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Troubling stoicism: Sociocultural influences and applications to health and illness behaviour

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Abstract

In light of the ambiguity of meanings attributed to the concept of stoicism we critically explore its use as a label to explain and describe health and illness behaviour, juxtaposing the often negative portrayals of contemporary stoicism against its classical and philosophical origins. By reflecting critically on the term ‘stoicism’, its application and dimensionality, we show how the term has evolved from classical to contemporary times in relation to changing context, and explore different understandings of the term across medical and health literature. We attend to sociocultural factors that are seen to influence the conceptualization of stoicism such as generational influences, gender and geographies. We make the assertion that by applying the label of ‘stoicism’ as it is known today, there is a danger of too readily accepting a term that masks particular health behaviours while missing an array of sociological factors that are important to how people deal with adversity arising from chronic health problems. We therefore encourage further questioning of this term.

Keywords

ageing and life course, chronic pain, health, illness behaviour, sociocultural influences, stoicism

Introduction

The word ‘stoicism’ is common in lay and academic parlance. In health literature it is used to describe illness behaviour characterized by silent endurance and lack of emotion – often

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described as a 'stiff upper lip'. The conceptualization of stoicism has been largely overlooked in the sociology of health and illness, receiving most attention from behavioural psychology researchers. Murray et al. (2008) and Pinnock et al. (1998) note this to be an oversight, particularly in relation to its potential explanatory power in health, for example, having a stoic attitude has been reported as one way in which older people cope with the effects of chronic pain (Cairncross et al., 2007; Helme and Gibson, 1999). Such stoic attitudes are seemingly defined by a reluctance to label symptoms as painful to others and are commonly related to under-reporting of mild or weak pain. However, Helme and Gibson (1999) suggest there is little to substantiate this view and assert that it is difficult to estimate the extent to which stoicism, and other factors such as cautiousness and misattribution may influence pain reporting in older people. The literature on how older people cope with chronic pain provides relevant material for analysing the meaning and use of the term stoicism and will be drawn upon extensively in this article.

In studies of pain perception, Helme and Gibson (1999) suggest that stoicism is more prevalent at lower intensities of pain, resulting in the under-reporting of weak or mild pain but less likely to affect reporting of moderate to severe pain. This implies that whatever it is that the authors call stoicism has its limits and that if the pain were more intense then stoicism would not be evident. This may be so if the defining element of stoicism were simply silence. Helme and Gibson (1999: 109, emphasis added) also refer to 'stoicism or alternatively a decreased willingness to label a sensation as painful', which suggests that 'stoicism' might not be the best descriptor of what they are observing.

Wagstaff and Rowledge (1995: 181) – who formulated the Liverpool Stoicism Scale – defined the 'modern concept of stoicism' as a lack of emotional involvement and expression, and exercising emotional control or endurance. Their findings suggest there is some support for the stereotypical view that men are more stoical than women and that stoical people have a weaker emotional reaction to emotive stories and an unsympathetic attitude towards other's misfortune. The scale was not used again until Murray et al. (2008) further investigated its validity, acknowledging that the scale uses a unidimensional or reduced form of stoicism. Although the scale proved to be reliable, its unidimensionality weakened the study.

Apart from the lack of evidence to support stoicism, there is also conflict over whether it is a positive or negative trait (Murray et al., 2008; Spiers, 2006). This confounds the problem of defining what stoicism has come to mean. For example, an undefined label of 'stoicism' may be seen to mirror other kinds of coping methods (silence, distraction, endurance, acceptance) which may be explained by social construct forces that have little to do with stoicism. While there is evidence in the social, biomedical and health literature to suggest that there are psychosocial, gender, geographical, economic and cultural differences between people who display 'stoicism' and those who do not, the term is never well defined which arguably leads to its misapplication (Bendelow, 1993; Bendelow and Williams, 1995; Cairncross et al., 2007; Charmaz, 1983; Helme and Gibson, 1999; Richardson, 2005; Sanders et al., 2002; Spiers, 2006).

In this article, we seek to reassess the sociological and psychological landscapes of stoicism exploring how the term has been used in different ways at different times, particularly in relation to chronic persistent pain, such as pain associated with a long term condition.

