

STRESS DISCOURSE AND WESTERN BIOMEDICAL IDEOLOGY: REWRITING STRESS

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Popular psychosocial theories of stress and coping are based on an empiricist paradigm and a Western biomedical framework that reflect Western ideologies and values about health and illness. Problems associated with this discourse lie mainly in the ideologies that emphasize naturalism, individualism, rationalism, and objectivity. We suggest that stress and coping theory should be concerned with the ways in which power relations and social institutions produce the meaning of stress. The inclusion of alternative discourses that attend to the micro and macro social and historical factors is necessary for the further development of stress and coping theory and practice.

Despite the popularity of the “stress” construct, scant attention has been paid to the ways in which discourse influences the subjective experience and understanding of both the lay public and health care professionals. “Discourse” is used here to designate a social system produced by language and other semiotic signs, transmitted between individuals and institutions, and manifested within discursive practices (Foucault, 1982). The assumption is that dominant discourses produce meanings through social and institutional rules and practices that shape and influence social relations and the production of knowledge (Foucault, 1980; Hall, 1997; Purvis & Hunt, 1993). Discourse as a system of representations has been viewed as an “assemblage of knowledge that creates ‘truth

effects' . . . which in themselves are neither true nor false" (Foucault, 1980, p. 198). Given that the dominant discourse around stress appears "natural," the purpose of this paper is to analyze this discourse critically in order to deepen our understanding of how the meanings of stress are produced—to explore the social organizations and relations that underlie the development of stress theory and practices.

STRESS DISCOURSE

Mulhall (1996) and Pollock (1988) have noted the close resemblance between scientific and lay discourses of stress. Not only has the scientific conceptualization of stress had a direct effect on lay beliefs and behaviors, but also the scientific and lay conceptualizations of stress are in many respects parallel; they overlap and mutually reinforce each other. Reviewing concepts of stress and coping within the social and behavioral science literature, several scholars (e.g., Mulhall, 1996; Newton, 1995; Pollock, 1988; Young, 1980) have identified themes that are often expressed in the stress discourse of both the lay public and health professionals. First, stress is seen as an inevitable part of modern living with its multiple demands, little time for relaxation, and pressure to achieve. Not only is stress assumed to be on the increase, but also in many situations individuals can apparently do little to reduce the amount of stress that surrounds them. Thus, stress is often perceived as a constraining force with which people must cope (Mulhall, 1996; Pollock, 1988). Second, too much stress is assumed to be harmful because it upsets an individual's balance and well being, and causes both physical and psychological illnesses. Many disorders have been associated with stressful life events. Heart attacks and "nervous breakdowns" in particular are the most often cited diseases connected to stress (Pollock, 1988; Whittaker & Connor, 1998). Third, the responsibility to cope with stress rests with the individual. Finally, an inherent "weakness" predisposes some individuals more than others to succumb to the effects of stress (Meyerson, 1998; Mulhall, 1996).

Although experts advise people that stress is of epidemic proportions and therefore it is normal to be stressed "out," they also suggest that one should not be alarmed by stress unless it reaches a maladaptive level (Mulhall, 1996). This can be seen as an attempt to normalize stress, and at the same time "problematize" it. Stress can be equated to eating. Like food, stress provides "nourishment" for the body; however, too much or too little stress can jeopardize one's health. Excessive amounts of stress will cause illness and a lack of stress will make one feel "unchallenged." Moreover, people are admonished that they should know how much

stress they can handle, and are expected to take control of the stress in their lives (Newton, 1995; Pollock, 1988). The dominant stress discourse suggests that for individuals who can handle stress, stress is not pathogenic but rather adaptive (Pollock, 1998). Thus, within the dominant stress discourse stress is naturalized, normalized, problematized, and individualized.

