EXPLORING FOLK AND TRADITIONAL MEDICINE PRACTICES AND SELF-CARE AMONG MEXICAN-AMERICANS WITH DIABETES

by

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ABSTRACT

MICHAEL R. VILLANUEVA. Exploring folk and traditional medicine practices and self-care among Mexican-Americans with diabetes (Under the direction of DR. AMY PETERMAN)

The burden of diabetes mellitus (DM) is high among minority populations. In the United States, approximately 1 in 10 Hispanic individuals face this burden. A subgroup of these Hispanic individuals, Mexican-Americans, is disproportionately affected by DM compared to their White counterparts. Research highlights a disparity in outcomes among Mexican-Americans with DM compared to the general population. While researchers have examined both cultural and psychological characteristics of Mexican-Americans suffering from DM, there is a paucity of research in areas related to folk and traditional medicine practices and their relationship to self-care of DM. Additionally, White, English-speaking practitioners often fail to understand that self-care practices are associated with the cultural understanding of DM. Interestingly, *susto* (i.e., a state of anxiety or distress due to a traumatic event), a culturally-specific condition endemic primarily to Mexican-Americans, has been implicated as the primary cause of DM by many Mexican-Americans. This paper examined how folk and traditional medicine and the cultural understandings of DM through the lens of *susto* are related to self-care practices for Mexican-Americans suffering from DM. The results revealed that while participants storied their experience with DM in a manner that emphasized self-care through curative approaches used in biomedicine, other treatment modalities such as folk/traditional medicine and psychotherapy found partial support as therapeutic options to treating *susto* and DM. Furthermore, the historical definition of *susto* was not supported in this study, whereas the more current worldview of *susto* found moderate support. Results of this study also revealed unexpected findings, including how *curanderos* (i.e., folk/traditional healers) are “hidden in plain sight” and appear to be more accessible today than in the past. Yet, there is confusion and contradiction as to the nature, location, and utilization of their services. Consideration was given to issues of researcher bias as well as rigor. Implications for clinical practice, limitations of the study, and directions for future research are also discussed.

DEDICATION

I dedicate my dissertation to generations of family members and friends who have battled and ultimately succumbed to diabetes with grace and dignity. And to those who continue the battle, may you use your voice to share stories of struggle and triumph. And may this voice echo a narrative of movement toward recovery of improved health for yourself and for those who hear your story.

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CHAPTER 1: INTRODUCTION

> At the beginning my health was very good, but afterwards I got sick because of an experience with *susto*. One day my sister and I were seated at home. My sister was sewing on a sewing machine, and I was folding clothes. When I finished folding clothes, I came over to the table to sit down. That day it was raining very hard and lightning was striking around the house. I became very scared because a huge, red ball of fire was coming out from the refrigerator and struck me when I opened it. Then I imagined that I would turn around and find my sister thrown on the ground given all the fright and *susto* that it gave me. But thanks to God nothing happened. I asked her if she was all right, and she responded, "Yes, why?" I asked her, "Didn't you see the ball of fire that came out of the refrigerator?" She replied, "No, I didn't see it! I was busy with the machine and didn't pay attention." After that *susto* and 3 months later, I found out that I had diabetes. (Monica, a 46-year-old Mexican-American with Type II diabetes)

Background

According to the American Diabetes Association (ADA: 2009), DM is one of the most common chronic diseases impacting both children and adults in the United States (US). It is estimated that DM affects nearly 8% of the US population (i.e., roughly 24 million children and adults), with a significant portion of those unaware they have the disease (Steinbrook, 2006). Furthermore, the number of Americans diagnosed with DM doubled over the past two decades (i.e., 1980-2002), and prospective reports suggest that approximately one in three individuals will be diagnosed with DM in their lifetimes (e.g., Senemmari, 2005).

The risk of developing the DM is impacted by many risk factors including poor self-care practices (Hunt, Pugh, & Valenzuela, 1998), age (i.e., being over the age of 45), weight (i.e., being obese with a body mass index (BMI) ≥ 25 kg/m2), lifestyle (i.e., failing to endorse physical exercise), family history (i.e., demonstrating a family history of DM), and ethnicity (e.g., African-American, Hispanic-American, Native-American, Asian-American, and Pacific Islander are all at an increased risk of developing DM compared to other ethnic groups; ADA, 2009; Jimenez-Cruz & Bacardi-Gascon, 2004). Furthermore, a condition termed pre-diabetes, which is biomedically described as a glucose and hormonal dysfunction approaching but not meeting the criteria for DM, has been implicated as an associative risk factor for developing the disease (ADA, 2009). Other associative risk factors include a positive history of gestational diabetes, delivery of a newborn in excess of 9 lbs, hypertension, dyslipidemia, polycystic ovary disease, and vascular disease (ADA, 2009; Jimenez-Cruz & Bacardi-Gascon, 2004; Poss & Jezeweski, 2002).

Diabetes Mellitus is described as the most common reason for hospitalizations (after obstetrical admissions) for Mexicans who reside in Mexico and ranks as the third leading cause of death among Mexicans living in Mexico. Between 1993 and 1999, prevalence rates for DM in Mexico were calculated to have increased from 8.8 to 11.4 percent. In some parts of Mexico, particularly the southern region which is inhabited by a large constituency of Mexican-Indians, prevalence rates approaching 15% are not uncommon (Jimenez-Cruz & Bacardi-Gascon, 2004).

As mentioned, obesity is a known risk factor for the development of DM (Jimenez-Cruz & Bacardi-Gascon, 2004). The projections within the United States are similar to that of Mexico in that an increase in the number of individuals projected to develop DM is expected to be associated with an increase in the prevalence of obesity—another contributing factor for the development of DM. In fact, given the proximity of

Mexico to Mexican-Americans living in the US and the infusion of traditional, Mexican food items to the everyday diets of many Mexican-Americans, it is reasonable to assume that the obesity rates, and by extension the DM rates, among Mexican-Americans living in the US will mirror those in Mexico (Jimenez-Cruz & Bacardi-Gascon, 2004).

In the United States, slightly more than 10% of Hispanics over the age of 19 have been diagnosed with DM compared to nearly 8% of European Americans (Thompson, Horton, & Flores, 2007). Given that one-third of Hispanics in the US carry no health insurance, the burden of living with a chronic disease like DM has been difficult to negotiate (Lorig, Ritter, & Gonzalez, 2003). Furthermore, Hispanics as a whole are disproportionately affected by DM compared to other ethnic populations (ADA, 2009; Poss & Jezeweski, 2002) and represent one of the fastest growing minority populations within the US (i.e., 13% of the total population according to the 2000 census).

Mexican-Americans, who are part of a subgroup of all Hispanic individuals, constitute nearly 60% of all Hispanics living in the United States (Galanti, 2003). As a whole, they are disproportionately impacted by DM (i.e., 2 to 3 times higher prevalence of non-insulin dependent DM and poorer outcomes) as compared to their non-Hispanic white counterparts (Flegal, et al., 1991; Galanti, 2003; Stern & Mitchell, 1998). Reasons for these disparities include genetic predisposition (i.e., 40-80% of disease susceptibility among those with non-insulin dependent DM; Holt, 2004) and high obesity rates in addition to geographic, linguistic and cultural factors (e.g., placing the family's needs above their own; Thompson et al., 2007). Other studies have implicated low socioeconomic status (e.g., income), barriers to healthcare access (Chou et al. 2007; Peek, Cargill, & Huang, 2007), and low (health) literacy levels (Carbone, Lennon, Torres, &

Rosal, 2006) in influencing the prevalence of DM in ethnic minorities. However, it is unclear how these factors influence self-care behaviors.

While there is some evidence from research studies describing models designed to improve DM health outcomes among ethnic minorities such as Mexican-Americans, little has been done to summarize or evaluate this evidence (Peek et al., 2007). In fact, Boyle (2002) asserts that little is known about how the practice of culturally-congruent care should be accomplished, and she recommends that healthcare professionals familiarize themselves with cultural concepts such as folk and traditional medicine (FTM) perspectives and practices in order to minimize the differences in interpretations about the causes and the appropriate treatment of DM. In an effort to optimize positive healthcare outcomes, culturally-congruent and appropriate healthcare practices require a clear understanding and acceptance of how patients conceptualize their illnesses, how FTM practices inform patients' self-care practices, and how these self-care practices in turn influence patients' relationships with healthcare providers.

In order to examine these important issues, I will first review the literature on models to understand DM. Next, I will examine the literature on the biopsychosocial understanding of DM. Subsequently, I will review the literature on the traditional Mexican-American understanding of DM, including a review of the historical roots and current folk and traditional healing systems of practice. Afterward, I will review the literature on the current self-care practices of DM among Mexican-Americans followed by an evaluation of curanderismo as a resource for Mexican-Americans. Next, I will examine the literature on *susto* and DM, including *susto's* prevalence, course and treatment. Then I will compare FTM with biomedical and biopsychosocial models while discussing implications for self-care of DM. I will next discuss clashing models of self-care during practitioner-Mexican-American patient encounters and conclude the review by discussing current gaps in the literature and implications for future research.

Model to Understand Diabetes Mellitus

Biomedical models of disease focus on the biological agents of sickness that are observable and cause physical harm (Loustenau & Sobo, 1997). Medicine practiced within this model is guided theoretically by beliefs that biology and chemistry can explain illness and define treatment. The biomedical model is principally mechanistic in nature, viewing the body as a machine prone to malfunctions and in need of tune-ups or replacement parts (Hallenbeck, Goldstein, & Mebane, 1996). In the United States, biomedicine developed in part as a health practice model promoted by the rise of the American Medical Association (AMA). Over time, the AMA's impact on medicine has placed an emphasis on biological malfunctioning while simultaneously de-emphasizing the role of the patient in the process (Loustenau & Sobo, 1997; McNeill & Cervantes, 2008). As a result, the reduction of sickness into biological terms has resulted in more curative than preventative trajectories in biomedical patient care (Loustenau & Sobo, 1997).

The principal focus on treating biological malfunction and de-emphasizing personalized patient care is well-evidenced among patients suffering from DM. Within a biomedical model, DM represents a group of metabolic or endocrine diseases characterized by hyperglycemia as a result of decreased insulin secretion and/or its mechanistic course of action within the body (Kaiser et al., 2003). Oftentimes, poor self-care practices, such as non-adherence of proper dietary measures and pharmacological interventions, can lead to uncontrolled and persistent DM, which in turn may result in long-term deleterious effects of many major body systems (e.g., the eyes, kidneys, nerves, heart and blood vessels; Kaiser et al., 2003; Poss & Jezeweski, 2002). If DM remains undiagnosed for a period of time, the risk of stroke, coronary artery disease, peripheral vascular disease, and associated comorbidities (e.g., hyperlipidemia, hypertension and obesity) significantly increases (ADA, 2009).

Clinicians' attitudes toward DM and their patients stem from numerous sources, including the culture of medicine and personal culture. However, within the culture of medicine, overarching sets of shared medical beliefs are sometimes not grounded in science or empirically-based data (e.g., beliefs guided by cultural roots; Freeman & Loewe, 2000). Yet, many practitioners use scientific information to form their own attitudes and beliefs about illnesses—which are often very different from the attitudes and beliefs of their patients (Freeman & Loewe, 2000; Hunt, et al., 1998). As a result, developing an effective system of care for patients suffering from DM is often difficult for many medical practitioners treating cross-culturally. In part, this difficulty persists because healthcare workers often characterize DM mechanistically according to level of metabolic control, adherence to a restricted diet and glucose monitoring, and situational control (i.e., patients feeling they are in charge of their daily plan or activities; Freeman & Loewe, 2000) and subsequently fail to conceptualize DM more holistically (i.e., as having biomedical, biopsychosocial, and cultural influences; Hunt, Arar, & Akana, 2000; Hunt, Pugh, & Valenzuela, 1998; Thompson, Horton, & Flores, 2007). Metabolic control (i.e., being in or out of control) in the biomedical model refers in part to inclusion or exclusion of patient diagnostic values (e.g., blood sugars) within a range of acceptable values and also on discussions between practitioners and patients about self-care practices. Unfortunately, the practitioner repeatedly fails to elicit discussion of patient self-care practices as it relates to their perception of control, further complicating DM management (Freeman & Loewe, 2000).

Increasingly, medical healthcare workers appear to be frustrated about treating patients or pessimistic about the patient's knowledge of DM in general because of perceived non-adherence of DM. According to a qualitative study undertaken by Freeman and Loewe (2000), interviews with doctors, attendants, physician assistants (PA), and nurses elicited surprising admissions. For example, an attending physician said, "I think especially NIDDM (Non-Insulin Dependent Diabetes Mellitus) is frustrating to take care of," a nurse said, "They're [people with diabetes], I think, the hardest people to work with," and a PA who works primarily with patients suffering from Human Immunodeficiency Virus (HIV) stated, "Diabetes is probably one of the most frustrating things I have to deal with…HIV patients are much easier to deal with." With regard to discontinuity in consultation between practitioners and patients, another PA remarked "I think most of them have 10 or 15 concerns that are ahead of the diabetes, so we're having to get through all those things before we hit the behavior change in dealing with diabetes. You know, child-care issues, transportation issues, violence. Everything. You've got to find those things that are ahead of the diabetes" (Freeman & Loewe, 2000, p. 511).

Biopsychosocial Understanding of Diabetes Mellitus

An alternative to the biomedical model is the biopsychosocial model commonly used by psychologists to understand health conditions and behaviors. Broadly, the biopsychosocial model is concerned with understanding how biology, social contexts and behavior influence health and illness among individuals (Brooks & Feist, 1997). In addition, the biopsychosocial model challenges traditional disparate views of the mind and body and proposes a more tripartite view based on interaction of the physiological with psychological and social, environmental factors (Baum, Perry, & Tarbell, 2004). To that end, numerous research studies have found evidence that chronically-ill patients' beliefs concerning their illnesses predict self-care practices and outcomes (Hampson, 1997; Petrie, Weinman, Sharpe, & Buckley, 1996; Scharloo & Kaptein, 1997).These personal beliefs are referred to as illness representations, and along with personal models, serve as individual frameworks for appraising symptoms and exercising self-care practices (Meyer, Leventhal, & Gutmann, 1985). Patients use illness representations to conceptualize their own illnesses—using them to guide responses to somatic experiences and to appraise the efficacy of changes in self-care practices (Lange & Piette, 2006). Sometimes the patient's conceptualization of his/her own illness can be in sharp contrast to the biomedical framework many healthcare professionals employ in practice (e.g., it was God's will that the patient acquired DM; Hatcher & Whittemore, 2007). When incongruencies in illness conceptualizations occur, there are inherent risks that healthcare professionals will interpret a patient's self-care practice as constituting irrational behavior and thought, yet the patient is acting predictably given the patient's understanding of his/her own illness (Murphy & Kinmonth, 1995).

Although underscoring a biopsychosocial conceptualization of DM includes understanding physiological causes, DM can also be influenced by patient self-care practices and behaviors, which are heavily influenced by the patient's own beliefs about his/her DM (Freeman & Loewe, 2000). When communication between patient and practitioner is strained, barriers to effective treatment strategies for DM begin to emerge (Hunt, Pugh, & Valenzuela, 1997; Kaplan, Chadwick, & Schimmel,1985). Furthermore, poor communication and misinterpretation stemming from differences in medical term understandings, in areas of healthcare focus, and personal/professional advice pose potential barriers to effective DM management (Freeman & Loewe, 2000). Endorsing appropriate self-care practices is essential to effectively managing chronic diseases, which if not managed can have deleterious consequences. Chronic diseases result from a combination of genetic predisposition, environmental factors and poor self-care practices that complicate effective treatment among patients (Freeman & Loewe, 2000; Holt, 2004). Moreover, some researchers have suggested that practitioner attitude toward self-care practices among those suffering from DM may be more critical than their actual knowledge of the disease itself (e.g., Weinberger, Cohen, & Mazzuca, 1984), yet there is a lack of research focusing on how clinician beliefs and practices influence outcomes including self-care practices. Gaining a better understanding the complexities of the beliefs that Mexican-Americans have about DM and its self-care will require a further examination of the self-care practices Mexican-Americans use to manage their DM (Lange & Piette, 2006).

Traditional Mexican-American Understanding of Diabetes Mellitus

Historical Roots. Gaining an understanding of the ethnohistory of Mexico provides a foundation for the appreciation of the Mexican-American beliefs about health, lifestyle, and self-care practices. Individuals have populated what is now known as Mexico for over a period of 22,000 years. The Amerindian civilizations remained isolated from European beliefs for many centuries, before the Colombian exchange. These civilizations co-existed and mingled in a region known as Mesoamerica, which spanned from central Mexico to Honduras and Nicaragua during pre-Columbian times.

In spite of many ethnic and linguistic differences, Mesoamerican cultures shared a common, cultural homogeneity in several areas, and these cultural values and traditions constitute core beliefs in Mexican-Americans today. The 6 Mesoamerican cultures considered the most influential included the following: the Olmecs (i.e., the oldest American culture best known for leaving behind 17 giant stoneheads), the Teotihuacans (i.e., associated with the city-state of Teotihuacan, known for its religious, political, and economic influence throughout Mesoamerica), the Toltecs (i.e., occupied northern regions of the Mexican valley; they had a strong influence on both Mayan and Aztec cultures), the Mayans (i.e., exalted for their achievements and significant influence throughout pre-Hispanic culture; they ruled a huge empire and were well versed in mathematics, astrology, skill trading, architecture, and engineering), the Zapotec and Mixtec cultures (i.e., associated with the Valley of Oaxaca, they are known for their artistry and building skills; their culture continues to persist today and inhabit the State of Oaxaca in Mexico proper), and the Aztecs (i.e., arguably the most well-known of all Mexican ancient cultures; they had a huge empire and occupied the Valley of Mexico in what is known as present-day Mexico City; Embajada de Mexico, 2009). All of these ancient Mexican cultures displayed strong farming skills (Padilla, 1984), had a singular structure of government, and used a 365-day calendar. Furthermore, these cultures built pyramids and used similar rituals to worship gods and goddesses of the sky, nature, fertility and war and also shared similar concepts of cosmic duality (i.e., the belief that there is a beginning and an end to life; Miller, 1985).

The rich composition of what became Mexican culture, stemming from the merging of various ethnicities and religions, has greatly influenced the spiritual traditions and self-care practices across the Latina/o cultures throughout the United States (McNeill & Cervantes, 2008). *Mestizos*, a mixed-race people in the Americas, including those of African American, American Indian, Asian American, and European heritages, hold specific worldviews that impact personal behavior, including that the person is an open system interacting and learning from others; that the spiritual world holds the key to destiny, personal identity, and life mission; that a community identity and responsibility to the group are of central importance in development; and that duality of origin and life in the universe (i.e., a psychological concept derived from the cultures of Central and South America and Caribbean indigenous peoples that influenced the Nahuatl and Mayan cultures) plays a central role in personality development (Ramirez, 2004). In fact, the openness to experience and diversity reflected in these worldviews in part encouraged some level of curiosity among indigenous peoples to other ways of life and philosophies (Ramirez, 1998). This *mestizo* worldview extends from the mutual influence of the Iberian and Nahuatl cultures in the Americas through a continual process of interpretation, synthesis and transformation (Gruzinski, 2002; Ramirez, 1998). It incorporates beliefs in the supernatural, the supernatural’s activity in the natural world, the interconnection between these two planes of reality, access to the supernatural through religious and spiritual leaders, and that such supernatural activity in the natural world can be deemed miraculous. Furthermore, the *mestizo* worldview characterizes wisdom as having a sense of wholeness and an interconnectedness to self and community and self and balance (i.e., maintenance of physical and psychological well-being and an encouragement of self-care practices; Pardo, 2004).

These sophisticated worldviews that constitute Mexican-American culture have deep historical roots. When the Spanish conquistadors first encountered the tribal Aztecs, they were impressed by their highly developed civilization, which showcased advancements in architecture, medicine, farming and also public health (e.g., mental health), along with a library of medicinal herbs and their uses (McNeill & Cervantes, 2008). Furthermore, there is evidence to suggest the Aztecs described mental illness, such as insanity, in terms of an active or passive condition, influenced by biochemical agents (e.g., narcotic/poisonous green plants and fungi such as jimson weed, peyote, and hallucinogenic mushrooms) found in nature (i.e., active insanity) and the passive form which resembles what is currently described as schizophrenia, depression, and mania (Padilla, 1984). These medical conditions were treated by special healers known at the time as *tonalpouohqui*, who often endorsed practices including dream interpretation and psychotherapy. The Aztecs, much like health psychologists, conceptualized psychopathology in terms of a biopsychosocial model, although there were some differences (e.g., the Aztecs believed in a spiritual, supernatural component to psychopathology). Socially, a disturbed person was viewed as an imbalance of forces within the community which negatively impacted the weather, crops and its general welfare. Physiologically, the heart represented the core emotional center, and thus was associated with affective and behavioral functioning. Lastly, psychological dysfunction was addressed by the *tonalpouohqui* who was assigned to cure an individual of evil spirit possession (McNeill & Cervantes, 2008).

Implicit to the understanding of self-care practices among Mexican-Americans is how FTM practices have evolved over time. Early accounts by Spanish explorer Alvar Nunez Cabeza de Vaca, who was shipwrecked in 1535 in what is presently known as northern Mexico and southern Texas, demonstrate the mergence of indigenous and Spanish cultures in FTM practices. He chronicled his life during that period of time in what is known as *The narrative of Cabeza de Vaca* (Cabeza de Vaca, 2003). His adventures described complicated systems of herbal remedies and folk practices involved in physical and psychological healing (Cabeza de Vaca, 2003; Krieger, 2002). In fact, he even participated in ritual healing ceremonies that eventually became well-known for their curative powers, and, in the process gained the trust of the native people of northern Mexico and southern Texas. He wrote the following about one of his accounts in his book:

> The manner in which we performed cures was by making the sign of the cross over them and blowing on them, and praying a Pater Noster and an Ave Maria, and as best we could, beseeching our Lord God that he grant them health and move them to treat us well. Our Lord God in his mercy willed that all those on whose behalf we made supplication, after we had made the sign of the cross over them, said to the others that they were restored and healthy, and on account of this they treated us well, and refrained from eating in order to give their food to us, and they gave us skins and other things. (Cabeza de Vaca, 2003, p. 94)

Mexican-American folk and traditional medicine practices have continued in essentially the same form across time and cultural changes. Cultural elements have persistently influenced self-care practices of Mexican-Americans. Self-care practices have been influenced by personal beliefs, peers, folk healers, religious groups, and the medical healthcare system of majority culture (Kennedy, DeVoe, Ramer-Henry, & West-Kowalski, 1999). As a result, oftentimes Mexican-Americans rely solely or adjunctively on herbal and natural medicines to treat underlying medical or psychological conditions. Unfortunately, many practitioners do not ask patients about their use of these remedies when providing Western-oriented medical services.

Current Folk and Traditional Healing Systems of Practice

Traditional folk practices have been persistently utilized to meet healthcare needs of Mexican-Americans. This is particularly true among elderly Mexican-Americans, many of whom retain strong ties to indigenous values (Applewhite, 1995). Culturally-specific attitudes and beliefs among Mexican-Americans guide their use of health-related, self-care resources, yet little is known about the role of such belief systems within the context of modern healthcare practices (Burgoon & Hall, 1994).

Oftentimes, *folk medicine* is viewed synonymously with witchcraft and considered irrelevant to healthcare practice. This limited view has significantly impacted the patient-practitioner relationship and serves to promote cultural conflicts between Caucasian practitioners and a subculture of patients with alternative healthcare beliefs and practices (Creson et al., 1969). No where is this conflict more evident than at community health centers, which have seen an exponential increase in interactions between Mexican-American patients and European American practitioners over the past few decades (Smith & Money, 2004).

Given the disparate healthcare models and beliefs about the causes and treatment of health conditions of Mexican-American patients and their White practitioners, modern healthcare practice has failed to embrace culturally-appropriate approaches to meeting their healthcare needs. Currently, there is no universal system in place to evaluate and interpret the health attitudes and beliefs of Mexican-American patients in a culturally relevant way, which can leave too much room for subjective interpretation (Wing, 1998). In spite this deficiency, folk medical systems of practice have played essential roles in the lives of many Mexican-Americans and may be characterized but not limited to the following beliefs: health as harmony and balance; interrelation of body, mind, and spirit; magical or supernatural elements; thoughts and emotions as etiological factors; positive and negative energies; transference of energies; meaning of illness (i.e., how an individual conceptualizes his/her illness. These folk medical systems have persisted for generations, have deep historical roots, and continue to influence self-care practices among Mexican-Americans (O’Connor & Hufford, 2001).

Understanding Mexican-American folk medicine requires a comprehension of concepts of Mexican-American folk illnesses. The most commonly identified Latina/o folk illnesses include *susto* (i.e., soul loss resulting from a traumatic experience), *mal de ojo* (i.e., the evil eye; observed as a strong vision of admiration of someone else’s child without touching him or her; the child is thought to fall ill because of an evil force or power that was transmitted through an intense gaze), *empacho* (i.e., food sticking to the stomach walls, *nervios* (i.e., nerves), and *caida de mollera* (i.e., fallen fontanel; see Chavez, 1984, Rubel, 1998, Trotter, 1998). Of the folk illnesses listed above, *susto* has been linked to DM in Mexican-American folk medical systems.

Within a framework of a folk medical system, folk illnesses are understood as illnesses “that have no apparent equivalent in bioscience…in that their clusterings of signs and symptoms do not conform to bioscientific diagnostic categories” (Browner, Ortiz de Montellano, & Rubel, 1988, p. 684). In the biomedical model, folk illnesses tend not to be pathologized but rather deferred to psychological terminology (i.e., reducing sickness to categorical, diagnostic, psychological terms such as depression and anxiety), adding to the complexities associated with separating disease processes from the cultural responses to them (Rubel, 1984). Moreover, there is a persistent belief that psychotherapy, religion, and folk healing share valued roles in the therapeutic process (Csordas & Kleinman, 1990). Perhaps the most rewarding approach to understanding folk illnesses is to seek a sociological and biological link (Rubel, 1984), but research has yet to uncover such associations.

In a break with a long-standing tradition of exclusion, the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) now includes a relatively new diagnostic category, “Religious or Spiritual Problems,” under “Other Conditions that May Be a Focus of Clinical Attention.” (American Psychiatric Association, 2000, p. 675). This represents the first time the DSM has acknowledged distress associated with religion and non-pathological problems (Turner, Lukoff, Barnhouse, & Lu, 1995). Use of this diagnosis (i.e., V62.89) is indicated when the focus of clinical attention extends from a religious or spiritual problem. Some examples include “distressing experiences that involve loss or questioning of faith,” and “questioning of spiritual values” (American Psychiatric Association, 2000, p. 685). Moreover, the DSM-IV highlights culturally-bound illnesses such as *susto* (i.e., fright or soul loss). *Susto* is described as a “folk illness prevalent among some Latinos in the United States and among people of Mexico…*Susto* is an illness attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness…and may appear any time from days to years after the fright is experienced” (American Psychiatric Association, 2000, p. 848). Perhaps the inclusion of this diagnostic category will enhance awareness among practitioners of the clinical importance to elicit Mexican-American patients’ health beliefs about DM in an effort to bridge the gap between models used to understand DM.

Current Self-care Practices of Diabetes Mellitus Among Mexican-Americans

Research on poor adherence or non-adherence to self-care practices focuses on the knowledge-base, motivation, and psychological characteristics of patients (Hunt et al., 1998). While many studies investigate the reasons why patients fail to do what they should be doing to manage their DM and provide suggestions for increased motivation for behavior change, other studies examine actual patient practices and their rationale for such behaviors (e.g., Freeman & Loewe, 2000; Hunt et al., 1998). Effective management of DM has been a challenge for many individuals because of the difficulties associated with managing a disease whose course can be decades long (Hunt et al, 1998), and failure to comply with treatment recommendations has been reported as a serious and widespread problem throughout the US (Hunt et al., 1998). Inherent to the practice of effective management are behavioral changes on the part of the patient that promote improved self-care behaviors. To that end, numerous studies have addressed the issue of poor management of DM among patients and have suggested strategies to enhance self-care behaviors, including improved education and treatment strategies (e.g., Kennedy et al., 1999; Thompson et al., 2007; Wissow, 2006).

Studies examining the poor self-management of DM among Mexican-Americans have often focused on cultural characteristics, including *fatalismo* (i.e., the belief that events are predetermined and individuals have little control over the outcomes; Lange & Piette, 2006) and locus of control (i.e., defined in health psychology literature as perceived control or the extent to which one believes they can control events in their lives, including health; O'Hea et al., 2009). Many models for adherence have focused on psychological characteristics that determine self-care behaviors and practices (Hunt et al., 1998). However, there is a paucity of research examining the impact of folk and traditional beliefs on the self-care practices or the motivation to use self-care practices among Mexican-Americans living with DM.

