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Contrasting Models of the Healer's Role: South Texas Case Examples

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This article compares two models of the healer's role: physicians and Mexican American folk healers *(curanderos)*. The effects of culture on the delivery of health care are manifested in three areas: the protection of patient modesty, the locus of control over diagnosis and treatment, and the role of the healer as a cultural interpreter of teherapeutic regimens. Case examples are presented that illustrate the differences in the roles of the two types of healers.

The Lower Rio Grande Valley of South Texas has been the focus of medical anthropological research since the late 1950s, with special attention being given to the ethnomedical beliefs of Mexican Americans. Both historical and "state of the art" descriptions of that research are summarized or expanded upon in other works (e.g., Trotter, 1979, 1981a, 1981b; Trotter & Chavira, 1975, 1978, 1980, 1981). A few works have attempted the more arduous task of comparing elements of the ethnomedical and conventional health care system in order to aid cultural change (Clark, 1959a, 1959b; Madsen, 1961; Rubel, 1960, 1966). This article takes these earlier works a stage further along the continuum of analysis previously started, by explaining the role similarities and role differences present amongst physicians and *curanderos* (Mexican American folk healers) practicing along the United States–Mexico border.

In many ways, the Rio Grande Valley of Texas presents a natural laboratory for comparisons between physicians and *curanderos*. Both share an overlapping set of clients and even, occasionally, refer clients to one another (see Trotter & Chavira, 1981). The clients also share a common physical and social environment as well as a relatively homogenous cultural mileu. This becomes extremely important for the validity of the comparisons presented here, since

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it is being assumed that the behavior expected of healers, their cultural set of "bedside mannerisms," is determined by their cultural context of healing. Further, it is assumed that if healers do not exhibit these traits, they are considered poor healers, almost regardless of their technical skills, and clients will only utilize their services if they lack alternatives. Indigenous members of a culture would therefore tend to behave appropriately toward their patients, unless they have been heavily socialized into a different system, but also would tend to assume a role inappropriate to members of another culture, and their inappropriate behavior would directly interfere with the delivery of health care to the patient.

The total "role" of healer is too complex for an article the length of this one; therefore, this paper will concentrate on what the author considers the three critical elements of that role in those areas where failure in cross-cultural healing encounters may most often occur. The first element discussed below is the role of the healer as a cultural interpreter of therapeutic regimens. This is the behavior that stems from the condition that healers must present their treatments wrapped as culturally appropriate packages, acceptable to patients. The second element in the healer's role presented here is the acceptance by the healer and patient of a specific locus of control over the therapeutic interaction. By its very nature, healing normally involves some level of a healer's control over patient behavior, but the differences of degree of control amongst various cultures drastically effect the success or failure of treatment within a particular cultural context. The third element of the healer's role discussed in this paper is the protection of modesty in healing situations. Healing is, of necessity, an intimate interaction, and it frequently involves both the healer and the patient temporarily setting aside strong cultural taboos involving touch, viewing, talking to a particular person, or talking about intimate subjects. The ways imposed by one culture on the healer to protect modesty within this context of forced intimacy may be diametrically opposed to the way expected (and needed) by members of another culture. This particular set of contrasting roles was chosen because of the light it sheds on the cultural expectations of some patients and healers in the Anglo majority population of the United States compared with some patients and healers in the second largest, and most rapidly growing, minority population in the United States, Mexican Americans, within the geographical and sociocultural context of the United States.

