard healthy as having healthy thoughts. Healthy goals! That, that, you know freedom from addiction. Emotional health too, it really plays a big part. Guilt. Low self-esteem . . . so, you know, definitely I'd include, as far as physical goes, average weight and no physical pain. But the emotional, mental are real big ones, and there is no pill, really, for that.

What contextualizes Sage's definition of health is her on-going "battle" with addiction. It is the addiction that makes her feel "too skinny" and it is also the cause of the lower lumbar infection that causes her "horrible," unrelenting pain. More than anything, the addiction is an enormous mental and emotional burden for Sage. She references this addiction repeatedly through our interview, and her words make it clear that this is an all-encompassing physical, mental and emotional struggle for her.

I know I'm going to have a clean [urine] sample. I'm determined that I will. Because tomorrow's a very frightening day, tomorrow's going to be welfare day. . . I gotta get the signs up in the window. Literally on the door. Um, "Visiting okay but please no drugs!" I'm kinda trying to compose a statement and pin it on my front door and put one in the window so that they don't knock and bring the drug. So I don't have to look or see it right there . . . And they're very tricky about getting in. I'm like, 'No, no, no' and they're like "Oh please, please can I use your bathroom? I have to pee so bad! Please can I please get in, I just need . . ." You know, there's a million ways they find to get in. The biggest [hits table with her hand for emphasis] is answering the door. Believe you me they can make their way through. [Clears throat] So many times I've been through that so tomorrow, here we go, time to buckle down and prepare to do battle. I just can't anymore, its over, it has to be over because you know, of all that I've said. It's all been too much and um, so I am in a good place today, I'm thankful to be alive, really. And above all, getting the one up on this drug, just getting myself to win because it's so sad how many people we bury every year.

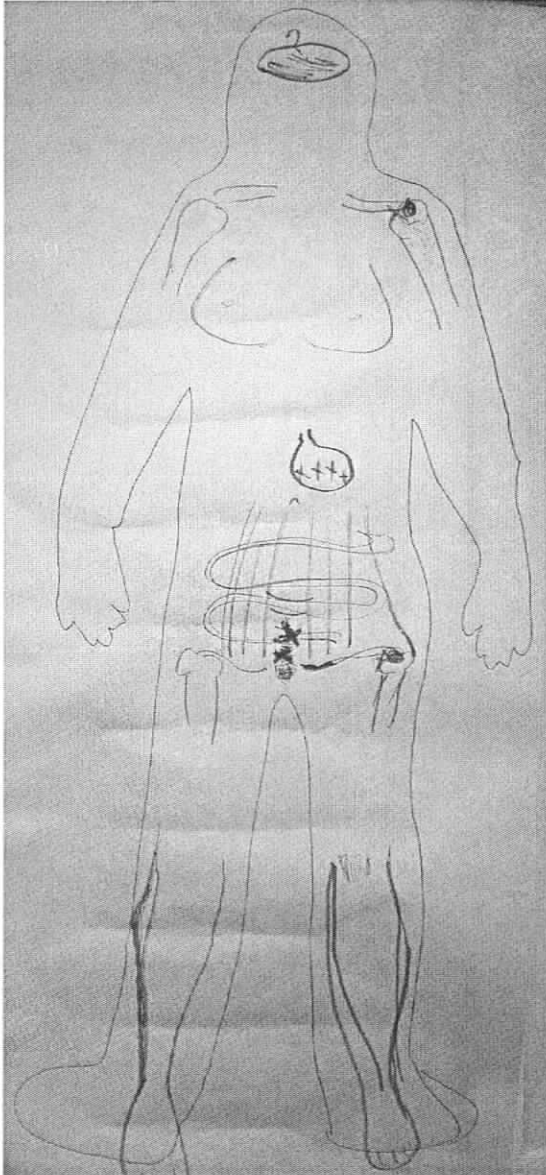


Figure 1: Sage

Threaded throughout Sage's narrative is her need to control her drug addiction. If she can "get the one up" on her desire to do drugs, and control the people whom she comes into contact with, Sage believes she will be healthier in all aspects of her life.

Sage's body map [see figure 1] reflects what she conveyed verbally. Although visually Sage doesn't make explicit reference to her drug addiction, she does draw all the places where she experiences pain, and she locates her emotional health concerns in her stomach with a series of red 'X's. What is interesting about Sage's body map is that it also demonstrates the theme of control. Sage drew each line on her drawing with purpose and precision. Where many women drew loose lines, scribbles or used symbols to

represent particular body parts, Sage took the time to accurately draw what she felt represented the way her body looks and feels. An example can be found in Sage's dialogue while drawing her calves,

See this kind of goes that way otherwise I have this leg kind of frontal [spends a lot of time drawing]. I'm trying to do a muscle bulge I guess. This one's a little more graceful. There's also some grace in the line, eh? Okay, that's a pretty good line, I'll leave that.

There. This is actually really nice I won't touch that but . . . what I have here [mumbles throughout about what should go where on her body map]. A bit sloppy here but . . .

What is salient to point out about Sage is that both her body map and her discussion of health are strongly influenced by a biomedical model of the body and disease. Her body map explicitly draws her bones and how they fit together. As well, she uses highly specialized medical terminology to discuss her various health problems.

In contrast to Sage, whose definition of health was focused around a single issue, there were women whose definitions of health were less stable and more likely to change depending on the conversation. Tobi, for instance, at the beginning of the interview defined health as primarily a physical state of being, but as the conversation progressed, she slowly began to allow that there was a link between her physical pain, stress and fatigue and her mental and emotional well-being.

Tobi is in her thirties. She owns her own business, which she loves, and she is also a mother of three children. Tobi is currently working through a number of personal issues that she feels are related to a past drug addiction, financial problems, low self-esteem and a challenging relationship with a recovering alcoholic parent. Happiest while at work, Tobi says she doesn't always look forward to going home because, as she puts it,

I'm not a very good mom. I'm not saying that in a negative way. I'm just not your stay-at-home typical, really 'Good Housekeeping' mom. So its, it's an effort for me and um, I don't always look forward to it. And I like being at [work] but I don't always like being at home.

Tobi shares in the course of our conversation that these personal circumstances make her stressed and anxious. Although she feels that she is quite good at managing her stress, she does experience a lot of anxiety [see figure 2]. She identifies back and shoulder pain,

headaches, difficulty
breathing, “stomach
problems” and “shakiness”
as all related to the stress
and anxiety, yet she is
hesitant to consider these
“health” concerns.

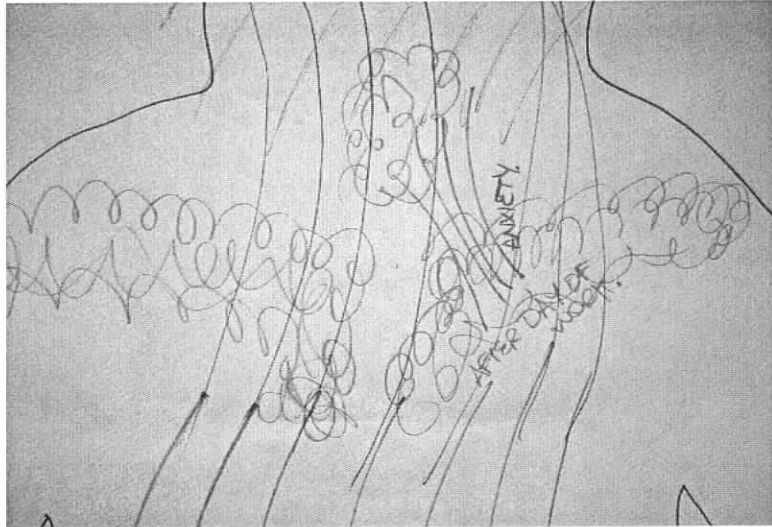


Figure 2: Tobi (chest)

When I asked Tobi to define health, her initial response was, “I don’t know” and then, “I don’t think about that a lot.” After a pause she said,

Tobi: I don’t. Um, this last six months or so I’ve gained a lot of weight. Almost 40 pounds. And um, I don’t like it [small laugh]. Actually I know that I need to incorporate some sort of exercise routine into my schedule.

I: I guess, when I am asking you to define health, I’m wondering if you look at it as a physical thing, a mental thing, an emotional thing, a combination of different things?

Tobi: Um, [pause] um, I guess I would mostly look at it as a physical thing. Um [long pause]. . .

When probed a little further to find out if any of the specific personal issues we had discussed were impacting her health, Tobi said reluctantly and with some doubt,

I guess, yeah, but I’ve never considered that health so much as um, just me. But overall looking at it I understand that it’s related, you know what I mean? I’ve just never really delved into that part of anything because there are so many other things to deal with first . . . so I just sort of want to deal with the priorities and knowing that if I understand who I am and I’m in a good place, having good health and having an exercise routine and having money and all that stuff will just fall into place. That’s what I’m thinking.

Tobi does identify a number of physical problems (excessive weight gain, back pain, headaches and a chronic disease) that she feels are health-related, but she tries not to think about these issues.

So knowing that I have [chronic disease] is not affecting me because I don't drink or abuse my body so much. But I tend to eat a lot of sugar and stuff like that now so I know that's another issue that I have to deal with because I don't want to get sick. I understand that . . . I mean I see other people with diabetes with this or with other things and they're dealing with it on a day to day basis and I think, "that would be really horrible to have to deal with that." Although it's never in the forefront of my mind because I don't want to have to deal with it [wry laugh]. Just, I mean, I don't want to have to deal with a lot things so I tend to push them back.

What Tobi is communicating throughout our interview is that she has a number of physical health problems that she knows should be a concern, but that she doesn't want to deal with them. She also mentions at other places in the interview that her physical health problems, specifically her weight, are affecting her emotionally because they are damaging to her self-esteem. She also indicates that if she can work through her personal troubles then perhaps her physical health will improve. So, while Tobi did not explicitly make the connection between the different aspects of her health at the beginning of our interview, as our conversation evolved to talk about a number of different issues affecting her, her definition of health slowly became more holistic as well. This is clearly articulated in the body mapping portion of our interview. Tobi's body map [see figure 3] indicates that her health is contingent on a number of physical, mental and emotional factors. It is also drawn in a way that echoes Tobi's feeling of being overwhelmed by the extent of her various issues and health concerns.

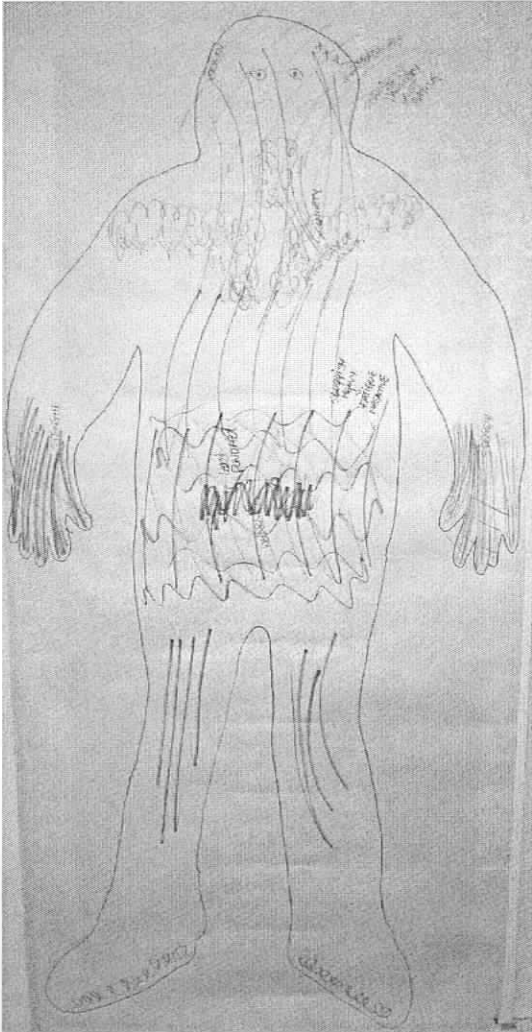


Figure 3: Tobi

And [long pause], and then just recently . . . oh what can I do here [considering her body map]. This hurts, upper stomach is just gross. You know like it's not like a pain but it's just a real yuck! [Laughs] I just don't even know how to describe it. It's just not good at all and I mean I hear people say to me over and over and I know it . . . "If you don't look after yourself you're going to get sick." And I just think its coming. I don't want it to. So, um, I also think that with the reading I'm doing [Dr. Phil] some of it is coming out.

For instance, Tobi situates her anxiety in her chest, stomach and throat and her stress is placed through her back and shoulders. She identifies an overall shakiness throughout her body and a terrible “yuck” feeling in her stomach that has an unknown etiology. Notably, all of these experiences are drawn as overlapping and non-localized scribbles that connote the pervasiveness of the problems but also a certain amount of confusion. When asked to describe some heavy, dark lines she had drawn, earlier defined as “heaviness” and “sluggishness,” Tobi segues into a conversation about her stomach problems.

Tobi's final comment reveals three things. First, it conveys that her concept of health is flexible and subject to change. Second, Tobi believes that her problems come from inside of herself. Third, it alludes to recent changes she has made in terms of how she

conceptualizes her health. Tobi articulates that she has been learning how to heal herself with the following comments,

Tobi: Anyways, just in this last little while I have been learning how to take responsibility for my actions and how to create my own environment and I'm learning how to deliberately create rather than having coincidences and being a victim and things like that.

I think that if I ever get to the point where, and I'm trying very hard, where um that doesn't bother me in our relationship [with mother] then I'll get to the point where I will be able to keep my house clean and have um, financial responsibility without any effort. Because right now, if I had that, it would be a very, very strong effort on my part. Like it would be a lot of willpower which, I'm not ready for that. So, that's what my goal is at this point. And it's funny because everything I read says you should write down your goals and I still haven't done that, I don't why I haven't done that.

I: You'll get to it, I'm sure.

Tobi: I'm sure I will [laugh]. It's funny how you put things. Actually I read somewhere that we self-sabotage because we get a pay off from it. If we didn't get a pay off then, then we wouldn't be doing it. Something is in some way a benefit from our self-sabotaging.

I: Mm.

Tobi: Dr. Phil. [By which she refers to the fact that she learned about self-sabotaging from Dr. Phil]

In addition to a strong commitment to changing the way she thinks about her health, Tobi's comments also evoke the theme of control. She feels that to be healthy, she is going to have to exert more control over her actions (willpower), something that she is working very hard to do. These themes of learning and control are also threaded throughout Athena's narrative.

Athena was one of the three women that told me that she was in the best health of her life at the time of our interview. Although she had previously indicated significant levels of pain, stress and fatigue during ISW interviews, she had made changes in her life that resulted in positive improvements to the way she feels. According to Athena, these changes were brought about, in part, by her attendance at a workshop in Vancouver that was geared toward the management of stress. It was here that Athena learned that people “embody” their stress as physical pain and illness.

When we started the more formal part of the interview by talking about her childhood, Athena communicated a considerable level of ambivalence. Her parents were divorced early on and she had little to do with her mother

thereafter. She couldn't remember any particularly happy times. However, when I moved our conversation into the present day by asking her to describe herself, Athena became more animated and shared with me her insights on how to live a healthier, happier life. Athena said the following,

Um . . . I have a very high work ethic. Um, I'm, I have a short temper [small laugh]. I uh, I'm a very, very compassionate person;

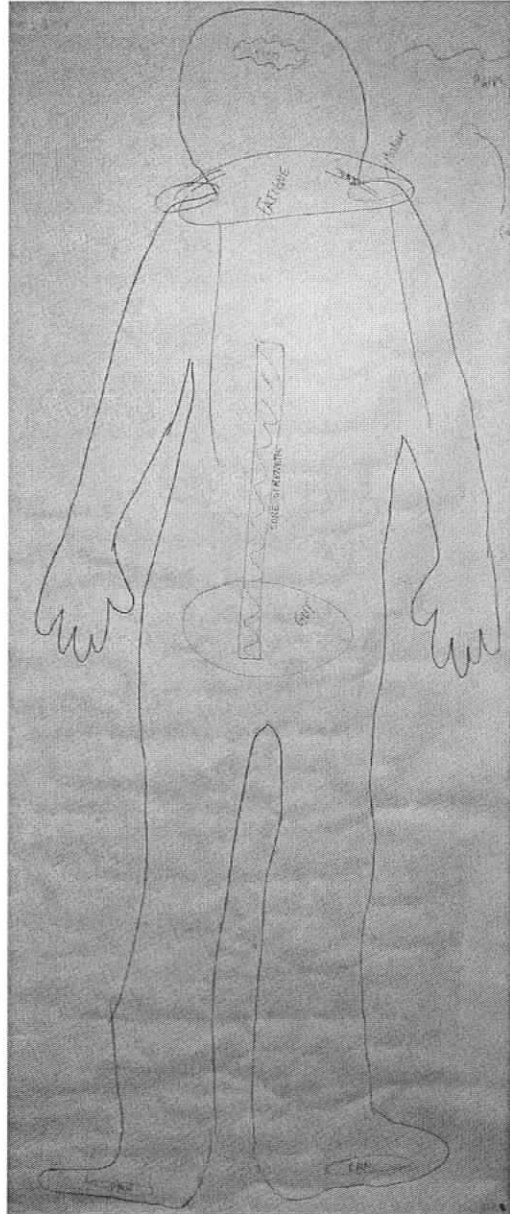


Figure 4: Athena

I'm a very compassionate person. And [pause] I'm constantly changing for the better but like still learning about myself and how I feel about things or things I enjoy or don't enjoy and to finally stop doing those things. You know, sometimes it's just realizing what's happening and what you need to do about it. So, um trying to . . . what I think of as a negative trait, I mean some people think it's a positive but if I think it's a negative then it's a negative for me and I need to let that go. So, so not conforming to what other people think too. To, you know, do your own thing and make your own path for what's going to make you happy because I look back and I think, [changes to higher tone] "Jeez I haven't really been that happy" [changes back to normal voice] because I have never really gone with what I feel like doing, a lot of the time I do what I think I should do or what other people feel I should do. So, not more, more not asking anyone else but asking myself and sitting with it for a while rather than responding right away and things like that.

At the time of our interview, Athena articulated a strong belief in her ability to change and control the way she feels physically, mentally and emotionally. According to her, there was a time when she felt she was *unhealthy* and *unhappy*, and it has only been over the last four years that she has learned she has the ability to change the way she feels. As an example, when I asked Athena how stress affects her health she said,

Athena: I mean stress is something we impose on ourselves. We can do it or we can not do it and I've just chosen not to do it and its much easier [small laugh].

I: Is it that easy?

Athena: Well it is but I mean to get to that point there are many different steps to get there but in the end it's that simple. No one is forcing you to be stressed out; you're doing that to yourself. If you learn the tools of how to make you not stressed out, which is individual, then, then it's, it's a feeling of total power and control. You know, somebody could be yelling at you and your boss or someone could be going off the handle and your heart rate stays the same and your emotions stay the same and I mean it's their thing it's not you so you just . . . you understand sometimes that other people are going through problems and it wasn't necessarily something you did but you just happened to be the person that's standing right there. And, it doesn't make everything acceptable but again it makes you more compassionate to what's happening.

When we began body mapping, Athena indicated that if we had done this exercise several months previously it would have likely looked different (“more extreme”), but because she was feeling healthy at the time of our interview, she didn’t have as many things to add [see figure 4]. What her body map does highlight is Athena’s belief that her health is multidimensional and dependent on a number of factors related to her physical, mental and emotional well-being. For example, Athena indicated that her favorite aspect of herself is her “core strength” which she locates in the center of her body. For Athena, core strength is “. . . physical and mental and it’s all encompassing. And it allows[s] me to, like it allows me to participate in everything, right.” Intriguingly, when I asked Athena to tell me what she felt was the weakest aspect of body she indicated it was her “constitution” and she located this in her “gut,”

My [pause] intuition has been, or not my intuition my constitution, like my whole, I couldn't quite figure out why, if my mind is strong, if I feel strong, why is my body kind of failing, like my insides. So, um, it's something sort of deeper that, about yourself it's . . . well, what is considered to be your gut, right.

Visually, Athena’s body map also reflects her belief that health is simple and easy to control, once you figure it out. Her choice of lines, shapes and colours is simple, straightforward and clearly expressed.

Jules, Stephanie and Charlene

In this section on embodiment, three women are introduced who indicate that their bodies are “communicators.” Virtually all of the women interviewed indicated that their bodies would signal, through experiences of pain, illness, discomfort or fatigue, that something was ‘wrong.’ Some women indicated that they had learned to “listen” to their

bodies; by paying attention they have become more aware of the factors that can potentially affect their long-term health and well-being. Other women were less verbally explicit about how they embody their suffering and distress, yet their body maps also reveal the notion that their bodies are communicators.

Other themes emerged within this category of embodiment beyond that of 'body-as-communicator.' Women also evoked the notion of 'transition' as in being in passage from one place to another. They communicated this idea literally by using the term "transition" and/or figuratively by using synonyms like "shift" and "process" to convey the circumstances under which their bodies were most likely to signal distress. The idea that "trauma" could and would affect the body also became readily apparent among the women's stories. As well, the body maps revealed that the "stomach" or "gut" was the area of the body most likely to embody experiences of stress and anxiety. These themes will be developed in more depth in Chapter Five, for now it is enough to simply point out their use.

