Lost in Translation: An Ethnographic Study of Traditional Healers in the Açorean (Azorean) Islands of Portugal

by

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ABSTRACT

This interdisciplinary research project investigated the process of healing utilized by Açorean Portuguese traditional healers. The purpose was to facilitate an understanding of this process for multicultural counselling practices in North America. The theoretical framework is informed by medical anthropology and the work of Arthur Kleinman (1980, 1987). Kleinman has been called an ethnographer of illness because of his belief that suffering is social and, as such, culturally constructed. He contends that without consideration of the experience of suffering and the social aspects of suffering, health care practitioners face poorer outcomes in treatments (Kleinman, 2005). The current ethnographic study was carried out in the Açorean Islands of Portugal and asked the following research question: How do traditional healers in the Açorean Islands facilitate wellness in people suffering from illness? Illness was defined as the personal experience of physiological and/or psychological disease or distress (Kleinman, 1980). This research contributes to the growing body of knowledge dealing with multicultural counselling as follows: a) it adds knowledge by contributing an in-depth description of Portuguese Açorean traditional healers, which was previously absent from the counselling psychology literature: b) it expands on existing research to further explicate the significance of suffering in the world for Portuguese Açoreans and the role traditional healers play in witnessing this suffering; and c) it highlights the multifaceted impact of language when English speaking counsellors work with second language English speaking clients.

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PREFACE

The following document requires a brief word to prepare the reader for the unique process provided by using ethnography from within the discipline of counselling psychology. The extended time spent in the field affords the researcher with the opportunity to develop and strengthen their understanding of the research topic while maintaining a relationship with the informants. As a consequence, definitions change, patterns evolve, and new questions develop as data is being collected. The reader will become aware of this process as they move through the document which serves the function of allowing, or possibly forcing, them to become more flexible in how they engage with cultural knowledge. The investigation of human experience by an ethnographer can be seen as a similar practice that is to be found in counselling. Relating to my process in the field is a core component to the usefulness of the findings and the implications for multicultural counsellors. The reader is cautioned that in many ways, this body of work asks more questions than it answers.

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DEDICATION

This project is dedicated, in its entirety, to Dr. James Andrew Foster (1937-2005).

CHAPTER ONE

Introduction

"He is possessed only of the human and legitimate desire to see what others see, set his feet in the footprints of others."

~Saramago, 1990, p. 24

Introduction

This interdisciplinary research project investigated the process of healing utilized by Açorean Portuguese traditional healers to understand the implications of this process for multicultural counselling practice in North America. This initiative was based on the notion that value systems and belief orientations, which are influenced by culture, affect our conceptualization of causality, treatment, and cure of mental illness and distress (Kleinman, 1980). As such, theories and methodologies from anthropology and counselling psychology were woven together to capture the experience of healing when traditional healers are engaged by Portuguese Açorean immigrants. As healing can be defined as the process of curing or becoming well, this study investigated the beliefs and practices that traditional healers utilize to heal people or families who seek their services.

This ethnographic study was carried out in the Açorean Islands of Portugal[1] and the study focused on traditional healers in that region and how they conceptualized and worked with mental illness and distress. The following research question was used to guide this ethnographic study: How do traditional healers in the Açorean Islands facilitate wellness in people suffering from illness?

To permit exploration of contextual details and the complexity of the narratives, this manuscript does not follow the traditional format for presentation and interpretation of research data and findings. Chapters One, Two, and Three include the Introduction, Literature Review,

[1] A description of the Açorean Islands of Portugal is given in Chapter Four.

and Methodology respectively. Chapter Four provides the context for the fieldwork which is highly significant and necessary to the analysis of data in ethnographic work. While Chapter Five provides the narratives of the informants, Chapter Six has been added to provide the researcher's interpretations of the narratives and to help the reader make sense of the significant cultural nuances that were observed in the field. In the Chapter Six, the Discussion, the findings and interpretation are considered in light of the current literature. Consistent with ethnographic study, new literature is introduced in the final chapter to supplement the analysis of the data collected in the field.

The Present Study

Purpose

The purpose of this study was to develop knowledge about traditional healers in the Açores to inform counselling practice with the Açorean population in North America. Specifically, it is hoped that counselling practitioners who work with this immigrant population will be informed by a clearer understanding of the process of healing ascribed to by this population. Canadian census information (Statistics Canada, 2001) reported that 357 690 Canadians claimed Portuguese ethnic origins. In the province of British Columbia, in the same census, 30 085 respondents reported Portuguese origins while 16 535 of those respondents reported solely Portuguese ethnicity. The census does not distinguish between Açorean and mainland immigrants; however, as indicated in Chapter Four of this manuscript, historically a large number of Açoreans emigrate to North America due to lack of employment and harsh conditions (Anderson & Higgs, 1976). Previous research used to develop the current research question was done solely with Açoreans immigrants in Canada and the United States (James, 2002; James & Clarke, 2001; James, Navara, Clarke, & Lomotey, 2005; James, Slocum, &

Zumbo, 2004). The aim of this project was to provide a contextualized description of the Açorean experience of healing to inform counselling practice with this population.

Rationale

This research project builds on a growing body of research within multicultural counselling. First, although there are a number of books and journal articles exploring traditional healing systems (Gadit, 2003; Halliburton, 2003; Vontress, 1999), a recent content analysis of the *Journal of Counseling and Development* found that only 6% of the articles discussed indigenous healing (Arredondo, Rosen, Rice, Perez, & Tovar-Gamero, 2005). Further to this, Portuguese healers were noticeably absent from the literature. Research within this immigrant community in Boston indicated that traditional healers were accessed by almost 50% of the sample surveyed (James, Navara, Clarke, & Lomotey, 2005). Further research in Canada demonstrated similar patterns (James, 2002), consistent with other literature reporting that traditional healers of other cultures are accessed in great number as well (Csordas, 2004; Dein & Sembhi, 2001; Moodley & West, 2005; Vontress, 1999).

This project was designed to provide much needed information on the belief systems of illness and healing inherent in the work of traditional healers in the Açores. Second, by systematically researching this population of healers and disseminating the information to mental health professionals, the profession in general will benefit from information that further develops concepts of multicultural counselling. Specifically, the Portuguese immigrant community will benefit from a more complex understanding of the process of healing which is inherent to the population and, more generally, the greater profession of multicultural counselling will benefit from much needed information on different worldviews that challenge our own North American ways of knowing.

Definition of Terms

A description of the terms relating to multicultural counselling is necessary as there is no one unifying theory in this area and, as such, no uniform agreement on an appropriate lexicon for professional discourse. Culture, diversity, race, and ethnicity are used interchangeably depending on the context or the author. The act of counselling can be considered cultural, cross-cultural, multicultural, transcultural (Harper, 2003), or culturally infused (Arthur & Collins, 2005a), all with different connotations, but often used interchangeably. The American Psychological Association distinguishes between culture and ethnicity by equating the former to a worldview that encompasses a shared belief system and value orientation, and by association the latter with race (American Psychological Association, 2002). Race and ethnicity are more closely linked to biological factors but still remain a socially constructed phenomena, with race being assigned by society and ethnicity being accepted by the individual (American Psychological Association, 2002).

A quick glance at the literature attests to the lack of consensus on the meaning of multicultural counselling, or even a concise list of acceptable and definable terminology. The use of either a broad or narrow definition of culture dictates the type of research and/or practice that researchers and counsellors adhere to. Within the multicultural counselling literature the broad definition of culture includes social system[2] (nationality, ethnicity, religion, language), demographic characteristics (age, gender, place of residence), status (social, educational, economic), and affiliation (formal and informal) variables. Using this definition, we must consider all counselling multicultural. The utilization of such a broad definition of culture lacks necessary parameters to be of any real value for research and practice. This is supported by Pedersen (1997b) and other authors in related fields (Al Krenawi & Graham, 2000; McMillen,

[2] Nationality and ethnicity are coined as 'ethnographic' characteristic in the multicultural literature; however, the word 'ethnographic' has a more general meaning in the discipline of anthropology. Social system has been used to describe this level of difference to minimize confusion for readers in different disciplines.

2004). The narrow definition of culture, which serves to focus professional discourse, includes social system variables and differences in nationality, ethnicity, language, and religion.

The narrow definition of culture has been used to define the sample of informants in the current study. This serves the purpose of focusing the inquiry to inform multicultural practice that is defined as a therapeutic relationship between two persons that do not share the same ethnicity. The data collected was done so from within this cultural group, in the narrow sense; however, the data represents the beliefs and values of a complex societal group that includes informants from different cultural groups in the broad sense. The informants are diverse in the sense of age, gender, social class, education level economic status, and formal and informal affiliations.

Drawing on anthropological literature, culture can be defined as a "…historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men [sic] communicate, perpetuate, and develop their knowledge about and attitudes toward life" (Geertz, 1973, p. 89). Using a narrow definition, culture is considered "historically transmitted patterns of meaning" that are influenced by nationality, ethnicity, religion, and language. Kleinman (2005), a psychiatrist and medical anthropologist whose work provided the framework for this study, further noted that culture is not a "thing" but rather "a process by which ordinary activities acquire emotional and moral meaning…" (p. 952). He further defined culture as, "the patterned ways that we have learned to think about and act in our life worlds and that replicate the social structure of those worlds" (Kleinman, 1988, p. 5). In the multicultural counselling literature, Pedersen (1991) suggested that culture can be seen as learned perspectives that are unique to a particular group and universals that are shared. Thus, culture is linked to worldview, which Sue and Sue (2003) have defined as a persons' view of the world based on his/her cultural perspective and life experiences, or the way a person perceives and experiences his/her relationship with the world.

The term traditional healer is used to distinguish between practitioners who ascribed to folk medicine traditions and health practitioners who received training in degree or diploma granting institutions, such as counsellors, social workers, physicians, psychologists, and psychiatrists. Indigenous healers (Vontress, 1999) and healer (McMillen, 2004) are terms used interchangeably with traditional healer in this manuscript. Specifically, traditional healer, indigenous healer and healer will be defined from the medical anthropology literature as,

> …[a] non-biomedical health practitioner who has inherited, trained in or created methods that utilize botanical, animal, and mineral products, perhaps symbolic methods and ingredients as well, and is sought out to treat physical, mental and social diseases, and conflict in his or her community. (McMillen, 2004, p. 891)

As healing can be defined as the process of curing or becoming well, this study investigated the beliefs and practices that traditional healers utilize to heal people or families who seek their services. The work of Arthur Kleinman (2005, 2001, 1998, 1997, 1988, 1987, 1980), a psychiatrist and medical anthropologist, who contrasts the human experience of suffering with the biomedical trajectory of disease, provided the framework for understanding the role that traditional healers play in the Açorean community.

CHAPTER TWO

Literature Review and Theory

This chapter reviews relevant multicultural counselling literature and describes Kleinman's work. A brief historical background of multicultural counselling is given and the status of the profession in Canada is contrasted with that which exists in the United States. Salient issues for the profession are discussed and relevant elements of medical anthropology are described. Finally, an argument is developed for the integration of methodologies from medical anthropology with research practices in counselling psychology.

Multicultural Counselling

Is counselling psychology culturally encapsulated? In the early 60's, Gilbert Wrenn (1962) first wrote of the dangers of counsellors being *culturally encapsulated*. His article continues to be cited regularly in today's multicultural counselling literature. He challenged the dominant discourse of counselling psychology by recognizing that practice and theory had evolved from values, assumptions, and beliefs of the dominant White Euro-American concept of mental health. He argued that traditional definitions of counselling, therapy, and mental health arose from monocultural and ethnocentric norms that excluded other cultural groups in such a way as to adversely affect the efficacy of the counselling process. More than 40 years later multiculturalism is considered the "hottest topic in counseling" (Sadeghi, Fischer, & House, 2003, p.179) and is credited with having introduced "a permanent paradigm shift" (Pederson, 2001, p. 15) in counselling. Current literature criticizes counselling as "essentially Eurocentric, ethnocentric, and individualistic" (Moodley, 1999, p. 139) suggesting that accepted treatments may actually represent cultural oppression (Sue & Sue, 2003).

Further evidence of the ethnocentric nature of early rhetoric in the profession is found in the language used to describe minority groups. Authors often utilized terms like *culturally deprived* and *disadvantaged* to signify minority groups (Harper, 2003). Shortly after Wrenn's

article, Vontress (1967a), considered a pioneer in multicultural counselling, exchanged *culturally deprived* for *culturally different,* in an attempt to dispel the unspoken myth that non-White populations were devoid of culture. More recently, Sue and Sue (2003) have changed the title of their classic book *Counseling the Culturally Different*, now in its 4th edition, to *Counseling the Culturally Diverse*. Diverse is meant to encompass an inclusive or broad definition of culture that does not use White Euro-American norms as a benchmark to measure difference. In Canada, Arthur and Collins (2005a) have adopted the term culturally-infused counselling. They advocate for the term non-dominant, in contrast to the term minority, to refer to "those groups who are commonly marginalized in society by virtue of their difference from the dominant Anglo-Saxon, male, heterosexual culture" (p. 13). Although the terms used in the field are evolving to be more inclusive and are attempting to lessen power differentials by adopting language that promotes pluralism and not marginalization, there is no agreed upon language between practitioners and researchers.

The Basic Behavioural Science Task Force of the National Advisory Mental Health Council (1996) presented strong research evidence that counsellors in the United States rely solely on Western perspectives of psychology and, as such, are in fact culturally encapsulated. The advisory council found that cultural beliefs have a significant influence not only on symptom expression, but on the diagnosis and treatment of mental illness as well. In one instance, they compared two different ethnic groups in a specific geographical area in the United States. For example, in the case of schizophrenia, symptoms were considered either a result of "nerves" and from being "sensitive" or as "insane" behaviour, two distinctly different conceptualizations of a specific mental illness (p. 723). In the former case, recovery was considered possible and the duration and intensity of the illness was much less, whereas in the latter case, recovery was considered less possible and symptoms lasted longer and were more intense.

Psychologists, psychiatrists, and anthropologists have provided numerous accounts of idioms of distress or culture bound syndromes that defy North American nosology. For example, a few such idioms include, *nerves* in Newfoundland and Norway (Davis & Joakimsen, 1997), *ataques de nervios* in Puerto Rico (Guarnaccia, 1993), and *agonias* in the North American Açorean immigrant community (James, 2002). Numerous others can be found in the back of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, APA, 2000). Diagnosis, and thus treatment, differed across cultures with variations in diagnosis being connected to categories relevant to the majority populations, most often reflecting the culture of the health care provider (Basic Behaviour Science Task Force of the National Advisory Mental Health Council, 1996). Research has also found that minority populations underutilize mental health care services (Constantine, Myers, Kindaichi, & Moore, 2004; Fraga, Atkinson, & Wampold, 2004) and are more likely to terminate prematurely (Robinson & Morris, 2000; Sue & Sue, 2003). There is little research that speaks to the reasons why services are underutilized and services are terminated prematurely.

It is generally accepted that worldview [a belief system or value orientation] influences an individual's psychological processes (Kleinman, 1987), and that such effects will enter into the therapeutic relationship in some manner (Fuertes & Brobst, 2002; Harper, 2003; Pope-Davis *et al.*, 2001; Wrenn, 1962). It has been well documented in the literature that it is the ethical responsibility of practitioners to provide treatment and interventions that are sensitive to cultural diversity (APA, 2002; Ibrahim, 1985; Pederson, 1997b; Sue & Sue, 2003; Wrenn, 1962). As a result, the onus is on the researcher to provide research on the efficacy of various interventions to meet the changing needs of clinicians who practice in multicultural societies (Pedersen, 1991; Ponterotto, Fuertes, & Chen, 2000). There is a general agreement that to engage in a therapeutic relationship with an individual while ignoring their cultural context would be unlikely to meet with much success. Pedersen (1997a) goes so far as to say it is "misguided, naïve, and

dangerous" to attempt to "assess, understand or change behaviours" without first acknowledging the cultural context of the client (p. 222). The most recent revision of the DSM-IV-TR (APA, 2000) includes input from cultural experts (Kleinman, 2001). The cultural formulation in the current edition offers guidance to evaluate the "impact of the individual's [client] cultural context" on the manifestation of disorders (APA, 2000, p. 897). Clinicians are instructed to include narrative summaries in five different areas of possible cultural impact to support the multiaxial diagnostic assessment: cultural identity of the individual; cultural explanations of the illness; cultural factors related to psychosocial environment and levels of functioning; cultural elements of the relationship with the clinician; and overall cultural assessment for diagnosis and care. Nevertheless, the DSM-IV-TR still represents a predominantly Eurocentric orientation (Spanierman & Poteat, 2005).

The lay of the land. The cultural movement in counselling can be traced to the US civil rights movement in the 1950's and 1960's (Harper, 2003). Vontress (1966, 1967a, 1967b, 1969a, 1969b) consistently wrote of the specific challenges of working with Black clients. Young and Nicol (2007) note that Canadian psychology is "embedded historically…in the larger North American context" (p. 22); however, they also acknowledge the unique context that reflects an approach to counselling psychology that displays Canada's "distinctiveness" (p. 21). In 1971, Canada became the first country to address multiculturalism by affirming the pluralistic nature of the nation and changing the focus from assimilation to integration in federal public policy (Arthur & Collins, 2005b).

Statistics Canada (2003) reported that 5.4 million people or 18.4% of the Canadian population were born outside of Canada; the highest percentage in the past 70 years. Further to this, more than 200 different ethnic origins were reported, with many people reporting multiple ethnic ancestries. The Canadian tradition of promoting diversity has led to the use of a mosaic metaphor, which contrasts with the melting pot metaphor commonly used to describe policies in

the United States. Lalande (2004) noted that, in Canada, the national conceptualization of multiculturalism "maintain[s] a variety of cultural perspectives" and "protects and embraces cultural differences." This sets Canada apart from the United States where the emphasis tends to be on amalgamation (p. 278). Two of Canada's chief non-dominant groups, French-speaking Canadians and Aboriginals, have long fought for the preservation of their distinct cultures within Canada. One clear reaction to this in the counselling profession the growing body of literature dealing with the distinct counselling needs of Canada's Aboriginal peoples (Chandler & Lalonde, 1998; Heilbron & Guttman, 2000; McCabe, 2007; McCormick, 1995; McCormick & Ishiyama, 2000; Poonwassie & Charter, 2001).

The diversity in the demographic characteristics of non-dominant groups between the two countries has been another factor that has introduced variations in the profession on either side of the border. Bowman (2000) noted that two non-dominant groups in Canada are French-speaking Canadians and foreign-born immigrants, whereas the two largest minority groups in the United States are people of African American and Hispanic/Latino decent. Historically, this has presented interesting challenges for Canadian institutions to negotiate when seeking accreditation or involvement in American organizations that adhere to perceptions of diversity based on US demographics. As Canadian practitioners, our position is further challenged by the fact that the United States has been a significant source of the production of knowledge for the profession; much of the culture specific research has reflected the demographic characteristics of the United States.

Understanding the focus. Although multicultural counselling has made a significant contribution to counselling psychology, practitioners still lack a comprehensive theory to guide practice. Navigating the quagmire of terms advocated by influential authors in the field adds confusion to practicing within a diverse cultural context. As mentioned previously, counselling can be considered cross-cultural, multicultural, or even transcultural, terms that are often used

interchangeably but have distinctly different foci (Harper, 2003). Theories that have evolved over the past four decades can be classified into two categories: universal (etic) theories and culture specific (emic) theories (Patterson, 1996; Ponterroto, Fuertes, & Chen, 2000; Sue & Sue, 2003). Although a dichotomous relationship is implied, an either/or perspective does not stand to benefit the profession and ignores the complex nature of the human condition.

The development of multicultural counselling competencies (MCC) by Sue, Arrendondo, and McDavis (1992) provides the only unifying theoretical conceptualization for the profession. Considered the foundation for counselling training, the MCCs were adopted by the American Psychological Association as the "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" (APA, 2002).

The authors conceptualize multicultural competency to be a factor of three separate domains: 1) attitudes/beliefs, 2) knowledge, and 3) skills. The first domain, attitudes/beliefs, mandates a practitioner's deep awareness of their attitudes, beliefs, and values, and how they affect their understanding of culture, race, and ethnicity. Furthermore, awareness of one's cultural privilege and socio-political history and the impact of discrimination and oppression on marginalized groups is necessary. The second domain, knowledge, mandates an extensive knowledge of different cultural worldviews and the socio-political history of different cultural and/or ethnic groups. The third domain, skills, mandates a comprehensive knowledge of culturally sensitive interventions and the ability to draw on cultural knowledge to implement culturally sensitive practices. Pedersen (2001) described Sue and colleagues' MCC model as a "developmental progression from *cultural awareness* of basic underlying assumptions to *cultural knowledge* about relevant facts and information toward *cultural skill* [all italics added] or ability to intervene appropriately" (p. 21).

Although the advent of multicultural competencies is considered a "transformative event" for the profession by some (Arredondo & Perez, 2006, p. 1) and a "major event" by others

(Collins & Pieterse, 2007, p. 14), there is little research that shows the impact of increased multicultural competencies, as presented by Sue and colleagues, on practice (Fraga, Atkinson, & Wampold, 2004; Worthington, Mobley, Franks, & Tan, 2000). In a content analysis of the *Journal of Counseling and Development*, Arredondo, et al. (2005) discovered that less than 8% of the articles in a recent 10-year period were dedicated to the discussion of multicultural competencies. They noted that, "the concept of multicultural competencies was advocated without a definition for the concept" (p. 158).

Interestingly, one study found that although practitioners were conversant in multicultural competencies, this knowledge did not transfer into practice (Hansen, Randazzo, Schwartz, Marshal, Kalis, Frazier, et al., 2006). The authors noted that, for 86% of the 52 competencies they identified in the literature, the practitioners did not "practice what they preach" (p. 66). Furthermore, their study found that individual experiences were more influential in practice than professional guidelines and codes. Although MCCs have been widely accepted in the profession, there is ample evidence to suggest the shift towards multicultural competence is still in its infancy (Robinson & Morris, 2000).

As the theory and the practice of multicultural counselling becomes more sophisticated, controversies develop between scholars. Specifically, Pedersen (2001) noted two fundamental controversies that plague multicultural counselling as a subdiscipline of counselling psychology. The first controversy questions whether or not counselling is culturally encapsulated, as Wrenn suggested in the early 1960's. Many researchers and practitioners argue that, in one sense or another, all counselling can be considered multicultural, and it is more productive to focus on universal processes rather than on idiosyncratic group beliefs and behaviours (Fischer, Jome, & Atkinson, 1998; Patterson, 1996). This controversy was discussed at the beginning of the chapter and an argument that supports Wrenn's claim of cultural encapsulation was given.

The second controversy is the debate between using a narrow definition of culture that includes ethnicity and nationality as determinants of culture or using a broad definition that includes age, gender, status, disability, and sexual orientation as determinants of culture. Those in favour of a broad definition argue that all marginalized groups face discrimination, and thus these concerns should be integrated into all multicultural counselling research and practice. Others argue that, for people of ethnicities other than White-European the issues salient to the counselling process differ greatly from those of sexual diversity or disability, for example.

For the purpose of this research project the narrow definition of culture is used and the research question seeks to inform practice between two persons that do not share the same nationality and/or ethnicity, specifically North American counsellors and Portuguese Açorean immigrants. This does not negate the necessity for research and theory development concerning other possible determinants of cultures. However, utilizing a narrow definition does serve to focus the discussion on the unique elements of a therapeutic relationship when more than one distinct ethnicity is present. Ponterotto, Fuertes, and Chen (2000) used a similar definition in a chapter dedicated to reviewing different models of multicultural counselling. They noted that their purpose was to provide specific boundaries in the plethora of multicultural counselling literature.

Traditional Healers

The majority of the literature that systematically studies the beliefs, values, and behaviours of non-conventional systems of healing and its impact on conventional health care practices comes from either anthropology (e.g., Halliburton, 2003; Koss-Chioino, 2000; McMillen, 2004) or biomedical fields like medicine and psychiatry (e.g., Crawford & Lipsedge, 2004; Dein & Sembahi, 2001; Yen & Wilbraham, 2003). In Canada, a growing body of literature focusing on aboriginal healing traditions and healing elders is available for counsellors working within this population (Blue & Darou, 2005; France, McCormick, & Rodréguez , 2004). Authors

argue that the aboriginal peoples of Canada have a rich culture with a "defining sense of community and spirituality" (Arthur & Collins, 2005b, p. 5) that is not addressed by the philosophical foundations of individualism and mind/body dualism that underlies psychological theory. The goal for non-aboriginal counsellors is to develop awareness of these traditions and facilitate the re-engagement of community resources and to reintegrate clients into healing groups if necessary. France, McCormick, and Rodréguez (2004) noted that utilization of aboriginal healers is necessary because non-aboriginal healers "can never learn the [healing] teachings since the teachings are rooted in culture" (p. 278). There is a noticeable absence of information regarding traditional healers that represent non-dominant cultures in Canada.

Research has established that immigrants in North America access traditional healers from their country of origin while simultaneously utilizing local public health care services (Csordas, 2004; Dein & Sembhi, 2001; Moodley & West, 2005; Vontress, 1999). Little research has measured, either qualitatively or quantitatively, the outcomes of using traditional healing methods that are consistent with ethnic heritage; the pattern of simultaneous use of systems of healing makes is hard to decipher the efficacy of either system. Although there is a small body of counselling psychology literature that has investigated traditional/indigenous healing practices and their implications for multicultural counselling (Constantine, Myers, Kindaichi, & Moore, 2004; Moodley & West, 2005; Vontress, 1999), there are no reports of systematic research conducted to gain a better understanding of traditional systems of healing. Counselling psychology has traditionally relied on anecdotal descriptions of healing systems to inform practice.

The Açoreans

A robust pattern of emigration to North America of Açorean families began in the 19th century and continues today. Harsh conditions and lack of sustainable employment [this is

elaborated on in Chapter Four] led to large numbers of Açoreans leaving the islands for *melhorar a vida* [a better life]. Initially, in the mid 19th and early 20th, century, fishing companies attracted many Açorean immigrants to coastal areas to work as whalers. As well, textile mills held promise for many unskilled workers. In 1957, a volcanic eruption in the archipelago displaced many families and started what could be called the second wave of immigrants to North America, which continues today.

In many ways, Açorean immigrants have remained almost undetectable as an ethnic minority in Canada. The population may superficially assimilate into North American society, yet they maintain strong adherence to traditional beliefs. Moitoza (1982) describes this as an intense pull from two directions that may serve to alienate them in both worlds. Further stressors have been put on Açorean immigrants by a sponsorship program that promotes the dependence of new immigrant families on previously settled Açorean families, thereby, causing schisms in usually strong family units (Noivo, 1997).

James and colleagues have provided practitioners with the only systematic research with this immigrant population. Using both qualitative and quantitative methodologies, their program of research has reported on an idiom of distress used by Açoreans to label their suffering. *Agonias* [directly translates to agonies] defies psychiatric categorisation, linking psychological processes, somatic responses, social contexts, and a religious belief system. Hence, *agonias* is often misunderstood and misdiagnosed by practitioners (James, 2002; James, & Clarke, 2001; James, Navara, Lomotey, & Clarke, 2006; James, Navara, Clarke, & Lomotey, 2005; James, Slocum, & Zumbo, 2004). It was from this program of research that the help seeking behaviours of Açoreans first became evident, illuminating the significance that this immigrant group placed on traditional healers (James, Navara, Clarke, & Lomotey, 2005). James (2002) specifically suggested that because "diagnostic categories are limiting" there is a need to "learn about other healers" (p. 106). It is from this body of work that the current project was developed.

