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THE SUBJECTIVE EXPERIENCE OF HEALTH AND ILLNESS IN OCUITUCO: A CASE STUDY

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Abstract—This sociological study aims to understand the subjective experience of health and illness of the inhabitants of Ocuituco (Mexico). This interpretation is made in connection with the *social* and *subjective* contexts of this town. Four factors characterize Ocuituco's *social context*: (1) economic deprivation (poverty); (2) male domination (patriarchy); (3) a process of medicalization; and (4) a decline of traditional medicine. Ocuitucans view their world (*subjective context*) with: (1) a sense of being exploited; (2) a sense of being at the bottom of the social scale; (3) a sense of uncertainty; (4) a familiarity with a patriarchal and violent order; (5) the negative view that individuals have of themselves; and (6) a sense of change in the community.

The literature review differentiates between normative and interpretive sociological approaches. The analysis is based on 74 in-depth interviews with women and men, conducted in two stages (1988 and 1992). Individuals' accounts constitute a double indicator: they express individuals' subjective experience of health and illness while at the same time they also index the social order of which they are a product. The analysis comprises both the *concept* and the *experience* of health and illness. An analysis is made on the subjective experience of symptoms and causes of disease. The main findings refer to the parallel between individuals' general view of the world (subjective context) and their view of health and illness. Ocuitucans perceive health as an unlikely achievement in a world full of constraints. This is linked to the existence of elaborated conceptualizations of health in this town. The notion of strength is central in the subjective experience of illness. A sense of uncertainty is evident in relation to symptoms and the causes of disease. 'Endurance' is a central notion regarding both the process of becoming sick and the process of getting well. This paper concludes by emphasizing the importance of theorizing the link between social order and subjective experience of health, considering the existence of intermediate domains such as individuals' subjective context.

Key words—experience of illness, social structure, subjectivity

I. INTRODUCTION

Several sociological* studies have showed that the experience of health and illness is, above all, a social phenomenon, that is, that social factors of different kinds play a central role in shaping individuals' subjectivity. This article presents some of the results achieved through an interpretive sociological study of individuals' subjective experience of health and illness, conducted in Ocuituco, a rural town of central Mexico. The first part discusses briefly the relevant literature. The second part presents the conceptual and methodological approach used in this study. The third part presents a brief characterization of the main socio-structural features of the community under study. The fourth part analyzes the Ocuitucans' view of their own world (the subjective context). Drawing on both the socio-structural features and the subjective context, the fifth part discusses the main findings regarding the social nature of Ocuitucans' subjective experience of health and illness. The sixth part points out the main coincidences and differences, in conceptual terms, with some of the studies mentioned in the first section. This paper ends by emphasizing the importance of theorizing the link between social order and subjective experience of health, considering the existence of intermediate domains such as individuals' subjective context.

*The experience of illness has also been studied from an anthropological perspective. In this article, however, this perspective will be left aside, since the paradigm and epistemology of sociology is, by nature, distinct from anthropology. The aim of this study is to explore this topic in a Mexican community from a sociological perspective.

II. THE LITERATURE

The experience of health and illness has been studied, from a sociological perspective, following both normative and interpretive approaches. *Normative* approaches tend to emphasize the role that social factors play on the constitution of individuals' subjectivity. This is done, however, at the cost of foregoing some of the creative capacities of the actors, who are portrayed as "victims of the illusion of having [themselves] created that which actually forced itself from without" [1]. *Interpretive* approaches, in turn, emphasize the actors' capacity both to attach meaning to

different social situations, and to act—and not only 'react'—accordingly. Sometimes, however, this is done at the cost of sacrificing, in analytical terms, the role of social structure as a determinant or at least as a factor to be seen conditioning individual freedom.

Within the **normative** perspective, several schools can be distinguished. First, following Parsons' formulation of the "sick role" [2], Mechanic developed the notion of *illness behaviour* to account for the differential way in which symptoms are perceived, evaluated and acted (or not acted) upon by different persons [3, 4]. This concept is the most interpretive one within the functionalist tradition (which is not an interpretive approach) in the area of medical sociology. The main authors [5–7] within this tradition, however, have not addressed the experience of health and illness directly, but have been more interested in actual behaviors.

A second school draws on Durkheim's notion of *collective representations*. Authors [8–10] within this tradition have addressed the role of *social representations* in the shaping of individuals' experience of health and illness, and have illustrated how these representations reflect the logic of the social order on which contemporary industrialized societies are based: the logic of productivity. Herzlich [8] contends that the social representations of health and illness are a double indicator as they reflect the relation of the individual to both illness and health, and to society. The language of health and illness, she claims, takes as its basis the relation of the individual to others and to society: *the images of society and its constraints, as seen by individuals, can be accessed through the language of health and illness.* Drawing also on the notion of *social representations*, other authors [10] have also shown that individuals' social class plays a crucial role in shaping their perception of health. In these studies, however, the concrete features of such a social order are assumed, but never fully discussed. Moreover, little is known about *how the actors actually see their world.*

Also from a normative standpoint, a third school draws mainly on the concept of *social class*. Boltanski [11], for instance, sustains that the perception and identification of morbid sensations depends on the number and variety of categories of bodily perception available to the individual, what he calls individuals' *medical ability*. Individuals' medical ability is a function of their social class: those from upper social classes are more exposed to modern medicine, and hence are better able to express, in much more refined terms, their subjective experience of health and illness than those from lower social classes.

In studying how individuals define the concept of health and the notions of causality associated with disease, Blaxter [12, 13] finds that the lack of control working-class women have over their conditions of life is also reflected in their theories about causality of disease: *a sense of randomness* and inevitability permeates their accounts. Blaxter and other authors [14, 15] conclude that lower class women's notions and experience of health and disease are indeed a product of their objective conditions of living.

It appears that studies based on the concept of *social class* spell out with some detail the nature of the society where these studies were conducted, but purport the existence of a too direct link between society and the subjective experience of health and illness. Studies in this category typically either ignore or assume the existence of an intermediate cognitive structure existing between such a huge level of reality—society, and such a focalized aspect of individuals' subjectivity—the experience of health and illness. For instance, Boltanski [11] points out that individuals' *medical ability* is a function of their social class, but he does not characterize the cognitive structure to which such a *medical ability* belongs. Also for Blaxter and Paterson [12, 13] lower-class individuals' lack of control over their own circumstances directly results in the development of etiological theories based on randomness. Here again, an intermediate cognitive structure is not theorized, but simply assumed.

Finally, a major conceptual tradition cites the growing tendency of modern medicine to become the dominant paradigm, just as religion and law were in former times [16]. The main contention of the thesis of *medicalization* is that modern medicine is becoming the central cultural, ideological and cognitive referent which individuals use to guide and interpret their lives. The thesis of medicalization has been explored in terms of its ultimate consequences by feminist theorists. The match between the thesis of medicalization and feminist analyses results in a striking hypothesis: medicine is another means that *patriarchal* societies have used to reinforce domination over women. Thus, from a normative perspective, the feminist hypothesis within this field is that ideologies of gender inform and shape both the way in which medical scientists work and define their study objects and, consequently, the way in which the public understands and experiences issues related to health, illness and medicine [17, 18]. These gender ideologies, in turn, are thought to be determined by wider economic, class and racial ideologies [19–21]. Many feminist authors argue that medical concepts and metaphors affect how men and women experience their own physiological reproductive processes.

The feminist perspective has adopted also an **interpretive** approach. For instance, Popay [22] has argued against conventional beliefs that women feel freer to adopt the sick role because they are less constrained than men to do so. Her findings show that women do not perceive themselves as having the freedom to get sick. The responses of significant-others, mainly husbands, to women's experience of disease (i.e. tiredness) is also crucial: men do not tend to consider housework to be strenuous enough for women to feel tired. And as the adoption of the sick roles requires

the approval of others, women are indeed constrained from feeling tired.

Feminist studies, then, can be classified according to their approach to the experience of health—normative or interpretive. The former rest on the concept of *patriarchy*, but tend to assume, rather than to explain, women's actual subjective experience of health and illness. The latter, in contrast, elucidate many aspects of such a subjective experience but often remain silent about the central features of the social structure where women live.

Other interpretive studies have emphasized that individuals' subjective experience of health and illness cannot be fully understood unless they are analyzed in the context of individuals' lives as a whole. Cornwell [23] argues that structural sociological approaches, by emphasising the role of medicine as an institution of social control, advance analyses which invalidate 'ordinary people's' view of health and illness. She proposes a distinction between *public* accounts (socially legitimized sets of meanings) and *private* accounts (related to individuals' experience and feelings). She compares individuals' common-sense views of health, with their views of other areas of everyday life, such as family and work. She finds much that is parallel between all of these areas; in all cases, the distinction between public and private accounts operates, for in all there is a dominant ideology to which individuals adhere in public, and from which they may distance themselves in private. Cornwell's work constitutes an advance in extending our understanding, in the sense that she seeks to link social structure and common-sense together, and on this basis then to explore the subjective experience of health and illness.