Curanderismo as a Resource Among Mexican-Americans

Curanderismo, or folk healing, is associated with the treatment of a variety of both physical and psychological ailments with a combination of herbs, religion and psychosocial interventions. Curanderismo evolved from Western European medicine (i.e., pre-Columbian medicine) and early Aztec civilizations (Applewhite, 1995; Krajewski-Jaime, 1991), based on a perception that healing is an art that integrates culturally-appropriate methods of treatment and uses recognized healers as vessels to deliver services. Curanderismo also capitalizes on a patient's faith and belief systems in the process of treatment: beliefs in natural and supernatural illnesses, connections to the spiritual world, and views that the divine has a principal role in everyday life (Applewhite, 1995).

Folk healing, however, should not be confused with withcraft, the worship of saints (i.e., *santerismo*), or concern with things of the spirit (i.e., *spiritism*). Spiritism, associated primarily with Puerto Ricans, involves the belief that an invisible spirit world is in communication with human beings on Earth. Sometimes they become embodied as human beings, while those who remain disembodied communicate either positively or negatively with human beings on Earth through mediums or individuals who have developed *facultades spirituales* (spiritual faculties; Krajewski-Jaime, 1991). Implicit to a discussion of folk healing practices are that individuals from different cultures may present with different views of illness, some who view illness as an imbalance of forces (e.g., hot/cold theory, which among Mexican-Americans relates to the idea that a disproportion of hot or cold will lead to illness; Bellack & Edlund, 1992) or as being influenced by unseen forces such as spirits, demons, hexes or curses (Hallenbeck et al., 1996). These variable, cultural perspectives lay a foundation from which individuals appraise and evaluate personal illness and also provide the impetus for purposive action (e.g., endorsement of self-care practices; Hunt et al., 1998; Thompson et al., 2007). Particularly noteworthy are research studies suggesting that a majority of Mexican-Americans (i.e., approximately two-thirds) use some form of FTM practice (e.g., meeting with curanderos, who are folk/traditional medicine healers in Latin America dedicated to curing both physical and spiritual illnesses) to treat chronic illnesses such as DM (Hunt et al., 1998). Curanderos often fill this role for many Mexican-Americans who believe that *susto* is either the primary cause or one of many causes of DM and, by extension, are also involved in the successful management and control of DM (Flaskerud & Calvillo, 2007).

Susto and Diabetes Mellitus

Mexican-Americans who suffer from DM often attribute *susto* as the causative agent (Coronado, Thompson, Tejeda, & Godina, 2004; Flaskerud & Calvillo, 2007; Jezewski & Poss, 2002). *Susto*, or Spanish for "fright," is a colloquial term deeply rooted in Mexican-American culture. It is used to describe a state of "fright sickness" (i.e., an immediate feeling of acute fear and anxiety) with compelling psychological undercurrents. Today, the term persists as a reminder that folk illnesses continue to embrace many cultures throughout the world in spite of or even because of its lack of universal understanding (Baer & Penzell, 1993; Flaskerud & Calvillo, 2007).

While there is a paucity of research on *susto*, previous studies have focused on its social, epidemiological, public and community health characteristics, along with its relationship with toxicants and other health related conditions (Baer & Penzell, 1993; Trotter, 1991). These studies have highlighted a significant fact—that disparities exist between the biomedical model of diseases and Mexican American health beliefs. In fact, as a folk illness, *susto* establishes implications for anthropological work, which include "1) a person suffering from a folk illness manifests symptoms recognizable by his culture as a type of illness, regardless of different interpretations of the condition made from the perspective of another culture, including the biomedical culture; 2) the causes of the illness, in whole or in part, is regarded as supernatural or magical by the people who recognize it or as resulting from causes to be unique to the culture; 3) within his own cultural context, the patient is treated differently by others and in turn is expected to behave differently toward others, on the basis of a sociocultural definition of his condition. The healthy role gives way to the sick role; and 4) disease categories classed as folk illnesses are not given recognition as bona fide conditions by Western medicine." (O'Nell, 1975, p. 42). The curandero's role in treating *susto* is to revive an individual's spiritual essence by recombining their soul with their physical body (Applewhite, 1995). In theory, this intervention should help patients suffering from DM improve their condition while also encouraging improved self-practices (e.g., self-management) and control (Flaskerud & Calvillo, 2007).

Prevalence, Course and Treatment

While *susto* can impact anyone at any age, it tends to affect more women than men (Baer & Penzell, 1993; Flaskerud & Calvillo, 2007) and its community prevalence may be as high as 50% among Mexican-Americans living in Texas and Mexicans (Weller et al., 2002). Current beliefs about *susto* among many Hispanics put it at odds with traditional beliefs, which associate *susto* with "soul loss" (Glazer, Baer, Weller, Garcia de Alba, & Liebowitz, 2004). Historically, *susto* has been defined by the work of *curanderos* who perform the rituals for many who suffer from folk illnesses such as *susto.* Today, however, there appears to be two different views about *susto.* The old view, held by less acculturated (and typically older) Mexican-Americans, contends that the soul is separated from the body during a frightening experience and that this separation leads to an imbalance of forces, a deterioration of one's spiritual essence, and a decline in physical health (i.e., the onset of DM among Mexican-Americans). The new worldview continues to embrace a large piece of the old worldview, but those who are more acculturated (and often younger) are increasingly reluctant to fully endorse *susto* as the sole cause of physical decline (i.e., the onset of DM) and less likely to subscribe the view that *susto* actually involves a separation of the soul from the physical body. Instead, more acculturated Mexican-Americans are more likely to implicate biomedical reasons for the decline in physical health (Castro & Eroza, 1998; Flaskerud & Calvillo, 2007; Glazer et al., 2004; Trotter & Chavira, 1997). Comparing the two worldviews, it is important to note that "fright" exists in both models. However, in the old worldview, the soul is believed to be separated from the body, whereas in the new worldview it is possible that the soul remains in union with the body but may somehow continue to negatively impact the health of an individual.

When asked about whether they believed if *susto* was an illness, 87% of Mexicans and 85% of Mexican-Americans living in Texas agreed that it constituted consideration as an illness (Weller et al., 2002). However, traditional versus more acculturated beliefs about *susto* appear to vary by location (i.e., urban vs. rural), age, and level of education. For instance, those living in Mexican rural areas were more likely to characterize *susto* in both emotional and physical terms, whereas those living in urban areas were likely to use descriptive terms based on only emotions; moreover, those living in rural areas were more likely to try remedies to cure them of *susto* as compared to those living in urban settings, who preferred to "do nothing, relax, wait" (Glazer et al., 2004; Trotter, 1991). Age and education were related to *susto* such that those who were older and less educated were less likely to attribute *susto* to "soul loss." While there were no differences between men and women in reporting having heard of "soul loss," women were nearly 1 ½ times more likely to associate *susto* with "soul loss." And among those who were asked to describe "soul loss" differences were also noted between those who had *susto* and those who did not have it, such that 58% those who had never experienced *susto* thought "soul loss" was either part of *susto*, associated with depression or related to a wandering soul;

on the other hand, those who had experienced *susto* personally tended not to associate "soul loss" with *susto* but rather as part of the death experience or also related to a wandering soul (Glazer et al., 2004).

Treatment for *susto* varies among regions, but there is some overlap among treatment options. Consistent within the literature is the idea of performing a *barriada* or an effective "sweeping" of the body to rid it of *susto*. During this ceremony, prayer is almost always performed in conjunction with the *barriada* by a *curandero*. The afflicted individual's body is often "swept" with fresh herbs or even an egg and sometimes sugar or sugar water (Glazer et al., 2004). In some instances the ceremony is performed just once, while other times it is performed repeatedly until the illness subsides completely. Oral remedies are equally variable by region (e.g., some regions such as south Texas are replete with ingredients, such as cacti, that are used in tea remedies to treat DM) and often include teas made from brazil wood, orange blossom and marijuana that are used to treat *susto* (Glazer et al., 2004). As McNeill and Cervantes (2008) describe, "natural ailments are seen as being in the realm of God or good spirits, and unnatural ones as being the result of evil spirits of the devil…consistent with a culture with a collectivistic orientation that values smooth interpersonal relationships,…most of the folk illnesses are closely related to social relationships and are connected with faulty interpersonal relations" (p. 284).

Comparing FTM with Biomedical and Biopsychosocial models: Implications for Self-care of DM

A clear difference between biomedical and FTM models is the curative process (i.e., a positive physiological response stemming from medical treatment) endemic in biomedicine and the healing process (i.e., the body is designed to heal, and the term *healing* begins with a holistic view of the mind and body; the capacity to heal is related to the psychological and physiological fortitude one brings to an encounter with illness) more prevalent in FTM (Berlin & Fowkes, 1998). Furthermore, in biomedicine, health is almost always disconnected from social relationships, which is not the case with FTM. Biomedicine aims to target the mechanistic process of injury or harm to the body on an organ or cellular level (McNeill & Cervantes, 2008). FTM practices are more holistic (i.e., focus on more broad-based illness experiences), whereas biomedicine tends to target specific, physical areas of inquiry and distress (i.e., physical symptoms). Inherent with the practice of FTM is the involvement of the patient with "metaphysical entities....which requires a process of understanding the underlying rationale for the appearance of illness in the body" (McNeill & Cervantes, 2008, p. 260). Diseases are natural events that are described by variable languages across cultures. Sometimes, however, the language meant to describe the disease is limited by descriptors inherent to specific languages. As a result, an understanding of the intricate nature of the disease is further complicated by the drive to describe it in the dominant form of thinking specific to the population within which one is immersed (McNeill & Cervantes, 2008).

When conceptualizing the role of *susto* among Mexican-Americans suffering from DM, there are clear differences in the assessment, treatment, and management of *susto* using FTM and biomedical models. FTM models are equipped to assess symptoms not often assessed during routine biomedical interviews, such as anxiety, worry and sadness. Moreover, a social/family history and a history of stressful life events aimed at revealing the fright (e.g., traumatic events) are essential components of inquiry in FTM consultations (Flaskerud & Calvillo, 2007). It is often during FTM consultations as opposed to biomedical consultations that a history of self-care practices (i.e., treatments), home remedies, or FTM practices are established (Latham & Calvillo, 2007). Given what are often deeply engrained cultural beliefs inherent in FTM practices among Mexican-Americans, the use of herbal or alternative therapeutic remedies to treat both psychological and somatic problems appears to be an appropriate and releveant self-care practice for Mexican-Americans (See Table 1). In contrast, the biomedical model, in its current form, is not equipped to effectively manage and incorporate the cultural beliefs and preferences of Mexican-Americans suffering from DM (Flaskerud & Calvillo, 2007; Latham & Calvillo, 2009).

Similar to the FTM model, the biopsychosocial model is more global in scope. Both are broadly concerned with understanding how biology, behavior and social/cultural contexts influence self-care practices among Mexican-Americans suffering from DM (Brooks & Feist, 1997; Kennedy et al., 1999). Both FTM and the biopsychosocial models challenge the Western biomedical view that distinguishes between mind and body (i.e., psych and soma) and discounts traditional and cultural health beliefs that may be in conflict with such ideology (Latham & Calvillo, 2009). The FTM and biopsychosocial models acknowledge the potential disconnect associated with poor communication and misinterpretations between Mexican-American patients suffering from DM and their healthcare provider (Freeman & Loewe, 2000). Additionally, both models understand the importance of self-regulation of behaviors required to maintain proper and essential self-care practices in the management of DM (Thompson et al., 2007). However, while the biopsychosocial model is equipped to effectively manage DM, its efficaciousness is contingent on the broad cultural knowledge of competent psychologists. Arguably, the field of psychology fails to meet the standard required to deliver culturally-competent and appropriate treatment to Mexican-Americans suffering from both *susto* and DM—in large part due to the dearth of empirically-based, culturally-relevant research offering guidance to the practicing psychologist (Lubkin & Larsen, 2002).

Perhaps it would be sufficient to understand and negotiate between the truths inherent in each model. However, based on the evidence presented thus far, the FTM and biopsychosocial models appear most compatible at promoting a better understanding and negotiation of self-care practices and improved DM management among Mexican-Americans. Not one stand-alone model can effectively deal with the complexities inherent with illnesses that transcend the physical realm, such as *susto*. For example, given the chronicity of DM, the biomedical approach is essential in managing glycemic levels and any physical complications that may arise from poor self-management of DM among Mexican-Americans (Flaskerud & Calvillo, 2007). Best practices demand that healthcare professionals recognize that individuals draw simultaneously from various health systems—using this information to guide self-care practices in a complimentary as opposed to competing fashion (Hunt et al., 2000).

Clashing Models and Self-care: The Practitioner-Mexican-American Patient Encounter

Medical practitioners use biomedical science to explain disease processes. Their role in a professional setting with a patient is to evaluate, diagnose and disseminate information (including self-care behaviors necessary for maintenance or improvement) to the patient about their illness. In contrast, individual patients use a variety of sources (e.g., friends, folk healers, religious groups, and the medical healthcare system) to guide their level and practice of self-care behaviors (Kennedy et al., 1999). Sometimes, medical practitioners' focus on science competes with an understanding that patients are also cultural beings with cultural roots. This lack of awareness may lead to a decrease in practitioner-patient collaboration and minimize the potential positive impact of the encounter (Hatcher & Whittemore, 2007).

An encounter with a patient suffering from *susto* can have serious implications among professionals who are unfamiliar with its construct. Current research highlights interpretive differences between medical professionals and Mexican-Americans concerning folk and traditional illnesses, such as *susto*. For example, healthcare professionals in meetings with patients highlighted health issues and consequences. In contrast, Hispanic patients emphasized both psychosocial and quality of life domains (e.g., cultural (family support), religious, emotional) related to their illnesses (Coronado et al., 2004; Hatcher & Whittemore, 2007). A more culturally sensitive interpretation of DM and its link to *susto* may elicit positive health outcomes among Hispanic individuals by impacting the mismanagement, disappointment with current level of care, responses to treatment and misunderstandings related to healthcare directives (Hatcher & Whittemore, 2007).

Explanations about the etiology of diseases like DM among the Hispanic community must be delivered in the context of cultural beliefs about FTM practices. *Susto* is a striking example of how cultural beliefs can impact sickness attributions and self-care practices (Glazer et al., 2004; Hatcher & Whittemore, 2007). In fact, many Hispanics believe that *susto* lies dormant in their bodies and is at risk of being activated given an encounter with a significantly frightening or startling event. The trigger is thought to occupy both positive and negative emotional valences, such as joy, fear, sadness and depression (Hatcher & Whittemore, 2007), while eliciting potential symptoms such as dizziness, diarrhea, insomnia, goose bumps, fatigue, feeling faint and muscle tics (Poss & Jezewski, 2002).

Poss & Jezewski (2002) reported in their study examining the role and meaning of *susto* among Mexican-Americans suffering from type 2 DM that the onset of *susto* can occur many years after the initial exposure to the frightening or startling event (e.g., one individual reported a precipitating event that occurred 20 years prior to her diagnosis). Statements highlighting Hispanics' beliefs about the role of *susto* as a culturally-bound etiological agent included those such as "I got diabetes because a child drowned in front of me and from that time is when I started with diabetes. I believed that is why I got diabetes because of that fright" (Poss & Jezewski, 2002, p. 370). Individually-based susceptibility was also reported, and temperament was listed as a causative agent among Hispanic individuals (Hatcher & Whittemore, 2007). Being strong and young and even strong and overweight are seen in curanderismo as protective factors in Mexican-American culture. As one Hispanic individual put explained, "Sometimes the body may endure many terrible things and at other times it won't. For example, two people eat the same food and one gets sick and the other doesn't. Why is this? Because the one that got sick had a predisposition at the time to get sick, and the other had more resistance to disease at that precise time" (Poss & Jezewski, 2002, p. 370).

From a patient-provider perspective it may be worthwhile for providers to ask questions which may elicit more culturally-sensitive information about Hispanic adults' beliefs about their illness in order to provide the best quality of care possible. However, this is a barrier between the practitioner and patient that is recognized within the research literature (e.g., Freeman & Loewe, 2000). Questions practitioners could ask to enhance the collaboration between the patient and themselves may include “Do you believe in *susto*? If so, did you experience it? What happened? Did God play a role in causing your illness?” (Hatcher & Whittemore, 2007, p. 542). Do you use any healing techniques to help manage your illness? How has God helped you in managing your illness? These are just a few examples of some questions which may elicit important information from the Hispanic patient. In order to attain a high level of competent healthcare practice, it is imperative that healthcare providers remain informed of the various cultural practices, rituals and beliefs of those individuals who seek their services in order to optimize the quality of their healthcare practices.

Many individuals of different cultural backgrounds use both Western biomedical therapies and folk and traditional medicine practices in the US. Moreover, the FTM and biomedical models both offer little investigation concerning which remedies are more efficacious and also fail to provide a clear understanding of each remedy’s mechanism of action. Promoting an increased understanding of folk and traditional medicine use and their contributions to healthcare (i.e., self-care practices) of an individual can incrementally improve the overall disposition of responsible, efficacious, and culturally-sensitive healthcare practice. It is imperative that healthcare providers understand the clash of models about causation, treatment and medications (and herbs) and how this can impact how an individual conceptualizes their own case of illness or disease. Healthcare professionals could benefit from knowledge of the three health belief system model perspectives discussed in this paper to develop culturally-congruent and appropriate healthcare plans to treat DM and *susto*. These models could guide healthcare professionals to understand and communicate more effectively with Mexican-American patients as they attempt to negotiate Western biomedical models about DM, self-care practices.

Gaps in the Literature

There is a paucity of research on the FTM and self-care practices of Mexican-Americans suffering from DM. Further research is needed to explicate the effects of ethnicity on self-care practices and misconceptions that can have an adverse affect on patients' physical and psychological well-being. One theme encountered while reviewing the literature on Hispanics' FTM practices was the inconsistency by which ethnicity was assessed (e.g., Mexican-American, Hispanic, Latino, Chicano). In addition, acculturation level of minority ethnic groups was often unmeasured. It is important to denote what is meant by label terms given that cross-comparisons sometimes provide less significant findings when comparing Mexicans residing in their native land to those that have been acculturated to American value systems, for example (Levers, 2006; Marks, 2006; McNeill & Cervantes, 2008).

One important methodological issue regarding the patient-practitioner relationship, given the qualitative methods used to procure information, centers around language. Among Mexican-American patients, for example, fluency in Spanish or access to excellent interpreters and translators are essential for ensuring the veracity of collected information from an interview with a patient. In fact, many Mexican-American patients prefer to use Spanish even when their English is proficient, thereby enhancing the possibility of miscommunication and misperception between the Mexican-American patient and the White, English-speaking practitioner/interviewer. Furthermore, the accuracy of translated, written materials remains a concern when collecting data from these individuals.

Studies also demonstrated a lack of consensus on conceptual definitions and operational definitions of key concepts such as health beliefs, illness/sick role behaviors, attitudes and culturally-congruent or appropriate healthcare (Applewhite, 1995; Krajewski-Jaime, 1991; Feldmann, Wiemann, Sever, & Hergenroeder, 2008; Poss, & Jezewski, 2002). These studies provided an introduction to folk belief systems and traditional perceptions of illness and disease management. However, additional research is needed to estimate the prevalence of employment of and efficacy for folk and traditional medicine practices in terms of their impact on health outcomes, specifically DM and its link to *susto*.

The healthcare management of Mexican-Americans living with DM often requires balancing many factors (e.g., spiritual, psychological, physical (increase physical activity/adhere to dietary regimen)) to maintain some degree of wellness. Longer anticipated life spans are anticipated to tax limited resources as estimates suggest more individuals will be living with chronic conditions in the future. As a result, understanding chronic illnesses that differentially impact Mexican-American populations by age, such as DM, and how these individuals conceptualize their illnesses to guide self-care practices and treatment is critical toward a more efficacious collaboration between psychology and biomedical practices (Lubkin & Larsen, 2002).

The biopsychosocial model conceptualizes illnesses using five characteristics. These include their diagnosis and symptom manifestation, their consequences, their biological or psychosocial causes, their duration, and their management or potential for a cure (Sperry, 2006). Interpretation of these symptoms is the first step in the formulation of an explanatory model of illness, and this process involves both a cognitive component (i.e., threat appraisal) and an emotional component (i.e., anxiety, fear). In fact, the FTM, biomedical, and biopsychosocial models all require that an individual navigate through a process of evaluation and interpretation of their own symptoms and illnesses. Following an evaluative and interpretive process of their symptoms and illnesses is a coping process, which requires an individual to evaluate information, formulate expectations, make decisions, and effectively modulate emotions aroused by the threat appraisal (Brannon & Feist, 2000; Sperry, 2006).

Conceptualization models of illnesses can be obtained from individual patients, their families, and healthcare professionals. Each model is essentially a case conceptualization (i.e., a story) based on an individual's perception of their own illness or that of another individual. FTM and self-care practices are guided by how an individual interprets his/her illness (Hatcher & Whittemore, 2007). For example, if a Mexican-American individual believes his/her *susto* caused his/her DM, it is possible that he/she may fail to endorse biomedically-relevant self-care practices because there is no logical explanation for linking curative biomedical practices with FTM practices. For other Mexican-Americans, combining biomedical and FTM strategies to combat the deleterious effects of poorly managed DM may prove beneficial. Still others may endorse a fatalistic view of *susto* (i.e., God's will) and fail to practice any self-care strategies to improve their health condition—thereby leaving his/her fate to chance. Unfortunately, research has failed to outline a rationale for such approaches in self-care practices among

Mexican-Americans suffering from DM. As a result, more research is needed along this area of inquiry.

Narrative Theorizing

“People tell stories not just to work out their own changing identities, but also to guide others who will follow them” (Frank, 1995, p. 17). They are natural storytellers who use stories as a way to give meaning to experiences (Frank, 1995). These stories or narratives serve as a way for individuals to communicate knowledge, feelings, values, and beliefs on a particular subject (Burke, 1969) and also provide a mechanism by which human beings can cope with the rigors of everyday life (Carabas & Harter, 2005). The task of communicating what we know, feel, believe, or value can vary in difficulty. With continuous fluctuation of stability and change, we inevitably have to come to terms with variations in value and belief systems, knowledge, and perceptions of self and the world within which we live (Burke, 1984; Frank 1995). Telling stories in essence allows us to come to terms with or make sense of these variations. In fact, storytelling is critical in the process of sense making, allowing individuals to cope with chaotic, obscure, and confusing conditions of everyday life (Carabas & Harter, 2005). How we negotiate these conditions is influenced by our level of physiological and psychological functioning (Yalom, 1998). Moreover, because stories serve as narrative frameworks within which we make our experiences meaningful, one of the primary functions of storytelling is to negotiate and mediate the plots we co-construct with others (Carabas & Harter, 2005). We use narratives not only to make sense of experiences but also as a platform from which to express our multiple identities (Langellier & Peterson, 2004).

Implicit in enhancing our understanding of human behavior is comprehending human construction and use of symbols in times of suffering or crisis. Although we variably negotiate responses to environmental stimuli, we use symbols within an already constructed social setting to guide these responses. However, these responses are not necessarily guided by the specific vocabulary of the cultural group into which we are born. Rather, we identify certain relationships as being more meaningful than others and use our interpretations of these relationships to reframe our perceptions of reality (Burke, 1984; Frank, 1995). While humans use self-perceived, normative patterns to guide their lives, change is the catalyst for much learning. We humans are well-versed in negotiating flux and change and are continuously striving to maintain some form of stability within the chaos that is everyday life. Although complete stability or balance will never be attained, developing an efficacious communicative style may help negotiate positive changes (Burke, 1954; Harter, Japp, & Beck, 2005a).

Storytelling or narrativity connects the self to both others and the persona of the storyteller (Carabas & Harter, 2005). It is as much for others as it is for oneself (Frank, 1995). It allows us to come to terms with the chaos and uncertainties in our lives and helps us create or recreate patterns of stability within it (Burke, 1984). In this sense, narrativity asks that we shift beyond deductive, scientific interpretations of the world and authenticate storied human experiences. From a psychological standpoint, there is a need share stories that describe our experiences because the process of creating stories also creates a memory structure that will contain the meaning of the story for the rest of our lives; in essence, talking is remembering, and remembering allows us to engage in conversations that help us make sense of ourselves and of the world in which we live (Carabas & Harter, 2005).

"There is no such thing as an intuitively obvious and essential self to know, one that just sits there ready to be portrayed in words. Rather, we constantly construct and reconstruct our selves to meet the needs of situations we encounter, and we do so with the guidance of our memories of the past and our hope and fears for the future" (Bruner, 2002, p. 64). Narratives, as the storied expressions of human experiences, recognize the multiple telling and retelling of events. These narratives navigate between an inner world of thoughts and feelings and an outer world of observable actions and behaviors. In fact, meaning lies in the interface between stories rather than the mind or the words of the individual storyteller. The storyteller in this sense is a co-constructor or co-author of the narrative, much like the stories reflected in medical settings between patients and practitioners (Geist-Martin, Ray, & Sharf, 2003; Harter, Japp, & Beck, 2005b).

A single, unified story is a myth. Experiential narratives are constellations of individuals' experiences—recognizing individuals' struggles with abiding tensions and concerns (Harter, Japp & Beck, 2005b). These tensions and concerns are not disparate events that occur outside individual experiences. Rather, multiple and sometimes divergent narratives become evident as stories converge and collide with each other (Boje, 2001). These stories represent an open-ended opportunity to learn from and reflect upon multiple events in one's life while deepening and accentuating narrative meaning. Narratives "acknowledge the diversity of stories lived and told and develop constructive ways of weaving the differing stories together to create new ones" (Barge, 2004, p. 109). As such, they become the primary means by which we negotiate our way through the complexities of life and our ever-changing identities—requiring a deeper level of inquiry into the matrix of relationships between ourselves and these complexities (Geist-Martin et al., 2003; Harter, Japp, & Beck, 2005b).

Narrative Discourses of Health and Illness

Each day we live between dualities of wellness and illness and embodiment and disembodiment (Geist-Martin et al., 2003). These dualities are negotiated by an individual's available resources for self-care practices. In clinical settings, western medicine models have consistently reduced the diversity of suffering among individuals to that of a general, unifying model of clinical medicine—one which claims the voice of the sick individual and fails to encourage an exploration of what illness may represent to them (Frank, 1995). This medical model often constricts an individual's ability to fully describe their experiences. It has resisted or has been unwilling to modify its inability to accurately account for symptoms that have no etiologic basis (Japp & Japp, 2005). As a result, individuals who are ill continue to surrender their bodies to medicine, and in turn, their voices are silenced (Frank, 1995; Harter, Kirby, Edwards, & McClanahan, 2005). However, for many, there is a desire to hold on to their own storied experiences. In such cases, refusing to surrender stories becomes an activity of reflexive monitoring and thus an exercise of personal responsibility (Frank, 1995).

As Frank (1995) explained, "the body is not mute, but it is inarticulate; it does not use speech, yet begets it. The speech that the body begets includes illness stories" (p. 2). These stories take different stylistic body forms based on the cultural influences of different populations. Yet, at any one time the body often finds itself immersed in different cultures, expressing complex, mutual relationships between the body and culture. Kleinman & Kleinman (1994) describe these complexities as infolds and outfolds. "Symptoms of social suffering, and the transformations they undergo, *are* the cultural forms of lived experience. They are lived memories. [Symptoms] bridge social institution and the body-self" (p. 716). These symptoms are the infolding of cultural suffering and distress into the body. As these bodies interact with the environment and create a history of experiences, these symptoms outfold from the body and into the social space of that history (Frank, 1995).

As bodies, cultures, and lives interweave to create storied experiences, individuals use these stories as an opportunity to provide testimony to their experiences and also to enhance connectivity to others (Frank, 1994; Japp & Japp, 2005). Their stories forge connections to other individuals and his or her world and reflexively provide insight into one's own world (Japp & Japp, 2005). For those who are ill, their wounds exert a form of narrative power; they are wounded storytellers. Their experiences are embodied as a result of the physical manifestation of illness (Frank, 1994). Although those suffering from illness are often wounded in body and voice, they become storytellers to recover the voices that illness and its treatment often take away. These embodies stories often have two sides—one personal and one social (Frank, 1994; Sharf, 2005). However, given the broad influence of the biomedical model within the U.S., the medical narrative often trumps all others. As a result, those suffering from illness are compelled to endorse a biomedical model which endorses medical care and treatment for illnesses (Zoppi & Epstein, 2002). The obligation of seeking medical care results in narrative surrender or the submission of an individual's storied experiences to biomedical descriptors of illness (Frank, 1994).

Sometimes, biomedical descriptors of illness are insufficient. For many individuals, the description of illness from a biomedical model fails to capture the complexities of individuals' experiences as human beings. (Japp & Japp, 2005; Zoppi & Epstein, 2002). Moreover, in medical settings, when biomedical evidence is nonexistent, healthcare practitioners tend to believe the origin of patients' symptoms must be psychological in nature. A dualistic view by medical culture posits that people can control their mind but are at the mercy of their body. Yet, this explanation creates an impasse between dueling viewpoints (i.e., dualistic vs. monoistic views of mind and body) and can lead to self-doubt and alienation for the patient (Japp & Japp, 2005).