Research Area

The data analyzed in this paper were collected through ethnographic research in both the conventional medical care system and in the folk healing system of the Lower Rio Grande Valley of South Texas. The Valley, as it is called by its inhabitants, consists of a group of closely spaced, small and medium-sized towns along the United States–Mexico border at the mouth of the Rio Grande River and upstream for about 100 miles. Nearly 80% of the approximately half-million inhabitants are Mexican American, slightly more than 20% are Anglo Americans, and less than .5% are Black. The effects of the nearly one million people living in Reynosa and Matamoros in the state of Tamaulipas, Mexico, are significant and due, in part, to the relative isolation of the region from other major urban centers in both the United States and Mexico. This condition is heightened by the fact that the river acts as a very weak semipermeable membrane to filter the flow of people back and forth across the border. Not only is the border basically wide open, for those without documented right of entry, the river is often easily waded due to the use of the water as an irrigation resource rather than a social barrier. The consequence of these conditions is that the area is dynamically multicultural and is bound to remain so into the forseeable future. A more extensive description of the area is presented by Trotter and Chavira (1980,1981).

The conventional medical system is probably well known to the reader, and will, therefore, only be described in detail where necessary to the general flow of the paper. While the same may not be true for *curanderismo,* the Mexican American folk medical system, it is now sufficiently well described so as to make an extensive reiteration of the system unnecessarily redundant. In fact, up to a point, the values, attitudes, theories, and practices of both medical professionals and *curanderos* closely parallel one another. After that point, the divergence is significant. This condition of overlap and divergence is due to the common history of both systems. The history of modern medicine and of *curanderismo* not only parallel one another, but are nearly identical up to the end of the 1700s. Thus, the idea of balance or homeostasis, the use of a pharmacopea, and the use of physical manipulations of the patient's environment are examples of common parts of both systems, historically and currently. The point of divergence is the continually increasing secularization of modern medicine from the 1800s on (based on an

increasingly frequent use of the scientific method), contrasted with a continued emphasis on the divine and on the supernatural within *curanderismo*.

Perhaps the divergence of the two healing systems is best exemplified by the difference in the method of selection of practitioner's operant in the two healing systems. In modern medicine, the choice of this occupation is based on an interest coupled with a basic set of academic skills. The key element is the existence of an individual, secular choice. Within *curanderismo,* one is "chosen" by the presence or absence of a gift *(don)* for healing. Without the *don,* usually thought of as a divine gift, no amount of training will create a *curandero,* regardless of intelligence, desire, or any other quality. In this case, the key element is one of being *chosen* without personal volition and perhaps even against personal preference. The differences in the origins of the ability to become a healer in these two systems relate directly to the performance of the healing role within the two contrasting cultural environments.

A second result of the secular and spiritual divergence of *curanderismo* and modern medicine is in what are considered "problem states" or illnesses. Both systems recognize the importance of physical health and deal with a basically identical set of problems, although *curanderos* accept some ailments as having been caused by supernatural means and needing supernatural treatment. Both systems recognize the importance of psychological well-being and provide appropriate counseling. Beyond this, *curanderismo* also accepts some social conditions (bad luck in business, family disruption, problems with the law) as either illnesses or the causes of illness and treats them according to the techniques of the three healing levels that constitute the backbone of its theoretical system (Trotter & Chavira, 1980). Finally, the *curanderos* recognize some spiritual or supernatural conditions as being illnesses, and treat them through supernatural means.

Even given these differences in organization, structure, and theoretical approach, the role of the healer is similar enough in each of the two systems to provide an interesting contrast between the needs and expectations of the patients, vis-à-vis the healer's role in each system.

The Healer as Cultural Interpreter

One of the primary elements of the healer's role is to translate clinically sound knowledge into culturally appropriate therapy, normally by placing the treatment within a culturally approved symbolic context. In no healing system in the world does the knowledge of the healer correspond on a one-to-one basis with that of the patient. Thus, part of the healer's role is to take a technique, a treatment, a therapy, and surround it with the appropriate cultural accoutrements that make it acceptable to the patient. Sometimes the translation is nearly purely linguistic, as in the case of changing over from "medical talk" to common speech, in order to explain something. On the other hand, the translation may be of a more subtle nature. When the healer fails to place a treatment within a symbolic context that is appropriate to the patient, the therapy is likely to fail, as can be seen by the following case.

