Ecuadorian illness stories
CULTURAL KNOWLEDGE IN NATURAL DISCOURSE

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The theme of illness occurs frequently in conversation. In Quito, Ecuadorians often tell one another about health problems that they or others have suffered. Many different cultural models can be discerned in this discourse, but it is situational knowledge of social roles that is most dramatically and exhaustively encoded. Ecuadorian illness stories often transcend their topical focus and express general models of the family, of neighbors and friend relationships, and of social hierarchy in Ecuadorian society. Before discussing these models, this paper briefly summarizes the ethnographic context of illness stories.

Ethnographic context

This analysis is based on one year's field research in a marginal, largely Mestizo neighborhood of Quito, Ecuador. Residents of the barrio, here called Las Gradas, tell numerous stories that can be broadly labeled misfortune tales. In addition to illness narratives, some of these stories concern car accidents, domestic conflicts, and presidential assassination. This discussion refers only to accounts of illness. Data are "extensive stretches of naturally situated talk," to use Michael Agar's phrase (1982:83). Even though I listened to many stories, I cite examples here only from the recorded narratives of 14 individuals discussing 4 cases of illness. As described in Appendix 1, 3 of the afflicted individuals are children; the fourth
is a middle-aged woman. The 14 narrators are all people who played an active role in the illness situation they describe. In addition to hearing conversations about these cases, I observed some of the events and relationships pertinent to each case. Such ethnographic observation promotes more valid analysis of narrative material. For instance, observation reveals aspects of a situation that narrators downplay or omit from their accounts; such omissions often suggest underlying assumptions about shared cultural knowledge on the part of the narrator.

A NATURAL FORM OF DISCourse
Evidence that illness stories are a natural form of discourse, rather than a task imposed by the investigator, comes from participant observation in the social life of the neighborhood, from the form of the recorded narratives, and from the many references to other stories that informants say they heard from other people. Friends in the barrio told me illness tales before I showed any special interest in them. Once begun, narrators typically continue their stories with little or no prompting. In some of the transcripts, the same information is presented two or three times in the same basic form and even in many of the same phrases. This suggests that certain narrative sections are remembered by the narrator in chunks, perhaps with particular phrasings or key terms attached. Probably, the same chunks had been related before to other listeners. Few of the storytellers refer to being in an interview frame in Tannen’s sense (1979).

Most compelling of all the evidence for natural occurrence of this discourse is that about half of the 14 recorded narratives refer to other illness stories that narrators had previously been told and had remembered. These “stories within stories” demonstrate that not only do people communicate vital information about illness in story form, but they also remember and apply stories they have heard to situations that arise in their own or others’ lives at a later date. For instance, in the narratives about Isabel, the child’s mother and grandmother retell stories they had heard about two other individuals with similar disabilities and their treatments.

IrrNESS STORIES IN SOCIAL CONTEXT
Illness stories occur most often in conversation among good friends and among barrio residents and relatives living elsewhere. Women tell the most illness stories, and they tell them mainly to other women in settings of semiprivacy. Some individuals are especially adept at telling this type of story, and such “specialists” tell them more often than others. Barrio residents derive a number of cognitive and social benefits from telling and listening to illness stories, although these benefits are generally not consciously sought or recognized.

First, conversation about illness has problem-solving value because it transmits useful technical information about such things as home remedies, disease symptoms, health care specialists. Even if this information is not immediately relevant to the listener’s current problems, it enlarges his or her fund of cultural knowledge with which to meet future illnesses.

Second, through exposure to the many causal propositions in illness narratives, listeners expand and refine their own theories about disease. Such propositions constitute the raw material from which people weave “folk systems of interpretation” (Bohannan 1957). In actual illness situations, a viable cultural model helps individuals locate problematic experiences in a framework of meaning and allays some of the anxiety associated with the situations.

Third, many illness stories focus attention on the caretaker role of the narrator. The narrator frequently asserts in an implicit way: “I did the right thing.” This public declaration constitutes a way of negotiating the meaning of the illness events and may be an important source of social validation for the narrator. Finally, it may be hypothesized that sharing illness stories reinforces bonds of mutual support among individuals and intensifies friendships, much as sharing life stories appears to deepen social relationships among middle-class North Americans (Linde this volume).

Structure of illness stories
The illness story follows rules for internal coherence and can be regarded as a speech act in the sense of a component of a speech genre. It is an unlabeled speech act, though, and Ecuadoreans do not as clearly acknowledge it as a distinctive unit in the way that North Americans acknowledge, for example, a therapeutic interview, lesson, or court case as distinctive units (Hymes 1972; Linde this volume).

Several features set the illness narrative apart from the rest of the conversation. The beginning of the narrative is anchored in a particular time and place, the orientation, to use Linde’s term (this volume). Typically, the orientation describes how the illness started, its earliest symptomology. Sometimes, however, the narrator begins the story further back in time with description of what caused the illness. In a few cases, the narrator’s particular role in the events may lead to his or her anchoring the story at the point at which he or she entered the action. Finally, if the narrator has already told the audience at some other time about an on-going illness, he or she may begin subsequent segments of the story at a time and place appropriate to the new installment.

From the beginning time and place, the narrative moves forward chronologically, describing various events along the way that are pertinent to the illness, such as attempts to treat the malady, struggles to get funds to pay for specialist care, and family interactions about the illness. For an illness story to be coherent, the narrator must at some point discuss cause. This usually occurs at or toward the beginning of the story but may recur throughout the narrative, as the unfolding events are associated with changing notions of cause. Like life story segments, many illness narratives
contain a coda or end phrase. Common ones are: “And, so, that is what happened,” or “And now, she is as you can see.” Appendix 2 points out the structural features identified in one illness narrative used in this analysis.

**Cultural models in illness stories**

Stories told among Las Gradans acquaint listeners with entire episodes of illness that they have not personally experienced. As evident in the retelling of such stories, the entire episode often gets stored in listeners’ own memories of events, in streamlined form. Such discourse plays a dynamic role in the construction and refinement of shared cognitive models pertaining to illness. Second-hand episodes contribute to development of schemas, particularly schemas for situations that do not occur very often. Furthermore, natural discourse about illness transmits factual information about treatment and specialist alternatives, causal notions, situation knowledge about social roles in illness, and a picture of the narrator’s feelings about the events he or she describes – the affective propositions expressed in a narrative (Labov & Fanshel 1977:105).

Although notions about the causes of health problems are usually more explicitly stated, situation knowledge (Holland 1985) about appropriate behavior when someone falls ill constitutes the pith of what these narratives communicate and is the primary focus of this analysis. Such situation knowledge is organized within more broadly applied cultural models of the family, of extrafamilial social support, and of social hierarchy and biomedicine in Ecuador.