Within the interpretive perspective, sociological studies have also been conducted regarding the experience of chronic illnesses. Authors such as Bury [24], and Charmaz [25, 26], have analyzed some of the practical ways in which such experience becomes manifest: Bury talks of forms of biographical disruption, whereas Charmaz talks of loss of self. These studies emphasize that the different forms of subjectively experiencing chronic diseases arise out of specific patterns of social interaction which, in turn, are the result of individuals' interpretation of those diseases. The conceptual costs of this approach, however, are immense: they omit practically any reference to the specific features of the social structure, and also about the prevailing cognitive traits of the subjects. Other interpretive studies on the experience of chronic illness have been conducted mostly drawing on Charmaz' and Bury's works [27–29]. Most of these studies' aim is to describe the actual subjective experience of illness for its own sake. They tend to emphasize the interactional nature of the suffering arising out of the experience of being ill, although practically none of them tries to explain the nature and variations of this experience in connection to the social structure.

In conclusion, normative and interpretive approaches have faced the dilemma of taking either the features of the social structure, or the interpretive ability of individuals as the starting point in the sociological study of the subjective experience of health and illness. Normally, the choice of one of these options has resulted in the under-theorization of the other. As contrasted to both strictly normative models, and to purely interpretive approaches, this paper seeks to emphasize the importance of drawing upon two starting points: the social structure, and the actors' subjective views of such a structure. This approach results from the main two metatheoretical assumptions of this research, namely:

(1) that despite being the product of human activity, social factors effect a degree of autonomy which enables them to shape, to a certain degree, human behavior; and
(2) that a precondition for social factors to exist is individuals' creativity which, consequently, does not disappear even when human behavior appears to be too constrained by such forces.

In what follows, an account is given of the main findings of research conducted from this perspective in Ocuituco, a rural Mexican community.

III. METHODOLOGY

The main objective of this research is to *understand*, through interpretation, how Ocuituco's inhabitants attach meaning to issues related to health and illness and how they experience these matters. The interpretive analysis of this study is based on Ocuitucan's verbal accounts, as people's language is assumed to be a privileged means of conveying meanings. The language of a given social group represents the objective storage of significant amounts of meaning and experience of such a group [30]. By extension, the language that a given group uses to express symptoms and to talk about illness, constitutes by itself the objectified experience of such a group regarding these matters, at the same time that it serves as a means to express it [11]. The basic postulate of this study is that individuals' experience of health and illness must be understood in connection with the central features of both the social structure and individuals' view of them (or subjective context). For this reason, the following two sections of this paper are devoted to characterizing these two levels of reality, so as to facilitate the interpretation of the data which follows.

This research is focused on the analysis of 74 in-depth interviews with women and men conducted in Ocuituco in two stages, the first one during 1988, and the second during the summer of 1992 [31]. Interview guides were designed in order to collect the accounts of individuals on health and illness. Interviews were conducted in each informant's house and followed the format of informal conversations. As other authors [23, 32, 33] have shown, this technique

relies on a fundamental principle: if encouraged to elaborate freely on their stories and concerns, rather than being forced to answer rigid schedules, people tend to disclose their actual views on the matters being discussed. Interviews were analyzed through a qualitative approach following, in general, a grounded approach [34].

IV. OCUITUCO'S CONTEXT

Ocuituco is a rural community of about 3200 inhabitants located approx. 90 km south-east of Mexico City.* This is not officially an indigenous community. Ocuituco, however, was established before the arrival of the Spaniards [35], and is located at the centre of a Nahua ethno-cultural region.

Ocuitucans over age 14 enjoy an average of six years of schooling. While men over 14 years have an average of 6.2 years of education (which is equivalent to having completed primary school and a fraction more), women have an average of 5.9 years. About 13% of the population of the municipality over 14 years is illiterate [36]. The distribution of illiterate people by sex is very significant: 34% are men, and 66% are women. Regarding educational opportunities, gender has been a discriminating variable for a long time, as the testimony of a 63 year-old woman well illustrates:

> (I only got to the second year of primary school) because I happened to be the oldest daughter† and because, well, in former times grandmothers would intervene a lot in family matters, wouldn't they? So once my father's mother said: 'this girl is already very good to wash diapers, what the heck is she going to the school for. To the school they only go to learn bad things'. Imagine! (F32/1992)‡

At present, a person's sex continues to be a good predictor of illiteracy in this town: women are twice as likely to remain illiterate during their lives as men. According to the 1990 census, 53% of the municipality's population between 5 and 14 years old who do not attend a school are women. Indeed, women are *the* disadvantaged group regarding practically every aspect of education.

Ocuituco is a community marginally inserted into the capitalist system, the dominant mode of production in Mexico. And yet the main features of such a system are clearly observable in the town: goods are produced and accessed through an economic exchange which ultimately results in both the accumulation of capital in a few hands and the material deprivation of the vast majority of the population. A sense of being exploited is present in most of Ocuituco's inhabitants. As a farmer indicated:

> ... here what directly damages us and traps us is the Rural Bank, you know? They give us some loans, they say that in order to help farmers, but they don't help us indeed. Because if they lend you two hundred thousand pesos, they also charge you a very high interest rate ... It is very hard ... (M41/1988).

Most of the male population are agricultural workers, ejidatarios or farmers—80%—as compared to only 14% of women. During the daytime, since men are working at their plots, Ocuituco seems to be a women's and children's community. At noon, however, the town appears to be empty since one of the daily activities of women is to bring lunch to men working in their plots. This often entails an hour walking from home to the land, and another to return.

Most women who work outside the home are school teachers (20%), domestic servants (17%) or merchants or sellers (15%). It is common for many women to go to neighbouring towns to sell their products. The region has a market system whereby a 'plaza' is held every Saturday in Ocuituco. These 'plazas' are the sources for people to acquire their main necessities: food and second-hand clothes. However, not all female vendors, specially the part-time ones, are included in official statistics: every day from sunset to 8 or 9 in the evening, many women come out of their homes, often with their children playing around, place a chair and sometimes a little table by their front doors, and sell some typical food or home-made bread or cheese.

As there is no irrigation infrastructure, farmers depend exclusively on annual rainfall. Often, a rainy season that comes too early or too late is enough to destroy the livelihood of many families. Income levels are low in this community. Overall, the main point to be noted is that from official statistics about 90% of the Total Labour Force earns less than the total of the equivalent of three times the minimum-wage set by the government. In 1990, the official minimum wage for this area of the country was 9140 pesos per day, which is the equivalent of about U.S.$ 3.10. This is a subsistence level of income, one that permits only day-to-day economic survival.

A further indicator of the economic marginality of this community is its housing conditions. According to the 1990 population census, there is an average of 5.81 inhabitants per dwelling in the municipality of Ocuituco. If we combine three basic services (availability of electricity, piped-water and sewage service) into a simple index of dwellings' services, we find that only 15% have all three services, 60% have only two, 14% have only one and 5% have none. No information was available for the remaining 6%.

The average of live births among women over age 11 with at least one birth, is 5.2 children, with these figures going from 1.3 among women between 15 to

*Most quantitative data quoted in this section were generated by the author through a population census carried out in 1988.

†Being the oldest daughter implies having particular responsibilities in looking after the remaining members of the family.

‡For obvious reasons, the informant's identity cannot be disclosed. From now on, excerpts like this will be identified simply by the sex of the informant ('F' or 'M'), an ordinal number (ranging from 1 to 74), and the year of its collection (either 1988 or 1992).

19 years, up to 7.9 among women from 50 to 54. On average, women had their first delivery when they were 20.1 years-old. About 72% of those who had at least one child, had their first delivery before age 22.

The community has been directly exposed to the influence of modern medicine during the last 40 years, when the first private physician established his practice in the community. However, it has only been during the last 25 years that the community has been regularly monitored by the health State authorities. Moreover, during the last four years the presence of modern medicine has grown significantly as two more private physicians have moved to this town in order to work as health services providers. Additionally, Ocuituco relies on the services of several midwives and traditional healers.

Compared to many other rural towns in central Mexico, there is nothing special about Ocuituco. The people of this community speak Spanish, share a common traditional (Nahua) background, and live a peasant-like daily life. However, it is precisely the town's 'ordinary status' that makes it interesting for this research, that is, beyond its apparent 'communality' there is a rationality, a vision of the world—that is different from that assumed by modern medicine—which has direct consequences on the way health and illness are experienced.

In summary, there are four basic factors which can be pointed out as sharply shaping Ocuituco's social reality:

(1) As a result of its marginal insertion within the market economy, Ocuituco is a community where most of its inhabitants live under conditions of deprivation and *poverty*.

