DOCUMENT RESUME

ED 247 045 RC 014 821

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TITLE Ethnicity and Health: Mexican Americans. A Guide for Health Care Providers.
SPONS AGENCY National Fund for Medical Education, Cleveland, Ohio.; National Inst. of Mental Health (DHHS), Bethesda, Md.
PUB DATE 84
GRANT MH-00047
NOTE 27p.
PUB TYPE Information Analyses (070) -- Reports - Descriptive (141) -- Guides - General (050)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Acculturation; Cultural Background; *Cultural Influences; Cultural Traits; *Ethnicity; *Folk Culture; Health; Health Activities; *Health Education; *Mexican Americans; Professional Continuing Education; *Traditionalism
IDENTIFIERS Cultural Values; Curanderismo; *Folk Medicine

ABSTRACT

Several characteristics and perspectives of how Mexican Americans regard health care are presented for health care providers. Following a brief discussion of culture and health, the guide describes the traditional and modern value orientations of Hispanics and the external forces that contribute to their adoption. Four key concepts to understanding interpersonal relationships among Mexican Americans are discussed: dignity, respect, hospitality, and personal interactions. Perspectives of the following five major types of indigenous healers in the Mexican American folk-medical tradition are provided: curanderos, yerberos (herbalists), sobadores (folk chiropractors), senoras (professional readers of tarot cards), and parteras (lay midwives). Signs and symptoms generally recognized in Mexican American communities as indicative of illness are listed, along with home remedies involving herbs, vegetables, minerals, and animals. A description of some of the major Mexican American folk illnesses and their folk explanations is followed by an overview of several features which distinguish folk medical systems in general and Mexican American folk medicine in particular. The guide concludes with some general guidelines for providing health care to traditional Mexican Americans. (NQA)

# ETHNICITY AND HEALTH: MEXICAN AMERICANS

## A Guide for Health Care Providers

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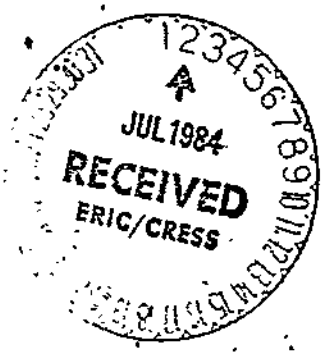



1983 - 1984

Preparation of this document was supported in part by a grant from the National Fund for Medical Education and by grant number MH 00047 from the National Institute of Mental Health.

# CULTURE AND HEALTH

The concept of culture, as used by sociologists and anthropologists, refers to the sum total of human heritage. Put somewhat differently, culture is the distinctive way of life of a group of people, their complete design for living.

Culture consists of language, customs, codes, institutions, techniques, tools, concepts, beliefs, etc.

Viewed another way, the components of culture are:

1) physical (artifacts and edifices)
2) behavioral (such as kinship patterns and child-rearing practices)
3) symbolic (language, beliefs, attitudes, and norms)

Culture determines our attitudes, beliefs, knowledge, and behavior about illness and disease, including what signs and symptoms are legitimate, what we do about them, and how others react to our illness.

The impact of culture on health occurs in at least three ways:

1) As etiologic agent - For example, through diet, mating patterns (genetics), child-rearing practices, beliefs about causes of disease, social change and social stress.

2) In symptom formation - Different cultural groups perceive, label and respond to common sets of signs and symptoms in diverse ways; in fact different cultural groups employ their own distinctive taxonomies of disease with the salient signs and symptoms, thereby directly influencing diagnosis.

3) In therapeutic response - Culture defines what illnesses should be treated, when treatment is appropriate, how an illness is treated (in terms of available technology and knowledge), and who treats the illness (legitimate healers).

Every cultural system is composed of smaller components, the most important of which (for our purposes) are subcultures, ethnic groups, and minority groups.

Subcultures are variants within a larger cultural context, i.e., groups defined in terms of geographic location and/or ethnicity, primarily.

Ethnic groups are collectives identified in terms of kinship patterns, religious affiliation, language or dialect, national origin, and physiognomy (primarily skin color).

Minority groups are ethnic groups which are usually, but not always, numerically smaller than the dominant ethnic group and also are disadvantaged by virtue of having less power, privilege and prestige (examples: Chicanos, Blacks, Puerto Ricans).

Ethnicity and minority group status are examples of what behavioral scientists call "ascribed status", that is, a status attribute which is determined at birth and generally remains fixed throughout life. Example: sex, race/skin color, caste (as in India).

By contrast, "achieved status" is an attribute an individual acquires by virtue of his or her actions, such as education, occupation, spouse, parent.

Three fundamental aspects of ethnicity (Harwood, 1981):

1) Ethnicity establishes social ties by reference to common origins, i.e., it is transgenerational.

2) Ethnicity also implies that the people of a particular group share at least some learned standards of behavior - that is, symbols or social norms that shape the thought and behavior of individual members.

3) Ethnic groups participate with one another in the larger social system (the result of this interaction defines identity of group and its status relative to other groups).

In America, two somewhat different kinds of ethnic manifestations have been observed (Harwood, 1981):

1) Behavioral ethnicity (sometimes referred to as old ethnicity), in which distinctive values, beliefs and behavioral norms and dialects are learned during early socialization. In this context ethnicity functions largely as an ascribed status, since you are born in and grow up in the ethnic collective. Examples are first and second generation immigrants and minorities with a history of exclusion from power (Blacks, Hispanics, Native Americans).

2) Ideological ethnicity (sometimes called new ethnicity), which is based largely on customs that are neither central to a person's life nor necessarily learned from early socialization, i.e., food preferences, holidays, clothing, or other outward manifestions. Examples of this type of ethnicity would be individuals who "go back" to their cultural origins by adopting largely external indicators of the ethnic group.

In every society groups occupy different positions with regard to the amounts of power, privilege, and prestige which they enjoy. The ordering of ethnic groups in America is based primarily on the interaction of three factors:

1) Class - The amount of economic power (wealth) controlled by the collective, particularly in terms of the group's relationship to the means of production.

2) Color - The color of the skin and other distinctive physical attributes such as facial structure (nose, lips, eyes) and amount of facial or body hair.

3) Culture - In particular, language, religion, and national origin.

