Journal of INDIGENOUS SOCIAL DEVELOPMENT

Volume 13, Issue 2 (2025)
https://ucalgary.ca/journals/jisd
E-ISSN 2164-9170
pp. 1-28

A Qualitative Study of Traditional Healers and Their Experiences of Marginalization by Biomedical Professionals

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Keywords: • Indigenous medicine • Traditional medicine • Collaboration

Abstract
U.S.-born and migrant Latiné communities historically access traditional healers, preferring culturally informed treatment approaches. Biomedical practitioners occasionally integrate traditional healers into treatment to inform culturally bound syndromes. This study used a qualitative framework to explore traditional healers' lived experiences of working with biomedical practitioners. Eight traditional healers who specialize in one or more traditional healing art sat for semi-structured interviews on their attitudes and beliefs about collaboration, steps to collaboration, and ways to overcome barriers. Findings reflected the oppression, marginalization, and obstacles to collaboration traditional healers often encounter from biomedical practitioners. The findings highlight the role of cultural preservation as a form of resistance against the Latiné health paradox, which posits that Latiné migrants experience poorer health the longer they are in the United States. The findings can inform legal mandates and policies on how best to incorporate traditional healers into treatment.

Introduction

Black, Indigenous, and people of color (BIPOC) often have worldviews and epistemologies that biomedical mental health professionals do not easily understand. Power patterns established through colonial rule continue to define mental health treatment for marginalized communities (Maldonado-Torres, 2007). The belief in and continuation of Western

healing processes when reaching out to minoritized populations denies their social reality and limits the availability of therapeutic interventions for diverse communities.

There is a need to decolonize hegemonic biomedical theories of mental health, which originated from a colonial mindset of dominant race and gender and specifically refer to White cisgender men. In part, decolonizing healing practices requires examining power imbalances affecting the types of evidence-based treatments distributed by biomedical mental health professionals. We conducted this study to document practice-based treatment of traditional healers by biomedical professionals (e.g., psychologists and other medical doctors) and to present ancient healing in the Latiné community that is culturally specific and maintain Indigenous worldviews separate from those practiced in modern Western society.

Traditional Healers

C*uranderismo* is an Indigenous healing intervention based in teachings and ceremonial practices from Mesoamerica, Africa, and Spanish diasporas (Pérez-Aguilar, 2023). To bridge the gap between Latiné diasporic worldviews and the dominant theoretical discourses in Western society, traditional healers, or *curanderas*, have attracted attention in research. However, these healers have rarely been given the appropriate voice and means to integrate into Western theoretical modalities (Hoskins & Platt, 2022). Traditional healers have also largely stayed out of academic research because of stigma and marginalization in a society that does not view their practices as evidence-based (Hoskins & Padrón, 2018).

Latiné communities tend to avoid Western medicine, instead turning to traditional healers for their traditional medicine, for spiritual healing, and to maintain health that reflects their cultural beliefs (Nahin et al., 2010). Guillén (2004) noted that newcomers seeking traditional healing tend to be less acculturated to American culture and that language has been used as a

proxy to identify people who may be less acculturated. In a study on Indigenous Oaxacan Mixtecs in California, González-Vázquez et al. (2016) confirmed that maintaining cultural ties with traditional healers improved health. Other research has shown that Latiné migrants engage in medical pluralism, seeking care from traditional healers and physicians (Sandberg et al., 2018).

Inequities Experienced and Service Usage Patterns by Latinés in the United States

For Latiné and underserved populations in general, several factors can result in health inequities, including language barriers, stereotypes, and structural racism (Squires, 2018). Structural racism is of particular concern, identified as a key predictor and underlying cause of the health inequities experienced by Latiné peoples and marginalized populations (Churchwell et al., 2020). Structural barriers contribute to the risk of stress-related health disparities (e.g., obesity, diabetes; Pérez-Escamilla, 2011), compelling the need for interventions promoting health and well-being with greater relevance to clients' worldviews and belief systems.

Traditional healers engage their clients through similar worldviews, which can encompass religion/spirituality (Hoskins & Padrón, 2018). In the United States, traditional healers can be the first point of care for Latiné individuals with limited access to care. They also act as culture brokers for individuals who distrust biomedical health care systems. A systematic review of 85 studies found that the use of traditional healer among Latiné individuals ranged from 6% to 67.7% (Sandberg et al., 2018).

Limited Relevant Theory/Intervention

Various challenges can create cultural mismatches between evidence-based mindfulness programs and worldviews in Latiné communities (Castro et al., 2004), including reluctance to

seek mental health services (Paniagua, 2013); the lack of Latin- and Spanish-speaking mental health providers to offer possible racial, ethnic, and linguistic concordance (Alegría et al., 2013); and the presence of culturally specific symptoms, and increased risk of traumatic exposure in Latiné immigrants (Donlan & Lee, 2010; Paniagua, 2013). A mismatch of worldviews can result in adverse effects of dominant practices for Latiné migrants who have fled countries due to war or civil unrest (Hoskins et al., 2023). Moreover, even if the client identifies as Christian, Latiné religious and spiritual practices are diverse and may encompass Indigenous and Black diaspora practices as well as herbs and traditional medicine (Hoskins & Padrón, 2018).

Purpose of the Study

Our focus in this study was to illuminate ways to engage and work appropriately in collaboration with biomedical mental health professionals by exploring the lived experiences of traditional healers working with Latiné communities. We argue that by identifying views and experiences from past collaboration, we could provide better treatment for Latiné communities and offer guidance for other underserved communities with different worldviews from mainstream mental health providers. Ultimately, we discovered ways to decolonize mental health treatment for Latiné communities and provide liberating approaches to the lived experiences of traditional healers with expansive philosophies about health and wellness. Our results identified issues related to colonialism and oppression, liberation, and discrimination.