The most common type of chronic pain is musculoskeletal pain, such as that associated with rheumatoid and osteoarthritis, and is the main cause of disability in later life (World Health Organization, 2003). The treatments for chronic pain are complex (Blyth et al., 2007; Gatchel et al., 2007). Because of the individual variations in the experience of pain, a significant amount of attention has been given to psychological factors, most notably the way in which individuals differ in ‘coping’ (Linton, 2000; Turk and Okifuji, 2002). However, a careful consideration of both psychological and sociological approaches to health and illness are required to achieve a deeper understanding of illness behaviour in relation to both chronic pain and illness in general. Illness behaviour is defined here as ‘the ways in which people respond to bodily indications and the conditions under which they come to view them as abnormal’ (Mechanic, 1986: 1).

Recently McCracken (2010: 420) discussed developments in psychological approaches to pain and the adoption of more theoretically based and ‘contextually sensitive’ methods. Being contextually sensitive requires a sociological approach to chronic pain, that takes into account the historical context from which the construct emerged. The origins of stoicism are important to our understanding of how its meaning has changed over time.

The origins of stoicism

Stoicism originated in Greece. It was one of the most influential philosophical schools of the Hellenistic period. Its founder Zeno, ‘the philosopher of Citium’, was born in the late 330s BC. He taught in the colonnade in Athens known as the Stoa Poikile or ‘Painted Stoa’ from which the term derives (Erskine, 2000). Little contemporary evidence of Zeno’s writings remains. While the main tenets of stoicism are well known today, it is not possible to know whether these same tenets were also held by Zeno, and if so, how he argued for them (Erskine, 2000). Despite this, it is taken that the two most important elements of Stoic philosophy were Reason (*logos*) and Nature (*physis*), evident in the Stoic emphasis on emotional constraint and acting in harmony with nature.

Evans (2008) describes stoicism as a product of the era in which it developed. The Greek city-states experienced tremendous upheaval as the Roman Empire sought to conquer them, and war and bloodshed made everyday life uncertain and brutal. Roman dictators imposed their will on the people:

If the city-state fell, the true philosopher could maintain his equanimity, because he was not just a citizen of Athens or Sparta, but a citizen of the universe, a Cosmopolitan. The universe, Stoics believe, is governed by a universal law, which they called the Logos. When we cultivate acceptance of change and indifference to externals, then we live in harmony with this divine law. (Evans, 2008)

One of the core foundations of stoicism was to be free of the *passions*, which in ancient times translated as *anguish* or *suffering* (Seddon, 2005) and today might be termed ‘emotions in excess’. Thus, if the reason for silence is fear, anxiety, embarrassment or indignity (emotions in excess) then stoicism is not the reason for silence, though silence may be the face of how these emotions are presented outwardly. Seddon (2005) distinguishes

between these excess emotions or *pathe* (anguish and suffering), and the instinctive physical reactions that accompany them (trembling or turning pale in the face of danger), and the *eupatheiai* – literally the ‘good feelings’ – which are felt by the stoic sage:

Where the non-stoic experiences fear, pleasure and desire, the stoic experiences caution, joy and wish. In this way, the stoic sage therefore enjoys *apatheia*, literally ‘freedom from passion’ or ‘freedom of spirit over the nervous excitability produced by the passions: steadiness and imperturbability won through their mastery. (Emmet, 1966: 41)

We argue that it is this sense of mastery in conjunction with core principles, such as mindfulness, and emotional control, which have been lost over time as the meaning of stoicism has evolved.

Stoicism and the emotions

While contemporary definitions of stoicism suggest that it is wise to remain *indifferent* to changes in fortune and to pleasure or pain, Edelstein (1966: 5) asserts that, ‘The Stoa at no time endorsed a theory of indifferentism’ as there is a distinction between a thing that is ‘good’ (virtue) and other things that are preferred or rejected. This distinction, Edelstein asserts, is the very essence of stoicism; if things were without ‘value’ (a word the Stoics invented) morality itself would be destroyed. Stoicism, defined as a lack of emotional involvement and expression or the exercising of emotional control and endurance (Wagstaff and Rowledge, 1995), acknowledges its deeper roots as a more developed philosophy based on rationality, reason and natural order. However, within contemporary health literature, there seems to be a tendency to ascribe stoicism in a rather limited and unidimensional manner to explain the element of silence and lack of emotional response, without questioning the *reason* behind this behaviour. The philosophy of stoicism incorporates much more than an apparent silent indifference. It is the *reason* for silence that is the key.