In his book entitled *The Wounded Storyteller,* Arthur W. Frank (1995) discusses narratives individuals commonly use to give meaning to illness experiences. The most common is the restitution narrative, where individuals who are ill are restored to perceived, ideal functioning through a process of treatment and healing. Another type of is the chaos narrative, the equivalent of narrative wreckage, where an individual remains in a state of suffering (i.e., their voice is lost or has been taken away) and disrepair unless their illness is redefined as a treatable condition. It is at that point that the restitution narrative is restored. Lastly there is the quest narrative, which describes how an individual who is suffering accepts the experience of illness as the beginning of a journey in which his or her voice can story the experience of illness and restrain chaos. The restitution, chaos, and quest narratives are presumably integral parts of the Mexican-American experience with DM, *susto,* FTM and self-care practices and serve to frame and describe phenomena while providing access to agency and voice to those who identify but are not consumed by illness.

Narrative Discourses of Diabetes Among Mexican-Americans

While some research has examined the quantitative and qualitative experiences of diabetes among Hispanic and Latino populations as a whole (e.g., Garcia, 2008; Hunt et al., 2000; McElmurry et al., 2009; Parchman, Flannagan, Ferrer, & Matamoras, 2009; Thompson et al., 2007), qualitative studies exploring narrative discourses of Mexican-Americans living with DM require a more exhaustive search in the literature. Although studies identifying traditional Mexican-American health beliefs and explanatory models within the context of DM are available for review, there are a few specific components that are consistent across these studies. In fact, there are certain beliefs and approaches to illness that are shared, even across many different Hispanic communities. For example, many believe that DM is hereditary and that diet and/or an imbalance of emotional states can impact its development and course (Hunt et al., 1998; May & Rew, 2010), while others find difficulty accepting DM as part of their personal identity as evidenced by the following narrative excerpts from a study by McEwen, Baird, Pasvogel, and Gallegos (2007):

> Well, for me it was very difficult to accept that I have diabetes…It was difficult to recognize this as an illness and I am going to have it for the rest of my life and I am learning how to eat…It took a lot for me to say this problem, but it is the truth…When I was told I had diabetes, it was hard to admit until after a year. I think that is when I started to take it more serious…I am conscious about 80% of the time that I have diabetes and if I do not take care of my diabetes, it is not going to lead me to nothing good (p. 208).

Another consistent finding in DM research among Hispanics is the bridge between historical behavior patterns or genetic predispositions and current health functioning. For instance, Hunt, Valenzuela, and Pugh (1998) performed an ethnographic study of Mexican-Americans with DM and found that participants sought to link their disease in an immediate and specific way to their personal history. For example, one Mexican-American individual said, “We all have it. It’s just that it hasn’t developed in most. Cancer too. I know that we all have it, all of these illnesses, but they haven’t developed in some as they have in others. You have to have traumas (choques), operations, things like that, for these illnesses to come out” (p. 961). Another stated, “You might work all night and in the morning you go and drink, gamble until all hours of the afternoon, and then go take a shower and change clothes without no sleep. So this is what leads you to getting like this, they say. It’s not good not getting your proper sleep, not eating your proper meals, staying out, drinking and partying too much” (p. 961). And yet another explained, “It was the medication that they gave me in the hospital for atrial fibrillation. Ever since then, they began to read the diabetes in my blood. It was a chemical reaction. Whatever they gave me mixed in with my system and threw everything off. That, and I would say, maybe the beer was the one that caused it and stress. I really was going through a lot of stress” (p. 962).

While many studies have found that cultural beliefs about DM among Hispanics are often in agreement with the Western biomedical model of illness, there are next to none which has addressed the issue of *susto* as the cause of DM among Mexican-Americans. Moreover, although research has described various treatment strategies for DM among this special population (e.g., pharmacological medications, folk remedies), no study has outlined a rationale for these (or other) approaches in self-care among Mexican-Americans by exploring the intersection of storied experiences with DM and *susto* and the frameworks of treatment strategies (i.e., biomedical, biopsychosocial, and/or FTM) one may use to navigate through such experiences. This study aims to elucidate these gaps in the literature.

Research Questions

The current proposal offers a novel approach to document the complexities associated with DM among Mexican-Americans. It seeks to explore associations and interpretations of FTM and self-care practices among Mexican-Americans with DM. Folk illnesses, such as *susto*, highlight the need for an integration of mental and physical healthcare. Furthermore, it stresses the expertise required to appropriately and effectively deliver healthcare services to Mexican-Americans suffering from DM and effects of *susto.* Although an understanding of and adherence to conventional self-care practices among Mexican-Americans suffering from DM may be less than optimal, this proposal provides a framework from which a research study with the goal to enhance the understanding of this phenomenon and potentially influence outcomes can be devised. Diabetes and *susto* provide an excellent case example for illustrating the need to consider merging of FTM, biomedical, and biopsychosocial practices in treatment. While current research has examined the frequency of use of FTM practices in the treatment of illnesses (e.g., herbal remedies), there is a paucity of research examining the influences of using such remedies on the adherence of self-care practices among Mexican-Americans with DM.

Research questions that emerge from an exhaustive review of the literature include evaluating the relative importance of self-care practices among Mexican-Americans with DM to culturally relevant perceptions about healthcare practices and how these beliefs impact the utilization of biomedical treatment services and practices. How do Mexican-Americans story their experiences with DM? What are the sociocultural influences that guide self-care practices among Mexican-Americans with DM? How does an experience with *susto* influence these practices? And how do these beliefs influence the use of biomedical, biopsychosocial and/or FTM treatment strategies among this special population?

CHAPTER 2: METHODS

In this section, I outline my methodological orientation to this study and explain how it relates to exploring FTM and self-care practices among Mexican-Americans suffering from DM. My approach to exploring the healthcare practices among this special group required a flexible approach and one that would encourage collaborative communication between respondents and me. Furthermore, this exploration aimed to elicit an in-depth and intimate understanding of Mexican-Americans' experiences with emotionally charged and sensitive topics such as DM and *susto* (Hertz, 1997). To accomplish this goal, I needed to consider a methodological orientation that would specifically address these topics.

One methodological approach that made empirical sense was an interpretive case study using semi-structured interviews. This methodological approach works to interpret meaning from interviewer-participant guided interviews, while also following topic trajectories in the conversations that may stray from initial interview questions as appropriate. As Geertz (1973) described, "believing…that man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search of meaning...The whole point of a semiotic approach to culture is…to aid us in gaining access to the conceptual world in which our subjects live" (pp. 5, 24).

An interpretive interview approach for this research allowed me to explore inherently meaningful actions behind participants' behaviors. These behaviors are interpretive experiences within a large framework of meaning for these individuals (Lindlof & Taylor, 2002). As such, an interpretative approach recognized each individual's perspective and understood that there were multiple telling and retellings of stories. These multiple interpretations rendered thick, layered descriptions of events and allowed me to better grasp the meanings behind participants' actions and performances in order to convey a better understanding of their lived experiences (Frank, 1995; Geertz, 1978; Lindlof & Taylor, 2002). In this dissertation, I sought to capture the voices and experiences of Mexican-Americans, explored the ways in which they made sense of folk illnesses (e.g., *mal de ojo, susto)* and DM, and remained reflexive and open to the narratives which they shared. I hope I provided a richer understanding of the complexities associated with negotiating DM and *susto* through the lens of Mexican-American culture. There was an earnest attempt to provide a detailed portrait of the DM-*susto* experience by privileging the voices of Mexican-Americans as a first step to understanding the cultural milieu of self-care practices among this population.

Research Concerns, Biases, and Reflexivity

The discussion of whether or not in-depth interviewing and observation are the best methods to obtain thick, layered descriptions offers an opportunity to highlight research concerns specific to this dissertation. There were several concerns that I had to negotiate and constantly be reflexive about during the research process. Being reflexive meant to live in the present while simultaneously having an open-ended conversation about experiences (Hertz, 1997) or "consciousness about being conscious; thinking about thinking" (Meyerhoff & Ruby, 1982, p. 1).

The goal of qualitative research is to seek to understand. Qualitative research is precisely measured by the depth of understanding and is less concerned with the relationship history between researcher and participant (Lindlof & Taylor, 2002). As such, one can immerse themselves in the field with either someone previously known or unknown to them. Moreover, qualitative methodology does not pretend to be objective. Rather, any biases a researcher may have is written in as a source of data and analyzed.

"Cultural reflection on how social…processes shape or mediate how we experiences our selves and our environment is, perhaps, the most prominent feature of cultural studies" (Saukko, 2005, p. 350). As qualitative researchers we are active participants in the research process, so it is essential to understand our *selves* in the constellation of gender, class, and ethnicity, as examples (Hertz, 1997). For my part, I wrote several journal entries about my own biases so that I was aware of them prior to and during my immersion in the field. It was important that I gave voice to my own self-aware biases in the field and ensured that they were written down and became part of my analyses. This process is termed *reflexivity*.

While every researcher has biases, good, qualitative research is reflexively conscious. Good, qualitative research acknowledges these biases, writes them in, and analyzes them in a reflexive manner (Goodall, 2000). It requires that any researcher not only be mindful of who he or she "is" but also of who he or she "is not" in the field (e.g., I am not an Arab, Jew, or European American; I am not female). Moreover, it asks one to understand the importance of these non-identities as to not encourage one to place themselves in a position of privilege within the field. As Rabinow (1986) summarized, "reflexivity in ethnography is rooted in the awareness, first of all, that the ethnographer, as a positioned subject, constructs interpretations of experiences rather than simply reporting the “facts” discovered during fieldwork” (p. 234).

As a reflexive qualitative researcher, I actively constructed and interpreted my experiences interviewing participants for this study. In doing so, some concerns during this active process arose. One concern was that of gender. I am a male researcher who entered a field of inquiry that wished to equally encourage the participation of both genders. As in clinical practice, the art of establishing rapport with individuals from various cultural backgrounds requires a delicate balance of communication skills and a cultural understanding of the lives of those with whom you interact. I consider this to be one of my strong skill sets, and my interactions with the participants in this study reflected good rapport building skills and ease of communication that appeared to have elicited quality responses from each participant.

In my clinical experience thus far, women have constituted the majority of individuals I have seen, which is not entirely surprising given that women generally tend to seek psychological care more than men. This pattern has been consistently seen among Hispanic individuals as well. I had some concerns given the possibility that I may meet with Hispanic males during the interview process. These concerns were initially raised because although I have had positive rapport-building experience with both genders, I believed that it would be difficult to encourage the participation of Hispanic men given my own gender. At the end of the study, only one male participated, and this individual was pleasant and friendly, and reciprocal flow of conversation was balanced throughout the interview process. That said, I still felt there were appropriate, empirically-supported reasons for me to be mindful of a potentially negative outcome.

Other researchers have noted that male Hispanics are somewhat reluctant to disclose extensive personal information to other Hispanic males, particularly if these males grew up in families where the mother-son bond undermined their authority as a patriarch (e.g., Falicov, 1998). Another potential reason is the strong cultural emphasis on the word *machismo*, which has been misinterpreted across Latin cultures. Machismo has been misconstrued to mean macho. Traditional Mexican-American culture may be viewed as patriarchal, and although machismo plays a part in this structure, the true ideal of machismo based on historical Spanish interpretations is for men to protect and defend their families through strength of character (Caetano & Galvan, 2001) and physical strength (Falicov, 1998). However, the definition of machismo has both negative and positive attributes. Negative connotations of machismo include womanizer (Grace & Glaz, 2010), jealousness (Falicov, 1998), aggressiveness, self-centeredness, hypersexuality, and dominance (Ojeda, Rosales, & Good, 2008), while positive connotations include family man (Grace & Glaz, 2010), integrity, and responsibility (Ojeda, Rosales, & Good, 2008). Unfortunately, the negative attributes of machismo have been endorsed by many Hispanic males. As a result, males of Mexican descent, who endorse these negative characteristics of machismo, were less likely to reveal personal information to another male individual such as myself (Falicov, 1998; Grace & Glaz, 2010). This in turn had the potential to negatively impact my recruitment efforts as some Mexican-American men may not have wished to discuss their belief systems that may have served to undermine their perceived strength of character and power (Falicov, 1998). Fortunately for me, this was not a concern for this study.

A second concern I had would be whether my entry into the Hispanic community as a Hispanic researcher would label me as an outsider or an insider doing research. Normally, a researcher's privileged position of power is a concern for researchers because of the current focus on marginalized groups (McCorkel & Myers, 2003). However, for me, the insider/outsider concern was mitigated by my overall experience engaging with my community here in Charlotte, North Carolina, and with the participants. It's true that while I share many characteristics among Hispanics who live in Charlotte, North Carolina, there are numerous differences between us as well. For example, I am a Hispanic individual self-described as highly acculturated, well-spoken without a Spanish accent, and of light to medium skin tone compared to many Hispanics around the Charlotte area. To some, I suspected I would be accepted as an indigenous member of their community, while others may have viewed me as an outside researcher based on a perception of my acculturative status. In my overall experience working on this project, I did not encounter an overt difficulties navigating through the community in terms of reciprocity and flow of conversation with members of the community. I also did not experience feeling like an outside member of the community. Rather, I felt inclusive and welcomed at all times. I also felt that the experience of sharing their story had some type of intervention effect for them. Some of my impressions were based on observations, whereas a couple of participants gave some indication that talking to me felt therapeutic. That said, it is entirely possible that I may have missed more subtle indications of being privately labeled as an outsider. The nature of some of the more sensitive interview questions certainly provided opportunity for one to feel uncomfortable or to feel like their story reflected unshared beliefs with other members of their community, including myself. For my part, I relied on my strong rapport-building skills while also remaining well aware that research within this special community demanded that I reflexively examined any assumptions about what I believe constituted indigenous knowledge (Naples, 1996).

Setting and Participants

Gaining Access to the Clinic. Data collection for this study took place within the Charlotte, North Carolina (NC), metropolitan area, whereas one participant from south Texas was interviewed as part of this study. Initial efforts to collect data commenced at a local community health clinic in Charlotte, NC. The community health center serves an impoverished area of the city. Its mission is to provide acute, episodic, and chronic disease medical and psychological care to uninsured, low-income adults living in Mecklenburg County. This service is provided through a culturally diverse, volunteer-based organization with an emphasis on education, training, and community outreach.

Gaining access to the community health center was facilitated by my familiarity with this clinic. At the time, I was a clinical health psychology student trainee at the community health clinic, where I provided both individual and group therapy for those who were suffering from psychological distress. Many of my patients at the clinic were of Mexican-American descent and suffered from DM. Over the years, my conversations with these patients have enhanced my interest in acknowledging and enhancing my understanding of the complexities associated with negotiating direct or indirect experiences with *susto*, folk and traditional medicine and self-care practices to treat chronic medical conditions such as DM. Having had access to this special population served to facilitate initial efforts to acquire relevant data for assimilation and analyses.

In consideration of maintaining high ethical standards while conducting research, recruitment of potential human subjects did not consist of patients to whom I was currently providing therapeutic treatment. This rule helped me avoid the possibility of an ethical dilemma, such as psychological coercion (i.e., in this case, manipulative methods used to persuade another or others to conform to the wishes of a researcher) and/or an imbalance of power (i.e., taking advantages of situations of power or superiority over patients in professional practice), while simultaneously working to ensure delivery of the highest ethical standards to the patient in care. As such, those who were actively receiving psychotherapy at the clinic with me did not meet criteria for inclusion into this study.

Qualitative research is more concerned about representation than sample size (Davis, Gallardo, & Lachlan, 2010; Lindlof & Taylor, 2002). The goal of this research study was to grasp a thorough understanding of the healthcare experiences (i.e., folk and traditional medicine and self-care practices) of Mexican-Americans with DM who also had direct or indirect experiences with *susto*. To meet this goal, I needed to ensure I sampled to represent the population of interest. This was accomplished not by numerical representation but rather by behavioral representation (Davis et al., 2010).

Although sampling methods vary in qualitative research (e.g., snowball and network sampling), I employed a purposive sampling technique, which sampled individuals for a purpose and provided a guideline for their inclusion into this study (Davis et al., 2010). In an attempt to ensure that the population selected for the study was representative of the population of interest, I attempted to employ a maximum variation sampling strategy, as indicated, that “selects study participants to find examples that represent a wide range of characteristics that are present in the population and are of interest to the research" (Davis et al, 2010, p. 171). In general, the sample size derived from any relevant sampling process is meant to be used for the sole purpose of representation. After my sample participants were identified, recruited, and consented, my goal was to begin interviewing participants and collecting data until I began to approach understanding of these phenomena (Lindlof & Taylor, 2002). In spite of the smaller sample size, significant sub-themes, themes, and meta-themes emerged from the data. From this sample size and specific population of participants, over the course of several years of investigative inquiry, all insights were obtained, all themes were categorized, and at some point no new information was acquired.

Individuals who were over 18, have DM, and had either direct or indirect experiences with *susto* were potential candidates for this research study. To determine whether each prospective participant met criteria for inclusion into this study, age and disease status information was initially confirmed using clinical medical record data, whereas brief screening questions were provided for those participants who were included into the study by way of purposive snowballing recruitment efforts. Experience with *susto* was identified by asking each prospective participant whether he or she had any direct or indirect experience with *susto* at any point in their lifetime. Those who met recruitment for the study after a purposive and maximum variation sampling was undertaken were asked to participate in the study. Those who agreed to participate were asked to consent to the study by reading and signing the research consent form (See Appendix A). There was no monetary compensation for participation in this study. Once consent was given, the participant and I set a time to meet at the health clinic or in the community for our first face-to-face meeting and for all follow-up meetings. A data recording device (i.e., an electronic voice recorder used specifically for picking up voice data) was set up for the initial and follow-up interview session, and the participant was informed of the interviewing process each time. The process included acquiring voice and field notes recordings in an effort to maximize the quality of data collection acquired throughout the interview processes. The first interview protocol form (i.e., a getting-acquainted form version) was used to gather data from the first meeting. All questions on this form were written in an open-format style aimed at encouraging spontaneous communication from each participant. Subsequent question forms were used, as necessary, after data coding and analysis was performed and until data saturation was met. A final interview protocol (i.e., a member check protocol) was completed once the final interview had taken place.

Data Collection

In-depth Interviews. An interview-styled approach was used to interact with participants and have in-depth discussions with them. The interview is an integral part of qualitative work because it allows for participants and researchers to introduce topics that they might not have the opportunity to otherwise (Ellis, 2004; Patton, 2002). Because of my history working at the community health clinic, there was the possibility that I may have had brief, informal dialogues with prospective participants. These informal dialogues had the potential to shape the nature of the in-depth interviews and may have facilitated rapport-building with these individuals. To that end, only one participant in the study had previous discourse with me at the clinic, one had previous discourse with me outside the clinic, whereas the other two participants were unfamiliar and had no record of discourse with me prior to participation in this study.

Miller and Crabtree (2004) explain that in-depth interviewing is “a partnership on a conversational research journey” (p. 185). As such, I proposed a semi-structured approach to these interviews, using protocols consisting of open-ended questions and probes to guide the conversations (See Appendix B for examples of these protocols). As necessary, these questions were modified to ensure new, incoming dialogue did not overlap with previous information I gathered about an individual from previous encounters or informal conversations. Furthermore, additional questions did emerge throughout the interview process, and data collected as a result of these additional questions were assimilated into the final revision of this study.

This study aimed to potentially interview 5 to 10 Mexican-American individuals who were suffering from DM and had direct or indirect experiences with *susto*. As highlighted earlier, the goal of qualitative research is to interview a representative sample of prospective participants and get to know them very well. The projected numbers for participant recruitment were estimates and did not represent the number necessary to reach data saturation. For purposes of this study, efforts were made to ensure that the final recruitment number was reflective of an in-depth representation of my sample of interest. Overall, there were a total of 9 in-depth interviews with 4 participants throughout this dissertation project. Specific information related to the range and average length of the interview sessions is reported in the results section. The in-depth interviews were recorded using a high-quality, digital voice recorder. The notes were transcribed from Spanish to English, as necessary, and notes from interview sessions were included in my field notes. As a result of the multiple interviews collected throughout this dissertation project, participants opened up more and provided richer data over time.

In the end, data collection efforts did not include ancillary medical/healthcare staff working directly with Mexican-Americans (e.g., healthcare practitioners, psychologists) in order to better understand the complexities associated with working directly with these individuals who are suffering from chronic diseases such as DM and whose traditional health belief systems may be intersecting or colliding with the biomedical frameworks of such practitioners. Finding ancillary medical/healthcare staff in this community who works directly with Mexican-American populations was difficult. There were no viable entry points into the community that presented themselves during the course of this study inquiry. As such, any reference to patient-practitioner relationships came directly from the participants themselves and are analyzed and discussed in the following chapters of this study.

Given that interviews are essentially negotiated conversations, I was especially mindful to ensure there was a working level of mutual respect and good rapport. Understandably, rapport-building was not solely contingent upon my actions and efforts, but I also recognized that I could not force good rapport and mutual respect to happen. Rapport is a social accomplishment that is constructed by the multiple interactions between the interviewee and me (Lofland, 1995). Through this process I better understood these individuals and gave them voice. Qualitative research is concerned about giving voice to individuals. It asked for their voice and my voice but discouraged my voice speaking for them (Davis et al., 2010; Hertz, 1997). As a result, continuous efforts were made to ensure each participant’s voice was respected and that their willingness to participate in this research was appreciated and valued.

Observations. Observation was used as a primary method of data collection in the field. The goal for effective observation strategies was to experience and record the social setting of the organization in order to immerse myself in the context of social action. One way I was taught to think about observation through the lens of qualitative research was to consider the term *crystallized.* I was asked to “think of a prism of crystal where you want to see all of the colors. So if you only look at the crystal or prism from one direction, you are not going to see the entire picture—the whole picture.” (personal communication, C. Davis, September 21, 2010). The role of observer was one of continuous negotiation with participants in striving to build rapport and perform in responsible ways that made sense to them (Lofland, Snow, Anderson, & Lofland, 2006).

Participant Profiles

Monica. Monica is a 47 year old Mexican female who emigrated to this country from Mexico more than a decade ago. She is currently single and has been married once in the past. She is monolingual and speaks only Spanish. She understands very little English. Monica suffers from Type II diabetes, which was first diagnosed 16 years ago when she was 31 years of age. Monica is currently employed and has a sibling who lives with her. Her parents currently live in Mexico and visit her and her siblings in the United States at least once every year. Monica is the only participant to describe shadow stories and believes that she acquired diabetes after an experience with *susto* 16 years ago. She has had other paranormal experiences in her lifetime and reveals these fears and tensions throughout her interviews. Monica endorses biomedical services for the treatment of her diabetes and has engaged in psychotherapy in the past to work on her anxiety and related *susto* experiences. She has not had access to psychotherapy over the past several years but uses adjunctive strategies, such as deep breathing exercises, to mitigate her stress and anxiety. Monica describes making efforts to endorse appropriate self-care practices but admits that the dietary component gives her much struggle.

Hortencia. Hortencia is a 69 year old Mexican female who emigrated to this country from Mexico over two decades ago. She was legally married when she moved her, but her husband decided to stay behind in Mexico; as such, she considers herself to be unmarried and single. Hortencia currently lives in the community with her son and his family. She is monolingual and speaks Spanish but also describes herself as being minimally proficient in speaking some English words. Hortencia suffers from Type II diabetes, which was diagnosed 13 years ago when she was 56 years of age. Hortencia is a retired nurse who practiced extensively in Mexico before retiring several years ago. She described having second-hand experiences treating some patients who described *susto* experiences during her years in practice. She attributes her career in nursing medicine as the reason she is able to adhere to a strict dietary regimen to regulate her blood sugars and maintain good linear measurements for her diabetes. She endorses biomedical services for the treatment of her diabetes and denied using FTM services as an adjunctive measure to treat her condition. She has never engaged in psychotherapy or seen a mental health practitioner to address any problem areas. Hortencia described having a mother who used curandera-like techniques to cure her and her sibling of ailments throughout their childhood, although she was quick to point out that she did not consider her mother to be a curandera.

Carmen. Carmen is a 46 year old Mexican-American female who was born and raised in south Texas. She is bilingual and is fluent in both English and Spanish. Carmen is currently married and has one child; she has been married in the past for a brief period of time. She currently lives in south Texas and works as a Registered Nurse. Carmen developed Type II diabetes 11 years ago when she was 35 years of age. Although Carmen has had a moderately extensive childhood history of visiting curanderas to treat fears and phobias, she has refrained from using that type of service throughout her adult years. She believes that knowledge and education is a pathway to further enlightenment and that FTM services, at least for her, are not necessary to treat her diabetes. Carmen denies that she has suffered from *susto* or acquired her diabetes from a *susto* experience but understands why people make seek out FTM services to treat ailments and spiritual conditions. She also described believing that she has a special energy or power such that her intense gaze has caused unexplained incidents a few times in the past (e.g., caused a woman's necklace to break apart and fall on the floor). While Carmen admits that she has the knowledge from which to well-manage her diabetes, she admits that she is challenged by the dietary component necessary for good diabetes management. Carmen described never having engaged in psychotherapy or mental health services but believes that one can benefit from that type of service.

Vincente. Vincente is a 44 year old Mexican male who emigrated to the United States from Mexico nearly a decade ago. He is the only male participant in this study. He is monolingual and speaks only Spanish. Vincente has three children and has been married to his wife for nearly two decades. The entire family lives together in the community. Vincente describes himself as a hard laborer who developed Type II diabetes

6 years ago when he was 38 years of age. He further described himself as someone who has engaged in biomedical services for the treatment of his diabetes. He attributes his strict dietary regimen as the reason he has maintained good management of his condition. He denied ever engaging in either FTM services, psychotherapy, or any mental health-type services but believes that one could benefit from engaging with a psychologist to talk about issues related to *susto*, guilt, stress, anxiety, and worry. This participant denied that he acquired his diabetes from a *susto* experience but began to reveal tensions throughout his interview that may have described a *susto*-like experience.

Data Analysis

The data from interviews was collected through a narrative and observational lens. As highlighted previously, my interest in this approach to qualitative inquiry stemmed from my desire to enhance my understanding of how Mexican-Americans negotiate FTM, biomedical, and/or biopsychosocial practices in the treatment of their DM and experiences with *susto.* The research questions guided the construction of the interview protocols that asked Mexican-American individuals to story their experiences with DM and *susto*.

A comparative method of data analysis, known as grounded theory, was undertaken once a collection of personal narratives were populated (Charmaz, 2002; Charmaz, 2005). A grounded theory approach to qualitative inquiry was appropriate given that my research questions focused on the experiences of individuals over time within a social context (Davis et al., 2010, p 329). Originally developed by Barry Glaser and Anselm Strauss (Glaser & Strauss, 1967), grounded theory in qualitative research often takes a “constructivist approach” developed by Kathy Charmaz (Davis et al., 2010, p 329). As a constant comparative method, grounded theory required me to take control of my data and analysis, and in turn these methods gave me more “analytic control over their (my) material” (Charmaz, 2002, p. 676). It answered the question, “How does the social process of ‘X’ happen in the context of this environment?” (Davis et al., 2010, p329).

Because constant comparative analysis is an ongoing activity, I was continuously engaged in and with the narratives of my project. Grounded theory suggested that there should be a continuous play between data collection and analysis (Charmaz, 2002). Furthermore, grounded theory studies “emerge from wrestling with data, making comparisons, developing categories, engaging in theoretical sampling, and integrating an analysis” (Charmaz, 2005, p. 510). As part of this process, being immersed in comparative analyses encouraged the proliferation of emergent themes. This was also facilitated or enhanced by ensuring I read through the narratives as they were collected and transcribed—keeping a watchful eye on any necessary changes to the protocol that needed to be made or any unexpected issues that may have arisen from such a thorough process.

After coding my entire body of transcripts, constant comparison data analysis allowed me to make note of patterned regularities about participants and the ways in which they talked about and enacted their experiences. The choice to personally transcribe all interviews and observation notes was made well before the preparation for data analysis. There was a benefit from personally transcribing my own work as it gave me an opportunity to re-immerse myself in their work and uncover additional, emergent themes. In some cases, the timeline required to complete a study is met with strict deadlines. In the event of such a situation, hiring an online transcription service was an available, yet cost-prohibitive option. That said, at no point during the research process did that option become necessary. All data was transcribed by me, including all translations from Spanish to English. The resulting transcriptions were further reviewed multiple times throughout the research process to ensure accuracy.

Conceptualizing Rigor

Truth and trustworthiness are at the heart of qualitative research and addresses multiple criteria related to rigor. The tools used to evaluate the rigor of any interpretive field work include the following: credibility, authenticity, relationality, and reflexivity. In order to understand how these four standards coalesced with my project, I must first briefly discuss my position on truth and how I see my perspective on truth impacting this project.