(2) During the last 45 years an inexorable process has been taking place in this community: the growing presence of modern medicine and its concomitant disqualification of alternative ways of defining health and disease. In this study, this process is referred to under the notion of *medicalization*, understood as "one instance of the much broader process of 'rationalization' which Habermas defines as the key process in modernization ..." [23, p. 19]. Thus, rather than defining *medicalization* as the process by which deviant behavior is re-interpreted in medical terms [16, 37], this concept is understood here as the specific form that rationalization (and legitimation) adopts in the area of health and illness.

(3) Ocuituco is located at the core of a specific indigenous area, that of the Nahuas, the ethnic group where the ancient Aztecs came from. Very significant traces of the Nahua cosmovision have survived until the present through oral and written *tradition*.

(4) Last, but not least, besides the cultural, economical and medical domination within which this community exists, a fourth fundamental social factor to be taken into account is that referred to as *patriarchy*. As in most contemporary societies, women from Ocuituco live under the direct control of men, a phenomenon which can be observed in practically all aspects of social life. As suggested by Fox, the use of the concept of *patriarchy* must entail a simultaneous study "of both social structure and subjectivity, which are two different but inseparable and constantly interacting levels of reality" [38]. Consequently, in the following section more data is provided to account for the subjective dimension of *patriarchy* as it exists in this town.

The question still remains about how is this world seen by Ocuitucans themselves. What kind of cognitive elements can be found in Ocuitucans' commonsense within this context of poverty, patriarchy, medicalization and tradition? And mainly, within this general vision of the world, how are health and illness seen and understood from the standpoint of Ocuitucans?

V. OCUITUCO'S SUBJECTIVE CONTEXT

Ocuitucans see their world from the viewpoint of the oppressed. First of all, Ocuitucans are aware of their deprivation. This awareness is sometimes expressed in terms of a *sense of being exploited.* Ocuitucans identify several kinds of oppressors: these oppressors variously include the banks, the market economy in which they participate in a disadvantaged manner, and sometimes the government itself:

> Everything is now very expensive. This is what the government should consider; they say that they are going to help us, but how? if, on one hand, all that the campesino* sells doesn't get a good return, and on the other hand, fertilizers are now very expensive (...), so where is the help they say they are going to give campesinos? They are deceiving us, because they always cheat the poor people: campesinos always end up paying more (F26/1992).

Secondly, reality is perceived with a *sense of uncertainty* which, for analytical purposes, can be broken down into five dimensions. First, there is a sense of *randomness*, that is, a sense that many things are unpredictable and well beyond an individual's control. Ocuitucans know that they have a limited control over their own fates and at the same time perceive what happens to them as depending strongly on 'chance' and 'opportunity'. For instance, this element of randomness is regarded as playing a significant role, in the first place, in determining the degree of success (or failure) in the harvest. Working hard is necessary but not enough to guarantee certain economic success. Thus, things depend, in the second place, on God's will:

> There is something else: God doesn't assist us with money but he does with children, so even if we work hard and *all*

*Peasants.

that,* I think that when God wants to help, he will, and when he doesn't, he won't, despite how hard one works (M38/1988).

Good weather, God's will, or the level of market prices are all crucial factors which individuals cannot control but which are perceived as occurring randomly. This lack of control of their circumstances makes them perceive many things, at least implicitly, as occurring randomly. This perception of uncertainty, in turn, makes possible a striking paradox: Ocuitucans are trained to assume the unexpected as being normal. Thus, in addition to the already mentioned sense of randomness, a second dimension characterizing Ocuitucans' sense of uncertainty is the *normality of the unexpected.* This orientation allows them to adapt to sudden events, which can occur in all areas of life. In some cases, unexpected events might be very unpleasant and with direct consequences in one's life. For instance, a single teenager who gets pregnant is referred as someone who '*found* her baby in the street'; or a woman might suddenly find herself living with a man:

I was 12, and he took me and carried me away in the heavy downpour and from that time he never left my side. I wasn't even asked for my consent (. . .) He simply grabbed me in the street (. . .) When he took me, honestly I didn't like him and I didn't want to marry him but all them, all his people pressured me, and he said that just my person should be the dowry, and that I shouldn't denounce him and well, as I was a fool we got married (F8/1988).

In a world where *randomness* and the *unexpected* are central cognitive traits, it is difficult, though not impossible, to plan and to foresee. As a matter of fact, Ocuitucans keep on planning their lives, even though many of their plans and hopes remain unfulfilled. Thus, a third dimension of the sense of uncertainty is a generalized *orientation to the present* which stems from their vision of the world.

Randomness, the unexpected, and the immediacy of present events culminate together in a fourth dimension of uncertainty, namely, *a sense of precariousness* of daily life:

A year ago my daughter was going to go to the University in Morelia† but it happened that my wife *failed*, she had an accident. She broke a leg, I spent a lot of money and I couldn't send my daughter. Can you believe that for 30 thousand‡ pesos she didn't go. I didn't have them and I couldn't get them because I was very burned with debts: I spent and spent the money on my wife (M42/1988).

In a world where most enterprises are undertaken under conditions of extreme precariousness, it is not surprising that the word *failure* is used to refer to someone who in a way can be blamed for the collapse of a given project. The precarious equilibrium which would allow a member of the family to attend university had to be sustained by everyone. If someone *fails* in this collective effort, the whole project is aborted.

Consequently, a fifth dimension of the sense of uncertainty is a *familiarity with an inability to complete projects.* Ocuitucans tend to take for granted that for any enterprise they engage in, there is a high probability of not being able to finish it. Sometimes this entails that the agricultural work of a whole year has to be abandoned. Sometimes it is other projects such as schooling that cannot be completed. Still other times it may be the family itself that is left. It is so common for children to grow up without a father being present that this situation can be taken for granted in an everyday conversation:

I was once in Cuautla's downtown and suddenly a child approached me. It was late and he looked very pale (. . .), he was 9 years old, and I asked him: 'why do you work?' and he said: 'because I have to help my mother, my father *you already know*, and my mother demands me to bring home 50 thousand pesos every day, otherwise she won't give me anything to eat (M45/1992).

In the third place, this everyday sense of exploitation and uncertainty makes Ocuitucans perceive life and society in a way in which *strength* is a central value. This is reflected in how individuals talk about the purpose of working:

—So your mother worked very much?
—Yes, she worked very much, she became a widow when I was starting to crawl. She had many children, then she worked very much *to lift us up*, and then we later got married . . . (F32/1992).

The use of the expression "to lift up" reflects a *hierarchical vision of society as seen from the bottom*, which is the third trait of Ocuitucans' common-sense we want to emphasize here. In Ocuituco, surviving implies to overcome the weight of society, which is perceived as 'on top of oneself'. This is a contrast to the urban middle-class expression 'to get ahead', which presupposes a much more horizontal vision of society. Both expressions—to lift up, and to get ahead—are used to refer to economic success in life. Both imply movement. However, in one case, it is a vertical, upwards movement (which reflects oppression, and demands strength); in the other case, it is a horizontal, lateral movement (which reflects a much more comfortable insertion in society, and demands ability). Both expressions index a subjective experience of society, a specific vision of one's social condition.

The perspective of the oppressed is shared by men and women, for most Ocuitucans live in conditions of

*The expression *all that* is a summarized reference to the capitalistic discourse which purports that hard work, responsibility, and a restricted life, are prerequisites to attaining a secure economic condition. Clearly, Ocuituco's inhabitants have been exposed to this ideology, and yet from their standpoint things do not exactly follow this supposed rational sequence.

†Sending an offspring to the University is an extraordinary achievement. As it was pointed out in the previous chapter, it is not common for women to be ready to attend a University, nor for a family to be able to afford the costs that this implies. This excerpt, however, is representative of the way the verb *to fail* is used in Ocuituco.

‡About U.S.$22 in the year of reference, 1987.

economic deprivation. However, in terms of gender (a fourth dimension), the view of the world differs between the sexes, since women are under the control of men. This domination is reflected both in common-sense assumptions, and in everyday social norms, roles and values. In Ocuituco, women serve men, women depend on men, and also many women are basically afraid of men:

> I warn my daughters about the dangers that there are now, so many young women who get pregnant. I tell her: 'no daughter, you are going to have your boyfriends and all that, but don't you get too confident about them because what they want is to take advantage of women' (. . .) And, as opposed to my mother who never told me anything, I tell my daughters: 'if you go to a house or to a store and there is only a man there, never go in, if he tells you 'come in' you don't go in; if there is a woman, ok, if not, say good bye' (F26/1992).

