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Pujal i Llombart, Margot; Mora, Enrico; Schöngut-Grollmus, Nicolás

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The psychosocial diagnosis of gender in public health: propos and application through a case study[1]

O diagnóstico psicossocial de gênero na saúde pública: proposta e aplicação por meio de um estudo de caso

Margot Pujal i Llombart[a]
[a]Universitat Autònoma de Barcelona. Departamento de Psicología Social. Barcelona, Espanha.
E-mail: margot.pujal@uab.cat

Enrico Mora[b]
[b]Universitat Autònoma de Barcelona. Departamento de Sociología. Barcelona, Espanha.
E-mail: enrico.mora@uab.cat

Nicolás Schöngut-Grollmus[c]
[c]Universidad Alberto Hurtado. Facultad de Psicología. Santiago, Chile.
E-mail: nschongut@uahurtado.cl

Abstract

In this article, we present the development of a methodological diagnostic tool for the field of public health from an interdisciplinary perspective that articulates the biological, psychological, and social dimensions of human health from a post-structuralist and feminist perspective and epistemology. In prior research, we have developed a methodology for the study of chronic pain without an organic cause, or fibromyalgia (FM), that we call the psychosocial diagnosis of gender. That work addresses the analysis of the research object itself and, above all, a critical reconceptualization of health in general. We have also used qualitative fieldwork methods (life stories, discussion groups, and documentary material) in our study of people diagnosed with FM. Here, we present the actual tool we use in the Psychosocial Diagnosis of Gender, using a case study that enacts a displacement of the clinical diagnosis of FM towards its articulation with the psychosocial diagnosis of gender.

Keywords: Psychosocial Diagnosis; Gender; Methodology; Health; Chronic Pain Without Organic Cause.

Correspondence
Nicolás Schöngut-Grollmus
Universidad Alberto Hurtado, Facultad de Psicología, Oficina 221.
Av. Almirante Barroso, 10. Santiago, Región Metropolitana, Chile.
CEP 8340575.

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Resumo

Neste artigo apresentamos o desenvolvimento de uma ferramenta de diagnóstico metodológico para o campo da saúde pública a partir de uma perspectiva interdisciplinar que articula as dimensões biológica, psicológica e social da saúde humana com base em epistemologia e um ponto de vista pós-estruturalista e feminista. Em pesquisa anterior desenvolvemos metodologia para o estudo da dor crônica sem causa orgânica ou fibromialgia (FM), a que chamamos "diagnóstico psicossocial de gênero". Esse trabalho aborda a análise do objeto de estudo em si e, acima de tudo, busca uma nova concepção crítica de saúde em geral. Também utilizamos métodos qualitativos do trabalho de campo (histórias de vida, grupos de discussão e material documental) em nosso estudo de pessoas diagnosticadas com FM. Aqui apresentamos a ferramenta que usamos na diagnóstico psicossocial de gênero, usando um estudo de caso que encena um deslocamento do diagnóstico clínico de FM para a sua articulação com o diagnóstico psicossocial do gênero.

Palavras-chave: Diagnóstico Psicossocial; Gênero; Metodologia; Saúde; Dor Crônica sem Causa Orgânica.

Introduction

In this article, we aim to present the epistemological foundations of our psychosocial method of diagnosis, to describe it, and to provide a demonstration of its application. This three-part objective responds to characteristics of the Western medical knowledge and practices. The first phenomenon is the medicalization of life through biomedicine (Barker, 2005) and its ample reach as a source of knowledge and diagnosis concerning life. The biomedical pretentions to truth identify biological and bio-psychological causal mechanisms for the subjectivation and objectification of life, which might otherwise be understood in terms of social, political, and economic processes (Rose, 2001). Situating the explanation of life in biology and bio-psychology is arguably to severely reduce the analysis of human life - regarding its quality and what can count as a good life (Butler, 2001b). Similarly, as a form of power/knowledge, this type of explanation constitutes an indirect barrier against the exercise of democracy. We call this phenomenon the bio-psycho-medicalization of human life. The second characteristic of Western medicine is the epistemological occultation of feminization - that is, the medicalization of femininity together with its pathologization (Barker, 2005), which constitutes a second obstacle for the advancement of an egalitarian and equitable society -, of the free exercise of citizenship with full political, social, and psychological rights. For a long time, it has been described in theoretical and empirical terms that gender operates not only as a descriptive category, but also as an analytic stance (Scott, 1986) that allows understanding the power relations behind gender-defined relationships and their impact on health and quality of life (Almeida-Filho et al., 2003; Blanc, 2001; Gutierrez, 1994). Finally, the third characteristic is the presence of inequality in apparent equality (Pujal i Llombart; García-Dauder, 2010) and the interrelation between different social models of gender that currently coexist (traditional, transitional, contemporary, egalitarian) (Velasco, 2009), whose combined effects generate disorientation about subjects in the contemporary world and about the respective impact of their bodies on that world.

These three characteristics of contemporary Western biomedicine intersect in the analysis of an emergent, growing, and polemic ailment: chronic pain without organic cause (which we prefer to call "chronified pain" - CP), identified in recent times as fibromyalgia (FM). Such emergency and growth of this diagnosis is located in globalized and neoliberal societies because of an exponential increase of avoidable suffering, which is the effect of life-threating conditions in the heart of neoliberal societies and different structural and symbolic forms of violence that mostly affect vulnerable populations (Arruda Leal, 2001; De Vogli, 2011; Ramos, 2009).