Stress also has been medicalized and is linked with diagnoses of chronic fatigue, depression, panic attacks, alcoholism, and over-eating (Newton, 1995). Treatment or cure for stress is accomplished by focusing on the individual, who needs to “work out whether the real problem lies in your psyche or in your way of life . . . [and] to examine yourself since that is where the sources of stress lie” (Newton, 1995, p. 4). Individuals are told they can prevent stress by appropriately managing their life—by delegating, prioritizing, and learning to use methods developed to reduce stress (such as exercise, relaxation, therapy, meditation, aromatherapy, counseling). Stress is seen as involved in the etiology of a number of diseases; for example, Selye (1956) maintained that maladaptive responses to stress play a decisive role in the development of a great many illnesses. Although evidence relating stress to illness is often weak and unconvincing, the belief that stress causes both physical and emotional disturbances has gained acceptance within both lay and professional stress discourses (Mulhall, 1996).

The ways in which stress has been popularized and incorporated into an individual’s understanding of health and illness reflect dominant social and cultural ideologies about the distribution of role expectancies between men and women. As a consequence, unequal social relations and divisions between the sexes have been produced and reproduced (Whittaker & Connor, 1998). Dichotomies such as mind/body, rational/irrational, and normal/abnormal that are prevalent within stress discourse, reflect “strong” and/or “normal” ways of coping with stress associated with images of masculinity, independence, and autonomy. Alternatively, femininity is often associated with abnormality, irrationality, dependence, and a weak mind and body that often may be affected by stress.

Dichotomies within stress discourse also have influenced how health care professionals view, assess, and treat stress in health care institutions. As noted by Meyerson (1998), health care providers who work in medically focused acute care settings tend to view stress as individual loss of control, which is undesirable and abnormal. In contrast, health care providers who work in more psychologically focused settings and provide chronic care view stress as an unavoidable occupational hazard. These health care providers consider emotional control as not only

difficult to achieve but also as a barrier to care. Mental health nurses often work within both contexts and may find themselves facing these oppositional perspectives. For example, they are expected to exert control over their own emotions; and if they fail, they are held responsible for having ineffective coping mechanisms. In contrast, nurses are expected to have feelings and empathy for their clients. A “good nurse” is often a nurse who can relate and have empathy for his or her clients, and yet be “in control” of his or her own emotions. Thus, the stress discourse is reflected in the message that to provide effective health care one must have control over one’s own emotions, yet act in such a way that shows one’s capacity to feel as a human being.

Stress theory is used by institutions to regulate an individual’s behavior and can be illustrated through the ways employees are expected to feel and cope with stress (Newton, 1995). Employees are encouraged by their organizations to learn stress-management skills and to become effective copers (i.e., to become “stress-fit” workers). Through fostering their employees’ ability to cope with the job, the organization’s interests as well as the individual’s interests are reinforced. The worker who is concerned with being stress-fit will “deliver the last drop of her labour to her employer” (Newton, 1999, p. 246). Thus, the stress discourse contributes to a form of employee control.

Although attempts have been made to develop objective and universal criteria for analyzing successful or effective ways of coping with stress that include a wide range of coping strategies (Filipp & Klauer, 1990), reaching a general agreement on universal criteria remains problematic (deRidder, 1997). Aldwin (1994) and others have expressed concern that identifying the “right” or “correct” coping behavior could result in an over-generalization of certain behavioral strategies (Lazarus, 1993). Moreover, this approach to classifying coping strategies fails to provide health care professionals with detailed descriptions of coping strategies specific to the situational and cultural contexts.

In summary, the negative connotations of stress, the assumptions that stress is an inevitable part of life, that stress causes illnesses, and that coping with stress is the individual’s responsibility, have been broadly popularized in the media (television, magazines, popular self-help books) and frequently expressed in professional health care discourses. These ideologies reflect dominant Western values of naturalism, individualism, and objectivity, and have influenced the direction of knowledge production and the practice of mental health care. Because discourse provides a medium through which thought, action, and communication are expressed, articulated, and controlled (Foucault, 1980), the study of stress should emphasize how our knowledge of stress is constructed and used

in social interactions and how this knowledge influences our consciousness, social values, and, in fact, our practices. Thus, an analysis of stress discourse should focus on “issues concerning stake and accountability, and look at the ways in which people manage pervasive issues of blame and responsibility [and] . . . the way that descriptions are put together to perform actions and manage accountability” (Potter, 1994, p. 129).

