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Palpable insecurity and Sen's comparative view of justice: anthropological considerations

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Amartya Sen's comparative approach to justice makes clear that notions of justice are shaped by human agency and experience, and both his focus on the 'internal view' of *well-being* that emphasizes suffering as a central feature of illness and his recognition that social and cultural factors shape perceived injustice are critical to this approach. However, Sen questionably depicts the contributions of anthropological research to this project as limited to 'the sensory dimension of ill-health.' Focusing on mental health in the context of global justice, I argue that Sen's treatise on justice can be refined through an ethnographic method that synchronizes attention to (1) cultural knowledge and social relations in ecological settings; (2) fundamental human needs; and (3) levels of analytic specificity involving situations, categories, and events. This method integrates analysis of internal phenomenology and external constraints of political economy and ideology. To demonstrate I discuss three cases involving students and violence in Rio de Janeiro, women and witchcraft in Ghana, and historical migration and war trauma among Vietnamese immigrants in which external conditions of insecurity and inequality contributed to deteriorating mental health conditions including depression, trauma, and debilitating anxiety.

Keywords: anthropology; justice; global health; gender; mental health; witchcraft

Introduction

> If the demands of justice have to give priority to the removal of manifest injustice […] rather than concentrating on the long-distance search for the perfectly just society, then the prevention and alleviation of disability cannot but be fairly central in the enterprise of advancing justice. (Sen 2009, p. 259)

In the landmark volume *The Idea of Justice* (2009), Amartya Sen advances the case for a comparative approach to justice that takes into

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account plural, competing senses of justice. His argument is a welcome departure from conventional thought in political philosophy classified by Sen as 'transcendental institutionalism.' In this tradition,[1] ideal arrangements are formulated by getting institutions 'right.' Such thought is remarkably non-cognizant of the multifaceted realities of actual societies. Sen's comparative approach makes clear that all notions of justice are shaped by culture, history, human agency and experience.

Sen (2009) asks us to think in terms of two basic oppositions. The first is that between well-being and agency, which we can gloss as modes of political subjectivity corresponding to the relationship in existential terms between being and becoming. The second is that between freedom and achievement, or the circumstance in which one can act without undue constraint and the process by mastery of which one has the capability of attaining goals.[2] In this paper, I examine the domain of *well-being* that holds such a prominent place for the development of Sen's theory of justice. An emphasis on well-being is critical for a globally comparative approach to justice. My argument is that Sen's treatise on justice can be refined through theoretical and methodological moves that synchronize attention to (1) cultural knowledge and social relations in ecological settings; (2) fundamental human needs;[3] and (3) levels of analytic specificity involving situations, categories, and events. I maintain that ethnographic method is conducive to this kind of analysis and that such an approach takes the idea of comparison a step forward in calibrating the conceptual scale of justice.

In Sen's formulation, the prominent place accorded to well-being aligns well with the recent turn toward global health in the social and medical sciences. Within the field of global health, I have been particularly concerned to draw attention to global mental health (Jenkins 2007, Jenkins and Del-Vecchio Good in press). Indeed, as recently declared in *The Lancet* (Prince *et al*. 2007), 'there is no health without mental health.' Prince and colleagues draw on data from the World Health Organization (WHO) for 2005 to reveal that for non-communicable diseases worldwide, mental disorders are associated with the highest degree of disability and economic 'burden of disease.'[4] In this light, insofar as justice and injustice have not customarily been conceived in relation to health and well-being,[5] it is worth recalling Sen's observation that to *address* problems we must first *recognize* them.[6]

Cultural orientations to knowledge and experience

I begin with some conceptual orientations and premises. First is that more than any other discipline within the social sciences and humanities, anthropology has been engaged in debates on what in human experience and social organization is universal and what is particular to specific societies. Such questions invariably entail comparison. Second, within anthropology

today the indivisibility of culture and knowledge is commonly accepted. Culture is defined not in terms of belief that is invariably at odds with knowledge, but in terms of that which is taken for granted and therefore invariably conditions knowledge, whether on the part of indigenous peoples or the scholars who study them. Third, the cultural and interpretive approach that I advance highlights an interlocking set of assumptions including (1) the primacy of lived experience and agency; (2) the centrality of local moral worlds; (3) the significance of social determinants of health and illness (gender, class, age, ethnicity); and (4) the reciprocal shaping of the subjective experience of individuals and the social relations and institutions of nation-states. Finally, ethnographic work recognizes that contemporary social forces are increasingly comprised through the dialectic of local and global courses of action. Globalization is not a one-way street whereby dissemination of ideas and institutions of North America and Europe flow unilaterally; the local comes to shape global ideologies and practices (Jenkins 2011).

