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Reported folk beliefs and practices of Mexican-American women seeking non-traditional health care

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Reported Folk Beliefs and Practices of Mexican-American Women Seeking Non-Traditional Health Care

by

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Abstract

This exploratory study was developed to gain insight of Mexican-Americans' folk belief system and its influence on health practices. Mexican-Americans are one of the largest ethnic groups in the United States. However, data are limited, confusing and difficult to retrieve. Also, research on the Mexican-American people is primarily from out-dated studies that generally characterized them as traditional people who adhered to folk beliefs and practices in health care.

In this study, the investigator surveyed 40 Mexican-American women on their knowledge of folk beliefs and practices attributed to Mexican-Americans. Responses were described and compared to a select list of existing literature and were found to be different from beliefs and practices previously reported.

Eight folk conditions: Brujeria, mollera caida, empacho, mal ojo, bilis, susto, mal aire, and mal puesto were recognized by the subjects, although susto and bilis were normal occurrences that did not require intervention. Also, the meaning and symptoms of the conditions were not as well known and treatments were no longer as magical or ritualistic as previously described. The data suggest that some Mexican-American women are combining knowledge of traditional beliefs and practices with non-traditional treatments; at times, the women consulted physicians for treatment of folk ailments.

The findings of this study are important, as they indicate that recognition of folk conditions did not necessarily imply belief in the conditions. The information provided by this study is useful to health providers, as it calls into question previous findings and contributes new information on Mexican-Americans' folk beliefs and practices.

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CHAPTER I

The Study Problem

Mexican-Americans, or Latinos of Mexican origin, are the largest and one of the fastest growing ethnic groups in the United States. It is estimated that Latinos of Mexican origin comprise 60% of the Latino population in the United States (U.S. Census Bureau, 1980). In California, ethnic minorities comprise 33% of the population and the majority are Latinos of Mexican descent (20%). In Southern California, approximately one-third of Los Angeles County are Latinos. The "barrio" in Los Angeles has been considered the third largest Mexican city in the world, surpassed only by two major cities in Mexico: Mexico City and Guadalajara (Steiner, 1970). New estimates indicate that within 30-40 years, Latinos of Mexican origin may comprise 35-40% of California's population (Hayes-Bautista, 1987; Perez-Stable, 1987b).

Spector (1985) notes that census figures on Latinos can serve only as broad estimates, and these are often underestimates, owing to the continuous influx of immigrants from Mexico, the ability of many Latinos to avoid census counts, and the lack of uniform terminology in defining and identifying Mexican-Americans. As Hayes-Bautista (1987) has pointed out, there is presently no commonly accepted method for defining and counting individuals of Latin American origin or descent in the United States.

A brief historical review of terms used by federal and public health agencies shows that beginning in the 1930s, nationality was

used to denote race. Therefore, "Mexican" became a racial category. In later years, Mexicans were listed as White. By the 1950s, the Mexican-American population was classified as White of Spanish surname. By 1970, Spanish surname, language, birthplace, and parentage were utilized to denote Spanish heritage, further blurring the differences between specific Latino groups and compounding the problems in identifying Mexican-Americans. At this time, the federal government attempted to improve and facilitate data gathering and adopted the term "Hispanic" to refer to individuals of Mexican, Puerto Rican, Cuban, Latin American, or other Spanish culture or origin, regardless of race.

The continuous use of different identifying labels throughout the years creates problem when retrieving data on Latino populations. Hayes-Bautista (1983) points out a major flaw in terminology is the tendency to combine incomparable groups and to apply research findings to all Hispanics, as though all members were homogeneous. This flaw is most evident when one reviews and attempts to compare studies with a Mexican or Mexican-American sample with newer studies (post 1960s) using Hispanic samples. The samples are clearly different, incomparable, and confusing for anyone wishing general information or health data on Mexican-Americans.

The Hispanic classification presumes homogeneity between widely differing ethnic groups. The term ignores the diversity of ethnic people and disregards race, country of origin, culture, and

language (Giachello, Bell, Aday, & Anderson, 1983; Hayes-Bautista & Chapa, 1987; Perez-Stable, 1987a).

In addition to the problem of identifying Mexican-American individuals, there is a paucity of research on the people. Among the largest minority groups in the United States, the least has been written about Mexican-Americans (Burma, 1970). Stenger-Castro (1978) reported that prior to the 1960s, the general public knew little about Mexican-Americans and "most people were not even not curious, much less concerned" (p. 19). More recently, Perez-Stable (1987a) acknowledged that until recently, Mexican-Americans were not counted as a distinct and separate ethnic group (depending on the time period, they were White or Spanish surnamed). What little information is available on Mexican-Americans and their health beliefs and practices is primarily based on research of the 1940s-1960s (Clark, 1959; Madsen, 1964; Rubel, 1966; Saunders, 1954).

The early studies of the 1940s-1960s described Mexican-Americans in terms of "village" life and provided descriptions and interpretations of family structure, kinship system, and health and illness beliefs and practices. With the exception of Clark (1959), who focused on an urban population in California, early ethnographers concentrated on small, rural, lower-class people in New Mexico and Texas. The selected samples fit the preconceived stereotypes and gave credence to researchers' theories. Ethnographic studies

portrayed Mexican-Americans as traditional people who relied on folk medicine and magico-religious practices for the prevention and treatment of illnesses. These researchers suggested that adherence to folk beliefs and practices interfered with acculturation and the acceptance of "scientific" western medical care (Madsen, 1964; Rubel, 1966).

The early studies have recently come under much criticism. Weaver (1973) and Zinn (1979) questioned the scope, methodology, and reliability of previous ethnographic studies. These authors suggested that the early descriptive studies lacked objectivity and perpetuated negative stereotypes about Mexican-Americans or Chicano families. The authors pointed out that the focus of research was on the differences between the Mexican culture and the mainstream (American) culture. The health behaviors displayed by some Mexican-Americans were highlighted and presumed to be a result of culture (culture-bound) and therefore, deviant. Furthermore, the small homogeneous samples of early ethnographic studies could not be considered representative of all Mexican-American people.

Unlike the homogeneous characterizations found in the early studies, Mexican-Americans are a heterogeneous people whose only similarities are a common language, cultural heritage, and ancestry. The majority of Mexican-Americans now live in urban areas (Perez-Stable, 1987a). Many are native U.S. born and are moving away from the lower-class Mexican traditional culture

toward Anglo American middle-class culture (Penaloza, 1970). There are also language differences and variations in what Mexican-Americans chose to call themselves. For example, some Mexican-Americans are bilingual; some speak English only, some speak Spanish only, and others speak "Spanglish." Mexican-Americans themselves may add to the confusion. They identify themselves either as Americans, Hispanos, Mexicans, Mexican Americans (with or without the hyphen), or La Raza. However, it is generally agreed upon that the most recognized and accepted term remains Mexican American (Burma, 1970).

It is obvious that generalizations cannot be made about this diverse ethnic group and in reality, there is no "Mexican-American family type" (Murillo, 1978). However, the general assumption remains that Mexican-Americans are primarily Spanish speaking immigrants who are employed in agriculture and adhere to traditional folk beliefs and practices.

The significance of the stereotypes presented in the literature is that they suggest a "typical" Mexican-American health behavior exists. According to some health providers, Mexican-Americans reportedly prefer traditional medicine and "marginal practitioners" who massage, manipulate, and utilize herbal treatments (Abril, 1977). Furthermore, Mexican-American clients are skeptical of Western medicine and seek advice from Western practitioners only after home remedies and folk-healing practices have failed (Gonzalez-Swafford & Gutierrez, 1983).

These authors suggest that the "typical" Mexican-American clients hold health beliefs and practices that affect both the seeking and delivery of "scientific" health care.

The ideology presented in the literature has serious implications in the health care arena. Not only may the relationship of health provider and client be seriously affected, it suggests a lack of understanding and sensitivity on the provider's part. Furthermore, such an ideology undermines the ability of Mexican-American clients to understand, seek, and accept "scientific" medicine. Ultimately, one's perception of what a client will accept affects not only the services offered to the clients, but also the programs developed to meet their health needs offered to individuals. As Spector (1985) has reported, if providers become more knowledgeable and sensitive of the issues surrounding health care, and accepting of traditional health behaviors, more appropriate comprehensive health care may be provided to all clients.

Definitions

Several terms are used throughout this study. A brief summary of terms is presented here. A list of Mexican-American folk syndromes appears in Appendix A.

Mexican-Americans are individuals of Mexican descent living in the United States. Traditional medicine (folk medicine) refers to health beliefs and practices attributed to Mexican-Americans. Folk beliefs are beliefs on health and illness causation assumed

to influence health behaviors. Folk practices include any rituals, herbs, and home remedies used in maintaining health, warding off or treating of illnesses. Folk beliefs and practices are popular, rooted in the past, and vary from practices generally sanctioned by non-traditional medical practitioners. In contrast, nontraditional medicine refers to the biomedical model of care and is commonly referred to as "Western," "scientific," or "modern" medicine.

Objectives of the Study

The three major objectives are (a) to expand and update the current pool of knowledge on the health behaviors of the Mexican-American people, (b) to call into question early stereotypes that persist, and (c) to provide nurses with culturally relevant clinical information on one ethnic group. As a nurse interested in working with different ethnic groups in the United States, it seems that without current data, nurses will not have sufficient understanding of ethnic groups on which to base interventions that are relevant and culturally acceptable.

Purposes of the Study

The purposes of this study are (a) to describe the knowledge of folk beliefs and practices held by a select group of Mexican-American women in Los Angeles, California; and (b) to compare the knowledge of folk beliefs and practices of these Mexican-Americans to those described in the literature.

Significance of the Study

As previously noted, Mexican-Americans may soon comprise 35%-40% of California's population. As a major segment of the population, the Mexican-American people have the potential for becoming the largest segment of health consumers in the state. As a group, Latinos in general tend to be at greater health risk for hypertension, diabetes mellitus, depression, tuberculosis, parasitic conditions, and other infectious diseases. Compared to other groups, Latinos are also less likely to have any form of medical insurance (Perez-Stable, 1987b). A special report by the Robert Wood Johnson Foundation (1986) noted that medical care among the nation's poor, minority, and uninsured citizens had deteriorated since 1982. This situation describes the plight of many Mexican-Americans, as they tend to be overrepresented in low-income jobs and tend to be underinsured or non-insured (Spector, 1985). Clearly, the Mexican-American people face serious medical and social conditions and yet, there is a paucity of data, they are misunderstood, and their health needs are not being addressed.

This study also has special significance to the researcher. As a Mexican-American, fluent in Spanish, familiar with the culture and mores, and a resident of the area studied, the investigator hopes to further the understanding of the richness and diversity of the Mexican-American people. As a nurse and former employee of the site utilized for this study, the

investigator is interested in improving the quality of culturally sensitive care to all clients, in this case, Mexican-Americans.