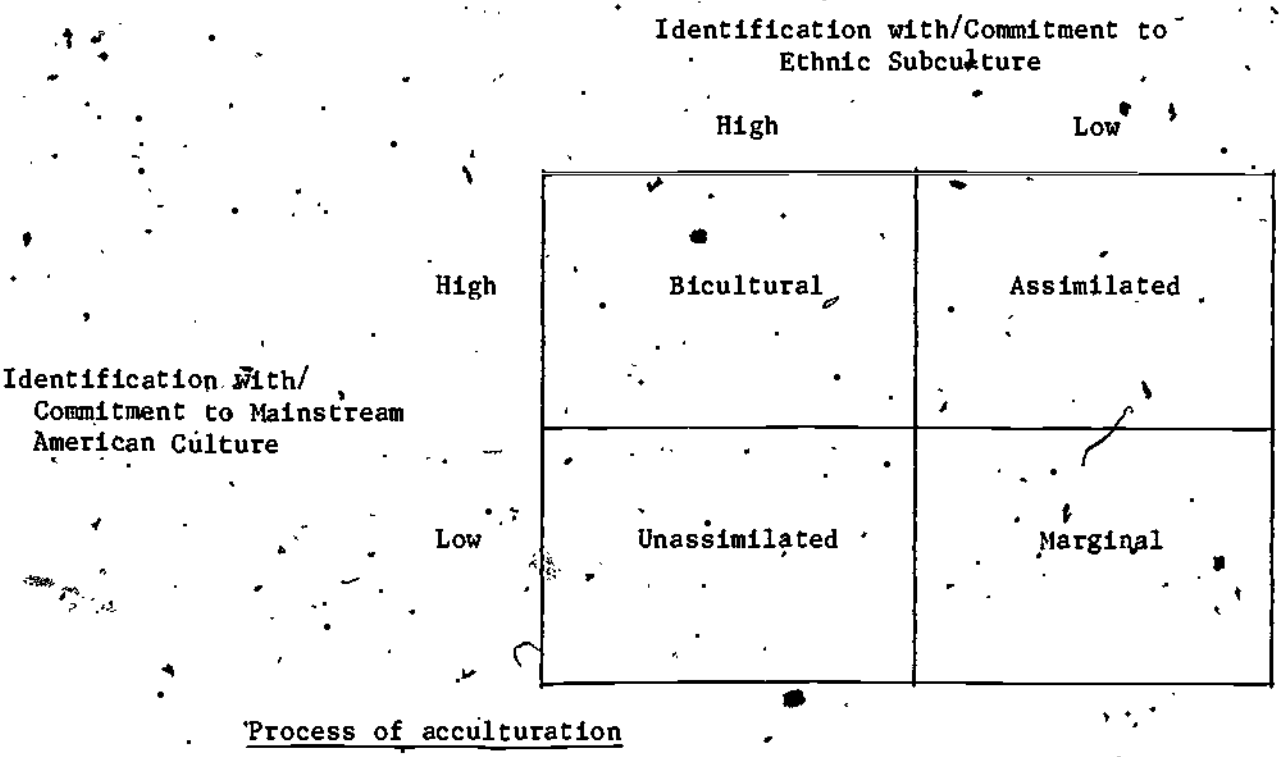
In American society, the more a group departs from being light-skinned, upper status, English-speaking, Protestant, and Northwest European in origin, the lower the status, the greater the discrimination and the longer the time required for assimilation.

Acculturation is the process by which members of a subculture take on elements from the culture of another. When a collective has fused completely with the larger society it is said to be assimilated. In other words, acculturation has been total. Accommodation occurs when there is mutual adjustment of interacting groups so that each retains its own identity and interests.

Figure 1 is an attempt to define American cultural types in terms of where the group falls in the acculturation process. The fourfold table is entered in the lower lefthand cell, representing newly arrived immigrant groups or groups isolated from the dominant cultural themes by geographic and/or cultural factors. The process of acculturation is generally toward the upper righthand cell, or toward assimilation, although many would argue that complete assimilation, in terms of a totally homogeneous society, is rare indeed. Biculturality consists of an accommodation between the culture of origin and the dominant culture so that individuals move freely between the two. Marginality, on the other hand, is an example of when someone has rejected, or been rejected by, both the culture of origin and the dominant culture. The marginal individual is in, but not of, either culture.

FIGURE 1

AMERICAN CULTURAL TYPES



Examples of persons falling into these four categories are found in every ethnic collective. However, the relative proportions of people in each varies by group, based on considerations of class, color, and culture (as noted above).

In fact, due to these factors, the time required for acculturation or, more specifically, assimilation, can vary tremendously. In their discussion of this process some years ago, Broom and Selznick (1963) presented a detailed analysis of ethnic groups in America and their assimilation experience. Although somewhat dated now, the central theme is still appropriate. Table I presents some central examples from their classification. As can be seen, for those groups who are nonwhite, non-Protestant, non-European, and non-English-speaking, the time required for assimilation is very long.

Table 1

Examples: Ethnic Groups*

| Cultural Type | Skin Color | Degree of Subordination | Time for Assimilation |
|---|---|---|---|
| 1. English-speaking Protestants (e.g., English, Scots, Canadians) | light | very slight | one generation or less |
| 2. Non-Protestants not speaking English (e.g., French, Belgians, Italians) | light | slight | 1-6 generations |
| 3. Non-Christians not speaking English (e.g., fair-skinned European Jews and Mohammedans) | light | moderate | 1-6 generations or more |
| 4. Non-Protestants not speaking English (e.g., dark skins of Racial Type I, also Sicilians, Portuguese) | dark | moderate | 6 generations or more |
| 5. Non-Protestants not speaking English, mixed race (e.g., small groups of Spanish-Americans in the Southwest) | dark | great | very long |
| 6. Orientals, Blacks (e.g., most American-born Chinese, Japanese, Negroes) | nonwhite | great to very great | very long to indefinitely long |
| 7. Non-Christians not speaking English, foreign-born (e.g., Orientals and Africans) | nonwhite | great to very great | indefinitely long |

*Adapted from Table XIII:3, Broom and Selznick, 1963.

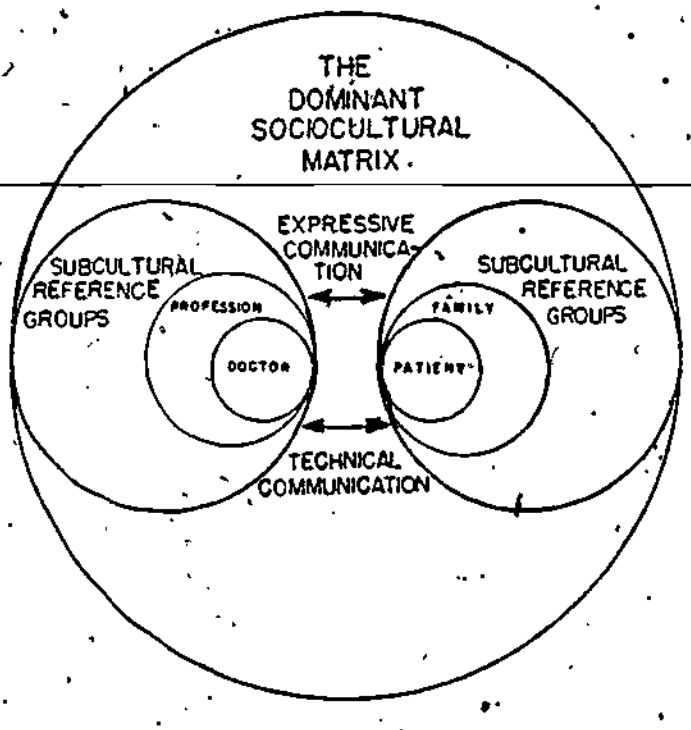
Not only ethnic groups have distinctive cultures. Medicine is a subculture itself.

The culture of medicine consists of those practices, methods, techniques, tools and substances, together with a set of values, traditions, and beliefs, that provide the means of maintaining health and preventing or ameliorating disease and injury to members of society.

The medical encounter involves the interaction of at least two subcultural contexts, that of the physician and that of the patient. And both of these are imbedded in the larger cultural milieu.

FIGURE 2

THE TOTAL COMMUNICATION SYSTEM




Adapted from Bloom, S.: The Doctor and His Patient. Russell Sage Foundation, 1963.

Figure 2 is an attempt to depict the interaction of the physician and the patient, both influenced by their respective cultures.

The two respective "cultures" provide (according to Goodenough, 1963),

standards for deciding what is

standards for deciding what can be

standards for deciding how one feels about it

standards for deciding what to do about it

standards for deciding how to go about doing it

As long as there is congruence between the culture frameworks of physician and patient, there is reasonably smooth interaction, subject to the vagaries of individual styles.

