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Conceptualizing violence for health and medical geography

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ABSTRACT

Despite the fact that violence is a major threat to public health, the term itself is rarely considered as a phenomenon unto itself, and rarely figures explicitly in work by health and medical geographers. In response, I propose a definitionally and conceptually more robust approach to violence using a tripartite frame (interpersonal violence, structural violence, mass intentional violence) and suggest critical interventions through which to apply this more explicit and conceptually more robust approach: violence and embodiment via substance abuse in health geography, and structural violence via mental illness in medical geography.

Violence is a major cause of death and injury in society – Reza et al. (2001) estimated that in 1990, close to 4% of all global deaths were from preventable violence (homicide, suicide, and war), and violence recently ranked "among the top twenty causes of worldwide loss of disability-adjusted living years" (Wolf et al., 2014, p.220). But for a phenomenon so pervasively threatening to people's well-being, it remains marked by conceptual lassitude; the fields of health and medical geography have not escaped this lethargy (but see Loyd, 2009; Tyner, 2009; Vine et al., 2010). A systematic appraisal of appropriate literature (designated as the top twenty most impactful journals in 2012 for the ISI Web of Knowledge category 'Public, Environmental and Occupational Health') revealed that health geography –defined as focusing on place and well-being, and a socio-ecological rather than biomedical model of health - has rarely engaged with concepts of violence. Only five articles in *Health and Place*, arguably the showcase journal for health geography, had 'violence' as a keyword. Conversely, medical geography, with its biomedical model and its focus on disease ecology, spatial analysis of communicable diseases, and health care provision (Mayer, 2010), has treated violence more as a localized hazard while "blind to [wider] social structure and cultural meanings" (Wacquant, 2004, p.322). In *Social Science and Medicine*, arguably the most important journal in medical geography, a search of the 100 most relevant articles using the term 'violence' revealed that 71% of the articles focused on everyday and domestic violence between individuals, and only 14% on political violence and war. Even when health and medical geography approaches are combined, as in the *Companion to Health and Medical Geography* (2010) or the *Annals* special issue on health (2012), scant attention was paid to violence. But in the cases when violence is fully considered – and there are such cases, including as domestic violence - approaches remain balkanized and lack broad and critical conceptualizations of violence in its own right. As such, the term has become taken-for-granted, with relatively little critical development overall.

To rectify, I aim to (1) provide some much-needed definitional and conceptual clarity to the term 'violence', i.e. to study violence in its own right, and (2) suggest critical interventions through which to apply a more explicit and conceptually more robust understanding of violence, seeking to raise the visibility of violence across both health and medical geography. The *first aim* presupposes that we still do not know enough about violence, or that we are using it imprecisely, or that it is insufficiently conceptualized and disconnected from wider currents and debates in the social sciences. In *On Violence* (1970, p.8), Arendt captured this curious combination of empirical importance and conceptual under-development, stating that "no one engaged in thought about history and politics can remain unaware of the enormous role violence has always played in human affairs, and it is at first glance rather surprising that violence has been singled out so seldom for special consideration".

A working definition of violence is thus in order, building upon and linking up previously far-flung works while simultaneously emphasizing its spatiality:

1) Violence is harmful, conceived as: "… individual, group, or institutional actions, or a consequence of the dominant social relations, that inhibits self-development and self-expression of

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individuals or communities" (Fleming, 2012, p.486). But harm can be more than physical or instrumental; it must include the emotional and social (Scheper-Hughes and Bourgois, 2004);
2) Violence must be linked to social and collective structures, contingently and contextually, not inherent or universal to the human condition but historically and spatially cross-cutting, a phenomenon in its own right (Thrift, 2007);
3) Violence is a process, and despite appearances it cannot be captured in a singular event (Lawrence and Karim, 2007) – this enables us to see violence as both acute eruption but as something more chronic and structural;
4) The agents of violence are many – collective, state-sponsored or individual; and crucially,
5) Violence has a geography to it, and that space and place have both a passive (i.e. violence inscribes upon it, as an unequal expression of violence) and active role to play (i.e. space and place animate, transfer and consolidate acts of violence) (Blomley, 2003; Garmany, 2011).

While useful, definitional clarity is but a first step given the sprawling nature of violence. Further conceptual framing is necessary to enter into a conversation with concepts from the silos of medical anthropology, history, political science, psychology and psychiatry, and theology. I propose three frameworks: violence as interpersonal, structural and mass intentional. While they do not provide an exhaustive coverage of violence, they do provide conceptual direction and precision to frame violence in both health and medical geography.