During one of the author's visits with a *curandera,* Doña Elena (I am following the common practice of using pseudonyms for the healers in order to protect their anonymity), a case that clearly indicates the need to place therapeutic regimens within symbolically appropriate contexts was observed. A young woman of 20 or so was brought to Doña Elena for relief from a physical complaint. She had recently given birth to a child, with no complications, and upon the advice of her mother had begun to breast-feed. Since this was her first child, she had apparently allowed the child to nurse for prolonged periods of time, which made her nipples tender. Coupled with improper post-feeding hygiene, her nipples became raw, cracked, and probably mildly infected. The soreness created by this condition caused the young woman to stop breast-feeding, at which point the breasts continued to produce milk in quantities stimulated by the earlier levels of feeding. The young woman's breasts then became rock hard and extremely painful due to internal pressure, further complicating the existing problems of her areolae and nipples. The young woman soon began to complain of the pain to her mother, who took her to see a physician. The physician recommended that the young mother soak towels in hot water, wring them out, and apply the hot towels to her breasts. This would stimulate the flow of milk, reduce the internal pressure in the breasts, cleanse and possibly soothe the nipples, and consequently reduce the pain for the young woman.

The young woman, by the time she had been brought to Doña Elena, was in acute pain. She was extremely restless and irritable, was moaning audibly and frequently, clutching her breasts as she rocked back and forth saying "they hurt, they hurt." It was difficult to communicate with her, but her mother was willing to explain the problem to Doña Elena. Upon questioning, the mother stated that she and her daughter had tried the procedure suggested by the physician several times, but that it had not helped, so she had

decided to bring her daughter to Doña Elena, in whom she reposed great confidence since her ability as a healer was widely known

Doña Elena did not fail her. She told the woman that she had had several cases just like this one and that she had a cure for it that had never failed. She told the mother to take the daughter home and to prepare a warm bath. Into the bath the mother was to place a pack of the herb *rosa de castillo* (rose petals; *Rosa sp.*), which had just the right healing properties for this problem. Then she was to submerse the daughter in the bath and the young woman was to recite a prayer, *El Credo* (The Apostle's Creed), three times. She was to follow this treatment three times a day for three days, and the problem would disappear.

The use of "three" in this case was probably recognized by both the healer and the patient as being symbolic of the Trinity, thrice repeated. The healer chose this number of baths on two grounds. First, the use of the "three" invoked number magic to ensure the success of the healing; and second, it gave the patient a specific number of times to complete the therapy. This is contrasted with the patient's report that the physician said to leave the hot towels on until the swelling went down, without saying how often to repeat the process. The young woman followed the *curandera's* advice, the problem went away, and she returned to breast-feeding her baby.

This example is particularly powerful in demonstrating the need to translate medical knowledge into the appropriate cultural format. In this case, both healers presented the same basic therapy—one in a straightforward, secular fashion, the other as a less obvious part of a healing ritual. Subsequently, the therapy worked best for the individual healer who accurately read the patient and, in a cultural translation of therapy, provided the symbolic context that was correct not only for the daughter, but also for the mother (who appeared to be the important focus, in terms of assuring that the therapy was carried out). Had the cultural background of the patient been different, a reversal of the effect presented her could easily have happened. The secular therapy could have been the one to work, the ritual of the *curandera* the one that failed.

Assumption of Control Over Therapy

When patients approach a healer, they come already equipped with a set of expectations about who is in charge of, or in control of, their interaction with the healer. If the expectations of the patient

are not matched by those of the healer, communication between them is often made difficult or impossible. When communication breaks down at this level, the healing process will often be interrupted on a permanent basis. In some healing systems, control is placed firmly in the hands of the healer, to the extent that the patients are not only told how the treatment is to be conducted, they are told what is wrong with them without any questioning of their symptoms or feelings, practically without any patient participation in the diagnosis. The other end of the spectrum is where it is the healer who is told by their patients what is wrong and how they want it corrected. In either case, or in any case that falls between these two extremes, as long as the expectations of the healer and patient match, the process will work effectively. The following case is presented to show the manipulation of a patient's life that is possible in a system where the therapist has more control, more social power associated with his role as therapist, than exists in the conventional system.