The greater the disparity, the greater the potential for problems.

The greatest potential for problems occurs with lower status patients, particularly those from ethnic minorities (such as Blacks, Hispanics, Chinese, etc.).

Now let us consider how patients from one ethnic collective, Mexican Americans, may present a perspective somewhat different from that which most physicians bring to the medical encounter.

## MEXICAN AMERICANS

Mexican Americans represent an interesting and important ethnic population, from several perspectives.

First, Mexican Americans constitute the largest minority group in Texas and four other Southwestern states (Arizona, California, Colorado, and New Mexico), and the second largest ethnic group in the country (after Black Americans). For example, more than 1 in 5 Texans is Mexican American or Mexican in origin (over 3 million in 1980), compared to 1 in 3 in New Mexico and 1 in 5 in California. Altogether, there were over 9 million Mexican Americans living in these five Southwestern states in 1980. About 4 out of 5 live in large metropolitan areas such as Los Angeles, San Diego, Phoenix, El Paso, San Antonio, and Houston. In fact, in some urban areas Mexican Americans now constitute half or more of the population.

Second, compared to the general population, Mexican Americans are a disadvantaged minority, having less education and income, and larger families than other groups. For example, about 1 in 4 has less than a junior high school education, the median family income is only about half the national average, and family size is about 25 percent larger (average family size is 4).

Third, Mexican Americans are culturally distinctive in terms of language, national origin, and particularly, in terms of their indigenous health system. The overwhelming majority of this population uses Spanish at least part of the time and a substantial minority have difficulty with English most are Catholics, a substantial proportion are only one-two generations removed from Mexico, and many practice, or at least have some familiarity with, elements of curanderismo, or Mexican American folk medicine.

Fourth, although health data for this population have been sparse historically, data are becoming increasingly available and these data suggest that Mexican Americans are somewhat disadvantaged in this regard as well. For example, Mexican Americans have somewhat higher infant mortality, particularly post-neonatal mortality, related probably to their disadvantaged economic status. They also have a somewhat lower life expectancy, overall, and markedly higher death rates for diabetes mellitus, infectious and parasitic diseases, influenza and pneumonia, and digestive diseases (Roberts, 1977). In terms of their use of medical services, Mexican Americans are less likely to have a regular source of care (such as their own family physician), to have health insurance, and to get regular medical and dental examinations. Although in general Mexican Americans seek medical care somewhat less frequenly in response to signs and symptoms than the general population, when social class is held constant, the rate of medical care utilization for symptomatic relief is comparable to that of other groups with similar socioeconomic status (Roberts and Lee, 1980). Likewise, although some early studies reported lower utilization of mental health services by Mexican Americans, more recent studies report little or no difference between Mexican Americans and other groups, particularly when services are available and accessible and language and cultural barriers are minimized (Cuellar and Roberts, 1983).

## Value Orientations

Levine and Padilla (1980) present an excellent discussion of two major value orientations of Hispanics in the United States -- traditional and modern. Traditional value orientations are more pronounced among older Hispanics, recent immigrants, the rural, and the poor. Modern value orientations are more prevalent among the more affluent, more acculturated Hispanics. What do Levine and Padilla mean by "traditional and modern value orientations"? They describe eight value orientations: (1) familism; (2) patriarchal family structure; (3) passive attitude toward stress; (4) physical combativeness; (5) present-time orientation; (6) machismo; (7) field-dependent orientations; and (8) folk medicine.

Traditional Mexican Americans are more present- rather than future-oriented. Great importance is attached to present experience, particularly personal relationships. There is also a belief that future events are "in the hands of God," and that an individual can exert only minimal control over future events. Traditionally-oriented Hispanics also believe that events are determined by forces outside their control, so that the emphasis is on coping with adversity, rather than actively fighting against it. Traditional Mexican Americans place a high value on affiliation, the need for warm, mutually supportive relationships. The family is also a central component of a good life. There is emphasis on the extended family, including godparents (comadres and compadres). Grandparents and godparents are highly influential and children are encouraged to seek their counsel and assistance. Family issues typically supercede individual issues. The family structure is usually patriarchal, with the husband considered the

primary economic provider and decision-maker. Machismo is associated with maleness (often in a derogatory manner in the media). However, the concept in Hispanic culture connotes male assertiveness, virility and sexual vigor, strength, and justice. It also may involve sensitivity to insult and a tendency toward physical combativeness. Traditional Hispanic females are generally subordinate, and committed to home and family. Children are expected to be respectful and obedient to adults, and are taught to be dependent on their parents and supportive of their siblings. Traditional individuals are more field-dependent; that is, they tend to interpret an event in relation to its surroundings rather than making interpretations about it by focusing on its features. Regarding health and illness, traditional Mexican Americans are much more likely to have knowledge of, belief in, and be practitioners of curanderismo, traditional Mexican-American folk medicine.

By contrast, Mexican Americans with a more modern value orientation, essentially those who have been upwardly mobile in terms of social class, are similar to other upper status persons in value orientation. That is, there is more emphasis on individualism, the nuclear family, egalitarian familial relationships, an active attitude toward stress, future time orientation, field independence, and a reliance on modern, scientific medicine as the main source for coping with health problems. But even middle class Mexican Americans may encourage their children to speak Spanish and may encourage a knowledge and appreciation of Mexican history and culture. For example, the institution of compradrazgo still is observed by many middle class Mexican Americans, although it often implies a bond of friendship rather than a religious bond of coparenthood (Levine and Padilla, 1980).

There are also four key concepts to understanding interpersonal relationships among Mexican Americans: dignity, respect, hospitality, and personal interactions. Dignity, or dignidad, is a trait generally attributed to Hispanics and highly valued by them. One should behave and treat others with dignity. Another trait of great value is respeto (respect), treating others with proper recognition of their status (particularly the elderly) and properly observing social customs. Hospitalidad, or hospitality, is the practice of entertaining travelers and strangers (mi casa, su casa). Personalismo is the desired way of interacting with others, dealing with others on a very personal or intimate level. Traditional Hispanics will adhere to all of these preferred modes of behavior and, more importantly for health care providers, will expect others to do likewise.

Garcia (1982) has recently identified a set of behavioral and attitudinal preferences which identify a traditional cultural orientation among persons of Mexican origin in the United States. He divides these orientations into "cultural" and "associational" preferences of Mexican Americans. Under cultural preferences, Garcia lists preferences (1) to visit Mexico frequently or maintain contact with Mexico; (2) to read about Mexico; (3) to watch Spanish television; (4) to see or hear Mexican entertainers; (5) to speak Spanish; and (6) to celebrate traditional Mexican holidays such as May 5 and September 16 (independence days). Under associational preference are: (1) having co-workers of Mexican origin; (2) living in a Mexican neighborhood (or barrio); (3) attending Mexican churches; (4) visiting or having visitors of Mexican origin; and (5) having Mexican-origin friends and playmates for children.

Recalling Figure 1, you would expect to find the most traditional Mexican Americans, those with the strongest Mexican cultural orientation, located predominantly in the unassimilated category, or in transition to biculturality or early in the process of assimilation.

Figure 2 depicts the content of traditional and modern value orientations as described by Levine and Padilla (1980), and suggests the forces in society that may impede or facilitate the process of acculturation, in the sense of adoption of one or the other core set of values. The arrows on the top and bottom of the diagram show forces that tend to keep the two spheres of values separate, such as rural origin, recent immigration, lower socioeconomic status, barrio life, etc. The arrows on the sides depict forces exerting pressure for fusion of the value sets, in particular, dominance of the modern set, such as reduced prejudice, equal opportunities in education, employment and housing, urbanization, and minority political power.

