The Sociosomatic Course of Depression and Trauma: A Cultural Analysis of Suffering and Resilience in the Life of a Puerto Rican Woman

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Objective: This study sets forth the premises of psychosomatic and sociosomatic approaches in medicine and psychiatry and considers how these approaches differentiate or complement one another. The course of persistent mental illness is examined in sociosomatic terms by considering a life defined by a cycle of expectation, violation, illness, and recovery. *Method:* A case study of a Puerto Rican woman is drawn from a larger study of the course of depression and schizophrenia among 80 Latinos and Euro-Americans. *Results:* Analysis of the patient's narrative reveals a set of interrelated themes in terms of which this cycle is structured. *Conclusion:* The study concludes by offering a structural model of the sociosomatic reticulum that define the interaction between bodily experience and social relationships or conditions. **Key words:** sociosomatic, depression, trauma, resilience, women/gender, culture, Puerto Rican.

Sufrir me tocó a mi en esta vida
Llorar es mi destino hasta el morir.
No importa que la gente me critique
Si así he de vivir
Por causa de este amor.
Yo soy yo y mis circumstancias.

[To suffer is my lot in this life
To cry is my destiny until I die.
It matters not that people criticize me
Is what God must have meant for me
As a consequence of this love.
(Latin-American folk song).]

I Am Me and My Circumstances
Jose Ortega y Gassett

This study is an analysis of the course of persistent mental illness in "sociosomatic" (1, 2) terms. We begin by summarizing the central tennets of psychosomatic and a sociosomatic approaches in medicine and psychiatry and consider how these approaches differentiate or complement one another. The psychosomatic model in medicine "... is built on the premise that many disease states arise, at least in part, from the internal responses of individual human beings to psychological and psychosocial events. The responses evoked are as distinct and unique as the individuals in which they are aroused. Many different aspects of the individual are involved—genetic and biochemical makeup, cultural background, and general psychological profile or 'personality'" (Ref. 3, p. 222). In our understanding, the psychosomatic model is organized by the following ideas and assumptions: a) the primacy of psychological experience; b) a conceptualization of psychosocial events as vulnerability or protective factors in the onset of disease states; c) the role of psychophysiological stress in response to psychosocial events; d) the role of emotion in the stress response where emotions are conceived as universal psychophysiological events; e) a conceptualization of the self as an independent, bounded individual of relatively autonomous agency; and f) the determinant role of individual characteristics (biogenetic, cultural, and especially personality) in response to events that mediate stress-related conditions. Taken together, this set of interactive factors can produce particular states of mind, which, in turn, may be converted into physical symptoms. Thus, health and illness are defined in terms of the interaction of mental and physical characteristics of individuals in response to the psychosocial environment.

By contrast, the sociosomatic model advanced by Kleinman (1, 2) can be set forth in terms of: a) the primacy of social events, conditions, and relations; b) the conceptualization of social events as potentially productive or ameliorative of disease states; c) the role of bodily experience in relation to social world; d) the role of emotion in bodily experience where emotions are anthropologically defined, for example, "... as self-concerning, partly physical responses that are at the same time aspects of a moral or ideological attitudes; emotions are both feelings and cognitive constructions, linking person, action and sociological milieu." (Ref. 4, p. 128); e) a conceptualization of the self as intersubjectively constituted in relation to the social world; f) the shaping and patterning of bodily processes through a dynamic interaction of subjective experience, cultural meaning, and situated context. Taken together, these factors may mediate the onset or course of illness. Thus, illness and health are conceived not in terms of a mind-body dichotomy that would separate biological or psychological characteristics, but rather as the embodiment of social events and conditions.

Whereas a psychosomatic approach is based on the primacy of the psychological and individual factors, the sociosomatic centrally concerns social conditions and relations. By "psychosomatic" we typically refer to the interaction between psychological processes or dispositions and bodily experience, whereas the notion of "sociosomatic" indicates the interaction between social relationships or conditions and bodily experience. In focusing on the sociosomatic mediation of illness experience, our interest, therefore, goes beyond the psychosomatically driven notion that a stressful day may well aggravate duodenal ulcer, but also that specific social relations and conditions are converted into specific illness processes and symptomatology. As Kleinman (Ref. 1, p. 146) has put it, illness meanings constitute "... the symbolic bridge, the sociosomatic reticulum that ties failure to headaches, anger to dizziness, loss and demoralization to fatigue ..." such that the understandings reflexively become part of the bodily processes themselves. This interaction is culturally constituted in the sense that the meanings of social relationships and bodily experiences are mutually informed.

Whereas a psychosomatic approach may render somatic symptoms as a particular psychological process, that is, somatization, a sociosomatic approach regards somatization as "... normative and normal, ..." a "... bodily mode of expe-

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riencing personal and political distress, . . ." which should not be regarded as a ". . . substitution for something more basic . . ." (that is, psychological process) (Ref. 2, pp. 9, 101). In the sociosomatic approach we are outlining here, it is possible that the culturally orienting "ethnopsychology of emotion" (5) may be constituted in largely psychological terms in one sociocultural context (eg, middle class Euro-American) and in somatic terms in another (eg, working class Puerto Rican).

