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Bridging Psychiatric and Anthropological Approaches: The Case of “Nerves” in the United States

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Abstract

Psychiatrists and anthropologists have taken distinct analytic approaches when confronted with differences between emic and etic models for distress: psychiatrists have translated folk models into diagnostic categories whereas anthropologists have emphasized culture-specific meanings of illness. The rift between psychiatric and anthropological research keeps “individual disease” and “culture” disconnected and thus hinders the study of interrelationships between mental health and culture. In this article we bridge psychiatric and anthropological approaches by using cultural models to explore the experience of nerves among 27 older primary care patients from Baltimore, Maryland. We suggest that cultural models of distress arise in response to personal experiences, and in turn, shape those experiences. Shifting research from a focus on comparing content of emic and etic concepts, to examining how these social realities and concepts are coconstructed, may resolve epistemological and ontological debates surrounding differences between emic and etic concepts, and improve understanding of the interrelationships between culture and health.

Keywords

“nerves”; cultural models; metaphor; psychiatry; embodiment

People in many different parts of the world have described problems related to their nerves (Davis and Whitten 1988; Finkler 1989), although few recent studies have examined nerves in the United States (Camino 1989; Van Schaik 1989). Researchers studying nerves have been challenged by differences between “emic” or “folk terms” and Western diagnostic categories (“etic” or “professional terms”). Guarnaccia and Rogler (1999) point out that one common strategy has been to attempt to map emic terms to diagnostic categories; investigators taking

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Appendix

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this approach have argued that *nerves* is “really” a folk term for a universal psychiatric category (Jorge 2003). Others have criticized this approach by emphasizing the unique cultural meanings and contexts surrounding locally conventional terms (Cayleff 1988; Skultans 2003). These two approaches have long been at odds (Kleinman 1977; Singer 1975, 1977): psychiatry emphasizing the universality of an underlying disease entity, anthropology the culture-specific meanings of illness.

Although both biomedical and social science research strands have contributed to understanding social processes and health, their separation is problematic. In this article we bridge psychiatric and anthropological approaches, using cultural models to explore the experience of nerves among 27 older primary care patients from Baltimore, Maryland. We frame our analysis of nerves by suggesting that cultural models such as nerves are developed and socially distributed in relation to other cultural ideas and to shared experiences because patterned experiences inform cultural models, and cultural models in turn shape individuals’ experiences. In the following introductory sections, we summarize the advantages and limitations of previous psychiatric (positivist) and anthropological (constructivist) approaches to the study of nerves, and describe how integration of theory on cultural models, embodiment, critical medical anthropology and social epidemiology may offer the basis for a third approach that transcends limitations of either positivist or constructivist paradigms alone.

Mapping Folk Terms to Diagnostic Categories: A Psychiatric Approach

Clinical research seeks to delineate narrow diagnostic categories to test the effectiveness of specific treatments matched to specific classifications of disease in randomized control trials. Much clinical literature on nerves throughout the world has sought to translate nerves into one of several such Western psychiatric diagnostic categories. Clinical studies have interpreted correlations between report of nerves and responses on psychiatric scales as showing that *nerves* is really a folk term for some psychiatric disease such as depression (Cabassa et al. 2008; Jorge 2003; Kiev 1972; Littlewood 2000). Attempts to translate lay terms into diagnostic categories are generally motivated by the need to provide effective treatment; by classifying patient complaints a disease-matched treatment can be identified (Luhmann 2000).

Psychiatry increasingly adopted the biomedical model during the 1970s while transitioning from a classification system based on etiology and psychological process, to one based on checklists of observable symptoms (Good 1992). The revised psychiatric nosology sought to provide a universally valid description of psychiatric disorders (Spitzer 1994) based on a positivist assumption that diagnostic categories are direct descriptions of observed empirical realities. The biomedical framework assumes that disease processes operate in the natural sphere, unaffected by culture, and that culture is merely an interpretive and descriptive layer that obstructs understanding of the underlying physical reality. The clinician and clinical researcher’s jobs are thus seen as translating the patient’s (cultural) interpretation into a biomedical category to identify the real underlying disease and match this with appropriate treatment (Kleinman 1988b; Van Schaik 1989).

Anthropologists have criticized this nosology, arguing that it: (1) determines *a priori* the relevant signs and symptoms defining disease; (2) focuses on the individual and the biological to the exclusion of psychosocial and interpersonal context (Sadler et al. 1994; Scheper-Hughes and Lock 1987); (3) medicalizes social problems (Rozemberg and Manderson 1998); (4) omits cultural meanings of terms, ignoring the role of social construction in the development of medical concepts (Good 1994; Hunt 1998; Kleinman 1988a; Mattingly 1998; Monks 1995; Sadler et al. 1994); (5) falls into the category fallacy of assuming Western psychiatric categories are universal whereas local categories are culture bound (Fabrega 1974, 1975; Good 1994; Kleinman 1977); and (6) uses a narrow set of criteria for diagnoses that improves reliability at

the expense of validity (Tien and Gallo 1997). Although symptom-based psychiatric nosological systems (exemplified in the *Diagnostic and Statistical Manual of Mental Disorders [DSM-IV-TR]*, American Psychiatric Association 2000) have increased reliability of diagnosis (Spitzer 1994) and provided insight into distinctive “phenomenology, social origins, prognosis, and psychobiology” (Good 1992:186), the psychiatric approach has not accounted for the role of culture in phenomenology, social origins, prognosis, and biology of psychiatric conditions.

Focus on Context-Bound “Social Meanings”: An Anthropological Approach

Anthropologists have studied nerves as a symbol and social tool, folk idiom or lay idiom of distress (Davis 1989, 1997; Guarnaccia and Farias 1988; Migliore 1993; Nations et al. 1988; Nichter 1981; Parsons and Wakeley 1984), an ineffective idiom of distress (Camino 1989), a folk ailment (Rebhun 1993), a folk illness (Mathews 1987), a culture-bound syndrome or culture-specific complaint (Barlett and Low 1980; Dresch 1985; Low 1981), a culturally constructed episode (Guarnaccia and Farias 1988), a culturally interpreted syndrome (Low 1985), a metaphor or embodied metaphor (Low 1994; Scheper-Hughes and Lock 1986), an embodiment of distress (Lyon and Barbalet 1994; Traverso-Yepez and de Medeiros 2005), and as social commentary (Lock 1989; Reynolds and Swartz 1993; Scheper-Hughes and Lock 1986; Sobo 1996). This anthropological research has elucidated messages about morality and social commentary inherent in cultural models of distress, and highlighted the role of social interaction in constructing both lay and biomedical models.

Nonetheless, a purely constructivist approach ignores aspects of the process and experience of distress encompassed by nerves. Byron Good suggests that overt rejection of a mind–body dichotomy notwithstanding, anthropology has tended to view mental illness as a cultural construction while viewing physical diseases as universal processes coated in cultural interpretation (1992:187). Not only is a purely constructivist account “increasingly naïve ... in the study of psychopathology” (Good 1992:186), but it also divorces culture from physiological and social processes involved in health and illness. Focusing solely on the messages communicated through emic terms may exclude the embodied, felt experiences people aim to express through those symbols (Csordas 1990), and obscure the role of societal structure and power in shaping health and illness (Singer and Baer 1995).