Don Pedro is widely known healer who sees between 40 and 60 patients each day. He has had a significant amount of exposure to the scientific medicinal system by working for several years as an orderly before he started healing full time. He also utilizes the conventional system for such personal problems as tachycardia. He has a great deal of respect for modern medicine and often refers people with purely physical ailments to physicians. At the same time, he makes the point that while he understands and acknowledges the usefulness of physicians, he feels that they are foolish for rejecting out of hand his theories and practices when they would be of significant help to their patients, especially to some of the patients that the physicians themselves fail to help.

Don Pedro is extremely powerful, according to the assessment of peers in his own system. He works on all three of the healing levels of *curanderismo*. He is also an accomplished counselor, and has read widely in psychology in addition to having approximately the equivalent of 2 years of college as a psychology major. He often consciously uses counseling over magic in his practice, because of the lower energy drain of counseling compared to magic and because of the psychic and spiritual dangers inherent in the magic he uses. If both magic and counseling appear to him to have equal chances of working, he uses counseling. If only magic will work, then he uses magic. This condition, the latent ability to use magic, is important in his role as a healer and often activates a level of confidence in his clients that might be difficult for a conventional therapist to

achieve. This allows Don Pedro to fully control the therapeutic process and to suggest treatments that even go against some of the ingrained values of the cultural system that he works in, as happened in the case described below.

Several brothers and sisters got together and approached Don Pedro to see if he could help eliminate their father's drinking problem. The man frequently drank to excess, and in doing so he became belligerent and difficult to handle. The drinking had caused the man to lose several jobs, and the children were frightened that the problem would only get worse.

Don Pedro listened to the details of the problem presented by the man's children and decided on an oblique approach. It was felt that the man would not voluntarily come to see Don Pedro nor would he readily accept responsibility for his problem or seek help on his own. Therefore, Don Pedro asked the children to invite him over to their house several times, without revealing his role as a healer, so that he could observe the father's behavior first hand.

After observing the father's behavior several times while posing as a friend of the children, Don Pedro brought the brothers and sisters back together to give them his decision. He told them that the father's drinking problem stemmed from his relationship with their mother. The two parents apparently hated each other and lived in a state of perpetual conflict. This conflict drove the father to drink, as an escape mechanism and as punishment against the wife. Don Pedro suggested that the children could help by separating the couple. The father should be sent to live with a daughter in Houston while the mother remained where she was, with the children still at home.

The children followed Don Pedro's advice, with striking results. Within 6 months of arriving in Houston, the father had sobered up and dried out. He had managed to acquire a decent job and was living in harmony with the daughter and her husband. At this point, the other children returned to Don Pedro and thanked him for his help. They also asked him to allow their father to come back home to the Valley, since he was doing so well and had obviously been cured. Don Pedro felt that this action would be disastrous so he suggested that the children call their father and ask him if he wanted to come home. They did so, and the father replied that he in no way wanted to return. He was glad to be sober, have a job, and not be anywhere near his wife. So he remained in Houston.

In this case, the agreed-upon role of the healer was such that the *curandero* not only assumed the responsibility for diagnosis without patient consent, but also, without the patient's knowledge, assumed

the direction of the course of treatment. Both of these conditions violate basic tenants of the conventional health care system. Don Pedro was even able to bend, if not break, a very significant social bond within the cultural system, the man's marriage. He was able to do so, in part, because his role makes even such a drastic approach appear to be culturally/socially acceptable. When the father went (was sent) to Houston, he lived with a daughter, and thus the family was still "intact" although geographically separated. The fiction that the father had gone to find work could be used to explain his absence, since good jobs are scarce in the Valley. This makes his separate residence an acceptable variation on a cultural theme of the family staying together, regardless of the problem. It is doubtful that a counselor from the conventional system would be willing to assume the type of responsibility for therapeutic intervention that Don Pedro accepted, if for no other reason than the extremely prevalent value, especially in alcoholism therapy, that each patient must take full responsibility for his or her own actions and cannot pass that responsibility on to others. Thus, the *curandero* often accepts greater responsibility along with greater control over patient behavior than does the physician.