Methods

Participants

We interviewed a purposeful sample of eight traditional healers working in predominantly Mexican and Central American communities in California. Inclusion criteria

required self-identification as a traditional healer with at least five years of practice and offered at least one type of traditional healing method. Participants must have learned their vocation directly from another traditional healer and be fluent in Spanish (see Table 1).

Table 1: Participant Demographics

Participant	Language	Client ethnicities	Area of expertise	License	Clients of Mexican descent	Years of practice	Gender	Age	Region where practices were learned
Cristina	English, Spanish	Mexican, Mexican American, Anglo-American	Sobadas	MT & N	> 300	30	Female	63	New Mexico; Cuernavaca, Mexico
Griselda	English, Spanish, Nahuatl	Chicano, Latiné, Native to Mexico, African American, Asian American, European American	Spiritual, herbalist	Psychology	5,000	50	Female	77	Oaxaca, Mexico
Harriet	Spanish, English, Nahuatl Lakota	Mexican American, Native Mexican, Native American	Spiritual, herbalist	LMFT, HP	7–800	35	Female	58	New Mexico; Michoacan and Oaxaca, Mexico
Francisca	Zapotec, Spanish	Northern Oaxacans, Mexicans	Traditional midwife		> 5,000	58	Female	75	Northern Oaxaca, Mexico
Alberto	Maya Quiche, Spanish	Mayans, Latins	All		> 1,000	> 40	Male	48	Maya
Guadeloupe	English, Spanish	Mexicans, Chicanos, Native Americans, Anglos	Sobadas, herbalist, temascalera, suction cups	MT	3–500	10	Female	57	Jalisco and Morelos, Mexico

Participant	Language	Client ethnicities	Area of expertise	License	Clients of Mexican descent	Years of practice	Gender	Age	Region where practices were learned
José	English, Spanish	Mexicans, individuals from Latin Americans, Caucasians	Spiritual, talks		> 100	20	Male	63	San Luis Potosi, Mexico
Juan	English, Spanish, Nahuatl	Chicanos, Mexicans, Indians	Spiritual, herbs, talks	Master of Arts in Psychiatry	>1,000	35	Male	60	Chihuahua and Aguas Calientes, Mexico

Note. MT = massage therapy; HP = holistic practitioner; N = naturopathic

Measurement

We conducted in-depth interviews in English or Spanish depending on the participant's language preference. Traditional healers who spoke an Indigenous language (e.g., Mam or Zapotec) completed the interview in Spanish, given the lack of interpreters for these languages. However, they expressed confidence in dialogue in Spanish. In keeping with phenomenological theory, the interviews consisted of open-ended questions to cover areas underrepresented in the current literature.

Recruitment and Data Collection

The director of a mental health agency who studied curanderismo for 25 years provided contact information for traditional healers. We also used snowball sampling with enrolled participants. The small sample, similar to Lieblich et al.'s (1998) recommendations, facilitated a meaningful and deep understanding of the participants' lived experiences as practitioners of curanderismo and connections with biomedical providers.

All study materials and procedures were reviewed and approved by a university institutional review board. Data were collected on two separate occasions, approximately 1–2 weeks apart. Each interview was 1–2 hours, for a total of 2–4 hours per participant. All interviews were audio recorded and transcribed with the interviewees' permission. Before conducting the interviews, the principal investigator reflected on his expectations and values related to the study. Reflexivity allows researchers to increase their awareness of the dynamics between themselves and the participants (Nilson, 2017).

Data Analysis

We used Langdridge's (2007) methodological framework to develop distinct narrative stories for each participant, highlighting the range of lived experiences and situated traditional healers as heterogeneous communities. We explored stories to identify rhetorical tone and function and how participants constructed and presented their identities. Using critical phenomenology as a methodological lens, we critically analyzed narratives from the perspective of knowledge and oppression in biomedical spaces, deconstructing how traditional healers lived experiences—both inside and outside of biomedical spaces—are shaped by anti-Indigenous racism and sexism as structures of White settler colonialism that subjugates Indigenous ways.

We then used phenomenological critical narrative analysis, which combines hermeneutics with critical theory to expose hidden power imbalances and challenge the status quo (Langdridge, 2009), to explore issues directly influenced by power issues such as traditional healer interactions and oppressive treatment by biomedical providers. Filtered through the lens of liberation psychologies, we identified significant patterns in the data, reading and rereading the texts several times, pointing out emerging ideas and highlighting key sentences. Inductive nodes were captured separately for each participant, followed by comparing nodes between

participants to determine relationships between them, categorize them, and develop topics from them. The analysis was an iterative process, requiring several revisions of the original transcripts to refine the categories and core themes. Destabilizing the narrative involved using critical theory to analyze narratives from a place that would deprivilege Western approaches to mental health.

We sought specific interactions and effects of colonial oppression, considering the relational dynamics and historical roots of biomedicine that maintain oppression and disadvantage between traditional healers and Indigenous communities. We identified salient commonalities and engaged in discussions to challenge, question, and justify interpretations. From our critical point of view, we identified the main themes and interactions influencing oppressive possibilities and also highlighted how traditional healers resist biomedical forms of oppression to revitalize Indigenous ways of healing. From an Indigenous epistemological standpoint, the participants' narratives revealed the nuances of what it will take for collaboration between traditional healers and biomedical providers to break free from the coloniality of mental health care, where legitimacy is given to those with educational credentials rather than community recognition and trust.