Drawing on Interdisciplinary Knowledge

For more than 20 years, Arthur Kleinman (1987, 2001), an anthropologist and psychiatrist, has advocated a practical integration of medical anthropology and psychiatry in which a reciprocal relationship is nurtured and knowledge from both disciplines is used to inform each other. By privileging the knowledge of two academic disciplines, anthropology and counselling psychology, research will develop toward elaborating "a richer, more complex, multisided vision of human conditions and experience" (Kleinman, 2001, p. 16). Psychiatry and counselling psychology have distinctly different lexicons, as well as different values and practices, yet the desired outcome is the same: to facilitate wellness for people suffering psychological distress. By using Kleinman's framework, which integrates medical anthropology with psychiatry, knowledge from medical anthropology can be utilized to further develop theories and practice in multicultural counselling.

Combining Knowledge: Drawing on Anthropology

Arthur Kleinman has been called an ethnographer of illness because of his belief that suffering is social and, as such, culturally constructed. To fully appreciate the suffering experience, physical and/or psychological, he employs theories and methods from anthropology to develop knowledge that will inform the provision of health care. He contends that, without consideration of the experience of suffering and the social aspects of suffering, health care practitioners face poorer outcomes in treatments (Kleinman, 2005).

Suffering, therefore, exists on three levels: society, practitioner, and individual. On a societal level, a *sickness* is infused with social meaning, as in the instance of alcoholism or HIV / AIDS. Historically in some societies, both types of sickness have been associated with a stigma that has adversely impacted the functioning of some people; whereas alcoholism implied weakness and chronicity. HIV / AIDS implied homosexual or unsafe promiscuous sexual behaviours or chronic drug use. On an individual level, Kleinman (1988) described two levels of

understanding suffering that have different meanings and must be considered when investigating health systems and health care practices: disease and illness. A *disease* is considered a practitioner's formulation of a disorder which draws on theory and training from a specific health discipline. Kleinman (1988) explained,

> Disease is what practitioners have been trained to see through the theoretical lenses of their particular form of practice….the practitioner reconfigures that patient's and family's illness problems as narrow technical issues, disease problems….The healer - whether a neurosurgeon or a family doctor, a chiropractor or the latest breed of psychotherapist - interprets the health problem within a particular nomenclature and taxonomy, a disease nosology, that creates a new diagnostic entity, an "it" - the disease. (p. 5)

An *illness* is considered "the innately human experience of symptoms and suffering" and "refers to how the sick person and the members of the family or wider social network perceive, live with, and respond to the symptoms and disability" (p. 3). Quite simply, illness "is the patient's perceptions, experience, and communication of symptoms" whereas disease is the clinician's reformulation of these perceptions, experiences, and symptoms (p. 450).

For example, at the disease level, depression is diagnosed by identifying a cluster of symptoms that are outlined in the DSM-IV-TR (APA, 2000). Psychologists, psychiatrists, physicians and other mental health care practitioners become versed in this formal nosology through training or through interaction in mental health institutions. At the illness level, depression may be a distinctly different experience. The experience becomes a dynamic interplay of the past, present, and the future that is unique to an individual; e.g., having a family member whose life ended in suicide after a long battle with depression impacts a child's own experience of depression. Through the practitioner's lens, depression is seen as a disease that sets in motion a specific treatment protocol that might include Cognitive Behavioural Therapy and medication; through the individual's lens, depression might be seen as an illness with a life

sentence. These two distinctly different conceptualizations of depression are at odds with each other and Kleinman believes this disjuncture severely impacts outcome.

Kleinman has long advocated that culture must be more central to the understanding of treatment of psychopathology. He contends that the constructs of illness and disease are often in opposition when mental health services are provided to a diverse population with different value systems and belief orientations. He noted that, "we express our distress through bodily idioms that are both peculiar to distinctive cultural worlds and constrained by our shared human condition" (Kleinman, 1988, p. xiii). He describes depression in Chinese society as a *sickness* that is "morally unacceptable and experientially meaningless" (Kleinman, 2005, p. 951). He further notes that the *illness* experience of depression is physical and expressed as "boredom, discomfort, feelings of inner pressure, and symptoms of pain, dizziness, and fatigue" (p. 951). This symptom cluster is distinctly different from the *disease* nosology described by the DSM-IV-TR.

At all three levels [society, practitioner, and client], the *explanatory models* (Kleinman, 1988), or the notions about specific disordered episodes, impact healing and create a dynamic process from which health care systems develop. Utilizing this conceptualization, healing must be considered as both a biological or psychological process, and as a personal/social process (Kleinman, 1980), in other words, as healing of the disease and healing of the illness. The latter is considered by Kleinman (1988) to be cultural healing which "is a necessary activity that occurs to the patient, and his family and social nexus" (p. 360). Considering this, it is counterintuitive to assume the stability and universality of categories of distress across cultures if symptoms and diagnosis are a negotiation between cultural experiences of the client and practitioner. For multicultural counselling, a component of the health care system that provides mental health services to people of other cultures and/or ethnicities, the dynamic relationship of disease and illness creates an interesting mixture of belief systems.

Cause for Integration. Within the lexicon of counselling psychology, the process of healing is considered to be the process of clinical practice. Medical anthropology developed out of "…an intellectual, academic interest in describing and understanding the ways in which various non-Western peoples have explained illness and given treatment to the sick…" (Pelto & Pelto, 1996, p. 293). As counselling psychologists, our practice is developed from a theoretical orientation and training that has been influenced by our social worlds. Beliefs, diagnosis, disordered behaviours, treatments, societal reactions and sanctioned cures, result from a number of interrelated factors that are all impacted by culture. Research has shown that health care practitioners translate the illness experience to disease nosology when clients communicate their suffering in culturally unique ways (James, Navara, Lomotey, & Clarke, 2006; Kleinman, 1997). Kleinman (2001) stated, "No science can restrict itself to knowledge produced in a single society…" (p. 15). Thus by integrating theories and methodologies, anthropology provides counselling psychology with a global perspective on suffering and healing.

As the field of counselling psychology seeks holistic models to serve a more varied immigrant clientele, traditional healers provide an underutilized resource to supplement Western modalities of mental health care. Vontress (1991, 2001) has long advocated for a culture general approach to cross-cultural counselling that utilizes indigenous knowledge to provide counselling that more closely resembles the client's worldview. Research has highlighted the importance of mental health clinicians understanding and eliciting the help of indigenous and religious healers within immigrant communities (Constantine, Myers, Kindaichi, & Moore, 2004; Fink, 2002; Gadit, 2003; Halliburton, 2003; McMillen, 2003; Vontress, 1999; Yen & Wilbraham, 2003). Kleinman (1988) stated that practitioners are ill-informed about indigenous forms of healing "even when such knowledge is relevant to understand non-compliance and poor outcome" (p. 262).

Christopher (1996) noted, "…if we assume we are being neutral, unbiased, or value-free as counsellors, then we are simply failing to recognize the prejudices from which we operate" (p. 23). When we consider other ways of working with people in distress we become more understanding of our own cultural and historical embeddedness, which reduces the risk of misdiagnosis and mistreatment. Integrating systems of healing and other conceptualizations of wellbeing serves to expand our knowledge base and skill set to better accommodate the changing demographics of our society (James & Prilleltensky, 2002). Csordas (2004) considers this a process of the "intertwining or braiding of … two ways of thinking and knowing" (p. 5). This notion of intertwining and braiding is what Shweder (2003) would consider *pluralism* which privileges neither one belief system nor the other but rather considers them to be equal but different. The idea of pluralism as a way to reduce cultural embeddedness necessitates the examination of narratives that illuminate the processes of healing in non-dominant cultures.

Psychologists, psychiatrists, anthropologists, sociologists, and health professionals around the world have faced the task of understanding how symptoms of suffering are expressed in other cultures (World Health Organization, 1995). The literature is rich with accounts of symptom clusters in different cultures that do not correspond to mental health diagnoses in North America (Kleinman & Becker, 1998). What multicultural counselling has to offer is a more complex view of how practitioners can work with explanatory models of distress that are different from the theoretical lens of the profession.

Anthropology provides insight and knowledge into social and emotional processes through a long history of research in other cultures. Methods traditionally used by ethnographers investigate human experience from the point of view of the individual; a similar practice that is to be found in counselling practice (Krause, 2003). A true integration of both – medical anthropology theory and practice / counselling psychology theory and practice – sets the stage for the development of a contextual translation of healing that can be used to inform theory and

practice. Moodley (1999) eloquently noted the direct benefits to the profession of contextualizing healing practices from other cultures. According to Moodley, "In recognizing traditional and alternative cultural healing methods, the eurocentric [sic] and individualistic discourse of counselling will be challenged and transformed. Multicultural counselling experienced in this way will also challenge the existing epistemologies that inform counselling and therapy" (p.149). By "challenging existing epistemologies" we distance ourselves as a profession from being *culturally encapsulated* and are therefore more prepared to acknowledge the diverse needs of our practice. The practical integration of anthropology and counselling psychology provides a contextual understanding of cultural systems of healing. The ultimate contribution is global perspectives of healing and suffering.

CHAPTER THREE

Methodology

The purpose of this research project was to provide knowledge of the ways in which traditional healers in the Açorean Islands work with people in distress. It is anticipated that the knowledge presented from this systematic study of a different system of healing will broaden the knowledge of counselling practitioners and raise questions that challenge Westernized ways of knowing. This specific ethnic group was chosen to focus the research and to build on an existing body of literature dedicated to examining culture specific idioms of distress within Portuguese Açorean immigrants in Canada and the United States (James, 2002; James & Clarke, 2001; James, Navara, Clarke & Lomotey, 2005; James, Slocum, & Zumbo, 2004). To this end, an ethnographic methodology was chosen to structure this investigation. The research question that guided this inquiry was as follows: How do traditional healers in the Açorean Islands facilitate wellness in people suffering from illness?

Research Design

Traditionally utilized by anthropologists, ethnography has gained a wider acceptance in the social sciences as a qualitative method of inquiry which focuses on meaning, experience, and culture (Hammersely & Atkinson, 1995; Jeffrey & Troman 2004; Tedlock, 2000). Not unexpectedly, there is a tension created when using methods from one discipline, anthropology, not traditionally used in another discipline, counselling psychology. In effect, there needs to be a process of translation when marrying two different paradigms. Anthropology typically studies human life and culture whereas counselling psychology studies individuals and their functioning in the world. The anthropologist's "primary concern is to improve [the] understanding of the social world" (Kleinman, 1998). The counselling psychologist strives to understand the cognitions, emotions, and behaviours of the individual. One provides a rich understanding of human kind and the other provides knowledge to ameliorate dysfunction or distress in humans to

improve wellbeing and resolve crisis. I have tried to bridge these differences in methodology and theory by providing explicit explanations of my process. Two examples of situations that do not translate directly from anthropology to counselling psychology research methods are the following: 1) Ethnographers do not traditionally provide a comprehensive list of informants who fit a specific criteria, as is common practice for qualitative researchers in counselling psychology, and 2) Ethnographers consider data collection to commence in the initial stages of conceptualizing a research project, whereas for other qualitative methods, data collection is understood to take place in the formal process of interacting with the identified participants.

The reader may identify other areas in this text that may not match their own ways of conceptualizing the research process, depending on their educational and professional origin. However, in what Suzuki, Ahluwalia, Mattis, & Quizon (2005) called "cross-pollination of disciplines" (p. 213), we achieve what Kleinman (2001) considered "a richer, more complex, multisided vision of human conditions and experience" (p. 16). Suzuki, et al. (2005) argued "that ethnographically informed methods enhance counselling psychology research conducted with multicultural communities and provide better avenues towards a contextual understanding of diversity as it relates to professional inquiry" (p. 206). This makes the tension and possible growing pains inherent in "cross-pollination" beneficial in the long run.

Ethnography endeavours to describe and understand the beliefs, motivations, and behaviours of a specific cultural group (Tedlock, 2000). Through prolonged contact in the field, ethnographers become part of the group and challenge themselves to represent meaning from the point of view of the cultural group members. Consistent with concepts in multicultural counselling, culture is understood to structure meaning. There is no one universally accepted definition of ethnography (Chambers, 2003). Stewart (1998), however, suggests four generally accepted characteristics of ethnography: participant observation, holism, context sensitivity and

sociocultural description. The following section provides a description of these four characteristics.

Participant observation, the hallmark of ethnography, defies one specific definition. While it has been argued that simply *being there* is participant observation, to be an effective strategy for collecting data for scholastic pursuits, more than physical proximity is necessary (Wolcott, 2005). Participant observation can be described as fieldwork, participating and observing, formal and informal interviewing, engaging in rituals or ceremonies and/or conversing with the community. As such, it can be considered "a way to collect data in a relatively unstructured manner in a naturalistic setting by ethnographers who observe and/or take part in the common and uncommon activities of the people being studied" (Dewalt & Dewalt, 2000, p. 260). Further to this, participant observation is the analysis and recording of the data as a means to produce a document that will add to a scientific body of knowledge. In this way participant observation is both an analytic tool and collection of data and ethnography is both a process and a product.

Tedlock (2000) considers the term, participant observation, to be an oxymoron because it implies becoming emotionally involved through participating while remaining an objective observer. Ethnographers are expected to walk a fine line between becoming *involved enough* to develop an understanding and becoming *too involved* and thus losing objectivity. As with counsellors in a therapeutic relationship, "…ethnographers are expected to maintain a polite distance from those studied and to cultivate rapport, not friendship; compassion, not sympathy; respect, not belief; understanding, not identification; admiration, not love" (Tedlock, 2000, p. 457).

As is evident in the intention behind doing participant observation, an ethnographer takes a holistic stance and maintains that any particular outcome is a result of a great number of interrelated factors. The outcome is impacted by the personal and social processes that are

influenced by cultural beliefs and values. Invoking Geertz's (1973) definition of culture as a "…historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate, and develop their knowledge about and attitudes toward life," holism can be seen as one of the fundamental values behind this research project (p. 89). This notion of holism is consistent with Kleinman's (1988) conceptualization of illness as the individual experience of disease. Illness is the product of a number of interrelated factors in which diagnosis is but one. A body of literature exists that provides a contextualization of illness as it is experienced by Açorean Portuguese immigrants in North America and residents of the Açores (James, 2002; James & Clarke, 2001; James, Navara, Clarke & Lomotey, 2005; James, Slocum, & Zumbo, 2004). This study provides a contextualizing of the experience of healing of residents in the Açores.

The third and fourth characteristics suggested by Stewart (1998), context sensitivity and sociocultural description, are consistent with what Geertz (1973) named "thick description" (p. 6). Contextualized and sociocultural description, or thick description, combines all the knowledge and information collected by the ethnographer to develop links in beliefs, motivation, and behaviours which place observations into a larger perspective (Fetterman, 1998). This is possibly one of the most distinguishing characteristics of ethnography. While not only highlighting reoccurring patterns and underlying themes, the thick descriptions of ethnographers ensure that what is not happening is also identified (Wolcott, 2005). In studying culture, context and sociocultural variations are significant as it is these variations that provide the most information on diversity (Kleinman, 1987; Krause, 2003). Miller, Hengst, and Wang (2003) provide a comprehensive definition of ethnography which closely resembles my own conceptualization. They state,

> Ethnographic research involves taking up a rigorous program of scientific inquiry marked by repeated and varied observations and data collection; detailed recordings of, and

> reactions to, such observations; a skeptical stance by the researcher that forces as many questions from the continuous interpretation of the data as it provides answers; and the presentation of the ongoing interpretations to the larger scientific community. (p. 223)

A Discussion of Methods

> Beginning fieldwork in a foreign culture is a bit like diving into an unfamiliar pond in which you suspect that there may be underwater hazards. You may examine the surface of the pond at length (and breadth and width for that matter); you may even review the observations of others who have swum in the pond, yet when you leap in yourself, you still have an excellent chance of landing headfirst on a submerged boulder.
>
> ~Raybeck, 2000, p. 17.

A customary practice for ethnographers is to immerse themselves in the existing data before actually arriving in the field. As the quote above suggests, I examined the surface of the pond at length; in essence, I started collecting data a year and a half prior to travelling to the Açores. Instrumental to the birth of this project was a chapter I coauthored as a result of my analysis of existing research data on Açorean traditional healers (Bezanson, Foster, & James, 2005). Another significant contributor to the development of this project was my involvement in a research lab that was investigating idioms of distress within the Açorean immigrant community in Canada and the United States. As part of my work in this lab, I worked with a research assistant[3] (RA) to prepare her for field work in the Açores. I have maintained contact with this research assistant and she has continued to provide invaluable cultural translation in many different ways.

To satisfy my curiosity about the place and the people, I read descriptive literature, both fiction and non-fiction. This helped build a body of knowledge around the history, the people, and the customs in Portugal and specifically the Açores. While still in Vancouver, I enrolled in

[3] This research assistant was a first generation Canadian of Açorean decent.

Portuguese language courses. These classes consisted mainly of young Açorean Canadians who were trying to gain fluency in their ancestral language. Through these connections, I attended many Portuguese cultural events in the area. Some of these events included musical concerts, poetry readings, soccer games, and *cerveja* [beer] at a Portuguese social club.

Pelto and Pelto (1996) note that often ethnographers must rely "heavily on serendipity" in locating informants and becoming close enough to gain access to necessary information (p. 309). In an unrelated trip to Sri Lanka, before leaving for the Açores, I met and worked with a Portuguese non-profit organization called *Medico do Mundo* [Doctors of the World]. As fate would have it, two of the relief workers were psychologists. They provided interesting information on their country and profession and they contributed in many ways to my project.

On another trip to attend the *International Association for Counselling Annual Conference*, Buenos Aires, Argentina, I presented the results of the aforementioned research analysis (Bezanson, Foster, & James, 2005). The intention of the presentation was to challenge counsellors to examine the usefulness of traditional healing practices in the counselling process. The counselling profession in Argentina is still in its infancy (W. A. Borgen, personal communication, 2005). The Argentinean and other South American counsellors were hesitant to consider traditional healing methods while the counselling profession was in the process of gaining credibility by developing professional policies, guidelines, and ethical codes. The reactions to my presentation in Argentina strengthened the formulation of my research questions and methodology and prepared me for this response in Portugal.

These activities provided the foundation for the development of this research project. I gained a basic understanding of the people and the place in relation to the world. The Portuguese nationals and immigrants I met offered practical advice on travelling to the Açores and insight into customs, traditions, and what it means to be Portuguese. Language training, taking part in cultural *festas* [party/celebration], and reading literature all played a part in preparing me for

doing the research and, in fact, became part of the research as I was a participant observer in these situations.

Pelto and Pelto (1996) describe the initial time in the field as a period of "ethnographic exploration" and indicate that it can take the form of "loitering about in public places" (p. 309). They note it is necessary to carry out unstructured conversations with a wide variety of community members to develop a sense of the local community and to create a focus for more relevant data collection. This *loitering* in the field started upon my arrival in Lisboa where I enrolled in a language school; data collection in Portugal commenced at this time. In conversation with people, the inevitable question of what I was doing in Portugal would arise. After describing my research, a dialogue would inevitably ensue full of rich descriptions of folklore and strong opinions on traditional healing and its place in conventional health care. As I would find to be true for the residents of the islands, residents of mainland Portugal drew distinct lines between their own culture and that of the Açores.

I arrived in the Açores in February 2006. From this time until I left Portugal at the end of May 2006, I maintained accommodations on the island of São Miguel. During this time, I travelled to the island of Terceira twice to meet with an RA who was working on another related research project. To initiate "ethnographic exploration" upon my arrival on the islands, I visited the Canadian Consulate, I joined a yoga group, and I registered in a language course at the university (Pelto & Pelto, 1996, p. 309). Through these contacts I met the RAs, faculty and staff at the university, professional care givers, and many other community members who became informants. Living in the community provided daily interaction with my informants on many different levels. Some informants I met once or maybe twice, others I maintained relationships with while on the islands and with still others, I continued to communicate via internet after I left the islands.

While in Portugal conducting this research project, I simultaneously worked on two other related projects: 1) a quantitative study investigating *agonias* and *problems de nervos*, both idioms of distress in the Açores, and 2) a qualitative study exploring the meanings ascribed to *agonias* and *problems de nervos* by biomedical and mental health practitioners. To assist me with all three projects, I hired two RAs and secured one volunteer[4]. All three consented to act as cultural informants in my ethnographic study and provided an invaluable filter for the information I was receiving. At a later date it was necessary to hire one more research assistant for translation only[5].

Initially I tried to keep the three projects separate. This proved to be a less than effective way to proceed. It drew fictitious lines around information and directly contradicted Stewart's (1998) idea of context sensitivity and holism. I found that, while soliciting participants to fill in the quantitative questionnaires or investigating possible interviewees, I would have interesting discussions that would lead to other informants for other parts of the study. The three projects complimented each other and provided a process of triangulation where I would discuss questions and preliminary themes with members of the community.

Hiring two RAs to complete the majority of the interviews was both necessary and beneficial. Both were fluent in Portuguese, which allowed for in-depth, lengthy conversations that my own level of Portuguese would not allow. They also acted as gatekeepers and gave me access to community members that would otherwise be hard to reach. During the training sessions with the RAs, we 1) translated the interview script to resemble the local speech, 2) practiced probing for information, 3) practiced the informed consent process, and 4) discussed the theoretical foundations for the research project. We held regular meetings together and I met individually with each RA to debrief their interviews. In total, I hired three RAs and secured one

[4] One RA and the volunteer were Açorean. The other RA was from the mainland of Portugal.
[5] This RA was from the mainland and had lived on the islands for 4 years.

volunteer. All four members of the research team developed into cultural guides and helped me navigate my way around the community.

Data sources. An artefact of ethnography is the impossibility of being able to provide a complete list of participants, whom I refer to as informants. Some informants I met with regularly and they continued to be a part of this project until the final text was completed. Included among these informants were: the Açorean RA, one Açorean Canadian living in Vancouver, a psychologist from mainland Portugal, a businessperson from mainland Portugal, a member of a Portuguese cultural society in Vancouver, and two residents of the Açores. These informants ranged in age from early 20's to early 50's. As well as being part of the formal data collection process, these informants provided language and cultural translation during the analysis and writing process.

The primary informants of this study were members of the community who had been born and raised in the Açores. A total of twenty-five formal interviews were conducted. The RAs conducted their interviews in Portuguese, while I conducted my interviews in both Portuguese and English with interviewees who felt competent in both languages. Written consent was obtained for all formal audio taped interviews. For all other interactions with informants, the project was explained and verbal consent was obtained. All informants were given my local phone number to enable them to contact me if they had any concerns or wanted to give more information.

All the informants [including formal interviews and informal interactions] for the current study were community members who self identified as having utilized the services of a *curandeiro*[6] or who had knowledge of *curandeiros* in the Açores. Informants in the aforementioned projects, who also provided info relevant to the current project, were, 1) nurses, psychologists, and physicians working in the community, and 2) women in the community. Four

[6] A *curandeiro* is a traditional healer and is described in depth in the *Findings* section.

formal interviews were conducted with informants who identified as having utilized a *curandeiro* and one interview was conducted with a professional health care giver that community members identified as a *curandeiro*. Of these 5 interviews, I conducted all but one. Interviews with female community members and health care providers were part of the other two projects.

Although the formal interviews with the health care practitioners and the female community members were specifically for the other two research projects, the topics overlapped and they provided valuable information about traditional healing practices which informed the current study. In the interviews, the RAs often stimulated conversation about traditional healers while at other times, the topic was initiated by the informants. This reflects a holistic understanding on knowledge and the infeasibility of disentangling information concerning healing, wellbeing, and distress. The informants offered definitions, names, stories, histories, and their opinions of the usefulness and hazards of seeking traditional healers. Most of the information collected dealt specifically with *curandeiros* while other informants focussed on *herbalistas, endireita, mulher quem ler do livro* and *bruxas*. *Herbalistas* [herbalists], *endireita* [bone setter], *mulher quem ler do livro* [the woman who reads the book], c*urandeiros* [healer] and *bruxas* [witch or medium], are all traditional healers identified by the informants[7]. The *Curandeiros* seemed to be what the informants and RAs felt was most pertinent to the topic of psychological distress and counselling psychology. Table 3.1 gives a summary of how the formal interviews were carried out.

Other informal ongoing interactions with members of the Açorean community who were familiar with traditional healers in the Açorean Islands also provided data for the current study. Examples of these community members were as follows: a local diplomat and his administrative assistant, my landlady and her husband, employees at the university and public libraries, my

[7] An full description is provided in Chapter Five: Findings.

language tutors, members of a local yoga group, professors at the university on São Miguel, and employees at health food pharmacies. Interactions with my informants varied, some I visited in their homes or at their places of work. Further to this, *loitering* took place in many different venues and often where I least expected it. One entry in my field notes is titled *Research Happens When You Least Expect It* and begins "I was dying for my tape recorder today…" I often found myself in the middle of discussions in which my presence was ignored while locals debated the usefulness of my research and the usefulness of *curandeiros*. Whenever I met someone new they would immediately ask me what I was doing in the Açores and that would start a discussion that would fill the pages of my field notes with observations and questions.

Table 1: Description of Formal Interviews

Informant	# of interviews/informants	Language	Interviewer
Community Member: self-identified as accessing a *curandeiro*	4	English/Portuguese	Researcher - 3 RA - 1
Health Care Professional: identified as *curandeiro* by community members	1	English/Portuguese	Researcher
Female Community Member	7	Portuguese	RA
Health Care Practitioner	13	Portuguese	RA

Other data sources consisted of numerous forms of written material that I collected prior to arriving in the Açores and during my stay there. For example, while in Lisboa, I learned of a famous book[8] written in the 1950's that chronicled a physician's life in the rural areas of Portugal (Namora, 1976, 1956). Sections of this book dealt with the physician's interactions with *curandeiros* and other types of healers. In the process of trying to translate this book with my informants, more significant conversations about healers were initiated. When I returned to

[8] Retalhos da Vida de um Medico [Remnants of the Life of a Doctor].

Canada I found an English translation. In another interaction, one of my informants gave me the name of an American researcher who, in the 1970's, conducted research similar to mine in the Açores. This researcher later sent me numerous unpublished manuscripts, which permitted interesting comparisons to be made across two different generations (Like & Beck, nd; Like, 1977/1978; Like, August, 1978; Like, April, 1979). Further to this, my informants gave me other written pamphlets concerning medicinal herbs, cultural traditions, and religious *festas* [party/celebration].

Data Management. The sheer volume of data produced by ethnography is notorious for overwhelming even the seasoned ethnographer. I kept files of interviews (audio and written translations), field notes, and pictures on my laptop. These files were backed up regularly. I also used three notebooks to record field notes.

Fetterman (1998) considers field notes "the brick and mortar of any ethnographic edifice" (p. 114). I recorded my observations in a notebook when in the field and on my computer when in my residence. While in the field, I recorded names and numbers given to me by informants. Quite often, after an interview or informal meeting, I sat in a café or at a bus stop and recorded my observations and thoughts. Field notes are simultaneously considered both as data and analysis (Dewalt & Dewalt, 2000). Thus, either when writing or reviewing my notes, I developed more questions and/or decided on my next action. I kept ongoing lists of questions and observations that I then used to direct my dialogue with informants, and to help guide my telephone consultations with my research supervisor in Canada. I also recorded my reactions to the written material that I collected in my field notes.

A fundamental attribute of ethnography is the flexibility necessary in the field. Data in ethnography are considered to be "all recorded results of empirical observations in fieldwork…," including "recorded responses on structured interviews…photographs, documents and other physical materials" (Pelto & Pelto, 1996, p. 297). At no point during my time in the Açores did I

feel like anything other than a participant observer. My research was often the topic of conversation in my yoga class, in my Portuguese class, and in my boarding house. I visited *ervanarias* [stores that sell natural products to promote both a health body and a healthy mind – *bem estar,* to be well] and spoke with shopkeepers about psychological health and people who act as healers. I took part in religious ceremonies and I traveled around the island of São Miguel and engaged locals in conversations about Canada, children, fishing, and anything else that naturally worked its way into our chats. I collected pamphlets, advertisements, photographs, programmes, guide books, and many other artefacts that have all contributed to my understanding of the context and the process of healing in this culture.

