Title: For the Sake of our Children: Hispanic Immigrant and Migrant Families’ Use of Folk Healing and Biomedicine
Authors: Tracy J. Andrews, Vickie Ybarra and L. LaVern Matthews
This is the authors’ post-print. Please cite the final version of the article, available at http://dx.doi.org/10.1111/maq.12048.
Tracy J. Andrews  
Department of Anthropology  
Central Washington University

Vickie Ybarra  
Robert Woods Johnson Foundation Fellow, Political Science  
University of New Mexico

L. LaVern Matthews  
Department of Anthropology  
Portland State University

For the Sake of our Children: Hispanic Immigrant and Migrant Families’ Use of Folk Healing and Biomedicine

This article documents beliefs among Hispanic immigrant and migrant families in central Washington State about the etiology, symptomology, and appropriate treatments for illnesses experienced by their young children. Similar information was gathered from health care staff at several area biomedical facilities. We integrate data from the childhood health project and the authors’ previous research to refine the ethnomedical knowledge base and assumptions about the impact of migration histories and acculturative forces on Hispanic health belief systems and therapeutic decision-making. The analysis is situated in the region’s political economic context, dominated by agribusiness, which reveals the enmeshed structural forces that influence the children’s health care. We conclude that only when cultural and structural factors are considered in concert, can these approaches most effectively contribute to understanding family responses to childhood illness at local community levels as well as at broader analytic scales, and to the development of culturally relevant and effective health care. [ethnomedicine, migration histories, child health, Hispanic healing, therapeutic decision-making]

Some [illnesses] are not of the clinic. [Josefina]

*****
You take them to the doctor and they say that ... [the children] ... are fine. The [doctors] don’t give them anything. ... There aren’t doctors that believe [in] this. ... haven’t ever told [doctors that I massage my children] ... because I know when they have empacho and I massage them ... that takes care of it. [Victoria]

*****
All the time children are affected, I am not going to go to curanderos or anything like that. All the time I think it is a better idea to seek help from the doctor. [Sara]
Recently, anthropological studies have reintensified their gaze on children, including parents’ impact on their sociocultural and moral construction (see Barlow and Chapin 2010; Bluebond-Langer and Korbin 2007; Lancy 2008). Although currently an area of limited research, our focus is on adult decision-makers’ illness treatment choices for children too young to take action themselves. Hispanic children are the fastest-growing U.S. ethnic subgroup, and our research area in central Washington State is characterized by a longstanding and growing Hispanic population.

The introductory quotes reflect family participants’ choices in seeking effective therapies for sick children, with a focus here on gastrointestinal illnesses. They reveal both shared cultural knowledge of Hispanic folk healing and variation in whether it is used. This study assesses sources of variability in local Hispanic family responses to childhood illness in a pluralistic health care setting where both biomedical and folk healing are available. Several approaches within medical anthropology offer potentially relevant explanatory tools; most specifically, we draw from ethnomedical and immigrant health research as well as critical theory.

The first quotes indicate there are conditions that biomedical healers cannot treat effectively, with a specific reference to one folk illness, *empacho* (indigestion or a gastrointestinal obstruction). Victoria notes that she has learned and administered a required massage treatment for *empacho*; in other cases, the skills of a *sobador* (massage specialist) or a more general and powerful folk healer, a *curandero*, may be required. Sara clarifies that Hispanic families may prefer biomedical healers—and we asked participants why they selected specific pathways in caring for their sick children. Medical pluralism has been widely documented, and generally one medical system (biomedicine in this study) is dominant (Leslie 1980; and see Capps 1994; Kamat 2008; Lehmann 2008 [orig. 1985]; Poss and Jezewski 2002).

Explaining the complexity of reasons why and how patients make choices among different available systems worldwide, and discerning patterns, is a continuing challenge (Baer 2011). Erickson (2008:107), among others, concludes that “variation in both knowledge of and belief in traditional healing systems within cultural groups, … is largely based on education and acculturation level.” Thus, Sara’s preference for biomedicine in treating her children’s illnesses might reflect a longer residence in the United States and greater familiarity with, and belief in, the efficacy of biomedicine. The longstanding and varied immigration histories of Hispanic families in our study area provided an opportunity to assess the relevance of this assumption. Our research also highlights the significance of social networks, and clearly as more than economic safety nets (Vasquez-Leon 2009).

In designing this project, we followed closely two general goals of ethnomedical research: (1) understanding the learned cultural meanings and treatments associated with illness experiences; and (2) medical translation, or how emic perspectives of one group (micro level) can contribute to a broader (macro level) understanding of how to improve health-care delivery (Erickson 2008; Good 1994; Green 1999; Kleinman et al. 1978; Low and Merry 2010; Nichter and Lock 2002:1; Quinlan 2011:383–384; Sobo 2011:10–12).

Building on our previous research and professional health care work in the community, we knew that folk healing is a part of local Hispanic family health-seeking behavior (Andrews 2001; Andrews et al. 2002). However, Garro (2000) identifies intracultural variation in understandings about illness, particularly in postmodern contexts of increasing globalization, as a key challenge to the continuing relevance of disease causation theories that are often based on information several decades old. Ethnomedical research to date has focused on adults managing
their own health care, and we argue that readjusting the lens to examine adult therapeutic decision-making for children can both help refine the knowledge base and address childhood health issues from new perspectives (Granich et al. 1999; Miller 2011; Ryan and Martinez 1996).

Critical medical anthropology emphasizes an additional component of our participants’ lived experience—global, national, and regional political economic forces that may impinge on family therapeutic decision-making and options for their children’s health care (Baer et al. 1997; see Farmer 1999; Singer 2007). In biomedically dominant contexts, lack of access has often been identified as creating structural barriers to use of both traditional and biomedical treatments. Locally, Hispanic families have access to folk healers and ethnopharmacology as well as to biomedical services, including a network of migrant health clinics that serve low-income families in the region. However, hegemonic power and structural constraints are often exerted more subtly (Baer et al. 1997:14; Kamat 2008). Here, we examine how local power dynamics in biomedical care settings and the agribusiness-dominated economy permeated Hispanic families’ treatment decisions for their young children.

We assess when and how both cultural and structural factors impinge on the lived experiences of families and biomedical staff as they seek to receive and provide the most effective health care for the children. Individually, however, neither ethnomedical nor critical theory adequately captures the complexity in the families’ lived experiences or the context in which they make decisions about their children’s health care.

**Background**

This project developed in collaboration with the regional migrant health organization and its satellite clinics (referred to here as the Migrant Health Clinic [MHC]), and other programs serving local Hispanic populations.

**Ethnomedicine and Immigration Histories**

Hispanic or Latino ethnomedical beliefs regarding a range of illness conditions have been documented in various cultural and geographical settings. However, Hispanic communities in central Washington State, which have histories of transnational immigration for over a century, have received little attention. Also, juxtaposing biomedical and immigrant beliefs about the same illness is uncommon in the many recent studies of ethnomedical systems worldwide (Baer 2011:419; Chavez 2003:208). We use this approach to uncover overlaps and discordance between Hispanic immigrant families and biomedical practitioners in beliefs about illness transmission and prevention. The discordance can create a barrier to biomedical health care use beyond simple access; the overlaps may provide options for developing treatment options that families find most effective.

