Chapter IX

Old Ways of Coping with New Forms of Emotional Distress in Chile

9.1 Introduction

In this chapter, I discuss the manner in which migrants manage and cope with distress in Chile. I explore how they mobilise various resources to deal with illness and distress. The terms “coping” and “managing” differ in two respects. Firstly, coping involves strategies put in place by the affected person to deal with distress – which may or not be successful. Managing may involve a third person who may merely administer to this distress. Secondly, while in managing distress, the problem is not really addressed. With coping, the strategy used seeks to overcome the problem.

This chapter begins by discussing what has changed between previous experiences of distress and current ones. The lack of social support appears to be a significant change in the new challenges migrants face in the host society. I examine how this lack of social support introduces changes in migrants’ illness experiences. I then discuss culturally framed practices and coping mechanisms that emerge refashioned in the new context. In doing so, I look at how notions of femininity and masculinity influence means of coping, expressing and interpreting emotional distress. While both men and women migrants seem to channel distress through dancing; drinking seems to be more practiced mostly by males. Here, I look particularly at the use of alcohol by migrant men as a mechanism to cope with emotional suffering in the absence of other resources.

In addition, I examine the connection between physical symptoms experienced by men and its emergent construction as idioms of distress. This is so, since men tend to read the physical strains caused by alcohol consumption and by the demands of their work as more viable explanations for the origin of the somatic problems experienced by them in periods of emotional distress. Other ways to manage emotional distress available to migrants are also discussed here. Migrants’ typical means of coping with distress in the medical setting and at the workplace are examined. While migrants’ access to medical care is limited, they are also confronted with – and resistant to – an incipient process of medicalisation of their emotional distress. This appears to take place especially in the case of women at the workplace.

In discussing the sphere of work, attention is placed mainly upon women. The nature of domestic work in which migrant women mostly engage, often involves live-in regimes. This situation places them in constant personal contact with their employers and limits their mobility outside the employers’ household. All such factors lead to women’s distress being revealed at the workplace and their employers getting involved in its management. The role employers play in facilitating or blocking migrant women’s healthcare-seeking is also discussed here.
Throughout this chapter the relationship between language used to communicate distress as well as the coping mechanisms migrants put in motion is discussed. Specifically I am interested to explore the affects of this relationship upon migrants’ bodies, subjectivities and general well-being. I especially look at the extent to which the use of language(s) empowers or disempowers migrants by providing or depriving them of their agency to manage their own distress.

9.2 Changes in illness experiences: confronting new plights in the absence of emotional support

This section looks at some of the forms of emotional distress that, in migrants’ life stories and perspectives precede their current experiences. Changes in symptoms are signalled in reference to shifting social contexts where these forms of distress emerge. Absence of reliable social support appears to be a relevant factor related to mechanisms migrants set into motion in the new environment to cope with their emotional distress.

Rather than holding a dichotomist approach in which changes are framed within a ‘before and after migration perspective’, I propose they must be seen in a continuum. Along with this continuity, an analysis of illness and idioms of distress opens a window to observe how individuals position themselves in shifting contexts. Also, it reveals the extent to which continuities in migrants’ marginal social standing is structuring their illness experiences.

Marianela had experienced emotional problems in Peru, but in a different way. There, she felt trapped in the situation where she “did not have anywhere to go”. She describes the feelings of impotence she experienced while facing conflicts with her ex-husband in Peru. This situation in turn, triggered her ‘convulsions’.

L: Is the experience you had in Peru different from your current experience?
M: Yes, the feeling of impotence (experienced in Peru) got me to an extreme (situation) that I ended up in a state of shock. (While in Peru) I reached an extreme that I began to convulse and I did not stop. They had to take me to hospital. The ‘shaking’ did not stop. I totally lost control. It was because I felt so impotent that I could do nothing. Nothing. Because I used to see him (her husband) all the time.

Contextual elements also appear to be relevant in explaining the new form Marianela’s distress has taken. Also, the meaning conveyed to her through emotional distress must be taken into account. Convulsing was an extreme occurrence in Marianela’s past illness experience. This took place in a more ‘safe environment’ as she had the social support she needed. Indeed, her social milieu witnessed her convulsions and helped her out. Although, it seems that Marianela’s convulsions played out as ‘a form of protest’ enacting her feelings of impotence in the face of a situation she felt she could not otherwise change. Convulsions were then, her reaction to feelings of being trapped in a situation where she did not see a way out.

Convulsions or crises are popular categories recognised by people in Peru and described in the study of Perales et al as: “People who fall down suddenly, yell, they roll their eyes from side to side, twist their bodies, foam at the mouth, their bodies go a royal colour of purple for a while; after all this they become sleepy and lay down and afterwards do not remember anything, sometimes they fall down and hurt themselves” (Perales et al 1995:56).
The emotion Marianela recalled as triggering her distress is exactly the same in Chile as it was in Peru – “a feeling of impotence”. The difference in both experiences is entrenched in the resources she has available to manage her distress, and in the meaning she associates to the form in which her distress manifests. All of which, in turn, relate to the contexts where the distress emerged.

When Elena was going through her divorce in Peru, she suffered from a facial paralysis which later compromised her one arm and leg. She believes this problem was triggered by the depression she then suffered. As part of medical treatment, her doctor discussed her condition with her family and asked them to participate in the treatment. In Elena’s view, her recovery was possible due to the support she got from her family and friends.

My mother helped me a lot. She gave me so much love in a short period of time and got very attached to me. My friends too. Those who saw me like that, they invited me also. Let’s go Elena here and there… I would forget about my things and I began to go out. I had reached a limit I am telling you. …That people talked to me and I did not. I did not even hear. They would talk and it was not with me, the conversation. I was there but I don’t know what was going on. I don’t remember, and what everybody tells me – that I was like that, with a deep look (in her eyes)… I never knew (what the doctor said). “My mother told me: daughter I talked to the doctor, and the doctor reprimanded me because I never gave you love, true (love). I offer you that love, I love you so much, in my own way, but now I am going to show it more to you”. I thanked her. I felt as if I had been born again, as if my mother was loving me, as If was little girl like that. I am her only girl child.

