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# Use of Alternative Folk Medicine by Mexican American Women

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Nontraditional health care resources available to Mexican Americans are many. The Mexican culture is rich with alternative health and illness beliefs and remedies which have their origins in ancient Mestizo/Indian folklore which viewed the causes of illness to include social, spiritual, and physical forces. This perception calls for culturally relevant folk practitioners who can treat all aspects of the perceived illness. This study of 70-Mexican American women explored their knowledge of and use of alternative Mexican folk medical practitioners in their own health maintenance. Results provided some evidence that, even among highly assimilated Mexican American women, there persist traditional, indigenous beliefs, and practices.

**KEY WORDS:** health; Latinas; alternative folk medicine.

## INTRODUCTION

Two continuing phenomena provided impetus for exploring the health behavior of one group of ethnic minority women. First, as the nation's economic downturn continues to threaten existing, precarious health care services for the poor, it becomes most imperative that we assess the availability of alternative health care paradigms for the poorest consumers. As cities and counties propose major cutbacks in publicly financed safety nets and as unemployment dissolves employment-connected health benefits, the burden of finding affordable, accessible health care is exacerbated. A second phenomena regards the changing demographic realities in our country which includes a burgeoning Latino consumer population for whom health care must be made accessible and effective. This study sought to increase our knowledge about the use of indigenous health care resources among one large segment of the Latino population—Mexican American women.

Latinos in the United States constitute almost 13% of the U.S. population, with the largest subgroup (approximately 66%) composed of Americans of Mexican descent (1). The unique nature of Mexican Americans as both the oldest émigrés and the most recent émigrés provides for the continual renewal of cultural and ethnic patterns and practices across many areas of behavior. The retention of remnants of traditional, indigenous belief systems is also enhanced by the close proximity of Mexican Americans to Mexico. While acculturation has diminished many Mexican cultural traits, others persist in the form of oral tradition and folk practices in many areas of domestic life, including health maintenance (2). Perceptions of health and illness and help-seeking behavior very often include not only formal health care systems found in the United States, but also may include informal, "complementary" or "parallel" health care systems derived of traditional Mexican Indian folk practices and spiritual belief systems (3, p. 132). Indigenous Mexican folk healing is commonly referred to under the umbrella term of *curanderismo* and includes a variety of centuries-old practices, treatments and perceived afflictions.

### The Dual Health Perspective

Indigenous Mexican health care beliefs contrast with Western European systems in notable ways.

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Western European medicine is predicated on theoretical foundations and techniques dependent on "scientific investigation" (4, p. 234). It is a perspective thought to be "neutral and impersonal and ... grounded in scientific objectivism" (5, p. 6). The melding of Spanish and Aztec scientific and religious beliefs added to the scientific rationality perspective a supernatural element incorporating metaphysical connections to a spiritual world with the power to cure, as well as the power to impose illness (6–8). It is a perspective that recognizes psychosocial contributors to illness and to health. Niska and Snyder (9) surveyed young, Mexican American parents who described health as " ... more than freedom from illness" (p. 229). Their perception of optimal health was expanded to include the "physical, emotional, social interactional, and spiritual integration of their ... family" (p. 229). From this broader perspective of health dynamics, modern medicine omits potential contributors to illness as they seek to diagnose the causes of illness in some Mexican American patients through strict scientific, intellectual investigation (5, 10). Folk medicine provides a broader perspective which takes into account the cultural significance and the personal and social meanings of illness (5, 11).

Krajewski-Jaime (12) outlined three central aspects of folk medicine among Hispanics: first, the role of the kin in diagnosing and treating illness; second, the connection between religion and illness which fostered the use of religious ritual in healing practices; and third, the universality of many health beliefs, symptoms, and regimens of healing among Latino communities (p. 161).

Inherent in these aspects is the need to maintain psychological, spiritual and interpersonal homeostasis:

> ... a healthy body is maintained through the balancing of biological needs and social-interpersonal expectations, physical and spiritual harmony, and individual and cultural-familial attachments (13, p. 115)

The *personalismo* which is often used to describe Mexican American social interactions speaks to the primacy of positive social relationships as a goal in day to day life (6, 14, 15). Cox and Ephross (16) suggested the "marginal-to-poor level of existence" make informal, traditional, and personal social networks particularly important for "the information, practical assistance, contacts ... (and) major sources of support and integration into the new society" (p. 87). Within today's ethnic Mexican American communities, Mexican traditions and belief systems can persist in isolation, particularly when surrounded by mainstream resources which are hostile or inaccessible, or are perceived as such. For some Mexican Americans, the need to fulfill health care needs can mean utilizing accessible mainstream services, and it can mean calling upon known informal, indigenous health care systems. Rivera and Erlich (17) spoke of the concept of "neo-gemeinschaft" which is thought to typify ethnic minority communities. These are relatively homogenous and closed communities where English is not often spoken; where there is a shared experience of racism and oppression among many extended family networks.