Although we have set forth the points of contrast for these two orientations, the points of convergence should also be noted. Psychosomatics and sociosomatics seek an integrative analysis that is neither mechanistic nor static. In psychosomatic medicine, for example, elaborations of what was initially imagined to be the work of mental states in directly and independently affecting bodily systems has been elaborated through research on the immune system (3). In the sociosomatic approach outlined here, the notion of personal agency has become more central to an anthropological understanding of emotional experience and expression. Methodologically, both approaches require a complex interpretation of symptoms that eschews reductionism. Both are concerned with subtle interactions of social milieu and psyche or subjective experience.

In the following discussion, we will identify the sociosomatic reticulum of depression and traumatic disorder. In this context, by *social course* we refer to the way in which social relationships and symptoms change in relation to one another. This is quite different from arguing for the social etiology of an illness, although, for example, Brown and Harris (6) have convincingly identified provoking and vulnerability factors that play a causal role in depression among women. In their epidemiological and clinical study, social factors of particular significance include: a) unemployment; b) presence of three or more children in the home; c) lack of a confiding relationship with a partner or spouse; and d) loss of mother before the age of 11. Although this specific constellation of social conditions engenders real illness and suffering for individual women, these empirical findings provide a conceptual basis for considering social situations a more apt target of diagnosis than individual women.

Our case study of a Puerto Rican woman is drawn from a larger study of sociocultural factors associated with the course of persistent mental disorder, comparing the experience of schizophrenia and depression in Latino and Euro-American men and women in a North American metropolitan area. This is a particularly vivid case for our purpose, both because the Brown and Harris social factors are salient among many depressed women in the study, and because our Puerto Rican study participants are characteristically articulate about social relationships and conditions in their own narrative accounts. Following a description of the case, we will propose a structure for the sociosomatic reticulum centered on a set of narrative themes in terms of which the prereflective experience of illness and distress is formulated. The methodological emphasis is to analyze the narrative framework through which the social course of illness is experienced in daily life and over the life course. We shall illustrate the deployment of narrative themes in constructing what, in this case, is a coherent biographical trajectory of personal illness experience derived from a cultural repertoire of narrative structure and meaning.

ILLNESS EXPERIENCE OF SOLEDAD ROSARIO

Soledad Rosario is a 44-year-old woman, born in a rural area of Puerto Rico. Of medium height and slender carriage, her large dark eyes alternatingly brood and shine. We encountered Ms. Rosario at a local psychiatric hospital where she had been receiving out-patient treatment for 2 years. In all, she has received 16 years of psychiatric treatment through a combination of in-patient (one 2-month hospitalization in Puerto Rico) and outpatient services. According to the research diagnostic criteria of the Schedule for Affective Disorders and Schizophrenia (SADS) clinical instrument, she suffers from chronic depression. Her principal current symptoms include depressed mood, irritability, loss of energy, lack of appetite (with associated weight loss), difficulty sleeping, difficulty concentrating, and feelings of guilt and worthlessness. Past symptoms include several features of posttraumatic stress disorder (PTSD), such as intrusive imagery of her stepfather in the context of sexual abuse, hypervigilance, and nightmares. Although the patient does not meet full diagnostic criteria for PTSD because "avoidant" symptoms are largely absent, her illness profile should nonetheless be conceived in relation to trauma. This is important not only because the comorbidity of depression and PTSD has been reported as common, but also because the appropriate symptom parameters (including the nonreporting of "avoidant" symptoms) have been called into question in relation to gender and cultural diversity (7–9). In addition, the patient describes episodes of what seem to be unexplainable fevers and tremors, itching all over her body, occasional choking sensations, and the urge (prompted by fear of suicidal impulses) to abandon her house at night.

In Puerto Rico, her dire poverty and an abusive marital relationship obliged Ms. Rosario's mother to send her young daughter to live first with her grandmother and subsequently her aunt. Ironically, and in spite of the mother's protective intention to shield her daughter from family violence, Ms. Rosario's childhood was marred by sexual abuse by her "new" stepfather from the ages of 8 to 12. At the age of 12, her family sent her to the United States to live with an uncle, purportedly to allow her a better life than the one she had in Puerto Rico. Instead, Ms. Rosario was treated like a servant and not allowed to leave the house or attend school.

At the age of 19, she returned to Puerto Rico and disclosed to her family the earlier sexual abuse she had suffered. The familial response to this disclosure was to send the offending man away and Ms. Rosario states that he subsequently died from a long, painful illness. At this time Ms. Rosario claims that she holds no animosity toward this man, but she is also keenly aware that the experience of sexual abuse continued to cast a shadow on her conjugal experiences with men or her ability to maintain a stable marital relationship. Although she has had a child with each of three *maridos* (common-law husbands), the relationships have all been relatively short-lived, ending in disappointment. Consequently, she has raised her three children, Danny, Maria, and Angie (aged 20, 13, and 6 years, respectively), on her own. Although Ms. Rosario worked for 7 years as an unskilled worker, at present she is unemployed. Debilitating depressive symptoms, as well as

[1] This name is a pseudonym.

lack of an education and work skills, contribute to her unemployed status. She and her children are supported by social security and public assistance. Despite meager resources, Ms. Rosario has provided a stable home for her three children. Located in relatively safe surroundings in the inner city, her rented apartment is spacious, well-furnished, organized, and clean. Her children are well-fed and well-cared for. She has regular contact with neighbors and friends, and can count on a few persons in her social environment to reciprocate with acts of kindness or concrete help. From her point of view, however, her success with her children and her social supports do not make up for the lack of a stable marriage. She continues to long for and despair of ever finding a male partner with whom she can share her life. However, she is not willing to tolerate indefinite periods of abuse by male partners. Memories of the sexual abuse, including intrusive imagery of the "face" of her abusive stepfather, contributes to her lack of sexual interest or enjoyment. She holds herself "at fault" for a lack of interest in sexual relations, and reports having told the men in her life "I am not responsible because it is that problem [sexual abuse] which has affected me greatly."