In the realm of cultural orientations, Sen praises analysis of the 'internal view' that emphasizes suffering as a central feature of illness, as found in the work of anthropologists such as Arthur Kleinman (Kleinman 1988, 1995). Inexplicably, however, he also concludes that this anthropological perspective is thus limited to 'the sensory dimension of ill-health' (Sen 2009, p. 285). This is patently not the case in any form of medical anthropology with which I am familiar, and exhibits a narrow conception of both the sensory and of ill-health, since the sensory is the ground of social meaning and ill-health opens on to the broadest issues of social justice and inequality. In fact, anthropology's strength comes in large part from its insistence on an analytic stance precisely at the intersection of the internal and external views, or what is referred to in the discipline as emic and etic perspectives. Medical anthropology examines the physician's mode of knowledge and discourse as equally a part of the cultural system as are patient perception and experience, and goes on to articulate the relationship between them, often in terms of power, justice, and equality as well as health policy. In doing so it explicitly renders problematic the range of analytic levels extending from the nuance of phenomenological indeterminacy to the constraint of political economy and ideology, or what are referred to as micro and macro levels of analysis.

Fundamental human needs

To develop further Sen's interest in well-being as a matter of global justice, I think it useful to draw on empirical evidence to make a claim for the relevance of a concept of fundamental human needs. Among the fundamental needs that are well-established as significantly linked to psychological well-being are: (1) social support (Cohen and Wills 1985, Jenkins

and Karno 1992); (2) social safety and security (Desjarlais *et al*. 1996); (3) adequate resources for housing, food, water, healthcare, and subsistence (Gureje and Alem 2000, WHO 2001); (4) cultural meaning and interpretability (Kleinman 1988, Good 1994, Jenkins and Barrett 2004); and (5) integration of psychological functioning (Ryan 1995, Lehman *et al*. 2004).

Examples of the consequences for well-being when such needs remain unmet are plentiful. First, persons with mental disability who live in households and communities for which social and emotional support is lacking (specifically, characterized by criticism and hostility) remain more severely ill for longer periods than their counterparts living in more tolerant and sympathetic social environments (Jenkins and Karno 1992). Second, the social and emotional response to illness is mediated substantially by the cultural conception of the problem (Jenkins 1988). How people interpret and define problems (as illness, witchcraft, personality defect) can make a vital difference for who gets better and who remains ill (Jenkins and Karno 1992). Third, perhaps the single most robust predictor of health and illness worldwide is social isolation. Persons who are socially abandoned or isolated uniformly fare poorly on all indices of health, mental, and physical alike. Fourth, there really is no useful way to differentiate the effects of mental and physical well-being since as a matter of lived experience these are inextricably interrelated. Research with colleagues from the poorest state in Mexico – Chiapas – revealed that the best indicator of maternal mental health was the nutritional status of her children. Mothers of malnourished children often suffer both depression and anxiety (Collier *et al*. 2000). Fifth, people living under conditions of unrelenting violence, warfare, and dislocation suffer disproportionately from trauma and depression (Jenkins 1991, Desjarlais *et al*. 1996). Overall, conditions of what physician–anthropologist Paul Farmer (Farmer 2003) terms 'structural violence' produce disease and discomfort with disturbing regularity.

The social, cultural, or economic denial of fundamental needs, through a societal failure to recognize them as both legitimate and requisite, may adversely affect well-being to produce discomfort, illness, suffering, and death. This can occur under a variety of conditions such as cultural devaluation by gender, age, or social status; entrenched ideologies of suspicion and witchcraft; and violence experienced as daily routine or political violence and warfare. Judgment that needs remain unmet and of how unmet needs negatively affect well-being is a matter of perspective on what is 'unfair' or 'unjust' from the internal or external view; and within the internal view, it rests on the basis of social position and 'sense' of violation of an implicit or explicit social contract or moral economy, as well as on the basis of whether one is among the afflicted or not. In the instance of the afflicted, a perception that 'something is wrong' or that some violation has caused harm may be conscious or unconscious, culturally cognized or unrecognized. There may be a bodily consciousness that is mentally

unconscious. A culturally critical discourse may be present, inchoate, or absent; culturally reinforcing discourse may be circulated by the afflicted and non-afflicted alike. Among the non-afflicted, response (or non-response) may be mediated by care, self-interest, hostility, or indifference.