Researcher Positionality

The research team was three scholars with shared and distinct identities across race, class, gender, ability status, age, etc. The first author is a bilingual Mexican American who has practiced psychology with Latiné populations for most of his career and has personal experience with traditional healing. The second author is an Indigenous Xicana scholar with Zapotec roots and lived experience navigating the mental health system as a provider, service user, and activist. The third author is a Mexican physician, a specialist in family medicine, with postgraduate

training in social anthropology and expertise in urban and rural traditional healing in Mexico and Latin America.

Results

We next discuss the results for the three theme-focused analyses (i.e., beliefs and attitudes toward collaboration, lived experiences of collaboration and obstacles, and how they were overcome). Participants are identified by pseudonyms. The themes reflect the importance of structural equity in collaboration and recognition of Indigenous roots in cultural constructions or worldviews by working with practitioners from different backgrounds.

Attitudes and Beliefs Toward Working With Biomedical Providers

Most traditional healers had positive attitudes toward collaboration and focused on the values of openness and respect in the collaborative process. They saw value in collaborating with biomedical professionals, identifying aspects such as differences between therapeutic approaches as a reason for doing so, as shown in Cristina's statement: "A traditional healer works with a person spiritually, but a therapist may have more to offer in terms of ongoing therapy, such as improving relationships."

Several participants said biomedical professionals regularly contacted them for consultations. Alberto noted that biomedical mental health therapists would call him regarding healing interventions "when the relationship [between practitioner and patient] is not working." He added that psychiatrists referred clients to him, usually when they had difficulty assessing psychosis and differentiating it from a culturally specific syndrome.

Reasons for Collaboration

The participants generally refer to mental health therapists in three situations: when they identify clients needing long-term work, when clients are in acute crisis, and for medication evaluations, even when there is apprehension about pharmaceuticals. Cristina explained, “When I see a client repeatedly for the same problem or there is no progress, the person gets stuck.” José spoke about the importance of medication: “Sometimes medication is necessary when some of the immediate symptoms are disrupting your life. Herbal medicine is slow acting and takes a little time. Western medicine, in the right doses, in the right regulation, can be helpful.”

Several participants felt they had the knowledge and ability to intervene through psychotropic drugs. However, when working in the United States, they referred clients who needed psychotropic drugs to psychiatrists due to U.S. laws. José described his collaborative process in these cases: “There are times when I think it’s better for the psychiatrist to do it, because even with Indigenous knowledge, we need to use certain psychotropic drugs, and I’m not authorized to do it here.”

Compliance With U.S. Laws

Some study participants earned degrees or certificates in areas such as biomedical mental health, certified massage therapy, holistic practice, and naturopathy to practice legally in the United States (see Table 1). This showed the traditional healer’s ability to navigate both Indigenous-centered and biomedical spaces through code switching when necessary.

Of the participants who did not have a degree in biomedical mental health, most said they referred clients to a physician when they felt it was warranted. For example, José, a traditional healer employed by a hospital, stated:

> Sometimes, I work with a traditional therapist [because] I believe in the team approach. So, I like to know what kind of treatment, what kind of medication … what their therapist, the doctor is doing and complement or work as a team with them.

The Need for Structural Equity in Collaboration

The participants described establishing a relationship between the therapist and the traditional healer as intertwined with structural equity. Francisca said, "I believe many things are possible, but for me, collaboration means that people know each other as equals. For this reason, the initial connection should express a level of respect on the part of the therapist." Griselda explained how relationships are ideally initiated from a position of structural equity:

> Well, you [the therapist] call them [the traditional healer], you honor them by acknowledging something about the work they do, that you've heard positive things about the types of interventions they do that you need their help, that you have someone you're working with who you think needs culturally appropriate interventions, that you know you can't do, or that you don't know enough about, and that you would like them to talk to this person to see if they can help.

The participants also stressed the importance of having connections to whom they refer. Many stated that they must know the agency to which they send a client and only refer to therapists with whom they can develop relationships and feel comfortable with. This established connection fosters trust in traditional healers who are committed to the well-being of the people they serve. Francisca said she had never collaborated with a psychologist and expressed reluctance when asked if she would collaborate: "Maybe, if I see what the psychologist does, if he or she is really doing what he or she should be doing, and if he or she is managing the patient properly, but if they are not, I would not agree."

The participants emphasized that collaboration should be reciprocal, and that a lack of initiative on their part can hinder it by preventing a sense of mutual exchange. Although Albert has received referrals, collaborated with psychiatrists and medical doctors, and has received

clients from psychotherapists, he has not initiated collaboration with therapists because "If I put a lot of time and energy into obstacles, because there are many, it probably won't help a lot of people." He added,

> I haven't gotten into the subject of psychotherapists because I understand that I have my forms of treatment, it's not like I know about [psychotherapists'] knowledge, what's good work, what's not, it's that person's responsibility, and I understand that. There is no framework, they cannot comment on my work, they cannot give an opinion about the work I do. They can say that I am not a professional, I have my job, I have my mission, I have my vision, I have my responsibility and my respect.

Because of how she was treated in past interactions, Francisca, an elder from the Zapotec tribe of Oaxaca, Mexico, said she would not refer to a biomedical mental health provider but did give evidence of referring to physicians. She described a lack of empathy in biomedical practice resulting in maintaining a distance between psychologists and clients, which is different from the ways traditional healers use their hearts and spirit to connect with the people they serve: "Especially when I worked with these psychologists, it grieved me greatly because they had sickness of the soul."