A Percussive Word on Data Translation

All formal interviews were audio taped and transcribed verbatim by myself or one of the RAs. Translation of the audio taped interviews from Portuguese to English was done by the two RAs who performed the interviews and by a third RA who was hired after the interviews were completed. First, one of the RAs translated the interview verbatim. Second, I went over the translations to correct grammar and spelling and clarify any passages that were confusing due to literal translations. All translators had a strong command of conversational English but had not used their English skills outside of a classroom context; thus, the translations were sometimes confusing and incomprehensible. Below are examples of the types of changes that I made in the initial stages of analysis. The Portuguese transcription [italicized] is shown, followed by the translation by the RA, and finally my changes are given:

> *Então não tem tido doenças, para além dessas que já referiu*?
> So you don't had any disease, beside those you spoken?
> So you haven't had any illness, besides those you spoke of?
>
> *Eu fui operada.*
> I've been operated.
> I was operated on.
>
> *Por exemplo,*

By instance,
For example,

O que é que é então os problemas de nervos?
What are then *problemas de nervos?*
What are *problemas de nervos* then?

Many words proved to be problematic to translate. For example, *doença* can be translated to sickness, illness, or disease, which all have different connotations in English. As most of the discussions centered on mental illness, I often changed the translation of *doença* from disease to illness unless the context suggested otherwise. This process of ensuring the transcriptions were comprehensible was the first step in my analysis of the formal interviews. A layer of triangulation occurred as I consulted with the RAs and other members of the community to ensure I had captured the intended meaning.

A further note on translation. Language became a very important focus in this research study on a number of different levels. In many instances, I chose to include the original Portuguese words in the text as many of these descriptions lose their intensity when I relied on the literal translation. I felt it was important to give the reader the opportunity first to experience the richness of the language, and then second, to provide enough information so that the reader could draw individual conclusions regarding the essence of the speech. To increase the reader's ability to understand this text with ease I have done the following: 1) All Portuguese words and phrases are italicized, 2) literal dictionary translations are provided, 3) in some cases I provided the research assistants' specific translation, and 4) if necessary, I comment on words or phrases that do not translate easily or have a different meaning in the Portuguese language.

Some of the informants were interviewed in English, which in all cases, was their second language, or in some cases, even their third language. As a result, the direct quotes sometimes seemed awkward. Quite often, the informants mixed tenses or used tenses that did not reflect their intended meaning. Other times, the informants struggled for words or repeated phrases. For

the most part I did not change these quotes, except for the types of grammatical changes discussed above. My purpose was to give the reader the opportunity to, at some level, experience the problems inherent in communicating with people whose first language is different than the language being spoken, and to decide how this impacts the research and the information I have provided.

Analysis

Geertz (1973) considers analysis "sorting out the structures of significance" (p. 9). Analysis of data started early in the process and continued throughout the inquiry to guide and direct this ethnography. Miller, Hengst, and Wang (2003) call this "the evolving and inductive coding practice" of ethnographers. Data was continuously compared and contrasted as it was collected. As new information was gained, decisions were made regarding possible new informants, which rituals to gain access to, and which questions should be asked. In this way, constant and continual analysis shaped this program of research in the field. Fetterman (1998) lists the first tool available to ethnographers for analysis as the "ability to think – to process information meaningfully and usefully" (p. 92). I reviewed my field notes as a way to continually revisit the theoretical foundations of the study and re-evaluate what was being researched (Wolcott, 2005).

During this revision process, I made notes on my notes. In the ongoing process of journaling, I considered personal observations and reflections, emerging themes, and speculations. This activity continuously and consistently forced me to return to my research questions. Aside from the records of *thick description*, this journaling process facilitated the ongoing interpretation of the *thick descriptions* and the cultural artefacts I collected. Credibility "is in part a result of well-documented and systematic analysis of the data" (Miller, Hengst, & Wang, 2003, p. 228). The ongoing analysis in the field offered ideas and themes that I was then able to take back to informants to verify and elaborate.

Triangulation is a process of analysis as well as a process of validation. One source of information is tested against another, and possibly another. Although the term triangulation implies three points of clarification (Morrow, 2005), the process involves multiple points/people/artefacts to provide not only a form of verification but a more complete analysis. This provides an assurance of the quality of the information and the quality of the understanding. Member checks, or what Hammersly and Atkinson (1995) call "respondent validation," is an attempt to ensure that the informants involved are able to recognize their beliefs and behaviours in the thick descriptions of the researcher (p. 227). As well, since informants have access to information that the ethnographer does not [unshared thoughts and histories, for example], triangulation and member checks can add contextual details to create a more holistic understanding. My involvement in the community over time allowed for triangulation; I continuously shared my ideas and analysis with my informants which prompted a holistic understanding. In the case of the formal interviews, if significant questions arose during transcription or translation, the informants were contacted and clarification was attained.

Ethnographers search for patterns in beliefs, motivations and behaviours. Patterns are a form of reliability in ethnographic research (Fetterman, 1998). While in the field, I compared and contrasted bits of information until themes and patterns became more obvious. Exceptions and variations became important and I tried to clarify the meaning of stories and absolute statements. The complexity of human experience defies the writing of a coherent narrative or description with a concrete beginning or an end. My experience in the field fit well with what Suzuki, et al. (2005) described as the investigation of stories that are "messy, complicated, and [a] dialectical reality of people's thinking and behaviours" (p. 208). While in the field I fell into a process of reading, writing, sense making and questioning, that continued in a circular pattern until I dotted the last *i* in this manuscript.

By the time I left the field, tangible themes had begun to emerge. The themes were a result of participant observations, meetings with my team, and my initial reading of the transcripts. I used these themes to begin formal analysis of the transcripts. On my return to Canada I began a more formal analysis of the date. I read through the interviews with the informants, I recorded quotes and added information from my field notes on cue cards that represented each different theme. More themes emerged as I read and reread the transcripts. The headings in the *Findings* section represent the major themes. The subheadings are themes that initially seemed to stand alone but later seemed to logically collapse into other themes as I wrote the text.

Maintaining Quality

"…if we consider the minuet, with its set movements and prescribed gestures, one dancer's arm movements may be very different from another's even as both are dancing the same dance."

~Janesick, 2003, p. 70

Qualitative researchers struggle with the prescribed research referents of generalizability, reliability, and validity, the traditional stamps of approval developed in the positivist tradition for quantitative research. Credibility, transferability, dependability, confirmability (Denzin & Lincoln, 2003b), standards of goodness (Morrow & Smith, 2000), along with trustworthiness, and authenticity (Lincoln & Guba, 2003) have been suggested as the appropriate lexicon for standards to measure quality in qualitative research.

Ultimately, it is the usefulness of the knowledge provided by research that provides the final judgement (Johnson, 2000; Vidich & Standford, 2003). However, standards of quality need to be adhered to along the way. The theoretical considerations that influenced this inquiry are consistent with an interpretive/constructivist paradigm. Kleinman's framework assumes a relativist ontology, a subjectivist epistemology that necessitates utilizing a naturalistic set of

methodologies. To ensure credibility in the final product I maintained transparency through thick description, reflexivity/self-awareness by continuous writing, consultation, and collaboration with the informants.

Although initially developed within the discipline of anthropology, the task of thick description (Geertz, 1973) has been adopted by qualitative researchers as one means of ensuring credibility. It is the researcher's task to remain transparent and "…describe the cases in sufficient descriptive narrative so that readers can vicariously experience these happenings and draw conclusions, which may differ from those of the researcher (Stake, 2003, p. 141). I adhered to a sense of what Sanjek calls "theoretical candour" and "explicit description" (as cited in Suzuki et al., 2005, p. 212). Although I was flexible and reactive in the field, the research remained rooted in its theoretical framework to maintain standards of rigor. Specifically, I often reviewed Kleinman's articles and books that elaborated on illness as the personal experience of disease and the impact culture can have on healing. I maintained a clear focus on the theoretical foundations of my work by providing thick descriptions and continually writing as a way of interpreting these thick descriptions. This, Tedlock (2000) refers to "observation of the participation" (p. 465). Simultaneously a form of analysis and means of promoting credibility, *observing the participant* is a self-reflective process in which I was able to *observe* my process of discovery and then take these observations and discoveries back to the informants to ensure they were rooted in the experience of the community.

Other activities that ensured credible analysis of data and interpretations were consultations with colleagues and informants. A positive consequence of being in the community is the ability to continuously "learn from the interviewee how well the researcher's interpretations reflect the interviewee's meanings" (Morrow, 2005, p. 254). This was done through continuous contact with my research team and with the community I built during my

stay in the Açores. As well, I maintained communication with my research supervisor who is conversant in both the Portuguese culture/language and the process of ethnography.

Throughout the manuscript, I have attempted to be transparent and explicit to promote rigor and maintain trustworthiness in the findings. Morrow (2005) also suggested that to maintain dependability in qualitative research careful tracking of "research processes and activities; influences on data collection and analysis; emerging themes, categories or models; analytical notes "by keeping an "audit trail" (p. 252). My field notes, which filled three separate note books and 15 computer files of varying lengths, provided the basic structure of my audit trail. Further, I have numerous email correspondence with informants, the research assistants, and professional colleagues that outline the data collection and analysis of the data. Telephone conversations held with my research supervisor while I was in the islands provided more transparency in data collection and analysis.

We can only know an experience through a representation, and an objective reality can never truly be attained (Denzin & Lincoln, 2003a). Ethnography is highly situated in place and time. This ethnographic research project provides a description of beliefs, motivations, and behaviours that concern wellbeing, *bem estar*, and the process of moving towards it when in distress. The primary informants represent residents of the Açores who felt they had information that would add to this project. Various forms of data were collected, combined and analysed, and the descriptions of the findings seek to broaden our conceptualization of healing.

The Researcher

Krause (2003) suggests that "the choice of fieldwork, the choice of topic and the choice of informants, and the style of communication and investigation always says something about the ethnographer herself as a person, about her (hi)story and about her inclinations" (p. 6). A typical practice for qualitative researchers is to explicitly present their "worldviews, assumptions, and biases" (Morrow, 2007, p. 210). In the following section, I will highlight the

journey that led me to this qualitative research project, and I will attempt to make my biases transparent so that the reader will be able to identify my voice in this text.

I share no direct ethnic heritage with the people of Portugal. As an outsider, there were beliefs and values that I could not *see*; First Nations scholars suggest the knowledge that traditional healers privilege is unknowable by outsiders because it is cultural knowledge and, in their view, unattainable (France, McCormick, & Rodréguez , 2004).On the other hand, there were beliefs and values that I could see but proved to be difficult to bring into my dialogue with my informants; the fish does not often see the water they are swimming in. As I experienced in Argentina[9] prior to commencing fieldwork in the Acores, local psychologists did not see the relevance or usefulness of contemporary healing methods and traditional healing methods; it was as an outsider that these questions seemed relevant.

Researcher subjectivity is inevitable; in terms of my own subjectivity, I went into this project with the expectation of knowing. I was knowledgeable on many aspects of the people, the language, and of the healing practices; however, it took doing the research to truly understand what I did not know and what I could not know. This, paradoxically, became a limitation of the research and, ultimately, what the project has to offer.

Although I attended to the prescribed methods of ethnography[10] to ensure rigor, dependability, and trustworthiness, ultimately, this is my interpretation of my informant's experience. I have provided a representation of what I saw and understood to be the significant information that would answer the research question behind this project. The relationship between my own salient identity referents and the findings that I present cannot be completely identified; however, it is important to make explicit my identity as a Caucasian women approaching middle age who has embarked on this project with a combination of personal

[9] See Chapter Three, A discussion on methods.
[10] See Chapter Three

interest (as explained below) and professional necessity (the partial requirement for graduation). The development of this project can be linked to my own history.

My interest in multicultural counselling and traditional systems of healing was born out of years living in other cultures and engaging with traditional healers. Experiencing people who have benefited from working with healers who draw on theories and practices that deviate from my own has nurtured a curiosity in seemingly incommensurable systems of healing. Through travel, it has become evident to me that there are many similarities between North American therapeutic modalities and modalities from other parts of the world. There are some who believe that the basic components of counselling are universal, but remain culture specific in practice (Torrey, 1972). Vontress (1999) wrote, "We [counselling psychologists] recognize ourselves as members of a global community of helpers devoted to the same mission – assisting people who need therapeutic companion from time to time as they move through life" (p. 335). I agree with Torrey and I consider myself part of the global community Vontress described.

Research suggests that traditional systems of healing can be integrated to expedite the journey to mental wellbeing (Bojuwoye, 2001; Vontress, 2001). As well, the research has supported the fact that traditional healers, as defined previously, play a part in the healing process of people in distress and are accessed concurrently with Western trained practitioners (Csordas, 2004; Dein & Sembhi, 2001; James, 2002; Moodley & West, 2005; Vontress, 1999). These findings are consistent with my own experience; positive outcomes are readily exhibited by people who utilize traditional healers that are consistent with their ancestral knowledge. Yet, traditional healers remain an underutilized resource in mental health care.

My experience as an expatriate in Lebanon, the Kingdom of Saudi Arabia, Brazil, and Sri Lanka heightened my awareness of the experiences faced by immigrants to my own country. These experiences in other cultures have strengthened my ability to learn from diversity. As a practitioner, I will be challenged to provide care to clients with different worldviews than my

own. Professionally, my research is driven by the desire to extend my beliefs so that I can remain open to understanding other worldviews and increase my efficacy with diverse populations. Personally, my research is driven by a desire to understand alternate views of healing and wellbeing as understood by cultures other than my own. Ultimately, I seek to challenge my own beliefs, which were shaped by my rural Nova Scotian upbringing.

CHAPTER FOUR

Contextualized and Sociocultural Description of the Açorean Islands Place and Time

The Açores is an archipelago of Portuguese islands approximately 1200 kilometres [2 hours flying time] off the coast of Portugal and 3900 kilometres [5 hours flying time] from the east coast of North American[11]. The nine islands are divided into three groups: the Eastern Group [*Grupo Oriental*] consisting of São Miguel and Santa Maria; the Central Group [*Grupo Central*] consisting of Terceira, Graciosa, São Jorge, Pico and Faial; the Western Group [*Grupo Ocidental*] consisting of Flores and Corvo. The islands are spread over 600 kilometres and are situated between New York and Lisboa.

Although part of Portugal, the Açores have been an autonomous region since 1976 with self-rule by a regional government and a regional legislative assembly with the executive section of the local authority located in Ponta Delgada on São Miguel, the legislative in Horta on Faial, and the judicial in Angra do Heroísmo on Terceira. Autonomy was gained not due to ethnic distinction but because of the great distance from Lisboa, the country's capital. Residents of the mainland and the Açores consider the two geographic locations quite distinct. When asked to discuss illnesses unique to the Portuguese, one Açorean health care provider highlighted a general theme in the responses, "Look, the Portuguese… I feel like talking of the Açorean people [only]."

Figure 1: West coast of São Miguel

Another suggested a different belief and value system for the two locations, "I mean my reality… on the mainland and in the Açores…the complaints are different. Maybe people don't complain about different things but they give different values to the complaints, right?"

[11] The reader is directed to Appendix B for more photographs of the Açores.

The current population of the islands is approximately 243 000 (The Green Guide: Portugal, Madeira, The Azores, 2001). São Miguel is the largest island, running 65 by 14 kilometres with a population of 130 000, while Corvo, at the far north western tip, is the smallest island running 6.5 by 4 kilometres with a population of 300 to 400 (Sayers, 2004). Terceira, the third largest island, is the site of a large American Military Base. Entry to the base is heavily restricted and many services are provided on the base rendering the community self-sufficient; there is little evidence of the American residents on the rest of the island.

Often considered as being in the middle of the Atlantic, there is an incredible sense of remoteness and isolation to the islands. This sense of isolation, combined with the severe climate conditions, has a strong impact on the residents:

> …the Açores has tremendous [extreme] characteristics, on a social level, which is precisely [related to] the isolation and the climate. A climate that is permanently changing, whether the sun is shining, whether it rains, whether there is fog, the relative moisture of the air usually is always above 80%. That causes people to usually be *angustiadas* [anguished], to be burdened, to have a tremendous weight on one's back, like people use to say, *'Que peso que eu tenho na cabeca.'* [What a weight I have in my head.] This has a little bit to do with isolation, with a certain smallness…The act of leaving to go anywhere always forces us to catch a plane and we always have to subject ourselves to storms or not. While on the mainland people travel by car or travel by train anytime and whenever they want.

As this informant suggested, the residents are often at the mercy of the extreme weather conditions. Another informant said that "outsiders" tend to feel claustrophobic and may even have to leave the islands. The same informant pointed out that the locals are unaware of the effects and do not suffer as outwardly as "outsiders:"

> It can be seen in the people who are from the mainland and who live here, but I think that the islanders don't care much about that [the remoteness] because they lived here all their lives. That's their reality…it's something that I notice more in outsiders. And I am not even mentioning sick people, I'm talking about people who feel more claustrophobia…I never thought about that. But it's a phenomenon from the outside to the inside…. [People] who's not feeling well here, ends up leaving.

These two quotes highlight how the remoteness and climate affects people and for the residents becomes a way of life and is inherent in being Açorean.

A Tenuous Way to Live

The islands, the result of volcanic activity, have been subject to intense seismic eruptions since they were settled in the 15th century. The benefits can be seen in the lush flora and the dramatic black cliffs that rise out of the often tumultuous Atlantic. The town of Biscoitos [translation - biscuits] on Terceira received its name for the strangely shaped black lava that forms natural pools that locals frequent in the summer months. The town of Sete Cidades [Seven Cities] on São Miguel consists of natural *caldeiras* [kettle or boiler] formed from volcanic upheaval that created two lakes of visibly different colors. It is said that the lakes were formed from the tears of a forbidden love; the green lake from the poor shepherd boy and the blue lake from a princess whose father forbade the union[12]. Tourists from around the globe are attracted to other smaller more active *caldeiras* that bubble, belch, and send steam smelling strongly of sulphur into the air. Whether it is the hot springs or the *cozido nas caldeiras* [stew of the *caldeiras*; a meat and vegetable stew cooked for 7 hours underground] the remnants of the volcanoes are often a curiosity for the tourists. However, for residents seismic activity is a constant reminder of the extreme and fragile conditions of life on the islands.

[12] Much of this historical information was learned through conversations with locals and then verified and elaborated on through other sources, both verbal and written.

The first recorded eruption occurred on the island of São Miguel shortly after it was discovered in 1445. This eruption destroyed huge chunks of a mountain range; it is said to have simply disappeared leaving only a crater. In 1522 an earthquake completely destroyed Vila Franca do Campo, then the capital city of São Miguel, and buried 5000 inhabitants. In 1810 there was a violent volcanic eruption on the island of São Jorge which covered the island with streams of lava. In 1957 Fayal trembled and people were said to have suffered from nausea "as if they were on a rocking ship at sea" (Emilio, 1990, p. 22). As recently as the early 1980's, Terceira suffered overwhelming losses when much of the capital city of Angra was devastated and some villages on the island were almost completely destroyed. The constant awareness of the impermanence and the fragility of life strengthens a fear and uncertainty in the future. Açoreans manage the remoteness and the obvious force of nature in many ways; the two most obvious are religious devotion and emigration.

Religion. Religious festivals are popular in the islands. One such festival that is representative of the penance and sacrifice practiced as reconciliation with the Divine is the socio-religious tradition of the *Ramarias.* In the month before Easter, a time for penance, groups of men [*Romeiros*] pray and sing hymns as they walk from parish to parish over the entire island of São Miguel. It is generally accepted that this ritual originated during the time of seismic crisis between 1522 and 1563 (Silva, 2003). The ritual is characterized by intense prayer and penance. Time is taken away from family and work with the "idea of pardon and reconciliation with the Divine and with spiritual renewal…" (Silva, 2003, p. 254). The entire family is involved and although women do not take part in the actual pilgrimage they take up all the home duties and support their husbands and sons as they move from village to village.

One of the most important festivals, *Senhor Santo Cristo dos Milgeres* [Lord Holy Christ of Miracles], is celebrated on the fifth Sunday after Easter. The weeks prior to the *festa* [celebration] are consumed with preparing the city of Ponta Delgada on São Miguel and the

airport is congested with tourist and Açoreans from North America, Africa, Brasil, and other parts of the world. Balconies and windows are adorned with elaborate floral arrangements and on the day of the procession the streets are decorated with intricate designs of brightly colored wood shavings [originally flowers were used]. Media coverage is constant throughout the celebrations and telephone calls from Açorean immigrants suffering intensely from *saudade*[13] [loosely translates a longing, nostalgia, or homesickness] are broadcast on the local radio and TV stations. The procession is lead by an image of Christ with a crown of golden thorns that was a gift sent from Rome in the 14th or 15th century. Locals boast it is the second longest procession in the world[14]. To show gratitude to the Lord for His blessing in times of suffering and in the harsh conditions of the islands, some participants circle the cobblestone streets of the main square on their knees or carry heavy bundles of massive candles on their back.

Religious practice is also embedded in daily activities and plays an important role in the Açorean way of life. One local researcher goes so far as to state, "Putting their religious sincerity and faith in doubt is to insult them; not taking their religious dimension seriously is to betray them" (Silva, 2003, p. 252). Another obvious indication is the location of the parish *igreja* [church] in the community. The positioning of the *igreja* in the communities that dot the hills and coastal areas of the islands gives the impression that all roads entering the township lead to the place of worship. This main *praça* [square] serves as a meeting place and is often littered with coffee shops were the locals sit to catch up on the current news and *fofoca* [gossip]. The term *freguesia,* which literally translates to parish or parishioners [collectively], is still used as a regional designation. This term is often hard for the locals to translate to English as there is no

[13] An excellent definition of *saudade* can be found in McCabe and Thomas (1998). They consider it a "dynamic cultural construct" that originated in the sixteen century (p. 60). *Saudade* is "the memories that touch the soul - not only longing, it is also belonging" (p. 60).
[14] The claim to being the second longest and not the longest highlights the distinct absence of self promotion of the Portuguese.

corresponding term that involves both church and state.[15] In a survey collected at the same time as the current study, 88% of the respondents endorsed Catholic when asked to choose between 1) Catholic, 2) Protestant, 3) I don't have a religion, and 4) Other as their religion practice[16].

Emigration. Emigration has always been a fact of life for the people of the Açorean Islands. The population of the islands in 1960 totalled approximately 327 000; approximately 84 000 more than the current population of 243 000 (The Green Guide: Portugal, Madeira, The Azores, 2001). Emigration has played a huge part in the decreasing population and thus, the majority of people are intimately associated with the hazards and refuge provided by emigrating either from first hand experience or that of a close family member or friend. Between 1955 and 1974 alone, 130 000 Açorean emigrated (The Green Guide: Portugal, Madeira, The Azores, 2001) which amounts to the current population of São Miguel. Although Portuguese can be found in many parts of the world, many Açoreans immigrated to California, Massachusetts, and the greater Toronto area. In the province of British Columbia 30 085 people responded to the Canadian census as having Portuguese heritage while 16 535 of those respondents report solely Portuguese ethnicity (Statistics Canada, 2001). Seismic activity, lack of employment, and dreams of a better life have promoted the high numbers of people emigrating to North America and other parts of the world (Anderson & Higgs, 1976).

Economy. The rich soil, resultant of the seismic activity and adequate precipitation, provides the foundation for the agrarian society of the islands; however, limited land, massive craters, enormous *caldeiras*, dormant volcanoes, and hilly, rocky fields makes the rich soil an elusive asset that is hard to capitalize on. The determination of the Açorean people to produce a crop well tailored to their environment has created a repetitive cycle of a boom/bust economy that

[15] Guill (1993) in his written history of the Açores translates *freguesia* to civil parish.
[16] This sample is from unpublished research (James, 2006) conducted on the islands of São Miguel and Terceira and consisted of 407 respondents, 62% of which were women. The mean age was 34 years and the age range was 17 to 84 years.

started with the early settlers in the 15th century (Williams, 1982). Sugar, woad plant,[17] wheat, flax, grapes, oranges, lemons, pineapple, tobacco, and various vegetable crops all played an important role in the search for a suitable mainstay for the economy. None resulted in a sustainable cash crop. Small scale remnants of many of these attempts can still be seen in the fields.

Farming is a major source of income for many Açoreans. The importance of dairy farming is made obvious by the acres and acres of grazing cattle contained by miles of traditional rock fencing. The residents of the mainland joke, if Portugal is reprimanded by the European Union council for any reason it is most likely the over production of dairy products by Açorean farmers that should be blamed. Even though modern technology is available to farmers, it is not odd to see milk being delivered in a donkey drawn cart, even within the city limits.

Although fish stocks have diminished, fishing remains an important part of the local economy and way of life. The coastal areas are littered with small vessels that supply local restaurants with the *prato de dia* [plate of the day]. In the past, whaling was also a significant contributor to the livelihood of many Açoreans. Whaling was a dangerous trade and the "hardy peasants of these rocky shores" supplied North American whaling ships and took countless Açorean men far from their families (Melville,1851, as cited in, McCabe & Thomas, 1998, p. 21). Whaling continued until 1981 but the Açoreans "still look back nostalgically to the dangerous days of hunting" (The Green Guide: Portugal, Madeira, The Azores, 2001, p. 314). Souvenir shops are full of scrimshaws [etchings on whale teeth] and other folkloric artefacts from a time long gone. Originally an activity to fight the isolation and boredom of life on the whaling ships, scrimshaws are now impressive pieces of art that can range in price from €50 [approximately $70] to €1250 [$2000] (Sayer, 2004).

[17] Woad plant was an important source of blue die in the 15th and 16th century (Williams, 1982).

Tourism is a growing industry and many *ecotour* companies have opened to capitalize on the temperate climate and volcanic attractions that nurture the abundance of natural beauty. Vegetation is diverse with tropical species and European plants growing side by side. White and blue hydrangeas, possibly the most well known of the area, crisscross the hills in striking patters. A travel agent offers a description of the islands' way of life to prepare visitors for the cultural experience in the Açores (Sayers, 2004):

> Slow down, relax and enjoy yourself. As the Azores is so little known beyond Portugal and so many visitors arrive at this archipelago with mixed ideas of what to expect, most are surprised to discover how green the islands are. At the same time we are not a place for sun-drenched holidays, entertainment or busy nightlife. Please accept the Azores, its landscape and many interests for what they are and not what you might expect. If this is your approach right from the start, we are sure the islands will give you a lifetime of happy memories of your visit. Slow down and adapt to our way of doing things. We don't have bustling pressure found in other places of Europe; we have our own scale, things still get done, although they may take a little longer. It is time for you to relax and enjoy yourself. (p. 38)

The frustration caused by the flexibility of time on the islands is juxtaposed against the relaxed ambience that the locals embrace as the primary advantage to their bucolic island life. The tranquility of the countryside and farming and fishing villages stand in stark contrast to the constant buzz of jumbo aircraft landing at the international airport and the expensive European cars manoeuvring the narrow cobblestone streets. In many ways these contradictions verify the tight grasp the Açoreans have on traditional customs and their craving for the conveniences and stability of modern life.

From the Outside Looking In: The researcher's perspective

Early in my stay on the islands a bank teller asked me what I was doing in the Açores. After hearing about my research, she told me that they didn't have "those problems" in the Açores; life was relaxed and people were not "stressed" like they were in other places. She was concerned that I would not find what I was looking for. I heard this same sentiment from Açoreans in Canada and continued to hear it from other informants during my stay. Yet, the people I met were busy people, running from one commitment to the other. Although rarely formally verbalized, my informant's behaviours and descriptions of life on the islands spoke volumes: I could hear them saying; *"Que peso que eu tenho na cabeca."* [What a weight I have in my head.]

