KAJA FINKLER

SYMPTOMATIC DIFFERENCES BETWEEN THE SEXES IN RURAL MEXICO

ABSTRACT. This paper addresses the problem of the differential presentation of illness by women and men in two Spiritualist temples and a physician's office situated in rural Mexico. Women's morbidity raises the broader anthropological questions of the interplay between symptomatic expression and women's unequal status in the social structure, their cognitive evaluation of specific life experiences, cultural etiological explanations and Western models of dysphoria. Symptoms presented by patients in different health care delivery sites are compared and case vignettes of patients' illnesses and attributions are presented to demonstrate the ways in which culturally constructed illness attributions and illness expressions comprise a somatic grammar for the articulation of experiential distress. The sick population is compared with a control group of healthy women to highlight the socio-cultural and psychosocial variables that promote illness in women from the same sociocultural strata of rural Mexico. Collective understandings of the role of life events and emotional expression in illness attributions legitimize somatization as a coping style under adverse existential conditions.

INTRODUCTION

The object of this paper is to explore the nature of symptomatic expression among women in one rural region of Mexico and to examine the reasons why more women than men report illness there. The problem of women's morbidity also brings into focus the interaction between somatic expression of illness and Western models of dysphoria, as well as the relationship between life events and depressive disorders.

In my study of treatment seeking behavior in two Spiritualist temples and a physician's office, both situated in rural Mexico, I noted that more women than men seek treatment (Finkler 1984). There is an extensive literature on differential symptomatic expression along sex lines (Brown and Harris 1978; Dohrenwend and Dohrenwend 1976; Gove 1978; Hinkle 1960; Lieban 1978; Mechanic 1978; Nathanson 1975, 1979; Rosenfield 1980; Weissman and Klerman 1977) that lends support to this finding, and that conduces to at least two important questions. First, what are the reasons for the differences in the expression of illness between men and women? Second, and perhaps more important, what do the differential symptomatic expressions tell us about the condition of women within the context of the society in which they live?

The sexual disparity in symptomatic expression is particularly intriguing in view of the fact that women live longer than men (Nathanson 1975) the world over (cf., Weller and Bouvier 1981). Are they, then, constitutionally more prone to illness? Perhaps the earliest explanations were based on obvious
biological differences between the sexes and were linked to women's reproductive capacities and their hormonal make up. This explanation has been disputed, however, by many scholars (Gove 1978; Nathanson 1975; Rosenfield 1980; Weissman and Klerman 1977) who favor social structural and psychosocial explanations. These explanations turn on three complementary propositions: a) women are culturally permitted to express illness, whereas the sick role is unmasculine; b) women's social roles are more stressful than men's resulting in more illness among women; c) women's roles are more compatible with the sick role than men's roles because women have more time to be sick.

The first two propositions assume that women's status and roles in the social hierarchy produce stresses which are expressed in physical and psychological disorders. Although this argument has been advanced for women in industrial societies (cf., Dohrenwend and Dohrenwend 1976; Tuck 1976), it has also been made for developing countries, as for example when it is suggested that Mexican women suffer more often from susto (fright) with its attendant symptoms (Rubel 1964) because they experience more role stress than men (O'Nell and Selby 1968). The last proposition assumes that most women have less flexibility to delay their obligations. Thus Nathanson (1975) observes that gainfully employed women report fewer illnesses than housewives; she maintains that the number and character of the women's role obligations must be considered.

In examining illness expression among rural Mexican women, my concern is with the stress models that associate women's experience of illness with their unequal status and roles presumed to be stressful to women. Viewed from an etic perspective, there is no doubt that an unequal relationship prevails between men and women in rural Mexico. Following Sanday's (1981) definition of inequality of the sexes, women in rural Mexico are excluded from economic and political decision making and physical coercion of women, as in wife beating, is practiced, if not condoned. Given the unequal status of women in Mexico (cf., Finkler 1981a), it can be assumed that women are subject to more stresses than men which, following the social stress model, would promote more illness among them.

Yet, the social stress model fails to take into account important phenomenological elements associated with illness. As is convincingly argued by Good and Good (1981a, 1981b) and others (cf., Kleinman 1981) symptomatic expressions condense "... in a culturally appropriate idiom a series of personal tragedies" (Good and Good 1981a: 169). Clearly, as we shall see, not all women within the same sociostructural position experience illness. This is not to deny the power of explanatory models which center on stress of traditional female status and role but rather to emphasize the importance of the subjective and cultural dimensions. This is especially important when we deal with developing