

Reframing (Dis)Ordered Bodies: Understanding *Agonias* via the *Habitus*

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Abstract

The expression of *agonias* among Portuguese populations is an embodied experience of emotions and/or illness that defies Western medical categorization. Within Portuguese communities *agonias* has multiple meanings. This paper proposes that the embodiment of *agonias* can be understood via the *habitus* where the body is a meaning (re)producing social agent.

Résumé

Au sein des populations portugaises, l'expression *agonias* incarne une gamme d'émotions et/ou la maladie qui défie toute catégorisation du monde médical occidental. Au cœur des communautés portugaises, *agonias* a plusieurs sens. Cet essai suggère que l'incarnation de l'*agonias* peut être comprise par l'entremise de l'*habitus*, tandis que le corps représente un agent social de (re)production.

Within the disciplines of anthropology and sociology, research has shown that illness and emotions are socially specific and culturally meaningful categories. For instance, Margaret Lock's cross cultural analysis of North American experience with menopause in contrast to a Japanese experience explores the ways in which menopause and female aging are culturally understood in different ways (Lock 1998). Janis Jenkins and Norma Cofresi have explored the condition of *sufrimientos* (suffering) in the Puerto Rican context determining that "*sufrimientos*...is a culturally sanctioned expression of sorrow that reflects difficult life circumstances or troubled interpersonal relationships" (Jenkins and Cofresi 1998, 443). Simon Williams and Gillian Bendelow take a social constructivist approach to understanding the "emotional body" arguing that "emotions...vary socially and cross-culturally in terms of their meaning, experience and expression" (Williams and Bendelow 1996, 127).

This sociological and anthropological research explores the social and cultural situation of illness and emotions, conditions of being that are at times inextricably related. A type of social practice and expression that is culturally specific is that of *agonias* (the agonies) (James 2002, 88) which can be understood as both an expression of emotion and/or illness. In this paper I explore current research on the experience of *agonias* as found in Portuguese communities in North America and offer an additional approach to understanding the embodied character of *agonias*. I understand emotions and illness as socially and culturally constructed and meaningful embodied states of being and action that reflect our involvement in the social world. Furthermore, I propose that the work of Pierre Bourdieu, specifically his concept of the *habitus*, provides a valuable route for understanding how emotion and illness are embodied and, more specifically, how the Portuguese experience of *agonias* is

one that cannot be expressed nor learned without interaction of the social body. By social body I mean that the body is not simply a physical materiality that functions within the world at the will of individuals. Rather, bodies are marked by the social world through various practices, such as naming practices that gender bodies and place individuals within identity structures that are imbued with various social meanings. Furthermore, the manner in which individuals use their bodies—for instance, through their gestures, ways of walking and speaking, and bodily adornment—(re)produces the social structures within which bodies function while making sense of the social world. Later in this paper, I will elaborate how Bourdieu's theory of the *habitus* can help us understand the body as a social body.

The Socio-Cultural Meanings of Emotion

This section is dedicated to providing a short analysis of some key ideas about the socio-cultural meanings of emotions as well as an account of how some emotional expressions, such as anxiety or depression, are taken up as illness by the medical institution and, more specifically, by psychiatry. Following the work of Michelle Rosaldo, I agree that emotions or affects “are no less cultural and no more private than beliefs” (1984, 141). In 1984, Rosaldo argued that feelings had not been adequately considered in anthropological literature. She argues that emotions are embodied social processes that structure our social world and reflect our situation in the world, and “feelings are...social practices organized by stories that we both enact and tell. They are structured by our forms of understanding” (1984, 143). Emotions are significant to our being in the world and they are meaningful social actions that are both shaped by and shape our understanding of the world.

Similar to Rosaldo, Williams and Bendelow argue that sociological inquiry has neglected emotions and their significance in understanding our ways of being in the world. Williams and Bendelow suggest that this neglect of emotions is due to a tradition in Western philosophical thought that “historically has sought to divorce body from mind, nature from culture, reason from emotion, and public

from private” (Williams and Bendelow 1996, 125). Following the lead of Susan Bordo, Williams and Bendelow refer to this trend in Western thought as the “Cartesian masculinization of thought” (1996, 125). After reviewing literature on the sociology of emotion, Williams and Bendelow are optimistic that emotions are emerging in an important way while highlighting a move towards a “form of embodied sociology” where emotions and the body play a central role in advancing social theory. Nick Crossley directly challenges the reason/emotion binary by arguing that emotions are reasonable and rational, contrary to a Cartesian dualism that “assumes a very narrow, instrumental view of reason” (2000, 278). Crossley's paper on emotions as rational is also significant because he argues there is an increased use in psychological technologies, such as pharmaceuticals, to manage emotions, and that this trend may result in a decrease of people's capacity to cope with their feelings in the social world.

