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EXPERIENCES OF WESTERN CLINICAL PRACTICE AND TRADITIONAL MEXICAN AMERICAN HEALING WHEN THE PROVIDER IS THE SAME PERSON

Helen Marie Tafoya

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**EXPERIENCES OF WESTERN CLINICAL PRACTICE
AND TRADITIONAL MEXICAN AMERICAN HEALING
WHEN THE PROVIDER IS THE SAME PERSON**

By

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B.A., Psychology, University of New Mexico, Albuquerque, 1991
M. A., Clinical Psychology, Arizona State University, Tempe, 1995

DISSERTATION

Submitted in Partial Fulfillment of the
Requirements for the Degree of

**Doctor of Philosophy
Counselor Education**

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Dedication

This dissertation is lovingly dedicated to the generations that came before, specifically my parents Cleofes Tafoya, Jr, and Rupe Tafoya. To the generations that came after, specifically my sons José Barraza and Fernando Barraza, as well as to my grandson, Gabriel Barraza. You inspire everything I do. And to all those who walk the healing path, serving their communities by example, in ceremony, and in political action.

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I am particularly grateful to those who have allowed me to assist them on their own healing journeys.

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ABSTRACT

In counseling ethics and standards, there is a call to integrate practices and for practitioners to become more aware of other cultures and traditions (Sue, Arrendondo, & McDavis, 1992; Ratts, Singh, Butler, Nassar-McMillan, & McCullough, 2015). Very little research exists that addresses when the Western mental health practitioner and the traditional healer are the same person. The current work explored the experiences of licensed mental health practitioners who are also traditional Mexican/Mexican American healers in their practice of both modalities. The theoretical frameworks for the current study are multiculturalism and social justice.

Six research participants from the Southwestern region of the United States participated in the study. The participants included four individuals who identified as female and two individuals who identified as male. The participants ranged in age from 46 to 69. All participants mentioned growing up with traditional healing practices and identified a relative as a practitioner. All participants mentioned at least one mentor/teacher from whom they specifically learned traditional healing practices. All participants identified as Spanish/English bilingual and were able to conduct psychotherapy and traditional healing in Spanish and/or English as needed.

I used an Interpretative Phenomenological Analysis approach to explore how the participants described their experiences. I identified four major themes. Theme one is identity as a healer and that training in traditional healing is lifelong. Theme two reflects barriers and integrations to dual practice. Theme three is social justice, that is, traditional healing as a statement of cultural power, reclamation, political activism, and social justice. Theme four is about the healing methods used including different techniques, use of the *plática* specifically, and traditional healing as heart energy. I present implications for practice, teaching, and future research. In addition, advocacy for the client and the counselor from both mainstream and marginalized groups, as regards third party payment is a key direction for future practice, teaching, and research.

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Chapter 1

Introduction

Ethical standards call upon licensed counselors to embrace multicultural approaches and honor diversity (ACA, 2014). Based on this, one might expect that the American Counseling Association (ACA) code of ethics would provide information to a counselor about how to best consult or work with a traditional healer when the client's belief systems and culture reflect that of the traditional healer. The assumption is that the traditional practitioner and the Western practitioner are two different people from two different cultures. However, these standards do not go far enough and do not address when the practitioner is both a traditional healer and a licensed Western-trained therapist. William West (2005) observed that there is a difference between the public discourse of what a practitioner claims to do in a therapy session, including in supervision, and what actually happens in the therapy session. Therefore, there is a need to first discern how individual practitioners who are both traditional healers and licensed mental health practitioners integrate the two different approaches.

Problem Statement

In counseling ethics and standards, there is a call to integrate practices and for practitioners to become more aware of other cultures and traditions as well as the counselor's awareness of their own

positionality in relation to the client (Sue, Arrendondo, & McDavis, 1992; Ratts, Singh, Butler, Nassar-McMillan, & McCullough, 2015). Very little research exists that addresses when the Western mental health practitioner and the traditional healer are the same person. The current work seeks to explore the experiences of licensed mental health practitioners who are also traditional Mexican/Mexican American healers in their practice of both modalities.

Purpose of the Study

The purpose of the study was to investigate how individuals who are licensed mental health practitioners and traditional Mexican American healers describe their experiences and practices. For the purposes of this study a licensed mental health practitioner is understood to be a licensed professional clinical mental health counselor (LPCC), licensed marriage and family therapist (LMFT), licensed professional art therapist (LPAT), licensed psychologist, licensed clinical psychiatrist, licensed alcohol and drug abuse counselor (LADAC); licensed mental health counselor (LMHC); licensed master's level social worker (MSW), licensed independent social worker (LISW), or other mental health practitioners who are legally licensed to practice in their state of residence. A traditional Mexican American healer is someone of Mexican or Mexican American descent who practices indigenous healing practices more commonly understood to be in the *curanderismo* tradition. The practice of *curanderismo* involves a

holistic approach to healing technologies that represent an integration of Iberian, particularly Spaniard, Muslim, and African healing practices and spirituality with healing practices and spiritual traditions indigenous to the Americas (Avila & Parker, 1999; Kiev, 1968; Torres & Sawyer, 2005; Trotter & Chavira, 1981).

Ethical legal standards call upon licensed practitioners to embrace multicultural approaches and honor diversity (ACA, 2014). Based on this, one might expect that the ACA code of ethics would provide information to a counselor about how to best consult or work with a traditional healer when the client's belief systems and culture reflect that of the traditional healer. The assumption is that the traditional practitioner and the Western practitioner are two different people from two different cultures. However, these standards do not address when the practitioner is both a traditional healer and a licensed Western-trained mental health practitioner. Therefore, there is a need to first discern how individual practitioners who are both traditional healers and licensed mental health practitioners experience, or make sense of their experiences, in the practice of the two different approaches. An initial goal of this study is to understand how a practitioner practices the two modalities when the practitioner is the same person.

Understanding the Terms: Race, Ethnicity, Culture

Before starting on a study which is heavily weighted in multicultural issues it is best to clarify why the use of one term versus another.

Anthropologists and researchers rarely agree on the definitions of terms such as "race," "ethnicity," and "culture." These terms are often intellectual and political concepts which illicit strong emotional reactions (Sandefur, Campbell & Eggerling-Boeck, 2005).

The term "race" as used in strict biological terms refers to defining groups of living organisms based on shared characteristics and is not a useful distinction for the purposes of categorizing and studying the different peoples that make up humanity (Johnson, 1990; Pigliucci & Kaplan, 2003). Historically, Caucasoid, Negroid, and Mongoloid were the racial distinctions used in research (Johnson, 1990). However, a social definition was the basis for the distinction rather than a biological basis (Johnson, 1990). This over simplified categorization left out large groups of people such as Asian and Pacific Islander groups as well as the various peoples of Australia (Johnson, 1990). Certainly, in terms of classification of large groups of peoples for the purposes of research and service provision using such limited terms as "race" is counter-productive. That said, today the Office of Management and Budget (OMB) delineates "racial and ethnic" identifiers for use in the US Census as being "White" which refers to those with origins in Europe, the Middle East or North

Africa; "Black or African American" which refers to those with origins in any of the Black racial groups of Africa; "American Indian or Alaska Native" refers to those with origins in any of the original peoples of North and South America; Asian refers to those with origins in the Far East, Southeast Asia of the Indian subcontinent; "Native or Pacific Islander" refers to those with origins in any of the Pacific Islands (US Census Bureau, 2011). A sixth category introduced for the 2010 census "some other race" which refers to those who identify with none of the aforementioned racial and ethnic identifiers (US Census Bureau, 2011). These individuals are usually of mixed race/ethnicity (US Census Bureau, 2011).

The term "ethnicity" refers to social groups who share a common ancestral heritage and have a shared sense of identity even if individuals within the identified ethnic group are of different race categories (Nerenz, McFadden, & Ulmer, 2009). The OMB sets forth only two ethnic identifiers for the use in the US Census and other Federal agencies. These are "Hispanic or *Latino*" and "Not Hispanic or *Latino*" (US Census Bureau, 2011). The term "culture" is even more difficult to define and is a synonym for "social race" (Johnson, 1990). Definitions of culture include patterns that are specific to places and times and include knowledge, skills, attitudes, and an implied way of life (Johnson, 1990). Currently, the US Census Bureau and many researchers follow the guidelines for

race and ethnicity as set forth by the Office of Management and Budget (OMB) *1997 Revision to the Standards for the Classification of Federal Data on Race and Ethnicity* (US Census Bureau, 2011).

The attempt at having a “unified” method to categorize individuals into larger groups for study and service delivery can be beneficial. The notion is that homo-sapiens are not homogeneous enough and that understanding the differences and similarities within and cross-culturally will aid in understanding disparities and being better able to increase health outcomes (Nerenz et al., 2009). One impediment to the understanding of health disparities and service delivery is that different authors and data sources utilize different race and ethnic categories (Sandefur et al., 2005).

The specific focus of the study relied on country of origin identifiers, specifically those who identify as Mexican, Mexican immigrant and/or Mexican American. Those interviewed for the purpose of this study must also possess, or if retired, had possessed a license as a mental health practitioner in the United States.

Rationale and Significance of the Study

The rationale of the study was that given the ethical codes, standards of practice and guidelines to which a mental health practitioner must adhere and all the guidelines, standards of practice, and traditions to which traditional Mexican American healers must adhere that little

guidance or pragmatic advice on how to proceed or best merge or navigate the opposing value systems and world views is currently available. The purpose of the study was to investigate how individuals who are licensed mental health practitioners and traditional Mexican American healers describe their experiences and their practices. The theoretical frameworks for the current study are multiculturalism and social justice.

Three Times Knowledgeable and Competent

I argue that traditional healers who are also licensed mental health practitioners must be three times knowledgeable and competent. The healer must be versed and practiced in traditional healing practices as well as educated, licensed, and competent to practice in the Western modality. Then the healer/practitioner must be knowledgeable and competent to practice in the intersection or combination of the two. Truly, this is not about either/or, but about both at the same time, knowing where the differences as well as similarities are and how best to proceed with each individual client. Neither traditional healing practices nor Western mental health practices exist exclusive of one another.

Therefore, the intersection of these two modalities is key. Conventional thought is that the two world views are separate and distinct, but indeed, they are not. Western mental health practitioners need to be multiculturally aware and competent and Mexican American traditional

healers strive to learn and gain knowledge from multiple sources and must practice within the existing laws of the United States.

Positionality Statement

I am from the Mexican American culture and was born in Albuquerque, NM to parents who were from the Northern part of the state. My father was from Las Vegas, *San Miguel* County, NM, and my mother was from Rainsville, *Mora* County, NM. My father identified as "*Chicano*," while my mother identified as "Spanish." However, if one asked my mother in Spanish, "*¿quien somos?*" Who are we? My mother would reply, "*Semos Mexicanos.*"¹ We are Mexican. However, when asked in English she would say, "We are Spanish." Both my parents would talk about "*los Indios*," Native Americans that were different from *Chicanos*, *Mexicanos*, or Spaniards. During course work for my undergraduate degree, I took many *Chicano* Study classes. I came to realize that we were not just a "blend" of Native American and Spaniard blood, but culturally blended as well. I learned that in New Mexico there are many *genízaro* villages. *Genízaros* are detribalized, Native American's who may not have blended blood lines but had the Spaniard ways, traditions, mores, and religion imposed upon them (Avery, 2008).

¹ "Semos" is an archaic form of Spanish. The more contemporary word is "somos" which means "we are."

I identify as *Latina/Chicana*, a mixture of Native Mexican and Spaniard blood. My maternal great-grandfather was Irish and immigrated to the United States after fleeing the priesthood. He married a native woman and settled in Northern New Mexico in the small village of *Llano del Coyote* which today is Rainsville, New Mexico. My paternal grandfather, who was born and raised in Northern New Mexico, identified as Spanish and married a woman who by phenotype appeared to be Native American. To this day, my paternal aunts and uncles claim to be of Spanish descent and do not identify having indigenous blood.

My first experiences of healing came quite young. My mother would tend to her sick children with herbal teas, prayer, and intuition. I have distinct memories of my mother engaging in what I consider normal activities. I would see her cook special dishes and prepare *remedios*, or remedies, for certain ailments. These included *atolé* and mint tea for stomach ache, *oshá* for a sore throat, and warm olive oil for ear aches. My mother was my first teacher. I learned by watching her example, by listening to her stories, and by following her direct instruction. My father was a great role model. He was the breadwinner and disciplinarian. He earned his living as a meat cutter and we spent countless weekends every fall going to *matanzas* (literally "slaughter" but in general use refers to the entire set of events surrounding when an animal is butchered to use for food). He would cut up meat and prepare it for

storing in deep freezers or dried for jerky. From him I learned about a way of life too few are able to experience today. He modeled kindness, caring and compassion. I strive to emulate his example to this day.

I earned a Bachelor of Arts in Psychology from the University of New Mexico (UNM). I then moved to Arizona and earned a Master of Arts degree in Clinical Psychology from Arizona State University (ASU). I later returned to live in Albuquerque and actively pursued a Ph.D. in Counselor Education from UNM. I am the Clinical Manager at the University Psychiatric Center's (UPC) Psychosocial Rehabilitation Program (PSR). PSR is a day habilitation program which serves those with serious mental illness. Prior to that, I have worked in various clinical and administrative settings in the mental health field. These include as the Clinical Manager of UNM Hospital's (UNMH) *Milagro*, an outpatient counseling and residential treatment center for pregnant women with addictions; quality consultant for first UNMH adult critical care and then the University Psychiatric Center; as a clinician in UPC psychotherapy services; as a grant writer for UPC; a case worker, case manager and supervisor of the intake department at the Addictions and Substance Abuse Program (ASAP); and as a case worker with the Center on Alcohol, Substance Abuse and Addictions (CASAA). Prior to that, I was a clinician with the Treatment, Assessment, Screening Center (TASC) in Phoenix, AZ and a

researcher/grant writer with ASU's Hispanic Research Center in Tempe, AZ.

While pursuing my undergraduate degree I worked at UNM's Hispanic Research Center and became involved with *Chicano* academic staff and social activists. Through this, I met several women who identified as practicing traditional healers. These were a powerful group of women, who shared knowledge of traditional healing methods, traded treatments, and participated in healing ceremonies. While I was in Arizona, a group of women formed the *Kalpulli Izkalli* in Albuquerque. The *Kalpulli Izkalli* is a traditional healing community which works to reclaim and preserve spiritual and healing practices.

While in Arizona, I met several Native American traditional healers. I formed deep friendships with these women and again we shared knowledge, traded healings, and participated in ceremonies together. Upon my return to Albuquerque, I reengaged with the local traditional healing community. While I was with the *Milagro* program, the Board of Directors for the *Kalpulli Izkalli* invited me to join them as a board member and practicing healer as well as in an apprenticeship capacity to one of the founding members.

Less than a year after I moved back to Albuquerque, I met an individual who would become one of my key teachers and mentors. He is also a gifted healer, shaman, and professional psychic. I continue to

apprentice as a traditional healer in the *Mexica* and other healing traditions. My teachers include my mother, Rupe Tafoya, and mentors Sylvia Ledesma and Robin Gile. I distinctly remember about the age of 11 or 12 (likely the spring after the 1972 presidential election) providing a whole day of services on my own for the first time. Since then I have consciously expanded my skills set and have trained in different healing modalities. My work as a counselor is in line with my work as a traditional healer. In traditional practice, we refer to it as "the Work" or "*el Trabajo*." This refers to the notion that no matter where one receives training or what modality one uses; it is a part of the great work of facilitating the healing process.

In conducting this research, I have been continuously aware of how my position as a healer may affect the information provided in both positive and negative ways. As a member of a healing community, I am more of an insider and for that reason may be more trusted and respected than someone from outside the community. As both a traditional healer and an independently licensed mental health practitioner, my positionality will help in my obtaining more candid responses as I am trusted and respected in this community. The consideration of reciprocity or how one gives back is not an issue. I belong to this community and have spent countless hours providing free services at health fairs, physical labor in building a *temazcal*/traditional

adobe sweat lodge, cleaning the *oratorio*/altar room, running errands, formatting brochures and agenda, attending planning meetings etc. I am part of this community and the notion of the outside researcher exploiting an indigenous community is not one that applies in this instance.

Chapter 2

Literature Review

“When we don’t understand your technologies, you call us ignorant. When you don’t understand our technologies, you say we believe in magic.”

Unknown

Introduction

As with any research and practical endeavor, it is useful to know how we got to where we are today. There appears to be a clear separation between Western medicine, Western psychotherapy, and traditional healing in general. These separations did not always exist, and the more we learn about health and healing the more we learn about not only the importance of integrative practice but how it would be less than ethical, and harmful, to do otherwise.

Cultures throughout the world have traditional healing practices (Shore, Richardson, Bair, & Manson, 2015). Long before the advent of the Western medical doctor, indigenous peoples have been caring for their own families and communities. Healing activities such as, recommending certain herbs for identified ailments and assisting a woman in childbirth existed in antiquity, are some of the earliest forms of medical practice (Bunney, 1993; Gonzales, 2012). Western medicine, as we typically conceive of it, came from many different cultures and traditions. It began from the prehistoric use of plants and herbs and slowly evolved to

dividing health from disease and emphasizing scientific study (Mantri, 2008; Tsuei, 1978).

Hippocrates (460-370 BC) is the “father of medicine” in the Western world and many of his teachings are recognizable today. While it is uncertain which of the writings and teachings credited to Hippocrates, Hippocrates wrote himself and which his students or followers wrote, the influence of these teachings remain (Bulger & Barbato, 2000).

Hippocrates is reputed to have been a keen observer and some of his teachings included, the importance of maintaining cleanliness, having clean water, using food as medicine, not doing harm, using empiricism, abiding by the Hippocratic Oath, caring for all aspects of a patient’s life beyond the medical concerns, walking and physical exercise as key to overall health, using herbs in healing and working with spiritual healers to better benefit the patient (Bulger & Barbato, 2000; Savel & Munro, 2014). The anthropologist Margaret Mead has pointed out that in the Hippocratic traditions physicians and sorcerers tended to be the same person and it was not until the fourth or fifth centuries when the Greeks imposed a separation (Bulger & Barbato, 2000). Spirituality and spiritual practice were the basis for the earliest forms of medicine. The imposition of formal research and science into healing disciplines came much later in history (Savel & Munro, 2014).

Western psychotherapy and psychoanalysis originated with Sigmund Freud (Paris, 2013; Schultz & Schultz, 2011). Paris (2013) argued that psychotherapy developed in a historical and cultural context and as a clinical theory did not emerge until about 1900. He lists those who influenced Freud's theories as including the philosophers Friedrich Nietzsche, Arthur Schopenhauer as well as medical doctors Joseph Breuer, Jean-Martin Charcot, and Peirre Janet. Paris' argument is that talk therapy as we currently conceive of it did not exist in Western practice prior to that time.