Negative views such as these cannot be separated from the structural violence of the medical industrial complex, which has traditionally stigmatized and marginalized traditional healers. One feeling among the study participants was that biomedical mental health professionals believe traditional healing practices are not credible due to the noninstitutionalization of Indigenous practices. Griselda stated, "Particularly the psychiatrists, who called me as a last resort, I was a woman, Native and short, and they were skeptical, arrogant in their behavior, so that was always difficult."

Griselda described biomedical arrogance as a feeling of knowing everything or a form of law that reflects the qualities of Eurocentric hegemony (ideology) in biomedicine. Ultimately, it is other forms of healing as prescribed by traditional healers like Griselda simply because they

are not evidence-based. As a "last resort," Griselda recalled her intersectional identities as a Zapotec woman that marginalize her and how aging in the community allowed her to adopt an assertive communication style and develop critical awareness. Alberto gave a concrete example:

> In my case, I suggested some treatments [using a particular drug] that are the same treatments that a doctor would suggest, and he can [prescribe] it because he's a doctor, and I'm not authorized to [prescribe it], and there were people that day who said, "Why do you suggest this guy?" So in cases like this, they [the doctor and the client] don't think I'm a professional.

Although Alberto and the other healers are, at worst, perceived as unprofessional, they externalize oppression by reminding themselves and others that they know enough about biomedical interventions and can code switch between these two spaces.

Establishing Relationships With Other Providers

The participants detailed key steps for establishing relationships with biomedical providers, including assessing the need for services, defining the scope of work, and determining the linguistic and cultural competence of collaborators. Defining the provider's scope of work is a critical step in collaboration. José said, "For me, I like to know where the therapist is going with this person, what their plan is." Similarly, Francisca emphasized the importance of redefining the scope of work, stating,

> We need to see the value of what each of us is doing, that we share information and that we have similar goals in mind, that we understand objectives and goals, that we complement [each other]. My role is not to replace anyone else's work but to complement. The client will benefit, and the family will benefit, the community will.

Francisca's view aligns with Albert Marshall's two-eyed seeing approach to seeing the world, described in Moorman et al. (2021) as being able to understand and use Indigenous forms of healing and the biomedical model.

Defining the scope of work may also encompass awareness of one's limits in training, knowledge, and necessary licenses and generally describes a sense of cultural humility in the healers' perceptions of themselves. While expressing frustration with the biomedical and governmental gaze that limits what he can do as a traditional healer, Alberto also embodied a humble approach in acknowledging when his knowledge of the body and wellness has peaked:

> I have the confidence, the ability, the experience, the energy to do it, the plants are similar, but I can't. The same governmental state law here will not allow it. In my case, I respect that. I respect this law.

Language and Cultural Humility

Determining language and cultural humility is also important. Both are potential obstacles to collaboration, such as when a traditional healer speaks an Indigenous language and the therapist is unable to engage in dialogue with the traditional healer. Understanding the cultural language of distress is necessary to recruit a traditional healer who can adequately address the client's needs. Alberto noted the importance of having nuanced explanations of health and healing related to a specific culture, a better cultural understanding of idioms of distress, and the negative outcomes of treatment if a therapist does not employ a traditional healer:

> Most people never had the confidence to share that [culturally specific explanation of distress] with the doctor, male or female doctor, and there are times they don't; for example, the Indigenous peoples in Mexico, and the Maya, the Indigenous peoples of the South, such as Bolivia, Ecuador, Peru, Colombia, Panama. The character of Indigenous peoples is that they don't give confidence [to mainstream practitioners] very quickly. If you are not a person from your own culture, they will not share information.
>
> The other thing is that the language of the individual is important. [For example], the thought of Indigenous peoples, that the heart is in the navel of the person, and so the person will tell you that their heart is causing them pain, and while you wait for them to put their hand on their chest, they put it upside down, and that means that the heart is the center of the person, in the middle of the person. Most Indigenous people talk that way, and therefore the therapist, the doctor, the professional will not understand issues like that. We must also understand the perspective of Latinés, of Indigenous peoples. How

> they classify, the names they use, their forms of healing, meanings. For example, the meaning of color, as for cultures here the danger is red, but in the Indigenous culture it means hope and light.

Knowledge of Culturally Based Syndromes

Traditional healers expressed knowing that people have cognitive cultural constructs or worldviews that align with traditional healers as an important element in establishing relationships with other providers. Using therapists who do not understand clients' cultural worldviews or who cannot properly integrate traditional healers' practices into their own can lead to negative psychiatric outcomes. Griselda gave a specific example: "Because, particularly the community [name of the specific region], there are Mexicans, immigrants, and they still carry those forms [beliefs in traditional healing] with them."

Traditional healers do not expect therapists to know how to address culturally specific symptoms and syndromes. Alberto noted that "[psychiatrists] don't understand many parts, for example, [people with schizophrenia] … They didn't find the answer with the analysis, the examination, the labs, and they want to understand the client's part of the disease." As Harriet stated, "Particularly for mental health professionals, not everything they are taught in their classes, like psychopathology or whatever, is universal, there are some experiences and responses to those experiences that are culturally specific."