My position on "truth" is influenced by the traditions of methodological interpretation (i.e., the study of the art, theory, and practice of interpretation). Truth is not universal or absolute but rather fluid and contextual. There are multiple truths that span across the multiple, yet occasionally shared belief systems of others. My position of multiple truths is grounded in how we make sense of and understand our social realities. We create some kind of "truth" as qualitative investigators by co-creating, along with participants/clients/patients, a meaningful account of an experience (Gadamer, 1989). As Moules (2002) explained,

> Our strengths,…lie in a belief in the interpretability of the world and in a willingness to allow ourselves to be read back to us. (It) demands that we proceed delicately and yet wholeheartedly, and as a result of what we study, we carry

> ourselves differently, and we live differently…I cannot remove my subjectivity from my work, but I can take it up with a sense of responsibility in recognizing how it translates into the way I listen to my participants, what I hear, what stands out to me, and how I interpret it (p. 24).

My belief that there are multiple truths means that I not only saw and appreciated others' conceptualizations of truth but also that their truths influenced my truths. Moreover, while I could not completely divorce my subjectivities from my own work or truly write myself out of research, I maintained an awareness of my biases as a researcher (Gadamer, 1989). As cautioned by Fine, Weis, Weseen, and Wong (2000), trying not to include myself in research is just as silencing as not including the voices of participants. My own personal biases made it possible for me to witness things I may not have otherwise witnessed. It was like looking through a special lens that allowed me to view the field in a different manner. And in doing so, I was able to appreciate the subjectivities of my participants (Olesen, 2000).

My fluid and contextual conceptualization of truths provided me with evaluative tools for assessing rigor of my qualitative research. The first is that of credibility (Lincoln & Guba, 1985; Whittemore, Chase, & Mandle, 2001). Credibility refers to the believability of the data and is also concerned with the "conscious effort to establish conference in an accurate interpretation of the meaning of data" (Whittemore, Chase, & Mandle, 2001, p. 530). Moreover, as Lincoln and Guba (1985) argued credibility is concerned with whether an interpretation of participants' experiences is reflected in a believable manner. There is recognition at this point that there are multiple interpretations to an experience or event and that I presented one interpretation. As a researcher trying to ensure rigor in qualitative research, I must present a believable interpretation of the participants' experiences. For issues related to FTM and self-care practices, this was especially important because how Mexican-Americans negotiated self-care practices was often significantly different within group. It was my duty to recognize and express any contradictions, confusions, and tensions that arose between participants' stories and experiences.

Credibility's interest in recognizing the contradictions, confusions, and tensions between participants' experiences coincides with the second evaluative standard for rigor: authenticity. Authenticity focuses on the degree researchers honorably and fairly described participants' experiences. It is concerned with portraying these experiences in a meaningful and authentic manner such that participants' perceived experiences are appropriately captured. As Olsen (2000) points out, authenticity appreciates the interpretative work of the lived experiences of others that is reflected by the textural nature of their multiple voices in a socially constructed manner. Narratives allowed for voices to be heard, and the retelling of these stories allowed me to appreciate differences experienced by the participants. Moreover, their credibility and authenticity supported a concern for an interpretive validity that appreciated respect, empathy, and an openness to their voices and experiences (Davies & Dodd, 2002).

The third evaluative tool that can guide rigor in qualitative research is relationality. Relationality is rooted in relationships and posits that knowledge is relational and not owned by any one individual. It further describes how participants' beliefs and behaviors are guided by a value system from which researchers are expected to develop relationships. Some type of connection is important to qualitative research and the evaluative tool of relationality appreciates these connections as well as the relational power between researchers and participants (Lincoln & Guba, 1985). Relationality also recognizes the connections developed between researchers and participants and is rooted in caring and equity (Hall & Callery, 2001). As such, it was critical for me to develop rapport with the Mexican-American population while acknowledging, respecting, and appreciating their storied experiences.

Lastly, the fourth evaluative tool for assessing rigor is reflexivity. Reflexivity constantly assesses the relationship between knowledge and the ways of doing knowledge. "Serious attention is paid to the way different kinds of linguistic, social, political, and theoretical elements are woven together in the process of knowledge development, during which empirical material is constructed, interpreted, and written" (Glaser & Strauss, 1967, p. 110). Reflexivity asked that I considered how my own thoughts, feelings, and behaviors interacted with my research sites and the research itself (Davis et al., 2010). It also asked that I be sensitive to participants and the communities in which they live (Fine et al., 2000). Reflexivity challenged me to critically engage my own subjectivities and actions while in the field. I felt I was able to accomplish reflexivity in several ways. First, I was able to be upfront about my research choices. This was particularly true in my previous discussion about using in-depth interviews as the primary data in this study based on my research questions. Second, I entered the field with an informed understanding of DM and the FTM and self-care practices of Mexican-Americans. While authentic voices in this study storied experiences with FTM, self-care practices, DM and *susto,* I recognized these individual stories represented a collection of personal truths which were partial and indeterminate. However, as a constellation of stories taken together, I recognized that what emerged from this study served to incrementally add to an understanding of how experiences with DM and *susto* and FTM and self-care practices among Mexican-Americans continuously shape and change the lens through which they view, experience and interpret life.

CHAPTER 3: RESULTS

Participants

The Institutional Review Board of the University of North Carolina at Charlotte granted approval for this study. Individuals who were over 18, have DM, and have had indirect or direct experiences with *susto* were potential candidates for this research study. A total of 10 participants were contacted for possible inclusion into the study. Of those 10, a total of 4 participants (75% female) provided informed consent and fulfilled prescreening requirements. Of the 4 participants, one was active in her role as a registered nurse, whereas another was retired from her nursing career. Of the remaining 2 participants, both (1 female and 1 male participant) were both Mexican immigrants to the United States. One individual was recruited through the Charlotte Community Health Clinic located in Charlotte, North Carolina, after determining eligibility, and this individual was able to participate in the interview portion of this study. One individual was recruited through The Ada Jenkins Center located in Davidson, North Carolina, after determining eligibility, and this individual was able to participate in the interview portion of this study. One participant was recruited through an independent autism educator and spokesperson who travels around the state to speak at many local churches and community centers. This individual was determined to meet study eligibility criteria and was able to participate in the interview portion of this study.

Another individual was recruited from a geographical area located well outside of Charlotte, North Carolina. This individual was recruited from south Texas, a region that is heavily populated by individuals who self-identify as Hispanic and/or Mexican-American and one that extends from San Antonio, Texas, at its northernmost border to Brownsville, Texas, at its southernmost border. This individual met eligibility criteria and agreed to participate in the interview portion of this study. Her role as a nurse provided a unique perspective related to a dual role of healthcare provider and someone living with DM in addition to someone who had extensive experiences with curanderos(as), folk illnesses, and traditional remedies for healing purposes.

The 4 participants were between the ages of 44 and 69 (mean age = 51.50 years) and reported being diagnosed with DM at an average age of 40 years. To ensure that the participant responses reflected areas of desired study inquiry, a restriction was placed on the type of chronic physical illness and folk/traditional illness that were included in this study (i.e., diabetes mellitus and *susto*, respectively). For *susto,* those with either direct or indirect experiences were included in this study. All participants self-described as suffering from DM, and all identified as being of Mexican descent. Three out of the four participants provided interviews in Spanish. These recorded interviews were translated by the primary investigator, transcribed into a word document, and coded to reveal themes.

Interviews ranged in length from 18 minutes and 55 seconds to one hour and 4 minutes (combined interview time = 8 hours and 27 minutes; average interview length = approximately 51 minutes). The resulting transcripts totaled 152 single-spaced pages. The number of questions asked during the interviews varied and were guided by principles of qualitative inquiry (i.e., grounded theory methodology).

Findings

A total of 8 themes and 22 sub-themes emerged across all four research questions, and there were occasions where elements of participant discourse were shared between categories (See Appendix C for a review of themes and sub-themes). As such, it was common for the same narrative/story to traverse categories that emerged from data analysis. Yet, particular attention was placed on not repeating exemplars wherever possible. There were often more than sufficient exemplars to illustrate findings; as a result, they were used judiciously throughout the data analysis reporting process. Participant interviews provided numerous examples of narratives and stories. Their words reflected their power and intent to construct their surroundings, and exemplars from their stories were used to support findings. In all cases, direct, unadulterated statements were used to support findings, and participants' names were de-identified to protect their identity and maintain confidentiality. At times, in order to provide clarity on participants' inferred words or phrases and their use of pronouns (e.g., it, that), contextually-appropriate words within parentheses "( )" were used to provide clarity to the messages participants were trying to convey in their stories.

Research Question 1: How do Mexican-Americans Story Their Experiences with DM?

A total of 3 themes (i.e., "meta-physical beliefs," "physical impact of DM," and "emotional symptom reporting of DM") and 7 sub-themes ("shadow encounters predominate stories of one individual's DM experience," "definition of *susto* does not parallel old, traditional definition," "third person and indirect statements about susto acquisition," "*susto* can be healed or cured," "DM can be reversed if caused by *susto*" for the theme "meta-physical beliefs;" "DM viewed as a serious illness that can be managed through self-care practices involving dietary monitoring" for the theme "physical impact of DM;" and "guilt, worry, stress, and anxiety as factors influencing health and illness (DM)" for the theme "emotional symptom reporting associated with DM" emerged in response to interview questions that inquired about how participants stories their experiences with DM. These stories revealed how some individuals saw DM as having hereditary components as well as being influenced by dietary consumptive patterns and even guilt and worry. Other stories captured struggles with maintaining appropriate sugar levels, whereas one participant discussed how her nursing career has helped shape her self-care practices. Stories also ran across details surrounding the acquisition of *susto* while also providing discourse about what *susto* meant to each participant. While all stories described DM as a serious illness that involved elements of self-care practices to maintain health, one participant described several meta-physical experiences that she believed directly impacted her anxiety and diabetes.

Meta-physical beliefs: *Susto* and Shadow Encounters Predominate Storied Experiences with DM

Sub-Theme: Shadow Encounters Predominate Stories of One Individual's DM Experience

A finding from this study revealed one participant who characterized her experience with *susto* as having a negative impact on her health and acquisition of DM and described numerous encounters with meta-physical events that surrounded shadow stories. The following exemplars highlight this finding:

> There were things that caused me a lot of fright. I would see black objects crossing my room. One time at my sister-in-law's home I was walking up the stairs and I saw a dark shadow that came down from the side toward the animals. I turned to see it but I didn't see anything. I thought to myself, what could that

> have been? I started to worry a lot as well. I talked to my ex-husband at the time about what I had seen. He asked me, “Why are you seeing those things?” and then told me to go back to bed. After a few days, I saw him sitting atop the bed. I then turned around so I would not see him. Shortly after I turned around and he was not sitting in the same position. I asked myself, if I just saw him sitting here why do I now see him on the other side? I told him “you moved. You were sitting over here on this side of the bed.” He said, “No woman!” I said, “Yes you were over here seated.” He replied, “No. I was over here asleep.” After that I began to worry a bit more. I thought to myself, “Ok, if I just saw him sitting over here, why is he over here asleep?” (Monica)
>
> Well in the home where I live things started well. Then my sister and I started to see a shadow next to the laundry room. I told my sister, “You know what? Someone is in the garage by the laundry area. Someone is inside. She said “No, let’s go look!” I said, “Let’s go!” and then we went to go look and saw nothing. Then later we began to see that dark shadow that sometimes passes through my room or the kitchen or laundry area. It sometimes comes out and then returns back. Then I would ask my sister, “Did you see it?” She would respond, “Yes! Just leave it alone.” I remember that I was told that when you see a black shadow it was bad vibes. When it was a white shadow it was a good vibe. I then started to see the house as being weird. Now we have been there a while and have seen the shadow for a long time—a dark shadow. One time I was cooking and I heard a sound. We had framed pictures hanging in the living room, and it had been thrown to the ground…one of my sister’s paintings flew off the wall. (Monica)
>
> Well at my home I still experience seeing shadows, but I don’t see it when it’s coming out of somewhere. It just shows up. (Monica)
>
> When I am feeling relaxed I see them. I’m sitting on the sofa, and then I see them passing in front of me. At times, I see them 2 or 3 times per day, but this week I haven’t seen any. Not in these days. There are times when I’m just seated and it just occurs like that. And now I don’t frighten at much. (Monica)

This participant also began to describe color variations in the shadows, including what qualities some of the colors represented.

> Well, when it’s white, they say it’s a positive person. When it’s a dark shadow, then it’s negative. When it’s white that person is not with mal intent. They don’t want to do harm to the person. But when it’s dark, people say that it tries to do harm onto others. (Monica)
>
> When a shadow is dark it is negative, but when it is white it is positive. But others say that there is another color of shadow that is purple, which is in between the white and black colors. It means that it is also another person that is dangerous. It is the more negative of the colors. (Monica)

> At home, the color of the person has changed. The shadows are white. Since the last time we spoke, I saw black shadows only twice. If it's a bad person who comes to do harm, it's best that the person leaves. But if it's a person who is good, there is no reason for one to be afraid of them. And because of that thinking I am not afraid of them, but I used to be very afraid. (Monica)

She also described how experiencing the shadows made her feel both physically and emotionally.

> I used to get the chills when I saw them. When I saw the dark shadows I used to feel very cold. I felt very scared. (Monica)
>
> Since the last time we spoke, something really strange happened to me. A couple of nights ago the alarm went off on its own. The alarm to the house. When you go to open the front door, the alarm will go off. I asked my brother-in-law, "Did you hear the alarm?" He said, "No." I had been bending over grabbing some water with my hands under the sink when I heard the alarm. I began to scream and thought to myself—what is happening because I had never heard that before. The next day I was seated on a chair and I saw a shadow pass before me. I had been asleep but then woke up because I felt there was something near me. So then I woke up and saw a white shadow move. It was white. I felt it was like a person, but when I turned to see it, it backed away. It backed away from where I was seated. Because when I was sitting there I immediately felt that I was accompanied by someone else. But after I saw it it retrieved away from me to the area where the bathroom is. At that point it just disappeared. There have been many times when this has happened. (Monica)

At one point during one of the interviews, this participant talked about seeing a yellow light that was different than her shadow stories but to her represented a meta-physical phenomenon.

> (Something happened at my job) today. I went to get a bottle of water and I turned around toward the refrigerator and I saw something that was yellow in color and brilliant. It was like a brilliant yellow light. It took the form of a small square, about 4 inches, and came out of the wall. When I went to get the bottle of water, it came out of the wall where I was grabbing the bottle of water to the other side. It passed in front of my very quickly…quickly. I turned around and said, "Oh my God!" It was 5 o'clock in the morning. Immediately I felt chills. Then I turned around and turned around repeatedly thinking that I would see it again. (Monica)

Sub-Theme: Definition of *Susto* Does Not Parallel Old, Traditional Definition

In addition to shadow stories predominating one participant's DM experience, other meta-physical beliefs systems surrounding *susto* also predominated narrative discourse from 3 participants in this study. These stories discussed beliefs about how *susto* can be acquired and these belief systems were often in contrast to old, traditional view that attributed susto to "soul loss" stemming from a frightening experience that left the body in disequilibrium. Not one participant described *susto* in specific terms related to "soul loss." Rather, *susto* was defined in terms that often highlighted being frightened or viewing an accident or experiencing trauma, as highlighted by the exemplars below:

> Well when one gets frightened, they begin with strong heart palpitations and then they are left feeling weaker. And there are times when one can't speak or yell when that happens. For example, me…I don't know how to yell. Instead of yelling outwardly I yell inwardly. I feel attacked. (Monica)
>
> Some of them thought that *susto* was something that happens—an accident, choking child, child in an accident; things like that cause diabetes to develop. But the people don't think that this happened like that…that maybe it was caused by something else…but some of them say, "Ok…I had such a strong experience and developed diabetes." They notice that something has changed—that the sugar no longer functions well—that their pancreas is not functioning well. (Hortencia)

When this participant was asked whether she believed there was a spiritual link to the *susto* experience, she replied:

> I've heard of that, but not in this case. They tell me that they were frightened and that it was a tremendous *susto*…and that happened and their sugars went up or that they developed diabetes. (Hortencia)

And when another participant was asked whether he thought there was a connection of feeling worried to *susto*, he responded with the following exemplar:

> When one worries about what is going wrong in their lives. One thing is the worry, and the other thing is the *susto*. *Susto* is when one witnesses or sees something happen. Worry is when something thinks about maybe a debt that they owe and are worried about how they are going to pay it off. (Vincente)

He also failed to link *susto* to fright as highlighted by the following exemplar:

> It is different. Fright is like when one is afraid of spiders or rats. (Vincente)

He also explained that fright could not cause trauma, which is in contrast to both old and new worldviews of the *susto* experience:

> That no. I think not. (Vincente)

Oftentimes but not always, as noted above, stories about *susto* acquisition touches upon the word *fright* or reveal experiences with trauma. Exemplars to highlight this finding are listed below:

> For example, if one person is behind a door and I open it. And they yell. Well then I get frightened a lot. Why do you scare me? That's what I believe about how someone can acquire *susto*. (Monica)
>
> It's something that one can acquire from an accident or something that happens in the family. One can witness an accident. I think something like that…caught from seeing things. (Vincente)

Sub-theme: Third Person and Indirect Statements About *Susto* Acquisition

Interestingly, however, two participants who made no statements related to having a direct, personal experience with *susto* shared stories about *others'* experiences with *susto* and trauma and spoke about these experiences in the third person or in an indirect manner. The following exemplars reveal third-person stories about the *susto* experience as described by these two participants:

> For example, I recall that I have a sister-in-law who developed *susto* after she witnessed her uncle being killed she developed diabetes. And she wasted away. She was very thin. She just stated that she began to feel badly when she saw her uncle laying there killed. And from there she began to lose and lose weight. (Vincente)
>
> There was this person that I knew—a young man who was in an accident. Before that he didn't have diabetes. And from the *susto* associated with the accident he

> became diabetic. During the time he was hospitalized he developed diabetes (Hortencia)

> And there were other patients who used to describe that they experienced a hard loss... lost a close family member and from that incident they ended up developing diabetes. (Hortencia)

In another passage this same participant expanded on her description of *susto*, as highlighted in the exemplar below:

> And normally, susto is like that. It's something external that causes that fright. It's so big that some people have heart attacks from the experience. (Hortencia)

And when asked to describe *susto* in more detail, this participant explained *susto* using a first-person exemplar, as follows:

> I am the one who was frightened. Frightening me from something that "espanto-ed (scared)" me. I am the one who suffers from the *susto*—a change in my body congruent with the magnitude of the *susto*. And from that you can get diabetes or a heart attack. (Hortencia)

The lone male participant in the study, who did not directly attribute his diabetes to *susto* shared personal stories of trauma and described these events in an indirect manner, as represented by the following exemplar:

> My father was one of those types who was strict. My family experienced domestic violence. I saw how my father used to hit my mother. A lot of time has passed. I was about 13 or 14 years old. (Vincente)

Furthermore, this individual stated that he didn't experience a *susto* from the event but then explained that it was indeed traumatic but did not constitute a *susto* experience for him, as the following exemplar described:

> No, it wasn't susto. And then I would see my mother with something on her face and would ask her, "What happened here?" She would say, "I don't know." Like I said, my father was very strict and he would hit her. That was a trauma. I have a trauma from that. And to this day I haven't forgotten about it. (Vincente)

He then went on to explain that he felt domestic violence had a role in the acquisition of DM in his mother, as the following exemplar succinctly highlighted:

> Yes, I think that is an important factor—the domestic violence—because my mother was perfectly healthy and then my father gave her a bad life…and then the diabetes came. (Vincente)

Sub-Theme: *Susto* Can Be Healed or Cured

When participants began to engage in discussions about whether *susto* could be healed or cured, I observed that a couple of participants vacillated between positions to this question. At some point throughout the interview process, these participants held a moderately strong position on the subject of *susto* and healing/curing, as highlighted by the following exemplars:

> Well it goes away if the trauma goes away. Well I'm not sure because it's possible that he still remembers the incident where he saw his dead uncle. I think that every person…how do I say it—that if people are not overly emotional that they could forget things. And if it's something that they don't give much importance to, then they can forget it. But if there are thinking about it, well… (Vincente)
>
> No. It's only about the moment. But then after that it doesn't go away. Yes it can go away. It's only in the moment when one witnesses trauma…someone gets frightened. (Vincente)
>
> You know like a said before that the cactus, aloe vera, and the garlic is good for the diabetes. And there's something else whose name I don't recall that is also good for diabetes….something that they say to take in a tea. The curandera can cure the *susto* apart from the diabetes. (Hortencia)
>
> I believe that it is something that cannot be cured. I think it's something that one's sensitivity intervenes. For example, for you, if I tell you something you can either be scared by it or not. For example, take a spider. It can either scare you or not so it's dependent on the sensitivity of the person. There are things that frighten one person and not the other. (Hortencia)

And in almost the same breath, this participant amends her position and begins to describe a possible link between fright and physical/physiological health, as highlighted by the following exemplar:

> I think with psychological help. They can be helped to deal with their specific phobias. There are *sustos* where one doesn't know what will scare them or *sustos* that occur because of sudden events like an accident or bad news...you don't know what is going to frighten you. For example, someone comes to you and tells you that your child was in an accident or your mother or father or other loved ones…and that is a serious impact for many people. So it depends on one's sensitivity (vulnerability) and how you can handle that situation. So we are…how can I tell you…our glands have hormones in them and those hormones each have different functions in each of us. For example, there are times when I am very worried or something is weighing heavily on me…that my kidneys will hurt. And the kidneys have some glandular tissue…like hats that are on top of the kidneys, no? (adrenal/suprarenal glands) So I feel that my kidneys are hurting. It's something that I've noticed. Or something, for example, that if I'm going to go speak in public to people I don't know I begin to feel that my kidneys do that. So I have noticed my kidneys are very sensitive—that my supra-renal glands are very sensitive when I feel excessively pressured. Well you know diabetes is associated with the pancreas and it's a gland, right?...that carries insulin…and the insulin is of bad quality or not sufficient to get the sugars into the cells, no? so it (sugars) takes outside (the cell) which causes the sugar levels to rise. And then there are people who because of a frightening experience develop pancreatitis and die because the pancreas is not sustainable. (Hortencia)

Sub-Theme: DM Can Be Reversed if Caused By *Susto*

Throughout the interview processes, there were only a few occasions where participants described their impression about whether DM could be reversed if caused by *susto*. One, a 44-year-old Mexican-American male, described how medicine could cure his DM and began to give voice as someone who felt he may have experienced *susto* or something he felt was related to it. He is the same individual who used descriptors such as worry and guilt and described traumatic events but failed to self-identify as having experienced *susto*. The following exemplar highlights this narrative tension:

> I think so because it's been 5…..8 years that I've had diabetes, and I was given metformin…half a pill and I wasn't feeling well. Then I went to the doctor and

> told him I was going to take a pill because I was feeling faint. I was working at the time. Then I ended up taking a pill and started to feel better. But my sugar levels had never had low sugar levels like 90 or 70. I've always had numbers like 100, 150. (Vincente)

Another participant, a retired nurse, described her impressions about how patients she used to care for had perhaps an incomplete understanding of diabetes and *susto* and/or approached self-care practices in a more casual manner, as represented by the following exemplars:

> Those who spoke about it who had a strong experience, which is *susto*, they used to think that their diabetes would go away at some point but it's not like that. They thought like that and for that reason they didn't stay on a diet and didn't take care of themselves. (Hortencia)
>
> They thought that if they got *susto* and it went way that they no longer had diabetes, but it's not like that. (Hortencia)
>
> The majority of them thought like that. There are some who took it more seriously. Those think of it like an illness and seek medical help, take medications and have control over their food intake, but only very few people do it that way. (Hortencia)

Physical Impact of DM

Sub-Theme: DM Viewed as a Serious Illness That Can Be Managed Through Self-Care Practices Involving Dietary Monitoring

There were also storied experiences from participants that described the severity of the DM and how dietary monitoring of consumptive patterns was critical in managing their illness. A couple of participants held strong positions about the serious nature of DM, as highlighted in the following exemplars:

> I thought it was an illness like the flu, but now seeing the illness being more serious, I don't see it like that. Now I see it as an illness that is very bad. (Monica)
>
> Diabetes is a serious thing. You have to pay attention to your body every single day. You can end up with a low blood sugar and end up in a coma. You know you can end up you know…so many things can happen to you body if you don't eat,

> complications happen along the way. If you don't take your medication and your blood sugar is never controlled then all that time your blood sugar is out of control it is abusing your body. And all that can lead to complications like dialysis and amputations. It's a learned thing. You know that it is something serious. You know that you have to change your way of living and your way of doing things. (Carmen)

However, all participants held a position that dietary consumptive monitoring was an important self-care practice for the management of their DM. Reports of linear measurements (e.g., a1c values and blood sugar levels), medication management, and specific dietary food guidelines constituted several parts of their narratives, as described in the following exemplars:

Linear measurements and medication management:

> I've been able to maintain things well with my insulin. And if there are times that my family wants to eat something that is not good for me, then I may indulge with a crispy tortilla and cheese…and the next day my sugar is 125…and when I don't eat excessively like that...then 89, 98, 83…in the morning. It all depends on how one manages things. (Vincente)

> I am much better…my insulin is going down. It has been coming out at around 6-point something. It used to be 8.0. I have made changes in my life. I have refrained from eating a lot of fatty foods. I have started cooking foods on the stove without using oils. I have reduced the amount of coffee I have been drinking too. (Monica)

> Regarding the diabetes, the medicine helped me a lot, along with the dietary plans to help reduce my sugar levels. (Monica)

Dietary discussions surrounding consumption of starchy foods and high-carb beverages:

> Well at times I am drinking them on a daily basis and at other times I don't drink them. If there are sodas in the house I will drink them. I'm not going to lie; I drink sodas every day (when they're at home), but when there aren't any, I'll maybe drink them once every 3 days. But at that time I'll be drinking a diet Coke or a Coke Zero. But every time I drink a coke, I drink 3 times the water. (Monica)

> I have refrained from eating a lot of tortillas. Well, 1 or 2. (I ate) about 10 corn tortillas per day. I'm just not accustomed to eating flour tortillas. There are times when we buy cheese to make quesadillas, and I'll maybe eat some then but not usually. (Monica)

> Well in reality if I don’t eat at least a tortilla I don’t get full. My doctor has told me that I can eat 2 or 3 but only corn. I hardly ever eat flour tortillas, but I will eat corn tortillas. But if I’m hungry I often instead eat a piece of fruit or lettuce with cucumber and some lemon. (Vincente)

As well as discussions surrounding struggles with following a dietary plan:

> Sometimes I do and sometimes I don’t. As they say…we want to eat what we shouldn’t be eating. (Monica)
>
> Ok, I told the doctor that I cannot follow a diet. I’m not going to lie to you. I just cannot do it with the diets. Is there another form that you can take to help me so that I can reduce my appetite?...because I am just eating and eating and eating. (Monica)
>
> Well firstly, one has to guard their diet. Secondly, it depends on the type of activity one engages in because for me, the doctor told me to talk half a pill, and I took it as prescribed. But I do heavy work and my body would work and work and my sugar levels would go down. I would start to tremble. And because of that I had to start eating a little more and then started feeling better. But for me, using insulin has caused drops in sugars to around 50. And when that happens, I end up feeling sleepy. (Vincente)

Looking at dietary monitoring of DM through the lens of nurses with DM who participated in this study highlighted moderate differences in self-care practices. There was an overall impression from their storied experiences that self-monitoring and self-care took on a more meticulous, insightful, and arguably a more sophisticated approach toward DM management. The following exemplars emphasize this point:

> So fortunately I have been able to control my sugars. I have been very careful with the food I consume. I’ve come to believe that the food is an essential part toward controlling my diabetes. (Hortencia)
>
> I pay a lot of attention when I go to the supermarket and look at all the items. If I don’t know something I’ll read the labels. I read how many carbohydrates it has; how much sugar it has; how much fat it has. (Hortencia)
>
> I think it makes you look at life from a different perspective. It makes you because being a nurse makes you look at things more in depth, and you see people that are negligent with their care. And you say, I don’t want that to happen to me. I don’t want to end up like that person who was so young and in dialysis because

> they didn’t take care of their diabetes or end up with an amputation because they fail to follow-up with their doctor and did not participate in their plan of care. You look at life totally from a different angle and you learn to pay attention to your body and learn to take care of your family in a different way. (Carmen)

> Well, one of my biggest weaknesses is eating. One of my favorite things is cake. I don’t really care for salty food as much as I would care for cake. If you put a salty food in front of me and you put, you know…a taco on the other side my weakness is always going to be cake. And I’ve learned that it’s ok to have the cake, but you are not going to have 2 or 3 slices. You’re only going to have a little bit of that cake and get it over with. And this is something my endocrinologist taught me along the way when dealing with my diabetes. Because he asked me, “What is your weakness when it comes to sweets?” And I said, “Cake!” And he said, “Well ok. I can allow you to have your cake.” It’s all in your mind. As long as you can have it and taste what you truly want then you can get over it. And it’s true! I’ve learned that if I can just have a piece of that cake and savor it in my mouth and savor the flavor I can go on. I can move on. I don’t have to have the whole piece or I don’t have to have 2 slices of that cake only because it’s my favorite cake. I can have a piece and I’m ok. A little piece and I’m ok. (Carmen)