Mexican American traditional healing arose from indigenous healing practices in the Americas that were in place long before the occupation of the Spanish. Yet, we know that "*the plática*" or having conversations to relieve emotional distress, prayer, meditation, and ritual are mentioned in codices, other historical documents, and religious texts such as *The Torah*, *the Sri Guru Granth Sahib*, *the Quran*, and *the Bible*. The Greek philosopher Epictetus maintained that the foundation of all philosophy was self-knowledge and he observed that people are not upset by things but by their thoughts and reactions to things (Graver, 2013). Certainly, there have been countless philosophers, across cultures, and across time that have been keen observers of truth as well. To say Freud began talk therapy is very much like saying Christopher Columbus was the first to discover America. It discounts the centuries of those who were on these

continents long before Columbus and those who practiced healing and talk therapy technologies long before Freud.

The images of the folk healer are many and varied in mainstream media. Dr. Granny in the *Beverly Hillbillies*, “Witch doctors” on Gilligan’s island, depictions of apothecaries, palm readers, and psychics in countless movies and television shows including Henry VIII in the Netflix series *The Tudors* who dabbles with tinctures and poultices. Certainly, mainstream media depictions of traditional healers are innumerable, prolific, and frequently derogatory or comedic in nature. Aztec and Mayan codices document the role of the healer in pre-Columbian societies (Aceves, 2012). It is clear that traditional healing predates written history and predates the modern conceptualization of what we identify as Western psychotherapy.

Mexican American Traditional Healing in an Historical Context

Some of the earliest mentions of establishing criteria for the licensing of medical practitioners including who is allowed to practice and recommendations for a fee structure can be traced back to approximately 1772 B.C. in ancient Mesopotamia with the *Code of Hammurabi* (Levine, Schwartz, Bryson, & DeMaria, 2012). Prior to that there were other codes written in the Middle East that were similar to the *Code of Hammurabi*. These included the *Code of Ur-Nammu*, (circa 2050 BC), and the *Code of Lipit-Ishtar of Isin* (circa. 1870 BC), though there were others. These

ancient codes had several commonalities and it is reasonable to believe they influenced each other and/or derived from the same sources (Andrews, 2013). These codes established definitions for who could practice medicine, parameters for contractual agreements, punishments for specific crimes, as well as established who could be educated and who could practice medicine. The *Code of Hammurabi* sets forth a presumption of innocence when one is accused and stipulates that the accuser and the accused may both present evidence (Andrews, 2013; Levine et al., 2012). *The Code* allowed for "trial by ordeal" and set forth the notion of a minimum wage. The influence on modern law and why one would consider these ancient codes in the current work is clear.

It is well known that in Europe from the 14th to 17th centuries there was wide spread witch hunting and persecution of female healers (Ehrenreich & English, 1973). Women were tortured, beaten, burned at the stake and suffered untold atrocities for the offenses of sexual crimes against men, that is of having and using their own sexuality; the crime of being organized, that is meeting in groups of women who shared knowledge and assisted each other in times of illness or childbirth; and lastly of having magical powers affecting health which could harm or heal, especially as relates to obstetric and medical skills (Ehrenreich & English, 1973). During this time, 85% of those killed were old women, young women, and children. The witch hunts and persecution of women

endorsed and carried out by the Catholic Church which were influenced at least in part by the *Code of Hammurabi* (circa 1754 BC) and teachings, specifically the *Summa Theologica* (1265–1274), by St. Thomas Aquinas. These historical documents demonstrate that the persecution of women as healers has existed at least as long as recorded history. This history is apparent today in the struggle of women, in the struggle of female healers, in the struggle of those who despite all the laws and all the ethical codes remain persecuted, regulated, and treated as criminal for exercising knowledge and personal power.

In the Americas, ancient civilizations were also flourishing and developing knowledge, architecture, practices, and codes. The Olmec predate the Maya by more than a thousand years and were the first peoples to develop a great civilization (Williams, 1997). The Olmec developed the first calendar system and the first form of Mesoamerican writing in the form of glyphs. The Maya and the Aztecs came later and would go on to develop their own highly developed civilizations, codes, structures, and healing practices. The arrival of the Spanish and the subsequent Spanish colonialism in the 16th century forever altered the history of Mesoamerica (Avila & Parker, 1999; Carmack, Gasco, & Gossen, 1996; Kiev, 1968; Leon-Portillo, 1992; Torres & Sawyer, 2005; Trotter & Chavira, 1981).

Ari Kiev (1968), in his seminal work *Curanderismo: Mexican-American Folk Psychiatry*, provided one of the earliest formal Western examinations of *curanderismo*. John Trotter and Juan Antonio Chavira of Northern Arizona State University are likely the second most recognized scholars on the topic with the publication of *Curanderismo: Mexican American Folk Healing* (1981). Other portrayals of the Mexican American healer include Rudolfo Anaya's novel *Bless Me Ultima* (1972) and Clarissa Pinkola Estés in *Women Who run with the Wolves* (1992). More recently, Eliseo "Cheo" Torres of the University of New Mexico authored several books on the topic and facilitates a two-week intensive seminar, *Traditional Medicine without Borders* during the summer sessions at UNM in Albuquerque. Elena Avila published a personal account of being a healer in her book *Woman Who Glows in the Dark* (Avila & Parker, 1999). Patrisia Gonzales, of the University of Arizona in Tucson, published a self-reflective work titled *Red Medicine: Traditional Indigenous Rites of Birthing and Healing* (2012). Certainly, Mexican American traditional healers are no longer as obscure, hidden, and unseen in the Western world as they once were.

Traditional healers have been practicing since time immemorial. Conventional medical practice did not spontaneously develop on its own fully formed and functioning as a formal healing system. It came from somewhere. The first healers were women who attended at the births of

their own mothers, sisters, and other tribal members (Ehrenreich & English, 1973). Women as the life givers and caretakers learned to treat the afflictions of their people. Therefore, one can surmise that traditional healing, in any tradition, in any culture, has a long and well entrenched history.

Call for Integration

There is abundant literature which calls for the integration of healing practices mostly in the forms of increasing understanding of cultural healing practices as well as collaboration and cooperation among healers (Bojuwoye & Sodi, 2010; Del Castillo, 2015; Hoogasian & Lijtmaer, 2010; Hoskins, 2012; Krassner, 1986; Oulanova & Moodley, 2010; Padilla, Gomez, Biggerstaff, & Mehler, 2001; Ratts et al., 2015; Sue et al., 1992). That is the suggestion that Western medical or mental health professionals work with and collaborate with traditional healers to better serve the client and attend to multicultural issues. Hoskins (2012) discussed and described a set of best practices to facilitate collaboration between *curanderas* and mental health professionals. These are: 1) assessment of client's beliefs and indicators for collaboration, 2) obtaining a release of information to facilitate communication between the practitioners, 3) establishing a professional relationship with the other provider, 4) assessing the practices of the other provider, 5) defining the realm of work for each provider, 6) considering possible legal

ramifications, and, 7) education as an ongoing step toward collaboration (Hoskins, 2012).

Hoogasian and Lijtmaer (2010) described three areas of similarity between *curanderismo* and psychotherapy. These are 1) client's ability to affirm relationships with loved ones; 2) to discover objects or symbols that carry deep meaning; and 3) ability for the client to experience change through manipulating objects. Hoogasian and Lijtmaer (2010) also discussed two areas of divergence between *curanderismo* and psychotherapy; these are 1) Western counselors are hesitant to draw upon a client's spirituality, and 2) conflicting values of individualism and collectivism. Their conclusion is that whether or not counselors choose to incorporate ceremony into psychotherapy that the therapeutic process would benefit from incorporating ceremonial components such as symbol manipulation, symbol discovery, and affirming relationships with loved ones in order to enrich the healing process (Hoogasian & Lijtmaer, 2010).

The imposition of Western values and methods on traditional healers contributes significantly to a type of cultural genocide. As explained by Duran, Duran, and Braveheart (1998), "*cultural genocide* refers to actions that threaten the integrity and viability of social groups" (p. 64). Mexican Americans in the United States had European, especially Spaniard traditions and religious practices imposed on them while their own social structures, religious and healing practices were limited or

destroyed. Through this process, Mexican Americans became a colonized and detribalized people (Avery, 2008). As such, the prohibitions against cultural healing and religious practices are a form of cultural genocide that endures to this day (Duran et al., 1998).

The United Nations in the *International Covenant on Economic, Social and Cultural Rights* (1976) provided ethical prohibitions against cultural genocide, which make explicit that stopping an individual from engaging in their culture is a violation of their human rights. Historically, concerns for public safety were the justification to ignore or minimize concerns for culture, religious freedom, and due process to impose restrictions on traditional healing practice (Donlin, 2011; Duran et al., 1998). The earliest documentation of persecution against traditional healers for practicing without a license dates back to the 1600s (Ottman, 2010).

In an effort to protect these cultural practices and knowledge, several states have adopted "safe harbor" laws which protect the rights of traditional healers to practice without a license. According to the American College of Healthcare Sciences (2014) these states are: Idaho, *Exemptions to the Medical Practice Act: Unlicensed Practice, Penalties and Remedies Relating to Unlicensed Practice* (1976); Oklahoma, *Parameters for Jurisdiction of Physician Licensing Act: Allopathic and Surgical Licensure and Supervision Act* (1994); Minnesota, *Freedom of Access to*

Complementary and Alternative Health Care Practitioners (1999); California, *Complementary and Alternative Health Care Practitioners* (2001); Rhode Island, *Unlicensed Health Care Practices* (2003); Louisiana, *Louisiana Revised Statutes 20-37 VI-B* (2005); Arizona, *Arizona Revised Statutes Sections 32-2911 Amended* (2008); New Mexico, *the Unlicensed Health Care Practice Act* (2009); and, Colorado, *the Alternative Health Care Consumer Protections Act* (2013).

The regulation of traditional healing in sovereign nations is much more complicated as the arguments against certification, licensing and credentialing include considerations related to both sovereignty and religious freedom. In Hawaii, there is a history of much different iteration of laws requiring licensing for traditional healers. These include methods such as requiring a formal license, having the healers themselves come up with a method for licensure, then not requiring any license, then using some sort of a certification process. From 1865 to 1997, in Hawaii all attempts at certifying or licensing traditional healers have failed or were repealed (Donlin, 2011). One of the considerations in this process is that native Hawaiians were experiencing negative health outcomes. To address this crisis, lawmakers in Hawaii lifted the requirement for certification and licensure of *Kāhuna*, traditional Hawaiian healers. In 1998 the Hawaiian legislature passed Act 162, known as the "Healers' Law," which exempted traditional Hawaiian healers from the prohibition

against unlicensed medical practice. Cutting ties to state regulation and thus allowing *Kāhuna* to engage their practice and to allow the Hawaiian people to engage their culture was significant in the support of Hawaiian physical health (Donlin, 2011). Title V of the *Indian Self-Determination and Education Assistance Act of 1975* (Public Law 93-638) stipulates that traditional healing practices can be incorporated into all forms of medical practice and qualify for reimbursement (Indian Health Services Tribal Self Governance Program, 2012).

The value articulated here is that as tribes know their people best, they are most adequately equipped to determine the types of health services needed to serve their own people (Indian Health Services Tribal Self Governance Program, 2012). Due to the Spanish conquest and the Hispanicization of some of the native peoples, Mexican and Mexican American practitioners do not enjoy the same protections of religious freedom and sovereignty. Mexican/Mexican American healing traditions are religious and spiritual practices. Therefore, ethical and legal considerations protect these healing traditions by virtue of religious freedom. It is interesting to consider if the case of Hawaii has generalizability as regards the Hispanic paradox. The Hispanic paradox, in part, is a concept related to the observation that more acculturated *Latinos* manifest more negative health outcomes than those who are less acculturated and that those of lower socio-economic status exhibit

greater mental and physical health than expected (Borrell & Lancet, 2012; Castro, 2013). Could a return to and reclamation of protective cultural practices such as traditional healing lead to better health outcomes for more acculturated Mexican Americans and other *Latino* groups?

Indeed, as Ari Kiev in his seminal book *Curanderismo, Mexican American Folk Psychiatry* (1968) concluded that *curanderos/as*, who base treatment on a combination of skills including cultural knowledge, native insight, religious ideology, and use of traditional medical techniques, produce therapeutic results. According to Kiev (1968), dynamic forms of psychotherapy demonstrate no evidence of being of more value than the treatment of *curanderos*. He went on to describe conventional psychiatry as being cold and detached while traditional healers, who share similar values with their clients, are preferred to conventional practitioners by those whom they serve (Kiev, 1968).

From a more modern perspective, process outcome literature informs the conceptualization of the therapeutic alliance and the efficacy of the various treatment modalities (Norcross & Wampold, 2011; Ulvenes et al., 2012; Wampold, 2013). The psychotherapeutic relationship is fundamentally a human relationship and both the client, and the practitioner bring their origins, cultures, biases, strengths, personalities, and expectations to that relationship (Norcross & Wampold, 2011). The

therapeutic relationship itself is as much responsible for the positive or negative outcomes as the therapeutic method used (Norcross & Wampold, 2011; Rogers, 1961). Implications for practice with indigenous and Mexican American clients include using a treatment model that involves prayer, ritual, ceremony, belief in the earth as a healing force, as well as exploring life stories, cultural identity, and reconnecting with indigenous roots (Cervantes, 2010; Comas-Díaz, 2010).

The New Mexico Unlicensed Health Care Practice Act (2009) and the Question of Credentialing Traditional Healers

The New Mexico Unlicensed Health Care Practice Act 2009, hereafter "the Act," was enacted after various coalitions came together to work on the language of the bill. Its purpose was twofold. The first was to protect access of community members to practitioners of complementary and alternative medicine (CAM) including Mexican American traditional healers. The second purpose was to protect the rights of CAM practitioners to practice without fear of persecution for practicing without a license in the State of New Mexico as long as the practitioner meets certain criteria. These criteria address what the CAM practitioner cannot do and what they must do. In section four of the Act, CAM practitioners are barred from engaging in certain types of practices which include performing surgery, setting bones, giving x-rays, manipulating the spine, conducting invasive treatments, prescribing, or dispensing controlled

substances and advising a client to go against the advice or recommended treatment of their medical doctor (New Mexico Unlicensed Health Care Practice Act, 2009).

In section five of the Act, it lists the duties of the CAM practitioner. Primarily, that the CAM practitioner must provide a client with informed consent. This informed consent would include the name, address, and phone number of the practitioner. In addition, it would include contact information for the New Mexico CAM Board in case there is a complaint or concern regarding the practices or services provided by the CAM practitioner. The informed consent document is also required to include a statement that the CAM practitioner is unlicensed to perform the services provided, details the rights to confidentiality as well as the limits of confidentiality, lists the method that case notes will be stored, the service to be provided and the expected outcome or results of the service (New Mexico Unlicensed Health Care Practice Act, 2009).

It is important to note that the states that have instituted some version of a safe harbor, or freedom to practice act, all specify the limitations of the practice allowed. Even the use of the terms "unlicensed" and "folk" is a value judgment about lack of legitimacy which limits the perception of traditional healers in the community and therefore limits their practice as well. As the practice of traditional healers is already severely restricted, the comparative risk to public safety versus the risk

of cultural genocide is negligible. Further, these Acts purport to protect the practice of traditional healers as long as the healers “behave” like Western practitioners in that they have an informed consent form, keep chart notes, and otherwise conduct themselves by the rules and customs of Western practice. Certainly, imposing these expectations on the work and practice of traditional healers is not within the scope of protecting and honoring one’s cultural practice.

Criticism exists for the practice of traditional healing. Ari Kiev (1968) refers to *curanderismo* as being unscientific and super naturalistic. These are value laden terms from one cultural context used to describe phenomena from a different cultural context. Moreover, certainly the need to have laws with names such as “the unlicensed practitioner act” is evidence of the same. Few scientific, controlled studies exist on the efficacy of traditional treatments. One may conclude that if controlled, clinical trials have not legitimized the healing modalities then the healing modalities must not be valid and are therefore suspect. This line of thinking is incredibly misguided. Shared community knowledge and wisdom handed down through the ages is frequently not as valued due to the lack of empirical support. This narrow view is the impetus behind the caution that lack of proof of any concept, object, person, place, thing, or any phenomena, in and of itself, is not proof of absence (Harris, 1954).

Indeed, requiring Western empiricism to legitimize non-Western practices is imposing the values of one culture onto another.

Evidence in the existing literature shows early attempts at limiting the practice of traditional healers. For example, in 1650, Ysabel de Montoia, a practicing *curandera*, was charged in the Mexican Inquisition with practicing witchcraft and abuse of Catholic symbols. She was found guilty, sentenced to receive two hundred lashes, was exiled from her town of Puebla, and served a term of three years working in a hospital which treated syphilis patients (Ottman, 2010). In 1661, she was again charged in the Mexican Inquisition with practicing witchcraft, medical quackery, and making claims of possessing Divine healing power. She was imprisoned for two years and suffered torture, interrogation, received another two hundred lashes, and was again sentenced to serve at the hospital for syphilis patients (Ottman, 2010).

Indeed, when reviewing the history of attempts at instituting licensure for traditional healers, we can see these attempts were racially and religiously motivated, classist, and misogynistic (Ottman, 2010). Due to the process of professionalization, women were excluded from practicing medicine as the capacities to learn and engage in rational thought were attributed solely to men (Ottman, 2010). Subjugated peoples have long had to fight for survival not just for the people

themselves, but also for the survival of cultural practices and healing traditions.

In addition, licensure usually requires a formalized training program with a minimum number of classroom and training hours necessary to qualify for the credential. This would serve to eliminate any person who was illiterate or did not have the financial means to engage this process. This was certainly the case when credentialing processes began for midwifery in New Mexico (Ortiz, 2005). In the early 1900s, before New Mexico became a state, there were over 800 practicing *curandera-parteras* (midwives) in the State of New Mexico (Ortiz, 2005). Most of these were women whose grandmothers, mothers, or other female relative were *parteras* before them and the knowledge and practices were handed down through the generations (Ortiz, 2005). The *parteras* were usually from the same culture, the same geographic area, the same religion, and a similar socio-economic status as well as spoke the same language as the mothers they served (Ortiz, 2005). In the 1920s and 1930s, the practice of midwifery in New Mexico decreased due to the availability of federal monies for public health initiatives.

The Midwifery Consultant Program offered classes in cleanliness, recognition of danger signals, the use of silver nitrate, and how to complete a birth or death certificate (Ortiz 2005). Women who were illiterate or did not speak English, who were geographically isolated, or

from a lower socio-economic status had a difficult time accessing the information in these classes as well as the subsequent certification process that emerged (Ortiz, 2005). "Certified" *parteras* were deemed to be following good practice skills and the others quickly earned a bad reputation for not having taken the training and many women would no longer go to those without the certification for services (Ortiz, 2005). Today the practice of midwifery has gone from the *curandera-partera* model of the early 20th century to a nurse midwife model that focuses on formal university study and eliminates the transmission of knowledge from one generation to the next.