Falicov (18), among others, portrays typical Latino health belief systems as possessing three distinct qualities: " ... belief in traditional folk illness; belief in hot/cold theories of illness; and belief in the supernatural, magic and bewitchment ... " (p. 132). Ancient Mexico, for centuries, was governed by the holistic perspective that an imbalance in the "opposing forces of the cosmos" could lead to illness. Disease and illness "could be inflicted by one of the many gods as punishment for bad behavior, or a person with special powers could inflict it" (19, pp. 28–29). It is a perspective of illness that recognizes the power of the supernatural both as healer and as malevolent spell-caster (20). Mexican folk medicine today reflects a melding of native American Indian naturalist religions and the Roman Catholic notion of health or illness as "God's will" or somehow attributable to a religious deity (19, p. 49). The blending of these belief systems is a prime example of the hybrid *Mestizo* culture which typifies Mexico today:

> *Mestizo* refers to a dynamic, synergistic process developed from the amalgamation of peoples, philosophies, and cultures bridging the European continent and the Americas; the intermingling of physical, psychological, cultural and spiritual ties between the Spaniard and the Indian (13, p. 105).

## Common Folk Illnesses

The *curanderismo* that many Mexican American families practice today perceives of illness both as a biological event (Western European perspective) and as a "social-interpersonal matrix" of causes and cures (13, p. 114). Folk illnesses are differentiated from other microbial illnesses due to their quality of personal transmission, or due to their supernatural origin (21). With the Spanish subjugation of

indigenous Mexico, the Hippocratic theories of humoral pathology contributed an additional theoretical framework for explaining disease, which was also incorporated into the Mexican Indian medical lore (19, 22). Physical health was viewed to be dependent on a proper balance of the body's four humors: the hot fluids of blood and yellow bile, and the cold fluids of phlegm and black bile. The body's symmetry is thought to be restored through ingesting foods and herbs with opposing qualities, sometimes with the guidance of persons with particular knowledge of herbal and food properties (22). The confluence of the disease-centered health paradigm with the personal and spiritual serves to explain the unexplainable in illness for many Mexican Americans (10).

Equally powerful in causing imbalance are the *mal aires* or *mal de aire* (or bad airs) which can cause a range of illness including pain, cramps, and even paralysis in individuals (23). Cold drafts can result in everything from headaches to colds, to tuberculosis and must be restored to harmony with "hot" foods (22, p. 155). Likewise, the "hot" illnesses, which can include digestive maladies, kidney ailments, rashes, and sore throat, must be remedied with foods of opposing forces (24). Pregnancy is also thought to be a "hot" imbalance requiring "cold" foods to restore balance (22, p. 140). While there is wide variation in the categorizing of food, there is some agreement that strong foods such as pork, eggs, and dairy products are often involved in such imbalance (12, 25). A particular folk illness related to an imbalance of foods is the physiological condition of *empacho* (8, 15). More than indigestion, *empacho* is believed to be caused by food or concentrations of saliva that cannot be dislodged from the sides of the stomach, leading to stomach pain, constipation, bloating, or other digestive disorders (15, 26).

A unique body of disorders involving spiritual and socio-personal imbalances forms the bulk of folk illness. Perhaps the most feared of the folk illnesses are those which could be construed by Western European practitioners as potential mental disorders, although modern clinicians are diversifying their categorizations of culture-bound diagnostic categories (27). This group of illnesses is composed of the personally transmitted, supernatural illnesses of *mal ojo* (or evil eye), and *embrujo* (or supernatural hex) (15, 22). *Mal ojo* (also expressed as *mal de ojo* or simply *ojo*) can cause headaches, fever, or even death in the person who has been the subject of intense and covetous glances as Green depicts:

> The eyes of another person can be the virulent agent for initiating this condition . . . Children are particularly susceptible to the admiring looks of adults, and women may be exposed to danger from the glances of men (15, p. 65).