As time has passed, the meaning of what it is to be stoical has changed. The label is applied uncritically to those who do not complain, but can we really call this stoicism? Before answering this question it is necessary to examine critically the psychosocial factors that have been linked to contemporary stoicism and health behaviour.

Age and generation

There is little acknowledgement of the sociocultural factors that play a role in the development of ‘stoic attitudes’ and behaviour. Stoicism has been attributed to cohort effects, where certain generations necessarily developed attitudes and practices in response to the cultural, political and social economies of the time, in order to survive (Hofland, 1992; Kunkel and Williams, 1991; Murray et al., 2008). While stoicism is commonly associated with older people (Yong et al., 2001), we suggest that because of this some health behaviours are mistakenly or uncritically attributed to stoicism. There are a range of sociocultural factors that influence this association.

Older people may have grown up in a culture that more strongly valued attitudes of stoicism, in relation to pain for example, such as the 'war generations' – the 'Old Americans' – third-generation and American World War II veterans, who were shown by Garro (1990) to have a tendency to hide their pain in the belief it was a sign of weakness. Zborowski (1952) shows that cultural influences are evident in different ethnic American populations, such as the Protestant 'Old Americans' who encouraged their children not to complain and to expect pain in sports and games. This was in contrast to the Italian and Jewish Americans who were more protective of their children. Such attitudes may be termed 'stoical' in hindsight, but as Helman (2000: 135) suggests many of Zborowski's findings are 'no longer relevant to patient populations in the USA from any of these cultural or religious backgrounds'. While this suggests that cultural responses to chronic pain may be characteristic of generations, Helman notes Kleinman et al.'s (1992) warning against using ethnic stereotypes, emphasizing the acknowledgement of an individual's personal story, their community, historical time and their own beliefs and outlook. The thrust of this argument is that we should be cautious about assigning labels of stoicism to particular pain behaviour based on the assumed characteristics of individuals who belong to a certain generation, religion or ethnicity.

Similarly, in the UK, Cornwell (1984) finds that residents from a deprived area of East London showed generational differences in attitudes towards health and illness, including chronic health conditions, reflecting an 'individualistic' ideology that encouraged independence. 'Having the right attitude' was particularly valued by older people who had lived in the slums and knew financial hardship that was not alleviated by the NHS or wider welfare system. The 'self-reliance' that older generations were seen to most value was taught to them by their parents prior to the existence of a welfare system. Like Kleinman et al. (1992), Cornwell (1984) warns against making any generalizations about 'working class' concepts of health and illness, suggesting that because they appear to stem mainly from public accounts, it makes it difficult to know whether they should be taken as evidence of similarities across different social groups and sub-cultures, or as evidence that they share the same common sense theories about health and illness.

While such examples are common, and despite warnings against making generational assumptions, 'stoical attitudes' to pain are still seen as common in older age groups, perhaps as a result of adverse events, for example, World Wars, the Great Depression (Yong et al., 2001). Based on such adverse event criteria, one would expect a stoical attitude to be prevalent in the present younger X and Y generations who are living through turbulent times, hindered by unemployment, unattainable housing prices and the current financial debt crisis. However, if we look towards the development of the NHS and current health care availability, today's generation enjoys a greater access, equity and quality of service than older generations would have done. Developments in sick pay policy and health insurance mean that people no longer have to work through illness. In addition, better pain medication is now widely available. Perhaps as a result of this they are less 'stoical' than older generations because there is less requirement to be so, despite grievances as to how the welfare state is managed (Cornwell, 1984). We can infer that previous generations *had* to be stoical because of the lack of availability and access to services and welfare, and they had less of a personal choice whether or not to be 'stoic'. However, the flipside of this argument is that it assumes absolute adversity as opposed to

relative adversity. Townsend (1979) argues that the level of adversity that one feels is experienced in relative comparison to what others in the same generation experience, rather than in relation to how much better off they are in comparison to the previous generation. This essentially weakens the generational hypothesis of stoicism.

The commonality of examples suggests that stoicism is *partially* a 'generational' phenomenon, challenging ideas that it is a psychological trait inherent in some individuals. Indications are that it might also be a question of social context, where certain attitudes are seen to be valuable in effectively dealing with pain and adversity. However, there is little evidence that health behaviours in older generations are governed by attitudes that can be attributed to stoicism.