At the time of our interview, Jules was in the middle of a self-described "major life change." She had decided to pack up all her stuff and make an international move so that she could reconnect with her family whom she had been out of touch with for over ten years. The decision to move led naturally to a number of other significant life changes. Jules had to quit her job and was, at the time of our interview, "transitioning out of a number of personal relationships" with friends, co-workers and clients whom she had formed strong personal ties with through the years. When I arrived at Jules' home to do our interview, the place was chaotic with large, professional moving boxes scattered

throughout. When asked to talk about and describe how she has been feeling recently, Jules responded,

Jules: It's not been overly great this last couple of weeks.

I: Okay, what's up?

Jules: Because the stress levels are through the roof. And, I'm getting headaches, muscle fatigue, huge muscle fatigue, joints are all creaky, my knee today coming down to find you was like my knee was all tweaky and I'm like what's going on?! Everything is spazzing out, today has been an exceptionally bad day. Well umm, I'm feeling a lot better I did a coaching session with one of my mentors and I coached him a bit, I actually feel better. . . Like I'd of been feeling really good, so if it was today without this transition it would be different but the stress levels right now are really hurting my body and I'm noticing. I'm nauseous a lot, I've got a stress cough, I wake up in the morning and cough a lot which is a stress cough which makes me feel like I want to throw-up and then the nauseousness kicks in and it takes quite a while to calm all that down. That's typical. I used to live like this every day for years on end and I didn't know that this wasn't normal [laughs] and when I got through all this stuff last year [break-up with boyfriend after seven years] I noticed very quickly when my body is telling me that it isn't happy. So, I get on and do something about it. I'm a little astounded at the level of stress I'm under right now. I'm astounded at the reaction. I'm a little amazed about that. I thought I would cope a lot better. I realized I would be going through a lot; I'm just a little amazed at what my body is doing. I thought it would cope a little better because my state of mind, even though I'm stressed is a little more mature about everything. So, I am a bit boggled about that.

When Jules indicates that she “used to live like this everyday” she is referring back to her childhood and early adolescence. Jules told me at the beginning of our talk that she had lived in fear as a child because her mother was “mentally unbalanced.” Through hindsight Jules realized that this fear was the reason why she always felt sick or unwell as a child. Jules describes her mother’s suicide in her teenage years as a relief from the “emotional burden” of her mother’s erratic behaviour.

While Jules indicated earlier that she was surprised by her body's response to her stress, she later contextualizes this comment by saying that she believes it is a normal response to the transition she is going through. She indicates that it is a necessary "process,"

I also figure this is a process and this last week of pulling this packing together has been heavy because it's on a time limit, I can't just put things off I've got to do things. And there are so many things that could go wrong. I haven't been able to sell my truck and I don't know why and I don't know what to do about it because I've dropped the price and it still won't sell so it's not a price issue, it's like, what do I do with my beautiful [truck] [laughs]? And I have three weeks to sell it and if I can't sell it, what do I do? It's like what do you do with it? So there's all sorts of things going through my head, things that feel that they are beyond my control and my body and my body does not like feeling like I can't control things so it struggles a bit. I hate it.

Jules expressed, throughout our interview, a strong belief that her body was an instrument for communicating to her when she is feeling stressed and anxious. Although she references the fact that she often felt physically ill as a child because she was always feeling anxious and/or frightened, she wasn't able to clearly make the connection between what was happening to her physically, mentally and emotionally until she went through a major break-up with a long-term boyfriend. She describes that time as follows,

Umm, so basically when I acknowledged it was over, I truly acknowledged it emotionally and not just in my head, I crashed. It was one ugly, ugly time. I was a jibbering idiot, I couldn't function, I was sick, depressed, you name it, I had it going on. But I allowed myself to go through it for the first time; I didn't try and block it out. I lay on the couch and cried all day if that is what I wanted to do. I called my friends in a panic not being able to breathe telling them that I was hysterically panicky because I was without [boyfriend] and I would let them talk me through it. I've never done that before, I've never reached out, I've never, I've done my work I've gone to counselors, I've read books, I've done journaling, I did all that as well but I really reached out and I allowed myself to go through it. Through that process I just learned so much about who I was, where

I'd been formed by my mother of mine and how much of an influence it had had . . . But that relationship, breaking that relationship, and taking the 18 months or whatever it's been to really figure it out has been has been the biggest, strongest, most painful learning journey I've had.

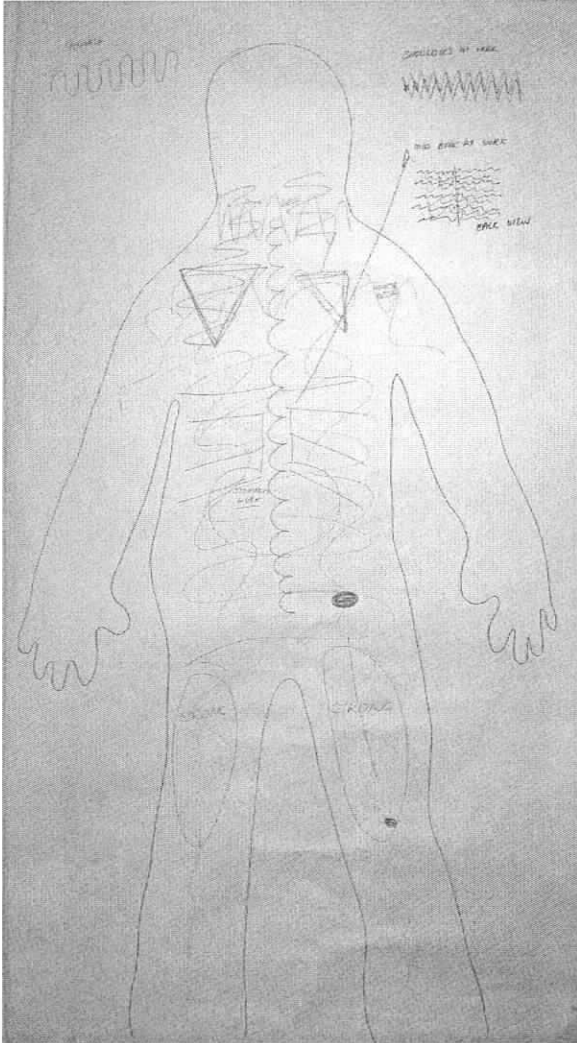


Figure 5: Jules

Jules told me that after she went through this painful journey, she became more aware of how her body responds to stress and unhappiness; consequently, when she starts to “drop weight” and experience “headaches,” “muscle fatigue,” “creaky joints” and especially “nausea,” Jules knows that “something is going on with me.”

This way of thinking about her body was easily translated by Jules into a body map [see figure 5]. Jules purposefully chose colours, shapes and line types (wavy, straight, and jagged) to convey the way she embodies her *dis-*ease. For instance,

I: So you have purple up there for the weaker areas [pointing to specific sites on the map] which is your core area and through your shoulders a bit. Why did you choose purple?

R: *Umm, it has a depth to it. It's umm, funny enough it's quite a nurturing colour. Umm, it's also the colour of communication so I think it's where my body tells me that it's not happy. Umm, my stomach especially, it's my big communicator and I don't take that*

into consideration nearly as much. I mean I do but just even talking to you makes me realize that my stomach tells me quicker than anything what is really going on.

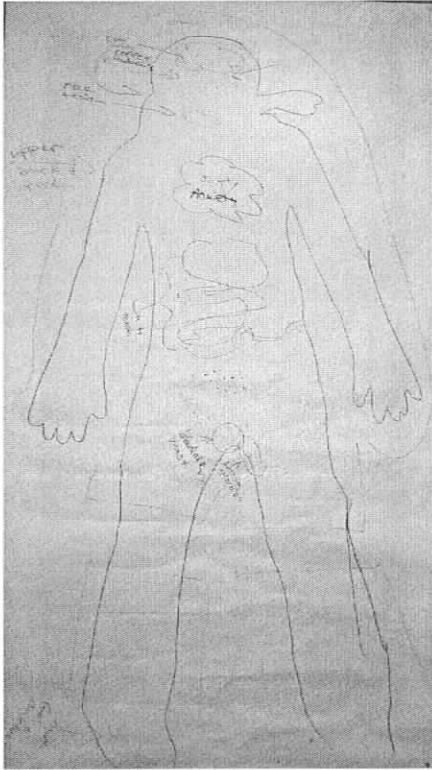


Figure 6: Stephanie

Jules was certainly not the only participant to make such evocative use of words and images to talk about how and where in her body she embodies the personal circumstances of her life. Stephanie presents a similar example.

When Stephanie was in her early adolescence, she began having “fainting spells” which she says were the result of “not being able to deal with her emotional issues.” Those emotional issues hinged around the sexual abuse that was inflicted on her by a member of her family. The fainting spells resulted in Stephanie being diagnosed with “somatization

disorder”² and eventually being sent to an “adolescent psych ward.” Stephanie clearly articulates that her placement in this institution was “ethically questionable” and an inappropriate place for her to be sent. It was her feeling that it is unsuitable to place kids with “internal” issues (of which she considered herself one) with children that have “outward behavioral problems.” In the end, Stephanie did not stay long at the institution. She was briefly placed in a foster home, and eventually made her way back to living with her parents and siblings.

Today Stephanie describes herself as a “type-A personality.” She is an overachiever at school where she is enrolled in a highly demanding academic program.

She also indicated that she is currently going through a period of transition.

I: So, you said that you are going through a personality shift, what does that mean? What are you shifting from and to, and how is it happening?

Stephanie: I was in this relationship for a really long time and I was a really good girlfriend, you couldn't of found a better girlfriend. I was like the best girlfriend ever and it like took up a lot of my time and energy and it also precluded developing intense like, girlfriends too. It was also a fairly hideous relationship where like, I just got kicked around a lot so um, I've just been in the process of shifting that identity into something that I haven't quite negotiated yet. So, um I have lots of girlfriends and I'm not putting emphasis on my relationship, but there is some balance to be found that I haven't quite, like I don't really know if I want to be in a relationship, I'm at a bit of a loss. Plus like, the difference between student and [graduate] student is quite large and there is this shift in class and power that is a bit difficult to negotiate. Like it's a whole new feel basically that I'm not used to.

When Stephanie was asked how she has been feeling lately she expresses the following concerns.

Um, well, several weeks ago it was quite crappy because I was so burnt out and sick and tired. And then it has not been great because I haven't really, I didn't have any reprieve time between when I quit work like Labour Day and when I started school the day after Labour Day so I didn't really have enough time to shift. So, I think that impacted both my physical and mental well-being because I didn't even get the time to like shop for school clothes for example. And um, um and then I got the flu which didn't really particularly go away and then I was throwing up and getting up and studying again. I just haven't been giving myself enough time and I don't feel like I have [enough time] to give myself. And so it's been kind of up and down depending on, I think I am quite susceptible to colds, etcetera, right now. Um, and I have this chronic bladder infection too, which isn't very good and these chronic, reoccurring yeast infections which is like even worse.

Earlier in our interview Stephanie makes a concrete link between what is going on emotionally and mentally for her and how her body responds. For example, when Stephanie was asked to talk about how stress affects her health, her initial response was to laugh because she felt as though it was a redundant question. When probed further to get more details she said,

Like I don't get sick unless I'm not feeling well emotionally or, um, I am totally exhausted. Like the two are so interconnected that it's sort of . . . it's hard to differentiate the two [mental and physical] and most of the things that I have been sick with throughout my life have been related to stress. So, I think there is a fairly intense link between the two . . . There are some components of it that are all over the shop but there are some very specific things that happen under very specific circumstances. Like, um if I'm under family stress and instead of acknowledging that things aren't going very well, I'm pretending to them that things are going well and I pretend to them that I am doing really well, then I get a migraine. Like a really bad migraine and it happens as soon as I leave the stress, I get wiped out for a while. And I have some fairly serious stomach intestinal problems from ongoing stress for such a long period of years and years.

This link Stephanie makes between her mind and body is further elaborated though her body map [see figure 6] where she concretely locates particular points of stress in and on her body. Most notable, Stephanie, like many of the women, locates her (di)stress in her stomach/gut and intestines (this is similar to all three women discussed in the previous section). When asked to draw how her stomach concerns affect her Stephanie draws [see figure 7] while making the following comments,

I: Maybe you could describe for me now what you've drawn?

Stephanie: I think its like, kind of just there. It's not like traumatic or [inaudible] or anything like that it's just like, pain, walking along.

I: So, it's a constant pain?

Stephanie: It's just a constant pain and you know, I mean it does get worse or better but it's never gone, so it's never, like if it's noticeably worse it still isn't intolerable or anything like that, its just hanging out.

Not all the women interviewed were as explicit as Jules and Stephanie about the link between physical pain and social suffering. Neither did all the women utilize cultural ideas about 'transition' and 'process' to explain their experiences. To be precise, three women did not draw on these themes. This is not to say that they did not embody their personal, social and cultural experiences. In many cases they did, but they did so in subtler ways that require some interpretation. Charlene provides an example of this. Before introducing her, I should make a few comments about our meeting.

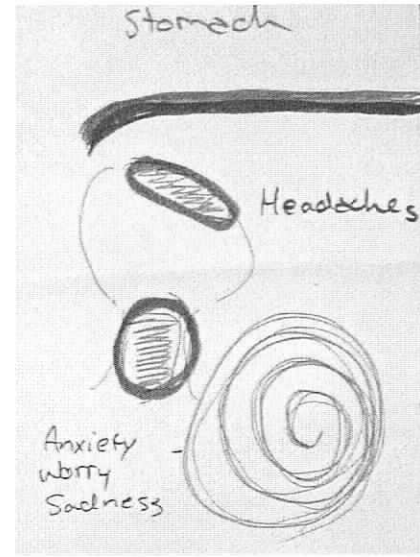


Figure 7: Stephanie (detail)

When Charlene was contacted to do the interview she was more than willing to participate. However, when she arrived at the interview I found that she had difficulty answering some of the questions, and the result was that many of her responses were either limited to one or two words or ambiguous. Her behaviour throughout the interview, in addition to her comment that her mother and siblings were "severely retarded," leads me to believe that Charlene may also have had some slight cognitive or developmental challenges herself. Consequently, while Charlene told me about a number of health problems that included various diffuse and unexplainable experiences of pain, fatigue and illness, it was often difficult to pinpoint how exactly Charlene was feeling. For example, Charlene indicates that "there is something wrong"

with her and that she “feels tired all the time,” however she offered few details and had difficulty articulating anything more.

Charlene showed up for our interview in good spirits. She has a deep, throaty chuckle and used it frequently throughout our interview; this was despite the fact that she had a troubling story. The very first thing I asked Charlene was to tell me what it was like growing up. This was her response,

Charlene: My life. It wasn't good.

I: No?

Charlene: It was abusive. I wasn't raised by mom or my dad. I was raised by a grandmother, she was not good woman.

I: No?

Charlene: Too much abuse in my family. I tried to kill myself when I was 13 because I didn't want to stay there anymore.

Charlene didn't want to stay with her grandmother because she was a “wicked woman with a terrible temper.” Besides being regularly locked in a cellar, Charlene was beaten and labeled by her grandmother as “the devil's daughter.” Once Charlene was old enough, she left home and moved to another province where she worked in a number of different types of service jobs to get by (housekeeping, nanny and waitress). At the time of our interview, Charlene was in her fifties and living, full-time, in a downtown street shelter.

When asked to define health, Charlene seemingly didn't understand the question. When the question was repeated she simply stated, “Health? I'm not healthy.” From there I asked Charlene,

I: Why aren't you healthy?

Charlene: I don't know, I feel weak all the time. I have something wrong with my blood, eh. So, I take this Paxil, some Paxil pills. I see my doctor all the time.

I: So what do you think is wrong with you?

Charlene: Um, my mom, same thing, same thing wrong with her blood is wrong with my blood. And I don't keep my appointments half the time. And like when I'm walking I feel so . . . drained. I just want to sit down, don't move for a while.

Throughout our interview, Charlene makes unusual connections between her mental and emotional well-being and her physical experiences of pain and illness. For instance, Charlene makes a connection verbally between her depression (for which she is taking a medication called Paxil) and her blood. Charlene may be embodying her depression figuratively in her blood, or it may be that she believes her depression is hereditary. She also indicates that she is concerned about her weight and frequent, enduring colds. Interestingly, she locates her colds, in part, in her ankles.

I: Anything [other health concerns] beside your eyes and your fingers? No? So, do you feel pretty healthy otherwise?

Charlene: No, I have to lose weight. I'm okay but I catch a lot of colds, easier. I don't know what's wrong with this weather. You get cold, you get sick, you get hot, you get cold. But everybody gets a cold. The last cold I had lasted 4 months. I had it really bad in my chest and in my ankles.

Although it is far from clear how, or if, Charlene is making a connection between pain and illness and the personal suffering she has endured in her life, her body map *is* very clear. When I first asked her to mark down all the places where she feels pain, Charlene's first response was to say, "You mean where he hit me?"

On her body map Charlene indicates the places where she was hit in the head with an ashtray; burned with a cigarette on her arms and hands; stabbed in the shoulder and

chest; kicked in her jaw and her eye. Along with this, Charlene indicates that this past boyfriend “broke many bones in my body, I couldn’t walk. I always got up and walked on my own because they said I wouldn’t walk again. I was pregnant and lost my baby too. He beat me really bad.” Charlene marked all these areas with brown ‘X’s’ [see figure 8].

When asked if she experienced any other pain not related to this beating, Charlene simply and poignantly drew a valentine heart and placed four black ‘X’s’ in the center. She

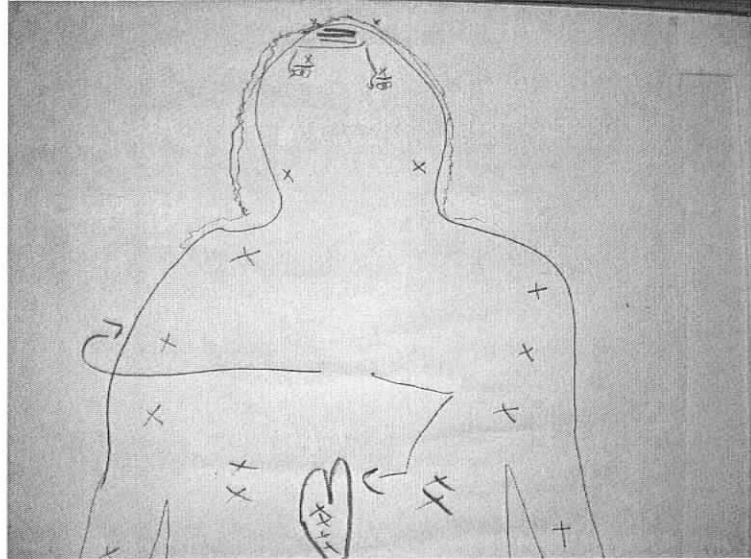


Figure 8: Charlene

indicated that the ‘X’s’ in her heart represented “how he hurt me and all the abuse, everyone abuses me.”

Although Charlene does not attempt to create meaning in her life by drawing on the notion of embodiment or using cultural concepts like ‘transition’ or ‘process’ as other women in the study did, her words and drawing clearly show that the suffering she has endured throughout her life has been inscribed in and on her body in a lasting and unforgettable way.

Coral, Jane, Sam and Sparky

What originally brought this disparate group of women together was their involvement in one of three interactive service jobs. While many of the women no longer work in one of these service industries, work remains a vital way for women to

contextualize their experiences with pain and illness and frame their identities. Among all the categories touched on in these interviews, work elicited the greatest disparity in terms of lived experience. In other words, there was little agreement among the women in terms of the role work plays in their lives. For some, work is vital to self-esteem and a sense of purpose, for others, work is a source of shame and disempowerment. It was common for all women to report mixed feelings about work that depended on the day; one day might leave them feeling happy and energized; other days might end in physical and mental exhaustion. This is commonly reported by people whose jobs consist of interacting face-to-face with the public and doing emotional labour. The women, however, did not engage with the term “emotional labour” explicitly, and they did not always make a connection between how they feel at the end of a shift and the emotional management they do while working.

As discussed in Chapter One, all three occupations share a number of structural characteristics; despite this, there were few similarities in the way that women spoke about their work. I say “few similarities” because there were two themes that did emerge. First, all of the sex trade workers spoke about feeling ‘exposed.’ As no other women mentioned or referred to this feeling of vulnerability, it is likely that this is a condition of working in the sex trade, particularly because four of the five sex trade workers interviewed work from the street, where, it could be argued, they are put on display for public consumption. The second, and more pervasive theme was, once again, ‘control.’