*Envidia,* or intense jealousy, may precede *mal ojo* when a known or unknown person desires what the other person possesses. If this imbalance in this personal relationship is not broken by actually touching the victim, the physical manifestations can include insomnia, fever, vomiting, or restlessness (23). Equally powerful is the condition of *embrujo* (also known as *embrujada* or *mal puesto*). *Un embrujo* is thought to be a personally transmitted hex which signifies an imbalance between positive energies and evil spirits (13).

*Susto* and *espanto* comprise another group of interpersonal maladies. *Susto,* and most often *espanto,* have been described as "soul loss" (22) or "spirit attack" (10) first indicated by physical weakness, depression, introversion, and apathy among other symptoms. *Susto* is typified by serious fright as a result of a traumatic incident. Left untreated, death can be the ultimate outcome (5, 10). *Susto* is thought to particularly occur in the childhood years. A variant of *susto* is *espanto* which is said to be caused by extreme fright due to supernatural causes which has caused the soul to separate from one's body (12). Symptoms of *espanto* are comparable to those of *susto,* but may escalate to include anorexia, insomnia, and hallucination (26, 28).

## The Folk Practitioners and Treatments

The "folk systems" used by major Latino groups today incorporate folk and religious treatments in an accessible, secondary health care system. It is a system composed of practitioners who have been informally trained or who are recognized as having inherited the "don" or gift of healing (21).

The *curandero* (male) or *curandera* (female) is recognized as a folk healer with the ability to both diagnose illness and provide therapeutic, psychosocial interventions in the natural physical and psychological realm, as well as the supernatural realm. (8, 28). They are empowered with the ability to force the return of an evil spell (*un embrujo* or *mal puesto*) which has been cast on the patient. *Curanderos* are able to serve as a link with spirits who can direct positive or negative forces in assisting the patient (8). Healers utilize what Castillo (10) refers to as

"transformational healing symbols" which may include herbs, medications, massage, prayer, holy objects, incantations, penance for sin, proverbs, scripture, or sacred words (pp. 82–83). The healer is often said to perform "una limpia" (22) or "una barrida" (6) or "un bano" (14) all of which figuratively translate to "a spiritual cleansing". As in the case of *mal de ojo*, the touch of the person who cast the ill will is sought out to break the negative bond. If that does not occur, the victim may choose to seek out a *curandero* who has particular expertise in the use of spiritual, religious, and medical tools. Treatments may include the use of eggs, herbs, oils, candle lighting, laying of hands, and prayer (6, 26). *Curanderos* may treat a full range of physical, mental and spiritual afflictions, even to the point of performing exorcisms (6).

Faith healers who have no particular medical expertise, but who attempt to heal the soul only are those (generally) women referred to as *senoras* or *espiritistas* or *espiritualistas*. Their expertise lies in reading spiritual cards or performing a séance to discern problem relationship areas and outcomes for the spiritually anguished client (8, 25).

A second tier of folk health practitioners involves the *yerberos* (herbalists), (6, 22). *Yerberos* may maintain a public "*botanica*" where natural herbs, homeopathic medicines and religious amulets are made available for purchase, along with medical consultation and direction (29). They may dispense *estafiate* as a purgative tea for *empacho* (12); *yerbabuena* (peppermint) teas for stomach pain and for discomfort attending pregnancy (30); *manzanilla* (chamomile) for a wide range of physical and emotional ailments, including labor pains (31); *flor de tila* (linden blossom) for insomnia; or *borraja* (borage) to cut a fever (8). Torres (32) undertook extensive research in documenting hundreds of herbs used as analgesics, antidotes, antiemetics, antiseptics, disinfectants, expectorants, purgatives, sedatives, and stimulants. One particular herb is noted for its "magical" properties, *pirul* (pepper tree), and is thought to be used by *curanderos* to cure *susto* or *mal de aire*. Trotter and Chavira (8) note the use of such medicinal herbs by *curanderos* who may prescribe teas, herbal baths, or poultices as a form of "primitive chemotherapy" (p. 74).

A final category of practitioners includes those who deal exclusively with physical imbalances. These are the *sobadores* (or *sobaderos*) (traditional masseuses) and *parteras* (lay midwives) (30, 31). *Sobadores* may perform simple massages (*masajes*) to alleviate pain and tension; or they may also be instrumental in treating *empacho* or in manipulating sprains (25). More experienced *sobadores* may be called upon to function as *hueseros*, or bone-setters (8).