Because of the FM context characteristics, our analysis of this illness led us to construct the psycho-social gender diagnosis, which can also be applied to the diagnosis of other illnesses, despite its specific origin. Our research objective was to present a critical, theoretical, and epistemological perspective on the analysis of CP/FM, and to develop a methodological tool that was in accordance with such perspective. Such tool was the focus of our attention in this article, which is structured in three parts. First, we elaborate a historical and socio-structural approach to the biomedical sciences and to their relation with social and human sciences addressing health and quality of life in the contemporary society. When applied to health and the sex/gender system, the bio-psycho-social perspective allows us to apply a specific model of analysis that we call, following Velasco (2009), "the system of subject/sex/gender in the study of CP/FM." Second, we offer an example of this methodological tool in the case of a woman who has been clinically diagnosed with FM. Thus, we proceeded by reconstructing her life story as it emerged from two in-depth interviews. Third, we present the very methodology of the psycho-social gender diagnosis, based on the epistemological foundations elaborated in the prior section. The objectives of this tool are: (1) to consider the different dimensions of the new subject of pain, who displaces the binary subject (of the bio-psycho-medical model); and (2) to develop a dynamic articulation of these dimensions in the construction/production of a body with chronified pain (CP), such that the body moves away from a mechanical model to become a performative body with a "grammar of life."

Health, social and human sciences, and biomedical sciences

The issue of health poses major challenges for the social sciences at present, for reasons that derive as much from everyday life in a global and neoliberal society in crisis, as they do from life in the contemporary academic community itself. In Latin America, for example, it is possible to observe contradictory outcomes of health policies in the last decades: while critical indicators suggest that there have been substantial progress in this field (life expectancy, infant mortality, and fertility have come closer up to high-income country standards), there are internal inequities in almost every Latin American Country, where the access to and quality of health services are very much segregated on the basis of socio-economic status (Cotlear et al., 2015). "This segregation is becoming increasingly unacceptable as citizens' expectations are associated with economic growth" (Cotlear et al., 2015, p. 1248). As Luz (2011) notes, one of the reasons why health poses such a challenge is the constantly increased demand in the contemporary society for "medical attention" - for the improvement of individual, group, and community health through medicine and prevention programs -, as well as the expectations that come with the consolidation of democracy and the idea of health as a social right among citizens (Cotlear et al., 2015). This demand can be interpreted as a cultural response to increases in chronic and degenerative diseases, as well as in epidemics, which have returned due to the fragility and poverty caused by the current crisis. But this increased demand may also arise as a response to the exponential increment, in recent decades, of avoidable suffering and ill health due to adverse social conditions in life, characteristics of the current urban world, structural violence in a broad sense, and to the global organization of labor; phenomena that comprise the current neoliberal regime (in crisis) and the information society. In this sense, we can speak of the social determinants of health as the intense and growing presence of social and cultural values in social interactions that are not at all healthy (De Vogli, 2011). These values are far from healthy insofar as they ignore human vulnerability and fragility under the neoliberal individualist imperative that rests on competition without ethical norms and on compulsive information consumption as a form of status and social prestige.

Another reason to consider health as a central challenge for the social sciences is of an epistemological and methodological character. An asymmetric contribution from the social sciences in the field of health in comparison with that of the medical sciences has arisen from the same historical origins as the relationship between the social and medical sciences itself. This asymmetry is also obtained insofar as the social sciences conform to the medical-scientific rules of the game (a positivist and empiricist epistemology). In fact, the dialogue has not occurred, that is, a real contribution of the social sciences to the health field through the introduction of its (anthropological, philosophical, sociological, psychological, etc.) concepts and methodologies (Luz, 2011). This work is just beginning. In making this observation, we do not mean to suggest that social understandings have been absent in the study of health until now, since in fact such study began more than a century ago. What we could call "social medicine" research, or research on medicine with a "sociological" component, has existed mostly since the second half of the eighteenth century and beginning of the nineteenth. But this form of research on medicine with a social component was a social history of collective illnesses, associated with the rise of industrial capitalism and its economical and labor conditions. These studies did not use social scientific concepts, theories, or methods (as these were developed later). To produce "histories of illness" and their "social etiology" is to remain in the disciplinary field of medicine, while working in medico-social terms (Luz, 2011). As Luz suggests, these studies had two main characteristics that created an adverse context for social scientific contributions to the field of health throughout the twentieth century: (1) a clear evolutionist theoretical vision, established and ruled by the biological sciences during the nineteenth century. This approach would not be disrupted until the mid-twentieth century with the rise of structuralism, which emerged out of linguistics; (2) the social sciences found themselves submerged into an epistemological vigilance, in Gaston Bachelard's words, to which they continue to find themselves subjected to a large extent today. That is, the natural scientific model has been the norm in the social sciences, and even more so when they have addressed the field of health.