Many health care practitioners that I spoke with cited alcoholism as one of the biggest societal problems on the islands. I saw many advertisements for psychologists and therapists in the local newspapers. I heard many stories from health care professionals of people going to the emergency room to alleviate a deep loneliness and to reduce an anxiety that did not seem to be organically based. My conceptualization of the calm, serene, paradise that people described to me did not match up with what I experienced as a participant observer on São Miguel and Terceira.

I was struck by the reserved demeanor of the residents. The houses on the islands that I visited had metal shutters on the windows that were presumably to weather severe storms. However, these shutters were often closed, rain or shine, and it was hard to tell if the house was inhabited or not. It gave the impression that the owners were off visiting family who have long since immigrated to some far off place. In contrast, when the shutters were open, people hung out of their windows and held animated conversations with their neighbours and the people who passed by. The fronts of most houses sat directly on the edge of the street, which meant community members would stand in the streets and slow the passing traffic. Not much would

stop the important community activity of catching up on the local news. The latter is an oddly opposing behaviour to closing the shutters and remaining invisible to the outside world.

My informants were gracious hard working people and the formal hospitality that was extended to me was truly heartfelt. In many cases they did not see the significance of studying Açorean traditional healers but they always offered many stories, suggestions, and directions to help me complete my task. The previous section provides factual information as well as my perceptions of the people and the place in the time I spent in the Açores collecting data.

CHAPTER FIVE

Findings

Introduction to Findings

The following chapter presents the findings of this research project through the voices of the informants and their descriptions of traditional healers. First, a concise description of the different types of healers that the informants identified is given; *herbalistas, endireitas, as mulhers quem ler do livro, bruxas, and curandeiros.* These descriptions provide a contextualized understanding of how traditional healers facilitate wellness. A more in-depth description of *curandeiros* is given, which is provided for two reasons: 1) The informants discussed *curandeiros* more often and they indicated that information about *curandeiros* was more significant to counselling psychology, and 2) Many informants discussed the similarities between *curandeiros* and psychologists.

The section called *Filling a Need* discusses the community's needs that were not met within the conventional health care systems. The section called *Lost in Translation* discusses the many layers of difficulties I encountered when attempting to translate the language and concepts of distress from one language to another and from one culture to another. The section called *The Portuguese Way* gives examples of how the informants conceptualized the Portuguese and Açorean people, and their understanding of being different from other cultures. Finally, I discuss the barriers I encountered to collecting data for this project in a section called *Access Denied*. These barriers have strong implications for multicultural counselling and it is for this reason that *Access Denied* is included in the *Findings* chapter and not in the *Methodology* chapter; these implications are developed on in the *Researcher's Interpretations* chapter and the *Discussion* chapter.

The narratives come from informal conversations and formal interviews, as is consistent with reporting ethnographic studies. I name four informants and elaborate on their narratives in

the text because they best represent what the whole community of informants shared with me. First, Elise is a middle-aged professional woman. She is well educated and her husband holds a prominent position in the community. We met initially at the suggestion of her husband because he knew she had accessed a *curandeiro* when she was a younger woman and he thought it would inform my research. I maintained contact with Elise while I was in the Açores; I visited her often at her work and joined her in her home for celebrations. Second, Paola is a young woman in her late 20's who I met early in my stay on the islands. She shared her family's story with me and provided me with invaluable cultural information and guidance during my stay in the islands. Third, Luis is a health care professional who was initially identified as a *curandeiro* by community members. Luis was able to provide an Açorean narrative that he contrasted with a view of North American healing and suffering because he practiced his profession in both places. And fourth, Fernanda is a 48 year old grandmother who had ongoing relationships with healers to address her grandson's distress and suffering. Other quotes from individuals not specifically identified represent the many different informants, in the many different situations, that informed this project.

Types of Traditional Healers

Herbalista

A *herbalista* uses natural remedies to provide relief for physical ailments and distress. *Herbalistas* usually work from an *ervanaria* (root word *erva*; herb or grass), a shop that could be easily confused with a North American health food store selling vitamins and natural remedies. The shelves are stocked with health food stuffs, natural beauty products, creams, dried herbs, vitamins, teas, and various other remedies in boxes, bottles, and bags. Unlike most other traditional healers, *herbalistas* work solely with the physiological aspects of an illness, and are quick to incorporate other forms of care by referring to other traditional or conventional health care practitioners if they think that it is necessary. *Herbalistas* act less as experts and more like

investigators, gathering information and giving suggestions on treatments from which clients can then choose.

Knowledge of herbs and healing was usually passed down from family members. An informant's father opened an *ervanaria* "only for himself [because] he has some knowledge from his father." This informant described how her father quit his office job in order to work with herbs because he found he was able to help people; hence, his vocation became more important than his job. *Antigamente* [in the old days] *herbalistas* worked mainly from their homes or other locations with little signage or indication of what was inside; becoming a *herbalistas* was a consequence of having "the gift," and the community accessed them in their homes. *Ervanarias* have become more popular recently and now resemble health food stores as described above.

The streets of Angra, on Terceira, and Ponta Delgada, on São Miguel, are lined with stores that advertise natural products for various ailments and beauty concerns. One informant suggested why they are so popular:

> People prefer natural medicine; they go to the *lojas naturistas* [naturalist shops or *ervanaria*]. They [*herbalistas*] give some teas, some things. That is what they seek sometime because they are already sick and tired… they don't believe very much in the medication that medicine provides. They go to those naturalist shops and anyway, they find something… a tea or anything that makes them hold on.

In the present day, an *ervanaria* is often the physical entrance for a naturopath's office.

Endireita

An *endireita,* or bonesetter, works with people who have sprained or twisted a joint, or who have a fracture not severe enough to require a cast from a physician. The word *endireita* comes from the verb *endireitar*, or to straighten. This healer uses hot water to relax, and oils to massage sprains and less severe fractures. One informant, who self identified as an *endireita,*

suggested that her skill had not been taught but rather that she had the "sensibility" to cure. She indicated, "Let me tell you, I consider myself an *endireita* because I can set the bones right…. No *endireita* has previous preparation because you can't teach a thing that most people haven't the sensibility to heal." This healer distinguished between a pain and a sprain; a pain requires more time to heal where a sprain can be "set" in one day. Usually with no office, people access this healer by visiting the healer's home or calling for her to come to their home.

As with *herbalistas*, *endireitas* tend to deal with physical ailments and, more specifically, physical injuries. However, *endireitas* seem to provide comfort for the injured in a way most physicians do not. Quite often, their help is sought after a physician has decided no treatment is necessary. One *endireita* explained how she was able to help a woman in pain when a physician was not able to:

> The thing is that she twisted a foot in Ponta Delgada. Poor lady! Her foot swelled up and she went to the hospital. There they only told her that it was not broken and that she has a sprain. They sent her home and she had to take care of it by herself. …And then she knocked at my door. …the lady was cured, right? That's what matters.

A Mulher Quem Ler do Livro

Another type of healer or practitioner sought in times of distress is *a mulher quem ler do livro*. Directly translated this means, the women who reads the book. These women use the *livro do Senhor Santo Cristo*[18] [the book of Christ] to tell the future and they are mostly accessed when individuals are facing a myriad of problems in their lives or if they have to make major life decisions. *A mulher* often gives advice and specifically tells people what to do or what not to do. One informant described the procedure *a mulher* follows:

> How does she do it? We put our hand in the book and she opens….She says some prayers and then opens the *livro do Santo Cristo* and then she starts to read that page to

[18] *O livro do Senhor Santo Cristo* is described in greater detail in Chapter 6.

> us. And sometimes, it is right with our life…. There are many people going there also. Those women are always full, those houses are always full.

Another informant, whose mother regularly goes to *a mulher*, indicates that it is not only the future that is important:

> …they read it and they try to read between the lines what will happen to you. That is like telling the future, or the present, or even the past. They ask you if you want to know the past, the present, the future.
>
> These women closely resemble what would be called a fortune teller in English.

Unlike fortune tellers, *as mulhers* were considered to play a significant role in the healing practices of the society. Many of my informants talked about *as mulhers*, confirming that they were found in the many communities on São Miguel. As the quote above suggested, they are often very busy. Nevertheless, many informants did not seem to take them seriously. One reported,

> They read the book and they interpret it, they identify what is going to happen, the future, supposedly, the future. Now if anything of that is believable [laughs] I don't know! But I know they exist, they do. I know that they exist because I know people who already went there.

One informant described her unsuccessful interaction with *a mulher quem ler do livro*:

> Look, there is one in Livramento [township close to Ponta Delgada]. I've been to that one with a girl for [out of] curiosity. But because she saw me so sceptical to everything she practically didn't say anything. She told me that I didn't believe, that I didn't need to be there.

Even the informants who did not feel these women were credible were quick to suggest I visit them; many had visited themselves. I received many invitations to be taken to visit an informant's favourite *a mulher* but, despite my readiness, none of these invitations materialized.

Bruxa

A healer most commonly associated with black magic or evil is a *bruxa,* which can be translated to witch, sorceress, or enchantress. Another research project has defined *bruxas* as mediums as well (Bezanson, Foster, & James, 2004). Since *bruxas* were not seen to facilitate wellness, the informants did not discuss them often. Residents of the islands were quick to warn against visiting them. It seemed that, as an outsider, I would be easy prey for people who misuse their gifts.

Bruxas are sometimes sought after by women when their husbands are thought to be having extramarital affairs, or when a young bride wants to ensure that her groom makes it to the altar. Previous research in North America with Açorean immigrants (Bezanson et. al., 2005) suggested that *bruxas* do help people by fending off bad spirits with the aid of rituals that offer prayer, fruit, flowers, incense, and/or candles; however, the informants in this study more commonly associated *bruxas* with evil curses. None of my informants spoke specifically about a *bruxa* they were acquainted with. Many spoke of a *bruxa* on the island of Corvo, the smallest island, who caused a death by using poisonous herbs; this seemed to have happened in the recent past.

Curandeiro

C*urandeiros* are another popular kind of healer on mainland Portugal, within the Portuguese immigrant community abroad, and in the Açores. The name comes from the word *curar*, to cure or heal. The *curandeiro* works with community members to provide healing on three levels; psychologically, spiritually and physically. This informant described the role of a *curandeiro* in the Açorean society:

> Now, *curandeiros* have a social role. In the first place they are people from the *freguesia* [small parishes] and many times they are even reference people for the patients. And they have many times, a tranquilizing role because as they [*curandeiros*] even know the

[client] and they know how they live and they know that you have *nervos* disease. They can help you with a tea and any way and many times they have a relational role. Almost a role a little bit like a psychologist, because he is a peer among them. He is a person who has a certain knowledge, who developed a certain knowledge and sometimes they even bring a certain peace of mind, a certain tranquility. The *curandeiro* has a little bit the role that the psychologist has in big institutions.

A Closer Look at *Curandeiros*

Characteristics of the "Good" and of the "Bad"

The informants made a clear distinction between *curandeiros* who used their abilities for positive outcomes and those who used their abilities for their own personal gain or to cause harm; the "good" versus the "bad." It seemed very important for them to warn me, an outsider, of the possible harm that could come to me from not knowing how to tell the difference. One informant described the type of *curandeiros* I needed to avoid as "*charlatães,*" which translates to charlatan, or someone who pretends to have a special skill. The research assistant translated this word in the interview transcript as "a tricky person (a false)." There was a strong implication that if a *curandeiro* used their abilities in a negative way they were not truly a *curandeiro* but should be considered a *bruxa*. This suggested an inherent goodness in *curandeiros* that is tied to their ability to help people. However, not everyone believed in this inherent goodness. A physician describes how vulnerable people were preyed upon, "Lets put it this way…this turns out to be a little bit clandestine with bad faith and a little bit to take advantage of people's disgrace and suffering." Some members of the conventional health care profession felt that many *curandeiros* took advantage of people who were vulnerable because of illness. The following demonstrates this attitude. A physician described the fragility of people, "I consider it abuse because people are fragile and that person [the *curandeiro*] has a power, right, and says it's

going to happen this, or that will do that, right? And there, because people are fragile [they] need any help …."

A nurse further described the dangers:

> They exploit a lot. There was a very serious case in Pico [an Açorean island] of a *curandeiro* who gave a medication that was toxic….This was about three years ago. There are serious situations of people who use… I don't know! ... b*ruxarias* [witchcraft] and things like that and I don't believe in those things more or less. I mean, it is like this…I think that mostly they use a lot of those techniques to fake and to extort from people.

Another physician called bad *curandeiros* "*pseudo vidente.*" *Vidente* can be translated to clairvoyant, visionary, or prophet. In this case, the research assistant chose prophet as the appropriate translation in the context of the interview.

There seemed to be consensus that if a *curandeiro* asked for money or had a price attached to their activities they were taking advantage. Charging a fee for their services was a strong indication that they were not to be trusted: "Ah, there are many [who do harm]! Now I can tell you, you know that to do that, a women [a client] that goes to hurt other women, they [*curandeiro*] take money;" "Some people do this for money, they take advantage of people." There are some who advertise in local newspapers and generally, the informants frowned on this practice, "The ones that put the ads in the paper, I don't think they are successful at all." The only acceptable way to learn about a good curandeiro is by "*boca [á] boca,*" word of mouth. This informant described why she chose a specific *curandeiro* for help:

> Because he was very famous here. If you ask in the island the people that would be from their 80's until their 30's I think everybody has heard about [name of the *curandeiro*].…Even immigrants will know about it [him].

Being well known by the residents of the islands gave some credibility to their status as a good *curandeiro*. Elise, who had received treatment from a *curandeiro* for skin discoloration when she was a young woman, clearly expressed her disbelief to me for their practices now that she was an adult. Elise originally went to a *curandeiro* because her family suggested it and, as this quote implies, she might be persuaded even today to return if there was a need, "But if I had a disease maybe I would try. I would try. I don't know. But if someone said you have cancer and someone got cure[d] going….I don't know where I would try."

Good *curandeiros* never asked for money but rather accepted what people wanted to give, "He's a good person, a great person. He doesn't take our money. We give what we want." Paola remembers a situation when she was an adolescent and a *curandeiro* was called to remove evil spirits from her home, "That is the thing, I don't know. One thing I know, we never give the money in hand and there is never a price. I don't know how they agree on the price. It is strange." No one was able to give me an example of how much services would cost. Elise did mention paying a small amount in cash for teas to cure her illness:

Elise - [The curandeiro said] 'And you have to take this, I am going to give to you.' And I think he would wrap in a newspaper thing, I am not sure…so you keep [take] and you pay. I don't know how much we paid….

Researcher - Do you think it was very expensive?

Elise - No, cheap, cheap.

R - But you paid in, not Euros but….

Elise - Escudos[19], yes.

Often *curandeiros* have formal employment, such as work in a bakery or on a farm, and see their clients in the evening or in emergencies. They are often called on at odd hours and *the good* are always available. This informant is clear about the availability of her *curandeiro*, "He

[19] Escudos were the Portuguese currency prior to adopting Euros.

came at 1 o'clock in the morning. He goes [comes] anytime we need him." Luis, a health care professional, contrasted the accessibility of conventional health care providers with the accessibility of a *curandeiro* to point out the lack of dedication in the former:

> …most of the time some doctor go to be doctors because of money. He doesn't go to be a doctor because he has the vocation to be a doctor to help people and save lives…. *Curandeiros* dedicate his own self to these people…sometimes 3, 4 o'clock in the morning you go knock on these peoples' [the *curandeiros'*] door.

Wisdom is another important characteristic of the good. Paola defined a *curandeiro* as, "Someone with an ability of seeing something that no one else does, that it is a problem, not physical but spiritual I guess." Another informant describes how wisdom, which cannot be completely explained, helps people:

> I mean [*curandeiros*] have some respect for the issues….I believe there are people [*curandeiros*] who have sensitivity to certain kind of situations. And in one way or another, there can be people who, that is effective for. Now, there are a lot of unanswered questions.

An informant who lives in a rural area described a well known priest in the city as a "good listener" who "gave good advice" and was "wise." Interestingly, this informant said that women would choose to have their babies in their homes with a midwife because the city was too far away (approximately a 20-minute drive), yet she would go to the priest in the city, whom she considered a *curandeiro*, when she had "strong" problems. Wisdom extends to *curandeiros* knowing their limits as another informant described:

> The *curandeiros* call the doctors the *batas brancas* [white robes]. When, if it is anything for the doctors, he says, 'That is for, for the doctor, for the white robes…that is not for me; that is for that guy, that is for the doctor.' If it is a *doença de médico* [doctor's

disease/illness]…he says go to the doctor…. If it isn't a *doença de médico*, he cares for people.

The *curandeiros*, however, did not seem to want to access information from the *batas brancas:*

> And, ahh, if people came with explanations from the doctors, from what I hear, he [the *curandeiro*] didn't like to hear about the doctors. You would, he would ignore the information about the doctors. If a person said, 'Oh I went to the doctor and the doctor said, this and this,' [the *curandeiro*] would say, 'I don't care about the doctor.'

The information from the medical realm was not transferable into something the *curandeiro* found useful. *Curandeiros* would work together when the case was especially hard or when the "spirits are very strong."

Manner

Curandeiros were described as "very serious" and "very authoritative." They sometimes created a sense of mystery to their work. Elise described her situation when she went to a *curandeiro* many years ago:

> Elise - It's a garage door, old garage door. We knocked and after someone would open and he would be in a, would be like a little window, and he would be kind of hiding. He would create a mysterious environment [laughs]. He wouldn't [be] smiling. He would ask, 'What is your problem?'…. But he [was] very, ahh, crafty [laughs] … he would create a mysterious environment…. Frightening.
>
> Researcher - You were afraid when you went?
>
> Elise - [It] was strange…was strange.
>
> R - Did that make you not want to take the teas or anything like that?
>
> Elise - No, no because I, for me I believed it was natural things. Probably eventually it would be so common that you would grow in that garden or something. At that time we didn't think that about much [sic] drugs or stuff like that.

R - Did he ever open the door? Did you get to see him?

Elise - No. Physically, would be the face and the, just part of him. I never saw him walking [laughs]. It was before the revolution[20] so it was...the other century.

R - So what he was doing, was he allowed to do that?

Elise - Nobody would care. Like nowadays there are other people that do it and sell teas and stuff like that and people don't, the police don't, knock at your door.

Paola noted a similar "frightening" experience as she tried to explain how a *curandeiro* helped remove evil spirits from her home. She could describe the actions of the *curandeiro* but when asked what he did on a more abstract level she was unable to answer, "I don't know. I was not that aware what it was happening because I am not into the *curandeiros*. I do not know the rituals. But it was scary." She described another *curandeiro* she interacts with as a community member but not as a healer:

> …he's strange though…. If you are expecting to hear a straight answer, you are not going to get it. He is very vague…. but if you ask him why, how come [you are sick], he will answer but in a certain way that, not, [struggling to explain]. I don't get it. My mom, she… 'Oh I know', cause she knows the rituals[21] or whatever [laughs]…. He is, ahh, quite, calm and it is like an introspective person - very into himself…. I think he is a private person but there, the thing about him is there is no way of me knowing what will he do. He is so unpredictable, for me, because I am out of those rituals.

She had warned me in the very beginning of my visit that a translator would have to accompany me if I visited a *curandeiro*. As she pointed out above, *curandeiros* speak in a way that is hard for many people to understand. She suggested that someone like her mother, who frequents

[20] The revolution that Elise talks about put an end to Europe's longest dictatorship in 1974. Time for many Portuguese is denoted as *before* or *after* the revolution.

[21] Paola uses the term ritual to describe the way curandeiros talk and act.

curandeiros and *as mulhers quem ler do livro* often, would be able to provide more than just Portuguese language translation for me.

The Gift

As the reader will surmise as they become more familiar with this research project, in the case of *curandeiros* and healing, there are very few points that Açoreans are willing to agree on; however, one agreement is the origin of a *curandeiro's* abilities. If an Açorean believed that *curandeiros* were able to heal, they were adamant that this ability to heal was a manifestation of the Divine on earth. A health care professional describes the relationship, "I think this [ability] comes through tradition, family to family, many, many, years. He had [has] a connection…between God and the people in this world." For most, there was no need to understand why a *curandeiro* has this connection or to prove this connection. Luis emphasized that there are not always answers:

> Sometimes I say I don't know what God has to do with this but the faith comes along….In your case [counselling psychology] and in psychiatry, you need proof to see....New doctors today need proof.…And sometimes, this is what I believe, I think if God doesn't want you to have the truth, you are not going to get it. You can look. I think you can go looking for anything around you but you're not going to have proof. Because some things can't be shown to you….Doctors have been stubborn…looking for solutions for this and this and that. And sometimes people have, for example *curandeiros*, have been giving solutions to people that their own doctors don't believe in. That is why people most of the time people prefer *curandeiros* or a naturopath doctor because most of the time *curandeiros* and naturopath doctors agree. Sometimes he closes the eyes…[to] what he learned…and go to the other science.

The "other science" is considered to be the gift or an ability to know what is wrong and how to fix it.

An Açorean proverb (Emilio, 1990) highlights this trust in God, *Deus é quem cura e o médico leva o dineiro* [It is God who cures and the doctor who gets the money]. In his well known book Namora (1956), *Retalhos da Vida de um Medico* [*Remnants of the Life of a Doctor;* translated version, *Mountain Doctor*], chronicles his life serving a rural population on mainland Portugal. He wrote of *curandeiros*, ″The doctor was, so to speak, merely a professional without a real vocation; it was safer to trust someone born with the gift″ (p. 118). *Curandeiros* have an ability to understand distress and execute an intervention without gathering information through questioning or utilizing medical or psychological tests. As Namora noted, this ability is often called a *gift* or *condão* which translates as a special virtue, magic powers, prerogative, mental power, or ability. Most often, the gift is used to know or *diagnose* the root of distress that a person is suffering simply by looking at them. As Paola mentioned previously, the *condão* is the ability to see what others cannot see. She elaborated on this ability:

> I think it is the [*curandeiro's*] ability of seeing within yourself [the client], if you have envy or all those other things…upon you, not [you] having them but other people sending them to you, energies, bad energies…. And they have the ability to see that.

Another informant describes this ability, "He looks at people and I guess he sees through, he sees inside us and he sees what we have." Many informants stated that *curandeiros* are able to look at you and immediately know what is keeping you from good health. One health care professional believed that the *curandeiro's* ability to give him information about his life was proof of the gift:

> When you go to go see somebody like *curandeiros* and he say you have this problem, this problem, this problem [counts off on his fingers] you have been divorced, you have a son, and this person never met you. This is sometimes, honestly, don't have no explanation.

For a *curandeiro* with a gift, there is no choice to use the gift or not. As Paola described, the only choice was how to use the gift:

> ...that is what he [*curandeiro*] told us because my brother has the ability to become one if he [brother] chooses. He [*curandeiro*] says it is not something he [*curandeiro*] chooses; it is something that chose him [*curandeiro*]. So he [brother] could become a doctor or go through this line [become a *curandeiro*] which he [*curandeiro*] says, "Please if you have any power on him try to make him not go to this cause it is very tiring."

As informants have mentioned previously, *curandeiros* are available to the community at any hour, and as the reader will learn, helping can be very involved.

Faith

Religious faith is deeply tied to healing and wellness in the Açores. The *curandeiro* works by accessing a gift from God. A physician highlighted the trust the Açoreans have in God, "When it goes well, it is always 'Our Lord' but when it goes wrong it is immediately the doctor's fault." One psychologist stated that all people need "is to cling to something." For many, the *curandeiros* connection to the Divine is what they cling to. Another informant suggested that people need something to overpower them, "And people I think they tend to get disoriented if they don't have something to believe [in] that is overpowering them that they can turn to, to go to [for] help."

As mentioned previously, *curandeiros* do have to prove themselves and become well known by the community. An informant stated, "Of course you have to trust, you have to trust the person to believe that she has the ability." Another informant elaborated on this point, "I think they [*curandeiros*] can probably help in the sense that if the person fully trusts the person who is treating him, that is a way to cure." For this physician, religion may not be the foundation of this faith, "I notice they go a lot because it is the unknown…. People go to *curandeiros* because they believe. They have faith. I don't know if it has to do with religion. They have faith

and then it is the unknown." For another informant, there is no question where the faith comes from, "This, a solution of a *curandeiro*, [he] give you a solution for the people… or teas, or burned incense, or use some object from a church or…because they use faith. Faith can move many things. Prayer can move things."

Reasons to Go

Açoreans seek help from *curandeiros* for many reasons. Problems for *curandeiros* can be physical, psychological, and/or spiritual. Some of the physical problems that informants listed are as follows: anemia, high cholesterol, *escamas de peixe* [scales of the fish or a rash], sinuses, problems in the intestines, high blood pressure, and liver problems, "because lots of men drink."

Elise described how she and her mother decided to go to a *curandeiro* for their physical problems:

> The thing was, I had spots like dirt on my neck, greyish and whitish, and other people had that too, also. Plus my mother also has [had] a problem that she has [had] like pimples on her cheek, once in a while. So we had known this guy was there for many years, but we never, well we heard that other people would go there and because my mother went to so many doctors, medicine for that, for her problem and it didn't go away. Like for two years she tried different [inaudible] and different other medications. And she decided to go there because some family insisted, 'Try, try those teas' and because she went, I went with her too.

Informants believed psychological reasons to be, distress caused by emotional problems, conflicts with family/community members, or *comportamentos perturbados* [disturbed behavior]. This informant described the reasons her friends have gone to *curandeiros:*

> One went because she was between two brothers who didn't like each other, who fight a lot. Another went because her life wasn't going right. One went because she was

> pregnant…and the families told her that her baby would be born with a physical disability.

She goes on to describe more spiritual quests or problems, "Many people search it [*curandeiros*], many! No one knows what they are looking for but many go….People search for *curandeiros* when they are not well with their lives."

Health care professionals also suggested that people seek help from *curandeiros* for psychological or spiritual reasons. This informant, a physician, suggested that *curandeiros* are useful for problems that deal with spirits and the spiritual world, "...there are also other beings, other entities, that might be dead people or not, that do wrong [hurt other people] and the cause is in that and so the cure isn't in the doctors, it is in the *curandeiros*, right?" A nurse more clearly states that "mental issues" are reasons to go to a *curandeiro*, "I think that in some situations they [her patients] do go to the *curandeiros*. Specially when it is about mental issues." Another physician indicates that there is a social stigma around some illnesses and for that reason, a person must go to a *curandeiro*, "For example, there are diseases which the social brand is maybe not going directly to the doctor….Now I'm not quite sure of that, that is, trying to do *desmanchadeiras* [describes the act of breaking a spell]."

It is worth mentioning at this point that this community does not draw distinct lines between what is physical, psychological, and spiritual. Paola described her younger brother's ailment as one that could not be compartmentalized neatly into one type of illness:

> He was about, almost two years old and we went to all the doctors. He would not sleep. He would wake up every three hours to have milk, but even after that he would cry all night, unless you would be holding him and going around and around, cause if you sit he would start screaming all over again. So he even took some sleeping pills for kids, for babies, but it didn't work…. Every night at about midnight he would wake up and start pointing at things and screaming.

In this case a *curandeiro* told the family that the boy had "…the ability to gain powers to [for] good or bad." He was suffering from distress on a spiritual level which was causing him physical distress. As well, the young boy's suffering was impacting the whole family on many levels. Paola described her mother, the boy's mother, as suffering from *esgotament*[22]; in this case, she seemed to be physically exhausted and distraught over her son's behaviour.