The arguments for licensure or certification center on protecting the public welfare (Donlin, 2011; Epstein, 2003). Inability to discern true practitioners from charlatans and the need to maintain quality control are considerations. Another is that credentialing traditional healers in some way would contribute to formalizing a grievance process to track practitioners and complaints against them. In addition, a certification or licensure process could lead to an increased sense of legitimacy of traditional practitioners and increase the public trust. Practitioners must demonstrate a minimum level of knowledge and experience prior to independent practice (Public Health Accreditation Board, 2013).

There are also financial arguments for licensure. Certified, licensed, and credentialed practitioners would likely be better able to access

payments from third-party payers and would benefit from a fee schedule that would increase their income. Revenues generated from licensing fees could also sustain the costs of practitioner oversight. Further certifying, licensing, and/or credentialing traditional healers might serve to increase practitioner legitimacy in the eyes of conventional practitioners leading to increased opportunities for consultation and collaboration. The strongest arguments for certification, licensing and/or credentialing of traditional healers is to maintain quality control in order to reduce errors, increase accountability, increase collaboration, and thus possibly result in better health outcomes. (Public Health Leadership Society, 2002).

Formalized training programs could change and harm the practice of traditional healing. Licensing or credentialing of traditional healers would allow anyone who took the courses and achieved the minimum requirements to identify as a "*curandera*." While this might result in increased formal training, it would serve to reduce the years of total training, apprenticeship, and oversight from a more skilled healer. Further, it would open practice to those not of the culture and who may not adhere to the same value system and appreciation for the historical context (Donlin, 2011). In addition, there is no single person or entity that has the authority to determine what constitutes a full training program. Western practice advocates a system which recognizes the "end" of formal study as a gateway into professional practice. Mexican

traditional healers ascribe to a value of lifelong training and humility as fundamental to their practice (S. Ledesma, personal communication, November 16, 2013). Lifelong learning goes beyond earning continuing education credits and is part of a basic value regarding education and training. Ascribing the title of "*curandera*" to oneself would suggest a lack of humility that is dangerous and could lead to treatment errors (S. Ledesma, personal communication, November 16, 2013). The value placed on humility and ascribing to lifelong learning are key contrasts between traditional healers and conventional, allopathic practitioners.

As the cultural value of the training process is that it is a lifelong endeavor, no set of curricula or competencies could meet these criteria in a manner conducive to qualifying for licensure in a timely or culturally competent manner. Amanda Lokelani Donlin (2011), in her article on the history of Hawaii's traditional healer laws, observed, "It is not for the author of this comment, or the government, to tell the Hawaiian healing community to institute certification or how to define traditional healing practices (page 248)." The strongest argument against credentialing traditional healers is that to do so would result in cultural genocide and cause a loss of cultural knowledge as well as loss of wisdom and practices (Ortiz, 2005).

Theoretical Framework: Multiculturalism and Social Justice

Across the span of history, social justice acquired many forms and was perhaps one of the earliest types of intervention. If we look at the Western canon for psychology, however, we can conceive that this started with reactions to Freud's theories. That is Freud was one of the first people recognized for identifying psychological processes (Paris, 2013; Schultz & Schultz, 2011). Freud focused on the individual and the internal processes within the individual. Humanism and behaviorism arose out of a response to Freud's psychodynamic theory (Ansbacher & Huber, 2004). Alfred Adler also adamantly disagreed with Freud (Ansbacher & Huber, 2004). And perhaps, Adler's early resistance to Freud's ideas is a form of social justice work. Freud was the leader in the field at the time and required that those who studied with him did not consult Adler (Ansbacher & Huber, 2004). Despite these social pressures, Adler continued in his work and his influence in current psychological thought and clinical practice is so entrenched many clinicians do not recognize his influence.

From there we can look to the social justice movements of the 1960s and 1970s. The 1960s saw the signing of the *Civil Rights Act* (1964) and later the *Americans with Disabilities Act* (1990). These historical events took place concurrently with the growing field of psychology and counseling. Multicultural counseling theories and ethics

came into play. Derald Wing Sue, Patricia Arredondo, and J. Roderick McDavis drafted the multicultural counseling competencies (Ratts, 2008, 2011; Sue et al., 1992). A more recent update of these guidelines specifically addresses social justice and multicultural competencies (Ratts et al., 2015).

The theoretical frameworks for the current study were multiculturalism and social justice. The integration of Mexican American traditional healing with Western mental health counseling is a multicultural issue and has strong social justice and policy implications. Indeed, there is no demarcation between multicultural and social justice considerations. Ratts (2011) described multiculturalism and social justice as being two sides of the same coin as they share recognition that oppression has a destructive effect on mental health and both perspectives acknowledge the importance of diversity. One, in effect, cannot have one without the other.

The Multicultural Counseling Competencies (MCC) developed by Sue et al., (1992) identified nine competency areas using a three by three model (1992). This model has three characteristics and within each of these characteristics are three dimensions. The three characteristics identified are counselor awareness 1) of their own cultural values and biases, 2) of the client's worldview, as well as 3) intervention strategies which are culturally appropriate. Within each of these characteristics, the

authors identify three dimensions. The dimensions are a) attitudes and beliefs, b) knowledge, and c) skills (Sue et al., 1992).

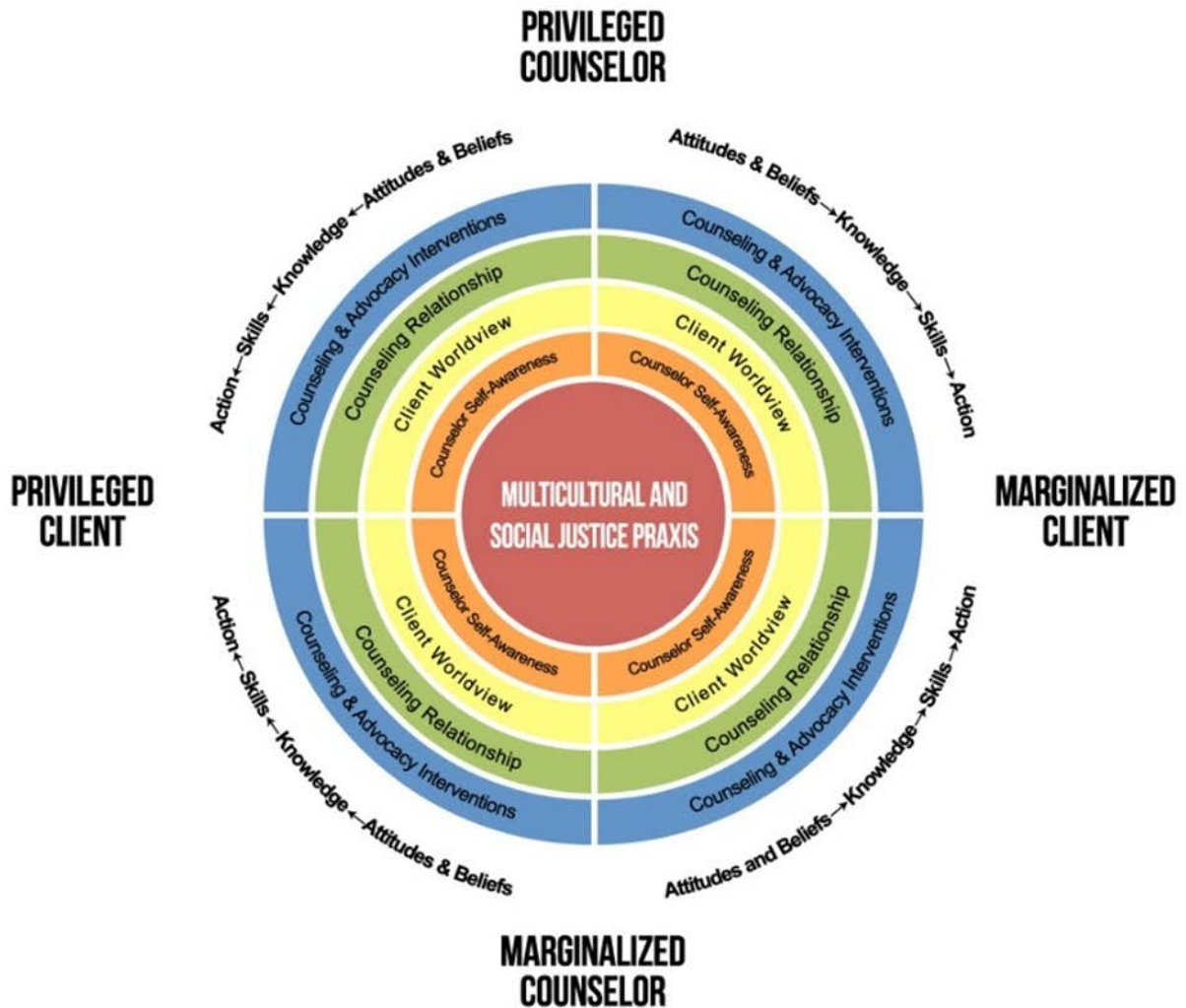


Figure 1. Multicultural and Social Justice Counseling Competencies. Retrieved from <http://www.counseling.org/knowledge-center/competencies>. Copyright 2015 by M.J. Ratts, A.A. Singh, S. Nassar-McMillan, S.K. Butler, & J.R. McCullough. Reprinted with permission.

In 2014, the Association for Multicultural Counseling and development (AMCD) appointed a committee consisting of Manivong Ratts, Anneliese Singh, Sylvia Nassar-McMillan, Kent Butler, and Julian

Rafferty McCullough to revise and update the MCCs to address the changing needs. This committee expanded the MCCs in definition and scope. The resulting work is the Multicultural and Social Justice Counseling Competencies (MSJCC) (Ratts et al., 2015). The MSJCC use a conceptual framework to show a visual map between the constructs and competencies. As shown in Figure 1, this framework demonstrates the complications in the relationships between the counselor and client in four distinct quadrants. The quadrants are privileged counselor/marginalized client; marginalized counselor/marginalized client, privileged client/marginalized client, and privileged counselor/privileged client. The authors explain that these quadrants show the relationship of identities and how they relate to power, privilege, and oppression. The developmental domains show the different layers that lead to multicultural and social justice competence. These are: 1) counselor self-awareness, 2) client worldview, 3) counseling relationship, and 4) counseling and advocacy interventions. Within the first three developmental domains, aspirational competencies identified are: 1) attitudes and beliefs, 2) knowledge, skills, and actions (AKSA). The fourth domain, counseling and advocacy interventions list the following: a) intrapersonal attributes and intrapersonal interventions, b) interpersonal, c) institutional, and d) community. In addition to addressing the needs of historically marginalized cultural groups, the committee added

considerations for other marginalized groups such as a lesbian, gay, bisexual, and transgender groups (Ratts et al., 2015). Sue and Sue (2008) observed that all counseling is multicultural counseling as the historical and political context affects each client. This is the case in the southwest region of the United States, which has a strong indigenous legacy combined with the history of colonization. It makes sense that one who is interested in the healing arts would become educated, knowledgeable, and competent in the healing practices of both cultures. Although the current Western literature base provides many guidelines for clinical practice it still fails to adequately guide the practitioner who applies multiple cultural paradigms (Hoskins, 2012; Krassner, 1986; Oulanova & Moodley, 2010; Padilla et al., 2001; Ratts et al., 2015; Sue et al., 1992).

Each individual cannot be understood in isolation but rather is better understood in the context of multiple identities. This means that the counselor must be aware that they may be in a different place than the client on any dimension at any time. For example, a white male counselor has privilege when working with a Black male client. However, if the white male counselor was gay and the client was heterosexual, then the counselor would be a marginalized counselor on that dimension. Therefore, the identities on this framework can be fluid and multidimensional and it is up to the counselor to maintain perspective

about their own privilege/marginalization as well as the client's perspective on any dimension. Ratts et al. (2015) make a distinction between multicultural and social justice counseling as multicultural counseling is on a more individual basis such as psychotherapy in an office setting while social justice work happens in a community setting. The current study utilizes both a social justice approach and a multicultural approach. Both approaches are necessary in counseling research and are part of the ethics of clinical counselors.

It is interesting that Ratts et al. (2015) emphasize that multicultural and social justice competency is a lifelong process with the practitioner continuously aspiring to further their understanding of cultural competence and practice cultural humility. Cultural humility is the ability to maintain a humble perspective in a thoughtful and reflective manner and to be open to another person's experience, view, or opinion in relation to aspects of cultural identity that is most important to the other person (Chang, Simon, & Dong, 2012; Hook, Davis, Owen, Worthington & Utsey, 2013). The reason this is so interesting to me personally, is this is very similar to what I have heard *curanderas* describe as a lifelong practice. That is, one continually educates oneself on healing practices such that learning is ongoing and never considered complete. In addition, the humility in practice is a strong value among the traditional healers interviewed.

Ethical Considerations

There are several codes of ethics, standards, and legal documents which address the standards of practice considered for the current study. These include the American Counseling Association Code of Ethics (2014); American Medical Association (2001) Principles of Medical Ethics; American Psychiatric Association (2009) The Principles of Medical Ethics especially applicable to psychiatry; American Psychological Association (2010) Ethical Principles of Psychologists and Code of Conduct; Association for Counselor Education and Supervision (2011) Best Practices in Clinical Supervision; the Indian Self-Determination and Education Act (1996); the New Mexico Unlicensed Health Care Practice Act (2009); Title V of the Indian Self-Determination and Education Assistance Act (1975); the United Nations (2008) Declaration on the Rights of Indigenous Peoples; the United Nations (1976) International Covenant on Economic, Social and Cultural Rights; and, the World Health Organization (1978) Declaration of Alma-Ata. What these standards have in common is they all indicate that one must honor and respect cultural practices but are they are not as articulate in explaining the mechanisms or processes on how that honor and respect take place.

One of the difficulties in multicultural practice is reconciling the differing world views, ethical codes, and standards of practice of practitioners and clients. In their seminal work, Sue et al., (1992)

addressed some of these conflicts and argued that cultural competency is a process and not an end; therefore, defining what is cultural or multicultural competence is problematic as our collective understanding continues to grow. Nevertheless, Sue et al., (1992) presented a conceptual framework for cross cultural competencies based on the key areas of 1) counselor awareness of one's own assumptions, values, and biases, 2) understanding the world view of the culturally different client, and 3) developing appropriate intervention strategies and techniques. In the latter, counselors are specifically instructed to respect client's religious and/or spiritual beliefs and values as well as to respect indigenous helping practices and help-giving networks (Sue et al., 1992).

The ACA (2014) Code of Ethics specifies that counselors communicate in such a way that is both culturally and developmentally appropriate for the client served. The ACA Code of Ethics prohibits treating anyone with whom one currently has or has had a sexual and/or romantic relationship. Counselors need to consider the risks of accepting as clients those with whom one has had any previous relationship whether it was distant, casual, or members of a professional organization or community. While Mexican American traditional healers frequently treat someone unknown to them, they also treat family, friends, business partners, intimate partners, and community. This is not only ethical, but it would seem odd or unusual to refuse treatment to someone who the

practitioner knows personally. A conflict exists in the ACA ethical code itself; is a practitioner expected to demonstrate culturally appropriate communication and awareness while discounting the world views and norms of the not only the client's culture, but the practitioner's culture as well? The code does not adequately address this question. The Association for Counselor Education and Supervision (ACES) acknowledged that the ACA Code of Ethics does not adequately address every situation (2011). The clinical supervisor needs to recognize that all supervision is multicultural supervision and incorporate this view into the supervisory dynamic (ACES, 2011). The ACES suggestions for best practices include the requirement that supervisees "consider" culture, power, and privilege in client case conceptualization as well as in diagnosis and treatment planning. In addition, the supervisor is to encourage the supervisee to develop knowledge and skills needed for advocating on behalf of a client. Is the same true for the student/trainee? That is, is the clinical supervisor required to develop knowledge and skills needed for advocacy on behalf of a student?

Conclusion

Traditional healing practices exist in cultures throughout the world (Shore et al., 2015). Long before the advent of the Western medical doctor, indigenous peoples have been caring for their own families and communities. Questions of those allowed to practice, the required

training, the fee structure, and the process used to address issues of malpractice have likely existed throughout time. There is abundant literature which calls for the integration of healing practices mostly in the forms of increasing understanding of cultural healing practices as well as collaboration and cooperation among healers (Hoskins, 2012; Krassner, 1986; Oulanova & Moodley, 2010; Padilla et al., 2001; Ratts et al., 2015; Sue et al., 1992). That is the suggestion that Western medical or mental health professionals work with and collaborate with traditional healers to better serve the client and attend to multicultural issues. More research is necessary to explore how individuals who are concurrently practicing in both traditions integrate their practice and to identify best practice guidelines when a practitioner who is versed in both traditions integrates their practice.

Chapter 3

Methods

Introduction

Ethical standards call upon licensed counselors to embrace multicultural approaches and honor diversity (ACA, 2014). Based on this, one might expect that the ACA code of ethics would provide information to a counselor about how to best consult or work with a traditional healer when the client's belief systems and culture reflect that of the traditional healer. The assumption is that the traditional practitioner and the Western practitioner are two different people from two different cultures. However, these standards do not go far enough and do not address when the practitioner is both a traditional healer and a licensed Western-trained therapist. William West (2005) observed that there is a difference between the public discourse of what a practitioner claims to do in a therapy session, including in supervision, and what actually happens in the therapy session. Therefore, there is a need to first discern how individual practitioners who are both traditional healers and licensed mental health practitioners integrate the two different approaches.

Problem Statement

In counseling research, there is a call to integrate practices and for practitioners to become more aware of other cultures and traditions. Very little research addresses when the Western mental health practitioner and

the traditional healer are the same person. The current work seeks to explore the experiences of licensed mental health practitioners who are also traditional Mexican/Mexican American healers in their practice of both modalities.

Purpose of the Study

The purpose of the study was to investigate how individuals who are licensed mental health practitioners and traditional Mexican American healers describe their experiences and their practices. For the purposes of this study a licensed mental health practitioner is understood to be a licensed professional clinical mental health counselor (LPCC), licensed marriage and family therapist (LMFT), licensed professional art therapist (LPAT), licensed psychologist, licensed clinical psychiatrist, licensed alcohol and drug abuse counselor (LADAC); licensed mental health counselor (LMHC); licensed master's level social worker (MSW), licensed independent social worker (LISW), or mental health practitioners who are legally licensed to practice in their state of residence. A traditional Mexican American healer is someone of Mexican or Mexican American descent who practices indigenous healing practices more commonly understood to be in the *curanderismo* tradition. The practice of *curanderismo* involves a holistic approach to healing technologies that represent an integration of Iberian particularly Spaniard, Muslim, and African healing practices and spirituality with healing practices and

spiritual traditions indigenous to the Americas (Avila & Parker, 1999; Kiev, 1968; Torres & Sawyer, 2005; Trotter & Chavira, 1981).