The varied nationalities and cultural belief systems included in broad categories such as “Hispanic” ethnomedicine render generalizations about the beliefs of individuals questionable (Glazer et al. 2004; and see Garro 2000; Weller and Baer 2001; Weller et al. 1993). There is an ongoing need for ethnomedical research to both update information to assure its relevance for contemporary settings and to clarify distinctions between symptoms and Hispanic folk illnesses linked to different beliefs about causation and transmission (Weller et al. 2002). This holds true for childhood gastrointestinal illnesses, wherein diarrhea may be identified as a distinct
condition, or as a symptom associated with several Hispanic folk illnesses (Kendall et al. 1990; Ryan and Martinez 1996; Weiss 1988). For example, based on their multi-site study of intracultural variation, Weller et al. (2002:452–453) report that susto “is seen as a fright-induced sickness with regional variations in symptoms and treatments”; however, diarrhea may or may not be a related symptom. In fact, susto is not one of the four most common types of folk illnesses that are associated with gastrointestinal disorders in the academic literature: empacho, mal de ojo (evil eye), caída de la mollera (fallen fontanel), and lombrices (worms) (Baer and Bustillo 1993, 1998; Kendall et al. 1990; Trotter and Chavira 1997; Weller et al. 1993).²

Families in our study reported some types of childhood gastrointestinal symptoms that would require biomedical treatment, while others associated with illnesses like susto and empacho, are “not of the clinic,” require folk remedies or healers, and are not considered transmissible. We assess how these responses fit with extant ethnomedical information on Hispanic folk beliefs and local biomedical public health approaches to managing childhood diarrhea.

The acculturation process in immigrant studies focuses on change toward the dominant/host culture; in the midst of debates about its usefulness, it continues to be used widely in health research in the United States to understand intracultural variation among Hispanic populations (Brettell 2000; Fitzgerald 2010; Hunt et al. 2004; Lopez-Class et al. 2011). Our research foregrounds new aspects of social networks in understanding immigrant health and demonstrates the need for a longer baseline for assessing change. To address these issues, we also incorporate data from our previous undocumented Mexican Immigrant Women (MIW) study whose initial analytic focus was on how having children influenced the women’s immigration histories (Andrews 2000; Andrews et al. 2002). Here we include MIW information regarding the use of folk healers in the participants’ Mexican home communities and their health care choices in the United States.

*The Political Economic Context*

We draw on critical theory to assess impacts of participation in the regional agribusiness economy on Hispanic family options for their children’s health care. However, we remained attentive to caretaker agency when making decisions to avoid depicting individuals simply as passive recipients of imposed change (Brettell 2007:125; Hirsch 2003:251). A focus on immigrant agency also avoids a reification of Hispanic “culture” as a static, closed system, whose influence on health-seeking behavior creates a fixed response determined by traditional healing beliefs.

In the study area, Yakima County in central Washington State, Hispanics constitute 45% of the total population (OFM 2008a; U.S. Census Bureau 2010). They are mainly Mexican immigrants or migrants³ who have provided a critical regional labor force since the early 1900s, when large-scale irrigation projects turned this rural, semi-arid, shrub-steppe environment into a center for agribusiness (Gamboa 1990). Yakima Valley is now “one of the most intensely irrigated and diverse agricultural areas in the United States” (Sell and Knutson 2002:7) and it ranks 12th in total value of all U.S. agricultural products sold (USDA 2009). It also is home to the greatest concentration (28%) of immigrant and migrant farm workers and families in Washington State. The pattern of Hispanic immigration in this area has received little scholarly attention; however, it fits Massey et al.’s (1994) characterization of behaviors and values that encouraged certain household members to emigrate as part of a long history of managing family
economic survival (Andrews et al. 2002; Gamboa 1981; Martin and Midgley 1999). More recently, segments of the local community have “settled out” and are characterized by longer term residence, usually maintaining ties with their home communities.

Currently, Hispanic children up to age 19 make up 63% of the overall child population in Yakima County (Larsen 2009; OFM 2008b). This demographic trend is expected to continue nationally and has influenced the growing emphasis on childhood health issues at the local MHC. The main impetus for our focus on childhood gastrointestinal illnesses was the developing concern about nitrate concentration levels above EPA safety standards found in area wells and likely connected to regional agribusiness enterprises. Elevated levels of nitrates are associated with conditions potentially linked to recurring gastrointestinal problems and specifically diarrhea in infants and young children—a key target demographic in this research project (Knobeloch et al. 2000; see Gleick 2002).

Recurring childhood diarrhea can contribute to both immediate and long-term health vulnerabilities, and counties in central Washington have some of the highest incidences of diarrheal disease in the state. The MHC and regional public health programs had been communicating information about this health concern for about a year prior to our project. Initially, we sought to document if and how Hispanic family participants’ beliefs regarding childhood diarrheal illnesses incorporated this new causal agent and whether such information influenced treatment choices (Andrews 2005). Apparently, the issue of nitrate-drinking-water contamination was too nascent at the time of our study to emerge as a key component of either family or biomedical practitioners’ therapeutic decision-making. Although this element was not available for analysis, the project generally provided a rich database for refining ethnomedical theory and addressing community-based childhood health care issues.

Methods

Ethnographic methods were used to allow all study participants to identify and define intersections of culture, health, and socio-political circumstances significant to them—and from their own perspectives. Qualitative open-ended interview questions are particularly important to avoid oversimplifying ethnomedical models or health-seeking behavior in the context of transnational migration and medical pluralism (Brettell 2007; Chavez 2003; see Foner [2003:25–31] for elaboration of relevance to immigration studies).

Initially, we interviewed Hispanic immigrant adults who were decision-makers for the health care of the family’s children, and they are the focus of this article. A second set of interviews was conducted with biomedical staff at the MHC; we include their information where it converges with salient topics. We did not include interviews with “expert” folk healers because our focus is on how families “interpret and act in situations of illness” (Garro 2000:309).

The Families

Ideally, when interviewed the families had children younger than 2 years old, the age group most vulnerable to the immediate impacts of extended diarrheal illnesses. By the required end of the project’s fieldwork stage, we had met our goal for family participant sample size (N = 36). All interviews were conducted in person, and most occurred in the family’s home. The family participants were an opportunity sample recruited through community organizations serving
Hispanic immigrant and migrant populations. Project staff offered to conduct the interviews in either Spanish or English, and all participants gave permission for audio taping to ensure accuracy in data collection.

The semi-structured family interview schedule included mainly open-ended questions, focused on documenting the family participants’ ethnomedical explanatory framework, including the causes of childhood gastrointestinal illnesses—specifically when diarrhea becomes a “problem,” beliefs about disease transmission and prevention, and factors that influenced treatment decisions (Kleinman 1980; Kleinman et al. 1978). We did not introduce the names of any specific folk illnesses when we first asked about use of folk healing, and many participants initially were reluctant to discuss the topic. We used the concepts of stomach problems and diarrhea because they were familiar to both families and biomedical staff and because we wanted to avoid directing the discussion from the onset to particular folk illnesses. Later in the interviews about their children’s health, as project staff’s knowledge of and interest in folk healing became apparent, most participants offered their perspectives in some detail.