In Chile, Elena found the support in the Catholic Church, from a community whose mission is to work for the migrant Catholic population. Members of this community came to visit Elena one day and found her crying in her room. Since then, they have been supporting her emotionally and have helped her to get access to a medical doctor. Elena is now part of the community and devoted to the Chilean Saint Padre Hurtado, patron of the Catholic mission.

While Elena is in better health now, she always fears her paralysis can affect her again. However, she knows she has to avoid taking on too many problems by herself and takes additional precautions.

It is like a warning signal that I get, when I have too many problems. It [her body] gives me a warning signal. My face begins to tremble, like this, and the feeling of ants in my body. This, an arm, a leg, so it is like a warning signal that one gets. So one has to try to get better, to relax, to do exercises, to try to hide it. Because this is very treacherous eh?

For Felix, the symptoms of his current distress are the same as those he experienced in previous episodes he had in Peru. However, previously, he felt no pain in the stomach.

L: Have you experienced these health problems before?
F: Yes I believe, but I did not have stomach aches. But yes, I did have all the symptoms I am experiencing now. – The fear, the fright, I cried, and cried. …When I listen to… for example, a melancholy music
L: So what has changed?
The pain in the stomach.

Depression as defined in the context of life in Chile is, for many migrants, a new experience. However, similar emotional states have been previously experienced by many migrants and are described as feeling tristeza (sadness). Clearly, sadness is a more recognisable feeling for migrants.

F: Here in Chile, I have heard of it (depression). Here in Chile, because sadness is very different to depression.
L: And, in Peru do you rather call it sadness (these emotional states)?
F: Yes sadness, I believe.

Felix describes the way in which sadness is dealt with in Peru – through emotional support given to the person affected.

L: And sadness? How is it dealt with in Peru?
F: Sadness. Sadness, well you feel the family support. ...That what now is happening to me, I believe that if I were with my family I would not have any kind of illness. Your family is your support no matter how sad you may be. Your family is a permanent support. ...Imagine, when my mother passed away for me to not be in that permanent (grief), my family, my uncle took me to practice sports. ...There, I entertained myself. Sure I missed my mother but that sadness started to go away, as time passed by. Yes... as time passed by, and with the support of my father, of my brother, slowly we were killing that sadness together.

Sadness is understood as a consequence of difficult events that may happen in ones’ life. Its causes are understood by the migrant’s own milieu, which can often provide the one affected with the necessary emotional support. However, for Felix, depression is more difficult to cope with.

L: And depression, how do you deal with it?
F: Depression is difficult. For me, it is something difficult to solve.

Ideally, in migrants’ own environment, coherence between the social order and the individual’s emotional experience is expected to be maintained. For example, cases of strong identification with the mother or other close relative are not seen or judged in terms of normality or abnormality. Furthermore, the range of emotions and behaviours permitted within the frame of the individual’s socially accepted role is very wide. It includes anger and violence as accepted behaviour if the “triggering reasons” are justified within the societal order.

When emotions are congruent with the social expectations (e.g. sadness from missing one’s mother, worrying for one’s children’s well-being) even though these may overpower the person, they are taken as natural feelings. In situations where the emotion experienced by a person contradicts expectations, she or he is not seen as needing any process of ‘cognitive adjustment,’ such as one that may be achieved in therapy. In general, affection and emotional support of the person’s own social environment is provided in situations where people go through difficult emotional states.
In the new environment, emotional support is difficult to obtain. Although, in Chile, the presence of a migrant community constitutes an important source of support providing migrants with information, contacts and material resources, generally, migrants distrust their fellow Peruvians. Migrants express that they do not easily confide their problems and their causes of emotional suffering to other members of the community. Moreover, members of the same community often act against their fellow Peruvians, spreading rumours and gossip which gets passed on to the migrants’ families and friends in Peru. This causes the affected migrant even more tribulations and emotional suffering.

Generally and overall, distrust seems to be very present in the Peruvian society, and among migrants, this fundamental distrust is exacerbated by competence that exists among migrants. In fact, underlying migrants’ mutual support is also a high degree of individualism. This is well expressed in the common saying ser mosca (to be fly-like) — a desirable personal trait among Peruvians. It means to be quick in reacting and able to take advantage of any opportunity for self-interest. In consequence, disclosure of personal information to others means opening up the possibility of it being used against the person in question. This lack of trust becomes critical at times when migrants’ need to express and vent their emotions to others.

Marianela knows this very well. When support was most needed she was targeted by gossips who circulated rumours in her compound. I have now chosen to (just) greet everybody and that is all. (I have had it) up to there! No more. No, I don’t get involved. I don’t talk. I prefer to go out to the street. I prefer (to be out) over there, and not here, because I had bad experiences (here). They (migrants in her compound) made me feel bad. On top of the problem I had at work, they made me feel bad because they say my boyfriend was using me sexually. That he was coming only to take advantage of me sexually and then ciao (bye)... I was feeling extremely bad, super bad, because I said, I am in total crisis in my work and I come here to relax and what is the use of it? This world here is (even) worse... They harass me, then I was lost. From then, I became harsh, cara de palo (hard face). Now, they talk about me and I am indifferent. They taught me to be like that... I used to come here (to her room), and I would start crying. I said: why do they talk that way? And then I would get doubts. Can this be true? Am I being silly? Where is my dignity? To which extreme have I got? (What) if my family knows? What would they say? Oh, (it) was like that.

In situations where migrants cannot speak about their problems, venting alternatives should be sought. In the next section I will discuss other methods used by migrants in the community in dealing with emotional distress.