A couple of participants also described special foods that they considered beneficial toward the management and treatment of diabetes, including a description of a curandero(a) recipe used in folk practices. A common food, cactus, was mentioned by both of these participants as having DM-associated benefits and has been highlighted in several books and articles (e.g., Glazer et al., 2004; McNeill & Cervantes, 2008) in addition to finding voice in anecdotal discourse. When asked about any special foods for diabetes, some participants described eating cactus and drinking teas, as the following exemplars highlight:

> Oh yes, such as eating cactus for diabetes. My mom used to drink bitter teas. (Vincente)

> I saw some people who had diabetes consume a lot of cactus with aloe vera. They would liquefy the cactus and aloe vera and also put in garlic and would drink it in the morning. (Hortencia)

There were several other foods for DM maintenance that found their way into participant narratives. While several of the foods listed below are often viewed as being contraindicated for DM given their high glycemic index score, most participants talked about consuming these foods in a balanced manner assuming good dietary management of their DM. The following exemplars highlight these observations:

> Apples, papaya, peaches, kiwi, jicama (and) oranges. (Vincente)
>
> I eat a lot of soy. There's also a food called tofu that I eat a lot. I drink soy milk. (Hortencia)
>
> I eat a lot of vegetables either raw or cooked, such as a lot of broccoli, Swiss chard, spinach, cabbage, squash, bell peppers…but only the green one because it's less sweet than the red or yellow kind….tomatoes, onions..what else..what else do I eat? I'll also eat leafy foods like cilantro, epazote (green leafy herb), thyme. I always put some of that on the food to give it some extra flavor. The only meats that I eat are fish and chicken. I don't eat meat and hardly ever eat pork. (Hortencia)
>
> I eat oatmeal with some fruit. A portion of oatmeal with water and some fruit, such as papaya, strawberries, blueberries, grapes, apples, bananas. If the banana is a medium size, I'll cut it in half. If it's a big size I'll cut it in thirds. I only eat 15 grapes, for example. If the apple is too large, I'll cut it in half and eat half of it. I'll only eat 12 cherries. I count things out. If I'm eating kiwi, I only eat one. And regarding melon, I only eat a small slice. (Hortencia)
>
> There is fruit that I don't eat such as mangoes…nor oranges because they have a lot of sugar. (Hortencia)

Emotional Symptom Reporting Associated with DM

Sub-theme: Guilt, Worry, Stress, and Anxiety as Factors Influencing Health and Illness (DM)

There were also several passages from a couple of participants that described how guilt, worry, stress, and anxiety influenced health and illness, in particular how it had an effect on DM. Some stories talked about how DM improved when stress levels were attenuated or reduced and how a chronic pattern of worry also contributed to the development of DM. Several exemplars highlight this finding below:

Well with my grandmother, she acquired it from a strong feeling of guilt that others made her feel. She came to this side—to the United States and one of her daughters ran her out of her house. They ran her out of the house. They asked her why she had not taken good care of her children. And she lasted a month over here and then went back. She was purchased a ticket so she could return. And when she returned she was crying and talked to the entire family. And then she started to feel ill. She developed high blood pressure that wouldn't go down. And then she was told that she needed to take care of herself because she had diabetes. (Monica)

Well when I was a little girl I didn't have any worries because I was with my parents and siblings. But when I got married that changed. That is when the worry, anxiety, and nervousness began…because my husband was also a person who was very macho. And also because of all the *sustos* that he caused me. I believe that that also caused my illness. (Monica)

It (my diabetes) just improves when my stress is reduced… because if my stress and anxiety increase, my illness is going to get worse because I will begin to build resistance toward the medicine that I am given. Therefore, I need to maintain a sense of calm and relaxation to maintain my current levels…keeping sugars and high blood pressure down. (Monica)

The environment (stresses me). One was my supervisor at work. She would call me 3 to 5 times per day to tell me the same, the same thing. She would keep telling me what to clean over and over again. She would call me often to tell me that. It started to occupy my thoughts, and I told myself that this could not continue or I would start to complain. I spoke to my boss, and he had a talk with her because he knew that someone with diabetes could not function well under a lot of stress. The sugar levels would go up. (Monica)

It was very stressful because we owed a lot of money. Just paying out and paying out. And that was it. I think it was from all the worry associated with me not being able to pay out so much money. And also because I had left my sons behind in Mexico. (Vincente)

And now my siblings ask me how things are going with me and how my numbers are doing. If it's high, they'll tell me not to eat this, don't eat that. More than anything, you just monitor your diet and not eat excessively. How do I tell you? There are different types of people who, like me, do heavy work but if I monitored my diet well and I do manage my sugars well…I've been told in the book that I can eat a hamburger, a small one, and I do eat it but after an hour my sugar falls back down. My body needs more food than that when I am working. (Vincente)

Interesting, the lone male participant who failed to directly implicate *susto* as causing his DM revealed that he believed that stress and emotional instability were factors that could lead to the development of DM. His discourse highlighted connections to worry, stress, and DM, and although he never explicitly stated that he had a *susto* experience, he used words (e.g., worry, stress) that often intersect with discussions surrounding the *susto* experience and DM. The following exemplars highlight these discussion points:

> In reality I am someone who is very worrisome. It's like one worries because I'm not a person who doesn't care about life. I worry about life and about problems that keep coming. We have to find solutions for them, but I am a worrier. I worry a lot in general, and I think that is another reason that I got diabetes. (Vincente)
>
> To me it's just that one is overly stressed. The stress gives one diabetes. If one is stressed or tense because they cannot fully relax. (Vincente)
>
> I know there are a lot of people who develop diabetes, but I'm not sure how they acquire it. I think it depends on their emotional stability. That's one. The other is if they eat disorganized or have worry. That's all it can be. (Vincente)

Research Question 2: What are the Sociocultural Influences that Guide Self-Care Practices among Mexican-Americans with DM?

A total of 2 themes (i.e., "hidden" and "marginalization") and 7 sub-themes (i.e., "hidden in plain sight" and "you have to ask them the right question to elicit hidden statements" for the theme "hidden;" and "unsure healthcare providers ever heard of/don't believe in *susto* or other folk illnesses," "providers never ask about *susto* or other folk illnesses or act as if it's not there," "perception FTM practices are for the poor and/or uneducated," "perception healthcare providers don't have time to talk about FTM practices or don't believe in them," and "perception patient will be criticized if they disclose use of alternative beliefs" for the theme "marginalization") emerged in response to interview questions that inquired about the extent to which participants were comfortable seeing curanderos(as) for self-care needs.

Hidden: FTM Practitioners, Locales, and Tools are Hidden within the Community

Sub-Theme: Hidden in Plain Sight

One finding from this study was that some participants reported FTM practitioners, their places of practice, and tools used to help heal, cleanse, or resolve a problem their patient may be having were not hidden from the community but rather "hidden in plain sight." One participant discussed how they were more open in plain sight in central Mexico. The following exemplar highlighted this finding:

> For example, at the markets (in Mexico City) you'll find a section where they sell only herbs. There are not many stores, but there are stores that have sections where people sell the herbs (Hortencia)

Sub-Theme: You Have to Ask Them the Right Question to Elicit Hidden Statements

Another finding that came out of this study surrounding FTM practitioners being "hidden in plain sight" highlights statements describing how one has to ask these practitioners or those who have access to these practitioners the right questions to elicit hidden statements that reveal access points. Statements supporting these findings come from a 69-year-old Mexican-American female who used to work as a nurse in central Mexico before moving to the United States in the early 1990s. She described how asking the right questions to the right person could reveal access points to either a curandero(a) or FTM practitioner or to herbal recipes that are designed to have curative properties, whereas other statements described how some access points are more obvious is some geographical areas than others. An exemplar supporting this finding is represented below:

> And the same ladies who sell the herbs will inform the customers what the herbs are good for. So one can arrive at the store and tell them…hey, I need an herb for diarrhea or stomach pain or for a headache, for high blood pressure, and they'll give you the herb and tell you how to drink it. (Hortencia)

Marginalization: Patients Fear Being Marginalized by Their Practitioner if They Disclose Folk Illnesses or use of Alternative Practices

Sub-Theme: Unsure Healthcare Providers Ever Heard of or Don't Believe in *susto* or Other Folk Illnesses

An important finding from this study described how participants felt that their interactions with their practitioner highlighted interpretive differences and at times clashed with an internal desire to discuss other personal struggles (e.g., emotional, psychosocial, quality of life) that often fall outside of biomedically-focused areas of health illnesses and consequences. While participants were able to share several positive stories about their experiences with practitioners, these stories often reflected information (i.e., linear measurements, medication management guidelines, and progress/setbacks related to adherence to treatment recommendations) that was biomedically detailed and that which focused on health issues and the consequences of not following treatment recommendations. However, when asked to share stories that relayed some of their more unfortunate experiences with their practitioners, two participants shared experiences that reflected feeling marginalized by their providers if they spoke about concerns that fell outside the biomedical arena. One participant felt unsure that her practitioner had ever heard of or didn't believe in folk illnesses, such as *susto*. The following exemplars highlight her concerns:

> I can come to the clinic and say that, but I'm not sure if the doctors believe in *susto*. (Monica)

> Well maybe they don't believe in *sustos*…because they may think there are other causes of diabetes and for that reason I don't talk about it. (Monica)
>
> I've never heard of them talk about it. (Monica)

Sub-Theme: Providers Never Ask About *Susto* or Other Folk Illnesses or Act as if It's Not There

This participant also shared discourse that highlighted her practitioner-patient relationship such that no provider had asked her about her *susto* experience or whether she had experienced any other folk illnesses either currently or in her past. She described how she felt that her practitioner would probably act as if her *susto* was not there and would instead focus on her DM. The following exemplars highlight her concerns:

> They order lab work. I feel really good about the doctors here. They ask how my health is doing…whether I'm following my diet. They'll tell me to take care of myself. When it comes to *susto*, there hasn't been a discussion about it with them. (Monica)
>
> I don't know how to tell you. There are some doctors that believe in *susto* and some that don't. (Monica)
>
> When I first found out about my diabetes, I did talk to my doctor. That I thought that I became ill because of *susto*. She said that we were going to look at what caused your diabetes and nothing more. They didn't give me answers about my illness. (Monica)
>
> I'm not sure how they will take it (the discussion about *susto*). (47-year-old Mexican-American female: Type II diabetes)

Sub-Theme: Perception Healthcare Providers Don't Have Time to Talk about FTM Practices or Don't Believe in Them

In addition to sharing stories about her interactions (or lack thereof) with her practitioners about her *susto* and DM, this participant briefly highlighted how she perceived healthcare providers don't have time to talk about FTM practices or simply don't believe in them, as illustrated below in the following exemplar:

> They have a lot of patients and there are times when I don't want to talk about (my *susto* and how I care for myself) because I may feel that I'm taking away from their time. (Monica)

Sub-Theme: Perception Patient Will Be Criticized if They Disclose Use of Alternative Beliefs

At times participants described feeling pressure not to open up about their beliefs given fear that they may be criticized for doing so. There were elements of conversations with participants that implied needing to feel more courageous as patients in order to convey that message. There were themes of feeling marginalized or made fun of for sharing stories that reflected self-care practices that fell outside more Western medicine practices. The following exemplars reflect these sentiments:

> No I haven't talked to them about it. I am not bold enough to talk to them about it. (Monica)

> It's just my way of thinking. Many people make fun of people who have stories like this. (Monica)

> Everything depends on the patient and how they feel about information they receive. Sometimes patients don't say how they're feeling because they may feel embarrassed. (Vincente)

Sub-Theme: Perception FTM Practices are for the Poor and/or Uneducated

Another participant, a registered nurse, described how she felt her own evolution from remembering as a little girl how her mother would take her to curanderas to heal her of fear to one that has adopted to a significant extent the belief that education can lead one outside the world of traditional/folk practices. She described efforts to enhance her scholarship and educate herself and how as a young girl imitation of parental behavior, belief systems, and practices was expected. There was an impression from her storied experiences growing up in an impoverished environment with few resources that FTM practices are for the poor and/or uneducated. The following exemplar highlights this finding:

> You grow up and you educate yourself as to what that…it's not a practice anymore. You don't see people talk about it anymore. You grow up and you become a different culture. You become a different person. When you're living with your parents you follow their way of believing things and doing things. It's a pattern for you because you're a child and growing up in their home. You imitate what they believe in and what they do. And I think that's mostly true for every child. Once you grow up and out of the home, then you start learning your own things and your own way of doing your own things. They become your beliefs now, and you get to decide as a mature adult…am I going to continue to believe in this or am I going to acquire my own beliefs. And that's what happened to me. You acquire your own beliefs along the way, and that's why I didn't continue it because it was something that I did when I was with my parents. (Monica)
>
> I respected the fact that when people do that and what they believe in. I respect the person behind that belief and perform that kind of work on somebody. And to this day I respect that and do respect that belief, but I don't think that it did me any harm. I think that when people believe in something and I guess I could say as a parent and a mother, my mother felt that it was something right for me, I have to agree with her. If that's what she felt was right for me then I'm ok with that. (Monica)

Research Question 3: How Does an Experience with *Susto* Influence These Practices?

Only one participant openly shared that she felt her DM was acquired by a *susto* experience, whereas the other participants often shared indirect or 3rd person stories about *susto* experiences, which was covered under the section Research Question 1. The one participant who shared stories about her experiences with *susto* and DM talked about using various treatment modalities to help reduce her anxiety and stress and by extension help her manage both her DM and *susto*, including the use of psychotherapy, relaxation strategies, prayer, and biomedical services. Overall, however, I was unable to collect a sufficient amount of information to adequately describe how an experience with *susto* influenced self-care practices. There was an impression from discussions with these participants that some didn't feel comfortable talking about *susto*. Behavioral observations from meetings with the participants revealed elements of psychomotor agitation and mental distress (e.g., wringing of the hands, moving around slightly in their chair, fiddling with their bottled waters or coffee cups, axial-truncal rotations). These elements of psychomotor agitation could stem from mental tension and anxiety, and I suspect some participants may have experienced *susto* but weren't comfortable talking about it. I probed the participants with several questions regarding *susto* and felt that some of them didn't seem to fully understand what I was talking about. Not only were there indications based on their definitions of *susto* that perhaps they associated it with various emotionally-charged descriptors, such as guilt, worry, and stress, but there were also stories about fear and experiences with domestic violence that caused them to feel traumatized by these events. Yet, during those instances, I observed body language and behaviors that suggested that they were uncomfortable talking about it further and were not likely to tell the story through the lens of *susto* or any other folk illness in the event they truly had experienced a *susto* event.

All but one participant were more freely able to have discussions about *susto* when it concerned others, including relatives, neighbors, and friends but never did share personal accounts of a *susto* experience but appears to circumvent the issue with descriptors often used by others to describe such an experience. There were also descriptions from two participants describing how their mothers used knowledge about herbal remedies as elixirs and/or ointments purchased locally to cure maladies, such as *empacho* (i.e., a folk illness understood to mean indigestion or gastrointestinal malaise) or general stomach discomforts, *espanto* (i.e., a folk illness traditionally described as a being caused by fright of supernatural origin and considered a more severe form of *susto*, although it is often used synonymously with the word *susto*), fever, and throat infections. The following exemplars highlight these experiences:

> My mother, for example, would cure us of *espanto*. She would cure us of *empacho* (indigestion). Her, her. She would give us. For example, for *espanto* I recall that she would sit us down so we could get some sunlight for a good while and after we were outside in the sun for a while she would put a small amount of alcohol in our mouths..it would be in our mouths and then she would take it and put it on our heads…she would blow while it was on our heads and call out our names real loudly. She would hug us, and wrap us up with something and with that she would cure us of (*espanto*)…to cure us of *empacho*...*empacho* is like when you eat something and it stays stuck to your stomach. (Hortencia)
>
> Well at times there is diarrhea and you go to the doctor where they give you medications and nothing happens. You continue with those bothersome issues. Most of the doctors do not know how to cure *empacho* like mothers used to do back then. My mother used to buy an ointment called Pampuerco. That's the medicine my mother used to buy. And with that Pampuerco she used to rub it on our stomachs using her hands...in a circular formation to the right…following the direction of the intestines. She would rub our stomachs for a good while. She would also put it on our lower mouth and the back of our spine and rub for a while. And once she had rubbed it well, she would take the skin of our backs and she would shake it and shake it..and it seemed that something thundered/ boomed…and that would cure us of the empacho. (Hortencia)
>
> And for example, when we were sick from our throats such that we had a throat infection my mother used red tomato or green tomato along with baking soda. She would add it to the tomato, but the tomato had to be well roasted… Yes, a whole tomato. She would put it to roast…to roast. And when it was pretty well roasted/burnt, she would press it down a little she would put some baking soda on it. She would put gauze over her finger and her finger would fill up with the tomato and baking soda mixture. She would then put her finger down our throats and clean it and clean it and we would be cured. It was a pretty vigorous, but we were cured. In just days we were cured. That is something that I had used on my kids before. If we had a fever she also put cabbage leaves under the axilla of your arms. She would also put them on your head and the stomach. The fever would go down with that. For example, when we had something not like a throat infection but just throat discomfort she would give us lemon with honey as well. Just a mixture of lemon and honey she would give us. (Hortencia)

Another participant described other types of recipes for teas to treat maladies:

> I remember my mother would make some hot tea for me. They'd give us simple remedies that they knew worked to make us better. You know, they…my parents of course did not have like parents nowadays have. You know when you open up

> the cabinet and see 10 different medications that you can pick from and make your child well. In those days it wasn't like that. You know it was remedies. It was hot tea. You know, it was you know...putting Vicks on your body to help you loosen up all that phlegm. My mom was very attentive to my needs. She would do things like that. She would cook foods…comforting foods that would make my body better. (Carmen)
>
> But also they didn't neglect us in any way. They still found ways to make our body better. Like I said in those days they had their own remedies, and they worked. A hot tea. A poached egg. Something that was going to provide that protein in your stomach. This was tea that you would make from an orange. Like you would peel an orange and you would put the peels in the water to boil and that was supposed to settle your stomach. It was things like that. (Carmen)
>
> I know they used to go to a little place here where they would buy like little leaves that would create that tea that would make your stomach settle down, but I don't recall what the name of the tea was. My mother had like those little leaves..um. You know, I don't know what she would call it, but that particular tea would make your stomach feel a whole lot better. (Carmen)

Research Question 4: And how do these beliefs influence the use of biomedical, biopsychosocial, and/or FTM treatment strategies among this special population?

A total of 2 themes (i.e., "confusion & contradiction" and "therapy as a treatment modality and access point may help those suffering from folk/biomedical illnesses") and 5 sub-themes (i.e., "no consensus as to what the FTM services are," "no consensus as to where these services are located," and "no consensus as to who utilizes FTM services" for the theme "confusion & contradiction;" and "patients/clients view therapy as having positive effects on health & well-being," and "FTM practices viewed as having psychological benefits," for the theme "therapy as a treatment modality and access point may help those suffering from folk/biomedical illnesses") emerged in response to interview questions that inquired about participants' views surrounding FTM services and the appropriateness of therapy as a treatment module to address folk illnesses.

Confusion & Contradiction: There is No Consensus as to the Nature, Location, and Utilization of FTM Services

Sub-Theme: No Consensus as to What the FTM Services Are

Beliefs are an interpretation of one's reality, and at times these realities can clash with others' beliefs about similar phenomena and experiences. That was captured by a finding from this study surrounding stories of confusion and contradiction. Participants had variable stories as to the nature of FTM services, where these services were located, and who utilized or did not utilize these services. While there were elements of stories that overlapped in a thematic manner, there were also parts of the discourse among participants that were dissonant and lacked consistency. Moreover, while the term *curandero(a)* was used often to describe individuals who performed FTM services, other descriptors, such as *witches*, *witch doctors, Satanists*, and *herbalists* found their way into the narratives. Exemplars supporting the finding that demonstrated a lack of consensus as to the nature of FTM services/practices are represented below:

> There are times when they (curanderos) contradict each other. They speak of different things sometimes. That's why I don't believe in them. My sister-in-laws have been to them. (Monica)
>
> You know in the time I was growing up you would hear about a lot of these people because I think people did not have…it was more of a dominant thing at that time. Now it is not perceived the same. You hear about a curandera nowadays and it's like, "Oh my God it's scary! How dare she thinks she's greater than God." People, I think, have taken that gift that they're given and imitate God with it. And I think that that's where we people see now…or I at least see people now, some people, take it to a different level. You know I think that at the time when my mother did believe and she went, it was more of a toned-down thing where none of these people thought they were greater than God. But now you see people…they think they can heal and they think that they can do this and think that they're God. And they're not by any means will ever replace God. Society has changed. It's about them and the power they have. They don't always see God. They think that they're special and chosen but they take it to a different level. (Carmen)

Sub-Theme: No Consensus as to Where These Services are Located

There were also exemplars that described an overall lack of consensus and contradiction related to where these FTM services could be found. There were brief accounts of individuals having direct access to curanderos(as) within neighborhoods because they knew someone who was connected to someone who had access to them, but these stories were mainly historical in nature, as highlighted in the following exemplars:

> I do remember some of the experiences with my mother. I was young but I still remember going to this lady's house. My mother would tell her. I don't know what my mother would tell her, but she would perform a ritual over my whole body and sweep the broom and say some prayers and that was supposed to, I guess, cure me of any fears that I had. It was frightening to me because it was of course something new to me. I didn't know what they were doing. Like fear of the unknown. Like when you don't know. My mom knew what was going on, but I didn't. I was a child and my innocence. And did not know exactly what was taking place. Yeah I guess I can summarize that and say it was fear of the unknown. (Carmen)
>
> She was a lady who was a friend of my grandmother's. That's how my mom knew her because she lived close to my grandmother. (Carmen)

Sub-Theme: No Consensus as to Who Utilizes FTM Services

Participants also shared stories demonstrating a lack of consensus as to who utilizes or does not utilize FTM services. Stories varied across visits to *witches* to find help for a child who had a learning disorder to stories that described looking for remedies for someone who felt they were being harmed by someone. Other stories talked about how simple illnesses were likely to be treated at home and not by visiting a curandero(a); this was also a sub-theme briefly discussed in Research Question 3 (i.e., one mother's use of an ointment to cure physical illness). Another story highlighted how one participant who experienced seeing shadows let the events occur without reacting to them or seeking some type of treatment or service to assist with recovery, whereas another participant suggested that without trust access to curanderos(as) and FTM services wouldn’t even be an option for someone needing their assistance and that she herself respected the curandero(a) and felt that there was no harm in seeking out their services when she was a young girl. The following exemplars support this finding:

> (My sister-in-law) used to take her children to the witches to find out what they had. The girl had trouble learning in class. The other girl…well she was not sure what was happening to her but felt someone was trying to do her harm. So they wondered who was trying to harm them. The mom would also punish her children. They were going to places they shouldn’t be going to. I just don’t believe in all that. But when I used to live with my ex I used to see various black objects as well. But I let those things just occur without reacting. But now I don’t believe in those things. (Monica)
>
> That I don’t think that it was because of finances. I think that…I really don’t because if I really got sick or whatever they would take us to the doctor. I think they saw it as something simple that they could take care of at home. I wasn’t in a critical physical state that they couldn’t do something about it. It was something simplified like a cold or a fever that they could take care of it right there and then. As opposed to somebody just being really, really sick and not knowing what to do. They always knew what to do. It was something simple. A simple illness. (Carmen)
>
> It was obvious that she only did it for people that she was close to or people that she trusted. It was more of a trust thing. If she trusted you she would invite you to her home. If she didn’t then she wouldn’t; the availability wouldn’t be there. (Carmen)
>
> Well, I will say this much. I respected the fact that when people do that and what they believe in. I respect the person behind that belief and perform that kind of work on somebody. And to this day I respect that and do respect that belief, but I don’t think that it did me any harm. I think that when people believe in something and I guess I could say as a parent and a mother, my mother felt that it was something right for me, I have to agree with her. If that’s what she felt was right for me then I’m ok with that. (Carmen)

Therapy as a Treatment Modality and Access Point May Help Those Suffering from Folk/Biomedical Illnesses: Patients/Clients May Benefit from Sharing Stories and Processing Events Related to Folk and Biomedical Illnesses

Sub-Theme: Patients/Clients View Therapy as Having Positive Effects on Health & Well-Being

Because of my years working with underserved populations in both a biomedical setting and more currently in clinical practice as a student clinician in health psychology, I understand the numerous barriers that exist for many patients seeking help—particularly those who are underserved, impoverished, and lack the resources to access treatment services. Findings from this study in the area of seeking treatment for issues related to *susto* and DM highlighted good support for the positive effects of therapy on health and well-being. There were exemplars from participants who believed that sharing stories was therapeutic and that in doing so they were able to purge many of the narrative wreckages that had consumed their lives in a negative manner. There were numerous discussions surrounding the therapeutic value of attenuating stress and anxiety to assist with DM management, including the use of other types of treatment modalities (e.g., singing, praying, meditation) when therapy was no longer accessible. The following exemplars highlight this finding:

Individual and group therapy experiences:

> When we had a group therapy, it was good to hear other peoples' stories. Sharing stories was helpful. (Monica)
>
> Well, individual therapy was more helpful because there were times when I would disclose things that I didn't feel comfortable sharing in a group format. (Monica)
>
> By participating in therapy with you, I improved a great deal…a great deal. (Monica)

> Talking to you has helped me the most. I was able to expunge everything that was inside of me. Everything came out. (Monica)
>
> Regarding the diabetes, the medicine helped me a lot, along with the dietary plans to help reduce my sugar levels. But the psychological part allowed me to talk about everything that happened in the past and what was happening currently. (Monica)

General impressions for therapy as a treatment modality to help with DM

> When one is engaging in therapy, one can reduce their stress. And someone who has diabetes needs not to have excess stress and anxiety. That's what has helped me. (Monica)
>
> When my stress is reduced I begin to do other things around the home. Before, I used to get so stress that I've often find myself chewing on my fingernails. (My diabetes) improves when my stress is reduced. (Monica)
>
> If my stress and anxiety increases, my illness is going to get worse because I will begin to build resistance toward the medicine that I am given. Therefore, I need to maintain a sense of calm and relaxation to maintain my current levels…keeping sugars and high blood pressure down. (Monica)
>
> Well I haven't had therapy in a long time. But I do use singing and praying to help me. And I use that because I haven't had therapy and use it to help me out. (Monica)

Alternative practices to assist with reducing anxiety:

> But when I begin to feel distressed, I begin to touch my head and my shoulders to help relax. Just tapping on them so I can feel more relaxed and reduce my anxiety. (making an Ohmmmm sound) I've seen it on TV that you can do that with your fingers and make the Ohmm sound to help relax. Yes. Meditation. (Monica)

There was less, direct support for therapy as an effective modality to treat *susto* as the mechanism of action and recovery were not presented in participants' stories, as the following exemplars highlight:

> I think that every person...how do I say it….that if people are not overly emotional that they could forget things. And if it's something that they don't give much importance to, then they can forget it. But if there are thinking about it, well… Perhaps a psychologist (can help with *susto*). Someone who could offer therapy so they could forget about it. (Vincente)

> Well I think the susto and the trauma…that they have similar effects because someone can be traumatized by what they witnessed and have it on their mind. And time passes and the life goes on and they remember…perhaps it doesn't go away but maybe with therapy...a long process. Those things are held in the head. If one is worried then they have to figure out how to resolve that issue. This happened to my son….it's the same. (Vincente)

Sub-Theme: FTM Practices Viewed as Having Psychological Benefits

One participant described viewing FTM practices as having psychological benefits, which was reinforced by her early childhood experiences visiting a curandera. The following exemplar represented this part of her story:

> (FTM treatment) was really psychological because my mother would reinforce the fact that we were just taken care of by going there. When you tell somebody…you know what this was done for you and you are now well and you're going to be ok. You believe it. So it was a matter of being convinced, and as a child, you believe your parents. You go by whatever they say. So yeah. I did believe at that time that the healing had taken place because that's what my mother believed so that's what I believed. (Carmen)

Other Findings

Cultural Implications for Practitioners: Practitioners Must Gain Cultural Competency in the Geographical Areas in Which They Practice

Sub-Theme: *Susto*/Folk Illnesses May Have Evolved Due to Assimilation of Cultural Populations Over Time

One additional finding from the study revealed that participants reported stories that described *susto* and folk illnesses as having perhaps evolved in part because of the assimilation of Mexican cultural populations over time, that participants also shared beliefs about the importance of practitioners understanding the cultural implications of their practice, and that practitioners should be aware that FTM practices can be used for both positive and negative purposes. One theme ("cultural implications for practitioners") and 3 sub-themes ("*susto*/folk illnesses may have evolved due to assimilation of cultural populations over time;" "practitioners should understand the cultural implications of their practice;" and "practitioners should be aware that FTM practices can be used for both positive and negative purposes). Each participant revealed passages that talked about their experiences with *susto*. The old, traditional (less acculturated) view of *susto* found little support in the stories of the participants in this study, whereas others moderately supported a newer, less traditional, perhaps more acculturated, view of *susto* (i.e., more likely to implicate biomedical reasons for the decline in physical health). No one endorsed *susto* as the sole cause of physical decline but rather implicated several other factors, as mentioned previously, including poor diet and increased negative emotionality. The shadow experiences of one participant also found their way into the discourse on the subject of the evolution of the term *susto.* The following exemplars highlight the variable nature of the *susto* description, including no mention of "soul loss" as a contributing to a decline in physical health:

Exemplars form the lone participant who attributed *susto* to causing her DM:

> I got sick because of an experience with *susto*; After that *susto* and 3 months later, I found out that I had diabetes. (Monica)
>
> Well regarding my diabetes I still believe susto is still the reason I have diabetes. (Monica)
>
> Well at my home I still experience seeing shadows but I don't see it when it's coming out of somewhere. It just shows up. (Monica)
>
> When I'm feeling relaxed that I see them (shadows). I'm sitting on the sofa, and then I see them passing in front of me. (Monica)

Exemplars from the lone male participant who used words such as guilt, worrisome and trauma to describe his emotional state but failed to use the word *susto*:

> It could be that it is connected to the anxiety and the stress. (Vincente)
>
> It's something that one can acquire form an accident or something that happens in the family. One can witness an accident. I think something like that. Caught from seeing things. (Vincente)
>
> *Susto* is only about the moment. But then after that it doesn't go away. Yes it can go away. It's only in the moment when one witnesses trauma…someone gets frightened. (Vincente)

Exemplars from a practicing nurse who felt *susto* has outgrown the time:

> You don't see people talk about it anymore. (Carmen)
>
> You acquire your own beliefs along the way, and that's why I didn't continue it because it was something that I did when I was with my parents. (Carmen)

Exemplars from a retired nurse who provided discourse from experiences treating others as patients who had experiences with *susto*:

> That they had a strong experience, got diabetes, but that it was going to go away on its own…without doing anything. (Hortencia)
>
> Some of them thought that susto…was something that happens….an accident…choking child…child in an accident…things like that cause diabetes to develop. But the people don't think that this happened like that…that maybe it was caused by something else…but some of them say Ok…I had such a strong experience and developed diabetes. (Hortencia)
>
> Well they notice that something has changed…that the sugar no longer functions well. That their pancreas is not functioning well. (Hortencia)
>
> No mention of spirit in this case;…were frightened and that it was a tremendous *susto*. (Hortencia)
>
> They tell me that they were frightened and that is was a tremendous susto…and that happened..and their sugars went up or that they developed diabetes. (Hortencia)
>
> And normally, susto is like that. It's something external that causes that fright. It's so big that some people have heart attacks from the experience. (Hortencia)
>
> A change in my body congruent with the magnitude of the *susto*, and from that you can get diabetes or a heart attack. (Hortencia)

> So it depends on one's sensitivity (vulnerability) and how you can handle that situation. And then there are people who because of a frightening experience develop pancreatitis and die because the pancreas is not sustainable. (Hortencia)

Sub-Theme: Practitioners Should Understand the Cultural Implications of Their Practice

There was also participant discourse throughout the study that provided support for the need for practitioners to be much more mindful of the complexities surrounding self-care practices among this population. One participant shared a story about how cuanderos(as) offer a patient comfort and can improve their quality of life, much like that ascribed to many practitioners in biomedical settings, for example. There were discussions with one (retired nurse) participant about how their profession in Mexico is revered to have curandera-like knowledge that is often used to treat patients, yet she didn't believe that doctors had the same skill set either in Mexico or the United States. Moreover, a participant spoke briefly about the role of medicine and faith in health and illness, whereas one participant described experiencing *bilis* (i.e., meaning "bile," it is a term used to describe suppressed anger in an individual and often accompanied by somatic complaints realted to the gastrointestinal system) after her *susto* experience but implied that the word *bilis* was never discussed with her practitioner but rather that the focus was on the physical symptoms related to the illness. There were also implications from participants' storied experiences that briefly highlighted concerns related to language barriers, including a perception that having an interpreter in the room assumes that the patient-practitioner relationship minimizes the potential for clashes or misunderstandings. The following exemplars support these participant experiences:

> They may think there are other causes of diabetes, and for that reason I don't talk about it (*susto*) (Monica)

> (Curanderas) give you quality of life…you don't feel you have to carry that burden alone (Carmen)
>
> **S**ociety has changed. (Carmen)
>
> **N**othing more than medicine and faith in God (can cure *susto*) (Carmen)
>
> Hardly any professionals in Mexico but nurses (have curandera-type knowledge) (Carmen)

Exemplars about other folk illnesses:

> Now I feel I have *bilis* that came about after *susto*; doctors took x-rays; I've had (biles) for 22 days since they took the x-rays. (Monica)
>
> Most of the doctors do not know how to cure empacho like mothers used to back then (Carmen)

An exemplar highlighting the relationship between patient and interpreter:

> I feel I am capable (of talking to doctor in English). (My doctor's office) gave me an interpreter…was there with me; I said…I need you. Just stay here in case I need you (Carmen)

Sub-Theme: Practitioners Should Be Aware that FTM Practices Can Be Used for Both Positive and Negative Purposes

An additional finding in this study demonstrated that should discussions about curanderos(as) and/or the associated FTM services they provide ever find their way into the practitioner exam room, it is very likely that these practitioners would be uninformed about the various types of curanderos(as) in practice and that there is a duality of intent (i.e., good versus bad) among them, as the following exemplars describe:

> Two types of curanderos: one type is more like a Satantist; second is positive; diabolical type is there to do harm to others; white curandero will not harm others (Monica)
>
> Some people think curandera is bad; it's not all bad; it's how you see it and your perception of it; she has some power (Monica)

> (In the past) none of these people thought they were greater than God; now they think they can heal and think they're God; they are imposters (Carmen)
>
> There are people who are given this true gift; curandero (father-in-law) would pray for you; (he was) able to read your mind; he helped a lot of people. (Monica)
>
> I think there are 2 sides to it. Some people do it with a clean heart and some people do it with dirty heart. I think she (ex mother-in-law) had the dirty side of it. She wanted to do people wrong. I didn't know anything about it. I was very innocent about the fact that all…that she had witchcraft and things going on in her home, which I had no concept of. I had no idea what she was doing. She was just an evil person. She was just bitter. She had a hard life. She didn't love anybody but her children. I think she loved her children. I'm not sure. I know she didn't love the rest of her family, but she was just somebody that you would not want to have a relationship with. (Monica)
>
> In Mexico I have learned that there are very good curanderas. They are good curanderas who are well-recognized and know the types of plants/herbs that exist. In the end all medicine comes from there, right? So she knows a lot about herbs and knows what each herb is good for. So they are good….those who have that type of knowledge are good healers. (Hortencia)

In summary, several themes and numerous sub-themes were derived from the storied experiences that were obtained from this present study. While there was some overlap among participants' responses that extended from shared beliefs and thoughts, there were also several instances of within-sub-theme variations in the stories that the participants shared. That said, given the uniqueness and individual nature of these stories, variegation was expected. The implications of these findings will be discussed in the next chapter. Attention will also be given to my biases as a researcher and clinician, my cognitive and emotional reactions to participants' stories, reflexivity examining myself as a researcher in a researcher relationship with participants, and any difficulties encountered during this process. The next chapter will conclude with a discussion of study limitations, directions for future research, and final reflections.

CHAPTER 4: DISCUSSION

The current study investigated FTM and self-care practices among Mexican-Americans with DM, a topic on which there is little empirical work. Four research questions guided exploration of participant narratives and provided information as to the cultural, philosophical, clinical, and theoretical ramifications of each finding. The first research question (How do Mexican-Americans story their experiences with DM?) revealed a wealth of information. A notable finding surrounded shadow stories. These types of stories have no equivalent in bioscience and are often psychologized, making it difficult to separate disease processes to the cultural response to them. One participant's extensive experiences seeing shadows overlapped with an experience with *susto* and her perception that it gave her DM. This participant also reported satisfaction with psychotherapy and believed that it helped her reduce her anxiety which in turn helped her better manage her DM. Yet, given her undocumented status, access to appropriate treatment services is limited, and she has had to seek other self-care practices to mimic the anxiolytic effects psychotherapy provide her in the past (e.g., meditation, prayer).

Other storied experiences touched upon the description and acquisition of *susto*. An interesting finding along this area of inquiry was that the old, traditional definition of *susto* found only limited support in this study. The description of "soul loss" related to having an experience with *susto* found no support in this study. A less acculturated worldview by typically older Mexican-Americans contends that the soul is separated from the body during a *susto* experience and creates a physical imbalance that negatively impacts spiritual health. In contrast, the discourse from participants in this study described frightening experiences, witnessing of accidents, and experiencing trauma, but also several references to other causes of physical decline, including feeling worried, stressed, guilty, and anxious. No stories highlighting "soul loss" and physical or spiritual health decline found its way into participants' storied experiences.

Both traditional views of *susto* included an experience of "fright." However, embedded in the new worldview are several elements of the old worldview with a key difference being that the new worldview does not fully endorse *susto* as the sole cause of physical decline or as contributing to "soul loss." It is this new worldview that found moderate support in this study. This newer worldview is supported by more acculturated Mexican-Americans, who are more likely to implicate biomedical reasons for the decline in physical health. Although the participants in this study were less acculturated in many regards, they did not hold onto the old worldview of *susto.* All study participants described currently living in urban areas and also indicated that their formative years were spent living in rural settings. Research studies have examined the differences in symptom reporting between those living in Mexican rural areas and those living in urban areas (Glazer et al., 2004; Trotter, 1991). Those living in rural areas were more likely to characterize *susto* in both emotional and physical terms, whereas those living in urban areas were likely to use only emotional terms to describe *susto*. Moreover, previous studies have described how those living in rural areas are more likely to seek out remedies to cure their *susto* compared to their urban counterparts who preferred not to address the issue and would rather sit back and do nothing.

In this study, results could be somewhat misleading as all participants had lived in both rural and urban settings. For example, all participants endorsed the use of remedies (e.g., teas, herbal compounds) to treat illnesses in youth, but currently maintain a position of proactive use of biomedical (and in one case psychological) treatment modalities as self-care practices to address any health and illness concerns. That said, there remain numerous barriers to treatment services for those who are poor and underserved, and access to psychological services is often more challenging for the Hispanic population given fewer access points to Spanish-speaking practitioners in several areas throughout the United States.

What remained apparent in this study is that storied experiences related to folk illnesses remain strong and vibrant and reflect real personal accounts by individuals in spite of or even because of its lack of universal understanding. When questions surrounding emotional symptoms associated with *susto* and/or DM were being storied by participants, their narratives revealed a remarkable amount of emotional stress symptom descriptors (e.g., fear, guilt, anxiety, and worry) that both preceded their development of DM and remain part of the current storied experiences of DM. Moreover, participants also referenced physiological descriptions associated with DM status with emotional stress symptom reporting descriptors in such a manner that often revealed a positive association between improved health markers and decreased emotional stress symptom reporting (e.g., "my diabetes just improves when my stress is reduced…because if my stress and anxiety increase, my illness is going to get worse because I will build resistance toward the medicine I was given").

Other narratives that supported findings for this research question revealed the physical impact of DM related to self-care practices involving dietary monitoring. All participants described adherence to dietary monitoring to manage their DM, whereas several also admitted to having significant struggles following biomedical-prescribed dietary guidelines for their DM. Nevertheless, there appeared to be a global understanding that dietary monitoring was a critical component of DM management, although the explanatory model of illnesses adopted by these participants are heavily influenced by years of patient-practitioner interactions in the medical exam room. Yet, the lack of access to additional treatment modalities, such as psychotherapy, present as obstacles for clients seeking answers for emotional symptoms, meta-physical experiences, and other non-biomedical concerns. Often these individuals find themselves accessing biomedical providers who either don't ask, don't care to, or are unaware that they should inquire about other illness concerns and/or self-care practices their patients are using adjunctively to treat illnesses such as *susto* and DM. Simple, practical questions, such as "Are you using other self-care practices in addition to prescribed medication to treat your DM? If so, do these self-care practices address issues that haven't been addressed here previously? Have you or anyone you've known ever had an experience with folk illnesses, such as *susto*? Are you currently suffering from the effects of a folk illness? If so, what are you doing to care for it? And how has it contributed to your DM?" could offer significant entry points for practitioners to address the complex realities and storied experiences of the Mexican-American patient. These types of questions are consistent with Hatcher & Whittemore's (2007) recommendations that providers explore folk illness beliefs and their contribution to the development of DM by asking questions that elicit responses about Hispanics' beliefs about DM.

The second research question (What are the sociocultural influences that guide self-care practices among Mexican-Americans with DM?) uncovered themes related to how FTM practitioners, their locales, and their tools are often hidden within the community. There were descriptions about how these places are often hidden in plain sight and offer access to herbs for the use in treatment remedies. This is in contrast to historical information from some participants detailing the more hidden, embedded nature of curanderos(as) within neighborhoods. Curanderos(as) have traditionally been an access point for individuals seeking treatment for various maladies, including folk illnesses such as *susto*. Furthermore, they have played a significant role in building social relationships with their patients. Their connection with their patient is an important component of their relationship, such that their ability to read and respond to the feelings and needs of their patient is one reason that individuals seek out non-biomedical treatments.

Additional narratives that supported findings for this research questions surrounded a theme of marginalization. This theme echoed concerns that the emotional component that is often shared by curanderos(as) and their patients is lacking in patient-practitioner encounters. In fact, participants highlighted impressions that there are interpretive differences in the appraisal, evaluation, and treatment recommendations that often clashed with a desire to discuss other personal struggles that fall outside of the biomedical framework used by practitioners to address illness concerns with their patients.

Participants also described feeling as if their practitioner would make them feel embarrassed or guilty for expressing concerns related to folk illnesses or illnesses that fell outside their biomedical framework of practice. One participant pointed out that she didn't think that her current doctor believed in *susto* based on a previous negative experience with her practitioner who essentially silenced her when she told her that they would focus on her DM and not her *susto* in the examination room. This participant made initial efforts to talk about her folk illness in the biomedical exam room but was marginalized instead. Effectively, she lost her voice and was silenced for many years until she engaged in psychotherapy. When speaking about past interactions with practitioners, participants described avoidance patterns related to discussions about historical context (i.e., childhood stories of FTM encounters with curanderos(as) and the use of herbal remedies to cure common maladies) that would help provide appropriate (medical) history to guide assessment and treatment planning. There are certainly significant clinical implications to this type of practice. This experience is also consistent with literature describing how individuals who fall ill continue to surrender their bodies to medicine, and in turn feel silenced (e.g., Frank, 1995; Harter, Kirby, Edwards, & McClanahan, 2005). A patient who feels they have lost voice or effectively been silenced are likely to feel that there are residual physical or psychological concerns that need to be further addressed. If these concerns remain unaddressed, there is the possibility that the physical and psychological tensions could lead to other clinical conditions.

The third research question (How does an experience with *susto* influence these practices?) received limited support from the narratives collected in the study. Only one participant endorsed having a *susto* experience that lead to her DM. Her experiences with *susto* did not include stories about accessing curanderos(as) to address her illness condition. Rather, she engaged in both biomedical and psychological treatment services to address issues related to fear (*susto*), anxiety, stress, and DM. However, an interesting finding surrounded an impression from narratives that talking about *susto* as a first person storied experience was tense and silencing. There appeared to be a "big secret' associated with revealing more personal stories of *susto* experience.

Psychological observations revealed tensions and avoidance maneuvers in participants. These tensions represented events that occurred within individual experiences. Sometimes narratives diverge and become evident as stories converge and collide with each other (Boje, 2001). Their narratives represented an open-ended opportunity for these individuals to reflect upon these experiences while deepening and accentuating narrative meaning. At a deep psychological level, there are perhaps internalized oppressions stemming from a history of oppression and displacement given Spanish conquistador and Columbian influences. As a result of those influences, the Mesoamerican cultural homogeneity was severely disrupted and contributed to the crumbing of a cultural consciousness (McNeill & Cervantes, 2008). And as Duran (2006) described, this generational insult on the psyche can be described in terms of psychological trauma and long-standing history of post –traumatic stress. Perhaps it is these shared beliefs and internalized feelings that may help explain some of the tensions revealed during narrative discourse with participants, and perhaps the "big secret" also describes narratives of psychological wandering and a deep sense of shame and trauma that resulted in a history of geographical dislocation.

The fourth and final research question (And how do these beliefs influence the use of biomedical, biopsychosocial, and/or FTM treatment strategies among this special population?) revealed significant areas of confusion and contradiction related to what FTM services are, where they are located, and who utilizes these services. FTM models are often compared with the dominant biomedical model, although measuring and defining efficacy is difficult. Moreover, although research studies in the area of FTM practices contribute to the confusion given their clear distinction between the terms *folk healing* and *witchcraft,* participants storied FTM practices using multiple descriptors aside from curanderos(as) to describe folk healers, including as *witch doctors, witches, herbalists,* and *Satanists*. This confusion serves to perhaps alter the perception of the types of services curanderos(as) have traditional offered their patients. There were historical reports of curanderos(as) or spiritual healers being embedded in neighborhoods and more modern-day stories that described an ability to find access points within the community, if necessary. There was also a lack of consensus as to who utilizes FTM services (e.g., someone with a learning disorder but not someone who could create remedies at home), which complicates a comparison between the effectiveness of using one or multiple health models to treat individuals suffering from *susto* and DM.

Emerging Theories

Constructing cultural meaning related to self-care practices of Mexican-Americans with DM was explored through the multiple storied experiences provided by the participants in this study. Several theories emerged from this study. One, relevant theory was a strong impression that sharing stories related to folk illnesses, such as *susto*, was one “big secret.” While all participants shared stories about folk illnesses related to

DM, many of them spoke in third-person terms and provided indirect statements about family members, friends, and others who had those experiences. Behavioral observations from these sessions suggested that participants were uncomfortable talking about this subject, While that can be explained by the very nature of "fright" associated with *susto*, there were other non-verbal indicators (e.g., psychomotor agitation) as well as verbal inflections in speech that suggested attempts to actively avoid discussing distressing events or experiences.

There are also religious or spiritual associations (i.e., described as supernatural, paranormal, or magical) that are important elements in folk systems, and there were more overt indications from some participants that God or some belief in faith played an important role in their lives, including health and well-being. At times throughout those specific interview moments, there were impressions that perhaps participants struggled with the comparison that is often placed between folk models of illness and the dominant biomedical model. The decision to use one over the other, neither, both, or another type of treatment modality can leave one with tensions that challenge the perceptions of what it means to be healthy, well, and free of disease and illness. Perhaps these tensions help explain why many of these stories failed to describe more direct and personal experiences with *susto* and why these stories remained hidden within the narrative.

One participant, in particular, felt more comfortable using the words *worrisome*, *stressed*, *trauma*, and *guilt* to describe events in his life but never did use the word *susto* as a descriptor that may have better explained how he was feeling. Yet, when asked directly about this, the participant began to discuss his experience witnessing domestic violence within the home when he was younger. He described how the "trauma" from the experience has been with him since his childhood, and when asked about whether *susto* was an appropriate descriptor to represent his symptoms, inflections in his voice and changes in tone as well as a quick, stern response “No!” reflected elements of distress and suggested he was attempting to avoid the subject of *susto* altogether. Moreover, this participant immediately mentioned after this part of the interview that he felt it would be healthy for one to seek out psychotherapy to help “purge all of that stuff.”

Another participant spoke about her experiences visiting curanderos(as) when she was a young girl. While she denied any experience with *susto* throughout her interviews as well as any connection between *susto* and DM, she described being a very fearful little girl. She also talked about believing that she has some “powers” that were described as being “handed down” to individuals based on how “you lend yourself out.” She was unable to fully describe her fear but it was interfering with her overall quality of life to the extent that her mother often brought her to see curanderos(as) for treatment. There were some elements of confusion related to specifically why she was there and exactly what illnesses the FTM practices were supposed to specifically address. This participant also held a strong position that she did not suffer from *susto* while at the same time ascribing some of her early childhood symptoms to “fears of the unknown.” Yet, this individual currently practices as a nurse and has strongly adopted the biomedical model of illness based on discourse from the interviews. There were impressions throughout the interviews that she has strongly adopted the biomedical model of illness to explain her DM and give support to her self-care practices. Moreover, there were no overt or even subtle indications from the interviews that suggested she would have considered another model of illness (e.g., the folk system model) to explain her illness. She felt very comfortable talking about her illness through the lens of biomedical science in spite of her impression that she may have been handed down some powers for which she has no full understanding. There was an overall indication from her narrative that keeping her past experiences a secret was more protective to her, especially among fellow colleagues and other healthcare professionals who may not share in her explanatory models of illness that constituted a significant part of her childhood experiences.

A second theory that emerged from the study described influences of acculturation and importance attached to cultural knowledge both broadly and more specifically given interactions with practitioners and other healthcare providers who discount the role of folk illnesses and meta-physical experiences in health and illness. A primary difference between the biomedical and folk system approach is the curative versus healing nature of the practices. In non-biomedical settings and practices such as *curanderismo*, health and social relationships are intertwined; in fact, this social relationship encompasses an emotional component with the healing practices that is an important reason many individuals seek out these types of services. Folk healers, such as curanderos(as), are believed to have an innate ability to read and respond to the needs of those seeking treatment, and this emotional connection was storied in the experiences of participants describing encounters with curanderos(as). In contrast, stories about participants' encounters with medical practitioners lacked the emotional tone that was used to describe stories within the FTM encounters with curanderos(as). There was a "clinical" aspect to the conversations as evidenced by the linear measurements each patient was able to provide regarding their DM health status. Although participants generally described a level of satisfaction with their current level of medical care, there were also stories that talked about feeling marginalized because there were impressions that their doctor had never heard about *susto*, never asked about *susto*, acted as if it was not there, and generally didn't want to consider focusing on any symptom reporting that fell outside of biomedical science.

The degree to which a patient is fluent in a particular language will determine the level of comprehension experienced, and this is particularly true with any patient-practitioner (and even interpreter) encounter. Three participants were immigrants to the United States from Mexico, whereas another participant was a natural-born citizen of the United States. In terms of acculturative status, all participants grew up with Spanish being their primary language and the only language spoken at home, with the exception of the natural-born citizen, who spoke only Spanish at home with her parents but became more proficient in English as she immersed herself in the mainstream American population growing up. Compared to the other participants in the group, this participant could be described as being more acculturated and more assimilated into mainstream society as evidenced by her proficiency in English, an adult pattern of English usage over Spanish, and a positive attitude toward a traditional family structure that values the voice of the woman. In contrast, two of the participants were undocumented immigrants and spoke Spanish (i.e, lacked proficiency in English), needed interpreters when engaged in a patient-practitioner relationship within the exam room, and placed value on preserving their Mexican cultural origin. One participant fell somewhere between the others: she was born and raised in Mexico, but she moved to the United States to be with her children well over a decade ago, understands and speaks some English but prefers to speak Spanish, and asks that an interpreter be present in the medical exam room in the event she has problems communicating with her practitioner.

There were exemplars from the interviews that highlighted doubts about whether practitioners were aware of or even cared to be informed about folk illnesses such as *susto*. While participants were aware that medical practitioners use biomedical science to explain disease processes, there was also an impression from participant's storied experiences that perhaps the biomedical framework competed with an understanding that they are patients with cultural roots. Explanations about the etiology of diseases such as DM among the Hispanic community must be delivered in the context of cultural beliefs about FTM practices, but these conversations do not appear to be occurring in the exam room according to the participants. Non-biomedical healing practices often involve some type of social relationship with a healer, such as a curandero(a), whereas medical practitioners place an emphasis on localization of disease on the body and its impact on the organ system.

The emotional connection often experienced in the traditional healer-patient interaction is less common among patients who describe their experiences with a medical provider. It may be worthwhile for providers to ask questions that may elicit more culturally-relevant and sensitive information about patients' illnesses in order to provide the best quality of care possible. No participant described engaging with a provider who asked them about any alternative self-care practices, beliefs in folk illnesses such as *susto*, or whether they believed there were connections between biomedical conditions and folk illnesses. Providers have opportunities to bridge the gap that exists in terms of patient satisfaction with their medical care by asking culturally-relevant questions to their patients, such as the following: Do you believe in *susto*? If so, did you have an experience with it? Can you tell me what happened? Do you use any self-care practices to help manage your illness? Providers would be well served to gain knowledge about frameworks of self-care that reach beyond biomedicine and consider the healing practices that many individuals within the Hispanic community are using as adjuncts to other treatment modalities.

A third theory that emerged from the study described the importance of psychological concerns, both those that might precede the acquisition of DM and those that might partially be the result of DM. Participants described antecedents to the development of DM that generally highlighted heightened emotional symptom reporting, including numerous stories about how stress, anxiety, guilt, worry, or PTSD-like symptoms encompass many areas of their lives, impact their quality of life, and places them at risk for physical decline and illness. It is this type of chronicity of events related to heightened arousal that can have deleterious effects on one’s overall physical and psychological well-being.

There were several narratives from participants that described their impression that psychotherapy would have good utility among individuals suffering from *susto*. While only one participant described having engaged in psychotherapy to assist with her anxiety and fear related to her *susto*, other participants described how they believed psychotherapy could assist someone suffering from folk illnesses, such as *susto*. The biopsychosocial model as proposed in this study addresses these concerns. It talks about a connection between mind and body and acknowledges the disconnection associated with poor communications and misinterpretations between patients with DM and their healthcare provider. However, effective use of this model with Hispanic populations requires a broad cultural knowledge by competent psychologists for which the field is currently lacking. While the proposed use of multiple models (i.e., the FTM and biopsychosocial models) to address concerns related to DM and *susto* may have some utility in practice, there was not clear support for the combined treatment modality in this study.

Participants further described stories that valued the role of therapeutic interventions for stress and anxiety to assist in management of their DM, whereas another participant described the adoption of alternative practices, such as praying and meditation to keep her anxiety levels in balance which in turn would help her better manage her DM. There were also stories about how one's DM condition could be improved if their stress was properly addressed and attempts to recovery from it successful. Participants generally engaged in discourse that described how an increase in stress and anxiety caused their DM to worsen given perceptions that stress and anxiety negatively impacted medication efficacy (i.e., pharmacotherapeutic resistance within the body).

One participant's shadow stories provided further support for this theory. Her stories about experiencing various types of shadows coincide with psychological concerns and associated emotionally-based symptom reporting. She further described physical symptoms, including chills and feeling "very cold" and used several psychological descriptors to emphasize that her symptoms related to fright, stress, and anxiety both preceded and have impacted her experience with DM and *susto*. This participant also represented the only person to have had previous experience with psychotherapy. She expressed that her psychological concerns related to both *susto* and

DM were appropriately-addressed in therapy, such that she experienced significant improvements on linear biomedical markers related to her DM—thus providing support for the utilization of the biopsychosocial model to treat DM and *susto*.

Reflexivity

Research bias is an important consideration when working with individuals in a direct manner that elicits storied experiences. Their storytelling gives meaning to personal experiences and is therapeutic in nature. It provides opportunities to address complexities found within various environments. It is often used as a tool to guide one through accounts or experiences that defy simple explanations and requires a deeper level of inquiry into the complexities of relationships between individuals and related tensions, issues, and concerns. It also boasts power in its potential to impact and transform lives and is less concerned with its inherent semantic properties.

Consideration of the role of the researcher in qualitative research is essential, and the importance of the balance of being an active listener while also keeping one's own personal beliefs and impressions about a participant's story from influencing the interview process cannot be overstated. Careful and deliberate consideration must be given to the delicate and fluid process of qualitative inquiry at the risk of influencing the veracity of participants' stories and obscuring their tensions and concerns. Reflexivity asks that the researcher be mindful of the potential problematic relationship between reliable "real world" representation of participants' stories and the interpretive nature of these stories in a qualitative framework.

My collective roles as a student, therapist, and researcher while in graduate school positioned me as important collaborator of this social research process. The interview process and qualitative methodology utilized in this study demanded that I be mindful of both the subjective and objective nature of the process. My connection as a researcher to the research setting, which in this case was each participant's social world, was particularly close. Moreover, the participants were conscious, self-aware beings who were susceptible to influences by me as a researcher. This influence found its way into the research process at times and had the potential to influence outcomes and also make it less predictable. These concerns are central to the practice of ethnographic research given the intimate and long-term relationship between researcher and participant as well as the complexities introduced by the self-consciousness of these participants in the research setting.

I found this to be a notable challenge during the research process. I was keenly aware that I have a tendency to use non-verbal cues (e.g., facial expressions, hand/arm gestures) as a way to communicate how I feel about messages I receive from others and to convey an opinion at times without speaking. I found myself having to be vigilant that I did not convey such messages and found myself struggling initially in the interview process. As in therapy, the collaboration or alliance that is created from positive interactions with individuals is an asset to the interview process, but there are also potential pitfalls. Another challenge was to put aside my therapeutic nature to assist, guide, and provide consideration points for those who appeared to demonstrate difficulties recognizing problem behaviors that revealed narrative wreckages and punctuated silences in their stories.