In traversing the conceptual terrain frequented by medical anthropology, Sen made a critical observation about such positional variations that form subjectivity in relation to perception of morbidity in different regions of India. In Kerala, where healthcare is well developed and education levels are high, and life expectancy is relatively long, rates of self-perceived morbidity are relatively considerably higher than in poor states like Bihar and Uttar Pradesh where the conditions are reversed. This 'objective illusion' of greater rates of illness is for Sen an artifact of greater attention focused on bodily or sensory experience in Kerala (Sen 2009, pp. 164–166). For Sen, both forms of perception are examples of an indigenous, emic, subjective, or what he calls an 'internal view,' and 'there is a conceptual contrast between the "internal" views of health based on the patient's own perception, and "external" views based on observations and examinations by trained doctors and pathologists' (pp. 284–285). It is important to point out that this association is reversed among Euro-Americans with variable access to healthcare for whom the self-appraisal of subjective well-being is significantly predictive of morbidity and mortality; that is, if one perceives oneself to be in poor health, there is significantly greater likelihood of disease or mortality (McGee *et al.* 1999).

Situations, categories, events

In this section, I provide three brief ethnographic examples of challenges to well-being in terms of generalized anxiety, major depression, and psychic trauma. For my purposes, these examples also serve as comparative material for an analysis of well-being and human need across varying levels of specificity. Rather than defining these levels in terms of institutions, nation-states, and international relations, however, my contribution as situated from an anthropological standpoint is to identify levels in terms of generalized social situation, specific social category, and discrete historical event. First, to illustrate a situation of generalized insecurity that affects the well-being of the entire populace I provide an example from everyday street life in Rio de Janeiro, Brazil. Second, focusing on a specific social category, I consider a vulnerable group of middle age and elder women in a rural Ghana. Third, I consider the unique circumstances of an historical event in the case of a Vietnamese man who migrated from his home country following civil war.

My goal in the ethnographic examination of these instances of what I have termed 'palpable insecurity' (Jenkins 1991) is to point toward a strategy for bridging the internal and external approaches, as well as phenomenological and political levels of analysis.

Situations: palpable insecurity and everybody violence in Brazil

Nothing could be more stark than the contrast between a tenuous existence on the threshold of violence experienced by inhabitants of poverty-ridden and drug-infested Brazilian *favela*s portrayed in films such as *Orfeu* (1999) and *City of God* (2003) and the architectural artifice of security produced by the gated communities of Brazil's privileged classes described by Teresa Caldeira (Caldeira 2000). During my time in 2002 as a Visiting Professor at the Institute of Social Medicine in Rio de Janeiro, my family and I inhabited what I experienced as a spartan apartment at the site of a formerly renowned international luxury destination, Copacabana beach. Across six lanes of earsplitting continuous automobile traffic, the Atlantic beat inaudibly from the balcony. Daily I would travel almost an hour across the sprawling city to give lectures and to visit the psychiatric institute, returning in the evening to be with my husband – also a visiting professor at a different university in Rio – and our ten-year-old twins. It was in the context of this working routine in Rio, among Brazilian colleagues and family, that I began to get a sense of the contradictions of everyday lived experience in that setting.

> Copacabana is the nub of everything most refined and most violent about Rio de Janeiro. Within one square meter I have seen an elegantly dressed woman, a man in shorts going to the beach, a college student with a backpack, a homeless street urchin, and a little old lady. In ten years I've only been robbed once, coming out of the automatic teller machine.

These are approximately the words of an anthropology graduate student at a lunch following a lecture at the university, when the violence of everyday life became an explicit topic – the skirting of and flirting with that topic is the topic of observations for this section, which are a reflection on habitus and perception, as well as on adaptation and denial, in the face of danger and the necessity of surviving in its presence. My point in quoting the graduate student is not so much to emphasize the marvelous diversity of the renowned beach neighborhood of Rio, but to probe the cultural issue of what needs to be taken for granted in order to be able to report it as good news that one has only been robbed once in ten years.

This was the winter of the World Cup during which Brazil took the international championship and Rio urbanites (or *Cariocas* as they would prefer), well known for a love of public life to include street dancing, drumming, dining, and *capoeira*,[7] were in full swing. Yet palpable insecurity shot through the social fabric of everyday life in the face of crime and indignities, petty and otherwise. The triumphant bus tour of the victorious Brazilian soccer team, anticipated on Avenida Âtlantica for many, many hours by the public, turned from pride and pleasure to anger and violence when it at last became clear that the athlete's tour was abruptly canceled

and the unending hours of waiting were, in Copacabana, to no avail. The bus was attacked, windows smashed, insults hurled.