An important thing to bear in mind in regard to the values of individuals, however, is that because of idiosyncratic values and changing life-styles, a particular individual may hold mixed values. One cannot assume that value-sets are monolithic, or that because you have a knowledge of values in one area of life you can necessarily infer others from that knowledge.

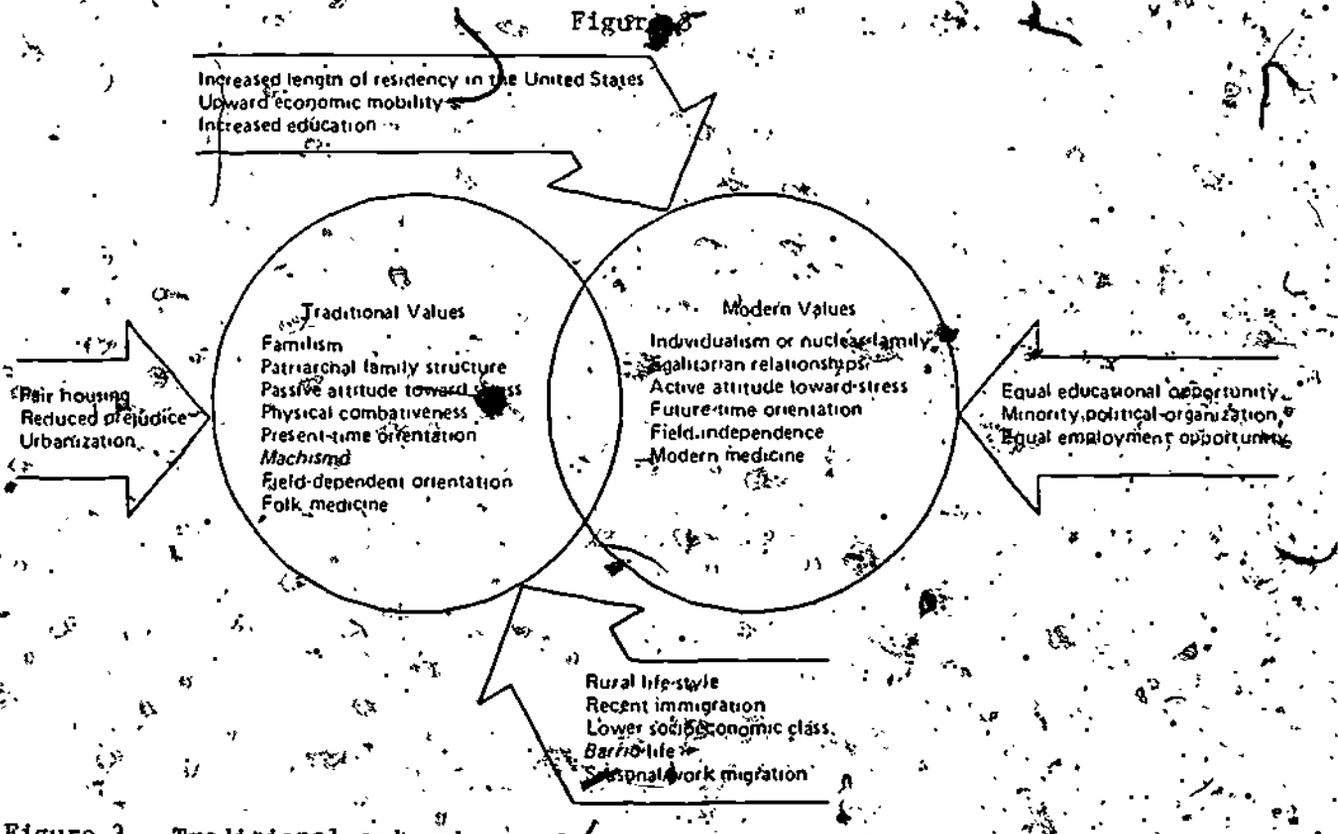



Figure 3. Traditional and modern values and the external forces that contribute to the adoption of one or the other set of values or of a combination of the two.

*barrio = ghetto in an urban area; in the semi-urban areas of South Texas (often unincorporated), the ghetto is called a colonia.

Concept of Health.

Like many groups, Mexican Americans tend to define health as an absence of pain and an ability to perform socially expected roles. Thus there is a tendency not to accept the sick role if there are no overt symptoms or if the illness does not engender obvious role impairment. However, among more traditional Mexican Americans there is also the belief that healthy people are robust, and that robustness is indicated by a well-fleshed body (Schulman and Smith, 1963).

In curanderismo, or the Mexican American folk medical system, the concept of etiology of disease is an admixture of Spanish medical knowledge and native American beliefs dating from the sixteenth century conquest of Mexico by Spain. The Spanish element in this belief complex is a simplified version of Hippocratic humoral theory. In fact, the central derivation from humoral theory is the idea of balance, or homeostasis. In Mexican American folk medicine, health is believed to be the result of a balance between social, physical, and spiritual life domains. Curanderismo stresses that illness is caused by disequilibrium in life. One of the more prominent examples is the hot/cold theory of illness, in which illness is believed to result from exposure, either internally or externally, to excessive amounts of "hot" or "cold". Historically, "hot" and "cold" were determined not by temperature per se but by qualities believed to be inherent in individuals and in particular substances, such as medicines, air, foods or objects (Schreiber and Homiak, 1981). For example, water, night air, a cold floor, and "cold" foods are sources of extreme "cold". Examples of foods sometimes considered "cold" are raw eggs, avocados, citrus, beer, uncooked greens such as lettuce or cabbage, carrots, watermelon and vinegar. Strong emotional experiences, fright, exposure to the sun, and "hot" foods are sources of excessive heat. Examples of some "hot" foods are vitamins, cola, liquor, raw milk, wheat products, brown sugar or molasses, pork products, hard-cooked eggs, black pepper, and goat milk products. Too much cold is supposed to be countered by eating "hot" foods, using emplastos calientes (hot-poultices) or drinking herbal teas. Too much heat is supposedly countered by rubbing the body with an uncooked whole egg, eating "cold" foods or herbal remedies, or by applying emplastos frios (cold poultices). Examples of neutral substances, which avoid extreme cold or heat, are beef, chicken, fish, vegetable oil, corn, beans, rice, white sugar, salt, apples, peaches, fried or scrambled eggs, and products made from pasturized cow's milk. Although the hot/cold theory of illness among Mexican Americans traditionally referred to the effect something had on the body, it increasingly refers to the actual temperature of a substance or of the bodily condition. In fact, Trotter and Chavira (1981) report that knowledge and understanding of the hot/cold theory is disappearing in the Mexican American community, except among the elderly and among folk healers. Few of their subjects in South Texas, for example, had any knowledge of this concept.

Two other notions of balance and illness should also be noted. The structural parts of the body are believed to have a specific place and function, and any change is presumed to cause illness (Scrimshaw and Burleigh, 1978). Also, loss of blood in any amount (even for laboratory tests) is thought to create an imbalance, weakening a person and causing illness. Blood loss is particularly feared by males, since it is believed to impair sexual vigor (Scrimshaw and Burleigh, 1978).