Any researcher bias on my part, including previous knowledge gained from immersion into the field of psychology and the topic of diabetes and *susto* acquisition contributed to my overall understanding of the data that was gathered. My observational skills were also critical throughout the process. As a culturally sensitive and increasingly competent student practitioner I am acutely mindful that my close involvement in the society and culture of my client with whom I work has significant implications toward progress and recovery. As such, my immersion into the field of qualitative inquiry provided several surprises in terms of the skill set required to effectively negotiate the process of ethnographic research. This process required numerous adjustments on my part to help ensure that any biases that I had were aimed at further helping me better understand the data I collected. In the next several paragraphs, I describe several occasions where I found myself wanting to interrupt and probe the participant on discourse that elicited a visceral response in me. Active self-control was strongly required of me, and that was certainly a challenge throughout the process—more so toward the initial stages of the research process.

Additional challenges during the research process surrounded elements of relationality to the stories being told. While there was only one instance of a gender match throughout the entire research process, all participants reflected some level of congruency related to cultural identity. Moreover, there were stories of anxiety, worry, guilt, and more specifically meta-physical phenomena that I could relate to as well. These presented as challenges throughout the process as I had a desire to engage in mutual storytelling several times. I recognized that this was not an appropriate approach for ethnographic inquiry and had to restrain myself several times given these tensions. Furthermore, there were observations that some of these participants may have expected the interview process to be more therapeutic in nature. They were briefed prior to and reminded, as necessary, how the research process was not intended to be deliberately therapeutic but could result in having a similar intervention effect given the opportunity for them to disclose personal and often distressing personal experiences. In spite of these clarifications, it was entirely possible for participants to experience the interview process in such a manner.

Discourse among participants that revealed stories about folk illnesses and meta-physical events elicited several instances of controlled internal reactions as well as moments of self-reflection given that I have yet to reconcile my own personal experiences as a young boy living in fear. These early childhood experiences and multiple sociocultural narratives helped shape my overall mental and physical development as a young child growing up in south Texas. Some of these stories included folklore-based and meta-physical type activity, whereas other stories explored the textural nature of these experiences to the development of self over time. There has been little discussion in peer-reviewed literature examining the role of folk and traditional belief models on the health practices of individuals of Mexican-American descent. Nevertheless, the story I share below represents my truths as I remember them and those which have shaped me and continue to shape me in to the person I represent today.

Becoming Part of the Story

As I approached outlining and writing my own reflexive story, I considered myself a co-constructor of this narrative because alternate voices helped form some of the structure of the story. What became apparent while writing my reflexive story was the observation that it had numerous gaps or narrative silences. There were many occasions where I simply was not able to employ perceived, valid memories to tie in gaps in my story. Yet, I felt compelled to tell my story. I'm a person who appreciates symphony (i.e., grasping a global, big picture orientation to something) when constructing, analyzing, and searching for solutions to everyday issues and concerns. To me, the gaps in story represent areas of inquiry that underscore the need for more clarity. They can represent numerous psychological, psychosocial, or biopsychosocial realities and tensions (e.g., repressed memories, dysregulation of social behaviors, high levels of stress, anxiety and/or depressive symptomatology), yet many of us struggle to find punctuated moments in our extended life story to address these issues or concerns.

I can appreciate that my story may elicit strong, uneasy feelings given its meta-physical theme. It is a personal story that is often not shared with others. Nonetheless, it is a story that has persisted over time—one that lies in darkness but begs to see the light. Throughout my childhood years, I vacillated between alternate narratives (i.e., that my own memories were either real or factitious). Without question, the part of my psyche that aimed to protect me from extreme distress wanted to purge these memories into oblivion, but the co-authorship to this part of my story (i.e., my aunt's account of meta-physical activity) kept these memories within beginning in late adolescence. Over time, coping skills have been developed which have allowed me to remove numerous hurdles and obstacles and has improved the overall quality of my life. However, elements of darkness will always persist, but sharing stories and actively working to minimize the impact these experiences continue to have on me are active processes that require daily monitoring. It is hoped that sharing this story can help bring others who read this paper out of their own darkness and allow them to witness and experience some level of relationality to the story such that they can begin their own process of healing.

My Background Story

Many of my childhood memories are pleasant. I grew up surrounded by my paternal grandparents and my maternal grandmother. My mother had a strained relationship with her father, which along with a language barrier, meant that my opportunities to get to know him in any meaningful way were limited. Instead, I remember visiting my maternal grandmother along with aunts and uncles who were still young and living at the ranch where my mother grew up. I recall receiving love and affection from my family, although I had extreme difficulty communicating with my grandmother given our language barriers.

I am Mexican-American born in a small south Texas community with a population near 20,000 and less than an hour away from Corpus Christi, Texas. I represent one of many familial generations who were born and grew up in the surrounding community. I have one sister who is 4 years younger than me and a nephew and niece, all of whom are back home in south Texas. I grew up surrounded by many relatives in large part because my parents grew up in large families. My father is one of 7 siblings born to parents who spoke primarily Spanish but began to acculturate more to the American system that values English as a spoken language once grandchildren began to populate the picture. We grandchildren were encouraged to speak English growing up because at some point it was determined that the English language would create more opportunities in terms of career choices and potential roads leading away from poverty. My mother, in what was not considered to be so extraordinary at the time (i.e., 1940's, 50's, 60's), grew up as one of 17 siblings born to parents who only spoke Spanish. She grew up in a ranch near home. There was one sibling I learned about just a few years ago who was “sick” and only lived until he was about 6 months of age. I had never had discussions with my mother about her brother while growing up nor did any of my aunts or uncles ever mention him. It wasn’t until just recently that I asked and was told his name. Yet, I was confused because I grew up knowing I had an uncle with the same name. He’s alive and well and living in Dallas, Texas! My mother provided me with no explanation to help clarify why this name was reused and not permanently assigned to her brother who died in infancy. Before that, I had always been told that there were a total of 16 members of her family and learned about him. My mother grew up in a ranch near my hometown, and because of the size of her family grew up with only a few of her 16 siblings. She developed special relationships with many of them but has remained disconnected to some of them.

Early Childhood Memories and the Emergence of Fear and Anxiety

My earliest recollections of events and experiences that have become the basis for fear and anxiety in my life began around age three. I was merely a little boy who, at the time, lived with my parents. My sister, who is four years younger than me, had not yet been born. I have fragmented memories of my early childhood, but some themes from childhood have persisted. I remember living in an average-sized home that was constructed of wood and painted white. We lived in a corner lot located in the middle of the street. To the outside world, it must have appeared as a mundane home, but to me, it was anything but mundane.

I distinctly remember an incident inside the home that has persisted in my memory for decades. It was daylight outside, and I remember my parents and I were taking a nap. Standing at the foot of the bed, my mom was positioned on the right side of the bed, my dad in the middle, and I was positioned on the left side of the bed. I recall that I was lying on my tummy with my left arm, forearm, and hand slightly stretched out to my left as well as my head turned to the left facing away from my parents. Although I was not aware of this at the time, I was told years later that we had no pets at that time in this house. What I recall at some point during my nap is the neurosensory impression of the tip of a long fingernail scratching my left arm. I could both hear and feel the scratch moving perpendicularly down my arm. It happened once, and then it began to repeat itself. The scratch felt both deliberate and slow. My memory of that day cannot precisely estimate how many times I was scratched, but I was awakened at some point by the scratch (perhaps immediately) and refused to open my eyes. Instead, I nudged my father with my right elbow and woke him up. Once both of my parents woke up, I recall waiting for a verbal alarm to go off, which ostensibly would provide credibility to my story. There was no alarm. I recall telling my parents what happened, but I do not recall many more details of that event. Perhaps my psyche decided to protect me by repressing that memory to some extent.

Over time, living in that house became my own personal nightmare. I recall having a vision of a scary person in my mind, a monster to a three year old child, if you will. That face would come up repeatedly, but perhaps at the time I did not have the language to articulate my story to my parents or extended family (e.g., aunts, uncles, cousins). What was certain was that I developed a deep sense of fear while living in that house. We had a long hallway that always appeared to be dark. The organization of the light switch was such that the only way to illuminate the hallway was to turn the switch on and off at the far end of the hallway—the end farthest away from the bedrooms. I recall running and looking behind me in the dark when I had to either run down the hallway or turn off the switch and run to one of the bedrooms. I recall being a child who was easily startled and one who felt there might be some presence in the house along with my family and me. I thought I may have even seen an empty chair in a bedroom rock on its own, but that memory is rather vague.

Nevertheless, a story about an event that took place within the home was described to me by an aunt years later. Her story provided strong support to my recollection of memories I had about my life in that house. She told me that one night she came over to babysit while my parents were out at some event. She explained that while I was in the back bedroom (i.e., my parent's bedroom), she came up front to the living room to "straighten it out and organize the pillows on the sofa." She said that after organizing the living room she came back to the bedroom to spend time with me. After a few minutes, she said she heard loud noises coming from the living room that subsided after a few seconds. She ran from the bedroom to the living room to observe what had happened. She said she could not believe what she saw. The living room was found in complete disarray. The sofas were turned over, and the pillows were strewn about the entire living room. When I asked her about pets being the possible culprits, she stated that we did not have pets at the time. When I prompted her with questions as to her immediate reaction after witnessing that event, she told me that she reorganized the living room and went back to the room to check on me. She did not elaborate much more on the event other than to say that she felt the house was haunted. She pointed out that her brother (i.e., my mom's brother) and his wife occupied the house after my parents and I moved out. They too began to experience meta-physical activity, which was extinguished after the house was blessed. As of this day, I have not communicated more extensively with her about any of these experiences, although I feel comfortable that I could revisit these stories with her at any time.

Within a couple of years after that incident, we moved out of that house and into another home in town. I have fond memories in that home but also recall that my fears that constituted much of my time in the old home followed me to this home. I remember being scared of dark closets and at times thought I saw a pair of eyes staring back at me. However, I also remember that I was into Swamp Thing, a mythical, green swamp creature that both thrilled and scared many of us little children during that time. I am convinced that I had a life-sized poster of the Swamp Thing that glowed in the dark. Perhaps that is what I remember seeing in the closet—at least that is how I have rationalized that moment in my head. Otherwise, life inside that home was mostly unremarkable.

At some point, based on my own interpretation of the events (and my own recollection of memories), my parents understood that I was a fearful child. I say this with confidence because I recall an event when I was around five years of age where my dad took me outside and asked me to look into a small brush fire he had created. I remember him throwing something into the fire and asking me to look into it. He told me that looking into the fire would cure me of fright. He told me to look for a red eye in the fire and asked me repeatedly if I saw the red eye. The process took a few minutes, but I reiterated to him at the time that I did not see the red eye in the fire. After a few minutes, I remember feeling that my efforts were futile and that the process had seemingly ended.

My family and I lived in that home for only a few years before moving to the home that my parents currently live in.

Life took over after that. For the years that followed, I spent time living life and meeting milestones that were expected of me. There were instances, however, where my dad and extended family had to deal with other meta-physical activities. For example, when my paternal grandfather passed away, my dad experienced meta-physical activity. I did not witness any of these events but was told about them during the days following my grandfather's passing. My father told me during the time between my grandfather's death and his funeral, there was a knock at the door. When he opened it, no one was there. However, there were swirling winds around the front door on a day when the climate was calm. He also told me that he saw a dove perched on a planter hanging outside the front door. He explained that it was unusual to find any doves around our area during that part of the year (i.e., early January). I was fascinated at the time to hear about my grandfather's story, but I was not afraid. Growing up, I was conditioned to hearing about folk stories and the occasional story of meta-physical activity. Our culture is rich in stories related to death and dying and fear, pain, grief and loss. Couple those stories with a traditional Catholic upbringing, which constantly invoked fear of Satan and Hell in me, and perhaps I can understand why fear persisted for some time or perhaps why I may have necessarily hidden away some of those fears for years.

At some point, although I cannot specifically recall when, the fears that pervaded my life when I was a child began to fall to the background. Over time, the darkness has given way to light, and I have been able to move forward and do well in life. Perhaps the "noise" of the busy life of adolescence and young adulthood has masked or silenced some of the darkness that has lain hidden away over the years. Or perhaps the stories that I want to share have coalesced with a resolve to form an alternate story that may give new meaning to some of the experiences I have had since childhood. Perhaps through my quest for answers I will gain new insight and be able to successfully attenuate fears that have impacted my life for several decades. It is further hoped that this enhanced level of awareness will translate into becoming a more effective clinician in the future and equip me with the tools to help others who share similar stories of fear and anxiety to also begin to the see the light.

Exploring the Story Through the Lens of Psychology

For me there is an implication of struggle and of overcoming the struggle to the extent that one's "ship" remains afloat and can endure most storms that come in its direction. To some readers, my story or that of others presented in this study may not warrant inclusion into a compendium of health narratives, but what health means to an individual is subject to broad interpretation. From a biopsychosocial angle, these meta-physical accounts may significantly impact levels of stress, distress and anxiety such that their chronic nature leads to a decline in health functioning and illness. Chronicity of events related to heightened arousal can have deleterious effects on one's overall physical and psychological well-being.

I can attest with some degree of confidence that I have been negatively impacted by the heightened sense of fear and anxiety associated with these experiences over time. It is possible that aggravating factors such as fear and anxiety may have contributed to the variable expression anxiety and physical illness throughout my life. As Geist-Martin, Ray, & Sharf (2003) describe, our bodies tend to disappear when functioning without observable or perceived problems but often grabs our attention where there is a shift in sufficient or optimal functioning. It is during those poignant moments that our bodies begin to give voice to energies or forces that stand to create disequilibrium or disrupt the flow of energies within our bodies.

Reinterpreting the Story Through Theory, Research and Practice

In reverence to the work of Arthur W. Frank (Frank, 1995), I think of myself as a wounded storyteller whose wound holds narrative power and whose voice, though often silenced by my fears and anxieties, yearns to be heard. Perhaps more recently I have wanted to share my story with others because I have wanted to assume more responsibility for my life. I believe I am at a crossroads where two options lie before me. I can decide to either leave my story interrupted and my voice silenced, or I can take responsibility and overcome the desire to leave an uncomfortable story untold.

In his book entitled *The Wounded Storyteller,* Arthur W. Frank identifies three types of narratives individuals commonly use to give meaning to illness experiences. The most common is the restitution narrative, where individuals who are ill are restored to ideal functioning through a process of treatment and healing. The second type of narrative is the chaos narrative, the equivalent of narrative wreckage, where an individual remains in a state of suffering (i.e., their voice is lost) and in disrepair unless their illness is redefined as a treatable condition. It is at that point that the restitution narrative is restored. The third type of narrative is called the quest narrative, where a suffering individual accepts the experience of illness as the beginning of a journey in which their voices can tell the story of illness and restrain chaos (Frank, 1995).

I can understand and relate to all three types of narratives as depicted by Arthur W. Frank in his book. In early childhood, the chaos narrative guided my story, although for many years I was unable to articulate my feelings and emotions into words. However, I knew what I was feeling at the time. I could distinctly conjure up imagery that was associated with the fingernail running perpendicularly down my arm. The face that haunted me during those occasions pervaded my memory for years. During these chaotic times, I am convinced I gave my parents some indication of my distress. There had to have been numerous non-verbal (e.g., tantrums, defiance, oppositional gestures) or even verbal (e.g., the rate, frequency, and duration of my crying spells) cues that were displayed to my parents during that time. I know my messages were ultimately received because I had to endure a failed attempt to cure me of fright by taking part in a folk ritual (e.g., “red eye in the fire” curative ritual) ostensibly designed to attenuate or extinguish my fear.

As my “illness” progressed, the story began to shift over time. There have been brief moments throughout my history where the quest narrative has afforded me a voice as the narrator of my own story. Today, I am on a quest to share my story or as Carabas & Harter (2005) described it—to retell my story over and over again in an effort to slowly rebuild my wrecked ship. During moments where my psyche determined it was best to protect me from extreme distress and repress some of these memories I began to experience some level of restitution. While there was no treatment involved during those times, there was a perception of healing that took place. Through early adolescence and adulthood, my understanding of psyche and soma and the psyche’s ability to protect the mind from acquiescence, was limited. As a result, this limited understanding may have enhanced my protection to some degree because I was not able to effectively reconcile these tensions at the time. Perhaps this explains why over time these memories have begun to re-surface. Perhaps I am developmentally more equipped to immerse myself in the difficult task that often engulfs those ill-prepared or just more confident that I can weather the storms inherent to the journey.

Continuing the Conversation and Embracing an Alternate Narrative

There has been less anxiety associated with the re-telling of my story today than in the past due in large part to my impression that I am surrounded by audiences (i.e., friends, family, coworkers) that are truly interested in hearing what I have to say. Perhaps I have an impression that an “intellectual forum,” such as a classroom or clinical setting, is an example of a setting that is non-threatening or at best is least likely to conjure up feelings of distress and helplessness. However, that may not have always been the case. I imagine that I may have always considered an “intellectual forum” or an “average social forum” just as equally threatening. Nevertheless, what constitutes who I am at this point in my life is a history of the exponential power of the narrative (i.e., the resulting force of experiences storied over time that have built upon one another to deepen and accentuate the meaning of my experiences), and I am encouraged by movement in a direction that aims to inquire further and one that appears to be self-sustaining at this time.

I am aware that as my story evolves so does my self-identity (Sharf, 2005). In fact, there is a constant impetus to define and redefine my self-identity. However, I also understand that as long as we live and breathe, some level of fear and anxiety will persist within each of us. Perhaps that is meant to be part of the human experience after all. What I can do for myself is learn how to confront the fears and anxieties and use my voice as a coping strategy to render these negative emotions powerless. As Harter, Kirby, Edwards, & McClanahan (2005) explain, “narratives can serve as points of struggle or tension over meaning and can also enable and constrain the human spirit, health communication, and healthcare decision-making” (p. 87). It is my hope that the experience of telling their stories will have enhanced the lives of my research participants.

Study Limitations, Strengths, and Implications for Clinical Practice

This study is not without limitations. One limitation involved sample size and sample representation. In spite of considerable efforts to find participants for this study, persistent barriers to accessing them provided a challenge in terms of sample size. They tended to be embedded within the community and often inaccessible. While it may have been more feasible to acquire participants who were Mexican-American and had diabetes without knowledge of *susto*, this approach was not supported by the study design and would not have yielded meaningful, empirical results. While the purposive sample strategy provided a guideline for this study and also provided a range of characteristics present in the population and of interest to the research study design, the small sample size provided a challenge to data saturation. Yet, researchers have indicated that one factor that might impact sample size may include studying groups of special interest that require intensive study (e.g., Ritchie, Lewis, & Elam, 2003), whereas some grounded theorists have supported smaller studies with modest findings (e.g., Glaser, 1998; Stern, 1994a).

Another limitation was the composition of the study’s sample. Participants in this study represented a higher age range of adulthood, 44-69, with a cluster of participants within the 44-47 range. No participants reflected a younger adult demographic, which did not allow the study to further explore differences in acculturation and descriptions of how *susto* may have been variably defined by generational gaps. Furthermore, the majority of participants were female (i.e., 75%), with only one male in the sample. As such, the study participants did not fully represent a robust age range or reflect diversity in gender, which is as a limitation of the study.

An additional limitation of this study reflected a non-measurable approach toward acculturation status and an assessment of ethnic self-identity—at least explicitly through intentional design. Rather, information related to acculturative status was inferred through qualitative inquiry throughout the interview process and used to describe theoretical (in)congruencies related to the evolution of *susto* definitions within the folk system of health and illness. Moreover, ethnic self-identity was not fully assessed in this study beyond qualitative descriptions extending from questions, such as “Tell me a story about what it is like to be Mexican-American.” Throughout the study, no participant challenged the forced-choice descriptor, which may also reflect another limitation of the study in that participants may have felt that they needed to respond in a manner that was consistent with what they felt I, the researcher, expected to hear.

A subsequent limitation concerned the role of gender in this study. While only one male participated in this study, there were overt, observed psychological and physical tensions in his speech and affect. As previously mentioned, male Hispanics are often reluctant to disclose extensive personal information to other Hispanic males. While this participant appeared to be initially more reluctant to disclose personal information at the beginning of the interview, he was able to overcome his tensions to a moderate extent and provide indirect clues as to the nature of his distress, worry, and anxiety. In this case, there was no overt evidence of machismo at work that included efforts by this participant to exert elements of aggressiveness or dominance throughout the interview. Rather, an ease of discourse was quickly established throughout the interview, which may have provided opportunities to witness some level of indirect disclosure of information from this participant. However, the fact that only one interview was obtained with one male participant does suggest that future research might explore gender differences in the constructs in this project.

Another limitation of the study reflected the need to interview a younger demographic population to explore generational definitions of *susto.* There is a need to gain better understanding as to whether *susto* still exists, is in flux, or has changed name or meaning over time. While older Hispanic populations have embraced the traditional definition of *susto* according to empirical data, it is unclear whether that traditional definition has changed meaning over time. Unfortunately, this study was unable to clarify that question given difficulties finding a younger demographic population who had both diabetes and an experience with *susto.* It is possible that the traditional definition of *susto* may be in flux and that a more broad age representation in this study may have provided more clarity along this area of inquiry.

One additional consideration that potentially represented both a limitation and a strength was my level of Spanish proficiency as the study researcher. There were both within and between-group, regional dialect differences evident in this study. That said, my proficiency in Spanish does not meet the level of fluency such that I am able to both translate and back-translate multiple Spanish dialects. Regional dialect differences present a significant challenge for most researchers, including Spanish-speaking researchers. Anecdotally speaking, I recall having discussions with other interpreters well-versed in Castilian Spanish, for example, while a student practitioner in a medical clinic setting who described the difficulty in understanding more “Spanglish” or “Tex-Mex” forms of Spanish, which is often associated with south Texas and parts of the border regions adjacent to areas of northern Mexico. From my experience, being proficient in “Spanglish” and “Tex-Mex” has had good utility in practice. Throughout the study, this proficiency was useful in that it helped me effectively translate and capture intended meanings of words from multiple Spanish dialects. This helped ensure that participants’ stories were accurately represented in the study. That said, there were occasional when participant statements needed further discernment as to their intended meaning by the participant. In all cases, clarification was requested during or after the interview in the event the parts of the discourse was not completely understood because of a perceived language barrier.

In terms of strengths of the study, the greatest strength is that it reflected a novel approach to examining stories of self-care practices and diabetes through the lens of folk illnesses, such as *susto*. Effects of ethnicity on self-care practices and misconceptions about their storied experiences have had deleterious effects on the overall health of many Mexican-Americans. Furthermore, their encounters with practitioners (i.e., historically White practitioners) have been strained by a disconnect between the cultural frameworks that often clash in the examination room. As the study revealed, participants felt they would be marginalized if they openly shared stories about beliefs in folk illnesses and self-care practices used to treat those conditions. The originality of this study offered new insights and increased the “usefulness, and the subsequent value of the contribution” (Charmaz, 2006, p. 183).

A case could be made that conducting multiple interviews that provided openings to create meaning from participants’ rich experiences represented a strength of this study. Multiple interviews provided opportunities for rich, meaning-making of participants’ experiences. Three out of the four participants were able to provide multiple interviews throughout the study. These multiple interviews provided several trajectories that I was able to follow to obtain deeper information. In some cases, tensions were revealed and previously unspoken stories were shared. As a whole, participants began to feel more comfortable sharing their stories throughout the interview process and slowly began to reveal intimate details about their personal lives. This created richness in the data and contributed to theme generation and theory making processes.

Another strength of this study is its relevancy and timeliness in addition to its worthiness as a topic of inquiry. It is those studies that are counterintuitive and question take-for-granted assumptions that are often worthwhile. As mentioned above, there is little research to guide the relationship between patients and practitioners/clinicians who are of different cultural backgrounds. Furthermore, there are only occasional studies that talk about both diabetes and explanatory models of illnesses that extend beyond medical science (i.e., psychological sciences) among individuals of Mexican-American descent. The literature also does a poor job of assessing ethnicity among Hispanics who engage in FTM practices, and there is no delineation between acculturative markers such as Mexican, Mexican-American, and Chicano, for example. There is also a lack of consensus on definitions of concepts related to health beliefs and illness and sick-role behaviors among Mexican-Americans. Often studies focus on traditional perceptions of illness and disease management, but this study delved into folk belief systems and non-traditional perceptions of illness and diabetes management.

Another marker of excellent qualitative research is a study characterized by sincerity, and there is reason to believe this study meets that criteria. This study includes a thorough review of self-reflexive biases and values and offers a candid description about the challenges faced throughout the study. It also offers resonance in that it has the potential to affect or move readers given its evocative representation of storied experiences that include meta-physical phenomena. These experiences reflect a level of relationality for a variety of audiences given that there are numerous stories of reported transpersonal experiences throughout history and across cultures. Individuals who experience such transpersonal events sometimes seek therapy, although – unfortunately - there is no consensus among the field of psychology on how to help these clients. As such, the implications for clinical practice are wrought with indecision and uncertainly.

This study also provides a significant contribution in conceptual, practical, and heuristical terms. Conceptually, this study reflects often hidden stories that reflect new tensions and provide insight into considerations to improve clinical practice. It also provides clarity to what remains confusing while making visible what is hidden or inappropriately ignored. Moreover, it offers a sense of insight and incremental understanding of the explanatory models some Mexican-Americans use to address illness and recovery through the use of non-traditional self-care practices. There is also heuristic value in this study in that it has the potential to move others to explore, research, or act upon the research in the future. This study drives curiosity and has the potential to strongly influence a reader to want to learn more about themselves in addition to areas that inspires new discoveries. The implications from this study are such that it has the potential to spur additional research and influence a variety of audiences (e.g., other researchers in multiple fields, the lay audience, or even policy makers).

Lastly, another strength of this study is that it offers consideration points or highlights deficiencies in therapeutic and medical practices. The reader is provided with insight as to the clinical significance of practitioner self-awareness. There is an emphasis on the importance that being sensitive to one's own beliefs and assumptions of health and illness given how biases have the potential to influence therapeutic and clinical processes. Moreover, it purports to demonstrate how important it is to recognize the limitations of personal knowledge of indigenous practices and worldviews and places value on potential collaborative relationships between biomedical practitioner and folk healers. This study also demonstrates how gaining culturally-specific knowledge of explanatory models of illness can positively impact the practitioner-patient relationship in a positive manner such that the patient is provided a level of treatment that appropriately and effectively addresses their concerns and offers a meaningful approach toward recovery. There is also an implication from this study that gaining competency in areas related to alternative treatment modalities and using culturally-specific descriptors in proper context is a more ethically responsible approach in clinical practice.

Implications for Clinical Practice: Meta-Physical Experiences of Clients Seeking Treatment

As is the case in medical practice, the use of FTM practices for those suffering from folk illnesses are often considered irrelevant to psychological practice. This limited view has significantly impacted the therapist-client relationship and serves to promote cultural conflicts between therapists and a subculture of clients with alternative healthcare beliefs and practices (Falicov, 1998). As a result, modern psychological practice has failed to embrace culturally-appropriate approaches to meeting the psychological needs of clients. Currently, there is no universal system in place to evaluate and interpret the psychological attitudes and beliefs of patients in a culturally relevant way, which can leave too much room for subjective interpretation (Wing, 1998). Nevertheless, individual's unconventional belief systems have persisted for generations, have deep historical roots, and continue to influence their understanding of phenomena (Aranio & Lindeman, 2007; Lazar, 2001).

As Lazar (2001) points out, "a major obstacle to the thoughtful consideration and integration of paranormal evidence is the fact that paranormal phenomena do not fit within the generally accepted models of how the universe works" (p. 113). Its existence violates the generally accepted laws of the universe. Furthermore, she explains that another issue facing more global acceptance of meta-physical phenomena is the argument that its effects are more subtle and cannot be consciously or sequentially replicated. I certainly have not heard any evidence from my clients describing an ability to replicate meta-physical activity at will, but that should not minimize their experiences.

Understandably, meta-physical experiences are often inexplicable in terms of scientific laws or normative perceptual patterns of reality. Sollod (1993) highlights that meta-physical activity is more prevalent than one might suspect. In fact, she highlighted some information from past surveys. According to those surveys, 29% of American adults reported visions, 67% reported extra sensory perception (ESP) experiences, 31%

had experienced clairvoyance, while 67% indicated *déjà vu*. Furthermore, according to an antiquated but interesting finding in a 1985 Gallup poll, participants reported experiences with spiritual phenomena over two generations ago with 43% reporting an unusual spiritual experience at the time and 15% reporting having had a near-death experience. The topic of near-death experiences has not come up in therapy thus far nor has the topic of clairvoyance or ESP. That in itself is an interesting observation given the population I work with most often. What I have encountered most often in therapy are discourses related to unusual spiritual experiences that are culturally-bound. With no universal system in place to guide me, I have done my best to help individuals remove obstacles from their lives in order to enhance its quality. The task has not been simple, but there is some merit in positioning myself as an active listener who is there to help these individuals.