Limitations of the Study

This study is limited to surveying women who sought medical care for their infants at a large Southern California hospital. Hence, the sample is biased. Since the women voluntarily sought "Western" health care, they may represent individuals who do not routinely subscribe to folk medicine. Therefore, generalizations about health care beliefs and behaviors are restricted to this group. However, the sample is appropriate for health care studies since "Western" practitioners provide health care for clients when they seek "Western" health care.

The investigator's interest in the Mexican-American people also may have influenced the research. The investigator was conscientiously aware of this throughout the study. To compensate for possible misunderstanding during data collection, responses were reiterated by the investigator and written down verbatim. Also, copious field notes were taken during the collection process and completed immediately after the interviews. During analysis, responses were carefully screened and coded. Field notes served as confirming evidence; they contributed to the interpretation of responses in the final analysis.

CHAPTER II

Review of Literature

Research on health care beliefs and practices of Mexican-Americans is limited and relatively new. Ethnographic studies conducted during the 1940s through the 1960s are the most noted and cited research. The studies were approximate chronologies of the 1940s, 1950s, and 1960s, were cumulative endeavors, and provided "three generations" of research (Weaver, 1973). Functioning as generations, the first generation (1940s) provided the framework for succeeding generations. Second and third generations (1950s and 1960s) built upon the work of the previous ones and continued to explore the central theme: that Mexican-American health care behavior was a consequence of their culture (Farge, 1975; Weaver, 1973).

Current research of the 1970s-1980s varies from the "generational studies" in several respects. Although newer studies continued to describe the health behaviors of Mexican-Americans, the newer research expanded its scope by exploring and promoting the health care needs of the Mexican-American people. No longer limiting itself to the ethnographic and detailed case study approaches used by early sociologists and anthropologists, current research now includes field studies, case studies, surveys, and anecdotal accounts produced by several disciplines.

For the purposes of this study, only research clearly pertaining to the Mexican-American people is reviewed. A historical analysis of the research is presented in chronological order. The "generational studies" of the 1940s-1960s (primarily anthropological) are presented first. These studies are followed by the current research of the last ten years, by discipline: anthropological, medical, and nursing.

A summary of the major folk syndromes presented in the literature reviewed is presented in Appendix A.

The First Generation (1940s)

Lyle Saunders (1954) is the sole representative of this era of research. Where prior studies had focused on tracing the roots of folk medicine and the historical development of folk rituals, Saunders was the first to apply basic anthropological concepts to Mexican-American health care behaviors (Roeder, 1982). Saunders is therefore considered the primary contributor of this era. He is referred to as the "pater familias" of Mexican-American health care studies and his influence is noted throughout subsequent literature (Weaver, 1973).

Conducted in the late 1940s in New Mexico, Saunders' study provided information for "Anglo" practitioners working with Spanish speaking clients. Saunders presented Mexican-Americans as "coming from a village way of life" where health was a matter of chance and the "supernatural" was frequently a cause of illness. Focusing on differences between Mexican-American people and

"Anglo" practitioners, Saunders' reported the interrelationship between medicine and culture and described the "healing ways" of the Spanish speaking people. In the community, Saunders noted a dependency on folk medicine, home remedies, and folk practitioners. This dependency presumably inhibited some families from using established medicine and functioned as a barrier to the acculturation of the Spanish speaking people (Mexican-Americans). Furthermore, Saunders suggested that acculturation of the Mexican-American people was the solution and ultimate goal for improving relations between Mexican-Americans and "Anglo" practitioners. Saunders' study established the model that health care behaviors of the Mexican-American people were culturally determined (Roeder, 1982; Weaver, 1973).

The Second Generation (1950s)

Research conducted in the 1950s followed the "culturalist perspective" model established by Saunders. Researchers of this era concentrated on further describing the folk beliefs and practices of Mexican-Americans (Farge, 1975; Roeder, 1982; Weaver, 1973). The primary contributors, Clark (1959), Madsen (1964), and Rubel (1966), conducted field studies of working class rural and village populations in California and Texas.

Clark (1959) presented an ethnographic study of poor Spanish speaking seasonal migrant laborers living near San Jose, California. The study was designed to describe relations between the Mexican-American community and the "Anglo" public health

personnel. Based on observations and supplemental information provided by 14 families, Clark provided vivid, extensive descriptions of folk beliefs, home remedies and practices utilized by the "barrio" (neighborhood) people.

In this study, folk diseases were classified into six categories. The categories and their corresponding syndromes were:

1. diseases of "hot and cold" imbalance: "hot and cold" foods, illnesses, and medications

2. diseases due to the dislocation of internal organs: mollera caida (fallen fontanelle)

3. diseases of magical origin: bilis (loosely translated as "bile") and susto (soul loss)

4. diseases of emotional origin: mal ojo (evil eye), mal aire (bad, evil air), and brujeria (witchcraft)

5. other folk-defined diseases: empacho (surfeit)

6. "standard scientific" diseases.

Clark (1959) found that folk illnesses were frequently encountered in the community. Senoras and curanderas (healers) were regarded as specialists and their expertise often sought. Any ideas inconsistent with folk medical beliefs were likely to be rejected as false or relegated to a special category of disorders that "doctors did not know about." Accordingly, anyone who denied the existence of folk syndromes was either a "fool" or a "liar". Recommendations for health workers were included at the end of the

text, as Clark suggested that through better understanding of the people, acceptance of scientific medical practice would improve. Clark's study confirmed Saunders' premise that health care was culturally determined (Farge, 1975).

A second researcher of this era, Madsen (1964), conducted an ethnographic study from 1957-1961 in Texas. Based on individual case histories, folk beliefs were described in detail. Illnesses were classified as "natural" or "supernatural." "Natural" illnesses (good illnesses) were due to the imbalance of the natural world controlled by God and were corrected by restoring the balance between the individual and his environment. Pregnancy was especially dangerous for women, because a naturally occurring phenomena (a full moon or lunar eclipse) could deform the fetus. "Supernatural" illnesses were associated with Satan or resulted from punishment from God. "Supernatural" illnesses as bewitchment, evil eye, fright or fallen fontanelle were presumed to be anxiety-reducing in individuals unable to cope with stressful situations. The importance of this study was Madsen's hypothesis that folk illnesses protected individuals from a stressful acculturation process. Furthermore, belief in folk medicine varied inversely with social class. The lower class placed faith in folk medicine while the "anglicized" upper class denounced belief in the supernatural.

Rubel (1966), a student of Madsen, also gathered his data from 1957-1961. Utilizing participant observation, key

informants, and a questionnaire, Rubel conducted a two year field study of seasonal agricultural workers in the lower Rio Grande Valley of South Texas. Rubel, like Madsen (1964), focused on the traditional beliefs and practices of the Rio Grande community and also described illnesses as "natural" or "unnatural"; i.e., within the realm of God or the devil. Illness resulted from bodily malfunctions, undue influences (hostility, enviousness, witchcraft), or unseen forces (germs). Anecdotal case studies highlighted the four major folk illnesses found in the community: (a) susto, (b) empacho, (c) mal ojo, and (d) mal puesto (a spell resulting from witchcraft).

Of particular interest was the contrast between physicians and healers. Curanderos (healers) were viewed as "helping the people," whereas physicians were negatively viewed as a result of their fee-for-service policy. Unlike Clark (1959), who presented curanderas as neighborhood women with special knowledge, Rubel presented curanderas as individuals who derived divine powers from God. Rubel hypothesized that resistance to "anglicization" (acculturation) was a major obstacle and impeded utilization of "scientific" medicine.

First and second generation studies of the 1940s and 1950s provided vivid descriptions of home remedies and folk practices. Despite their limitations, due to their uniformity of methodology and ideology, these early ethnographic studies have provided much

of the information presently accepted by "Western" health care providers.

The Third Generation (1960s)

Studies produced in the 1960s vary from the earlier research of the 1940s and 1950s. Researchers of this era no longer concentrated on rural populations nor on refining Saunders' subculture model of health care. Instead, this generation seemed more intent on confirming or questioning the assumptions of the past (Farge, 1975; Weaver, 1973). Researchers who continued the culturalist perspective were Nall and Speilberg (1967) and Kiev (1969). The primary challengers of this ideology were Karno and Edgarton (1969).

Nall and Speilberg (1967) surveyed individuals in the lower Rio Grande Valley of Texas. The authors explored the relationship of cultural and social factors with the acceptance of medical treatment. Their findings were that use of folk curers, religious practices, and commitment to folk beliefs were not related to acceptance or rejection of medical treatment. However, the authors suggested that the Mexican-American culture established a psychological dependency between individuals and the family unit. This dependency reportedly could interfere with acceptance of medical treatment when treatment required separation from the family.

Kiev (1969) produced a study on Mexican-American folk psychiatry. Based on a small sample which included curanderos

(folk healers) and clinical cases in Texas, Kiev suggested that central values found in the Mexican-American culture contributed to psychological conflict within the individual. Further, the author suggested that the services of curanderos were often sought. The "folk therapists" were credited for maintaining low levels of mental illness in the communities they served.

Karno and Edgarton (1969) were the primary challengers of the "culture-mental illness" perspective. Noting Mexican-Americans were underrepresented in some psychiatric facilities, the authors conducted a five year study in Los Angeles. The authors relied on large surveys and field work (including visits to curanderos) to determine if underrepresentation in mental health facilities was related to a lower incidence of reported mental illness. Reporting that underrepresentation did not necessarily reflect a lower incidence of mental illness, the authors suggested that social and cultural factors (strong family support), frequent use of family physicians (for counseling and support), and lack of mental health facilities were the primary factors in sustaining Mexican-Americans out of mental health facilities. With strong support from relatives and family physicians, individuals were able to function in their communities. Folk medicine, folk psychotherapy, and the "Mexican culture" were not considered prime factors in the underrepresentation rates. Reported preference for the family physician during times of stress contrasted Kiev's findings (1969).

Current Research (1970s-1980s)

Studies produced in the last 10-15 years differ from the generational studies. There is now a tendency to pull away from the culturalist perspective and stereotypes have begun to disappear, although not completely. Many disciplines are now represented and include sociology, anthropology, medicine, and nursing. Methodology has also expanded and includes ethnographic studies, surveys, case studies, and anecdotal accounts.

In the following section, literature is grouped by discipline. Presenting the literature in this format gives an idea of the direction that research on Mexican-Americans is taking. Sociological studies are presented first, followed by anthropological, medical, and nursing studies.