At the time of our interview, Coral was unemployed, but she fervently expressed a desire to start a career. When she was a hairdresser, Coral felt as though, “I was just limping along in my life. I wasn’t ready for a career before; I had way too much I had to

deal with. I'm just ready to get on with it [now]." While she was not sure what career she would like to have at the time of our interview, Coral knew she did *not* want to be a hairstylist. Eight months previously Coral was fired from her job at a hair salon, and she describes the event as "the best thing that ever happened to me." When she arrived at our interview, Coral came armed with a thick pile of notes outlining, in detail, the problems she encountered at her job before she was fired. These problems encompassed all aspects of her work, including but not limited to: personality conflicts with two consecutive managers and other co-workers; feelings of inadequacy in regard to her skill and ability as a hairstylist; feeling powerless to choose her work location (it was a franchise) or control the number of days and hours she worked; a lack of job security; personal discomfort with physically touching strangers. Some of these issues are typified by Coral's description of a particularly bad day,

I told [manager] I wanted to quit, that I couldn't take it anymore. I was working more days than I ever wanted to. I stated to [manager] that I did not know how to do "up do's." She said that was not a problem. That day I melted down. [Manager] told me that I would have to learn them [up-do's] to get my raise. I asked [co-worker] if she could teach me. I explained I had no clue how to even twist hair, that I needed an "up do's for dummies" class. During the class [co-worker] was trying to show me something and I wasn't getting it. She announced, "It really is an 'up do's' for dummies class" and everyone laughed at me. I felt embarrassed and ashamed.

Although Coral paints an unpleasant picture of what it was like being a hairdresser she does admit that there were some positive aspects to the job,

A lot of days were easy, like a lot of things were smooth, the conversations were great, I had some really, really neat conversations. And that way it was like doing research. I really found it interesting. Some of the people I really, really liked. I always had a problem though with me being a hairdresser. Because it just did not feel like my calling in life . . . I didn't feel that there was much control.

In terms of her health, Coral felt as through her work as a hairdresser “aggravated everything, I think it aggravated everything to do with me.”

I felt like [work] was ruling my whole life. My days off felt peppered with the whole thing. Everything felt like this job . . . It [schedule] was like nothing that . . . everything I agreed to and they agreed to, didn't happen. So physically, I was going against my beliefs, physically I was going against my own everything. It was going against everything I believed in. My body was rejecting every single day it felt like.

This bodily rejection included a number of health problems, including: “intense” neck

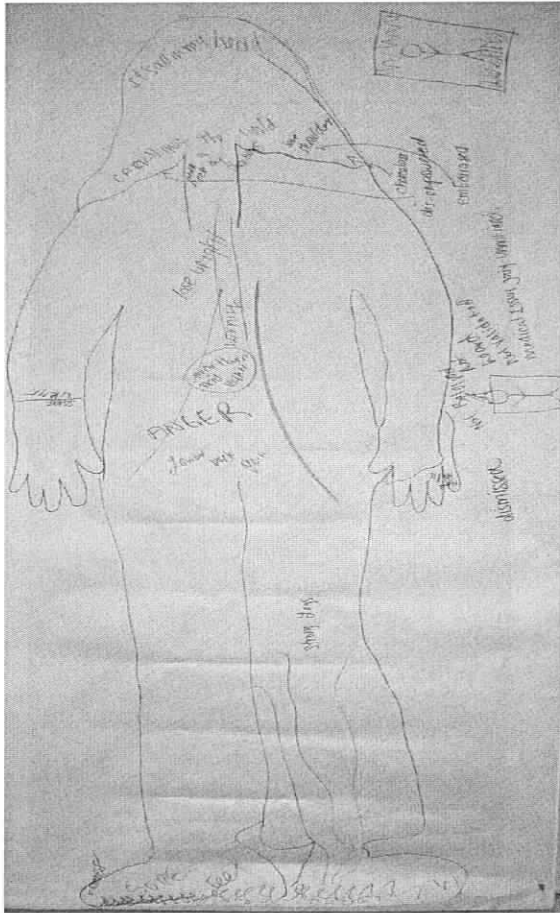


Figure 9: Coral

pain, “stomach issues,” repetitive strain injury, “shooting” pains through legs, chronic ear infections, “crying all the time” and an inability “to move or get out of bed.” All of these problems are made explicit by Coral’s body map [see figure 9]. While work was not the sole cause of these problems – Coral also identifies a car accident a number of years earlier and some personal trauma earlier in her life – she feels that work amplified and exacerbated her preexisting feelings of inadequacy, insecurity and

disempowerment. Consequently, when Coral was asked to draw the impact that physical, mental and emotional pain had in her life, Coral drew [see figure 10] a bed with a stick figure that expressed her feeling that,

I can't draw [light laughter]... but fire like the burning of the, the burning coming up, just wanting to sleep. Not wanting to get up and go to work. Just the physical pain...this is on the bad days. There were some good days. But...I really found when I don't like my job I slept way too much. I just slept...it was just like healing.

Coral's narrative is an extreme example of the potential negative impact of work. Other women expressed the feeling that the work they did was rewarding, even a positive contributor to their mental and physical health. One such example is Jane, a person who has been working as a hairstylist for 40 years. When I met Jane she was going through a difficult separation with her husband

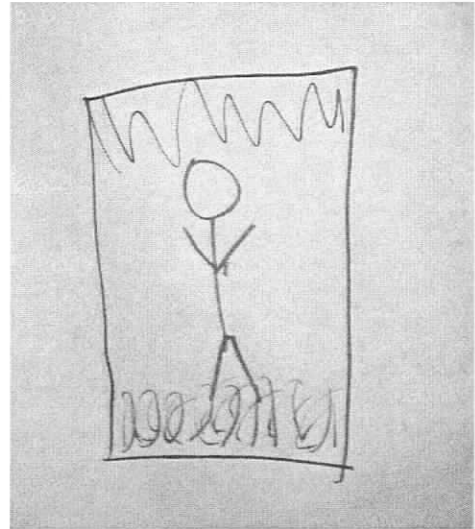


Figure 10: Coral detail

whom she was hoping to reconcile with. This split was causing her an enormous amount of pain which was being embodied in a number of different ways and in various parts of her body [see figure 11]. When I asked her to describe the green, jagged lines she had drawn and labeled "stress," Jane said the following,

I: Okay so maybe you can [describe] the green stuff. How does that feel?

Jane: Oh! That's easy! The green where its stress? Oh, it's quite easy to do that. It has horns.

I: It has horns?

Jane: It's literally sooo awful [Silence while drawing].

I: And why horns?

Jane: Well because it's very hard and it's so scary.

I: Hard and scary.

Jane: You know it's like frustration, and it's frightening when you feel so, again, so out of control. You don't feel like you even have control. So that's why it's all these peaks, it's nothing smooth you see. This [indicating work-related pain] is feeling old and tired. This [personal pain] is feeling, "what can I do with it?" That's [indicating work-related pain again] going to get better because with rest it will but, this [personal pain], how can I change that? How can I get out of that pain?

On the other hand, Jane works at a high-end spa/hair salon which offers a number of therapeutic and beauty-related services. While Jane reports experiencing some repetitive strain injury in her wrists and minor feet and hip pain from standing all day (see orange lines on body map) she feels that her job is the best thing about her life.

Jane: Very good job. I like it a lot. I really like my job. If I hadn't had my job here I probably would have left a long time ago. The job's really kept me going because it's really enjoyable.

I: Okay. So how do you feel at the end of the day? At the end of a shift?

Jane: Usually pretty um, fulfilled. Quite physically tired but it's a very gratifying job and uh, yeah I just get a lot more tired because I tend to not look after myself as well as I should. In the work day, I don't take enough breaks, drink enough . . . so I'm a little frustrated by that but that's my fault. But yeah, it's quite a rewarding job.

And although Jane expressed some regret that her manager wasn't more professional and that she wished she had more control over her schedule, she frames her discussion of work in terms of personal growth and fulfillment,

I'm very taken up with what I do. I care about it a lot . . . you get a lot of feedback [from clients] and sometimes I think it's quite a growing thing, the more people with situations, the more situations you're exposed to, you learn, right. And you benefit, everybody does. I mean, that person you are meeting, it's a nice revolving situation. And, so I think emotionally I think it can be good.

It is interesting to compare the experiences of Jane and Coral because, although both work as hairstylists, identify similar work-related pain (repetitive strain injury, sore feet

and legs) and are dealing with a number of personal problems including feeling out of control and powerless, work plays a very different role in each of their lives. For Jane, work is a haven from mental and emotional pain, so much so that she tends to minimize her work-related physical pain and fatigue. Conversely, Coral's job exacerbated and intensified all of her negative feelings and health problems.

Another perspective on work and health is presented by Sam. Sam is a woman in her mid-forties who started working in the sex trade in her early thirties. Working in 'the trade'³ gave Sam financial freedom for the first time in her life. Specifically, the money she made gave her the opportunity to get on her feet after a failed (abusive) marriage and job loss due to health problems. When I met her, Sam was still working occasionally

(although she did tend to refer to her work in the past tense) but felt like it might be time to get out of the trade. Her reasons are as follows,

I didn't like standing on the street corner. I didn't like the exposure. I got pennies thrown at me, eggs, beer, tomatoes [sigh], there were assortments of other things. Um, that I didn't like and lots of [inaudible] of course. Didn't like the harassment from the cops. I don't like the way they treat you. Some are nice but the bad ones overshadow the few nice ones. Really overshadow. Uh, I didn't like the cold, didn't like the rain, I didn't like the bar dates. Fuck I'm too old, I've got arthritis, I mean come on. Even at thirty-two cause the arthritis in my back started at twenty-five so even at thirty-two I did not like doing a B.J. in the back of a car, or the front of a car. Guys

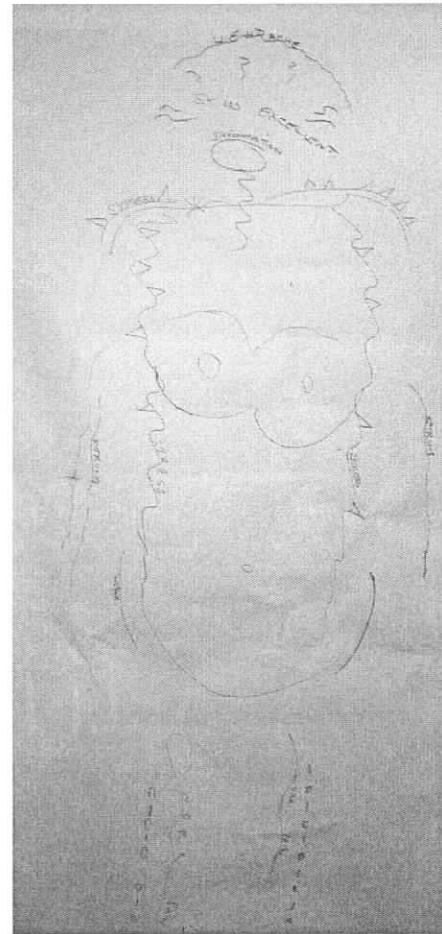


Figure 11: Jane

so fat you can't get head between the steering wheel! [Laughs uproariously] It's just hard! But so I didn't like that but there were so many positives that outweighed the negatives.

Despite the drawback of working on the street, Sam felt like working in the sex trade was a pretty good way to make money, especially in comparison to her last regular job working in an egg packaging company.

Sam: The first night I went out I did, I did a B.J. for fifty bucks and at the time . . . my last regular job was in candling. I would stand for ten hours at eight –or, five dollars an hour. So that's fifty bucks, right. And of course you take taxes and shit taken off. I would stand at this, on this metal plate watching three and a half dozen eggs go by a minute and your hands are going like this [makes rapid hand gestures] and you're taking the old eggs, you're picking them up to throw them in the garbage and they break and they drop all over you and you just end up smelling so bad! And at the end, actually nine hours of that, at the end of nine hours the machines are turned off and you take this little paint scraper thing [makes scraping sound] and get down and crawl underneath the machines and scrap off the eggs off the floor. Cause this is forty-five degrees and this is cement floors so I'm down on my hands and knees, again with arthritis, scraping dried eggs off the floor, right. And at the end of the day, that's fifty dollars minus taxes, right.

I: So giving a blow job for fifty bucks isn't such a bad . . .

Sam: Yeah! It hurt my back a little bit right cause I mean its an awkward position whatever but, it's fifty bucks, it's fifteen minutes, I get out the door and I can go home and that's a days work!

For Sam, when she weighs the pros and cons of working in the sex trade and compares these to the manual labour jobs she has had, she actually wishes that she had started to work in the sex trade earlier in her life. In part because it was good money, and in part because, as she puts it, "I'm *completely* in control. I've never . . . I worked in an agency in [Canadian city] for two months. Hated it." In addition to this, Sam says her health actually improved while working in the trade.

I: 14 years. So, do you think that working in the trade has impacted your body at all?

Sam: It's made it better.

I: It's made it better?

Sam: Unless this growth is a direct result of what I'm 'eating' from work. That's the only way it could not be.

I: From what you're . . . ?

Sam: From what I eat from work . . . by eat I mean the crap I take and the feelings I put down. If the growth is a direct result of work.

I: So pushing down negative feelings . . .

Sam: [interjects] But I've been pushing down for years and, and, and the result is the IBS, the arthritis and the [inaudible]. Those are definitely, and the stress headaches, I was getting stress headaches in my teens, um, now these ones coming from the back are from the growth, like I said, I don't know. The growth may have come itself. It may have come whether I'd stayed in waitressing or went to work the way I was doing. Don't know. Have no way of knowing.

While Sam does have a number of health concerns including the chronic pain related to her arthritis, she does not explicitly relate these problems to her job. Throughout our interview Sam predates most of her health problems to *before* she was working in the sex trade. Sam believes that her problems, which include disassociation and depression, developed early on from the physical, mental and sexual abuse she endured throughout her life from childhood through to the break-up of her marriage. Sam's body map is very explicit about her mental health problems. When I asked her to tell me the impact of the various mental, emotional and physical pain in her life, she drew a large bubble around her head [see figure 12]. This visual image when combined with her verbal explanation of pain and illness is,

I, I really believe a lot of my, my health issues are a direct correlation to my mental health. That I 'suck' back. I don't get mad, once in a while when I blow, I blow. But for the most part I take everything in and um, I keep it in. I think the arthritis formed so early because of that. Because a lot of other things do to. You know I've got IBS and I've got some other things that are related, stress headaches. So, so I really think they all play a part.

As is evident, Sam reports mixed feelings about work, and this is common among all the women. As a final example, I will introduce Sparky.

Sparky is a vivacious woman in her late-fifties. She describes herself as a mother who is "very honest," emotional and hard-working. By far the most important thing in her life is her son; she talks about him at length throughout our interview. Even when I ask her about her health Sparky references her son,

Usually I put myself down last. I guess I should think about myself first but, here I go again . . . my son. If he's happy, I'm happy. And it almost seems like it reflects. If he's not happy, I'm not happy.

Oh yeah it's a joke in my family. My sisters says when [son] is 40 and I'm 70 I'll be still phoning him [laughs and puts on a 'mothering' voice], "Did you brush your teeth? Are you eating okay?" But that's the type of person I am.

Apart from her son, Sparky describes her life in simple terms; she works, she's married to a "nice man" and she likes spending time on the computer. I asked Sparky what she does to unwind at the end of the day this is what she said,

I look forward to going home and I do smoke in my house and I'm not proud to say that but in my kitchen. And I enjoy going home with my husband. Some people have a drink but I have a cup of coffee and a cigarette and I love it. I look forward to it. I mean it's, you know, Saturday night what do you do? Everybody's going out drinking, well I sit in front of my computer, I look stupid, I turn on and listen to my son's [sport] game and I have a cigarette going and I have a cup of coffee. That's my Saturday night. And I do go to the casino, sometimes. That I find very relaxing.

In terms of work, Sparky is getting close to retirement. She has a chronic illness (that she has had for twenty years) that qualifies her for disability, but Sparky prefers to work. When I asked Sparky if she had a health plan that would allow her to quit working, she told me,

No. The only thing I could do, which I really don't want to, is go on disability. I could, because of my [chronic illness] but it's such a rigmarole you have to go through . . . no. I'll just keep going the way I am.

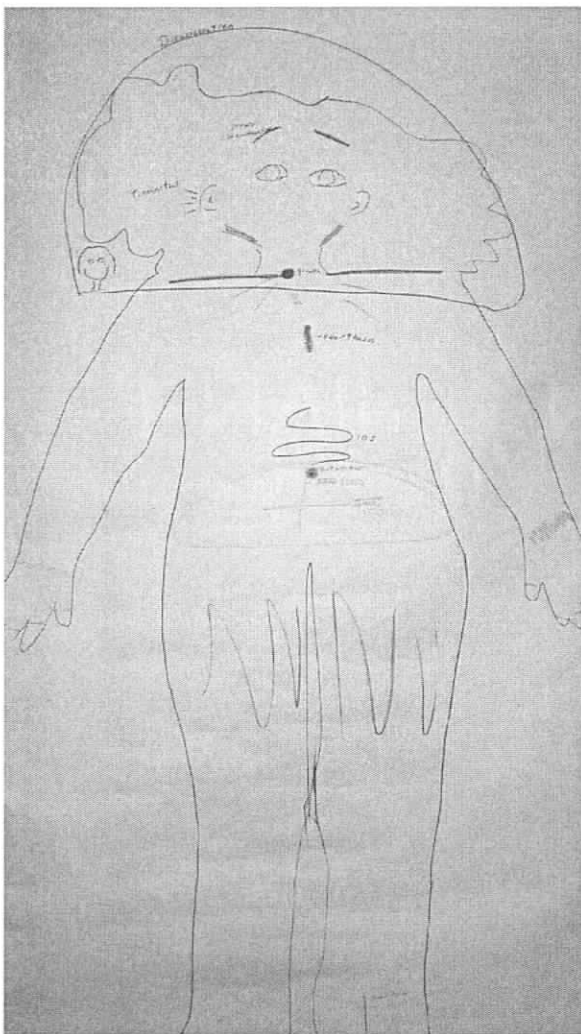


Figure 12: Sam

Sparky does find her job very physically demanding, but she sees that as both a positive and a negative. When asked if her work has affected her body, Sparky said rather enthusiastically, “Yeah! It’s kept me slim!” but then she also admits that some weeks can be hard on her,

All last week it was terrible. Saturday I could hardly move I was so sore and it was in my butt, everywhere it was like the first time exercising after ten years and I could hardly walk. I don't know what caused it. But it was like that all last week. This week I'm fine.

Generally speaking, work is a very important part of Sparky’s life. Despite some physical pain, she believes that going to work gives her a sense of purpose. When

asked if her job is important to her Sparky told me,

Yes it is. It's a very . . . and you know I was just thinking when I said two more years [till retirement], and I know in two more years I will probably still want to work. What would I do? I really enjoy being with people.

Sparky also admits that she has it pretty good as a server because her job is unionized. This means she makes well above minimum wage, and with her seniority, she is able to dictate her schedule and take time off when she wants it.

Evelyn, Brandy and Shirley

Previously Jules, Stephanie and Charlene were introduced to show how women draw on the notion of embodiment to make sense of their experiences with pain and illness. As indicated, it is common for women to view their bodies as 'tools' that communicate when something is 'wrong' or at least, 'not quite right' in their world. Here again the focus is on the body and embodiment, but attention has shifted to the way each woman thinks and feels about the size and appearance of her body. What the women's words and drawings indicate is that there are a number of ways that women conceptualize themselves and their bodies in relation to the world around them. Specifically, women were negotiating their position in relationship to cultural discourses about 'the body beautiful,' 'self-esteem,' 'self-realization' and 'transformation.' The difference between this discussion of 'the body' and the previous one on 'embodiment' is one of degree. Women's bodies are symbolically acting upon and/or reflecting the social, cultural and political environments in both cases; however, the women themselves are explicitly making the connection between their experiences trying to negotiate this discourse and their physical experiences with pain and illness. While they are cognizant that the concept of an ideal feminine body is pervasive in Canadian society, and potentially

damaging to their self-esteem, they do not clearly connect this with physical health concerns as they did in the previous discussion of embodiment. It should be noted that 10 of the 14 women interviewed made some deprecating comment about their weight or their general appearance in the course of our conversations. Of the four that did not, two told me they were purposefully trying to think and talk positively about their bodies. One woman made no reference to her appearance but she was also one of the two women who did not create a body map. The final woman was quite pleased with her appearance and told me that she was “happy with the whole package” although, she was also able to point out several shortcomings.



Figure 13: Brandy

When Brandy showed up for our interview she was noticeably uncomfortable.

She had a nervous laugh that punctuated much of our conversation. As she became more relaxed sharing the details of her childhood, Brandy spoke with increasing conviction, yet she continued to intersperse our conversation with laughter. What was disconcerting was that this laughter was often in sharp contrast to the painful memories she was sharing.

I: Your dad hurt your mom while you were camping?

Brandy: Yeah, [laugh] yeah. My dad, yeah he does have a bad temper but my mom she'll like, she won't drop things and she'll just .

. . . my dad will go into his room and shut the door and she'll break the door down and try and yell at him and yell at him. She like, she's done stuff to me like that too. Like break into the bathroom, punch me in the face while I was in the bathtub [laughs]. Like these aren't things that happened all the time but they are things that did happen.

Brandy shared a number of childhood memories during our interview that can only be characterized as emotionally and physically abusive. In Brandy's words, her family was "dysfunctional," but in her view, "what family isn't?" It is not surprising that this personal history had a damaging effect on Brandy's self-esteem. Although she indicates that in the last few years she has become increasingly more self-confident and happy with her life, it was not always this way.

