

Week 9

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Article

"FOLK" OR "TRADITIONAL" VERSUS "COMPLEMENTARY" AND "ALTERNATIVE" MEDICINE: CONSTRUCTING LATINO/A HEALTH AND ILLNESS THROUGH BIOMEDICAL LABELING

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Abstract

This article explores the social interpretation of labeling Latino health beliefs associated with botanicas and unlicensed clinics as "folk" and "traditional" as opposed to "complementary" and "alternative." Using a critical medical anthropological approach to trace the development of these labels, this article analyzes the hegemonic impact of biomedicine on Latino epistemologies, and traces the difficult application of static interpretations of Latino cultural practices in public health. One qualitative account of a modern experience of susto is provided to indicate the complexity of "folk" illness experience. Ultimately, this article asks, "What does it mean to define Latina/o beliefs and practices as "folk," "traditional," "complementary," or "alternative"?

Keywords

culture; folk illness; traditional medicine; complementary and alternative medicine; public health; susto



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399**"Illegal Care Attacked on Two Fronts"**

The death of 13-month-old Christopher Martinez, allegedly at the hands of a man impersonating a doctor, has sparked a flurry of efforts to keep immigrants from going to unlicensed doctors. But Monday's death of Selene Segura Rios after her visit to a Tustin gift store allegedly dispensing drugs and injections shows that the problem hasn't been solved. "We believe that some of (the unlicensed clinics) have gone underground or are operating out of their homes," said Sara Murrieta, co-chair of the Santa Ana Safe Medicine Coalition. "It's still a problem." The coalition was formed over the summer to urge people to make sure they are seeing licensed doctors and only use medicine prescribed by a licensed doctor.

Santa Ana police working with state and federal health inspectors have had some success shutting down phony medical merchants, said police spokesman Steve Despenas. More than 20 medicinal "botanicas" have been checked by undercover officers since April. Most were obeying the law, he said. But on – Botanica La Purisima on South Bristol Street – was found to have more than 200 illegal drugs, hypodermic needles and syringes, which it sold over the counter, Despenas said.

(Collins, 1999)

As this excerpt from the newspaper, *The Orange County Register*, indicates, following the deaths of 13-month-old Christopher Martinez in 1998 and of 18-month-old Selen Segura Rios, who in 1999 received two injections of a pain and fever drug called Neo-Melubrina (dipyrone) at an Orange County, California, gift shop,¹ the local media identified botánicas along with other types of Latino/a stores as unlicensed clinics where illegal practices occur. While botánicas provide a variety of services that range from counseling in legal to health matters as well as in products such as herbs, teas, and nutritional supplements, they are mostly associated with the spiritual paraphernalia of such religious practices as *Santería*² and *Espiritismo*,³ and are commonly listed in the yellow pages under the caption "Religious Article Stores."

Concerned with the potentially illicit behaviors occurring in botánicas and other non-conventional clinics, the Departments of Public Health in both Los Angeles and Orange Counties responded to this perceived threat by developing a set of enforcement and educational strategies meant to effectively address practices such as the distribution of substances, as well as "traditional" therapeutic techniques deemed to be illegal, in an attempt to serve the interest of a broadly conceived public. Attempts to classify behavior hinged on understanding how Latino "culture" influences health-seeking behavior in accessing "culturally appropriate health care options" (Gomez-Beloz and Chavez, 2001). While the public health department in Los Angeles focused on enforcement strategies of monitoring and restricting presumed proscribed practices, the

1 Her autopsy determined dehydration as the cause of death.

2 In the larger study from which this article is drawn, I worked with a community of *Santería* practitioners. *Santería* is commonly defined as a Yoruba-based syncretic religion that emerged from Cuba as a result of the colonial slave trade (Brandon, 1997/1993).

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Practitioners explained that the religion is authentically referred to as *La Religión Lacumí* and *La Religión Ocha*. For scholarly debates regarding interpreting religions such as *Santería* as syncretic, see

Diaz-Stevens (1994), Shaw and Stewart (1994), and Van der Veer (1994).

3 As it is beyond the scope of this article, I will not elaborate on the details of these distinct spiritual practices. I mention them here in relation to their applied importance to health-related behavior.

4 The UCI Family Health Center is a free and low-cost community clinic. Located in Santa Ana, it primarily caters to residents in the area of which 76% of the population is identified as Hispanic as per the 2000 Census.

public health department in Orange County focused its attention on developing educational strategies meant to define appropriate and inappropriate official treatment methods and facilities. Both enforcement and educational campaigns used the term “traditional” in relation to Latino or Hispanic culture. This article contributes to the deconstruction of the racialization of Latina/o health practices in the United States by comparing the meaning elicited by the terms “folk” and “traditional” as opposed to “complementary” and “alternative” in reference to non-conventional health treatment in the classification of public health practices.