By sidestepping the debate about the validity of emic versus etic models, and focusing primarily on social meaning and uses, constructivist discussions can still be read as providing a distinct and separable piece of the puzzle with psychiatric research covering the universal pathological processes and anthropology the local interpretations and meanings of those same conditions. Allowing culture to be conceptualized as separate from what psychiatry aims to study and implicitly downplaying interactions between culture, biology, and social structure, makes it possible for anthropological research to be assimilated into a psychiatric framework that separates out culture as unrelated to clinical interests. In contrast, we suggest that exploring relationships among cultural models, social structure, and bodily experience may offer a fruitful path effectively integrating psychiatric and anthropological frameworks in the study and treatment of distress.

Toward a Third Approach: Cultural Models and Embodied Experience

Cognitive anthropology offers a promising starting point for conceptualizing relationships among concepts of distress, sociopolitical context, and embodied experience. Locating culture within individual minds permits study of the distribution of ideas. Ideas are linked to collective structures and experiential factors in dynamic cultural processes (D’Andrade 1995; Ellen 2006; Ross 2004). We are interested in a reciprocal aspect of these relations: how shared

experiences help form cultural models (and their distribution), and how cultural models in turn shape experience (Strauss and Quinn 1997:115–118).

Each individual has mental models that incorporate both idiosyncratic and shared ideas and experiences (Collins and Gentner 1987); mental models that are to some degree shared by multiple people are called “cultural models” (Quinn and Holland 1987; Strauss 1992). Cultural models consist of ideas about a domain and a structure for describing relationships between elements in the domain (Lutz 1987; Quinn and Holland 1987). Strauss and Quinn (1997) build on connectionist theories of human learning to suggest that cultural models consist of networks between bits of information, associated with one another through experience (Strauss and Quinn 1997:52). Thus,

schemas as construed in connectionist models are well-learned but flexibly adaptive rather than rigidly repetitive. They can adapt to new or ambiguous situations with “regulated improvisation,” to use Bourdieu’s term (1977:11). [Strauss and Quinn 1997:53]

Because cultural models are flexible associations among elements of experience, rather than sentence-like statements about the world, a cultural models framework helps account for how people are able to reason about new situations in ways that are based on past experience but without exact replication of those experiences (Shanks 1997). Researchers have used cultural models in medical research to understand how patients conceptualize diabetes, AIDS, breast cancer, cervical cancer, and depression, and decide whether and where to seek help (Baer et al. 1999; Chavez et al. 1995; Chowdhury et al. 2000; Coreil et al. 2004; Farmer 1994; Garro 1994, 2000; Loewe and Freeman 2000; Mathews et al. 1994; Switzer et al. 2006).

On one side of the reciprocal relationship, shared experiences serve as input for cultural modeling. An individual’s mental models are formed and altered through experiences across their lifetime, with “the weights on connections between units [of the model] ... modified through repeated exposure to examples of associations that need to be learned” (Strauss and Quinn 1997:52). Experiences of and in the body, social, cultural, and natural environments have all been studied with regard to their role in shaping cultural models. For example, bodily experience shapes cultural models of emotions, such as in the U.S. metaphor of anger-as-heat reflecting a rise in skin temperature often accompanying the emotion (Kövecses 2000; Lakoff and Kövecses 1987). Specialized experience also shapes cultural models: curers in West–Central Mexico “share more knowledge about illness because they have more experience in dealing with and communicating about illness” (Garro 1986:354), and work in ethnobiology (Atran 1998; Berlin 1992; Boster 1987; Ross 2004) has suggested that “a large part of culture sharing may be the result of common inferences from common experience of the environment” (Boster 1987:919) shaped within the context of community discourses (Waxman et al. 2007). Because individuals learn models through social interactions and through experiences in a socially shaped environment, cultural models often reflect broader knowledge about ways to function as a legitimate member of a group and about how the world works (D’Andrade and Strauss 1992; Holland and Quinn 1987; Lakoff and Kövecses 1987).

Just as cultural models are formed out of various social and physical experiences, on the other side of the cycle they also play a role in shaping those experiences. Because people draw from cultural models in reasoning, cultural models influence how people categorize and respond to health problems (Baer et al. 1999; Chowdhury et al. 2000; Coreil et al. 2004; Garro 2000). For example, we have found that older American adults’ cultural model for depression emphasizes the need to “pull yourself up by your bootstraps.” Older adults draw from this model to suggest that a depressed person should depend on themselves to get better (Switzer et al. 2006). Terms such as *depression* or *nerves* have a dramatic social impact because they are linked to cultural models interrelating ideas about causation, responsibility, outcome, and personal character.

Stigma and social support, for example, emerge from the use of illness terms as a result of associated inferences derived from cultural models (Camino 1989; Davis and Joakimsen 1997; Dressler 1985; Finkler 1985; Monks 1995; Skultans 2003,²⁰⁰⁷; Steffen 1997; Thurston 1987; Waxler 1981; Yang and Kleinman 2008).

One way in which cultural models connect to broader cultural knowledge about how the world works and the role of people in it, is through metaphors—linguistic devices that create linkages across conceptual domains through analogic reasoning (Lakoff and Kövecses 1987). Metaphors are useful for identifying cultural models because they index unspoken widely shared cultural notions (Quinn 2005). Although researchers agree that metaphors are common, debate persists over their precise role in thinking and communication. Lakoff and Johnson (1980) argue that metaphors constrain inferences in reasoning according to specific metaphorical entailments: “We claim that most of our normal conceptual system is metaphorically structured; that is, most concepts are partially understood in terms of other concepts” (Lakoff and Johnson 1980:56). In contrast, Quinn concludes from her research on marriage in the United States that people draw creatively from an array of metaphors thus facilitating communication of particular ideas in situated interactions (Strauss and Quinn 1997:141). Based on the findings we present below, we suggest that older U.S. Americans often understand distress through metaphors employed in a cultural model for nerves. These metaphors constrain reasoning by carrying associations from target to the source domains. Yet subjects also appear to draw creatively from a variety of metaphors to express their experiences.

Complicating the approach to cultural models to be taken up here are issues of social distribution (Ross 2004). Subjects construct cultural models as their lived experience and historical conditions unfold over time. These models are likely to persist so long as they continue to be useful in making sense of experience and in coordinating social action within broader contexts (Cayleff 1988; Garro 2000; Strauss and Quinn 1997). Because lay terminology indexes such models, we find that lay terms for distress offer a ripe area for studying how certain cultural models of disease are distributed. In addressing this issue we find it essential to turn to sociopolitical dynamics as these are perceived to affect bodily experience (embodiment and phenomenology). By drawing insights from cognitive anthropology, phenomenology, critical medical anthropology, and social epidemiology, we suggest an integrated framework for exploring the content and social distribution of cultural knowledge.