Many informants had gone to physicians for physical ailments but had been told they were not sick. After having many medical tests they would go to a *curandeiro* who treats people on a more holistic level. This informant, a young physician, gave an interesting account of how the medical profession misses an opportunity by not providing more holistic care:

> They [*curandeiros*] help in the illness. I guess they do.... Holistic medicine…faces people like a whole, in several areas psychological, mental, thought, life guidance. There, we need much more time and more availability and sometimes that is the way it works. It's more like relieving the mind for the body to be able to react to the disease later…

Another physician explained the importance of considering the mind and the body when treating people in distress, as she believes *curandeiros* do:

> I believe it's more in a mental balance that it [*curandeiro*] easily helps. It's the thing, body health has a deep impact on our mind. Mind and body have to be united. …if they live separate, you are never going anywhere."

Desperation. For many of the informants, desperation was the main reason to seek help from a *curandeiro*. There was a sense that people had "reached their limit and they want help." As Paola's indicated, her mother got to a point where she felt there was no other resource to help her son who would not sleep. She described the situation:

[22] *Esgotament* is a culture bound syndrome that is not present in the literature. I discuss this form of distress later in the section *Lost in Translation.*

> We tried everything. At first we thought it was colic so we gave him teas and the massages. We took care that, like when he was drinking the milk, we took care that no hair would go in cause that would get him some kind of pain too. But, we went to the doctor constantly to see if everything was ok with him and everything was ok so we couldn't do much. If he is ok what are you going to do? There is nothing to do. Maybe he is feeling sick just that day or…and it went on and on and on until he was almost two and nothing was working. … It got to the point my mom was desperate; she went to the *curandeiro* to find out. I think it was the despair of my mother. And she does believe in that sort of thing. And I guess all of us started believing because it was strange, why would he wake up?

Paola described why she felt other people went to *curandeiros* for help, "…they feel sick and they have tried everything and nothing is working and the last resource is they go there to try to fix it."

Many health care providers seemed to believe that their patients were not looking for treatment, but more so, wanted a cure or a way to fix their problem. When the medical profession did not offer this cure, people would go to *curandeiros*. A physician stated, "After going to the doctor and seeing that they're not having…that they're not solving their problem there, they go on to the next stage." The next stage is the *curandeiro*, someone outside of the hospital as another physician suggested, "…and sometimes they come to the doctors and don't get the solution….so people search outside." A nurse noted that answers were what people wanted, "and when people don't find answers in other places [hospital], they turn to everything and anything else." This informant suggested that people could find a solution with *curandeiros*, "That happens when people are very desperate. They can't find a solution and they go there [*curandeiro*] to find one." A community member noted that people are "…trying to get what they can't in medicine….They try to solve by other ways. I think basically, it is this. They search

for a hope they can't find in other places." Yet another physician suggested it is the remedies that *curandeiros* provide that gives people hope. "They find something, a tea or anything that makes them hold on." As this community member described, people access *curandeiros* for support and for answers that can be associated with many types of problems and distress they face in their lives:

> Yeh, for all sorts of reasons. Some go there to listen to something they already know. But for some they need someone else to take the burden of responsibility... I think most people go there for that reason and there are a few that go there for health reasons cause they feel sick and they have been to every treatment and nothing is working and the last resort is they go there to try to fix it.

Treatment

Curandeiros can use many different types of treatments depending on the nature of problem. Most often, a *curandeiro* will give a mixture of *ervas* [herbs] that people will drink as *cha* [tea]. One informant, suffering from *esgotament*, was told to drink tea made from the leaves of a bitter orange tree and to "be calm." In her case, she said she had been very nervous and the hair on the front of her head had fallen out. She was grateful that the *curandeiro* had cured her; when I met her, she did not seem concerned that her hair still seemed to be falling out. Fernanda, who had been to many *curandeiros*, was told to wash her grandson in a mixture of herbs; she was able to identify rosemary as one of the herbs but could not identify the others. Her grandson "saw things of… a soul, souls from the other world." The young boy also described people pulling his feet, which caused him to faint. His treatment seemed to be ongoing at the time of the interview. Fernanda had also been instructed to burn a bunch of *ervas* or herbs, called *defumadoiros,* while praying in the boy's home to get rid of the evil spirits. This is a common activity that is prescribed by *curandeiros* for people who suffer from *quebrantos* or the evil eye.

People can be treated in a group setting in the *curandeiros* home as this informant indicated, "…no we're all there…other people saw everything, like we also saw the people that are there." Depending on the problem, *curandeiros* may go to the home of the person suffering. In Paola's family's case, a *curandeiro* had told them that their two-year-old son had a gift but that bad spirits needed to be taken away. Paola explained the situation:

> …he was a baby and he couldn't sleep. He was so white and he had like dark circles around his eyes. It was strange. We couldn't understand what was going on. At first we thought it was baby things [rubs her stomach]…he would not sleep…he has the ability to gain powers good or bad. So he [the curandeiro] had to expel the bad powers that were taking over him.

In this case the *curandeiro* went to the home to provide the treatment. The informant described the treatment process:

> He didn't do anything to my brother at all…. He explained to us what was going to happen but my brother was just laying there, he was just a baby. He wanted to expel the spirits I guess from the house or from there…. 'I am going to try to go out.' That is what he told us. 'I am going to try to go out the door and by no means are you going to let me.' And he brought like four men, huge men, and they were all sweating like crazy. And he was like crawling like I don't know, like savage, trying to go out….I was scared to death. What the heck is going on? [laughs] That is what happened. I don't know what he put inside a pan, a pot I think….He went with my father to bury it in some place that we would never cross over cause I don't know why. I guess that thing would come out again. It is strange isn't it [laughs].…He wouldn't let us go in there. [We] were like in the living room and he was in the kitchen while he was trying to get out the door. And he said for us to keep there. I was just hearing and seeing but not his face because there was four men, two on each side and he was like this and like that [makes a back and forth

movement with her head] like a bull trying to get out. So the face was covered and I couldn't see his face.

In order for this treatment to be effective, the *curandeiro* requested that all immediate family members be present in the home. This situation shows the hardships that *curandeiros* face to provide treatment for their community members. Paola was unable to indicate how long this treatment lasted, but she implied that it was a stressful and a tiring situation for everyone involved.

For health care providers, treatment from *curandeiros* provides a valuable service, as one physician noted, "They provide psychological support, the placebo effect, which is very important." Another physician considered the value to be in the "healing expectancy," "He [the *curandeiro*] can't do anything real in terms of surgery and medicine, but in psychological terms it can relieve, giving new expectancy to the person, a healing expectancy." And for this physician, it was clear that a line must be drawn between being helpful and offering a cure:

> This is something that helps people daily. Some of those teas, perhaps even have a therapeutic effects that haven't been studied yet and therefore can't be accepted…it makes people feel cozy. I think that mainly, in psychic terms, most people feel comforted by it and it eventually helps, but it doesn't cure.

However, for the community, this distinction did not seem to be important. Fernanda felt that what was helpful *was* the cure, as was evident in the follow exchange with a research assistant [RA]:

> RA - [Name of the grandson] gets different when he [*curandeiro*] touches him?
>
> Fernanda - He gets calm. And when he is with that [without the treatment] he gets very angry…[he] gets aggressive. And then when he is with that [with the treatment] he sleeps all night, peacefully. When I do the *defumadores* [burn herbs]… he sleeps peacefully. When I don't do it, when he is with that [without the

> treatment]… he screams, he wakes up at night, he starts screaming, 'Mommy he is there, mommy he is grabbing me!' The mother goes to the window to see what it is. 'Mommy close the window because he is there,'[but] and we can't see him.

This young boy was diagnosed with the same problem by three different *curandeiros*, yet only one was able to "find results." For Fernanda, the herb bath and the *defumadores* caused a change in the boy's behaviour; it does suggest a cure in this case. For most of my informants, something *real* did happen.

Outside the Country

Curandeiros often provide services for Açoreans who no longer live in the area. One Açorean, who grew up outside of Portugal in Europe and was attending post secondary school in São Miguel, told me that his parents would regularly take him to a *curandeiro* when he was growing up. As a result, even though he did not grow up in the Açores, he was very familiar with *curandeiros*. One informant who worked for the Portuguese airline told me that a local *curandeiro* took a direct flight to Boston four times in a five-month period:

> And I told that to my mom and she said, 'Yes, he goes because people pay him to go there. To go fix things there that they only trust him to do.' So people, probably immigrants, for sure, they pay his ticket to go from here to there to solve their problems. That is how famous he is.

Another informant explained how immigrants can be treated if they do not have the funds to arrange for a *curandeiro* to come to them or if they could not travel to the Açores, "...even immigrants will know about it [him], because immigrants send him letters and by explanation on the letters he would recommend a… and the payment of the dollars for the tea. He would recommend medications."

Defining the Indefinable

What should be noted in the above discussion of *curandeiros* is the lack of specificity in the definition of a *curandeiro*. Only one informant was able to provide a succinct definition, while others most often would answer this question by telling me about what *curandeiros* do or why a person would visit one. Early on in this discussion of *curandeiros*, I suggested that the informants seemed to feel that *curandeiros* who took advantage of people and harmed others should be considered *bruxas,* yet, they used the two terms interchangeably. As previously mentioned, one informant referred to a priest when I asked her about *curandeiros.* Although she told me about other healers who more closely resembled my conceptualization of a *curandeiro*, it was this priest is who she would travel 20 minutes to the city to see when she had a "strong" problem.

Luis is a health care professional who had been educated outside of Portugal and practiced both in the Açores and in North America. I was initially told by a group of women that he was a *curandeiro*. On meeting him, I indicated that I had been sent by these women because he was a *curandeiro*. He adamantly denied being a *curandeiro* and wondered why these women would suggest he was one. In our first interview he talked about witchcraft and tricky people. Later on in our relationship he expressed a pride in being considered a *curandeiro*. Despite contradictions such as this, in my successive conversations with informants it became apparent that a newer version of a narrative did not require the original narrative to be untrue[23].

This lack of specificity in defining what I was gathering information about added to the initial confusion I experienced in the field. When I became more comfortable with the multiple definitions that people had, I was able to be more comfortable with the ambiguity. This led to the stories that contributed to an understanding of the need that *curandeiros* fill in the community.

[23] This idea is elaborated on in the upcoming sections.

Filling a Need

The informants "mixed" conventional with non-conventional healers when seeking treatment for illness. For most it seemed that, by accessing *curandeiros* and other non-conventional healers, they would receive a more holistic type of care to supplement what was available through conventional medical health care systems. As one informant expressed, the community was "trying to get what they can't in medicine" when they accessed non-conventional healers. Mixing many types of health care providers gave a sense of security. As this informant explained, "There are people who want psychological support. They want to go there [emergency room] to have support to feel that there is always someone there available for them if necessary." The reality of the hospital environment made it impossible for the health care system to provide this. Physicians and nurses recognized this need in the community but were unable to address it. As a health care professional indicated, "It [non-conventional healers]… can even provide, in a psychological point of view, a great support, which classical medicine can't provide due to lack of means." Another noted, "If you have 30 people to see in 4 hours, you can't be there consoling them."

Conventional health care professionals reported believing this requirement for healing was being met by *curandeiros.* Time and the opportunity to talk did not seem to be part of a cure or of healing for these professionals, yet they acknowledged it meet some kind of need:

> While with some [*curandeiros*], people go there, they go more and what they do is talk, talk, talk, that thing that they sometimes [are] seeking in the emergency room, which is the fact of us being there to talk to them and we don't have time to do that. In the emergency room we don't have time to be there talking to people a half an hour, and hour, as they want us to.

Another health care practitioner suggested that listening was an important need as well, "because witchdoctors [*curandeiros*] take the time to listen to you, to talk to you, to listen to your

problems and to talk to you about spirituality because spirituality in this country is very important." As he noted, *curandeiros* did not compartmentalize people's needs and were willing to approach illness and distress in a more holistic manner. This physician highlighted the general theme in the medical system: religion and spirituality are not part of a biomedical milieu. He reported, "I know most of the people have some support from the religion, in personal terms. Usually the [medical/psychological] problems are never seen from the spiritual side. I also confess that I don't bring much of that spiritual side to the interviews with these families." Medical health care professionals commonly referred patients to their *padres* [priests] when they felt religion or spirituality needed to be addressed:

> I also send them to the priest we have here in the hospital and she [the patient] goes there, ahm, [to] give [get] support because [of] that person's physical discomfort - it has to do with this area of … of how she faces the religion and the spiritual side of it.

In some cases, it seemed that physicians had to urge community members toward adopting a more "logical" approach to their distress:

> Sometimes it is hard to deal with it because we are tying to concentrate [focus] them and explain to them what's happening in logical terms and they don't accept the explanation. What they want is something else that we ignore. But sometimes it is hard to know what they want.

Many informants implied that community members were searching for answers that were not always possible for a physician to give. In this case, their needs were not being met, "…and sometimes they come to the doctors and don't get a solution."

Psychologists faced similar problems. Clients searched for solutions that would be given to them by an expert. One psychologist reported:

> This belief still exists. 'I go to the psychologist, I tell my problem. I am going to tell my problem and afterwards I shut up and he is going to solve it.' Right? So, it doesn't

> work like that and I notice that some people arrive with this belief, kind of ahh, 'Now I told you, now solve my life'

Another psychologist concurred that the community looked to *curandeiros* to offer them solutions, "They give themselves to the *curandeiro.* Once again, they don't have to do anything, isn't it? The *curandeiro* talks, says what they have to do, what they don't have to do."

In the following example, Fernanda described how the medical system did not meet the needs of her family:

> The mother went the first time [to the physician] because he [the child] was with a fever and all [the physician said] he has nothing. They sent him home. They even told the mother to go to those head doctors [psychiatrists/psychologists]. [Then the father] went with him to the doctor. He told the doctor what was going on and the doctor didn't want to believe in that, so the doctor said he should go to a psychiatrist of the head. If I [Fernanda] was there, I [would have] told the doctor that he should go.

Clearly the family did not feel the physician's assessment of the situation was accurate or helpful. The physician's referral to a psychiatrist or psychologist was not taken seriously and thus, ignored. The informant highlighted the general feeling that the community had for "head doctors." *Curandeiros* seemed to be an acceptable way to address *doença de mentais* [direct translation - illness/disease/sickness of mental, or mental illness]. Luis described the holistic care that *curandeiros* provide:

> This is what *curandeiros* most of the time is about. He push people from the floor to up, where it is mostly of the time the doctors that put the patients down. You have problems, you are crazy or sometimes you need to be locked up for awhile and he pumps more drugs. The solution that fix peoples most of the time is not drugs but simple things. For example, teas, herbs that help your brain, take time to talk about problems. Sometimes

people need somebody to listen. And what I see most of the time in Canada and the US, the doctors don't listen….. and sometimes people need to [be] listen[ed to].

According to the informants, much of what was not being addressed by the health profession seemed to be the domain of psychology; however, psychologists are a relatively new profession on the islands. One informant noted that they did not exist when he started his medical career 19 years previously. As the informant suggests, the stigma of accessing "head doctors" is strong.

Lost in Translation

The Meaning Gap

Words and the way healers in the Açores talked to people was often an important issue for the informants. The ways of expressing symptoms, causes, and cures differed for people, and this created a divide. This divide created a *meaning gap* between the healer and the person or family in distress; what held meaning for one in the healing process was meaningless to the other. As mentioned by an informant previously, *curandeiros* speak in a way that people would find hard to understand if they were not familiar with this type of healer. This difference could be explained by generation gaps:

Old *curandeiros* use old technicians [techniques]. The old dies and the new is more for the new generation. Because some words being used years ago, the new generation don't understand. And the new *curandeiros* use the new words for the people to understand.

The above quote suggests that *curandeiros* are evolving to suit the needs of their community. Differences between the generations was not the only explanation for the *meaning gap*.

For some, the words healers used were an important part of healing and if the words were not right, healing would not happen. One physician explained that using the words that people understand resonates with them and gives them "comfort" and creates a "space" for healing:

By giving comfort to the person. By listening to that person. Saying things that make sense to that person. By giving space to that person, I think that mostly through [the act

of giving] space. A priest, or a *curandeiro*, a psychologist, even a doctor….We ourselves, when we go to the doctor and the doctor attends us kind of like a report, 'Yes, no, good afternoon, good morning.' We don't like it.

And for others, this divide was a negative factor when the words or ways of speaking did not match their conceptualization of distress. An informant in her early 20's clearly stated her suspicions in how *curandeiros* used words, "… they say what people want to hear….they know the people… people talk and talk and they [*curandeiros*] say what they hear…I don't like *curandeiros*." For most informants, however, it was an important aspect of the healing process. Informants described situations where a breakdown in communication can lead to problems that distance the health care professional from the client. Luis, who has practiced in both the Açores and North America, described what he thought was the problem that Açoreans face when they access health care services in Canada:

Sometimes people are tired [sigh] and sick because they go see doctors and psychiatrists [in Canada] and most of the time psychiatrists says, 'You know what, you're crazy. I'm going to put you on Prozac, I'm going to put you in a mental institution' and that is it…This is why most of the time people say, 'No, I'm not crazy. I'm seeing things.'

He explained how the mental health care milieu of Canada effectively silenced immigrants because the Açorean ways of expressing distress is often misunderstood:

Researcher - I am sure if an Açorean were to go to a psychologist in Canada and talk about that [spirit possession] he would have quite a problem.

Luis - He don't talk because [for] the psychiatrist [sic]…these things don't exist.

For Luis using words and terms chosen by the clinician and not the client would result in the premature termination of services. In his response, Luis described the danger:

Researcher - But why are you able to fix him and I am not? Is it because I label it wrong? Because I call it something different?

> Luis - You are going to use words that people don't accept. People don't accept the words from doctors… you're crazy, you're mental and you need to go see a psychiatrist. You need to be in the mental institution for a while to get fixed. This is not what people want to listen [hear]. …you need to use the exact words of the people. If you don't use the exact words of the people, people will ignore you. …people will not go back to you…you need to use the proper words to speak to the people.

He also suggested that providing unfamiliar types of treatment can cause similar problems. One example is his use of *cha* [tea] for medicinal purposes for people who abuse alcohol in the Açores. When I asked about the *cha* on the shelves in his office that were clearly marked for alcohol abuse, he told me they were very effective in the Açores and he "prescribed" them often. He added he would never use *cha* for people who abuse alcohol in Canada because people would think he was "crazy."

Luis continued to refer to psychiatry even though I clearly told him my area of practice and study was counselling psychology. At one point, I became aware I was experiencing what he was describing; I was becoming increasing uncomfortable with him labelling my profession as psychiatry and using terminology such as "crazy" and "mental" as if they were acceptable diagnoses in psychiatry or counselling psychology. This tension was caused by words that did not resonate with me. It caused me to question the relevance of his input to my research; in effect, he was not using the "exact" words that I wanted to hear. An experience that, I later realized, mirrored counselling situations when a counsellor doesn't use the "exact" words that fit the client's lexicon for symptoms, causes, and cure. This situation could be a factor in premature termination of services that he talked about.

On one hand, people who did not access *curandeiros* or other types of non-conventional healers were suspicious of the words the healers used to express symptoms, causes, and cures;

however, this problem extended into conventional health care interactions as well. This informant, a physician, highlighted the *meaning gap* that is present between health care professionals and the community:

> So even nowadays, I have here a child that, that has a problem with attention control and the mother, as much as you explain it's an attention control problem, right, the mother always asks 'But is he *nervoso*?' Right and so we have to explain that he is *nervoso* but his *nervoso* only reveals itself in the difficulty to control his attention, right?

I have already described my initial confusion in the field when I felt I was receiving information that I was unable to make sense of. This confusion was also caused by a *meaning gap* that was an artefact of language translation. Many informants used the word, *esgotament,* to name a form of distress they experienced. The word comes from the verb, *esgotar,* which means to exhaust. In the context of my discussions, it seemed that *esgotament* meant physical exhaustion to the point of being unable to function. I truly *felt* I understood; however, when I would try to clarify by using this definition I would inevitably get the following response, "No… no, that is not it."[24] Whenever this word came up, my informants would struggle to help me understand what it meant. In the following example, Paola tried to help me understand the concept:

> Paola - She went in to a deep, ahhh, how do you say, *esgotament*?
>
> Researcher - Like post partum?
>
> Paola - No not like post partum depression. Like she couldn't sleep and she had to go to work every day. So she umm, not stressed out, but also, she went to the doctor because she was fainting.
>
> R - Physically exhausted?

[24] This is not a verbatim quote from an informant but rather, it was contrived by me to show a pattern in the responses I was receiving.

Paola - …*esgotament*, I don't know how you say it in English. That is a medical term, I mean when you have *esgotament* it's because you have run out of energy…. She wasn't stressed, she was, she had a…she was knocked out [laughs].

The health care professionals I spoke with did not indicate that *esgotament* was a medical diagnosis. When I attempted to clarify the meaning with a health care professional, he clearly disagreed with my definition, "*Esgotament* is from here [points to his head]. *Esgotament* is not from the body, it is not use[d] [as] exhausted, tired. " Another informant explained that she had suffered from *esgotament*. Although this informant's English was very good, she could not provide a translation she was happy with. Somewhat exasperated, she settled on, "You guys would call it a nervous breakdown. Yeh, I had a nervous breakdown." Even though I was an outsider with knowledge of the language and extensive knowledge of the community, as a clinician, I still felt I was missing something important.

The above is an example of an acceptable diagnosis used by the community that loses its meaning in translation from Portuguese to English. The following is an example of a cause that is acceptable to Fernanda, the grandmother who was mentioned earlier, but has no meaning to conventional health care professionals:

RA - You went there [to the *curandeiros*] several times and he always did the same thing?

Fernanda - Yes, he always does the same thing. He always says the same thing.

RA - What did he say?

Fernanda - He said that it is souls…it's a soul from the other world that the little one got caught.

RA - But he didn't explain why?

Fernanda - No, he says he is given to it. That he is with open veins…and when he is between doors and something he is going to get it again.

For Fernanda, the explanations, "souls from the other world" and "open veins," were suitable and treatment continued. Later in the interview, she noted she did not receive acceptable or helpful information from a conventional health care professional:

RA - So you're not going back to the doctor?

Fernanda - No. The doctor always says the same thing, that he is not sick….He gets sick at home.

RA - So the doctor doesn't believe?

Fernanda - He doesn't believe! Doctors don't believe in that.

Many informants explained the *meaning gap* as an artefact of the culture. They believed the expression of illness or distress to be idiosyncratic to the Açorean people. One indicated that, "[While] I don't believe that [complaints are specific to the Açoreans] … [they seem different] probably because they are complaints that are characteristic of their culture and they express them according to their culture." Although the types of distress are the same, the way they are expressed is different. For one physician, expression was related to the values of the community, "Maybe people [cultures] don't complain about different things but they give different values to that complaint." Like other informants, this young physician suggested the inability to communicate within conventional health care settings to be the problem:

> It is related with a difficulty of expression and communication, of the domain of language that a great part of the population has. And one notices this. Anyway, talking a little bit about my experience as a doctor, making a comparison even with other places where I have already worked with different populations. There is a difference in this population of São Miguel, in Açores….The clinical interview, which is as they teach us in college, [is] the main tool of diagnosis, the main instrument that any doctor has in his power to be able to understand what's going on with the patient. Here the value of the clinical interview is [a] lot less than in most places where I have been.... Why? Because,

> most of the times, it is difficult, as I said, to characterize the symptoms. The patient arrives and complains of *agonias*[25] and now what are *agonias*? It can be a lot of things. And this difficulty of language is not only related to expression, it has to do with understanding. Many times I have the notion, the certainty that the patient is not able to give me a more closed answer, more concrete, because he doesn't understand the question that I am asking.

This informant was Açorean and would be familiar with the term *agonias*; nevertheless, she did not find it acceptable or adequate even though it is often how community members chose to express their distress. This inability to express distress adequately to conventional health care professionals is not understood to be merely "explained by the academic degree" or education level, of the clients. As an informant mentioned, the *curandeiro's* services were for illiterates but "in fact, some educated people might go as well." It did not seem that this *meaning gap* could be explained by socio-economic status or education.

The *meaning gap* was present between many different groups of people in the Açorean community. Overall, conventional health care professionals suggested that Açoreans were not well equipped to express their distress adequately and, therefore, were hard to treat appropriately. As an outsider, I was not able to completely understand the meaning of the way in which symptoms, causes, and cures were expressed, and I consistently felt I was missing something. Even within groups - generational, regional, or otherwise - there seemed to be many ways of expressing distress that were not ubiquitous.

[25] *Agoinas* is a culture bound syndrome reported by this population (James, 2002).

The Portuguese Way

"The Sick Person is the Portrait of the Society Where She Lives"

Many health care providers agreed that although the types of complaints related to health and wellbeing in the Açores may be the same as in other areas of the world, the expression of these illnesses was distinctly different. They spoke at length of the problems they faced treating this community. While conventional and traditional healers held an expert position in the community and were sought for answers, it is the culture that paints the picture of what the salient health issues are. As one informant suggested, "The patient… The person… The sick person is the portrait of the society where she lives…. For example, I think that the Chinese will never have problems with *agonias* like we do."

A way of being. Expression and how the community communicated their distress was an artefact of the outlook towards life that the Açoreans shared with mainland Portugal. Suffering was not enough for the Açoreans; the suffering must somehow be communicated to the world. There is a contrast between suffering in silence and *suffering in the world* as it was suggested the Açoreans do.

The informants thought that, in general, Portuguese people faced life with a negative attitude. This informant described the negative attitude as an identifying characteristic, "I think the Portuguese illness [weakness] is to praise the negative." They suggested that for the Açoreans, this was linked to environmental factors. As this informant described, "I think that sometimes people get sick due to context. Economical difficulties, social difficulties, excess of work….I also think here, I don't know, I think the Portuguese people are sad and they shouldn't be …they are very pessimistic." The pessimism that this informant mentioned did not manifest in the community as a defeatist attitude but more of an acceptance of the unchangeable, harsh, and severe conditions of the islands. Although this attitude could be sensed on the mainland, it

was somehow different in the islands. One psychologist pointed out the difference, and commented on this acceptance of what she considered to be a problem:

> But the notion that I have, and this is in general, is that the Portuguese people, some Portuguese people and some Açoreans, isn't it, always have that tendency to complain; [they] have a greater tendency to regret, [they] have a much more depressive mood. They aren't a very cheerful people, they aren't a very happy people. And talking about the Açores, the *problemas de nervos*[26] [directly translated to problems of the nerves] are also very connected. … And then there is the issue of the depressive mood, very, very, very, very, present here in our region [the Açores]. But people don't face this as a problem.

For the Açoreans, the isolation, space limitations, and seismic activity were constant reminders of their vulnerability that they experienced in their island life.

The following informant, who had been a nurse on the islands for close to 20 years, expressed their suffering as a means of acquiring meaning in life:

> I think that the Portuguese people, the Açoreans, I think they are people who are ashamed of the disease of being happy. Brasilians are the opposite. They are ashamed of being sad…. In the middle of a very great sadness, they [Brasilians] are always happy! ….I think that the disease of the Portuguese people is to praise the negative, to praise in quotations. When people have an illness, this gives life a meaning…. And afterwards, sometimes, they cling to that illness….We must have a cross [to bear] and that cross can even be illness.

It seems that to suffer was to live, but to be happy was self-indulgent and inappropriate. In Brasil, which was colonized by the Portuguese and still retains many reminders of their Portuguese heritage, I experienced a distinctly different approach to life[27]. The following

[26] *Problemas de nervos* is a culture bound syndrome reported by this population.
[27] My experience was informed by the two years spent working in Salvador de Bahia, Brazil.

informant points out an even more specific contrast that exists between Açoreans and the mainland Portuguese:

> But I don't know why, here there is a lot more [than the mainland]. It is an impressive thing. Five people go there [Emergency] and at least three people have it; anxiety problems, problems of depression. And here are many people without apparent reasons, healthy people who never had any health problems but who have panic attacks, they actually faint, they seem to have convulsions.