There are many testimonies which indicate that women are often beaten or harassed by men. But violence is simply an extreme form under which male domination over women takes place. Without making a direct reference to violence, it is often possible to notice, indexed in individuals' comments, the subordinated condition of women. Men are accorded a dominant position even within marriages which are considered to be 'ideal', where there is no evidence of violence and where the relationship between the couple is regarded, at least by one of the actors, as affectionate and harmonious:

> We have always had a quiet life. To me my husband is a saint; he has got a very, very nice character. He is very quiet, very tranquil. We have been married for 43 years and he has never used an obscenity on me (. . .) We never argue or fight. And I never go out *without his permission.* If I go to mass, I ask him: 'do you give me permission to go to mass?' or I tell him: 'if you come back from milking and I am not around, I went to mass'. I only go out for a doctor, for a necessity. There is harmony (F31/1992).

And fifth, Ocuitucans, particularly those over age 45, perceive their society to be *changing* in several aspects. Some of these changes (i.e. economic change) are perceived as being negative for the community, whereas others (education) are regarded positively. In contrast, other changes (health services and family dynamics) are assessed by older Ocuitucans as resulting in both positive and negative outcomes, that is, with a great amount of ambiguity.

In summary, Ocuitucans' view of the world (or subjective context) is composed basically by five elements, namely:

(1) a sense of being exploited;
(2) a sense of uncertainty (which, in turn, is composed of five dimensions such as randomness, a disposition to face the unexpected as normal, an orientation to the present, a sense of precariousness and a familiarity with an inability to fulfill projects);
(3) a sense of being placed at the bottom of the social scale, and a consequential view of economic success as 'lifting oneself up'. Hence, an implicit emphasis on the value of 'strength';
(4) a familiarity with a patriarchal and violent order, which places women in a secondary position relative to men; and
(5) a sense that the community is undergoing a series of unprecedented changes, particularly in the areas of economy, education, health services and family dynamics.

VI. OCUITUCANS' SUBJECTIVE EXPERIENCE OF HEALTH AND ILLNESS

What does 'health' mean to Ocuitucans—who see themselves as having to *lift* themselves *up* in order to survive? What is the meaning of 'illness' for them—who live with a permanent sense of being exploited? How are illnesses experienced by Ocuituco's inhabitants, who perceive everyday life—in turn interpreted as undergoing a process of change—with a great sense of uncertainty, and who reflect in their common-sense assumptions the values of a social order which oppresses women? In summary: how do Ocuitucans attach meaning to issues of health and sickness in a context of economic deprivation, patriarchy, medicalization and tradition?

VI.1. Concepts of health and disease

In Ocuituco, the ideas of 'health' and 'illness' are pure abstractions at a general level of analysis. But for flesh and blood individuals, health and illness in everyday life are experienced as concrete phenomena. In talking about them, individuals resort to specific ways of naming these phenomena which reflect their subjective experiences while at the same time *indexing* the nature of, and their position in, the society where they live. In a research like this aimed at exploring the way individuals subjectively experience and attach meaning to health and disease, it is crucial to begin by exploring how Ocuitucans *name* these phenomena.

An initial finding is that Ocuitucans refer to health (salud) by using the spanish term *gordo, gorda* (which simultaneously means fat, corpulent, fleshy, stout and plump*). This is a term with no negative connotations and it is used as a synonym of 'healthy'. Thus, to indicate that someone is a healthy (saludable) individual, Ocuitucans say "she is *gorda*, she is ok". The term *gordo(a)* is used as a synonym for being 'healthy', which is also a well known and used concept. For instance, to refer to the unexpected death of her daughter, a father describes her as a healthy girl by saying:

*In English, *fat* and *plump* have different connotations. The word *gordo(a)*, on the contrary, is used ambiguously to embrace both meanings in Ocuituco. For middle- and upper-class urban people, *gordo(a)* is normally meant in the sense of *fat*, hence with a negative connotation. They normally differentiate between *saludable* (healthy), and *gordo(a)*. Ocuitucans use *gordo(a)* in both senses.

She was born ok, very *gorda*, good-looking, a pretty girl. But then I don't know what it was [and she got sick and died] . . . (M38/1988)

The term *gordo(a)* suggests, by implication, its antonym, namely, *thin* (*flaco*). This term is also used to indicate the opposite to health, namely illness. For instance, in describing both healthy and sickly women, a man characterizes the former as "*gordas*, plump, pretty"; and he refers to the latter as being "very thin, ugly" (M37/1988). Given the marginal economic conditions in Ocuituco, to get *gordo(a)* (in the sense of well fed) is something that is not taken for granted, as opposed to what urban middle- and upper-class sectors do. It is, consequently, a state of affairs to be recognized and named each time it occurs. By definition, things taken for granted are normally not mentioned, but they may be clearly implied in everyday conversation. Thus, in a society where economic deprivation is the central feature of everyday life, to get or to be *gordo(a)* is both a worthy accomplishment to be acknowledged, and a state readily recognized as an indicator of health.

A second term that Ocuitucans use to refer to health is *contento(a)* (glad, animated, happy). As in the case of *gordo(a)*, Ocuitucans use this term as a synonym of health and on occasion instead of 'healthy'. *Contento(a)* might be used as a synonym of an absence of symptoms:

. . during the day they might be very *contentos* but then about nine or ten o'clock in the evening, we are watching TV and [suddenly one of them starts to complain about his stomach] (F1/1988).

Sometimes, on the contrary, individuals use the opposite term, *sad* (*triste*), *to refer to the fact that someone is sick*:

—And how do you know when they are sick?
—Well, they get *sad* and they don't want to eat (M47/1988).

As to be *contento(a)* is the opposite of being sad, of unhappiness, the use of this term indexes a vision of the world in which one is healthy–*contento(a)* or sick–*sad* simultaneously. In contrast, in the urban sectors of the Mexican population, there is a clear distinction between these pairs of concepts. Given that these concepts (health-gladness) are matched in the case of Ocuituco, studying the meaning of 'health' inevitably leads to an analysis of the meaning of *contento(a)*. As noted above, it is not irrelevant that Ocuitucans seldom use the concept 'health' (salud) in their everyday language and prefer instead the concept *contento(a)*. This preference reveals that the word *contento(a)* is much more meaningful to them than 'health', and that it is a concept much closer to their subjective experience of physical and mental well-being than 'health'. This is the result of a life of pain and suffering, in which it is difficult to distinguish 'disease' from other hazards, and the other problematic conditions (poverty, marginalization, oppression, uncertainty) which may result in unhappiness. In other words, from the Ocuitucan vision of the world, 'health' is too specific a concept, one that is difficult to differentiate from the related ideas of 'joy', 'gladness', and 'happiness'. Thus, these concepts simultaneously tell us something about the social setting within which they are used, and at the same time they refer to an individuals' subjective experience of health and sickness.

Up to this point, however, we still know very little about the specific nature of the subjective experience of disease. To accomplish this, we must move towards a more detailed analysis of Ocuitucans' accounts of these issues. A first insight is provided by analyzing some of the answers provided to the question 'how sickly have your children (or yourself) been?'

Ocuitucans tend to minimize, by characterizing them with a single physical attribute, those less serious diseases that they have actually had, and to differentiate them from others that are regarded as grave or authentic diseases. Benign diseases (cold, fever, *bronquios*) are defined by Ocuitucans as 'brief', 'simple' and 'slow' diseases:

—And your grandsons, have they gotten sick?
—Well yes, but only like this, not seriously, only *slow* disease (F36/1988).

By characterizing non-serious diseases as *slow* ones, they are implicitly comparing them with other 'faster' diseases which are indeed fatal:

—So your wife has 11 children?
—She had 11, one girl died when she was 15 months old; she started vomiting at five o'clock in the morning, then she had diarrhoea, and by nine o'clock in the evening she was dead (M40/1988).

In contrast, *real* diseases are defined at least in two ways. The first is also by mentioning their main physical attribute or consequence. Thus, a grave disease is characterized by Ocuitucans with terms like 'hard', 'rooted' (chronic), 'deadly', 'strong', 'which leaves one paralytic', 'bad', 'which gives attacks', 'ugly' and 'big'. The second criterion is by mentioning the medical attention that they may require. However, modern medicine's role in defining what a disease is has only recently become important. The process of *medicalization* that has occurred in the definition of disease among Ocuitucans is clear. Older people, for example, tend to equate the increasing availability of medical services with a rise in the occurrence of diseases (or vice-versa: they tend to equate the former relative lack of medical services with a lower prevalence of disease):

—And . . . did you get sick when you were young?
—No, as I'm telling you, when I was breast-feeding my children there were no medical services, here there wasn't anything (F31/1992).

The effects of *medicalization* have been different for the elderly and for the new generations. The elderly have not adopted a medical language to characterize their diseases and, at the same time—as indicated above—tend to notice that at present there are more

diseases than there were in former times. Younger persons, in contrast, do not have an opinion on whether there are more diseases now than in former times (for they lack the experience to make any comparison), and at the same time have a much more medicalized language to refer to the gravity of diseases than the elderly:

—What diseases have you had?
—Only Tonsillitis and colds. So far nothing of serum, hospital, operations and anything like that (F27/1992).