In comparison with her own mother who "sent her away" and unwittingly allowed her to be abused, Ms. Rosario takes pride in protecting her children from abuse and neglect and in "loving them all the same." Compared with her early life experiences, the current family life is relatively stable. Her oldest son Danny managed to graduate from a local public high school. Her hopes for a college education for him are impeded by his desire to work to alleviate the family's financial distress. As the eldest son, he has taken on the responsibilities of "the man of the house," and at times he is said to abuse this prerogative. When he is verbally and physically abusive of his younger sisters, Ms. Rosario intervenes. This is in fact the major area of conflict with her son. Although she argues with her son about his behavior at home, she reports being aware (however ambivalently) of his need to take on a "manly" role. She encourages him to work and to have outside activities. Similarly, she is attentive to her daughters' differing developmental needs. She laments that she cannot always buy her children things they need or take them to the places that they want to go. When frustrated by her inability to meet her children's growing demands, and when she has had a "bad night," she yells and screams at them. She then worries that her behavior will have an adverse impact on her children's *nervios* (nerves). A "bad night" is one spent remembering early traumas and, as she puts it, her depression feels as if "her soul has been taken away." "Soul loss" may not be a typical way to refer to distress among Puerto Ricans, and is apparently not a culturally specific syndrome as *susto* (or fright illness) seems elsewhere in Latin America.

For many Puerto Ricans, the experience of mental illness is biographically linked to life events, inhabited spaces, and important others. Thus, for some of the patients in our sample, to be questioned about their illness experience is to be questioned about their past and present life circumstances. The following excerpt from Soledad Rosario's narrative recounts her ordeal and includes her explanations of her early illness experiences. In response to the first interview question, "How would you describe your current life situation?", she begins her narrative by placing her experiences in a context, describing not only the place she comes from, but the social conditions in which she lived. However, the cultural emphasis in this account is on the harm (*daño*) inflicted by her stepfather and her family.

> I come from Maricao, it is near Mayagüez. [My stepfather] He would abuse her [my mother] and hit her hard, very hard and we saw it all. (With blows?) Yes, with blows. We saw how he would strip her naked and hit her hard. Yes, he, sometimes he went to town to buy something. If he came home and did not find her, then he would hit her. And he also abused us, not with blows, but he was sexual with us (*se propasaba*). Then, one time when I was about 8 years old . . .. Even though I was not brought up with her, I loved her so much. I escaped from . . .. [Wants to cry] On that day, I cut out of school and I went to see if I could find my mother. She lived near a river, in a little house, very poor. Then, I was . . .. I was living with my aunt. I left early from school because I had the desire to see my mother. Well, that day, when I left school, it got to be late. My mother was at home. She said to me: "Who brought you?" . . .. [I told her] "I was trying to find you because I did not know where you now lived." She had moved. A boy in school had told me that he knew where my mother lived. But to get to the place where my mother lived, we had to cross a river . . .. I got out of school, then I went to see my mother. And that night, I was caught by the night still at my mother's. My aunt did not know where I was. My mother told me: "Don't worry." Then, my stepfather arrived and he . . .. He was a delivery man. I remember that he used a motorcycle to make deliveries. Then he told me: "Look at this girl, she was caught by the night and still here." Then he told my mother: "I'll take her home." And I, in trust (*a confianza*), I got on [the motorcycle] so that he could take me to my aunt's, where I lived. But, before taking me [to aunt's house], he took me to an apartment where he took photographs. And it was very dark. And he took me and put me on top of a table that he had and there he took off my underwear and everything. And he started playing with my [intimate] parts. And then he gave . . . I remember I wanted to cry . . . I said no. Then he gave me a dollar and told me: "If you tell, I will kill you." But because I was so little . . . now, the way things are, a girl- . . . would probably tell. But in the past, one was afraid, one lived more privately [did not discuss intimate matters]. Then, anytime he wanted he would take me, you know. It was like this that it started and I had all of those things [symptoms] because I did not tell what happened to anybody. I would get a very high fever at night. They would take me to the doctors, they took me to the hospital and nobody could find where the fever was coming from. But it was caused by the delirium, at night, I did not sleep thinking about the things. And from that time on, this affected my nerves because I never talked. And I would have many nightmares at night. I did not sleep at night having nightmares, because I would see him, like when he would get there, like when he would take me and you know. To me, he was killing me. That if I talked he would kill me.

NARRATIVE COHERENCE TO LIFE LIVED THEN AND NOW

In her illness narrative, rather than simply providing a symptom history, Ms. Rosario provides a history of interpersonal violations and exploitations, which she has survived. For her, illness experience is inseparable from the life she has lived so far. Thus, her experiences of sexual abuse, servitude, and forced isolation are an integral part of her illness experience *and* current life conditions. In her narrative, past life conditions and past suffering are intricately intertwined with the current life condition and current expression of suffering. She traces the inception of her *nervios* to the experience of sexual abuse *and* to her inability to talk about her suffering. Terrified into silence, she developed somatic symptoms that included unexplainable fevers, inability to sleep, and nightmares. In virtually every aspect of Ms. Rosario's illness experience, there is a narrative coherence to her story that systematically weaves past and present "life-worlds" to comprehend bodily symptoms, social relations, and moral-existential circumstances.