Drawing largely from sociological theory, Ian Burkitt proposes a relational approach to understanding emotions. Burkitt argues that “if emotions are expressive of anything it is the relations and inter-dependencies of which they are an integral part” (Burkitt 1997, 40). Understanding emotions as relational is significant because it is an approach that acknowledges emotions as a form of social action that is embedded in the social framework. Furthermore, Burkitt likens emotions to discourse and practices which are categories of inquiry that are often taken for granted in sociological inquiry. Referring to emotions as “complexes,” Burkitt acknowledges that emotions have a “physical element, as well as cultural” (1997, 39). Following in the tradition of Michel Foucault, who theorized biopolitics where the body becomes the site of power through discipline and regulation, Burkitt also understands emotions to be a form of production and regulation. Burkitt writes that individuals “discipline their body in ways of feeling and experiencing through the moral practices in which they engage. Emotional feeling is, at one and the same moment, produced and regulated” (1997, 50). Burkitt's assertion on the production and regulation of emotion is a unique one that acknowledges emotions to be related to biopower and

inextricably linked to the political structures of society.

Building on the idea that emotions are structured by and structure the political domains of society, Simon Williams proposes that the body has a language and that emotions help constitute this language. Williams argues that the body is a path for expressing “socio-cultural meaning” and that it is helpful to understand that people express their existential conditions through their body (Williams 2000, 303). For instance, Williams uses the example of pain as a possible expression of powerlessness. Williams’ example is clearly illustrated in the work of Janis Jenkins, who explores the “political ethos and mental health” of persons living in El Salvador and determines that the body expresses a language of distress in relation to traumatic socio-political conditions (Jenkins 1991). Jenkins also significantly addresses how the expression of emotions such as laughter can function as “powerful tools for survival” in potentially debilitating “socio-political conditions” (1991, 157). Jenkins also demonstrates how expressed emotions can sometimes be troubling for individuals to the point where clinical practitioners are approached for advice on managing and/or healing feelings of distress or anxiety.

As I will explore throughout this paper, *agonias* is an affective expression that, in the context of Canada and the United States, is taken up within medical institutions. *Agonias* is an “idiom of distress” where, on the one hand, it is understood as “a psychiatric disorder” and, on the other hand, it encompasses many other social meanings, such as the socio-religious connotations of sin and morality (James and Clarke 2001, 169). In order to understand the many meanings of *agonias*, the following section will provide an analysis of existing research on *agonias*. The research presented in this paper follows in the sociological and anthropological traditions of understanding emotions and illness as socially constructed and culturally meaningful modes of expression.

Agonias: Analysis of Current Research

Agonias is an embodied experience culturally specific to persons of Portuguese

descent. Current research focuses on the experience of persons who have immigrated to Canada and the United States from Portugal, including the Azores islands. Primary researcher on *agonias*, Susan James, a “cross-cultural clinical psychologist” (James and Clarke 2001, 170), has performed ethnographic interviews with Portuguese immigrant populations and clinicians who work with them. James and colleagues have avoided approaching *agonias* from a strictly psychological understanding while significantly drawing out various cultural and social implications that constitute the experience of *agonias*. Currently, the research only addresses Portuguese immigrant communities in Canada and the United States.

James and Clarke expose the embodied situation of *agonias* when they write, “When asked about *agonias* all of the women interviewed replied through their bodies, as words would not suffice. They pressed a hand on their chest and they inhaled quickly and suddenly as if someone had given them a scare. When pressed to verbalize this embodied state a few people said that it is *faltando de ar*, ‘you are missing air’” (James and Clarke 2001, 168). *Agonias* is not merely a mental state of being but rather an experience characterized by holism, where mind and body are integrated. Such a characterization challenges Cartesian dualism, a philosophical tradition that has given rise to a mind/body dichotomy, where thought (the mind) is privileged over senses (the body) (Crossley 2001, 10). I agree that the experience of *agonias* is holistically embodied and any approach that attempts to understand *agonias* should account for issues of embodiment, because bodily awareness and action shape our everyday lived experience; the expression of *agonias* is not free of bodily perception and awareness.