The Biomedical Healthcare Staff

Similar information about childhood illnesses was gathered in a set of in-person, semi-structured interviews with biomedical health-care staff (BHS) at several MHC facilities. For these, Andrews was the sole interviewer and sessions were tape-recorded. The interviews occurred during a difficult transition period to a new management model for MHC patient care, and BHS participants indicated this likely contributed to a lower-than-expected response from the target population of physicians. After modifying the BHS eligibility criteria to include other providers besides MDs, we exceeded the goal sample size (see sample characteristics below). The BHS interview schedule was composed mainly of qualitative, open-ended questions about providing health care for their Hispanic patients, including causes of childhood diarrhea encountered locally, experiences in treating children’s diarrheal illnesses, and knowledge of Hispanic folk healing and its use by patients.

Analysis

Our analysis relied heavily on qualitative interview data because of its potential for contributing “deep insights into health and well-being as embedded in everyday life contexts despite inconsistencies with actual behavior” (Garro 2010:473). This approach revealed unexpected and subtle, yet crucial, cultural and structural factors influencing change and continuity in medical belief systems and therapeutic decision-making. When family participants chose to be interviewed in Spanish, the discussion was conducted in Spanish and then transcribed by bilingual Spanish/English speakers. Digital recordings were transferred into electronic text documents used for rechecks of information with all participants. This also provided searchable text used in software programs specifically designed for qualitative text data content analysis, including information coding, themes analysis, and pattern finding. We selected Atlas.ti because it included a syntax-generating interface with SPSS as well as providing an efficient and flexible categorization process for our data. We present responses with numeric data from the interviews where appropriate to analyze potentially important variability in local communities, while parsing out shared experiences that are impacting treatment choices.
Sample Characteristics

Family participants were mostly mothers with their young children (92%). These mothers and other adult family members were the primary caretakers—a common term that belies the depth of meaning associated with making decisions for their children’s health. Most of the participants were the first generation of their families to live in the United States (83%), and almost all chose to be interviewed in Spanish (Table 1). Those who chose to be interviewed in English (8%) were born in the United States and have established second-generation families.

Table 1. Family Participants’ Age, Relationship to Child, and Education (N = 36)

<table>
<thead>
<tr>
<th>A. Age</th>
<th>No.</th>
<th>B. Length of Residence in Yakima Area</th>
<th>No.</th>
<th>C. Years of Education</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 20 yrs</td>
<td>3</td>
<td>&lt;6 Mos.</td>
<td>3</td>
<td>3 or less</td>
<td>6</td>
</tr>
<tr>
<td>21–25</td>
<td>14</td>
<td>6 Mos.–1 Yr</td>
<td>8</td>
<td>4–6 years</td>
<td>12</td>
</tr>
<tr>
<td>26–30</td>
<td>5</td>
<td>1–2 Yrs</td>
<td>2</td>
<td>7–10 years</td>
<td>12</td>
</tr>
<tr>
<td>31–35</td>
<td>8</td>
<td>2–3 Yrs</td>
<td>3</td>
<td>11+ years</td>
<td>6</td>
</tr>
<tr>
<td>36–40</td>
<td>2</td>
<td>3–5 Yrs</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 40 yrs</td>
<td>4</td>
<td>5+ Yrs</td>
<td>14</td>
<td>Avg. yrs</td>
<td>9</td>
</tr>
</tbody>
</table>

Seventy-two percent of the family participants had children ages 2 years or younger, and 95% had children 5 years or younger. In documenting employment history, “farm work” is defined here as consisting of field crops and associated warehouse processing work. Nearly 70% of all households included at least one parent with current farm work employment or with farm work employment as their primary employment prior to the interview. Over 80% of this group were first-generation families, and most of them (70%) worked as field crop laborers. Caretakers in the remaining families worked in a variety of occupations, including construction, industrial labor, secretarial work, service industry, and day care work, or they worked in the home. Based on generalized data from local Hispanic service programs, a representative range of Hispanic immigrant and migrant family backgrounds are included in this study (Table 1).

The BHS interviewees (n=12) represent an opportunity sample drawn from participants identified and contacted through the MHC. Andrews interviewed eight care providers (three pediatricians, two general practitioners, three physician assistants), and four support staff (one registered nurse, two certified nurse assistants, one medical assistant). This modification turned out to be very useful in elucidating additional perspectives on biomedical health care contexts. All BHS participants were bilingual except two; however, one of these had a working knowledge of Spanish. The sample included eight women and four men, and five identified as Hispanic. The average length of time participants had worked for the organization was 8 years, including one with about 30 years tenure.

We integrate data from this project and the authors’ previous research to refine the ethnomedical knowledge base and assumptions about the impact of migration histories and
acculturative forces on Hispanic ethnomedical belief systems and family therapeutic decision-making and to reveal the enmeshed structural forces that influence health care for their children. We conclude that only when cultural and structural factors are considered in concert can these approaches most effectively contribute to understanding family responses to childhood illness at local community levels as well as at broader analytic scales and to the development of culturally relevant and effective health care.

**Family Health Beliefs and Treatment Decisions**

*When Is a Child Sick?*

Most basic to ethnomedical explanatory models is documenting when a health “problem” exists. In order of increasing concern, family participants identified initial problematic gastrointestinal symptoms as consecutive watery stools, which begin to occur with increasing frequency (diarrhea), and are associated with a child complaining of stomach pains and losing interest in eating or drinking. If the child has a fever, some form of treatment will be started immediately.

Family participants described clear indicators that the severity of the illness has increased to the point of being very problematic, including: symptoms that continue into a second day, the child taking no food or liquid, and, chiefly, the child vomiting or passing bloody stool. The most frequent concerns noted by the families were dehydration (66%) and a child’s lack of appetite and thinness. One-fourth of the participants feared that the general symptoms might deteriorate so severely within two days that their child could die, although, as noted below, this was not a concern shared by biomedical providers in our study.

*Causes of Childhood Diarrhea*

Other factors in therapeutic decision-making, and part of ethnomedical explanatory frameworks, are beliefs regarding the cause and transmissibility of an illness. In the few cases where participants had not mentioned them by the end of the interview, we specifically asked about the most common types of folk illnesses associated with gastrointestinal disorders: empacho, mal de ojo, caida de la mollera, and lombrices.

Food was the most frequently reported cause of gastrointestinal illnesses among all family participants (60%), and the main issue noted was switching a baby’s formula and using different types of milk. Food that had “gone bad” or was not stored properly and “rich” foods or large quantities of fruit were also often described as causal factors. Next, uncleanliness and dirty hands were reported by 52% of the sample as linked to childhood diarrhea. Just over 40% of the families said folk illnesses were associated with their children’s diarrhea; empacho was most frequently cited (just over 50%), followed closely by caida de la mollera and susto. Although caida de la mollera was an expected response, susto was not one of the prompts provided, and occurred more often than expected based on the extant literature.