We suggest that the sociosomatic reticulum or symbolic bridge that spans bodily experience and social relationship in lived experience consists of two components. The first is a series of terms or concepts that serve as narrative themes by means of which, or conceptual nodes at the locus of which inchoate experience of distress is given expressive form. For Soledad Rosario and other Puerto Rican patients, we suggest that the following list of seven salient narrative themes: *nervios* (nerves), *sufrimiento* (suffering), *daño* (harm, damage), *maldad* (evil, malevolence, mischief), *propasarse* (to overstep sexual interpersonal boundaries, to sexually violate), *atender/estar pendiente* (to take care of others), and *desahogarse* (to unburden oneself emotionally).

Nervios (Nerves)

Ms. Rosario commonly refers to her illness in the widespread Latin American idiom of *nervios* (10–12). *Nervios* is a culturally meaningful illness category that connotes an assortment of embodied manifestations of distress understood to be caused by diverse biological, cognitive, and interpersonal factors. As a narrative theme in her discourse, *nervios* should be understood as the *primary* theme. For this reason, we elaborate this narrative theme more fully relative to others for discussion. Throughout her illness narrative, Ms. Rosario is tenacious in linking her *nervios* to her early life experiences and the specific onset of *nervios* to the time in her life when she was sexually abused by her stepfather. As we have seen, her early life was also marked by abandonment and exploitation by members of her extended family. By cultural definition, a life where such conditions prevail is a life of suffering (*una vida sufrida*). The accumulated suffering in her life is embodied in what she idiosyncratically calls *el nervio* (singular, "the nerve").

> Sometimes nerves come from too many worries (*preocupaciones*). It is not that my nerves came now. It is not that they come from things happening now. As you already know, my nerves come from when what happened to me *and* from my life [*la vida*]. But there are times, when my nerves . . . all my worries have an impact. Worries that I have to take this there, that there is not enough of this or that other thing. You must know, that those worries make one nervous.

For Ms. Rosario, *nervios* is the embodiment of social and traumatic experiences. At one point in the course of her illness, she relayed that she had suffered a particular nervous attack in which she ". . . lost her speech for about 2 months. I got nervous and I couldn't talk." This episode of mutism occurred on a family visit to Puerto Rico in which she became embroiled in a conflict with her sister over the way in which she (the sister) had treated her mother. After fainting, she was hospitalized for 2 months. After treatment, she regained her speech. This particular episode of mutism has been followed by subsequent attacks of choking, loss of speech, along with depressive mood:

> SR: I have gone to the hospital and they tell me that it is my *nervios*. It's possible. Like, I feel like I am going to choke and my speech can't get out . . .. Sometimes, I wake up with a bad mood, such a bad mood that my kids tell me: "Mami, what is wrong with you today? You are not well today." I get up with an entrenched bad mood . . ..
> JHJ: What is it that you feel when you can't sleep? What is it that you feel inside?
> SR: Well, I feel very nervous, if I can't fall asleep, afterwards I get *nerviosa, bien nerviosa.*

Even though *nervios* and depression are connected, she discriminates the two experiences. *Nervios* are manifested or experienced in the body "*los nervios, me coge el estomago*" (*los nervios*, they take hold in my stomach), "*no puedo dormir*" (I cannot sleep), and "*se me caen las cosas de las manos*" (things fall out of my hands). She describes depression, on the other hand, in terms of sadness and a lack of energy:

> SR: [depression] it is a thing, it is like one had, depression is a thing in which one seems to be dead in life (*muerto en vida*).
> JHJ: How does it feel?
> SR: Like there is nothing. They can come, and come and give you money, give you a new car, give you everything, but there is nothing. One can go anywhere, and still nothing.

The patient's use of the metaphor *muerta en vida* may be related to what Shengold (13) terms "soul murder" or a ". . . dramatic designation for a certain category of traumatic experiences—those instances of repetitive and chronic overstimulation alternating with emotional deprivation that are deliberately brought about by another individual."

During her episodes of severe depression, she not only feels she would like to sleep all day but also feels a pronounced fever ("*la fiebre*"). Ms. Rosario's experience of *nervios* is one in which body/mind symptoms amplify past/present distress. Accordingly, she describes her health to oscillate between states of well-being and states of overwhelming depression colored by recollections of her early life trauma.

Other current symptoms are no less dramatic embodiments of her childhood distress. She sometimes experiences an

itching sensation on her body (*me picaba todo el cuerpo*) and at yet other times she experiences a compulsion to leave her home (*irme, irme, irme*), usually after waking up from a nightmare. She describes fleeing her house while her children are asleep and going into the homes of neighbors that she knows. Because of this behavior, she believes that others will look on her as crazy, as she herself believes that she is "*loca*." She then adds that "something seems to tell her to kill herself," her flights seeming attempts to resist suicidal impulses. On the surface, the symptoms of itching, the impulse to flee, and suicidality seem different from the earlier symptoms of fever and fear, but phenomenologically, these symptoms seem related to physical arousal and possibly resultant feelings of guilt and *daño* as sequelae to the abuse.