9.3 Coping with emotional distress in the migrant community; killing the stress by dancing and drinking

Stress, in the new life context, provides the possibility to forget oneself; to be liberated from distress. This new language allows migrants to react in new ways to physical strain as well as emotional burdens. Therefore, these migrants party and engage in a myriad of social activities, rather than just going to bed, taking rest or spending time with family for support.
New forms of managing stress are all relevant aspects which appear in Gladys’ experiences of distress. In this new language of distress, tiredness becomes pressure – something needing to be actively released. The new context also provides for resources – economic, cultural, and social – to manage current productive distress in a different manner. Individuals are now entitled – because they are stressed – and given more freedom to release such pressures. Now new resources are available to cope with – her previously un-productive distress. Gladys expresses it as follows.

L: Is there any way to relieve that?
G: Well, it is to go out to dance and relax, drink something, share with people a happy moment.
L: And, it is done the same as in Peru?
G: Well yes it is done, but not everybody does it. I, myself almost never… Sometimes people came to invite me; mommy, go! (her children said to her). No, I said. I am tired; I did not feel with energy, no, no, I cannot.
L: And here; what do people do about it?
G: Here, is a little bit more liberal. Let’s say there is more freedom to go out. Here, I don’t have to pay attention to… or depend on anything. If I want to I go out I go, if I don’t, I don’t (she laughs). There instead (in Peru), I used to say; no if I go there, what people would say? Here it is different. The lifestyle is very different. …There (in Peru) people are a little bit more conservative than here. There, one fears to go out partying because (people) would say: oh look!, already they are gossiping. Here, instead nobody says anything. Nobody has anything to say because you go out or anything… (To go out) is a way to dissipate, to forget oneself for a moment. To think only in that moment that one is living, isn’t it? That one can dance, can laugh, and can enjoy a moment of happiness. There instead (in Peru), one feels more dull. Noooo! They say I can’t because the children are here or the husband (is here). But here (in Chile) instead, is the same with or without husband. They go out the same way, they just go out.

The association between the social context and the various forms to manage distress is visible in Gladys’ account. Unlike in her home environment, the current social context provides both: a more satisfying outcome for her productive efforts and a new language of distress. The bodily efforts invested in work are now productive. From this new position, body exhaustion – now body under stress – is reworked within the broader space the new society provides.

L: In which way is this distress relieved in Peru? Is there any way?
G: Well, it remains there because…Unless one… is too much… One could say “OK, I go out” one leaves and that is it. But that is rare. It is not very common. Here not. People say; “I have a problem, ah I’ll go out”. And even they go out to smoke a cigarette around the block, at least to breathe some air… Over there (in Peru), that cannot be done. Sometimes there was nothing to do. One is very tight (there) has (money) only enough to pay the tickets (transport) to work, to go and come back. At least here there is some liberation.

Music, dancing and engaging in heavy drinking are core activities at any social event among the migrant community. The perspective of going out to dancing is widely infused within the Peruvian migrant community. Felix describes the way other migrants deal with stress in Chile.

L: And, how should one relieve the stress?
F: Stress can be relieved by relaxing oneself, playing a baby football match, going to practice any sport. But this is almost not done here. It is done very little, and besides this, you know what my problem...is? I don’t have any vices, other people let’s say, would go out to dance. ...There (at the ballrooms), they kill the stress. I kill the stress dancing, but my problem is that I don’t know how to drink. I wasn’t born to drink, or to smoke either. That is what other people do. They kill it (the stress) dancing and drinking.

L: Here?
F: Dancing and drinking that’s all I can’t do because all that makes me feel bad.

Elena also has critical views on what going out to dance and meeting other Peruvians leads to.

They (migrant women) left their husbands there (in Peru). Here they get another husband. They (migrant men) left their wife there (in Peru), and here they find another wife. They go to some places downtown where they say they dance. So far, I don’t know (those places)... They dance, get drunk, and I know it is true because here are hundreds of people living (Peruvian migrants). They come back drunk. They forget their families. They go their own way, speak rudely... A very uncoordinated life... In Peru, this does not happen.

To face difficult emotional experiences, men drink. Drinking is a culturally legitimised practice among men in order to cope with troubled feelings, solitude or disillusionment. Dancing is integral with drinking. Although women may also drink, in general, drinking is more predominantly a male form of coping with emotional suffering. An ambience of celebration, in public places such a party often leads to instances where men drink heavily and allow themselves to cry, vent their grief, or openly state their disappointments.

Very frequently, alcohol consumption leads to physically violent fights in which men and women equally participate. Women drink as well, but not with the frequency and in quantity that men do. Irma sees clear reasons of why women don’t drink as much as men do.

I: I say maybe they (men) start to drink also because they feel sad. They feel lonely...women instead are different...
L: Why?
I: Because women cannot just begin to drink. (She laughs) It looks ugly if she does it, but some people vent in that way.

Moreover, culturally, women do not have the autonomy to drink as men do, as it is regarded not proper behaviour for women to drink on their own. As described in the ethnographic chapters (chapters V and VI), women should wait to be offered a glass of alcohol by a man. She must be served; only then can she drink. A woman would never take a bottle of alcohol and pour a drink for herself.

Lyrics of songs being played at migrants’ collective houses, or in ballrooms and bars where they gather, repeatedly recount stories of love, betrayal and disillusionment. The culturally sanctioned practice of “drowning one’s grieves” in alcohol is often expressed in the lyrics of popular songs. A good example is the very popular song Mozo una
cerveza, una y otra mas, (Waiter, a beer, another and another one’)

Music seems to convey and channel those emotions men find difficult to express in words – and in sobriety. Unlike men, women do not use alcohol to vent their emotions. More often, the use of alcohol is a “courage-builder,” to confront festering conflicts. However as said previously, women’s use of alcohol would always be mediated by a man who provides it for her.