BIOMEDICAL DISCOURSE

Cheek and Porter (1997) argue that one of the most important aspects of Foucault’s work was his challenge to the many otherwise taken-for-granted assumptions of contemporary health care and medicine. Through a Foucauldian analysis, Cheek and Porter assert that health and illness concepts are not objectively created, but rather are produced through the dominant discourse of biomedicine. This dominant discourse shapes the ways in which disease, illness, and health are conceptualized, which in turn promotes certain treatments of health problems. It also excludes other conceptualizations of health and disease treatments.

Foucault’s analysis of discourse and the ways in which it operates in knowledge production also illuminates the reasons why certain worldviews (such as realism or positivism) are considered “rational” whereas others are not, and how certain types of knowledge are considered legitimate and “true” (Cheek & Porter, 1997). Gilbert (1995) points out that “the present forms of truth and rationality, as determined by the dominant discourses in the health sector, determine the issues [that are] acceptable for research monies and publication” (p. 869). The dominant model also determines what issues are considered relevant and acceptable for mainstream health care (Cheek & Porter, 1997). Thus, the dominant biomedical discourse produces and validates knowledge that values rationality, and this knowledge influences the discursive attitudes of health care, which favors naturalism, individualism, and objectivism, while marginalizing other ways of knowing or assessing experience.

By relating stress discourse to the biomedical discourse, ideological similarities are illuminated. The similarities also reveal why the dominant stress discourse has gained popularity and is so readily accepted by the lay public and academics alike. Furthermore, the similarity of the ideologies reflected by these discourses explains why a certain type of knowledge produced by the dominant stress and coping discourse is more powerful than that produced by other discourses, and is “taken-for-granted” (Newton, 1995).

It has been argued by others that stress and coping theory has gained its power and popularity because contemporary stress and coping discourse

originates in the physiological and biological framework of biomedicine and adopts its empiricist ontology, epistemology, and discursive practices (Mulhall, 1996; Pollock, 1988; Young, 1980). The biomedical model forms the foundation of the Western health care system and its approach toward viewing human health is widely popularized. The modern view of stress has been popularized in similar ways. Yet Newton (1995) and Pollock (1988) both suggest that the dominant stress discourse gained much of its popularity because the ambiguity of the stress concept provided health care professionals with a ready explanation when biomedical explanations for the causation and treatment for many illnesses were inadequate.

Many scholars in health care disciplines have critiqued Western biomedicine as inadequate (Anderson, 1998; Capra, 1982; Good, 1994; Kleinman, 1980). Because Western biomedicine has its roots firmly planted in the empiricist paradigm, medical knowledge and practices are “grounded in a natural science view of the relation between language, biology, and experience” (Good, 1994, p. 8). The Western biomedical model also has adopted the mechanistic Cartesian worldview and Descartes’s philosophy of dualism. The Cartesian perspective views all “living organisms as physical and biochemical machines, to be explained completely in terms of their molecular mechanisms” (Capra, 1982, p. 121). Within this view, human beings can be described as complicated “machines” with physical and chemical interactions (Capra, 1982; Good & Good, 1993). Descartes’s philosophy of dualism views the body and mind as separate entities (Holden, 1991). Thus, disease and illness can be treated independently from the mind. According to Capra (p. 104), “because Western medicine has adopted the reductionist approach of modern biology, adhering to the Cartesian division and neglecting to treat the patient as a whole person, physicians now find themselves unable to understand, or to cure, many of today’s major illnesses.”