“Nerves” in the Spectrum Study of Depression

We explore here the language of “nerves” expressed spontaneously by older adults from Baltimore, Maryland, during interviews about mental and physical health. Our analysis draws from semistructured interview and survey data and attempts to bridge psychiatric and anthropological interpretations. First, we present statistical relationships among use of the term *nerves* and demographic, physical, and psychological characteristics, to explore characteristics of people who used this language to hypothesize about the social distribution of the cultural model for nerves. Second, we analyze how respondents talked about nerves during semistructured interviews, exploring the structure of phrases spontaneously used by respondents and ways they used metaphors to communicate the experience of nerves situated within broader views about society, personal responsibility, life circumstances, and health. By combining these methods and situating our results within the findings of previous research, we suggest a possible relationship between the social distribution of the cultural model for nerves among our participants, the experience they express, and socioeconomic context.

Methods

Study Overview

Data for this article come from a larger study, the Spectrum Study,¹ designed to characterize how depression presents in older primary care patients. The study included two phases. Spectrum I sought to describe depression in late life that may not meet standard criteria for major depressive disorder (Bogner et al. 2004; Gallo et al. 2005). Spectrum II was designed to understand the sociocultural experience of depression by asking a subset of respondents from the Spectrum I study to express their views about depression in an open-ended format (Barg et al. 2006).

Study Sample

In Spectrum I we recruited patients aged 65 and older from nonacademic primary care practices in the Baltimore, Maryland area ($n = 355$, sample described in detail in [Bogner et al. 2004; Gallo et al. 2005]). We sampled to achieve approximately half of participants scoring above and below the threshold indicating significant depressive symptoms on a standardized assessment scale (Center for Epidemiologic Studies Depression–Scale [CES-D]), described below.

Participants for Spectrum II were identified from the pool of adults who participated in Spectrum I who agreed to be contacted and interviewed again. Permission to recontact and interview participants was granted by the University of Pennsylvania Institutional Review Board. We used a purposive sampling strategy to select a total of 102 participants for Spectrum II. We began with eight participants selected at random from the pool of available participants to be interviewed (from Spectrum I). Based on our review of transcripts from this initial group, we developed selection criteria for the next subsample. Because we found that many of the participants in the initial group expressed a preference for a diagnosis of anxiety over a diagnosis of depression, the sampling criteria for the next subsample included persons with high or low depression scores and high anxiety scores. Each subsequent sub-sample was similarly chosen, based on ongoing discussion of transcripts, to further understand and develop themes raised by participants during semistructured interviews. Subsequent samples included persons with a family history of depression, persons for whom there was discordance between the level of depressive symptoms and the doctor's opinion about whether the person was depressed, men with relatively good physical functioning, and the oldest participants in Spectrum I. We purposively sampled to achieve an equal number of African American and white patients to be able to explore differences between physician identification, explanatory models, and experiences of depression among African American and white participants (Barg et al. 2006; Wittink et al. 2006). However, we did not notice major differences in the cultural model of nerves among African American and white participants and do not focus on comparisons by ethnicity for this article.

Data Collection

Structured Interviews

During the Spectrum I study, we obtained information on age, gender, ethnicity, marital status, living arrangements, ability to make bill payments, and level of educational attainment. Depressive symptoms were assessed with the CES-D (Devins et al. 1988; Radloff 1977).

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Anxiety was assessed using the Beck Anxiety Inventory (BAI; Beck et al. 1988). Participants were classified as currently taking an antidepressant if an antidepressant medication was among their medications recorded by interviewers. The Medical Outcomes Study Short Form–36 (SF-36) was used to assess dimensions of functional status (McHorney 1996; Stewart et al. 1988). We also asked participants' physicians to assess the patient for depression, anxiety, tendency to somatize (from 1 = *not at all* to 5 = *a great deal*), and overall health (from 1 = *poor* to 5 = *excellent*) based on their most recent visit.

Semistructured Interviews

Spectrum II interviews consisted of a series of open ended questions designed to obtain each individual's explanatory model for depression (Kleinman 1980). Before asking other open-ended questions, we used vignettes to elicit these models without using the word *depression* (Barg et al. 2006). After the vignettes, interviewers asked directly about depression and related topics with questions including: what is depression like, what causes depression, how should depression be addressed, and are there relationships between your emotional and physical health. Interviewers, trained and supervised by project investigators, were encouraged to probe topics raised by respondents. All interviews were conducted in the respondents' homes.²

Data Analysis

During review of transcripts we noticed repeated mentions of *nerves* and used N6 qualitative analysis software (using QSR N6) to do a text search of all 102 transcripts for the word *nerves*. Although we had not asked about nerves, 28 out of 102 participants (27 percent) spontaneously used the word *nerves* during the semistructured interview. One of these 28 used *nerves* while describing the regeneration of the nerves in her knee and was excluded, leaving 27 transcripts for analysis.

The authors performed close readings of text in which participants talked about nerves and read entire transcripts to understand how discussions of nerves fit into participants' larger narratives. We rechecked emerging ideas about nerves against transcripts and systematically explored nuances in themes within and between cases (Glaser and Strauss 1967). In this process, we noted that metaphors often arose when participants talked about nerves and analyzed these metaphors to gain insight into the analogic ways that older adults think about nerves in relation to their social worlds, suffering, and self, and to explore the role of metaphors in the cultural model of nerves.

After identifying the core metaphors and themes arising from transcripts, we explored syntactic and semantic patterns in participants' talk of nerves. We looked at the full list of phrases used and noted features of each phrase: the structure of the sentence, position and role of the word *nerves*, whether *nerves* were acted upon or acted on something else in the sentence, and clues about cultural models based on specific uses of the word. Finally, using our survey data we compared personal characteristics of respondents who mentioned "nerves" with those who did not (using χ^2 or *t* tests for comparisons of proportions or means, respectively). We set α at 0.05 to denote statistical significance, recognizing that tests of statistical significance are approximations that serve as aids to interpretation and inference.

²The full interview guide is included in an Appendix posted online as Supporting Information for this article.

Results

Characteristics of People Who Discussed Nerves

Of the 102 respondents in our sample, 27 mentioned *nerves* in the semistructured interview about depression (26 percent). People who used the word *nerves* were more likely than those who never mentioned *nerves* to be women, African American rather than white, have less than high school education, and to report difficulty paying bills. The mean age of the 27 who talked about nerves did not differ from the mean age of the 75 who did not (see Table 1).

People who used the term *nerves* had statistically significantly higher depressive symptoms scores (CES-D) than those who did not talk about nerves (mean 19.81 compared to 12.35; 17 is a typical clinical cutoff point suggesting significant depressive symptoms). There were no differences in rate of antidepressant use or in anxiety scores. People who talked about nerves reported a greater amount of bodily pain and were more likely to be rated by their physicians as “focus[ing] on medically unexplained somatic complaints” during their last visit. Physicians were no more likely to rate people who mentioned “nerves” as depressed or anxious (see Table 1).

Structure of Phrases Used By Participants

Among the 69 occurrences of the word *nerves* across all transcripts, we identified two main phrasal categories: (1) *nerves* were either acted upon or acted on something, and (2) *nerves* were either a permanent part of the person or an event (see Table 2). We designate the first grouping as “acted upon/acting on” (see Table 2) because the majority of nerves phrases (58 percent) were structured with the word *nerves* as recipient of action in the sentence (“acted upon” by something else), but occasionally participants also described nerves damage as “acting on” other parts of the self to cause additional harm (12 percent of phrases; using words like *until* and *so* to show that after a threshold, nerves damage was overwhelming). In other words we use the phrase “acted upon” to refer to instances where nerves were described as a passive object or recipient of some action, and “acting on” to refer to instances where nerves were described as actively acting on something else.