This difference sometimes creates confusion in patients who utilize both healing systems. They may expect the doctor, like the *curandero*, to tell them what is wrong. And when, instead, the doctor asks lots of questions (during diagnosis), they may come to feel that the doctor is ignorant or a "quack" since, after all, he is the one that has all that education, so he should be able to tell *them* what is wrong without a lot of questions. They lose confidence in the ability of the physician to perform his function. On the other hand, if their contact is primarily with the physician, patients may resent the fact that a *curandero* appears to be telling them what is wrong, without asking them anything, and the therapeutic intervention of the *curandero* is disrupted. In either situatuon, there is an incompatibility between the patient and the healer in regard to their expections about the locus of control of the healing intervention, which must be resolved before the therapeutic process can continue.

The Protection of Modesty in Healing

The healing interaction is a condition of forced intimacy between individuals who would not under ordinary circumstances become intimate. Normal social taboos that restrict touch or viewing of

another person are often violated by the healer, but this violation is acceptable since the therapeutic interaction is necessary and because it is considered a special case of interaction. For example, a physician may acceptably do a pelvic examination when even the remote possibility of illness or death are the motivating factor in initiating the exam, but when that motivation is lacking or a sexual motivation is present, the same type of behavior would be a violation of social mores. Nonetheless, even where the motivation for therapy is appropriate, modesty must still be protected within the healing interaction. Thus, healers have developed culturally appropriate behavior that allows the forced intimacy of healing to occur, but keeps it within acceptable social boundaries and reduces the embarrassment for all parties involved. Obviously, the method used within one culture to protect modesty may be opposed to the behavior that would protect it for a patient of a different culture. This is certainly the case for many Anglos and Mexican Americans in the Lower Rio Grande Valley.

The Anglo-dominated medical system has developed a device for protecting modesty that works well for certain patients, especially Anglos. It is called "assuming the professional role." Even if patients are close personal friends of the health professionals, the physicians or nurses (or whomever) take on impersonal roles as "healers" rather than "friends" during healing interactions, and this sets up social distance between the professionals and their patients. Modesty is protected in this case by having the healers symbolically stand back or place social distance between themselves and their patients. If, instead, the healers assumed a close personal role and symbolically moved closer to their patients, the perceived intimacy of the situation would become too pronounced and the patients would have to remove themselves from the interaction. Only by creating a social fiction of "disinterest," especially sexual disinterest, can the forced intimacy of the contact with the healers be tolerated.

The case appears to be reversed for many Mexican American patients. For them, the assumptions of impersonal professional roles by healers act as barriers to patient-healer interactions. When doctors take on this role, they are perceived as being cold and aloof, and much too difficult to talk to about intimate subjects. Instead, the patients' expectations are that healers should symbolically move closer, rather than backing away. When physicians reduce the social distance between themselves and their patients, they temporarily become as though they were "one of the family," and therefore intimacy is acceptable. One of the differences between Anglo and Mexican Americans in this particular situation is that there appears to be an assumption on the part of Anglos that increased intimacy automatically generates some level of sexual overtones, while Mexican Americans are able to perceive greatly increased intimacy without sexual considerations. Therefore, when healers establish a highly personalized interaction with Mexican American patients, they are able to protect modesty by drawing close, becoming "one of the family," and therefore becoming an acceptable respository for intimate information about their patients that cannot be shared with "nonfamily" in the outside world.