Thus, for migrants, listening to and singing song-lyrics, drinking and dancing becomes not only a social event but also an emotional cathartic experience. It is in this situation where migrant men most often recall past hurts and feel free to desfogar (to vent).

Marlo feels lonely. He feels like crying all the time and he drinks in excess. He sees the source of his affliction as related to his loneliness and to the successive betrayals of his partners.

M: I sometimes drink a beer, I listen to some music and then I begin to cry
L: When does it happen to you?
M: When I am out of work.
L: Is it only when you are alone or also when you are with someone?
M: When I am with my friends, I also cry. ...It happens from one moment to another, when I begin to think, to meditate, what my daughter is doing there (in Peru), and my sister... that they love me so much. (He is crying.)

When I asked Marlo about how friends support him emotionally, he says:

...It is very seldom that I tell my problems to somebody. No, no. It is seldom, seldom. Unless it is a friend that I have some trust in, but just like this, (openly, as we are talking right now) like this? No, no. When I drink, yes. When I am quite drunk, yes. Then, I tell them (his friends), and I cry. So, then I vent everything. Totally.

Javier remembers how he escaped his problems by drinking.

L: Tell me what did you feel, when you say you felt the pressure and depression. How did you experience that?
J: When I was weak, it was like I felt the pressure of my aunt. And, I would leave; go out to drink, to forget a little bit that I was under that pressure. (That I was) pressured (to put money together). To forget for a while, let’s say to feel liberated for a while, relaxed.

Drinking has been, for Johnny, a strategy to cope with his emotional suffering. He has been ‘illegal’ in Chile since his arrival, several years ago. This situation prevented him from following his partner to Argentina, where she went in search for a better job. However, he never told his partner what his real legal situation was.

129 The title of theme related songs are Vivo Tomando (I Live for Drinking); Me Emborracho por tu Amor, (I Get Drunk for Your Love); sung by the Peruvian singer, Dina Paucar, who is very popular with the migrant community. Other titles conveying love-related themes in Dina Paucar’s repertoire are: Falso Amor (False Love), No Me Quisiste (You Didn’t Love Me); Adios Amor Adios, (Good-bye Love Good-bye), Incomprensión (Incomprehension); and Lagrimas de Amor (Love Tears). Other popular family-related themes in song are: Madre (Mother) and Niños Desamparados (Deserted Children).

130 “Defogar”: (dar salida al fuego) to make an opening or vent in (to allow fire to escape).
I begged her not leave. (I told her) that we were fine here, and… during the time that she… with my separation from her… I devoted myself to drink. I abandoned myself. If I wanted, I worked, if I didn’t’, (I did) not. It was a kind of deception that I had, but it was not a deception as if she had cheated on me. (It was) only that we had got separated, because I never told her the truth about my papers. She thought I had my papers… fine... (in order).

Although not directly, Johnny mentions the impact of having lost his partner, which allows us to visualise his troubled emotional state.

J: And I drank more. I began to drink stronger drinks, like pisco or whiskey
L: Do you think that it affected your stomach?
J: Of course, because I did not feed myself. I practically did not have defences in my body. Everything was drinking, drinking. I would drink. I believe almost one bottle of whiskey and I would not get drunk. I had to drink more and alternate the drinks in order to get drunk and to be able to sleep. I had a process like insomnia, where I could not sleep, I was thinking, I would tell her ...are six months already that...(he and his partner were separated). I liked her because she was a down-to-earth girl. She did not drink. She was ‘a girl from her house’, centred, and centred in everything, in everything.

Men often make use of alcohol to cope with emotional suffering. In addition they tend to read the physical strains caused by the demands of their work as more viable explanations for the origin of the somatic problems experienced by them in periods of emotional distress.

Although these cases cannot be used as conclusive proof, these narratives show that ‘stomach aches’ among men are used as an idiom of distress. And, in this way, men’s emotional suffering becomes ‘objectified’ in physical symptoms. For Marlo and Johnny, affective related problems lead to alcohol abuse and altered eating patterns which, in turn, led to stomach aches. For others, as in the case of Felix – who at present does not drink –, his current work conditions affect his eating patterns, producing the same somatic effect. However, he describes the occurrence of these symptoms when he argues with his partner.

True cause and effect are often not recognised, especially among these migrant men. From the personal dimension which originally causes distress (broken love relationships), to the consequence of a culturally sanctioned practice (alcohol abuse), or a socially produced cause (bad work conditions), the actual problem is ignored. Instead, men believe the direct cause of their stomach problems should be found in their altered eating patterns. In this way, emotional and affective causes of suffering experienced by male migrants are transformed through their practices and interpretations into a somatic, ‘objectified’ reality. In Johnny’s view:

L: Do you think that your stomach problem is related to what was going on in your life at that moment?
J: I believe so, because I felt like this… I didn’t have… I ate irregularly also, only drinking, without having breakfast. This was affecting me in my stomach and moreover it was the painting (its noxious fumes).

Men’s abuse of alcohol is thus a gender framed coping strategy, and stomach aches are the somatic, ultimate consequence. Interestingly, at some point in each of the men’s
narratives, stomach problems are regarded as their main health concern and it justifies the search for medical help.

The masculine approach to emotional suffering is well illustrated in Nato’s attitude towards his own troubled emotions.

Nato’s stern sense of endurance is entangled with his ideas of how a man should behave. Showing worries, concerns and problems is, for him, a sign of weakness, and opposite to the idea of what an authentic man is about.

Eligio would never show sadness, worries or fear, he would rather minimise or hide these feelings. Furthermore, to him, a real man should show his endurance through illness and would not “run to the doctor”. This idea turned out to be even more extreme when Peruvian men deal with issues of mental health.

According to Eligio, Peruvian men who are affected by depression are at risk of being seen as weak. This kind of “weakness” in men is somehow connected with homosexual tendencies. Depression is something that may happen to women but not to men.