In summary: *health* to Ocuitucans means basically to be *gordo(a)* or *contento(a)*, that is, it is a general notion of well-being in a social environment full of threats against it, one which refers—by implication—to the real possibility of not having enough to eat (i.e. being thin), or being emotionally overwhelmed (sad) by the every-day conditions of living. A *less* serious *disease* is understood as one that is simple, brief or slow. This contrasts with a *serious* disease which is understood either as a hard, rooted or big disease (under a non-medicalized version, among older adults), or as a condition that requires hospital, serum, an operation or lab analysis (under a medicalized version, among younger adults).

VI.2. The subjective experience of symptoms

The epidemiological profile of this town epitomizes one in which *poverty* is the salient factor in most diseases. Infections, specifically those involving the respiratory and digestive systems constitute the main cause of disease. Some chronic diseases have started to alter this profile, such as diabetes and heart diseases. For the purposes of this paper, the vital sociological issue is how are these conditions seen and interpreted by the inhabitants of Ocuituco.

At first glance, symptoms, as presented by individuals during the interviews, present no special feature: dizziness, fevers and nauseas, which are reported by all kinds of interviewees in relation to most kinds of diseases; common sensations, such as tiredness, weakness, feelings of asphyxia and lack of appetite; common swellings, such as of the face, eyes, abdomen and thorax; different kinds of suspended bodily functions. These are referred to by individuals as symptoms of diseases, such as a sudden inability to see, to hear, to speak, to walk or to have a bowel movement; and a range of pains reported by individuals, such as headaches, stomach ache and pains in the gall bladder, kidneys, urinary tract, lungs, legs, back and bones.

This listing is an abstracted grouping of symptoms identified by Ocuitucans. What is critical is to understand more specifically how these conditions are experienced and, more importantly, how individuals' subjective experiences of them relate to their general view of the world and the objective conditions in which they live. Naturally, *pain* is a core category used by Ocuitucans to refer a symptom. A distinctive pattern which emerges is how Ocuitucans relate their symptoms to *pain*. There is a differential ability of individuals to localize their physical pains. Younger individuals refer to bodily parts and organs with greater familiarity than older individuals who tend to acknowledge a medical source to support their description:

Now I'm sick. Look, I have a pain which *the doctors understand* corresponds to the gall bladder (F13/1988).

Pain, then, is often experienced as a *symptom* by Ocuitucans. The fact that pain is regarded as an indicator of disease accounts for why many women talk about menstruation in terms of an illness:

—And when you were young, what diseases did you have? . . .
—*I started to get sick when I was 16.* I would have a lot of pimples (F30/1992).

In addition, there are at least three other ways that pain is interpreted.* First, it may be understood as *a cause of death*. For older individuals, who normally have had less education and, consequently, draw upon a limited *medical ability* [11], it is common to cite pain in accounting for the death of a relative:

—What did he die of?
—They say that *he died of pain*, but he would drink too much (F11/1988).

Pain may also be cited as *the reason for visiting a doctor*. Some Ocuitucans—particularly those from the older generation—tend to characterize modern doctors according to their ability to reduce their patients' pain. As a result, obtaining relief from pain is one of the main expectations that individuals have from their visits to doctors:

I change doctors as I change sandals. Because you can notice immediately whether the medicine they give you really eases your pain (. . .). They often get angry and say that one is just playing [because of the wandering around from one doctor to another] but *what I want is for him to calm my pain* (M13/1988).

The third way that pain is interpreted, specifically by women, is as a *means of knowing* the body, its diseases, or the impact of certain remedies or medical devices. When asked what she knew about her body when she got married, a 63 year-old woman replied:

Nothing because, look, the only thing that sometimes would hurt was my head. I would catch strong colds, that's what I would suffer from. Other than that, I didn't know about anything, anything (F5/1988).

Similarly, 'knowing' about a specific disease may be interpreted as a synonym of knowing how it feels or hurts when such a disease is acquired. For example, in response to the question "what do you know about AIDS?" several women answered in

*The fact that some of these dimensions of pain may exist in other societies does not undermine the legitimacy of indicating their existence in Ocuituco. For this study, rather than aiming to focus on what is exclusive of Ocuituco, seeks to identify, as much as possible, all that exists there, regardless of their exclusivity, in relation to the subjective experience of health and illness.

similar terms: "I don't imagine how it is or *what they feel*" (F9/1988).

In summary, several additional dimensions of pain can be observed within the general perception of this concept: *pain* can be experienced as a *symptom*, as a *cause of death*, as a *reason to visit a doctor*, and as a *means of knowing*. The existence of the latter dimension—as a means of knowing—allows us to interpret the intriguing dialogue between the field researcher and a 29 year-old woman who was using an IUD:

—And do you know how the IUD works?
—No, I don't feel anything. *I couldn't tell you that it hurts too much* nor that I feel something. No, nothing (...)
—And how do you think it works?
—I can't even imagine it: am I not telling you that it doesn't hurt and that I don't get nauseated? I don't know how it works ... (F9/1988).

At face value there seems to be a lack of communication in this dialogue since while the researcher is posing a question intended to elicit an answer based on 'objective' categories such as *cause* and *effect*, the woman being interviewed is phrasing her answer in terms of 'subjective' categories, such as *feeling* and *hurting*. In giving her answer, however, the interviewee is drawing on the notion of *pain as a means of knowing*. She does this precisely because she is being asked a question about her *knowledge* on the issue being discussed. The reasoning underlying her statement is of the same order of the woman quoted above, namely, "I don't know because I haven't felt any pain". In a world where individuals (particularly women) see their world from the perspective of the oppressed, it is not surprising that pain is one of the main cognitive categories that is drawn upon. Consequently, *pain* is one of their fundamental ways of *being in the world*. For them, getting to know this world is by necessity an experience closely associated with their experience of *suffering it*. This seems to be particularly true in the case of women regarding their subjective experiences of health and disease.

VI.3. Causes of disease

From the perspective of Ocuitucans, what are the main causes of disease? Sometimes, individuals display a view of causality in which diseases are seen to come from nowhere, to appear randomly. On other occasions, etiological theories are related to factors such as water, work, diet and accidents. It is important to explor in detail these patterns of interpretation.

(a) Randomness and contagious conditions. A first finding points to the tendency of many Ocuitucans to refer to diseases as being ailments which *suddenly* appear, and which seem to come from nowhere. At first glance, diseases appear to be experienced as autonomous entities existing outside the human body and which, consequently, may 'fall' on any individual. In Ocuitucans' language, a disease may be the subject of a sentence, and the individual suffering such a disease the object. That is, Ocuitucans often phrase their accounts as portraying an 'active' disease afflicting a 'passive' victim who is 'caught' in the web of the disease. For instance:

—How did your brother die?
—Cancer fell into his blood* (M43/1992).

Other common expressions are 'a cold caught me' (instead of 'I caught a cold'), or 'diarrhoea has been very tough recently' (instead of 'there have been many cases of diarrhoea recently'). Underlying this view of causality, there is clearly both a sense of *randomness* (for diseases appear to occur unpredictably) and a view of the individual as a helpless victim of disease. Experiencing diseases as 'just appearing out there' is also an expression of Ocuitucans' readiness to face *the unexpected as being normal.*

Closely related to this perception of randomness is the fact that the notion of 'contagious conditions' in modern medical terms is almost nonexistent. It is, indeed, remarkable in a community where infectious diseases constitute the most important ailments afflicting individuals, that the idea of spreading a disease by contact with others is so secondary. The notion of 'contagious conditions' is found in the interviews basically in two forms: (a) closely linked to *traditional* notions of health and disease; or (b) directly associated with AIDS. In other words, the notion of a 'contagious condition' is related either to an *ancient* way of understanding disease (the Nahua tradition), or to a recent *modern* ailment (AIDS). But in between these extremes, there does not appear to be an intermediate notion which would correspond to the contemporary general biomedical theory of contagion.

The Nahua *tradition* appears to account for some of the ideas about contagious conditions found today in Ocuituco. Some women believe it is dangerous for them to attend a wake if they are pregnant or menstruating. In former times under the Nahua paradigm, it was believed that a dead body would liberate some spirits greedy for heat and energy. Pregnant women were considered to be hotter than normal. Thus, they were easy targets for such greedy spirits. Today, while the *substance* of this belief has disappeared, its *structure*—adopting a new terminology—still continues. Some women believe that it may be dangerous for them to attend a wake while they are pregnant, for they may get 'cancer'. A 31 year-old school teacher narrated:

It happened to me [when I was pregnant]. When my aunt died they told me 'don't go [to the funeral] (...) your baby could be born damaged or dead!'. That's the belief. It's the same when a woman is menstruating. If the deceased person

*It is indeed difficult to translate in accurate terms the Spanish expression '*le cayó cáncer en la sangre*'. Expressions like this, however, are perfectly meaningful in Ocuituco.

died of cancer,* such cancer may befall that woman *who is menstruating, who has a wound.* That is the belief (F17/1988).

