THREE CASES OF FOLK DISORDER AMONG MEXICAN-AMERICANS: IMPLICATIONS FOR THE STUDY OF CULTURE CHANGE

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In this paper I will discuss three cases of emotional illness among people of Mexican origin in the Bay Area. Together they illustrate the persistence of some aspects of the folk-medical system known as *curanderismo*, and the modification of other aspects. The first field work I conducted in this community began twenty-five years ago in a Bay Area district known to the residents as Sal si Puedes (get out if you can); I have had sporadic contact with Mexican-American people in medical contexts during most of the intervening years, and my most recent research includes work among urban Spanish-speaking families in the San Francisco Bay Area.

The three cases of illness under discussion were observed respectively in the 1950s, 1960s and 1970s. The first episode was the illness of Marta, then a woman of 34 years, living with her husband and six children—the latter ranging in age from 1 to 6 years; she also had an 18-year-old married daughter with one child living in a neighborhood nearby. This case was first described in Clark, 1959:200-201. The onset of Marta's illness was fairly sudden. She began to have episodes of nausea and vomiting, accompanied by insomnia. She thought for a while that she might be pregnant, but when there was no cessation of menses, she gave up that idea. Shortly thereafter, her insomnia became more severe, and, although the nausea abated, other symptoms appeared. She began to suffer from shortness of breath, sweating, and rapid pulse. At first these were nocturnal symptoms, but they soon began to trouble her around the clock. She had to sit up in bed at night in order to breathe, and often she had dreams of some unknown object pressing down on her face and cutting off her breathing. She became so fearful of suffocation that she refused to go to bed, sitting up in a chair or pacing the floor. She lost her appetite, fearing that she would strangle on the food if she attempted to eat. Finally her husband and her married daughter became so concerned about her that they called in her sister and two of her *comadres* to discuss what should be done.

In reviewing the case, the family situation was carefully assessed. It was this: the family of Marta found themselves faced with acute financial problems as a result of a prolonged visit by the husband's brother, his wife, and their five children. The visiting brother had come to California from another state to seek work, but had not found a job after several weeks. Both families—fifteen persons in all—were living in a three-room house and trying to subsist on the wages of one common laborer. Their debt at the grocery store grew larger and larger, and finally the grocer would no longer extend them credit.

Marta felt obliged to provide food and shelter for her needy relatives but at the same time she feared that as a result of her hospitality her own children would have to go hungry. She also worried lest the landlord discover how crowded the house was and decide to evict the family. This was the social background of Marta's symptom development. She was ashamed to complain about her situation, and had been trying to have faith in God and pray that everything would turn out for the best. In discussing her symptoms with her sister and two of her comadres, she was enabled to escape from the dilemma she was in. They assured her that she was suffering from *susto* or magical fright. A neighborhood curandera was called in to diagnose and treat her for this disorder. When it was established that Marta was *asustada*, relatives and comadres insisted that she was ill, and should not have the responsibility of cooking for her brother-in-law's family. The visitors were encouraged to move on to another area where jobs were more plentiful.[1]

Illness in this case served to excuse the patient from social responsibility. She could not openly refuse to sacrifice the comfort of her own children in order to provide for even more destitute relatives. She would have been condemned as a selfish and unfeeling woman who cared nothing about her husband's family. However, when financial worries became acute, she began to have symptoms of acute anxiety. The symptoms were attributed to susto, a folk disease. Her illness was recognized, and her intimates insisted on a change to relieve her of extra responsibility. When the change was made, her anxiety was relieved, and the symptoms were

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lessened. Her rapid improvement was attributed to the excellence of the cure performed by the local curandera.

Cultures vary in the techniques customarily used in dealing with personal or social disturbances, and these techniques are based on shared existential propositions about disease and its causality which the patient and his associates espouse. In Mexican-American folk medicine, one of the existential propositions pertinent to the case of Marta's illness has to do with the conception of natural balance and order. In brief, it is the proposition that *normality is a balance of elements*. As long as a proper relationship among beings and things is maintained, everything is well. Disease, social conflict, and misfortune in general are due to planned or accidental contradictions of the natural balance. A prime example is the hot-and-cold concept of health and disease. In summary, this theory, derived from the humoral medicine of medieval Spain, holds that health is a temperate state of being, and an imbalance in the direction of either heat or cold can cause disease. Some illnesses, then, are due to an excess of heat in the body, and must be treated with cold substances whether drugs, topicals, or diets. These classifications often have no relationship to actual physical temperature (Foster, 1953; Foster and Rowe, 1951).