The hegemony of these epistemological umbrellas has consequences. The biomedical perspective has rarely reflected on what is meant by "health" or, in a more extensive way, what counts as "quality of life" (Valls-Llobet, 2010). The meaning of these terms has been taken as given. However, if the social sciences have taught us anything is that behind the obvious lie hidden reductionisms, whose actions and effects are more than debatable. In biological terms, "life" is the stage between birth and death, and in biochemical terms we could define life as a state of matter, with specific molecular structures that can sustain themselves in an environment, recognize and respond to stimuli, and reproduce. But to define life, we cannot remain in this biomedical reductionism, as even a plant is a living thing. To begin with, given the field we wish to elaborate, we must necessarily qualify the term "life": we are interested in "human life". With this very first operation, we open up a field of meaning that Butler synthesizes so well: "the question of life can be found in different ways in the center of the great majority of feminist theory and, in particular, in feminist philosophy. The question of life could be posed in different ways: What is a good life? How has a good life been conceived so that women's lives have not been included in its conceptualization? What would a good life be for women? Whose life is considered life? What threat of death is imposed on those who do not live gender in accordance with gendered norms?" (Butler, 2001b, p. 7).

Along the same lines, it would not be until the second half of the twentieth century that the first in-depth analyses would explicit the process and forms of power structuration over individual and social life that take place through institutions tied to medical knowledge and practice. Authors such as Foucault interpreted institutionalized medical knowledges and practices as strategies of social production that result in a growing regulation of bodies and populations in specific power (or bio-power) relations. We suggest that this *dispositif* is being renovated and exacerbated in the present day (Rose, 2001). That is why we start from a hypothesis about this intensified state that concerns the intersection of two intimately related contemporary processes of social transformation: (1) the exacerbation of the biomedical culture and the growth of its omnipresent character, which is at work in the construction of identities and everyday life; and (2) a renewed operativity of the sex/gender system in this western time of rhetorical "equality," which give rise to new forms of gender **in**equality that are different from modern and traditional forms.

This brings us to suggest that to speak of bio-power is to speak of **gendered** bio-power. We understand bio-power and its relation to gender as follows: Foucault situates the fundamental operation of power in spaces that are normally excluded from politics. In this way, power relations produce and regulate the everyday life and forms of the subject through daily social relations and practices (Pujal i Llombart; Amigot Leache, 2010). The term "microphysics" means the capillary reach that power relations acquire in the social field. Through microphysics, everyday struggles emerge, such that "ways of loving, the way in which sexuality is repressed or abortion is prohibited, are explicitly political" (Foucault, 1976, p. 428). In both *Discipline and Punish* (1975) and *The History of Sexuality* (1976), Foucault describes power *dispositifs* that model and traverse bodies. Power establishes dispositions and regulates courses of action; desires and pleasures also emerge in power networks (Foucault, 1975). Foucault argues that power, for the first time in history at the end of the eighteenth century, produces and regulates life (bio-power) by taking the individual body and the species-body as its objectives. The two dimensions of bio-power, the (individualizing) anatomo-politics and the biopolitics (species-body), find a nexus in sexuality. The concept of bio-power is crucial for de-essentialize the individual and gendered identities. From his *History of Sexuality* onwards, the feminine body appears as a strategic space in the exercise of bio-power, subject to a progressive process of objectification and control by medical and psychological discourses - what Foucault calls the hystericization of the woman's body. The feminine body's pathologization is burdened by the responsibility imposed on women for being in charge of the health of male and female children, the stability of the family as an institution, and the health of the society; a control that is related to the social production of the "sexual division of labor," identified in feminist analyses. Although there are evidently significant holes in Foucault's work regarding gender, it has also facilitated the configuration of research trajectories like the one here proposed: analyses of how the notion of gender lies at the heart of biopolitics and the idea of the species-body; the analysis of how bio-power relies on and supports the sexual division of human beings (Rodríguez Magda, 1999); and the analysis of how the regulatory politics of the life of populations have used the family as an instrument and affected women in particular ways.

The production of sexuality is one of the ideas that has afforded Foucault's work (1976) such extensive reception. Asking sex the question of what we are, in addition to interrogating sexuality, is to construct subjective truth; the subject is constituted in the process of sexual ascription. In this sense, we consider it essential to renew analytic strategies in the focus on gender, and even more specifically when we consider health, to make visible the impact of new inequality operations on women's experiences and lives as these operations articulate with the entrenchment of biomedical culture and bio-power (Barker, 2005; Foucault, 1976; Rose, 2001).

Towards a more balanced relationship between the social and human sciences and the health sciences

The growing social demand for medical care, noted previously, has disrupted conceptual and epistemological foundations in the social and human sciences as well as in health sciences. In the former, it has raised again the debate about the need for reconceptualizing the relationship between biology and culture and between the social structure and the subject, whereas the latter is understood in global terms as a bio-psycho-social entity or as one who is subject to social conditioning and practices of freedom. The disruption also entails moving beyond a modern binary epistemology. In the Latin American context, research experiences on health from a more social sciences standpoint has tended to focus on discussions and tensions about regional and local health policies: access, quality, models, and inequities have been some of the main topics (Atun et al., 2015; Cotlear et al., 2015; Heredia et al., 2015). Nevertheless, there are very few instances of applied research that analyze the interaction between body and culture in the everyday life. In recent years, we have seen an increase in the interest around this topic though, for example Rojas' research (2015) about the social, health, and the value of experience; Energici's studies (2016, 2017) about fatness, gender and social class; Castillo-Sepúlveda's (2015) and Rojas-Navarro and Vrecko's (2017) work around bio-socialites in topics such as public health insurance and medicalization in attention deficit disorder, respectively. To continue and expand this interest, we have sought to focus on a problematic such as CP/FM, whose incidence has grown exponentially in Western societies, within a population that is 90% female. In addition, the CP/FM analysis allows us articulating the debate we have mentioned concerning the relationship between biology and culture, which has been articulated in theoretical and epistemological terms with the sex/gender relationship, in the work of the feminist theoretician Butler (2001a, 2001b, 2001c, 2006).