## Healers and Healing

There are five major types of indigenous healers in the Mexican American folk medical tradition. Curanderos(as) are the preeminent curers, analogous to physicians, who treat traditional folk illnesses and a variety of psychologically and socially disruptive complaints in the Mexican American community. Traditional curanderos attribute their healing power to God and refer to their healing ability as a gift - el don. As Trotter and Chavira (1981) point out: "Professional curanderos generally concentrate on handling serious physical ailments (diabetes, asthma, terminal cancer), on resolving difficult social problems (marital conflicts, family disruptions, business partnerships), on alleviating psychological disturbances (depression, impotency, conversion hysteria), on changing people's fortunes (luck in love, business, or home life) and on removing or guarding against misfortune or illness caused by hexes (mal puestos) placed on their patients by a sorcerer (brujo) or an evil spirit at the instigation of a rival or enemy. A number of different types of professional curanderos exist, and they are distinguished from one another and among themselves primarily by their curing technique or combination of techniques. It is these healers who know about and utilize the theories, as well as the specific practices, of the three technical areas or levels of healing: the material, spiritual, and mental." (p. 72)

Curanderos thus cure on three levels; the material, the spiritual, and the mental. At the material level, the curandero manipulates physical objects and performs rituals which create an atmosphere conducive to treatment. Ritual behavior alters the client's view of the problem and the treatment procedures relieve pain, anxiety, depression, insecurity, or whatever ails the patient. Practitioners at the material level employ herbs (such as oregano, manzanilla and anis); fruits (oranges, lemons, papaya); nuts (such as pecans); flowers (roses and geraniums); animals and animal products (chickens, doves, eggs); and spices (onions, garlic, black pepper). Religious symbols also are frequently used; for example, the crucifix, incense, candles, holy water, oils, and pictures of saints (Trotter and Chavira, 1981). The basic ritual at the material level is the barrida or spiritual cleansing, which often literally involves sweeping the body of the patient with a broom, palm leaves or other substances. At the spiritual level, used much less frequently, the curandero enters a trance and acts as a medium or direct line of communication between the client and the spirit world. The mental level is much less common than even the spiritual level among curanderos. It typically involves psychic healing in which energy is channeled directly from the mind of the healer to the client's afflicted area. (For a good dicussion of both spiritual and psychic healing in curanderismo, see Trotter and Chavira, 1981).

Traditionally, curanderos charged no fees, although grateful clients were expected to honor the care-giver with some type of gift. However, professional curanderos are assuming more and more of the trappings of the medical establishment, including offices with waiting rooms, appointments, fees, "black bags" and attendant paraphernalia such as pills and syringes. Trotter and Chavira (1981) argue that increasingly the curanderos have become the main caretakers of mental hygiene in the barrio. Their counsel includes all of the traditional types of counseling found within social work and psychology and focuses on courtship, marriage, financial, legal, social, and business relationships.

The other folk healers in the Mexican American community are yerberos(as), sobadores(oras), senoras, and parteras. Sobadores function as folk chiropractors who treat physical ailments using massage to relieve pain. They administer masajes for generalized pain or nervous tension and sobaditas for specific problems such as a sprain or cramp. Yerberos are herbalists, and are major sources of herbs and home remedies in the barrio. They sometimes operate small herb shops called botanicas, which also carry other folk medical supplies, both sacred and secular. Senoras in the barrio were traditionally older women (grandmothers, aunts) who were viewed as specialists because of their accumulated knowledge of folk remedies and practices. However, increasingly senoras are professional readers of cards (particularly in South Texas) who use decks of cards to make predictions about the lives of clients in three areas, health, home life, and social relations (especially legal and business matters). They use the 52-card American deck, the 40-card Mexican deck, or tarot cards. Parteras are lay midwives who usually have a fairly extensive knowledge of folk medicine, particularly herbs. Parteras are a significant adjunct to obstetrical care in some areas (Shreiber and Homiak, 1981; Trotter and Chavira, 1981). For example, in South Texas they deliver about 1 in 5 babies. Some advertise in the Yellow Pages, some have group practices, some provide prenatal and postnatal care, and many are affiliated with physicians and provide referral services as well. Some states (such as Arizona) license midwives; in Texas they are excluded from the Medical Practices Act, which in effect makes assisting in the delivery of a child a nonmedical behavior.

According to several observers (Trotter and Chavira, 1981; Shreiber and Homiak, 1981), Mexican American folk medicine, or curanderismo, takes a much more holistic approach to illness, not making the sharp distinction between somatic and psychosocial problems that scientific medicine has. Like scientific medicine, curanderismo dichotomizes illness. But whereas in scientific medicine the distinction is between somatic and psychologic disease, in curanderismo the distinction is between natural and supernatural illness. The natural/supernatural dichotomy refers to etiology, not signs and symptoms. Essentially any syndrome or illness can be caused by either natural or supernatural factors. Thus, there is a natural form of diabetes or heart disease, and a supernatural form, which is caused by a supernatural agent such as an evil spirit or a brujo/bruja (a sorcerer or witch). Natural illnesses can be treated successfully by physicians, by curanderos, or by using herbs or other physical remedies. Supernatural illnesses are not considered amenable to treatment by scientific medicine, only by curanderos. Not surprisingly, one of the key problems for a curandero is identifying the nature of the causal agent for a particular illness. In fact, a key factor in making a differential diagnosis for a supernatural form of an illness is its failure to respond to natural or physical remedies such as herbs, drugs, physical manipulation, surgery or other procedures, by the healer (whether physician or folk healer). The task of the folk healer then is to identify the supernatural source and intervene using a magical/religious cure.

The bulk of the treatment for folk illnesses as well as for many minor health problems of all kinds occurs at home, in the context of the family. In traditional Mexican American families the mother has preeminent responsibility for health care and help-seeking. The mother typically makes an initial assessment, and if she is unable to make a diagnosis or determine proper treatment, then consultation is sought. Traditional Mexican Americans generally involve significant others, particularly kin, in matters of illness. The relatives

usually sought out first are members of the immediate family, such as grandmothers or aunts, elderly women (señoras) with a reputation for knowledge of healing. Included in this lay referral network are the comadres and compadres, and in some situations, friends and neighbors. The latter assume added importance by virtue of their age and in the absence of relatives and compadres. The extended family's counsel is generally sought as a matter of course for serious health care decisions, particularly for surgical procedures, hospitalization, or referral to a new, unfamiliar, or distant source of care.

There are, according to Kay (1978), signs and symptoms that are generally recognized in Mexican American communities as indicative of illness; some of the more important are listed below.

| | |
|---|---|
| caliente (hot) | pujo (griping) |
| frio (cold) | moco (mucus) |
| resfriado (a cold) | sangre (blood) |
| sereno (chill) | erupcion (rash) |
| cansancio (fatigue) | ponerse palido (to become pale) |
| agotamiento (exhaustion) | azul (blue) |
| debilidad (weakness) | rojo (red) |
| incapacidad (incapacity) | amarillo (yellow) |
| tarantas (dizziness) | |
| calentura (fever) | dolor (pain) |
| basca (nausea) | dolor agudo (strong pain) |

When home care is the treatment of choice, therapy involves the use of remedios caseros (home remedies). Remedios caseros include (1) herbal teas and purgatives for digestive disorders; (2) liniments, oils, herbal mixtures, ventosas (cupping), and sobadas (massaging) for aches and pains, (3) dietary regulation (for example, hot/cold balance), (4) patent medicines (tonics, salves, laxatives, aspirin, mentholatum), and (5) religious or magical rituals such as prayer. The variety of materials used for home health care is enormous and varies widely, depending on knowledge and availability. Kay (1978) and Trotter (Trotter, 1981; Trotter and Chavira, 1981) give excellent discussions of remedios caseros. Table 2 is adapted from Kay's work in an Arizona border community to provide an idea of materials that are used and what problems they are used to treat. The listing is abridged from a tabulation containing about twice as many entries, and these were identified in a single small barrio in Arizona.