Ethical and legal standards call upon licensed practitioners to embrace multicultural approaches and honor diversity (ACA, 2014). Based on this, one might expect that the ACA code of ethics would provide information to a counselor about how to best consult or work with a traditional healer when the client's belief systems and culture reflect that of the traditional healer. The assumption is that the traditional practitioner and the Western practitioner are two different people from two different cultures. However, these standards do not address when the practitioner is both a traditional healer and a licensed Western-trained mental health practitioner. Therefore, there is a need to first discern how individual practitioners who are both traditional healers and licensed mental health practitioners experience, or make sense of their experiences, in the practice of the two different approaches.

Research Problem

Clinical counselors adhere to a set of ethical principles which includes a commitment to recognize, be aware, and be considerate of cultural issues as they affect diagnosis, treatment, and the client's experience (ACA, 2014; American Psychiatric Association, 2013). Historically, best practices have strongly encouraged clinical counselors to be open to collaboration, or at least have awareness of alternative and

complementary medicine practices which the client may be pursuing (ACA, 2014; American Psychological Association, 2010; Arredondo, 1999; Sue, 2015; Sue et al., 1992). The current recommendations for Multicultural and Social Justice Counseling Competencies (MSJCC) call on counselors and other helping professionals to integrate multiculturalism and social justice into their counseling practice (Ratts et al., 2015). Laws governing clinical practice, as well as, ethical and legal guidelines for counselors, address when the counselor and traditional healer are different people and theoretically from different cultures. The supposition is that the Western clinical practitioner is from the dominant culture and the traditional healer is from the host culture. There are no legal and ethical guidelines that address when the counselor and the traditional healer are the same person. The project goal was to investigate how individuals who are licensed mental health practitioners and traditional Mexican American healers describe their experiences and their practices. The following research question is the focus of this study, what are the experiences of a licensed mental health practitioner who is also a traditional Mexican American healer in their practice?

Participants

Six research participants from the Southwestern region of the United States in the states of Arizona, California, Colorado, New Mexico, Nevada, Texas, and Utah participated in the study. All participants were

required to be 21 years of age or older and retired or currently licensed in their state of practice as a counselor, social worker, psychiatrist, marriage & family therapist, alcohol & drug abuse counselor or any other type of mental health practitioner who engages in counseling and psychotherapy practice. All participants have a minimum of a master's degree with three of the participants having completed doctoral studies. These participants also self-identified as a traditional healer in one or a combination of the Mexican or Mexican American healing traditions commonly referred to as *curanderismo*. In addition, all participants identified their ethnicity as Mexican American.

The six participants included four individuals who identified as female and two individuals who identified as male. The participants ranged in age from 46 to 69. Participants included three independent practice counselors (one of these is also a nurse practitioner), one independently licensed social worker; one licensed clinical psychologist who is retired, and two certified nurse practitioners (one of these also held licensing as an independent practice counselor). All participants mentioned growing up with traditional healing practices and identified a relative such as a mother, father, grandmother, grandfather, or aunt as a practitioner. All participants mentioned at least one mentor/teacher from whom they specifically learned traditional healing practices. Interestingly, although not criterion to participate in this study, all participants

identified as Spanish/English bilingual and were able to conduct psychotherapy and traditional healing in Spanish and/or English as needed.

Another observation was that the participants were quite open to participating in this study and understood the research process. This is likely due to each participant having at a minimum a master's degree in psychology, counseling, or a related field. Each was quite open with this writer and did not have many questions about the study or the process. Again, likely due to the level of education as well as experience in both Western counseling and traditional healing, each participant was quite articulate and did not require much prompting but spoke freely about their experiences and perceptions about their experiences. Frankly, the interview process was quite pleasant and enjoyable. I was gratified and honored to bear witness to their stories. In addition, I provided each participant with a paper and/or electronic copy of the transcripts of their interview/s. This had a benefit of each participant having a written version of their story to use for their own purposes and to document parts of their own history. At least two participants specifically mentioned that they appreciated having their transcript to use for their own purposes.

Research Design and Methods

Interpretative Phenomenological Analysis (IPA). Traditionally, mainstream psychological researchers have relied on quantitative methods of inquiry. The practice is to attempt to identify a hypothesis, then in attempting to disprove it and not being able to do so, one is able to support a hypothesis (Pietkiewicz & Smith, 2014). Quantitative research methods concern themselves with counting incidents of events, and the analysis of numerical data to describe the support for the target hypothesis. In qualitative research, there are usually no pre-identified hypotheses and the researcher is more interested in the meaning attached to events and phenomena. In other words, the quality of the lived experience is the focus of the study as opposed to the casual relationship (Pietkiewicz & Smith, 2014).

There are a number of qualitative research methods available for use and the most common of these include grounded theory, phenomenology, consensual qualitative research, ethnography, narratology, and participatory action research (Hays & Wood, 2011). Kline (2008) asserted that the selection of research methodology lies in what is congruent with one's research orientation and study purpose and that infusing this into all phases of the research project is a criterion for trustworthiness.

I used a phenomenological approach for this study. Phenomenology as presented by Edmund Husserl investigates how an experience appears to the individual having the experience and does not begin with a theory but with the study of the phenomena itself (Pietkiewicz & Smith, 2014). Its only purpose is to describe the meaning and depth of an individual's lived experiences (Hays & Wood, 2011). Therefore, phenomenology focuses on the study of how one would talk about how one is experiencing an object or event as opposed to using a predetermined categorical system (Pietkiewicz & Smith, 2014). The main objective of a phenomenological study is to explain the structure, meaning, and essence of lived experiences of a group of people or an individual around a specific phenomenon (Hays & Wood, 2011). In other words, the researcher strives to understand phenomena from the perspective of those with the direct, lived experience.

One type of phenomenological method that has become increasingly popular among qualitative researchers is Interpretative Phenomenological Analysis (IPA) (Pietkiewicz & Smith, 2014). IPA has its basis in phenomenology and hermeneutics (Smith, 2011).

Phenomenology as discussed by Edmund Husserl and Martin Heidegger is the study of experience as viewed by the individual (Pietkiewicz & Smith, 2014). Hermeneutics has to do with the explanation or the providing of an explanation. Therefore, phenomenological hermeneutics would be the

explanation of experience or phenomena from the perspective of the individual (Hays & Wood, 2011; Pietkiewicz & Smith, 2014).

Phenomenology also relies on ideography, which is an in-depth analysis of single cases and exploring the perspectives of individual study participants in their own contexts (Pietkiewicz & Smith, 2014). In other words, the individual experience is more the focus than the group or more generalized experience. Researchers originally applied IPA to questions in health psychology and the method later became more popular in other fields (Pietkiewicz & Smith, 2014). In addition, the IPA method includes what is referred to as a double hermeneutic, that is the researcher strives to make sense of the research participant trying to make sense of their own experience (Smith, Flowers, & Larkin, 2009). In other words, the researcher's interpretation of the participant's account contributes to a better understanding of the participant experience (Smith et al., 2009). This constitutes a dual role for the researcher as they are using the same personal and mental skills as the participant (Smith et al., 2009). Use of this method accepts that the researcher access to the experience is dependent on the information the participants provide (Smith et al., 2009). The researcher then needs to interpret this information to further understanding of the experience (Smith et al., 2009). IPA is most useful to research experiences of existential importance to the participant (Smith, 2011). Further, IPA emphasizes the

detailed analytic treatment of each case and the search for patterns across the cases (Smith, 2011). The IPA method then is concerned with balancing both the convergent and divergent themes within the sample (Smith, 2011). As IPA is committed to a detailed account of the participant experience, IPA studies use a small sample size which ideally, is fairly homogenous in order to better examine the information provided (Heffron & Gil-Rodriguez, 2011; Smith et al., 2009).

IPA data collection is normally in the form of semi-structured interviews. IPA also has strengths in cultural and cross-cultural contexts as well as when researching the psychology of indigenous, religious, and spiritual experiences (Pietkiewicz & Smith, 2014). As the current study encompasses clear cultural, cross-cultural, indigenous, and religious practices, IPA becomes an obvious and preferred research approach. The IPA method was particularly useful, as I am also both a traditional healer and a licensed counselor. This insider position allowed me to interpret the data in a different way than a researcher who is not an insider.

Recruitment strategies and procedures.

Selection of participants. Recruitment of research participants was through an emailed invitation letter and a flyer distributed through healing networks and social media, as well as through word of mouth. I provided any participant recommended through “word of mouth” with a

copy of the invitation letter and recruitment flyer prior to the initial individual interviews.

Informed consent. I met with each potential research participant to discuss the project and review the written consent form. I obtained consent from the participants and completed the Human Research Protections Training. See Appendix A, Sample Recruitment Flyer and Appendix B, Sample Recruitment Letter. I provided each participant with a written informed consent prior to beginning the interviews. See Appendix C, Consent to Participate in Research. The participant and I agreed on the time and location of the interview. All participants were adults who met the requirements to qualify for and obtain clinical licensure as a mental health practitioner in the state in which they reside and were either currently practicing or had retired. The participants self-identified as practicing traditional Mexican or Mexican American healing. All participants were able to provide their own consent. A copy of the signed consent form was provided to each participant prior to the date of the interview and then again at the time of the interview.

Methods of Data Collection

Data were collected through semi-structured interviews. The method in IPA consists of using a relatively small sample size in order to provide full appreciation and more in-depth analysis to each research participant's account (Pietkiewicz & Smith, 2014). Eliciting a rich,

detailed, and first-person account of experience and phenomena is a primary concern of IPA researchers (Pietkiewicz & Smith, 2014). In depth, semi-structured, one to one interviews are the most popular method to achieve this goal. These interviews allowed me and the participant to have a dialogue in real time and allowed for the flexibility for unexpected and original issues to arise. During the interview, I monitored the participant for fatigue, awkwardness, hesitation, or other markers of uncomfortableness. When I noticed any issue, I stopped the interview and discussed it with the participant. If needed, we scheduled another time to complete the interview. Participants were able to choose to stop the interview at any time.

Interviews. I obtained consent by providing participants with a verbal explanation of the project and participant responsibilities as well as with a signed consent document. The interviews took place over one to two sessions as needed to address the questions and information the participant wanted to share. Participants agreed to the location used for their own interview which easily enabled audio recording.

Interview questions centered on the participant's experience as a Western mental health practitioner and as a traditional Mexican American healer. See Appendix D, Semi-Structured Interview protocol. The protocol served as a guide to the semi-structured interview and allowed for a more natural flow in the interview process.

Focus group. After the individual interviews were completed, all participants were invited to participate in a focus group. A semi-structured focus group protocol was developed to guide the discussion. Due to time constraints and scheduling difficulties on behalf of the participants as well as geographic barriers, a focus group could not be scheduled which adequately represented a majority of the participants. To garner the additional information participants were emailed an additional set of questions. They could choose to respond via email, by phone, or by additional interview. Four participants responded to the additional questions.

Data Analysis

Smith, Jarman, and Osborn (1999) point out that there is not one, conclusive way to conduct qualitative data analysis. However, these authors offer suggestions for data analysis that they have found useful and there is an expectation that the researcher may adapt these methods to one's own way. I reviewed the more common methods suggested by Smith et al. (1999) for the current research. I audio recorded the interviews and took informal notes during the interview process. Professional transcriptionists transcribed each interview verbatim. I provided a copy of each person's transcripts to each participant. Participants reviewed their own transcripts in order to change, delete, or otherwise correct the information.

As suggested, once the data collection was completed, I immersed myself in the data in order to view the experience from the viewpoint of the participant as much as possible. This entailed creating an exact transcript of the interviews and listening as well as reading the transcripts through several times to help with data immersion and to gain insight (Pietkiewicz & Smith, 2014). I generated and reflected on comments regarding personal reflexivity prior to and during this process. I used manual review of interview transcripts, and listened multiple times to each recording, as well as organized key words with some assistance of HyperRESEARCH software. In addition, I took relevant pen and paper notes and listed quotes from the original transcript. The emerging themes were grounded in the participant's account. I then looked for connections between the emerging themes and clustered these together according to conceptual similarities. I kept notes referencing every mention of each theme. To increase ease of referencing the keyword or theme in the interview transcripts and written responses I made pen and paper notes as well as used HyperRESEARCH software.

The next stage was to compile a table of themes ordered in a coherent fashion. I generated a master list of themes from the first interview. I then used this master list to begin the analysis of the interview with the second participant. I then used the themes from the first and second interview to begin the analysis of the third interview, and

so on. This resulted in a final master list of themes. The codebook in the HyperRESEARCH software listed 349 code words and themes. Next, I ordered the table of code words and themes in a coherent fashion. Through this process, several subthemes and eventually four major themes emerged. These themes directly related to the transcripts.

There is more flexibility in writing up a qualitative study than a quantitative study. A researcher looks for themes that are essential or interesting. Themes chosen to be the focus require the researcher to use a selective process. The prevalence of a theme within the data is not the sole determinant of which themes become the focus. A narrative account emerges from these themes. I made an intentional decision to use extensive quotes due to insider status as well as previous history and relationship with those who may have qualified for the study. This was to ensure the authenticity of the participant voice and experience.

Trustworthiness

Trustworthiness is one of the qualities in qualitative research. The criteria for trustworthiness in a qualitative study is different from strategies for trustworthiness. As delineated by Hays and Singh (2012) the criteria for trustworthiness are 1) credibility, or the overall believability of a study and is analogous to the internal validity; 2) transferability, which is the generalizability of the study and is analogous to the external validity; 3) dependability, which is the consistency and

reliability of the study; 4) confirmability, which is the neutrality of the researcher; 5) authenticity, which is the honesty and truthfulness to the research participants; 6) coherence, which is the consistency of the research method and approach; 7) sampling adequacy, which is that the composition of the participants and the sample size are appropriate for the study; 8) ethical validation, which is the notion that the research conducted informs practice; 9) substantive validation, which is the idea that the research makes a worthwhile contribution; and 10) creativity, which refers to flexibility and novelty in research design.

The data supports the credibility of the findings. Strategies to increase credibility include triangulation, member checks, peer examination, and reflexivity. Triangulation involves using multiple methods and multiple sources of information such as observation, interviews, and focus groups. Member checks consisted of each research participant having an opportunity to review a copy of their own interview transcript to allow them to correct or modify their own interview responses to check if this indeed is what they said, what they meant and if the information is accurate. I invited those who had changes to add, delete, or clarify the information provided. Participants provided feedback by phone, email, or direct communication. Emergent themes included this additional information. A doctoral student peer reviewed the methods and data analysis to check if they arrived at similar conclusions and/or to

make suggestions on how they view the data differently (Hays & Singh, 2012). In lieu of a focus group, some participants answered additional questions via email.

Reflexivity refers to the researcher being self-aware of his or her own biases, values, and assumptions (Creswell, 2013). A positionality statement also lends credibility as it presents the researcher's position, her biases, values, and assumptions and is presented in the current work in chapter one. Consistency refers to the data collection and analysis being consistent. Strategies to increase consistency also included triangulation, member checks, and peer examination as described above, as well as saturation of data (Creswell, 2013). Transferability refers to the notion that the findings would be similar if the same or similar participants repeated the study.

Ensuring Confidentiality

Assigned pseudonyms maintained participant confidentiality. In addition, the Southwest region of the United States is a very large area. As there were six research participants, all of whom are currently licensed or retired practitioners as well as traditional healers it would be quite difficult to discern which one of the healers said what. No state location is identified for any participant.

Limitations and Delimitations of the Study

The limitations of the study included the difficulty accessing individuals in this population. Further, a long history of oppression against traditional healers, and female healers in particular, may have discouraged potential participants from wanting to be involved in this study. A delimitation of the study is that I to interview only traditional healers who practice from the Mexican or Mexican American healing traditions. Certainly, any issues identified in this sample would have some cross-over or similarities to those who integrate practice with other cultural healing traditions.

Conclusion

This study examined the experiences of mental health practitioners who are also traditional Mexican American healers. Historically, guidelines about how to provide counseling services to those of the non-dominant culture have focused on suggestions for the scenario when the counselor is from a different cultural background than the client. Suggestions on how to recognize and respect practice usually include suggestions for how to be aware of cultural practices and how to refer to and accept the practices of healers within the client's culture. In the literature, there are markedly fewer suggestions on how to practice when the mental health practitioner and the traditional healer are the same person. The data gathered from the present study can provide insight and information on

how those who are both a Western mental health practitioner and a traditional healer integrate their own practice to provide enhanced services to the client. The information obtained will further understanding on how practitioners who are both Western mental health practitioners and traditional Mexican American healers currently practice.

Chapter 4

Findings of the Study

Introduction

This chapter describes major themes and subthemes using examples from the participant interviews. I made an intentional decision to use extensive quotes due to insider status as well as previous history and relationship with those who may qualify for the study. This was to ensure the authenticity of the participant voice and experience. I identified four major themes and eleven subthemes. Theme one is identity as a healer and that training in traditional healing is lifelong. This theme includes the introduction to *curanderismo* when the participants were young children, each had mentors/teachers in the *curanderismo* tradition, identity as a healer, training in the traditional healing is lifelong, and one participant mentioned that she passed on traditional healing knowledge to the next generation. Theme two reflects barriers and integrations to dual practice including stigma and shame; legal and ethical concerns; integrations and tensions between the modalities; as well as that traditional healing is similar to Western practice. Theme three is social justice, that is, traditional healing as a statement of cultural power, reclamation, political activism, and social justice. Theme four is about the healing methods used including different techniques, use of the *plática* specifically, and traditional healing as heart energy.

Results

Theme 1. Identification and training in traditional healing is lifelong. All participants mentioned growing up with traditional healing practices and identified a relative as a practitioner. Each of the participants mentioned one or several mentors who helped them as adults in continuing to learn and have efficacy in using traditional practices. Each participant discussed their identity as a traditional healer, and discussed how training in traditional healing is lifelong and never really ends. While each participant mentioned having one or more mentors in traditional healing as well as having family members who themselves were practitioners, only one participant specifically mentioned teaching someone from the younger generation about traditional healing practices.

1A. Introduced to traditional healing as young children. All participants reported an introduction to traditional healing practices as very young children and having at least one, and sometimes several, family members who practiced traditional healing methods and familiarized the participant to these technologies from a very young age. Mateo spoke about his aunt being a midwife when he was a child:

I didn't know at that point, what that was, it was just what she did, you know. Hearing about her delivering another baby and I was like

okay and I guess she never went to school to deliver, she was never trained officially, or in medicine.