I've been going to a counselor since I've been about 10, so on and off. And I do a lot of reflecting and I do a lot of reading and things like that, so. Also my friendship circle too, like the last couple of years I have the most amazing friends in the whole world, like they're just amazing people, I love them so much. And when I first started hanging out with them I was really insecure and they're the sort of key people that like really helped me with my self-esteem and now, they're just like amazing. I used to like, and I still, I used to seek out their approval, [not their] approval but their guidance a lot and I was . . . over the past couple of years that's kind of changed now too, now I'm just an equal. You know, yeah, I tend to define those kind of roles with people where I was, you know, I was looking for guidance from people because I wasn't getting it from my parents, you know what I mean? [Small laugh]

Brandy's words make it evident that she has been going through a period of personal growth through which she has been able to transform herself and her relationships with others.

When we got to the body mapping portion of the interview, it became clear that Brandy was still struggling with how she thinks about and talks about her body [see figure 13]. My first question asking Brandy to describe her favorite aspect of her body

yielded the response, “I don’t like that question. It’s like saying that one part of my body is better than another part of my body.”

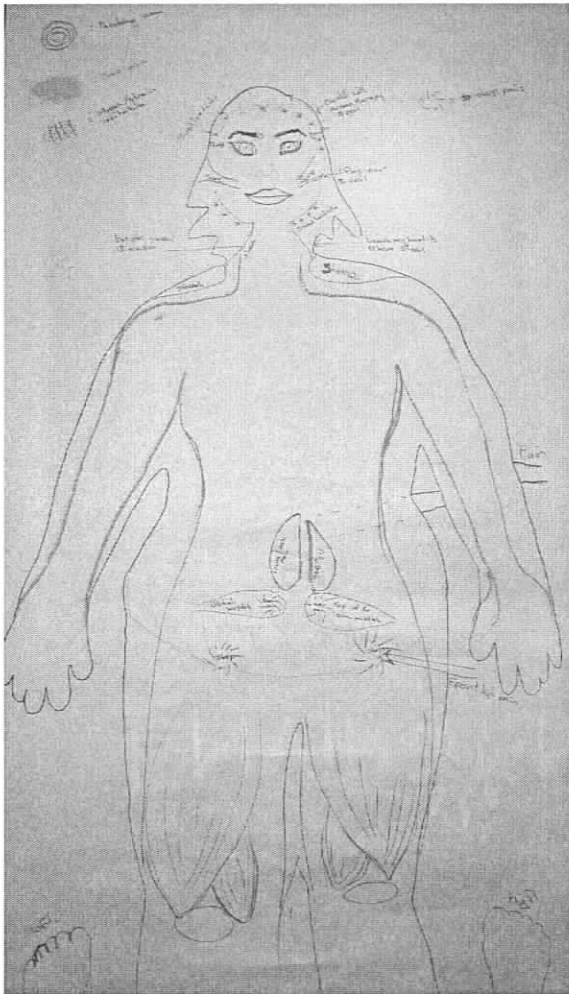


Figure 14: Evelyn

As I had seemingly offended her with my question I tried to rephrase it by saying, “It doesn’t necessarily have to be a physical part. Maybe, what is your favorite aspect or . . .” It was at this point Brandy interjected by saying,

Brandy: I guess I like my, I really like my legs [laughs].

I: The legs, okay, why don’t you add that to your drawing?

Brandy: How do you mean, “Add it to my drawing?”

I: However *you* want to [pause] there are no rules so . . . [pause while she starts to draw] so why are your legs your favorite aspect?

Brandy: They’re always in good shape [laughs].

I: All that walking you do?

Brandy: I get lots of compliments on them all the time too.

What is significant is that despite Brandy’s initial reluctance to identify a favorite body part, seemingly because she didn’t want to “think like that” she quickly volunteered her legs, even elaborating on how others liked that part of her body too. Next I asked Brandy,

I: Do you have some aspect that you like less or that you . . .

Brandy [interjects]: Yeah, I try not to do that anymore. I used to. I used to . . . I have big breasts and I used to carry a lot of weight right here and right here [indicates torso area and upper arms], not so much anymore because I've lost a lot of weight but I try not to do that anymore. Yeah, I don't really, I don't like to answer that cause I just . . . this is me and my whole body, I don't want to say that one part's better and one part's . . . like I wish . . . I'm changing [my] body by going to yoga and just getting stronger all around and all parts of my body are equal and I have to treat them that way or else I start thinking, "Oh if I could only get rid of this little bit right here or if I could just . . . if my breasts were a bit smaller or a little bit perkier." Whatever! [Laughs] Just don't want to think that way.

Brandy, like many women, is conflicted about her weight and physical appearance. On the one hand she is trying to resist the cultural idea that there is an ideal female body that she should try to attain; her goal is to accept her body the way it is. On the other hand, Brandy is actively trying to change her appearance and control her weight through running, yoga and diet. This contradiction is echoed through other women's stories as well.

Evelyn is an extremely well-spoken and expressive woman. Soon after we sat down to talk, she intimated to me that she "loves an audience." In high school Evelyn was enrolled in drama and won a prize for "best dramatic performance," and she was nominated to attend a summer drama school. When she was told she could not attend because she had broken one of the rules at her foster home, Evelyn was devastated. She considers this to be a fundamental turning point in her life,

I: What do you think would have happened if you'd got to go into the drama . . . ?

Evelyn: [interjects] Oh, I think I might have been an actress, I really do, I think I probably would have been . . . you know if not an actress then at least. . . I think had I'd gone to, had I gone to summer school and been supported in a creative way, in my creative life that kind of

would have put me up a class [social class]. Like, I would have been able to break through that. Yeah, at least I would have felt like I'd gone up a class, right You know, I would also have alternatives to umm, expressing myself because the sex trade is a very performance based occupation and I needed an audience, right. So, I think had I been supported in my creative endeavors in that way, that I would have probably found better ways of coping with my life and better ways of expressing myself and umm, probably would have had a bit more self-esteem or self-value, right. So, yeah, there was that one.

The issue of low self-esteem came up often in our interview, particularly in terms of her weight and how she 'performs' while working and in her life generally. For instance, at one point in our interview Evelyn indicates that when she is working more than usual she puts on extra weight because,

Well I think right now it means I've been getting more into my work, so I've been gaining a little bit more weight. For me, weight, having a layer between myself and my client and because my work is so physical, having a physical layer, right. But if I lose weight, definitely my income would increase a great deal but also will my social contact, people vying for my attention in my life, walking down the street. I call it "attacked" right because when someone demands something from me for free I call it being "attacked" [laughs]. But if I'm walking down the street and people want to talk to me or men are trying to pick me up, just because I'm thinner, I don't like that [lack] of barrier. When I'm walking out on my own I'm different then when I am at work... When someone wants to pick me up or is trying to hit on me on my own time, its very intrusive, very invasive. So having that layer makes it easier for me to keep my work at work and my me at me. It's really interesting actually when you think of it that way.

Despite Evelyn's inclination to put on additional weight while she is working, she also wishes she weighed less [see figure 14]. This is expressed in her body map where she has redrawn the outline of her body to show what size she wished she was. Even though the weight provides an emotional and physical barrier between herself and those who are either "attacking" her or paying for her services, she believes that being thinner is better.

I'm taught throughout my whole life that the size that I am is not the size to be and that achieving the ideal size will, you know, allow me the attention that I want, the affection I so desire and all those silly ideals that media tries to portray to all of us.

While Evelyn indicates that popular cultural values surrounding being thin are “silly,” she also believes that she will be “sexier” and consequently more “erotically stimulating” if she loses weight. At the end of our body mapping session, I asked Evelyn if she could help me understand why she simultaneously wanted to weigh *more*, so she has a layer of flesh protecting her from her clients, while at the same time wanting to weigh *less* so that she could be more “erotically stimulating.” Evelyn was cognizant of the contradiction when she said,

Yeah, it's definitely a conflict. Um, I think that if I felt better about hmmm . . . well beside my eroticism, being thinner to me would mean that I could do more things as far as creating some joy in my life. Being able to um . . . but unfortunately that joy has nothing to do with sexuality. So, um, but unfortunately my experience is that if I'm thinner, even if I'm doing something that has nothing to do with sexuality I'm forced to deal with it because of passer-bys or what not. So it's a real conflict, right. Certainly I'd like to be thinner because it means all these different things but it also means that I would be attacked, approached, persuaded, propositioned, all of those things. Intellectually or emotionally I don't have as much armor.

Evelyn has complex reasons for simultaneously wanting to conform to and resist the discursive notion of a body beautiful. Shirley's relationship with her body is similarly filled with tension, albeit much less explicitly than Evelyn or Brandy.

Shirley is a petite woman with a strong personality. While initially she was reticent to share *any* of her memories or thoughts with me, she eventually warmed up and told me a lot about herself. Shirley spoke at length about how she used to be “a real wicked

bitch” with a “don’t fuck with me” attitude that landed her in countless physical and verbal altercations. Shirley traces this back to her childhood,

I used to swear and fight back and wouldn't listen to my mom and dad and they never tried to discipline me. Probably because of the child they lost. That's what I think. I went, my dad took me everywhere he went, everywhere. My mom said that she used to have to come out and go looking for us when he was drinking because he'd go on binges and I'd be with him. She had a hard time.

Shirley indicates that it is her attitude that has helped her survive over the years, and she takes considerable pride in passing this same trait onto her daughter; in Shirley's words, “no matter how big or small or whatever they are, she'll stand right up to them.” Shirley obviously cares a lot for her daughter because she refers to her often in the course of our interview,

And we're, we're like this [crosses finger to show how close they are]. If you, if you didn't know us and you seen us together you wouldn't think we're a mother and daughter. You would think we were friends or sisters. People in the AA circles think that um, they use the word co-dependant on us. It's like we're um, married. Sometimes she takes the mother role and I'm the daughter.

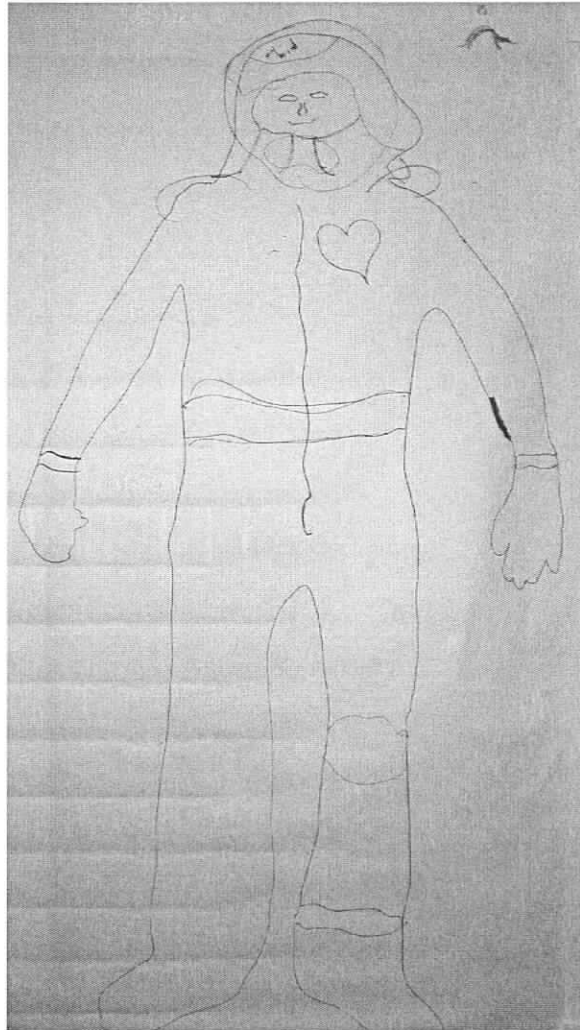


Figure 15: Shirley

Unlike many of the women interviewed Shirley did not make any derogatory comments about her weight or appearance within the context of our verbal interview.

Outwardly Shirley had a well developed self-esteem. This came across in the pride she takes in her approach to life, but she also made indirect comments about her appearance. For example, when she described her daughter, she said, “she’s beautiful, even more beautiful than me.” As well, Shirley showed up to our interview just after having her hair done and she seemed very pleased with how she looked. My first indication that her self-esteem might not be as well developed as it appeared was when I asked Shirley if she thought her work had affected her body,

Shirley: Yes because I am nothing but a skeleton.

I: As in you are thin or as in . . . ?

Shirley: [interjects] Yes, I’m very thin.

Although some women would desperately like to be as thin as Shirley, her tone suggested that she was *too* thin and that it was unattractive. After telling me that her body weight is relational to the drugs she consumes, Shirley dropped the topic of her weight. It was at this point we moved on to the body mapping portion of the interview, and when I asked Shirley to tell me what her favorite part of herself was she suddenly became withdrawn,

I: What’s your favorite thing about yourself?

Shirley: I don’t have a ‘favorite’ about myself.

I: What’s a *good* thing about yourself?

Shirley: I don’t have it. I don’t have . . . no there isn’t anything I like about myself.

I: Okay [long pause]. Is there any part of your body that you would like to change?

Shirley: Every piece of it.

It was at this point that Shirley began to cry quietly. It was as though when she was confronted with her body in the form of a drawing, Shirley's emotions flooded to the surface. Particularly telling was that while Shirley identified a number of places on her body where she experiences physical pain, the body portion of her body map is remarkably empty, except for simple references to knee and back pain [see figure 15]. Shirley indicated with her words and her drawing that she wanted to forget about her body. Her obvious level of anguish compelled me to not push the conversation further.

End Notes: Chapter Four

¹ To protect the confidentiality and anonymity of the participants, each woman was asked to provide a pseudonym that would be used instead of her real name.

² Within medical anthropology, experiencing pain through the body is sometimes referred to as "somatization." This term is inherently problematic as the implication is that emotional turmoil that is manifested physically is somehow not "real"; labeling a sufferer as "somatic" de-legitimizes their experience and consequently, the term will not be used here. Within psychiatry, it is called "somatization disorder" in which psychological conflicts are unconsciously expressed as physical complaint. While similar, the implication in psychiatry is that there is a diagnosed mental illness manifesting itself physically. Interestingly, women are diagnosed 10 times more frequently than men as having "somatization disorder."

³ Some women use the term 'the trade' to refer to the sex trade but this was not Sam's term, I am using the term as a form of short-hand.

CHAPTER FIVE: WOMEN'S LIVES AND BODIES

Building on the words and images discussed in Chapter Four, this chapter will offer analytical insight into why, and how, women are using their bodies to communicate interpersonal and social forms of suffering. Under discussion are the cultural categories (i.e. the quintessential way of patterning collective cultural experiences) and social processes influencing these women's experiences with pain and illness. What was discovered is that women are acting on and reflecting dominant discourses that are enmeshed within the cultural fabric of Canadian society; through active processes of negotiation, women are drawing on these discursive frameworks to make meaning in their lives. The four categories that women are using to frame their experiences with suffering will be discussed in more depth: 'health,' 'embodiment,' 'work' and 'the body.' Running through these categories are a series of overlapping and interceding themes that shape many of these women's conversations. For example, it was common for women to talk about 'transformation,' 'journey' and 'self-improvement' to signify their belief that they have the potential to change their life circumstances by making adjustments to themselves and their bodies.

Each woman's access to these cultural ideas is shaped by her particular social location in Canada. Social location is, in turn, influenced by each woman's personal history, age, gender, health and socio-economic status and experience with 'service' work. As such, each woman's engagement with the categories and themes is highly nuanced; these women do *not* represent a single experience. Nevertheless, there were strong patterns among the women in terms of how they use their bodies to mediate their social and cultural experiences.

As a final point, the importance of the body maps should be highlighted and the reader is encouraged to refer to these images throughout the discussion. The images are embedded within the text of Chapter Four but larger images are attached in Appendix 'B' to show more detail. These drawings can be seen as departure points to enter the life stories of these women. Often, words alone fail to capture the visceral impact of how an individual feels living in, and experiencing, their body. An image "does something" that is qualitatively different than words; images have the power to illuminate, captivate, repel and subvert in a way that can capture the imagination and offer meaningful insight into human experience (Rose 2001).

Conceptions of Health

According to the World Health Organization (WHO), health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO website accessed March 2006). This definition, which has not changed since 1948, is valuable for its recognition that health is not simply a physiological state. However, as this definition comes from the *World Health Organization*, the inference is that this is a universal definition of health that should apply to all people. As this research shows, and as anthropologist Naomi Adelson (2000:3) points out, conceptions of health are "interpreted, idealized and enacted in various ways" that are contingent on the historical and cultural embeddedness of the individual. Within the Canadian cultural context in which this research was situated, there are a number of prevailing conceptualizations of health that have imbricated themselves in the words and drawings of women. Women neither accept nor reject Canadian biomedical health models

wholesale, instead “individualistic conceptions of health, while replete with hegemonic meanings, [have] at the same time be[en] appropriated in an attempt to counter perceived obstacles to health and ultimately, identity” (Adelson 2000:8; Lupton 1995). In other words, health is not a static notion and it does not pertain only to the body. It is a flexible and dynamic resource from which women can draw to make individual, cultural and political statements about what it means to live in the world and experience pain and distress.

When women in the study were asked “How do you define health?” and “What does it take for you to feel (un)healthy?” their initial responses revealed much about what was concerning them at the time of our interview. For example, when Sage, a woman who suffers “terrible pain,” was asked to define health the first thing she said was “health is basically pain free.” She then went on to explain that in the past she had injected herself with “dirty coke” and it had caused a painful infection to lodge in her “lower lumbar.” It is, at this point, we learn that Sage is in the grip of a powerful addiction that is shaping her life. Or, when Jane was asked to define health her initial response was, “Health to me means uh, um healthy weight, not being over-weight, being active. Getting exercise. Eating properly or at least being able to eat in a controlled way.” From here we learn that Jane has developed an obsessive compulsive “eating disorder” that she feels is linked to feeling out of control in her personal relationships [see image page 180].

In the course of these conversations, it became clear that women have definitions of health that are flexible and subject to reinterpretation depending on the topic at hand. Women would continually reposition themselves in relationship to the notion of ‘health’ as a way to explain and interpret their experiences. A number of themes flowed through

these discussions. In particular, women spoke about the belief that they can ‘control’ and ‘change’ their health. These beliefs are lodged in a powerful and normalized vision of health that is promoted through biomedicine.

From a biomedical perspective, you are healthy if you have a “disease-free, fit and youthful” body that runs smoothly according to physiological principles (Adelson 2000:6). If you are “unhealthy,” biomedicine promulgates the idea that you and your body can be ‘fixed,’ ‘changed,’ and, ultimately, ‘controlled,’ with either therapeutic, chemical or surgical intervention. The persuasiveness of this discourse becomes evident when talking to Canadians because a large number assume this model of health is ‘normal’ and ‘universal.’ This discourse is illustrated in many of the women’s body maps; specifically, women represented themselves in the form of an anatomical body in that they drew intestinal tracts, stomachs, muscles and skeletal frames that reflect the images found in biomedical textbooks or on the walls of doctor’s offices. Typical biomedical illustrations include the androgynous human who stands skinless showing only layers of muscles, or the human torso that has had its abdominal wall removed to disclose the neatly packaged organs that lie beneath the surface. Nowhere is this discourse more evident than in Sage’s body map. She drew a detailed image showing her bones, sacroiliac and lower lumbar and she drew these parts of her body with precision and care so that she would get them ‘just right.’ In Sage’s own words, “that’s not quite right, this should be higher” (referring to the alignment of her hips in the drawing) [see image 169]. This imagery, in conjunction with Sage’s accurate use of medical terminology, suggests Sage is using a biomedical discourse to create meaning out of her suffering. By labeling her various physical, mental and emotional “problems” as health

concerns, Sage has given herself the medical option of changing and controlling her embodied responses to the social environment. In this way, Sage is able to maintain hope for the future because she believes she can be 'fixed' or 'cured' with treatments and specialized medical intervention.

What is problematic about a biomedical definition of health is that few are able to attain 'good health' according to its criteria. What's more, a biomedical view of health carries with it a host of social and cultural norms and values designed to make individuals feel inadequate, at risk or personally responsible for their health (Adelson 2000). Particularly relevant here is the ideological belief that health originates from *within* the body; this translates into health being a *personal* rather than a *social* responsibility. This belief was clearly demonstrated by Tobi, who feels that her health would improve if she could learn to regulate herself (including her thoughts, feelings, behaviours and emotions). The notion that health is a personal responsibility has profound moral and political implications.

Cruikshank (1999:48) states in her book *The Will to Empower: Democratic Citizens and Other Subjects* that the focus on the individual is "emblematic of the liberal arts of government; it is a technique for reforming both society and the individual by indirectly harmonizing their interests." The point Cruikshank is making is that the move toward individualization was (at its inception) a coercive technique used by governments to encourage people (the poor and downtrodden, in particular) to focus inward to find the root of their problems; by doing so, they would not be a burden on the state (i.e. the rich and privileged). While this movement can be traced back to the Victorian era, it remains an underlying value in Canada today. Many social welfare programs are aimed at helping

the marginalized help themselves rather than redistributing valuable resources or making long lasting changes to the structure of the welfare state. Rapping (1996) takes up a similar point when discussing feminism; she indicates that women have been compelled through societal change (or lack thereof) to look inward for the source of their problems.