Sociological studies. Farge (1975) is the primary contributor of this discipline. His study, "La Vida Chicana: Health Care Attitudes and Behaviors of Houston Chicanos" is frequently cited in other works. This study is best known for testing several hypotheses suggested by Saunders (1954), Madsen (1964), Rubel (1966), Nall and Speilberg (1969), and several other researchers. Farge surveyed three areas (150 households) in Houston, Texas. Utilizing a questionnaire, a total of 11 hypotheses were tested and compared with several variables including demographics and acculturation levels.

The major findings of this study were that belief in folk medicine varied inversely with socioeconomic status (higher

classes were less likely than lower classes to adhere to folk medicine) but belief in folk medicine did not interfere with the seeking of appropriate medical care.

Anthropological studies. Kay (1977) conducted an ethnomedical study of four families in a "barrio" in Arizona. The author studied "Mexican" diseases (including mollera caida, susto, and mal ojo) and several typical "Western" conditions. Major findings were that variations existed in the meaning of folk ailments, symptoms, and treatments. In this study, "aire" meant "gas", "mal ojo" was not a major concern, and "hot and cold illnesses" were not readily recognized by the sample. Also, the usual sequential pattern for seeking health care (family members, curers, then physicians) was not reported. In the community, the women treated "simple" or "passing" diseases, while physicians were consulted for the "serious" illnesses. Curanderos primarily treated "Mexican" diseases and were consulted when family members became displeased with Western medicine and its practitioners. Finally, the women reported they would consult Western practitioners if economically feasible. Kay's findings suggested that folk medical practices were changing and the importance of economics in health care seeking behavior.

Trotter (1983) noted that throughout 20 years of extensive research in Texas, ethnographers (himself included) tended to emphasize magico-religious practices of Mexican-Americans. Concerned that highlighting unusual behaviors produced a "subtle

form of cultural stereotyping," the author conducted extensive surveys and collected over 1,000 case studies to report on the "more common and less spectacular" home remedies of Mexican-Americans in Texas. The author reported seven folk ailments that were frequently mentioned by the sample. Three of these: (a) susto, (b) empacho, and (c) dolor del aire no longer had magical connotations. Variations in the meaning and symptomatology suggested that reappraisal of "culture-bound syndromes" was warranted.

Medical studies. Medical practitioners have produced several articles on Mexican-American health care practices. Martinez (1977) and Meyer (1977) drew from their psychiatric clinical experiences and suggested that practitioners should become familiar with curanderos, if they were to be effective in Chicano communities. The authors reported that clients frequently consulted curanderos for "supernatural" illnesses. Both authors recommended that practitioners should provide referrals and consultations with curanderos.

Nursing studies. A literature search of the last ten years (1977-1987) produced two anecdotal articles (Abril, 1977; Gonzalez-Swafford & Gutierrez, 1983) and one research study (Mardiros, 1984). The anecdotal articles are included in this review to illustrate the paucity of nursing research and the limited nursing perspective.

Mardiros (1977) interviewed and observed 70 hospitalized Mexican-American clients to gain understanding of the hospitalization experience and to assess the relevance of folk beliefs during hospitalization. The author reported that information on folk beliefs was metered out and sharing of information was based on a client's ability to trust professionals. Furthermore, belief in a folk medical system did not affect the "hospitalization experience."

Abril (1977) reviewed literature on Mexican-American folk beliefs and provided anecdotal accounts from experiences with migrant populations in Arizona. Primarily a discourse on Clark's (1959) study, the author suggested that adherence to traditional customs affected acceptance of Western health care.

Gonzalez-Swafford and Gutierrez (1983) summarized anthropological and sociological literature and reported that a large percentage of Mexican-Americans adhered to folk beliefs and practices. The authors described folk beliefs and practices generally attributed to the Mexican-American people. They suggested that nurse practitioners should become familiar with these folk beliefs and practices, as folk conditions were frequently encountered in the Mexican-American people.

Summary of Literature

Beginning with the 1940s, social scientists began conducting research on small, rural or working-class poor Mexican-American communities in the Southwestern United States. Provided primarily

by anthropologists, the research characterized Mexican-Americans as traditional people who routinely adhered to magico-religious folk beliefs and practices. The general assumption implied that a distinctive folk medical system existed and that this was a consequence of the Mexican culture. Since culture was presumed to be the main contributing factor, it was suggested that a Mexican-American health care subculture existed which interfered with the seeking and delivery of medical care. These studies, limited in scope and methodology, have provided many of the characterizations and generalizations made about the Mexican-American people. Although the studies are now approximately 30 years old, the generalizations persist and are continuously found throughout literature.

More recently, scholars generally believe that a folk medical system exists only in some Mexican-American communities. However, the degree and extent to which this system is ascribed to is questioned. Unfortunately, the lack of research information limits understanding of this ethnic group. Also, some health care providers are now expressing concern that lack of data on the Mexican-American people and their health beliefs and practices severely limits the development of viable programs that addresses the health care needs of this large ethnic group.

CHAPTER III

Methodology

A survey and exploratory descriptive design was utilized to gain understanding of Mexican-Americans' views on folk beliefs and health practices.

Research Design

The investigator developed a questionnaire to survey a select group of Mexican-American women on folk beliefs and practices attributed to Mexican-Americans. The questionnaire was designed to gather demographic data, to elicit information on knowledge of folk beliefs and practices of individuals, and to gather information on the health practices of family and friends (Appendix B).

Utilizing the instrument as an interview guide, respondents were asked if they had heard of specific folk concepts/conditions and to recite what they had heard, or knew about each condition. Field notes were written immediately after each interview and supplemented survey data.

Research Setting

A major county hospital in Southern California served as the setting for the study. The hospital is a major county facility recognized for serving Latinos, primarily Mexican-Americans. Informants were chosen from two pediatric clinics in the outpatient department, the High Risk Clinic and the Well-Baby Clinic. Entry to the site was facilitated by the investigator's

personal relationship with a Medical Director of one of the clinics. It was expected that sample characteristics would approximate those of individuals described in the literature as adhering to folk beliefs and practices, Mexican descent, low income and educational level.

Sample

Human subjects assurance. The research proposal was approved by the University Committee for Human Rights and the Research Committee of the Southern California Hospital. Following approval, subjects were informed that participation was voluntary and confidential and would not interfere or affect their care at the facility. Following a full explanation of the study, consents were read to informants in their preferred language and signed. Signed copies were given to informants.

Nature and size. Forty informants were chosen as the sample of convenience. Of these, one completed half of the interview. Since much information provided by the informant would have to be dismissed if said questionnaire was eliminated, the partially completed questionnaire was retained. Therefore, findings either reflect a sample size of 40 or 39.

Criteria for sample selection. Gender and location were the primary criteria for inclusion in the study. Women waiting for scheduled pediatric appointments in the clinical areas who identified themselves of Mexican descent and freely consented to be interviewed participated in the study. Women were chosen as

informants because women are generally noted for their knowledge of a family's health care practices. Also, Mexican-American women are reportedly the primary health care providers/seekers for their families (Manzanedo, Walter, & Lorig, 1980; Rubel, 1966).

Techniques for Data Collection

Gaining entry and acceptance by informants. Prior to beginning data collection, the investigator spent one day at the health facility familiarizing herself with the site and clinical staff. The purpose was to establish an unobtrusive, "safe", and trusting relationship with staff and potential subjects. The investigator became a "fixture" in the area, provided directions to patients, served as Spanish translator (a gesture that endeared her to staff and patients), and generally befriended staff and patients. This introductory phase simplified the process for approaching and selecting clients and facilitated data gathering.

Procedure. Data were collected during the months of July and August 1987. Women identifying themselves of Mexican descent were informed of the research study and asked to participate. Those wishing to participate were fully informed of the research purposes and interviewed in a private room. All subjects were assured of privacy and confidentiality.

Utilizing a written questionnaire, women were interviewed once in English, Spanish, or a combination of both languages, depending on the individual's preference and language proficiency. In a few instances, respondents were called for scheduled

pediatric appointments and the interview was halted. With the exception of one respondent, all returned and finished interviews.

Instrument. A questionnaire (Appendix C) was developed by the investigator to elicit information on the folk beliefs and practices of Mexican-Americans reported in the literature. The questionnaire consisted of seven sections. Section I (18 items) gathered demographic data. Section II (18 items) elicited information on the health status of the individual. Section III elicited information useful for developing a three generational family tree. Section IV (26 items) elicited information on folk beliefs and practices. Section V (3 items) elicited information on the health practices of friends. Sections VI and VII (3 items) sought information on other sources of health care plus miscellaneous information (other information the respondent wished to report).

The instrument guided the interview. Interviews required one to three and one-half hours, with an average of one and one-half hours. Responses and comments were directly written on the questionnaire form by the investigator.

Validity and reliability. Before beginning the study, the questionnaire was reviewed by professionals familiar with Mexican-Americans, health care behaviors assigned them, and Spanish terminology in the community. The three professionals were a Spanish translator, a physician and expert in the field, and a health provider working with Latino clients. The three

reviewed the questionnaire for correctness of language (Spanish) and clarity. After revision, the instrument was pilot tested on two Latinas familiar with information sought.

Interviewing techniques. Based on information gathered from field notes taken throughout the interviews, it was apparent that some respondents were confused about the folk conditions researched in this study. Although researchers have clearly retained classed categories and definitions of folk terms, some respondents had difficulty keeping information catalogued. Folk terms have not been clearly defined within the Mexican-American community and the women's responses reflected this confusion. For example, many women did not distinguish between a full moon or eclipse, or between witchcraft and an evil hex. One woman admitted that she "gets all those things confused" when asked about mal puesto. In her confusion, the woman recited information about susto and mal ojo before admitting her confusion.

A second area for discussion was the practice of rewording or reconstructing questions when disclosing information. When asked about witchcraft, one woman exclaimed, "Ah, now I know what you're asking. You want to know about those superstitions!" This woman, as others, recalled information as the interview progressed and then returned to previous questions to add information or clarify previous comments.

A third area that warrants further discussion is the role taken by some respondents during the interview process. Some women took on the "teacher" role and their actions suggested the interviewer was the student. If they spoke rapidly, the women waited for the interviewer to finish writing comments. If the interviewer was not familiar with terms, the women carefully spelled the words and gave detailed descriptions. It should be noted here that if these women were not familiar with the conditions being investigated, some women offered to return with the information at a later date, or they could ask their mother or grandmother to return with them. Still other women who were unfamiliar with the folk conditions asked the investigator to teach them about these beliefs and practices.

On subsequent visits to the clinic, some of these women stopped by and asked how the research was progressing. The women were not only curious, they were interested in the findings and wanted to be updated. These women expressed satisfaction with the research and the interest shown by the researcher. Their attitude and comments suggested they were eager to learn and discuss issues that concerned them and welcomed further research.