In the field of health sciences, there is strong resistance against enabling an epistemological reformulation through these debates. They are, nevertheless, latent, and open up foundational questions in the medical field. These include questions concerning scientific models of thought and culture that have been hegemonic throughout medical history and have determined the rest of the field of health and knowledge in general: a mechanical and fragmented body, a biomedical model of health, an individual and autonomous subject, and of strictly pharmacological or surgical intervention, or care. Such questions undermine the western binary epistemology itself, including the fundamental division between biology and culture. This division has importantly grounded the health sciences' historical separation from and control over the social and human sciences, when the two fields worked together in social medicine throughout the XIX and XX centuries. This separation and control are currently being displaced, moving slowly towards a more equal interaction between the two domains.

As Bauman (1992) has argued, modern epistemology has emphasized above all the human capacity and desire, within the scientific *dispositif,* to transform nature, understood as an object susceptible to use, without autonomy, for being known and controlled by human beings. A similar argument has been formulated by feminist epistemologists through the critique of the gendered metaphor of scientific knowledge made by Francis Bacon, where the scientific (and male) mind of the scientist must marry, dominate, and rape a female nature to accommodate the scientific and social desires and needs (Fox Keller, 1991). This dichotomy and asymmetry continue to sustain the medical vision, which is almost unilaterally associated with scientific and (bio)technological progress and, by extension, becomes a fundamental source of human well-being and of models for a good life.

Nevertheless, it is not possible to overcome all obstacles, and the human body remains incompletely subjugated and controlled by human will; there continue to be elements that are only modified with difficulty. We can interpret CP/FM as a paradigmatic case of this phenomenon we propose, one that continues to resist despite its subjection to characteristic processes of medicalization and technologization, over-prescription and pharmacological trials oriented toward palliative treatment. Indeed, as those who are affected by the illness explain in their life stories, the techno-medical approach does not bring about improvement and can even aggravate the situation.

The growing control exercised by science and technology over biology and the body in the contemporary society contrasts, in another sense, with a society that is immersed in what Bauman (1992) called "liquid modernity". In this social-scientific conception of society, the virtuality and fluidity of identity reduces the importance of the material things, as well as the importance of bodies in the constitution of subjects and in social interaction. But this social scientific perspective paradoxically coexists with a growing objectification and control of the body through technology and medicalization. This brings us back to the importance of the interaction between these two domains: while they retain and develop new separations between the body and society/culture, the social and human sciences have also increasingly moved towards taking embodiment into account, such that the body becomes a generator of meaning and culture, and the social and cultural become producers of the body. In this sense, there is a desire to recuperate, as Pujal i Llombart (2006) and Mora (2003, 2005, 2007) have argued, the physical and the material in social scientific understandings of social processes, to correct the rationalist and linguistic reductionism to the psychosocial.

It seems that suffering and emergent illnesses that are exacerbated in current society offer a good opportunity for studying the interaction between different domains and for incorporating the social sciences within health sciences, fostering a dialogic process between them. We are referring to illnesses that express themselves physically, such as cardiovascular illness, cancer, and FM, among others, as well as syndromes associated with digestive diseases; and to more behavioral ones, such as chronified depression, phobias, growing anxiety and panic attacks in childhood, etc., and digestive metabolic disorders in the form of somatizations (Luz, 2011). These kinds of illnesses offer an opportunity for the current social sciences to open themselves up to the material dimension, beyond the "liquid" mode.

Emergent illnesses such as CP/FM need to be addressed creatively, and they also offer an opportunity to renovate the mode of scientific knowledge production. We have seen such approach in the case of other illnesses, such as obesity, in which Scott Yoshizawa (2012) identifies the need for interdisciplinary collaboration between social and health sciences to develop more complex approaches. Still, these illnesses have not been taken up as a way to problematize conventional modes of scientific analysis and to open up a search for solutions in social policies based in stable or provisional civil forms of social organization. Instead, the illnesses we have identified here have ended up being absorbed by every aspect of the health sciences (fundamentally in medicine), with a special focus on "public health" and a medicalized construction of illness.

They have followed a pattern identified by Luz (2011), in which social conflicts generated by the contemporary society, which could otherwise be formulated in political or social terms, are channeled by the public health. The challenge posed by shifting health issues towards the social sciences under these conditions is investigating and discovering to which extent and in what ways this medicalization process acts as a form of social control. Similarly, Spink (2010) argues that, whereas health has been historically transformed into a right, in current neoliberal society health has become extraordinarily prescriptive. It has become a normative force that regulates desirable styles of life and imposes the individual responsibility to govern one's own health. In the West, the regime of medical power-knowledge has evacuated any real sense of the State's responsibility to attend to and protect health as a civil right, converting it instead into an individual duty: the duty to be healthy, to have good health. This process obviously corresponds to a social control *dispositif*, and not to the potentiation of well-being and freedom. In the past few years, the humanities' and social sciences' increasing turn toward the study of health, the body, biotechnology, and medicine, including the domain of the clinic and surgery, expresses precisely this regulatory effect in social and psychic life. So powerful is this effect that it has become possible to speak of a biomedical regime of life, that becomes relevant for the social sciences as a social phenomenon, and so as an object of study, like any other form of power. This regulatory effect goes beyond the study of the medical framework itself as a control *dispositif*. Currently, it is a control *dispositif* for the Social Sciences in the same way that the religious phenomenon constituted a control *dispositif* for them in the nineteenth century.