Culture and geographies of stoicism

We cannot assume stoicism is solely a generational phenomenon if we are classing it simply as 'a decreased willingness' to complain about pain. Cornwell (1984) noted a deep unwillingness among her sample of East Londoners to discuss health, illness or to acknowledge pain. Such examples are found in industrial, outback, rural and lower socio-economic communities, and seem to be characteristic of what Cornwell (1984) describes as 'hard earned lives'. We suggest that stoicism is not simply generational, but also a sociocultural phenomenon influenced by environment (place), employment type and community, and that, therefore, there may be particular 'geographies of stoicism'. The vagueness of the contemporary use of the term however makes this hard to appreciate. Differences in attendance at health services between rural and urban populations may be attributed to an assumed 'stoicism' among rural residents, yet their lack of attendance is more accurately attributed to factors such as travel distance, stigma, cultures of self-reliance and the lack of anonymity (Deaville, 2001). Clark et al. (2004) found that in comparisons between rural and urban nursing homes, rural nursing home staff, 'more so than their urban counterparts, emphasized stoicism as an attitudinal barrier on the part of residents that interfered with pain assessment' (Clark et al., 2004: 745). This stoicism seemed to be attributed by the nursing staff to both generational and geographical influences. They suggested that, because of their age, residents expected pain, stating, 'It's how they age here' (Clark et al., 2004: 745). Whether or not this can be called stoicism it remains impossible to say in this case, but certainly there are notions that rural and urban generations and the staff who care for them differ in their attitudes towards pain. The question is to what do we attribute those attitudes?

Farmer et al. (2006) note the neglect of sociocultural factors in the differences between health seeking behaviour in rural and urban populations, suggesting that while there is some evidence for 'stoicism' it remains a poorly defined concept. In a more detailed analysis of the differences in consultation decision making between rural and urban populations a range of factors were found to be responsible. These included established doctor-patient relationships, access to services, consumerist attitudes and habits, and knowledge and perceptions of services (Farmer et al., 2006), thus showing that besides possibilities of 'stoicism' there are multiple sociocultural factors which must be accounted for before considering the label of 'stoicism'.

In exploring the spatialities of caring and mental health in the remote Scottish Highlands, Parr and Philo (2003) show how 'visible' social relations between patients with mental health problems and community practice nurses are seen as 'risky' where 'cultural norms include stoicism and non-disclosure about health and emotional problems' (Parr and Philo, 2003: 477). Parr and Philo do not define 'stoicism', but its close association with non-disclosure, 'gossip' and 'fear of difference' (Parr and Philo, 2003: 480) suggests a contemporary meaning more aligned with a fear of consequences, mirroring the same contemporary stoicism found in remote and rural communities in other parts of the world, such as Australia (Fuller et al., 2000).

International research points to the fact that the term 'stoicism' is used invariably to describe a range of behaviours which centre around the theme of not complaining about pain, chronic or otherwise. Pang (1995), for example, states that stoicism is an important part of the Korean culture where people are encouraged to be silent about their feelings and to suffer in silence, privately. Filipino nurses are noted to under-medicate patients who are in pain, because of the lack of pain medication available, fear of addiction and because 'stoicism is highly valued and, for Catholic Filipinos, suffering is an opportunity to demonstrate virtue' (Galanti, 2000: 278). Clark and Clark (1980) show that Nepalese porters have higher criteria ('stoical') for reporting pain than occidentals. In a review of the literature on affective responses to pain Davidhizar and Giger (2004) suggest that diverse cultural responses to pain usually fall into two categories: emotive or stoical, where Amish communities were shown to be stoical, as were the Irish, while Jewish and Italian communities were found to be more emotive. Narayan (2010) reiterates common beliefs that are interpreted as stoical, such as being a 'good patient' means not complaining about pain. There are also certain cultural groups and subcultures in which the notion of stoicism in the face of pain is valued. These may be termed occupational cultures of stoicism, such as those found among male and female athletes (Howe, 2001; Roderick, 2006; Turner and Wainwright, 2003). In the majority of these studies stoicism is seen simply as not complaining.