In summary, the primary narrative theme through which all bodily experience is sifted is that of *nervios*: "I am, I have always been, sick with nerves" (*Yo estoy, yo siempre estado enferma de lo nervios*). As we have indicated above, *nervios* is a culturally meaningful illness category that in its expression collapses the mind/body dichotomy. It also provides a cultural viewpoint that intricately links the inner experience of suffering with a social/familial reality. The emphasis of this viewpoint on placing the illness experience within a social/familial context belies a purely biological explanation of illness. Thus the experience of *sufrir de los nervios* articulates in a bodily way, subjective and intersubjective experiences of suffering. The following section will focus on the interrelation of *nervios* and *sufrir* as narrative themes.

Sufrimiento (Suffering)

Sufrimientos (suffering) or *sufrir* (to suffer) is a culturally sanctioned expression of sorrow that reflects difficult life circumstances or troubled interpersonal relationships. Suffering may be seen as a person's lot in life (*nació para sufrir* or she or he was born to suffer) or as a consequence of too many worries (*muchas preocupaciones*). The endurance of suffering implies spiritual and moral strength. However, suffering accumulates, and too much suffering may lead to *nervios* or illness.

In the following excerpt from her narrative she makes the connection between intersubjective suffering and illness:

> My son, he loves my daughter's father. But he doesn't want him here. Because, he gave me a lot of suffering. My son says that he will not change. He says that for *what* am I going to let him come back? All he will do is make me suffer more and that suffering will make my sickness worse.

Specific domains of suffering in her narrative include problems with male partners, her servitude after migrating to the United States, and of course the years of sexual abuse by her stepfather. For Ms. Rosario, however, the question of "Why me?," "Why have I suffered so?" revolves around the moral character of her perpetrator and her fervent wish that he had been a different, morally upstanding man:

> Sometimes . . . I get thoughts of why did this have to happen to me?, why did I have to go through it, why have I had to suffer so much. Those, all of those things [I think about] at night [on the bed], when I lay down. All of that comes to me. Why couldn't he have been a good man? Why do I feel so alone? Sometimes I feel so alone. Sometimes I feel, that nothing matters in life. You know . . . .

This case presents an interesting cultural contrast with respect to what Nolen-Hoeksema (14) has called ruminative (vs. distracting) styles of depressive cognition. In the ruminative pattern, apparently more common among women, the depressed person thinks a great deal about her own symptoms, the causes of her symptoms, and her own personal motives and actions in relation to her depression. This egocentric self-style of depressive rumination in relation to the "why" question of suffering differs from Ms. Rosario's other-oriented response style which holds her perpetrator morally culpable. Her narrative is filled not with "If only *I* had . . ." statements but rather "If only *he* had been a different kind of man—a good man, I wouldn't have these problems," which suggest that for some Puerto Ricans the experience of depression may be more sociocentrically experienced with its origins in social relationships gone awry. Although one must be careful not to overdraw a distinction between a "sociocentric" (socially centered) and an "egocentric" (individually centered) orientation for self and experience, it may be useful to think of Puerto Ricans as relatively more sociocentric (as compared to Euro-Americans, for example) in such domains. Certainly the particular cultural sense of the "why me" question is distinct from the depressive logic used among many Euro-Americans for whom events may tend to revolve around the efficacy of their own individual actions in relation to larger forces. This is why, for many Latinos, problems with *nervios* and associated suffering must be understood in a context of interpersonal forces of harm/damage (*daño*) and morally or spiritually related malevolence (*maldad*).

Daño (Harm/Damage)

Hacer daño (to cause harm) and *causar sufrimientos* (to cause suffering) are culturally related concepts. *Daño* or harm is a culturally pertinent expression of negative consequences to an individual's well-being. Although a person can suffer *daño* or harm consequent to catastrophic or distressful life events such as loss of a family member, loss of employment, or loss of property as occurs in natural disasters, the emphasis here will be on the intersubjective experience where a particular person's sense of well-being is harmed by interpersonal relationships. Thus, despite that she wishes to get better and makes efforts in that direction, her view seems to be that once you are severely afflicted by *nervios*, it is forever. This seems to be so for her because she associates her *nervios* with irreparable harm and the lasting somatic consequences of the *daño* (harm) caused her by the familial and social environment of her childhood and adolescence.

Ms. Rosario's difficulties in terms of love and work are experienced by her as direct repercussions of the intersubjective *daño*/harm she experienced in her relationship with her stepfather and the deprivation/exploitation she experienced when she lived with her uncle and his family as (in her terms) a slave. The interpersonal harm that she experienced is for her contrasted to her bodily state before the abuse and neglect, a time in which she was "*sana*" (healthy, whole, without any sexual knowledge, and without malice). The *daños* irrevocably changed all that. Her narrative makes clear that she has a strong notion of the intersubjective dimension of *daño* and the

possibility of witchcraft, while simultaneously disavowing its importance in her own case. In such processes, she believes the mind (*la mente*) and specifically the nature of one's thoughts, are all important:

> I, myself, I believe that, that if I . . ., let's see. If I did not believe in God, though that is the first thing that I believe in, in God. If I were living like that, if I was thinking in that manner, from my point of view it is the mind that does that to you more. Because if one starts thinking, that one over there is doing you spiritual harm (*haciendo el mal*), or she must be doing *el mal* (a "job" or act of witchcraft) to me, then it falls back on you (*le cae a uno*). Then one can become more crazy than one is, by thinking that the other person is doing you harm (*daño*). Do you understand? But, I have never done that, think that someone is doing harm to me, or that they were, but are no longer are doing it. I have never thought that way.