In this study, our epistemological, theoretical, and applied perspective aligns with the bio-psycho-medical model of health research developed by

Velasco (2009). We refer specifically to the line of analysis that considers social determinants of gender regarding health. Our object of study using this model is the life-health-illness-disease continuum, understood as a process in which biology, the social context, and subjective experience play a role. The social factors at work are psychosocial processes of gender, which are structured in terms of different social models, and we consider gender from an intersectional perspective that deal with the interaction between different axes of inequality that constitute and subjectivize individuals (class, ethnicity, age, sexuality, etc.). These axes are consolidated through social and cultural representations that establish ideals of how to become a man or a woman in a normative manner within a given society. Ultimately, such ideals regulate the subjectivities and bodies of men and women and their social relations to different degrees. Gendered social models and subjective ideals combine to regulate the attitudes and ways of living that, consequently, also influence ways of living, getting sick, contracting diseases, and dying.

From the biographical method to the psycho-social diagnosis of gender

Research studies framed in terms of the epistemology we have elaborated in the prior sections require a methodology that will allow us recognizing the dimensions implicated in the new subject of chronified pain (CP) and locating and articulating the dimensions of the construction/production of the body with CP in our results. The use of life stories of the French "clinical-sociological" school are not only a useful methodology for any psychosocial study but also adaptable to questions and issues we ask in the social sciences about "clinical pathologies" (Gaulejac; Rodríguez; Taracena, 2006). How and in what way does the emergence of a chronic illness, in a particular time and place, link to specific institutional forms? How do these institutional forms intervene in the constitution of the body with CP? How are these forms related to implicated subjectivities, psychic structures, and representations, as well as to the affected body? What relationship is there between the body and the social dynamics? And, conversely, using Foucault's *The Microphysics of Power* (1979), how does power traverse bodies?

One of the premises of these questions is that subjects are not just products of history, but also individuals with historicity, entities with agency who are constantly seeking to become subjects in this world. This allows us to show the analytic value of using life stories as a first step in the search for psychosocial data on FM/CP. It becomes increasingly clearer to us that we speak of subjects who relate to the world in situated ways, within a phenomenological continuum that extends from the individual to the social world and back. Life stories are a port of entry into: (1) how and in terms of what content history has been incorporated into individual experience and established its conditions; (2) what "family romance and social trajectory" (Gaulejac; Rodríguez; Taracena, 2006, p. 44) are used in the construction of self-ideals; (3) what psychic dynamics and mechanics of fixation on and search for a subject position within objective reality are at work; and (4) what corresponding mechanics of bodily grammars are in play. This last arena leads to a key aspect in the articulation of the axes that determine our vision. The specialization of scientific knowledge in our society has made us live within a fantasy of the mechanical body as something separate from our psychic and social lives (which are also segregated from one another). Nevertheless, focusing on the epistemological claims we pose above, we begin from another premise: we suggest that the physiology of the human body, in its different forms, is structured by the conservation of life but, at the same time, this structural articulation interacts with psychic and social structures. The result is that we can speak of a body with a "grammar of life" – in opposition to the isolated mechanical model –, which responds to the person subjection in the world, at the same time that the person is produced within that world. A biography is inscribed in the body, in the form of memory and a bodily grammar, which ensures the person continuation within a world of relationships. This double dimension is selective, clearly, and this is where power intervenes, according to the Foucauldian perspective and also that of Varela, Maturana, and Uribe (1974) (biology of knowledge), among others. This approach establishes a performative body, one that must necessarily get sick (the question is, what will this body become sick with?). And here we find the bodies with CP, diagnosed with FM as something invisible. A body with CP, from this perspective, is a performative body like any other. Like forensic scientists, we have sought to capture the psychosocial world in the "tissues" of this body. In doing so, we have integrated the results in a corpus of "psychosocial diagnosis," which we present as a construction/production mapping of a body with CP; a mapping of different superimposed languages (feelings, mechanisms, dynamics, grammars, meanings, symbols, identities, expectations, searches, structures) that, like an atlas, shows the connection/interaction evoked between the regularities of the social world, psychic structures, and bodily grammars. Given this approach, we understand the psychosocial diagnoses that emerge from the research as a meta-analysis and, simultaneously, as a tool for intervention and bio-psycho-social change.

To accomplish the latter, with the research project "Silenced voices in times of equality" as a general scheme, we deployed focus groups, in-depth interviews, a collection of different documents, and collection of entries in internet forums on affected women and men, as well as from health professionals. For this paper, specifically, we've used in-depth interviews, as this is one of the best instruments to access life histories and to collect and transmit experiences from participants to researchers. In-depth interviews help the objective to situate the researchers and the readers to the participants' perspectives concerning their lives, experiences, and different everyday situations (Gaulejac; Rodríguez; Taracena, 2006; Ruiz; Ispizua, 1989; Taylor; Bogdan, 2000).

These interviews were scheduled in two sessions of approximately three hours each. They were recorded in audio devices and transcribed ad-verbatim. Participants were informed about all aspects of the research and given an informed consent form to authorize these procedures. The topics covered in the interviews were organized into seven axes: disease trajectory, participation in organized groups of affected people, the meaning of being a woman, the meaning of being a hard-working woman, family and affective relationships, personal time and space, and conflict management.