Table 2

Remedios Caseros - Home Remedies

| Spanish Common Name | English Common Name | Preparation | Use |
|---|---|---|---|
| **Herbal remedies:** | | | |
| Anil | bluing | crushed | empacho (indigestion) |
| Anis | anise | tea | colico (pain in the abdomen) |
| Azahar | orange blossom | tea | corazon (heart)<br>nervios (nerves) |
| Canela | cinnamon | tea | la tos (cough) |
| Canutillo | mormon tea | tea | sangre debil (weak blood) |
| Chicura | ragweed | solution | lavado vaginal (vaginal douche) |
| Chilipitin | chili | tea | atrasos de la regla (late menstruation) |
| Cilantro | coriander | fried | dolor de oido (earache) |
| Cocolmeca | sarsaparilla | tea | dolor de rinon (kidney pain) |
| Estafiate | wormwood | tea | colico (pain in the abdomen) |
| Hediondilla | creosote | tea | rinon (kidney)<br>colico (pain in the abdomen)<br>pasmo (infection) |
| Granada | pomegranate | tea<br>solution | colico (pain in the abdomen)<br>anginas (tonsils) |
| Lanten | plantain | tea | disenteria (dysentery) |
| Manzanilla | chamomile | tea | colico (pain in the abdomen)<br>dolores de parto (childbirth pains) |
| Marihuana | marihuana | tea | nervios (nerves) |
| Naranjo | orange leaves | tea | colico (pain in the abdomen) |
| Nogal | walnut | douche | sangreada (hemorrhage) |
| Yerba buena | mint | tea | colico (pain in the abdomen) |
| Maiz | corn tassel | tea | rinon (kidney) |
| Oregano | oregano | tea | la regla (menstruation),<br>resfriado (cold) |
| Romero | rosemary | tea | atrasos de la regla (late menstruation) |
| Sauz | willow | tea | fiebre (fever) |
| **Vegetable remedies:** | | | |
| Ajo | garlic | suppository | tripa ida (locked intestines) |
| Harina | flour | toasted | quemaduras (burns) |
| Papa | potato | poultice | dolor de cabeza (headache) |
| Tomate | tomato | poultice | dolor de garganta (sore throat) |
| **Mineral remedies:** | | | |
| Azufre | sulfur flowers | dissolved in alcohol | pasmo (infection) |
| Carbonato | soda bicarbonate | solution | indigestion (indigestion) |
| **Animal remedies:** | | | |
| Cagada del burro | burro dung | tea | aire (gas) |
| Telarana | spider web | poultice | cortada infectada (infected cut)<br>sangreada (hemorrhage) |

Mexican Americans who believe in and practice folk medicine make a clear distinction between folk illness and medical illnesses. For example, even very traditional Mexican Americans know of common medical conditions such as heart disease (ataque de corazon), high blood pressure (presion), cancer (cancer), measles (sarampion), mumps (la chanza), pneumonia or bronchitis (pulmonia), diabetes (diabetis), colic (colico), or rheumatism (reuma). Even so, the cause may be attributed to a derangement or imbalance in social relationships, or to hot/cold problems. However, Mexican Americans also have a class of unique cultural illnesses. Some of the more common folk illnesses are described in Table 3. As Schreiber and Homiak (1981) point out, although these are the major "Mexican" illnesses in the Southwest, there is by no means universal recognition of the syndromes nor are they universally defined in the same way.

A common theme running through the Mexican American folk illnesses is gastrointestinal distress. In fact, of the eleven major folk syndromes listed in Table 3, only two, pasmo and mal puesto, do not include signs or symptoms of gastrointestinal involvement. Mal puesto, or bewitchment, tends to be a residual disease category, for several reasons. First, belief in brujeria or hechiceria (witchcraft) is declining in the Mexican American population as it becomes more urban and middle class. Second, mal puesto is used as a diagnosis only after other diagnoses and treatments have proven unsuccessful (Schreiber and Homiak, 1981). Bewitchment is believed to result from serious disruption in social relationships such as quarrels between lovers, unrequited love, or conflict between families or individuals. The offended party seeks out a bruja or brujo to place a hex on the offending party. Belief in and adherence to la cuarenta is becoming rare. Traditionally, after delivery women were supposed to avoid bathing, acid or cold foods, and sexual intercourse for a period of 40 days.

Table 3

Some of the Major Mexican American Folk Illnesses and Their Folk Explanations

| Type | Symptoms | Folk Explanation |
|---|---|---|
| Susto | Decreased appetite<br>Restlessness<br>Fatigue<br>Weakness<br>Withdrawal<br>Somatic complaints | Caused by fright or traumatic experience; fright may be natural (an accident) or supernatural (ghost). |
| Mal ojo | Headaches<br>Crying<br>Irritability<br>Restlessness<br>Vomiting<br>Diarrhea<br>Fever | Victim looked upon by person with "strong vision" or the "evil eye". |
| Mal puesto | Hallucinations<br>Amnesia<br>Ideas of persecution<br>Hysterical symptoms | Witchcraft; hex placed on victim. Motives are envy, jealousy (especially sexual), and vengeance. |
| Mal aire | Headache<br>Chest pain<br>Paralysis<br>Diarrhea<br>Stiffness | Imbalance of hot and cold elements in both the bodily functions and the environment. |
| Empacho | Constipation<br>Pain | Intestine blocked by bolus of food. |
| Caída de mollera | In infants, distress, crying, malnutrition | Fallen fontanelle. |
| Bilis and Envidia | General emotional turmoil, diarrhea, vomiting | Strong anger/envy causes an overflow of yellow bile. |
| Latido | Severe weakness, stomach contractions | Going without food for extended period of time. |
| Tripa ida | Constipation | Sometimes caused by susto. |
| Ghipil | In infants, loss of sucking ability, upset stomach, excessive crying | Mother has become pregnant before weaning child. |
| Pasmo | In newly postpartum women, edema, particularly of ankles and feet | Violation of la dicta or la cuarenta, the 40-day postpartum convalescence period. |

Susto, or fright disease, is by far the most frequently studied of the Mexican American folk illnesses. It is classified as a culture-bound reactive syndrome and is widely known thoughout Latin America. Although the syndrome affects persons of both sexes and all ages, it is particularly prevalent among the young, particularly young girls. Although generally not a fatal disorder, advanced cases (susto pasado) can be fatal and are characterized by a slow wasting away of the body. On the one hand, susto appears to be a culturally meaningful type of anxiety hysteria linked to role conflicts and self-perceived social inadequacies (Rubel, 1964; Klein, 1978). This view of the syndrome suggests to Schreiber and Homiak (1981), that susto is a social disease that serves both as an explanation and an excuse for a passive sick role. However, there are data indicating that susto can be more than a culturally-patterned defense mechanism. Rubel and O'Nell (1978) report that asustado persons have more organic illness and are less adequate at performing standard social roles than are persons suffering from other illnesses. Because of this, Schreiber and Homiak (1981) suggest "...in dealing with conditions like susto and mal ojo, which combine symptoms of multiple origins, according to biomedical concepts of etiology and nosology, the clinician is best advised to attend to the particular signs and symptoms the patient presents, rather than to the labels he may attach to them." (p. 295)