The notion of a contagious condition also underlies the association made between having a wound and the risk of being infected if a woman gets too close to a dead body. By juxtaposition, menstruation and having a wound are equated in these accounts by the informants.

There is also the widespread notion of the contagious nature of AIDS. This, undoubtedly, is the result of a national educational campaign on AIDS prevention. There are, however, some generation-specific differences in the use of the concept. Whereas younger individuals tend to use the Spanish verb '*contagiar*' (to spread by contagious infection), older individuals exhibit a more diffuse understanding of this mechanism:

The only thing we know about AIDS is that it is a disease caused by sex, *by making bad use of a woman.*† But only that. More than that we don't know (M42/1988).

However, the view of diseases as occurring randomly, as apparently emerging out of nowhere, is not absolute. On the contrary, individuals often identify a series of factors as the causes of their diseases, the main ones being water, work, diet, and accidents.

(b) Water. From the perspective of Ocuitucans, water stands as one of the most relevant causes of disease related to *poverty*. Water is seen to cause disease in several ways, with pollution being a major cause. The extent of this awareness, however, varies by generation. Younger individuals (usually better educated than the older generation) conceive of this issue in terms of the modern medical discourse which, in turn, purports hygiene as a basic preventive measure, and its absence as common source of disease:

Sometimes [the water] comes as if it had been in putrid mud, very bad. It comes black, and *I think* that, as a consequence, we get sick here. Another problem is hygiene: everything is very dirty, everywhere there is rubbish (M46/1988).

Older individuals, in contrast, speak more cautiously about this issue, and imply in their accounts a *change* over time in the nature of the medical discourse in this community:

Well, look, *today it is said* that people are getting sick because of amoebas, because of the water. *They say* that we drink very bad water. *They say* that this water runs by a place where people wash clothes ... (M37/1988).

Other perceived properties of water are evident in some of individuals' etiological theories. For instance, a second way in which water is understood as a cause of disease appears to be connected to *tradition*, that is, the ancient Nahua hot–cold theory. Some Ocuitucans recognize potentially dangerous effects of water due to its *cold* nature. Often, women who have worked for years washing clothes and dishes to say that they are sick because they have 'taken too much cold'. For instance, a local midwife said that she often gets sickness of the lungs,

because of having worked so much. I have taken too much cold in my lungs because I used to give herbal *baths* to women having babies. Then, after giving them a bath, I would come back to my home as soon as the *rain* was over.‡ I got *all that* cold (F22/1922).

Water's coldness is regarded as a potential threat to health. This includes all kinds of water, from rain water, drinking water and water used to wash. 'Playing' too much with water (as the local expression goes) results in cooling off the body. This coldness, in turn, may be transmitted to an infant by means of breast-feeding. For instance, a 46 year-old woman said her daughter used to have asthma. In accounting for this disease, she explained that during her pregnancy she often felt thirsty and would drink a lot of cold drinks:

and I would wash a lot of things, even in the evenings.§ After she was born I soon stopped breast-feeding her because I would touch too much water and [that was] more [dangerous to her]. And many people would tell me 'you know what, if you want to raise your daughter, stop breast-feeding her because as you wash too many [dishes and clothes], you are passing onto her all the wetness'. I stopped breast-feeding her when she was very little (F26/1992).

Implicit in these interpretations is an underlying notion of an unbalanced body. The healthy body is conceived of as having the right equilibrium between hot and cold. Touching too much water, or getting too wet is perceived as a potential cause of disease because the equilibrium of the body is threatened. This equilibrium, however, refers not only to the internal balance between hot and cold. From the perspective of some Ocuitucans, water itself may exist in inadequate proportions inside the body, which constitutes a third aspect in which this element is perceived as being potentially dangerous to health. On the one hand, diseases may arise as a result of having *too much* water inside the body. Some individuals regard as the cause of a relative's death the fact

*The notion of 'cancer' refers to a wide range of chronic dermatological disorders, resistant to medical treatments and which are difficult to heal [39].

†In Ocuituco, *having sex with a woman* is referred to as *making use of a woman*. Conversely, instead of saying *I have sex with a man*, women say *a man makes use of myself*, or *I give him service*. This is another instance in which the *patriarchal* order existing in this town can be observed.

‡*Rain* is thought to be a *cold* event which cools off the environment. This woman, then, is talking about a double jeopardy: giving baths to women and being outside just after it has rained. She means that she was exposing herself to too much *cold*.

§The expression *even in the evenings* refers to the fact that evenings are considered to be *cold* within the Nahua *tradition* (for there is no more heat from the sun). Thus, the risk of taking too much cold inside the body in the evenings is greater than taking it (washing) during the day.

that the body of the deceased "got completely full of water" (F26/1992). An extreme version of this theory contends that blood itself turns into water:

—How did your father die?
—My father was dropsical. That is [a condition in which] the stomach gets very big, because of water, and the blood turns into water (M44/1988).

In contrast, other diseases may result from having *too little* water inside one's body. For instance, a man narrated having suffered from 'terrible pains' when urinating, a disease whose name he did not remember. When asked what could be the cause of this disorder he said:

[the doctor] says that it is because of not drinking enough water. One goes to the field to work under the sun, and one doesn't drink water. My disease comes from that (M43/1992).

In summary, Ocuitucans regard water as an important source of symptoms and disease. From their *traditional* background of values, they rely on the notion of the healthy body as sustaining a required equilibrium. Water may disrupt this equilibrium, either by altering the balance between hot and cold inside the body, or by having the wrong amount (either too much or too little). In addition, they have recently learned that water itself may be contaminated and, consequently, that drinking it may result in new diseases.

(c) Work and diet. From the perspective of Ocuitucans, another major source of disease which is related to their condition of living is work. For many Ocuitucans, working hard is a cause of disease and, eventually, of death. Thus, on the one hand, they perceive themselves as having to work 'very hard' in order to *lift* themselves *up*. But, on the other hand, they also know that 'working hard' *wears* them *out*, and eventually contributes to their death:

—And your mother?
—She died . . . well, she worked very much, as she raised us alone, she was a single mother, she passed many sleepless nights (. . .)
—So what disease did she get?
—Who knows! She would complain about her belly, that it would hurt very much, that she couldn't even eat anything, it would swell, and her lungs, *because as she worked very much* [as a domestic servant] *she wore herself out* (F26/1992).

Many individuals, particularly women, understand 'work' in a broader sense to include many everyday activities which must be carried out to overcome the limitations of their living conditions. At the same time, 'work' is understood as an activity for which *strength* is required and which may ultimately result in a physical injury. In the search to identify a cause of a disease, some individuals, particularly from the older generation, interpret a whole period of their lives as accommodating a notion of *strength* within the causal chain. For instance, a woman who complained of a recurrent sensation of suffocation and a pain in the right side of her body, provided an interpretation of the nature and the causes of her problem in the following terms:

I think that it is something like a tumor that I have here, which is what suffocates me (. . .). This is because when I was a girl I suffered very much in my home. My parents were very poor (. . .). We didn't have water. It was necessary to carry it from far away in order to drink and to wash the dishes. I used to carry a big container. *I think that it comes from that: from having to go far away to wash big containers with clothes. From having to carry that much* (. . .). That's why I say that it is a rupture or a tumor that I've got (F16/1988).

Younger individuals also resort to the notion of *strength*, but unlike older persons, are more cautious about disclosing their own interpretations. They prefer to stick in the first instance to what a doctor might have told them. Only if further encouraged do they provide their own interpretations which may often revolve around the concept of 'work'. For instance, a 42 year-old man whose first daughter was born with a defect in her head, was asked:

—Why was she born like that?
—Who knows, doctors didn't know what to tell me.
—But why *do you think* she was born like that?
—Well, I think that it was due to the fact that, during the pregnancy, I was working on the land and my wife worked here in the store. *She would have to carry heavy things*, she would have to pull down the metallic curtain [door] which is very heavy. We think this is why the girl was born like that (M51/1992).

Accounts like this suggest that, given the effects of the process of *medicalization* which is taking place in this town, younger individuals are *learning* to distrust their own interpretations, or to accord them a secondary importance relative to the opinion of doctors. Older individuals, in contrast, resort more freely to their own etiological theories.

Conversely, remaining healthy after a long period of working 'hard' is taken by Ocuitucans as proof that someone is a strong person and able to endure harsh living conditions:

—So, do you remember any disease you might have had when you were a boy?
—No, then I wouldn't get anything, can you believe that? Not even a headache, no disease at all. Definitely nothing, and this *despite my being on the land, working, getting wet, not eating on time* . . . (M43/1992).