Techniques for Data Analysis

Guidelines suggested by Chenitz and Swanson (1986) and Strauss (1987) for analyzing qualitative data influenced the interpretation of the survey data. Guidelines presented by these

authors facilitated development of general themes, categories, and narrative descriptions.

The interviewer had asked respondents if they had heard of specific folk conditions. Respondents were then asked to report what they had heard or knew about each condition. This interview pattern generated four categories for analyzing responses. The categories were (a) familiar, (b) knowledge, (c) belief, and (d) experience. Individuals were **familiar** with conditions when they had heard of the folk term or condition. They had some **knowledge** of conditions if they could recite symptoms, treatments, or preventive methods. Two other categories, **belief** and **experience** were developed because familiarity and knowledge of folk conditions differed from what respondents believed could occur and what they could or had experienced. Additionally, some women reported that they had not experienced the conditions, although family members had. The family's experiences affected what was known and believed about said conditions. Therefore, the experience category included the number of individuals and family members experiencing conditions.

After the four major categories for analysis were generated, individual responses to each question were re-read for the purpose of comparing responses with information from the literature reviewed. Key words or phrases were then highlighted and picked out (coding). The coding process progressed to the grouping of responses and the development of two sub-categories that were

useful for making comparisons. The investigator developed the sub-categories of **folk** and **other**. Individual responses matching descriptions in the literature were classified as folk. Responses not matching these descriptions were classified as other.

The four main categories: **familiar**, **knowledge**, **belief**, and **experience** clarified the general knowledge of folk beliefs and practices of the women in this study. The sub-categories, **folk** and **other** provided the method for comparing the general knowledge of folk beliefs and practices with what has been previously reported.

Summary

Forty Mexican-American women whose infants received care from two pediatric clinics at a large Southern California hospital were surveyed on folk beliefs and practices. Demographic characteristics of the sample along with information on folk beliefs and practices of the sample was collected for this report. A questionnaire, developed by the investigator, served as an interview guide for exploring and describing knowledge of folk conditions most commonly noted in literature on Mexican-Americans.

Responses provided a general description of folk beliefs and practices attributed to the Mexican-American people. The information was reported as frequency distributions, summarized, and compared to a selected list of literature.

CHAPTER IV

Results

The purposes of the study were to (a) describe the knowledge of folk beliefs and practices held by a select group of Mexican-American women in Los Angeles, California; and (b) compare the knowledge of folk beliefs and practices of these Mexican-Americans to those described in the literature. Only findings related to folk medicine or the folk beliefs and practices of the Mexican-American women surveyed are presented in this report.

Data are presented in the following order: (a) the major characteristics of the sample, (b) a summary of responses (frequency distributions), and (c) short narratives describing current general knowledge of folk beliefs and practices of the sample and their comparison with previous studies. Data are displayed in Tables 1-7 and Appendixes A, B and C.

Sample Characteristics

All informants provided demographic information. A summary is displayed in Table 1.

Ages of the informants ranged from 16-39, with a mean of 24 years. Thirty-four (85%) were Roman Catholics, four (10%) were Christian, Pentecostal or Jehovah Witnesses, and one reported no religious affiliation. Twenty-one (53%) were married, 11 (28%) were single, seven (18%) were separated, and one was divorced. Fifteen (38%) of these women were heads of households. Number of

children, family and household size varied. The number of children ranged from 0 (pregnant) to 7; family size ranged from 1 (single and pregnant) to 7; and size of household ranged from 1 to 11. These numbers fluctuated as some family members remained in Mexico, while others joined relatives or friends in California, thus forming extended families.

The number of years in the United States also varied, as all but one of the women was born in Mexico. Twenty (50%) were in the United States less than 5 years, seven (18%) had been living here 6-10 years, and 12 had resided over 12 years in the United States.

The majority of the sample or 29 individuals (73%) were educated in Mexico. School attendance ranged from 2-14 years with a mean of 8 years. Twenty-six (65%) women had attended less than 10 years of school, 15 (38%) had 10-12 years of school, and one attended a professional (business) school after high school.

A total of 10 (25%) head of households were not employed, while 27 (68%) head of households were employed in factories, restaurants, construction sites, or service jobs. The monthly income ranged from $0-$2,000, and the median was $675 monthly. Thirty-six (90%) of the sample reportedly earned less than $12,000 annually. Medical coverage was provided by public assistance (Medi-Cal) for slightly more than half of the sample's children (24), two (5%) had private insurance, and 14 individuals (35%) did not have any family medical coverage.

Finally, all women identified themselves as Mexicans, with the exception of the U.S. born individual, who identified herself as a Mexican-American.

In summary, the sample can be characterized as predominantly Roman Catholic (85%), young (mean 24 years), recent immigrants (less than 5 years in the United States), of limited income and education (mean of 8 years), and medically underinsured or noninsured.

Knowledge of Folk Beliefs and Practices

The knowledge of folk beliefs and practices held by a select group of Mexican-American women in Los Angeles, California is reported and described in the following section. Results are displayed in Tables 2-7.

Religious Practices (Table 2)

Of the total sample, only 34 women responded to questions on religious practices and all were Roman Catholics. The remaining six individuals reported that either their religion did not view the selected practices as relevant to health or their religion forbade these practices.

In this sample, 33 individuals (97%) believed in God. Twenty-one women (62%) felt God influenced health and illness, but only six (18%) reported illness as due to punishment from God. Twenty-nine individuals prayed (85%), and 23 (68%) believed prayers affected their health in some way. Candles were offered in religious services by approximately half of the women (18

individuals), while 17 of these respondents believed offering candles affected their health in some way. Obviously, some nonbelievers of prayers and use of candles used them in their health practices.

Religion, belief in God and prayers played a large part in the women's lives for they reported that they routinely (almost daily) made the sign of the cross, talked or prayed to God. God was believed to keep the family "safe and healthy." If one became ill, God made them better. Some women prayed simply because they were taught to pray, others because praying made them "feel good" or "safe and calm." Most agreed that God and prayers affected their health, but they did not believe God determined or ordained illness. According to the women, the words "determine" and "ordain" were too strong. God was seen as benevolent. They did not believe that God punished or cause harm.

Approximately half of the women (53%) offered candles to God, the Virgin Mary, or other Saints at church (only 3 placed candles in their homes). Candles were used to ask for special favors, "I asked that my baby would be healthy" or to thank patron Saints, "I promised the Virgin Mary that if I became pregnant, I would light a candle for her." One woman who had never offered candles remarked, "Maybe I'll try it now" (now that she was asked about this practice).

Natural Forces and Health (Table 3)

Air, sun, water, and wind. Slightly more than half of the sample (55%) reported that air, sun, water, or wind could affect their health or cause illness. The majority of these women reported that aire (air) or aigre (wind) could cause generalized aches and pains. Some of these women did not distinguish between aire and aigre and interchanged the terms. Eight women (20%) reported that sun or water could cause ailments.

The women had heard and were knowledgeable of the dangers of excess exposure to the sun and impurities in drinking water. Seven women reported that "too much sun" irritated the skin or caused skin cancer. Drinking water that "was not good for you" produced stomach aches and diarrhea. Of interest is that these so-called folk conditions are the same as those recognized by practitioners trained in "Western" medicine (skin cancer, upset stomachs, diarrhea).

Nine of the 13 women familiar with conditions due to "el aire" (air/wind) used the term "mal aire" (evil, bad air). Mal aire had been previously classified as a magical condition (Clark, 1959; Rubel, 1966). Therefore, conditions attributed to aire are reported in the following section on conditions of magical origin.

The full moon and eclipse. The terms eclipse (eclipse) and luna llena (full moon) were used interchangeably by most women in the sample. Not only were the terms "luna llena" and "eclipse"

used interchangeably, symptoms and modes of prevention were also interchanged. Differences between the two terms were not clear. Two women explained "the moon is the moon," and the names did not matter. Since the women did not distinguish between a full moon and eclipse, their responses are combined in this section.

Depending on the term used, 83%-95% were familiar with the terms full moon and eclipse, 75%-92% could recite symptoms, 35%-65% knew some preventive methods, and 33%-53% of the sample believed exposure to a full moon or lunar eclipse caused physical or ailments or defects. One woman had a relative with a cleft lip, which the family attributed to an eclipse. Three women reported they had experienced the effects of a full moon; one had flu symptoms, a second went into labor prematurely, and the third suffered increased pain from an old foot injury.

A lunar eclipse or full moon caused problems for adults and unborn children. Pregnant women and their unborn were the most affected by the moon. If pregnant, women could experience increased fetal movement, quick deliveries or premature labor. An unborn child could suffer from birth defects, most commonly missing limbs or cleft palates. Other adults could behave differently, "act crazy" or become blinded from viewing the lunar eclipse. The women had been taught preventive methods by older relatives (mainly mothers) or friends. To protect oneself or prevent problems/defects, a red cloth or metal object (straight

pin, safety pin, scissors, gold ring) would be attached to clothing and worn throughout the pregnancy or during "the moon."

Therefore, at least 80% of the sample had heard that "the moon" produced ill effects, at least 75% had knowledge of symptoms, and 33%-66% of the women knew preventive methods. However, few women acted upon this information. For example, 14 women stated that they knew how to prevent problems caused by a full moon, and 21 stated that they knew preventive methods to use during an eclipse, yet only 6 (15%) utilized preventive methods. Most of these women attached straight pins or safety pins to their clothing during pregnancy, while one woman wore red underwear. One disbeliever seemed to take great pleasure in relating this story, "My older sister told me to wear a straight pin or safety pin. I didn't do it, and nothing happened."

Conditions of Magical Origin (Table 4)

Mal aire (bad/evil air). Twenty-four (60%) of the respondents were familiar with the term, almost as many could recite symptoms (55%), but half of these recited symptoms different from those reported in the literature. The new symptoms reported included eye infections, headaches, and colds. Only 12 (30%) of the sample could name treatments, and five of these reported that warm packs or eye drops were needed for infected eyes, or that a physician should be consulted. Eighteen women (45%) believed aire could cause ailments, and 15 women or their immediate family members had suffered the ill effects of aire.

Air that was "too cold" or "heavy" caused aches and pains. A "strong gust of wind" (aigre) or "too much air" most often caused ear aches. Symptoms and severity of condition depended on where the bad air "entered" or "hit" the body. Sudden environmental changes (quickly going from a warm place to a cold one), or being unprotected from drafts could cause resfriados (colds) generalized aches, headaches, earaches, sore throats, congestion, or aches and pains in the chest, back, or legs. One woman provided the following account: "If someone is sleeping, the person is nice and warm. If she opens the door upon awakening or goes outside, the air hits her and causes eye problems."