Rapping (1996) is a scholar who studies at the intersection of culture and media studies. Her work focuses on how gender, race, class and ethnicity affect the way media and popular culture are produced and consumed. In her book *The Culture of Recovery: Making Sense of the Self-Help Movement in Women's Lives*, Rapping (1996:5) suggests that feminism of the 1960's taught women "to see [their] problems as socially determined and to focus blame away from [their] own failing and onto those of society." However, this new awareness created unhappiness among women because, although they were aware that they wanted and needed something more in their lives, there were no concrete changes to society and the status quo. The ensuing backlash created the conditions in which women began to believe "that their problems [are] grounded in their own internal weaknesses and that the way out is to alter their own behaviours" (Rapping 1996:5). Women's unhappiness led to so-called "coping mechanisms" (shopping, overeating, excessive dieting and "loving too much") which has, in turn, been pathologized as 'addictive behaviours' or even, 'addictive personalities.' Rapping (1996:6-7) believes this message, which blames women for being victims and addicts, "is highly political, in a most reactionary and repressive way." Instead of looking outward at the social and cultural conditions that marginalize and oppress, women have been socialized to focus on themselves.

Bordo (1986) draws upon Foucault to expand on this argument that women have been subverted from being socially minded to historically conditioned. In her words,

In a decade marked by a reopening of the public arena to women, the intensification of such regimens appears diversionary and subverting. Through the pursuit of ever-changing, homogenizing, elusive idea of femininity – a pursuit without a terminus, a resting point, requiring that women constantly attend to minute and often whimsical changes in fashion – female bodies become what Foucault calls “docile bodies,” – bodies whose forces and energies are habituated to external regulation, subjection, transformation, “improvement.” Through the exacting and normalizing disciplines of diet, make-up, and dress – central organizing principles of time and space in the days of many women – we are rendered less socially oriented and more centripetally focused on self-modification (Bordo 1986:14).

While superficially Bordo is focusing explicitly on women’s bodies, her critique is meant to encompass the way women focus on the minutia of all their self-perceived faults. As such, in addition to having to change their appearance and body weight to be happier, healthier and more acceptable to their family, friends and peers, women also need to work on how they think, feel and respond to those around them.

Although women involved in this project are focused on controlling and changing the way they conceptualize their health in a bid to improve the circumstances of their lives, this does not necessarily mean that they are passive dupes of a dominant ideology. Instead, women are creating agency from these discourses in ways that allow them to change the circumstances of their lives. For example, shifting focus away from their perceived shortcomings has enabled some women to turn their energy to activities more important and meaningful for themselves and for society (i.e. starting their own business, raising a family or earning a graduate degree). This change in the way they think about themselves has made them happier and more content. For women who occupy a more

vulnerable and marginalized social location, the only changes available to them are the changes they make to themselves. They feel powerless to tackle the structural circumstances that turned them onto drugs, limited their job opportunities or confined them to low-income housing. Although women are committed to taking personal responsibility and control over their lives, this does not preclude them from identifying (either explicitly or implicitly) that their physical experiences with pain and illness are linked to a complex etiology of personal, social and cultural suffering. This is highlighted in the following discussion of embodiment whereby women talk about how their bodies act as “communicators” that can signal when something is wrong or, at least, not quite right with their world.

How Women Embody their Suffering

It is claimed or mentioned in virtually all health-based social science literature that Western cultures are imbued with a Cartesian legacy that compels us to separate our minds from our bodies. Biomedical knowledge and practice is certainly based on this principle of separation. As one Canadian medical doctor puts it,

We attempt to understand the body in isolation from the mind. We want to describe human beings – healthy or otherwise – as though they function in isolation from the environment in which they develop, live, work, play, love and die. These are the built-in, hidden biases of the medical orthodoxy that most physicians absorb during their training and carry into their practice (Maté 2003:3).

The implication of this biomedical perspective of the mind and body is that people in pain are “ill-equipped to contribute to the work of meaning-making or interpretation necessary for healing the person/body-in-pain. Instead, medical practice often offers frustrating

reification of pain experience that moves to contain and essentialize pain rather than accounting for fragmentary, non-wholistic experience” (Emad 2003:8).

While the discursive idea of a mind/body division is certainly pervasive in Canadian society, individuals do not accept the notion indiscriminately. Instead, as the women interviewed here demonstrate, individuals make sense of their experiences with suffering through on-going mediation with this cultural ideology. When they need to, women will draw a distinction between their minds and their bodies in order to manage and contain their suffering (Jules and Stephanie provide an example of this). At other times, they will draw abstractly on the notion of embodiment as a means of interpreting their experiences with pain and illness. Throughout these processes of meaning-making, women also engage with cultural metaphors and images of ‘transitions,’ ‘journeys’ and ‘processes’ to highlight that they are moving through these periods of pain and suffering. Jules is only one of the women to embody and evoke all three of these themes.

Like many of the women, Jules began her narrative with a discussion of the trauma she endured as a child¹. While her childhood was difficult, it also taught Jules that by listening to her body, she could gain insight into what it was that was bothering her. Now, Jules has become so attuned to her body that she is able to link the smallest physical changes in her body to the conditions of her cultural and social environment. For example,

Like the fact that I have been nauseous the last few days, to me nausea is rejecting, your rejecting what's going on, your rejecting life and you're rejecting the idea that you are living with right now. So, that made me aware the last couple of days . . . I was like ah you're rejecting this idea of going home, you're scared. Like rejection comes from fear right and I'm like, "Ahh, you're afraid of going home" so I will be aware that the stress is there and then I will take time to reflect to see what is the root cause, what's really going

on. Then I will analyze my feelings and talk my way through it. So often I will be aware of the stress and then I will take a moment to figure out what that stress is. It might be money because like, my body . . . I am aware where in my body I will be hurting and what it will mean. Like my knee hurting is inflexibility, its ego, its fear of moving forward. Hips, my hips have been giving me hell lately cause it's once again, that fear of moving forward. There has been a bit of lower back pain because there have been a few money issues and that's money. So, it all, there is always a piece of the body that reflects what's going on.

Jules is also very explicit that listening to her body is a “process” she needs to go through in order to surmount any obstacles. Moving forward in her life is equated with overcoming negative or unproductive feelings or emotions. Despite the rather sophisticated connection Jules makes between her physical, mental and emotion well-being, she does, at times, tacitly create a representational distance between herself (which she associates with her ‘mind’²) and her body. She does this by continually referring to her body and its parts as ‘things.’ For instance, it was common for her (and other women) to make comments such as, “my body needs a rest” or “my stomach needs more food.” By creating this separation, Jules is able to say ‘my body is suffering, but I am not’ and this kind of individuation allows her to cope [see page 172]. This sentiment was commonly expressed in women’s body maps.

What the body maps revealed is that women are locating their pain and illness in ‘the body’ portion of their body map while leaving ‘the head’ section blank. It was interesting that some women, when mapping their pain, did not even consider their head to be a part of their body. Or, if they chose to add something to the head section of their maps it was generally something they deemed to be “good,” as in it was a “strong” or “favourite” aspect of themselves; what was good was typically their “mind” or “brain.” For example, Stephanie’s body map [see page 173] shows that she locates the anxiety and

stress that has troubled her, her entire life, in her body (specifically her chest and stomach). At the same time, the head section of the drawing only contains Stephanie's brain because this is what she feels is the "strongest" and most useful part of who she is. In Stephanie's words, "my brain is what gets me where I want to go." Interestingly, Stephanie does not draw anything negative inside the head section of her body map (i.e. poor vision and headaches); she only draws arrows that point toward these problem areas. This is significant because, by not drawing the 'problems' or 'health concerns' inside her head, Stephanie is indicating that what is wrong is contained inside her body, leaving her the option to say, 'I am more than just my body.' Relevant here is that Stephanie and many of the women who either left their head blank or only added their 'minds' to the head section of their body maps commented on their unusual or extreme intelligence. It is as though these women lay stock in their ability to think through or past the suffering that is affecting their physical bodies. In essence, they are saying, 'I am smarter than this and intellectually strong enough' to manage and cope with my problems.

This pattern among the body maps suggests that women are emotionally distancing themselves from bodies that have betrayed them either by getting sick, experiencing pain or by not conforming to a biomedical definition of health. While seemingly this would contradict the previous suggestion that women are demonstrating an integration of mind and body, what it shows is that women have flexible and fluid ways to locate themselves and their bodies in the context of their personal suffering.

In the previous chapter it was shown that women are using cultural ideas, words and metaphors such as 'transition,' 'process' and 'journey' to establish that they are 'moving through a difficult period.' Several women made reference to a journey of

acceptance; they were either learning to accept the circumstances of their lives and move forward, or they were learning to accept their bodies the way they are. Becker (1997) discusses the use of metaphors in her book, *Disrupted Lives: How People Create Meaning in a Chaotic World*. Becker (1997:61) explains that metaphors “enable people to recreate a sense of continuity, to reconnect themselves to the social order after a disruption.” She elaborates by saying,

When life must be reorganized, metaphors can provide a transforming bridge between the image of the old life and the new one. Because metaphors frame and structure meaning, they may be highly significant in the process of attempting to reconstitute sense of self after a disruption . . . Metaphor lies at the intersection of what has been and what can be; the use of metaphor thus represents a critical moment in which the known field of reference is suspended and a new, more comprehensive picture is invented (Becker 1997:61).

Gibbs and Franks (2002:141) make a similar connection when they say “metaphors provide the intellectual and linguistic tools for communication about senseless suffering, and yet also offer a plan for personal transformation in coping with illness.” This same idea applies regardless of whether a person has undergone a serious illness experience or whether they are trying to cope with the quotidian experiences that are causing them to suffer. As the women involved in this study show, they need to have a plan for personal transformation in order for them to believe that things are going to improve or get better.

Metaphors, however, are more than just a linguistic tool used to convey meaning. Lakoff and Johnson (1980) theorize that metaphors are based on the way humans conceptualize and move through their physical and cognitive environments. They explain that the metaphor of a journey is common because it “reflects significant patterns of bodily experience” (Gibbs and Franks 2002:142). In other words, because humans are

constantly moving through social and geographic spaces, a journey is an apt metaphor because it is, at its essence, about movement through time and space. Just as a journey has a beginning, middle and end, so too does a pain or illness experience.

Within Canada, metaphors of a journey or transition are also enmeshed in the cultural value of progress. A person is deemed to have the correct attitude if they are pursuing cultural values of ‘improving,’ ‘evolving,’ ‘succeeding’ and being ‘proactive.’ The literature on chronic pain and illness clearly shows that people are viewed as malingerers if it is perceived that they are not trying to move forward or get well (Kleinman et al.1992). It is anathema to Canadian values to wallow in an experience and forego any attempt to ‘fix’ or make ourselves better. Thus, conceptualizing pain and illness (and the underlying suffering) as a transitory state allows people to show that they are mobilized and maintaining hope that things will get better. Even the women who reported that they were in good or exceptional health at the time of their interview spoke about their path and journey *through* poor health.

As a final point, there was pervasive theme that women evoked concerning their “gut” or “stomach.” Women expressed the belief that their stomachs embody feelings of stress, anxiety and fear. When Athena was asked to comment on why her “gut” is such an important location in the body, she said [see page 171],

Athena: It's your energy . . . and who you are . . . and all those things together. I . . . it actually does originate in your, in your gut.

I: And why does it originate in your gut?

Athena: Because [pause] because that's where you feel it the most. Like if you're stressed you tend to, your stomach's not feeling well and they've actually proven that it has its own system of feelings in there that are separated from the rest of your body and it has almost

something like a heart so that's why it gets so irritated with different feelings.

I: Right.

Athena: And so you need to listen to that more because it's trying to tell you something [spends time drawing].

In the field of anthropology much has been written about the cultural meaning or value we place on specific body parts. The heart, cross-culturally, is the centre of feelings related to love, loneliness and despair. This is seen in the 'romantic heart' attached to Valentines Day (i.e. the day for romantic love) or it is seen in the notion that a failed relationship can cause a broken heart. As Athena told me,

. . . [people] forget that their heart is an emotional thing, it's not just to pump blood and you know, recycle things, it's a big part of our emotions. It's actually been proven that you can die from a broken heart now, like it's been proven in the medical journal.

Within North America, many people feel a special connection to their stomachs because they feel that it is the source of intuitive knowledge. This is evidenced by expressions such as, "I have a gut feeling" or "What is your gut telling you?" The metaphor of the stomach or gut transcends age and gender, and is found in more than one cultural group. In particular, Ayurveda and other holistic approaches to medicine are grounded in the belief that the organs – but especially the digestive system – have sufficient enervation to be a center of thinking and feeling (Stephenson 2006).

Unpacking the Meaning of Work

There is much to say about the role work plays in women's lives. As already noted there is considerable divisiveness in the work ↔ health literature in regards to the costs and benefits associated with working in a service-oriented occupation. Women's own

words and images also contain inconsistencies and conflicts. What is known is that the occupations these women are engaged in are socially and economically marginalized for a number of reasons related to the structural characteristics of these jobs (as outlined in Chapter One). Despite this, many of the women report being satisfied with their jobs. Looking for a moment at an analysis of the survey measure of job satisfaction within the ISW project, 69 percent of all (303) participants (men and women) reported that they “agreed” or “strongly agreed” that they were satisfied with their jobs. When viewed from the perspective of gender, job satisfaction was not statistically significant: 68 percent of women and 71 percent of men report that they are satisfied with their jobs (Shumka et al. 2006 in progress). While there are differences when broken down by occupation – hairstylists report the highest job satisfaction; sex trade workers the lowest – overall these are surprisingly high rates of job satisfaction considering the occupational circumstances. Looking specifically at the 14 women interviewed for this project, only four stated definitively that they did *not* like their jobs. Three of those women were working in the sex trade. Despite disliking their jobs, all four of these women were able to identify something they did like: namely, the “easy” or “instant” money, the clientele, the ability to make clients feel good about themselves and the opportunity to be creative. Of those who enjoyed their jobs, three were unable to identify anything they *disliked*. All three of these women were hairstylists and they each identified the best thing about their job as being their interactions with clients and/or co-workers. Overall, most women identified a range of factors that played into their job satisfaction. Central to these likes and dislikes was the issue of control. Women either wanted to have more control over the pace or

scheduling of their work, they wanted the money to be more consistent, or they wanted the option to forgo certain work duties³.

Unpacking the meaning of work, we can discern that a woman's job plays an important and yet flexible role in her life. In certain cases, women see work as integral to their identity. In others, women describe their work in functional terms (i.e. as a way to put food on the table). Each woman identifies physical 'costs' associated with working in an occupation that requires the intimate performance of their bodies. However, the meanings women attach to the physical pain, stress and fatigue varies considerably.

According to DelVecchio-Good (1992:49) there is a conventional American discourse that says "work → stress → ill health." As is clear from the women involved in this project, this unilineal model is an unsatisfactory way to think analytically about work. Certainly, in some cases, work can have a profoundly negative health impact. For example, Coral experienced chronic pain as a result of her work, and this pain was "unmaking her world" (DelVecchio-Good 1992). However, as Coral unequivocally puts it, "Work has aggravated everything to do with me." Therefore, when Coral was communicating her profound dissatisfaction with her job and relaying her various work-related health problems, she was communicating about a wider and more complex set of problems that were rooted in her personal history and social location [see page 175]. Coral was, in many ways, using her job *dissatisfaction* to speak about a long history of suffering. By expressing her suffering within the context of work, she was able to legitimize her feelings to her family and friends and shed the designation of being a "slacker" or "fake" in a way that was previously unavailable to her.

There is also literature that suggests that, “. . . work may be an active process of meaning-making and of self-constitution, especially in the face of what Byron Good refers to as the “world-threatening” or “unmaking” dimensions of pain” (DelVecchio-Good 1992:50). This concept is reflected in the words of several of the women discussed earlier. Jane in particular felt that work was a haven from the emotional and mental pain surrounding her separation from her husband. Although she recognizes some work-related pain and fatigue, she minimizes it by saying that it is her own fault for not taking better care of herself. As her body map indicates, Jane’s work-related pain is intermittent and easily manageable with rest, while the pain associated with her personal life is constant and unmanageable [see page 180]. Additionally, although Jane is significantly lacking in self-esteem outside of work, she feels empowered and satisfied at work because she knows that she is good at her job and she is able to make people feel good about themselves. What is salient about Jane’s experience with work is that, like most people, she identifies that there are good and bad things about work. Although she wishes it were more consistently busy, Jane is focusing on the positive aspects of her work at the present time because it is providing a sanctuary from her everyday suffering.

Sam has a more complicated (and yet strangely pragmatic) relationship with her work. She acknowledges that the sex trade is a highly stigmatized occupation when she indicates that her “mission” in life is to “make people realize that the girls that are out there aren’t bad.” She also concedes that work can be demoralizing; this is expressed when Sam articulates how she feels at the end of some shifts; “Sometimes depressed but then depression has been an issue all my life. I’m depressed if I’ve got only low ball offers all night or jerks and the cops have bugged me and people have thrown things at

me and called me nasty names.” Yet despite all these things, Sam views work in terms of a cost/benefit analysis. Compared to other jobs she’s done, ‘the trade’ is a pretty good way to make money⁴. Not only can she make a decent amount of money in a short period of time, but she can decide when and where to work and she can decide whom she wants to work with.

According to Ratcliff and Bogdan (1988:51), “work [gives women] a major source of satisfaction, sense of self-control, and empowerment, regardless of job status.” Although this is arguably a contentious claim, Sam’s ability to exert some control in her job has certainly been a benefit. For example, she believes that working in the sex trade has improved her health, specifically her arthritis [see page 177]. This is not surprising when viewed from the perspective that DelVecchio-Good offers (1992:52),

. . . researchers hypothesize that women who work, especially those who have positions of high occupational control, not only may be empowered in their experience of competence and self-esteem, but this sense of empowerment leads to lower susceptibility to physical and psychiatric morbidity because of their diverse roles and high control activity.

Based on the data supplied by the ISW project, women working in the sex trade confirm that they enjoy relatively high occupational control. However, occupational control does not guard against the damaging effects of engaging in a deeply stigmatized occupation.

All five women working in the sex trade spoke about feeling exposed. This was expressed both literally and figuratively (often both). Both Shirley and Charlene, for example, mentioned their dislike of standing outside and feeling ‘exposed’ to the weather; in Shirley’s words [see pages 178], “I hate standing out there; I hate fuckin’ cold and piss ass rain.” However these women also communicated that they feel vulnerable when they work on the street because “anyone can drive by and look” at them. Charlene

and Sam both mentioned how they disliked it when *women* would drive by, not to purchase their services, but either out of morbid fascination or, in their estimation, to pass judgment. In other words, the women felt exposed to the stigmatization they feel from the general public. This feeling of vulnerability likely explains why sexual body parts were missing from these women's body maps.

Of all the women who drew body maps, only two added anything that could be considered a 'sexual' body part. Specifically, two women drew their breasts. One woman drew her breasts as her favourite body part and the other woman, a sex trade worker, indicated that her breasts were her least favourite part because they needed to be "higher" and less "saggy." Apart from this, none of the women working in the sex trade added anything to their body maps that was related to the sexual activities they perform on the job. As already mentioned, this was a surprise, especially when compared to the responses that Karen Messing (2002) got in her work with sex trade workers (as discussed in Chapter Three). A likely interpretation is that sex trade workers want to avoid making themselves more vulnerable by exposing the intimate parts of their bodies that are related to their job performance. For example, while Evelyn was willing to *spea*k about her work-related pain, she was not willing to draw it [see page 179],

Yeah, um, there's like extra, like there's uh, you know, excessive handling. Um, you know I'll have, if I have a string of Viagra lovers I'll end up having uteral pain and that kind of thing, right. Um, and not just because . . . like Viagra makes, a lot of the, a lot of the medications that help men with erectile difficulties ends up making it ultra hard. And so it would be like using a toy in an excessive way and you're not supposed to do that. So it's very similar. So I would have uterine pain. Sometimes I'll have pain around my labia depending on how vigorous or how long the experience is. I've uh, another client of mine who, who particularly likes oral and if I haven't seen him for a very long time my cheeks will hurt quite badly, my jaw and my cheeks. Sometimes my tonsil area.

I: Do you feel comfortable adding some of those things to your map?

Evelyn: Sure, sure [long pause] . . . mmm, yeah, maybe not.

The physical act of drawing something makes it more immediate and tangible, especially considering the intimate and subjective environment that these body maps were created in. It is likely that a women working in this industry would find it easier to cope with the stigmatizing context of the job by maintaining a representational distance between who she is (as represented by a body map) and what she does for a living.

A primary focus at the outset of this project was to reveal the embodied effects of performing emotional labour. Based on the literature, it was assumed that managing emotions under working conditions that are poorly compensated, insecure, physically demanding, sometimes stigmatized and regularly sexualized would be deleterious for a woman's health. However, what these 14 women articulate is that emotional labour is either a fundamental part of why they like their job or it is negligible.

Overall, women involved in the food and beverage and hairdressing industries like working with people. They all admit that there is the odd customer that can be emotionally or mentally draining; however, most indicate that human interaction is also one of the most rewarding aspects of the jobs⁵. For instance,

Jules: Umm, I love the fact that I can so easily make people happy. I learn a lot from my clients, I learn tons from my clients. And I know that they have the same huge trust and respect in me that I have in them. My clients are the best clients that a stylist could possibly want.