The second grouping, nerves as part of self or event (see Table 2), reflects how most phrases (83 percent) included a possessive pronoun before the word *nerves* to designate nerves as belonging to a particular person, but two participants also used phrases where the word *nerves* referred to an event or state that can occur: for example, “my nerves” and “her nerves,” compared to “goiter causes nerves” and “my nerves started then” (although this last example uses the possessive pronoun, it also designates nerves as an event that began at a particular time, rather than a permanent part of the body). We discuss these features in the context of participants’ narratives below.

Themes from Semistructured Interviews

Acted Upon and Acting On

Almost all respondents used phrases that describe the impact people and events have on an individual’s nerves (see Table 2). For example, some said that because of an accumulation of troubles, or after particular conflicts: “X affected my nerves,” “X gets on my nerves,” “X really plucks my nerves,” or “X made my nerves bad.” In all of these a direct cause is provided for the nerves problem. Even participants who did not explicitly talk of a cause in the same phrase implied a relationship between events and their bad nerves, for example, by describing an event and commenting “my nerves got bad then.” The typical structure of phrases participants used was “actor—verb—possessive pronoun—nerves,” with the person’s nerves as the passive

recipient of outside action. These phrases indicate that socially defined problems actively harm nerves and that people can generally identify specific circumstances that weakened their nerves.

Respondents identified interpersonal conflict as the primary cause for aggravated nerves (discussed by 19 of the 27 who mentioned nerves). Respondents attributed their bad nerves to situations in which they felt others had wronged them, tensions between themselves and others (family, friends, and neighbors), arguments over money, and needing help that family or neighbors were unwilling to offer. For example, one woman said, “I have a sister that really plucks my nerves because she’s well off and I owe her \$18 and every time she calls ... [she asks] ‘Did you send my money?’” In discussing nerves, many women described their role as head of the family and the concomitant responsibility for keeping their families unified. Conflicts between their children or among others in the family took a toll on these women’s nerves:

If I could just get them together to even act like they’re not enemies or I’m their enemy ... [I]f my daughter could walk in here and find her brother in here and they would speak to each other without her running away... And he don’t come because he’s afraid he’s going to run into her and that gets on my nerves.

Other respondents said their nerves were harmed by deaths, accumulated worries, depression, and money problems: “When you living by yourself and then people that dying, that most get on your nerves.” Similarly, another woman said she thinks that when doctors use the word depression they mean that “... everything worries you and it gets on your nerves and you figure what the heck’s the use. You try your best, you do your best you possibly can and everything goes wrong.” She conveys the sense that worries from life build one on top of another on the nerves to the point that regardless of the person’s efforts, it is just too much to handle.

In many cases participants described bad nerves as the inevitable response to life circumstances beyond the individual’s control. In the last quote, the woman talked about “you try your best” but “everything goes wrong,” similarly another woman (described more in the next section) connects nerves to “you went through a whole lot”—both suggesting that things happen to a person in life, regardless of their efforts, and these negative events hurt through your nerves. When asked how she deals with a fixed income and being unable to afford the things she needs, one woman responded quite matter-of-factly: “It gets on your nerves, that’s what it does. Because some people have very large income of social security, some don’t.”

When an individual experiences adverse social or economic events, these events become embodied through the nerves and are described as depleting the individual. When nerves have been weakened, the individual’s ability to handle additional challenges is decreased. For example, with regard to caring for her husband who has severe dementia, one woman said: “I know he can’t help it but my nerves can take only so much before I flip.” Respondents described a definite limit to the nerves’ strength, as reflected in Table 2; as one woman described, depressed people are people who:

let things burn, get on their nerves so bad so they get depressed with it ... You can’t do that. Cause if you do, that stuff will work on your mind so bad until you end up with a mental problem.

Nerves once weakened could bring on other more serious conditions, in particular, depression.

Bridging Body–Self and Social World

Participants talked about nerves as connecting events in life with the person’s well-being and body. One woman said that when doctors say the word *depressed*, she thinks they are probably talking about:

... the nervous system, the system concerning about your nerves and all and you done went through a whole lot of things in life. You dealt with a lot of negative things, a lot of things that weren't good for you, I guess.

This woman describes the nerves as part of or even constituting a bodily system (the nervous system) that is affected by the difficult things one goes through over the course of life. She says these negative events “weren't good for you,” using a phrase similar to common language used to describe foods as “not good for you” because of their physical composition being harmful to the health of your physical body. By analogy, life events are ingested (embodied) through the nerves and are not good for the person's health either.

Participants described nerves as a bridge linking events in the social world to a person's internal self; as such, narratives of nerves encompassed social, mental, and physical experiences. For instance, this woman's account connects loss of her husband, loneliness, feeling wronged by people she had tried to help, seeing her son less often, and stomach problems:

Respondent: [M]y husband passed too and that affected my nerves for a long time, you know, until it weared off ... It just affected my nerves a little—I was lonely, all the kids was married, I'm home by myself and I get lonely for that.

...

One thing that [started my bad feelings was that] ... I had people that lived downstairs. They were very nice people but they had run out [of money] and I give 'em [a place to stay]—I didn't charge them much but they was a Witness so I figured they were nice people, you know? So they went down there and said they paid me rent so I had to pay a whole lot back in tax. That got on my nerves and I think that's what got on my nerves, made my nerves bad.

...

Right and another thing that worried me too, my son had quit my church. One of my sons, the oldest one, always take care of me, he did—he was always around here. When he'd come home from work, he'd be here at my door. And all of a sudden his wife wanted him to go to her church, you see. So that just got me down feeling. I was sick for that. Oh, I didn't know I could get so sick! I got so sick in stomach.

...

Everybody around here will tell you, “that boy sure see about me,” call to see if I'm alright, see this and that, help cut the grass for me, he just was—he's still that way. He still do the same thing. But I don't see him as much.

Interviewer: Now when you said that you held your stomach, so—what did you—your stomach feels—?

R: Yeah, yeah, that nerve, yeah. I think that's my nerve. That's what I mean, my nerve, you know, I think I started having nerve in the morning. I never had nerves before then. When she [my son's wife] came I didn't have no nerve. My nerves was alright but my nerves started then.

In the above example, this woman's nerves began with the “social” events of her husband's death, being reported for taxes, and not seeing her adult son as often, included the “emotional” responses of loneliness, missing her husband and son, and feeling wronged, and the “physical symptom” of upset stomach. Like many others, she describes effects of the accumulation of hardships that built on her nerves. Other respondents also mentioned their bad nerves as involving stomach pains as well as headache, difficulty sleeping, and lack of energy.

Another woman described confiding in her pastor about her difficulties and fears in caring for her very ill husband, and her troubles with her sons. She agonized over the decision to keep her new phone number from one son who had been charging expensive long distance calls to her number, and was hurt to find out that the other son she thought was doing very well was in jail. It pains her to cut herself off from her children whom she worries about:

I would tell him [my pastor] how these men get on my nerves so until I couldn't sleep at night, wake up with a terrific headache and feel bad the whole day and then start the process over and over again.