While there are many other observations and stories I could highlight in working with special populations, in particular Mexican-American populations, I wanted to include a description about how meta-physical experiences influence and often complicate the delivery of optimal mental health services in therapy. Oftentimes the stories themselves are both fantastic and scary, but as a student therapist I must ensure that I leave any personal, biased beliefs about the meta-physical out of therapy. There have been occasions in the past while engaged with fellow colleagues in classroom settings where I have encountered resistance or even elements of marginalization because of the types of clinician-client experiences (e.g., meta-physical stories) I was sharing in class. While I could have appraised and reacted to that occurrence in a less than positive way, I actually appreciated the fact that a couple of classmates shared discourse on the subject of meta-physical stories in clinical practice. Those experiences have continually remind me to always stay balanced in thought and not allow myself to live in the extremes, while providing me with a critical lens from which to view and interpret the world.

The meta-physical stories I have had the privilege of listening to in therapy reflect a spiritual view that resonates loudly with my own cultural upbringing. Perhaps part of my own childhood experiences with spiritual or meta-physical phenomena may explain my curiosity with this topic. I see my work with clients as an opportunity not only to serve them but to serve myself. Should a day pass where I happen have a meta-physical experience, I wish myself the continued confidence and courage to share my story with others in the hope that it will illuminate the darkness that can envelope those who suffer from the anxiety, fright, stress, guilt, and worry that these experiences bring to them.

Directions for Future Study

Taken together, the study limitations provide entry points for discussion for future research design and inquiry. Such studies may benefit from establishing inclusion criteria that both maximize the potential for participant involvement while also maintaining rigor, credibility and validity of findings by exploring relevant research questions that extend from gaps in the literature. Currently, the literature fails to adequately explore inter-generational differences related to the description of folk illnesses, such as *susto,* and the impact such belief systems have on the self-care practices of people with diabetes. Furthermore, there is insufficient attention given to understanding individuals' explanatory models of FTM such that interventions are designed to inform healthcare providers about the cultural or indigenous worldviews of explanatory models of illness.

There is a need for more studies that explore the limitations of healthcare provider's knowledge of indigenous concepts and worldviews and the strain those deficiencies are having on the patient-practitioner relationship.

Future studies should also consider making considerable efforts to establish consultative relationships with folk healers to inform their research design or contribute to the interpretive process of the study by becoming part of the story as a participant. Such inclusion is critical in terms of clinical implications in practice as there is a dearth of information in the literature that provides guidelines for such collaborations between folk and traditional disciplines. Gaining insight into the practices of folk healers, such as *curanderos(as)*, can help dispel myths both Western medicine and the field of psychology have about such practices. The difficulty in finding access points can be further explored by designing studies that specifically address this question. There should also be consideration as to the geographical location of interest based on other studies that have identified general areas of inquiry that show promise (e.g., south Texas or the American Southwest). That said, given exponential growth of Hispanic populations throughout several regions of the United States, such as Chicago, IL, and even locally in Charlotte, NC, researchers in other geographical regions of the United States now have opportunities to explore research questions that have been historically restricted to areas that were proximal to the U.S.-Mexico border regions.

Another area of future study relates to the confusion and contradiction associated with the nature, location, and utilization of folk healers, such as *curanderos(as)*. Future studies should consider clarifying the label descriptors used to classify and characterize folk healers. There is significant confusion and contradiction as to the nature of their services, location of services, and who is likely to utilize their services. This study also revealed several names (e.g., *curanderos(as)*, *witches*, *Satanists, herbalists*, *witch doctors*) that provided a descriptive label by participants about who provided non-traditional, folk system-based care for those seeking help for some type of illness or concern. These multiple descriptors perpetuate a pattern of confusion in clinical settings and contribute to tensions that often find their way into the patient-practitioner relationship. There is a significant need for future research studies to untangle the complexities inherent with such descriptors and reveal shared practices and differences in treatment services offered to those who seek them out. To not do so perpetuates the stigma often faced by those who seek and those who provide folk treatment services. It also sends an implied message that practices that fall outside traditional, Western medicine models are not worthy of serious consideration for treating illness and general health concerns.

Future studies could employ a quantitative approach to further explore the relationship between *susto* and self-care practices among Mexican-Americans with diabetes. For example, a group of specific questions aimed at eliciting rich information about *susto* and self-care practices among Mexican-Americans with diabetes could find entry into large, health-related surveys, such as the National Health and Nutrition Examination Survery (NHANES) or the National Health Interview Survey (NHIS). Questions could be asked of all participants who identify as of Mexican descent. Possible questions include, but are not limited to, the following: have you ever heard of *susto*?; what label would you use for a *susto*-like condition or experience?; how do you define *susto*?; do you utilize any FTM practices?; do you or have you accessed FTM practitioners?; how did you find that person(s)?; why did you seek out an FTM practitioner?; did you use any adjunctive therapies as a self-care measure?; what did you hope to gain from it?; do you feel any of the treatment strategies worked for you?; if so, how?; and if not, why not?

Purposive sampling methods that aim to inform research questions and provide a guideline for the inclusion of participants should consider one's level of acculturation and self-identifying ethnic markers when designing future studies. In fact, exploring self-care practices among those who may engage or would otherwise consider adopting non-traditional approaches to healing and recovery from illness (e.g., visiting *curanderos(as)*, *witch doctors*, or *spiritual healers*) may reveal additional, perhaps hidden, tensions not yet explored in the current literature (e.g., meta-physical phenomena that may be shared among groups of individuals who choose to engage in non-traditional self-care practices) Several studies also fail to assess participant's level of acculturation and self-identifying ethnic markers prior to engaging in data collection efforts. These oversights likely extend from poor methodological design that leads to inadequate variation sampling efforts and may not adequately represent the population of interest. It is important that future studies be designed to overcome these potential threats to good qualitative research and that research questions further seek to clarify which ethnic populations are more likely to seek folk remedies to treat folk illnesses, how acculturative status factors in to this process, and whether age and gender mediate and/or moderate the relationship between acculturative status and self-identity markers.

Concluding Thoughts

This study explored self-care practices among Mexican-Americans with diabetes through the lens of *susto* and folk illness. Storied experiences revealed tensions and narrative silences while also capturing strong voices that shared stories about meta-physical experiences, such as seeing shadows. Narrative discourse further revealed physical and emotional symptom reporting that highlighted feelings of anxiety, stress, worry, and guilt. Participant's negotiation of self-care practices for diabetes and other non-medical concerns, such as *susto* and psychological concerns, also found voice in this study. Furthermore, tensions between patient and practitioner were also revealed, including perceptions that one would be marginalized or made to feel uncomfortable for disclosing their engagement in folk systems of care and with folk healers, such as *curanderos(as).* This study helped give voice to Mexican-Americans with diabetes who struggle to negotiate between multiple self-care practices to maintain good health. Their challenges reflect a Western worldview that embraces biomedical models of illness while minimizing the efficacy of other treatment modalities that purport to enhance physical, psychological, and spiritual harmony and balance.

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APPENDIX A: INFORMED CONSENT FORM

Informed Consent for Mexican-Americans with Diabetes

Research Study: *Exploring folk and traditional medicine and self-care practice among Mexican-Americans with diabetes*

I, ______________________________________, agree to participate in the research being conducted by Michael Villanueva, a doctoral candidate at the University of North Carolina at Charlotte, under the direction of Amy Peterman, Ph.D. (Department of Psychology), Christine S. Davis, Ph.D. (Department of Communication Studies), and Margaret Quinlan, Ph.D. (Department of Communication Studies), from the University of North Carolina at Charlotte, 9201 University City Blvd., Charlotte, NC 28223.

- Purpose of study

The purpose of this research study is to examine the healthcare experiences of Mexican-Americans with diabetes. More specifically, this study will explore the folk and traditional medicine practices and self-care practices of Mexican-Americans suffering from diabetes as it relates to their belief in *susto*, a folk illness of Mexican origin. You will be one of approximately ten (10) people involved in this research project at the Charlotte Community Health Clinic, and your participation will last for several weeks to months until all data collection efforts have been satisfied. Each interview will last approximately 1 hour.

- Who can be in this study?

You may participate in this study if you are Mexican-American, age 18 or older, have diabetes, and also have experience with *susto.* Participation in this study is completely voluntary. It is not part of your medical or psychological care that you receive at the Charlotte Community Health Clinic or part of any evaluation of you as a patient of this clinic. Your decision about whether or not to participate in this study will have NO effect on the care you receive as a patient of the Charlotte Community Health Clinic.

- What would I have to do?

After your questions have been answered and you have given your consent to participate in this project, a meeting will be scheduled between you and the Principal Investigator, Michael Villanueva. This meeting may take place on the same day or a different day, depending on what is most convenient to you. At the meeting you will be asked a series of questions pertaining to diabetes, self-care practices, and your experiences with susto.

Furthermore, you will be asked to participate in approximately 8 to 10 interviews with the researcher over the next several weeks to months. Each interview will last approximately 1 hour. You may agree or not agree to participate in any part of the research project at your discretion. Collection of research data (i.e., your verbal responses) will be digitally recorded and transcribed by the researcher. Non-verbal responses (i.e., your body language, behaviors, and gestures during the interviews) will be recorded in written form. Digital recording allows us to record your exact words so that we can better understand your experience, whereas written notes allow us to record non-verbal responses that are otherwise not captured by digital recordings. Both types of response recordings allow us to more completely capture your experiences throughout the interviews. The digital recording files and written notes will be identified only by a code number that can be linked to your name. The list linking the name and code number will be kept in a locked office with only the investigator having access to the information.

Throughout the interviews, you will be asked questions about your culture, your health, your diabetes, your spirituality, your lifestyle and diet, and your experience with *susto*. While it is important that you answer all of the questions, you can refuse to answer or skip any questions that you wish. You can also stop the interview at any time without penalty. There are no medical tests or drugs involved in this study. There will be up to 10 people participating in this research.

- What are the pluses and minuses of being in this study?

Pluses: You may or may not benefit from your participation in this study; however, the information learned may help others in the future.

Minuses: There is a small chance that participation throughout the interviews could cause minimal psychological distress as you think about the ways in which diabetes and susto have affected your life.

- Are there any additional costs to participating in this study?

There will be no additional costs to patients for participation in this study.

- Is there any compensation for participating in this study?

There is no compensation for participating in this study.

- Can I withdraw from this study at any time?

Your participation in this study is completely voluntary. You should feel under no pressure to be in the study. If you decide not be in the study, that will not in any way harm your relations with your doctors or with the Charlotte Community Health Clinic.

You are free to stop being in the study if you change your mind after entering it. This would not harm your relations with your doctors or the Charlotte Community Health Clinic.

- Privacy

Your participation in this study is protected. Steps will be taken to protect your privacy and maintain the confidentiality of your data. At no time will your identifying information be used in conjunction with your responses to the research questions. To ensure confidentiality, your responses will be assigned to anonymous identification numbers. Data will be store in a secured, locked cabinet that only the principal researcher and his advisor have access to in order to run analyses. All data, including digital recordings and written notes will be destroyed within one year after data collection is complete.

Please keep in mind that as a participant you will never be asked to give up any of your rights. There are no foreseeable risks to you stemming from participation in this research. You will receive no monetary compensation for your participation.

- Statement of Fair Treatment and Respect

UNC-Charlotte wants to make sure that you are treated in a fair and respectful manner. For questions about this study, contact the principal investigator, Michael Villanueva, or his advisor, Dr. Amy Peterman. For questions about your rights as a research participant, please call the Office of Research Compliance at the University of North Carolina at Charlotte.

This form was approved for use on *August 8, 2011.*

- Consent

I have read the contents of this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my liking. I am at least 18 years of age, and I agree to take part in this research project. I understand that I will receive a copy of this form after it has been signed by me and the person running this research study.

___________________________________ ______________________

Participant name (PRINT) Date

____

Participant Signature

I have explained and defined in detail the research procedure in which the participant has consented to participate.

____________________________________ ______________________

Investigator Signature Date

APPENDIX B: INTERVIEW PROTOCOL

UNC CHARLOTTE

Interview Protocol for Mexican-Americans with diabetes and experience with *susto*

Mexican-Americans with diabetes and experience with *susto*

Initial Interview Protocol

Note: These questions are provided as a guide to initiate discussion. The participant will carry the conversation in any direction he or she desires.

To Participant: I will be reminding participants that I am not collecting names or identifiers but am merely seeking information about their life experiences with health, illness, and self-care practices.

1. Tell me a story about the first time you remember falling ill.
    A) Tell me a story about how you recovered from or managed your illness.
2. Tell me a story about the first time a family member or friend fell ill.
    A) Tell me a story about how they recovered from or managed their illness.
3. Tell me a story about your experiences with any events which have caused you considerable distress in your life.
    A) Tell me a story about your experiences with any events which have caused you considerable fear in your life.
4. Tell me a story about the first time you heard about folk illnesses, such as *susto.*
    A) Tell me what *susto* means to you.
    B) Tell me how you believe someone can acquire *susto*.

5. Tell me about your experience with health as a person without diabetes.
6. Tell me about your experience with health as a person with diabetes.
    - A) Tell me a story about what you have done to manage your diabetes.
7. Tell me a story about your experience as a patient in medical settings.
    - A) Tell me a story about a typical interaction you have had with your healthcare practitioner.
    - B) Tell me a story about the best interaction you have had with your healthcare practitioner.
    - C) Tell me a story about the worst interaction you have had with your healthcare practitioner.
8. Tell me a story about your experience as a patient in any non-medical settings, such as experiences with a traditional healer or curandero(a).
    - A) Tell me a story about a typical interaction you have had with him or her.
    - B) Tell me a story about the best interaction you have had with him or her.
    - C) Tell me a story about the worst interaction you have had with him or her.
9. Tell me a story about what it means to be Mexican-American.
10. Tell me a story that describes how close you are to your family.
11. Tell me a story about how important religion or spirituality is in your life.
12. What do you think it is like not to suffer from diabetes?
13. What do you think it is like not to suffer from *susto*?
14. Tell me a story about the role food has played in your life.
    - A) Tell me a story about the role food has played in the life of your family while growing up.

Mexican-Americans with diabetes and experience with *susto*

Follow-up Interview Protocol

15. Here are some observations I have made about how you story your folk and traditional medicine and self-care practices as a Mexican-American with diabetes and experiences with *susto*. I'd like to get your reactions and feedback to them.
    A) Do you agree with me?
    B) What do you think this behavior means?
    C) Do you remember this behavior?
    D) How did it make you feel?
    E) When (this) _____ happened, what did you think your (family, friend, healthcare worker) _____ was thinking about you?
    F) What were you thinking when it was happening?
    G) What else was going on while this was happening?
    H) What are other ways your (family, healthcare worker) ___________ could have interacted with you at this time, instead? What would that have meant to you?

Mexican-Americans with diabetes and experience with *susto*

Member Check Interview Protocol

1. This is what I think I understand you given the information you have provided throughout the interviews we have had together.
2. Can you tell me if my understanding is correct?
    A) What parts of this analysis do you agree with?
    B) What parts do you disagree with?

   C) What do you find surprising?

   D) What parts of the story did I leave out?

   E) What stories do you want to add?

3. What was it like to have me involved with you for the past 6 months?

   A) How did my interaction with you make you feel?

   B) What suggestions do you have for me?

APPENDIX C: META-CODING OUTLINE

Code # & Meta-"Themes"	Sub-"themes"	Referenced Text
1. Hidden: folk & traditional medicine (FTM) practitioners/ locales/tools are hidden within the community	1a. Hidden in plain sight	1a. in the marketplace (in Mexico) you'll find a section where they sell only herbs/grasses
	1b. You have to ask them the right questions (to elicit hidden statements)	1b. the same ladies who sell the herbs will inform customers what the herbs are good for 1b. they'll give you the herb and tell you how to drink it
2. Confusion & Contradiction: there is no consensus as to the nature, location and utilization of FTM services	2a. There is no consensus as to what the FTM services are	2a. there are times when they (curanderos) will contradict each other 2a. they speak of different things, and that is why I don't believe in them 2a. I didn't know exactly what was taking place; frightening to me 2a. you hear about curanderas nowadays…"oh my God it's scary! How dare she thinks she's greater than God" 2a. they have taken gift and imitate God with it;…some people take it to a different level 2a. (curandera) is someone who dedicates their work exactly to curing people 2a. using herbs or things like my mother used 2a. curandera can cure susto apart from the diabetes
	2b. There is no consensus as to where these services are located	2b. I remember going to this lady's house; she would perform (ritual) over my whole body and sweep the broom and say some prayers 2b. was a friend of my grandmother's; she lived close to my grandmother
	2c1. There is no consensus as to who	2c. (sister-in-laws) used to take their children to witches to find

	utilizes FTM services	out what they had: one had trouble learning in class; the other felt someone was trying to do her harm 2c. something simplified like a cold of a fever that…could take care of right then and there 2c. it was (for) something simple; a simple illness 2c. if she trusted you she would invite you to her home 2c. I don't think that it did me any harm 2c. one time I used (Pampuerco ointment) on my daughter (for empacho)
	2c2. There is no consensus as to who does not utilize FTM services	2c. the medicines have helped, (so I don't see a curandero) because I don't believe in it 2c. I used to see various black objects…but I let those things occur without reacting 2c. I don't think the medicine helps with susto 2c. if she didn't (trust you) then…the availability wouldn't be there
3. Marginalization (by practitioners): patients fear being marginalized if they disclose alternative practices to their practitioner	3a. Unsure healthcare providers ever heard of or don't believe in Susto/other folk illnesses	3a. I'm not sure if the doctors believe in Susto 3a. maybe they don't believe in Sustos 3a. I've never heard them talk about it
	3b. Providers never ask about Susto/other folk illnesses –or- act as if it's not there	3b. there hasn't been a discussion about it with them 3b. there are some doctors who believe in Susto and some that don't. 3b. talked to doctor…(about) became ill because of susto..said (will)look into what caused diabetes…*nothing more.* 3b. not sure how they'll take it
	3c. Perception FTM practices are for the poor and/or uneducated.	3c. you grow up and you educate yourself; it's (FTM practice) not a practice anymore
	3d. Perception healthcare providers	3d. they have a lot of patients and there may not be enough

	don't have time to talk about FTM practices – or- don't believe in them	time to talk to them about it 3d. "oh well, doctors…they don't really believe in that stuff so we're not going to talk about it"
	3e. Perception patient will be criticized if they disclose use of alternative practices	3e. I'm not bold enough to talk to them about it 3e. many people make fun of people who have stories like this 3e. sometimes patients don't say how they're feeling because they may feel embarrassed
4. Cultural implications (for practitioners): practitioners must gain cultural competency in the geographical areas in which they practice	4a. Susto/folk illnesses may have evolved due to assimilation of cultural populations (e.g., Mexican-Americans) over time	4a. I got sick because of an experience with Susto 4a. after that Susto after 3 months, I was discovered to have diabetes 4a. I still believe Susto is still the reason I have diabetes 4a. I still experience seeing shadows; it just shows up 4a. it's when I feel relaxed that I see them (shadows) 4a. it could be that (Susto) is connected to the anxiety and the stress 4a. (my parents back in the day) wouldn't run to doctor; they would take care of (illness) themselves at home 4a. (back in the day) if I got sick (parents) would take us to the doctor; something simple could take care of at home 4a. you don't see people talk about it anymore 4a. you grow up and you become a different culture, person 4a. (in past) you live with parents you follow their way of believing in things and doing things 4a. once you grow up and out of the home, then you start learning…your own way of doing things 4a. I didn't continue it (the practice) because it was something that I did when I was

		with my parents 4a. I acquired my own beliefs along the way 4a. something acquired from an accident or something that happens in the family 4a. caught from seeing things 4a. (Susto) if only about the moment; it can go away 4a. (Susto) goes away if the trauma goes away 4a. had a strong experience, which is Susto; used to think that their diabetes would go away at some point but it's not like that 4a. I had such a strong (Susto) experience and developed diabetes 4a. (Susto) is something external that causes…fright; it's so big that some people have heart attacks from the experience 4a. no mention of spirit in this case; …were frightened and that is was a tremendous Susto 4a. a change in my body congruent with the magnitude of the Susto; and from that you can get diabetes 4a. there are Sustos where one doesn't know what will scare them 4a. or Sustos that occur because of sudden events like an accident or bad news 4a. it depends on one's sensitivity (vulnerability) and how you can handle that situation 4a. because of a frightening experience develop pancreatitis and die because the pancrease is not sustainable
	4b. Practitioners should understand the cultural implications of their practice	4b. they may think there are other causes of diabetes, and for that reason I don't talk about it (Susto)

		4b. now I feel I have Biles that came about after Susto 4b. doctors took xrays; I've had (biles) for 22 days since they took the xray 4b. (curanderas) give you quality of life…you don't feel you have to carry that burden alone 4b. society has changed 4b. nothing more than medicine and faith in God (can cure Susto) 4b. most of the doctors do not know how to cure empacho like mothers used to back then 4b. hardly any professionals in Mexico but nurses (have curandera-type knowledge) 4b. I feel I am capable (of talking to doctor in English) 4b. (doctor's office) gave me an interpreter…was there with me; I said…I need you. Just stay here in case I need you
	4c. Practitioners should be aware that FTM practices can be used for both positive and negative purposes	4c. two types of curanderos: one type is more like a Satantist; second is positive 4c. diabolical type is there to do harm to others 4c. white curandero will not harm others 4c. some people think curandera is bad; it's not all bad 4c. it's how you see it and your perception of it 4c. she has some power 4c. (in the past) none of these people thought they were greater than God 4c. now…they think they can heal…and think they're God 4c. there are imposters 4c. there are people who are given this true gift 4c. curandero (father-in-law) would pray for you 4c. able to read your mind; he helped a lot of people 4c. there are 2 sides to it 4c. some people do it with a

		clean heart 4c. some people do it with a dirty heart 4c. witchcraft and things going on in her home; she was just an evil person 4c. she was a witch; I don't think she was a curandera 4c. in Mexico…there are very good curanderas 4c. well recognized; know the types of plants and herbs that exist 4c. those who have that type of knowledge are good healers
5. Therapy as a treatment modality and access point may help those suffering from folk/biomedical illnesses: patients/ clients may benefit from sharing their story and processing events related to folk and biomedical illnesses	5a. Patients/clients view therapy as having positive effects on health & well-being	5a. when we had group therapy,…sharing stories was helpful 5a. individual therapy was more helpful because I would disclose things that I didn't feel comfortable sharing in a group format 5a. I was able to expunge everything that was inside of me 5a. participating in therapy…I improved a great deal…a great deal 5a. when…in therapy, one can reduce their stress 5a. someone who has diabetes needs not to have excess stress and anxiety…that is what helped me 5a. if stress and anxiety increase, my illness is going to get worse; I need to maintain a sense of calm and relaxation to maintain current levels 5a. someone who could offer therapy so they could forget about it (the susto/trauma) 5a. perhaps (Susto) does not go away but maybe with therapy…a long process; those things are held in the head 5a. (important to) purge all that stuff 5a. they can be helped to deal with their specific phobias…with psychological

		help
	5b. FTM practice viewed as having psychological benefits	5b. (FTM treatment) was really psychological 5b. mother would reinforce the fact that we were taken care of by going there (to a healer)
6. Meta-physical beliefs	6a. Shadow encounters predominate stories of one individual's DM experience	6a. I would see black objects 6a. saw dark shadow that came down from the side 6a. saw a shadow next to the laundry room 6a. saw dark shadow that sometimes passes through my room or kitchen or laundry area 6a. white shadow is a good vibe 6a. black shadow is a bad vibe 6a. it just shows up 6a. when I feel relaxed I see them 6a. when it's white…it's a positive person 6a. when it's dark, it's negative 6a. there is another color of shadow that is purple, which is in between white and black colors 6a. it is the more dangerous of the colors 6a. at home the color of the person has changed 6a. I used to get chills when I saw them. 6a. saw something yellow in color and brilliant 6a. form of a small square about 4 inches and came out of the wall
	6b. Definition of susto does not parallel old, traditional definition	6b. when one gets frightened, they begin with strong heart palpitations 6b. I feel attacked 6b. times when one can't speak or yell when that happens 6b. some of them thought that susto was something that happens 6b. people don't think that this happened like that 6b. they notice something has changed (physiologically)

		6b. (spiritual link?) I've heard of that, but not in this case. 6b. tremendous susto...their sugars went up or that they developed diabetes 6b. one thing is the worry, and the other thing is the susto 6b. fright is like when one is afraid of spiders or rats
	6c. Third person and indirect statements about susto acquisition	6c. I recall I have a sister-in-law who developed susto 6c. there was this person that I knew—a young man who was in an accident 6c. and from the susto associated with the accident he became diabetic 6c. and there were other patients who used to describe experiencing hard loss 6c. it's something external that causes that fright 6c. it's so big that people have heart attacks from the experience 6c. I am the one who was frightened 6c. my father was strict 6c. my family experienced domestic violence 6c. I saw how my father used to hit my mother 6c. domestic violence an important factor 6c. my mother was perfectly healthy and then my father gave her bad life 6c. then the diabetes came
	6d. Susto can be healed or cured	6d. well it goes away if the trauma goes away 6d. if it's something that they don't give much important to, then they can forget it 6d. it's only about the moment 6d. yes it can go away 6d. the curandera can cure susto apart from the diabetes 6d. I believe that it is something that cannot be cured. 6d. I think it's something that one's sensitivity intervenes

		6d. I think with psychological help 6d. they can help deal with their specific phobias
	6e. DM can be reversed if caused by susto	6e. I think so because it's been 5…8 years that I've had diabetes 6e. those who spoke about it who had a strong experience, which is susto, they used to think that their diabetes would go away 6e. thought that if they got susto and it went way that they no longer had diabetes 6e. majority of them thought like that 6e. there are some who took it more seriously 6e. very few people do it that way
7. Physical impact of DM	7a. DM viewed as a serious illness that can be managed through self-care practices involving dietary monitoring	7a. I thought it was an illness like the flu. 7a. I don't see it like that 7a. I see it as an illness that is very bad 7a. diabetes is a serious thing 7a. you have to pay attention to your body every single day 7a. so many things can happen to your body if you don't eat 7a. complications can happen along the way 7a. if you don't take your medication…blood sugar out of control 7a. it is abusing your body 7a. it's a learned thing 7a. you know that it is something serious 7a. I've been able to maintain things well with my insulin 7a. it all depends on how one manages things 7a. I've refrained from eating a lot of fatty foods 7a. I started cooking foods on the stove without using oils 7a. I have reduced the amount of coffee I've been drinking 7a. the dietary plans help reduce

		my sugar levels 7a. I drink sodas every day, but when there aren't any, I'll maybe drink them once every 3 days 7a. I have refrained from eating many tortillas 7a. in reality if I don't eat at least a tortilla I don't get full 7a. I hardly eat flour tortillas but I will eat corn tortillas 7a. if I'm hungry I often instead eat a piece of fruit or lettuce with cucumber and some lemon 7a. I told the doctor I cannot follow I diet 7a. firstly, one has to guard their diet 7a. it depends on the type of activity one engages in 7a. fortunately, I am able to control my sugars 7a. I am very careful with the food I consume 7a. food is an essential part toward controlling my diabetes 7a. I pay a lot of attention when I go to the supermarker 7a. you look at life from a totally different angle and learn to pay attention to your body 7a. eating cactus for diabetes 7a. my mom used to drink bitter teas 7a. I saw some people who had diabetes consume a lot of cactus with aloe vera 7a. apples, papaya, peaches, kiwi, jicama, oranges 7a. I eat a lot of soy 7a. I eat a lot of vegetables either raw or cooked 7a. the only meats I eat are fish and chicken 7a. I eat oatmeal with some fruit 7a. there is fruit I don't eat such as mangoes…nor oranges because they have a lot of sugar
8. Emotional symptom reporting of DM	8a. Guilt, worry, stress, and anxiety as factors influencing health and	8a. grandmother acquired it from a strong feeling of guilt that others made her feel

	illness (DM)	8a. when I was a little girl I didn’t have any worries 8a. when I got married things changed 8a. that is when the worry, anxiety, and nervousness began 8a. because my husband was very macho 8a. and also because of all the sustos he caused me 8a. it (my diabetes) just improves when my stress is reduced 8a. I will begin to build resistance toward the medicine I am given…if my stress and anxiety increase 8a. the environment (at work stresses me) 8a. it was very stressful because we owed a lot of money 8a. I think it was from all the worry associated with me not being able to pay out so much money 8a. my sisters ask me how things are going with me and how my numbers are doing 8a. if it’s high, they’ll tell me not to eat this, don’t eat that 8a. I am someone who is very worrisome 8a. it’s like one worries because I’m not a person who doesn’t care about life 8a. I worry about life and about problems that keep coming 8a. we have to find a solution for them, but I am a worrier 8a. I worry a lot in general 8a. I think that is another reason I got diabetes 8a. to me it’s just that one is overly stressed 8a. the stress gives one diabetes 8a. I think it depends on their emotional stability 8a. the other is if they eat disorganized or have worry. 8a. that’s all it can be