This research is based on anthropological field work I conducted in southern California from October 2000 until June 2002, for a total of 26 months that were divided into three phases. The ethnographic information presented here is garnered from five public health meetings I attended and 10 formal interviews I conducted with public health officials. Out of 30 formal interviews I conducted with patients at the UCI Family Health Center⁴ in Santa Ana, California, I also include one interview representing a contemporary experience of *susto* to illustrate the complexity and context of a folk illness experience in the “modern” world. Although *susto* was mentioned as a cause for illness in 22 of the 30 clinic interviews, I chose to include this particular interview because of its poignancy in addition to honoring a representative Latina voice that can go unheard in clinical environments that are regulated by biomedical physicians adhering to strict time frames during their consultations.

“Traditional” and “folk” categories or traditional medicine (TM)

In this section I draw from medical anthropological literature to explain how “traditional” categories of healing are associated with “folk” labeling, and how these labels can provide a fixed temporal understanding of customarily dynamic methods. In anthropology, the term “traditional” is historically used to describe ethnomedical and folk healing systems (Reiff *et al.*, 2003), thus emphasizing difference and incompatibility with biomedicine. In so doing, biomedicine consciously becomes the standard of measurement used to understand the complex terrain of health and well-being (Kleinman, 1980; Good, 1994). For example, folk medical systems are often defined as containing the following characteristics: primarily oral transmission of knowledge coupled with unofficial status; health as harmony or balance; interrelation of body, mind, spirit; vitalism; magical or supernatural elements; thoughts and emotions as etiologic factors; concern with underlying causes; positive/negative energies; transference of energies; moral tone; and meaning of illness experience (Kearney, 1978; Laderman, 1994; Rubel and Hass, 1996 [1990]; O'Connor and Hufford, 2001, 18). As a result of these distinct characteristics, folk medical systems are also believed to have exclusive categories of illness, otherwise

known as folk illnesses, simply understood as sickness that has “no apparent equivalent in bioscience...in that their clusterings of signs and symptoms do not conform to bioscientific diagnostic categories” (Browner *et al.*, 1988). Common Latino/a identified folk illnesses include *empacho* (food sticking to the stomach walls), *mal de ojo* (evil eye), *susto* (soul loss), *nervios* (anxiety), and *cáida de mollera* (fallen fontanel) (Rubel, 1984; Chávez, 1994; Trotter, 1998[1987]). Implied in the distinction of illness categories is conflict with biomedicine in that these illnesses fall outside what is considered diagnosable and, thus, treatable.

Modernity studies (Larou, 1993; Mitchell, 2000; Knauf, 2002) allow for the exploration of “folk” and “traditional” categories in emphasizing that contemporary interest in the classification of “traditional” and “modern” systems can exoticize sets of practices and define them as originating from a glorified and ahistorical past. In using this perspective from modernity studies in medical anthropology, social translation of “traditional” and “folk” can carry with it pejorative references to a set of practices and beliefs in conflict with sanctioned “modern” biomedicine. As O’Connor and Hufford (2001, 13) indicate in the following statement, systems labeled as folk can be antithetical to “modern” perceptions:

The most common interpretation of folk medicine in both popular and professional thought is that it represents a body of belief and practice *isolated* in various ways from the social and cultural “mainstream” and intriguingly unaffected by “modern” knowledge, with which it is frequently compared on the apparent presumption that “folk” and “modern” are mutually exclusive classifications.

(O’Connor and Hufford, 2001, 13; *my emphasis*)

This results in “traditional” and “folk” categories, temporally marking distinctions that may not be expressed as such by individual agents. In fact, where symptoms are described through the use of multiple lexical cues, first-person illness accounts can creatively interweave both (Kefe, 1981), providing those who endure illness with a richer vocabulary, as the *susto* account later in this article will demonstrate. In her autobiographical account, contemporary *curandera* Elena Avila (1999) explains how her 23 years of biomedical training as a nurse, with an earned masters degree, can be a source of conflict for her experience as a *curandera* when trying to conform to one method of illness description over another. In her experience, it can be difficult to draw distinct boundaries when painful biological and emotional symptoms are present. In order to meet the needs of those in pain, her approach is to honor both “traditional” and “modern” categories, while acknowledging that issues of translatability often arise and are not always adequately explained.

As the standard used in describing medical systems, biomedicine by definition focuses on the biological aspects of sickness and relies on the scientific paradigm of investigation to visually observe disease (Loustannau and Soho, 1997).

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5 Hans Baer *et al.* (1997) define hegemonic within a biomedical context as the "process by which capitalist assumptions, concepts, and values come to permeate medical diagnosis and treatment."

6 Removing the object of disease from the biological body.

7 Enhancing the current condition of the individual to counter the development of negative physical manifestations.

8 <http://www.nih.gov/about/ahmanc/organizational/NCCAM.htm>.