These two contrasting styles of protecting modesty became apparent in comparing the behavior of *curanderos*, who tend to use the style of moving socially closer, with medical professionals, who tend to use the assumption of the professional role to protect modesty. During the course of the research, the author was able to collect anecdotes from patients that indicated their extreme discomfort in situations where their expectations about protection of modesty were violated. Perhaps the classical case of a clash between the two styles of modesty protection is recorded by Madsen (1964):

> We saw the doctor in his office after a long wait while many Anglos went in first. The doctor asked my wife, "What is wrong?" I told him. I said my wife had no energy and often had no appetite. I told him how she had bad dreams and cried in her sleep. I explained that she must have *susto* but had not responded to the treatment of a *curandero*. Therefore, she must have *susto pasado*. I said I had come to him because my brother thought he could probably cure this disease. The doctor sat there smiling as I talked. When I finished, he laughed at me. Then he sat up straight and said sternly, "Forget all that nonsense. You have come to me and I will treat your wife. It is my job to decide what is wrong with her. And forget about those stupid superstitions. I don't know how a grown man like you can believe such nonsense!" He treated me like a fool. And then he really insulted me. He said, "Mr. Montoya, if you will please step into the waiting room, I will examine your wife." As I rose, he said to Carmelita, "Step over there and take off your clothes." This I would not stand, that my wife should be naked with this man. And he said this in front of me. I controlled myself and only said, "Come, Carmelita, we have no time now." The doctor said, "Okay, but make an appointment with the nurse for her to come in for an examination." And the lecherous goat added, "Mr. Montoya, you do not have to come with her every time." We never returned, of course, and my

> wife was treated by a curer. Maybe Anglos let doctors stare at their wives' bodies and fool with them but not me. And the fool did not even know about *susto*. He is lucky I did not reduce his arrogance right there. [p.94]

While this particular anecdote occurred more than 20 years ago, and most husbands would not now have this extreme a reaction to the situation, the fact remains that many Mexican Americans continue to complain about Anglo physicians' handling of the modesty taboo. Fortunately, there is growing number of Mexican American physicians and nurses in the Valley who are extremely clever at reading the needs of their patients vis-à-vis modesty, and adopting whichever role produces the greatest relaxation and diminution of discomfort in their patients. This factor is reducing the level of the problem considerably.

Conclusions

This article illustrates the effects of culture on the delivery of health care in South Texas by focusing on three elements of the healer's role in contrasting social environments. Clearly, the success of a therapy is dependent on adequate communication between healer and patient, and anything that interferes with that communication jeopardizes the treatment, whether it is the symbolic adjuncts to the treatment, the level of control over the treatment of the healer, or the protection of modesty in a condition of forced intimacy. Where the healer's behavior matches with the patient's expectations, the possibility for successfully completing a course of treatment is dramatically improved. Where the expectations of both the healer and the patient are in conflict, the chances of successfully completing a therapeutic regimen are significantly reduced in proportion to the level of interference created by the diverging expectations about mutual interaction.

Since South Texas is a multicultural environment, it seems appropriate to recommend that healers, especially medical practitioners, be trained to be sensitive to and to appropriately exhibit both of the contrasting behaviors exemplified above. While the examples do not exhaust the difference in the cultural expectations of the patient within the Anglo and the Mexican American communities, they do indicate that at least two models of behavior and expection exist. Without going so far as to recommend that physicians become *curanderos* (or vice versa), it seems completely plausible to recommend that both models be made available during the training of health care providers who will be working in South Texas.

Resumen

Este artículo compara dos modelos del rol de las personas que curan: médicos y curanderos. Los efectos de la cultura sobre la prestación de servicios de salud se manifiestan en tres áreas: la protección del pudor del paciente, el locus del control sobre diagnóstico y tratamiento y el rol de la persona que cura como intérprete cultural de prescripciones terapéuticas. Se presentan casos que ilustran las diferencias entre los roles de ambos, médicos y curanderos.

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