Through these research activities, while capturing and interpreting the forms and regularities of the bio-psycho-social world and its organization into categories, this double understanding ensures dynamic result presentations. It also ensures that these results will devolve to the affected persons as a meta-story of their individual history, as it searches out the production of resonances, reflections, and reflexivity in that history. Phenomenology tells us that the nature of the social order is always contingent on the subject's positioning in a given world. Since the body is the scene of articulation for all of the phenomena relevant to the subject under mechanisms of experience and life in the world, the way in which the subject articulates with the world can be transformed in consciousness to conform with the contingency of phenomena and the (contingent) way in which the "I" is related to them. Still, the act of reflection that we seek with the tool of diagnosis is not based in a belief in the "I"'s omnipotent control and capacity to change all physical and social processes, not least because these comprise different types of dynamics (bio-psycho-social); neither, evidently, is the reflection we seek based in the uncontrollable biological nature of bodily dynamics, but it is rather based precisely in the presentation of its experience as situated and also contingent. This will open up possibilities for re-situating affected persons and their suffering into a new set of terms.

The construction of a methodological instrument of analysis has been key for our research. We propose and construct a concrete tool that we call the "Psychosocial Diagnosis of Gender,"[2] which can analyze psychosocial determinants of gender in health, that we use as our model (Velasco, 2009). The theoretical objectives of our diagnostic tool are to account for the different dimensions of this

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[2] To fully comprehend the theoretical and methodological basis for this instrument, we recommend reviewing Pujal i Llombart's and Mora's paper "Subjectivity, health and gender: an approach to chronified pain through the Psychosocial Gender Diagnostic methodology" (2014).

new subject of chronified pain (CP), who displaces the binary subject (which corresponds to the bio-psycho-medical model), and to dynamically articulate these dimensions in the construction/production of a body with chronified pain (CP) that distances itself from the mechanical and organic body to become a performative body (Butler, 2001a, 2002, 2006) with a "grammar of life." We believe that this instrument might be applicable to the diagnosis of other malaises and diseases (both psychological and physical) but, within this research, we've limited to the study of FM.

The analysis of the interviews through our epistemology and attention to the axes of analysis (body, psyche, society), will demonstrate the existence of regularities within and between the dimensions we analyze. This preliminary analysis has led us to think about the dynamism of "chronified pain" as a descriptive metaphor not just for the different dimensions and mechanisms associated with FM/CP, but also for the interactions between these dimensions. A central methodological question has been **how to capture the dynamic of chronified pain**. Due to the process of coming and going that any research project entails, once we came to discern the dynamic of the general results, we developed an instrument that would allow us to **present the life stories of each individual person in terms of this dynamism**. Accordingly, through some specific examples, we present the Psychosocial Diagnoses of Gender for CP/FM as a tool for describing the bio-psycho-social dynamic associated with chronified pain (CP) without organic cause. We hope this diagnostic tool can accompany clinical diagnoses of FM and other contemporary illnesses (Wykes; Callard, 2010); and that it can be useful for thinking about integrated bio-psycho-social strategies of intervention for overcoming CP, or other related purposes, such as prevention.

The psychosocial diagnosis of gender: an illustration

We present, as an example, Bea's (name changed) psychosocial diagnosis of gender, which begins with two significant textual quotations. The structure of such a diagnosis begins with a description of the person in the present, with attention to the state of the illness and how she or he is living it. Then, the diagnosis connects like a web to different agents that it evokes as the main actors in the capture of her body in FM terms; doctors, the diagnostic process, family dynamic, and the self-ideals. Similarly, the web of the suffering body and its life connects with the body's previous connections regarding its development in work and life. In the same sense, this present state connects in a web with its physical life, and with the corresponding social dimensions of this physical life. In the next act, the diagnoses connect this diagram of the body with a family and work history, which includes the story of subjectivity implicated in either the family's life or its own experiences, with most being related to the construction of the person's social identity and the development of associated roles. Finally, we move through the person's interpretive universe, where his or her present life is valued concerning his or her condition of progress or stagnation and with attention to the person's living in the world – to that person's subjectivity.

> *R:* [when I was young] *I always had this duty* [to take care of all of my siblings, in addition to the one who was disabled, and of the house] *and my grandfather died – he was the only person who sometimes came to find me and took me to the theater to see 'Els Pastorets' and things like that. And, for me, my grandfather's death – he died at home and I watched him die... affected me so strongly, that I began to have dreams at night and crying and ever since then I started to have pain, and I had pain.*
>
> *P: Do you feel fulfilled as a woman?*
>
> *R: Right now, no. I used to feel fulfilled when it seemed like things worked. But then I have come to see that it's all fake, everything was a life, and everything had been a failure of education, of society, of an era... and that what I had to do was to wake up... be reborn... well, then it was about making myself feel something toward myself, me too, because I had disappeared, was negated, I didn't exist!*

Bea's current situation, at age 59, from the point of view of the generalized pain that accompanies the clinical diagnosis of FM, is one of a relief from pain, pain almost totally gone, recently, along with the easing of her subjective feeling of failure and profound personal crisis regarding her past life as a woman, a mother, and a person. She was working on the personal and subjective crisis at a therapeutic level, with a female psychologist who uses a gender perspective and specific relaxation treatments for the body. This therapeutic work has allowed her to begin a process of subjective gender transformation, which involves problematizing her identifications and representations of what it has meant and now means to be a woman, to be a mother, to be happy, etc., in our cultural context and recent history (she was born in 1950). She is living this process quite enthusiastically and with excitement, although it can be difficult and painful, and this is allowing her to begin a new chapter in her life. She feels more like a protagonist of her own life, herself, able to set limits, stop denying her needs in favor of others, able to care for herself, to make sure she is respected by others, and to have more control over her own life. It has been a long time since she used allopathic medicine, which she took for many years (5 or 6), because it did not work and, in some moments, she has made use of alternative body relaxation treatments, which have also temporarily helped relieve the body pain.