In the United States, biomedicine became a hegemonic⁵ health practice through the development of the American Medical Association (AMA), founded in 1847, and the publication of the Flexner Report in 1910. The AMA developed the scientific basis for the practice of medicine and consolidated the economic position of the medical profession within society, while the Flexner Report standardized US medical education by eliminating what was considered incompetent treatment (Loustaunau and Sobó, 1997). However, it also led to the discrimination of women, blacks, Jews, and immigrants in the field. Most importantly, the Flexner Report "established a new medical paradigm – that of the body as machine with an emphasis on research, therapy and repair (pathology and cure)" (Loustaunau and Sobó, 1997, 118). World War II served as a catalyst in defining disease as located in the body and as a tangible, physical, and oftentimes aggressive agent that wreaks havoc inside the human body (Good, 1994; Martin, 1994). In reducing sickness to biological terms, biomedicine has historically been concerned with addressing the physical component of illness, placing greater emphasis on curative⁶ rather than preventative⁷ approaches (Rhodes, 1996; Loustaunau and Sobó, 1997).

Complementary and alternative medicine (CAM)

In the United States, CAM was first defined by the Office of Alternative Medicine (OAM) in 1993 at the National Institutes of Health (NIH), as "an unrelated group of non-orthodox therapeutic practices, often with explanatory systems that do not follow conventional biomedical explanations" and also not taught in US medical schools, nor used by most physicians and hospitals, nor reimbursed for by most insurance plans" (Goldstein, 2002, 41–42). In 1998, the National Center for Complementary and Alternative Medicine (NCCAM) was established as an outgrowth of OAM with its stated mission to explore "complementary and alternative healing practices in the context of rigorous science; training complementary and alternative medicine (CAM) researchers; and disseminating authoritative information to the public and professionals."⁸ Of concern for anthropologists is that authoritative governmental definitions of CAM techniques indicate that biomedicine is co-opting alternative medicine (Wardwell 1994; Bates, 2002; Baer, 2003) and, in so doing, re-fashioning non-conventional systems of health maintenance to conform to a hegemonic and biologized interpretation of health.

Internationally, the World Health Organization (WHO) as a global institution has also dedicated itself to defining and investigating CAM health practices. In 2002, WHO conducted a study in which over 100 papers in MEDLINE, EMBASE, Cochrane Library and CISCOR databases were scanned to identify the use of CAM. A primary result of this search is that "all the surveys agree that the most likely users of CAM are female, affluent, middle-aged, well-educated and white" (Ernst, 2000, 255). It is useful to note that this outcome is directly

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related to the manner in which CAM is conceptualized and defined, especially because these surveys were conducted in industrialized countries. For example, the keywords that were used in this search were acupuncture, alternative medicine, herbalism, homoeopathy, hypnotherapy, massage therapy, naturopathy, osteopathy, phytomedicine, reflexology, relaxation therapy, surveys, and yoga (*ibid.*, 252).⁹ It is also worth noting that, “The typical user of traditional medicines in developing countries would almost certainly have different characteristics” (*ibid.*, 255). While differential construction perhaps facilitates classification, it cannot be considered a benign practice devoid of social implications. In reference to the classificatory limitations that arise in medicine, anthropologist Laura Nader (1996, 24) suggests, “While firm boundaries make for greater efficiency in processing information and coordinating action, sometimes dichotomies get us into trouble, as in confusing construct with reality.” In fact, the descriptive term “alternative” is created in a core/periphery structure where biomedicine is the identifiable core. This naturalized idea of centering makes it impossible to theoretically locate TM/CAM in a non-biomedically defined manner.

To better comprehend non-conventional therapeutic techniques, the WHO also devised a strategic plan in 2002. Central to this strategy is the acknowledgment of the widespread use of TM in developing countries, and of CAM in developed countries, with an emphasis on the discernment of “access and rational use of traditional, complementary, and alternative medicine.” The strategy then proceeds to define the terms TM and CAM:

“Traditional medicine” is a comprehensive term used to refer both to TM systems such as traditional Chinese medicine, Indian ayurveda and Arabic unani medicine, and to various forms of indigenous medicine. TM therapies include meditation therapies – they involve use of herbal medicines, animal parts and/or minerals – and non-medication therapies – if they are carried out primarily without the use of medication, as in the case of acupuncture, manual therapies and spiritual therapies. In countries where the dominant health care system is based on allopathic medicine, or where TM has not been incorporated into the national health care system, TM is often termed “complementary”, “alternative” or “non-conventional” medicine.

Accordingly, in this document, “traditional medicine” is used when referring to Africa, Latin America, South-East Asia, and/or the Western Pacific, whereas “complementary and alternative medicine” is used when referring to Europe, North America, and Australia. The comprehensive TM/CAM is used when referring to all of these regions. Cognizant of problematic definitions, WHO admits:

This is the first global WHO Traditional Medicine Strategy. It was drafted following extensive consultation. However, given regional diversity in the use

⁹ I am indebted to Leo Chavez for indicating that the very nature of these indexical markers biases the results obtained. For example, terms such as “spiritual healers” or “botánicas” were not categories used to distinguish complementary and alternative practices.