Another woman reported a co-worker's eye was red and appeared to be infected. The co-worker had told the respondent that she had "aire." But the respondent laughed and advised the co-worker that it was probably "due to smoking." This woman recommended her co-worker see a physician for antibiotic eye drops.

As reported above, treatments for these conditions were known by a few of the women (30%), and all were treatments not mentioned in the literature. Treatments included Ben Gay rubs "para calentar los huesos" (to warm the bones/aching areas); applying cotton balls treated with Vicks or alcohol and rue to the ear for ear aches; "limpias" (sweeping rituals) with eggs or lemon for sore throats or congestion; or drinking herb teas for colds. All were similar to Western home remedies and self care practices.

Physicians and antibiotics for eye infection were also recommended.

Brujeria (witchcraft). Thirty seven women (93%) had heard of brujeria. Half of these individuals called witchcraft mal puesto (evil hex). Other names were hechisera, maldad, or dano. Twenty-eight respondents (70%) were able to recite symptoms, but only 20 (50%) could recite treatments. Fourteen women (35%), believed brujeria existed and could cause ailments (one-half of those reciting symptoms). Twelve of the informants or 30% of the total sample reported that they or a family member had experienced witchcraft.

Brujeria was used to place hexes on individuals. Brujeria resulted when a witch or "someone" was consulted to harm an individual or entire family. Most often, this "someone" was consulted by a jealous individual or a rejected suitor who wished misfortunes on the family. One "knew" that witchcraft had been utilized when individuals suddenly displayed "strange" behavior, relationships between family members became strained, or illnesses occurred "and the doctor can't find anything wrong."

Mal puesto (evil hex). Twenty-four respondents (60%) reported they had heard of the term mal puesto (were familiar), 15 (38%) could recite symptoms, and only 10 (25%) could recite treatments for brujeria. On the other hand, 16 women (40%) had not heard of the term. Nine women (23%) reported they or a family member had, at some point, a spell (hex) placed on them.

Mal puesto resulted from the supernatural. The women had heard that "someone" who wished harm and "could do those things" was able to control an individual's actions or could cause misfortunes or physical ailments. Thirteen women mentioned that witches or spells were used for inflicting harm. Three women reported that dolls with pins stuck in them were used for placing a hex, most often producing pain or discomfort. Once a hex was placed, individuals acted "crazy," they suddenly became ill, jewelry was stolen, harmful gossip that strained relationships was spread, or fights between family members occurred. Four women reported physical conditions as tumors, sudden severe weight loss, diarrhea, or inability to walk or talk were due to a hex. One woman reported a relative had died from a hex, and a second relative had "guzanos en la cabeza" (worms in the head). Treatments were performed by a senora (healer) or "someone who knew about those things and could remove the spell."

Interestingly, seven women had heard of mal puesto only in Mexico. They suggested that brujeria occurred in Mexico, not in United States. As one woman stated, "Esas son cosas de Mexico" (those are things from Mexico). A second woman responded, "En Mexico se creen tantas cosas" (in Mexico, one believes many things/anything).

Other accounts were quite humorous. One woman, obviously trying to recollect what she had heard, began describing susto (fright) and mal ojo (evil eye). She quickly stopped herself

and remarked "I get all those things so confused." Another woman reported that when a friend had been rejected by a boyfriend in Mexico, she was advised by a neighborhood woman to "pray and use beer" to get her boyfriend back. This friend did what she was told but nothing occurred. The informant laughed while remarking, "I didn't think anything would happen."

Mal ojo (evil eye). Thirty-six women (90%) had heard of mal ojo, 22 women (55%) could list symptoms, and almost all of these respondents (53%) could recite treatments. Fifteen (38%) believed evil eye could occur and 7 women reported their child or a relative's child had experienced evil eye. All seven had been treated for mal ojo. In most instances, an older relative had treated the children with eggs, massages, or herb teas.

Most women could not explain why evil eye occurred or how it was diagnosed. The majority agreed that evil eye resulted when someone looked "funny" at infants or when an individual admired but did not touch the child. Twins or infants with blue or green eyes were most susceptible to mal ojo. Women "knew" a child with diarrhea, irritability, or red, swollen infected eyes had "ojo." Treatments included touching or kissing the affected infant (preferably by the adult who looked "funny" at them and caused ojo), or rituals with eggs, prayers or water (any water, not just holy water).

(Thirty-nine women provided information on the remaining syndromes/conditions).

Hot and Cold Syndromes

"Hot" foods, illnesses, and medications. Twelve women or less than a third of the sample had heard of "hot" foods. An even smaller number, five, had heard of a "hot illness" and only two women had heard of a "hot medicine." Of the handful that had heard of "hot foods", most reported the temperature of the food made it hot. Those responding to "hot illness" referred to the temperature of the individual during the illness. Individuals had a "hot" illness "because they felt hot."

Chili was hot because it was spicy and burned; abdominal upsets were hot because "the stomach felt hot." Of the two women who recognized penicillin as a "hot medicine," one had reportedly been advised by a physician in Mexico that antibiotics were hot. The second women assumed that "since penicillin has to be kept in the refrigerator, it must be hot". When questioned specifically about aspirin, none of the women had heard of it as a "hot" medicine.

"Cold" foods, illnesses, and medications. Responding to questions on "cold" foods, 26 women (67%) reported they were familiar with the term, 13 (33%) recognized "cold" illnesses, and five (13%) had heard of "cold" medicines.

Foods were cold due to their temperature. For example, "watermelon refreshes one in the summertime and tastes good."

Cold illnesses resulted from drafts or from being chilled. When one had a "cold illness", one felt cold and must warm the body. Cold medicines were those that produced warmth in the body. These included herb teas, Vicks, and several ointments that were rubbed on the area chilled. As one informant noted, "Ben Gay and alcohol rubs and warm the bones." This woman also used Ben Gay to treat conditions due to "el aire" (see mal aire).

Conditions of Emotional Origin (Table 5)

Susto (magical fright). Thirty-one women (80%) were familiar with susto. Twenty-nine (74%) could recite symptoms, and nine (23%) recited treatment methods. Twenty-two women (56%) indicated they believed susto occurred, and 16 (41%) reported they or a family member had experienced susto.

Susto was a normal occurrence. It occurred mainly while one slept and was similar to the startled response of infants. Women reported that in their sleep, infants dreamt and suddenly moved their arms, as if attempting to grab something. These women reported that infants needed to be held or their hands needed to be tied (swaddled).

Adults were also susceptible to susto. Adults could become nervous or frightened by unexpected experiences and therefore get susto. One woman remarked, "Anyone would get frightened when they see a terrible thing." Although four women reported conditions not previously attributed to susto (inability to speak, tumors,

diabetes, or a fallen fontanelle), the majority did not state that susto was an illness that required special attention.

Bilis. Twenty-seven individuals (69%) were familiar with the term bilis. Twenty-six women (67%) had knowledge of symptoms and 14 (36%) could recite treatments methods. Seven of these 14 women knowledgeable of treatments reported that "one needed to calm oneself." If unable to calm oneself, the women recommended medical attention. Sixteen women expressed belief in bilis and nine women (23%) had experienced it.

Bilis referred to a sudden, temporary episode of anger. Corajes (literally translated as rage but translated as anger by the women) caused stomach upsets or a sour taste in the mouth. Symptoms resemble anxiety reactions or panic attacks. The condition was not presumed to be serious, nor did it require special attention.

Miscellaneous Conditions (Table 6)

Fallen fontanelle (mollera caida). This condition was of some concern for the sample. Thirty-seven (95%) of the informants were familiar with the term, 26 (67%) had some knowledge of symptoms, and 31 (79%) recited treatment methods. Twenty-four of the individuals familiar with treatments recited treatments similar to those noted in the literature. More than half of the sample believed the condition could occur to infants (56%), and 14 (36%) reported their child or a relative's child had suffered from mollera. Two respondents knew how to treat mollera and had

treated others, while seven had relatives who knew how to treat the condition. None of these respondents called themselves senoras or curanderas (healers).

The mollera (fontanelle/soft spot) fell when infants were dropped, they were suddenly shaken, or a nipple was removed too quickly from their mouths. Mothers "knew" the mollera had fallen when infants became irritable, had diarrhea, or were unable (refused) to nipple. Three women associated the condition with the fontanelle area, although only one of these women looked at the area for diagnosis. This woman reported, "If you don't see it moving up and down (fontanelle area), the fontanelle must have fallen."

Eleven women reported that treatments were provided by "someone who knew how." Two women reported that curanderos treated the condition, and one reported that physicians were able to treat mollera. Treatments included:

1. placing the thumb inside the mouth of the infant and pushing the palate up, thereby lifting the fontanelle

2. holding the infant by the feet; this procedure would make the fontanelle return to its original position

3. placing one's mouth on the fontanelle area and suctioning the area up.

One woman reported that chocolate could be applied prior to suctioning.

One woman who witnessed her nephew being treated by a neighborhood woman "who knew how" reported, "Lo voltearon, le pegaron, le estiraban el estomago. Tantas cosas le hicieron!" (They turned him, spanked him, pulled his stomach. So many things were done!").

Empacho (surfeit). Empacho is another condition well known by the sample. Thirty-six informants (92%) were familiar with the term, 31 (79%) could recite symptoms, and 29 (74%) could recite treatments. Eleven of those knowledgeable of treatments reported some not previously described in the literature. Twenty-seven (69%) believed in its occurrence, and 10 (26%) had experienced empacho.

One half of the women reported vague symptoms with empacho. Empacho occured when "you eat too much food and the stomach doesn't feel right." It could also result from giving old milk to infants.

In adults or children, grapes, pan dulce (sweet bread), or old milk produced stomach aches, diarrhea, or vomiting, and therefore empacho. One woman reported that empacho meant "esta empachado" (the state of having empacho) and was surprised that further information was sought by the investigator. Treatments included rubbing the stomach with oil (or anything greasy), pinching the spine, ingesting Pepto Bismol or herb teas, or consulting with physicians and taking medication for infection.

Although a large number of respondents were familiar and knowledgeable of empacho, they did not seem as bothered by this condition as by a fallen fontanelle. Empacho was easily treated and was easily taken care of at home by the respondents.

Other Practices

Teas. The majority of respondents were familiar with and used teas. Most mentioned mint, camomile, and cinnamon. These teas were taken because "they taste good and my mother taught me to drink them." Others drank teas because they were soothing and helped relieve flu symptoms, stomach cramps, or colic.

Curanderos (folk healers). Twenty-seven (69%) had heard of curanderos or senoras. Eleven reported that senoras were different from curanderos. Women who treated relatives in their homes (as mentioned for mal ojo, empacho, or mollera) were not called senoras or curanderas, they were simply referred to as "those who know how." Eleven had consulted senoras, and 4 had consulted curanderos. Four individuals knew where to locate curanderos in Los Angeles County, and five different respondents knew where to find one in Mexico. (One woman responded "not yet" when asked if she had ever consulted a curandero.)