Just to the south, in upscale Ipanema, a small assembly of mostly middle-class residents gathered on Sundays to protest the brutal torture and assassination of Tim Lopes, a journalist who got too close for comfort to local drug lords. This public acknowledgement of the violence was more the exception than the rule, however. More typically, structural violence of all kinds was silenced and patently not to be acknowledged. No elaboration was required – indeed none was necessary to know that one does not go to the beach during the day to relax, even if mostly uninhabited. Particularly when relatively uninhabited. This was a particularly hard sell for our soccer-enthusiast ten year olds to abide. A saleswoman promoting free tours of a jewelry factory said, 'On the form you only need to write your passport number, you don't have to take your passport because, you know. Then the car will take you directly there.' What is it exactly that 'you know' but needs not be said, except that street criminals like to steal passports. Dengue fever, returning at regular intervals, was largely in abeyance at the time, although quiet washing of house plants was also a concern among the middle class, lest accusations by neighbors be whispered about the breeding of mosquitoes for the inevitable next round, as a perverse sort of domestic witchcraft. All the while, these same middle-class mothers brace themselves for what they consider the preordained car-jacking and only hope that their child is not in the car with them when it occurs. Yet another graduate student, just about to leave for dissertation fieldwork, frantically finds the need to make other plans in the wake of the kidnapping of his elderly mother, taken off the main commercial boulevard (Nossa Senhora de Copacabana) at gunpoint to withdraw all bank assets and hand them over to her captors. Still others, having been robbed, negotiate with thieves over the return of their stolen personal identification cards and cell phones.

Finally, my routine visit to the children's residential unit at the Psychiatric Institute finds 16-year-old Sergio vacant, deserted. Following his return to the hospital after a day trip to identify one of his friends who had recently been released upon his 18th birthday, he was able to make the identification on the basis of his friend's tennis shoes. That is all that was left after he was set alight with a ring of tires following his decision to keep rather than transport the cash given him by the drug dealers who gave him a livelihood where there otherwise was none after his hospital release. Now, back at the hospital, the highly dedicated child psychiatrist who runs the unit tells me simply: Sergio is 'gone.'

But perhaps the most stunning show of power in Rio occurred over the control of civic space (about a month after we returned) when incarcerated and infamous drug lord Fernadinho Beira Mar ('Seaside Freddy') orchestrated the door-to-door demand for a shut down of the city by closing, with few exceptions, all the commercial shops. While police made vigorous

efforts to reassure proprietors that they would secure their shops on the following appointed day of the shut down, few were convinced enough to open their doors. As intended, this shut down sent a wave of shock and terror among *Cariocas* throughout the city. Still, because certain sections of the city were not shut down due to their locale-specific 'control' by different *favela* commandos, one resident told me that:

> Fernadinho Beira Mar is making it so we won't be able to avoid a kind of war against this armed mafia. But in our neighborhood where I live it will never get so bad that we won't be able to get our *pao francesca* (French bread) fresh daily.

Thus despite this ensemble of everyday life violence and inconvenience, *Cariocas* pride themselves on the history, cultures, and spectacular geography of their city. In this city, identity prestige is marked by unbroken generational lines of residence that, for many, is the only city in which they could ever envision living. With such compelling beauty and history, who could possibly leave? How can such a question even be posed? While for differing reasons, the question of how such a question could even be posed resonates among middle-, upper- and working-class *Cariocas* alike. This is the case in Chico Buarque's (Buarque 1992) novel *Turbulence*, the story of a drop-out from Rio's privileged world of luxury beach apartments. The book is a surreal tour of the world he inhabits – by chance or choice is not clear – of what, for him, is the 'other' Brazil of desolate poverty and petty crime. In a world of dangerous insecurity, the narrator adopts a protective stance that 'immobility is his best disguise' (Buarque 1997, p. 4). This sort of frozen stance is likewise present, ironically, in Patricia Melos' (1998) *Inferno* in which she provides a window on children and drug trafficking within *favelas* to illustrate the fierce whirlwind of socialization into the ruthless hierarchy among dealers that is as inevitable to survival as it is inexorable. Throughout, the powerlessness or complicity of police and other governmental officials is rampant. Overall, the pervasiveness of crime is the organizing social force that dominates these accounts, as elsewhere in Brazil. In her book *City of Walls: Crime, Segregation, and Citizenship in São Paulo* (2000), Teresa Caldeira has written a broad-ranging and incisive account of crime as a disorganizing experience and an organizing symbol. In an ethnography of the pervasive violence within Rio, Goldstein (2003) provides an incisive account of the impress of extremity among the poorest of inhabitants in a Rio *favela*.