The moment of inflection that allowed her to beginning this life crisis and subjective transformation process was preceded by a physical breakdown and a profound psychological collapse, which were the low point in a long life trajectory in which she experienced excessive suffering (taken on as necessary and normal), was subjected to abuse and maintained abusive relationships, especially with her partner and her family of origin - abuse in the sense of multiple, intense, and continued kinds of "gendered violence" (sexual, psychological, economic, symbolic, etc.) in the couple for more than 40 years, and psychological and material abuse on the part of the family of origin.

Her life story tells of intense and excessive psychological as well as physical pressure since her childhood, on the part of her family of origin, in the form of premature and violent maternalization and maturation, as she was made responsible for the care of her three younger brothers (one of them disabled) and of domestic chores, etc., when she was still only 7 years old and even earlier. In addition, there was an absence of emotional care and consideration towards her. She only gets her family's attention concerning basic and primary needs of survival, such as food, clothing, etc., but not through affection or communication or interrelationship and space for playing that would allow a child to emotionally, affectively, and subjectively develop. Experiences that take place in the heart of a family, which lives within a context of political, patriarchal, and labor dictatorship (father baker and mother embroiderer), invaded by and centered on work (of the parents), without space for affection and care, very rigid and normative regarding gender roles, and with a "protestant" work ethic, that does not hesitate to use physical and psychological punishment (if they are necessary to achieve a goal) or to put the oldest daughter in the position of "child caretaker and precocious servant" that was imposed on her alone. There is also a compulsive repetition, on the parents' part, of a personal history of deprivation and rigid upbringing from their own parents. The family was presided over by a father, a patriarch, who aborted in the name of sex and gender his daughter's desire for, ability in, and possibility of completing a course of study (she was very dedicated, with good grades and a desire to learn), in favor of putting her to work at 14 as a domestic, despite the advice of her teachers who asked him not to disrupt his daughter's academic talent and trajectory. His goal was to offer an academic career to his son.

This life trajectory has constituted her subjectively in terms of a compulsion to adapt to the needs and desires of others while erasing her own; engaging in the juggling exercises of a positive, stereotypical, and fantastic (in the sense of fantasy) distortion of reality and of others, and the negation of her desire. The result is an erased "I", the product of the absence of any external recognition on which to depend in her development that has been translated into a sense of her own invisibility, which has made her subjectively similar to someone who will endlessly seek this visibility and recognition in others, outside herself, entering into a vortex of activity until the body finally says "enough!" The mode of life is to put oneself forward and adapt continually to the desires and demands of others (especially the partner, but also the children), an orientation toward alterity that will lead her to erase herself and to be a person truly unknown to herself, putting her in a state of "melancholic affect," cloaked in a romantic and normative discourse of gender (traditional model interacting with a transitional model). This trajectory will continue until the present, when a very profound person crisis and the desire to get out of it, along with the question of "why?", give rise to the beginning of a personal reflexivity that will allow her to find specific help and to realize that her subjective and gender positioning lead her inevitably to the opposite of what she seeks, thus continuing to be erased, abused, mistreated, and unhappy. The secret and central element that safeguards the fragile line separating emotional and physical or somatic ill health – the generalized pain of FM – which began at around 7 years of age according to her memory, was her grandfather, the only figure from whom she received a certain subjective understanding and esteem. He died when she was 7 years old, and his death represents to her the end of the only care and recognition she had received, just as she was "abandoned to the world." This made a generalized pain explode in her body, which intermittently remained over the years as a continual hazy subjective position. Pain must remain invisible to the family of origin and to herself in order not to make an already bad situation much worse for those around her (given that caretakers cannot be an object of care without the patriarchal codes and sex/gender system in a traditional mode or transitional model). This pain has remained a secret and intermittent burden until she was fifty, and it has not been until recent years that she stopped being intimate and secrete for others and became a clinical (and political) FM diagnosis, which presupposes a certain recognition. History and life position in the family of origin made her flee the family with her partner (an artist, she says) at 17, and which was a mirroring and stereotype constructed as an image of freedom and liberation from her father's imprisonment of her, without knowing that it would, in reality, become the opposite – a continuation in her life as an adult woman. The life and relationship with her partner have been marked by repeated temporary abandonment, that she would pardon for love, but that also served as a way to remove his responsibility as breadwinner and his emotional paternity; and by abusive relations and different sexual, economic, psychological, and physical abuse, in addition to her husband's alcohol problems, car accidents due to drunk driving, etc. Her own family, in which she had two children – a girl and a boy (that he legally rejected during the pregnancy, another one of the many acts of family abandonment), have made her into a lonely person for more than 40 years, mainly emotionally, both in her maternal role and as provider, as she has always had two or three jobs, given the time of women's liberation and "equality" that she had to live (the social model of transition of gender and multi-tasking). Although, she has never been able to do work she wanted to, or to enjoy it, or even to keep it when she had it. In addition, she has facilitated and financed her partner's artistic work for over 40 years of their relationship. A trajectory as a slave, provider, and servant at the economic, sexual, and emotional level within the couple, in which she has taken on alone and at every level the responsibility (both of theirs), and which has brought her in the end to be expropriated from herself, without the least external recognition, and without even having enjoyed owning any real estate (she even lost the apartment where she lived, which she bought with her wages) given that her partner's response in the separation was exacerbating his gendered violence at the economic level, with the aid of their mutual friends – from which she received no support.