Generally, in treating susto, the afflicted person lies down, is covered with a sheet or blanket by the healer, swept (called barridas) with the sign of a cross with palm leaves or a broom, and prayers are said. Then the patient is given a drink of water. For mal ojo, a whole raw egg is rubbed over the body in the sign of the cross, prayers are said, the egg is broken into a dish and placed under the patient's bed. In the morning, the dried egg signals the evil has been drawn off. Caida de mollera is treated by holding the afflicted child upside down and shaking it or inserting a finger in the child's mouth to press on the palate, or by applying a poultice of egg and soap on the top of the head, or by applying suction to the top of the head. Sometimes babies with gastrointestinal complications are brought to well baby clinics with egg/soap residues on the top of the head, indicating use of the folk remedy and possibly suggesting delay in seeking medical care. A chill (sereno) or a cold (resfriado) is treated with hot herbal teas and/or mentholatum and warm blankets. Empacho is treated by rubbing and pinching the back, or rubbing the stomach to dislodge the undigested bolus of food causing the problem. General aches and pains are treated either by massaging (sobadas) or by a procedure called ventosas (cupping). For this cure, a candle is mounted on a coin placed over the painful spot and lighted. A small jar or glass is then placed over the lighted candle. When the air is exhausted, the skin is pulled up by the vacuum created. A prayer is recited during the procedure, "en el nombre de Dios, que salga este dolor," or in the name of God, draw out this pain. The jar is moved around the afflicted area, and then the area is massaged with Aceite Volcanico (volcanic oil).

Folk Medicine: Overview

There are a number of features which distinguish folk medical systems in general, and Mexican American folk medicine in particular.

First, folk medical beliefs are ubiquitous; they exist in every sociocultural group to some extent although their distinctiveness varies substantially.

Second, folk medical concepts have broad cultural significance; knowledge of and belief in the folk medicine of a group confirms beliefs about the nature of the world, the individual, and social relationships. That is, folk medical beliefs and practices affirm group membership and identity.

Third, folk medical systems involve elements that are well-known and readily available to group members.

Fourth, folk medical systems co-exist with organized medicine, typically as an adjunctive or alternative source of care. Folk medicine is sometimes used before scientific medicine, as the initial therapeutic response, or concurrently to increase the probability of a successful outcome (what might be termed hedging your bets), or after scientific medicine has failed to produce the desired result, either therapeutically or interpersonally.

Fifth, most folk medical practices satisfy the cardinal healing proscription: do no harm. That is, most folk medical practices are, as far as we know, harmless. The main effect of most is psychosocial, i.e., that of a placebo.

Sixth, Mexican American folk medicine (like most such systems) integrates sacred and secular cultural elements. In the case of Mexican Americans, Catholic ritual and religious artifacts (oils, candles, crucifix, incense, holy water) play a dominant role in healing procedures.

Seventh, Mexican American folk illnesses generally involve some type of gastrointestinal sign or symptom: loss of appetite, vomiting, bloating and belching, indigestion, constipation, or diarrhea.

Eighth, Mexican American folk illness syndromes are believed to emanate primarily from disequilibrium in a person's life, in particular as a result of disturbed social relationships, spiritual transgressions, or hot/cold imbalances.

## Treating Traditional Mexican Americans

Given the still somewhat limited scientific knowledge base concerning the distinctive health beliefs and practices of most minority groups in the United States, it is difficult to formulate many guidelines specific to different clinical settings or clinical problems. However, there is sufficient information in the literature to formulate some general guidelines for providing health care to traditional Mexican Americans.

1. Illness and health are considered more or less a matter of chance, an act of nature, or of God, or of evil spirits. As such, a sick person is not responsible for the occurrence of illness, typically does not feel to blame, and so an attitude of blame on the part of the caregiver is inappropriate and probably will prove counterproductive.

2. Mexican Americans with little understanding of English and/or little knowledge of medical terminology or procedures are often reluctant to acknowledge that they do not understand explanations and instructions. Careful checking for comprehension should therefore be an integral part of the care process.

3. Family participation in medical decisions is very important, and diagnosis or treatment of a serious nature should be made giving the traditional Mexican American patient an opportunity to consult with other family members. In family sessions, fathers and elders should be consulted first. Children should be brought into the process gradually and carefully.

4. Regarding the doctor-patient relationship, traditional Mexican Americans:

- Expect health care providers to convey sympathy, warmth, and particularly reassurance.
- Believe that touching by the caregiver (a handshake, a clasp of the arm, or a pat on the head in the case of children) is a sign of concern and good will.
- Expect a "good" caregiver to listen attentively.
- Expect the caregiver to "take charge" and do something, perferably to cure with dispatch and with a minimum of pain and disturbance.
- As a sign of respect, may avert eyes from the caregiver or may bow the head sightly in deference.
- Tend to disclose little about themselves of a personal nature and to disclose such information slowly.
- Expect therapy, particularly psychological interventions, to proceed in a leisurely fashion, with much polite conversation, in keeping with the concept of personalismo.

5. Many traditional Mexican Americans, since they expect a healer to understand their problem and be able to do something about it, prefer therapy that is directive. However, in such individuals the concept of dignidad can make confrontation a difficult strategy to use, particularly in psychotherapy.

6. Since traditional Mexican Americans often expect quick, definitive results, they often engage in "therapeutic shopping" when there is not clear resolution of their health problem. This creates problems in terms of continuity of care as well as follow-up. An interesting corollary of this behavior is the "brown-bag syndrome" in which the patient carries a paper bag containing medications accumulated while "shopping" for a cure. This can sometimes provide clues as to other therapeutic encounters and medication history.

Some General Guidelines

Harwood (1981) suggests that anytime a health-care provider is not sure whether a minority group patient espouses ethnic concepts of disease, an attempt should be made to elicit the patient's model of disease. This is particularly advisable in four circumstances: (1) in dealing with chronic diseases, where patient-practitioner communication is critically important; (2) in diagnosing

and managing diseases that may involve known folk concepts of etiology and treatment; (3) in treating conditions whose symptoms overlap with a culture-specific syndrome; and (4) in life-threatening situations. Because differing cultural concepts and behavioral norms can influence the participation in and reactions to treatment by patients, cultural beliefs need to be made explicit in health care encounters (Kleinman, Eisenberg, and Good, 1978).

Kleinman, Eisenberg, and Good have outlined an approach for eliciting the patient's model of illness (1978, pp. 256-257), which has been modified by Harwood (1981, pp. 28-29) to make it more widely applicable. The approach involves a series of questions which permit the practitioner to elicit the patient's perspective.

1. What do you think has caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you? How does it work?
4. How bad [severe] do you think your illness is? Do you think it will last a long time, or will it be better soon, in your opinion?
5. What kind of treatment would you like to have?
6. What are the most important results you hope to get from treatment?
7. What are the chief problems your illness has caused you?
8. What do you fear most about your sickness?

One way to begin the query has been suggested by Harwood (1981), by way of a preliminary explanation: "I know that patients and doctors sometimes have different ideas about diseases and what causes them. So it's often important in treating a disease to get clear on how both the doctor and the patient think about it. That's why I'd like to know more about your ideas on [whatever disease or symptom is relevant to the situation]. That way I can know what your concerns are, and we can work together in treating your sickness." (Of course, clarification of patients' disease concepts may also be relevant to other clinical tasks, such as eliciting a history or explaining a diagnostic procedure, and the wording of the introductory comment would have to be modified accordingly.)" (p. 486)

After the patient's understanding of the illness experience is clear, the practitioner should clearly explain his or her own view of the patient's health problem in plain language that the patient can understand. Discrepancies between the two models should become apparent and should be addressed explicitly, in a nonjudgmental way that communicates a genuine desire to understand the patient's problem and to provide assistance.