Furthermore, just as there must be a balance of heat and cold in the individual organism to assure a healthy state, so the *emotions must be kept in balance* in order to avoid serious disease. Strong or prolonged emotional states—such as fear, shock, anger, and envy—can create an imbalance within the individual and result in folk-defined disorders such as *susto, espanto, bilis,* and *envidia*. Even sibling rivalry, if prolonged and intense, has its sequela: a condition known as *chipil*.

In cases like Marta's, folk disease provides a means for retreat, in the face of the stresses of urbanization or culture change, to the traditional and comfortable roles of Latino society. It has been emphasized that "the utilization of this mechanism is probably rarely conscious. The anxieties and threats of cultural transfer combined with the desire for relief may provide the psychosomatic genesis of disease symptoms. Successful reinstatement in society and resulting relief from physical complaint reinforce the cultural acceptance of folk illnesses. Belief in the reality of these diseases frequently result in the diagnosis of completely physical ailments as *susto, mal ojo*, or one of the other afflictions in the folk system" (Madsen, 1964:436).

It should be noted that in this case, as in the one to follow, the curandera is a member of the local community, whose diagnostic acumen is surely informed by her access to local gossip and her knowledge of what is transpiring in the patient's social network. As in many parts of the world, her function is nonetheless important, in that she confers ritual legitimacy on a commonsensical solution.

At the time I recorded this first case in 1954, I was reasonably sure that the Mexican-American medical folk-belief system was in its last throes in Northern California. Although I was impressed with the tenacity of that system in the preceding half-century, I attributed this in large part to the absence of other forms of medical care. I somehow expected that great inroads would soon be made by modern, so-called "rational scientific" medicine. Yet, within the intervening years, repeated new cases of *mal ojo* (evil eye), *aire* (bad air), and *brujería* (witchcraft) have come to medical attention among the Mexican-American population of San Francisco—some of them among second, third, and even fourth-generation residents of the United States.

The second case I want to summarize here was referred to me in 1966 by a staff psychiatrist at one of the Bay Area medical centers. A seventeen-year-old girl of Mexican-American parentage was admitted to a psychiatric service, suffering from visual and auditory hallucinations, in the absence of any evidence of drug use. She had been brought to the hospital by her mother, as a consequence of a suicide threat, following some strange behavior and incoherent speech. The patient, after three weeks in psychotropic drug therapy, was able to converse with the staff about her situation. She reported that she was in danger of being killed by agents or persons unknown to her and that her mind was being controlled by some unseen force. She was still agitated, but was no longer contemplating suicide. She was discharged from the inpatient service, and continued to be seen on outpatient status. During the ensuing weeks the following information was obtained:

Angie, as I will call her, is a third-generation resident of California. She was the last-born child of her parents, who were separated when she was six years old. At that time, because of her mother's financial

problems and because her grandmother had recently been widowed and was living alone, Angie was sent to live with her paternal grandmother; the grandmother was given Angie as her own, to rear to adulthood. This pattern of grandparental adoption used to be fairly common among Mexican-American families, and there was no conflict about it in Angie's family–at first. However, when Angie was 15 years old, her mother decided to take her back; the mother was now remarried, had smaller children with her new husband, and needed Angie's help in the house and as a baby-sitter. The grandmother, however, had no intention of giving up Angie. She felt the mother was selfish and exploitative, and there ensued a fierce competition between the two women for Angie's loyalty. Mother and grandmother did not fight with each other openly, but each tried to persuade Angie that if she lived with the other, she would be proving herself a wicked, disloyal, and ungrateful girl. Both threatened never to see her again unless she became more obedient to their respective wishes. Angie was in a painful conflict–she loved and felt obligated to both her mother and to her grandmother who had reared her. There was no one to tell her definitively what she should do. Her older brothers and sisters were divided in their opinions, and both they and her friends simply told her she should do what she herself thought to be right and best for everybody.

After several months of this discord, Angie ran away from her grandmother's house, and moved in with her mother's family. However, she began to have trouble sleeping, lost her appetite, and began to miss school fairly often. She began to envision her grandmother dying alone and abandoned. Six months later, she was evidencing the psychiatric symptoms for which she was admitted to the clinic.

I have indicated above that Angie had a rather rapid recovery from the acute phase of her illness. There is no doubt that the medication helped her, as did the temporary residence in the inpatient ward, where she was removed from all of her family members. After a relatively short time as an outpatient, however, she reported to her therapist that she was cured completely, and would not be coming to the clinic anymore. The psychiatrist elicited the information, tendered somewhat reluctantly by Angie, that she did not attribute her "cure" to the clinic or the therapist, but to the fact that her case had been properly diagnosed by a curandera who had prescribed treatment that had miraculously healed her mind. The curandera had been hired by Angie's older sister; after a semi-magical, semi-religious divining ceremony, this practitioner had diagnosed Angie's illness as brujería (witchcraft) worked, she was shocked to learn, by the grandmother. The curandera went on to say that, in Angie's unsettled condition, she should not have any unnecessary responsibilities such as caring for young children or doing heavy housework. For this reason, the curandera ordered that Angie should move out of her mother's house, live for awhile with her older sister, and begin a regimen of prayers and ceremonies to counteract the black magic.