Generally, according to Eligio, depression as a mental disease is not as pervasive in Peru as it is in Chile. In fact, for him the first time he heard of it was in Chile, and he is still surprised by the number of men who are affected by depression in Chile.

As Nato and other migrants also believe, ideas of masculinity are associated with being strong and capable – to be able to face and endure difficulties. Problems such as nerves or depression go against ideals of masculinity. To acknowledge them is to recognise before others that one is ‘soft’ or ‘fragile’ – not really a man.

9.4 Medicalisation of migrants’ emotional distress

At the beginning of my fieldwork, my household survey conducted among Peruvian migrants, showed 75% of those affected by some form of emotional distress did not seek medical aid. Out of the total, only 9, (4%) consulted with the public or private system and 15% sought alternative aid. This included, firstly, the help of relatives or partners, and secondly, a boss was mentioned. Reasons for not seeking medical aid for emotional distress are many and varied. For 12% of these cases, the problem was solved outside the medical system and 6% considered it was not necessary to seek medical aid at all. Another 6% did not seek professional help because their problem disappeared by itself. And, a final 6% did not know where to seek aid.

None of the migrants interviewed – who sought medical aid for their distress – found a solution to their problems within the medical system. The medication they were prescribed was unsuitable. Instead of it being a help, many felt their medication was an impediment to performing their normal work duties. In the end, Felix, Elena and Irma refused the medical treatment offered to them in Chile. Felix sought medical help for his stomach aches and was prescribed tranquilisers.

F: I went to the doctor and he told me that (those) were tensions. It is stress, so he gave me a pill. “Tensionet”
L: Tensionet?
F: Yes, that I cannot take even half. Because it leaves me like sleepy until 12:00 – 1:00 in the afternoon.
This doctor prescribed Elena both Paracetamol for her headaches and a progressive dose of tranquilisers.

(The doctor said to her) when you have headaches take Paracetamol, and at night begin by taking 1 pill (of a tranquilisers) and end with 6 pills, I had to finish (with 6 pills). The first one put me to sleep two days; I said with 6, I would never wake up! ...So my husband said to me: Don’t take that Elena, these are only tranquilisers and they are going to cause you more harm than anything else, so stop that.

Elena is dissatisfied with the biomedical approach held by the Chilean doctor who treated her.

Here, there is not much importance to (placed on) the sick person, only tranquilisers. Only that thing, it is not as if one goes to a private doctor. No, is not like that. He (a doctor in a Chilean public clinic) only asks you how are you daughter? - Just like that, doctor, always with my problems, – Yes, I will give you a pill that will calm you down, and that will be it. So I gave them back (the pills) to the doctor and I told him that I did not feel well with that pill. He then gave me other ones, but it was the same thing. So it does not (help her).

Irma also refused to take the tranquilisers given to her by her doctor:

I: The doctor prescribed me pills and so many things to be tranquil, but I did not take even one. …He told me: You have problems in your work …You don’t get help, and moreover you now have this loss. (Irma’s father had passed away) …Where do you find support? …You don’t have much support, he told me
L: And why did you not take them (the tranquilisers)?
I: Because I said if… they (the medicines) were to (be able to) sleep – I sleep perfectly, quietly, I don’t need those drugs to… to (be able to) sleep, and I did not take them.
L: What was the name? Do you remember?
I: Neuroran and other ones. … (They) were tiny little ones.
L: Did the doctor ask you if you had sleeping problems?
I: No he did not ask me. He told me: With this, you are going to feel better. You are going to take this and you are going to feel more calm, more relaxed. And on the other hand I said (to myself), if I am going to take this medicine, I am going to be blocked in my work. …No (I will no take them).

Rocio has not yet sought medical help for her distress. However, as she contemplates the possibility, she thinks she would not talk about her depression. Rather, she will talk about her physical distress.

L: How would you present your health problem to the doctor?
R: Ah, that I suffer from an initial form of tachycardia and I would then start explaining to the doctor that when I am sad, I get something... I start to feel a pain in my chest
L: When do you have what?
R: Ah, when I worry about my family. I start to feel pain in my chest. I feel lack of air. I can’t… What can I do? Who I can go to?
L: Would you say to the doctor that you feel depressed?
R: I don’t know. With other people, I cannot comment. I don’t feel… I am not used to talk about that
Cesar consulted a doctor for his chest pains. The doctor discussed his drinking habits with him, suggesting he quit drinking, but Cesar had already stopped.

For many migrants, depression continues to be inscribed into a medical realm and as such, its use provokes resistance. It is being defined as suffering from some sort of pathology. This is precisely the reason why Irma rejects seeing herself as depressed. She resisted the diagnosis of depression given by Chilean friends at work and later by a doctor. This resistance is linked to conflicting explanations – between her Chilean colleague and her own views – about the causes of her distress. In Irma’s view her distress was not ‘pathological’ but the logic consequence of the difficult circumstances in which she was living in Chile.

L: You told me that you got to know depression here. What does it mean that you got to know it here?
I: Because, I felt sad. Crying and crying and crying; nothing else. And, the people whom I worked for, they shouted so much and all that... And the children! ...I had never seen that, for me it was crying and crying, day and night. So then, I began to lose weight. ...Skinny, skinny! My friends became worried and my family too, when they saw me in pictures. It was due to the sadness, but I was told that it was depression. That it was all stress from so much work... But I said what I feel is sadness. That’s the only thing I feel. I wanted to leave everything and leave.

L: Who told you that you had depression?
I: Long ago, when I just arrived there in Champa, (a Chilean friend told her) Irma you are going to get ill, from depression, she told me. If you continue here, you will fall into a depression... You are going to get ill.

L: And, you thought it would be that way?
I: No! Then I thought what should I said to her? It is all about this crying. What happens is that I am very sensitive (she told her Chilean friend) and I am not used to this (that work environment). So that is why... To see these things, all of a sudden, is shocking. You have to be strong Irma that is all. Because you still have a lot to go (said her Chilean friend to her).