Situated within this methodological approach and conceptual framework, physicians and many other health care professionals have been trained to view disease and illness as particular parts of a complicated but malfunctioning human body—parts that can be “fixed” with specific solutions (Capra, 1982; Good & Good, 1993). Health care critics contend that this perspective of a mechanized human body neglects the wholeness of the patient and pays little attention to the social and environmental contexts of illness and disease. These critical charges have resulted in the claim that the biomedical model is no longer able to deal with the phenomenon of healing (Capra, 1982; Good, 1994), especially in the care of chronic illness and mental health (Bury, 1982).

In an empiricist paradigm, objectivity, rationality, and universal standardization become the basic criteria for quality and effective health care. By enforcing objectivity and universal standardization, critics claim that the biomedical model has overlooked both the individuals' subjective knowledge and the environmental influences on health. Moreover, the biomedical model reinforces the alienation of medicine from social relations and pays insufficient attention to the complexity of the interrelationship between subjective experience and social-cultural conditions (Good, 1994; Kleinman, 1980). For example, biomedical theories and practices have often excluded an analysis of the unequal distribution of health care, social inequities, and organizational policies that create barriers to health services. These exclusions have resulted in the medical profession giving inadequate attention to macrosocial and -historical factors of the health care system (Good, 1994; Newton, 1995).

As observed by Good (1994), contemporary biomedicine and medical behavioral science fails to address social and psychological issues by focusing on the modification of individuals' "irrational" behavior to reduce risk factors and increase compliance with medical regimens. In health care practice, knowledge is often assumed to lead to rational behaviors and this, in turn, leads to appropriate illness-preventing and health-seeking behaviors. Nevertheless, much evidence suggests otherwise. Not only do individuals often ignore health risks (Gifford, 1986), but health-seeking and/or illness-preventing behaviors should be seen as a situated product, largely shaped by the immediate circumstances and affected by contextual factors of the situation (Bloor, Barnard, Finlay, & McKeganey, 1993). Furthermore, it has been pointed out that an individual's apparently irrational responses to illness, which differ from the physician's assumed rational point of view, are not due to lack of information, but rather are grounded in culture and a system of beliefs and practices that may be different from those of biomedicine (Good, 1994).

The biomedical model also has been held responsible for sufferers' feeling marginalized and a general submission to the authority of medicine (Yardley & Beech, 1998). Because the dominant biomedical discourse depicts illness experiences as mainly physical sensations and pays little attention to the way individuals assign meanings to diseases and illnesses, sufferers are forced to communicate their experiences using the language of the dominant biomedical discourse within the context of biomedicine. Because illness experiences are mainly understood in accordance with the phenomena depicted by biomedicine in the form of medical symptoms, problems, and treatment procedures, voices that describe the meaning assigned to the sufferer's condition are absent. Individuals are thus limited in their ability to communicate and to

understand their illness experiences, experiences that connect the sufferers' lives with their relationships to the physical and social worlds. Yardley and Beech (1998) argue that this lack of voice further creates feelings of alienation and marginalization, which in turn reinforce the sufferers' helplessness and passive behavior towards health care.

Although many mental health nurses are committed to providing holistic health care, which pays attention to one's subjective feelings and other determinants of health that affect an individual's life, many are still influenced by a dominant discourse that may "devalue and suppress the emotions of patients" (Meyerson, 1998, p. 106) and value professional control over patient's bodies. The danger of such practices, as Meyerson points out, is that nurses might participate (albeit unintentionally) in a process that encourages "people to accept their losses and silence their complaints" (p. 106). Thus, the "sick role" requires people to suppress feelings and comply with medical efforts to make them well.

Modern stress theory is based on the empiricist paradigm and reflects the dominant Western biomedical ideologies of health and illness in emphasizing naturalism, mechanism, individualism, rationalism, and objectivity. As theorized by Smith (1999), ideology like genetic coding replicates its organization across multiple discursive sites. In the area of scientific knowledge production, ideology replicates its "code" by generating the same procedure or approaches in scientific inquiry, in writing, and in representing concepts in different discursive situations. The dominant discourse of health and illness has replicated its ideological "codes" within stress and coping conceptualizations so that these reflect White, middle-class ideologies of health, illness, and human social nature that have been widely accepted by both the lay population and professionals (Young, 1980).