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and role of traditional medicine, and complementary and alternative medicine, modifications may be necessary to take account of variations at regional levels. *Additionally, it should be noted that difficulties persist in defining precise terminology for describing their therapies and products.* The validity of related data is also frequently problematic. Methodologies used to collect data are often not comparable and parameters not clearly determined.

(WHO, 2002a; *my emphasis*)

In this strategic plan, the difficulty in attempting to use a biologized framework to understand beliefs and practices that are not biologically bound is made apparent. In describing medicine in *allopathic* terms, the inference is drawn by the very definition: a system of medicine that aims to combat disease by using remedies (as drugs or surgery) which produce effects that are different from or incompatible with those of the disease being treated.¹⁰ As Emily Martin (1990) indicates, in the United States, this framework developed into a system whereby disease is conceptualized as a warring agent upon the body that must be either destroyed or subdued. This view of treating illness in the body is distinct and incommensurable with TM/CAM therapies that “have developed rather differently,” valuing “a holistic approach to life, equilibrium between the mind, body and their environment, and an emphasis on health rather than on disease” (WHO, 2002b, 21). Second, the distinction between TM and CAM is based on the socio-economic status of the countries from which they emerge. Consequently, defining non-conventional health treatments is based on biomedical definitions of health and shaped by industrialized countries (Baer, 2002).

While the categorical references, “complementary” and “alternative,” are embedded in biomedical implications of modern progress, “traditional” and “folk” designations, by default, are inextricably linked with notions of isolation and placed within an ahistorical past. In fact, folk and traditional systems of health care are often identified as catering to lower classes and ethnic minorities, while the “holistic health movement” in which CAM practices is identified as catering to upper and middle classes (Baer, 2001). It is important to recognize that TM and CAM are constructed systems in which similar practices may not be differentiated by actual ideologies, but, rather, by economic and class distinctions.

Public health difficulties in using reified categories

In public health, “tradition” in relation to Latino-defined beliefs and practices is interpreted as a barrier towards achieving positive health status. In particular, during the course of fieldwork for this study, “traditional” labels were used in conjunction with the concept of Latino “culture” by public health officials in the

¹⁰ Merriam Webster Dictionary, <http://www.m-w.com/dictionary/allopathic>.

Los Angeles and Orange County Public Health Departments. Public health officials explicitly identified “culture” and “tradition” as structural barriers that restrict Latinos from accessing what is deemed to be appropriate health care and such behavior was condemned. Following are ethnographic examples culled from three formal interviews I conducted with Los Angeles and Orange County public health officials and one Orange County public health meeting I attended in an effort to qualitatively highlight the ambiguity in perception that public health members exhibited in their process of using “traditional” descriptions in relation to Latino “culture.”

In Los Angeles County, the Health Authority Law Enforcement Task Force (HALT) was established by the Department of Health Services in February 1999 to investigate activities deemed illegal in relation to health care, including the dispensation of pharmaceuticals without a license and unlicensed healthcare providers. The educational counterpart to HALT is the Binational Border Health Program (BBHP) with its goal of educating the Latino community about cultural practices that are illegal in the United States. As a HALT officer explained in an interview I conducted in June 2001, “HALT’s goal is to address any crime that endangers the public health,” including performing sting operations to “shut down” mercantile locations where illegal operations are allegedly performed.

From an anthropological perspective, the relationship between “culture” and “tradition” is important to the BBHP and HALT activities detailing illegal behavior affecting Latino health care. As the BBHP Director explained in an interview I conducted in June 2001, in reference to possible activities occurring in botánicas and unlicensed clinics:

Out of all the barriers, you know, caused the reason for this behavior, the main one is *culture and tradition*. And, you know, it is the norm in any of the Latin American countries. This is not illegal over there, so, we...are telling them that...they should not be doing what they have done all their lives. (my emphasis)

Here “culture” and “tradition” are used as catch terms to define the source of illegal behavior. The Director then provided me with a packet used in the Program’s educational campaign. The packet included the following working definition in Spanish: Culture: The ideas, ways of behaving, customs, beliefs, values, abilities, arts, religion(s), and prejudices of groups of people at a given time.¹¹

¹¹ My translation.

The BBHP Director accentuated that Latinos need to be taught about the dangerous element of their “culture” based on tradition. In the public health imagination, the broad definition used for “culture” encapsulates “traditional” elements that harbor the potentiality for causing harm, assuming essentialized features of Latino “culture” without accounting for individual socio-economic status factors and geographical distinctions among people from Central

America, South America, and the Caribbean (Santiago-Lizarray, 2001). This use of the "culture" concept also elicits the idea that there are those "with" culture, usually defined in particular ethnic terms, and those without (Rosaldo, 1988), disregarding other types of "culture," such as the biomedical one. The result is a reductionist account of "culture" as something that belongs to ethnic "others," whereby processes of change resulting in alternations is simply lost (Sapir, 1958).