This gendered violence of the couple has been repeated in her own daughter's and grandson's lives, so that she has had to again become responsible economically and emotionally for her grandson – his mother is not taking care of him. This repetition of gendered violence was also present in her own mother's story, although in a more normalized and crude way given that it was the Franco era, which had very strict and well-established gendered codes due to the traditional social model of gender.

Three generations of violence emerge in this life story, which offers a picture of an era and also a questionable transformation of social models of gender from the traditional to the current transitional model. At present, the search for external recognition and confirmation has ceased and shifted towards a search for recognition from herself through therapeutic work, and toward a dis-identification with the normative rules of gender for women, mothers, and people through a process of particularization. These processes led her to change the direction of her subjective position and her place in relation to others and to the world, which represents a beginning and a rebirth, as she says herself, which has direct repercussions for a significant improvement in her somatic pain.

Conclusions

Having presented an example of the Psychosocial Diagnosis of Gender, we move on to consider, in conclusion, shared aspects at the level of content that have emerged across the 20 diagnoses we have completed (15 women and 5 men). The diagnoses can be described as meta-stories of their life stories that, like a tapestry, weave in different variables until they describe a subjective phenomenological continuum that proceeds from the body to the social world and returns, each time passing by points of connection and fixity of and to reality. Therefore, the generalities of the psychosocial diagnoses of gender that we have elaborated demonstrate a way of living chronified pain as disabling, which functions together with:

- Bodies lost in perpetual activity: the life trajectory of the perpetually active body, not just regarding physiological activity in general, but a body that is unlimited in the performativity of a feminine role, that becomes ambivalent due to the incommensurability of this role's normative mandates within multiple contexts that are in play in times of equality (work, home, training, consumption). We speak of a body in perpetual search of confirmation for its activity, in ambivalent mandates and scenes (work and home, training, consumption), which leads to ambiguity of identity, i.e., to the negation of the validity of the confirmation available in a given scenario, on the part of the other; hence, it also encourages this unlimited dynamic of the body with CP, in perpetual and contradictory activity – that is, in perpetual but lost activity, without confirmation. Paradoxically, it seems as if the CP/FM goes to this body, to its capacity for self-limitation, for self-defense.
- A weakened ego: this corporeal dimension of CP/FM finds a corresponding psychic one that has to do with the impossibility of an ego that generates the ambivalence about roles in the search for the subject condition within this multiple context inhabited by contemporary women (Velasco, 2009). In general, this is a matter of an ego that subjects itself fiercely (irritated, exasperated) to the world through a norm, a being, or ideal of woman as worker/caretaker that, when confronted with the objective conditions of incommensurability among different establishments or spaces, cannot find a confirmation for its condition; a lost ego that blames itself and punishes itself due to this fact, an ego that finds itself lost in ambivalence and the unending search for itself. This is a psychic dynamism that, while it traces/translates onto the ego a normative mechanism, allows the unconscious filtering and animation of conflicts that arise from ambivalence. In this sense, while the normativity of female ideals is projected onto the body in the unlimited need to perform activities corresponding to the role, the unconscious projects onto the body the dynamic of the conflicts (Bayo-Borrás, 2003).
- Inequality in equality: these people's social mapping, family story, and living conditions alert us to the social organization of this body in pain, of this ego that is still unconfirmed. It is as if it was a matter of a representation of the universe projected onto the workings of a clock, the body with CP/FM contains the memory of a world of phenomena that can be organized in the following way (although not all of the psychosocial diagnoses contain them, these are partially repeated throughout them):

> the world of maximum maternal cure; the world of family abandonment; the idea of the woman as caretaker/provider; the world of delegitimation by the family (partner, children); the world of delegitimation in work; the world of social delegitimation (friends, etc.); the medicalization of life, and the longing constitution of the self in illness, medicalization and chronification of pain, the world of "times of equality" as an omni-comprehensive system.

As these shared elements suggest, applying the interaction of a feminist and poststructuralist perspective in the construction of knowledge with implications for intervention in the field of public health (a topic that constitutes another article in itself) is to recognize the essential importance of making visible the **subject/sex/gender system** in the experiences of avoidable ill health and suffering (Izquierdo, 1998) in relation to the socio-historical context and its production and regulation of subjectivities. This operation entails that a critical position on traditional modes of knowledge construction which claim to be "universal truths," objective knowledge, free of values, fragmented and without any trace of gender in the conceptualization of health. Such a critical position recuperates the capacity for resistance to the traditional and sexist version of science and commits to an ethical-political-scientific praxis and to social justice in the field of health and its interpretation of avoidable illness.

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Authors' contribution

Pujal i Llombart and Moral Malo were the principal investigators of the project and conceived the study. Schöngut-Grollmus participated in data analysis. All the authors contributed to manuscript composition.

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