Along this same line, Sofia shared that she grew up with *curanderismo*, "my mom was a *curandera*. Her grandmother was a *curandera*. ... My mother learned a lot of what she did from her grandmother, my great-grandmother. Yeah. So, the whole concept of *curanderismo* I feel like I grew up with it." Magdalena spoke about early influences, "I would say that the introduction to my traditional healing was with my family." Ignacio spoke passionately about his admiration of his grandfather as a healer:

He touched healed me from a nail puncture in my foot over a period of about six weeks ... You know, I really didn't realize it until I started getting involved in this stuff for what this man had done when I was a kid. That he didn't have any [supplies]. He didn't even have a first aid kit. He didn't have a band aid. He didn't have Vaseline. He didn't have anything. He got the materials around him and started healing this grandkid. With touch mostly and gentle rubbing and praying on his own. And chanting a little bit. And soaking it in kerosene. And man, then just lots of loving attention. Like for an hour a day or maybe two hours a day. This for a guy that had to go out and fix the fences, bring the cows, find the cows, find the calves, ride the horse, chain the horse, take the saddle off

the horse, comb the horse, feed the horse, and then feed the cows that were at the corral and then go up to the [house] to take wood into his wife who was going to cook for him. He had to do all that stuff and he found two hours every night to tend to this kid. And I took it in stride. Like that's just what grandpa does. My foot's all better and I'm good. Now, I'm saying that was an amazing magic this guy pulled off. And that was medical healing.

Isabel also spoke about her early experiences with her grandmother who was a *curandera* in her community who knew other rural *cuanderas* and would consult with them:

My first experience began at a very young age. ... My father, his mother was a *curandera* and she practiced more traditional medicine or *curanderismo* with us since we were very young. So that wasn't anything that was new to us, we grew up with that. The only time I went to the doctor was maybe for immunization but anything else was taken care of by our grandmother, who also took care of the whole family and then our community which was primarily a Mexican-American community. ... So, my grandmother, thank God, was a *curandera* who knew other rural *curanderas* so if she couldn't do something then they would help to get something done. And that was my first exposure to that.

Guadalupe had a similar observation from her youth about traditional healing, receiving treatments for ailments by her mother, and rarely going to the doctor:

I had been brought up in this medicine. My mom always treated us with herbs. I guess not everybody was brought up that way but there really were a lot of people in the community that were given herbs or whatever. We didn't hardly ever go to the doctor.

1B. Mentorship and teachers in the tradition. Participants mentioned one or several mentors who helped them as adults in continuing to learn and have efficacy in using traditional practices. Mateo spoke extensively about one of his teachers who would eventually mentor him in facilitating *temazcal* ceremony:

I met [a traditional healer]. ... We just hit it off. ... I decided to [ask], how can I volunteer, how can I learn more about this and she says well we have this group that we meet every Thursday. Why don't you come and join us? And so, there was this small group of us who studied, and we would practice what we learned in class.

Sofia shared about her mother being her teacher and other *curanderas* in the community that guided her, "I think my greatest teacher was my mom. ... I would say I had several teachers. *Curanderas* in the community that I observed and that I asked a lot of questions and

they guided me.” Sofia also mentioned one particular mentor with whom she continues to study and practice with and declines to speak about him or his teachings any further until she seeks his permission to do so.

Magdalena spoke about apprenticing for about 3 years to a *curandera*, “the big event was getting ready for the *velación*² for the Day of the Dead, but we did a whole lot of things.” Ignacio identified his grandfather as being his first teacher, “My first teacher was when I was seven years old. It was my grandpa.” Ignacio also spoke about meeting one of his mentors at work:

I was a mental health employee and she was a mental health employee in that context. So, I go to her office, introduce myself, and go well here’s another *Chicana* in the field. This is going to be cool. And we get to know each other. And we get to be friends. And we’re both very loquacious kind of people and so we start talking about the *Movimiento*³ and what we can do.

Isabel spoke of her grandmother, whom she greatly admired, and then other teachers she met later in life when she decided to pursue more knowledge about traditional healing methods:

I would watch my grandmother as she performed many things. If you had stomach pain she always had some kind of tincture or a

² A *velación* is a night long, and sometimes days long, prayer vigil and ceremony. The *velación* for the Day of the Dead is largely considered one of the most important celebrations in traditional Mexican culture.

³ *Movimiento* – refers to the *Chicano* Civil Rights movement.

salve or some kind of herb that she would take from her garden and make a tea. ... I decided on my own to pursue more education or more training in the area of *curanderismo*, so I began with [a teacher]. Then I kind of got hooked on it and did some more seminars with her. Then I did several conferences with her and then on my own I decided that I would go to Mexico and learn from other *curanderas*.

Guadalupe shared about her mother as a teacher, "My mom would give my daughter herbs, and she would give me herbs. And she would tell me how to make them and I would give them to my daughter." Then she spoke about a mentor she apprenticed with in the *curanderismo* tradition:

I always remember when we went to Mexico with [my teacher] there were quite a few of us. Those of us that were still left with her. She taught me many wonderful things and she taught me some very bad things. So, I feel like I tell people what I did was I took what I learned for myself and all the other things I learned what not to do also.

1C. Identity and traditional healing training is lifelong. Each participant discussed at length their identity in traditional healing and what that means to them. Along with the identity was the concept of training in traditional healing as a lifelong process. Those who had practiced traditional healing longer did not identify with being a

"*curandera* or *curandero*" but rather as a student or one who studies traditional medicine. The practitioner that had been practicing for the least amount of time was the one that identified as a *curandera*. At least two participants stated that they did not identify as a *curandera*, since it is up to the community to assign that identity but the practitioner themselves does not take on that identity. The hesitancy to self-identify with the label "*curandera* or *curandero*" is of particular interest here as each person was referred for this study due to their practice and reputations in their communities as traditional healers.

Mateo reflected extensively on his identity as a *curandero* and that there is no formalized training program comparable to Western practice:

We never used the word *Curanderismo*. Within traditional healing ...
I don't think there is a plan for it. Okay, done two years. Guess what? You are officially a traditional healer. It is like the power has to come from me. The way I experience it. It has to come not only from those who are giving you that title, but also accepting the title. There is more power in the individual, to claim yourself as a healer. This is just my perspective. I am sure other people have different perspectives. You know for me is that, that is scary to accept that title. Because you don't know what it really, completely, and totally means. There is not a book about, that is going to tell you okay here is *curandera* competencies you know? ... There is

struggle when you do go through this process. I think without struggle, you don't learn anything. And you have to accept that, that struggle. Because that is what teaches you to believe, is what I've come to believe. So, part of that struggle is that identity. ... I would rather use the sub label of *sobador*⁴ or *temazcalero*⁵. Those I can accept a little bit more. To me, I guess the reason why *curandero* is such a strong word for me is because of how I grew up. ... As an individual, I'm a doctor. As a member of community, I'm a traditional healer with a *sahumador*⁶. It's not an either/or. I think if we look at it in concentric circles, here's the individual which is much smaller and then here's who you are in the community versus vice versa. It would be here you're an individual, you're a doctor, and you're a healer, you know.

Sofia also reflected on the struggle of identifying as a *curandera* and likened it to the struggle she had in her identity as a psychotherapist:

I had the same dilemma when I first started in the field of counseling. It took me a long time to call myself a psychotherapist. Coming out of graduate school, I didn't feel like graduate school made me a psychotherapist or a therapist. ... Because I felt I didn't have the experience and when I got it, I felt more comfortable. The

⁴ *Sobador* – one who uses traditional massage.

⁵ *Temazcalero* – one who facilitates sweat lodge ceremonies.

⁶ *Sahumador* – traditional incense burner.

same thing with *curanderismo*. I felt like just because I call myself a *curandera* doesn't make me a *curandera*. What made me a *curandera* was my trying to help within that modality and feeling like I had helped some people. Feeling like people were benefiting from the healing practices that I was practicing. Then the other aspect to calling myself a *curandera* was doing the Aztec dance because I felt like that was enhancing the work that I was doing. So, between I guess, experience and experiencing being in that role and the Aztec dance practice I became more comfortable with calling myself a *curandera*. I felt like I was actually helping people and doing the work of *curanderismo*. ... I feel like I'm always learning from my colleagues and from my mentor.

Magdalena also reflected on her experiences in learning with a group of healers and her hesitation of taking on the identity of a *curandera*:

I was experiencing it like ... drinking from the ocean. ... I was so thirsty and there was an abundance of this you know love and feeling and ceremony and you know deep healing. ...I've been really shy about taking that identity on. Because there's just been so much internalized sexism on it. I was talking to a friend of mine, it's like you know when there's such that conflict that it looks like it's impenetrable. I just back away. That doesn't help anything. It's

like, how do I? ... How do I step forward and take on that identity? What do I need to do to get myself in better practice? I don't really know. I'm still a little shy about taking that on.

Ignacio also spoke about why he chose not to use the word *curandero* to describe himself:

It feels like a lot of unfinished business for me. Kind of like existentially in life. ... Yeah, a major part of it is those individual medicines. I don't want to tell people that I have the cure for them or that I can heal them. Really personally, I prefer to just heal them.

When discussing the value in traditional healing of lifelong learning, Isabel talked about how her Western training reflects that value. She states that she has seven college degrees which includes a bachelor's degree, several masters' degrees, and a PhD. She is also an independently licensed counselor and a nurse practitioner. Isabel also had strong feelings about calling herself a *curandera*, "I'm just a healer. There are no degrees. There are no titles. I'm just a healer. ... This is how I present myself. I'm here to be of service to you."

Guadalupe spoke on her identity as a *curandera* and how that is not a label she applies to herself as she feels she has not earned yet it although her community recognizes her as a *curandera*:

I've always thought of that title as something it's kind of like, I don't know that I've earned that. I don't know that I've earned that title. So, a part of me is very apprehensive in saying that I'm a *curandera*...There was one time when there was this beautiful Mexicana young woman she was probably in her late twenties and she was a healer and she one time said when we were all walking with her she says you never call yourself a *curandera*, your community will call you a *curandera*. That always stuck with me because people saying I'm a *curandera*.

1D. Passing on the knowledge to the next generation. While each participant mentioned having one or more mentors in traditional healing as well as having family members who themselves were practitioners, only one participant specifically mentioned teaching someone from the younger generation traditional healing practices. Guadalupe talked about sharing traditional healing knowledge with her grandson and that she feels he will eventually follow her into traditional medicine:

I showed him this is how you put the *romero* [rosemary]. You don't ever cut it. You pull it up. You always thank the mother earth for this and you say whatever it is in your heart. ... I said do you remember and he goes yes I remember. ... I think eventually he will [follow me into the medicine]. I think right now what's really nice

about our connection [is] he's interested in medicine and he's interested in healing. He's been receiving *limpias*⁷ from me since he was a little child. He always got some kind of comfort from it whenever he was sick. There was something about the *romero* that he has a connection to and the *sahumador* also. When he walks in he says, 'oh you've been burning *copal*.' Or there's times when he has had problems and he goes, 'Grandma, can you help me? I need to have a *limpia*.' ... I tell him whenever you want to learn something come over and we'll talk about it.

Theme 2. Barriers and Integrations. All participants discussed stigma and shame, or having to hide or not be as open about practicing traditional medicine especially with their Western colleagues. In addition, participants discussed integrations and tensions between the modalities and four participants discussed that traditional healing is similar to Western practice.

2A. Stigma and shame, legal concerns, ethical concerns. All participants discussed stigma and shame, or having to hide or not be as open about practicing traditional medicine especially with their Western colleagues. Sofia discussed intentions of giving up her counseling license when she retires so that she would not have to consider rules, regulations, legal considerations, as well as third-party payer

⁷ *Limpia* – refers to spiritual cleansing.

considerations and looking forward to practicing traditional healing full time without these worries:

“That’s kind of why I’m looking forward to retirement. Because I want to get rid of the license I want to ... just be a creative healer and let myself grow as a healer and give myself permission to do whatever feels right in a session that I feel is going to intuitively help my client.

Sofia also shared the difficulty she experienced in being a traditional healer and a psychotherapist as regards physically touching a client:

I think the dilemma for me as a traditional healer is what I mentioned is my feeling a very strong pull not to touch my client. That comes from the professional Western medicine. I struggle with that because I need, sometimes, you just need to touch your client. You need to participate more in touching your client to move the energy you know. My dilemma is that sometimes I’m a little hesitant to do that. I feel like that affects sometimes the quality of my work as a traditional healer. Then as a Western practitioner, I guess the challenge for me is that sometimes I do want to do some more *curanderismo* work with my clients and I feel like I can’t. But I think that what we’re talking about is that we, literally as healers, we live in two worlds.

Isabel spoke about being a Mexican American and a Spanish speaker in her public service and how she feels she has to be low-key about using traditional healing in order to protect the client as well as herself. Isabel said that she simply does not discuss when she uses traditional healing techniques but admits that it is likely that many of her colleagues are aware.

Usually if you have a Mexican American who doesn't speak English, or they came from Mexico, I get them. They [the other medical providers] don't really try too much, so I get them. So later when I have to do something else with them obviously I have to try to, if the patient allows me, well I tell them I'm gonna do it and try to explain what is going on in the course of their treatment. To explain so that they don't think that this patient is psychotic or has an understanding about their cultural beliefs. And sometimes I can't place them with various practitioners that they think it's all foolishness. It's a superstition. ... Sometimes a patient doesn't want me to tell about their cultural or spiritual beliefs to the next provider. ... I have to [reframe it] because if I framed it in another way the insurance would not pay. They would think I'm psychotic and would probably question my competency. I'm sure.

Mateo reflected on the stigma associated with traditional healing and how this relates to negative representations of a healer:

It is stigmatized, stigma to the whole traditional healing piece that I had to kind of work through because I was like wait a minute, this is working. I see a change not only in myself, the transformation amongst the other students in the class ... part of that stigma is... Comes the image of the representations of *curanderas* or *curanderos* as someone who makes these potions to control other people or make them feel bad or those sorts of things when very much the opposite is much more true.

Mateo went on to discuss legal and ethical considerations as it applies to his own practice:

Well, I guess in part I always question, am I breaking the ethics or the way that it is supposed to be done? And I am constantly trying to work within that. Here is the way I started to look at it, is that, this is a skeleton that I have been given. So, now it is time for me to bring out the meat of how ... the process can be done. And you know I continue wanting to stay in that world. However, I have to be flexible enough to include what is needed in that moment.

He further reflected that Western practice does not validate traditional healing due to lack of empirical evidence:

Just because it wasn't done in a lab by a psychologist, it doesn't mean that it doesn't have validation. I mean there is a particular reason why *curanderismo* or traditional healing has survived for

thousands of years. And you know there's that community-based evidence that comes into play. So, it's there it's just not validated by those in authority and so this is where I'm at right now. I mean going back and forth with all this. Yet, at the same time, I know that just because its evidence based in the Western world and that scientific, how we define science today, doesn't mean that it's actually going to work with all people, all the time. I just find that interesting. But yet, I'm tied to the ethics of our profession. Luckily here in [this state] traditional healers are protected by law and so that kind of protects me as well on that end of things. But I am not going to impose my practice on someone who doesn't know that I'm a traditional healer. In fact, I don't even bring it up.

Magdalena shared that she did not see any ethical dilemmas in her practice because she tends to use traditional practice for her own healing and centering before she begins her counseling sessions.

That's not my only modality. That's not my most common modality. I have an eclectic modality and I do use that. Mostly, most of the traditional medicine is about my centering, being centered myself. Doing that practice every morning before I start my counseling.

In addition, she shared about her experiences with stigma, secrecy, mystery, and superstition:

There's lots of those kinds of stories that really impacted the course of my family's life and a lot of yeah just a lot of no information you got to make up. I mean a lot of secrecy. So, there's like a lot of things we didn't know. And like why are things that way and nobody would talk about it. So a lot of secrecy around that. So I think there was a lot around my mom's altar and her mother. ... And there was a lot of mystery and superstition around it, so I never really wanted to go into mystery and superstition.

Ignacio reflected that he was comfortable blending modalities as he feels he had earned that right by completing Western education. He also said he feels there is an expectation that as he is a licensed practitioner he would help to legitimize traditional healing.

I felt completely justified because my prerogative had been earned by my education and my effort to get licensure or whatever. ... I could do it. But I couldn't find it in the DSM IV, you know? ... In other words, the system would dictate to me find what you did in this list of things. So, I find the one that was closest to what I did. ... It didn't say anywhere in there give this guy a *limpia* with *romero*. That's two ninety-one point two. It's not there. It's something like give him unconditional positive regard and make him feel comfortable or something. And then there's probably some diagnosis for that. Adjustment disorder or I don't know what. So,

that's what you say, right. We were the arbiters of that. ... And maybe that it's just that you are not supposed to talk about it when you are in the margins of something. That that's not part of the deal. I know that probably now there's probably people that say well yeah that's what you should be bringing forth. That's what maybe we are bringing forth or we should be bringing forth. I mean it's sad in a way because you've given up on the system and said okay I've played by your fucked up rules.

Guadalupe spoke about the secrecy in her childhood and about being a nurse and a traditional healer when working in a gynecology clinic:

I guess not everybody was brought up that way but there really were a lot of people in the community that were given herbs or whatever we didn't hardly ever go to the doctor and if we did my mom would say don't tell them that I'm giving you these herbs. Don't tell them what you're taking. ...You can bill on grief. You can bill on depression. There's a lot of diagnosis that fit right into it and like I said at the beginning that was like in the early 2000s when I was working for this OBGYN doctor that I think the billing processes was not as strict as it is now so that I was able to see patients for long periods of time but I think because I was doing that I wasn't making a lot of profit for the doctor and so I think that's what

happened why they finally asked me to start seeing GYN patients and doing women's health and things got kind of messy so I left. ...I ran groups there also for people with addictions. Every Wednesday we would have the group. The doctor would prescribe suboxone and I was doing the groups for them there and so as a nurse practitioner I billed but I couldn't bill as a *curandera*, but I was using *curanderismo* in the group. But it's healing. It's about healing work. And so, I've heard, and I've seen, where the insurance plans are starting to look at that to bring that into the whole picture but it's not very well defined. So, I bill on opioid addiction and remission and anxiety and those are things I bill for because I'm a nurse practitioner and that's an advantage because there's many *curanderas* who are not health care providers and they can't do that. So, I feel like being a nurse practitioner gives me the advantage of being able to do this work in the way that I want to do it. And it's all about healing. It's about health, helping people. It's about being the guide.

2B. Integrations, tensions between the modalities. All participants discussed integrations and tensions between the modalities. Mateo likened traditional healing and counseling to the aspect of duality in Mexican traditional thought:

There's this constant tension going back and forth and that's why I say that we have to practice this *Ometeotl*⁸ when it comes to healing therapy and counseling. Counseling on one hand and healing on the other. It's this back and forth. There is going to be tension. I think that's a good thing, you know. Because without that tension I don't think we can meet the whole needs of individuals or families or communities, whatever level you work with. We have to practice that all the time. ... Tension doesn't necessarily have to be conflict. So, I think there are some people who say, well no. We need to keep the traditions completely traditional being very obstinate about that same thing with the Western world. No, we can't deal with that mumbo jumbo. It's not real. And so, I think both sides can be like I said, can become very complacent in their ideas. As if culture is something that is so stagnant and not realize it is always evolving and changing. And then, we have to be aware that that's a continuous process. I think that's the beauty. That's where the healing for me is. Or because we cannot be, we're no longer isolated cultures in this if you look at this globally. I mean the Western world has affected the whole world or Western culture

⁸ In the Aztec tradition, *Ometeotl*, in the simplest of terms, is understood to be the God of duality, a concept that defies explanation. In this context, the reference of "this *Ometeotl*" would speak to the duality, the two worlds or approaches to healing, and the inability to accurately describe the complexity.

has affected the whole world. And I think it's only been until recently that indigenous practices are starting to be kind of okay.