Challenges to Collaboration and How to Overcome Them

An obstacle to effectively using the knowledge of traditional healers is that clients perceive marginalization by biomedical professionals and Western society at large and do not disclose the use of traditional healing practices. As a result, biomedical providers remain closed to possibilities for collaboration. Griselda said, "You know, if you ask [the client] if they use

traditional healing, they'll probably say no." She described why individuals would not disclose the use of a traditional healer: "They would feel that the doctor, the nurse, the therapist would think less of them [for using curanderismo]."

Several traditional healers noted concerns about using people who are not traditional healers but who present themselves as such as an obstacle to collaboration, which also speaks to concerns about the legitimacy of traditional healing practices in the eyes of the majority. Harriet emphasized the importance of being trained in the traditional way: being identified as a child as having the gift, undertake an apprenticeship, and then dedicate one's life to practicing traditional healing. She identified a negative consequence of legitimizing practices through research being that it could allow people who are not trained by traditional healer-elders to present themselves as traditional healers: "Yes, that's my concern because then what does it become? And then someone will take three workshops and be ready to go as a traditional healer, truth? Some of these magazines are really like, 'Come to a shaman's workshop.'" Harriet discussed the acculturation and commodification of curanderismo, including tensions between curanderas who are trained through family learning and curanderas who are trained by mentors or on their own.

If people do not recognize the practice as valid for a community, traditional healers will not be available. Griselda explained:

> So, I see it as a problem of the system, and also the system again recognizes it [curanderismo] as a legitimate intervention, which has validity for certain groups of people. Which means they recognize something else, apart from Western psychology and Western theory, and we're not there yet.

Alberto, who has directly experienced questions about his validity as a healer, said, "I've been repeatedly asked what grade I have, [questions like] 'Is that [traditional healer] something that is studied by degrees?' 'Who is your master?' Respect, it will still be years before the knowledge of Indigenous peoples is recognized." He added, "I think I mentioned that the domain of

professionalism is very strong [as an obstacle to collaboration], saying that curanderismo classifies the individual as having no empirical knowledge, knowledge that is not approved because it is not recognized in any state."

Guadalupe discussed the possible source of the negative views of curanderismo in her community:

> We have, here in the south of [specific region], a bonesetter who was treating people at home. It was very popular; I mean, people were in line and then one day someone died at his table when he was adjusting his neck; He was in jail immediately. He was deported and everything, and he was covered very badly in the news for someone who practiced without a license. But the Mexican community knew something else was going on with that person [who died]. Yes, because anything that isn't provided by the mainstream, is seen with a certain amount of, you know, guilt, really, or at least illegal, you know.

In this tragic situation described by Guadalupe, there are several theoretical concepts to point to, including state surveillance of traditional healers and how this incident was deliberately removed from its context to criminalize the huesero rather than exploring the totality of the situation and the various factors that played a role in the death of the person who sought traditional healing services.

Difficulties with documentation and other forms of medical bureaucracy are other common obstacles to collaboration. Insurance-related obstacles can arise when a therapist incorporates a traditional healer into the treatment and writes a note for insurance reimbursement. For example, the biomedical physician's organization may not receive reimbursement for services if insurance auditors do not approve the documentation, and traditional healing is a service that may not be allowed. José said, "When you work with a government agency, bureaucracy, hospital, private practice, they have certain guidelines, they may not recognize the work. In fact, they don't, because they don't pay for it."

Some participants discussed navigating potential deallocation by insurance companies by using insurance-friendly language in existing charts and forms. Harriet described her experience working alongside mental health professionals:

> Now, the graphics are specific, but I would say, 'A cultural intervention using traditions that are familiar to this person.' Maybe now you can say 'I prayed with them,' but they're rigid because of funding, but I think you can say prayer because it reduces symptoms and they can manage their anxiety.

In addition to obstacles to collaboration with biomedical health providers and ways to overcome them, participants outlined several strategies for sustaining their healing work, using resources from academic research and funding, and helping to train future generations of biomedical health providers.

Obtaining a License to Practice in the Host Culture

Having a license in a related field helps traditional healers practice legally in California. Cristina explained, "It's a somatic certification to touch someone; otherwise, you can't touch people." She described how this helps her in her practice: "That [sobada] usually consists of touching the person with massage or bodywork, you know, under the temazcal [sweat lodge], you know, a variety of things. Therefore, it requires physical contact." Cristina also explained that paying for a credential, such as a massage license, could be difficult for traditional healers: "Most of the people who do this work, they would never be able to [pay for education to get the license] because [the traditional healer] barely manages, they live with very modest [means], they can't spend $2,000 or $3,000 to get that certificate."

Needing to seek state-level licenses to achieve professional legitimacy supports another form of surveillance between credentialed and uncredentialed traditional healers. Study participants provided examples of attempts to address biomedical mental health providers'

perceptions that traditional healing is not a legitimate health practice, including education and publishing research that promotes traditional healing.

Education

The participants discussed education's importance in preventing obstacles to collaboration, citing numerous ways they have educated mainstream practitioners. José described his process for educating biomedical practitioners about his practices:

> You have to be very patient, and you have to be willing sometimes even to come back and not take that personally. That it says something about your work, that you practice [curanderismo], you don't take it personally, but you probably get out, and that's the open support, to help them, to educate.

José noted that he uses "language that will be more easily accepted, with a counselor, you know, the traditional healer is a teacher and a counselor as well." Harriet also described an approach she took: "I developed a project [specific name]. I found funding, two big conferences where 15 traditional healers gave talks and workshops."