Current research has predominately used a sociosomatic framework to explain the experience of *agonias* (James 2002; James et al. 2005; James et al. 2006). The sociosomatic model was developed through medical anthropology’s contributions to psychosomatic medicine and it is a fruitful model for understanding the social and cultural factors that are implicated in the social course of illness (Kleinman and Becker 1998).

Sociosomatic frameworks approach illness as a social construction and recognize that “illness has a social as well as biological course and that there is a reciprocal relationship between the body/mind and society” (James et al. 2005, 550). Current research has also demonstrated that the sociosomatic model is useful in drawing out the social and cultural factors that contribute to the experience and expression of *agonias* and also explains how these social and cultural factors interact. For instance, James acknowledges that the sociosomatic model allows one to consider *agonias* as a type of suffering that is both individual and social. James writes “suffering is no longer seen as situated only within the individual but takes on a socio-religious meaning” (James 2002, 89). Suffering is not only a condition that affects individuals but is also a social condition that connects individuals to a larger social group through the sharing of experience. While the sociosomatic model can help us understand how a condition such as suffering is a subjective experience, but one that is also socially and culturally shared, it does not answer the question: how does one learn to experience suffering? Later in this paper, I will return to this question and consider a sociological approach that can explain how one learns the bodily comportment of illness and emotion, specifically, the comportment of suffering (or *agonias*).

Meanings of *agonias* vary not only within communities that experience *agonias* but also among clinicians who assist in its “treatment.” The term “treatment” is used not only to designate a medical or therapeutic treatment, but also the social and, at times, religious management of *agonias*. Meanings of *agonias* are rooted in an individual’s or community’s experience with illness, religion, morality, and social conditions. It is important to note, along with its varying meanings, *agonias* has a “multiplicity of healing systems” (James 2002, 88). For example, in North America, those who are approached for treatment include family doctors, psychologists, traditional healers (such as herbalists), religious figures, and other community members (James and Clarke 2001; James 2002). *Agonias* is also used as an expression of complaint about physical well-being and illness. For instance,

agonias has been used to express the experience of indigestion and of symptoms linked to menopause and asthma (James 2002; James and Clarke 2001; James et al. 2005). When an individual accessed the medical system for treatment of *agonias* related to physical well-being, they were often treated using allopathic medicine, such as pharmaceuticals (James and Clarke 2001).

Expression of *agonias* is also related to social relations and conditions, such as working conditions (James 2002; James et al. 2005). Like other immigrant communities in North America, it is not uncommon for Portuguese immigrants to experience various forms of discrimination including labour market discrimination. Levels of education obtained in Portugal, as well as language barriers, prove to be obstacles to immigrants entering the work force in Canada and the United States. James and colleagues acknowledge that Portuguese immigrant populations frequently “obtain multiple semi- or unskilled jobs that afford minimal job security, inadequate factory management, unsafe work environment, and little communication with co-workers” (James et al. 2005, 550). These working conditions can be isolating and stressful and are one of several social conditions that contribute to the experience of *agonias*.

While James and others (2005) reveal that an individual’s *agonias* are related to an individual’s social conditions, I find their categorization of *agonias* in the paper “An Inquiry Into the ‘Agonies’ (*Agonias*) of Portuguese Immigrants from the Azores” particularly problematic because the categories overlook certain social experiences and conditions. James and others (2005) propose three main categories of *agonia*, which include *agonias* of death, *agonias* of illness, and *agonias* of premonition. These three categories were developed out of a study that investigated whether current psychological categories used for diagnosis, guided by the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, were able to capture the experience of *agonias*. The study concluded that “*agonias* does not appear to fit neatly into one of the psychiatric categories because it extends beyond the narrow domain of psychological distress into the domains of social relations...” (James et al. 2005, 560). While the authors