Thus, it came as no surprise to me when upon my return from Brazil I consulted my copy of the recent WHO's (2001, p. 24) report on global mental health to see that in a 15-country study of the prevalence of major psychiatric disorders in primary healthcare settings (Table 1) that Rio de Janeiro ranked highest of all (23%) for generalized anxiety disorders.

Table 1. Prevalence of major psychiatric disorders in primary healthcare (WHO 2001).

Cities	Generalized anxiety (%)
Ankara, Turkey	0.9
Shanghai, China	1.9
Seattle, WA, USA	2.1
Ibadan, Nigeria	2.9
Verona, Italy	3.7
Nagasaki, Japan	5.0
Groningen, Netherlands	6.4
Manchester, UK	7.1
Mainz, Germany	7.9
Bangalore, India	8.5
Berlin, Germany	9.0
Paris, France	11.9
Athens, Greece	14.9
Santiago, Chile	18.7
Rio de Janeiro, Brazil	22.6

The generalized atmosphere of insecurity as indexed in this case by problems with severe anxiety was, after all and with methodological issues notwithstanding, palpable on the streets as a social fact of everyday life. And, after all, had not Brazil only recently (in 1985) moved from a dictatorship with its first civilian president in 21 years? Even after the election of Workers' Party candidate, President Luís Inácio 'Lula' da Silva, issues surrounding security loomed as large as in the past. Moreover, it seemed to make sense that the second highest ranking for anxiety would befall Brazil's neighbor, Chile, when General Augusto Pinochet staged a bloody US-supported coup that led to the deaths of 3000 people.

Categories: vulnerable women in Ghana

I turn now to a groundbreaking ethnography published in 1960 by anthropologist–psychiatrist M. J. Field, *Search for Security: An Ethno-Psychiatric Study of Rural Ghana*. This ethnographic field study in a rural Akan area revealed depression to be common among both men and women; however, among women, depression was found to be quite frequent.[8] When the study was published, the findings and detailed case studies generated considerable consternation from the external view since mental illness among Africans was considered to be rare or nonexistent compared with Europeans (Kennedy 1973). Africans were thought not to have the human capacity to experience depression. British psychiatrist J. R. Carothers (Carothers 1951), author of an influential report released by the World Health Organization (Carothers 1953), reported his observation of the 'striking

resemblance between African thinking and that of leucotomized[9] Europeans' (Carothers 1951, p. 12) and that 'if the African seldom uses this cortex as the evidence indicates, then one would not expect depression, at least in classical forms, to be common in the African' (p. 42). Dr. Field's book, based on her training in both anthropology and psychiatry, called into question the prevailing ideologies of modernity, coloniality, and racism. It was marginally scandalous to some that supposedly 'simple' pre-modern people actually suffer from 'sophisticated' civilized ailments such as depression, and even more so that a signature sign of depression – *guilt* – long thought to be reserved for Europeans as a necessary ingredient of moral development– was clinically observed by Field as extremely common. These findings clearly constituted a major challenge to existing medical knowledge.

The empirical challenge to the cultural knowledge of biomedicine went further, however, in Field's analysis of the internal view based on local knowledge, for among the Akan, the distress that Field identified as 'depression' was not regarded as mental illness. The problem that Field identified as depression is well known as primarily a problem of witchcraft for which 'nearly all such patients come to the [healing] shrines with spontaneous self-accusations of witchcraft – that is, of having caused harm without concrete act or conscious will.' In this cultural setting, such an assertion is entirely rational such that the person 'is taken at her word when she says she has done harm' (Field 1960, p. 149). For middle-aged and elderly women in rural Ghana, Field finds depression with agitation to be 'one of the commonest and most clearly defined of mental illnesses.' The majority of these women are described as 'conscientious women of good personality who have worked hard and launched a fleet of well-brought-up children. Many paid for their children's schooling with money earned by diligent trading, market-gardening, or cocoa-farming' (p. 149). They describe themselves as having difficulty doing any work or sitting still, adding '(s)oon I knew that I was no good and had become a witch. I have done so much evil that I ought to be killed' (p. 150).