When discrepancies occur, Harwood (1981) suggests three general methods of handling them: (1) patient education, in which the practitoner attempts to change the ideas and attitudes of the patient; (2) working within the patient's conceptual system, in which a treatment plan is instituted which will be effective and which does not violate, or is not contraindicated by, the patient's model; and (3) negotiating a compromise, by which both parties agree to a treatment plan that accommodates each one's model to some extent, but which does not require either to accept fully the other's model of the disease.

Successful bridging of the cultural gap between practitioner and patient should reduce psychological and behavioral disjunctions in the medical care contact, thereby reducing dissatisfaction and distrust, which in turn should reduce delay in seeking care or discontinuance of treatment, thereby reducing the risk of greater discomfort, disability, and ultimately, death.

## REFERENCES


Acosta, F.S., J. Yamamoto, and L.A. Evans
1982 Effective Psychotherapy for Low-Income and Minority Patients. New York: Plenum Press.

Apple, D.
1960 How laymen define illness. Journal of Health and Human Behavior I:219-225.

Baumann, B.
1961 Diversities in conceptions of health and physical fitness. Journal of Health and Human Behavior 11(1):39-46.

Beccera, R.M., M. Karno, and J.I. Escobar (Eds).
1982 Mental Health and Hispanic Americans: Clinical Perspectives. New York: Grune and Stratton.

Bloom, S.W.
1963 The Doctor and His Patient. New York: Russell Sage Foundation.

Broom, L. and P. Selznick
1963 Sociology (Third Edition). New York: Harper & Row.

Chesney, A.P., J.A. Chavira, R.P. Hall, and H.E. Gary
1982 Barriers to Medical Care of Mexican-Americans: The Role of Social Class, Acculturation, and Social Isolation. Medical Care 16:533.

Chesney, A., B. Thompson, A. Guevara, A. Vela, and M.F. Schottstaedt
1980 Mexican-American Folk Medicine: Implications for the Family Physician. Journal of Family Practice 11:567-574.

Creson, D.L., Cameron McKinley, and Richard Evans
1969 Folk medicine in Mexican-American sub-culture. Diseases of the Nervous System 30(4):264-266.

Cuellar, I. and R.E. Roberts
1983 Psychological Disorders Among Chicanos. In J.L. Martinez, Jr. and R.H. Mendoza (Eds), Chicano Psychology, second edition. New York: Academic Press.

Diaz-Guerrero, R.
1977 A Mexican psychology. American Psychologist 32:934-944.

Engel, G.L.
1977 The Need for a New Medical Model: A Challenge for Biomedicine. Science 8(April):129-136.

Frank, J.D.
1974 Persuasion and Healing. Johns Hopkins, 1961, Revised edition, 1974.

Garcia, J.A.
1982. Ethnicity and Chicanos: Measurement of ethnic identification, identity and consciousness. Hispanic Journal of Behavioral Sciences 4:295-314.

Goodenough, W.H.
1963 Cooperation In Change. New York: Russell Sage Foundation.

Grebler, L., J.W. Moore, and R.C. Guzman
1971 The Mexican American People: The Nation's Second Largest Minority. New York: The Free Press.

Harwood, A. (Ed.)
1981 Ethnicity and Medical Care. Cambridge, Mass.: Harvard University Press.

Johnson, A.H.
1977 Behavioral science in family practice: an ethical imperative. The Journal of Family Practice 4(3):525-528.

Kay, M.A.
1978 Health and illness in a Mexican American barrio. pp. 99-166 in E.H. Spicer (ed.), Ethnic Medicine in the Southwest. Tucson: University of Arizona Press.

Klein, J.
1978 Susto: The Anthropological Study of Disease of Adaptation. Social Science and Medicine 12:23-28.

Kleinman, A., L. Eisenberg, and B. Good
1978 Culture, Illness and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research. Annals of Internal Medicine 88:251-258.

Levine, Elaine S. and Amado M. Padilla
1980 Crossing Cultures in Therapy: Pluralistic Counseling for the Hispanic. Monterey, CA: Wadsworth.

Lurie, H.J. and G.L. Lawrence
1972 Communication problems between rural Mexican American patients and their physicians: Description of a solution. American Journal of Orthopsychiatry 42(5):777-783.

Maloney, C. (Ed.)
1976 The Evil Eye. New York: Columbia University Press.

Prattes, O.
1973 Beliefs of the Mexican American Family. In D.P. Hymovich and M.U. Barnard (eds.), Family Health Care. New York: McGraw-Hill.

Roberts, R.E.
1977 The study of mortality in the Mexican American population. In: Teller, C.H., Estrada, L.F., Hernandez, J., Alvirez, D., eds. Cuantos somos. Austin: University of Texas, 131-155.

Roberts, R.E. and E.S. Lee
1980 Medical Care Use by Mexican Americans: Evidence from the Human Population Laboratory Studies. Medical Care 18(March):226-281.

Roberts, R.E. and E.S. Lee
1980 The Health of Mexican Americans: Evidence from the Human Population Laboratory Studies. American Journal of Public Health 70(April):375-384.

Roberts, R.E. and E.S. Lee
1980 Health Practices Among Mexican Americans: Further Evidence from the Human Population Laboratory. Preventive Medicine 9(September):673-688.

Rubel, A.J.
1964 The epidemiology of a folk illness: Susto in Hispanic America. Ethnology 3:268-283.

Rubel, A.J. and C.W. O'Nell
1978 Difficulties of presenting complaints to physicians: Susto illness as an example. In B. Velimirovic (ed.), Modern Medicine and Medical Anthropology in the United States - Mexico Border Population. Pan American Health Organization Scientific Publication No. 359.

Ruiz, R.A.
1981 Cultural and Historical Perspectives in Counseling Hispanics. In D.W. Sue (ed.), Counseling the Culturally Different. New York: John Wiley & Sons.

Schreiber, J.M. and J.P. Homiak
1981 Mexican Americans. pp. 264-336. In A. Harwood (ed.) Ethnicity and Medical Care. Cambridge, MA: Harvard University Press.

Schulman, S. and A.N. Smith
1963 The concept of "health" among Spanish-speaking villagers of New Mexico and Colorado. Journal of Health and Social Behavior 4:226-234.

Scrimshaw, S.C. and E. Burleigh
1978 The potential for the integration of indigeneous and western medicines in Latin America and Hispanic populations in the United States of America. In B. Velimirovic (ed.), Modern Medicine and Medical Anthropology in the United States - Mexico Border Population. Pan American Health Organization Scientific Publication No. 359.

Taylor, G.J.
1978 The mind-body dichotomy. Psychosomatics 19(5):264-267.

Trotter, R.T.
1981 Remedios Caseros: Mexican American Home Remedies and Community Health Problems. Social Science and Medicine, 15B, pp. 107-114.

Trotter, R.T. and J.A. Chavira
1981 Curanderismo. Athens: University of Georgia Press.

Zborowski, M.
1975 Cultural Components in Response to Pain. In Theodore Millon (ed.), Medical Behavioral Science. Philadelphia: W.B. Saunders.

Zola, I.K.
1966 Culture and symptoms--an analysis of patients' presenting complaints. American Sociological Review, October:615-630.

Zola, I.K.
1972 Studying the decision to see a doctor. In Z.J. Lipowski (ed.), Advances in Psychosomatic Medicine 8:216-236. Basel:Karger.