recognize the interaction of social relations in the experience of *agonias*, the three categories the authors develop for systematically understanding *agonias* does not adequately account for social conditions. For instance, as I will elaborate later in this paper, existing research has shown that *agonias* can be experienced as a result of violence in intimate relationships (James and Clarke 2001). While a correlation between the experience of violence and *agonias* has been made explicit (ibid), the three categories developed by James and colleagues (2005) do not account for the complexity of social relations, such as the relational experience of violence. *Agonias* of illness are characterized by physical symptoms of illness such as tiredness or breathlessness while *agonias* of premonitions are characterized as a worrying that “something bad is going to happen” (James et al. 2005, 556). *Agonias* of death are described as happening when someone is on the verge of dying (ibid). It is apparent that these three descriptions of *agonias* do not encompass some of the social conditions that contribute to the experience of *agonias*, such as violence. I recommend that future categorization of *agonias* explicitly account for the link between social conditions and the experience of *agonias*.

In regards to *agonias* being an expression of suffering that has socio-religious roots, existing research (James 2002) observes that *agonias* is a function of community building where people share in their experiences of suffering. Both on continental Portugal and on the Azores islands, religion, specifically Roman Catholicism, plays a central role in community festivals and celebrations. To represent the extent to which *agonias* are connected to the Portuguese socio-religious structure, I add that the Portuguese have a saint dedicated to the experience of *agonias*: *Nossa Senhora d’Agonia*, or Our Lady of Agony. At the end of August, an annual celebration is held in honour of *Nossa Senhora d’Agonia* in Viana do Castelo, a northern city in Portugal. The festival ends with a procession of boats into the sea of Viana, where a statue of *Nossa Senhora d’Agonia* leads the way. To have a saint dedicated to *agonias* and to organize an annual celebration dedicated to the saint reflects a social commitment and honouring not only of the suffering exper-

enced by a “divine” being, but also the suffering experienced by a community of worship.

Understanding *Agonias* via the *Habitus*

The research on *agonias* maintains that it is an embodied experience with varying social, cultural, and religious meanings and implications. While James and colleagues acknowledge the embodied situation of *agonias*, their research lacks a theoretical explanation of the structural conditions that constitute a subject’s experience of their body, how bodies (re)produce the social structures they thrive in, as well as how individuals perceive and express their social positions and identities.

Pierre Bourdieu’s theory of the *habitus* is useful for understanding how the body is a social body. In describing the structure of social space, specifically, how social agents both create, move through, and make sense of their social space, Bourdieu asserts his concept of the *habitus* to explain how individuals are produced within and reproduce the social structure. Bourdieu writes, “*habitus* is both a system of schemes of production of practices and a system of perception and appreciation of practices. And in both of these dimensions, its operation expresses the social position in which it was elaborated” (Bourdieu 1989, 19). Here, Bourdieu succinctly describes how the *habitus* is both a production and an *expression* of the social world in which social agents act, as well as a practice of perception of the place of self and others in the social world. *Habitus* is a concept that is fruitful for thinking of the ways in which social agents embody, perceive and engage with others in the social world.

Using Bourdieu’s theory of the *habitus* and inspired by Nick Crossley (2001) whose work moves away from a Cartesian dualism towards a theoretical understanding of everyday lived experience as embodied, I provide an understanding of *agonias* as a type of social action that is integrated into and expressed through the *habitus*. Crossley’s theory of embodiment largely incorporates the work of Bourdieu on the *habitus* while advancing a theory of social action that accounts for the incorporation of social structures and schemas. Crossley writes “individuals must acquire or incorporate the structures and

schemas of their society, such as language, in order to become the agents we know them to be; but those structures and schemas only exist insofar as they are embodied in the actions of other agents who pre-exist the individual in question" (Crossley 2001, 5).

Like language, the expression of *agonias* is a form of social action that is made possible by the incorporation of dispositions or schemas that constitute an individual's *habitus*. In the words of Crossley, the *habitus* "is an active residue or sediment of their past experiences which function within their present, shaping their perception, thought and action and thereby shaping social practice in a regular way" (Crossley 2001, 93). Crossley's definition of the *habitus* acknowledges the objective (social) and subjective (individual) elements that structure the *habitus*. It is both the social structures, which include culture and history, that shape an individual's *habitus*, as well as the individual's actions that (re)produce the social structure and therefore also (re)produce the *habitus*.