These same principles apply to women who, instead of referring to working the land (as men do), place their *having-worked-"very-hard"-without-getting-sick* within the context of their domestic chores:

Since I was a girl I started to make cheese. This is ugly and boring work. And I think that *although I used to do a lot of work*, I would never get sick (F31/1992).

Enduring hard living conditions is sometimes taken as a proof of physical strength and resistance. On other occasions, however, the terms are reversed, so that objective restrictions and constraints are thought to be associated to a good health. In other words, Ocuitucans know that conditions such as polluted water, children playing barefooted in the street, and

getting wet too often, stem from their economic marginalization. But some of them also believe that enduring these risk-factors may also contribute to making individuals healthier:

. . . my children grew up in the backyard which then didn't have cement [in the floor]. There were plenty of little puddles and soil and there they were, with their shorts, playing and playing (. . .). That's how all of them were raised, running around, without shoes and without underpants. *That's how people from the countryside are raised and they are raised healthier* . . . (M37/1988).

Another condition which stems from Ocuitucans' economic deprivation and which is also thought to be a cause of disease is having an inadequate diet. Ocuitucans point out that children often get sick because they eat the wrong food (for example, industrialized milk, green fruits, etc.). The same applies to adults, some of whom indicated that they have noticed that they get sick when they do not eat enough or when they 'eat too much fat'. But more importantly, as in the cases of getting wet or working hard, some individuals reported enjoying good health *despite* not having had a good diet during their childhood:

—And what do you think is the cause of you being so healthy?
—Well, I wouldn't know what to tell you, because we certainly didn't have a good diet. My mother supported us but poorly, not with all that is necessary (F32/1992).

In other words, whereas some Ocuitucans make a *direct link* between their economic deprivation, their unsatisfactory diet and their sickness, others—who have enjoyed better health—also cite a background of poverty in order *to contrast* these circumstances to their health status. Sickly individuals tend to think that they become sick *because* of their restricted living conditions. Healthy individuals, in contrast, indicate that they have remained healthy *despite* their economic limitations. In both cases economic deprivation is the general reference point to which individuals resort in accounting for the causes of their health status.

That individuals do not get sick *despite* having worked too much, or having gotten wet too often, or having been raised barefooted or having a poor diet, connotes a notion of *endurance*. In their accounts, Ocuitucans imply that, from their point of view, there were enough reasons (enough risk-factors) for them to get sick and that, *despite* these risks, they somehow have been able to remain healthy. They implicitly suggest that a logical outcome of their living conditions would have been for them to get sick, but that somehow they have been able to *endure* their circumstances.

(d) Accidents. In a high risk environment such as Ocuituco, accidents are frequently experienced by the inhabitants of this town and are, consequently, an important *cause* of disease and health problems. It is particularly women who exhibit a preference for 'accidents' to account for many of their health-related problems. Their interpretations are of two types: first, they sometimes subsume under the notion of an 'accident' events that have direct consequences for the health, but which could hardly be interpreted as such from a non-Ocuitucan perspective. The case of the woman who regards having been attacked with a machete by her husband as an accident illustrates this point:

—I had an *accident* [when I had my first child] (. . .)
—What happened?
—It was then that the father of my daughter beat me (. . .) he attacked me with a machete (. . .) (F12/1988).

Sometimes male violence is called an 'accident'. At other times it is the metaphors that women use to characterize the effects of male violence which convey a notion of an accidental event. A woman described the case of a younger woman who was attacked by her husband as follows:

he stuck the sharp end of a machete inside her. She had a wound [which looked] like *when you get between the barbed wires and your clothes are torn off* (F12/1988).

The second type of interpretation that women tend to make consists of subsuming under the story of an 'accident' things and events that from a non-Ocuitucan perspective could be considered as occurring independently. That is, accidents appear to constitute an opportunity for women to make sense of some of the events and circumstances occurring more or less simultaneously. Diseases, in particular, are often explained as resulting from an accident, even when the accident happened to someone other than the individual whose disease is being discussed. For instance, a 23 year-old woman narrated:

Two weeks ago I got very sick [because] my father fell from a horse with my daughter and I got *a kind of susto** and then fear. I felt that I got fear (. . .). I was almost dying and I would have a kind of colics. It was about four o'clock in the afternoon. My father took us to the doctor; he didn't have money either, who knows where he got it from, he says that my uncle lent it to him, he went to my uncle to borrow 50 thousand pesos.† But just the doctor costs 40 thousand pesos. Now the serum plus the taxi from there [Cuautla] to here it was 6,500 pesos more. And I came back at about ten o'clock in the evening (F1/1988).

Several observations can be made about an account like this: first, this woman attributes the cause of her pain in the stomach to the accident involving her father and daughter (falling from a horse earlier the same day). Second, once she has placed in context such an accident as the event triggering her disease, a full array of otherwise unconnected events are introduced in this account: (a) the fact that neither she nor her father had money, a situation which forced her father to borrow money from a relative. By

*Much has been written about *susto* mainly from an anthropological perspective. In the context of Ocuituco, the meaning of *susto* is related to the *traditional* Nahuat disease called *loss of the shadow* [40, 41].
†Approximately US$22.

saying that her father *didn't have money* ***either***, this woman makes clear that *economic deprivation* is such a constituent part of her everyday experience of health and disease that this fact is taken for granted in her story; and (b) she also makes it clear that *precariousness* is a dimension ever-present in her life, both in the sense that she was just lucky enough to have a relative around who lent them money, and in the sense that the fragile equilibrium of her life was completely disrupted by an accident, an *unexpected* event which led them to contract a new debt with a relative. From the point of view of this woman, several unexpected events took place as a consequence of a specific cause: an accident. By interpreting her father's accident as the trigger of the remaining events on that day related to her disease, this woman is able to make sense (at least partially) of a series of events that otherwise would remain unconnected from each other. For individuals who already perceive their world and their circumstances as occurring randomly and unexpectedly, accidents constitute a good opportunity to render accountable at least some of the 'things' that happen to them.

Blaxter [12] has identified a tendency among women to integrate a wide range of bodily events—from the past to the present—into their explanations of disease. Ocuitucan women exhibit a similar integrative tendency in relation to accidents, the difference being that they do not focus exclusively on their own bodily events; instead, they tend to include a wide range of other events occurring in conjunction with an accident. In a world perceived as a random series of events occurring beyond their control, diseases and accidents constitute a golden opportunity for many individuals to attach meaning to some of those occurrences.

VII. DISCUSSION

This research has focused on the links between three levels of reality in Ocuituco: the social structure, the actors' view of such a structure (subjective context), and the subjective experience of health and illness. This approach contrasts with that of the authors who studied the subjective experience of health and illness and its link with the *social representations* of disease [8–10]. However, despite the difference between her approach and that followed in this research, Herzlich's central finding that social representations reflect the relation of the individual to both illness and health, and to society, has, in a way, been replicated in this study. Expressions such as 'being *gordo* or *contento*' (to refer to health), or 'being healthy *despite* working too hard' (to refer to health *in contrast* with their economic conditions)—to cite just a few examples—illuminate both the individuals' experiences and some of the central features of the social order in which they live.

Boltanski's [11] concept of *medical ability* constitutes a central contribution which helps to conceptualize individuals' differential ability to interpret symptoms and signs. In Ocuituco, individuals are also able to identify symptoms that doctors cannot recognize. This, however, is not due to the fact that they have an over-developed medical ability (as Boltanski pointed out regarding the case of French population), but because their medical ability derives from several sources, of which modern medicine is one and the traditional Nahua paradigm being another. *Medical ability*, then, is a historical product, whose specific features are contingent upon the main characteristics of the society where individuals live.

Blaxter and Paterson [12, 13] state that lower-class individuals' lack of control over their own circumstances directly results in the development of etiological theories based on randomness. Here, as in the case of Boltanski, an intermediate cognitive structure is not theorized, but simply assumed. In this study, on the contrary, it has been shown that Ocuitucans' objective conditions of living correspond to a specific view of the world which they sustain, one where a sense of randomness is but one of several cognitive features characterizing their common-sense. The advantage of theorizing this intermediate structure—here called the *individuals' view of the world*—is that a number of traits emerge as closely connected to the objective conditions of living, and which also can be identified as a constituent element of the subjective experience of health and illness. This, in turn, makes it possible to recognize that the link between the experience of health and illness on the one hand, and society, on the other hand, is a much more complex one as that suggested by Blaxter and Paterson.