L: So, when she said that, you felt that you would fall into a depression?
I: No.

Irma is an active interpreter of her own suffering. In this process, agency is localised in her search for explanations of the causes of their own suffering. Irma challenged the commonly used medical diagnosis used in the new environment.

L: Did you ever believe this was (depression) what happened to you?
I: No. I never assumed that it was depression or those things. Because the only thing I feel is sadness. And that is what I am always going to feel – nostalgia.

The possibility of attending psychological consultations to deal with depression appeals to women more than it does to men. Women see in counselling an opportunity to confide their personal matters to a neutral and discrete third person. Marianela and Mary have tried to access psychological consultations. At the public primary health clinic, Mary was given an appointment but it would not occur until several months. She thinks when it is time to go; she will not need it anymore.

However marginal migrants’ access to healthcare system may be; it has not protected them from being misrepresented in their illness experiences within the medical system. Particularly, this happens with regards to the economic and social conditions from
which migrants’ suffering and distress emerges. Indeed, societal determinations of migrants’ illness experiences become obliterated by the moral discourse of the healthcare providers. Caregivers may often judge them as irresponsible and view their living conditions as morally deplorable forms of human degradation. Mary experienced misrepresentation of the medical system. Her own son was to be taken away from her. The child was being looked after at the compound by Mary’s sister while she was out working.

M: They even told me they would take my son away from me. “If the boy does not gain weight we are going to take him away from you.
L  Who told you that?
M: Here, at the primary health clinic. They told me that I had to see the social worker... They told me: can’t you have the boy? (Can she look after the boy?) I told her (the healthcare provider) that I can, that I worked and my husband too. And then she told me that the majority of the children of the Peruvians are always malnourished and that he (Mary’s son) was Chilean. So that (therefore) he was part of here (was Chilean) that they had to look after the child. They went on to accuse me that maybe I sometimes did not feed him on time, or I left him alone, all that they told me… but it was not like that. It was my need of going out to work that prevented me to stay here (in her room in the house) to look after him. But the social worker would not understand that; not at all.

This discourse also becomes compassionate seeing migrants as poor victims which in turn, become another form of misrepresentation. Thus the critical approach will highlight the extent in which the social origin of migrants’ illnesses is misrepresented by the practitioners in the medical consultations.

When Marianela visited the doctor, she expressed what she felt in terms of nerves and he diagnosed her as depressed. She expresses the reason for her distress in terms of her work conditions. The doctor suggested she quit her job.

I told him that I felt so... Sometimes, I did not sleep, and those things that were happening in my work and that I felt nervous. And he told me (the doctor), I know you are depressed and I understand you. But if you don’t feel comfortable there, Marianela (in her job), you should quit, because a person that doesn’t feel easy does not work well and you are damaging more your health. So, you must take a decision. It is either your health or you continue working (in the same place).

The micro level of analysis proposed by the critical medical anthropology highlights a relevant dimension of the problem of this study. This is the actual process taking place in the relationship between migrants and the healthcare system. Even though the interactions of migrants with the Chilean medical institution are limited an incipient process of medicalisation of their emotional distress can be observed as already taking place.

The medicalised approach to migrant’s distress, as it will be discussed in the next section, is not exclusive to healthcare providers and certainly not to the Chilean public healthcare system. The public healthcare should not be seen as leading this process, as the system itself is quite marginal in the context of a highly privatised medical system. Furthermore, as we have seen, migrants’ only access to the public health system is through scattered medical consultations. On the contrary, a medicalised discourse and
approach to migrants’ distress seems to be present in various spaces where migrants interact with the host society.

It is precisely, the power relations involved in the discourses constructed around illness which are of interest for the critical approach in medial anthropology. These are discourses particularly constructed by biomedicine and its practitioners. And, as in this case, the medicalised discourse is taken up by other agents, such as the migrant’s employer and other local agents, people with whom migrants interact in various spaces. As pointed out by Good (1994), an analysis of illness representation from this perspective requires a critical unmasking of the dominant interest, an exposing of the mechanisms by which these representations are supported by authorised discourse, making clear what is misrepresented, not told or hidden in illness such as the power relations surrounding and embedded in illness.

In the context of this analysis, one can also observe migrants’ agency and resistance as often they tend to disagree with the biomedical approach to their distress. In fact, the causes of various forms of emotional distress tend to be understood by migrants as embedded in their own socio-economic context. The logical consequence of this understanding is then the belief that individual the therapeutic approach as well as medicalisation will not resolve the causes of the problem.¹³¹

9.5 Managing emotional distress at the workplace

Women working as domestic workers often have to deal with their own distress at work. Employers – often other women – play a role in managing women’s physical and emotional discomfort. Often, not only do domestic workers not have a proper medical insurance but their movements are also restricted by their employers. Therefore, their availability to attend medical consultations is also limited. However, employers may also play a role in facilitating women with access to healthcare. The ways women’s distress is managed at their employer’s household is discussed here, as well as the extent women have room to manoeuvre within the limits imposed.

Gladys describes how she must carry on working in spite of her symptoms. Her distress is managed at work where her employer who is a medical doctor prescribes her with medicines.

L: And do you have to carry on working anyway?
G: The same, I have to go to work and sometimes tired like that. My eyes are swollen. You can tell by my face; my face disfigures. The tiredness, the tension and preoccupation that I have, shows. I try to hide it, but I can’t hide it. The more I try...

... ah Señora, that is OK. How are you? She looks at me and asks me have you measured your blood pressure? You have something, because they know already; she is a medical doctor.