"O.C. Slow to Go After Unlicensed Clinics"

Orange County has taken little action to shut down unlicensed clinics and medical providers after the death of a 1-year-old boy in April, in contrast to Los Angeles County, which has an undercover task force to ferret out sham medical shops. Even though Los Angeles County had no known deaths as a result of unlicensed care, a task force of health agency, police and Sheriff's Department employees has investigated 147 illegal clinics and arrested 52 employees. In Orange County, only a single city – Santa Ana – responded with a police task force. It investigated 32 clinics and arrested three employees in the two months after the death of Christopher Martinez, who received injections and other treatment from unlicensed doctors and nurses. Santa Ana has not searched any clinics since June. The death of a second child in similar circumstances last week brought criticism from leaders in the Hispanic community. Orange County officials vowed Wednesday to pursue more aggressive education and law enforcement.

(Kowalczyk *et al.*, 1999)

The Safe Health Care Coalition of Orange County (SHCOC) was established in 1998 at the request of police captain Dan McCoy after the death of Christopher Martinez. Its primary goal was to educate the Orange County community about safe and legitimate sources of health care, while also indicating the dangers of receiving care from unlicensed providers. In an interview I conducted with SHCOC Program Director in November 2000, he described the target group of this public health campaign as monolingual Spanish-speaking people with children, because of the deaths of Christopher and Selen. He emphasized that the educational curriculum does address the benefits and consequences of using traditional practices, such as *curanderos*, or "traditional" healers from Mexico and Central America, as well as herbs and teas, in addition to Western medicine. He explained that while the program does not condemn "traditional" practices, such as *sobadores* or shamans as good or bad, the stated goal of the Coalition is "to bring awareness with the intention of tying Western medicine to non-Western medications." According to his understanding, the use of such substances as herbs and teas can be perceived as non-Western "traditional" methods that are not in direct conflict with biomedicine. However, the practice of using unlicensed practitioners, as Selen's parents had done, is also perceived as a "traditional" method and is unsafe and dangerous. Here, "tradition," as a

categorical reference, is doubly imbued with historical wisdom and unprogressive and potentially harmful practices. In a similar manner to Santiago-Irizarry's (2001) analysis of the use of the concept of "culture" in mental health, where "culture" provides both the reason for illness as well as the cure, "tradition" also provides the means for illness through lack of logical education and cure through ancestral wisdom.

The weaving of "culture" and its association to "tradition" in the narrative of education and enforcement is best illustrated in an SHCOC public health meeting I attended on 28 October 2002 in which the District Attorney presented "Fraudulent Health Providers and Illegal Dispensers of Prescription Drugs." In his presentation he emphasized that Selen Seguro Rios did have medical insurance, but "unfortunately turned to old world medicine," without clarifying what "old world medicine" is or acknowledging that the dyprone injection is a biomedical "new world" product. He surmised that reasons why people seek treatment from unlicensed providers include not having to fill out paperwork, and language fluency, in that unlicensed providers speak Spanish, consequently interpreting Latino as "Spanish-speaking."¹² Throughout the entire meeting, the District Attorney emphasized the importance of regulating illegal behavior sourced in "culture," such as the dispensation of pharmaceuticals and services without proper licensing. As he explained, "I don't understand but then again it's from another *culture* and they bring it with them along with problems."

The final pervading question the District Attorney asked was why anyone with insurance, or with the knowledge of the services available at free clinics, would seek medical treatment in illegal places, and also admitted that "migrant people keep coming in with customs and beliefs." Underlying the District Attorney's presentation were the concepts of appropriate and inappropriate accessing of health care in relation to rational and irrational decision-making processes derived from traditional cultural belief systems.

Following the District Attorney's presentation, I presented preliminary data about the behavioral reasons cited for people identified as Latino to visit botánicas as sites for alternative medicine. The three primary reasons I explained were (1) holistic view of the body; (2) dynamic counseling between health practitioner and client; (3) personal difficulties previously experienced with biomedical treatment obtained through conventional sources. The District Attorney responded that the Latino population he referred to was distinct from the one with which I had worked, each seemingly impinging upon the other. His interpretation seemed to be contingent on a dichotomous victim/predator model, whereby the information I described related to the former and his to the latter.

The difficulty in understanding how to interpret and effectively employ diacritical referents is further explored in the following interview with the Executive Director of Maternal Outreach Management System (MOMS) Resource Center and the head of the health subcommittee for the Santa Ana

¹² As Santiago-Irizarry (2001) indicates, language proficiency regardless of class and socioeconomic status does not uniquely translate into interpersonal skills often assumed in cultural competency health programs.