As common as these women's misery and self-accusations of witchcraft is their experience of the unbearable strain of:

> seeing their husband take on an extra and younger wife so that he may continue to beget children. Flighty young girls in their teens are particularly attractive to men who are past their own prime, and the man frequently lavishes on the young woman money and luxuries which are among the fruits of his older wife's years of labour. (Field 1960, p. 152)

Whether described as depression or self-accusations of witchcraft, that the well-being of these women is severely compromised is without doubt. In case materials collected by Field, it is clear that these women are existentially shaken and confused that the local cultural logic of reaping the

benefits of hard work, senior status, and high moral standing is faulty. They have done everything right. They have exerted their own agency skillfully in ways that should convert to happiness and contentment. Within this system of local cultural knowledge, however, there is little sympathy for such women. Indeed, it is readily assented that they *must* be witches deserving of misery and should be socially shunned. For the (typically non-literate) individual living under such conditions, how *could* they do anything to alter the structural violence of a situation that devalues women and their right to economic and psychological well-being? Such a right is undermined by the gendered inequality of social privilege and opportunity.[10] In Sen's terms, the social conditions for well-being as freedom from suffering and agency freedom to act on their own behalf are missing. In its place is an embodied 'palpable insecurity' that women suffer as a collective consequence when a notion of individual agency can be understood either as thwarted or as some kind of conceptually distant *naïveté*.

To bring the problem of how witchcraft in Ghana affects the health and well-being of women into a more contemporary focus, we might imagine that the problem of well-being and modernity has improved. If so, we would be quite wrong. On the contrary, not only has the problem not improved but worsened dramatically since Adinkrah (2004) writes that older women suspected of witchcraft are not infrequently assaulted. At least some of these assaults are classified as witchcraft-related femicides. Adinkrah writes that '(p)atriarchal attitudes, misogynistic beliefs, and ageist values mediate witch beliefs in Akan society. It is believed that most witches are female [… as the] weaker sex and more susceptible' to becoming witches (p. 335). Not all women are equally likely to be accused of witchcraft, however. Those of lower socioeconomic status or poor, indigent, elderly, or with little formal education are particularly suspect. Those suspected are 'threatened, drugged, beaten, forced to submit to humiliating ordeals, or coerced into confessing to imaginary witch activities' (p. 337). In certain cases, the accused are abandoned by their families and communities with threats of violence should they return. The camps are abject sites for the containment of witches (predominantly women) and the mentally ill (van Dijk 1997, Palmer 2010).

When what is culturally common sense is a cultural logic which reasons that when bad, misery-making things happen, we need look no further for the source of such misery than to the errant individual – an obvious witch in the Akan case – it seems culturally apparent that, to some significant degree, these women's un-well-being is of their own making, their own inadequacy, their own failure to adapt to their circumstances. The Akan case shines a glaring light on the indivisible intersection of witchcraft and mental illness as a site of social danger for women not only as a matter of well-being but also life and death.

What physician–anthropologist Paul Farmer has termed 'pathologies of power' are social and political determinants of well-being and agency worldwide. Such precarious circumstances shape lifeworlds, but not to similar disadvantage since there is an unequal ratio of depression since women are twice as likely to be afflicted worldwide (Jenkins *et al.* 1991). To a significant degree, these differences are socially produced (Nolen-Hoeksema 1990). In their classic epidemiological work on the social origins of depression among working class women in southeast London by Brown and Harris (1978) were able to predict who would be depressed on the basis of concurrent factors: poverty/unemployment, loss of mother before the age of 11, lack of current social support, and the presence of three or more school-age children. The cases of Akan and London women raise the question of whether lack of well-being (as in the condition of depression) is better understood not as an individual condition but rather an inevitable social condition that stems from the injustice of structural violence. The upshot is that when gendered and economic inequalities are construed as culturally commonsensical, the question arises as to how we can consider these as *anything other* than injustices insofar as they are violations of human dignities – as moral matters that define what *really* matters (Kleinman 2006).

Events: historical migration and war trauma

My third case example of the production of palpable insecurity draws on data from a community study of refugees from Vietnam settled during the 1990s in the state of New Mexico.[11] This is an insecurity produced as part of an attempt to adapt to a radically new environment after having been torn from familiar surroundings as a result of warfare, dislocation, and being forced into the identity of refugee. This type of insecurity, then, is bred not by frozen immobility in the face of violence but rather by a forced mobility – that is itself a kind of violence – in the aftermath of war.[12]