The *second aim* involves suggesting critical interventions through which to apply these more robust understandings of violence derived through the first aim. The second aim places violence squarely on the medical and health geography agenda, much as Vine et al. (2010) proposed to put domestic violence on the public health agenda, or Loyd (2009) with her entwining of health and violence. Upon a conceptual framing of violence across the three abovementioned divisions, I suggest two critical interventions that emphasize (1) violence and embodiment through a case study for health geography in terms of substance abuse; (2) structural violence via a case study of mental health within medical geography. I conclude with the 'value added' of considering violence in its own right.

1. Framing violence: interpersonal, structural and mass intentional

Interpersonal violence is the most visible and obvious violence: direct and on the body, with an identifiable author and victim. It is gratuitous and usually interpreted as an everyday, individualized hazard. Structural violence is more abstract and indirect, always in the service of wider societal goals and experienced collectively, and acts as a vehicle to implicate the state's crucial role in health promotion or denial. Mass intentional violence is typically war or genocide, which implicates collective violence, state ideology and a monopoly of the means of violence within the hands of the state.

When dealing with these types of violence, it is first imperative to recognize that certain populations are more exposed than others. This necessarily involves understanding the concept of "surplus populations" (Tyner, 2013). An unfortunate but useful term, surplus populations include those "… .populations … legally [and economically] relegated to the realm of surplus and thus rendered expendable" (Tyner, 2013, p.708). Li (2010) and Evans (2011) understood surplus populations as being especially vulnerable to violence, a condition predicated on the notion of "bare life", abandoned by the state and outside of the legal structure, excluded from society and reliant on the goodwill of strangers (Agamben, 1998). Second, while the agents of violence are many, the degree and nature of state intervention proves especially crucial in distinguishing among the three frameworks: the state's intent and involvement in violence, its calculations around life and death, and ideas about 'making live' and 'letting die' all differ significantly. For interpersonal violence the state usually assumes a pacifying role, guarding against the excesses associated with wantonness. For structural violence, the state's role becomes rather more ambiguous, frequently neglecting (surplus) populations but also occasionally supporting them, and sometimes simultaneously as in the case of the homeless which will be revisited in the next section (DeVerteuil et al., 2009). For mass intentional violence, Arendt (2007) noted that totalitarianism was violence personified – "it is not an alternative to the violence of the state of nature, but is itself a violent entity, so that it actually becomes that kind of a state which is itself the Hobbesian state of nature, of lawlessness and war. This kind of state is centered on sites of violence [e.g. the concentration and extermination camp]" (in Lawrence and Karim, 2007, p.394). The state's role in violence will be knit throughout the remainder of the paper.

1.1. Interpersonal violence

In the popular imagination, violence is usually (and self-evidently) held at the individual level (Fleming, 2012). It is subjective, visible, interpersonal, and usually interpreted as an everyday hazard, deviant; for example, a leading cause of death among young people (e.g. Garmany, 2011; Soares et al., 1998), and domestic violence (e.g. Vine et al., 2010). This sort of violence need not sustain any particular set of social relations, and is seen as exceptional when set against a neutral backdrop of "no-violence" (Zizek, 2008, p.1). Keane (1996, p.6) adopted an interpersonal and direct understanding of violence in his definition: violence "as any uninvited but intentional or half-intentional act of physically violating the body of a person who previously had lived 'in peace'". This focus upon specific bodies means that violence is necessarily embodied, "… as a lived experience [and] by its very nature, experienced through the body" (Wilton and Evans, 2009, p.205). Embodiment may be defined as the "… constituent aspects of the body, including identity, power and the materiality of the body itself … [bodies are] simultaneously part of material forms, their social constructions and the materialization of their constitutive interaction" (Moss and Dyck, 2003, p.58). Embodiment focuses attention on corporeal spaces; yet ironically, the concept remains marginal in both health and medical geography. Embodiment is inspired by Sibley's (1995) pioneering work on difference, bodies and spatial exclusion, as well as Moss and Dyck (1996), who used qualitative methods to investigate the micro-geographies and embodied nature of disability and chronic illness at both the workplace and home, thereby combining the material conditions of the body with the discourse, identity and representations of it, of how bodies are sites of both oppression and resistance. If we take this concept seriously, then all interpersonal violence is necessarily embodied – that is, bodies absorb and inflict (and sometimes self-inflict) physical violence, and this embodiment is necessarily geographical.

Much of this work framed by an interpersonal definition of violence is heavily empirical and policy-oriented, and aims, sometimes quite explicitly, in making violence visible so as to put it on the public health agenda (Vine et al., 2010). An early example was Reza et al. (2001) article in *Injury Prevention*, entitled 'Epidemiology of violent deaths in the world'. This data-driven and policy-oriented article clearly falls within a public health approach to (individual and collective) violence, presenting violence as a health problem of global proportions. The authors defined violence

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