Harriet, who speaks at medical school conferences, discussed how doing so decreases stigma and raises awareness: "Medical school, when I go there, most of the people who go to the workshop are very interested, but some other people, I know they think 'this is a bunch of curanderismo.'" She named the spectrum of openness to curanderismo in biomedical spaces and highlighted the benefit of including curanderismo in the teaching curriculum in medical schools and in biomedical mental health training, to name a few.

In Mexico City, the National Autonomous University of Mexico has introduced the course of Medical Anthropology and Interculturality to medical students since 2010, which includes topics of medical pluralism and place-based medicine (Maya & Vega, 2021). There is also an optional course of Mexico, Multicultural Nation, where an exclusive session on

Indigenous health and traditional Mexican medicine is offered to university students pursuing various careers.

Editorial Research

Traditional healers identified published research as a way to lessen the stigma related to traditional healing. Griselda described her belief that academic research demonstrates the efficacy of traditional healing practices: “So this thing that happens around the battery, what NIMH did, they call legitimate community intervention.” She continued,

> It’s like an oxymoron. If you want evidence-based [treatments], how about 5,000 years for acupuncture and about 10,000 years for these interventions, we try to grid these things that come out of another system. With the battery it was possible because people, over the last 10 years, have been studying brain activity and what affects brain activity. They did it with drugs with different things, they started looking at vibrations, and so they were able to show that certain frequencies of vibration at certain levels of vibration had impacts on certain parts of the brain.
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> So, I don’t know if you read [a psychologist’s dissertation]. He wrote his dissertation on that [the healing effects of percussion]. He was the one who started it at [a specific agency]. There was already some evidence from researchers in general, the same research on prayers, and what that meant, and some other things they had done in Russia around auras and made it possible.

Discussion

We strove to understand the experiences of traditional healers when working with biomedical professionals. The findings highlight the role of cultural preservation when Latiné migrants seek out a traditional healer as a form of resistance against the Latiné health paradox of poorer health the longer they are in the United States. They also highlight the complexity of migrants’ emotional and mental well-being; specifically, how revitalizing Indigenous wellness approaches mitigates structural determinants of health. The core values of humility, respect, and

reciprocity can help dismantle the power differentials between traditional healers and biomedical providers.

Overall, the study participants indicated positive value working with biomedical professionals. However, structural challenges to collaboration were evident in the healers' lived experiences. They gave multiple accounts of being called by biomedical professionals when these professionals were unsure of how best to understand and/or treat clients with alternative worldviews, which highlights their critical roles as knowledge keepers and cultural bearers. Similar to the notion of structural vulnerability in Quesada et al. (2011), the participants described class-based economic exploitation and cultural, gender, and racial/ethnic discrimination, including complementary processes of formation of depreciated subjectivity. The negative experiences between the two opposing worldviews caused some traditional healers to only receive referrals and not to refer because of anticipated retaliation if something went wrong and the culture of surveillance embedded in Western health systems.

Study participants identified the value of increasing language proficiency when working with biomedical providers, as they (traditional healers) often speak Indigenous languages that may not be easily accessible to biomedical professionals. Understanding and being able to explain alternative views and causes of disease is an important value that traditional healers have. Previous research has shown that biomedical professionals use traditional healers not only to understand worldviews but also to access community and build relationships with the people they work with (Hoskins & Platt, 2021).

Although the participants gave multiple accounts of being contacted by biomedical professionals, they were concerned about practicing in the United States and being subjected to institutionalized and internalized forms of surveillance. Some obtained alternative licenses that

allowed them to practice. Whether traditional healers can legally work in the United States and employ culturally specific treatments is an ethical dilemma to which the American Psychological Association must respond.

Research continues to focus on the medicinal and measurable properties of Indigenous treatments (Chamorro & Ladio, 2020). While discovering new forms of pharmacology and psychotropics seems beneficial, the participants expressed concerns over biomedical professionals attempting to use traditional healing treatments without understanding the rituals and ceremonies that accompany their use, thus decontextualizing the practice from traditional healers' Indigenous roots. For example, earth-based ceremonies or prescribing herbs can be helpful for people with Indigenous worldviews. However, we argue against biomedical professionals employing these practices and propose collaborations that are with, by, and for traditional healers who embody transgenerational apprenticeship.

Sadly, what the traditional healers' stories strongly illustrated were multiple experiences of subordination, marginalization, and oppression by biomedical professionals. The traditional healers did not feel they or their knowledge, were taken seriously. The negative interactions they had experienced led some to eschew collaborating with biomedical professionals. In addition, it was evident that the patients tend not to share their belief systems and traditional healers' engagement with biomedical professionals due to the lack of legitimacy of traditional healing in the United States. Research has shown that the utilization of medicinal properties from traditional healing, or alternative medicine, continues among a high percentage of Latiné, Polynesian, African American, and Asian populations (Hoskins & Platt, 2022; Ouma et al., 2023). Research has also documented harmful effects when combining treatments (Fakeye et al.,

2009) and has provided credibility for the concern that all parties involved (the traditional healer, the biomedical professional, and the client) should work in tandem.

On the other hand, and independent of the settler–colonial and hegemonic ideological aspects of Western medicine, Latiné families who have migrated to the United States still preserve the place-based medical culture in the figure of grandmothers and mothers, where knowledge and practice on the most frequent diseases linked to culture (e.g., evil eye, fright, courage, nerves) are still recognized in the home environment. In Latiné families, medicinal plants are used; rituals are made without the need to go to medical providers as caregivers (e.g., mothers, grandmothers) are readily available to provide them.