There may be environmental factors which determine that in order to live as best as one can then being stoical would be advantageous and there would certainly be geographies of stoicism. However, if stoicism is taken to be simply not complaining then the reasons for this may be as varied and contextual as the locality, culture, sub-group and occupation. In determining whether geographies of stoicism really exist one must heed Kleinman et al.'s (1992) argument against using ethnic stereotypes.

Stoicism as a male trait

The difference between the Stoics and other philosophers, Seneca says, is the difference between men and women; those who have chosen the Stoa have chosen the manly, the heroic cause. (Edelstein, 1966: 10)

Contemporary stoicism seems at first glance to be stereotypically a masculine trait. In the times of Greek antiquity philosophy and education were almost exclusively the pursuits of the free man. Women in Ancient Greece had a different status than most contemporary western women – they were seen as the property of men and mostly confined to the

home, receiving no formal education and were thought to be irrational, given to excessive emotions, physical abuse and melancholy. Philosophers, with the exception of Plato, thought that women had less capacity for reason than men and were morally inferior (Boardman et al., 2001). It is interesting to consider that they could be perceived as stoical in contemporary terms however, as evidence from the Greek plays implies that they would have suffered any misfortune in silence (Boardman et al., 2001).

Using modern psychological measures of stoicism Murray et al. (2008) found that males displayed 'higher levels of stoicism' than women, based on a unidimensional measurement using the Liverpool Stoicism Scale (LSS). However, they found that although levels of stoicism appear to be higher in males, it is not isolated to males, having a core that has 'similar implications for both genders' (Murray et al., 2008: 1379). If stoicism is seen as a male trait there is a danger of circularity as behaviour in women is less likely, therefore, to be expected, recognized and labelled as stoical. Murray et al.'s (2008) findings point to stoicism as potentially 'maladaptive' and related to negative attitudes to seeking psychological help.

Bendelow (1993: 290) suggests that the ontological security of women is less threatened by the admission of pain than it is in men for whom 'the psychological structure of masculinity is predisposed to inhibit the admission of vulnerability'. Pinnock et al. (1998) attribute delays in and refusals to seek help among Australian men with urological problems to a stoical attitude, where stoicism defined illness as 'weakness'. We feel that this may be a part of the problem in the gendering of stoicism. Seeing illness as a weakness may be more a function of *machismo* (Sobralnske, 2006), and attributed to fear or *phobos*, embarrassment and appearing as 'less of a man', than to any stoic attitude of accepting illness as nature's course and seeking whatever help may be needed, and dealing with it in a more appropriate and rationally dispassionate way. As noted earlier, classical stoicism asserts that fear and embarrassment are emotions in excess that encourage irrational action, and that one should rise above in order to act appropriately and to remain in control (of one's health). Also, it is the 'appearance', the choice to display weakness, pain or strength to others which is key here to how stoicism and gender are constructed. Men avoid help seeking behaviour and hide apparent weakness and pain to maintain their dominance and social position. However athletes, men and women, *perform* despite injuries, breaking pain barriers, to display the attributes they are applauded for – strength, toughness, endurance, commitment and heart (Addis and Mahalik, 2003; Roderick, 2006; Turner and Wainwright, 2003; White et al., 1995). So, from a social constructionist perspective, gender is something that is performed in different contexts rather than a property of the individual (Addis and Mahalik, 2003). Health seeking behaviour is then dependent on the context in which one finds oneself. It is not a stable property of the individual, and depends largely on how a problem is perceived within a certain context. It is to the importance of context that we now turn.

The importance of context

Pinnock et al. (1998) state that 'tales of stoicism', as told by their respondents, spoke of 'suffering', 'failing', 'making do' and ultimately 'dying' without seeking help. Reasons such as having to take time off work, fear that something might be wrong or fear of being

seen as a hypochondriac can be attributed to external factors that influence their actions. This leads to what classical stoicism might see as an irrational course of action, based on emotional investment and a fear of consequential damage to one's self-image/esteem. Participants spoke of 'embarrassment', 'pride' and 'ignorance' as reasons for not discussing their health, or normalization of not talking about health as a 'male thing'. This kind of 'stoicism' has the potential for negative connotations as the consequences of non-disclosure may lead to a worsening of the condition and related problems. Similarly, Cornwell noted that within the hard-earned lives of men and women in East London talking about one's health was perceived negatively: 'Stan Flowers looked appalled when I asked if he ever discussed his health or anything to do with health with his friends at the local working-men's club, and said that men who did so were ostracized for being morbid' (Cornwell, 1984: 129).