While there is a shared *habitus* among those of a particular social group, it is important to remember that an individual's *habitus* will never be precisely the same as another *habitus* (Bourdieu 1972; Bourdieu 1989). Individuals have their own experiences, pasts or "biographies" that structure their *habitus* (Crossley 2001, 94). Furthermore, the material body, which differs among individuals, plays a central role in the varying ways in which individuals incorporate social structures.

An important function of the *habitus* is its capacity to render social practices intelligible because the *habitus* is the site where a "commonsense world" and "consensual meaning" are produced (Bourdieu 1977, 80) while maintaining community relations and bonds. In discussing clinicians' understanding of *agonias*, James and others importantly draw attention to "a discrepancy between the culture of the client and the culture of the therapist" (2006, 444). Not only is there a difference in culture that persists between client and therapist, but, more specifically, a difference in *habitus* that shapes the medical encounter between the clinician and the

patient. A difference in the *habitus* of clinicians and community members who express *agonias* is, in part, reflective of the educational training of clinicians. More specifically, clinicians are exposed to a scientific language that is incorporated into their *habitus* and informs their encounters with patients.

James and colleagues (2006) reveal how clinicians, even clinicians of Portuguese descent, encourage their patients to use the language of Western allopathic medicine, particularly psychiatric discourse, to express anxiety or depression in place of *agonias*. It is important to note that *agonias* is "treated" differently in Portugal than in North America. In Portugal, *agonias* is often treated with "community compassion" (James 2002), where in North America there is a tendency to view *agonias* as a psychiatric disorder where it then becomes medicalized and commodified (James and Clarke 2001). Community compassion refers to the social sharing of *agonias* where community members empathize with the experience of others. This form of sharing and compassion is particularly important for a community that is losing its traditions (James 2002). Erasing the language of *agonias* has the potential to reduce community relations which are important to immigrant communities who require support in navigating social barriers.

On the one hand, we can consider a type of symbolic violence at play when Portuguese immigrants who express *agonias* are encouraged to adopt the language of Western medicine to express their subjective experience. When responses to a particular experience do not follow expectations in line with past experiences, such as the expectation of community compassion, there is the potential to produce a "socially disrupted *habitus*" (Vitellone 2004). On the other hand, the language of Western medicine allows the individual to receive recognition within the North American context, especially within medical institutions.

Agonias is also a cultural tradition that risks rejection by youth raised in North America. For example, James (2002) suggests that an individual who expresses *agonias* receives recognition from family, particularly those family members of a younger generation,

only when they use the psychiatric language of anxiety and depression. North American-born youth increasingly adopt cultural beliefs and practices that differ from those of their Portuguese-born parents and, therefore, they may not have the past social experience that allows for the incorporation of particular dispositions and “know-how” of expressing *agonias*. There is a risk in losing a mode of expression that allows a particular form of suffering to be acknowledged.

Writing about how particular discourses receive recognition over others, Bourdieu advances the theory of the *doxa*, where orthodox opinions or beliefs adhere to the dominant order while heterodox opinions or beliefs challenge the accepted order. Tension exists within the order of the *doxa*, and those who are disadvantaged often have to submit to orthodox opinion if they are to receive recognition from others that allows them to engage meaningfully in society. Bourdieu’s concept of the *doxa* is useful to understanding the medical encounter where Portuguese immigrants are encouraged to adopt psychiatric language to express their *agonias*. We can consider how medical language is held as orthodox while the expression of *agonias* is heterodox because it challenges mind/body dichotomies that structure dominant psychiatric and medical practice (James et al. 2006). As Bourdieu proposes, there is value in adhering to orthodox practice as it provides one with recognition within the dominant social structure; however, such adherence risks erasure of a viable mode of embodied expression.

The risk of losing *agonias* as a recognized mode of expression is particularly problematic when we consider how expressing *agonias* allows for experiences that must remain unspoken to be acknowledged. For example, in one of James’ studies, a respondent explained how expressing *agonias* allowed her social acknowledgment of her experience with violence. The respondent said, “If I told you that I have *agonias* and if you’re my neighbour you would know that my father was beating me and that he had done so in the past” (James 2002, 93). We must consider how *agonias* is a way of expressing and resisting what must remain silent in

dominant social structures. In this case, we can consider how *agonias* is a form of resistant communication within the dominant social structure of patriarchy, where violence against women and children persists.