Clinical Implications

The traditional healers in this study gave voice to both integration and collaboration with biomedical professionals for reasons including adequately addressing clients' cultural worldviews, clinical stagnation, and the proven efficacy of practices such as the medicinal properties of herbs and drum circles. Furthermore, it is clear that the biomedical profession has encountered culturally specific expressions of distress as cultural responses to experiences but possesses limited knowledge of how to have a positive impact (see the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* [*DSM-5*], American Psychiatric Association, 2013). When clients exhibit culturally specific reactions that need to be addressed through culturally specific methods, as noted by Hoogasian and Lijtmaer (2010), biomedical mental health professionals may have difficulty conceptualizing and treating these individuals. Similarly, not working to incorporate a client's worldview and beliefs into treatment can involve further cultural trauma. For example, when a client presents as *embrujado* (haunted), if the

mental health biomedical professional denies this explanation or medicates the client, he or she inadvertently dismisses the client's cultural vision.

This study provides clinicians with guidelines for incorporating the assistance and expertise of traditional healers. Biomedical professionals should keep several points in mind when collaborating or considering collaboration with traditional healers. First, clients tend not to share their use of traditional healers. Therefore, it may be more important to assess preferences in forms of healing than to ask specifically about traditional healing. Biomedical professionals may share their own past experiences or show interest in connecting with alternative providers. Indicators of collaboration may include the cultural idioms of distress in the *DSM-5*. When speaking with a traditional healer, a biomedical professional should express respect for the healer's practice. Traditional healers have unique skills that biomedical professionals must evaluate to match collaborators to client needs.

Critical dialogue is a way to understand how to incorporate traditional healers into biomedical mental health. While there are apparent legal and philosophical difficulties in fitting traditional healing practices into a Western medical paradigm, this becomes a social policy issue that the American Psychological Association, along with other medical and mental health professional organizations, can address. One way to address legal and ethical guideline concerns is to investigate the regulatory systems in university environments in Mexico and Latin America in general. For example, Mexico legalized traditional Indigenous medicine in the second article of the Mexican Constitution in 2001. Since 2006, the General Health Law, at the federal level, established the government's obligation to recognize, respect, and promote traditional Indigenous medicine (Campos-Navarro, 2015)

Study Limitations

Our sample of eight traditional healers was small. Therefore, generalization is difficult, and it is important to note that traditional healers are not a monolith. All practitioners were located in California, and there was obvious selection bias as many were referred by other traditional healers. We found that traditional healers had been integrated into community hospital clinics to help biomedical professionals in addressing alternative worldviews. However, there was limited dialogue regarding how this integration was implemented.

Recommendations for Future Research

One recommendation is to conduct clinical trials within their cultural context to evaluate the purported medicinal properties of herbs. Another is to include a control group of individuals with culturally linked syndromes, comparing the efficacy of treatment by traditional healers versus biomedical providers. Additionally, research on the empirical knowledge and practices developed by Latina migrant grandmothers and mothers with respect to culturally related diseases connected to mental health—such as the evil eye, nerves, and fright—would be valuable, particularly where medicinal plants and specific rituals are used. Lastly, it is recommended that research on Indigenous healing practices, such as curanderismo, be conducted by, with, and for Indigenous peoples, in partnership with Indigenous scholars.

Data availability statement: The dataset used and analyzed during the current study can be made available from the corresponding author on reasonable request.

References

Alegría, M., Fortuna, L. R., Lin, J. Y., Norris, F. H., Gao, S., Takeuchi, D. T., Jackson, J. S., Shrout, P. E., & Valentine, A. (2013). Prevalence, risk, and correlates of posttraumatic stress disorder across ethnic and racial minority groups in the United States. *Medical Care*, *51*(12), 1114–1123. https://doi.org/10.1097/MLR.0000000000000007

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5.* (5th ed.). American Psychiatric Publishing. https://doi.org/10.1176/appi.books.9780890425596

Campos-Navarro, R. (2015). *Nadie nos puede arrebatar nestor conocimiento …: Proceso de legalization de las medicines Indigenas tradicionales en Mexico y Bolivia.* Universidad Nacional Autónoma de México.

Castro, F. G., Barrera, M., Jr., & Martinez, C. R., Jr. (2004). The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. *Prevention Science*, *5*(1), 41–45. https://doi.org/10.1023/B:PREV.0000013980.12412.cd

Chamorro, M. F., & Ladio, A. (2020). Native and exotic plants with edible fleshy fruits used in Patagonia and their role as local functional food sources. *BMC Complementary Medicine and Therapies*, *20*(1), Article 155. https://doi.org/10.1186/s12906-020-02952-1

Churchwell, K., Elkind, M. S. V., Benjamin, R. M., Carson, A. P., Chang, E. K., Lawrence, W., Mills, A., Odom, T. M., Rodriguez, C. J., Rodriguez, F., Sanchez, E., Sharrief, A. Z., Sims, M., & Williams, O. (2020). Call to action: Structural racism as a fundamental driver of health disparities: A presidential advisory from the American Heart Association. *Circulation*, *142*(24), e454–e468. https://doi.org/10.1161/CIR.0000000000000936

Donlan, W., & Lee, J. (2010). *Coraje*, *nervios*, and *susto*: Culture-bound syndromes and mental health among Mexican migrants in the United States. *Advances in Mental Health: Promotion, Prevention, and Early Intervention*, *9*(3), 288–302. https://doi.org/10.5172/jamh.9.3.288

Fakeye, T. O., Adisa, R., & Musa, I. E. (2009). Attitude and use of herbal medicines among pregnant women in Nigeria. *BMC Complementary and Alternative Medicine*, *9*(1), 53. https://doi.org/10.1186/1472-6882-9-53