Sofia observed that she feels we live in two worlds and that

Western medicine needs traditional healing:

We live in two worlds and ... we are challenged by those two worlds. We're having to try to be whole even though we feel a little bit divided. ... I believe that Western medicine needs traditional healing to complete the work which is why I continue to do it and want to learn more and go more in that direction. I don't feel that Western medicine gets how important the energy and the soul and that whole part of the person needs to be addressed, needs to be healed. I find myself very limited when it comes to the limitations of Western medicine. I feel like there were so many times I wish I could just do a *limpia* and a healing on some of my clients. But I know that might be problematic. ... I will touch people and I will do the energetic healing in the health fairs. But I don't use it in my counseling practice and I do feel like it's limiting. I wish I could and feel supported. But I don't feel supported. I mean I feel like I might get in trouble if I use some of my traditional healing techniques for healing my clients."

Magdalena shared about her experiences working in a hospital and then working in private practice,

At that time, I worked in the hospital and it was, I think it was pretty hard to integrate that, accept that I was different. I walked in the world differently and after that. I continued to do that. I've incorporated different things in my practice at various times. Now that I'm a private practitioner, there's a little more freedom about what to do. Or I should say, I keep coming around to continued awakening, a sort of the peace as I have encountered with other traditional healers. I think that then I walk stronger in those footsteps of the re-awareness of the awakening. I think that's what I do.

Ignacio discussed racism in academia when supervisors are White and they define best practices.

One expression of racism in that environment, when you are working in public service, is that a lot of the supervisors are Anglo professionals, where they have been licensed for years that have loyalties to the boards. That have loyalties to the professional rules and the ethics and stuff. The ethics were all very Western-minded and involved in taboos about touching and taboos about getting near the client. So that what was our context that we worked in. With these guys around. They might have been supervising you. They might occasionally review your notes. They might ask you in supervision what you did and why you did it and stuff like that. And

there was no point in telling them stuff like this guy needed a *limpia*, so I told him he should go see [my teacher]. Because they didn't know what *limpia* was and they probably would get morbidly curious about that and would probably judge you for it. So, you could make arguments about they need traditional healing, but they did not approve of you doing it.

Isabel shared about the tensions between the modalities as regards ceremony and healing practices. She talked about a ceremony she participated in with other healers in Mexico to help a woman who had been severely traumatized, "what they did probably if they did here it in the United States we would all be incarcerated. ... It was really quite an experience. When she came out of that she was a lot calmer." Isabel also discussed at length the differences in professional boundaries as regards self-disclosure and working within the client's cultural beliefs.

[The practice of *curanderismo*] is not so clinical. I think when we do an interview [in Western practice] it's very clinical in a way. ... Once you get trained [in Western practice], a lot of those things that are done in *curanderismo* are like big no, no's in Western medicine. Boundaries for example. How you get the patient into conversation? How much do you tell about yourself? So, it was much different how I was trained. The thing is that I was seeing patients over and over again and I was thinking, wow, you know, I actually received

training by Albert Ellis in REBT⁹. So, I went to the Phoenix, Ericksonian institute. ... We had many, many trainers at that Ericksonian Institute. ... You would learn different methodologies that you would use in psychotherapy. ... When did I start using *curanderismo*? I think it's after I got to a place in therapy where I didn't feel like I was getting where I wanted to get with the patient. I felt like there was more to it.

Guadalupe spoke extensively during the interview about how she integrates traditional healing with Western practice. This included that she has worked several times with medical doctors who specifically wanted a traditional healer in their clinic.

I was asked to participate as a traditional healer not as a woman's health specialist, that was easier. I was seeing them for more mental health issues, nothing more physical. ... I worked a lot as a clinician for the medical clinic for the mothers and children. I was able to do some *limpias* for some of the mothers there. ... I basically ran my own clinic. No billing. It was a non-profit. I was charging as a contract worker, that's how I got paid. I had my own clinic; no one knew what I was doing. Then ... around 2003 [I was] a nurse practitioner because I felt I could use this medicine with the people who are primarily undocumented. I did a few *limpias*. We didn't

⁹ REBT – Rational Emotive Behavioral Therapy

take insurance, so patients would come in and pay like \$30 or so. It was easier as we were only practicing traditional medicine. Then we came together with [other providers]. ... I would do *limpias* here and there... then around 2006, 2007, it was 2007 there was a huge need to work with people with heroin, opioid addictions. I thought we have to use this medicine somehow in working with people with addictions. I came up with [a healing] group. ... To me the most powerful part of that was the talking circle and then at the end we would do little *limpias*. ... I've done work on psychologists, psychiatrists, people who have, who stay too much in their head, and have a difficult time accessing their heart. I find when, especially when, they are educated, they stay too much in their head.

2C. Traditional healing similar to Western practice. Four participants, Mateo, Ignacio, Isabel, and Guadalupe mentioned that traditional healing is similar to Western practice. This includes the use of humanistic approaches, cognitive therapies, and the *plática*. Mateo reflected on the similarities with Western practice specifically humanism:

A lot of this is already familiar to me as well, not in the sense that you know, oh, I'm a *curandero*. Not in that sense, but in the sense of like ... wait a minute we do this in counseling, ... there are some things in here that resemble or parallel, should I say, with what I

have been taught in the Western model to a certain extent. ... In terms of counseling I'm just going back to my internship, when I was doing that and how what I know from a cultural standpoint of how people might heal. Or what I was brought up with back then. Because it was before I started actually studying traditional healing more. But I mean it just comes out. It's a very humanistic standpoint. That's every mode of bonafide kind of true type of healing, has a humanistic basis that's intentional to help the person grow, transform, change however you want to describe that.

Isabel talked about how she intentionally uses techniques in her Western practice that are similar to techniques used in traditional healing, "I try to do some CBT because I think it's very close to the whole thing about having a *plática*. What do you tell yourself? What do you think about? How did you get there?"

Ignacio spoke about how he blended traditional healing with Western counseling because the two are similar when it comes to cognitive therapy:

You could do cognitive therapy. And the terms were kind of loosely defined. So, you could do anything that involved verbal communication. And most of the methods of intervention involved some communication. You, as a therapist, can say you had a half hour with me and I stressed certain things. Or you can say I lit the

copal and the sun spirt shone through the *copal* and implanted in his soul a new way of looking at himself. And you, as a clinician can choose how you want to word that.

Guadalupe talked about some of her experiences working in a women's health clinic that specifically hired her to do *curanderismo* with the clientele. The language she used was very similar to language used in Western talk therapies.

It was at time that the HMOs had just started about 2003 or 4, and HMO's were not full blown. So, I would treat people for depression. I would treat people for grief. You know you had to use a diagnosis. But I would do *limpias*. I would do *pláticas*. I would see each person for five visits and every single time we would address one of their issues. ... Every person, I worked with at that time, was able to work through their sadness. Was able to work through their grief. We would work through their fears. ... I learned a lot from my teacher and the most that I learned from her was that I had to go through my own stuff. ... And a lot of times is, I try to encourage people to see how they participate in this drama of life. Sometimes it's like we all do this dance and I try to help them look at how their behavior is influencing the whole thing. And I guess that's what I like to say is that most of what we go through is about our own stuff. You can blame people you can be angry you can be resentful,

whatever. And we have sometimes reason to be. But what this is all about is about us as individuals to look at ourselves. In *La Tradición Azteca*, they say look at the smoking mirror. Look at the reflection back at yourself. That's one of the best lessons I've ever learned and sometimes it's the hardest. And so, what I try to do is I try to get people to see where their reflection is. And to remember to bring all those parts together. ... Or really just try to help them to see where they participate in their own pain. How they can stop that from happening. And another thing that this medicine is, is that it's really important to be clear yourself before you try to help anybody else. If you're wounded and you go to try to help somebody who is wounded, it's not going to work out like you want because your emotions get involved with others. They trigger things. ... This medicine helps me to come back. It reminds me okay you've got to step back. You've got to take care of yourself. You've got to take care of that little inner child yourself.

Theme 3. Social justice. Four of the participants, Mateo, Sofia, Ignacio, and Guadalupe discussed traditional healing as a statement of cultural power, reclamation, political activism, and/or social justice. Ignacio was the participant who was most clear and emphatic on this point. However, when asked, three of the other participants agreed and discussed their views.

During his interview, Ignacio was very clear that he approached traditional healing as a statement of cultural power and reclamation. He talked about this as being part of the *Chicano* civil rights movement and the importance of traditional healing in reclaiming cultural heritage.

Civil rights was getting important to me. And the impact of being a professional who is willing to take the risk of putting civil rights as part of your agenda as a professional. And advocacy as part of your agenda in the mental health field. I was getting to that point where I was trying to see the importance of being able to be in that posture. ... Some of the things that I did which are very related [and] came from *Chicano* civil rights, like men's groups. The *Conchero* movement so to speak. The circle or the sun dance in the Aztec way was beginning. And there were small groups because of the *Chicano* movement doing the dance of the sun. ... And how the *conchero* circles that have now been planted all over the United States. And it's basically saying *Chicanos* are Indians. We have all that background. And it's been hidden from us. We've had generations where it wasn't acknowledged. Where it wasn't talked about. Where it was kind of hidden away by our families. And now I guess since the civil rights act in the sixties people have dug it up. And can kind of trace their heritage. ... One of the exciting things

about the *Movimiento* was finding out that we had very similar experiences in different places, along the rocky mountain chain.

Ignacio went further and spoke extensively about his public service and the tension between the modalities:

When I was in public service. I felt kind of constrained by the boundaries of the academic training. Especially, once you're working as a licensed clinical psychologist. There's precariousness to that about getting thrown out of the profession by the *gringos*, you know, primarily. That you kind of have to walk a fine line and be careful with that kind of thing. Because they're not stamped with a stamp of approval with the profession until there began to be some academic literature during my career that validated some of that kind of work. And some defensive boundaries for those of us who used it and believed it. Because they were *Chicano* academicians and they were saying yeah, this is valid. This is important. Not only valid. This is the essential missing link in treating this population of fifteen million people. And it was at long last the drought was over for me.

Mateo talked about healing the differences between the modalities and being an advocate:

What I've come to understand as far as what healing is, it's also about healing these differences. Healing the differences between

these labels even if we take it a step further. The discrimination that we've faced throughout society and or the term Hispanic and the government defining us for example. So, taking into consideration, like even historical traumas now that the *curandera* has that particular role to take on, to help people deal with identity issues and historical traumas and so on and so forth that small communities weren't so much aware of. So, then what I'm saying is that there's a social justice piece that comes into traditional healing that I think is the future of *curanderos*. Because to me when I'm out there giving someone a massage I feel like I'm actually going against the system and I say that because there are people who pay top dollar to get *ventosas*, to get acupuncture, to get any of these treatments that should be an everyday kind of thing for people, and so to me my work as a traditional healer is to kind of reduce these disparities at some abstract level. You know because this is about the medicine. This is a medicine for everybody, for everyone, no matter what background you're from. No matter what culture you're a part of. And so, I feel like in a way I'm kind of being that advocate for those who can't afford those five-hundred-dollar c-wraps at some spa you know? Those kind of things that are critical to our everyday health, psychological and mental health.

When asked, Sofia agreed that traditional medicine is social justice work, "Actually, I do [agree] because it's an expression of our culture and its honoring our tradition and our genre. In that sense, it is a political statement. It's just like coming out as a lesbian." Guadalupe also agreed that traditional healing is social justice due to disparities:

Yes, I do see it as social justice for a few reasons. Social justice with healthcare. People are not treated equally. People are not treated equally depending on race, sex, ethnicity, and the money they can pay whether they are poor or not. So, where I work is making a statement. We suggest. We make recommendations. We bill insurance. But if someone can't pay, we see them anyway. ... It is necessary in this day and age for us to come together to make that kind of a statement. One of the biggest problems is that they separate all those things. All the clinicians at [my clinic] have that social justice perspective. That is exactly why we have that clinic. They [the clients] are treated like crap in an emergency room, especially addicts. We treat them with respect.

Theme 4. Healing methods. Healing techniques mentioned in the interviews included massage, sweat lodge, *limpias*, using plants, and participating in Aztec dance. Five of the six participants specifically mentioned use of the *plática*, while the sixth participant talked about the

technique without calling it the *plática*. Four participants described traditional healing as heart energy.

4A. Healing techniques. Healing techniques mentioned in the interviews included massage, sweat lodge, *limpias*, and using plants. Sofia mentioned that her participation in traditional Aztec dancing is an important part of her healing work. Mateo discussed some of the healing techniques he uses:

I think as far as where it first started for me was understanding herbs and what role they played within just general health. Herbs and nutrition, actually any of the foods we eat. Seeing food as medicine and herbs as medicine and I was encouraged by ... the healer that I work with. She said just test out different herbs to get to know the herbs to plant them you know try them out whether they be as teas or and I started experimenting with making salves and those sorts of things.

He continued to speak about the techniques he is learning from his teachers and mentors, "She's teaching us about *ventosas*, the fire cupping, and *sobadas*, it was very how to. ... Also the *temazcal*, the sweat lodge, [and] using that *plática*."

Sofia discussed how she saw the cultural implications and how, for her, a part of her traditional healing is her participation in Aztec dance:

One of the things that is similar to Aztec dance and traditional healing and the whole the culture that goes along with it is a strong respect of mother earth, of father sky. You know, the cosmos for directions. Any time you do healing, you first of all open up with, usually any health fair, is opened up with a ceremony. That's to connect you to the elements. Everything is so you become one with the elements. I totally enjoy ceremony. I feel like those that are practicing are enhanced by the ceremony, you know. That, I think is extremely important in doing the work, is connecting to God's energy but as it relates to nature, as it relates to everything around you. ... From personal experience, I just feel that the *danza* and the energy that is created from the dancing is totally a healing experience and I wish that I could put it into words. ... I have to first share it with [my teacher] to make sure he's ok with my talking about the effects of Aztec dance on my life. But it's been huge. It's made a huge impact on my life.

Magdalena talked about her traditional practices at home and in the community:

At home, what I do is I have an altar. ... I have a ritual every twenty-eight days. You know the full moon. Have that so you know, rejuvenation of that. In my home, I do prayers and light candles and give myself *limpias*. In the community, I have *pláticas* with my

comadres. I do that. In my private practice, I also light candles and I do *limpias* and you know the appropriated aromatherapy.

Ignacio shared about using ceremony prior to starting men's groups, "sometimes we would burn *copal* or pray to four directions before we started." He also spoke about using plants and his intuition in healing:

I healed somebody two years ago in Puerto Rico. Like by looking at the plants that were around me. And finding one that I thought was laurel and putting on those spiny things under the ocean on the injury. I put the laurel on it and it took away the inflammation. How did I know which weed it was or what? I mean it was a plant that looked like it had coolness to me. Cold. And I could see from the wound that it was heat. So, I just got the laurel and I put it on there. And five minutes later. Hey, it's getting better. It feels better.

Isabel discussed how she pursued some of her healing knowledge by going to Mexico to learn techniques:

On my own, I decided that I would go to Mexico and learn from other *curanderas*. I got a chance to go to *Xochicalco* where they had a huge gathering of all kinds of healers and they had different kinds of classes that we took like that would be very similar to reflexology, to sweat lodge, how to do *plática*, to learning about

tinctures, learning about herbs or different things around the environment that could heal folks.

Guadalupe talked about using her traditional healing practices while working at a gynecologist's office:

We would do little *limpias* in the clinic there sometimes. I would take care of their children, take care of them also, and I would do the GYN work with them at [a community service agency], I would go and work over there to do that kind of work with them. But sometimes I would do little *limpias* or little *pláticas* there.

4B. The *plática*. As regards traditional healing practice techniques, five of the six study participants specifically identified use of the *plática* as a healing technique while the sixth participant discussed the technique without naming it as the *plática*, and some participants discussed how the *plática* is similar to Western talk therapy techniques. Mateo shared:

I mentioned ... about the whole idea about *pláticas*. And so, one of my goals is always to just bring that element into counseling because that's in the counseling world that means therapeutic alliance or the real relationship. That's what the *pláticas* all about for me anyway so it's inevitable it's going to come in because it's a part of who I am and what I've been taught throughout my life.

Sofia reflected on the importance of the *plática* for her practice in making the connection with her clients:

The *plática* is how you join with the person that you're working with. You get to the core of what they're carrying. Just them sharing their burdens helps relieve them a lot. So, the *plática* is really important. ... That's a traditional healing method and it's obviously a clinical counseling method.

Magdalena talked about the similarities between the *plática* with counseling:

One of the things that I learned that gave me more confidence is that a lot of the healing work or the practice that you have with the clients involves the *plática* which is the counseling. You know getting to the core of why the person is seeking help and seeking healing. Then from there you connect with a client and they gave you permission to do the energy work with you.

Speaking about her grandmother's use of the *plática* in healing and how it influenced her practice, Isabel said:

She also did things like *plática* and these were talks that were from my heart to your heart kind of talks. So, if I think of them now as we would think of psychotherapy it could be like twenty sessions of psychotherapy in one hour. ... I think the biggest part is the *plática* and to understand that people want to be heard and how can I connect my heart to them. And one way is to identify, I know that you're suffering. I can see that you're suffering in a certain way and

certain things I say to them and how I speak to them I think we can condense twenty sessions into one session that I have. So, if I spend an hour with him then I am able to connect with him more. Guadalupe reflected how the *plática* was about people telling their stories:

I think for me when I was working in private practice and profit is the main point here right, so you have to work fast. A lot of times, I was behind but I think what happens is that you get key points and a lot of people would say that's not really in Western medicine you have to go through certain criteria and mixed in this was a conversation. It's peoples' stories. So, in that process the story was I would ask people you know what's going on. And most of the time it was a *plática*.

Although Ignacio did not mention the word *plática* specifically, he spoke about all interventions having some type of verbal communication. One example he gave was when he would facilitate men's groups using traditional healing practices: "One of our prayer meetings or whatever [would meet outside in an open space]. They were mutual support. ... We went up there and had kind of a long evening into the night."

4C. Heart energy. Some of the participants spoke specifically about *curanderismo* practice being heart energy. Mateo spoke about what he now recognized as his father doing healing work with his uncle, his

father's brother, "my Dad didn't necessarily give him advice per se or something concrete that he needed to do, but it was just the actual interaction, that heart to heart, that really close way of communicating."

He continued by explaining how he now perceives his own work:

I mentioned going through this Western training of medicine, or counseling and psychotherapy, this medical model thing, or even the contextual model or whatever, the whole process going through these institutions, basically split me into you know, the way I see this is, I have two hearts. I love the research, the procedures of science and so on and so forth. Yet what was missing also was that heart, that was more that sacred heart, that emotional, that spirit that was missing in all that.