After the reunification of the Democratic Republic of Vietnam (north) and the former Republic of Vietnam (south) in 1975, hundreds of thousands of prior military and governmental South Vietnamese officials were the target of the new government's crusade of reprisal through methodical detention, forced labor, and torture within now notorious socialist 're-education' camps. Although it is not known how many died (through malnourishment, toil, torture, or suicide), several thousand prisoners of these camps survived and were eventually allowed to go back to their communities. Following their discharge from a penal complex, many struggled for long periods of time to save or secure loans to pay the approximately US $150 required to process their petition to migrate to the United States.[13]

I draw from a case of an elder Vietnamese man, Mr. H., whose experience bears similarities to a certain segment of politically active and

militarily involved men who bore the brunt of reprisals following the defeat of the South. He held a relatively prominent position within the South Vietnamese military forces prior to their detention in a re-education camp in 1975.[14] Born in Nihn Thuan province in 1936, Mr. H. was raised in a Catholic village known for anti-Communist sentiment. In 1954, he became a member of the secret police to track Viet Cong activities, working in diverse locales. Mr. H narrated a particular sense of insecurity that derived from what he experienced as his enemy's inhumanity.

> Anybody with religion, it didn't matter whether they were Catholic or Buddhist, they would kill them and they didn't believe in religion […] they were very cruel. If others did not follow them or believe them, they would be willing to kill them. They would often kill people by burying them alive, by cutting their necks, and other horrible means. It's really kind of simple: the communists were very much against human nature. We learned to forgive many people and many things that happened, but not the communists because they were so much against human beings and human nature.

The matter of sorting out who was and was not the enemy was complicated, however, producing considerable anxiety about who to trust even among the most long-term of friends and allies. Mr. H reported that not only was he angry at the time at what transpired among the former leadership. He made it clear that his well-being had been severely compromised by the pain of what he felt (American assistance/interference notwithstanding) to be essentially as a Vietnamese problem and a Vietnamese betrayal. Being forced to send his family away for their safety, he also claimed he found that he only wanted to be alone since he had become 'very mentally isolated,' with nightmares, anger, anxiety, headaches, poor concentration, and near anorexia.

He was captured in battle and imprisoned on March 1975 for what he was told would be a period of seven weeks for 're-education.' This time stretched on for years until 1983, during which time he did hard and mostly useless labor. For a year and a half he had severe back pain and was eventually provided medical care for a herniated disc. Following surgery, he was returned to the camp but was released when it was clear that he was entirely unable to carry out hard labor. After returning home to his wife, they found themselves under continuous observation by the authorities. Further, he continued to have problems stemming from the long period of medical inattention to his back injury: chronic bowel and urination problems, erectile dysfunction, and constant pain. Nevertheless, he cultivated rice and worked on road construction. It took ten long years to save US$150 to pay the necessary fees to emigrate to the United States.

Throughout narration of his personal history, he noted that his health had improved since coming to the United States and receiving medical treatment. However, he cannot stop thinking daily about Viet Nam. To try

to forestall anxiety, he said that he tried to think of happy things, although while saying this his mind wandered to another time to recollect that 'I have no doubt in my mind that I would have killed myself [in prison] if I were not a Catholic.' At this point in the interview, his sadness overtook him when he recalled the many who actually did commit suicide in prison.

Living 'safely' now, he is free from surveillance, torture, and hunger. Yet the deep traumatic wounds to his body and psyche have produced a violent rupture in his life course. His relief in having fled his country is mitigated by the fear that he will die alone without relatives to surround him. His life is composed of personal and collective trauma that continue to curtail the possibility for agency and well-being.

Conclusion

There is a curious lack of parallelism in bringing the concept of security into dialogue with the reasonable or pragmatic justice of Professor Sen. That is, while security cannot be equated with justice except in the logic of autocracy or authoritarianism, insecurity can be equated with injustice insofar as both are an insult to human dignity. The manner in which insecurity is palpable in the internal view is directly related to the manner in which insecurity is produced by injustice in the external view. Justice and injustice are not the ends of an abstract ideal continuum, but have concrete and perceptible consequences for people's life possibilities, and these consequences are neither arbitrary nor unspecifiable.

Elaboration of these issues contributes to what Kleinman (2007) has called the anthropology of social danger. Although the urgency of an appeal is evident in the pervasive structural violences of everyday lived experience across an array of human conditions (Desjarlais *et al*. 1995), the precise ways to define and to probe the diverse forms of social danger requires systematic ethnographic explication of social suffering and what I have termed palpable insecurity. What makes suffering and insecurity dangerous? I would say that it is the suffering created by vulnerability, and further that this must be taken in a sense quite different than the notions of 'risk and vulnerability' as they are used in the discourse of public health – precisely because it is a phenomenological notion, having to do with the fragility of experience. Any perduring social condition that acts upon that fragility to produce mental conditions such as depression, trauma, or debilitating anxiety is harmful and in my view understood as structural violence.