González-Vázquez, T., Pelcastre-Villafuerte, B. E., & Taboada, A. (2016). Surviving the distance: The transnational utilization of traditional medicine among Oaxacan migrants in the US. *Journal of Immigrant and Minority Health*, *18*(5), 1190–1198. https://doi.org/10.1007/s10903-015-0245-6

Guillén, L. O. (2004). *Toward measurement of a more holistic conception of acculturation in the Mexican American population: Incorporating cognitive cultural constructs* (Publication No. 3160473) [Doctoral dissertation, Washington State University]. ProQuest Dissertations and Theses Global. https://ezproxy.lib.ucalgary.ca/login?qurl=https%3A%2F%2Fwww.proquest.com%2Fdissertations-theses%2Ftoward-measurement-more-holistic-conception%2Fdocview%2F305107788%2Fse-2%3Faccountid%3D9838

Hoogasian, R., & Lijtmaer, R. (2010). Integrating curanderismo into counselling and psychotherapy. *Counselling Psychology Quarterly*, *23*(3), 297–307. https://doi.org/10.1080/09515070.2010.505752

Hoskins, D., Hernández, M., Pérez, A., Spampinato, L., Tahir, P., & Chang, T. (2023). A novel multifamily treatment targeting symptoms related to Latinx caregiver deportation.

Psychological Trauma: Theory, Research, Practice, and Policy, *16*(S2), S409-S416. https://doi.org/10.1037/tra0001379

Hoskins, D., & Padrón, E. (2018). The practice of curanderismo: A qualitative study from the perspectives of curandera/os. *Journal of Latina/o Psychology*, *6*(2), 79–93. https://doi.org/10.1037/lat0000081

Hoskins, D., & Platt, J. (2022). Building a collaborative framework: A qualitative study of therapists collaborating with curanderxs. *The Journal of Mental Health Training, Education and Practice*, *17*(2), 159–177. https://doi.org/10.1108/JMHTEP-05-2021-0043

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. Pearson Education.

Langdridge, D. (2009). Relating through difference: A critical narrative analysis. In L. Finlay & K. Evans (Eds.), *Relational-centered research for psychotherapists: Exploring meanings and experience* (pp. 213–226). Wiley-Blackwell Publishing.

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). Demonstrative life stories. In A. Lieblich, R. Tuval-Mashiach, & T. Zilber (Eds.), *Narrative research: Reading, analysis, and interpretation* (Vol. 47, pp. 29–60). SAGE Publications.

Maldonado-Torres, N. (2007). On the coloniality of being: Contributions to the development of a concept. *Cultural Studies*, *21*(2–3), 240–270. https://doi.org/10.1080/09502380601162548

Maya, A. P., & Vega, R. A. (2021). Medical anthropology teaching at the National Autonomous University of Mexico Medical School: A reflexive analysis of programmatic development, challenges, and future directions. In I. Martinez & D. W. Wiedman (Eds.), *Anthropology in medical education* (pp. 195–213). Springer, Cham.

Moorman, L., Evanovitch, J., & Muliaina, T. (2021). Envisioning Indigenized geography: A two-eyed seeing approach. *Journal of Geography in Higher Education*, *45*(2), 201–220. https://doi.org/10.1080/03098265.2021.1872060

Nahin, R. L., Dahlhamer, J. M., & Stussman, B. J. (2010). Health need and the use of alternative medicine among adults who do not use conventional medicine. *BMC Health Services Research*, *10*(1), 220. https://doi.org/10.1186/1472-6963-10-220

Nilson, C. A. (2017). Journey toward cultural competence: The role of researcher reflexivity in Indigenous research. *Journal of Transcultural Nursing*, *28*(2), 119–127. https://doi.org/10.1177/1043659616642825

Ouma, A., Jacobsson, L., & Nilsson, L.-M. (2023). Sámi traditional medicine and complementary and alternative medicine—A descriptive study of use within the Sámi population of Sweden. *International Journal of Circumpolar Health*, *82*(1), 2222908. https://doi.org/10.1080/22423982.2023.2222908

Paniagua, F. A. (2013). Culture-bound syndromes, cultural variations, and psychopathology. In F. A. Paniagua & A.-M. Yamada (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations* (2nd ed., pp. 25–48). Elsevier.

Pérez-Aguilar, G. (2023). *Radical curandera politics: Transnational portals of politicized trauma healing spaces* [Unpublished doctoral dissertation proposal]. University of California, San Francisco.

Pérez-Escamilla, R. (2011). Acculturation, nutrition, and health disparities in Latinos. *American Journal of Clinical Nutrition*, *93*(5), 1163S–1167S. https://doi.org/10.3945/ajcn.110.003467

Quesada, J., Hart, L. K., & Bourgois, P. (2011). Structural vulnerability and health: Latino migrant workers in the United States. *Medical Anthropology*, *30*(4), 339–362. https://doi.org/10.1080/01459740.2011.576725

Sandberg, J. C., Quandt, S. A., Graham, A., Stub, T., Mora, D. C., & Arcury, T. A. (2018). Medical pluralism in the use of *sobadores* among Mexican immigrants to North Carolina. *Journal of Immigrant and Minority Health*, *20*(5), 1197–1205. https://doi.org/10.1007/s10903-017-0660-y

Squires, A. (2018). Strategies for overcoming language barriers in healthcare. *Nursing Management*, *49*(4), 20–27. https://doi.org/10.1097/01.NUMA.0000531166.24481.15