Ignacio shared about how he felt healing is heart energy and how he advised individuals he worked with to open their hearts:

I don't want to tell people that I have the cure for them or that I can heal them. Really, personally, I prefer to just heal them. Like with my heart energy. Or, tell them do some things with your heart. Don't hook your heart on every shit storm you see. That's not opening your heart. But, open your heart to your loved ones and to the healing things that are in your environment. And, I love doing that. I feel like I do that for everybody. And people say well that's

because you're a psychologist and I go yeah, it's that and it's everything else.

Isabel spoke about her grandmother having heart to heart talks with those she worked with and about the spiritual connection in traditional healing:

For me, it's going even a little deeper with them and even spiritually going deeper with them, according to their spirituality and their beliefs. And at times, some folks may say, 'well is that a boundary issue? Is that an issue that you're talking more?' Because you know sometimes in Western medicine we say we don't tell anything about ourselves right, we don't interject anything. But in *curanderismo*, we're able to say, 'look, I understand suffering because I too have suffered. All people suffer. But let me tell you how you can then' [You give] a little piece of yourself to the patient. And I'm not talking about disclosing where I live or but to disclose even what pain would look like. So that they can understand their pain a little. Sometimes it's very painful when you speak with folks. But I just feel like it's more intense because I think it's my heart speaking to their heart.

Guadalupe reflected that Western practice does not teach practitioners to connect on a heart level:

Most medical doctors and nurse practitioners don't ask so how are you spiritually. Where are you spiritually? ... In doing this kind of work, we do that *plática* and we do that connection on the heart the heart level. And you know what that's like it's different than doing the intellectual psychological or psych exam yeah that's helpful but that's not really where you get to know the patients. ... You can have all the degrees you want. You can be this person that has acculturated and has become this great well-known person and you know what? You can't connect on a heart level.

Guadalupe ended her interview with the statement, "I think what's most important is that this is heart medicine. This is heart to heart medicine."

Chapter Summary

This chapter began with a description of the data analysis process, as well as presented major themes identified from the participant interviews. These major themes were identification and training in traditional healing is lifelong; barriers and integrations; social justice; and healing methods. Within the first theme of identification and training in traditional healing is lifelong the subthemes of participants introduced to traditional healing as young children; having mentors/teachers in the tradition; identity and training in traditional healing is lifelong; and passing on the knowledge to the next generation. Within the second theme of barriers and integrations are the subthemes of stigma and

shame, legal concerns, ethical concerns, integrations and tensions between modalities, as well as traditional healing is similar to Western practice were discussed. Within the third theme of social justice, the subthemes discussed are traditional healing as a statement of cultural power, reclamation, political activism, and social justice. Within the fourth theme of healing methods, the subthemes discussed are the types of healing techniques used including the *plática* and traditional healing as heart energy.

The final chapter reviews the findings and the implications of this study for practice, teaching, and research. In addition, I discuss limitations, delimitations, and strengths of the study as well as recommendations for future research and practical application of the current study.

Chapter 5

Discussion

Research Question

The project goal was to investigate how individuals who are licensed mental health practitioners and traditional Mexican American healers describe their experiences and their practices.

Possible Explanations of the Findings

I identified four major themes and eleven subthemes. Theme one is identity as a healer and that training in traditional healing is lifelong. This theme includes the introduction to *curanderismo* when the participants were young children, each had mentors/teachers in the *curanderismo* tradition, identity as a healer, and training in the traditional healing is lifelong. One participant mentioned that she is passing on traditional healing knowledge to the next generation. Theme two reflects barriers and integrations to dual practice including stigma and shame; legal and ethical concerns; integrations and tensions between the modalities; as well as that traditional healing is similar to Western practice. Theme three is social justice, that is, traditional healing is a statement of cultural power, reclamation, political activism, and social justice. Theme four is about the healing methods used, use of the *plática* specifically, and traditional healing as heart energy.

The first part of the major theme was that participants were introduced to traditional healing as young children and having at least one, and sometimes several, family members who practiced traditional healing methods and familiarized the participant to these technologies from a very young age. This is consistent with what I have observed in Mexican American culture and what I know from my own experience. This is also consistent in other depictions of traditional healers including (Ortiz, 2005) who discusses that many *curandera-parteras*, or midwives, learned from their mothers and grandmothers. Gonzales (2012) makes this same point in her book on traditional midwifery. Cheo Torres has written several books which describe how common it is to be raised in a family and community where traditional healing was common and accepted (Torres, 1984; Torres & Miranda, 2017; Torres & Sawyer, 2005; Torres & Sawyer, 2014). Trotter and Chavira (1981) also discuss the same point. When families and entire communities adhere to certain cultural practices, then children are raised with that practice and do not see it as odd or abnormal.

The second part of the first major theme is having mentors and teachers in the tradition. Each participant discussed their mentors and teachers at length during the interviews. This is consistent with other works on traditional healing (Avila & Parker, 1999; Kiev, 1968; Torres & Sawyer, 2005; Trotter & Chavira, 1981). Trotter & Chavira, (1981)

discuss the importance of mentorship in the *curanderismo* tradition. In their work, *Curanderismo: Mexican American Folk Healing* the authors explain that the most vulnerable time for a healer is when they are first learning. That is, due to the lack of experience, one needs a mentor or teacher to show the novice healer how to handle the energies of the client, and of the power of healing as well (Trotter & Chavira, 1981). In a similar vein, Elena Avila in her book *Woman Who Glows in the Dark* writes extensively about her own various mentors and teachers in *curanderismo* (Avila & Parker, 1999). In addition, she emphasizes the importance of apprenticeship, as a healer must have the support of other healers and the greater community in order to continue to do healing work (Avila & Parker, 1999). I see this as key in this tradition as humility and respect for elders and more knowledgeable others is fundamental in learning traditional healing methods. That is, while the methods themselves are important, the approach and respect for the person imparting the knowledge is also important. The participants each communicated a profound respect for their elders and it was clear that the relationship with a mentor/teacher was important to each of the participants.

The third part of the first theme is identity and that training in traditional healing is lifelong. How each of the participants identified as a healer was interesting given the cultural and historical context of how traditional healing has evolved in the post-colonial context. Only one

participant, Sofia, the person who had been practicing *curanderismo* the least amount of time, identified as a "*curandera*." One participant, Mateo, identified by the type of healing technologies he uses, that is, as a *sobador* or massage therapist and as a *temazcalero* or one who leads sweat lodges. The others, three of whom are well-known in traditional healing circles as having apprenticed with prominent healers and all of whom their community identified as *curanderos/curanderas*, chose not to use the term *curandero/curandera* to describe themselves. The hesitancy to self-identify with the label "*curandera* or *curandero*" is of particular interest here as each person was referred for this study due to their practice and reputations in their communities as traditional healers.

This is consistent with my own experience working and studying with traditional healers. Guadalupe spoke about this when she related a story about meeting a young Mexicana woman who was a healer. She told Guadalupe, "you never call yourself a *curandera*; your community will call you a *curandera*." The participants discussed the reluctance to identify as a *curandera/curandero* as a statement of humility and recognition that the training is lifelong. That is, as one is always in training to call oneself a *curandera/curandero* would infer that the training was complete. In addition, I postulate the hesitancy to self-identify as a *curandera* or *curandero*, is rooted in practices that date at least to the 17th century and likely earlier. During the Mexican Inquisition

healers such as Ysabel de Montoia, were charged with practicing witchcraft and faced harsh punishments (Ottman, 2010). The Mexican Inquisition was part of the larger Spanish Inquisition which maligned and demonized women who practiced healing and birthing rituals (Gonzales, 2012). In addition, laws at the time allowed only men to practice medicine (Ottman, 2010). I suggest this history established the reluctance of traditional healers, especially female traditional healers, to identify by the term *curandera* or *curandero*.

This subtheme includes that training in traditional healing is lifelong. This is a similarity with suggestions found in the current literature. Multicultural and social justice competence is a lifelong personal and professional developmental process with the practitioner seeking to further their understanding of cultural competence and practice cultural humility (Arredondo & Tovar-Blank, 2014; Ratts et al., 2015). This is also consistent with what I have heard *curanderas* describe as a lifelong practice before I began this study. Lifelong practice is the notion that one continually educates oneself on healing practices such that learning is ongoing and never considered complete. As one writer observed, "whether *curandera*, *cantadora*, *partera*, midwife, *sobadora*, masseuse, or any of the other categories of kinds of *curanderas*, - the healer is forever in direct training, is never graduated or matriculated" (Avila & Parker, 1999, p. 11). Another writer frequently mentions the

"*don*" or God-given gift needed to be a traditional healer can come from long apprenticeships (Torres, 1984). I understand these long apprenticeships to be for a very prolonged length of time, sometimes decades, or longer. In the state of New Mexico, licensed counselors must have 40 clock hours of continuing education credits every two years to maintain the counseling license. This is a nod to the concept of lifelong learning. However, 40 clock hours every two years is a minimal requirement and does not sufficiently rise to the level of lifelong training and humility expected of someone practicing *curanderismo*.

The final subtheme of the first theme is passing knowledge to future generations. It is interesting that Guadalupe was the only participant interviewed for this study that spoke on this topic. What I know of traditional healers is that they often participate in knowledge sharing activities such as workshops, herb walks, and ceremonies where those with less experience participate alongside those with more experience. However, few take on formal apprentices. Several works on traditional healing speak about this important aspect of the tradition. Again, Avila spoke about *curanderos* passing on traditional healing knowledge from parent to child (Avila & Parker, 1999). In her article on midwifery, Ortiz explains that in the early 1900s, there were over 800 practicing *curandera-parteras* (midwives) in the State of New Mexico (Ortiz, 2005). Most of these were women whose grandmothers, mothers,

or other female relative were *parteras* before them and the knowledge and practices were handed down through the generations (Ortiz, 2005).

The second theme regards barriers to dual practice as well as integration between the modalities. This was not surprising given the laws and standards that affect the practice of traditional healers. As discussed earlier in this paper, various states have unlicensed practice acts regarding traditional healing practice. The states included in this study that have some form of an unlicensed practice act are: Arizona, *Arizona Revised Statutes Sections 32-2911 Amended* (2008); California, *Complementary and Alternative Health Care Practitioners* (2001); Colorado, the *Alternative Health Care Consumer Protections Act* (2013); and, New Mexico, *the Unlicensed Health Care Practice Act* (2009) (American College of Healthcare Sciences, 2014). Practitioners must also abide by the state laws governing clinical practice for counselors and other talk therapists as well as ethical guidelines by ACA, the American Psychiatric Association, the American Psychological Association, The Council on Social Work Education, or the accrediting body in the particular field of practice. Given the historical oppression dating back to at least the 1600s, as well as the laws and ethical guidelines in place from outside the Mexican/Mexican American culture, the hesitancy and concerns around practice from the Western perspective combined with *curanderismo* are understandable.

The third theme is about social justice. Several published works discuss the use of traditional healing practices as social justice and as a political act. Sylvia Ledesma, a *curandera* and the founding director of the *Kalpulli Izkalli*, spoke about this at length when interviewed for a class assignment and previous paper I wrote on traditional healing. She explained that the *Kalpulli Izkalli* was formed to not only offer healings to the community but to preserve our culture and traditional healing knowledge and reclaim that which was lost due to the history of oppression and colonization (S. Ledesma, personal communication, November 16, 2013.) Ignacio's strong social justice perspective is consistent with others who value political action and making cultural statements.

One article discussed Palestinian women who visited traditional healers in Israel, in part, as an act of resistance (Popper-Giveon & Weiner-Levy, 2012). These women used two different coping strategies, often in secret; to deal with the stressors they faced (Popper-Giveon & Weiner-Levy, 2012). The inward coping strategy is seeking treatment from a traditional healer while the outward coping strategy is pursuing education and acquiring knowledge. Both these strategies serve to help these women work towards autonomy and come at substantial costs including an increased awareness of exclusion and oppression of women in a patriarchal society (Popper-Giveon & Weiner-Levy, 2012). While

women in the United States no longer face these same types of prohibitions, we did at different points in history. Given counseling practices prohibitions against dual relationships, including treating members of one's own family, those with whom one has/had had romantic relationships, and those known to the counselor, the tensions between the modalities are clear. Unlicensed practice acts may be a step in the right direction as the intent is to protect traditional practice. However, these acts do not offer practical guidance for the traditional healer who is also a licensed Western practitioner.

The fourth theme is on healing methods. The existing literature supports the healing techniques described in this study. Ari Kiev (1968) addressed the healing techniques of using sweating therapy, ceremony, ritual, having an altar room in the home, herbs, teas, smudging, and the importance of the practitioner speaking to the client about the malady. Trotter & Chavira (1981) discussed methods of the *limpia* or spiritual cleansing, use of herbs, prayer, smudging, ritual, ceremony, and midwifery. Avila and Parker (1999) discussed the use of *limpias*, prayer, ritual, ceremony, herbs, inner child work, symbolism, soul retrieval, smudging, sweat lodge, talking circles, and specifically, the *plática* as healing techniques. Four participants specifically mentioned that they feel traditional healing is heart energy and as Isabel described "from my heart to your heart." Elena Avila in her book, *Woman Who Glows in the Dark*,

specifically describes the *plática* as being a heart to heart talk (Avila & Parker, 1999). Eliseo "Cheo" Torres (1984) discussed spiritual *limpias* or cleanings, use of herbs, prayer, ceremony, and ritual. While Torres does not specifically address the *plática*, it would seem that some conversation between the practitioner and the client would have to take place, so they would know what to treat. Chavez (2016) compared the use of the *plática* as a healing technique to counseling from a more humanistic perspective. Perhaps this is the central argument for all talk therapies that in order for healing to take place the practitioner whether a physician, a counselor, or a traditional healer must talk to their patient/clients for any healing to begin. It occurs to me now, after speaking with other dual role practitioners, that perhaps the traditional healing emphasis on the *plática* is why I felt drawn to the counseling profession. Being a talk therapist aligns well with my path as a traditional healer.

Limitations, Delimitations, and Strengths of the Study

The limitations of the study included the difficulty accessing individuals in this population. Further, a long history of oppression against traditional healers, and female healers in particular, may have discouraged potential participants from wanting to be involved in this study. A delimitation of the study is that I chose to interview only traditional healers who practice from the Mexican or Mexican American healing traditions. Certainly, any issues identified in this population would

have some cross-over or similarities to those who integrate Western practice with other cultural healing traditions.

A strength of this study is that I am a member of the target community. That is, I am a licensed clinical counselor as well as a practicing traditional healer. Membership in the community provided access to the group and an understanding of the traditions and practices. Further, the participants did not have to explain traditional concepts and healing methods in detail, as I understand these concepts and have experience with the methods discussed. This allowed enriched discussion and issues to arise as not a great deal of time was devoted to explaining basic concepts.

An additional strength of the study is that it explored practitioners' own experiences and how they made sense of their experiences. Those interviewed had their privacy protected and as many states in the southwest region, Arizona, California, Colorado, and New Mexico, have some variation of an unlicensed practitioner act or other protections for traditional healers this may have helped some of the participants have the confidence to participate in this study. In addition, I used an insider perspective and a large amount of trust and rapport with many traditional healers was previously established.

Implications of the Study

Practice. Implications of the current study for clinical counseling practice include that counselors need to be aware of two truths. The first is that their clients may have traditional beliefs and may be seeking out other practitioners. Studies that have compared alternative healing practices have found that clients frequently see a behavioral health professional and a traditional healer concurrently (Moodley & Sutherland, 2010; Moodley, Sutherland, & Oulanova, 2008). Counselors ideally would be aware of this and accepting of the other healing modalities. Counselor self-awareness is one of the developmental domains specified in the MSJCC (Ratts et al., 2015). If it is appropriate to do so in the context of the therapy session, counselors may choose to explore traditional healing beliefs with their clients and what types of practices the client uses.

Second, for those counselors who practice other healing technologies outside of talk therapy, to be aware of the limits and boundaries about when they can practice which modality. Although, the MSJCC and counseling ethics specify that counselors are to honor diversity and client's world view this does not translate into support and advocacy of dual practice for the practitioner (ACA, 2014; Ratts et al., 2015). In other words, one needs to maintain awareness of their state's laws, their licensing, and their discipline's code of ethics and how these allow for dual practice.

A practitioner must be aware if a third-party payer, such as Medicaid or other health insurance, allows or discourages the practice of other healing technologies. While ethical codes, such as the ACA Code of Ethics (2014), allow for integration of practice this largely does not extend into payment for services by third-party payers. I am personally aware of only one health insurance company in New Mexico that pays for traditional healing. Molina Healthcare of New Mexico (n.d.a) has information on their website about a Traditional and Non-Traditional Healing Benefit of \$100 paid to the member, one time per calendar year. The instructions on the application are that the member must complete a one-page application and fax it to a Molina Healthcare Care Coordinator to process the application (Molina Healthcare of New Mexico, 2016). Molina also offers a Native American Traditional Healing Benefit in the amount of \$250 paid to the member, one time per calendar year. The member must be over the age of 12 years old, complete a one-page application, list tribal affiliation, and fax it to a Molina Healthcare representative (Molina Healthcare of New Mexico, n.d.b). While Molina Healthcare states this is to honor the culture of its members, one can see the fiscal value. Tribal Native American traditional healing is valued at \$250 per year, while other culture traditional healing is valued at \$100 per year. In contrast, in the State of New Mexico, Molina Healthcare will cover all current or medically necessary behavioral health services for the

member for the year with or without a referral from a physician (Molina Healthcare of New Mexico, n.d.c).

Teaching. The implications of the current study for teaching include considerations in teaching multicultural or social justice classes.

The ACA code of ethics states:

Professional counselors recognize that the quality of their interactions with colleagues can influence the quality of services provided to clients. They work to become knowledgeable about colleagues within and outside the field of counseling. Counselors develop positive working relationships and systems of communication with colleagues to enhance services to clients.

(ACA, 2014, Section D: Introduction)

Again, the statement here assumes that the counselor is from a different culture than the client. The supposition is that the counselor is White and is counseling someone who is not the stereotypical White, cisgendered, heterosexual client.

I agree with Sue and Sue (2008) who observed that all counseling is multicultural counseling as the historical and political context affects each client. All classes in counseling are then, multicultural and social justice in nature. In this context, an introduction to other healing modalities is appropriate and preferred. The classes would introduce the concepts of various non-Western healing practices and teach the

importance of respecting these different cultural practices while also teaching the importance of not using these technologies themselves (Oulanova & Moodley, 2010). In other words, while introducing counseling students to other healing modalities the caution about using techniques that one is not adept in, or not from their own culture would be emphasized (Oulanova & Moodley, 2010). These include the cautions mentioned above in the section about mentorship and training (Avila & Parker, 1999; Kiev, 1968; Torres & Sawyer, 2005; Trotter & Chavira, 1981). The purpose in introducing indigenous healing practices to those who practice from a strictly mainstream orientation would be so that they could be aware of these practices to aid in collaboration and appropriate referral (Oulanova & Moodley, 2010.)