An important point that Crossley addresses with respect to the *habitus* is that individuals “have the capacity to turn back upon their habits and practices, to reflect upon them and ultimately therefore, to change them” (Crossley 2001, 158). In everyday performance, individuals can function without thinking about their dispositions and habits but individuals are also reflexive and have agency. This is an important point to consider because individuals who express *agonias* have the capacity to integrate new schemas and dispositions into their *habitus*. When clinicians encourage the use of psychiatric language in place of *agonias*, individuals have the capacity to resist and/or make use of medically recognized expressions.

When considering the case of *agonias*, the concept of the *habitus* can reveal how this mode of expression is a form of social action that is embodied and has shared meaning for persons of Portuguese descent. The *habitus* provides a theory for understanding how *agonias* is embodied through the incorporation of social structures, and how the expression of *agonias* (re)produces the social structure and, in the end, (re)produces the *habitus*. Individuals who express *agonias* are social agents who can reflect on their habits and decide when it is appropriate to express *agonias* and when it is unhelpful to use this mode of expression. Furthermore, expressing *agonias* has the capacity to maintain social relations within a community that shares a *habitus*.

Conclusion

This paper’s focus is premised on preliminary research that aims to rethink how *agonias* can be understood as an embodied experience using theories of the *habitus*. I acknowledge that this paper is limited in its analysis of gender, and this is in part due to the lack of access to primary data that would allow for such an analysis. Future research can elaborate a gendered analysis by focusing on gendered differences in the expression of *agonias*, as well as explaining how, as a social and cultural practice, *agonias* both structures

and is structured by gender matrices. In James' study, which included "twenty-six men and thirty-seven women" (2002, 91) informants, she reveals how *agonias* is expressed by both men and women. It would be problematic—in fact, wrong—to frame *agonias* as entirely a woman's "issue." However, like any cultural practice, the act of expressing *agonias* frames and positions individuals within the social world; it is important to understand how such an expression frames and positions individuals in the world as gendered subjects.

Working with the existing research on *agonias*, there are examples of gendered differences in the expression of this embodied affect. For instance, James and Clarke (2001) and James (2002) offer descriptions of *agonias* as an expression of distress associated with symptoms of menopause. While menopause is a socially constructed medicalization of women's aging, it is a construct that helps make sense of physical symptoms that appear to be specific to women. James and Clarke reveal that women also express *agonias* related to their experiences of "spousal mistreatment" or domestic violence (2001, 168). In addition, given the history of the medicalization and psychiatrization of women's bodies, and mental and emotional well-being, and where medicine has constructed femininity along definitions of emotionality and hysteria, it is important to explore how *agonias* fits within this socio-historical context. Taking into account the gendered differences in socio-historical understanding of emotion and differences in embodied expression of emotion, future work should elaborate on a gendered analysis of the experience of *agonias*.

Emotions and illness are embodied experiences that have multiple meanings that differ among societies and cultures. Current North American literature describes *agonias* as an embodied experience of emotion and illness and elucidates its many socio-cultural and religious meanings. The sociosomatic model used in current literature is useful to describe the social and cultural construction of *agonias* and its associated meanings, which include the meaning of suffering, death, distress, religiosity, and morality. However, the literature fails to account for the ways in which bodies (re)produce meanings. I agree

with the idea that emotions and illness, particularly *agonias*, are an embodied experience that is both socially constructed and meaningful, but, at the same time, it is important to understand how bodies engage in the (re)production of the social structure and its meanings. Emotions and suffering are forms of bodily language that speak to and about broader social structures.

The *habitus* is a theoretical concept that can help us understand how the expression of emotion and illness, such as *agonias*, operates at the site of the social body, is learned and integrated through dispositions and body techniques that are collectively shared, and shapes perceptions and understandings of individual and collective identity. Bourdieu's concept of the *habitus* can help us understand both the manner in which social structures produce bodies and the way in which bodies (re)produce the social structure and, ultimately, the *habitus*. Research that explores emotions and illness should consider how these socially and culturally specific experiences are embodied via the *habitus*. It is worthwhile for future research on *agonias*, and on other emotions or illness, to consider incorporating the *habitus* into its theoretical framework.

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