*Prevention, Transmission, and Treatment Goals*

Families identified specific measures to help their children avoid getting diarrhea and expressed intense concern for preventing their children’s suffering. Washing hands before eating was
mentioned specifically by over half of the participants; others noted it was important to keep the children’s hands out of their mouths in case they had touched dirt or other unclean objects. They also described avoiding or limiting the child’s intake of certain foods and ensuring the food was well cooked and washed.

When asked whether children can pass diarrhea to others or get it from others, 33% said yes—yet nearly half of these qualified their response by stating diarrhea was contagious only if it was caused by a virus. Over half the participants said that diarrhea was not transmittable or they didn’t think it was, with a few noting specifically that teething-related diarrhea could not be passed from one child to another. Also, diarrhea associated with empacho and susto was regularly noted as not being transmissible among children; in such cases, biomedical treatments are inadequate. Conversely, families generally categorized diarrhea caused by viruses or bacteria on dirty food or children’s toys as contagious in the biomedical sense; here, biomedical treatments are appropriate and often sought after.

For 75% of the families, whatever treatment they were using should end diarrhea by the end of the second day or it is considered ineffective. Stomach pains subsiding and resumption of eating are the associated immediate treatment goals. Family participants also described a commonly documented expectation that treatments should ultimately clean, or clear out, the child’s gastrointestinal tract. In particular, for empacho, the benefits of massaging the stomach included clearing it out—and this is a skill associated with folk healing.

Folk Healing: Some Illnesses Are Not of the Clinic

Nearly 60% of the family participants described using folk healing methods and/or healers for treatment of childhood diarrhea (Table 2). This figure is conservative since it represents use just for one childhood illness; it does not include participants who only use herbal remedies or teas but not other types of folk healing practices. These practices cut across first- and second-generation families as well as all age groups, with family members and skilled friends being consulted most frequently.

Table 2. Family Participants’ Treatment for Childhood Diarrhea (N = 36)

<table>
<thead>
<tr>
<th>A. Use Traditional Healing (N = 36)</th>
<th>B. Type of Traditional Healer (total responses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not use</td>
<td>Relative 23</td>
</tr>
<tr>
<td>Do</td>
<td>Friend 4</td>
</tr>
<tr>
<td>Use both traditional &amp; biomedicine</td>
<td>Sobador 11</td>
</tr>
<tr>
<td></td>
<td>Curandero 3</td>
</tr>
<tr>
<td>Folk Herbal Remedies/Teas</td>
<td>Yerbero 0</td>
</tr>
<tr>
<td>Use of Herbal Remedies</td>
<td>Espiritualista 0</td>
</tr>
</tbody>
</table>

Along with use of herbal remedies, families primarily sought out the skills of sobadores, or folk-healing specialists with massage and bone-manipulation skills. Sobadores were consulted
for stomach problems associated with empacho, susto, caida de la mollera, and mal de ojo. A few families described consulting a curandero, or folk healer with a broader skill set, in treating their children. However, there are circumstances where traditional healing was not appropriate (e.g., several families described their infants as being “too little for the sobador” or “too young for mint tea”).

Family participants tended to similarly conceptualize and respond to certain folk illnesses. For example, the following narrative reveals experiences shared by many families who use folk healing including: learning within the family, physical manipulation of the child’s back, association of empacho with food getting “stuck” in the stomach, and empacho being associated with specific treatment decisions.

Mother: What we say is that when you have diarrhea, you have empacho. When a food doesn’t settle well and it gets stuck in the stomach, like my grandmother would say. ... I don’t know if it’s true. With my (son)…, he’s the one that was cured of this. I cured him of empacho. My grandmother told me how to massage his back. First, here, the stomach going downwards, and afterwards the back, and pulling the skin on his back.

Interviewer: And where did you learn?

Mother: When an aunt from Texas lived here, she showed me. She was very old. ... She was good at helping during births … and with susto. It was a gift that she had.

Also significant in the passage is the unprompted inclusion of susto as an illness requiring traditional healing; such details within the participants’ narratives provide a view of folk illnesses that are locally important.

Herbal Remedies

Participants described using a range of traditional teas or beverages for their children, with manzanilla (chamomile) tea and rice water both being the most frequently used (by about half the families) (see Kay 1996; Waldstein 2006). The next most frequent remedy (20%) was yerbabuena (mint tea), and individual preferences included a lime leaf and water tea, and atole (corn- or rice-based drink) without milk. Examples of explanations for why these work included: “rice water solidifies excrement,” “mint helped lessen stomach pain,” and “rice water provides nutrients.” One participant described using a rice water tea mixed with Pedialyte, which reflects a recommendation noted below that one local physician often makes. We did not focus on, or hear reports of, barriers to acquiring folk medicines—with few exceptions they are commonly available in Hispanic communities of even modest size and duration (Chavez 2003:221).

Biomedical Health Care: When Is It Appropriate?

Almost all participants described using biomedical services for a health problem, although just over 40% of the families noted that they had taken their children to a biomedical facility for diarrhea. The majority of these families first tried herbal remedies or other folk healing practices and sought biomedical treatment when they perceived that symptom severity was increasing and the child had a fever. Similar to research with other Hispanic immigrants, several family
participants in this study move between both biomedical and folk healing systems (Table 2; and see Poss and Jezewski 2002; Reiff et al. 2003; Ross et al. 2011).

If key family members or friends cannot help, then specialists such as sobadores or curanderos outside the family are consulted. Such folk medical healers are often believed to have special God-given skills or gifts. If the traditional healing methods are not effective, it is likely considered “God’s will” that treatment be sought elsewhere, usually from biomedical services (Perrone et al. 1989). This does not regularly undermine belief in the potential relevance of folk healing: As one family participant explained, “if one person doesn’t work, then try another.”

The following interview excerpt reflects the type of treatment decision process characteristic of families who considered both folk healing and biomedical treatment approaches. This mother has learned massage skills that allow her to treat her own child:

Interviewer: Are [signs that diarrhea is a problem] the same for children of all ages?
Mother: Yes, I think so. It depends on what the problem is because if it’s because of milk, it’s okay, we know; but when it’s because of a virus, it’s different.

Interviewer: Thinking about the last time (child) had diarrhea, did you notice anything in the days before that might have caused it?
Mother: No, I only saw the problem with the milk. First I massaged him. After that, I cured him from ojo, because in Mexico you cure ojo when you see a child that has one eye smaller than the other one. Also, I cured him of this and “mollera” and when I saw that this didn’t take care of it, I took him to the [biomedical] doctor [emphasis added].

Interviewer: What do you think would happen if you didn’t massage children …?
Mother: I think that it would [be worse for him] because you take them to the doctor and they say that ... [the children] … are fine. The [doctors] don’t give them anything, and the [doctors] only give the [children] suero for empacho. There aren’t doctors that believe [in] this.

Interviewer: What do the doctors think about you doing massage?
Mother: I don’t know. … I haven’t ever told them because I know when they have empacho and I massage them and that takes care of it … because when they are empachados, they don’t eat.