Many Mexican American families practice their own traditions of folk medicine within their home and extended family networks. Candle-lit religious altars may be established in the home for commemorative, religious, and healing purposes. The use of home-made poultices, herbal treatments, and religious amulets are practices transferred from generation to generation which form a group of *remedios caseros* (home remedies) (6, 29, 30). Supportive professionals such as the *yerbero* (herbalist) dispense the needed medicinal herbs as illness warrants. Most typical of the herbs found in a majority of Mexican American homes where folk healing is practiced include *manzanilla and yerba buena* (30).

*Curanderismo* persists for practical reasons which confront many impoverished Mexican Americans for whom U.S. health care systems have failed. Lack of medical insurance (33), language barriers, lack of knowledge of and accessibility to mainstream medical services have also served to sustain an informal system of health care providers and home remedies (19, 34, 35). Equally important may be the lack of culturally sensitive providers available to this growing population (8, 36). One of the primary reasons that Mexican folk traditions may persist is that some of the folk illnesses defy ontological explanations or descriptions that can be readily understood by mainstream doctors (5). The mother who seeks medical care for her child who is believed to be suffering from *caida de mollera* (fallen fontanel) may often be confronted by a medical staff who view the child's dehydration and fever to be the result of "parental ignorance, superstition, or simply as abuse and/or neglect" (12, p. 157). In contrast, a curandero may offer understanding and relief for the parent.

Some research suggests the use of folk medicine is but a small percentage of actual Mexican American health care practices (28, 37). Other recent reports (38) suggest dramatic increases in the number of Mexican Americans who return to Mexico on a regular basis for health care services which are typified, not only by low cost, but also by "cultural empathy". Much of the extant literature found stronger beliefs in folk healing among Mexican Americans of lower socioeconomic levels and lower educational levels (12, 26, 28, 39). In Baer and Bustillo's (40) study, 53%

of Mexican American farmworkers in one sample self-medicated using available, traditional resources. Yet, others suggest that reliance on folk healers and treatments may not necessarily be determined by social status or by level of acculturation:

> ... it is critical to understand which behaviors result from oppression, discrimination, and poverty, and which are reflections of ethnic values and norms. (16, p. 13).

In the belief that more empirical data would be advantageous in understanding health care behaviors of Mexican Americans, this study posed the question: To what extent do highly assimilated Mexican American women still retain traditional folk beliefs and folk practices in their own health care maintenance?

## METHOD

### Participants

The researcher selected a convenience sample of Spanish-surnamed Latina students in both an undergraduate (BSW) and graduate social work program in southern California. The study was limited to women because exiting literature suggests that folk traditions, including health care and dispensing of health remedies, are typically the purview of female members of the family and are handed down from grandmother to mother to daughter (30, 41). It was assumed by the researcher that a high level of assimilation and some level of acculturation had to be achieved by the women in order to have successfully enrolled in a rigorous professional program. The social work program that provided the sampling pool was a large one, with 619 graduate students and 123 undergraduate students. It provided an opportunity to use a convenience sample because of its high proportion of female students and Latina students. Over 86% of the students in this program were female and approximately 54% of the program's undergraduates and 25% of the graduate students identified themselves as Chicano/Mexican American upon application to the program. A letter soliciting subjects who self-identified as Mexican American, along with the survey, were placed in 200 randomly selected mailboxes of undergraduate and graduate students who were female and who had a Spanish surname. Of the 200 solicitations, 70 completed surveys were returned to the researcher's mailbox for a response rate of 35%.

### Measures

The self-administered questionnaire was developed by the researcher. In addition to demographic characteristics, information was solicited about family characteristics and extended family proximity and interaction, both in the U.S. and in Mexico. Other areas of inquiry included perceived religious practices and use of religious icons and altars in the home. Perceptions of health status, medical insurance coverage, number of visits to doctors and comfort level while meeting with doctors in the U.S. constituted another area of questioning. Knowledge of and exposure to Mexican folk illnesses asked specifically about *mal ojo, mal aires, envidia, coraje, embrujo, susto, espanto,* and*empacho.* The remainder of questions asked subjects about their knowledge of and exposure to select folk practitioners, such as *curanderos, sobadores, yerberos,* and *espiritualistas,* as well as use of and purchase of medicinal herbs as home remedies.