Within the tradition of *interpretive* studies, Cornwell [23] conducted one of the few studies that attempted, as this one did, to link together the objective conditions of living, the subjective context (common-sense), and the subjective experience of health and illness. Her concept of *public accounts* presupposes that modern medicine has become such an important paradigm, that it has actually become *the* dominant ideology. In contrast, modern medicine in Ocuituco may be on the way to becoming the dominant paradigm, but it still finds itself coexisting with the traditional paradigm. Living in this multiparadigmatic environment makes it easier for individuals to disclose their own points of view, since modern medicine has as yet been unable to 'regulate' more effectively their way of thinking. In other words, modern medicine is a paradigm which is constantly questioned and criticized, particularly when individuals resort to the *traditional* paradigm. This duality is the main reason why Cornwell's distinction between public and private accounts does not appear to pertain to the case of Ocuituco.

The studies carried out from a symbolic interactionist perspective [24–26] emphasize the *productional* aspect of the subjective experience, that is, they show how the subjective experience of health and illness arises, at least partially, out of specific patterns of

interaction between individuals. This aspect has not been directly observed in this study—since a symbolic interactionist perspective was not adopted—and yet, it has been possible to illustrate how the social order of Ocuituco results in specific patterns of social interaction which, in turn, contribute significantly to shape individuals' subjective experience. The case of women is illustrative: through their accounts it has been possible to reconstruct how their subordinated position prevails in their relations with men, and how this domination, in turn, is a key element that partially shapes their subjective experience of health and illness.

Finally, feminist studies have been classified here according to their approach to the experience of health—normative or interpretive. The former rest on the concept of *patriarchy*, but tend to assume, rather than to explain, women's actual subjective experience of health and illness. The latter, in contrast, elucidate many aspects of such a subjective experience but often remain silent about the central features of the social structure where women live. In this study, an attempt has been made to recover both dimensions by using the concept of *patriarchy* as proposed by Fox [38]. On the one hand, the social order of Ocuituco is one in which men dominate women. This can be appreciated, for instance, in the preference men are given over women in education and work, or in the many social norms that stipulate that a married woman must look after her husband and his parents. On the other hand, this social order is viewed by men and women in a way that women appear devalued as compared to men; in consequence, their own subjectivity eventually becomes a *gendered* one (subjective context). That is, both men and women tend to regard the domination of women as a given, as something that can be taken for granted. Thus, both levels of reality appear to have an impact on the subjective experience of health and illness. Consequently, the subjective experience of health and illness in Ocuituco is not primarily shaped by the biological aspects of diseases, but by the social circumstances (at the levels of both the social structure and the subjective context) which surround them.

VIII. SUMMARY AND CONCLUSION

Ocuitucans understand the concept of health not merely in a negative form (i.e. the absence of disease), but indeed in positive terms: for them, health means basically to be *gordo*(*a*) or *contento*(*a*). There is an historically specific Ocuitucan way in which symptoms are experienced and causes of illness explained. The case of the notion of *pain* is illustrative: in addition to being regarded as a symptom, pain in Ocuituco may also be seen as being associated with the main cause of death of certain individuals, and as the main reason to visit a doctor. Furthermore, *pain* is also a woman's way of knowing about her body and its disorders. For Ocuitucan women, *suffering* is a form of *learning*. This is meant literally in this town: a common way in which women express that they do not know something about the body is by saying that they have not felt any pain related to it.

In talking about their diseases, Ocuitucans sometimes resort to their view of the world as a *random* series of occurrences, involving elements well beyond their control. That is why they sometimes refer to diseases as 'falling' on individuals. Furthermore, in accounting for their symptoms, just as in accounting for the causes of their diseases, Ocuitucans reflect their conception of the world which is a view from the perspective of the oppressed. A central finding of this research refers to the tendency of Ocuitucans to *contrast* their health with their living conditions and frequently to *explain* their disease as resulting from those conditions. A hypothetical contrast to Ocuitucans' experience of health would be one in which health would mean basically *congruence* between *being* and *doing*. That is, under this notion there would be an overlap between living in the world (*doing*) and *being* healthy. It would be then possible for individuals to say that they are healthy *because* that is the way things are supposed to be. Ocuitucans' conception of health, on the contrary, is one in which there is a permanent *discrepancy* between individuals' *being* and *doing*. Thus, they talk of being healthy *despite* having to work so much, or *despite* getting wet too often, or *despite* not having an adequate diet, etc. The experience of *health as congruence* implies a view of the world in which a logical outcome of the everyday conditions of living is precisely 'health'. It is a view of the world in which, as it has been illustrated by Herzlich [8], health can be taken for granted. The experience of *health as discrepancy*, on the contrary, connotes a view of the world in which everyday reality is perceived as a permanent threat to the health, one in which, consequently, individuals perceive themselves as *resisting* their circumstances. A sense of oppression, of *being at the bottom of society*, is clear here. In this case, not only can health not be taken for granted, but indeed illness is perceived as a logical outcome of everyday conditions of living. Not surprisingly, then, the notion of *enduring* plays a central role in Ocuitucans' understanding of their health and illnesses. *Endurance*, however, is perceived by Ocuitucans as a limited attribute, one which erodes over time. It is clear then why Ocuitucans perceive the human body as an entity which is *worn out* by simply existing in this society, mainly when 'existing in this society' means, as it does to Ocuitucans, working 'hard' in order to *lift* themselves *up*.

The notion of *resisting* the harshness of everyday circumstances arises basically out of Ocuitucans' perception of being at the bottom of the social scale, that is, of their awareness of their economic deprivation. It is here that the validity of Herzlich's central thesis can be best appreciated: the language of health and illness of a given group reflects the fundamental nature of their relation to others and society.

This notion of *enduring*, however, is further reinforced by some concepts derived from the *traditional* (Nahuat) background, namely, the idea that the human body must maintain an internal hot–cold balance. Consequently, being constantly in touch with water may alter such an equilibrium. For individuals, however, who spend their lives either working at home washing and cooking, or working as domestic servants (basically washing someone else's clothes), or cultivating the land, it is impossible not to be in contact with water. Thus, work and water are perceived as threats to health, a perception which, in turn, reinforces the general sense of having to survive by *enduring* everyday reality. Water has become an additional threat to many Ocuitucans since they learnt that it may carry pathogenic germs. This is one of the many *changes* that modern medicine has introduced in this town. Today the older generation refers to this new knowledge by emphasizing that 'they' (doctors) brought it to this town.

Herzlich found that, among middle class individuals of an industrialized society, there is what she called a "morality of health", that is, a generalized situation in which individuals perceive themselves as having the 'duty to be healthy'. In Ocuituco, in contrast, the generalized situation is one in which individuals perceive themselves as being permanently threatened by their conditions of living. In this context, there are some individuals who are able to endure these conditions and to remain healthy. From their point of view, they do not have the 'duty', but the good 'fortune' of being strong enough to remain healthy.

Accidents, in turn, are perceived as true misfortunes which occur randomly. In the case of women, however, a double pattern is observed: they either interpret as an accident some *violent* events that from a non-Ocuitucan perspective are not accidents, or they subsume under the narrative of an accident events which indeed occur independently. What is clear in both cases is a tendency to include as many events as possible under the interpretation of an accident.

Throughout this paper it has been illustrated how some of the central features of Ocuitucans' *view of the world* are present in their interpretations of symptoms and causes. Some dimensions of the sense of *uncertainty* have been exemplified (e.g. randomness in the occurrence of diseases and accidents; a disposition to face unexpected events as being normal which is reflected in the tendency to regard some diseases as 'falling' on individuals; and a sense of precariousness present in some of the accounts in which a fragile everyday order is portrayed as disrupted because of the appearance of painful symptoms, etc.). Similarly, it has been argued that the notion of *health as discrepancy* is closely connected to the *sense of being placed at the bottom of the social scale* and the consequential need to work hard in order to *lift* oneself *up*; a *sense of change* is present in how older individuals' refer to the fact that water may contain 'bad germs' (e.g. "*now they say* that the water is polluted"). And, finally, the fact that violence is regarded by some individuals as a type of 'accident' is, undoubtedly, a reflection of the *patriarchal* order of this society.

In studying the subjective experience of health and illness we gain deeper sociological insight by addressing this problem in its interconnections with two equally important levels of reality, namely: (1) the social structure; and (2) the actors' view of such a structure (or subjective context). This is, indeed, the main conceptual contribution of this research. By using this paradigm, the social nature of the subjective experience of health and illness has been made clear again (as many studies have shown). Here, however, it has also been shown that the social nature of this experience is neither one completely resulting out of the features of the social structure, nor out of the individuals' freedom and creativity. The subjective experience of health and illness is a complex sociological phenomenon that draws upon both the objective and the subjective social realities. Unless these two levels are addressed simultaneously, the study of these issues will render results that emphasize either a too mechanistic or a too spontaneous subjective experience of health and illness. This phenomenon, however, does not appear to conform fully to any of these alternatives, and yet it appears to share the main features of each. It is contended that the use of the paradigm that has been proposed here yields a good solution to this problem.

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