Thus, although Ms. Rosario does not apparently place much conscious stock in the likelihood of spiritual harm, she does squarely place the blame for harm done to her on the shoulders of her family in Puerto Rico. In her view, her current afflictions are an expression of past suffering and in fact are *somatic indictments* against a family that failed to protect her from sexual abuse and provide a modicum of care.

> JHJ: Do you feel as if others are primarily responsible for your illness?
> SR: Yes, I do.
> JHJ: Can you tell me more about why you feel this way?
> SR: Because I think that my family harmed me a great deal in this regard. How one, in one's childhood, one grows up, understand, the environment where one is. It affected me greatly.

Two observations on the interrelations among sense of self, the narrative theme of *daño*, and the moral accountability for wrongdoing are pertinent. First, as a matter of ethnopsychology, or what anthropologists examine as the cultural presumptions about the nature of the self, cognition, and emotional processes, it is important to note that this indictment of others by virtue of holding them responsible for what has happened to her represents a cultural contrast to Euro-American ethnopsychology, which has traditionally held that blaming others for one's troubles was either a sign of paranoia or a developmental character flaw for not accepting personal responsibility for one's own life and health. In this respect, the culturally acknowledged presence of *daño* (harm/danger) by others is salient. *Daño* cannot be subsumed to personal cognition and personality traits. Second, the analytic framework we are developing here—that social relations and conditions temper the bodily experience of self and illness—converges with Ms. Rosario's own indigenous conceptualization of her illness experience with respect to the cause and course of her affliction. As we have already pointed out, illness may result from *daño* in relation to *maldad*, a closely aligned narrative theme for consideration.

Maldad (Malevolence)

Ms. Rosario affirms the possibility of *la maldad* (evil forces) in the production of illness. In her particular case, belief in God is thought to protect her from such harm. *Maldad*, in its mild form means merely mischief or possibly misdeed, but in its strong form may mean malevolence associated with the harnessing of negative spiritual forces, the harmful power of thought directed against another person, or the dangerous influence of negative feelings and aggression. In its strongest form, *maldad* connotes evil in a moral, interpersonal, or supernatural sense. Related to the preceding narrative theme, *maldad* can unquestioningly cause serious harm or damage (*daño*) to others in the form of illness, unhappiness, or even death.

> JHJ: How about (the cause of illness) from *brujería* (witchcraft) or from some spirit?
> SR: Oooh, I don't believe in that. I believe in *la maldad* (the power of evil), but not in any of that. No.
> JHJ: And what is *la maldad*?
> SR: Well, you know that it is said that there are persons *que practican lo malo* (working with evil spirits to cause harm). In that way, they can harm you.
> JHJ: Has someone done you harm in this way?
> SR: No, I don't believe so. I do not believe, but if in fact they have, then I always say that God is above all. Not me, I do not practice that, nor do I like it.
> JHJ: God protects you?
> SR: I think that God always protects one . . .. If it wasn't for God, I believe I would be crazy. But I am not, because I believe so much in God . . .. No, I don't believe anyone is causing me harm. I don't think so, because I do not have any [enemies], how should I say this? [Yet] I always avoid . . . I always stay home, I always try not to have any enemies nor any problems with anybody.

From her somewhat ambivalent viewpoint, one can be harmed by someone's bad thoughts for you; and by thinking that other's are harming you. Additionally, one can harm other people by wishing them harm (*desearle mal*). Because in any case it is difficult to be certain about such things, the cultural view of seeking protection and adopting a nonconfrontational social stance are clearly in order.

Propasarse (To Overstep Sexual Interpersonal Boundaries)

For Puerto Ricans, the bonds of the nuclear family are often informally extended to include extended and remote family members and friends who are then treated as trustworthy affinal kin. The cultural emphasis placed on interpersonal relatedness in familial circumstances is mediated by the implicit expectation that the person allowed interpersonal closeness will honor and respect the rights/needs of the other in the relationship. Violations of these expectations of honorable and respectful behaviors will result in the rupturing of the relationship, but will also be perceived by the aggrieved party as a betrayal of trust (*abusar de la confianza*) or interpersonal harm (*daño*). Inasmuch as sexual relationships are also rigidly mediated by this code of honor and respect, illness or *daño* may result from a failure to maintain appropriate interpersonal

distance in relation to others, particularly in the domain of sexualized contact.

Propasarse in the sense we are examining it here means to overstep one's sexual interpersonal boundaries. The culturally defined transgression of the boundaries of the self is seen as a violation, particularly in the case of improper sexual overtures (sexual harassment) or acts (sexual molestation). Because, ideally, sexual purity is culturally expected of unmarried girls and women, *daño* or harm can result from such a sexual boundary violation. Ms. Rosario's stepfather overstepped those boundaries by making sexual overtures to Ms. Rosario and her sisters when they were innocent, trusting children. The ultimate betrayal of family codes of honor and respect occurs when a young girl is sexually violated or penetrated. This is commonly referred to as *hacer el daño*. The victim of such a violation is perceived as damaged goods (*danada*). *Propasarse* is linked to the broader cultural expectation of *confianza* or trust, a betrayal of which also constitutes interpersonal boundary violations not necessarily of sexual origin.