While talk about health among friends and family may be negatively perceived, stoicism has also been strongly related to negative attitudes towards health seeking behaviour (Hinton, 1994; Murray et al., 2008; Pinnnock et al., 1998). This is different from the philosophy of the ancient Greek stoics, such as Marcus Aurelius. In his *Meditations*, Marcus Aurelius (2004: 11) wrote of the lessons he had learned from his adoptive father:

His willingness to take adequate care of himself. Not a hypochondriac or obsessed with his appearance, but not ignoring things either. With the result that he hardly ever needed medical attention, or drugs or any sort of salve or ointment.

That Aurelius' adoptive father took adequate care of himself and did not ignore conditions, implies that silence about illness was not a classical stoical way – at least not silence to a medical professional. It is evident that he did not ignore his need for, and received, medical attention as and when needed, but did not obsess about it either. There is no evidence that Aurelius' father remained silent about his condition to health professionals or that he avoided seeking help, with the result that it was 'hardly ever needed'. There is an obvious difference between avoiding emotional entanglement in the context of a philosophy which incorporated the pursuit of a rational and harmonic way to finding health, and the modern situation of avoiding admitting problems, for fear of the consequences, by remaining silent. In the UK before the introduction of the NHS, medical attention was expensive or not widely available for most of the population, had few effective treatments or was mistrusted, so that not seeking help was rational. In hindsight, using a modern setting, it has been mooted as 'stoical' and virtuous behaviour.

Pinnnock et al. (1998) in their study of older men's concerns about their urological health suggest that stoicism was evident in those who did not seek help from their doctor because they feared uncovering something that was wrong, such as prostate cancer, or because they would have to take time off work and, therefore, let others down. The authors noted that the men particularly feared prostate cancer because of the additional threat to sexual function. Not seeking help for fear of uncovering something wrong might be seen as irrational from a classical stoic viewpoint because it is based on emotion – fear of the unknown, such as, a threat to sexual function which in turn could challenge self-perceptions of masculinity. However, impotence, as a side-effect of treatment for prostate cancer, is a real possibility. The individual faces the dilemma as to which is perceived

to be the more calamitous outcome – having a condition going undiagnosed or the potential side-effects of a treatment if the condition is diagnosed. Arguably, avoiding exposure to the dilemma is a rational response.

Not acknowledging pain in non-self-limiting conditions, such as cancer, can lead to negative outcomes and poor pain management and treatment (Hillier, 1990). Contemporary stoicism is often therefore seen to be ‘maladaptive’ in this context (Spiers, 2006). However, there are differences of opinion about whether stoicism is adaptive or maladaptive. In a study of home-care nursing in Western USA (Spiers, 2006), patients were treated for a number of health conditions, including chronic pain. Spiers (2006: 296) describes a mutual expectation of stoicism between patients and nurses, where ‘stoicism did not imply enduring excessive pain but, rather, the ability to know where one’s pain boundaries lay and to take appropriate measures to keep pain within those boundaries’. By various communicative means the nurses facilitated this kind of effective stoicism. However, Spiers (2006: 296) noted an inappropriate stoicism where patients’ stoical attitudes ‘limited or obstructed nurses’ attempts to intervene in situations of inadequately managed pain’, where patients’ self-reports were incongruent with their verbal and non-verbal behaviour (winching, moaning, screams, agonized facial expressions). This kind of stoicism was criticized by the nurses as leading to inappropriate suffering. Spiers’ study seems to suggest that there are both positive and negative strands of stoicism. However, their explanation also appears to imply that the nurses’ view of what is effective (positive) stoicism is privileged over a patient’s view, implying that the nurse is rational and the patient is irrational. The question then arises as to who decides what is rational or irrational? Whose view is privileged? Rather than making judgements about rationality and attributing behaviour to being stoical, would it not be better to question the reasons for silence if silence is obvious?