Food and beverage servers in particular mention that they work in the service industry because they enjoy people⁶. Even women employed in low-prestige establishments who exert very little occupational control describe the personal satisfaction they get from

working with the public (Owings 2002). This is confirmed in Ehrenreich's (1999) article entitled *Nickel-and-Dimed: On (not) getting by in America*. Despite their poor working conditions and low wages, the women Ehrenreich worked with at an American diner made it clear that there are tangible rewards associated with being able to nurture and care for another human being. They did this in small ways, either by giving free coffee refills or buying meals for people who appeared down on their luck. Anecdotally, younger servers associated with the ISW project also mention that a primary motivation for becoming involved in the food and beverage industry is that it is a good way to meet people and expand social networks.

Sex trade workers tell a different story. They are not working in the sex trade because it is something that they are drawn to or because they love interacting with people. Women work in the sex trade primarily to make money⁷. In terms of emotional management, women in the trade likely do a significant amount of 'work.' While this is not necessarily the case for some street workers who more commonly get clients seeking quick, anonymous exchanges, many women mentioned that they have (or had) "regulars" or "sugar daddies." The benefit of having these customers is that they are a dependable source of income and what they want in terms of work-related tasks is predictable. On the other hand, women indicate that these customers often desire an intimate relationship that can be time consuming and emotionally taxing. Women involved in this study tended not to focus on discussing this aspect of their job; however, this may be because the revulsion many feel in having to perform sexual acts with clients (who can be unclean, rude or aggressive) overshadows any concerns associated with having to perform emotional labour.

Women's Bodies: Symbolism and Agency

The notion of the 'body beautiful' is ubiquitous in Western popular culture. If you are a woman living in Canada or the United States you need to have just the right amount of fleshy curves and well-defined muscles to be considered physically desirable (Bordo 1986;1993). This notion has infiltrated Westernized cultures so pervasively that many women believe that in order to be happy, loved or deemed worthwhile they must try to make their bodies conform to this ideal. Feminist writers such as Bordo (1993), Gremillion (2005) and Wilshire (1986) have been documenting the progression of this popular discourse over the past 20/30 years and point to its destructive effects. Women (and men) everywhere are bombarded by media images that provoke them to engage in damaging behaviours that range from: overspending on cosmetics and fashion accessories to undergoing invasive cosmetic surgery and even developing eating disorders such as anorexia and bulimia. Together, institutions of power – the medical establishment through its pathologization of fat (LeBesco 2004), cosmetic and fashion industry giants through advertising, and media conglomerates through movies and television – have used their power to produce explicit and implicit messages about how we *should* look. Every woman interviewed, with the exception of one, perpetuated and reproduced their belief in the body beautiful to some degree, either verbally or through visual means. Women, however, are cognizant of these social pressures to make their bodies conform to an idealized image of femininity, and they struggle to find middle ground between compliance and resistance. What is clear is that discussions about the body are implicitly conversations about self-esteem, willpower and control. The body mapping exercise

brought the struggles women have to reconcile disparate personal, cultural and social expectations to the surface.

There was often a disjuncture between how women spoke about their bodies and the visual images they produced. For example, some women seemed to be resisting the notion that they should have a 'body beautiful' with body maps that showed bulging stomachs, stretch marks, large bellybuttons and sagging breasts. However, the women's words indicated they were not celebrating their curves and small imperfections. Instead, women were articulating their sense of personal failure in having a 'non-conforming' body. Threaded through the women's narratives was a message that indicated they felt weight gain signifies a loss of self-control and willpower (Bordo 1993). This was especially true for Jane, who makes a connection between gaining weight and feeling unhappy and out-of-control in her personal life. Specifically, Jane feels as though she doesn't "like herself very much" and that this is a "detriment" to her ability to be successful in all aspects of her life. Jane feels that if she could control her eating she would lose weight; in turn, this would result in increased self-esteem and personal happiness.

Transcripts of the body mapping portion of the interviews show that many women spoke disparagingly about their bodies. Their stomachs in particular were viewed as an area that is "fat," "weak" or a part they would like to change. Women referred to themselves as "old and fat," "flabby" or "too skinny, like a skeleton." As previously mentioned, Evelyn went so far as to redraw the entire outline of her body while she explained that this was the size she *wished* she was. Her relationship with her body was particularly challenging because her weight is tied to her ability to do her job (i.e. the

more she weighs the greater emotional distance she can put between herself and her clients) and her personal happiness (i.e. if she weighed *less* she would be more physically desirable to her romantic partners and have increased self-confidence). Evelyn's body map alone did not impart this knowledge; it was, rather, the marriage of image and text that revealed her desire to simultaneously resist and conform to the body beautiful.

Women communicated verbally and visually about the challenges of being a woman (and having a body) in our historically, politically and socially situated Canadian cultural context. What many women mentioned is that they knew, logically (i.e. intellectually), that trying to attain the body beautiful is damaging and unhealthy for their self-esteem, yet it was common for these same women to desire a slim, conforming body. Athena was only one of the two women interviewed who explicitly made mention that she had altered the way she thinks and feels about her body. When she began mapping her body, and was asked to draw her favourite part, she said, "I would have said [a] body part before but I just don't feel that way any more. I just don't see the point in it because it's about how I feel; it's not about how I look." Athena's assertion that it is about how she feels and *not* about the way she looks is maintained throughout the rest of our conversation. However, her aversion to gaining any weight, even five pounds, can be interpreted as a need to have a socially desirable thin body,

. . . one thing that I am about "body image" wise, I am, I do think about it a lot in terms of having children, if I'll end up looking differently. Because, I feel like I look, or my body is the way it is supposed to be right now and even if I gain five pounds, it's not that I've gained five pounds, I feel so uncomfortable, I feel like I can't sit properly and I can't, even when I'm lying down, get comfortable . . . So, I guess most of the time you just see women after they've had children, they've gained a lot of weight. I don't really mind gaining the weight but it just makes me feel so uncomfortable, like physically.

Relevant here is Athena's choice of words; she says, "I really don't *mind* gaining weight but it just makes me *feel* so uncomfortable *physically*" [emphasis mine]. Consciously, or perhaps intellectually, Athena knows it is 'okay' to gain weight but she communicates that it is her body that is unwilling. Athena then is reproducing a Cartesian dualism and inverting the view that the physical body (health, appearance, fitness) is the outcome of a strong mind (will power).

Brandy was another woman who made it clear that she has been on a "journey" of self-acceptance and she was deeply offended at being asked to identify a favourite part of her body during the body mapping exercise. At the same time, Brandy had no qualms saying that she likes her legs because she received compliments on how attractive they are. This is also the same woman who, outlined in some detail, the exercise regime she had implemented to help her lose weight and become more toned [see page 176].

In the process of trying to mediate and challenge cultural values surrounding the body beautiful, women in this study are communicating that 'the body' is "a prime site for the contestation of social and individual power; it is the locus of both oppression and empowerment, simultaneously" (Reischer and Koo 2004:314). Some women were able to find an uneasy balance within this power struggle. Others found this struggle to be detrimental to their sense of self-worth and they were suffering as a result. Salient here is that a discussion of 'the body' inevitably broadened to include a conversation about the flexibility and mobility of 'the self' (which is arguably more inclusive than a discussion of the body). Ultimately, a conversation about 'the body' and 'the self,' provides an intimate glimpse into how women manage and cope with the issues that were causing them to suffer.

End Notes: Chapter Five

¹ Trauma, as defined by Scaer (2001), occurs when an individual's boundaries are disturbed or punctured in some way. According to him, children are particularly vulnerable to trauma because they have clearly delineated safety boundaries that are easily transgressed.

² The fact that Jules is associating her 'self' figuratively with her 'mind' is not surprising. North Americans regularly locate the 'self' either figuratively or literally in their 'mind,' 'brain' and/or 'head,' because culturally, we value intelligence and cognition abilities and these qualities are associated with the brain which is, of course, located in the head. On the other hand, the 'body' is metaphorically thought of as an 'unthinking' biochemical machine (Kirmayer 1988).

³ For example, hairstylists frequently mentioned disliking doing "perms"; servers dislike doing "back end" work such as setting up banquet tables and polishing silverware; sex trade workers disliked "going all the way" with clients.

⁴ It should be pointed out that Sam chooses to frame her discussion of working in the sex trade in terms of doing manual labour. However, Sam has a significant amount of education and is trained to do business administrative-type work that could garner a considerable wage.

⁵ While much of the work-related literature on emotional labour focuses on a workers interactions with customers and clients, what ISW data shows is that it is the emotional management required through interactions with co-workers and managers/bosses that can have the greatest negative impact on health and job satisfaction.

⁶ Hairstylists do as well but they are equally as likely to talk about their skills and ability to be creative as vital to their job satisfaction.

⁷ In a few rare cases, women involved in the ISW project indicate that they work in the sex trade because they want the social support they get from co-workers. One woman mentioned that she began working as a sex trade workers because she felt isolated and wanted to meet men. However, these sentiments were not expressed by any of the women involved in the *Working through the Body* project.

CHAPTER SIX: CONCLUSION

This project began with the understanding that what brought this diverse group of women together were their gender and their engagement with interactive service work. What was discovered is a group of women ‘working through their issues.’ The underlying concerns may differ, but each woman is on some stage of a “journey” that is designed to help her manage and cope with the issues that are causing her distress. The women do not all use the metaphor of a journey, but they do communicate through conversations about health, work and their bodies that they are ‘moving,’ ‘changing,’ ‘learning,’ ‘growing,’ ‘realizing’ and ‘transitioning.’ The words have different denotative meanings yet they connote a common theme about the mobility and flexibility of the self. The majority of these women are responding to quotidian experiences of suffering by engaging in disciplinary acts of ‘working on’ and ‘reworking’ the self.

Kleinman warns that there is a tendency within anthropology to “create cultural archetypes out of the always messy and uncertain details of a personal account of illness” and that this is as “invalid an interpretation of the human core of suffering as is the biomedical tendency to create a purely biological metaphor of pain” (Kleinman 1991:280). With this warning in mind, it should be reiterated that not all the women involved in this study fit neatly into a single overarching narrative that explains all their experiences with pain and illness. To highlight this point this discussion will end with the women who did not explicitly engage with the cultural discourses discussed thus far. However, there is a persistent, underlying theme threaded through the majority of these women’s illness narratives and body maps and that is, the self is a lifelong project that needs to be worked.

When women speak about themselves as a project they are engaging with a set of ideas that link self-realization, personal growth, self-help and self-improvement. Together these concepts make-up a powerful ideology that is rooted in Canadian values of independence, accountability, self-sufficiency and social responsibility. Increasingly, it is becoming the “norm” within Canada to subscribe to the notion that we have a personal responsibility to improve ourselves. This is not limited to physical improvements such as exercise, dieting, adornment and modification; we can, and should, change how we think, feel and behave in order to be considered ‘healthier,’ more well-adjusted individuals. According to Cruikshank (1999), who draws on Foucault’s 1978 notion of “governmentality,” the state and other institutions of power have made it “normal” for individuals to think that they must take an active role in their own self-betterment and self-fulfillment. Cruikshank explicitly links self-esteem to the normalization of ‘helping-self’ in western societies when she says,

Self fulfillment is no longer a personal or private goal. According to advocates, taking up the goal of self-esteem is something we owe to society, something that will defray the costs of social problems, something that will create a ‘true’ democracy. Hence, the solution to the current ‘crisis of governability’ is discovered in the capacity of citizens to act upon themselves (Cruikshank 1999:89).

While this perspective on self-esteem and the underlying issue of self-regulation is applicable to all people, it is particular relevant to women. Rapping (1996) and Bordo (1990;1993) argue convincingly that there are a series of private and public discourses that focus on women and encourage them to concentrate on the minutia of their own self-regulation as a means of dissuading them from taking an active role in larger social and political affairs.

The self-help movement is particularly relevant to women because it is marketed directly at them through daytime talk shows and gendered advertising. The issues that are deemed in need of self-help are also highly gendered; it is rare to hear about a man who 'loves too much' or doesn't 'love himself enough.' Despite the focus on women however, this movement appears to have captured the collective North American imagination, you have only to turn on the TV, open a book, drive past a billboard, or walk past a community center to discover one more 'issue' that needs to be 'fixed' or 'cured.' Despite the relatively recent explosion of self-help (as it is currently presented to us), women involved in this study take seriously that self-betterment is a personal responsibility. This is evidenced by several women who, over the course of our interview, recommended books they felt were instrumental to read. These books were based on subjects such as, 'how to de-stress your life,' 'how to read what your body is telling you' and 'learning the steps to forgiveness.'

The self-betterment ideology is tremendously powerful for women who are suffering and feeling out of control in their personal lives. Believing that they can change their life circumstances by making minor (and sometimes major) changes to themselves allow women hope for the future and it gives them agency. Agency is largely about personal control and having a voice and this is a fundamental concern for women who occupy social locations marked by their engagement in a socially and economically marginalized occupation. While self-betterment has obvious benefits in the lives of individuals, it is important to question the larger social implications of this 'culture of self-help.'

There are a number of powerful institutions that underwrite the discursive set of ideas that make-up the self-help movement. Self-betterment is facilitated by media, fashion and cosmetic industries and it is backed by a host of “health-based” organizations – ranging from physical fitness and diet programs, alternative medicines, 12-step programs, lay counseling and biomedicine in the form of psychology based services – that are designed to legitimize these discourses. By promoting the belief that we each have limitless potential and opportunity for self-betterment, these various consumer-driven institutions of power have created a market that is without a saturation point. Tremendous profits can be made from making people believe that there is something ‘wrong’ with them.

Perhaps more troubling, is that a belief in limitless potential for change perpetuates the suffering associated with diminished self-esteem and feelings of inadequacy. With the mantra, “There is always room for improvement!” ringing in our heads, is it possible that we can ever be good enough, smart enough or well-enough adjusted? The culture of self-help creates the condition whereby each is doomed to fail because there are infinite ways for us to not live up to personal and social expectations. Although the women involved in this study did not explicitly mention the drawbacks of engaging in self-improvement, many communicated a sense of failure, either through their drawings or words, that they had not been able to master their perceived inadequacies. This is articulated simply, but poignantly, by Jane when she says,

I think that I am more confident than I was. I think that I'm still very vulnerable, I think, and I haven't really learned to like myself that much. I'm very, very conscious of that. And I think that's a detriment to me. I should work on that one, I think [says wryly]. But, I've come a long way as well. I, I feel much more capable in my job. So, yeah, I've come a long way in that regard but um, the whole self-

sabotage thing, I think about the . . . I haven't yet learned to deal with and that's a disappointment.

While superficially self-help appears to improve the lives of women and enable them to frame their experiences of suffering in terms of personal growth, there is a harmful and potential damaging aspect that cannot be overlooked. Considering the pervasiveness of this idea, the question becomes, can we option-out and not subscribe to the notion that we should improve ourselves? While the answer to that question defies a straight-forward response, we can look at the three women involved in this study who did not engage with these cultural ideas and values centered on bettering themselves.

Charlene and Shirley share a similar experience in that they occupy very similar social locations. They are undoubtedly the two most socially and economically marginalized women in the group in that they are both visible minority women in their fifties, are in need of stable/safe housing and lack a supportive social network of friends and family. This is in addition to Shirley's status as an IV drug user and Charlene's cognitive disability. It could be argued that these two women do not have equal access to a discourse of self-help (although they have both been exposed to crisis counseling and drug and alcohol rehabilitation programs). They certainly lack the financial and social resources that many of the other women have. Another possibility is that these women are too caught up in daily survival to be concerned with self-help and self-fulfillment. It is equally as likely, however, that both these women have chosen to option-out of this discursive set of ideas. Shirley in particular is aware of the destructive behaviours she engages in and she does not articulate any regret, disappointment or desire to change; nor does she wish to be told that she should feel these particular emotions/feelings.

A third woman, who also did not reference a desire to improve, lives in very different social and biographical circumstances. She has a stable home, loving family and a decent job. Sparky, however, has had many reasons to suffer throughout her life and she currently deals with a chronic disease. Despite this, she does not feel compelled to frame her experiences in terms of a journey of self-realization and self-improvement. It may be that Sparky has had many disappointments and failures in her life and she simply does not want to set herself up for more failure by buying into the idea of self-help. There is also the possibility that she is more concerned with the health and happiness of her only child and doesn't view her own self-improvement as important.

What this discussion of the 'self as a life-long project' highlights is that, regardless of whether women subscribe to this vision or not, they all have flexible and fluid ways to locate themselves and their bodies in the context of their personal suffering. Each woman is coping, managing and making-sense of her experiences in a way that will fit within the messy and ambiguous conditions of her everyday lived reality. In the process, they may be reflecting and defying (sometimes simultaneously) discursive Canadian values, but this is not necessarily their purpose. As Athena puts it, "all we every really want is to be happy, isn't it?"

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APPENDIX 'A'

The following is a list of the women interviewed. Included are their pseudonym, age, original occupational group, current work status, health-status and the page on which their body map is presented.

ATHENA:

28 years of age ▲ server ▲ employed and also self-employed ▲ minor work-related aches and pains ▲ conveys being in best health of her life with some mental fatigue, shoulder and feet pain ▲ body map: page 90 (figure 4) and page 171.

BRANDY:

27 years of age ▲ server* ▲ employed ▲ no work-related pain ▲ conveys being in best health of her life with some pain in ankles and shins; pain in neck and shoulders; anxiety in stomach and head ▲ body map: page 115 (figure 13) and page 176.

CHARLENE:

55 years of age ▲ sex trade worker* ▲ unemployed and on disability ▲ no work-related pain ▲ conveys all over body fatigue; arthritis in hands; kidney problems; back and hip pain; heart hurts; multiple injuries from physical abuse; poor eyesight; depression ▲ body map: page 102 (figure 8) and page 174.

CORAL:

33 years of age ▲ hairstylist* ▲ unemployed and on workman's compensation ▲ major health concerns linked to work ▲ conveys shoulder and neck pain; pinky finger hurts; lower back pain; stomach problems and heart burn; disempowerment; sore feet; tendonitis in wrists; anxiety ▲ body map: page 106 & 107 (figures 9 & 10) and page 175.

EVELYN:

32 years of age ▲ sex trade worker* ▲ unemployed ▲ minor work-related pain ▲ conveys sore gluteal muscles; neck and shoulder pain; headaches; cheekbone and ear pain; labial and vaginal pain; jaw pain ▲ body map: page 117 (figure 14) and page 179.

JANE:

56 years of age ▲ hairstylist ▲ employed ▲ minor work-related aches and pains ▲ conveys sore arms; throat and mouth pain; pain through core of body; neck pain; headaches; leg fatigue; teeth hurt ▲ body map: page 109 (figure 11) and page 180.

JULES:

37 years of age ▲ hairstylist* ▲ unemployed ▲ significant work-related pain and illness ▲ conveys right hip and knee pain; spine and shoulder pain; mid-back spasms and pain; sore ribs; neck tension; stomach and digestive problems ▲ body map: page 96 (figure 5) and page 172.

MISTY:

54 years of age ▲ hairstylist ▲ employed ▲ conveys being in perfect health except for some emotional stress ▲ no body map.

SAGE:

47 years of age ▲ sex trade worker* ▲ unemployed and on disability ▲ conveys lower back spasms; IBS; shoulder pain; infection in lower lumbar; hairline fracture of tailbone; hip problems; anxiety ▲ body map: page 84 (figure 1) and page 169.

SAM:

46 years of age ▲ sex trade worker ▲ self-employed ▲ feels work makes health better ▲ conveys bone spur; pain from IUD; pain and scarring from Chlamydia; heart burn; headaches; arthritis; neck “growth”; IBS; disassociation; depression; tinnitus ▲ body map: page 113 (figure 12) and page 169.

SPARKY:

57 years of age ▲ server ▲ employed ▲ minor work-related aches and pains ▲ conveys stomach problems related to stress; anxiety attacks; sore arms, legs and “butt” muscles ▲ no body map.

SHIRLEY:

49 years of age ▲ sex trade worker* ▲ unemployed and on disability ▲ conveys arthritis in hips, knees and hands; knee problems; heart aches; bad memory; depression; pain in shoulder ▲ body map: page 123 (figure 15) and page 178.