Curanderos were different from "senoras" (women neighborhood healers). They knew how to treat many more conditions and therefore were special. Women had learned of curanderos in Mexico or from relatives, and most did not know where to contact

one in Los Angeles. Two of the women reported that they had relatives who were curanderos in Mexico, and both women had been treated by them for various conditions.

It was interesting to note that when the sample was questioned about healers, some quickly denied knowledge of curanderos. Others laughed and seemed hesitant about providing further information. This issue needs to be investigated further.

Summary of Knowledge of Folk Beliefs and Practices (Table 7)

Eight folk conditions/syndromes were recognized by at least 60% of the sample. These were (a) mollera caida, (b) brujeria, (c) empacho, (d) mal ojo, (e) bilis, (f) susto, (g) mal aire, and (h) mal puesto. However, the percentage of individuals who were familiar with these conditions and the percentage of individuals who believed and experienced these conditions differed greatly. It was also evident that familiarity of folk terms did not necessarily imply belief in them. Also, one could not assume that familiarity with a condition would cause one to experience the condition. While at least 60% of the sample recognized eight folk conditions, only empacho was believed capable of occurring by at least 60% of the sample. Furthermore, none of the conditions had been experienced by at least 60% of the sample. Mollera caida was the condition most experienced by the sample and their families. Only 36% reported they had experienced mollera. The remaining conditions: empacho, susto, bilis, brujeria, mal puesto, mal

aire, and mal ojo had been reportedly experienced by 30% or less of the sample and their families.

Comparison of Literature Beliefs and Beliefs of Subjects

In the following section, the knowledge of folk beliefs and practices as reported by the women surveyed are compared to what is described in existing literature (reviewed in Chapter II of this report). A comparison of the eight folk conditions most recognized is displayed in Appendix C.

Religious Practices

Although religion and prayers played a large part in the women's lives, their responses did not confirm the descriptions by other researchers that Mexican-Americans believed that illnesses were punishments from God, and that adherence to religious rituals assisted in maintaining health (Clark, 1959; Rubel, 1966; Spector, 1985). The idea that illness was due to "the wrath of God" (Abril, 1977) was also not confirmed. Several women smiled, almost holding back laughter at the idea that God determined health and illness. A few seemed annoyed at the idea of God punishing. As one woman reported, faith and prayers were not all that was needed. According to this woman, "you also have to take care of yourself."

Natural Forces and Health

Air, sun, water, wind, and health. Only a third of the women attributed aches and pains to "el aire." Responses were similar

to what was previously reported by Clark (1959) and Madsen (1964). However, the respondent's observations that skin cancer and stomach upsets were caused by overexposure to the sun or the drinking of impure water have not been previously reported.

The full moon and eclipse. The data confirms previous findings that women did not distinguish between a full moon and eclipse (Madsen, 1964). Similar to Abril's report (1977), it was found that most women had heard that anomalies were due to a lunar eclipse. However, very few women utilized preventive methods, and none of these women wore a belt with keys as reported by Madsen (1964) and Abril (1977).

Conditions of Magical Origin

Mal aire. With the exceptions of two individuals, the sample did not express the notion that air contained evil or magical forces that attacked or possessed individuals (Clark, 1959; Rubel, 1964). Instead, the women described air that was "too cold or strong" as being "bad for you." Air was not innately "bad," it was only bad when "it hit you." The consensus was that a "strong gush of wind hits" and produces aches and pains.

Brujeria. Although many had heard of brujeria, fewer numbers believed witches were involved in causing illness. The findings reported by Clark (1959) that witches turned into owls and that rituals were utilized to ward off evil forces were not confirmed by this study.

Mal puesto. Mal puesto was a vague concept and confusing for the majority of women sampled. This term was used to explain conditions or ailments that had no reasonable explanation, or could not be comprehended. At some point, the women had heard that hexes could be placed on people, but they were unsure as to who placed them, how they were placed or removed. As with brujeria, mal puesto was not as magical nor ritualistic as reported by Madsen (1964), Clark (1959), and Abril (1977).

Mal ojo. Women strained to remember information they had once heard, and most of their recall was general and vague. Their descriptions did not match what was previously reported by Madsen (1954), Clark (1959), and Rubel (1966). The women could not report why "ojo" occurred, and except for two individuals, they could not describe the rituals involved in treating the condition. Furthermore, diagnosis was based on symptoms and not the events leading to the condition (i.e., an adult with a strong gaze had visited and admired but failed to touch the child). Unlike previous reports, eye conditions became part of the mal ojo syndrome.

Hot and Cold Syndromes

"Hot" foods, illnesses, and medications. The responses on the "hot and cold" nature of foods, illnesses, and treatments did not confirm findings of previous researchers (Clark, 1959; Abril, 1977). Foods were "hot" or "cold" on the basis of their temperature, not from their innate qualities that required

balance. Furthermore, aspirin and penicillin were not recognized as "hot," and vitamin C was not recognized as "cold." Therefore, it was not confirmed that these medications would be rejected if prescribed for inappropriate "hot and cold" illnesses (Gonzalez-Swafford & Gutierrez, 1983).

"Cold" foods, illnesses, and medications. As with "hot" foods, illness, and medications, the women classified foods, illness, and medications on the basis of their temperature, not their innate qualities.

Conditions of Emotional Origin

Susto. None of the women interviewed associated susto with "soul loss" (Rubel, 1966). Furthermore, none of the respondents were familiar with rituals utilized to coax the soul back, as presented by Clark (1959).

Bilis. Clark (1959) reported that although Bilis did not always imply disease, it required treatment. In contrast, the women in this sample considered bilis a temporary state that required intervention only if one "could not control themselves." Bilis, as susto, was a condition that was "normalized" by the sample.

Miscellaneous Conditions

Mollera caida. Unlike the findings reported by Clark (1959), Madsen (1964) and Rubel (1966), most women did not associate the dislocation of a bone, or the actual falling of the fontanelle with mollera caida (only three women surveyed associated the

condition with the fontanelle area). While symptoms and treatments were vague and did not seem as ritualistic as previously described, they remain significant health concerns.

Empacho. The sample in Clark's study (1959) based the diagnosis of empacho on a swollen stomach or "balls" in the abdomen or calves. The women in this study based diagnosis on the symptoms of stomach aches, diarrhea or vomiting. Treatments were similar to those noted by Clark (1959) but not as severe or ritualistic as kneading the spine or ingesting teas or quicksilver. The condition was also not considered fatal after three months (Madsen, 1954; Rubel, 1966).

Other Practices

Teas. The use of teas in this sample did not differ from how mainstream society uses teas; they were purchased in supermarkets and did not have magical or ritualistic qualities.

Curanderos (healers). Curanderos were different from "senoras" and "women who knew how to treat" folk conditions. The sample did not confirm Clark's findings (1959) that senoras were curanderas, nor Rubel's findings (1966) that curanderas had divine powers from God.

Summary of Comparison of Literature Beliefs and Beliefs of Subjects

Many folk beliefs and practices were well-known by the sample. Folk conditions were based on characteristic signs and symptoms and not on the event that proceeded the condition. Also,

most signs and symptoms were general and vague, and the selected treatment methods were not as magico-ritualistic as previously reported (Abril, 1977; Clark, 1959; Madsen, 1954; Rubel, 1966). In some cases, "folk treatments" were combined with "scientific" methods (physicians, antibiotics). In other cases, beliefs and practices were called into question by the women themselves.

Folk terms have therefore survived, but knowledge of their conditions, symptoms, and treatments are less clear. Furthermore, the subjects often seem to bridge practices and meanings of traditional terms with contemporary "Western" methods.

CHAPTER V

Discussion

Conclusion and Significance

This exploratory study provides some insight into the knowledge of folk beliefs and practices of a group of Mexican-Americans. The study revealed that several folk conditions: brujeria, mollera caida, empacho, mal ojo, bilis, susto, mal aire, and mal puesto were known to the sample, but meanings, symptoms, and traditional treatments were not as well known and in many cases had changed since their description in the literature. The sample's knowledge of symptoms and treatments for the majority of the traditional conditions were vague and were not as magical or ritualistic as previously reported in literature. In two cases (susto and bilis), the conditions were normal occurrences and no longer considered illnesses.

The study also showed that the sample's recognition of folk syndromes did not correspond to the traditional knowledge, belief, or experience of the conditions. The most frequent pattern that emerged during the interviews was that although a large number of individuals had heard of the conditions, smaller numbers actually knew something about them, still smaller numbers actually believed folk conditions occurred, and an even smaller number had experienced or suffered the conditions. In some cases, folk conditions were managed by "western" practitioners with contemporary "scientific" medicine. For example, physicians were

consulted and treated mal ojo or mal aire with antibiotics, thus converting their understandings of traditional constructions of illness to conform to modern medical understandings. Also, these physicians were probably not informed that they were treating folk conditions.

The findings of the study are important since the data demonstrate that some Mexican-American women retain knowledge of folk illnesses and combine traditional beliefs with non-traditional practices. Therefore, the sample did not restrict treatment to traditional means only. In view of these findings, two questions come to mind: (a) Why are the results different from what has been previously reported (Clark, 1959; Madsen, 1964; Rubel 1966; Saunders, 1954)?; and (b) Why have some folk conditions survived while others have been eliminated? These questions, while simply stated, may not be answered definitively. However, several possible explanations can be posed.

The results from this study may vary from those previously reported for several reasons. The early researchers of the 1940s-1960s did not indicate possible intervening variables as their ethnic background, previous contact with the communities used in the study, or Spanish language proficiency. And with one exception (Clark, 1959), early researchers did not define "Mexican-American". Most importantly, previous researchers did not distinguish between "knowledge" of conditions and "belief" in them and mistakenly inferred that knowledge implied belief. This

overinterpretation of data is a major discrepancy that perhaps contributed to the misunderstanding of the Mexican-American people and led to negative portrayals in the literature.

The early researchers also came from different disciplines than this investigator and used different methods and samples. The earlier researchers (Clark, 1959; Madsen, 1964; Rubel, 1966; Saunders, 1954) were ethnographers who predominantly utilized small homogeneous samples of Mexican-Americans from low-income rural communities. This investigator is a nurse who surveyed low-income urban residents of varying backgrounds. Furthermore, early researchers frequently characterized Mexican-Americans as different from "Anglos" and highlighted the differences, while this investigator did not presume that differences existed. The investigator only explored beliefs and behaviors that had already been documented as distinguishing characteristics. Therefore, numerous confounding variables not only affected data collection but its interpretation, and these produced different results.