What an ideal solution to Angie's conflict! The folk explanation relieved the patient of responsibility for her grandmother's loneliness, her mother's fatigue and overwork, and even her own madness. She reported to the psychiatrist that the moment she had lit the first candle in her healing ceremony, she felt the evil leave her body: "I could feel it let go of my shoulders, then my neck, and finally fly out of the top of my head." Angie never returned to the clinic again.

These two cases, occurring twelve years apart, are almost identical in terms of the way the folk medical belief system was utilized to resolve a thorny problem in human relationships. There was one principal difference, however: the *hierarchy of resort*, that is, the relative primacy of choice from among a set of possible therapies. In Marta's case, the Anglo-American or cosmopolitan system, based on medical doctors and clinical facilities, did not enter into the case at all. The first and only resort was to the system of curanderismo. In the case of Angie's illness, regular hospital-based clinical services were called upon first; only later was the curandera consulted. Consider, however, the fact that in both cases the "cure" was attributed to the folk-healer.

The third case, that of Victoria (known to her friends as Vicki), reached crisis proportions in the 1970s. This case is of a slightly different order. The folk belief system is still important, but it is combined with elements from another American belief system, which I will call contemporary eclectic mysticism. A psychiatrist at a private San Francisco hospital brought the case to my attention. Vicki came into the psychiatric walk-in clinic with her three fellow commune members, two young men and another young woman. They

were concerned about Vicki because she had been making a number of seemingly suicidal gestures—darting towards traffic-laden intersections, or running at windows of the upstairs rooms as though to throw herself out, for example. Her history was taken in part from Vicki herself and in part from her roommate, Ben.

Vicki's mother had died when she was an early adolescent, and her Mexican-American father reared her. Her only sibling had died in infancy. Vicki was lonely at home, and frustrated by her father's attempts to see that she did not go out too much without supervision, that she remain at home in the evenings, and that she not get involved in premarital sexual relationships. She did manage, however, to get acquainted with Ben and his friends, some of whom were Anglos and others who were of Mexican-American backgounds. Finally, she broke with her father, who was vociferous in his disapproval of these friendships, and moved into the commune. These young people did some experimentation with "soft" drugs, but did not take heroin or other opiates, according to Vicki's report.

Just prior to Vicki's move into the commune, Trini, a young Chicano friend of Ben's, had committed suicide by taking an overdose of barbiturates. Ben felt greatly responsible for not having prevented Trini's death. He talked about this to Vicki at length. He introduced Vicki to Trini's grieving mother, and the two women became extremely close friends. Vicki began calling Trini's mother "Mamá," and spent several hours a day visiting with the older woman. Trini's mother gave Vicki some pictures of Trini, and Vicki asked if she might have some of his clothes—a jacket and a couple of shirts. After two or three months of this growing relationship, Vicki began to wear Trini's jacket, and to have periods when she would speak with Trini's voice, and assume his identity. She eventually developed a full-blown case of spirit possession, when she believed herself to be the dead boy. When she was free of her possessional state, she was terribly frightened, and tried to re-establish contact with her father. Her father, however, would have nothing to do with her. He called her a *bruja* (a witch) and forbade her to come into his house again. At this time Vicki began to make suicidal gestures; the episodes of possession increased in frequency and duration.

Vicki's friends decided they would try to help her by taking her to a psychic healer, an Anglo spiritualist medium in San Francisco, for exorcism. Her friends had become convinced that the spirit of the deceased Trini, jealous of Vicki's invasion of his former precincts, had indeed possessed her, and would destroy her unless she could be exorcised. The medium did try several times to help Vicki, but to no avail. Vicki called and begged her father to take her to a curandero, but he refused. At last Vicki's frightened friends brought her to the psychiatric ward for help.

I cannot tell you how this case was resolved, because Vicki left the clinic and didn't return. The psychiatrist had planned to try to enlist the father's help, and obtain some supplementary aid from the Latin-American folk-belief system. It is clear that Vicki herself had attempted to rally the Mexican-American folk medical system as a bridge back to her father and to her ethnic identity. Her well-meaning Anglo friend, Ben, tried in vain to help her through his own folk-psychiatry—a visit to a spiritualist medium. Further work with cases of this sort will surely enlarge our understanding of ethnic interactions and conflicts, and the role of various medical systems in their resolution.