The lack of clear definition of what stoicism constitutes and implies, and whether it is to positive or negative ends is aptly summarized by the findings of Murray et al. (2008: 1371):

Consistent with the assumption that stoicism confers resilience, a positive association has been reported between stoicism and quality of life amongst muscular dystrophy patients (Ahlstrom & Sjoeden, 1996). Likewise, evidence that cognitive therapies are efficacious treatments for distress disorders (Nathan & Gorman, 2002) suggests that stoicism may be an adaptive orientation. On the other hand, stoicism has been found to generate harmful inertia in the face of some medical symptoms (Hinton, 1994; Pinnock et al., 1998). More broadly, it could be proposed that stoic minimization of difficulties and consequent negative attitudes to seeking professional help may generate detrimental consequences for mental health and wellbeing.

What we think Murray et al. have not determined here is that stoicism in each of these cases may have been construed in different ways as it is not explicitly defined within any of these studies. Murray’s assertion that ‘positive’ stoicism confers resilience is in accordance with Gattuso’s (2003) concept of resilience as the ability to maintain a sense of identity and self over time and in the face of adversity. Links have been made between cognitive therapies and classical stoicism (Evans, 2008; Still and Dryden, 1999) and there also seem to be similarities which suggest that the construct of resilience has much

in common with classical stoicism, whereas stoicism that is seen to be maladaptive focuses on silence, non-admission and non-help seeking behaviours.

Discussion

A rather mixed evidence base seems to suggest that there are generational influences on stoic behaviour, though this should not be overstated as hardship and adversity are experienced relatively in comparison to one's peers rather than to previous generations (Townsend, 1979). People's personal geography (one's social and physical environments) may also have some influence (Clarke et al., 2011; Cornwell, 1984; Deaville, 2001; Farmer et al., 2006) though the lack of definition and assumptions about perceived stoicism makes this difficult to establish. Poor consideration of sociocultural factors in establishing differences in health behaviour and attitudes to health and illness, such as chronic painful conditions, between urban and rural populations makes the attribution of 'stoicism' tempting but perhaps inappropriate.

Additionally, there seems to be a wider unwillingness to acknowledge that psychological constructs such as stoicism do not exist independently of social structure, policies, institutions, economics, social identities and many other factors that impact on the context under which individuals develop such philosophies. A sociological approach to a study of stoicism takes such factors into account. The literature on chronic pain provides a pertinent and productive focus in carrying out a sociological analysis of stoicism.

In trying to disentangle the various influences and meanings attributed to the term, we have attempted a partial delineation of the conceptualization of stoicism. While we have addressed some of the major themes in classical stoic thought such as rational thinking and disentanglement from the *passions*, and the differentiation of good from bad stoicism a more detailed account is beyond the scope of this article and we are left at this point with the question of who ultimately decides what is good and bad? If health is to be seen as more than the absence of disease, and to include for example older people seeing health as maintaining functional ability and independence (Blaxter and Paterson, 1982), then not seeking help from health care practitioners or family for fear of compromising that independence makes sense. They may fear they will be treated as an invalid, or pressured into entering a care home. While health care practitioners and family may see this as ineffective stoicism, for their part the older person may already have experience of being treated as an invalid and so do what they think they need to do to reassert their independence (Yardley et al., 2006), a consequence of which might be not admitting to pain in order to preserve that independence.

Also the questions remain; to whom do we attribute such behaviours, and who claims them? Stoic behaviour may be attributed in hindsight to someone who displays certain 'stoic' characteristics and understandings of the world in response to pain or adversity, or it may be consciously developed as a life philosophy, deliberately utilized in order to deal effectively with pain and adversity (Sherman, 2005). Regardless of whether it is consciously developed or not, classical stoic behaviour might be seen as potentially conferring psychological benefits in the contemporary world. Indeed, connections between classical stoicism and cognitive behaviour therapy have been made (Evans, 2008).

Conclusion

While it is evident that the philosophy of stoicism has evolved over time and in relation to changing contexts, there has been little exploration of stoicism in the sociology of chronic illness. Multiple contextual factors including age, generation, gender, culture and geography, have been shown to impact on notions of what constitutes contemporary stoicism. The contemporary term has become largely associated with silence, non-admission and endurance of adversity, such as pain, without complaint (or help seeking). There is a danger that applying a label of stoicism may in fact only serve to hinder the questioning of illness behaviours which might otherwise benefit from further exploration. We would suggest that a more considered exploration of the context in which the term stoicism is used is important to furthering an understanding of how people cope with and manage chronic illness, particularly painful health conditions. Silence in the face of ill health and pain is not necessarily a marker of stoicism, and the basis and reason for an individual's silence should warrant closer scrutiny.

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