The instrument has strong content validity based on an exhaustive review of the extant literature in both the English and Spanish languages. Internal consistency reliability scores ranged from good (0.5231) to excellent (0.8419).

## RESULTS

Table I reflects select characteristics of the respondents. Age of the 70 female subjects ranged from 20 to 47 years, with a mean of 28.8 years (SD = 7.61). Fifty-four women (77%) were U.S. born, while 23% were born in Mexico. Most subjects self-identified as middle class (71%), with 26% self-identifying as lower SES. Eighty-one per cent stated they were fluent in the Spanish language; 14% were somewhat fluent; and 4% were non-Spanish speakers.

The women described their family configurations as large, extended and highly interactive in 27% of the sample, while 49% noted their families were extended but had occasional interactions; and 24% noted they belonged to nuclear families with little interaction with other relatives. The geographical location of extended family members ranged from having most family members located in the same city (17%); to having family members mostly in the state of California (19%); to having family both in the U.S. and in Mexico (53%); to those 11% whose family members were primarily located in Mexico. In their practice of Mexican traditions, 37% considered

**Table I.** Characteristics of Respondents ($N = 70$)

| Characteristic | *n* | % |
|---|---|---|
| Age | | |
| 20–24 | 27 | 39 |
| 25–29 | 22 | 31 |
| 30–34 | 5 | 7 |
| 35–39 | 6 | 8 |
| 40–44 | 6 | 8 |
| 45+ | 4 | 6 |
| Place of birth | | |
| U.S. | 54 | 77 |
| Mexico | 16 | 23 |
| Socioeconomic status | | |
| Upper class | 2 | 3 |
| Middle class | 50 | 71 |
| Lower class | 18 | 26 |
| Spanish language fluency | | |
| Fluent | 57 | 81 |
| Somewhat fluent | 10 | 14 |
| No Spanish fluency | 3 | 4 |
| Family interaction | | |
| Extended with high interaction | 19 | 27 |
| Extended with occasional interaction | 34 | 49 |
| Nuclear family interaction only | 17 | 24 |
| Extended family proximity | | |
| Family members in same city | 12 | 17 |
| Family members in same state | 13 | 19 |
| | 37 | 53 |
| Family primarily in Mexico | 8 | 11 |
| Practice of Mexican traditions | | |
| Very tied to traditions | 26 | 37 |
| Somewhat tied to traditions | 35 | 50 |
| Occasionally practice traditions | 7 | 10 |
| Do not practice traditions at all | 2 | 3 |

*Note.* Percentages have been rounded off.

themselves very much tied to traditional practices, while 50% felt only somewhat tied to traditional Mexican practices. Subjects were asked how many times they actually traveled to Mexico in the prior 24 months. Number of trips to Mexico ranged from 0 to 10 with a mean of 2.74 trips (SD = 2.08) over the 24-month period (Table I).

Religiosity of subjects was probed by asking about religious items maintained in the home and by asking subjects to rate their own religious practices. Religious items found in the home were: image of the *Virgin de Guadalupe* (the Mexican patron saint) (79% of respondents); crucifix (86%); lighted altar (36%); depiction of the Last Supper (54%); and other religious pictures or statues (80%). A majority of subjects (71%) rated themselves as only somewhat religious, with 21% stating they were not very religious at all, and 6% stating they considered themselves to be extremely religious. The above items generated a religiosity subscale for further analysis.

A health subscale was also generated based on responses to questions about perceived health status, comfort level felt with U.S. doctors and perceived ease of communication with U.S. doctors. Subjects' perceptions of their own health status ranged from very healthy (31%), to mostly healthy (57%), to having some medical problems (10%). They rated their comfort level with current U.S. doctors as very comfortable (33%), usually comfortable (41%), and sometimes uncomfortable (26%). Subjects expressed their ability to communicate their medical problems to their U.S. doctors: 36% indicated they never had problems in this area; 59% indicated they sometimes had problems communicating; while 6% indicated they often had difficulties with communication. Subjects were asked to note the number of visits to U.S. doctors in prior 24 months. Visits ranged from 0 to 19, with an overall mean of four visits in the 24-month period. Seventy-one percent of the sample stated they had some form of medical insurance (Table II).