A young physician, who had been practicing medicine in the Açores for close to two years, summarized the significance of place by contrasting the Açoreans[28] to the foreigners that visit the islands:

> I think the way they express those complaints is very specific of the Portuguese. We see that, because lately a lot of foreigners have come to the Emergency who are passing by, who are on vacation, some of them even living here…. the social-economical status is usually different, but even if it is the same, the culture that people have, the way they express themselves is different. The Portuguese is much more expressive, much more anxious than an English, a Swedish, or a Norwegian…. Usually they [foreigners] describe what is happening with them in a much more clear way and in a much easier way for us. …many times we lose ourselves in great descriptions of symptoms that afterwards we realize that clinically are not the most important ones. Also, because many times people can't evaluate what is happening, or they don't have the knowledge, or they don't care, and because the way the Portuguese perceive disease is different than the Spanish and the Italian, [or] from a person from the Nordic countries, and that is a really big difference.

[28] I have made the assumption here that since all of this doctor's medical practice has been in the Açores, she contrasts specifically the Açoreans with members of other countries.

Expressing psychological distress. Psychological distress and mental illness are not as visual as more physical types of illness, and for the Açoreans, this poses a problem in communicating their suffering to the world. Informants suggested there was a need to make illnesses that impact on emotions, behaviours, or cognitions more "palpable." This need can be seen as a desire for a person's suffering to be witnessed, which positions them as a good person in society:

> The thing about the mental problem is that many times the person is not understood. That's it. The mental illness is not understood. S/he wants a physical illness also. When the person's suffering is not understood, when the person doesn't feel empathy. … And the patient, in those cases, I think that the suffering increases. As many times, mental illness can deprive people from fitting in, socially, in terms of career.

Hence, psychological distress deprived people of *suffering in the world* as it was associated with undesirable personality traits instead of true *doença* [illness or disease]:

> With a physical problem, everybody offers themselves to help; with a psychiatric patient, there are still a lot of taboos, a lot, a lot, a lot of prejudice. Sometimes we associate mental illness with laziness, with cunningness [a personal agenda], with several things, with irresponsibility…. Now, I think, for instance, with a cancer patient, everybody offers themselves to help. Also physical disease, unlike [a] psychological one, is visible, isn't it?

A physician called the need for more physical problems *exteriorização* or exteriorization. He explained the difficulty that medical professionals have in locating the root of a patient's complaints:

> [In] many situations for which we can't find, after having studies and seen and re-examined that patient, we can't find a reason for a so-called somatic complaint, a physical complaint that he has, and we can, many times, justified it as being a, to

> transform a psychological problem into something somatic, inclusively, converting. A problem that upsets him mentally and he transforms that into a, perhaps, physical complaint.

When problems are *exteriorização,* then suffering can be *seen* by the community and suffering is not done in silence, it is what I have labelled as *witnessed.*

Answers, por favor. Community members did not often question health care professionals and they maintained the attitude that, *Você é que sabe* [It is you that knows] when dealing with physicians and nurses. Some health care professionals believed this was because of a lack of health education. One elaborated,

> The fear of 'What do I have?' A little pain that transforms itself into a huge pain, a big thing that sometimes is nothing. Do you understand? We see that a lot here. Here, I mean, not only here but in the whole country we see a lack of health education. You don't know what you have, you are afraid, then you go to the doctor for any reason.

The community conveyed a resolve that the physician was the keeper of information. The patient's role was to share an elaborate story of suffering, and the physician's role was to provide *treatment then cure*. One physician reported:

> They don't want to know much beyond what is said. They don't want to know. They want quick information. They want to see their analysis to know that they don't have anything, but they don't want to know much more beyond that. That, deep inside, it's difficult to understand. As I have explained about diabetes, that's the same thing. They want to see their analysis with the parameter. If the parameter is good, they don't care about the rest. They don't want to know what they can do to change, what they can do in their life to change it and to not happen what they fear. It's not fear, but they want to avoid in the end.

The idea of *treatment then cure* was important to the patient and had a significant impact on the relationship with a healer. For people in distress, healers represented a one-stop solution:

> RA - What kind of help do people seek when they are sick?
>
> Informant - Immediate [laugh.] They want an immediate thing. They don't accept, many times, they don't accept that an illness has a period of…a more extended recovery period. What they want is to go to the hospital, immediate service, go home well.

This attitude is extended to mental health care practitioners as well. Luis spoke specifically about the practice of North American psychiatrists:

> Some people have some sessions from psychiatrists and, most of the time, people go to see psychiatrists mostly don't see results. They go over there and da, da, da, da ,da and they don't get any results. People don't want that, specifically, the Portuguese people don't want that.

This concludes the narratives of the informants. In the following chapters I provide my interpretations of these narratives and I describe the implications they have for multicultural counselling practice.

CHAPTER SIX

The Researcher's Interpretations

This chapter provides an interpretation of the findings through my voice as the researcher. An experience is only known through a representation, and an objective description of reality can never truly be attained (Denzin & Lincoln, 2003a). As such, this represents how I, as an ethnographer and a counselling psychologist, made sense of the information that my informants shared with me. While in the field, I was acutely aware that, "the observer influences what is being observed" (Irvine Yalom, personal communication, May 23, 2007). As a participant observer, I was conscious that I was looking for something [namely information on *my* conceptualization of traditional healers] and, in this process, I influenced the information that my informants offered. In my field notes, I wrote over and over again, "Just let them talk," and I practiced ways to describe my research that were ambiguous enough to allow people to give me information on what they felt was relevant to healing and traditional healers.

I begin by describing my experience of the research process in the field. Then, I elaborate on the difficulties I faced with language that went far beyond the simple translation of Portuguese to English. My experiences and the difficulties I faced have strong implications multicultural counsellors who provide service in English to second language English speakers. I continue by exploring the role of suffering in this community along with the robustness of traditional healing practices in the Açores. Finally, I discuss the inherent problems in conducting scholarly research on helping practices that have no bases in empirical science. The reader should note that I have used examples from the literature to better explicate my interpretations. The *Discussion*, which follows, chapter also links the findings to the literature and uses these links to provide the implications of this research for theory and practice.

Understanding the Process

During the initial weeks of fieldwork I felt like I was going around in circles. My informants were speaking freely about *curandeiros* and other traditional healers but I was not able to understand exactly what I was being told. As time went by, I discovered a pattern in many of my conversations. The following interpretation represents the response I often got when I first met an informant[29]:

> Oh, she wants to know about *curandeiros.* [laughter] Why would you want to know about *curandeiros*? [more laughter] Me? No, no. Sure I know this *curandeiro* and wasn't there one who lives in such and such a place? But he died. And there was one over there too I think? I remember once my mother/sister/uncle/cousin/niece went to a *curandeiro*. Yes, she/he is much better now. Me? No, no. Oh you know, I don't believe. Only silly people go to *curandeiros* and I am not the type of person anyone would consider silly.

I often felt like the cute five-year-old who said something precociously endearing at the family gathering. I noticed that it was usually the second meeting before my informants would tell me a story recounting how they *had* gone to a *curandeiro* after initially denying they had ever visited one. The pattern was: laughter, denial, disbelief, second-hand knowledge, disclosure. When they did disclose having gone to a *curandeiro,* it was as if they had always spoken of their involvement: a newer version of their narratives did not require the original version to be untrue. The following are excerpts that were taken from an interview done by one of the research assistants. These excerpts are a good example of how people would provide information. It is written in the original order, however, the complete dialogue is not included, only the parts that highlight the confusing nature of the informant's responses:

> RA[30] - Do you know any *curandeiros* in São Miguel?

[29] This not a verbatim quote from an informant but, rather, a contrived exchange to highlight a pattern in responses I identified.
[30] This research assistant is Açorean and has always lived on the island.

Informant - Yes, I do, I do. One of my friends is a daughter of one. … I went to see him several times.

RA - So you already went to a *curandeiro*?

Inf - But I didn't go to solve my problems. I went with my son. My son couldn't sleep. He cried, cried, and cried! But he said it was gas [laughs]. It wasn't anything! And there, as he was a friend of the family, I went there with my son without knowing what was happening with my child, feeling desperate. And he said it wasn't anything serious, that it was only gas, it was nothing serious. …Besides that, I'm not a believer in *bruxarias* [witchcraft].

RA - What did Mr. [*curandeiro's* name] do?

Inf - What did he do? He looks at people and I guess he sees through, he sees inside us and he sees what we have. …

Because once he told me, 'That belly of yours is so swollen.' And he said like this, 'Look you have an ovary infection. You're going to drink some teas.' And by the way, I took the medication. The medication? I mean the teas! It went away. I was cured.

He looks to your home and sees what you have. I don't know how! He has those magics.

RA - Do you think that *curandeiros* help people to become better?

Inf - I don't have an[y] experience in that.

RA - Didn't you go to one?

Inf - No I have no experience in that. He prescribed me those teas…they cured me.

This woman gives two examples of successful personal interactions with a *curandeiro*. She speaks about the gift or "magics" and their ability to diagnoses by sight. Yet, when asked if they helped, she responds she has "no experience."

In another situation previously mentioned, a group of female informants described Luis as a *curandeiro* in a neighbouring town. They assured me he was very good and they urged me to talk to him. When I went, I was surprised to see a large store front for a health care professional's office. Ironically, the potential informant was not available because he was in North America where he had another office.

When I finally met with him, I told him that the women I spoke with had told me he was a *curandeiro*. He was offended and adamantly denied he was a *curandeiro*. He showed me his degrees that were granted by a university in Europe. He used the term "witches" in English and said he did not believe in "witchcraft." We met four times and the more we spoke the more positively he spoke of *curandeiros* and he later disclosed a time when he went to see a *curandeiro*, "I'll be honest, my own self, I've been once because I been, I have very strong problems." The last time we spoke he seemed almost proud of his abilities to help people and his association with *curandeiros*. His responses mirrored the pattern that was developing in the responses that I was receiving and that the Portuguese research assistants were receiving as well.

Many informants denied believing in the gift or in the powers that *curandeiros* seemed to have; however, they showed a robust respect for these powers. Paola was very clear that she did not "go for that kind of stuff." When I asked her if her brother was cured by the *curandeiro*, she responded:

> Paola - That exact night I cannot remember because it was too nervous. But he calmed down, didn't cry anymore. He started being a normal baby.
>
> Researcher - That was it?
>
> Paola - This is what he needed. And all of us too.

She went on to describe a *curandeiro* that she encounters in the community:

> You talk to him and he is listening to you but you don't really know if, the thing is you don't know if he is reading your mind or whatever. That is what creeps me out…

[whispers]… 'Oh my God. I don't believe, does he know that? [laughs] Does he know I don't believe this?' [laughs]

Although she doesn't believe, she remained fearful of the powers he might possess. Most of the informants that I spoke with would be considered educated and middle to upper class. These informants often suggested that it was the people who lived in the rural areas who were not educated that most often went to *curandeiros*. However, they would tell me stories of their visits to *curandeiros*. Elise explained this contradiction by saying, "We [her family] are not sick, we are healthy people. This was very special."

For the most part people did not talk about accessing *curandeiros*. As this physician noted, it depends on the person, "There are people who don't mention it right away. There are others who don't mention it, but if we ask them they'll answer… they say the truth." Elise explained that it is just not part of daily conversations:

Researcher - Do you have people in your circle of friends that might go to a *curandeiro*?

Informant - I don't ask.

R - Is it something that people probably don't talk about?

Inf - Yeh, this is not a social thing.

Elise suggested there were "taboos" but then clarified there were not strict rules:

Research Assistant - There is a certain social taboo?

Informant - Yeh, there is something very… I don't know if it is quite a taboo.

Disclosing seemed to be situational and up to the individual's discretion, "Yes, we don't talk much about it. It is kind of a taboo, who goes to a *curandeiro*. Now that depends on who the healer is and the kind of answer that the person seeks there."

The following quote is from a physician who had been practicing for close to 20 years. He was clear in the beginning that only fools use *curandeiros* but then he suggested there were exceptions:

> …it isn't accepted culturally. There is a cultural punishment for this. [Those] who search for *curandeiros* are people who don't think properly and they are fools, illiterates, right? There is a social punishment, but in some *freguesias* [small parishes], in the families, it's accepted if one goes to him, although society criticises but it is accepted to go, right? But usually who goes are people from low social classes, although, in fact, some educated people might go as well.

Again, this physician highlighted the contradictions within responses. Informants often answered both yes and no to questions about traditional healing. Acknowledgement of the existence and the usefulness of these practices did not seem to depend on where the conversations were taking place or on who I was talking to, as Elise suggested. Rather, it seemed to depend on my comfort level with the ambiguity of the content. In my conversations with the informants, I faced difficulty when I requested a comparison between conventional and traditional systems or when I tried to answer "why" questions. The more I sought specificity in the responses, the more confused I became.

I did meet people who considered *curandeiros* an artefact of the past that were no longer necessary. However, I did not meet any one during my time in the islands that denied the existence of *curandeiros* and felt they provided no service, in any way, to the population. Everyone had a story to tell, even if it was something they had vicariously experienced through a family member or a friend.

Elusive. The information I sought in the Açores seemed to be everywhere; as I have indicated, everyone had a story and was eventually eager to tell it. An entry in my field notes is titled *Swimming in Info and Drawing Lines* and begins, "I feel like I am in a big pool with all this important/significant info just floating around me." However, I do not go on to write pages and pages of this important/significant information, rather, the pages are full of question marks and incomplete attempts to make sense of what was happening to me as a participant observer. I

was “swimming in info,” but for some reason I was not actually getting wet. The second part of the journal entry title refers to my early confusion over the lack of specificity in people offered defining healers. Shortly after, there was another entry in my field notes that expressed my frustration in attempts to find *arroz dolce* [sweet rice], a regional dessert. This was something I had been told that I must try when I went to the Açores; I had the impression this would be an easy task. I inquired in every restaurant and after many attempts a waiter finally told me that they rarely made it because it was usually the staff that ended up eating it.

Similarly, many of my informants gave me directions to find *curandeiros* and other healers that I was never quite able to follow through on. I was told so and so, who was very well known, lived in Livromento, Vila Franca do Campo, Lagoa, or some other easily accessible place. One informant that I spent an afternoon with told me that every small village had a *curandeiro* except hers; otherwise we would visit of course. People offered to accompany me to *as mulhers quem ler do livro* who seemed to be in abundance on the islands. Even one of my research assistants offered to take me to her friend who was an *endireita.* For no reason that I can name, these direct contacts and specific invitations never materialized.

Even before leaving Canada I was told about a healer in the Nordeste [a region in the north eastern part of São Miguel] that I should interview. Dr. Roberto, as he was called, was considered a physician and a *curandeiro*. This was intriguing because I had never heard of a physician who also had the gift. My informant could give me no further information but assured me he was very famous and just about anyone would be able to direct me to him. Dr. Roberto proved to be as elusive as *arroz dolce*. I continued to hear about Dr. Roberto from many other informants on São Miguel. He never seemed to live in the same place and sometimes the name was the same while other times the informant could not remember the name, but the description was always the same.

Another informant on São Miguel suggested I speak with a *padre* [priest] that owned a well known *ervanaria* [a store selling health food and body products] in Ponta Delgada. She said he gave "very good advice" and implied that he had the gift. On my first visit to see the *padre*, I was told he was not in but I should come back the following day. On my second visit to see the *padre*, I was told that he was sick and had been admitted to the hospital but it did not seem serious and I could come back next week. On my third visit to see the *padre*, I was told he was still in the hospital but I should come back in a few weeks and certainly then I could speak with him. In what turned out to be my fourth and final visit to see the *padre*, I was told he had died in the hospital the previous week. At this point, it was hard not to feel the universe was conspiring against me.

The confusion I experienced in the Açores trying to understand my informants' eagerness to give information and, at the same time, their reluctance to be specific can be examined in light of Portugal's historical context. The lack of specificity could be embedded in larger fear of retribution, which has been a part of the political and social landscape for hundreds of years: The Spanish Inquisition and Salazar's 34 year dictatorship provide two examples.

The Inquisition in medieval Spain and the Iberian Peninsula created harsh conditions in Portugal for anything that was considered inconsistent with the true faith of Catholicism. Traditional healing practices have often been interpreted as a mystical phenomenon, which stood in stark contrast to the dominant Christian hegemony (Sato, 2005). Perry and Cruz (1991) described the pervasiveness of the fear created by the tribunals: "The Spanish Inquisition established permanent tribunals in major towns and cities, developed a large bureaucracy to carry out investigations in most communities of the realm, and permeated all areas of human life, both private and public" (p. ix). However, the attempts to unify society under one religion did not address the practical needs of the common people and as such, the official policy of the State and the means by which underprivileged people met their daily needs was irreconcilable.

Quezada (1991) explains the practical necessity of healers versus the intolerance of their mystical powers;

> The contradiction presents itself in ideological terms: on the one hand, their [traditional healers'] services were required as experts on the human body, as able as surgeons, and as superior herbalists; on the other hand, they were harshly repressed for the magical part of their treatment... (p. 38)

These contradictions in what was lawful behaviour and what was necessary behaviour continued well into modern day Portugal with the creation of the *Estado Novo* [New State]. During the more than three decade dictatorship (1932-1968) of António de Oliveira Salazar, Portugal as a country experienced political, economic, and social order. However, much of the country lived in impoverished conditions (Anderson, 2000). Salazar continued to cultivate a society of secrecy in Portugal that had historical roots dating back to the inquisition.

Both periods in history were defined by a conflicting need in the community that could be addressed by what was considered by the State as an immoral practice; often the only services available to meet the health care needs of the poor were those of traditional healers. Curandeiros and other traditional healers thrived and continued to meet these needs but they did so at a huge personal risk. Persecution, loss of life or limb, incarceration or at the very least, harsh conditions, was a consequence of using what many community members considered a gift from God. A code of secrecy resulted; as Elise implied in Chapter 5, if things remained unknown the police would not "knock at your door."

In the end, I did leave the islands without tasting *arroz dolce*; however, I was given a recipe. Aside from Luis who was considered by some to be a *curandeiro*, I did not knowingly meet a healer who fit my initial definition. I did, however, leave the islands with many stories.

Learning the Language and the Ways of Speaking

I recognized the tension created by trying to choose the terms and the words to be used in an ethnographic study before fieldwork had commenced: one of the main objectives of ethnography is to "see the world from the insiders' perspective" and to "uncover the world view of people from cultures other than our own" (Tierney, 2002, p. 11). In effect, I knew *doing* the research would name the concepts and artefacts that helped me understand how traditional healers worked with people. Inherent in this was gaining an understanding of the lexicon used to give voice to these perspectives and worldviews. I found that learning the learning *the language*[31], I also had to learn the *nuances of the communication* that were more intangible and less obvious than simple English to Portuguese translation.

Learning the Language. A key example is provide by *as mulhers quem ler do livro* [the women who read the book] who did not initially fit my conceptualization of traditional healers. Rather, they resembled what I would consider to be fortune tellers. The frequency with which my informants discussed them caused me to reassess my original ideas about what a healer provided for this population. I initially defined traditional healers from the perspective of a medical anthropologist:

> …[a] non-biomedical health practitioner who has inherited, trained in or created methods that utilize botanical, animal, and mineral products, perhaps symbolic methods and ingredients as well, and is sought out to treat physical, mental and social diseases, and conflict in his or her community. (McMillen, 2003, p. 891)

This definition did not provide me with the breadth of understanding to identify *as mulhers* as traditional healers as my informants considered them to be. *As mulhers* [the women] were usually sought to help with an important decision or to provide information about the course of

[31] By *language* I mean the actual words in both Portuguese and English that the residents used to discuss what I wanted to gain information about.

an illness or an interpersonal conflict. They did not appear to be "health practitioners" and the informants did not suggest *as mulhers* had inherited, trained, or created their methods of healing. I was forced to broaden my conceptualization of "health practitioner." My informants helped me understand the use of religious writings by *as mulhers* to "treat physical, mental and social diseases, and conflict in his or her community" as "symbolic methods" that served a need in the community. *As mulhers* provided witness to complicated situations and suffering, whether medical, psychological, or familial. McCabe (2007) provided a definition from the perspective of psychology:

> Traditional healing is the use of ancient cultural knowledge, beliefs, and methods, as applied by a designated person (a traditional healer) to help individuals find positive ways of dealing with spiritual, physical, and psychological problems. (p. 148)

This definition, which is influenced by Aboriginal Canadian healing belief systems, aptly adds spiritual distress to the list of problems addressed by traditional healers. The latter definition is much less specific but includes cultural knowledge and beliefs which allows for a broader understanding of the ways in which communities address distress.

Endireitas [bone setters] initially seemed to be traditional healers who dealt solely with physical ailments such as fractures and sprains, which fit the former definition more closely. What was less obvious was that they too seemed to provide a necessary witness to suffering. Treatment encompassed physical attention and also acknowledged a need; when conventional health care practitioners did not acknowledge suffering, *endiretas* addressed this spiritual dilemma by witnessing their pain and suffering, as was indicated by the woman who had twisted her ankle and received no treatment from the hospital.

In the beginning, I told people I was researching traditional healers. I later switched to using the specific terms for the respective types of traditional healers. Traditional healer was not a term that residents used in either English or Portuguese and the term caused confusion. Early in

my field work I began to tell people I was interested in learning about *herbalistas, curandeiros*, and *bruxas*. My informants guided me to discontinue the focus on *bruxas* and to add *endireitas* and *as mulhers quem ler do livro;* these were identified as the name of the healers who helped people with spiritual, physical, psychological, and social distress and conflict in their communities.

Learning the Ways of Speaking. There are many entries in my field notes that tried to make sense of how the informants responded to the research project. The following entry is representative of the challenges I faced. Although many people were very interested in the research, they had difficulty understanding the significance that I attributed to the topic:

> I had an interesting lunch with [informant's name]. She was very interested in being helpful and even offered to be a translator for me. She announced my research to the yoga classes and most people seem very interested in helping and in the research. People usually smiled and sometime laughed, it seems most feel it is a *silly little thing* to research. [Informant's name] said, "You said *agonias* like it is a disease," to which the whole class laughed. Is this because it is so familiar that it is insignificant or is this because it *is* insignificant?

This informant highlighted the fact that while I was becoming conversant in the language, I still had difficulty understanding the *ways of speaking* about distress. Even though I had spent two years immersed in research on this immigrant group in Canada and the United States, I did not understand the ways of speaking. There was an obvious tension created by an outsider, even an informed outsider, when trying to initiate a conversation about these Açorean customs and traditions.

This tension seemed to manifest in laughter and jokes about the *ways of old people*. The majority of my informants were between 20 and 50 years of age and many told me that their generation did not access these types of healers but that their parents and/or grandparent's

generation did. Interestingly, an ethnographic study [32] in the mid 1970's reported similar responses by his informants (Like, 1977/1978; Like, August, 1978; Like, April, 1979; Like & Beck, n.d). Given that this research was carried out a generation ago, his informants, who had denied knowledge of traditional healers, would now be part of the generation my informants considered *older* - the generation they considered to use traditional healers.

Furthermore, there were other similarities between these earlier findings and my findings in 2006. The kinds of treatments reported by Like (April, 1979) were also reported by the informants in my study; *ervas* [herbs], *chas* [teas], and rituals that resembled Paola's description, in Chapter 5, of her brother's treatment. The informants in the earlier study indicated, as my informants did, that Açorean immigrants while in North America continued to access *curandeiros* on the islands. Like also described a similar *pattern of negotiation* in his discussions with his informants. This quote, from a 15 year old girl, suggests that Like's informant went through an initial stage of denial before disclosing knowledge of traditional healers and there ways of treating distress: "Although claiming not to know much about the old beliefs and traditions, she was aware of a larger number of folk medical remedies and was able to tell me a great deal about how they were prepared and used" (p. 6). Desperation seemed to be a motivating factor for accessing *curandeiros* then, as it is now. Hence, these similarities suggest the presumption that traditional healing practices are becoming extinct with greater access to more modern health care systems, as my informants had suggested in our initial conversations, does not appear to accurately represent the situation.

The journal entry mentioned above suggested that many of the informants considered traditional healing practices to be "silly," and dismissed their importance. However, another entry suggested that traditional healers were not considered insignificant. This entry went as

[32] Robert Like, a medical student at Harvard Medical School, carried out research in Sao Miguel, Portugal, and Cambridge, MA, USA which investigated Açorean popular health culture.

follows, “Whenever I talk to anyone about *curandeiros* there is a fair amount of excitement generated; no one is indifferent to this topic.” The section titled *Understanding the Process* demonstrates the frustration I encountered in the process of collecting my informant’s stories. The conversations tended to follow this pattern: laughter, denial, disbelief, second-hand knowledge, disclosure. When I met informants, there was an initial phase of tension as I searched for a way to communicate with my informants about traditional healers and healing.

Embracing the Language of Modernity. The Açores is an example of a community in transition toward adopting a more biomedical approach toward illness and disease as practitioners, both physiological and psychological, become more available to the residents of the islands. As recently as the early 1950’s, physicians and nurses were not trusted in the more remote areas of Portugal and residents depended on traditional healers for expert opinions on healing. According to Namora (1956), “No patient ever took his prescription to the chemist without first getting it approved by Senhor Ernesto [a *curandeiro*],” (p. 118). Written by a physician in a chapter titled *Quacks and Healers*, the communities continued reliance on Senhor Ernesto underscored the ongoing tension between conventional health care and traditional healers. Like (August, 1979) noted, “Individual psychotherapy and other forms of group therapy are [were] virtually nonexistent [in the Açores in the mid 1970s](p. 3);” similarly, a physician the current study indicated that psychological support was not available in the health care system 19 years before when he started his practice on São Miguel.

As I had experienced in Argentina in 2003 when I tried to open a dialogue regarding the usefulness of utilizing traditional healers as a health care resource, people in the Açores maintained an either / or stance rather than a both / and stance toward healing with respects to conventional health care versus traditional ways. As conversations progressed, people were more willing to discuss traditional approaches when they talked about *problemas* [problems] as opposed to sickness and disease; sickness and disease were reserved for conventional health care

practitioners. *Problemas* were how the community gave voice to their personal experience of distress, whether the distress could be attributed to spiritual, physical, psychological, and social distress, or to conflict within the community. For this community, *problemas* were what Kleinman (1988) called *illness,* which he described as the personal experience of disease or distress. As the informants indicated, treatment for illness was found with traditional healers, and treatment for disease was found with conventional health care practitioners.

The major conflict seemed to be in the two distinct ways of giving voice to illness and disease. Research has shown that conventional health care practitioners translate illness or, in this case, *problemas,* to contemporary disease nosology (James, 2002). The current project supported this finding. The conventional health care practitioners that were interviewed considered the *problemas* of the community as not diagnosable nor translatable, and therefore not needing treatment. In an earlier example given in Chapter 5, a mother was concerned her son was *nervoso* whereas the physician diagnosed attention problems. As a doctoral student in a discipline that was relatively new to the islands, I represented modern health care. When I tried to combine the two, ways of treating illness and ways of treating disease, it caused tension and my informants typically followed a pattern in their responses: laughter, denial, disbelief, second-hand knowledge, disclosure.

Other ethnographers have found a similar complexity in trying to access narratives of illness. An ethnography that investigated witchcraft in Western France (Favret-Saada, 1977) quoted an informant who explained the problem:

> The psychiatrist says [sic] to me you have to be mentally deranged to believe in spells. Because, he says, in the old days people were so backward! But now one mustn't believe in that. We doctors, he says, we're strong, medicine's stronger. We… science is so modern that it's able to deal with any illness…' (p. 250)

The researcher represented an academic modern world that was based in experimental knowledge and informants appeared "credulous" and "backward" if they discussed their experience in alternative ways (p. 3). The informants in the current study seemed acutely aware of the inability of modern science to accept the power of healing from methods of traditional healers. Although they implied they did not "go for that stuff" as Paola noted, an overwhelming majority of the Açoreans I spoke with, showed a strong reverence for the power of traditional healers in their community.