Desahogarse (To Unburden Oneself Emotionally)

Desahogarse or to unburden oneself is meant to convey an embodied expression of relief as a consequence of verbally sharing with another person one's accumulated suffering or distress. Conversely, the reasoning behind not holding on to resentment is that resentment and hate of another person can also cause illness. This seems related to the cultural norm of minimizing interpersonal conflict, epitomized by avoidance of hurting others physically or emotionally. Thus, what might seem initially to be an intrapsychic issue, eg, that excessive rumination can cause exacerbation, essentially revolves around social concerns of suspicion or resentment in particular relationships. This is particularly salient in the context of family relationships, where family unity and interdependence is often maintained at high costs.

Two examples from Ms. Rosario's illness experience will shed light on this cultural notion. First is her experience of psychiatric treatment as helpful, in that she can *desahogarse* or unburden herself. When asked about the effects of treatment and medication on her illness, she answers that psychotherapy and medications are helpful, but without lasting effect. By talking she experiences relief ("*desahogarse*"). Additionally, the doctor gives her good "*consejos*" (advice). Given that her explanation for her nervous condition is an interpersonal one, it seems to follow that her expectation for relief is also an interpersonal one. The second example implicitly conveys the need to not hold on to negative emotions, such as resentment or hatred:

> JHJ: Not holding on to resentment, is that important?
> SR: Well, look, to my understanding, I believe that if I held on to resentment and hate for a person, then I would get sicker. What am I going to get out of holding on to resentment and hate, of thinking: "Oh, I hate that person, I hate that person." It can get to the point where one can injure that person and one can even kill that person. Do you understand? I limit myself to saying that I am angry at that person because of whatever, but I, I don't believe in holding on to resentment or hating anybody.

Although Ms. Rosario explicitly states that she does not hold on to resentment toward the man who sexually abused her, it is interesting to note how *desahogarse* cycles back into a related dimension of suffering, that is, as punishment for hateful acts.

> Not even for that man [stepfather] could I continue to hold resentment. The only thing is that I always say, look, what he did to me, he was punished for. Because he died, and he did not have a good death. He died of a cancer, you know. And he, he did not . . .. He died blind and everything. Because he suffered a great deal.

Based on the belief that in harboring resentment and hate will in turn have a negative impact on her health, she places punishment and revenge, in the "hands" of God.

Atender/estar Pendiente (To Take Care of/Support)

The narrative theme of *atender/estar pendiente* (to take care of) channels the set of expectations and constraints associated with the culturally prescribed notion of family obligation for care toward each of its members. The meeting of these familial expectations of support and care contribute to each family member's sense of worth and well-being. When Ms. Rosario positively contrasts her current life situation with her previous life condition, she states that her life is better now because she can openly get sick if she feels the need. The implication that in the past she was not allowed to take to bed when sick is additional evidence of the failure of her family to fulfill cultural expectations of mutual support and care.

> It is only now that I live well, because, thanks to God, I am in my own house *and* if I feel like getting sick, know for a fact that I will throw myself on my bed.

In Ms. Rosario's case, her damaged sense of self consequent to family neglect and sexual abuse by a family member is made explicit when she says: "Well, I feel as if I am not worth anything" (*Pues me siento como que no valgo nada*). She elaborates on the connection between family actions and sense of self by comparing herself to the "ugly duckling": "I was like the ugly duckling. Nobody loved me." (*Yo fui comes dice la patita fea en casa. Nadie me quiso.*)

Ms. Rosario's conviction that God (*padre celestial*) will take revenge in her behalf, as well as protect her from additional illness and harm parallels the cultural expectation that family should protect and care for its members. For most Puerto Ricans, both parents are seen as the source of care and protection. In that her family failed to provide protection against sexual abuse and additionally failed to provide her with the opportunities to better herself, she holds them socially and morally responsible. Her daily engagement with God may be one source of her resilience in seeking to recreate a family for herself that can help to alleviate past wrongs. She states that caring for her children and ensuring their well-being also helps her to protect herself from exacerbation of her illness. In recompense, she is satisfied that her children show concern and care for her when she is ill.

THE SOCIOSOMATIC RETICULUM

The foregoing narrative themes are key to understanding Ms. Rosario's bodily experience and symptom formation. For this patient, and we propose for Puerto Ricans in general, illness experience is embedded in such a matrix. As narrative

themes, they constitute the tools for the emplotment of her story (15), formulating psychiatric illness as the consequence of suffering through distressed interpersonal relationships or in terms of embodied metaphors (16, 17) of traumatic events produced by physical or sexual violations. To be precise, we propose that these notions structure narrative in terms of a cycle of expectation, violation, illness and recovery (Figure 1). Expectations of support, care, and protection summarized by the theme *atender/estar pendiente* are violated and expressed in terms of the narrative themes *abusar de la confianza*, *propasarse*, and *maldad*. The result is *daño*, which leads to the condition described in narrative terms as *nervios*. The *sufrir* that is an inevitable consequence of *nervios* can be relieved through *desahogarse*, which presupposes or leads the narrator back to a situation in which she feels supported and cared for, that is a return to the condition of *atender/estar pendiente*. Within this context, expectations for care or for relief from psychiatric symptoms are also embodied and intersubjective, involving moral and material dimensions of attention and care.