Finally, studies of the 1940s-1960s are now 25-30 years old and outdated. One cannot assume health behaviors attributed to Mexican-Americans in the 1940s-1960s can be generalized to Mexican-Americans in the 1980s. As one cannot write of the "typical" American, one cannot write of the "typical" Mexican-American. Mexican-Americans are a rapidly changing heterogeneous ethnic group with regional, socioeconomic, language, and ethnic identification differences. Large scale public health

sampling methods are needed to obtain a truly representative sample from which to make more valid inferences.

The question of why some folk conditions have survived while others have not is interesting and similarly complex. Six folk conditions were recognized as illnesses by the sample, although they were not as mythical as previously reported. The concept mollera caida has survived almost intact. Five conditions: brujeria, mal puesto, empacho, mal ojo, and mal aire were known but in very general or vague terms.

The five folk conditions do have some common ground which may serve to explain their survival. Four of these conditions: mal ojo, mal aire, brujeria, and mal puesto have "magical" or supernatural origins. Knowledge of the supernatural, evil eye, and curses is strong in the Mexican-American culture as well as in other cultures. Italians, Germans, Iranians, and Africans may also attribute illnesses to the evil eye or curses (Spector, 1985). The belief in the supernatural also exists to some degree in the United States, although some may acknowledge them only as simple superstitions. Some Americans cross their fingers for good luck while others refuse to walk under ladders or throw spilled salt over their shoulder to ward off bad luck. Still others use numerology or consult astrologers for assistance in health or personal matters. These beliefs defy clear explanation. Since the illnesses or symptoms associated with these folk concepts are poorly understood, they are often relegated to the supernatural.

Mysteries are often based on traditions and passed from generation to generation until a clearer explanation can be obtained. While the actual reasons remain a mystery, the question of retention of selected folk beliefs is open for further study.

Three folk conditions which have survived over time also have elements in common. Mollera caida, mal ojo, and empacho primarily affect children, and all three conditions result in digestive upset and diarrhea. It appears that women in this study (women seeking health care for their infants) may retain information on the subject that most concerns them--their child's health.

Implications for Nursing

This study contributes to the knowledge of Mexican-Americans' folk beliefs and practices. It calls into question past stereotypic views of Mexican-Americans' health behaviors and provides a contemporary description of one sample of Mexican-Americans located in Southern California. The information is useful to nurses and other practitioner in the health arena for it refutes traditional schemas in categorizing health beliefs and practices of Mexican-Americans. Since the beliefs and practices of Mexican-Americans are changing, health care workers can no longer infer that neighborhood curers and magical potions will only be sought by Mexican-Americans for relief of ailments.

Nurses may find the information in this study useful in clinical settings for it once again puts emphasis on the uniqueness of individuals and the need for client-specific

nursing. Simply knowing old health traditions of Mexican-Americans is not enough to provide culturally sensitive care to Mexican-American clients.

In clinical settings, health providers can better assess the client's health belief system with a few well-phrased questions: (An example of an eye infection is given, since the condition was frequently a concern of the women sampled.)

1. You have an eye infection?
2. Tell me about it.
3. When did it start?
4. What were you doing when this started?
5. What do you think happened?
6. Why do you think it happened?
7. What have you heard causes eyes to get this way? (not What do you believe?)
8. Has anyone said something about your eye?
9. Has anyone suggested you do something for your eye?
10. Have you gone to anyone else for your eye? (not Have you seen another physician/nurse?)
11. Have you used anything, done anything for your eye? (not What treatment or medications have you used?)
12. What do you think we should do?

This set of questioning enables practitioners to probe a client's health belief system and specifically what they have heard, what they believe, what they have used, and what they would

accept. This interview format provides a structure which clarifies knowledge and shows respect for a client's health belief system, whether it is of a folk or a "scientific" orientation. Clients are also asked to participate in their plan of care which may affect acceptance of subsequent therapies or interventions. Furthermore, an accurate assessment facilitates the development of a plan of care that is attractive, acceptable, and meets the client's needs.

Future Research

Current research on the health care practices of Mexican-Americans is severely limited, thus the scope of possibilities for future research are extensive. The results of this study suggests that knowledge of folk beliefs and practices of the selected sample differs from previously reported studies. With this in mind, the questions and methodology from this study might again be used to survey other groups of Mexican-Americans for the purpose of comparing findings. If the instrument, methodology and findings are consistent, larger surveys can be conducted to enable better understanding of Mexican-American health beliefs and practices.

Since literature on Mexican-Americans shows them as a heterogeneous people who vary on a number of traits--level of acculturation, language, and various socio-economic variables--research in the area may be expanded by conducting research which reflects the changing demographics of the

Mexican-American people and includes individuals not commonly researched--the middle and upper socioeconomic groups.

Research on health care seeking behaviors is a further area for study. Previous research has suggested that Mexican-Americans seek health care only after home remedies and self-care practices have failed. This area can be investigated by exploring contemporary health practices and the sequential health care seeking pattern.

The subject of folk curers was only briefly touched on in this study. Future research on why these curers are contacted and the conditions they treat are areas for future study. Information of this nature would benefit health providers in understanding these client's needs.

Lastly, continued research in the areas of health beliefs and practices is important to the development of curriculum for health care professionals. Nurses are expected to provide care to a great variety of people and to be sensitive and respectful of a client's belief system. Research would provide information that would enable educators to address these issues more adequately and incorporate culturally sensitive content and skill development into the nursing curriculum. The practice of nursing would, as a result, benefit as would our clients.

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Appendix A

Major Folk Syndromes Found in Literature

Bilis (loosely translated as "bile")

This referred to an emotional experience that ranged from nervousness to uncontrollable rage. Two days after the emotional attack, chronic fatigue and malaise resulted. Various herb teas were used to treat the condition.

Brujeria (Witchcraft) and Mal Puesto (Hex)

Witches who received their power from Satan reportedly harmed or placed spells. Witches disguised themselves as owls or cats and used "black magic", rites, or dolls with pins to either harm or place victims under someone's control. Conditions occurred from jealousy, enviousness, or unrequitted love. Symptoms included misfortunes, erratic behavior, bad luck, generalized aches and pains, or vague ailments which could be fatal.

Empacho (Surfeit)

The condition occurred when foods stuck to the wall of the stomach. Overeating certain foods (i.e., cheese, eggs, bananas, breads, tortillas, fried pork skins) or swallowing gum produced indigestion, weight loss, inability to eat, or colic. The condition was diagnosed by the presence of "little balls" on the calves or a large ball on the stomach. Treatments included rubbing and pinching the spine until a snap was heard, massaging the stomach with oil, purges, or ingesting herbs.

"Hot and Cold" Foods, Illnesses and Medications

Disorders derived from an imbalance of the four "humours" in the human body (blood, black bile, yellow bile, and phlegm). Foods and illnesses were classified as "hot or cold" and an imbalance of these required appropriate "hot or cold" remedies or medications. Penicillin was "hot" and Vitamin C was reported as a "cold" medication. "Hot" foods were primarily chili, garlic, and beans. "Cold" foods were most vegetables, fruit juices, beef, pork, and milk. Nosebleeds resulted from being overheated ("hot") and were treated by cooling baths. Burns ("hot") required a cooling substance. "Cold" illnesses included colic, ear aches, and body aches. Treatment included diet, avoidance of drafts, herbs, and cupping.

Mal Aire (Bad Air)

Evil spirits or magical forces inhabited the air. If this evil air entered the body, individuals suffered various ailments. Symptoms included aches and pains (in areas "hit" by the air), facial twisting, or paralysis. Oil or herb massages were the preferred treatments.

Mal Ojo (Evil Eye)

The condition most commonly occurred in children and was of magical origin. The condition was caused by adults with strong vision who looked admiringly at children yet failed to touch them. Symptoms included irritability, excessive crying, convulsions, aches, pains, and vague upsets. Mal ojo was prevented by

requiring individuals with a "strong gaze" touch children they admired. Treatments included ritualistic touches by the person who caused the ailments. If the guilty party was not found (some adults were unaware of their powers), rituals utilizing eggs, holy palms, or prayers were used and found effective. Diagnosis was made by "sweeping" the body with an egg (barrera) and then breaking this egg. If a red spot or "eye" appeared on the yolk, the child had "ojo."

Mollera Caida (Fallen Fontanelle)

This referred to a condition caused by dropping an infant, shaking them, or pulling a nipple too quickly from their mouth. As a result, the anterior fontanelle fell down into the upper palate and interfered with feeding. Symptoms included irritability, digestive problems, and lack of appetite. A depression in the "soft spot" or "bollitas" (little bumps) on the upper palate were diagnostic for the condition. Treatments included:

1. placing a thumb in the infant's mouth and applying pressure to lift the palate

2. suspending the infant upside down while holding the head above a dish of water (thereby allowing the fontanelle to return to place)

3. holding the infant upside down while slapping the soles of the feet and praying

4. applying a paste on the fontanelle and suctioning the fontanelle.

Western practitioners now report a depression in the area of the fontanelle signifies dehydration. The condition is worrisome to health providers as its seriousness may go unrecognized.

Susto (Magical Fright)

An individual's inability to cope with frightening, traumatic experiences caused the soul to leave the body. Symptoms included exhaustion, restlessness, helplessness, listlessness, lack of appetite, pains, or sores. Treatments included religious/magical rituals with candles, branches, prayers, and herbs. Barreras were used to coax the soul back into the body.

Appendix B

Questionnaire

I. Demographic Data

1. Age:_____

2. Status: Single____ Married____ Separated____ Divorced____

3. Religion:_____

4. Number of years of education:_____

5. Where educated:_____

6. Occupation of head of household:_____

7. Monthly income:_____ Yearly income:_____

8. Source of income:_____
   Source of medical coverage:_____

9. Number of individuals in family:_____
   in household:_____

10. Number of children in family:_____

11. What number is this child?_____

12. When did you first come to the U.S.?_____
    When did you first come to live in the U.S.?_____

13. Number of continuous years in U.S.:_____

14. Previous living style: Rural_____ Urban_____

15. What ethnicity do you consider yourself?

    Mexican____ Mexican-American____ American____ Other____

16. Who is responsible for seeking health care in your family?

    _____

17. Why are you here today?_____

II. Western Medical Model

1. How have you been?

2. When was the last time you were ill?

3. What do you think made you ill?

4. What do you do to make yourself better?

5. When was the last time you received medical care?

6. By whom?_____ For what?_____

7. Have you ever been hospitalized?

8. Have you had any surgeries?

9. Do you have any allergies?

10. Are you taking any medications?

11. Do you have any family history of heart disease, hypertension, strokes, cancer, diabetes?

III. Three Generational Family Tree (draw)

IV. **Folk Beliefs and Practices**

1. **Do you consider yourself religious? Do you believe in God?**

2. **Do you think prayers affect your health? Do you pray?**

3. **Do you think candles affect your health? Do you offer candles?**

The following questions are about the natural forces and your health.