Use of medical resources in Mexico was probed by asking if subjects had ever traveled to Mexico to buy medicine not available in the United States. (It should be noted here that the Mexican border is approximately a 2-hr drive from the sampling site.) Fifty-seven percent had traveled to Mexico to

**Table II.** Respondents' Health Characteristics ($N = 70$)

| Characteristic | *n* | % |
|---|---|---|
| Health status | | |
| Very healthy | 22 | 31 |
| Mostly healthy | 41 | 57 |
| Some medical problems | 7 | 10 |
| Comfort level with U.S. doctor | | |
| Very comfortable | 23 | 33 |
| Usually comfortable | 29 | 41 |
| Sometimes uncomfortable | 18 | 26 |
| Communication with U.S. doctor | | |
| No problem communicating | 25 | 36 |
| Sometimes have problem | 41 | 59 |
| Often have difficulty communicating | 4 | 6 |
| Have health coverage in emergency | | |
| Have coverage | 50 | 71 |
| Have no health coverage | 20 | 29 |
| Mexican health resources used | | |
| Purchased medicine in Mexico | 40 | 57 |
| Obtained medical care in Mexico | 15 | 21 |
| Purchased medicinal herbs in Mexico | 35 | 50 |
| Purchase *manzanilla* for medicinal purposes in home | 50 | 71 |
| Purchase *te de Yerba Buena* for medicinal purposes in home | 56 | 80 |

*Note.* Percentages have been rounded off.

**Table III.** Knowledge of Indigenous Illnesses ($N = 70$)

| Illness | Heard of this illness | | Knew someone with illness | |
|---|---|---|---|---|
| | $n$ | % | $n$ | % |
| *Mal ojo or ojo* | 63 | 90.0 | 29 | 41.4 |
| *Mal de aire* | 46 | 65.7 | 16 | 22.9 |
| *Envidia* | 55 | 78.6 | 18 | 25.7 |
| *Coraje* | 65 | 92.9 | 41 | 58.6 |
| *Un embrujo* | 62 | 88.6 | 25 | 35.7 |
| *Susto* | 65 | 92.9 | 48 | 68.6 |
| *Espanto* | 49 | 70.0 | 21 | 30.0 |
| *Empacho* | 57 | 81.4 | 36 | 51.4 |

*Note.* Illnesses probed were: *mal ojo* (evil eye); *mal de aire* (bad airs); *envidia* (envy); *coraje* (rage); *un embrujo* (a hex); *susto* and *espanto* (debilitating shock or fear); and *empacho* (indigestion or constipation).

purchase medicine; 21% had obtained medical care there; and 50% of the subjects had brought back to the United States medicinal herbs purchased in Mexico. These items composed a Mexican medical resources subscale for additional analysis. A vast majority of the subjects maintained the traditional medicinal herb tea of *manzanilla* in the home (71%), and also maintained the herbal *te de yerbabuena* (80%) (Table II).

Subjects were asked if they had heard of or had known of anyone to suffer from specific folk illnesses listed (Table III). Over 70% of the sample had heard of all 8 folk illnesses listed by the researcher. A majority knew someone who had suffered from *empacho, coraje,* and *susto* depicts these responses, along with responses to queries about knowledge of and use of folk practitioners. Table IV depicts responses to questions about personal knowledge of and use of various folk practitioners. Over 70% of the sample had heard of the practitioners *curanderos, sobadores, yerberos,* and *espiritualistas*; and a majority had known of someone who had used all but the *espiritualista*. Personal use of the practitioners by the subjects was limited to *curanderos* (25.7% had used); *sobadores* (38.6% had used); and *yerberos* (20% had used them).

## Analysis

Several subscales were generated to explore the effects of demographic variables and subject characteristics on health and health care beliefs. Pearson's $r$ analysis disclosed a significant relationship between age and whether they had heard of folk healers ($r = 0.286$; $p = 0.016$) and between age and whether they had known of someone who had used the services of folk healers ($r = 0.283$; $p = 0.018$). Older respondents were more likely to answer in the affirmative for these questions. Birthplace also showed a significant effect. An independent samples $t$-test revealed that women born in the United States had significantly more medical problems than subjects born in Mexico ($t = 2.110$; $p = 0.039$). Analysis of language use and other demographic variables yielded no other significant outcomes.

A negative correlation was found in analysis of use of Mexican medications. Increased use of Mexican medicines was correlated with fewer doctor's visits in the United States ($r = -0.248$; $p = 0.039$).