In the task of developing an anthropology of well-being and insecurity we are required to trace the variable routes of violence imprinted by nation-states and forces of globalization but also as conditions in local settings. Everyday conditions of violence, warfare, and witchcraft create cultural orientations of insecurity that, as a matter of lived experience, are

ominous, and go variously named and frequently unnamed as eeriness, foreboding, and insecurity. Broadly speaking, we are pressed to understand these effects – particularly in post-colonial settings – as a matter of global public health and human rights. Though pathbreaking work has already provided compelling arguments for the state production of dysphoric affect, mental disorder, and social suffering (Good and Good 1988, Kleinman 1988, Scheper-Hughes 1992, Jenkins and Barrett 2004, Farmer 2005), the human and medical sciences have yet to flesh out fully the particular psycho-political dimensions of such experience as the occasion for bodily and psychic marring, on the one hand, and remarkable resilience and resistance, on the other (Jenkins 1991, 1998). We are concerned with extending contemporary thinking on these dimensions of lived experience as reciprocally productive of anxiety and insecurity within the nation-state and body-self. In anthropology, understanding the direct parallels between a post-colonial regime and the body-self productively shifts the discourse from the political and economic impacts of postcolonial transformations to the experiential impact of these developments. As a matter of global justice, we would then seek what Sen has invoked, the art of the possible: what I could conceive as a cultural imaginary that recognizes violations of human dignities through social abandonment or erasure as real social danger to the well-being of persons in real worlds – worlds that matter – as we seek to situate the heart of the matter of justice, local and global.

Notes

1. This line of thinking has been characterized as 'the view from nowhere' as noted by Jasanoff (2005).
2. We can then understand well-being freedom as freedom from suffering and agency freedom as freedom to act; well-being achievement would be the domain of health promotion and illness prevention, while agency achievement would be the circumstance in which one is actively engaged in the realization of goals.
3. For my purposes here, discussion is focused on 'need-based' requirements for theories of justice in contrast to 'rights-based' discourse that is not the purpose of the present paper.
4. Mental disorders account for the highest rate of global burden of disease (28%) compared with any other type of non-communicable disease such as cancer (11%), organ impairment (10%), or respiratory disease (8%) (e.g. Prince *et al.* 2007, p. 3, reporting 2005 data from the WHO, with permission). When considering all forms of disease, the Harvard School of Public Health, the WHO, and The World Bank rank major depressive illness as the second leading cause of disease burden worldwide as projected for 2020 (Murray and Lopez 1996).
5. A notable exception is the work of Gerry Mackie (Mackie 2000).
6. The lecture, entitled 'Justice: Local and Global,' was delivered by Amartya Sen on March 31, 2011 as the Helen Edison Lecture for the inauguration of a conference on 'New Frontiers in Global Justice,' organized by Fonna

Forman-Barzilai and Gerry Mackie at the University of California – San Diego. I thank the organizers of this conference for their invitation also to present a lecture. This paper is a longer version of the lecture I gave for the conference session on 'Local Knowledge and a Comparison View of Justice' on April 1, 2011.

7. *Capoeira* is a popular Afro-Brazilian martial arts street dance and game.
8. For a cross-cultural overview of depression, see Jenkins *et al.* (1991).
9. May also be referred to as 'lobotomized.'
10. See also Sen's (2005) discussion of gender inequality and well-being.
11. Michael Hollifield, MD, was Principal Investigator for this National Institute of Mental Health-sponsored study entitled 'The New Mexico Refugee Project' (Hollifield *et al*. 2005). The ethnographic case materials for the present essay are drawn from this larger study. I worked as a community ethnographer for the study, working with local Vietnamese and Kurdish populations in their neighborhoods and in clinic settings.
12. A fuller account of this ethnographic case has been provided elsewhere by Jenkins and Hollifield (2008).
13. The process of relocation involved not only sometimes perilous journeys, but also the uncertainty of knowing precisely where one was to be relocated, with variations contingent on which of three main waves of exodus (flight with Americans in 1975; escape during 1975–1989; or the joint US–Vietnamese governmental program of 'Orderly Departure' beginning in 1989).
14. Thus, this narrative is gender-specific insofar as the particular terms of analysis may hold relevance for men whose political commitment to their version of the nation-state was forged in opposition to the anti-religious, communist north.

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