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13 Santa Ana received Federal Empowerment Zone (FEZ) designation through the US Department of Housing and Urban Development (HUD) in 1999 for a four-square mile geographic area as a result of being identified as distressed (e.g. below average and decline in per capita income, earnings per worker below county average, number of persons on welfare higher than county average, per capita property tax base low, average number of years of school completed lower than county average, illiteracy rates high, school dropout rates high, teen pregnancy highest in the county, substantial population increase, increase in safety concerns, increase in health problems). The Effective Strategic Plan and Executive Summary identified Health as one of 10 areas of emphasis. The other areas include Education, Job Training and Placement, Business Development, Safety, Childcare, Transportation, Housing, Recreation and Youth, and Arts and Culture.

Empowerment Zone¹³ and her assistant. MOMS is a non-profit organization in operation since 1992 that provides health resources for pregnant and parenting women in Orange County, with 65% primarily Spanish-speaking female clients. I conducted this formal interview in February 2001 in a conference room at MOMS, and focused on the opinion of botánica services in Santa Ana:

KH: What are some of the things that they [your clients] say about why they visit botánicas?

ED: I think that our clients will view, take a stereotype which is the least dangerous to you, that they will view the doctor as this powerful authority figure, while the woman at the botánica is someone they respect but she's a friend. She'll listen and there then lies the difference. And you know, *I don't see a whole lot of difference between our clients going to botánicas and the middle class Caucasians going to Trader Joe's or GNC.*

A: I haven't seen much difference in it, really. The botánicas always have that spiritual side to it, but in some ways it's, it's prevalent throughout, all of our, and I think that might be why there's a proliferation too. Two years ago insurance companies did not even address chiropractic or acupuncture, for that case, and now all these things are becoming part of our norm. So yeah, I think alternative medicine, you know, has added to that, because *I think that there are also other cultures using the botánicas, not just the Latino culture.*

KH: What do you mean?

A: Um, other cultures that are here if they can't get their hands on certain herbs, one way or the other, will go to a botánica. Ortiz, you know somebody [speaking to someone in the other room]? Like I just met one of the development directors at a meeting last week, who said that he's had this cough for four weeks, you know, and he said "*my wife is into all this traditional medicine,*" so he's having, "I'm taking my Echinacea, drinking all these different teas." Well, she has to get them somewhere, and if you don't want to order from catalogues, you are going to go to a botánica and get them, get them cheaper and by hand, rather than opening a catalogue and ordering them.

ED: I think they sell Echinacea at Target.

A: Right.

Further in the interview, the Executive Director referred to purchasing herbs from botánicas and potentially establishing relationships between botánicas as distributors of alternative medicine and mainstream health centers:

ED: As we go forward with wanting to look [at] developing relationships with botánicas so that there can be referrals made. I'm not sure for the first couple of ways *unless I can I find out that I can buy my Echinacea there cheaper than I can at Target.* But I know that we can help the botánicas. "Look we're not trying to put you out of business. We're not disrespectful of

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what you're doing" and the, you know, you don't have to have an M.D. behind your name to be able to become and we can say "send them to us" and then we'll help them. We'll see, I mean I think it's in its embryonic stages.

We'll see how that goes. (*my emphasis in italics*)

This interview excerpt illustrates the colloquial weaving of health narratives and the ambiguities that CAM designations presuppose. Other "cultures," not simply "Latino culture," are using TM, which is primarily identified as the use of herbs in the form of herbal supplements and teas. And culture-ridden botánicas are not solely responsible for herbal distribution; Target also carries Echinacea. Here, botánicas are defined as falling within the alternative rubric and interest is shown in their potential mercantile aspect of selling Echinacea inexpensively. While the intention is to view the products and services of botánicas alongside other viable alternative health providers, it is important to ask, what is implied by the expectations that botánicas provide products (e.g. Echinacea) at a reduced rate in comparison with conventional outlets (e.g. Target)? In using the Latino label to refer to "traditional" products and services, it can be inferred that Latina/os are put in a double bind of competing attributions: to provide alternative medicine as defined by biomedical parameters *and*, simultaneously, to provide these products at a reduced rate. If this transaction does not occur, do Latino beliefs and practices remain "traditional" and "folk"? Or can they become "complementary" and "alter-native" without losing Latino "culture"?