Family participants who used biomedical services described suero (serum; Pedialyte) as the most frequent treatment provided, and nearly 50% of them said it was the most successful treatment. When asked why suero worked, several participants described a link to preventing dehydration—a view shared with biomedical health providers. Although this could be considered a socially desirable response, or “official account” (Garro 2010), the interview data include folk practices such as herbal teas that are congruent with the use of Pedialyte. For the families, suero was considered effective in “clean[ing] the digestive system,” an important outcome from a folk healing perspective. However, the perceived effectiveness of suero may be influenced by the cause of diarrhea; in the example above, the mother indicates that suero itself will not be an effective treatment for empacho.

In contrast to reports of self-administration of antibiotics being common among Hispanics groups in the United States (Larson et al. 2003; Pylypa 2001), just two participants listed antibiotics as the type of treatment children under 2 years old should receive when their diarrhea is a problem. One of them identified her child as having been diagnosed specifically
with a bacterial infection at the clinic; she said that the antibiotic worked because it “kills the infection.” No family participants described requesting or expecting antibiotics themselves as an indicator that something is “really being done” for their sick child, although the over-the-counter availability of antibiotics in Mexico has been suggested as contributing to this perspective (Corbett et al. 2005; Gartin et al. 2010).

Biomedical Health-Care Staff: Beliefs and Practices

The BHS generally emphasized wanting to provide appropriate and high quality care for their Hispanic patients, and several described coming to work with the MHC specifically because of its historical emphasis on immigrant and migrant health care. They reported that about half of the patients they see are young children, and about 25% of these have been brought to the clinics because of the caretakers’ concerns about childhood diarrheal illnesses. Only about 5% of the cases were estimated as severe.

Causes of Childhood Diarrhea

For Hispanic children, the BHS identified viruses and bacteria as the most frequent causal agents (in equal numbers, \( n = 9 \)), followed by parasites (\( n = 6 \)). Single references were made to other causal factors including food allergies, teething, change in formula, and unsanitary living conditions presumably associated with poor socioeconomic status. Most BHS noted that Hispanic caretakers do not offer their own explanations about the cause or the staff do not ask families any questions about the etiology of the children’s illness. Those who learned about the caretakers’ beliefs said that food was the explanation given most often, which matches the most frequent cause offered by the family participants as noted above.

If the BHS did not mention caretakers’ folk medicine beliefs about diarrhea, specific prompts regarding empacho, caida de la mollera, lombrices, and mal de ojo were offered. The BHS identified empacho, followed by susto, as the most common folk illnesses associated with diarrhea, as did the family participants. However, family participants described caida de la mollera as frequently as susto, while BHS did not report caida de la mollera at all.

Folk Healing: Questions and Opportunities

Most BHS (80%) reported that they believe their Hispanic clients use some form of folk healing in treating childhood diarrhea, either alone or in combination with biomedical treatments. They noted that a few folk remedies potentially assist with their advised biomedical treatments, and specified that manzanilla tea and rice water are clear liquids that can help children stay hydrated. Several BHS also identified others that were found to be potentially dangerous and problematic because they are not regulated by the FDA. The MHC providers do receive training about folk remedies that emphasizes awareness of potentially lethal treatments such as greta and azarcon that contain lead, and these are particularly known as remedies for empacho (Trotter 1985). None of the doctors in this study had encountered such lethal effects of folk remedies.

Massaging a child’s stomach, including skills of sobadores, was identified by several BHS as offering some potential benefits—as long as “it’s not too vigorous.” One physician noted that sobadores:
can do a lot with relaxation and people have a really, really high belief that it’s not just the touching or the moving of your hands, it’s something else that’s going on. And … rubbing a child’s belly in certain ways for colic, rubbing their bowels … [can be effective because it is] … calming. And [I] think a lot of childhood massage that we see in really high-priced white neighborhoods are sobadores.

This same provider offered a cautionary note about dehydration as an issue that is understood poorly by the general population as well as a method to remedy the problem with families who use Hispanic folk healing:

They [parents] do understand the whole concept of dehydration but just like white people, they don’t understand the concept very well—that dehydration doesn’t mean lack of water but lack of salt water. So they give kids a lot of boiled rice water or other chamomile teas, things like that, which do help, but they can make kids’ salt level go down so far that it makes them have more vomiting.

I teach people how to make chamomile Pedialyte. It doesn’t matter to me if the [base liquid] is water or chamomile tea, but the grandmothers think it’s the hottest thing … because it respects what they believe but it helps fix it, so it’s a better practice. And so it just takes a lot longer to teach patients [emphasis added].

Yet, the BHS consistently emphasized that the limits imposed on their time with patients means such discussions are rarely possible.

Challenges in Biomedical Care: Revealing Discordance

The biomedical staff were asked what they considered to be major issues for their Hispanic patients in using or seeking out biomedical therapies for childhood illnesses. One commonly noted barrier in health care settings occurs when providers and patients do not speak the same language. However, no member of the staff reported hearing about problems with language barriers impacting patient use of such services locally, which matches family participant responses. This alone represents progress toward effective communication and its importance should not be underestimated. Yet, fluency in Spanish may not translate to basic knowledge of folk illnesses or treatments. For example, staff members may speak Spanish and have heard the word empacho but they also say they don’t know much about the meaning of the word or the attendant folk etiology and remedies. On the other hand, half of the BHS report hearing that clients have transportation and access concerns; they also said that occasionally money issues were raised.

The general category of “educating” parents about hand washing was described as by far the greatest challenge BHS see to effective treatment of childhood diarrhea among Hispanic families. However, family participants reported hand washing as the most frequently used method to help their children avoid becoming sick and preventing illness transmission. This inconsistency between provider beliefs and family participant knowledge will be considered further below. Several BHS also emphasized that some education issues related to the general population as well (e.g., how bacterial and viral infections differ and the associated limitations on treatment by antibiotics).

Discussion
Adult therapeutic decision-making for their children offers an important opportunity to refine the ethnomedical knowledge base and theory and demonstrates its relevance in contemporary health care settings. An interactionist, relational analytic approach, incorporating structural and cultural phenomenon, is essential for understanding both local Hispanic immigrant treatment choices for their children and for immigrant health issues on broader scales (Fisher 2007:1, 39; Hahn 1995:74; Sargent and Larchanché 2011).

**Therapeutic Decision-making: Rethinking Acculturative Forces and “Trust”**

The complexity of factors impinging on Hispanic immigrant health in U.S. contexts of medical pluralism has resulted in “a number of paradoxes in the medical literature” (Chavez 2003:206). One example is debates about research indicating second-generation immigrants, and especially children, may be less healthy than those of the first generation (Fitzgerald 2010). Another paradox is reflected in conflicting reports about use of traditional healing among Hispanic immigrant populations and whether it is remaining stable or declining. However, research on use of biomedicine and/or folk healing in country of origin is rarely linked with current medical systems use patterns. We incorporate data from our previous undocumented Mexican Immigrant Women (MIW) study to clarify why this is essential baseline information for assessing change in ethnomedical beliefs and therapeutic processes.

Although our current Childhood Health Study (CHS) included families with much longer U.S. residence, the proportion of families who use traditional healing (near 70% total; 58% for childhood diarrhea) was very similar to that found in our previous MIW study (71%). Further, about 20% of the CHS family participants spoke strongly against folk healing beliefs and practices, although these responses did not cluster within a particular age group or among the more recent immigrants as compared to longer term residents. Nearly the same proportion of MIW participants described a longstanding and strong distrust of or disdain for traditional healers beginning when they lived in Mexico. This was because healer lacked “education” and technology or because of their negative experience with a folk healer in Mexico.