She wishes her children were doing better and that she could somehow help them, but feels she has no choice but to separate herself because “these children are going to put me in my grave if I let them and I refuse to let them.”

Nerves bridge physical and mental (and individual and social), but when participants were explicit, they categorized nerves as physical. When asked what physical problems affect her mood, this woman talked about her nerves:

I: What physical problems do you have that affect your mood or the way you feel emotionally?

R: I think my nerves—I guess your nerves are bad and then it makes everything go off you know?

Another woman thought that her definition of depression may differ slightly from her doctor's definition in that depression could be a problem of the mind (as the doctor implied), but she thought those types of feelings could also be owing to nerves:

I: What do you think doctors mean when they use the word depressed?

R: It means you got something on your brain and you can't get it off. You let it worry you and gets you depressed.

I: When you use the word *depressed*, do you use it with the same meaning?

R: It's either that or nervous. It's either the mind or the nerves. (underlining added for emphasis)

The first respondent quoted above included nerves among the set of physical problems that can affect emotions. In the second quote, another respondent contrasted “the nerves” with “the mind.” The expressions respondents used to describe nerves, such as “plucks my nerves” and “straighten out your nerves,” reflect a history in which nerves were thought of as physical cords or strings running throughout the body (Davis and Whitten 1988). Respondents said life events “get on” and “build up on” their nerves, as if nerves were physical objects in the body.

Moreover, the great majority of phrases participants used to talk about nerves placed a possessive pronoun in front of the word “nerves,” indicating that nerves belong to a specific person (see Table 2). Only two of the 27 people who talked about nerves also used the word *nerves* to indicate a state or event that could occur, begin, or be caused, such as in the phrase, “goiter causes nerves” (as opposed to “she got on my nerves”; Table 2). The predominance of language indicating personal possession of nerves, along with the broader narratives, imply that what changes is not the nerves' presence or absence, but their variable levels of health over time. Even though people may no longer literally think of nerves as physical cords in the body, they talk about nerves as behaving as if they were physical entities in a person. In other words, respondents used metaphors that treat nerves as physical strings, and reason about nerves in ways analogous to physical parts of the body.

The analogy of nerves to physical, rather than mental, objects in the body carries with it other ideas about personal and societal responsibility for individual distress. When talking about the mind, older adults emphasized personal responsibility for mental processes, such as when this woman said that: “a person’s got to be responsible for their own peace of mind, their own outlook (Dahlberg 2008).” By contrast, this language of personal regulation of thoughts and outlook (associated with “the mind”) was missing in discussions of nerves. Older adults instead talked about life events and their embodiment as more inevitable, as “just how things are.” In the phrases participants used, nerves are positioned as passive objects in the body that are acted upon, not something that the person controls (see Table 2). When the woman above said “you done went through a whole lot of things in life” she talked of life as something that happens to you or that you survive through. Whereas many participants talked about causes of depression by placing the person as the actor in the sentence (as in “he is submerging himself in his illness”), external events usually were the subject of sentences about nerves, and these events (or other people) acted upon the nerves (as in “the office job was starting to affect my nerves”). Issues of personal control were complex in participants’ discussions of depression (and are beyond the present scope), but causal agents tended to be more person located for depression and more externally located for nerves, as reflected in sentence structure.

The woman above who said problems like depression could be either in the mind or of the nerves went on to draw a parallel contrast between issues doctors can and cannot treat:

I: But do you think you use it the same way that doctors use it?

R: I don’t know; couldn’t tell you. Doctors can use it [the word *depression*] to say different things; I don’t know. But I think it all boils down to about the same thing. Doctors can give you something for some of it, some of it they can’t do nothing about.

When she described what she thinks doctors mean by *depression*, she says they define depression as a problem with your brain, and that it is caused when a person “lets” things worry them and stay on their brain. Elsewhere in the interview, this woman contrasts herself with this image of the depressed person who she says “fixates” on problems. Instead she says she is proactive and if she is ever bothered it is about something, in particular some external constraint, rather than internal worries. For example, in response to being asked to free list words that describe her when she feels down or blue, she replies:

R: That very seldom happens.

I: Seldom happens, uh-huh.

R: “Use a word that describes”—I don’t know.

I: When you are feeling down in the dumps, blue or your spirits are low.

R: Well I must be upset about something, that’s all I know. I guess it could be—it could be a form, some depression starting or something.

I don’t know; I don’t get that way because if I start feeling low or something worrying me I get up and go out and do something, take care of it. That’s it. It doesn’t affect me.

I: You can’t think of a time when you were feeling low—

R: Only thing I’m ever low in I don’t have enough money to pay the bills! That’s about it. That’s all that made my—only thing upset me or worry about much.
(underlining added for emphasis)

In analogy with the way respondents construct phrases positing an outside actor that harms nerves (and thus provide a clear cause for bad nerves), here the speaker contrasts the depressed person who she implies has no real reason to be depressed, with herself who would only be

worried “about something,” such as when her bills cause her worry. This association of physical body and social context with inevitability, and mind and self with personal responsibility and control, illustrates one way in which analogy and metaphor contribute to cultural models, and inform individuals’ responses to labels, such as *nerves* or *depression*.

Within a Normal Range of Distress

Respondents described nerves as encompassing a range of normal, not pathological, responses to life troubles. Hardships in life could accumulate and wear down respondents’ nerves. Weakened nerves could make a person susceptible to more serious conditions such as depression. Still, the language respondents used posited nerves as a normal part of life, particularly of life in difficult but common circumstances. As opposed to *depression*, *bad nerves* did not mean the person was recategorized as disordered or sick; participants talked about “depressed people” and used the verb *to be* to talk about “being” (even temporarily) depressed, whereas they talked about the ways things in life got on and affected their nerves gradually, and did not use the verb *to be* to indicate becoming a type of person as a result. One woman remarked:

A lot of people they get down. You’re going to have your problems, you know and it’s not all the times it’s depressed. You got somebody that just gets on your cotton picking nerves.

Rather than using the term *nerves* as a category describing a temporally bound event or state that happens to a person, most participants talked of nerves as a permanent part of a person affected by outside events and thus at varying levels of health or strength across time (see Table 2: rows 3–4).

Fewer than half of the people who mentioned nerves suggested treatments. This fact is noteworthy because it fits within an overall model that considers wearing down and subsequent recovery as natural processes lived through rather than a disease requiring treatment. Some respondents were explicit that bad nerves would wear off over time, either because one got used to a situation or because time simply heals: “My husband passed too and that affected my nerves for a long time, you know, until it wore off.”

Still, several respondents described changes they made when their nerves were bothered. Given that external events press on nerves, these changes focused on changing situations. People found ways to remove or get a break from the cause of their bad nerves often by enlisting paid help or getting assistance from adult children or other family members. For example, the woman quoted above who is struggling to care for her husband, finds that getting as much help as she can afford is helping her nerves:

... my husband has dementia and ... so it’s been very, very hard for both of us for the last three years because it’s changed our whole life ... Now he goes to daycare three times a week just to give me a break which I need desperately ... because I get so agitated with him. I mean I know he can’t help it ... but my nerves can take only so much before I flip ... They pick him up in the morning, bring him home in the afternoon and it’s working out pretty good.