The psychiatrist quoted above implied that there is nothing to be learned from traditional healing such that Kleinman's concept of illness - the experience of disease - would seem to be of no consequence to the advancement of modern science. In the current study, that was similar to the 13 conventional health care practitioners interviewed. None of the 13 health care practitioners reported knowing or having accessed a *curandeiro* or other types of traditional healers[33]. This contradicted the pattern with the rest of the informants who almost unanimously reported some knowledge of healers either directly or indirectly.

This analysis of the informants' stories strongly suggested that utilizing traditional healers is currently a robust practice for Açoreans. Although traditional approaches to healing are used simultaneously with biomedical approaches, they are not often spontaneously discussed outside of the confines of the healer / patient relationship. In part, this may be due to the transition towards embracing more modern health care practices, in that, to espouse the benefits of modern science, was to dismiss the usefulness of traditional practices.

The Language of Suffering. Religion plays a significant role in the life of all Açoreans, as indicated by the following:1) the questionnaire responses from the quantitative project - 86% endorsed Catholicism as their religious affiliation (James, 2006); 2) the centrality of the church

[33] Many of the health care practitioners suggested that they were aware that their patients accessed traditional healers but this seemed to be the only knowledge they had.

in towns and villages; 3) the high number of people who participate in regular Sunday church services; 4) the elaborate preparation and large number of participants in religious *festas* [party/celebration] and; 5) the significance of the church in non-religious celebrations, such as graduation and birth. Even the informants who did not observe regular religious rituals indicated they participated in special religious *festas* and they identified as Catholic. The following section explores the significance of suffering in light of the community's strong affiliation with religion.

Ehrman (2006), a religious scholar, suggested that, in I Peter, "the author [of I Peter] urges his readers to face their suffering strongly, since they are to suffer as their master, Christ himself, did" (p. 75). One informant, a nurse, indicated the purpose of suffering for the Açoreans, "When people have an illness/disease, this gives life meaning.... We must have a cross [to bear] and the cross [to bear] can even be illness/disease. Why not? It gives life a meaning." James (2002) also supports the redemptive value in suffering and the relationship suffering creates with the Divine for the Açoreans. When conventional health care practitioners did not provide treatment they, in effect, communicated to the person and their community that there was no suffering and thus, no penance for the individual.

The informants frequently reported unsatisfactory results from the medical profession; physicians often considered people to be well, and informed their patients they were not sick and, as such, not suffering. For example, the woman who had sprained her ankle was sent home to rest, yet she was suffering. Another example was Fernanda's grandson who saw souls from the other world. The physician said he was not sick; however, he and his family were suffering. In both situations, the suffering was not translatable to contemporary disease nosology that required treatment and, as such, the illnesses were neglected.

All traditional healers seemed to have one thing in common: they listened to the client's interpretation of the problem; they accepted the information even though they might have changed how the problem was labelled, and they provided some kind of solution / action. No

informant told a story of a healer who did not identify some kind of problem when a person was suffering. *Curandeiros* and other traditional healers embodied a Portuguese way of being in their practice and in their interactions with their community. As experts, they provided treatments that validated suffering and often externalized causes. No informant described a situation where a traditional healer would ever suggest that there was nothing wrong; the presenting problem always warranted a treatment of some kind and validated suffering. This was distinctly different than the message they often received from physician, nurses, and psychologists. *Curandeiros* and other traditional healers validated suffering in the world by providing an answer that, in many cases, provided some form of instant relief.

The community members did not suggest that talking and being listened to was an important aspect of treatment received from *curandeiros*; however, they did imply that *curandeiros* understood their distress. Only one informant, who was described in Chapter 5, suggested she has been turned away from a healer; “She told me that I didn’t believe, that I didn’t need to be there.” What was absent in all the informants’ accounts of traditional healers was the disbelief of their suffering that conventional healers [physicians and nurses] demonstrated so readily.

The term "witness" implies that the healer both observes and attests to the fact that something has occurred. In "witnessing," the healer must provide a concrete response that says, "Yes, I see that you are suffering." In that sense, these traditional healers provided the informants with validation of their suffering. For the informants, witnessing was the healer’s validation of their suffering. A significant part of witnessing was the act of providing some means for removing their suffering: *Herbalistas* provided herbs and teas; *Endireitas* used oils to massage; *Mulhers* used *o livro* [the book] to provide guidance or answers; and *Curandeiros* gave teas or herbs or possibly even removed spirits. In every case, the traditional healer acted on the community member’s suffering, therefore witnessing their suffering and providing a conduit to

suffer in their community; medical professionals did not. The communication of their suffering to their community is a necessary process for Açoreans to maintain their status as good Christians. To face suffering strongly, as Ehrman (2006) suggested as honourable and moral behaviour for good Christians, suffering must be shared with the community. Suffering in isolation lacks the necessary validation from the community of the Açoreans "cross to bear."

Chasing Language

By now, the reader will have understood that I did not knowingly speak with any traditional healers, as my research question suggested I set out do. The earlier section in this chapter titled *Elusive* elaborated on the difficulties I faced in trying to find a healer to speak with face to face. The numerous leads and directions I received resulted in dead ends and, in one case, the actual death of a potential informant. Not only did healers prove hard to find but answers to what appeared to be straight forward and objective questions turned out to be equally elusive. For example, during my stay I asked many of my informants the name of *o livro* [the book] that *as mulhers* [the women] used. At some point after I left the field, I realized that I still did not know what book *as mulhers* used. I was horrified that this seemingly simple question remained unanswered; I felt as if the validity of my whole research project depended on this knowledge. On another level I was aware the unidentified book symbolized my quest for information on traditional healers in the Açores; I searched for answers and it was not the answers that were important. The response I received from an email request I made to one of my informants in the Açores helped put this lack of knowledge into perspective:

> I asked my aunt what book did the woman who reads the book of *Senhor Santo Cristo dos Milagres* read to her and she didn't quite know. She first told me that it was the Bible, but when I asked her if she was sure, she wasn't. She finally told me that was some kind of religious book, a 'church book', as she put it, maybe to convince me that it wasn't black magic or something like that. I don't think it could be the Bible, because if

> it would, people would just call it the bible and not the book *of Senhor Santo Cristo dos Milagres*, our local saint. It must be a religious book related to the life of Jesus. It makes more sense to me than the Bible.

It did not matter what the book was, it only mattered that *as mulhers* were able to use it to heal. As my time passed in the field, I became more comfortable with what I saw as the lack of specificity. It did not matter how the healer healed or who the healer was, it only mattered that the healer listened, the healer accepted the suffering, and the healer acted in some way. In this way, community members are witnessed as they "suffer as their master, Christ himself, did." (Ehrman, 2006, p. 75)

Favret-Saada (1977) noted a similar problem in her research on witchcraft. In her own experience she noted, "I was soon forced to change my plan to study the beliefs and practices of witchcraft … into that of acknowledging the truth of a discourse" (p. 13). She argued that what is considered witchcraft is a discourse that is not interchangeable with a scholarly discourse or a medical discourse of misfortune or distress. She surmised that, "since peasants know both [discourse of witchcraft and biomedical terminology] and can use both, we must assume that referring to one or to the other does not involve the same relationship of meaning" (p. 13).

What I collected in the field were words and narratives about traditional healers. I recorded a discourse that initially confused me and seemed impossible to understand. My mistake was trying to translate what I was hearing into something I could consider data. When I became more comfortable in the ambiguity of the language and the ways of speaking, I began to accept the information I was gaining. The pattern in my conversations with informants [laughter, denial, disbelief, second-hand knowledge, disclosure] was conveyed by the negotiation of a suitable language that enabled us to communicate about things that do not share the *same relationship of meaning*. The negotiation was a dynamic interaction of beliefs and personal agendas; while conventional health care practitioners cured the disease, traditional healers cured

the illness. In my attempts to compare and contrast these two processes I alienated either one or the other.

In an attempt not to appear "credulous" my informants relied on humour and denial. As we negotiated the topic, I became more conversant in the ways of speaking, which distanced me from being viewed as a representative of the biomedical field who was experienced in the dominant discourse of counselling psychology. The more stories I heard, the more I understood that the significance was not to be found in the details of the stories; rather, what was important was that traditional healers listened, accepted, and provided some kind of action/solution. The healing was in the witnessing of suffering; the process of validation of the honourable and moral behaviour of *good* Christians.

CHAPTER SEVEN

Discussion

Kleinman (1987, 2001) has used his conceptualization of disease versus illness to develop theories of health care that are intended to improve the medical and psychiatric care provided to people with non-dominant worldviews. He has advocated that the personal experience of a disease, the illness, must be attended to and understood by practitioners in order for healing to progress. Since beliefs, diagnoses, disordered behaviours, treatments, societal reactions, and sanctioned cures all result from a number of interrelated factors that are impacted by culture, Kleinman (1998) utilized methodologies and concepts from medical anthropology, which have a long history of contributing knowledge to the cultural construction of disease categories.

By extension, the current project utilized Kleinman's integration of medical anthropology methodologies and concepts to ask similar questions regarding the illness associated with psychological distress and disorders from the point of view of counselling psychology. By enlisting the "anthropology of experience," as Kleinman (1997, p. 316)[34] has named it, valuable information was obtained in this investigation to answer fundamental questions about methods of healing considered to be specific to the Açorean culture. The research question that guided my inquiry into the value and process of traditional healing in the Açorean Islands was: How do traditional healers in the Açorean Islands facilitate wellness in people suffering from illness?

Kleinman's early work did not acknowledge the complexity of individual suffering and did not situate the sufferer in a greater societal, historical context. His later work (Kleinman, 1997; Kleinman and Becker 1998) broadens his original explanatory model to a somatomoral perspective which identifies suffering in the context of a social world; the sufferer cannot be

[34] Kleinman identified the anthropology of experience as a brand of medical anthropology that examines the experience of suffering. For a deeper exploration of this concept see Kleinman, 1996.

understood in isolation from their historical and contemporary society. Throughout this manuscript, the dialogue of suffering has been considered from the community member's perspective. I have alluded to the impact of the geographical and economic reality of the islands and the historical and religious evolution of the society; however I have not fully situated the sufferer in their society.

Admittedly, the analysis of suffering in the Açores and the process of healing requires a deeper exploration of suffering as a social process. There is little debate within the counselling psychology profession that context impacts the counselling relationship; however, there is no agreement on how or how much the societal history and current reality of an individual client influences the process of counselling. Pedersen, Crethar, and Carlson (2008) have recently presented a model for counselling that is more inclusive of historical and societal realities of the individual client; however, suffering as a social process has not been widely accepted by counselling psychology scholars and practitioners and as such, Kleinman's early work is used in this project to facilitate the integration of counselling and anthropology.

Numerous studies have explored idioms of distress and suffering in Açorean communities in Canada and the United States (James, 2002; James, & Clarke, 2001; James Navara, Clarke, & Lomotey, 2005; James, Navara, Lomotey, & Clarke, 2006; James, Slocum, & Zumbo, 2004). These studies have shown that this immigrant group accesses traditional healers while simultaneously accessing conventional health care practitioners in North America. The current project has added another layer to what is understood about the experience of suffering for Açoreans by focusing on the role traditional healers play in the process of healing. This knowledge moves towards "a richer, more complex, multisided vision of human conditions and experience" for this immigrant community in Canada (Kleinman, 2001, p. 16). Ethnography offers a powerful vehicle to deepen our understanding of non-dominant worldviews, which serves to challenge dominant counselling psychology theoretical orientations. In light of the

findings, the contributions and implications of this research are discussed in more depth in the following section.

Contributions and Implications

This research contributes to the growing body of knowledge dealing with multicultural counselling in the following ways: a) it adds knowledge by contributing an in-depth description of Portuguese Açorean traditional healers, which was previously absent from the counselling psychology literature; b) it expands on existing research to further explicate the significance of suffering in the world for Portuguese Açoreans, and c) it highlights the multifaceted impact of language when English speaking counsellors work with second language English speaking clients. Each contribution is outlined below and the implications for theory and practice are discussed.

Adding Knowledge

Theory. The need for this type of inquiry is firmly supported in the counselling psychology literature as noted by authors who specifically demand multicultural counsellors engage with ways of healing that challenge their own understanding of becoming well (Arthur & Collins, 2005a; Constantine, Myer, Kindaichi, & Moore, 2004; Stermac, 2005; James, 2002; Moodley & West, 2005).This research project provides a contextualized understanding of Portuguese Açoreans and the ways they attempt to alleviate suffering by utilizing traditional healers. Pedersen, Crethar, and Carlson (2008) have recently contributed a book that focuses on expanding the concept of empathy to include different cultural worldviews, which they believe to be necessary to developing awareness, knowledge, and skill in multicultural counselling. Clark (2007) explains empathy as vicariously experiencing the feelings, perception, and thoughts of another. The worldviews that are represented in these narratives will provide counsellors working with this population information that will enable them to more deeply empathize with their client's suffering.

When Dr. Pittu Laungani was presented with the Lifetime Achievement Award in Counselling and Multicultural Psychology by the University of Toronto in 2005, he noted:

> My own feeling is that there ought to be a greater concern among Western counsellors and therapists to understand the attitudes, beliefs, and values of their clients from non-Western cultures…. Western therapists in general tend to see their own world and the world of their client from a Western perspective. And this makes it very difficult for them to crawl into the skin of someone from another culture and study the person from that point of view. Such a situation often leads to an impasse. I think that it is important if therapy across cultures is to work. Westerners must show the humility and willingness to study cultures intimately - not superficially as appears to be the case….One needs the willingness and the humility to learn from each other's cultures (Stermac, 2005, p. 275).

One of the main objectives of this project was to add contextual descriptions of Açorean systems of healing to the literature consistent with Dr. Laungani's call for humility and a willingness to engage with epistemologies that challenge North American theories of counselling psychology. As stated previously, this immigrant group continues to access traditional healers while concurrently accessing conventional health care practitioners in North American (James, 2002). Contextual descriptions are necessary to promote holistic care and the provision of appropriate mental health care services to Açoreans. Exploring how traditional healers in the Açorean Islands facilitate wellness in people suffering from illness provides an alternative narrative that contributes to a more complex understanding of the human condition of this immigrant group. This knowledge has previously been absent in the counselling psychology literature. Disseminating this knowledge to practitioners helps protect service providers from the dangers of cultural encapsulation, which is seen as relying solely on theories and concepts developed from Western constructs.

This project purposely attempted to *de-exoticize* Açorean healing practices, which were not developed from empirical scientific research. France, Rodrígues, and Hett (2004) suggested that it is human nature to distrust what is different and, for counsellors to deliberately overcome this tendency, repeated engagement with different cultures and with what is *different* is necessary. Moodley (1999) noted the importance of exploring traditional healing practices:

> A failure to fully comprehend the role of traditional healing may lead to a narrowness of understanding 'race,' culture, ethnicity and psychopathology in clinical settings. Although research in the area of culture and representation of illness is still very limited, we are aware that ethnic-minority communities respond differently when it comes to representing illness, discomfort and distress…. In recognising traditional and alternative cultural healing methods, the Eurocentric and individualistic discourse of counselling will be challenged and transformed. (p. 149)

James (2002) has highlighted the need for information specifically on *curandeiros* and other healers from the Açores. The narratives add a human context to the ways the community members and the traditional healers respond to illness, discomfort and distress. By opening a discourse on traditional healing practices and validating the robustness of these practices, counselling psychologists are encouraged to broaden their understanding of how these practices are significant to suffering and wellness for Açoreans.

The findings of this project validate the usefulness of traditional healers to Açorean immigrants; traditional healers, a) listened to the community members' interpretation of their problem, b) accepted the community members' information about their distress, and c) provided some kind of solution / action. Traditional healers often provided this after a conventional health care practitioner failed to communicate their understanding or provide service. These findings provide the impetus to stimulate similar research to better understand the role traditional healers play in other immigrant communities in Canada. In effect, this project challenges other

researchers to develop theories of cultural healing systems and to disseminate that knowledge to practitioners. For counsellors working specifically with Portuguese immigrants, this project provides contextualized knowledge to better inform their conceptualization of healing. In general, this study offers knowledge for counsellors working with a diverse clientele that challenges North American attitudes, beliefs, and values, and that encourages them to explore the attitudes, beliefs, and values of people with non-dominant worldviews. The findings of this research project strongly suggest that the limits of our ability to work with people who draw on ethnic ancestral knowledge of healing are not clearly understood. For many immigrant communities in Canada, counselling psychologists do not know what ancestral knowledge holds significance for healing and wellness.

Practice. Theorists in counselling psychology have advocated for the integration of traditional or indigenous healing practices to better serve the growing diversity of the Canadian population (Arthur & Merali, 2005; France, Rodrígues, & Hett, 2004; Moodley & West, 2005). Arthur and Collins (2005b) have challenged counsellors "to expand their views about what constitutes counselling, where counselling is delivered, and what constitutes effective service provision" (p. 151). To meet these challenges it is necessary for researchers to provide practitioners with clinically relevant literature that explores the traditional healing methods of various ethnic groups.

Credibility refers to the client's perception of the counsellor's ability to provide effective care. As the narratives have shown, for counselling psychologists to facilitate wellness for this population, they must first understand the significance of suffering. Sue and Zane (1987) have argued that underutilization of services and premature termination of services by non-dominant populations is often due to the counsellor's lack of credibility. Salvendy (1999) believed that credibility is "fostered by conceptualising the patient's problem in a manner that is congruent with his/her culture" (p. 447). Torrey (1972) considered a "shared world-view [sic]" between

client and counsellor a necessary component of healing which mitigates negative outcomes (p. 13). Neither author advocates for privileging one conceptualization or worldview over the other; however, both strongly imply that global perspectives of healing and suffering are necessary to provide mental health services to people with ethnic heritages that favour values and beliefs that are not consistent with North American culture. Shweder (2003) referred to this as *pluralism*; neither one belief system nor the other is privileged but rather both are considered equal. Pluralism goes beyond simple tolerance and requires a depth as well as breadth of knowledge from non-dominant cultures. To promote pluralism, a complex understanding of values and belief systems not based in North American research is necessary.

As previous research has shown, Açoreans and other immigrant groups continue to access healers from their country of origin even after emigrating to North America (Csordas, 2004; Dein & Sembhi, 2001; James, 2002; Moodley & West, 2005; Vontress, 1999). Many authors caution that to assume healing techniques are appropriate and efficacious simply because they are culturally relevant to the client, is neither ethical nor in the client's best interest (Arthur & Merali, 2005; Constantine, Myers, Kindaichi, & Moore, 2004). Much of the literature on traditional healing practices is found in helping disciplines outside of counselling psychology, for example, medicine (Baskind & Birbeck, 2005; de Andrade, 2005; McMillen, 2003; Struthers, 2003; Yen & Wilbraham, 2003) and medical anthropology (Hallilburton, 2003; Raimo, 1999; Riley, 2001; Turner, 2004; Whitehead, 2000). Recently, the healing systems of the aboriginal peoples of Canada and the necessity to integrate these practices into counselling psychology practices have been evident in the literature (Blue & Darou, 2005; France, McCormick, & Rodrígues, 2004). Literature on the healing practices ascribed to by the Portuguese immigrant community is noticeably absent. This project provides knowledge of healing methods specific to this group that challenges the current counselling psychology discourse. Specifically, the role and existing significance of traditional healers for this population was illuminated, which

strongly suggests their relevance to counselling practice has been ignored by practitioners and academics.

The narratives presented in the current project help to develop multicultural competencies (Sue, Arrendondo, & McDavis, 1992) by expanding *cultural awareness* of Açorean immigrant beliefs and values, and challenging the existing dominant *cultural knowledge* thereby, leading to more informed *cultural skill*. Kleinman (2001) has clearly stated, "No science can restrict itself to knowledge produced in a single society…" (p. 15). Knowledge derived from societies outside of North America promotes humility and encourages pluralism by *de-exoticizing* traditional ways of healing.

Suffering in the World

Theory. Another significant contribution of this project is the expansion of the understanding of suffering and its place in the Açorean community. More specifically, this project further explicates the significance of suffering in how its meaning and relevance might impact the therapeutic process.

Earlier research with Açorean immigrants has characterized suffering as a means for "interpersonal compassion" within the community (James, 2002, p. 93):

> Participants develop a personal relationship with God through their bodily suffering and subsequent prayers for compassion. Similarly, a way to develop close relationships with others is to listen compassionately about bodily suffering, thus paralleling the relationship that they have with God" (p. 95).

Suffering plays a supportive role by engaging other community members and bringing together family and friends.

This was also evident in the numerous religious *festas* [celebrations] that took place in the short time I was in São Miguel where the community gathered and took part in rituals that were characterized by penance and sacrifice. Kleinman (1997) highlighted the purpose that

suffering appears to have in these *festas*, "The suffering body became [becomes] the meeting place for the human and the divine; healing became [becomes] the material manifestation of Christian power" (p. 322). In essence, suffering enabled the Açoreans to nurture relationships with the divine and with their community thus combating the deep sense of isolation of the islands. The process of suffering and healing in turn confirms their place in the world as good Christians.

To assume suffering serves a necessary purpose is counter intuitive to theories in counselling psychology and other helping disciplines that seek to minimize suffering and, in most cases, remove it. As Kleinman (1997) points out, the consequence of empirical science and its advancement is a tension between the redemptive value of suffering and our desire to control it:

> Many Americans, together with increasing numbers of people in other affluent societies, seem to regard suffering as something that no one need feel, that one can and should avoid, that is without any redeeming virtue, and as something to which society should respond primarily with the high technology that defines our age. (p. 332)

The early years of Christianity provide ample illustrations that reveal the relationship of suffering to personal prosperity and spiritual growth. St. Francis of Assisi (b. 1182) epitomizes the redeeming virtue of suffering. St Francis' interaction with a leper demonstrates how suffering holds beneficial powers rather than destructive control. St Francis spoke, "My son, be patient. Bodily ills are given to us in this world for the good of our souls, and they can be of great spiritual benefit to us" (Hopcke & Schwartz, 2006). St. Francis then performed a miracle by bathing the leper and "just as the skin was healed, so, too, did the man's soul begin to heal" (Hopcke & Schwartz, p. 79, 2006) .

The informants in the current study explicitly stated that conventional health care professionals often told them they were not sick when they sought treatment. In effect,

physicians and nurses failed to witness their suffering. It was at this point that community members sought help from traditional healers. The informants reported that healers would: listen to their conceptualization of the problem; accept the information even though they may change how the problem was labelled; and provide some kind of solution / action. For those community members who did not experience this witnessing with conventional health care practitioners, they did not get well, thus, they sought traditional healers.

In an ethnography investigating witchcraft in Western France, Favret-Saada (1980) found that the "unwitcher's[35] first task is [was] to authenticate his patient's sufferings" (p. 8). Traditional healers in the Açores effectively authenticated or witnessed the community member's suffering and, by providing a solution / action, they supplied a necessary conduit for divine power. Solutions and / or actions could be accepting advice [as with *as mulhers quem ler do livro*], physical contact [as with *endireitas*], the act of burning herbs [*defumadores*], prayer, consumptions of teas, or a ritual to remove evil spirits. In this way, traditional healers played an important role in the community; a role conventional health care practitioners did not fill. In this community, until the suffering the person is witnessed, there can be no healing of the soul.

Practice. Arthur and Collins (2005a) define counselling as a "purposeful and collaborative relationship in which the counsellor draws on psychological, health promotions, developmental and educational processes to facilitate wellness, personal growth, healing, problem solving, and healthy personal and interpersonal development within individuals, groups, communities, or larger systems" (p. 16). They further note that culture-infused or multicultural counselling is "the conscious and purposeful infusion of cultural awareness and sensitivity into all aspects of the counselling process and all other roles assumed by the counsellor or psychologist" (p. 16). Lalande (2004) considers counselling psychology in Canada to be

[35] Unwitcher is the translation of the term the researcher used to identify the person who reverses evil spells. The French term is *désorcelleur*.

"constantly evolving, not static;" however, the profession has not yet addressed the significance of suffering for people of non-dominant worldviews (p. 273). Western counselling practice assumes the desirability of change which contradicts the essential role of suffering and distress in this population. Hence, this project highlights the fact that, while counsellor and Açorean may frequently find themselves to be at cross purposes, traditional healers often have matched purposes when it comes to validating the suffering in their community.

This project is consistent with the findings of previous research that highlighted the significance of suffering for this immigrant group in Canada (James, 2002). Further, it has presented the role that traditional healers play in the Açores by witnessing suffering in contrast to the inherent problems that exist within a biomedical model that seeks to immediately eliminate suffering. Counselling psychologists are in a unique position among the health care professions to address this discrepancy in that the discipline typically focuses on "fostering and improving normal human function" (College of Psychologists of Ontario, as cited in Young & Nicole, 2007, p. 23).

This project provides a contextual understanding of *normal human functioning* for Açorean immigrants in Canada. Suffering is necessary and a common experience to bring community together and closer to the Divine. It is necessary to value suffering and to witness suffering to enable healing because through suffering; Açoreans are good Christians, or good people. Traditional healers provide this in the Açorean community when suffering is not witnessed by conventional health care givers.

Language

My intent as a researcher was to understand how traditional healers in the Açorean Islands facilitate wellness in people suffering from illness. Ethnography was chosen as the means to answer this question because it "is more than a 1-day hike through the woods. It is an ambitious journey through the complex world of social interaction" (Fetterman, 1998, p. ix).

Ethnographers are committed to studying meaning and culture is understood to structure meaning (Miller, Hengst, & Wang, 2003). Although the methodology was initially chosen because it was consistent with the type of information the inquiry sought to understand, i.e. cultural knowledge, the methodology became a key component of the findings and directly served to challenge current multicultural counselling theory and practice. By immersing myself in the community, I became acutely aware of the difficulties presented by translating the language of suffering and the concepts of psychological distress. Counselling psychology is silent on how practitioners can negotiate these difficulties when working in English with second language English speakers.

The situation created by ethnography curiously parallels the therapeutic relationship where the counsellor [researcher] must communicate an understanding to the client [informant] in order to build a therapeutic [productive] relationship. The counsellor [researcher] attempts to access information from the client [informant] that may only be partially accessible to the client [informant]. This, Kleinman (1988) believes, is where ethnography and counselling converge. Therefore, as I indicated in the Preface of this work, my process as a researcher developed relevant and necessary questions to further advance multicultural counselling theory and practice. The difficulties I faced in the field as a researcher provided valuable information that challenges the dominant ways of providing mental health services to people of non-dominant ethnicities. The first difficulty I encountered was my frustrated attempts to translate concepts that did not share what Favret-Saada (1980) has described as a "relationship in meaning" (p. 13). Second, I struggled to understand the language my informants used to describe their distress and their healing; this created what I named a *meaning gap*. In light of these difficulties, the impact on theory and practice are discussed in the following sections.

Theory. Collecting data illuminated the complexity of translating concepts and language from one culture/language to another and is a significant finding of this project. The problems I

encountered as a first language English speaker in a Portuguese speaking community highlight many significant questions for counselling psychology researchers and practitioners. There is a distinct lack of theory for practitioners to draw on regarding the effects of second language use in counselling practice. For example, we do not understand the impact a second language has on the counsellor's ability to communicate empathy. This meaning gap is more prevalent than is acknowledged by counselling psychologists.