Length of residence in the United States is often cited as a key variable that is positively associated with loosening ties to traditional Mexican cultural beliefs and traditions, including folk healing practices (Holliday 2008; Hunt et al. 2004; Lopez 2005; Martinez 2009; Molina et al. 1994). In our current study, the use of folk healing remains fairly consistent across families with the shortest through the longest histories of U.S. or local residency. In fact, the lowest proportion of families using folk healing was among a group with local residence for six months or less. This challenges the assumption that use of traditional healing steadily declines over time, and the MIW participants’ experiences highlight several important complicating factors when considering a family’s health care choices. For example, although only a few MIW participants had actually used Hispanic folk healers in the United States, over half said they would if they or their children experienced symptoms that indicated folk healing treatments were needed. Thus, the shorter the local residence time, the greater the chance an illness will not have occurred that requires such treatments.

Another equally important issue was the mothers’ lack of familiarity with local healers who they know can be trusted. As one MIW participant explained: “We don’t know curanderos locally except for what is heard on the radio about such people—but we do not have confidence in them because we don’t know them.” This was the case even though the undocumented status
of the MIW study participants might have been assumed to encourage the use of less visible folk healers, rather than biomedical clinics. Thus, in both of our studies, a shorter length of residence in the United States did not link with use of folk healing in ways that reflected cultural beliefs alone. In fact, families with longer residence in central Washington have greater opportunities for access through family and friends to a network of affordable and trusted folk healers. Here, the significance of social networks is highlighted and clearly as more than economic safety nets (Vasquez-Leon 2009).

Our research focuses on Hispanic communities in a region considered rural, which could be assumed to impact the participants’ acculturation status. In contrast, Lopez (2005) reports on use of folk healers and traditional medicines among a group of 70 urban-based Latina women (ages 20–47 years) in southern California. This sample is characterized by “a high level of assimilation and some level of acculturation,” contributed to by their enrollment “in a rigorous professional [social work training] program” (Lopez 2005:27). Even among this “highly assimilated” sample, with long-term residence in the United States, Lopez concludes, “that these … [folk] ... healthcare systems exist as a viable resource in Mexican American communities” (2005:30; and see Chavez et al. 2001).

Use of biomedicine was considered a credible option by participants in both of our studies. All of the MIW participants had some familiarity with biomedical health care during their lives in Mexico and noted impacts of structural issues there on their treatment choices. For some participants, biomedical care was free where it was available in rural Mexican settings although folk healers charged for their services; others had the opposite experience. In central Washington, several women were connected to services through the MHC; however, for certain types of symptoms and illnesses, treatment was sought through folk/indigenous healers and remedies rather than from the biomedical system. As one MIW study participant noted, some conditions are “not of the clinic”; other specific sets of symptoms (e.g., high, prolonged fever, prolonged vomiting, blood from the nose) indicated that the use of biomedical care was most appropriate.

**Folk Healing and Biomedicine: Intertwined Cultural Beliefs and Structural Constraints**

Family and biomedical staff narratives highlight the complex intersections of cultural factors related to Hispanic folk illness and biomedical belief systems and the structural constraints inherent in agribusiness and the dominant U.S. biomedical health care system. In both of our studies, family members noted symptoms that would prompt them to seek biomedical care. These contrasted with other specific symptoms that they knew would not be taken seriously, or be treatable, by biomedical healers. They expected to hear criticism for use of traditional folk practices in biomedical settings, and several BHS noted their biomedical training and enculturation process had supported ignoring, at best, such topics during patient appointments.

Generally, families described the clinic as a separate realm of health care, so it would not be a relevant topic to bring up themselves. Further, what the families consider a “problem” is often part of the normal progress of diarrhea in the biomedical model. The BHS emphasized keeping a child hydrated, but letting the diarrhea “run its course” if no specific bacterial or parasitic causal agents are identified—a process that may naturally take several days. However, Weller et al. (1993:118) documented general agreement among their participants at Latin
American and U.S. study sites that, left untreated, empacho can lead to death. This echoes concerns of our family participant who worried that after two days, unmanaged diarrhea could be lethal, whereas the BHS estimate only 5% of the cases they see in children could be considered severe. Such disconnects between short-term goals for treating childhood diarrheal illnesses were recognized by a number of the BHS, who cited lack of education and/or folk illness beliefs as problems associated with families bringing in children too often and too soon.

Ethnomedical beliefs are not always a major issue, and for about a quarter of the family participants they were not relevant. Despite biomedical services being spread across the study region and in the form of several migrant health clinics, about 25% of the family participants said access problems influenced decisions not to use biomedical services. The BHS reported an even higher figure; about half of the Hispanic families they treat voiced similar concerns. The agribusiness labor market imposes constraints that penetrate into the fabric of therapeutic caretaker decision-making for their children; it is the primary income source for 70% of the family participants. For example, particularly during harvest seasons getting a ride at a specified appointment time is often difficult or impossible.

Family and neighbors with access to transportation may work in the fields until sunset, and if a child’s diarrhea and disinterest in eating or drinking has persisted and increased during the day, only emergency rooms are likely to be open by the time transportation is available. Although there are some community-based transportation programs, these often require advance notice of at least 24 hours and so are not consistent options. The MHC also has several walk-in clinics that are open into the early evenings and on Saturday, but funding constraints limit their availability across its service area (see Horton and Barker 2010). Further, such options belie the fact that “structural violence” within migrant labor camps and work settings themselves may impede farm workers from even considering seeking biomedical health care (Benson 2008).

Use of biomedical treatments for childhood diarrhea also is encouraged by institutional settings that recognize and reinforce its legitimacy. Several families reported the need to meet licensed day-care provider expectations as the motivation for their treatment decision; state or federally supported programs often require signed documentation that a child with runny stools has been seen by a biomedical care provider. This supports current widespread public health efforts to limit the spread of infectious diseases, yet it also amplifies access challenges and may force increased use of emergency rooms. Currently, the impacts of such requirements in institutional contexts, especially day-care centers, is being scrutinized to ascertain whether this actually coincides with biomedical recommendations for mild symptoms—especially given its economic impact on families (Hashikawa et al. 2010). Too often, the implications of institutionalized biomedical dominance are not examined and the focus shifts back to patients; providers’ perceptions of their cultural traits are often viewed as the major source of problems.

The Muddled Reality of Contemporary Settings: Ethnomedical and Critical Approaches Are Pivotal

Over half of family participants said that diarrhea was not contagious or they didn’t think it was. Weller et al. (2002:467) have documented that susto is generally not considered contagious. Although not similarly described in the extant literature, our study indicates that childhood diarrhea associated with empacho also is neither contagious nor responsive to biomedicine. This underscores an ongoing challenge in Hispanic ethnomedical research and theory—distinguishing
symptoms as distinct from general folk illness categories (Weller et al. 2002). Weller et al. (2002) also note diarrhea was not consistently linked with susto by participants in their multi-site study, although it was in our project. Further, our family participants report that causes of childhood diarrhea include unclean or inappropriate foods, viruses or bacterium, and the like that are not linked to folk illnesses. Diarrhea as a distinct condition reflects a biomedical construction that may or may not correspond to folk illness categories. Studies of folk medical models must consider the implications of conflating symptoms with distinct illness categories in ways that can obscure understandings of therapeutic decision-making (Ross et al. 2011).