Another woman told us: “My daughter’s taking me on this cruise, trying to help the nerves.” Several people (6 of 27) mentioned “nerve pills” prescribed by physicians that could be taken as needed to “straighten out the nerves.” As one woman explained, “When I take medication it calms my nerves down and I don’t think and worry about things as I usually do.” Others used vitamins, herbs, or calming tea. Various responses to nerves overlapped with treatments older adults mentioned for depression: talking about problems to someone (such as friends or adult

children), socializing, seeing a counselor, prayer, and simply “trying not to let things get to you.”

Discussion

In our study, nerves were raised by just over one fourth of participants (27 out of 102) during interviews about depression. Among older adults, nerves served as a bridge between the social world and the individual body: respondents experienced interpersonal conflict and financial troubles as directly affecting their health via their nerves. Women, African Americans, people with difficulty paying monthly bills, and people with greater depressive symptoms were more likely to mention nerves.

Nerves has a long history within medical literature (the late 1800s was marked as “the age of nervousness”) and is not just a “folk illness” distinct from medically recognized constructs (Davis and Whitten 1988). The term *neurasthenia*, which grew out of *nerves*, was not dropped from the *DSM* until the second edition was published in 1968 (*DSM-II*; American Psychiatric Association 1968). Our cohort of adults over age 65 grew up in a period in which “nerves” held greater professional acceptance, whereas “major depression” was only introduced in the *DSM-III* in 1980 (American Psychiatric Association 1980; McPherson and Armstrong 2006). We emphasize this because ethnomedical systems and models are often considered fantastic, exotic, and existing outside modern Western societies. In fact the lessons we have learned from cross-cultural psychiatry apply within cultures as well as between them. Although current psychiatric categories are largely professionally accepted in the United States, the lay public also uses multiple other cultural models for distress (including ones with relationships to medical systems [Wittink et al. 2008]), allowing us to explore the conditions in which these cultural models arise and persist, and how they shape individual experiences of distress. After reviewing limitations of our findings, we therefore revisit psychiatric and anthropological approaches to discuss a way of bridging these approaches in an interpretation of nerves.

Limitations

Our analysis focuses on persons who spontaneously brought up nerves and we cannot know who might also consider themselves to suffer from nerves but happened not to use that language in our interview. Although our approach does not allow us to generalize about the prevalence of nerves, it does provide a more in-depth understanding of the cultural model for nerves and its variable usage because we were able to observe ways respondents spontaneously use the model. Had we first asked a survey-style question about nerves, such as “do you have bad nerves?” we would have screened out less severe “nerves issues,” and not necessarily observed the same range of expressions or experiences.

D’Andrade points out that “an interesting characteristic of many kinds of cultural models is the awareness of the model displayed by informants. In the case of the model of the mind, for example, most informants do not have an organized view of the entire model. They *use* the model but they cannot produce a reasonable *description* of the model” (D’Andrade 1987:114). For this reason, our data were well suited to studying the cultural model of nerves. We observed references to nerves naturally occurring during conversations about depression, rather than asking respondents to directly reflect on the model.

We also note that because our statistical comparisons were based on spontaneous discussion of nerves we were unable to compare people who may use the cultural model for nerves in their daily lives with those who do not. Nonetheless, that participants brought up nerves spontaneously suggests it may be salient for them. Rather than conceiving of statistical tests in this context as hypothesis testing, we used analyses to generate hypotheses about the cultural model for nerves and its distribution among older adults in the United States.

Acknowledging these limitations, this mixed methods study allowed unique insights into “nerves” as experienced and expressed by a group of older adults in the United States. The combination of survey and transcript data supports the idea that cultural models and sociocultural experience reflexively shape one another. Analyzing metaphors participants used when talking about nerves helped us to appreciate the impact language has on the meaning and experience of distress: the analogies reflected throughout the cultural model for nerves carried ideas from source domains to the cultural model of nerves, and participants appeared to think about their distress in terms of these ideas about natural wearing and healing processes. We found several important ways in which the nerves model differed from the biomedical model underlying past psychiatric research on nerves, and also caution against emphasis on cultural meaning alone to the exclusion of social and bodily experience, both of which were part of participants’ experiences of nerves. Below we critique biomedical and constructivist approaches to nerves, and present a third framework for interpreting nerves as both arising from and informing individuals’ life worlds.

Nerves as Folk Term for a Diagnostic Category

Positivist psychiatric research attempting to map nerves to diagnostic categories anticipates one-to-one relationships of labels with objects of clinical importance and judges words as “true” as used if observed to describe these objects and “false” otherwise (Good 1994). Good argues that this referential theory of language is rooted in a folk epistemology that views reality as divided into physical and interpretive realms (1994:116). Operating within this folk epistemology makes it appear reasonable to study mental illness (as biological disease) and the cultural interpretations and meanings attached to that disease separately. Anthropologists, however, criticize this approach, suggesting constructivist and hermeneutic emphases on how the terms people use are linked to particular sociocultural models and assumptions about the world (Agar 1980; Harré 1986) with the consequence that “there can be no understanding independent of interpretation” (Van Schaik 1989:18). Moreover, work in phenomenology has suggested a more complex interrelationship between cultural constructions and experience and seeks to study the process by which “perception ... constitutes and is constituted by culture” (Csordas 1990:9).

Our findings about nerves suggest that language, and in particular metaphor, express meaningful experience in ways not otherwise available. Although psychiatric literature has tended to frame folk terms as “cultural” in contrast to “real underlying disease,” we follow anthropologists in drawing attention to how cultural models shape speakers’ experiences of distress and others’ responses. The approach we take suggests a reciprocal relationship between experience and language: experiences shape cultural constructs, and these socially shared constructs in turn shape the experience itself (Strauss and Quinn 1997). Meanings are not simply added to core experience but are part of the process of perceiving feelings in the first place (Csordas 1990). Framing culture as a part of reality parallel to and separable from empirical reality, as in psychiatric approaches, obscures processes intermixing culture and experience, and prevents researchers from understanding experiences communicated through terms such as *nerves*.

In addition, many of the heuristic divisions made in biomedicine were bypassed in ways respondents talked about their nerves. The biomedical model organizes mind and body, individual and sociocultural, into separable realms:

Even in psychoanalytically informed psychiatry and in psychosomatic medicine there is a tendency to categorize and treat human afflictions as if they were either wholly organic or wholly psychological in origin: ‘it’ is *in* the body, or ‘it’ is *in* the mind. [Scheper-Hughes and Lock 1987:9]

Corbett found that clinicians forced diagnosis into either physical or mental categories, never both (1986). Although the biopsychosocial model has been encouraged in medical education and research as a way to incorporate a patient's experience into health care and disease diagnosis and management (Engel 1978), whether and how this is operationalized in practice remains a question (Dowrick et al. 1996; Masters 2006).

Psychiatric diagnostic categories such as depression tend to locate disease and cause in the individual, whereas through nerves, participants expressed the influence of difficult social and economic circumstances on a person. Respondents often used the word *nerves* to refer to an embodiment of conflict and suffering: The hardships an individual endured literally wore down the body (through the quasi-physical nerves) and took a toll on the person as a whole.