**Analysis of Illness Stories**

Just as a life story reveals the cultural knowledge by which an urban addict survives (Agar 1980), and interviews with North Americans reveal cultural models of marriage (Quinn 1982), so do Ecuadorian illness stories contain numerous “traces” of cognitive models that bear on interpretation of illness. Because tacit (understood) knowledge shapes natural discourse to such a large degree, important traces are found not only in what is said, but also in what is left unsaid.

In telling illness stories, narrators take for granted that listeners share many of their assumptions about how the world works. The missing “shared knowledge” must be filled in, if outsiders are to understand the logical connections among utterances, and the cultural models that underlie them. For example, Passage A in Appendix 3 forms part of a narrative by Olivia about her little sister Susana’s acute illness at the age of 1. Olivia describes the treatment and says: “We did that and it helped her.” Her account does not mention the fact that, at the time, Olivia was quite young (12 years of age) to be taking an active role in the treatment and care of her sibling. If a similar story were related in North America, the speaker probably would have included her age as a salient fact. In contrast, among marginal Ecuadorians, young girls are typically expected to carry grave responsibilities in the care of younger sisters and brothers. The Ecuadorian narrator might lose the audience if he or she emphasized this feature of the action. By not making a special point about such behavior on the part of a 12-year-old, such a narrative both reflects and reinforces cultural expectations that such behavior is “normal and natural.”

What are, from the outsider’s standpoint, omissions of information (due to narrators’ assumptions about shared cultural knowledge) tell us a great deal about cultural differences between North America and Ecuador. We must also assess parts of the narratives that seem unusual to us as outsiders in the opposite way: that is, why some facets of a story are presented with what seems to us to be overelaborate detail.

Often, elaborations indicate a deviation from the standard expectations for role behavior. For instance, one narrator delivers a lengthy, detailed description of events that prevented her father’s presence when her brother died. Clearly, this section of her story constitutes an apology for deviation from the Ecuadorian schema for dying. Narrative passages may also be elaborated not because they represent deviation from expectations but because they depict events that are in themselves highly salient to speakers and listeners in highland Ecuador. An example of this is the description of wakes and funerals in Ecuadorian illness stories. The elaborate detail accorded these events no more indicates deviation from the situation schema than does the elaborate detail accorded the dress of the bride and bridal attendants in traditional accounts of weddings in the United States. To understand discourse, we must first determine what the culturally salient actions in a given domain are. Second, we must pay careful attention to narrative context in order to discover how a particular section of highly elaborated discourse relates to the cultural model in question.

Illness stories contain many other traces of cultural knowledge beside the inclusion/exclusion of detail and elaboration patterns. Some other traces explicitly used to analyze discourse include repetitions, key words, generalizations, metaphors, false starts, evaluative statements, and hedges (Bohannan 1957; Labov & Fanshel 1977; Lakoff & Johnson 1980; Quinn 1982; Tannen 1979). Many other discourse analysts undoubtedly base their conclusions on some of these linguistic patterns but are less explicit about doing so. An important question to consider is how each of these traces relates to the underlying knowledge structures that are generating the utterances. E. Hutchins (personal communication) puts the question this way: “By what connections can we claim that generalizations, repetitions, key words, counterexamples, and evaluative statements (and inferences) are traces of knowledge structures in discourse?” A related question concerns the choice of which particular indicators or traces to use in an analysis. With analysis of key words, for example, it is implied that the knowledge structures behind that discourse are primarily organized by way
of key words? The following analysis emphasizes patterns of omission and elaboration to show how illness stories transmit cultural information about social roles in illness situations. Evaluative statements and a narrative device I call the counterexample are also shown to be important vehicles for ideas about what is inappropriate or unexpected behavior within the Ecuadorian cultural model of illness.

Situation knowledge, organized within particular cultural models, consists of generalizations about the parts people play, the usual activities these entail, and the role-identities associated with a particular kind of situation (Holland 1985). Without exception, illness stories encode significant cultural knowledge about the role the narrator played in the events of an illness. Whether husband, neighbor, mother, or sister, the storyteller always focuses considerable attention on action in which he or she took part. The following discussion of cultural models and schemas must necessarily be limited to consideration of these knowledge structures as they relate only to the interpretation of illness. Although it is suggested that the cultural models described here are more broadly applied to other kinds of interpretations and other kinds of tasks, this analysis does not encompass those broader applications.

Cultural Model of the Family
Responsibilities and activities of mothers occupy a distinct and central place in the Ecuadorian model of the family. The mother is the core of the family, as conceived by marginal Ecuadorians. Mother also constitutes an extremely powerful symbolic entity in cultures that, like Ecuador's, are shaped by Hispanic Catholicism. The symbolic power of the mother image derives from associations with the Virgin Mary, "Mother of God," and with numerous miracles attributed to her - miracles that have detailed histories, concrete locations, and tangible commemorative events associated with them. Since motherhood is modeled after Mary, it symbolically entails that peculiar mixture of ravishing but saintly beauty made somehow more beautiful through suffering the pain of love and death. Motherhood as an image embodies the ideal of love that is superhumanly strong but that nevertheless offers practical help and is gentle and approachable.

Motherhood in illness narratives. A striking example of cultural assumptions about mothers' roles is found in the narrative Sra. Maria tells about her crippled daughter, Susana. The assumptions are revealed not only by what she says but also by what she does not say. In her story of the events, Sra. Maria never mentions that for months she daily carried her 6-year-old daughter (in a cast from waist to ankle) down a 200-step flight of public stairs and 4 blocks to the nearest bus stop so the girl could go to physical therapy. This constitutes an extreme example in that the father of the child drives a bus parked near the house every night. During the many months of this grueling routine, the couple never made arrangements to shift some of the responsibility for Susana's transportation to the father. Also, people talking about the child's condition take for granted this herculean effort on the part of the mother; such efforts are the unmarked case for mothers. General statements about mothers and counterexamples in the stories reveal cultural knowledge about the significance of the mother's role. Narrators say, "Only God knows the mother's heart," and "the pain of a mother is like that." Explicit general propositions about husbands or daughters or other roles or role-identities do not appear in these illness narratives.

Counterexamples, or narrative descriptions of individuals who are not fulfilling their roles adequately or in expected ways, throw into sharp relief the role expectations attached to mothers in illness situations. Passage B of Appendix 3 describes the behavior of mothers who leave their children in the public hospital and do not participate actively in their care during hospitalization. The emotionally charged tone of the passage should be evaluated in light of knowledge about hospitals in Ecuador, with their inadequate nursing attention and risk of death. Both the tone and the repetition of "She didn't come, she didn't come..." reveal not only that the narrator is making a statement about a deviation from her cultural schema for the mother's role but also that she has strong feelings about such a deviation. This passage and others like it reveal feeling and thought as "parallel systems of processing" (D'Andrade 1981; Zajonc 1980). The mother is saying, in effect, "Mothers are supposed to be near their children and take part in their physical care, especially if they're in the hospital, because they will probably die otherwise." The emotions attached to this counterexample can be paraphrased as, "I feel bad about these sick, abandoned children and good about myself for not being a mother like that." Affective propositions are more central to most of these illness narratives that it can be said that if cultural models of social roles drive the narratives, emotional propositions are the fuel that empower them.

More counterexamples about motherhood occur in the narrative told by Elsa's neighbor, Mercedes. In fact, Mercedes's account of Elsa's condition is one long counterexample; it thoroughly dramatizes a number of instances in which Elsa failed to meet her responsibilities as mother of a family. Passage C exemplifies counterexample material in Mercedes's illness story. The same facts also appear in accounts of the illness given by other individuals but are not presented to imply personal fault. For instance, Elsa's daughter Rosa mentions the multiple miscarriages as a possible cause of her mother's illness but does not imply that these could have been avoided. The point here is that counterexamples can easily be constructed out of facts pertaining to an illness, but narrators who present counterexamples usually have an affective point to make.

A corollary proposition to the one that the mother is the vital core of family life is that marriages that produce no children are in trouble. In the
Las Gradan model of the family, children not only bring fulfillment to the mother, they are also what “glues” (pegar) a man to his wife and conjugal home over the long run. All of this logically fits given the initial premise that a family unit must have a mother to flourish; children are what turn a wife into a “real” mother.

Gender differences, collective responsibility. The cultural model of family revealed in these illness stories shows clear gender differentiation in expectations about decision making, economic arrangements, nursing, and other role activities associated with health problems. Female family members (e.g., wives, mothers, sisters, daughters) are expected to bear the main burdens of nursing the ill at home and making forays into the specialist health-care system on behalf of their families. Although the prototypic family role for a woman is that of mother, the cultural model prescribes that the burden of caring for the ill be borne collectively by related females within a household compound. (Ethnographic observation confirms this as a general behavioral pattern.) Expectations of collective female responsibility for therapy management and caretaking of children are reflected in narratives about 3-year-old Isabel. The child’s mother, grandmother, and aunt reside in the same compound. In talking about attempts to cure the child, each of them uses the plural pronoun “we” rather than “I.” Context shows that the “we” refers to the three women. Males make cameo appearances in the accounts but are always clearly identified when they play a part.

Cultural knowledge about male roles. What do accounts of illnesses convey about Ecuadorian folk theory concerning male roles in such situations? The male head of a household may be described as padre de la familia (father of the family) or just as frequently as jefe de la familia (chief of the family). This is partly an administrative position but also involves financial support of the family unit. All adult males in the household are expected to earn money and contribute some of their earnings to the family. Apart from this expectation, male roles in family life at home are not as clearly defined as are female roles – there is no single prototypic male role identity nor set of usual activities within the home as there are for females. The model accords males the freedom to come and go, with their primary responsibility being to support the family financially. Even though pain is manifestly and prominently part of cultural expectations about the mother role, male roles within the family are not associated with suffering or pain. It appears that the Ecuadorian cultural model of the family allows, indeed encourages, women to feel fully the anguish of a calamity that befalls a family member but does not prepare men either psychologically or socially to acknowledge that kind of anguish.

Illness narratives indicate that men have, or know where to get, cultural knowledge about seeking therapy and about home treatments. The narratives also indicate, however, that no one expects men to get involved in those activities if women in the family are available to assume the responsibility. In Passage D of Appendix 3, Carmen (the mother of the toddler who fell on the public stairs) recounts events at a moment when the child’s condition worsened. She mentions Ramiro’s reluctance to wake up and help care for the child but does not evaluate his behavior negatively. Rather, she excuses it by pointing out the hard work that led to the father’s fatigue. His refusal to get up does not indicate lack of affection for the child according to his wife’s story. She later describes him as desperately wanting to obtain good specialist treatment for Lucia. While at home, however, he sleeps, secure in the knowledge that the mother will do everything she can do to care for the child and in the knowledge that he is not necessarily expected to get actively involved at home.

What happens, given the Ecuadorian model of family life, when the mother of a family becomes chronically ill? Clearly, this kind of situation would be likely to generate different interpretations than the same condition suffered by a child or a male member of the family. Among other things, this type of situation can produce serious role strains within the family, which will be reflected in illness narratives. In Case 4, which is summarized in Appendix 1, Fernando takes an active part in managing his wife’s therapy. His 17-year-old daughter is too young to take on full responsibility for this, although she does do all the primary caretaking of her invalid mother at home. (Neither she nor her father point to her full-time devotion to her mother’s care as anything worthy of praise; such a role for the eldest daughter at home is the unmarked case.)

Themes of money and treatment costs pervade Fernando’s account of his wife’s affliction. He talks at length about the expense of various consultations and treatments, giving precise figures, and also about his personal efforts to obtain funds to finance specialist care. Overall, men’s narratives show more concern with the economic dimension of illness situations. In addition, female narrators often make a special point of noting the participation of men in the economics of health care. An example of this is found in Passage E, in which Isabel’s mother and grandmother give credit to the child’s grandfather, her mother’s father, for playing a vital role in financial decision-making about treatment. This and other passages reveal that the cultural model of illness situations prescribes an active role for males in matters of money, especially in negotiation with formal financial institutions. (The primary source of commercial loans for marginal Ecuadorians is at their place of employment. Men are more likely than women to hold structured employment. So, men’s greater responsibility for this aspect of coping with illness derives from both economic contingencies and cultural ideals.)

Sra. Maria also emphasizes male participation in certain decisions made about surgery for her daughter. She describes her early attempts to get help for the child. The third doctor she consulted told her the child needed
an operation immediately. Her story continues, as noted in Passage F, in which she shows that her husband has the final say about treatment. A few years later, Sra. Maria took her daughter to traditional curers, and then, following her mother-in-law’s advice, she consulted a physician. First, she says that she went to see the doctor. Then she amends this and specifies that she and her husband went to see him. Passage G, like many of the narratives, indicates the special recognition given to a man for playing even a minor part in the management of an illness in the family. Narratives reinforce the cultural expectation that women automatically assume major responsibility for caretaking and seeking therapy, while the final authority lies with men to make decisions about treatment that involves more than incidental expense.

Fernando’s story about his wife’s problems demonstrates abundant knowledge about certain aspects of the specialist health care systems; the majority of this account centers on his efforts to get effective treatment for his wife. The narrative also reveals a cultural bias in favor of including women, even young ones, in efforts to manage the therapy of a sick family member. On most of his forays to seek specialist care, Fernando took along one or more of his older daughters. His grown sons who live at home did not participate actively in the illness situation. Their behavior elicits no special criticism, just as the daughter’s caretaking behavior elicits no particular praise; both the sons and the daughters are conforming to the cultural expectations in a case of this sort.

Folk “physics” of health behavior. Narratives reveal the cultural notion that a special impetus is needed to “get moving” on health problems. A key concept in the “physics” of motivation is embodied in the phrase hacer empeño. This phrase means “to get someone (or oneself) moving to accomplish something.” Even though people take for granted tremendous ambivalence about acknowledging a health problem as serious and about “moving” into action to seek specialist care, they also expect family members to monitor each other’s health and push for specialist consultations. In Passage H, Sra. Maria credits her mother-in-law with pushing her (putting her in motion) to see another surgeon about her child’s infirmity. Isabel’s mother and aunt discuss their efforts to get a cousin “moving” toward treatment. Illness narratives suggest that the typical “motivator” is a member of one’s family network, but not necessarily of one’s immediate domestic group. In addition, narratives reveal that pushing for action on a health problem does not necessarily entail expectations of follow-up help with the mechanics of finding or financing specialist care.

MODEL OF EXTRAfAMILIAL SOCIAL SUPPORT
Ecuadorians hold distinctly different notions concerning roles and social support within the family and roles and social support characteristic of extrafamilial relations. Many illness stories implicitly address this ques-

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“Too many visits make you less welcome.”
“Give the hand, get grabbed by the elbow.”
“Every burro with its own saddle.”
“Today for you, tomorrow for me.”
“Hands that give, receive.”
“If you give bread to a strange dog, you’ll lose the bread and lose the dog.”

Explanations of these proverbs by Las Gradans indicate that people interpret them primarily as advice to use caution in conducting relationships outside the family. Ethnographic observation shows that neighbors and friends do, in fact, help one another considerably in coping with various problems. But this fact in no way detracts from the authenticity of the cultural propositions that they do not, or the admonition that one should not depend on them to do so.

Another counterexample reveals the proposition that only family will help. A neighbor of the toddler’s family describes how doctors regard her supportive behavior in that family’s crisis as quite unusual. She describes events at two institutions where she accompanies the child’s mother to seek treatment. At both locations, staff members ask her: “Who are you? Are you the child’s mother? If you aren’t, why are you so concerned and involved in this?” Here, the narrator presents her own behavior as a counterexample. By elaborating on the surprise of the medical personnel, the narrative shows that the neighbor interprets her own behavior as an exception to the standard cultural model.

Even while the cultural model of extrafamilial social relations leads
marginal Ecuadorians to limit expectations of aid from nonrelatives, it also embodies knowledge about culturally appropriate strategies for developing the kind of extrafamilial relationships that most likely will result in instrumental and other social support. People obtain much of this knowledge from descriptions other people give of how they managed to build these connections. Isabel’s family recount how they pursued the ideal strategy for marginal Ecuadorians faced with serious illness. They found benefactors. As described in the narrative, the primary benefactor was located on the advice of a friend and a salesclerk. Isabel’s mother and grandmother credit this female doctor (doctora) with saving the child’s life and curing her infirmity.

Cultural Model of Social Hierarchy and Biomedicine

Many different terms exist by which people in highland Ecuador place one another within a distinct social hierarchy. As Stark (1981) demonstrates, how people use these terms in one highland town varies systematically according to the social category in which the speaker fits. However, social classifications are organized in a very clear-cut way on the basis of palanca (literally, “lever,” or “handle”). Degrees of palanca ranging from “no access to goods and services” to “high access to goods and services” are interpreted as the distinctive features that differentiated people from one another within the social hierarchy. As such, they were used as implicit markers, rather than as explicit labels, of social categories (Stark 1981:391).

Las Gradans also conceptualize the social world as a place in which various categories of people have greater or lesser amounts of palanca. This term comes up in a number of the illness stories in connection with biomedical institutions. For instance, a friend of Isabel’s family talks about their attempts to get assistance with medical expenses: “[The Patronato] is an organization that helps poor children, sick children, and like that. But you know the bureaucracy, no? If we have no ‘leverage’ (palancas), they don’t help us.” The cultural model of social hierarchy found in Las Gradas conceptualizes people as possessing different amounts of palanca. It also divides them in a dichotomous way according to wealth. This division is represented in the terms pobres (poor people) and ricos (rich people). Residence in certain barrios of Quito almost automatically certifies one as a pobre or a rico. It is tacitly understood that biomedical institutions belong to and are staffed primarily by people belonging to the latter category. Models of wealth and palanca together form the cognitive landscape that pervades schemas of biomedical health care.

Physicians in illness stories. In their illness tales, Isabel’s family describes a greedy, unethical doctor who lied to the family during the early stages of their attempts to get treatment for the child. Their descriptions of this physician were constrained and understated, partly because the narrators were uncertain about where I stood with relation to doctors and other professionals, but more because lack of ethics is nothing remarkable in a doctor from their standpoint. A narrative about a different case shows the ramifications of the proposition that physicians are, as a rule, not to be trusted. The mother of the toddler who suffered fatal head injuries says, “I imagine, frankly, that the doctors gave her a poisonous injection so she would die right away.” In effect, this narrative proposes that it is not out of the question to suspect doctors of hastening the death of an ill child.

In contrast, narrators from Isabel’s family describe the female doctora who befriended them in glowing and elaborate detail. She is transformed into another counterexample. By emphasizing and elaborating the doctora as a character in their stories, the narrators again reveal that expected behavior on the part of physicians does not include real affection for patients, genuine sympathy, “vows of poverty,” or being willing to wait for payment. Their effusively grateful language communicates knowledge about how they expect the typical doctor to act.

Because the doctora’s behavior constitutes a surprising deviation from the cultural model of social interactions with professionals, Isabel’s family attempt to explain this exception to the rule. They do this through references to person theory (Holland 1985). Passage I expresses their proposition that the doctora is kind and compassionate toward poor children because she is pretty and an unmarried woman with no children of her own. Many other passages in the accounts of Isabel’s illness also reveal person theory at work, including direct quotes of the doctora’s explaining her own unusual behavior as due to “conscience” and other personal factors.

How do counterexamples relate to knowledge structures concerning social roles in illness? First, narrators who present counterexamples are talking about “exceptions to the rule” that are usually highly salient to them. The exception matters because the rule matters. For instance, counterexamples concerning mothers and doctors indicate that these roles are pivotal ones in the domain of illness behavior. Second, this material throws into sharp relief the cultural model of social roles by capturing the essence of what a mother or doctor does not act like, in the usual course of events. By definition, counterexamples pinpoint the “difference that makes a difference” (Bateson 1972; Hutchins, personal communication) from the emic point of view. Thus, from the two counterexamples discussed here, we find that a standard entailment of the mother role is that, “A mother tends her children, whatever happens.” A standard entailment of doctor can be embodied in this proposition: “A doctor expects his fee immediately, whatever happens.”

Nurses in illness stories. The Ecuadorian model of biomedical institutions clearly distinguishes doctors from nurses in terms of their interac-
tional style with pobres. Before specific cultural propositions about nurses are identified, it should be noted that enfermeras (nurses) is a category that marginal Ecuadoreans use to refer to practically all the nonphysician practitioner roles women play in biomedical treatment systems; in other words, Las Gradans do not generally distinguish between the Ecuadorian equivalents of registered nurses, licensed practical nurses, and nurses’ aides. The differences in licensing and education between these practitioner types are not salient to most Las Gradans.

Medical doctors are thought of as typically greedy and not compassionate, but at least they can be approached by pobres. As Sra. Maria says, “Oh the doctors, yeah, they’re nice enough. They answer when they are greeted.” While you may not get good treatment from a doctor, at least they are ‘civil.’” Marginal Ecuadoreans put a great deal of emphasis on respectful interaction styles, particularly on greeting and leave-taking rituals. In contrast to physicians, nurses (particularly nurses who work in hospitals) are widely described in natural discourse as groseras. This term can be roughly defined as “rude, uncivil, brutal.” One narrator says:

There are children who can’t move [in the hospital]. They can’t move and the nurses come and throw their food on the bedside table, [saying] “If you can eat, eat; if not, then don’t eat.” That’s how it is. That’s how this type of Señorita is — they have no heart, we could say a word. There was one child that couldn’t eat, bedridden like this, they had him with a weight attached to his little leg. I fed him when I came. But, the nurse said to him: “There it is. You have to eat it. What do you want me to do, put it in your mouth? If you can eat, go ahead and take it, go on, eat,” she said.

Two things should be pointed out about the proposition that nurses are groseras. First, not all illness story narrators communicate that proposition, although they would certainly all recognize it as a common idea in their neighborhood. Second, the cognitive model of social hierarchy as applied to biomedical systems in Ecuador dramatically differentiates hospitals (and hospital nurses) from private clinics (and clinic nurses, by extension). Thus, cultural propositions about nurses may not have as much to do with categorizing the type of person who works as a nurse as with categorizing the typical behavior of nurses who work within a certain type of institution.

Clinics versus hospitals. Private clinics in Ecuador are like small-scale hospitals, with their own surgical facilities and patient accommodations. Clinics are expensive and are associated with ricos (rich people). Hospitals, on the other hand, are public and are supposed to charge nothing, by a recent act of national law. Hospitals are associated with pobres and with inadequate, uncaring treatment. Passage J is profoundly shaped by cultural knowledge about how to maneuver as a “marginal” in urban Ecuador. It reveals a proposition that doctors and nurses, with few exceptions, should not be trusted to give adequate or compassionate care if one is poor. A concrete expression of this proposition is found in references to “tipping” hospital personnel. The reference to “tips” in Passage J reveals the assumptions on the part of barrio residents that hospital staff expect to be paid directly for giving good service to patients and that inadequate care will be given to patients who fail to observe this custom.

Schemas of therapy management in getting biomedical treatment are profoundly shaped by the distinction people make between clinics and hospitals and encompass a behavioral routine that guides Las Gradan interpretation of efforts to get biomedical care. It is considered important that therapy managers at least attempt to get private clinic treatment before resorting to hospitalization. Only after inquiring about the expense of clinic treatment and finding it too expensive do they turn to hospitals. Not only is this a behavioral routine, but it also constitutes a highly salient element in illness narrative. Many of the 14 narrators gave attention to the clinic-first, hospital-second pattern. As explained in a later section, when narrators describe their efforts to obtain treatment at private clinics first, they are making a social and affective statement that they “did the right thing.”

A cultural model of social hierarchy informs schemas concerning biomedical treatment among marginal Ecuadoreans. These 14 illness narratives show that biomedical practitioners are associated with higher social status; a distinction is made between doctors and nurses based on interpersonal interaction styles; private clinic and public hospital treatment facilities and personnel are regarded as dramatically different, partly on the basis of social class factors; and, on the whole, their cultural model of biomedical guides marginal Ecuadoreans to be wary and mistrustful, unless they manage to develop a personal relationship with someone who has palanca in the biomedical system.

As the analysis presented in this section shows, illness tales communicate extensive cultural knowledge about social roles in illness situations, including expectations of male and female kin, neighbors and friends, and physicians and nurses. Communication of such information through conversation and narrative both augments and reinforces shared cognitive models used to interpret illness situations. These models constitute a subset of cultural models of social relations in general, as held by marginal urbanites in the highlands of Ecuador. However, illness narratives do more than encode situation knowledge. The following sections show how narrative communication also acts as a dynamic vehicle for subtle negotiations about illness causation and about feelings associated with illness situations.

Theories of causation in illness stories

Illness narratives reveal much greater fascination with the causes of an affliction than with its symptoms or diagnosis; stories present numerous theories about what caused this or that health problem. A preference for
problems of cause has been documented in other cultures as well. For instance, North Americans have been shown to think more about “the consequences and preconditions of illnesses” than the attributes or features that define disease (D’Andrade 1976). Ecuadorians take seriously the task of identifying causes of a sickness, especially in cases of serious or chronic affliction. During informal discussions, people evaluate the truth value of the causal propositions of others. Cultural consensus emerges as participants in a conversation work out the relationships between different beliefs and so refine their explanatory models.

Narratives put forth three kinds of instrumental, or immediate cause. These include physical factors (e.g., temperature), emotional factors (e.g., anger), and behavioral factors (e.g., “She was playing on the stairs.”) (Glick 1967). Some narratives also suggest “ultimate” causes, notions that involve some degree of moral judgment of the ill person or family.

MULTIPLE NOTIONS OF CAUSE

It is striking that many narrators put forward a number of different causes for any given illness. Sra. Elsa’s daughter, for example, attributes her mother’s disease to at least six distinctly different factors: too many miscarriages, anger (iras) at children and husband, anger held inside, her son’s death, drinking hot medicinal teas prescribed by a curer but not staying in bed afterward, and doing laundry too soon after giving birth to her last child. The daughter’s narrative also cites other causes for the disease that have been identified by various health-care specialists and other family members. Sra. Elsa and her husband refer to many of the same causal notions independently of their daughter and each other. The family has obviously discussed the problem of causation, and family members are aware of each others’ theories, although no consensus has been reached. Intrafamilial verbal communication about illness is another way in which individuals refine cultural models of illness.

Some narratives demonstrate not only multiple notions of cause, but also an effort to judge the truth of various causal propositions, particularly those promoted by other people. Susana’s sister first states that the child’s hip malformation was caused by her mother’s work as a weaver when pregnant with Susana. Later in her narrative, she returns to the question of cause, presenting a causal notion she has heard from her mother and rejecting it. In Passage K, we see an individual striving for logical consistency between various body notions and propositions about illness causation. Several narrators take such a logical and “constructive” approach to causal theories bearing on illness. In telling illness stories, some individuals are also striving to clarify relationships between different causal notions.

Moral cause and situated social purposes. Relatively few of the 14 recorded narratives express the proposition that an illness or accident was due to someone’s immoral behavior. When these propositions are expressed,
The point here is that cultural knowledge can best be conceptualized as a system of ideas that people use according to their needs and purposes, rather than as a deterministic grid that directs their thinking. The next, and final, section considers natural discourse from the standpoint of people's social and emotional needs in conversation about illness. Not only do narratives communicate situation knowledge and causal notions, but they also dramatically communicate the narrators' feelings and purposes in the situations they describe.

**Communication of feeling in illness narrative**

Affect powerfully influences how people apply cultural knowledge to cognitive tasks, as Hutchins shows (this volume). His analysis identifies the affective (in this case, subconscious) connections that lead a Trobriand villager to use a particular myth to explain a seemingly unrelated phenomenon of malevolent spirit visits. It is not surprising that affect also influences the task of formulating interpretations of illness and that many illness narratives make important statements at the affective level.

Most of the recorded narratives analyzed here express feeling in a powerful way, while ostensibly only describing events. The pattern of using narrative to communicate strong feelings indirectly has been documented in other cultures and conversational genres, most dramatically by Labov and Fanshel (1977) in a study of North American psychotherapeutic discourse. In a classic example, they show how a client expresses angry rejection of a therapist's request by telling a story about her aunt. The expanded meaning of the client's story was inferred partly from the authors' knowledge of the client's life (revealed in other therapy sessions) and from such physical factors as the speaker's intonation, pauses, repetitions, and movements. The affective propositions in these Ecuadorian illness narratives have also been inferred partially through contextual information and nonverbal cues.

"I DID THE RIGHT THING."

Many of these illness stories dramatically encode the affective proposition that "I did the right thing" (i.e., "I am a good mother/daughter/neighbor/husband"). The more caretaking responsibility a narrator has for the afflicted person, the more pronounced this affective message tends to be. The more distant the teller is, socially, from the events and the individuals involved in them, the less pronounced this affective message is. Logically, the "I did the right thing" proposition appears in its most distilled and dramatic form in stories mothers tell about their children's illnesses. The Ecuadorian schema associated with "mother" very clearly incorporates an affective component. Just as the term _hot_ fuses together a representation of the "factual external condition" and how we feel about that (D'Andrade 1981), so the term _mother_ among marginal Ecuadorians automatically entails a large potential for pain. People are aware of this component of the role and even point it out with general statements. Part of this cultural knowledge is directly experiential. The personal experiences, however, are shaped and reinforced by cultural representations, particularly religious representations.

A mother describes her second round of struggle to get treatment for her child (Case 1). The public hospital to which Sra. Carmen wants the child admitted tries to get her to take the girl to another hospital across town. In Passage L, the woman asserts implicitly that she did all she possibly could to ensure the child's recovery by struggling to keep her in what she thought was the safest hospital available. The same mother presents a second variation of the proposition "I did the right thing" when she describes her resumption of normal life after a long period of incapacitating grief. First, she recounts the events in which a female acquaintance advises her not to cry any more. She describes how friends urge her to moderate her grief, reminding her that the child is in heaven and is watching over and praying for her mother and the rest of the family. Even more central to Sra. Carmen's narrative is description of a dream she had in which her deceased daughter appeared as an angel. In the dream, the child asks her mother not to grieve any more, because the mother's tears are keeping the child from entering a beautiful paradise. Both sections of narrative implicitly assert that the narrator is "doing the right thing" by overcoming depression about her child's death and going on with life.

In his story about his wife's illness (Case 4), Fernando communicates two major affective propositions. The familiar "I'm doing the right thing" assertion is embodied in his repeated and detailed accounts of the many hospitals, clinics, doctors, and religious healers he has taken his wife to see for diagnosis and treatment. The second proposition is the less common, "This illness [ill person] makes me angry and frustrated!" Fernando communicates this proposition through detailed description of how his wife accuses him of being unfaithful, makes unreasonable demands on his time, and does not "really try" to get well (see Passage M).

Another account of Elsa's illness, by her caretaker daughter Rosa, contains the complete and spontaneously included narrative of how Rosa's brother died from cancer. As part of her narrative, she recounts her brother's dying words:

> My aunt told me, "Your brother said this to me. He told me to tell you that he is going to take care of you, to keep watch over you, in order that you go on caring for her." Because I am the only one [of us in the family] that takes care of my mother, that takes care of her, that has the strength to take care of her.

The affective point of this segment of narrative can be paraphrased: "I am struggling, and afraid of this burden, but I am proud of the strength I have shown so far." Of all the illness situations, that of a disabling chronic
of the family and of extrafamilial social support, a cultural model of social hierarchy (with associated schemas of biomedical institutions), and a set of interrelated notions about illness causation. Narratives show that most of the cultural knowledge Las Gradans bring to bear in interpreting illness episodes is situation knowledge. References to person knowledge (e.g., values and attitudes, general character, person “types”) are rare. The elaborate personality trait model to which North Americans often resort when interpreting behavior does not appear to be part of the explanatory tool kit Ecuadorians use in talking about illness.5

Two kinds of roles are thrown into sharp relief in illness narratives: roles played by close family members and roles played out in interactions between the poor and biomedical personnel. Some family roles, such as that of mother, are seen in these stories to entail many obligatory activities in illness situations; other roles allow for more leeway and personal choice. Illness sets in motion superhuman efforts by mothers that are, typically, taken for granted. It may also set in motion superhuman efforts by men; but, if so, these efforts will be highlighted in the narratives. The cultural model of family also specifies the feelings that are predictably and acceptably attached to each particular role. For instance, it is accepted that male relatives may feel and express resentment about the demands of being a caretaker for someone who is ill, whereas women, typically, may not.

Expectations about family roles in illness situations, as reflected in illness discourse, can be regarded as a subset of a broader model of roles in everyday family interactions. Likewise, much of the cultural knowledge encoded concerning interactions with medical personnel and institutions is also used to understand encounters with other nonmedical professionals and institutions. Much of the social role knowledge discussed here is not restricted to interpretation of only illness situations but should also show up in narratives about other kinds of situations. On the other hand, the same cultural models may be used somewhat differently in accomplishing other “tasks,” for instance advice-giving or actual treatment-choice.

Hearing illness stories can influence knowledge structures in several ways. Individuals gain information about entire illness episodes without having personally experienced those events. Such secondhand episodes are integrated with those the person has directly experienced and become part of his or her current scripts concerning illness. Since illness situations are quite variable, no one is likely to experience enough episodes firsthand to develop robust scripts. Verbal transmission of the outlines of other episodes also affects development of general cultural models. Because illness stories occur in the context of conversational exchange, they contribute to “socially generated knowledge” (Clement 1982). Cultural models are carried by individuals, but they are partly constructed and refined through conversation and reflection. Nowhere is this more clearly seen than in the discussions of causation in illness narratives. As demonstrated here, there is a fascination with causal propositions, and narrators not
infrequently turn their attention (and that of listeners) to the truth value of various propositions.

Finally, it is argued here that many illness narratives have an important affective dimension that must be taken into account in analysis of this discourse. Propositions such as “I did the right thing” are often what people most emphatically communicate in telling an illness story. Ecuadorians rely on narrative communication more than do North Americans to express feelings they are not allowed to express directly in conversation. Furthermore, feelings as well as thoughts and accounts of particular events are socially negotiated through exchanging stories and assessing responses to them.

To sum up, the illness story as told among this population of marginal urban Ecuadorians may be regarded as a culturally identified (although unlabeled) way of talking about illness, with certain structural features that set it apart from ordinary conversation. This type of discourse encodes multiple cultural models, most importantly, situation knowledge about social roles in illness. The discourse also implicitly encodes affective propositions made by narrators about the events and provides a vehicle for social negotiation about thoughts and feelings. Verbal communication of this type supplies both raw material and a forum for the refinement of cultural knowledge bearing on illness. For all of these reasons, the verbal traditions concerning illness that exist in Las Gradas are important in the transmission and generation of cultural models.

Appendix 1

ECUADORIAN ILLNESS STORIES - CASES AND NARRATORS

1. Lucia - toddler who suffered head injuries in falling on the public stairs in front of her house; taken to hospital, released; condition deteriorated; taken back to different hospital, died there.
Narrators - mother, female neighbor, another female neighbor.

2. Isabel - 3-year-old born with foot deformity; treated at private clinic for long period of time with no improvement; ultimately received operation in a different private clinic thanks to intervention of a doctor who befriended the family; considerable community involvement in helping this family.
Narrators - mother, aunt, grandmother, male neighbor, female community leader.

3. Susana - 6-year-old who suffered severe hip malformation, starting at the age of about 1 year (possibly due to polio); many different health care specialists consulted and therapies tried to bring about cure; ultimately received operations on both legs in the public children's hospital, then physical therapy, then spiritual curing after physical therapy proved less than totally effective.
Narrators - mother, child's older sister.

4. Sra. Elsa - middle-aged woman with degenerative nervous system disorder of about 5 years' duration; mother of nine children, youngest age 2; many different health care specialists consulted, diagnoses made, and therapies tried; family under great strain in trying to cope with the illness and the recent death of the oldest son in the family.
Narrators - husband, caretaker daughter, female neighbor, and Sra. Elsa.
Appendix 2

STRUCTURAL FEATURES OF A TYPICAL ILLNESS NARRATIVE

(Case 1, Mother Speaking)

Initial events of illness
[Orientation]

Susana walked normally at 1 year of age. Then she got an infection. We took her to a clinic.

At the clinic, they gave her IV and four injections. We believe the injections created little “pellets” or balls in her hips.

From then on (after the injections), she began to limp, sway from side to side like a duck.

When she was 2, I took her to a doctor in Ambato; he said we had to operate immediately. My husband raised objections and there was no money. Then, I consulted a bone specialist in Latacunga. He said there was no reason to operate, that she would be an invalid all her life. That caused me so much pain, I didn’t have her examined by anyone else. Then we came here to Quito to live. My mother-in-law was the one who “got me going” to go consult Dr. G. in the hospital to see if he could operate.

Before going to see him, I took her to Conocoto for treatment from a “bone-setter”; but that took too much time and I couldn’t keep doing it; besides she wasn’t getting better.

At this time, she wasn’t in pain.

Then I [correction] we, my husband and I, went to see the doctor; he gave us hope and said “Bring her in.”

The doctor operated on the first leg. In physical therapy, the doctor said it wasn’t so good. I massaged the bone here at home with a remedy I know, and the bone began to move bit by bit into place.

Then they operated on the other one.

The outcome still isn’t known.

After 6 weeks, they will look and see how it is. For the first one, they called me after 4 weeks to see how it was; it was 3 months before they took the cast off.

I believe it will be 3 months for this one, too.

I am praying to God that it will all come out OK, whatever happens after that.

Causation

Final coda

[Questions by investigator lead to further narrative segments.]

Interview with social worker at the hospital concerning possibility of reduced charges.

Remedies used and care of Susana in recent past.

Stories of two children in the hospital, the nurses’ interactions with them, and her own role.

I hope that God’s will is to cure her. There is no [other] help, nothing to do but bear the pain of a mother.
Appendix 3

PASSAGES FROM ECUADORIAN ILLNESS STORIES

A. Narrator: Olivia, older sister of Susana, child with hip malformation (Case 3).
"The neighbors said she had eaten something, maybe, something that stayed in her intestines and couldn't get out. So they said we had to give her an internal bath with camomile, lemon [and glycerine] in order to clean everything out of there. We did that and it helped her. Then we put grape leaves on her stomach with almond oil, you see, curing her on the outside. We put that on her and she got better. . . ."

B. Narrator: Maria, mother of Susana, child with hip malformation (Case 3).
"I have seen mothers go to leave their children in the hospital there. They [the children] are forgotten there and the mothers don't go to see them again. One Señora left a little boy about 2-years-old. He was there, he was there 15 days. They had already operated on his little leg, and his mother didn't come, she didn't come. I don't understand that. She didn't come. I don't know how it turned out, since my daughter was discharged. I don't understand it. [Pause.] The poor little thing just stayed right there. I didn't know if she would come get him or not. Another Señora from Santo Domingo did the same thing."

C. Narrator: Mercedes, neighbor of Sra. Elsa (Case 4).
"She went to events like soccer games, outside [al aire] almost unclothed. To dances, in that air, can you believe it? And, on the second or third day after miscarrying [the same thing]. . . . One should take care of oneself, and the Señora, note that in one month it's said she had three miscarriages, in one month. That is, neither she nor her husband were taking care [of her health] to conceive again right away. . . . [Elsa does not take her medicine] because she doesn't want to. She's irresponsible. Doesn't it seem so to you? If she were a responsible person, she would try to get better, strive to overcome it. The way I see it, overcoming things in order to keep the home together is the essence of the "mother." And she doesn't like any of that, no. So there it is. And that's why her family doesn't love her."

D. Narrator: Carmen, mother of toddler who suffered head injuries in a fall (Case 1).
"My daughter started to have convulsions, to shake. I saw it and tried to wake my husband up because he was sleeping. I told him that the child was getting worse. He had gotten up at dawn and worked until late at night. So I told him, 'Look, the child's getting worse.' He didn't answer me. Then he said, 'Let me sleep.'"

E. Narrators: mother and grandmother of Isabel, child with foot deformity (Case 4).
Mother: Then we came to our senses about my child, who was crippled in the same way. . . . She wanted to talk and she couldn't and she cried. So in view of that, we took the risk of trying to find someone who would operate.
Grandmother: But, on the other hand, my husband said: 'My dear daughter,' he said, 'and the money, the money? Where are we going to get it? Where are we going to get it from?' And he applied [for a loan] in order to be able to do it, because he works at the utility company. But, the loan was refused. It looked like everything had gotten messed up and we couldn't obtain the money, we just couldn't. We had no place to get it.

F. Narrator: Maria, mother of Susana, child with hip malformation (Case 3).
"But, my husband told me that it couldn't be that, all of a sudden, like that, she had to be treated, to be operated on. And, at that time, there was no money. So she stayed like that. . . ."

G. Narrator: Maria, mother of Susana, child with hip malformation (Case 3).
"I went to the doctor. [correction, "We"] went, my husband and I, to his office. He gave us such hope. He said, bring her, we will operate - in the clinic if you want, or in the hospital, if you want. My husband said, 'Doctor, how much would it cost us to do it in the clinic?'

H. Narrator: Maria, mother of Susana, child with hip malformation (Case 3).
"My mother-in-law was the one that got me going, the one who gave me the impetus to go and consult Dr. G., there in the hospital, about doing the operation."

I. Narrators: mother and aunt of Isabel, child with foot deformity (Case 2).
Mother: She is so wonderful, the doctora! She charges so little, and she really got things going to get the operation done fast.
Aunt: That's why we finally did take the risk enough to do it. And she's really fine, really pretty. She helps the poor more than anything. And, above all, she's attached to children. It's because she's an unmarried woman.

J. Narrator: Maria, mother of Susana, child with hip malformation (Case 3).
"I don't know what it is with hospitals. There's a lot of favoritism shown toward some people and nothing for others. . . . I think it's because one doesn't have money, that's why they don't take care of you. People who give them their tips get the attention."

K. Narrator: Olivia, older sister of Susana, child with hip malformation (Case 3).
"We thought the crippling must be due to the injections they gave her in the clinic. But, no. I believe that an injection won't move a bone, no. The injection was right here, but the bone is over there. I think the cause was the dehydration she suffered [during her illness at 1 year of age]. The dehydration affected the bones. That is, she was cured of the illness, but it affected the bones."

L. Narrator: Carmen, mother of toddler who suffered head injuries in a fall (Case 1).
"I wasn't daunted because a woman had told me, she said, 'Don't take her to Ortiz,' she said. 'You will never be able to take her out of there; she would die there,' the woman said. 'It's much better to take her,' she said, 'to Espejo.' So that's how it is my little child died in Espejo."

M. Narrator: husband of Sra. Elsa, woman with nervous system disease (Case 4).
"I am currently waiting for some insurance money [from his son's death]. With that money, I have to get her diagnosed, whether she wants it or not. I must
 Notes

1. Thanks go to the National Science Foundation and R. J. Reynolds, for financial support of this research project. Much appreciation also to Dorothy Holland, Ed Hutchins, and Wendy Weiss for their valuable contributions to the development of this paper. Earlier versions of the paper were delivered at the “Conference on Folk Models” and at the 80th Annual Meeting of the American Anthropological Association in Los Angeles in 1981, in a symposium organized by Dorothy Holland and Naomi Quinn and entitled “Folk Theories in Everyday Cognition.”

2. There are two primary types of natural discourse about illness between non-specialists in Ecuador: illness stories and therapeutic recommendations. Therapeutic recommendations pertain to ongoing health problems and may be solicited from, or offered spontaneously by, family members, friends, or neighbors. Even though the structure of this discourse is conversational, it does not follow the pattern of chronological narrative that characterizes illness stories. Therapeutic recommendations lead rather naturally into narratives, however, if a story exists to be told, if it permits, and the social context is appropriate.

3. For Ecuadorian women, the genre of illness storytelling constitutes what we might call “shop talk” because one of their special gender role responsibilities is management of family illnesses. Such conversations have immense problem-solving value, and women tend to launch into conversation about illness much more readily than men. One exception occurs when men are known to be carrying out direct therapy-managing roles in an illness situation; these men will be the recipients of therapeutic recommendations from friends and family and will be told pertinent illness stories, just as female caretakers are recipients of such communication.

4. Although illness stories do transmit information about specific remedies and home-treatment principles, there is less of it than might be expected given the widespread use of home therapies in Las Gradas. Why do cognitive heuristics such as home treatment sequences (Mathews 1983) not figure more prominently in this discourse? A plausible explanation is that home treatments are less valued than those prescribed by specialists and so receive less attention. Another probable explanation is that narrators de-emphasize or omit these details from their accounts because they assume their audience already possesses that information or will ask for it specifically if they need to know. Just as a storyteller in the United States would assume that listeners know the heuristic of drinking plenty of fluids and taking aspirin for a cold, so do Ecuadorian narrators take for granted that everyone knows the more common herbal remedies and specialist treatment options. This cultural pattern also affects ethnographic data collection. To obtain detailed information about such treatments, the ethnographer must usually ask about them directly.

5. Reasons for not openly acknowledging propositions about moral causes for a particular illness include family loyalty, self-implication by such an interpretation, and inappropriate audience.

6. Whether North American narrators instantiate propositions about personality traits in telling illness stories is a question that requires further research. Only with documentation of the illness storytelling genre cross-culturally can analysis be made of differences between the models that shape the discourse, and of the social or historical reasons for such differences.

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