Hand washing was the key topic that BHS emphasized was needed in education about diarrhea contagion. Family narratives, however, were saturated with statements that emphasized the importance of cleanliness generally, and the washing of hands, food, and children’s toys as important in preventing childhood diarrhea. The disjunction exists between each group’s ethnomedical concepts of illness transmissibility and has clear implications for the spread of diarrhea among young children. Further, beliefs about folk illnesses do not necessarily create barriers; families demonstrated an openness to and comprehension of the predominant biomedically based educational materials. The design of such materials requires specific information about what Hispanic families already know and about local ethnomedical beliefs and therapeutic decision-making in contexts of medical pluralism.

Few BHS said they had a good understanding of Hispanic folk healing beliefs and remedies, although one described a method for combining traditional remedies with biomedical treatments. The use of Pedialyte combined with a folk remedy is an example of what Buchard (2005) calls the “cultural reintegration” of a pharmaceutical product. This process can take place outside of biomedical control and thus raise concerns about safety (Bledsoe and Goubaud 1985; Buchard 2005). Here, the hybrid suero represents a cooperative exchange between the doctor and caretaker that effectively contextualizes Pedialyte into an existing ethnomedical model and may, in fact, positively influence the “perception of its effect” (van der Geest 1988:343). In the short term, giving hybrid suero to children with diarrhea also addresses a common knowledge gap concerning the need for salts, not simply liquids. Clearly, effective interconnections between biomedical treatments and traditional healing approaches can be designed without waiting for, or requiring, major changes in medical belief systems (Harwood 1971).

Beyond having appropriate ethnomedical information, effective health care for Hispanic immigrants depends on direct communication with patients. However, the MHC physicians reported that they rarely, if ever, have the time available for such discussions with parents of sick children. Thus, even if MHC practitioners are so inclined, structural constraints in the U.S. biomedical health care system mean such opportunities may be lost. Time limitations aside, however, physicians generally thought this topic was discussed by support staff, several of whom were Hispanic and so should know the appropriate questions to ask families. Yet support staff also emphasized that time constraints made this impossible. Generally, most BHS, including support staff, indicated they did not have a more than rudimentary familiarity with folk medical systems themselves and that their biomedical training already had encouraged them to, at best, disregard folk healing practices as having little value (Holmes 2012). Younger support staff, in particular, indicated they would feel especially uncomfortable talking with older Hispanic patients about their use of folk healing.
Contributing to the development of culturally relevant and effective health care has a rather long history within medical anthropology (Clark 1959), but only more recently has a broader range of disciplines, and the biomedical profession itself, begun to consider the potential benefits of such efforts. Challenges exist at key junctures; family participants said that they don’t often discuss their use of home treatments and folk healers, and BHS providers said they rarely have time to ask. Ironically, similar to family participants’ statements, this often was not considered a relevant topic for the clinic settings.

The recent burgeoning of cultural competence training programs for staff in hospital and clinical care settings indicates a broader biomedical recognition of other ethnomedical belief systems (Chrisman 2007), although funding for such training is often vulnerable in the face of competing patient care expenses. Such training often must be completed in a matter of hours or a few days, and critiques include that that the training is too generalized and superficial. This can create a false sense of confidence in understanding other cultural perspectives and their significance for individual patient care (Bustillos 2005; Kleinman and Benson 2006). And, if limited training/funding means education is focused mainly on worst-case scenarios, such as lethal effects of a few folk remedies, then both the level of competence and the scope of cultural knowledge are deeply flawed. Although BHS training in cultural competence may be a component of the solution, it is insufficient without structural institutional changes that will sustain changes in practice.

For the Sake of Our Children—The Future

In 2003, Foner noted that “huge recent immigration” presented a challenge for anthropology as well as other social sciences to unravel its effects in the United States and elsewhere (Foner 2003:6); a decade later, transnational migration continues apace. Our research refines theoretical assumptions about immigrant health and intracultural variation in the context of medical pluralism and contributes to understanding change and continuity in ethnomedical belief systems. Importantly, Hispanic immigrant families in our studies make health care choices that are not determined solely by cultural beliefs or structural constraints. Concentrating on one or the other, rather than taking an interactionist approach, might provide a more parsimonious analytic focus but it would not capture the “muddled” reality of contemporary settings (see Schneider 1965).

Investigating adult health care decision-making for their children is a rarely used avenue for understanding learned cultural meanings and therapeutic decision-making associated with illness experiences—the key components of ethnomedical belief systems. The importance of this approach is amplified by the rapid regional and national increase in the numbers of Hispanic children. Nearly 60% of the family participants described using traditional folk healing methods and/or healers for treatment of childhood diarrhea, and the majority of families who took children to biomedical clinics for diarrhea problems first tried herbal remedies or other folk healing practices. Expressed through their commitment to improving their children’s health, a focus on Hispanic parents’ beliefs about childhood illnesses can contribute to expanding ethnomedical knowledge while potentially providing additional information for addressing the health of adults.

Our research also emphasizes the need for reassessing the assumed impact of migration histories on immigrant health. In the context of medical pluralism, information about use patterns
in home settings is an essential baseline for more accurately assessing change and persistence in treatment patterns. The use of folk healing among our study participants cut across first- and second-generation families, all age groups, and recent immigrants as well as long-term residents. In the extant literature, it is generally assumed that longer residence in the United States, characterized by biomedical dominance, correlates with declining use of folk healing. Our study of participants’ lived experiences contradicted this expectation; in fact, those with the shortest length of residence used folk healing less than those with the longest residence histories. Such community-based research not only contributes to understanding intracultural variation in Hispanic ethnomedical models and therapeutic decision-making, it also reveals factors relevant to understanding immigrant health on broader, global scales.

Finally, assessing both the details of contagion in ethnomedical models, as well as embedded structural issues related to biomedical dominance and agricultural labor histories, was essential for clarifying how and why Hispanic immigrant families make treatment choices for their children. Through juxtaposing biomedical and immigrant beliefs, we identified important areas of discordance in Hispanic family and biomedical practitioner beliefs about illness transmissibility and appropriate prevention measures.

Our research supports Holmes’s (2012) conclusion that the culture of biomedicine and the structural limitations it imposes on the provision of effective health care are essential components in biomedical competency training. Yet we find that ethnomedical knowledge also remains very relevant in contemporary health care settings, and medical anthropologists are particularly well trained to design and carry out pertinent research.

In some cases, the ethnomedical information is already documented, but the potential linkages with clinical care and medical anthropology’s opportunities to contribute to more effective health care are unrealized. In many other cases, additional information is needed; although not the primary cause of inadequate cultural competence training, if current information doesn’t exist, it can’t be used.