Losing folk, becoming alternative: latino CAM

The public health respondents interviewed for this study used the term "tradition" as a means to describe aspects of Latino "culture" as it pertains to health practices. For the BBHP Director, "tradition" stemming from "culture" harbors illegal behavior and activity, while the SHCOC Program Director and MOMS Executive Director see value in "traditional" remedies as long as they conform to standards derived from biomedicine and the market economy. Moreover, the District Attorney condemns "old world medicine," without acknowledging diversity and contextual experience. Herbal remedies are particularly acceptable based on the biomedical definitions described by the NIH and the WHO. Consequently, labeling Latino practices as CAM instead of TM allows for the negotiation of status within a biomedical framework. In an article about culturally appropriate health care for Latinos, Gomez-Beloz and Chavez (2001) define Latino CAM services and practitioners as *curanderismo*, *espiritismo*, *hierberismo*, *sobador* (massage), *quiropático* (chiropractic), and *homeopata* (homeopath). Throughout the article, and because of national and international interest in CAM-defined practices, definitions of "folk" and "traditional" are interchangeably used with

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“complementary” and “alternative” ones, resulting in a method by which to market “folk” practices as “alternative” (Classen and Howes, 1998). Biomedical hegemonic discourse provides the structure for defining sets of beliefs and practices that do not operate solely in biologized ways. By using the terms “complementary” and “alternative” instead of “folk” and “traditional,” Latino/a ideologies are validated as modern through the invocation of a contemporarily accredited label. While this is a well-intentioned effort, it also creates the need to critically examine contemporary experiences of “folk” and “traditional” to better understand what these terms signify in present time. The following section offers to do so with a commonly identified Latino folk illness.

A case of modern *susto*

Susto is described in anthropological texts as an illness having a particular etiology and set of expected experiences. Based on fieldwork conducted in Oaxaca, Mexico, Arthur Rubel (1984, 6) describes *susto* through a series of symptoms with the primary feature being the loss of a vital substance, such as the soul, that results from having a frightening experience. Common interpretations reduce this definition as simply “soul loss.” The resulting physical consequences are restlessness during sleep and otherwise listless, debilitated, depressed, and indifferent to food and to dress and personal hygiene. At the forefront of Rubel’s (1998 [1964]) description is his attempt to understand the multi-dimensional experience of illness, which includes the interaction between social and biological factors. In recognition of this and to further explore the meaning behind a modern experience of *susto*, the following ethnographic interview is introduced in an effort to provide broader meanings within and about cultural contexts, recognizing that contexts shift and hardly remain fixed in spatial or temporal locations.

14 Pseudonym.

I conducted the following interview with Celestina,¹⁴ a 56-year-old woman originally from Mexico, in May 2002, in a waiting room at the UCI Family Health Center located in Santa Ana, California. It was initially intended to be an exploratory interview and resulted in a 2-h, heart-wrenching empathetic emotional exchange between us. I approached Celestina in the same manner I approached other potential interview subjects, by introducing myself while she waited for an appointment to see a physician and asking if she would like to participate in this study. In Celestina’s case, she was taking care of her granddaughter while they both waited for her daughter to finish with her medical appointment. Here is her account of *susto*:

C: But it was because [he] said I had bile, well I carried *susto* (fright), right?

And this was what made me feel like this, the *susto* (fright) I took with me.

KH: What does it mean to “carry fright”?

C: A bad, an impression, well, of a misfortune, an accident of sight.

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Here, Celestina describes *susto* as “an accident of sight,” “an impression of a misfortune” but does not make reference to the loss of vital substance, or her soul. Below she explains what caused her to “have an impression.”

KH: But, do you know what shocked you?

C: Yes, a misfortune that happened.

KH: Can I ask you what this was?

C: Well, of a son who took medication; he fell in a depression. And, well, he fell in a depression and I took him to ask for psychological help.

KH: Here in the United States?

C: At a clinic in Santa Ana. I took him and they gave him a medication called Prozac. And he had just a few days taking it and, well, with this medication instead of helping him...[starts crying]

KH: What happened to him?

C: Well, it came to him, I don't know, he, when he fell into a depression he was just sad, quiet, and well worried. And he would say that he wanted to die because he no longer wanted anything and he didn't have, well, he couldn't work because of how bad he felt.

KH: How old was he?

C: Twenty-three years old. And, then, I told him that he needed professional help and I took him. And, well, but there the doctor, a therapist saw him. He then saw a psychiatrist and afterwards the psychiatrist sent him a medication called Prozac. And he told him to take it, that it was an anti-depressant, that it was going to help him with his depression. And he gave him medicine to sleep at night. But the doctor never, never, never told me. I went in, I went in with my son with the therapist and the psychiatrist and I, well, because he, when he's depressed he doesn't want to tell what is happening to him and that's why I took him there so that he could talk with that doctor. And I well told the doctor that my son, that he wanted to kill himself and I. Well, I tell you, he fell in a very strong depression but the doctor never told me that you're not supposed to leave him alone. No, no, no [crying] or what could happen, the medicine or nothing. And my son committed a crime with a child.

KH: Under this medication?

C: And that was what made him commit the crime. And my son is imprisoned [crying]. I got very ill when I carried this impression.

Celestina then spoke about the psychiatric assistance she received at another clinic as well as her visits to a *Naturista*.