As a symbolic bridge, we propose that this cycle of narrative themes lies at the intersection of three dimensions critical to the sociosomatic understanding of illness experience (Figure 2). Throughout our discussion of the narrative themes we have emphasized the manner in which they constitute what Kleinman referred to as the symbolic bridge across the horizontal dimension defined in Figure 2 as linking social relationships and bodily experience, and we will not elaborate additionally on this dimension. In the vertical dimension, the set of narrative themes mediates an overarching set of global orientations and the personal, idiosyncratic orientations that each individual brings to the narrative process. The global cultural orientations that define Puerto Rican and other Latino cultures provide consistency in the way the narrative themes are deployed in the discourse of illness. These orientations are familiar to students of Latino cultures, and include familism (18, 19), machismo and marianismo (20), and spiritism, dignity, and respect (18–22). This partial

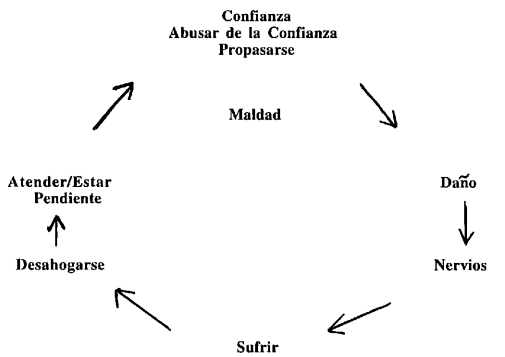

Fig. 1. Cycle of narrative themes. *Confianza* = trust; *abusar de la confianza* = betrayal of trust; *propasarse* = to overstep sexual interpersonal boundaries; *maldad* = malevolence; *daño* = harm/damage; *nervios* = nerves; *sufrir* = to suffer; *desahogarse* = to unburden oneself emotionally; *atender/estar pendiente* = to take care of/support.

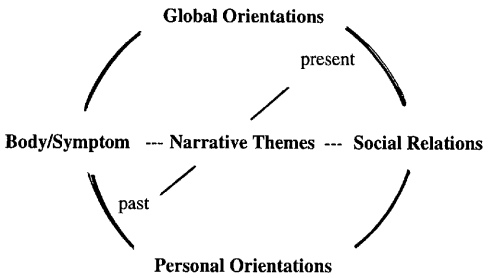

Fig. 2. Structure of the sociosomatic reticulum.

set of interlocking global orientations are relevant to an understanding of the structure of the symbolic reticulum.

The final dimension depicted in Figure 2 is the temporal one. This patient's deployment of narrative themes provides a link between her past traumatic experiences and the consequent suffering in her life. To facilitate understanding, in our presentation we have divided her illness experience/symptoms into two temporal components, but in this context we emphasize that the patient experiences these as overlapping and continuous. The past symptoms of nightmares, fevers, and disorder, and the present symptoms of fevers with sweats, feelings of choking, and itching sensations seem to be specific, embodied expression of traumatic experience. Concurrently, her depressive symptoms, which include ruminations about her suffering, lack of energy, irritable mood, worthlessness, and suicidal ideation, seem to be more global expressions of a suffering/damaged sense of self. Nevertheless, they are closely interwoven and mutually inform one another in her contemporary narrative.

Our cultural analysis of the biographical trajectory of Soledad Rosario reveals the primacy of cultural, social, and situational contexts in shaping the onset, symptoms, and course of her illness. Central to this process are culturally specific orientations that are engaged in the narrativization of her life experience. From a sociosomatic analytic framework, as well as her own perspective, illness cannot be accounted for primarily in terms of personal characteristics. As we have seen, her own interpretation that it was the absence of moral character in her oppressor that led to her own personal suffering is salient. Rather, social conditions and relations must be seen as substantially tempering her symptomatic distress. However, personal agency, including resilience and resistance, is nonetheless impressive in creating a life forged by such oppressive life events and conditions. Despite an ongoing struggle with depression and sequelae to psychic trauma, her decision to recreate a life that breaks free from a cycle of abuse and violation marks a creative and even courageous response.

In this study we have proposed a model of the sociosomatic reticulum that, on the basis of an intensive case analysis, has implications for the cross-cultural study of the social course of illness. We have intentionally framed the presentation both in terms of the social course of illness and in a selected case that vividly demonstrates the dynamism of social relationships in illness experience. This is substantially different from, for example, a more delimited kind of psychodynamic viewpoint

that would interpret symptoms as expressions of internalized psychic conflict. Rather, the viewpoint outlined here posits symptoms primarily as embodied expressions of trauma and of suffering produced by the social environment. Certainly one can infer conflict from some of the symptoms, but the social dimensions of such conflict are equally or more vivid than the intrapsychic. Thus, conversion disorder may incorporate the conflict of whether to tell or not to tell about the sexual abuse under threat of being killed for doing so; delirium (*delirio*) and itching (*le pica*, sometimes used to mean in need of sex) may be expressions of distress caused by premature sexual stimulation. The symptoms are induced by trauma, but maintained in a social/familial/cultural context that defines a sexually violated girl as no longer *sana* (*danada* or damaged goods). Although we have not been able to integrate them adequately into the current discussion, the case requires recognition of the impact of sociopolitical conditions (colonization, economic exploitation, poverty, and migration) that permits a young girl to be denied schooling, forced to migrate, and be physically abused by men. Finally, although we have sketched the outlines of this structure in the Puerto Rican case, the comparative task on the horizon is to examine the bridges built of other cultural materials spanning differently constituted flows of lived experience. Analysis of this woman's narrative, for instance, renders problematic the distinctions between psychopathological and normal experience (7, 23, 24), such that a study in "depression and trauma" might easily and productively also be conceived in terms of resilience, resistance, and recovery.

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