Social epidemiologists have questioned biomedical assumptions about the sources of inequalities in health, asking “do the causes lie in bad genes? bad behaviors? or accumulations of bad living and working conditions born of egregious social policies?” (Krieger 2003:429). Studies have found, for instance, that neighborhood violence increases depression among residents (Curry et al. 2008), and along with unemployment, may also lead to higher risk of coronary heart disease (Sundquist et al. 2006). Anthropologists have also observed that in ethnomedical systems, in contrast to biomedicine, “social relations are also understood as a key contributor to individual health and illness” (Scheper-Hughes and Lock 1987:21).

Differences underlying the biomedical and nerves models make translation between folk terms and clinical diagnoses problematic. Viewed through a biomedical lens that separates mental, physical, and social, a cultural model for nerves that blurs these boundaries will be misunderstood. Psychiatric approaches to the study of *nervios*, which also encompasses physical, social and mental components (Baer et al. 2003), for example, have tended to label *nervios* as an example of somatization: “depression is usually expressed in Latin American countries more through somatic symptoms or complaints of ‘nerves’ than through subjective feelings of sadness” (Jorge 2003:9). In the *DSM-IV-TR*, *nervios* and *ataques de nervios* are described as overlapping with Somatoform Disorders, and “‘neurasthenia’ ... is classified in *DSM-IV* as Undifferentiated Somatoform Disorder if symptoms have persisted for longer than 6 months” (American Psychiatric Association 2000:491). In our study, the overwhelming majority of older adults who mentioned “nerves” during semistructured interviews were rated as somatizing by their physicians. We do not know if people who mentioned “nerves” in our interviews were more likely to use similar language when speaking with their physicians, but physicians seemed to see something in these patients that they interpreted as somatization.

In sum, whereas the positivist framework used in past psychiatric research on nerves may be based in part on a clinical aim to classify to treat distress, it is limited in its potential for understanding nerves because of its reliance on a truth conditional referential theory of language, theoretical divisions between mind—body and individual—social, and an individual versus sociopolitical etiology. We turn our attention now to anthropological constructivist approaches to the study of nerves.

“Nerves” As Context Bound “Social Meanings”

There are practical implications of terms (and corresponding models) people use: not only in the ontological claims they make but also through the effect they have on peoples' lives. People may respond differently to a person who says something is “getting on their nerves,” than they do to the “depressed person” and assume different things about each (e.g., do they have a disorder? or are they surviving through difficult situations? did they put themselves in a bad mindset? or are they dealing with larger problems beyond their control?). Labels such as *nerves* and *depression* convey different messages about personal responsibility and societal conditions, which in turn shapes the way a person experiences distress. The ethnographic

research Veida Skultans conducted in Latvia during the transition to a biomedical psychiatric system captures the profound impact the shift from “*nervi*” to “*depression*” had in that context:

The move from somatoform to psychological disorders and depression, in particular, represents the internalization of a heightened sense of accountability and responsibility for one’s life circumstances albeit limited opportunities for changing those circumstances. Thus, changing subjectivities are not simply a response to changing concepts but reflect the experience of a different kind of social world. [Skultans 2003:2429]

Nervi had captured the shared experience of having survived hardships collectively endured under Soviet rule, and the shift to *depression* located within a disordered individual, Skultans argues, “changed the nature of the individual’s engagement with society” (Skultans 2003:2423).

Studying nerves in Newfoundland, Costa Rica, and the U.S. South, researchers concluded that talk of nerves helped garner support from peers to relieve distress (Davis 1984; Low 1981; Nations et al. 1988). In contrast, Camino argues that black women in a southern U.S. city avoided talking to others about nerves for fear of stigma, but that when they did so, complaints were dismissed as “normal” for women and thus were ineffective as calls for help (Camino 1989). Jenkins suggests that different degrees of stigmatization associated with *nervios* and schizophrenia among Anglo- and Mexican Americans shapes who uses which terms and when (Jenkins 1998). In Newfoundland, Davis found that the doctor served as “moral adjudicator with the power to undermine the patient’s reputation as a good woman in the community” by either judging the woman as the stoic endurer of hardships or as a weak complainer (Davis 1984:273). Across contexts, applications of labels for distress have powerful social implications.

Older women in our study discussed nerves as a normal response to common hardships, in contrast to more severe or disordered depression. Although a diagnosis of depression may require the person become recategorized as disordered or abnormal, the nerves model appears to allow an individual to describe a wide range of situations and distress within a framework of shared normal life experiences. Much as Mathews et al. (1994) found that women in her study thought of breast lumps as natural processes that come and go, older adults thought of nerves as naturally wearing down and recovering through time, and thus not requiring treatment. The structure of phrases participants used most often referred to nerves as a permanent part of the person, not a state that is entered. Respondents used metaphors that compared nerves to physical cords in the body that were directly acted upon by the environment. These narratives coincide with Tanya Luhrmann’s observation in her ethnography of psychiatric training that:

If something is in the body, an individual cannot be blamed; the body is always morally innocent. If something is in the mind, however, it can be controlled and mastered, and a person who fails to do so is morally at fault. [Luhrmann 2000:8]

In our study, when talking about depression treatment, older adults emphasized the individual’s obligation to “pull themselves up by their bootstraps,” get a more positive attitude, and think themselves better (Switzer et al. 2006). Although older adults’ model for the mind involved personal responsibility for regulating thoughts and mental health (Dahlberg 2008), participants seem to suggest that physical health (nerves included) was less directly subject to personal control.

It appears that through analogic reasoning, using metaphors that connect body with nature and inevitability, and mind with self, reasoning, and responsibility, participants have come to think of nerves as a natural process outside of human control. At the same time, there may be a

propensity to choose these metaphors because they best fit older adults' experiences of nerves; that is, an experience older adults may feel is best expressed as a wearing down of the body. Through analogy of nerves to physical strings, participants emphasized social and economic over individual causes of distress, and expressed how social circumstances become embodied. Our results support Setha Low's interpretation of nerves cross culturally as embodied metaphors; she suggests that "body metaphors provide a possible solution for the expression of lived experience that can communicate bodily sensation, as well as social, cultural and political meaning" (Low 1994:143), and that "the form and experience of *nerves* embodiment suggest that the bodily experiences are metaphors of self/society relations, with the body acting as the mediating symbolic device" (Low 1994:157).

Bridging Psychiatric and Anthropological Approaches to Nerves

Drawing on work from cognitive anthropology, critical medical anthropology, social epidemiology, and phenomenology, we propose that a focus on cultural processes in relation to structural variables and physical experience, offers a way to bridge psychiatry with anthropological approaches to cultural models of distress. Because we had not planned to study nerves our results here are suggestive although not conclusive. Still we have supplemented our data with previous work, and suggest that future studies could combine epidemiological and ethnographic methods to explore how cultural models such as nerves are socially distributed and employed in relation to structural level variables raised by participants, and how participants feel cultural models fit with their experiences.