¹³¹ One of the contributing factors prompting migrants to avoid medical consultation is an obvious stigma associated with psychological care. There is a close association between the need of psychological therapy and madness (locura). The label of madness holds very negative connotations among the studied group. The acknowledgement of the need of psychological therapy implies a self-recognition of insanity. There is a large risk in being seen by the social environment as having any degree of disability, in which migrants are not willing to put themselves.
To avoid the cost and the trouble of having to go to a medical consultation, Gladys medicated herself with medicines she requested from Peru.

L: What do you bring from Peru?
G: I ask for more Aldomed, or this Naproseno Sodico, that is also there. But the Alocodran, the Omitrin that is an anti-inflammatory, that is because I have bad joints. And, the Amonpicilina or Magacilina, and the antibiotics that cannot be sold here without medical prescriptions. Well, there, (in Peru) you go and say: I got a pain here, I got a pain there. Ah, they say, take this Megacilina, that is all. Pa, pa, one gets that (injected). Well if that does not makes you feel better, then we go to the doctor but they give us the same medicine. (She laughs)

Other times, Gladys’ employer provides her with medicines or arranges for her special appointments with relatives who are also medical doctors. These appointments are always placed after Gladys workday hours, making sure she would not leave the household unattended. Gladys feels the pressure exerted upon her and the restrictions imposed. She knows the ultimate cost of her illness can be to lose her job.

G: If I demand my rights, even if she does not want to, she (her employer) has to allow me to go to the doctor. But now it is (what Gladys has) not so much of an urgency and besides this, I am always buying (my own) medicine. So that ah I feel pain, and pla, pla, pla, I medicate myself. … Sometimes I ask (somebody in) Peru; send me that medicine, somebody that is coming (to Chile). They bring them (to me) and I get calmed. So I have not allowed (her employer) to see me (sick) (because I don’t want) …them to say “leave!” Only this last time, that I was very sick. I got flu, I even got a fever... I came (to work). And, she told me (her employer): but Gladys, you should not have come, it is only because you got a fever that I am allowing you to go back home. Because if you only had a bad cold, I would not have given you (sick) leave just like that. ...I looked at her and I say: “We will talk señora, it is ok. Thanks”. I left and came back here.

L: Is she a medical doctor?
G: She is a doctor, that is why I say, but if I get to do my way, I ask her and she can’t... well she can’t deny it. The only thing is, if she wants, she can deduct it (a day from her salary) but then when the time comes, when I will have to really go (to hospital). When my body cannot resist anymore, I will have to go to the doctor anyway.

Sickness is therefore an unaffordable disruption of the possibility to continue working. The value of health is visible in the fear provoked by it’s opposite – illness. Falling ill is seen primarily, as an impediment to carrying on productive work. Fears are aggravated by the reality of not having a social safety net to rely on for care.

For Gladys, there is a basic understanding of mutual cooperation between her and her employer. However, in this understanding she unfortunately is not reciprocated.

She (Gladys’ employer) says that she needs somebody that (would not get sick). She told me that she can’t give me permission every time in case of a,b,c. If I get sick or something happens to me, she would fire me. I say to her señora Maria Elena, for a,b,c reason – God would not allow it. – I have a problem you would not be able to help me to solve it? Then I don’t know what is… I say the harmony that should exist between the boss and the employee. Because (Gladys says to her employer) If I work for you I am solving your more basic priorities that are to look after your children, caring, cooking for them and
looking after the whole household, and due to a, b or c (reasons) I need you. You are going to tell me you can’t? Well that is (something) to have present (in mind).

Mary finds her discomfort is not acknowledged in her workplace:

But whether the lady would tell me: OK Mary, you got the flu. ...Look go to the hospital. No, no. (Mary said to her employer) – You know Sra., I can’t work, because of my bronchitis. I suffer from bronchitis. ...Sra. can I work half a day? (Sra. replies) Get everything done, the supper, beds and you can leave. I left everything done and she paid me less anyway.

When Irma is in distress, her employer provides her with medicines which for Irma are just palliatives. In a way what is happening here is a process of medicalisation of the labour relations.

I: She would say to me, when she sees me bad. The other day, for example, I was feeling bad. She did not give me anything, but some other times, when she sees me bad, then she says bring her something for her to take
L: Who?
I: The lady. But (her employer gives her) sedatives, nothing more.

However in a context where domestic work is in high demand, migrant women may quit their jobs to find another household where she is treated better. In that sense, women have some degree of manoeuvrability to escape an oppressive work environment that has been the source of emotional distress.

Stress is associated with oppressive working conditions migrants must endure. Mary, working as domestic says: I was too stressed in my work. She experiences the pressure of working long hours without rest during the week.

From 8:00 in the morning to nine in the evening… It was too much. I lost my job because the lady realised that I was stressed. I was about to collapse... So she (her boss) demanded more from me. My children demanded more from me and my husband demanded more.

Experiencing stress opens up the possibility to escape from current oppressive circumstances. An outburst creates opportunities for change in the present scenario. Mary recalls: ‘I exploded at home and in my job too’. She lost her job but at the same time, she transmitted a clear message to her milieu. The message was: she could no longer cope with all the demands that had been placed upon her. Stress leads to unpredictable outbursts, as in Mary’s case, to challenge an oppressive boss.

As in the case described above, stress can be interpreted as a cultural performance similar to nerves. Some authors have pointed to the relationship between nerves, nerves attack and structural inequalities in society (Dunk 1988; Guarnaccia 2006). Lock suggests that nerves can be interpreted as “part of the repertoire whereby those who lack overt power flex their muscles” (Lock 1993:143).

In Chile, Marianela doesn’t have the social network that can support her; however, she does have greater mobility to leave difficult situations when they arise. It seems she copes with the same feeling of impotence, by continuously changing jobs. This way of dealing with problems actually decreases the illness-causing impact difficult situations
have upon her. In Chile, she has not experienced any convulsions, as she can escape the situation that causes her distress.

L: Have you had the same kind of depression here that you had there?
M: In Peru, yes I have had depressions where I have ended up in hospital because of my partner. Yes I have got into Hospital. I have been hospitalised. They’ve put me on sedatives. They calmed me down, but these (experiences) are very different, as I say it to you, very different.