1. **Have you heard that a full moon can affect your health?**

2. **Have you heard that an eclipse can affect your health?**
   (R) cleft lip

3. **Have you heard that the air, wind, sun, or water can affect your health?**

The following questions are about magic or witchcraft, and your health.

1. **Have you heard that magic or witchcraft can affect your health?**

2. **Have you heard about witch's hex?**

3. **Have you heard about evil eye?**

The following questions are about "hot and cold" and your health.

1. Have you heard that "hot" foods can affect your health?
   (R) chili, meats, beef, water, fowl, fish, mutton, wheat products

2. Have you ever had a "hot illness"?
   (R) sore throat, fever, diarrhea, indigestion

3. Have you ever used a "hot" medicine?
   (R) aspirin, penicillin

4. Have you heard that "cold" foods can affect your health?
   (R) inexpensive meats, chicken, goat, rabbit, beans, corn products, dairy products, citrus, tropical fruits

5. Have you ever had a "cold" illness?
   (R) arthritis, rheumatism, ear ache, cramps

6. Have you ever used a "cold" medicine?

The following questions are about emotions and your health.

1. Have you heard of fright?

2. Have you heard of bilis?
   (R) yellow skin due to extreme anger

3. Have you heard of illness due to jealousy?

4. **Have you heard of illness due to sadness?**

The following are miscellaneous questions.

1. **Have you heard of fallen fontanel?**

2. **Have you heard of surfeit?**

3. **Have you heard of using herbal teas in health practices?**
   (R) anise seed, rose petals, mint

4. **Have you heard of using garlic, parsley, olive oil in health practices?**

5. **Have you heard of treatments with prayers, rubbing eggs, plants?**

6. **Who provides the treatment?**

7. **Have you heard of folk healers?**
   (R) senoras

V. **Practices of Friends**

The following questions are about friends and their health practices.

1. **Do you know someone who receives health care other than at a health center?**

2. **Do you know where they receive health care?**

3. **Why do you think they go there?**

VI. **Sources of Health Care**

The following questions are about other sources of health care for you.

1. **Where else do you receive health care?**

2. **How did you decide to come here instead of seeking other services?**

3. **How can we provide better service for you?**

VII. **Other Information**

Appendix C

A Comparison of Literature Beliefs and Beliefs of Subjects

Condition	Literature Beliefs	Modal Beliefs of Subjects
Brujeria and Mal puesto	1. Witches use satanic power, Black magic or rites to place hexes.	1. Witches or "someone who knows how" place hexes.
	2. Witches disguised themselves as cats/owls.	2. Disguises unheard of.
	3. Resulted in dramatic mania, bizarre behavior, hallucinations, deformities, misfortunes, or barrenness.	3. Typically characterized by "crazy" unexplained behavior, misfortunes, diarrhea, or illness "but the doctor can't find anything wrong."
	4. Prevented with amulets, spells, prayers, holy water.	4. Prevention unknown.
	5. Treated by witches or religious rituals.	5. Treated by senoras or "someone who knows those things."
Mollera caida	1. Infant's anterior fontanelle shifted/fell.	1. Infant's fontanelle "falls."
	2. Produced diarrhea, irritability, vomiting, or inability to nipple.	2. Symptoms typically include irritability, diarrhea, inability to nipple.
	3. Diagnosed by a depressed fontanelle.	3. Symptoms determine the condition.
	4. Treated by dipping infant's crown (head) into water, manipulation of palate, inverting infant, suctioning area, or religious rituals.	4. Treated by manipulating palate, inverting infant, or suctioning fontanelle area.
Empacho	1. Chunk of food stuck to the stomach wall.	1. "You eat too much" and it "doesn't feel right."
	2. Produced indigestion, weight loss, colic, or vomiting.	2. Typically characterized by an upset stomach, diarrhea, vomiting, or feeling sick.

Condition	Literature Beliefs	Modal Beliefs of Subjects
Empacho	3. Diagnosed by a snapping sound of the spine when pinched, feeling "balls" in the abdomen or calves.	3. Diagnosed by symptoms.
	4. Treated by kneading the spine, massages, purgatives, ingesting powder chalk or teas.	4. Treatments typically include abdominal massage, pinching the spine, pepto bismol, teas, or medical care.
Mal ojo	1. An adult admired but failed to touch an infant.	1. Adult admires or "looks funny" at an infant.
	2. Produced convulsions, loss of will, aches, irritability.	2. Typically characterized by diarrhea, irritability, or red, infected eyes.
	3. Diagnosed by egg rituals.	3. Diagnostic rituals not typically known.
	4. Treated by ritualistic touch or religious rituals.	4. Treatments include touching the infant, eggs, water, prayers (procedures unknown) or ophthalmic antibiotics.
Bilis	1. Uncontrollable rage caused bile to flow into the bloodstream.	1. Normal anger
	2. Produced chronic fatigue.	2. Characterized by indigestion.
	3. Treated with herbs.	3. One needs to "control oneself."
Susto	1. Magical fright/soul loss.	1. Refers to frightened or nervous adult or startled infant.
	2. Resulted in helplessness, listlessness, crying fits.	2. Typically a normal occurrence.
	3. Religious rituals or ritualistic ingestion of herbs was used to coax the soul back to the individuals.	3. No treatments required.

Condition	Literature Beliefs	Modal Beliefs of Subjects
Mal aire	1. Evil spirits inhabit the air and enter the body.	1. Cold, heavy air hits/enters the body (drafts).
	2. Results in paralysis, facial twisting, pains, cramps.	2. Typically characterized by aches, ear aches, chest congestion, eye infections.
	3. Barrenness prevented by wearing belt with keys over abdomen.	3. Unreported
	4. Treated with oil rubs or herb mixtures.	4. Treatments include Ben Gay rubs, ophthalmic antibiotics, warmth or teas.

Table 1

Demographics

	Number	Percent[a]
Age		
16-20	13	33%
21-30	21	53%
30-39	6	15%
Marital status		
Single	11	28%
Married	21	53%
Separated	7	18%
Divorced	1	3%
Religion		
Roman Catholic	34	85%
Christian	3	8%
Other/none	2	8%
Education		
1-6 years	13	33%
7-9 years	11	28%
10-12 years	15	38%
over 12 years	1	3%
Years in the United States		
0-5	20	50%
6-10	7	18%
11+	12	30%
other[b]	1	3%
Family size		
1-3	23	58%
4-6	16	40%
7+	1	3%
Medical coverage[c]		
Private insurance	2	5%
Public coverage	24	60%
None	14	35%

Note. N = 40

[a]The total percentage may not equal 100%. [b]Born in the United States. [c]Medical coverage for children (not necessarily informant).

Table 2

Roman Catholics Reporting Religious Practices

Religious Practice	Number	Percent
Believe in God	33	97%
Believe God influences health and illness	21	62%
God causes illness	6	18%
Utilize prayers/pray	29	85%
Believe prayers affect health and illness	23	68%
Utilize/offer candles	18	53%
Believe candles affect health and illness	17	50%

Note. N = 34

Table 3

Comparison Across Familiarity, Knowledge, Belief, and Experience of Natural Forces Influencing Health

Natural Forces	Familiar	Knowledge		Belief	Experience
		Symptoms	Prevention		
Air	13 (33.4%)	10 (25%)	------	11 (28%)	10 (25%)
Sun	7 (18%)	7 (18%)	------	7 (18%)	0 (0%)
Water	1 (3%)	2 (5%)	------	2 (5%)	1 (3%)
Wind	1 (3%)	1 (3%)	------	1 (3%)	1 (3%)
Full moon	33 (83%)	30 (75%)	14 (35%)	13 (33%)	3 (8%)
Eclipse	38 (95%)	37 (93%)	26 (65%)	21 (53%)	1 (3%)

Note. N = 40

Table 4

Comparison Across Familiarity, Knowledge, Belief, and Experience of Magical Forces Influencing Health

Conditions of Magical Origin	Familiar	Knowledge		Belief	Experience
		Symptoms	Treatments		
Brujeria (witchcraft)	37 (93%)	28 (70%)	20 (50%)	14 (35%)	12 (30%)
Mal puesto (evil hex)	24 (60%)	15 (38%)	10 (25%)	9 (23%)	7 (18%)
Mal aire (bad air)	24 (60%)	22 (55%)	12 (30%)	18 (45%)	15 (38%)
Mal ojo (evil eye)	36 (90%)	22 (55%)	21 (53%)	15 (38%)	7 (18%)

Note. N = 40

Table 5

Comparison Across Familiarity, Knowledge, Belief, and Experience of Emotional Forces Influencing Health

Conditions of Emotional Origin	Familiar	Knowledge		Belief	Experience
		Symptoms	Treatments		
Susto (fright)	31 (79%)	29 (74%)	9 (23%)	22 (56%)	16 (41%)
Bilis (bile)	31 (79%)	26 (67%)	14 (36%)	16 (41%)	8 (21%)

Note. N = 39

Table 6

Comparison Across Familiarity, Knowledge, Belief, and Experience of Miscellaneous Forces Influencing Health

Miscellaneous Conditions	Familiar	Knowledge		Belief	Experience
		Symptoms	Treatments		
Mollera caida (fallen fontanelle)	37 (95%)	26 (67%)	31 (79%)	22 (56%)	14 (36%)
Empacho (surfeit)	36 (92%)	31 (79%)	29 (74%)	27 (69%)	10 (26%)

Note. N = 39

Table 7

Rank Order Comparisons of Conditions Across Familiarity, Knowledge, Belief, and Experience

Condition	Familiarity	Knowledge		Belief	Experience
		Symptoms	Treatments		
Mollera[a]	1 (95%)	4.5 (67%)	1 (79%)	2.5 (56%)	3 (36%)
Brujeria[b]	2 (93%)	3 (70%)	4 (50%)	7 (35%)	4 (30%)
Empacho[a]	3 (92%)	1 (79%)	2 (74%)	1 (69%)	5 (26%)
Mal ojo[b]	4 (90%)	6.5 (55%)	3 (53%)	6 (38%)	7.5 (18%)
Bilis[a]	5.5 (79%)	4.5 (67%)	5 (36%)	5 (41%)	6 (21%)
Susto[a]	5.5 (79%)	2 (74%)	8 (23%)	2.5 (56%)	1 (41%)
Mal aire[b]	7.5 (60%)	6.5 (55%)	6 (30%)	4 (45%)	2 (38%)
Mal puesto[b]	7.5 (60%)	8 (38%)	7 (25%)	8 (23%)	7.5 (18%)

Note. [a]N = 39. [b]N = 40.