I have used these three cases of emotional disturbance to illustrate the remarkable tenacity of traditional health beliefs and practices. As we see the descendents of Mexican immigrants in a struggle for adaptation in the urban American environment, we are aware of the physical and psychological toll taken by the stresses of migrancy, acculturation, and culture change. There are continuing disturbances in family and community organization which upset traditional systems of security for the individual, rapid social change with resulting conflict between generations holding different values and fundamental attitudes, geographic mobility and its accompanying problems in adjustment, and population pressures and deprivations associated with poverty. It is my position that, in dealing with such personal and social disturbances, some of the premises and procedures of traditional medical systems have proved empirically useful as an adjunct to standard medical practices. Similar findings have been reported by Janzen (1978) in Africa and by many other investigators.

Anthropologists have previously written about some of the significant differences between standard psychiatric practice and folk-medical practice. For instance, Fabrega and Silver (1973) list thirty-three major

contrasts between Zinacantan shamanistic curing and the Western psychiatric system. Among those distinctions, the following seemed most important to my respondents:

1. The therapist in Western medicine is thought, by virtue of his training in "objectivity," to be impersonal and lack real concern for the patient. He is also a stranger, and therefore unlikely to share the existential propositions about disease and its causality which the patient or the patient's relatives espouse.

2. Folk medicine is functionally related to the rest of the culture; standard medicine is not–it is isolated in spatial, temporal, social, and symbolic context. Kiev had written of the functional nature of folk medicine:

> "To Western man, illness is an impersonal event brought about by neutral, nonemotional, natural agents, such as germs, while for the Mexican-American, illness relates to an individual's life, his community, his interpersonal relationships and, above all, to his God. In such a culture, illness is a social as well as a biological fact. Because of its central significance illness is clearly related to other beliefs and patterns in this culture. Disease is defined not only in naturalistic, empirical, symptomatic terms, but also in magical and religious terms. In the same way, diagnosis and treatment occur in the larger, more meaningful context of major institutions and belief systems, not isolated from them. . ." (1978:177).

3. The folk therapist draws no dichotomy between diseases of natural and supernatural origin; the secularization of standard medicine is felt to be a false and amoral world view in a sacred society such as that characteristic of most folk cultures, where the power to heal is felt to be a gift from God.

4. The folk therapist places no emphasis on biological determinism, and among some Mexican-Americans the mind-body dichotomy is not understood. Thus, many diseases are thought to be of magical origin, and strong emotional states are presumed to be capable of inducing physical disorders.

5. The reliance of Western practitioners on the hospital is in conflict with Mexican-American value on familial responsibility for the sick; it is felt to be an indication of moral delinquency for a family to surrender one of its sick members to the care of strangers.

6. Standard medicine is based on hieratic knowledge; folk medicine can be explained in lay terms. Effective communication encourages belief and confidence in both the patient and his collaterals. In Angie's case, this was the problem; her symptoms were relieved, but not explained in terms that she and her relatives could understand.

7. Finally, standard medicine has emphasized the development of diagnostic and therapeutic techniques for the most acute and deadly of physical ills. Standard medicine is remarkably effective when confronted with dramatic medical emergencies deriving from physiological disorders, such as episodes of acute febrile illness that were often fatal in pre-antibiotic days. Organ-system emergencies (cardio-vascular accidents, cardiac arrest, or renal failure) are handled well by modern hospitals with the use of such intensive care equipment as electronically monitored respirators, pacemakers, and artificial kidneys. Dozens of medical miracles–organ transplantation, restoration of sight to the blind through cataract removal or corneal transplants–are performed every day in modern medical centers throughout the world.

However, the vast majority of health problems in a population are not of this genre. They are the everyday infirmities, ongoing low-grade pain, slowly crippling degenerative diseases, the lethargy of chronically poor nutrition, and the emotional disorders that so often accompany prolonged stress: alcoholism, addiction, violence, child abuse. Standard institutional medicine does not handle these well. And here is the fertile field where folk medicine continues to play a vital role as an exotic but functional form of social psychiatry.

Until we can create physicians and medical treatment facilities in our country that share some of the characteristics of folk medical systems, these will continue to be successful competitors in the treatment of the ill among many groups in the United States.

NOTES

[1] I am grateful to Abner Cohen who reminded me of Gluckman's description (1958:98-99) of the social use of witchcraft accusations among the Zulu against the wife of one of a group of brothers sharing the same household. The linkages of brothers is a pivotal institution in Zulu life, and when it is necessary for practical reasons that a joint household be split, charges of evil-doing may be brought against one of the women, thus making it possible for the brothers to continue their vital social and economic cooperation. In this case the wife was regarded as an innocent victim, but no blame was placed on the brother-in-law; the cause of the susto remained a mystery.

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