L: Why is this one so different from your previous experiences in Peru?
M: (Because there) I was collapsing, shaking all over. I could not control myself. I was with convulsions.

In Chile, Marianela is able to leave the environment that produces her distress:

But here not (in Chile)...Here, the good thing is that if I have a problem, I leave my job and that’s it! I leave that problem behind and it is as if I free myself. …Ahhh, I can breathe calmly and say to myself: Finally I will not have any more problems. I won’t see her (her employer) anymore. I will not have to listen to her anymore. I feel relieved for a while, and feel calmer that is why I say that they (both illness experiences) are different; very different.

In Chile, she cannot count on social support but instead, has other means to cope with her distress such as changing jobs. Her current productive engagement has provided new resources to manage her distress as the availability of jobs gives her the option to move on when she chooses. In Peru, she felt trapped, where she was permanently confronted with what she identified as the source of her problems – her husband.

Most women find at the end of the day, that they must confront their suffering on their own, as Gladys puts it.

If I let my problems overpower me, let myself to be drowned, I will not be able to get up. That is why I try… well… if I think that… I cry, I vent on my own. I think: OK that it is over now (the worrying for her problem) and I carry on, because otherwise, I don’t know where (would she find help).

9.6 Conclusions

Changes and continuities can be observed in migrants’ narratives of their previous experiences when compared with their current experiences of emotional distress. As in Chile, migrants have also previously confronted various experiences of emotional distress in Peru. While in Peru, migrants’ distress was often linked to the hardships of their poverty-stricken lives. In Chile, their experiences of emotional distress emerged with circumstances of personal displacement as well as societal exclusion and discrimination.

In Peru, the various life events triggering migrant’s emotional distress appear to be compounded by the lack of material resources and alternatives to face the adversity of life. Yet, vital resources are available there to help them cope with distress, such as family emotional support. Migrants in Peru experienced distress in the form of
exhaustion, sadness, convulsions, or stroke. These idioms are commonly heard and recognised.

In Chile, forms of emotional distress such as depression are experienced in solitude. The absence of emotional support makes coping difficult. In other cases, stress opens up a myriad of new practices to engage in, socialise and feel liberated. With more material resources available but lacking social support, migrants learn to use other alternatives to handle their distress. One crucial question to be asked in the face of these developments is: Are the coping mechanisms migrants use in Chile harmful to their well-being in the long term?

Culturally authorised methods to relieve emotional problems among Peruvians in their communities are dancing and drinking alcohol. Stress in migrants’ narratives is experienced as tiredness or being tired and exhausted. It describes a physical and mental state. In Peru, this sign is read as the person needing to rest. However, in Chile, stress involves the need to release pressure, to free oneself from sources of tension – one goes out to bars, for dancing, drinking and getting distracted. The need to release stress leads migrants to socialise among themselves and opens up the possibility for more liberal behaviour. This is especially true for women who are often alone in Chile and find themselves in a far more liberal environment.

Alcohol consumption is a common and culturally legitimised way for men to deal with their emotional problems. Various factors should be attended to when appraising the importance of drinking as a coping mechanism among men. The lack of social support which affects migrants in general, is an important factor, but also the gender dimension which influences men’s behaviour. In fact, among the men studied, both the causes of emotional distress and the escape from it are framed within the prevalent gender ideology. Maleness is associated with the capacity to endure and resist. Men do not share or easily show their emotional suffering to other men, as this may be read as a sign of weakness. Therefore it should be avoided at all costs. Alcohol consumption proves to be an emotional catalyst for men as maleness is also associated with the capacity to drink.

As seen, gender constructions are prime factors explaining the particularly strong male resistance to openly acknowledging the affective dimension of their distress. Gender differences are clearly manifest in the means and use of language to express emotion. I have also explored how the interpretation of the causes of somatic symptoms experienced by men is constructed by them around drinking and not around their experiences of emotional distress.

The nature of domestic work performed by women migrants leads not only to an increase in women’s emotional distress but also determines mechanisms through which this distress is dealt with. In this process, not only is the prognosis of distress altered but also the individuals themselves. Their bodies, their self and subjectivities are transformed. The dynamics involved in the production and management of women’s distress can be better understood by means of an analogy. That is the metaphor of a ‘metabolic’ relationship between nature – in this case the physical body – and the social realm. Women’s distress can be seen as the ‘metabolised’ outcome of social relations which characterise domestic work as a particularly oppressive mode of production.
Framed within the social space of the employers’ household, medicalisation of emotional distress is often the favoured means promoted by employers to manage women’s emotional distress. This is particularly useful to the employer since medical categories of distress erase the social context where this same emotional distress emerges. Therefore, it is functional in diverting the responsibility of the employers and their families from women’s distress. However, medicalisation is not exclusive to that space as migrant women and men are also encouraged to use medical alternatives to treat their emotional distress outside their work environments.

Even though migrants have incorporated these medical constructions – *depression* and *stress* are primary medical terms – into their narratives, they are at the same time resisting the medical approach to their distress. Migrants often mistrust healthcare providers and fear treatments. In particular, migrants resist the medicalised approach to their emotional distress. Migrants often view their bodies chiefly for work and production. This last dimension becomes a narrow focus as their bodies are seen and used as means of survival. Migrants in turn have experienced medical treatment as a loss of control over their bodies and themselves. Often, treatment received limits their capacity to perform as workers, which is central to their material subsistence and main reason for their migration.

I have discussed here the extent to which the use of language(s) empowers or disempowers migrants by providing or depriving them of their agency to manage their own distress. This discussion was centred on how these new idioms of distress, have been learned through interaction with the host society. Medical categories of *depression* and *stress* are used by migrants to make sense of their experiences of personal suffering and to communicate similar experiences to each other.