STEPHANIE:

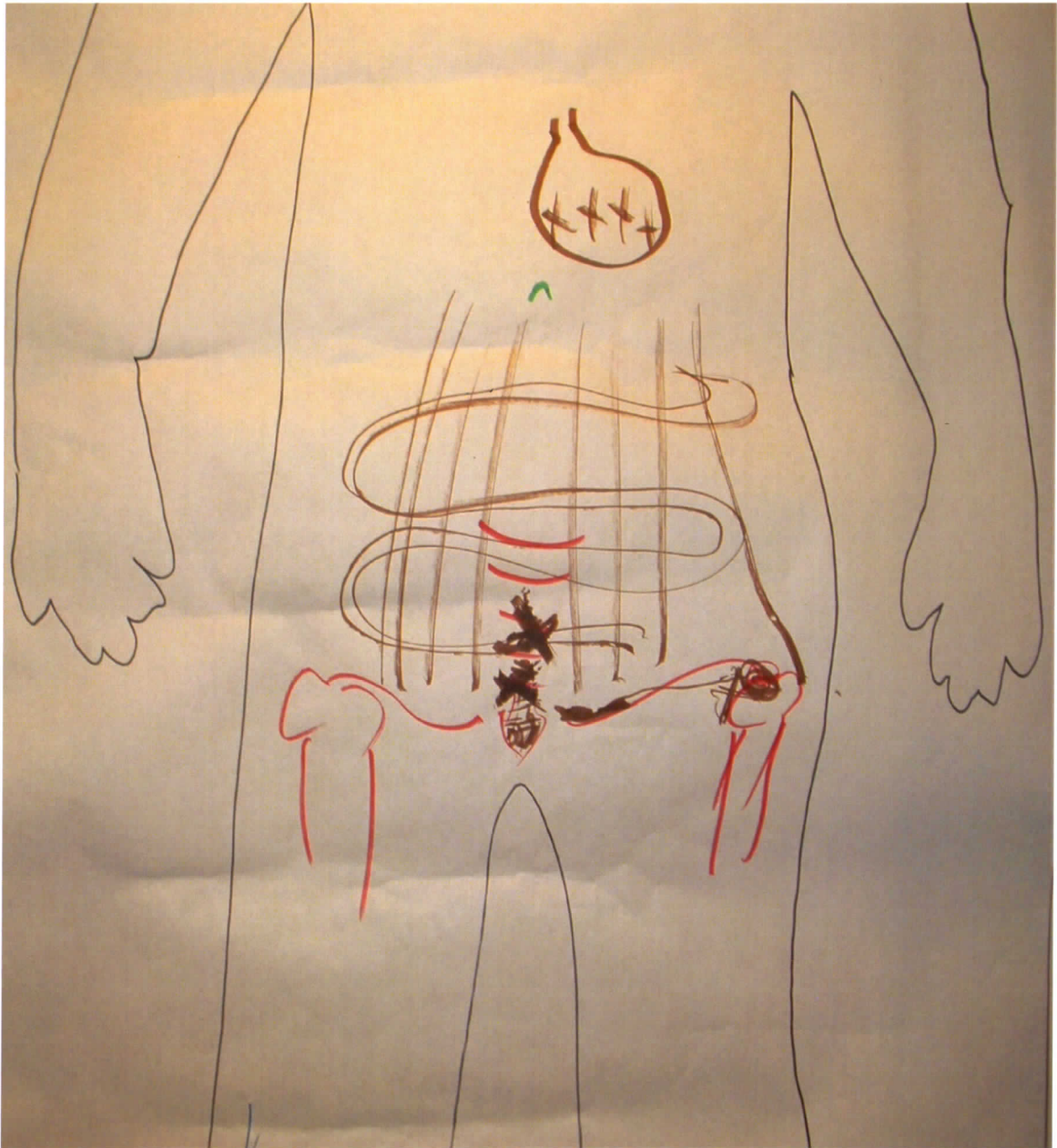
22 years of age ▲ server ▲ employed and enrolled in university ▲ significant work-related pain and illness ▲ conveys stomach pain and digestive problems; chronic bladder and yeast infections; hernia; upper back pain; headaches; feet and ankle pain; anxiety ▲ body map: page 97 & 100 (figure 6 & 7) and page 173.

TOBI:

38 years of age ▲ hairstylist ▲ self-employed ▲ minor work-related aches and pains ▲ conveys back and shoulder pain; anxiety; headaches; stomach “issues”; body fatigue; sore feet; chronic disease; weight gain ▲ body map: page 86 & 88 (figure 2 & 3) and page 170.

* no longer working in the service job that made them eligible for the larger ISW project

APPENDIX 'B'



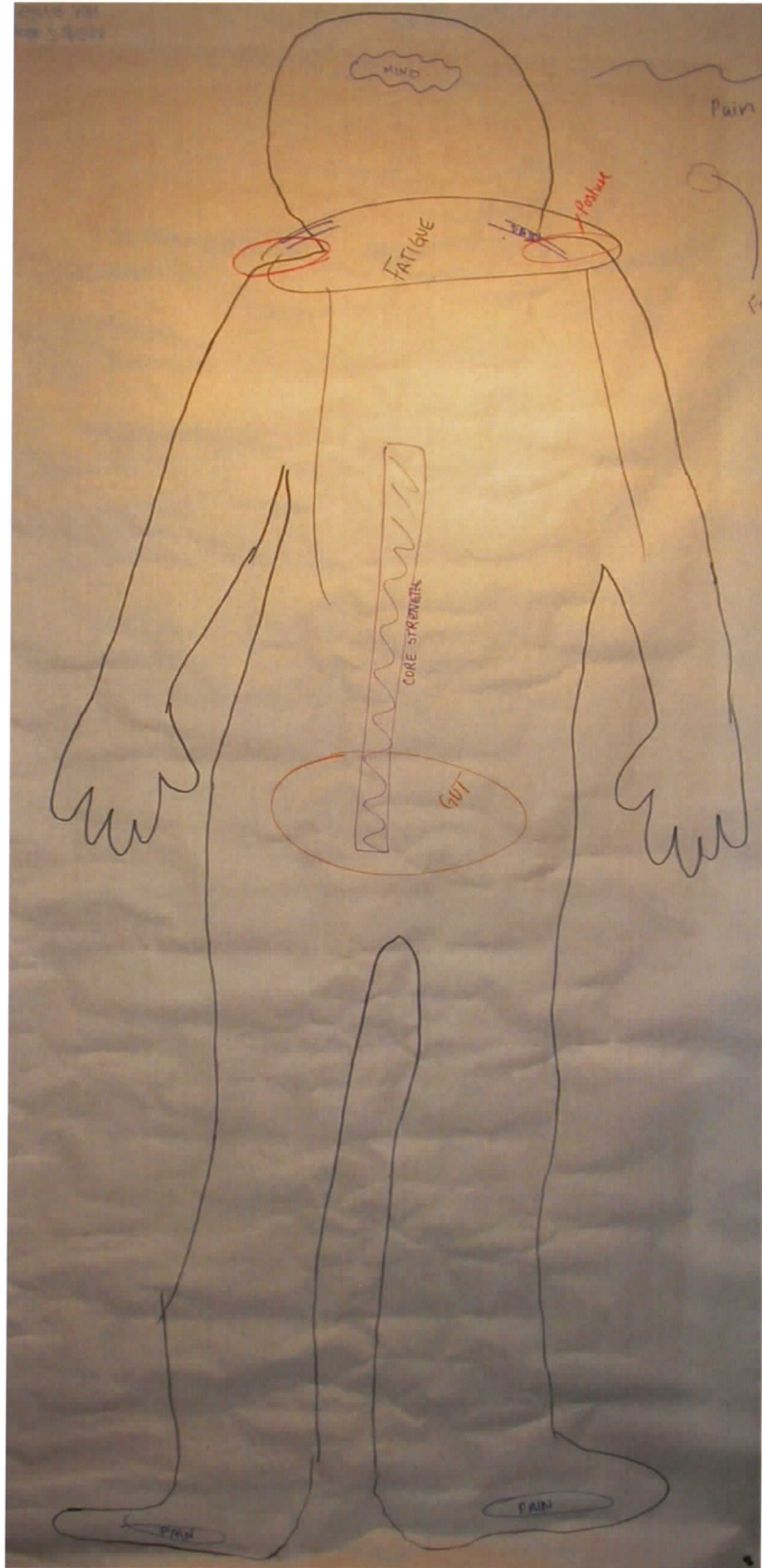
Body Map # 1: Sage (torso)



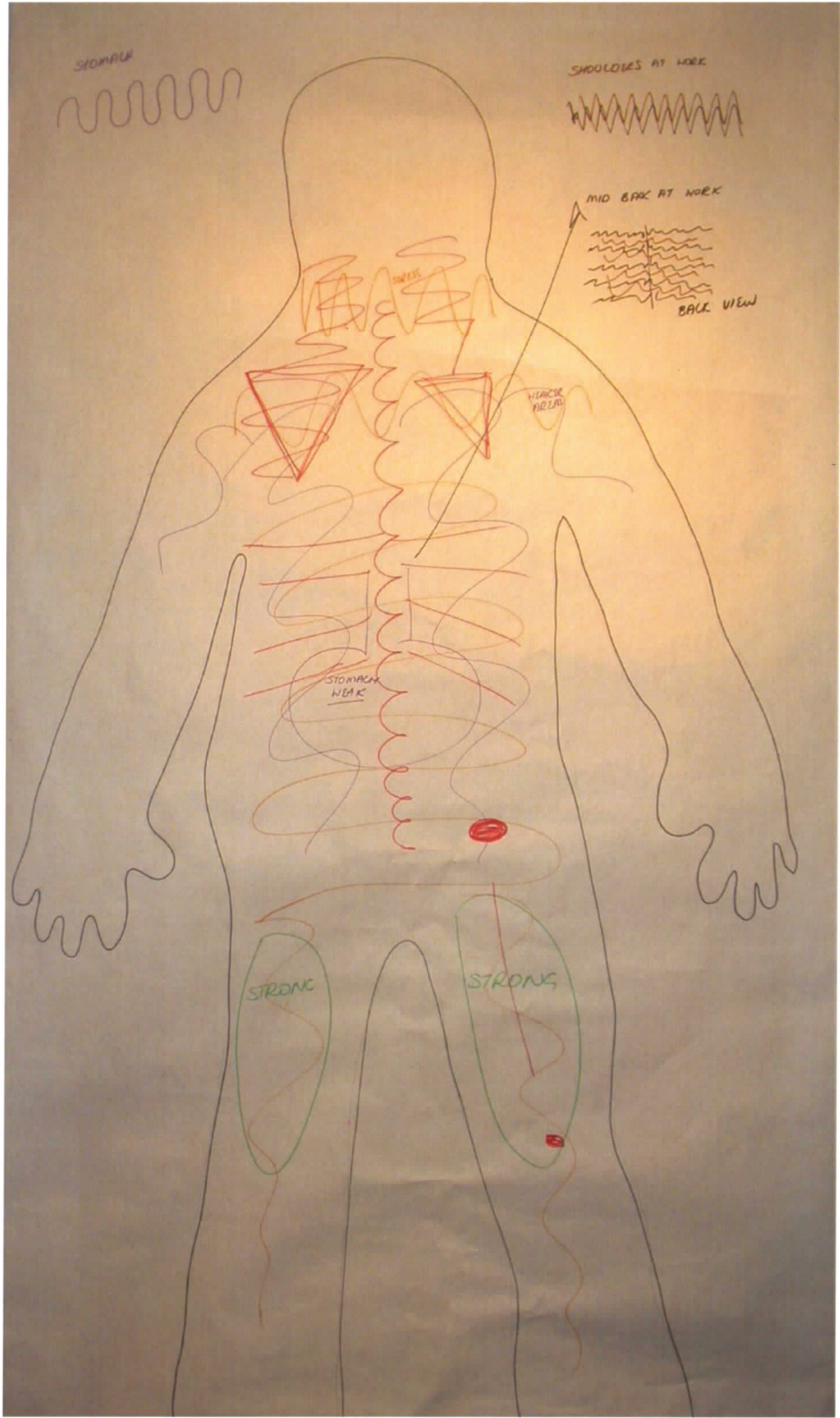
Body Map # 2: Tobi (torso)



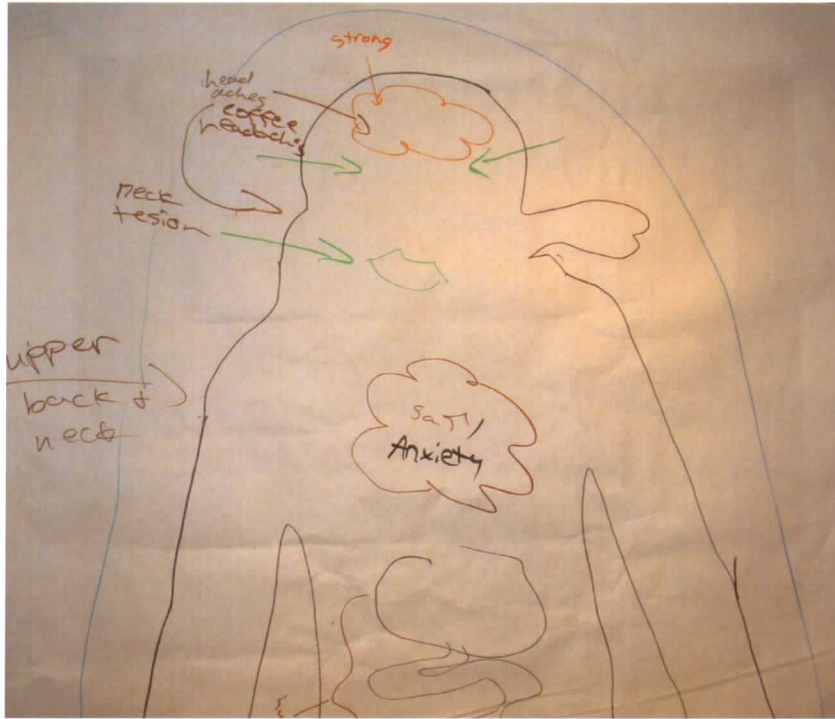
Body Map # 3: Tobi (head)



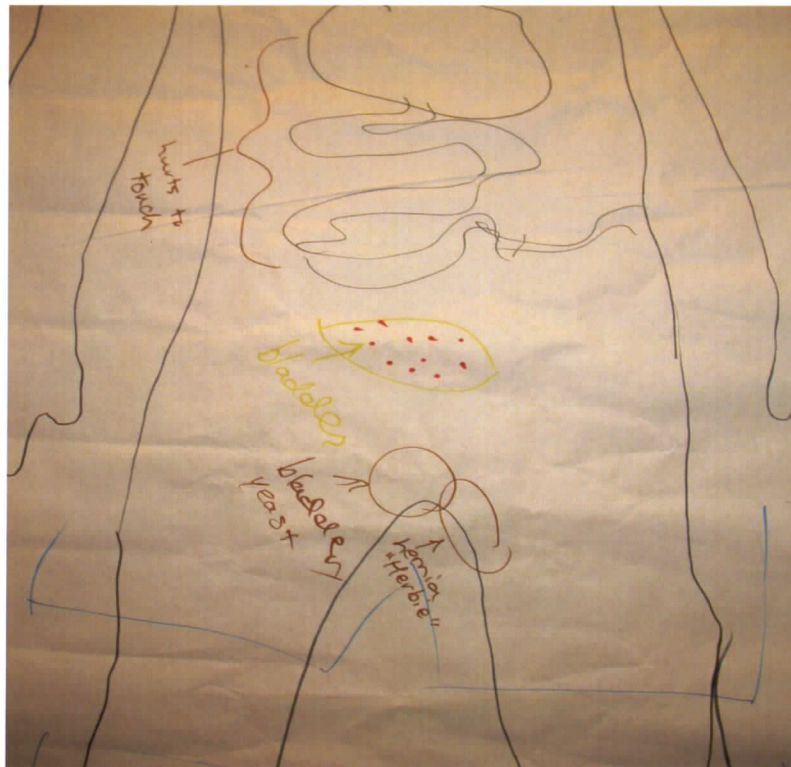
Body Map # 4: Athena (full body)



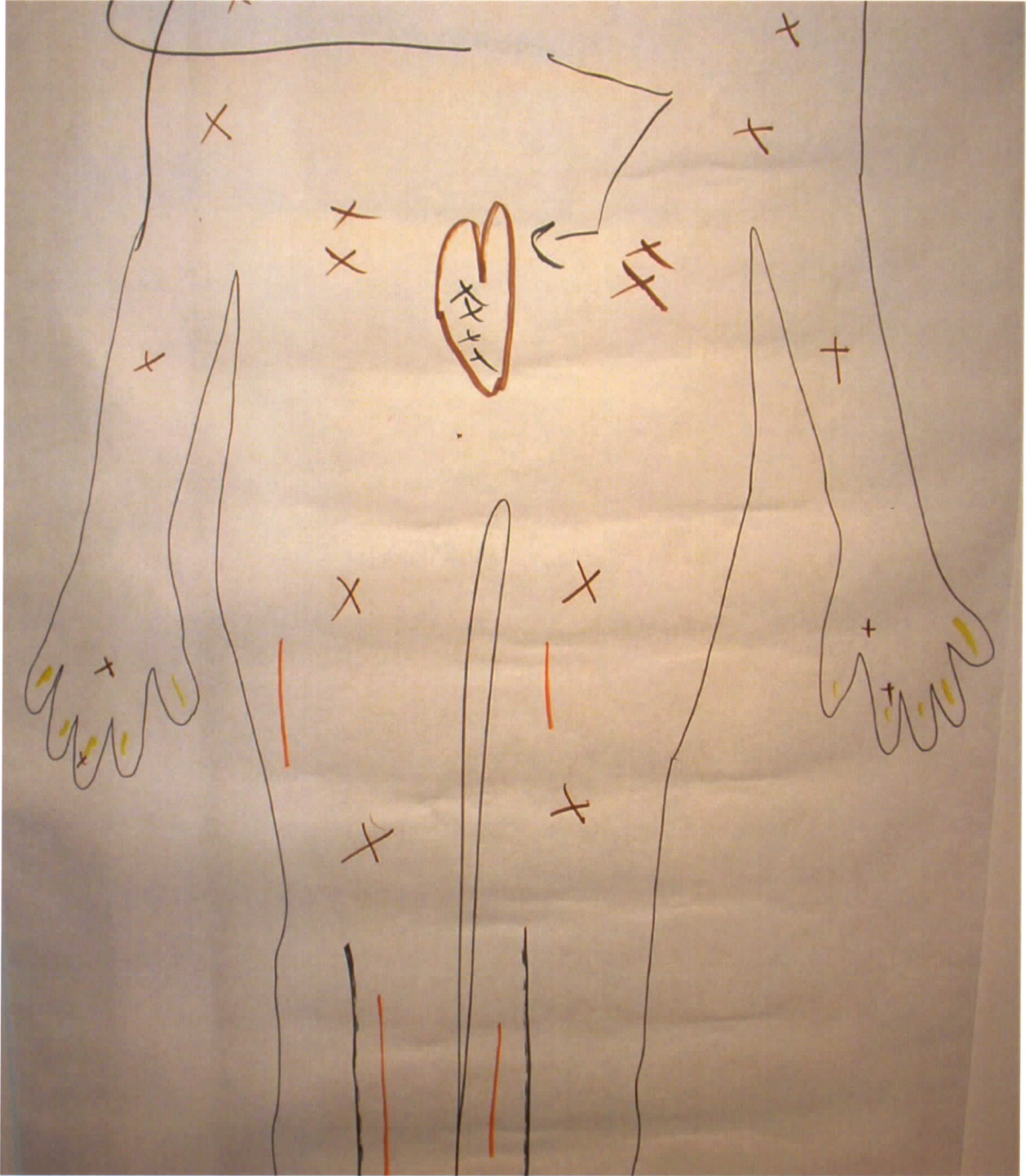
Body Map # 5: Jules (full body)



Body Map # 6: Stephanie (head)



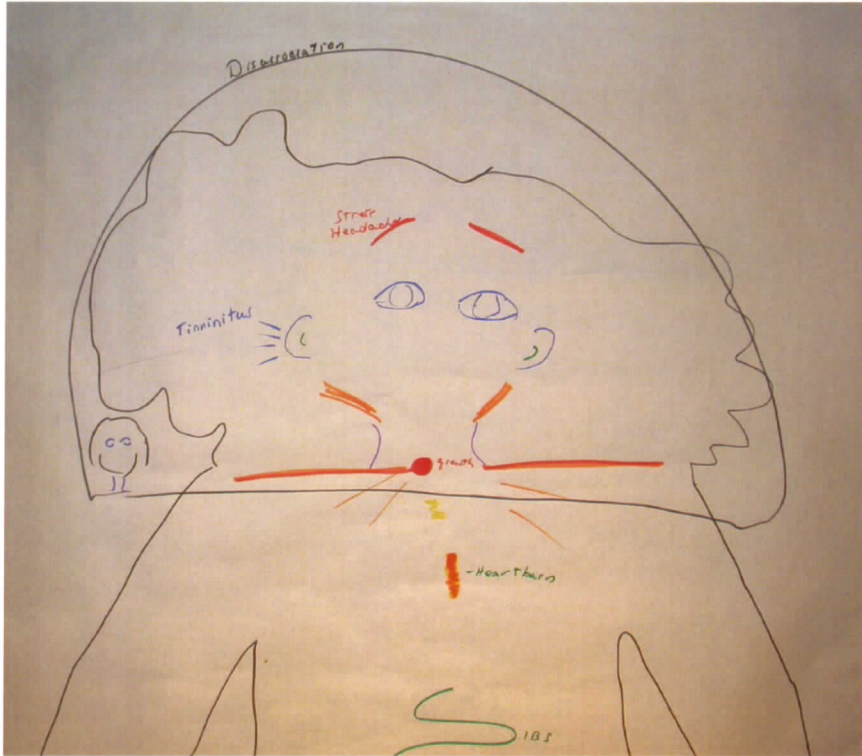
Body Map # 7: Stephanie (torso)