The same is true in the Western model and is specifically part of the counseling code of ethics:

Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and protect others from possible harm (ACA, 2014, C.2.b).

Every July, UNM hosts a two-week workshop on *curanderismo*. This workshop has met with some criticism as I have heard that participants in the workshop have taken the two-week introduction, used the techniques

demonstrated, and then applied the title of "*curandera or curandero*" to themselves. The UNM website for this class now carries a disclaimer:

This course, and the material provided, is designed for information purposes only. This class is not meant to train, certify, and/or substitute the advice, diagnoses, and/or treatment of any medical condition. Please consider professional assistance for any personal needs. (University of New Mexico, n.d.)

It could be argued that those not of the Mexican/Mexican American culture who are introduced to these practices and then use them for personal gain are appropriating the culture. Cultural appropriation is when one from the mainstream culture takes elements such as art, dress, and spiritual practices from a colonized or marginalized culture, and uses those elements without proper knowledge and respect (Matthes, 2016). Cultural appropriation becomes a question of which culture has more power. In other words, a culture which is deemed to have less power cannot culturally appropriate from a more dominant or powerful culture. Rather, the opposite is likely the case. That is, the less powerful culture experiences colonization not only of their lands, but of their language, food ways, mores, spiritual practices, and healing practices as well. I presented an example of this earlier in the present work as regards the *genízaro* peoples of the American southwest.

Future research. Implications for research include broadening the study to include healers and practitioners from other cultures who use different or similar healing methods. In the last few decades, research on other-than-mainstream populations has increased. However, the body of Western research on multicultural issues remains in its infancy.

Indigenous cultures have used their own healing methods since before colonization and these healing technologies have evolved. Research about these technologies and the efficacy of these technologies since colonization could inform clinical practice in both increasing awareness about these technologies and how to support clients when they pursue other healing modalities.

A key implication for future research is about the nature of cognitive or talk therapy itself. Lillian Comas-Díaz, a widely respected clinical psychologist, has long argued that there is a need for counselors to develop the vital skill of listening to a client with a “third” or “multi-cultural ear” and allow clients to tell their stories, in the manner the individual needs to tell them (Comas-Díaz, 2011). To me, this sounds very much like a description of the *plática* technique used in traditional Mexican/Mexican American healing. Indeed, Comas-Díaz discusses the *plática* in another article (Comas-Díaz, 2006).

What can Western trained counselors learn from traditional healers about how to conduct cognitive or talk therapies? Is there something

about the use of the *plática* technique that is different in traditional healing? Does the Western practice of limiting professional interactions with someone known to the counselor more a hindrance than a help? These are important questions. As clinical practitioners need to be more and more to be culturally aware, culturally sensitive, and to offer interventions that are more amenable to marginalized groups, we can look to techniques that have worked well for centuries. The value ascribed to Western research methods is, by definition, a Western one. While other peoples in other cultures throughout time have employed versions of the scientific method, Western research methods and values on publication are culture bound values to the Western world. Typically, research conducted by those from outside the host culture interpreted the data through their own social and cultural perspectives (Toombs, 2012).

Use of the IPA method itself imparts a value on one's experience and how one makes sense of one's own experience. Personal experience is strongly valued in how one makes sense of one's own world. Since Mexican peoples have been practicing traditional healing since before colonization, the experiences of this population, is validation itself. One study found when those from the Mexican/Mexican American culture had access to both Western and traditional healing resources for health, there were better health outcomes (Castro, Furth, & Karlow, 1984). More research and information about experiences from differing viewpoints,

values, and cultural perspectives is necessary to strengthen our understanding of the phenomena. How to proceed, in itself, is a difficult question. Following a Western approach would result in the research and validation of cultural practices of one culture by using the cultural values of another culture (Lindner & Nicklas, 2012; Michaels, 2017). I would argue that century old cultural practices are valid for those that use them. These technologies need no further validation because they are therapeutic and accepted by those of that culture (Hays, 2014).

Advocacy. I began this research project in an effort to further understanding of how other practitioners who are both Western trained and licensed talk therapists who also practice Mexican American traditional healing understand their experiences. I now have a better understanding of some of the different ways that these individuals practice. Despite the Sue et al. (1992) Multicultural Counseling Competencies and Standards followed by the Ratts et al. (2015), Multicultural and Social Justice Competencies, practitioners still need practical guidance on how to practice when trained from two different world views.

The original MCC assumes the counseling interaction occurs with a White counselor and a client from a different cultural group (Sue et al., 1992). In a follow up article, Arredondo et al., (1996) addressed this bias. The authors make a point of saying that when they reviewed the MCC

they found that the cultural awareness, skills and knowledge recommended for cross-cultural counseling also applies when the counselor and client share more similarities (Arredondo et al., 1996). While that is true, the original MCC do not provide adequate guidance for those who practice from the two modalities such as those featured in the current work. The participants in this study were hesitant to discuss their traditional healing practices with colleagues when they were in public service. That is, when they worked for large bureaucratic type organizations. Sofia made a point of saying that when she retired she would not renew her counseling license so that she would not be accountable to her licensing board. Isabel discussed at length how she simply does not mention her traditional healing practices to colleagues because she believes they will not understand and would view her negatively because of her beliefs. Guadalupe mentioned that even when she was hired to work as a *curandera*, she was later asked to perform services recognized by Western practice as those were more easily billed to third-party payers and therefore, more profitable to the clinic where she was working. To say the concepts delineated in the MCC apply to all counselors, whether from different or similar cultures as their clients, is not wrong; it simply is not as useful for the practitioner.

The current MSJCC revisited the original MCC in an attempt to update the recommendations to be broader and more inclusive in the

understanding of culture and diversity and “better address the expanding role of professional counselors to include individual counseling and social justice advocacy” (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016, p. 29). The current MSJCC are wordy and lose usefulness as the categories in which a counselor and the client differ increase. The model may be useful if the counselor and the client differ on one category such as race or economic status or sexual identity, but if they differ on all these and other categories, the model becomes convoluted and therefore has little practical application. It would then follow, that the MSJCC would be more useful for counselors who are more similar to their clients. However, the model speaks to positionality and awareness and does not provide practical guidance on how a practitioner is to navigate the different ethics, values, and cultural teachings from the two perspectives. In addition, even if the practitioner and the client were similar in many of the identified categories, e.g. ethnicity, socio-economic-status, sexual identity, languages spoken, etc. this does not account for individual differences and that the opinions, perspectives, and values held by each person may be quite different.

An additional thought on this topic is that while both the MCC and the more current MSJCC provide some guidance for counselors, these guidelines do little to promote counselors of color. While these guidelines call on counselors to advocate for their clients and for social justice, they

do not extend into advocacy for the practitioner. We live in a world where third-party payment for traditional healing practices is minimal when it exists at all. The conceptual values espoused in the MCC and MSJCC do not extend into fiscal value. While there is a call to the profession, there is no call to third-party payers.

Advocacy for the client and the counselor from both mainstream and marginalized groups is the most important direction for future practice, teaching, and research. This follows the lead from legislatures in Hawaii who found it was best if those who practice and those affected by the practice are the ones best suited to regulate the practice (Donlin, 2011). I feel that practical guidelines on how to integrate, not integrate, or otherwise use different modalities and different healing traditions are best left to those who are most affected. In carrying out the current study, I initially encountered some resistance and had to defend that I was an insider and had experience in this area. There are those who feel insider research is somehow inherently flawed and does not carry a higher degree of trustworthiness. I argue that research from an outsider perspective has the same critique. That is, researcher bias influences all research (Hayes & Singh, 2012; Toombs, 2012). To value an outsider perspective over an insider perspective is simple valuing one set of biases over another. Placing more emphasis on mainstream culture values and

perspectives does not adhere to the spirit of counseling ethics, multicultural and social justice competence, or advocacy.

Conclusion

Our field still needs to look beyond counseling per se, and embrace the ACA Code of Ethics value to honor diversity and embrace a multicultural approach in “support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts” (American Counseling Association, 2014, p. 3). Counseling organizations need to take more of a stand to legitimize counseling practice and to advocate for practitioners and the differences, complexities, and richness of all who practice in talk therapy modalities. Ethical guidelines would extend beyond delineating the expectations for practitioners and would embrace those same values in a meaningful way. Professional bodies need to take a greater stand in continued professional advocacy with third-party payers for those who practice from other than Western modalities.

As demonstrated in the interviews for this paper, practitioners who are licensed talk therapists, who also practice healing methods from their own cultures, are hesitant to speak about this dual practice to their colleagues. This is due to fear of a perception of mental instability or facing sanctions by their licensing boards and professional organizations. This is a historical concern dating back to at least the 1600s as in the case of Ysabel de Montoia and to the history of the Spanish Inquisition

where women's healing practices were demonized (Gonzales, 2012; Ottman, 2010). Today we can see the continuing impact of colonization on traditional healing practice and that the need for advocacy from a true multicultural and social justice perspective remains.

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Appendices

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Appendix A

Sample Recruitment Flyer

RESEARCH PARTICIPANTS NEEDED

If you meet the below criteria, you may be eligible to participate in a study exploring the experience of individuals who are licensed mental health practitioners and traditional Mexican American healers in their therapeutic practice.



- WHO:**
1. Licensed mental health practitioners who are legally licensed to practice in their state of residence who are 21 years of age or older.
 2. Mexican/Mexican American, traditional healers who practice indigenous healing practices more commonly understood to be in the curanderismo tradition.
 3. Re side in the southwest region of the United States, specifically Arizona, California, Colorado, New Mexico, Nevada, Texas, or Utah.

- WHAT:**
- A) Participate in one to three private interviews about yourself, and your Western as well as your traditional practice
 - B) Participate in an optional focus group session
 - C) Read a transcript of your interview(s) and confirm the accuracy or make changes.

For more information, email: Helen Tafoya at HTafoya@unm.edu.



Appendix B

Sample Recruitment Letter

Month, Day, Year

Subject: Research Study:

Experiences of Western Clinical Practice and Traditional Mexican American Healing When the Provider is Trained in Both Modalities

You are invited to participate in a research study conducted by Helen Tafoya, MA, LPCC, Student Investigator, University of New Mexico doctoral candidate under the supervision of Kristopher Goodrich, PhD, Dissertation Chair. The purpose of this study is to explore the experiences of individuals who are licensed mental health practitioners and traditional Mexican American healers in their practice.

You may qualify to participate in this research study if 1) you reside in the southwest region of the United States specifically Arizona, California, Colorado, New Mexico, Nevada, Texas, or Utah; 2) you are a licensed mental health practitioner who is legally licensed to practice in your state of residence and 21 years of age or older; 3) Mexican/Mexican American, traditional healer who practices indigenous healing practices more commonly understood to be in the curanderismo tradition.

If you decide to participate your decision is strictly voluntary and you can quit at any time without penalty. You may refuse to answer any questions you do not want to answer and still remain in the study.

All information obtained in the interviews or surveys will be kept confidential. Further, you will not be identified in any publication of the study's findings.

Your responsibilities in the study will be to:

1. Participate in a private individual interview. The interview is expected to be completed in a single session and make take up to three sessions. The total time for the interview is expected to take no more than three hours.
2. Review a transcript of the interview and confirm the accuracy of the information. It is expected this review will take no more than one hour.
3. You will also be invited to participate in an optional focus group which is expected to take no more than three hours.

If you are willing to participate in this study, please inform the Student Investigator Helen Tafoya, MA, LPCC by calling (505) 604-7840, or email HTafoya@unm.edu.

For additional questions contact Helen Tafoya, MA, LPCC, (505) 604-7840, or email HTafoya@unm.edu.

Appendix C

Consent to Participate in Research



**Experiences of Western Clinical Practice and Traditional Mexican American Healing
When the Provider is Trained in Both Modalities**

Informed Consent for Interviews and Focus Group
Version 08.24.16

You are being asked to participate in a research study that is being conducted by Helen Tafoya, MA, LPCC, Student Investigator under the supervision of University of New Mexico Associate Professor, Dr. Kristopher Goodrich, in the College of Education, Department of Individual, Family and Community Education. The purpose of this study is to investigate how individuals who are licensed Western mental health practitioners and traditional Mexican American healers describe their practices.

You are being asked to take part in this study because 1) you reside in the southwest region of the United States, specifically Arizona, California, Colorado, New Mexico, Nevada, Texas, or Utah; 2) you are a licensed mental health practitioner are legally licensed to practice in your state of residence; 3) a Mexican/Mexican-American, traditional healer who practices indigenous healing practices in the curanderismo tradition.

Your participation will involve participating in a semi-structured interview which is expected to take 1-3 sessions, and last a total of approximately 3 hours. You may also choose to participate in a focus group which will take place after all the individual interviews for the study are completed. This focus group is expected to take approximately 3 hours. During the interview and focus group sessions, your responses will be audio recorded to allow me to be fully engaged in discussions. These audio files will later be transcribed by an experienced transcriptionist and then erased. The interview and focus group include questions such as 1) Tell me about your experience as a mental health practitioner; 2) Tell me about your experience as a traditional healer; 3) Tell me about your experiences as both a Western mental health practitioner and a traditional healer. There are no known risks in this study, but some individuals may experience discomfort or loss of privacy when answering questions. Focus group participants will be asked to keep all information shared during the focus group confidential. At no time will any photographs be taken of any of the participants in the study. Limits of confidentiality are as required by law and/or ethical standards; for example, in the event of a court order; child abuse or neglect; abuse of a vulnerable adult; potential threat to self or others. Your involvement in the study is voluntary, and you may choose not to participate. You can refuse to answer any question at any time. There are no names or identifying information associated with your responses. All data will be kept in a locked file cabinet, in a locked room, in a locked building. The data will be kept in a different locked file cabinet than the informed consent forms. All identifying data will be destroyed seven years after completion of the study. No written or printed record of any identifying data will be maintained. All data stored on the hard drive and the flash drive will be erased; audiotapes will be erased, and written transcriptions will be shredded seven years after the study closed. Any research publications that come from this data will not contain any identifying data of any research participant. You will not be paid for participating in this study.

The findings from this project will provide information on the experiences of those who are both a Western mental health practitioner and a traditional healer. There may or may not be any direct benefits to you from participating in this study. This study seeks to contribute to the field of counseling and research. If published, results will be presented in summary form only. Quotes with no identifying information may be used.

If you have any questions, concerns, or complaints about the research study, please contact the student investigator, Helen Tafoya, MA, LPCC at 505-804-7840, or htafoya@unm.edu or the supervising faculty member Associate Professor Dr. Kristopher Goodrich, College of Education, 1 University of New Mexico, Albuquerque, NM 87131, (505) 277-2231, or kgoodric@unm.edu. If you have questions regarding your rights as a research subject, or about what you should do in case of any harm to you, you may call the UNM Office of the IRB (OIRB) at (505) 277-2644 or irb.unm.edu.

By signing below you will be agreeing to participate in the (check all that apply) **individual interview** and/or in the **focus group** for the above described research study. By signing this consent form, you are not waiving any of your legal rights as a research participant. A copy of this consent form will be provided to you.

| | | |
|--|--------------------------------|-------|
| _____ | _____ | _____ |
| Name of Adult Participant | Signature of Adult Participant | Date |
| _____ | _____ | _____ |
| Helen Tafoya, MA, LPCC, Student Investigator | | Date |

Appendix D

Semi-structured Interview Protocol

Practitioner Interview Protocol

Purpose of the Study: The purpose of the study is to investigate how individuals who are licensed Western Mental health practitioners and traditional healers describe their practices.

Semi-Structured Interview Guide

Prior to audio recording, the participant will be provided an opportunity to choose a pseudonym for use during the interview. The student researcher will state “To protect your confidentiality you may choose a pseudonym to use for the purposes of this interview or if you like, I can choose a pseudonym for you...”

This study will utilize qualitative research methodology. This is an open-ended, semi-structured interview guide to provide a framework for the interview. Each interview will address three primary questions, asking the participants about their experiences as a licensed mental health practitioner and a traditional healer.

1. What is your experience as a Western mental health practitioner?
2. What is your experience as a traditional Mexican American healer?
3. Tell me about your experiences as both a Western mental health practitioner and a traditional Mexican American healer.

Prompts that may be used:

Can you tell me more about that?

Can you give me an example?

What do you mean by ____?

It sounds like you are saying ____?

Why is that important to you?

Follow-up questions

1. Tell me about the modality/ies you use.
2. Tell me about the ideas or values that guide your practice.
3. Regarding ethical issues, (ask either 3a or 3b depending on the interviewee's previous responses.)
 - 3a. If the interviewee brings up ethical issues, a follow up prompt might be "I would be interested to hear about the processes you use to resolve these ethical concerns."
 - 3b. If the interviewee does not bring up ethical issues, a follow up prompt might be, "I wonder if you have ever encountered ethical issues or dilemmas in your work as a healer.
4. Regarding integration of practice (ask either 4a, 4b, or 4c)
 - 4a. If the interviewee brings up integration of practices, follow up questions might include:
 - i. In your work as a healer, have any ethical considerations/dilemmas come up for you as a practitioner of both modalities?

- ii. In your work, have you encountered any barriers that have made it difficult for you to integrate both modalities?
 - iii. Tell me more about what it is like for you, as someone who is trained to use both modalities.
 - iv. What is a good day like for you?
 - v. Are there challenges?
 - vi. How do you decide when to integrate the modalities, and when not to?
 - vii. Tell me about examples of when you have combined ideas from both traditions?
 - viii. Is there anything else you would like to tell me about what it is like for you when you combine traditional healing with Western counseling practices?
- 4b. If the interviewee brings up that they do not integrate practices:
- i. I would like to hear more about that.
 - ii. Tell me about how you keep the two practices separate.
 - iii. Tell me about your views and the professional guidelines that you use.
 - iv. Tell me more about what you were saying earlier about keeping the practices separate.
- 4c. If the interviewee does not bring up integration of practice at all, do you ever combine traditional healing practices with Western psychotherapy?
- i. I would like to hear more about this.

- ii. Tell me more about what you were saying earlier about ...
 - iii. Tell me about your views and the professional guidelines that you use.
5. Are there any ethical considerations/dilemmas that have come up for you as a practitioner of both modalities?
6. If the interviewee, brings up an identifying term as a healer, a follow up prompt might be, tell me about why you have chosen X identity.
7. If the interviewee does not bring up a primary counseling modality, (ex. cognitive-behavioral therapy, humanistic, family systems, motivational interviewing) a follow up prompt might be, tell me about your theoretical orientation of practice.
8. **Demographics – if during the interview the interviewees do not identify the below, these will be asked at the end of the interview:**
 - i. Gender/Gender Identity
 - ii. Age
 - iii. Religious/Spiritual identity
 - iv. Formal western Education
 - v. Traditional training
 - vi. Western license/state
 - vii. License/s held
 - viii. Identity as a healer
 - ix. Years of practice as a counselor
 - x. Years of practice as a traditional healer