C: And, well, they gave me professional help also because I was very bad. And, well, the Miss told me that I was very bad because every day I was deteriorating. I couldn't, I couldn't understand why all this had happened. And then, well, I saw a psychiatrist and they gave me medicine, I just don't remember what it's called, but I didn't want to take it. I told that, that I didn't want to happen to me what happened to my son with that medicine. It wasn't the same one but perhaps something could happen with, or

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something, right? And I was very scared. Then, because a daughter of mine got me an appointment with the Naturista and took me, the Naturista raised me (made me feel better).

KH: And, then, he gave you...

C: All the medicine, Ultra Stress, the herb, there are medicines I don't remember and I felt very good. That raised me. I have very much faith. I have a lot of faith in the Naturista because he helped me very much to overcome all that was happening and it wasn't necessary for me to take the psychiatrist's medicine.

KH: Then you didn't return...

C: Yes, I kept going and since I was going [to the psychiatrist] once a week when the Miss saw me she said that she was happy because she saw that I was doing better, right, that she didn't see me so bad.... And then she told me, "The medicine really helped you." And I told her, "Yes, but the Naturista's [medicine] not yours."

In this ethnographic example, the narrative weaving of many elements in the descriptions of symptoms and healing treatments is apparent. As mentioned previously, Celestina does not describe her soul or other vital substance leaving her body as a result of *susto*. Instead, Celestina gives meaning to her experience through the discourse of fear. Her physical reaction to her son's behavior is immediately made apparent by her inability to "hold down food." Of importance is the cause of Celestina's illness which she strongly associates with the biomedical remedy prescribed to her son for his psychiatric diagnosis of depression. Her initial impression of her son's depressive behavior causes fear as does witnessing his experience with biomedical treatment. Fear of biomedical treatment proves to be the culprit of physical malady in this *susto* case without the "folk" experience of "soul loss" verbalized. Celestina believes that biomedicine is the source of her son's incarceration and consequently is weary of seeking treatment from this source. Instead, the *naturista* provides emotional solace by listening to her alongside the use of herbs and vitamins. For Celestina, the "raising" she describes is two-fold: the *naturista* alleviates her emotional discomfort *and* remedies the physical repercussions that result from *susto*.

This account highlights the inadequacy of applying reductionist interpretations to Latino-defined folk illness and offers a contextualized explanation for the use of "traditional" methods. As Ross and Jeczewski's (2002, 374) suggest, "anthropologists and healthcare providers cannot assume that any one group or individual subscribes to folk or biomedical information in their traditional forms." As Celestina explains, she experienced *susto* as a result of the consequences of her son's behavior while under the influence of a biomedical substance legally prescribed by a physician. She is willing to seek biomedical treatment but weary of its results. Here, she is not acting in "traditional" ways solely as a result of cultural familiarity by visiting the *naturista*, but, rather

specifically as a result of her experience with biomedicine. "Tradition" and "traditional" do not prove to be useful identifiers here, especially when analyzing the context in which treatments are sought in the United States (Chávez, 1984). As Celestina's experience illustrates, a problem with "folk illness" categorizations is that they can assume temporal fixations without regard for contemporary experiences. I provide this rich ethnographic account to underscore the importance of context in interpreting health-seeking behavior identified as culture-bound.

Latino health practices: "folk," "traditional," "complementary", or "alternative"?

In Orange County, California, public health interest in the use of "traditional" methods was sparked by the deaths of Selen Segura Rios and Christopher Martinez where their respective parents were criticized and blamed for resorting to traditional cultural methods by seeking assistance at unlicensed clinics, or as the District Attorney indicated, turning to "old world medicine." However, their deaths as well as Celestina's experience with *susto* were all clearly marked encounters with biomedicine in the modern world. The deaths of the two toddlers incited an investigation of "traditional" methods and places where the concept of illegality was embedded in a broad understanding of Latino "culture." In fact, "culture" was targeted in the educational campaigns as the primary source for health-seeking behavior deemed to be dangerous. As the Binational Border Health Program, the District Attorney, and MOMS Executive Director show, categorizing Latino health traditions based on "culture" can embed dynamic beliefs and practices in a static past that provides both ancestral wisdom and ignorant logic, a cause for potentially illegal behavior.

As this article indicates, the use of the terms "folk" and "traditional" carry with them particular connotations different from "complementary" and "alternative" in reference to health beliefs and practices. Knowledge is not monolithic and actors, including those who are defined as ascribing to indigenous, traditional, or local knowledge systems (Gupta, 1998; Zhan, 2001; Walley, 2002; Santiago-Irizarry, 2003), are eclectic in drawing upon different domains, especially when experiencing illness. As Santiago-Irizarry (2001, 118) reminds us, "Naming and defining are inherently exercises in power." In the area of Latino health it is important to understand what is being labeled and how the labeling process affects those identified as Latinos and Latinas.

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