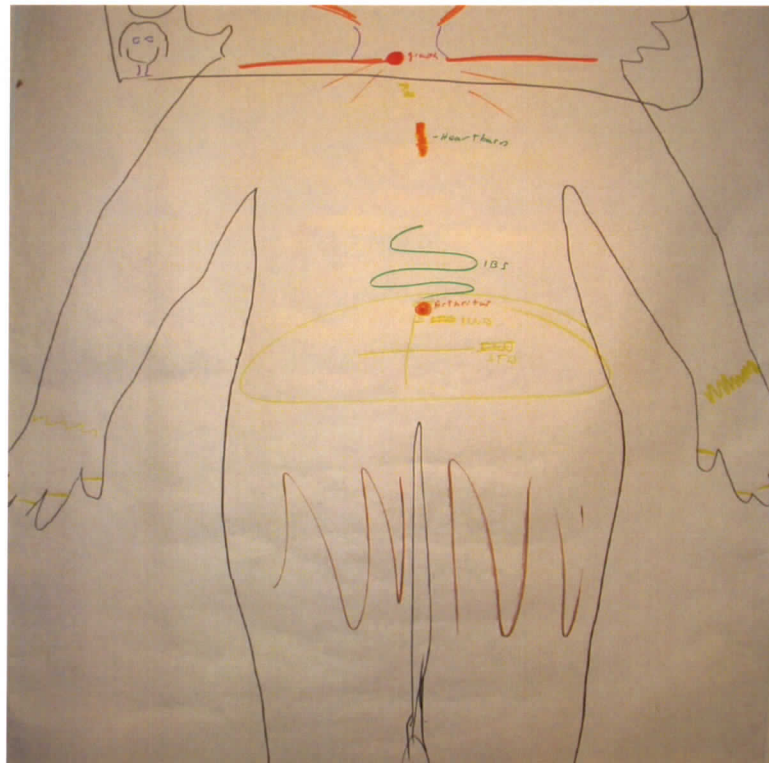
Body Map # 8: Charlene (torso)



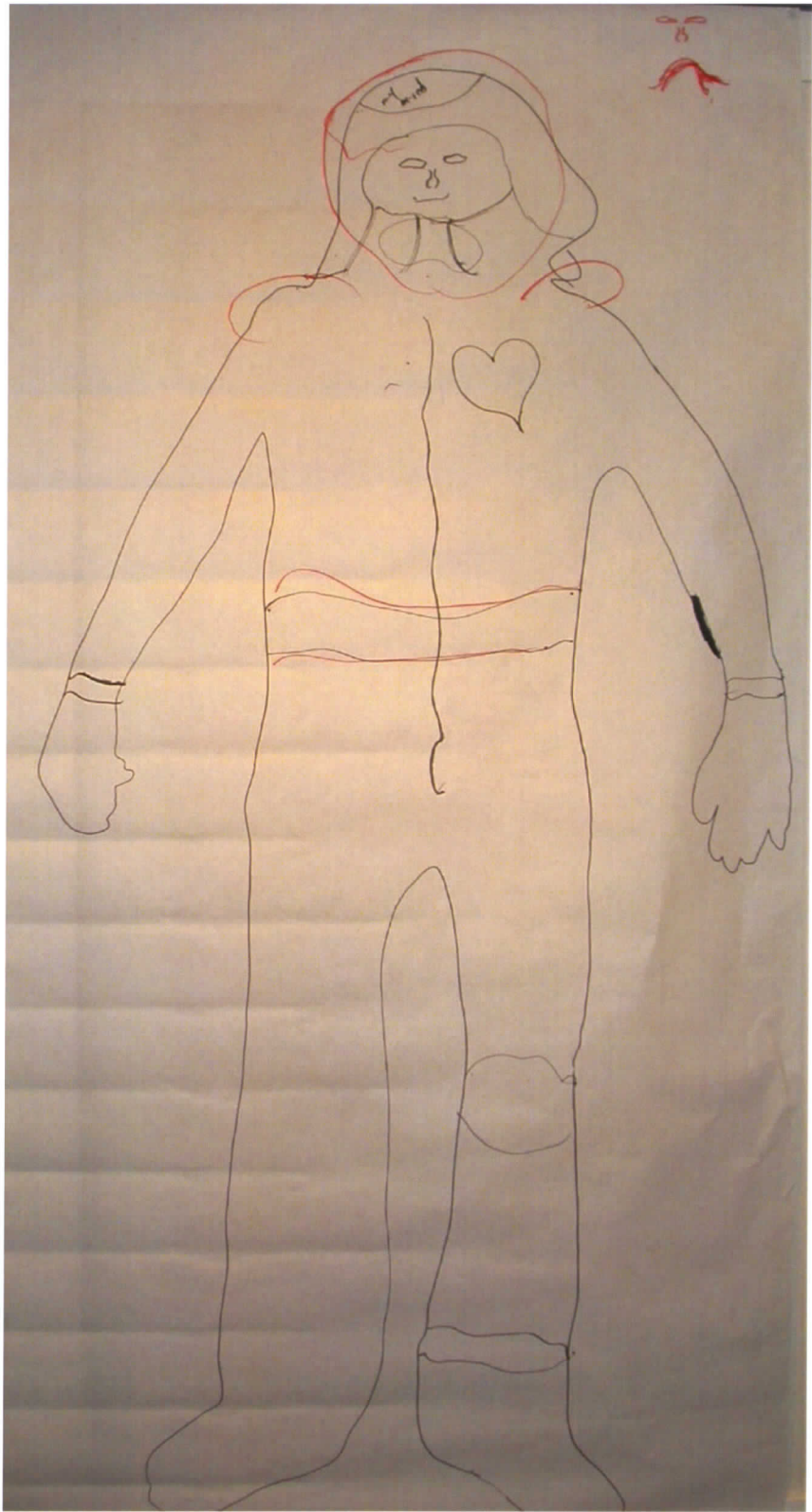
Body Map # 11: Brandy (body)



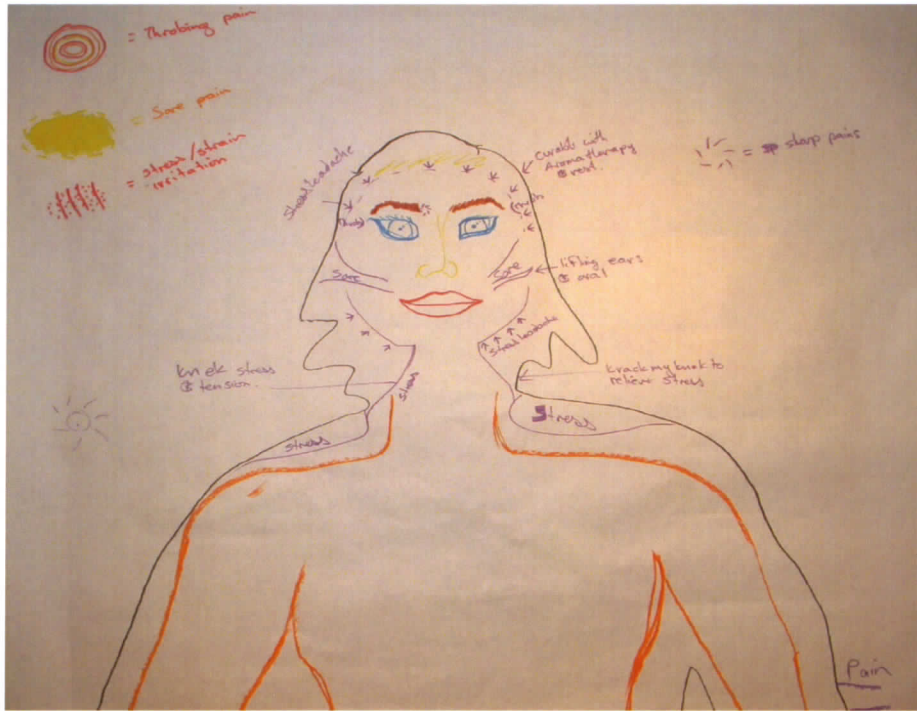
Body Map # 12: Sam (head)



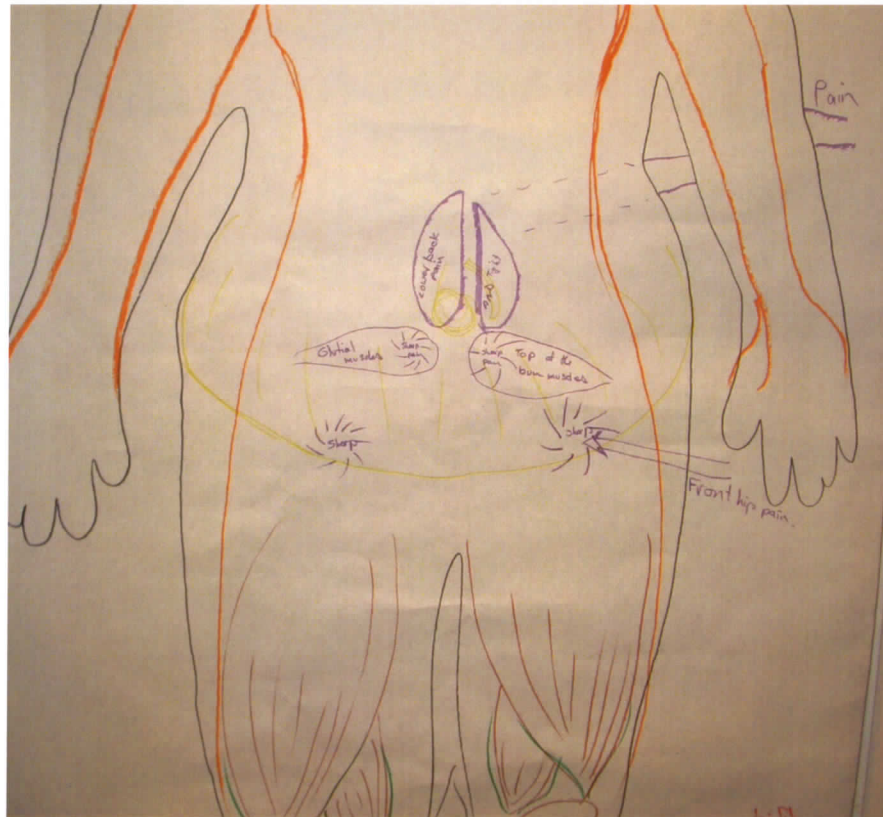
Body Map # 13: Sam (torso)



Body Map # 14: Shirley (full body)



Body Map # 15: Evelyn (head)



Body Map # 16: Evelyn (torso)



Body Map # 17: Jane (full body)

APPENDIX 'C'

INTERVIEW SCHEDULE

Thanks for coming in for the fifth, and potentially final, interview. We really appreciate all your insights on issues concerning occupation, health and safety thus far. Today we are going to do a more in-depth interview that focuses specifically on the connection between health, occupation and your social environment. As previously mentioned, preliminary results have shown that two-thirds of the participants in our study have reported significant work-related fatigue; 40% report experiencing work-related pain and 64% experience moderate to high levels of workplace stress. Overall, 22% of the participants consider their health to be only "fair" or "poor". These results have led us to questions how stress, emotional burn-out, physical injury and fatigue affect the bodies of service workers. Specifically, we want to understand how occupation directly and indirectly affects respondents' overall experience of physical, emotional and mental well-being. As you may already know, this follow-up interview is focused specifically on the experiences of women workers. There are two reasons for this decision. The first is that women predominate within our study at 77% and women make up approximately three-quarters of the total Canadian population working in front line service occupations. Secondly, there is a body of research that suggests that women may be more vulnerable to the negative emotional and physical health consequences of working in public service jobs. We are going to explore some of these research findings by taking a closer look at your experience with work and health.

General Life Questions

I would like to begin by learning a bit about you, your history and what's going on in your life. Some of these questions may seem repetitive but it's really important that I understand where you are at in life in order to understand your experience with pain, stress and fatigue.

1. What was your life like while you were growing up? (Probes: what are some of your most important memories? Who were the most influential people in your life? What events do you feel had the greatest impact on who you are today?)
2. What kind of person would you describe yourself as (in the present)? (Probes: What is important to you? What are the key relationships in your life? What do you do in your free time? Are you happy with where you are at in life? Do you wish you were doing something different?)

General Health and Wellbeing Questions

I would now like to get your views on health.

3. How do you define health? (Probes: is wellbeing a physical state of being? A mental state? An emotional state? What is it for you to feel healthy? What does it take for you to feel unwell or unhealthy?)

4. How would you talk about or describe *your* health today (or, over the last several weeks/months)? Do you consider yourself to be healthy? If not, can you remember a time that you were in really good health? What made you healthy? Do you consider yourself (un)healthy? If not, can you remember a time that you were unhealthy? Why was that?
5. How do you think that stress affects your health? (Does it manifest itself physically? Is it mainly a mental or emotional state of being?) Do you think that stress has a directly influence on your health and, if so, how and why?

Work-Related Questions

Now, I would like to discuss your work. While I know that you may have discussed some of these subjects during earlier waves of the study, today I would like you to expand on things you have said during earlier interviews and think about how your job and your working environment may directly and indirectly affect your health.

6. How would you describe your work? Or, Can you tell me about your work?
7. In general, do you like your work? Why? Why not? Are there aspects that you find attractive and others that are less attractive? [Probes: clientele, co-workers, managers, rude clients, scheduling, tips, long or short hours?]
8. Do you feel that you have control over what happens to you at your job? (Probes: do you feel free to speak your mind to your boss, co-workers and customers? Do you get to set your own schedule? What would happen if you just didn't feel like showing up for work?)
9. How mentally engaged do you feel with your work? How emotionally connected do you feel to your clients?
10. What are your thoughts about working in a service industry? How do you feel about "serving" or dealing with the demands of the public? (Probes: does it make you happy to be able to provide certain services for your customers? Do you ever find that it is demeaning or degrading?)
11. When people ask you what your job is, what do you say? Why do you describe it that way?
12. Can you tell me about how it went with your last client or, during your last shift at work? What was "difficult" about that interaction, what was "really good"?
13. How do you feel physically and emotionally at the end of a shift (or after your last client)? How do you unwind? Does it take you a long time to unwind? Do you feel emotionally drained at the end of most of your shifts? Do you still go through a process of unwinding after a really good shift?
14. How large a role does your work play in your life? Does your personal life affect your job? (Probes: do you keep your job separate from your personal life or are the

two intertwined somehow? I.e. do you find yourself thinking about your job when you are on your own time? Are the people you hang out with friends from work?)

15. Has your work changed your body in any way? If so, how?

16. In your opinion, what impact does your occupation have on your overall health?

BODY MAPPING

I am really interested in understanding the relationships between work and health. Sometimes, it is hard for each of us to put that relationship into words, so I'm using another approach. I've got a big piece of paper here and I'd like to trace an outline of your body onto that paper. Then, I'll ask you some questions about your body and you'll get to add things to the outline. Please be as creative as you wish during this process, there are no rules.

General Body Questions

1. What is your favorite aspect of your body? Can you add that to your drawing? Why do you like that aspect of your body?
2. Is there anything about your body that you'd like to change? Can you add that to your drawing? Why would you want to change that part?
3. Is there some aspect of your body that you think of as being really strong? Please add it to your drawing.
4. Is there some aspect of your body that you think of as weak or fragile? Please add that to your drawing as well.

The Body and Pain

5. Could you please mark all the places on your body map where you feel pain?
 - Does your body hurt while you are working?
 - Can you mark where it hurts while you are on the job?
 - How often does your ____ hurt?
 - What does the pain feel like?
 - Can you draw the pain that you feel here?
6. When you are working, does your body feel different than at other times?
7. Is there something you could draw to help me understand what that feels like?
8. If you couldn't put that into words, how would you draw it?

APPENDIX 'D'



Interactive Service Workers Occupational Health and Safety and Access to Health Services

Participant Consent Form (Wave 5)
(Interviewer copy)

Respondent ID Number: _____

*****The bold/underline sections are essential to verbalize**

You are being invited to participate in a community-academic collaborative study. This is a study about the work and health of interactive service workers who live in our community. Professors Cecilia Benoit, Bill McCarthy, Mikael Jansson and Bonnie Leadbeater are conducting this study. **If you have any questions about the study, please contact Leah Shumka at 858-0823, or by e-mail at lshumka@uvic.ca.** The main funding for this project comes from the Canadian Institute of Health Research.

What is the purpose of this project?

This project is interested in the experiences of women service workers as they predominate within our study (77%) and make up the majority of front line service workers in Canada (65-95%). There is also research that suggests that women are more vulnerable to the negative effects of work-related stress and are more likely to embody their stress. Within our project, preliminary results have found that two-thirds of the participants in this study report work-related *fatigue*; 64% experience workplace *stress* and 40% report experiencing work-related *pain*. Overall, 22% of the participants consider their health to be “fair” or “poor”. These results have been the impetus for a smaller fifth wave of interviews that focuses specifically on finding the connection between work-related “pain”, stress, fatigue and other factors on and off the job. We are interested in documenting the multiple and complex ways that occupation directly, and indirectly affects the health of female service workers.

Who is being asked to participate?

We have chosen to study three interactive service occupations, two of which are socially recognized as legitimate kinds of work – hairstyling and food and beverage serving – and one of which is not commonly regarded as a legitimate service occupation: sex work. You are being asked to participate in this 5th wave of interviews because **you self-identify as female and reported experiencing work-related pain, stress and/or fatigue during earlier waves of the study.**

Why is this research important and how will the information be used?

We hope the resulting report will be of interest to local service providers, work organizations and members of the general public. We also hope that the findings will help inform social policy regarding service workers' occupational health and safety, as well as that of their children. The research leaders will ensure that members of government, workers, and business owners, and in particular, workers themselves have access to the findings so that they are informed of the important issues that emerge.

After we have issued the final report, some of the data may be analyzed so that we can present our findings in books, dissertations or other publications. When we publish our findings we will only describe groups of individuals. **We will not provide data on single individuals and no one will be able to identify who participated in the study.**

What are you being asked to do?

This is the 5th wave of interviews. The interview will take approximately two, to two and a half hours long. We offer you a modest honorarium of \$35.00 for this interview, but you should not participate if you only do so because of the honorarium. Your participation will include **engaging in an open-ended discussion about your health and well-being, you will also be asked to participate in an exercise called body mapping.** Body mapping is a visual technique based on drawing in which we ask you to draw an outline of your body and then map the places where you experience either chronic or work-related pain. The purpose of this kind of technique is to gain a more complete understanding of how different kinds of pain, stress and fatigue affect your physical body and indirectly affect your emotional health and well-being. If you agree to participate in this research you will be asked to sign this consent form. **With your permission, I will tape-record the interview.**

Is your participation voluntary?

Your participation in this research must be completely voluntary. You may choose not to answer any question. You may withdraw at any time without any consequences or any explanation. If you withdraw part way through the interview, we will destroy the data already collected. If you decide to withdraw from the study (by not returning for or agreeing to a subsequent interview), we will use the data collected in earlier interview(s), unless you ask us not to do so. You will be asked to sign a consent form at each interview.

Are there any risks involved?

There are some potential risks to you by participating in this research. **Some of the questions may remind you of difficult events from the past.** In addition, some questions may be perceived as private and you may feel uncomfortable sharing the information. **If the interview raises concerns and you would like to meet with a qualified counselor we will help you to do that free of charge.** We have available a list of local health services and we can take steps to put you in touch with health services or emergency aid if needed. (The list of Services was made available in Wave 1).

How important is your privacy?

We would like you to know that we will always keep your name and contact information separate from the information you share with us in order to ensure that **the information you provide remains anonymous. Only the research leaders and project coordinators will have access to your name and contact information, and this information will only be looked at when we contact you to book a follow-up interview.** We will also maintain confidentiality by keeping the data under lock and key at all times. The interview questionnaires, tapes and contact information will be destroyed once the project is completed.

*****Verbally remind respondent of the limits of confidentiality (confidentiality does not apply in cases of potential child abuse or potential harm to self or others).**

What are the benefits of my participation?

There are many potential benefits from your participation in this research. First, your participation may provide you with insights into your own experiences as well as useful information and ideas about your health and occupation and the health of your children (where applicable). Second, your experience will be combined with others in order to provide better general knowledge of the situation of interactive service workers in our society. The study will allow us to make recommendations about the prevention of health problems and ways of increasing early and appropriate access to services for interactive service workers and their children (and others in service-related jobs). As mentioned earlier, we will ensure that government representatives (such as the Worker's Compensation Board), business owners, and workers themselves have access to the findings of the study so that they may use the information to become better informed of the health needs of persons employed in these occupations and advocate for occupational supports or conditions that will benefit interactive service workers and their families. Third, the research may place you in contact with services (including emergency services) that you may have been previously unaware of.

How are participants selected?

For this particular wave of the study, you were chosen based on whether you self-identity as female and have reported experiencing work-related pain, stress and fatigue.

In addition to contacting the research office above, you are also welcome to raise any concerns with the principal researcher, Dr. Cecilia Benoit at (250)-721-7578 (cbenoit@uvic.ca) or Dr. Howard Brunt, Associate Vice-President, Office of the Vice-President of Research, University of Victoria, at (250) 721-7971.

Your signature below indicates that you understand this consent form and that you have had the opportunity to have your questions answered.

Copy provided to respondent.

Name of Participant:

Signature:

Date:
