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Becoming *Asustado* (Scared): An Ethnographic Contribution to a Transdisciplinary Approach to Children's Health and Development

By Carolina Remorini & María Laura Palermo
Universidad Nacional de La Plata

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I. Introduction

It is broadly accepted in contemporary research about children's health and development that medical knowledge should sustain a dialogue with several disciplines that approach children's lives from different questions and perspectives. The idea of disease primarily as a natural, organic, or psychobiological entity has been contested since the pioneering studies in Medical Anthropology. Allan Young (1976, 1979) was perhaps one of the first anthropologists to assert that all knowledge and experiences about the human disease are socially and culturally determined. In this regard, the distinction between disease/illness/sickness was an essential contribution to early studies of human health from a socio-cultural perspective and methodology.

Author: Laboratorio de Investigaciones en Etnografía Aplicada. Facultad de Ciencias Naturales y Museo, Universidad Nacional de La Plata, Consejo Nacional de Investigaciones Científicas y Técnicas Argentina. e-mail: linea@fcnym.unlp.edu.ar

Culture, from an anthropological perspective, cannot be reduced to habits or practices analyzed as "risk factors." Such an idea is widespread in classic medical and epidemiological studies. Instead, ethnography poses the question about the living conditions and cultural practices that may explain the disease occurrence, distribution, and prevalence in specific individuals from a certain society. Indeed, for understanding the process of "becoming ill", we need to move beyond a reductionist and monocausal idea of a set of risk factors, to comprehensive and situated knowledge about the specific environments in which children grow and develop as part of cultural routines and social relationships.

However, the idea according to which biomedical and psychological knowledge about children's diseases or developmental problems should lead to research and interventions remains. In fact, "childhood development" is seen as a matter of pediatricians and mental health professionals. Confronting hegemonic visions of this subject, in the last decades, there has been substantial progress in the cultural study of children's health and development from an interdisciplinary point of view. Several authors acknowledge the contribution of anthropology to the debate about human development, in dialogue with psychology, neuroscience, epidemiology, demography, education, and medicine (Weisner, 1996; Remorini, 2012).

Anthropology emphasizes the notion that the development of children's emotional, cognitive, and social abilities, is driven by the interactions that children have in their immediate surroundings. In this sense, the importance given to the environment in the development from an ecological perspective (Bronfebrenner, 1987; Hertzmann, 2010) recognizes the heuristic value of Ethnography.

Building on these ideas, an ethnographic approach to cultural knowledge, practices, and routines regarding children's health care and rearing, as presented in this article, seeks for a critical understanding of the process through which children may be labeled as *asustados* (scared). We analyze and discuss the implications of becoming *asustado* for everyday child-rearing and children's health, sociability, and performance in different community endeavors from

ethnographic data. We describe *susto*(fright) and its variants (*aikado, quedao)* as health problems that affect children's development pathways based on the narrative about therapeutic itineraries of women/caregivers of children under six years old. We focused on the sequence of events around the emergency of these illnesses and how women link them to diverse issues that have several consequences in children's later health and development, as well as in their social and school performance. In those illnesses episodes, organic, emotional, and social factors interact and combine both in etiology and therapeutics. We analyze the caregivers' criteria and decisions regarding therapeutic alternatives based on their evaluation, combination and/or confrontation of different knowledge, resources, and practices coming from the local culture as well as from biomedical and educational institutions.

Our study is carried out in rural communities from the Molinos District, in the North-West of Argentina, located in an extensive region that includes the Southern Andes of South America. According to the last official census (2010), there are 5565 people living in Molinos. The area is not only geographically defined, but also by prevalent historical, political, economic and cultural process, being involved in the creolization of various indigenous cultures with Spanish colonialism -the *diaguita* or *calchaquí* and some groups speaking *Quechua* language, coming from the Inca expansion. This mixture resulted in certain homogeneity in cultural patterns and practices common to the entire Andean region and, even today, such fusion produces social and cultural barriers in regards to health care. The present economy is based on extensive farming, cattle breeding, and domestic farming for self-consumption. Although some people still perform those activities, young people are mainly engaged in other tasks such as commerce, wage labor jobs – both inside and outside of Molinos, or even state-administrative jobs.

As regards health services, Molinos District has one hospital located inside the town and six sanitary posts in the nearby rural farms, located several kilometers apart from one another. Molinos' hospital only deals with more easily treatable pathologies. More complex pathologies are treated in health centers located in nearby cities. Although an increasing number of people visit the hospital or one of the sanitary posts, some illnesses are still being treated in the domestic realm or with the advice of *medicos campesinos* (peasant doctors or traditional healers) because biomedicine is not considered capable of diagnosing and treating them (Remorini et al., 2012).

Susto is a very frequent ailment throughout the Andean area, whose origin is always associated with a traumatic, unexpected, or stressful experience or event that involves the temporary loss of a person's spirit, causing emotional and organic symptoms at the same time. The origin of *susto* is based on a widespread conception that an individual consists of a body and of an immaterial substance that can separate itself from the body, wander around freely, or else remain captive from supernatural forces. Children are considered especially vulnerable to suffering *susto.* Although *susto* is a very recurrent illness during infancy, the more significant expressions (*aikado* and *quedao*) generate caregivers' concerns. They not only reveal the inefficiency of the given treatment but also imply long-term consequences for children's health and social competence (Remorini et al., 2012; Remorini & Palermo, 2016; Remorini et al., 2018).

Susto has been broadly studied in indigenous communities from Mesoamerica and Andean regions by several scholars in the medical anthropology and cross-cultural psychiatry field (Rubel, 1960, 1964; Yap, 1967; Palma, 1973; Palma & Torres Vildoza, 1974; Crivos, 1978; Bolton, 1981; Trotter, 1982; Cassidy, 1982; Sturzenegger, 1989; Zolla, 1994; Rubel et al., 1995; Elferink, 2000; Idoyaga Molina, 2007; Idoyaga Molina & Sarudiansky, 2011). In these studies, a descriptive and classifying approach predominates. Some other studies have examined how *susto* is experienced and conceptualized regarding changes in the lifestyle and transnational migration. Most of them focus on the emotional disorders (stress, anxiety, depression) that people suffer in their processes of adaptation to novel socio-cultural and economic contexts or due to a person's inability to meet the expectations of their society concerning their social role (Klein, 1978; Signorini, 1982; Tousignant, 1984; Price, 1992; Pribilsky, 2001; Weller, 2001; 2002; Baer et al., 2003; Tseng, 2006; Castaldo, 2015; Brooks, 2016; Remorini & Palermo 2016; Remorini et al., 2018).

Susto and other "folk nosologies" have been classified as a "culture-bound syndrome." It was included as a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorder (APA, 1995) (DSM -IV, Appendix J, p.888). In DSM-IV, the classification system is based on the descriptive approach – categorizing psychiatric disorders by precise sets of behavioral manifestations and symptomatology. Many scholars who studied *susto* in Latin America have criticized the concept of "culture-bound syndromes" and its implications at a theoretical and empirical level (Tseng, 2006). This classification has raised controversies, since some authors state that all knowledge and experiences related to health and illnesses are culturally constructed and, consequently, depend on each cultural context. In this regard, Cassidy affirmed, "(...) because the designation of disease represents a systematic abstraction from experiential reality using explanatory models that are not universal, every defined disease entity must be culture-bound" (1982: 339). In this sense, the culture-bound syndrome can be applied to any disease not only to "forms of unusual individual behavior restricted in distribution to

discrete areas of the globe" (DSM-IV, 1995) or to "unusual psychiatric disorders" (Yap, 1967; Tseng, 2006; Idoyaga Molina & Korman, 2002; Idoyaga Molina, 2007). Moreover, the wide distribution of *susto* in Latin American communities and the analogies found in its etiology, symptomatology, and therapy, forces us to discuss the "specificity" linked to one culture (Remorini et al., 2012). As Brooks (2016) pointed out, most "cultural syndromes," exist within distinct cultural groups who share some larger cultural-historical similarities. In this regard, Tseng (2006) proposes the term "culture-related syndromes" arguing that it would be more accurate to describe a syndrome that is closely related to determined cultural traits or cultural features rather than bound especially to one cultural system or society.

Taking into account these antecedents and the obtained results, this article is oriented by the following arguments:

1. *Susto,* as a folk illness category, provides a cultural framework to understand and explain children's developmental pathways that are not consistent with local expectations about children's behavior and performance. In other words, *susto* serves as a hypothesis to explain and justify why "things are going wrong" with a child;
2. There exists a close connection between stress or negative emotional states suffered by mothers during pregnancy and postpartum and later child health and developmental issues. In women's narratives, the reconstruction of events that may have triggered developmental disorders, malnutrition or behavioral problems of the child lead mothers to attribute the ultimate cause of them to have suffered from *susto* which has not been suitably and in time cured during pregnancy or in early childhood;
3. Focusing on the process of becoming *asustado,* we recognize the complexity of the therapeutic itineraries. In the process of finding effective options for the resolution of children's episodes, these categories are integrated into new hypotheses about the diagnosis and appropriate treatment. Also, new categories are built to reorient the action. In this regard, we need to go beyond taxonomic, essentialist and dichotomic perspectives that characterize classic studies of "folk medicine" or "traditional medicine" as opposed to "biomedicine";
4. The need for a transdisciplinary approach to these issues, discussing categories and models for explaining growth and developmental process in childhood and children's vulnerability in specific cultural contexts, by integrating socio-cultural, emotional and organic factors into explanations. This approach will allow us to provide a comprehensive understanding of children's pathways and contribute to review interventions from health and education institutions based on monocausal or dichotomic explanations.

II. Theoretical Background and Methodology

We investigated daily childrearing and childcare practices and their relation to caregivers' knowledge and values about child development from an ecological perspective. According to it, human development is a multidimensional and multi-causal process; it is a result of people's participation and engagement with their environments. People are both shaped by and actively shape their environments (Bronfenbrenner, 1987; Weisner, 1998; Rogoff et al., 2003). The Ecology of Human Development (EHD onwards) relates patterns and pathways of development to the enduring and changing environments in which people live (Elder & Rockwell, 1979; Bronfenbrenner, 1987). These perspectives understand child development as an adaptation to different "developmental niches" (Harkness & Super, 1994; Weisner 1998) leading to different development trajectories (Greenfield et al., 2003). Developmental niche is defined as a system that consists of three basic components: (1) the physical and social settings of the child's everyday life; (2) culturally regulated customs of child care and childrearing; and (3) the parental ethnotheories. The latter represents specific cultural models, rooted in the collective history of the community, that provide a framework for adults to build experience and knowledge that guide their rearing practices (Harkness & Super,1994).

From these ethnotheories, particular children's behaviors, skills, and emotional expressions are privileged or sanctioned (Cervera & Méndez, 2006). In this sense, child-rearing is oriented by sociocultural knowledge and values in a particular historical moment. As Greenfield et al. pointed out: "(…) culturally relevant developmental goals are represented in the form of implicit or explicit ethnotheories of development, e.g., a system of beliefs and ideas concerning the nature of the ideal child and the socialization practices necessary to achieve this ideal. These ethnotheories are shared (and negotiated) among members of cultural communities (…)" (2003: 464-465).

Within the developmental niche, Harkness and Super (1994) have assigned parental ethnotheories the leading role in shaping and organizing children's physical and social settings. Following this idea, we seek to understand local ethnotheories about children's health, development, and wellbeing in the framework of more comprehensive cultural ideas about the person, the life course, and the cultural goals for being considered a competent person. About this, our study aimed to analyze and compare women's narratives to uncover their judgment of their own child's behavior

regarding wider ethnotheories (Harkness & Super, 1994; Cervera & Méndez, 2006) about "normal" and "healthy" child development.

Data analyzed here come from an ethnographic research based on a mixed-methods approach for describing and understanding local ethnotheories and practices around children's health, and their articulation at the micro and meso level. This paper is part of an in-depth study of everyday life starting in 2010, which is based on the complementary use of qualitative and quantitative techniques such as observation, interviews, genealogical surveys, document analysis, case analysis, and audiovisual record among others. Also, it implies rapport and participation in ordinary community activities.

For this article we intentionally selected 15 cases elaborated based on 55 semi-structured interviews with 15 women, all of them caregivers of children under 6 years of age (see Table 1). Interviewers were selected based on 1-women and/or children who have suffered symptoms of illness during the last year; 2-household composition, size, and location; 3-household subsistence activities; 4-women's schooling and access to health and educational services. All of them were between 25 and 55 years old at the moment of the interview.

We apply the case study methodology. Each case consists of a narrative of a temporal sequence of events related to the development of an illness, providing information about the therapeutic alternatives available and effectively used (Crivos, 1998). According to Creswell (1998), each case is a "limited system" in time and space, which includes multiple and highly context-sensitive information. Such cases are, indeed, analytical units of interest for their specificity and their heuristic value in terms of the elaboration and contrast of hypotheses (Creswell, 1998; Sy, 2008).

We analyzed the spontaneous references to episodes of *susto* and its variants, and for each one, we identify categories used by women to refer to these events during pregnancy, childbirth, and the puerperium. Also, we characterized and compared expressions used to describe the symptoms, and the sequence of diagnoses and treatments applied, identifying actors and their links, resources, and institutions involved.

We used Nvivo 11 (QSR International) for the semantic analysis of women's narratives. The software allows us to formalize, codify and systematize data coming from the interviews, to identify "native categories," to identify semantic relationships between them, to create a coding system that consists of nodes (semantic categories) and their horizontal and hierarchical relationships in order to characterize the conceptual domain.

This study has been approved by a Bioethics Committee. The interviewees gave their free and informed consent by provisions of Argentinian law 25,326, and personal data have been protected by using an identifier that corresponds to a database whose access is restricted to the authors.

Table 1: Interviewed socio-demographic characteristics. Source: Own elaboration by the authors, based on 55 interviews

Interviewee	Residence	Age	Children	Schooling	Marital status	Occupation	Household composition
ID 549	Molinos Town	28	3	Incomplete Terciary Studies	Single	Housewife	Extended Family
ID 1113	Molinos Town	37	1	Incomplete University Studies	Single	Merchant	Extended Family
ID 22	Molinos Town	30	2	High School	Single	Housewife	Extended Family
ID 986	Molinos Town	40	6	High School	Consensual union	Housewife	Nuclear Family
ID 340	Farm	34	4	High School	Consensual union	Housewife agriculture and cattle-breedig activities	Nuclear Family
ID 272	Farm	39	6	Elementary	Single	Housewife-agriculture and cattle-breedig activities	Extended Family

ID 299	Farm	44	9	Incomplete High School	Consensual union	Housewife-agriculture and cattle-breedig activities	Nuclear Family
ID 273	Farm	23	3	Elementary	Single	Housewife	Extended Family
ID 42	Farm	30	3	Incomplete High School	Consensual union	Housewife	Nuclear Family
ID 194	Farm	40	5	Elementary	Married	Housewife	Nuclear Family
ID 120	Farm	19	1	High School	Consensual union	Housewife	Extended Family
ID 157	Farm	43	5	High School	Married	Housewife	Nuclear Family
ID 1355	Farm	32	4	Elementary	Single	Housewife	Extended Family
ID 927	Molinos Town	35	4	Elementary	Single	Housewife	Extended Family
ID 1140	Molinos Town	55	11	Elementary	Consensual union	Housewife	Extended Family

III. Results

a) Becoming asustado: the impact of susto in children's development trajectories

Based on our qualitative analysis of women's narratives of their therapeutic itineraries and following the arguments presented before, in this section, we characterize how mothers of children under six years old, who have suffered themselves from *susto*, link this illness to specific stressful or traumatic events that happened at certain moments in their life trajectories, specifically, in the perinatal stage. We describe the "native" categories and meanings linked with *susto* and its variants, including etiology and symptoms, by confronting our data with other studies on the topic. We are particularly interested in highlighting the connections that women made between the idea of becoming *asustado* and children long term health and developmental issues, as well as their consequences in child-rearing and children later performance in community and institutional endeavors.

Infants and toddlers' health is nowadays a topic of great concern for caregivers in Molinos. The growing spread of biomedical interventions during the last decade in the region generated an increase of medical control of the mother-child health issues and children's growth and nutritional status. Even though we cannot affirm that the degree of influence of medicalization process is as influential as in urban settings, the greater availability of biomedical technologies and knowledge has an impact on how health problems are conceived and treated. Caregivers are more likely to resort to biomedicine for their health care during pregnancy and their children compared to previous generations. In this context, caregivers' knowledge and values, about the risks for children's health and development are confronted with those supported by health professionals. As a result, local cultural ideas are revisited and resignified in this framework of permanent confrontation with new knowledge, values and expectations about children's "healthy" and "normal" growing and development.

Previous research conducted in the region during the last decades (Palma, 1973; Palma & Torres Vildoza, 1974; Crivos, 1978; Crivos & Eguía, 1981; Crivos & Martínez, 1996; Pochettino & Martínez, 1998; Crivos, 1998; 2003) showed that *susto* is a recurrent illness during infancy, and it is naturalized by caregivers: "*Guaguas* (infants) become frightened easily"; "my children, they are all *asustados.*" However, its more critical expressions (*aikado* and *quedao*) generate parents' concern. They not only reveal the inefficiency of the given treatment but also imply long-term consequences on children's health and social competence (See Figure 1).

In describing etiology, *susto* could be attributed to a variety of situations, including the influence of other people, animals, supernatural entities and several

environmental hazards. However, serious forms of *susto* are always connected with a stressful or unexpected situation, contrary to the social expectations of caregivers, which causes various organic symptoms together with changes in individuals' behaviors. These situations are mainly connected to the display of emotions such as anxiety, anger, or crying, considered abnormal or even dangerous for personal well-being.

The etiology of *susto* in childhood must be understood in the framework of cultural ideas about the person and the life stages. Adults view infants as being particularly vulnerable and at risk for several illnesses. Infants are especially vulnerable to lose their spirit due to the unstable connection between body and spirit during the first months of life. Infants, called *guaguas* in the vernacular language, are considered *tiernitas* (fragile) and their body could be "open" easily. In this regard, the "openness" of the body is one of the most severe consequences of *susto*, originating a disbalance that should be restored, because an "open body" is exposed to several risks (La Riva Gonzalez, 2012). The main symptoms are fever, diarrhea, and vomiting.

Losing the *espiritu* (spirit) may cause losing children's *entendimiento* (understanding) (La Riva Gonzalez, 2012; Remorini, 2013). It could happen during infancy but also in the gestational period if mothers suffer *susto* during pregnancy. This is an especially extreme form of *susto* called *aikado*, which lead to several troubles in childhood and even in adulthood if it is not treated suitably and in time. Women make an etiological connection between *aikadura* and taboo-breaking during pregnancy. The mother could become frightened in situations like passing by cemeteries, attending funerals or *antigales* (places where ancestors are buried), or being near to dead people, and she transfers this condition to the unborn child. As a consequence, the baby will be born *aikado*. This term designates the child who suffers from *aique*, a term which derives from the Quechua term *aykkey* (to flee, to run away, escape) (Crivos et al., 2008) which means that the spirit runs and abandons the child. In these cases, children's symptoms are diarrhea, undernourishment, and slow growth. In brief, the mother figure is the one who, suffering *susto* for natural or supernatural reasons, becomes a vehicle for the *susto*-trauma (Castaldo, 2015). Nevertheless, the mechanism by which the woman transfers the *susto* to the embryo, as well as the effects on her own body and that of the child, has not been explained by our interviewees.

Likewise, the spirit can also flee and abandon the child beyond the gestational stage, for example, when he/she is attracted to some supernatural entity that, in general, is presented to them when they are in isolated or uninhabited places. The main sign of this situation is that children "do not want to return home" or "always want to leave and not return."

> *"[The aikado child is the one] that has problems to improve, to grow, to gain weight, he has diarrhea; during pregnancy it occurs, there, in the belly, babies become aikado, and they are underweight, undernourished"* (ID 927).

> *"[My cousin became frightened] he was cured but not properly, now he is intranquilo [restless], he works in one place and leaves, goes to another place. He is not a stable person; he has no peace of mind"* (ID 1113).

This is the most widely documented etiology of *aikado*. However, a compelling finding of our research is another type of causes we identified in women's narratives related to negative emotional states during pregnancy. They have to do with a diversity of circumstances such as raising their children without a partner and/or experiencing stressful or challenging situations in an unknown environment (e.g., seeking medical treatment for their children outside the town without family support). In their characterization of the circumstances that may cause *susto,* we find a correspondence with other states described for Andean communities, *nervios* and *pena* (nerves and grief) (Guarnaccia et al., 1996, 2005; Oths, 1999; Weller et al., 2008).

Additionally, women refer that suffering *susto* during pregnancy and not be cured accordingly may also cause premature birth or complications during delivery for the mother's health.

As a consequence, not providing proper and in time treatment could lead to children to become *quedaos*, which is considered an extreme condition. This expression designates those individuals affected by particularly severe forms of *susto*, or who were not cured in time. Mothers describe *quedaos* as children that do not grow and develop as expected, which leads to different degrees of disabilities. They included a wide range of symptoms, some of them temporary like crying, vomiting, and diarrhea, while others are more damaging and permanent like deafness and language disabilities (like stammering), cognitive impairment or show a behavior pattern contrary to caregivers' expectations (*being mad, bad, coward, angry, annoying, irritating, nervous, "all the time wants to be the center of my attention"*)

> *"medicos campesinos [local healers] always told me that I suffered a lot when I was pregnant, it is true, I always cry a lot. They told me [her son] is in this way because of that...his deafness, and they told me it was because I suffered from fright, and at that time I didn't recover"* (ID 1355)

> *"He was much more flojito [weak, lazy] than his siblings, he took a long time to walk (…) I saw that he was different, so I was concerned (…) in the hospital they told me he was deaf (…) most of the*

medicos campesinos that saw him told me he would be a mute child, he is born that way (…)" (ID 1355).

"All the medicos campesinos that saw him [his son] told me he has been asustado (scared) since the womb because I became asustada (scared) when I was pregnant (…) he was like desesperado [desperate], loquito [like crazy], wanted to draw attention all the time (...) A médica campesina told me that when they get asustados (scared) it's like they become malos, loquitos, trastornados, se les sube el mal a la cabeza [evil, crazy, mad of their heads]" (ID 1113).

"[quedaos] when they go to school they do not pay attention (…) they are asustados (scared) and they are not thinking about studying, they seem absent-minded" (ID 1140).

"*If you did not cure him when she/he was little, then when the child is older, they have anger, you don't know what happens to them, why they have that temper*" (ID 549).

"My granddaughter is already six years old, and she lives asustada (scared) since that time there was a fire in the village (...) her mother didn't take her to cure, medicos campesinos no le han llamado [haven't called her spirit], no se ha compuesto [she hasn't cured], she is always worried " (ID 1140).

Women's narrative focuses on "difficult" situations they went through in critical moments of their life (referred to as loneliness, uncertainty, lack of social support, responsibility for domestic care, among others) that put them in a vulnerable state, which combined with unexpected events may trigger *susto* episodes. In this regard, our analysis reveals the variety of meanings attributed to *susto* by women account for a complex interaction of psycho-social factors in the etiology of the illness, in which women's social network plays a prominent role. Thus, the possibility of being *asustado* may result from the non-resolution or accumulation of negative experiences along with the inefficacy of therapy.

"When I was pregnant, I felt like I was depressed. That is why he [her son] must be so nervous. I made him heal once or twice. In fact médicos campesinos say he has to be cured three times, but I did not cure him as they asked me because he did not want to take some remedies and he did not let himself be sahumadito [to be smoked] the medico campesino told me that this is why he is very nervous, asustado (scared), until now" (ID 1113).

Table 2: Illness categories and its consequences on children's behavior and health. Source: Own elaboration by the authors based on 55 interviews

Illness category	Psycho-social and organic symptoms
Asustado	Vomiting, diarrhea, lack of appetite, lack of sleep, underweight, malnutrition "mad", "bad", "coward", "angry", "annoying", "irritating", "nervous", "all the time wants to be the center of attention"
Aikado	Maturation delay, deafness, stutter, recurrence of diseases, underweight, malnutrition • "they are absent minded" • "they do not want to return home" • "they always want to leave and not come back"
Quedao	Maturation delay, underweight, malnutrition, disability, developmental disorders • "they become slow" • "they remain evil" • "they stay behind"

Along with the consequences on behavior, mothers express concern about the consequences of repeated episodes of *susto* on children's weight and nutritional status. Expressions such as "*so far my daughter is skinny,*" "*my daughters were always malnourished,*" "*my son did not gain weight,*" "*he did not want to eat,*" are an example of this. Although lack of appetite and its effects on weight fall within the typical symptoms described for *susto* (Crivos et al., 2008), we believe that changes in the health policies and interventions oriented to pregnancy and early childhood have a significant effect on maternal discourses. They reinforce the concern about the evolution of nutritional status and adequate eating habits, as a result of public health agents' practices, e.g., the promotion of exclusive breastfeeding, monthly height and weight control, report of risk factors for growth and nutrition, prenatal controls, among others (Remorini & Palermo, 2016).

We can say that caregivers made a clear distinction between merely suffering from *susto* as an ordinary experience (normal or everyday *susto*) and becoming *asustado* as a long term health condition (cf. Castaldo, 2015). As women's testimonies reveal, the latter is a result of an accumulation of stressful situations

and "*sustos mal curados,*" it means, when children were not accurately diagnosed or treated at time, and symptoms could appear later or persist for a long time or up to adulthood.

As we stated at the beginning of this article, *susto* provides a hypothesis to explain why some children being born *"con problemitas"* (with health issues) and to understand children's developmental pathways that differ from those considered "normal". In this sense, we identified specific values and expectations about children labeled as *asustaditos* that do not correspond to the expectations about those of "normal" and "healthy" children.

At that point, it is necessary to highlight that cultural ideas and values about children's health and development are decisive for understanding why some children's behaviors and performance are validated or positively valued while others are sanctioned and/or pathologized.

According to local ethnotheories, *guaguas* are supposed to be *buenitos* (good), obedient and quiet. *Guagua*is the term that refers to younger children (infants and toddlers) in Andean cultures, and it is associated with affection, protection, and innocence. It implies that babies should be protected and cared for not only by parents but also by the whole community; relationships between *guaguas* and their families are mediated by the idea of affection and reciprocity (Arteaga & Dominic, 2007). This means that parents should rear children with tenderness, care for them while they are young and vulnerable, but at the same time, children should behave similarly to their parents. That is, not only give them affection but also collaborate with them, be obedient, and when they are older, protect and nurture them. Caregivers prefer their *guaguas* to be quiet and silent; they should allow their mothers to perform their activities without upsetting them. Children who cry a lot too often make upbringing difficult. Mothers usually complain about *llorones* (weeping children) because they say they are difficult to rear, do not allow their mothers to work and cannot be left in the care of other members of the family. Consistently with these ideas, children are taught early to collaborate in several domestic tasks and adjust their behavior to domestic routines. These references about how young children should behave must be understood in close relation with what is thought to be right for an adult in their society. In this respect, caregivers stressed during the interviews the importance of being *fuertes* (strong) and "*tener coraje*" (be brave) to face different problems during the life course. In this sense, children's autonomy, together with their obedience and responsibility, are strongly valued (Remorini 2012; Remorini & Palermo, 2016).

Based on that, we argue that narratives about symptoms and consequences of *susto* and its variants in children's developmental pathways highlight ideas and values around acceptable ways of behavior and emotions expressions in this ecological niche.

Cultural perception about children's vulnerability is consistent with ideas about risks that may affect infants' growth and development, having several effects on the structure of the caretaking environment, specifically childrearing practices and taboos about places where children circulate and activities in which they are included. Parents guide their actions with their children by their cultural constructions of childhood; thus, they tend to reproduce culturally accepted behavioral phenotypes through the structuring of the developmental niche. They have a significant impact on the attitudes toward children and the quality of care given to them (Harkness & Super, 1994; Cervera & Méndez, 2006).

Explanations about the differences in children's behavior are revealed as a mechanism of social control with practical and moral implications. Ideas, values, and attitudes toward *asustaditos* account for the role of children's social environment in shaping a healthy and socially competent child (Murphy, 2007). As we described above, it is expected that children become aware of their behavior and learn, at an early age, to control emotions like weeping and anger, as they are non-adaptive conducts in this developmental niche. Children should adapt to multiple caregivers and allow mothers to do household chores. Appropriate behavior is defined about cultural expectations related to adult–children interactions and children's contribution to domestic assignments. In this sense, our results are consistent with studies of other Latin American indigenous societies (Gaskings, 2000; De León, 2003; Rogoff et al., 2003; Cervera & Méndez, 2006).

Moreover, women's narrative highlights what it is expected from mothers, e.g., they should avoid situations that put their children at risk, being aware of their behavior, and seek immediate treatment when they are ill. If children suffer from *susto* or *aique*, is because mothers failed in providing care, or they broke down a taboo, not being able to meet social expectations about their performance. Regarding this, our results are consistent with literature that emphasizes the role of the cultural environment in the etiology of *susto*. In this line, research on the topic (Sayres, 1955; Rubel, 1964; Trotter, 1982) shows that one of the most frequently reported factors in medical and psychiatric research as a cause of *susto* is stress; however, studies highlight that it will only appear in settings that patients consider stressful in each cultural context. The variety of situations that are likely to generate *susto* do not prevent us from recognizing that all of them refer to unexpected circumstances or strange contexts. Most studies emphasized individual adaptation difficulties associated with culturally conditioned states of anxiety and dissatisfaction with determined social roles and/or

relationships, especially in communities that undergo socio-economic and cultural change.

b) When children become asustados: therapeutic options and decision-making process in uncertainty contexts

In this section, we characterize how caregivers deal with children's difficulties in growth and development, once they realized their child is an *asustado*. We do not intend to describe the diagnosis and treatment procedures and resources (traditional local medicine), because they were extensively detailed in our own previous work (Remorini et al., 2012; Remorini & Palermo, 2016) and other studies in the area (Crivos, 1978, 2003; Crivos, Martinez & Pochettino, 2003). Instead, we aim to analyze how caregivers appeal to multiple knowledge and resources coming from different cultural frameworks. In this regard, we claim the need to go beyond taxonomic, essentialist and dichotomic perspectives that characterize classic studies of "folk medicine" as opposed to "biomedicine".

For understanding the process of elaborating the idea of *asustado* as a diagnostic category that explains children's pathways, it is necessary to situate the construction of the diagnosis and the decision making processes involved in the therapeutic itinerary. These itineraries usually begin as a result of seeking medical treatment for another disease or as a consequence of a school report about children's performance and behavior. For example, teachers report children's difficulties in adapting to the school environment, timetable or repeated episodes of seizures without an apparent medical cause. These dissimilar problems lead to multiple biomedical consultations (inside and outside Molinos), resulting in differential diagnoses and treatments. At this point in the itineraries, women attributed to *susto* the ultimate cause of their children's problems. When biomedical treatment demonstrated not being successful to provide a cure, other household members (women's mothers or grandmothers) intervene to support *susto* diagnosis and also for recommending the consultation to a *medico campesino*.

The analysis of women's narrative allowed us to recognize the role of each woman's social network in the itineraries. The decision-making process and its outcomes in seeking adequate resources for treatment depend mainly on women's ability to mobilize their bonds to access healing knowledge and resources located at different organizational levels.

Differences in the etiology of *susto* and the perception of its seriousness result in a variety of therapeutic itineraries in terms of the quantity of actors, resources, and actions involved. We recorded, on the one hand, the validity and relevance of healers, knowledge, and practices of traditional medicine. On the other, how these knowledge and practices are articulated and confronted with others coming from biomedicine, which is treated in fact, as complementary or alternative depending on the results of previous instances as well as the ecological factors that influence the availability of each alternative. For "ecological factors," we mean all the environmental facts, conditions, and relationships that have an impact on the access to different resources for medical care and also shape the trajectories. They include a wide range of variables from geographic location to cultural acceptability of a medical option.

The therapeutic itineraries emerging from women's narrative involve long sequences in which hypotheses about diagnosis and treatments are discarded, redefined, or confirmed through time. In this framework, the semantic extent of some illness categories is also modified, as part of a culturally framed interpretation of different responses to stressful, challenging or novel situations that affect women and children's wellbeing. It means that *asustado* or *aikado* are diagnoses categories to label children who show a set of symptoms, some of which fit with the classical symptomatology described for *susto* in this area and other regions of America.

The narrative stresses how *susto* arises as a hypothesis in the process of understanding a complex set of symptoms and illness problems, which seems to be unpredictable or surprising. Also, when health problems gain seriousness and cannot be solved by invoking existing knowledge. This process of hypothesis generation and testing in the process of seeking medical treatment results in a combination of resources and knowledge to which different roles, functions, and meanings are attributed. For instance, some organic symptoms (diarrhea, vomiting, weight loss) are left in the hands of doctors and nurses, while for treating spiritual symptoms, *médicos campesinos* are the exclusive option.

As we pointed out, we argue that by focusing on the process of constructing the diagnosis of *asustado*, it is possible to recognize that the appeal to nosological categories of local medicine is justified in those cases whose resolution involves long and complex therapeutic itineraries due to the inefficiency of biomedical treatments. Also, when there exists a suspicion - based on the persistence of problems in the behavior and health of children- that these situations derive from *sustos* that are not diagnosed or cured promptly. Thus, in the process of finding effective options to address these problems, the categories of *susto, aikado* and *quedao* are integrated into new hypotheses that reorient women's decision processes and actions.

Inhabitants never visit biomedical professionals for *susto* diagnosis and treatment but turn to traditional medicine because physicians "don't know how to deal with *asustados*." Only *medicos campesinos* can

diagnose and cure *susto* by the *llamado* (call of spirit) using different procedures that express the syncretism between catholic and indigenous knowledge, practices, and resources (Remorini et al., 2012). In this regard, *susto* does not appear as a diagnosis in medical records. Instead, we found categories such as "anxiety" or "depression". However, it is usual that doctors recommend women to see a *médico campesino* for complementary therapy, recognizing their "limits" for treating such kind of problems. The testimonies of women show that the effectiveness of the treatments derive from their combination and not only from the properties and efficacy of each one considered separately, as various researchers showed (Cosminsky & Scrimshaw, 1980; Alves, 1993; Young, 2004; Bellato, Santos de Araújo & Castro, 2008; Crivos et al., 2008; Remorini et al., 2012).

The situation described here accounts for a complex scenario in which children's health care and upbringing are at the center of health and education institutions and public policies aimed at promoting and protecting child development. However, in this region, these institutions usually show limitations for understanding and solving the diverse problems that affect children (malnutrition, disability, and developmental disorders), taking into account people's particular perspectives, experiences, and opportunities in the local environment.

IV. Concluding Remarks: Toward a Collaboration between Ethnography and Medicine in the Study of Children's Health and Development

In this article, we characterized and analyzed women's narrative around the idea of becoming *asustado*as a cultural way of understanding why children get sick repeatedly, or develop illnesses that become increasingly severe. These situations have a decisive impact on their development trajectories, generating different types of disabilities or moving the child away from the local and biomedical parameters of "normal development."

Studying *susto* facilitated the understanding of the complex risk factors associated with children's development and health in these Andean communities. However, by examining the diversity of symptoms and etiological explanations of *susto,* we were able to recognize intra-cultural variation within Andean populations. Molinos' people's descriptions of organic and behavioral manifestations of children who have been diagnosed as *asustados* or *aikados* do not strictly match with the typical symptomatology described in classic studies about *susto* in Latin-American communities. In this regard, our results are consistent with recent studies on the topic (Tseng, 2006; Weller et al., 2008; Castaldo, 2015; Brooks, 2016). Based on them, we noticed that *susto, nervios* and *pena* usually overlap in terms of etiology and symptoms, mainly, the emotional ones. In this regard, we need to move beyond the idea of "taxons" or discrete diagnostic categories, defined by a set of symptoms and causal explanations mainly associated with the loss of the spirit.

In that framework, our ethnographic research highlights that the definition of becoming *asustado* is highly dependent on the context. To understand women's and children's experiences and itineraries around illness, we need to know that women make a flexible and opportunistic use of these categories (*asustado, aikado, quedao*) to understand, diagnose, and classify, in a post hoc manner, the complex chain of circumstances and factors that causes troubles in their children's developmental pathways.

Although we found similarities in each case analyzed[1], the condition of being *asustado* shows substantial heterogeneity and reveals the intra-cultural variability of the cases. For instance, in some episodes, the organic symptoms are the ones that receive the most attention and generate mothers' deep concern (such as weight loss or delayed motor development). In others, emotional and behavioral symptoms gain more weight. Briefly, it could be said that the heterogeneity of the cases could be recognized in several aspects such as etiology, symptoms, therapy, duration of the episode, the period in life in which *susto* occurs (childhood, adulthood), and its impact on later development.

However, in the ways of perceiving and categorizing vital experiences, and their connection with *susto* episodes, we found similarities in women's narratives. In this sense, "*ser asustadito*" (to be frightened) or "*vivir asustado*" (to live frightened) serves, on the one hand, as a cultural explanation for those people who do not fit with cultural expectations about their phenotype and social performance in childhood and later in adulthood. On the other hand, we agree with Brooks (2016) who stated that *susto* is a culturally acceptable way of dealing with both physical and mental stress. It could be seen as a cultural way to manage stress for women in critical periods of their lives, such as the perinatal stage, perceived by them as full of risks and uncertainty.

Social support provided by male partners and elder women appears to be a central issue. Perception of loneliness during pregnancy and lack of help for child-rearing are associated with negative emotional states, and consequently, alleged as the ultimate cause of *aikado*. Mothers' perception of their exclusive responsibility for child care is reinforced by biomedical services and mother-child focused on public policies.

[1] A detailed analysis of the cases is part of María Laura Palermo's Ph.D. dissertation, which is still in progress and thus unavailable for publication yet.

Everyday interactions between mothers, teachers, and hospital staff show how different ideas about childhood, health, and "normal" child are shared, confronted and actualized. Moral judgments about mother's priorities, marital status, exposure to risks, and childcare practices are frequent. Expressions such as "lack of responsible care" or "careless treatment" are the most listened to when talking to them. Discourse and practices involved in Primary Health Attention and Social Security policies put the accent on check-ups during pregnancy and early infancy. These ideas about fetuses and infants' fragility and vulnerability contrast with local cultural ideas about women's vulnerability and fragility during pregnancy and puerperium. From health staff discourse, the child wellbeing and their development outcomes are seen as a responsibility of the mother's decisions. This perspective also impacts on how mothers elaborate their narrative about child-rearing and the difficulties they have in doing so. By their part, mothers assume their responsibility as they link *susto* episodes of their children to traumatic events in their life trajectories. As Castaldo (2015: 4) pointed out: "By searching through the memory of the person who has suffered the susto, one or more traumatic events are always recalled (...)." According to the *aikado* etiology "(…) the mother figure is the one who, suffering susto for natural and supernatural reasons, becomes a vehicle for the susto-trauma (...) Women are also responsible for this kind of susto since they can neglect its etiological power and are therefore liable to pass it on to their children" (Castaldo, 2015: 3).

In that sense, our results are in line with those of Lewis-Fernandez et al. (2002), Weller et al. (2008), Castaldo (2015) and Brooks (2016) that demonstrates that there is a relationship between stress and one's ability to enact culturally agreed-upon cultural models in their daily lives. Individuals who are better able to meet the social role expectations are under less stress than those who have trouble living up to the demands of their culturally defined social role.

Women's appeal to cultural nosological models is justified as long as *susto* episodes are linked to traumatic situations for which a favorable response is not found. This requires the resignification of the ways of solving these illnesses whose efficacy is culturally legitimated, such as local traditional healers' techniques for diagnosis and healing. In this sense, "traditional" medical beliefs, because of their practical and symbolic efficacy, offer to the women alternatives for solving problems, and also imply a lower dependence on biomedicine, whose options are not always effective, accessible or acceptable. In this sense, although biomedical professionals are consulted, local healers are mainly involved in the therapy (Remorini et al., 2018). Furthermore, our results stress that etiological explanations based exclusively on organic or physiological factors are simplistic (Tseng, 2006; Remorini et al., 2012). As we pointed out at the beginning of this article, a transdisciplinary approach to these issues is necessary for contrasting and discussing categories and models of children's growth and development and children's vulnerability in specific cultural contexts. This approach should integrate socio-cultural, emotional, and organic factors into the explanations. This will allow us to provide a comprehensive understanding of children's pathways and contribute to the review of interventions from health and education institutions based on monocausal or dichotomic explanations.

For a comprehensive understanding of children's pathways, we need to recognize that *susto* is usually merely the "tip of the iceberg," a label that mothers use to typify and group a set of symptoms, illnesses, behavioral "disorders," and children's inappropriate performance at school. Beneath them, there is a wide range of health and developmental problems that need a collaborative approach and work between disciplines and institutions to help children and their families. An ethnographic approach is necessary to elaborate a cultural description of the complex factors involved in the illness experiences and trajectories, such as cultural beliefs and expectations around personhood and developmental thresholds, family relationships, household and community social organization, women's activities, and material and cultural access to health services, among others. In other words, and following Tseng (2006), to study "culture-related syndromes," we need to move from the clinical scale to the total geopolitical, socioeconomic, and ideological circumstances of the society in which the phenomena occur. Only in this way will we be able to contextualize how individuals face cultural stress in a specific environment, without overlooking the fact that although diseases are suffered by individuals, health and illnesses are never individual processes.

However, we agree with Tseng (2006), who stated that there exists a risk in only focusing on social and cultural features of *susto* without considering clinical, pediatric and psychiatric knowledge and insights. Interpretations simply based on social aspects, ignoring clinical perspectives, or vice versa may suffer from bias.

Despite the wide attention that *susto* has received in the literature, there are still gaps in research about its incidence and prevalence as part of the morbidity profile in specific communities. As we pointed out elsewhere (Remorini et al., 2012), we believe that this omission results in a limited understanding of this illness, its causes and its effects on health, as well as the ecological factors associated with the vulnerability of individuals, following the line of hypotheses posed in classic studies on the topic (Bolton, 1981; Trotter, 1982; Zolla, 1994; Rubel et al., 1995). Accordingly, it is necessary to deepen the investigation into the

relationship between *susto, aikado, quedao,* and other local and biomedical nosological categories and the particularities of growth and development processes in the region such as low weight, undernourishment and infectious diseases (Remorini et al., 2012; Remorini & Palermo, 2016).

Moreover, we need to be attentive to the criteria and empirical basis used by biomedical and educational institutions to label these children as children with special education needs, developmental disorders, cognitive impairment, PDD (Pervasive Developmental Disorders), among others. The current tendency of "overdiagnosis" may lead children to unnecessary biomedical treatments and put their families at a crossroads if they have no resources and/or social support to afford them. Complex and long itineraries imply for the families to afford several treatments, spend money, traveling long distances to seek treatment outside the town, stay outside their homes and work. In this respect, it is always necessary to know the local social organization of health and education services to support family childcare and child-rearing practices and to provide cultural and clinical adequate treatment.

These findings justify a future in-depth interdisciplinary exploration of the relationship between *susto* and child development, due to its role in the configuration of vulnerability during childhood in communities of the Andean region of South America. This work constitutes an attempt to move in this direction, based on the recognition of the close association between being *asustado* and suffering from psycho-physical development disorders, of varying severity with diverse consequences in adult life. In this regard, health professionals' approach to children who experience developmental troubles needs to be informed by socio-cultural data coming from ethnographic research not only in these rural contexts with indigenous background but in many contemporary societies, which are becoming increasingly multiethnic and multicultural.

Data provided by the ethnographic research about mothers and children's itineraries allow clinicians and psychiatrists to take into consideration, during medical consultation, the diversity of social, material and symbolic dimensions intertwined in the patients' pathways which includes practices, social relationships and decisions that are consistent with the local way of life and are not necessarily linked to their trajectories within medical institutions. Most of these aspects are usually hard to see in the framework of consultation, especially when there is no confidence or previous relationship between patients and medical staff.

Another contribution of ethnographic data to medical diagnosis and treatment is to eradicate dualistic views on diseases, such as organic/psychosocial, objective/subjective, individual/collective, proper/characteristic of the hegemonic medical approach. The narrative of the process of elaborating the diagnosis of *susto* shows that the social environment plays a leading role in etiological explanations. In this sense, *susto* provides a plausible framework for social conflicts that have a decisive impact on mother-child everyday life and life pathways. *Susto* and other "culture-related syndromes" serve to recognize the cultural basis of any disease, even the "ordinary" ones. Additionally, they highlight the necessity of a comprehensive treatment, which may include the collaboration of people with different knowledge, such as traditional healers or spiritual leaders.

A bio-psycho-social, or more accurately, an ecological approach to health and development is needed (Bronfenbrenner, 1987; Herztmann, 2010). It implies integrating clinical, psychiatric, epidemiological, and cultural research (Brooks, 2016), optimizing each discipline´s theoretical and methodological tools, recognizing their boundaries, but also the possibilities of constructing a transdisciplinary research model to study these illnesses.

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