Other $t$-test analyses revealed significant findings for the variable of medical insurance coverage. Respondents who had insurance coverage were found to be less religious ($t = 2.630$; $p = 0.011$); had fewer health problems ($t = 1.969$; $p = 0.053$); and were less likely to use folk healers ($t = 2.088$; $p = 0.041$). Religiosity also proved significant in another area of comparison. Analysis of variance (ANOVA) was used to explore the relationship between religious practices and use of indigenous

**Table IV.** Knowledge of and use of Indigenous Health Practitioners ($N = 70$)

| Indigenous practitioner | Heard of them | | Knew someone who had used | | Personally received their services | |
|---|---|---|---|---|---|---|
| | $n$ | % | $n$ | % | $n$ | % |
| *Curandero* | 63 | 90.0 | 49 | 70.0 | 18 | 25.7 |
| *Sobador* | 54 | 77.1 | 52 | 74.3 | 27 | 38.6 |
| *Yerbero* | 56 | 80.0 | 39 | 55.7 | 14 | 20.0 |
| *Espiritualista* | 50 | 71.4 | 27 | 38.6 | 0 | 0 |

*Note.* Folk practitioners noted are: *curandero* (folk doctor); *sobador* (healer by massage); *yerbero* (healer by medicinal herbs); and *espiritualista* (healer through prayer).

healers. Greater religiosity of subjects suggested increased use of folk practitioners ($F = 7.266$; $p = 0.001$).

## DISCUSSION

This study found some evidence to support the persistence of indigenous health care beliefs and practices among urban, assimilated Mexican American women. The findings reflect a sample that is largely bilingual (Spanish and English), with some interaction among family members both here and in Mexico. The subjects felt themselves to be only somewhat traditional in Mexican cultural practices, while most retained religiosity in the form of traditional religious symbols in the home.

The health status of the sample was perceived as mostly healthy, with a great majority expressing their comfort levels and communication levels with U.S. doctors as not entirely positive experiences. A majority of the sample also engaged in securing medical resources in Mexico and maintained traditional medicinal herbs in the home. Much of the literature to date sustains the belief that both folk and conventional medicine are viewed as resources by Mexican Americans (12, 42). While an overwhelming majority had heard of the eight folk maladies specified in the survey, only *coraje* and *susto* had been observed in acquaintances of the subjects. Regarding the four types of folk healers, a majority had heard of folk healers and many knew of persons who had used them. Almost 26% of the sample had been treated by a *curandero*, although a greater number had used the services of a *sobador*.

Several limitations bear comment. While the use of college students as subjects served to secure a highly assimilated sample, it also presented one element of bias in assessing the availability of conventional health care resources for this sample, in that a minimal level of emergency health services are available on campus for all students via University enrollment fees. Lack of insurance coverage has been noted in several studies as one impetus to choosing folk alternatives (6, 16, 33). The insurance factor becomes a particularly salient point when recognizing the fact that approximately 35% of Latinos, and 44% of those Latinos living below the poverty level were not covered by health insurance in a recent accounting (43).

While Longres (44) and others suggest that the use of folk systems is exaggerated for ethnic communities and has been diluted over generations, these findings suggest that there is a continuing awareness that these additional health care systems exist as a viable resource in Mexican American communities and should be viewed by practitioners as such when assessing health belief systems and behaviors. Despite the relaxing of religious practices and Mexican cultural traditions, remnants of indigenous health belief systems appear to have been retained in Mexican American communities represented in this sample.

These findings suggest other public health policy implications which may improve our practice of inclusion of this complementary health care system used by many immigrant communities. Prevailing, formal health care systems are encouraged to recognize the folk belief systems and practitioners as opportunities to enhance outreach to ethnic enclaves. Magana and Clark (2) among many, stress the inadequacy of narrow health care paradigms which exclude indigenous and culturally responsive health belief systems which persist among immigrant populations. Rather than fearing or shunning folk practitioners, today's formal medical establishment should engage in collaborative activities of health education and preventive services. The gatekeeper role that informal folk practitioners can play in reaching otherwise disengaged needy may be underestimated and underutilized. With the vagaries of economic systems disallowing medical coverage and with anti-immigrant public initiatives reducing health care benefits and programs for one segment of the Mexican American population, this topic should be of concern. If, in fact, the mutual goal of both folk and establishment health care personnel is the enhanced health and functioning of the Latino patient, then a reciprocal understanding of the strengths of each system would ultimately benefit many seeking effective health care.

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