Several BHS suggested that further research on what the parents mean when they describe their child or themselves as “having empacho” would be useful because they hear it mentioned so often in relation to diarrhea and stomach problems. This topic especially could provide an important two-way educational opportunity between patients and biomedical healers while addressing the general impression among families that discussing folk healing in the clinic will only bring criticism. However, the growing economic costs of maintaining biomedical health care were often perceived as severely limiting direct communication options, even in contexts like the migrant health clinics.

Relying on published literature from Hispanic immigrant studies in other locations can be helpful, but such literature does not necessarily provide information relevant in local settings. Further, when limitations on cultural competence training leave it focused on worst-case scenarios, its influence on providers’ perspectives on folk healing and Hispanic patients may undermine effective health care.

An initial research goal was to assess how nitrate contamination of drinking water, as a potential new causal agent linked to diarrhea in young children, had entered the family and/or biomedical practitioners models of illness causation and appropriate treatments. Given that nitrate water contamination was a regional issue emphasized by the MHC and other organizations, one surprising result was that it was not a concern for any of our study participants. However, nitrate water contamination now is a major environmental health issue
regionally, nationally, and globally (EPA 2011; Harter et al. 2012; Sutton et al. 2011). This is of particular concern for children and is potentially related to a range of health issues to which medical anthropology has a great potential to contribute. Assessing interwoven ethnomedical and structural factors affecting both community members’ and biomedical providers’ illness beliefs systems and treatment decisions can play a part in not only anthropological theory—but can also address this and other emerging and extant community health concerns.

Notes

Acknowledgments. We greatly appreciate the participation of the families and biomedical health staff whose histories and experiences we recorded for this project. Staff members of the Migrant Health Clinic and several other regional social service agencies provided essential assistance with the field study segment of this project. We hope this article has contributed to all of their major concerns: improving health care for children. Funding for this research was provided by the Wenner-Gren Foundation (Gr.7229); the Washington State Department of Health, Environmental Health; and Central Washington University: Graduate Studies Program, Faculty Seed Grant, and Summer Faculty Research Appointment. Anonymous reviewers and Dr. Mark Luborsky, editor for Medical Anthropology Quarterly, offered valuable suggestions and support.

1. The common term used locally and comparable to “Latino,” which is in this community is considered to carry the sense of a more urban context.
2. For a succinct, general introductory historical and illness-specific overview see Chavez and Torres 1995. More detailed overviews are available on empacho (Weller et al. 1993) and susto (Rubel et al. 1984; Weller et al. 2002).
3. The term “Mexican immigrant” follows common usage to describe a person born in Mexico who has immigrated from Mexico and now resides in the United States. It is not specific to citizenship status (someone who naturalizes would still be an immigrant) or to legal state. “Migrant” refers to Mexican American or Mexican family participants who do not live permanently in the Yakima region but travel to work there on a seasonal basis from another home location in the United States (e.g., Texas migrant laborers who come for the hop or fruit harvest seasons in the Yakima Valley).
4. Administratively, the goal was to prioritize staff time to be available for patient care and to assure the sustainability of the clinic. Several clinicians emphasized that they felt pressured by this managed care approach, which provided a fairly comparable base salary with bonus incentive pay for higher productivity.
5. Half the interviews took place in an on-site clinic room; the others were off-site for interviewee convenience. Interviews lasted about 30 minutes; when possible, some continued longer.
6. The following guide to descriptors applies: “few” means 1–14%; “several” means 15–29%; “less than half” means 30–49%; “more than half” means 51–74%; and “most” means 75–99%.
7. In our MIW study, participants’ lived experiences of risk complicated the assumed distinctions between their initial undocumented/illegal status, and subsequent stages of legal documentation (Andrews et al. 2002). Their vulnerability is continually reinforced by reminders from administrative personnel that advancing through one documentation status adjustment hurdle towards citizenship is no guarantee against revocation or denial of future applications—and
ultimately deportation. Clinics such as the MHC may have legal protections for clients while on their premises—regardless of documentation status. This was the case for our research with the MHC, but recent U.S. immigration policy change has rescinded this option for many programs.


References Cited

Andrews, T. J.
Andrews, T. J., V. Ybarra, and T. Miramontes

Baer, H.

Baer, H., with M. Singer and I. Susser

Baer, R. D., and M. Bustillo

Barlow, K., and B. Chapin, guest eds.

Benson, P.

Bledsoe C. H., and M. F. Goubaud

Bluebond-Langner, M., and J. Korbin, guest eds.


Erickson, P.  2008  Ethnomedicine; Long Grove, IL: Waveland.


Fisher, M.
Fitzgerald, N.
Foner, N.
Gamboa, E.
Garro, L.
Gartin, M., A. Brewis, and N. Schwartz
Glazer, M., R. D. Baer, S. C. Weller, J. Garcia de Alba, and S. Liebowitz
Gleick, P. H.
Good, B. J.
Granich, R., M. F. Cantwell, K. Long, Y. Maldonado, and J. Parsonnet
Green, E.
1999 Indigenous Theories of Contagious Disease. Walnut Creek, CA: AltaMira.
Hahn, R.
Harter, T., and J. Lund (Principal Investigators)
Harwood, A.
Hirsch, J.
Holliday, K.
Holmes, S.
Horton, S., and J. Barker
Hunt, L., S. Schneider, and B. Comer
Kamat, V. R.
Kay, M. A.
Kendall, C., D. Foote, and R. Martorell
Kleinman, A.
Kleinman, A., and P. Benson
Kleinman, A., L. Eisenberg, and B. Good

24
Knobeloch, L., B. Salna, A. Hogan, J. Postle, and H. Anderson
Lancy, D.
Larsen, A.
 Larson, E. L., S. Lin, and C. Gomez-Durate
Lehmann, A.
Leslie, C.
Lopez, R.
Lopez-Class, M., F. González Castro, and A. Ramirez
Low, S., and S. Merry
Martin, P., and E. Midgley
Martinez, L.
Miller, E.
Molina, C., R. E. Zambrana, and M. Aguirre-Molina

Nichter, M., and M. Lock, eds.

Office of Financial Management (OFM)

Perrone, B., with H. Stockel and V. Krueger

Poss, J., and M. A. Jezewski
2002 The Role and Meaning of Susto in Mexican Americans’ Explanatory Model of Type 2 Diabetes. Medical Anthropology Quarterly 16:360–377.

Pylypa, J.

Quinlan, M.

Reiff, M., B. O’Connor, F. Kronenberg, M. Balick, P. Lohr, M. Roble, A. Fugh-Berman, and K. Johnson

Ross, N., J. Maupin, and C. Timura

Rubel, A. J., C. W. O’Nell, and R. Collado-Ardón

Ryan, G. W., and H. Martínez

Sargent, C., and S. Larchanché

Schneider, D. M.

Sell, R., and L. Knutson

Singer, M.
2007 Drugging the Poor. Long Grove, IL: Waveland.

Sobo, E.


Trotter, R. T., II

Trotter, R. T., II, and J. A. Chavira

U.S. Census Bureau

U.S. Department of Agriculture (USDA)

van der Geest, S.

Vasquez-Leon, M.

Waldstein, A.

Weiss, M. G.

Weller, S. C., and R. D. Baer