CONCLUSION: RETHINKING AND REWRITING STRESS

Because the discursive and practical fields in which stress has emerged were situated largely in the biomedical model, positivist philosophical perspectives and links between causation and control are pervasive. As a consequence, in order to rethink and rewrite stress discourse, other alternative discourses that give more attention to macrosocial and -historical factors are necessary. Taking into account alternatives to the dominant modern stress discourse would require a combination of different conceptual frameworks for viewing stress, its knowledge development, and ultimately its management practices.

Deconstructing and critiquing discourse, as suggested by Lather (1991), helps us understand the regulatory function of discourse that

articulates and organizes our everyday experiences. It also illuminates “how and why discourse works to legitimize and contest power, and the limitations of totalizing systems and fixed boundaries” (Lather, 1991, p. 89). The individualistic approach encouraged in current stress interventions and operating under many taken-for-granted assumptions, may help individuals cope, but are likely to overlook the social relations that contribute to and define stress (Fineman, 1995). Stress theory should not only be concerned with individual responsibility and individual welfare, but also with the ways in which social institutions create a stressed “subject,” which contributes to our sense of self and how we live our lives. In order to rewrite the stress discourse, it is necessary to challenge the discourse by re-examining philosophical and theoretical perspectives and rethinking the power/knowledge connection that shapes theory and practice (Newton, 1995). It is also necessary to view stress and coping as a dynamic process that changes over time, is shaped by its context, and is politically, socially, culturally, and economically dependent.

In conclusion, contemporary stress and coping discourse has been widely accepted in the lay public and academic disciplines. A critical analysis of the discourse clearly reveals the dominant values of Western biomedicine and society, which reflect the positive value placed on naturalism, individualism, rationality, and objectivity. Limitations associated with the dominant stress discourse lie mainly in this ideology that underlies its theory and practices. By naturalizing and individualizing stress, stress theorists have not paid adequate attention to the macrosocial factors that shape the ways in which we experience stress. To understand how the dominant stress discourse shapes our lives, our experiences, and our sense of self, a critical analysis of this discourse in relation to power, knowledge, and the dominant biomedical framework is required.

Mental health nurses need to recognize the way in which the dominant stress discourse creates the meaning of stress, and how these meanings shape the client’s subjective experience of stress, their coping strategies, and available social resources to deal with stress. For example, conducting clinical assessments that value emotion and personal narratives as legitimate would enable nurses to help clients validate their coping strategies that are specific to their own lived experiences. This shift in clinical assessment would allow clients to express their feelings of being “not in control,” “overwhelmed,” “stressed,” or “burned out” without concern that they would be seen as having “weak personal characteristics” or as lacking the skills to cope with stressful life events. This shift in perspective would encourage nurses to view physical symptoms not as the breakdown of functional body parts, but as an indication of one’s environmental condition (Meyerson, 1998). It might change the emphasis

from how stress is manifest in physical symptoms, such as headache, high blood pressure, or heart attack, to the ways in which social, cultural, and environmental conditions create stress for individuals.

With this shift in clinical assessment, treatment approaches might focus on reducing harmful external factors. The question of who is to blame and who is responsible might then be answered from a different perspective that disrupts and challenges the dominant discourse of stress. As Thomas (1997) has pointed out, socially constructed human relations and gendered role expectations can further create distress; therefore, mental health nurses need to assess how these perceived social relations and expectations impact an individual's health and health care. Thus, because health care requires an emphasis on individuals and their interrelationships within society, health care professionals should develop a discursive approach that emphasizes the meaning of stress and the social, cultural, political, and economic factors that frame our social organizations and human relations.

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