A general patterning of minority and low socioeconomic status with use of the term *nerves* and higher psychological scores indicative of distress has been observed by researchers studying a variety of cultural models for *nerves*, *nervios*, and *nervi* in many populations (Barlett and Low 1980; Davis 1984, 1989; Davis and Guarnaccia 1989; de Snyder et al. 2000; Dunk 1989; Finkler 1989; Foss 2002; Guarnaccia et al. 2005; Guarnaccia and Rogler 1999; Low 1985; Traverso-Yepez and de Medeiros 2005; Van Schaik 1989). In these studies, participants describe how social conflicts, worrying about friends and family, inequality, economic difficulties, and loss of loved ones become embodied. In Camino's survey of a black neighborhood in the American South, women were much more likely to report suffering from bad nerves and attributed this as owing to a greater amount of worry in women's lives:

Men get by in life so easy, honey—they just don't seem to worry that much about life. They don't have to look after as many people. They just go about their life, always having some woman doing for them—cooking, cleaning, fussing about them.
[Camino 1989:301]

Researchers have suggested various explanations for patterns of reported nerves. Barlett and Low suggested nerves in Costa Rica were linked to "social and economic realities of life," specifically including family problems, parenting stresses, sex role stress, economic problems, and general life stress (1980:553). Based on her research of nerves in rural and urban Mexico and the United States, Finkler argued that "nerves signifies the *embodiment* of generalized adversity and recreates in the internal world of the body the perceived contradictions and disorder of the external world" (1989:174; emphasis in original). Van Schaik similarly remarked that the true causes of nerves were "class and gender inequality and ... the lack of economic and social opportunities in the Appalachian context" (1989:25). Traverso-Yepez and Fernandez de Medeiros observed that women residing in a low income district in northeastern Brazil commonly reported suffering from nerves, and through a detailed case study suggested the suffering was related to social-structural limitations (2005). In other contexts, researchers have suggested that nerves indicate the embodiment of large scale violence and political oppression (Jenkins 1991; Scheper-Hughes 1992; Sluka 1989).

In our study in Baltimore, Maryland, the cultural model suggested by participants and the distribution of use of the term *nerves* also imply that there may be economic and social conditions experienced differentially by segments of the population that contribute to weakening of nerves. The language of nerves can be seen as a way to express these experiences. An alternative explanation is that the use of nerves as a cultural model is patterned along lines of culture transmission. These two possibilities could reflexively feed each other, suggesting a reciprocal model: models are picked up and remain in use so long as they fit shared experiences (Cayleff 1988; Strauss and Quinn 1997), and experiences in turn shape cultural models over time.

For anthropology, bridging positivist and constructivist approaches advances culture theory by suggesting ways to explore relationships between social distribution of cultural models and sociopolitical structure. For psychiatry, the proposed approach offers a preliminary framework incorporating cultural meaning and social context into explanatory models. Acknowledging multiple levels of influence on mental and physical health may help develop new methods of prevention and treatment, and improve doctor–patient communication by shifting clinicians from antagonism toward patient models to an incorporation of patient-derived etiology and meaning, thus increasing patient engagement in treatment (Sorensen et al. 2005; Wittink et al. 2008).

For both fields, a theoretical framework bridging psychiatric and anthropological approaches offers a more complete view of how cultural models for distress arise in relation to experience, and in turn shape experience. Future research should explore “conditions under which certain ideas are picked up and others not” (Ross 2004:66), whether models that “fit” life experiences from a person’s perspective hold greater convincing weight than those that run counter, what influence social context and consensus have on transmission of cultural models, and how cultural models shape individual experiences and health. The promise is development of theory that can evaluate coconstructive processes that constitute the biosocial-cultural dynamics of human health and distress.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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TABLE 1

Relationship between Mention of Nerves During Semistructured Interview and Personal Characteristics, Depression, Functioning, and Physician Rating

	Mentioned “nerves” (n = 27)	Did not mention “nerves” (n = 75)	p value
Sociodemographic characteristics			
Age in years, mean (<i>S.D.</i>)	80 (5.92)	78 (6.56)	.098
Women, n (%)	26 (96%)	49 (65%)	.002*
African-American, n (%)	20 (74%)	27 (36%)	.001*
Education less than high school, n (%)	17 (63%)	21 (28%)	.001*
Difficulty paying monthly bills, mean (<i>S.D.</i>)	2.44 (1.16)	1.63 (1.00)	.001*
Psychological measures			
Depression—CES-D, mean (<i>S.D.</i>)	19.81 (13.08)	12.35 (11.56)	.007*
Taking an anti-depressant, n (%)	12 (44%)	24 (32%)	.246
Anxiety—BAI, mean (<i>S.D.</i>)	9.78 (8.22)	8.61 (8.87)	.553
Functioning (SF-36)			
Physical functioning, mean (<i>S.D.</i>)	55.19 (30.27)	63.54 (29.30)	.211
Social functioning score, mean (<i>S.D.</i>)	68.98 (30.89)	70.33 (30.05)	.843
General health, mean (<i>S.D.</i>)	47.96 (19.87)	49.20 (19.59)	.780
Role emotional, mean (<i>S.D.</i>)	67.90 (46.67)	75.78 (39.07)	.396
Role physical, mean (<i>S.D.</i>)	44.44 (38.81)	45.33 (40.83)	.922
Body pain, mean (<i>S.D.</i>)	45.56 (25.62)	57.26 (22.38)	.028*
Physician ratings of patient			
Depressed, n (%)	13 (50%)	35 (47%)	.769
Anxious, n (%)	16 (64%)	41 (55%)	.452
Somatizing, n (%)	24 (92%)	45 (62%)	.003
Overall health rating, mean (<i>S.D.</i>)	2.35 (.69)	2.34 (.75)	.960

Note. Data from Spectrum I (2001–03).

*
 $p < .05$.

CES-D = Centers for Epidemiologic Studies Depression scale; BAI = Beck Anxiety Inventory; SF-36 = Medical Outcomes Study Short-Form 36.
S.D. = standard deviation.

TABLE 2

Frequency of the Different Nerves Phrases Used by Participants

Dimension	Discursive Feature	Number of mentions	Number of participants
(a) Acted upon/ acting on	Acted upon: "Nerves" as passive object/recipient of action (<i>"she gets on my nerves"; "that works on your nerves"; "that'd pluck my nerves"</i>)	40	21
	Acting on: There is a limit to nerves' resiliency, damaged nerves cause other problems, "acting on" other parts of the person (<i>"get on their nerves so bad so they get depressed with it"; "these men get on my nerves so until I couldn't sleep at night"</i>)	8	6
(b) Permanent part of self/ event or state	Permanent part of self: Possessive pronoun precedes "nerves" (<i>"my nerves"; "her nerves"; "their nerves"</i>)	57	25
	Event or state: Nerves as something that can be caused, occur, begin (<i>"goiter causes nerves"; "I started having nerve in the morning"; "my nerves started then"</i>))	5	2
TOTAL		69*	27*

Note. (a) Most phrases described how an outside person or event worked on a person's nerves, when these pressures accumulated past a threshold, they could lead to other problems; (b) Participants talked about nerves as a permanent part of their selves/bodies, more often than as a short-lived event or state.

* Phrases could have multiple features; there were 69 phrases with the word nerves in our transcripts. Some participants used the word *nerves* multiple times; 27 participants used it at least once.