Sixty-one percent of the immigrants who came to Canada in the 1990s reported speaking a non-official language in their home (Statistics Canada, 2003). Language is often cited as a significant barrier for immigrants who seek mental health services (Constantine, Myer, Kindaichi, & Moore, 2004); however, the topic is noticeably absent from the multicultural counselling literature. In a content analysis of the *Journal of Counseling and Development,* which reported the focus of 102 multicultural-centered articles, "language" was not listed among the topics discussed during the previous 10-year period (Arrendondo, Rosen, Rice, Perez, & Tovar-Gamero, 2005). Further to this, in text books dedicated to culture and counselling, the impact of language was not discussed as a separate and unique topic (Arthur & Collins, 2005a; France, Rodrígues, & Hett, 2004; Harper & McFadden, 2003; Sue & Sue, 2003). In fact, in *Culture and Counselling: New Approaches* (Harper & McFadden, 2003) the subject index indicated that language and communication were only discussed on 4 of the total 414 pages. In Canada, Collins and Arthur (2005c) began a discussion of the effects of language proficiency and the language barriers that arise when "the counsellor and the client are unable to communicate clearly in either the language of the counsellor or the language of the client" (p. 122); however, this discussion is based on experience and not systematic research. We have not even begun to understand what is lost when a client's experiences are communicated in the counsellor's language and not the client's.

Collecting data in the Açores required a negotiation between researcher and informant for the purpose of finding a shared translation of concepts from biomedical discourse to colloquial discourse, and vice versa. The inherent problem was that attempts to translate across paradigms, those of folk healing and biomedical healing, forces a conversion of discourses that do not have a "relationship in meaning" (Favret-Saada, 1980, p. 13). The informants initially reacted to my inquiries with laughter and by devaluing their ancestral knowledge. Favret-Saada (1980) described this problem in the following way:

> **…**when a bewitched person talks to an ethnographer, who is supposed to hold only the official theories on misfortune, he starts to talk about himself in just the same way as he would to the doctor, the teacher, and the ethnographer. He says that he only has a distant, indirect knowledge of spells, as well as of the *superstitions of the backward people* or the *beliefs of the old folk*… (Italics in original, p. 15)

This was clearly depicted by the young woman in the current study who described a situation where a *curandeiro* relieved suffering for her son and for herself, yet she denied having knowledge of the usefulness of *curandeiros*. This young woman was not an ongoing informant but rather was interviewed once by an Açorean research assistant.

Through the negotiation with ongoing informants [i.e., informants that contributed to the research over time] a pattern of *languaging* emerged that reflected the informant's process of communicating traditional ways to a contemporary health care giver/researcher. As previously stated, the pattern was: laughter, denial, disbelief, second-hand knowledge, disclosure. As I became more familiar with my environment and comfortable with the lack of specificity that was grounded in my life experience, I was able to enter into a discourse that better illuminated the values and beliefs I set out to understand. Favret-Saada (1980) described her process of developing *a way to do* her research:

> I therefore established, as a methodological principle, that the discourse of witchcraft and, for example, the scholarly terminology … cannot be interchangeable: since peasants know both and can use both, we must assume that referring to one or to the other does not involve the same relationship of meaning. (p. 13)

This calls into question the validity of qualitative methods traditionally used by counselling psychologists that favour more point-in-time techniques, such as in-depth interviews, to elucidate cultural knowledge. Single interviews with Açorean community members would have failed to expose the difficulties in communication that I faced in the Açores. Ponterotto (2005) considers these methods as "examples in postpositivizing" and lacking a sophisticated grounding in qualitative theory (p. 127). Methodologies based on theories within anthropology, such as ethnography, have become popular in educational research (Jeffery & Troman, 2004); however, ethnography is not yet widely used in counselling psychology.

This project advocates the use of ethnography as a research methodology to develop more complex concepts of facilitating wellness in people who have distinctly different concepts of wellness than are represented in current theories. A deeper understanding of values and beliefs around healing and wellness will develop richer more complex theories in multicultural counselling. The current lack of awareness of the influence of our culturally learned assumptions directly contradicts the Multicultural Cultural Competencies outlined in the Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2002).

The profession has not developed theories of the impact of language and communication on the counselling process. Until now, it is assumed that language barriers are defined as the inability to communicate fluently in a shared standard language between counsellor and client. The process of negotiating a shared language between me and my informants went far beyond translating words from Portuguese and English and vice versa. Communication improved when I

became comfortable with the ambiguity and lack of specificity in their responses; in effect, our communication improved when I stopped translating words, phrases, and concepts into my frame of reference. Theories in counselling psychology do not address the affects of this manner of translation in the moment by moment process of counselling. Without further development in this area, we risk remaining *culturally encapsulated* by continuing to translate ethnic systems of healing into practices and procedures developed within the North American zeitgeist.

The Meaning Gap: Practice. Beyond the necessary negotiation created by the concepts that did not have the *same relationship of meaning* described above, I faced two more specific problems at the level of language translation: I experienced a tension that limited my ability to receive relevant information when my informants used Portuguese words that, when directly translate to English, held a different meaning for me. Furthermore, I was not able to convey a sense of understanding when my informants described their distress in local Portuguese terms. These difficulties have implications for research and for practice; both inhibited my ability to receive information as a researcher and to fully communicate understanding to my informants, and both are an integral part of developing a productive research relationship and a productive therapeutic alliance.

The informants would often want to frame my research as dealing with *doença de mentais* [directly translates to illness/disease/sickness of the mental]. I struggled with translating this phrase into English. The direct translation was reminiscent of a derogatory term used in Nova Scotia, my childhood home, to describe the *crazy*, *insane,* or *less educated*. Even though I was cognizant that these feelings were a direct result of *my* literal translation and not the intention of the informants, I felt uncomfortable that my research would not be taken seriously and that I was using terminology that did an injustice to the topic. This caused a *meaning gap* between me and my informants; a benign phrase for my informants caused a tension for me that limited my ability to receive and process relevant information.

Another example of a problem created by language that inhibited my ability to receive information was in my relationship with Luis[36]. Luis and I spoke mostly in English. He consistently referred to psychiatry and psychiatrists when describing how Açoreans were let down by mental health services in North America. Luis also used terms like "crazy" and "insane to describe how North American practitioners conceptualized distress. In our initial meetings, I was more concerned with clarifying my discipline as counselling psychology and *not* psychiatry, and my profession as psychologist and *not* psychiatrist. I was preoccupied that we were talking about people who were *crazy,* which I felt showed disrespect to those in distress. In effect, my meaning of these English words caused me to react as though Luis was being disrespectful and lacking in professional credibility.

The *meaning gap* that I experienced as a researcher in the field and in trying to analyze the data directly parallels the situation created in therapy sessions when the first language of the client and counsellor differ. Literature suggests that language barriers often put clients whose first language is not English at risk of misdiagnosis or at the least at risk of having their problems misinterpreted or distorted (Marcos, 1976). A meta-analysis that included 76 studies that reviewed culturally adapted interventions found that interventions conducted in the first language of the client were twice as effective as interventions conducted in English when English was not the first language of the client (Griner & Smith, 2006). The study did not, however, provide any reasons as to why interventions in a second language are not as effective or suggest ways to remedy these problems. Multicultural literature is silent on how inaccurate perceptions that are an artefact of language translation affect the therapeutic process and the counsellor's ability to perform. As well, little is understood concerning how language affects the

[36] It is important for the reader to remember that Luis is a health care professional that practiced in both the Açores and in North America.

ability to communicate empathy, which is a necessary component of the therapeutic alliance (Wampold, 2001).

Oquendo (1996) noted that working with non-first-language English speakers is further "complicated because the rich web of meaning and associations that a word has in one language cannot be accurately conveyed by merely translating the word" (p. 615). *Esgotament* held meaning for all my informants; however, I was unable to convey a sense of understanding and empathy for this idiom of distress. The question of how language affects a counsellor's ability to "crawl into the skin" of their client in a multicultural therapeutic relationship has not been adequately addressed (Stermac, 2005, p. 275).

Limitations

The depth of engagement that ethnography provides is by far the most valuable aspect of ethnography and makes it a desirable choice for elucidating cultural knowledge; however, the findings must be considered in light of the limitations of the methods. I travelled to the Açorean Islands to access cultural knowledge. I prepared by developing a strong knowledge base and understanding of the community and while on the islands, I attempted to become part of a community to enable me to access this information. The extent of the effects of me being an outsider cannot be known and, as such, the findings must be considered as my re-telling and my interpretation of the information my informants chose shared with me.

The goal of my research was to gather information about traditional healers and the way they helped the community to alleviate distress. I initiated contact in many different ways; I joined a local yoga group, I commenced language training at two different locations, I introduced myself to people in public places [i.e., stores, the public library, tourism shops, restaurants, and café], I accessed professionals in the community and at the local university. In these settings I talked openly and often about my research; these contacts led to other contacts and so on. As such, the informants who had stories to tell lead me to other informants who had stories to tell.

Although it was not my goal to access stories of people who *did not* access traditional healers, the reader is advised that an alternate view on the position of traditional healers in the community does exist.

Ethnography is highly situated in time and place and, as such, must be accompanied by a note explaining that findings represent an interpretation of the informant's stories that existed in that particular time and place. It is a human desire to generalize information to make sense of our world; however, it is not a goal of ethnographic research to produce generalizable knowledge. The reader is cautioned that the experience of the informants in this study should not be unilaterally generalized to other Açoreans or to the experience of other ethnic populations.

Another limitation of this study was my Portuguese language ability. Portuguese is a language I acquired later in life and, although I lived in a Portuguese speaking country for 2 years and I received extensive language training, I would not be considered fluent. This limited my ability to communicate freely in the Açorean community; alternatively, the benefit that was realized was the deeper understanding of working in a second language. As well, the time I spent in the field [February 2006 to May 2006] could also be considered a limitation. Anthropologists do not identify a definitive time necessary to conduct field work; however, there is a general assumption that more time equates with a more complex understanding of values and beliefs.

The reader is advised to consider that the findings of this project ask more questions than they supply answers, and additional research is needed to strengthen the interpretations. For example, more time in the field might have explicated more fully the *patterns of negotiation* in understanding issues that were unique to this culture or if this pattern could be the basis for a model of cross-cultural communication. As I struggled to understand meaning, the crux of anthropological studies, I remained cognizant of my professional role as a counselling psychologist and specifically, a multicultural counsellor. As a result, I made choices to access knowledge that focused on understanding the impact of meaning on counselling and

relationships rather than trying to understand meaning as it related to the community. In effect, I focused on the *meaning* of the difficulties I found in accessing information, making sense of information, and communicating an understanding of this information.

Future Research

Previous research has shown the significance of suffering in this immigrant community in Canada (James, 2002). The narratives provided by the informants in the current study highlighted the role that traditional healers played in witnessing the suffering of the community in the Açores. Research within different cultures would contribute additional insight into the role of other traditional healers, and better inform practitioners concerning the significance of traditional healers for other immigrant communities in Canada.

Research is also needed in order to ascertain if North American practitioners can provide a witness to suffering for this community. This would be the next step in transforming acquired knowledge into concrete strategies and interventions that would improve care to Açorean immigrants in Canada. In the same vein, research that seeks to understand the usefulness of the acquired knowledge of Açorean traditional healers for enhancing the credibility of the counsellor is also needed.

The issues created by providing care in English to second-language English speakers have not been adequately explored and, as such, professional guidelines do not exist. A much deeper exploration of the impact of the use of a second language on the therapeutic alliance is needed. The impact of not having a felt sense for words used by immigrants to communicate distress and illness on the practitioner's ability to communicate empathy needs to be explored and conveyed to practitioners.

Research has shown that level of acculturation tends to affect help-seeking behaviours in immigrants in that acculturation has an inverse relationship to traditional healer utilization and the use of indigenous or folk healing methods (Constantine, Myers, Kindaichi, & Moore, 2004).

The current project suggests that, in the Açores, stage of life is an indicator of utilization of traditional healers; as generations age, they are more apt to rely on traditional healers than they were in their youth. Further research is necessary to determine if this pattern persists with those Açorean immigrants who do not return to their ancestral country to live, or if acculturation in the host country does indeed reduce the likelihood of relying on traditional methods in times of need. This would give us a better understanding of how ancestral knowledge is passed down and maintained by immigrants in host countries.

Concluding Remarks

This project, grounded in counselling psychology, utilized concepts and methodologies from anthropology to explore the culture of healing in the Açorean Islands of Portugal. Specifically, the research question that guided this inquiry was: How do traditional healers in the Açorean Islands facilitate wellness in people suffering from illness? The narratives provided by this research project explicate the value and process of traditional healing in the Açorean Islands from the perspective of the community members. These narratives represent a contribution to the literature which has previously been unavailable to North American health care practitioners. As well, this project has expanded on the concept of suffering and provided practitioners with significant information regarding the value of traditional healers and the process of suffering for the Açorean community. Furthermore, this project raises important questions about the use of second languages in counselling and therapy. Finally, the findings of this project strongly support the utilization of ethnography as a means for collecting data and as a philosophical foundation for research in counselling psychology. The ultimate goal is to engage practitioners, educators, and researchers in a dialogue that challenges the dominant discourse in counselling psychology

BIBLIOGRAPHY

Al Krenawi, A., & Graham, J. R. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. *National Association of Social Workers, 25*, 9-22.

American Psychological Association. (2002). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists.Retrieved March 11, 2005, from http://www.apa.org/about/division/guide.html.

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (DSM-IV-TR). Washington, DC: Author.

Anderson, J. M. (2000). The history of Portugal. Westport, CT: Greenwood.

Anderson, G. M., & Higgs, D. (1976). A future to inherit: The Portuguese communities of Canada. Toronto: McClelland & Stewart.

Angrosino, M. V., & Mayes de Peres, K. A. (2000). Rethinking observation: From method to context. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research*. Thousand Oaks, CA: Sage.

Arredondo, P., & Perez, P. (2006). Historical perspectives on the multicultural guidelines and contemporary applications. *Professional Psychology: Research and Practice, 37*, 1-5.

Arredondo, P., Rosen, D. C., Rice, T., Perez, P., & Tovar-Gamero, Z. G. (2005). Multicultural counseling: A 10-year content analysis of the *Journal of Counseling and Development. Journal of Counseling and Development, 83*, 155-161.

Arthur, N & Collins, S. (2005a). *Culture-infused counselling: Celebrating the Canadian mosaic*. Calgary, Alberta: Counselling Concepts.

Arthur, N., & Collins, S. (2005b). Introduction to culture- infused counselling. In N. Arthur & S. Collins (Eds.). *Culture-infused counselling: Celebrating the Canadian mosaic* (pp. 3-40). Calgary, Alberta: Counselling Concepts.

Arthur, N., & Collins, S. (2005c). Expanding culture-infused counselling in professional practice. In N. Arthur & S. Collins (Eds.). *Culture-infused counselling: Celebrating the Canadian mosaic* (pp. 151- 212). Calgary, Alberta: Counselling Concepts.

Arthur, N., & Merali, N. (2005). Counselling immigrants and refugees. In N. Arthur & S. Collins (Eds.). *Culture-infused counselling: Celebrating the Canadian mosaic* (pp. 331-360). Calgary, Alberta: Counselling Concepts.

Basic Behaviour Science Task Force of the National Advisory Mental Health Council (1996). Basic behavioural science research for mental health: Sociocultural and environmental processes, *American Psychologist,* 51, 722-731.

Baskind, R., & Birbeck, G. (2005). Epilepsy Care in Zambia: A study of traditional healers. *Epilepsia, 46,* 1121-1126.

Bezanson, B. J, Foster, G., & James, S. (2005). Herbalistas, Curandeiros and Bruxas: Lessons from Traditional Systems of Healing. In R. Moodley & W. West (Eds.). *Integrating traditional healing practices in counselling and psychotherapy*. Thousand Oaks, CA: Sage.

Blue, A., & Darou, W. (2005). Counselling First Nations peoples. In N. Arthur & S. Collins (Eds.). *Culture-infused counselling: Celebrating the Canadian mosaic* (p. 303-330). Calgary, Alberta: Counselling Concepts.

Bojuwoye, O. (2001). Crossing cultural boundaries in counseling. *International Journal for the Advancement of Counseling, 23*, 31-50.

Brown, K. (2001). (Ng)amuk revisited: Emotional expression and mental illness in Central Java, Indonesia. *Transcultural Psychiatry, 38,* 147-165)

Chambers, E. (2003). Applied ethnography. In N. K. Denzin & Y. S. Lincoln (Eds.), Collecting and interpreting qualitative materials (pp. 389-418). Thousand Oaks, CA: Sage.

Chandler, M., & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry, 35*, 191-219.

Christopher, J. C. (1996). Counseling's inescapable moral visions. *Journal of Counseling and Development, 75*, 17-25.

Constantine, M. G., Myers, L. J., Kindaichi, M., & Moore, J. L. (2004). Exploring indigenous mental health practices: The roles of healer and helpers in promoting well-being in people of color. *Counseling and Values, 48*, 110-125.

Clark, A. J. (2007). *Empathy in counselling and psychotherapy.* Mahwah, NJ: Earlbaum.

Crawford, T. A. & Lipsedge, M. (2004). Seeking help for psychological distress: The interface of Zulu traditional healing and Western biomedicine. *Mental Health, Religion & Culture, 2*, 131-148.

Csordas, T. J. (2004). Healing and the human condition: Scenes from the present moment in Navajoland. *Culture, Medicine & Psychiatry, 28*, 1-14.

Davis, D. L., & Joakimsen, L. M. (1997). Nerves as status and nerves as stigma: Idioms of distress and social action in Newfoundland and Norway. *Qualitative Health Research*, *7*, 370-390.

de Andrade, V. (2005). Beliefs and practices of Black South African traditional healers regarding hearing impairment. *International Journal of Audiology, 44*, 489-499.

Dein, S., & Sembhi, S. (2001). The use of traditional healing in South Asian psychiatric patients in the UK: Interactions between professional and folk psychiatries. *Transcultural Psychiatry, 38*, 243-257.

Denzin, N. K., & Lincoln, Y. S. (2003a). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 1-45). Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (2003b). Introduction: The discipline and practice of qualitative research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The landscape of qualitative research: Theories and issues* (2ed., pp. 131-166). Beverly Hills, CA: Sage.

Dewalt, K. M., & Dewalt, B. R. (2000). Participant Observation. In H. R. Bernard (Ed.), *Handbook of methods in cultural anthropology* (pp. 259-299). Walnut Creek, CA: AltaMira.

Emilio, C. C. (1990). *Azorean Folk Customs, Limited Edition*, San Diego, CA: The Portuguese Historical Center.

Ehrman, B. D. (2006). Peter, Paul, & Mary Magdalene: The followers of Jesus in history and legend. NY: Oxford.

Favret-Saada, J. (1977). Deadly words: Witchcraft in the Bocage (C. Cullen, Trans). London: Cambridge.

Fetterman, D. M. (1998). *Ethnography: Step by step.* Thousand Oaks, CA: Sage.

Fink, S. (2003). International efforts spotlight traditional, complementary, and alternative medicine. *American Journal of Public Health, 92*, 1743-1739.

Fischer, A. R., Jome, L. M., & Atkinson, D. R. (1998). Back to the future of multicultural psychotherapy with a common factors approach. *Counseling Psychologist, 26*, 602-606.

Fraga, E. D., Atkinson, D. R., & Wampold, B. E. (2004) Ethnic group preference for multicultural counseling competencies. *Cultural Diversity and Ethnic Minority Psychology. 10*, 53-65.

France, M. H., McCormick, R., & Rodrígues, M. C., (2004). Issues in counselling in the First Nations community. In M. H. France, M. C. Rodrígues, & G. G. Hett (Eds.). *Diversity, culture, and counselling: A Canadian Perspective* (pp. 59-76). Calgary, Alberta: Detselig Enterprises.

France, M. H., McCormick, R., & Rodrígues, M. C., (2004). The "red road": Culture, spirituality and the scared hoop. In M. H. France, M. C. Rodrígues, & G. G. Hett (Eds.). *Diversity, culture, and counselling: A Canadian Perspective* (pp. 265-281). Calgary, Alberta: Detselig Enterprises

France, M. H., Rodrígues, M. C., & Hett, G. G. (Eds.), (2004). *Diversity, culture, and counselling: A Canadian Perspective.* Calgary, Alberta: Detselig Enterprises.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy*. Baltimore, MD: Johns Hopkins University.

Fuertes, J. N., & Brobst, K. (2002). Clients' ratings of counselor multicultural competency. *Cultural Diversity & Ethnic Minority Psychology, 8*, 214-223.

Fukuyama, M. A. (1990). Taking a universal approach to multicultural counseling. *Counselor and Education & Supervision, 30*, 6-18.

Gadit, A, A, (2003). Health services delivery by shamans: A local experience in Pakistan. *International Journal of Mental Health*, *32*, 63-82.

Geertz, C. (1973). *The interpretation of culture*. New York: Basic Books.

Griner, D., & Smith, T. (2006). Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training, 43*, 531-548.

Guarnaccia, P. J. (1993). Ataques de nervios in Puerto Rico: Culture-bound syndrome or popular illness? *Medical Anthropology, 15*. 157-170.

Guill, J. H. (1993). *A history of the Açorean Islands.* Tulare, CA: Golden Shield.

Halliburton, M. (2003). The importance of a pleasant process of treatment: Lesson on healing from South India. *Culture, Medicine, & Psychiatry, 27,* 161-186.

Hammersley, M., & Atkinson, P. (1995). *Ethnography: Principles in practice*. New York: Routledge.

Hansen, N. D., Randazzo, K. V., Schwartx, A., Marshal, M., Kalis, D., Frazier, R., et al. (2006). Do we practice what we preach? An exploratory survey of multicultural psychotherapy competencies. *Professional Psychology: Research and Practice, 37*, 66-74.

Harper, F. D. (2003). Background: Concept and history. In F. D. Harper & J. McFadden (Eds.), *Culture & counseling: New approaches*. Boston, MA: Pearson Education.

Haverkamp, B. (2005). Ethical perspectives on qualitative research in applied psychology. *Journal of Counseling Psychology, 52*, 146-155.

Heilbron, C., & Guttman, M. (2000). Traditional healing methods with First Nations women in group counselling. *Canadian Journal of Counselling, 34*, 3-11.

Hopcke, R. H & Schwartz. P. A. (2006). Little flowers of Assisi. Boston, MA: New Seeds.

Ibrahim, F. A. (1985). Effective cross-cultural counseling and psychotherapy: A framework. *The Counseling Psychologist, 13*, 625-638.

Stermac, L (2005). In the therapist's chair: Professor Lana Stermac in conversation with Dr. Pittu Laungani *Counselling Psychology Quarterly, 18*, 261-276.

James, S (2006). Investigating the discrepancy between immigrant and medical conceptualization of symptoms. Unpublished raw data.

James, S. (2002). Agonias: The social and sacred suffering of Azorean Immigrants. *Culture, Medicine, and Psychiatry*, *26*, 87-110.

James, S. & Clarke, J. (2001). Surplus suffering: The case of Portuguese immigrant women. *Feminist Review*, *68*, 167-170.

James, S. & Prilleltensky, I. (2002). Cultural diversity and mental health: Towards integrative practice. *Clinical Psychology Review, 22*, 1133-1154.

James, S., Slocum, S., & Zumbo, B. (2004). Measuring *agonias* among female Portuguese immigrants: Construct description and psychometric properties. *International Journal of Testing, 4,* 183-188.

James, S., Navara, G. S., Clarke, J., & Lomotey, J. (2005). An inquiry into the "agonies" (*agonias*) of Portuguese immigrants from the Azores. *Hispanic Journal of Behavioral Sciences, 27,* 547-564.

James, S., Navara, G. S., Lomotey, J. & Clarke, J. (2006). From ancestral knowledge to clinical practice: The case of *agonias* and Portuguese psychotherapists. *International Journal of Clinical & Health Psychology,6, 441-454*

Janesick, V. J. (2003). The choreography of qualitative research design. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 46-79). Thousand Oaks, CA: Sage.

Jeffery, B., & Troman, G. (2004). Time for ethnography. *British Educational Research Journal, 30*, 536-548.

Johnson, J. (2000). Research design and research strategies. In H. R. Bernard (Ed.), *Handbook of methods in cultural anthropology* (pp. 131-171). New York: AltaMira.

Kleinman, A. (2004). Culture and depression. *New England Journal of Medicine, 351*, 951-953.

Kleinman, A. (2001). Why psychiatry and cultural anthropology still need each other. *Psychiatry, 64,* 14-16.

Kleinman, A. (1997). "Everything that really matters": Social suffering, subjectivity, and that remaking of human experience in a disordering world. *Harvard Theological Review, 90,* 315-335.

Kleinman, A. (1996). *Writing at the margin: Discourse between anthropology and medicine*. Berkeley, CA: University of California.

Kleinman, A. (1988*). The illness narratives: Suffering, healing & the human condition*. New York: Basic Books.

Kleinman, A. (1987). Anthropology and psychiatry: The role of culture in cross-cultural research on illness. *British Journal of Psychiatry, 151*, 447-454.

Kleinman, A. (1980*). Patients and healers in the context of culture: An exploration of the borderline between anthropology, medicine, and psychiatry*. Berkeley, CA: University of California.

Kleinman, A., & Becker, A. (1998). Sociosomatics: The contribution of anthropology to psychosomatic medicine. *Psychosomatic Medicine, 60*, 389-393.

Koss-Chioino, J. D. (2000). Traditional and folk approaches among ethnic minorities. In J. F. Aponte & J. Wohl (Eds.) *Psychological Interventions & Cultural Diversity*. Needham Heights, MA: Allyn & Bacon

Krause, I-B. (2003). Learning how to ask in ethnography and psychotherapy. *Anthropology & Medicine, 10,* 3-21.

Lalande, V. M. (2004). Counselling psychology: A Canadian perspective. *Counselling Psychology Quarterly, 17*, 273-286.

Like, R., & Beck, J. B. (nd). Criteria, beliefs, and practices pertaining to mental illness among rural Azoreans. Unpublished manuscript.

Like, R. (August, 1978). Attitudes toward mental illness in a rural Azorean parish: A preliminary study. Paper presented at the 1'st Congress of Azorean Commities, Angra Do Heroismo, Terceira, Azores.

Like, R. (1978/1979). *Dicionário do termos populares de medicina*. [Dictionary of popular medical terms]. Unpublished manuscript.

Like, R. (April, 1979). *Portuguese popular health culture: A discussion of three case histories.* Paper submitted to the Committee for Graduation Prized and Awards for Research at Harvard Medical School, Boston, MA.

Lincoln, Y. S., & Guba, E. G. (2003). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The landscape of qualitative research: Theories and issues* (pp. 131-166). Beverly Hills, CA: Sage.

Marcos, L.R. (1976). Bilinguals in psychotherapy: Language as an emotional barrier. *American Journal of Psychotherapy, 30*, 552-560

McCabe, G. H. (2007). The healing path: A culture and community-derived indigenous therapy model. *Psychotherapy: Theory, Research, Practice, Training, 44*, 148-160.

McCabe, M. L. & Thomas, J. D. (1998). *Portuguese spinners: An American story*. New Bedford, MA; Spinners.

McCormick, R. (1995). The facilitation of healing for the First Nations people of British Columbia. *Canadian Journal of Native Education*, 2, 249-319.

McCormick, R., & Ishiyama, I. (Eds.) (2000). Special issue: Counselling First Nations peoples in Canada. *Canadian Journal of Counselling*, 34, 3-67.

McMillen, H. (2004). The adapting healer: Pioneering through shifting epidemiological and sociocultural landscapes. *Social Science & Medicine, 59*, 889-902.

Miller, P. J., Hengst, J. A., & Wang S. (2003). Ethnographic methods: Applications from developmental cultural psychology. In P. M. Camic, J. E. Rhodes & L. Yardley (Eds.), *Qualitative research in psychology: Expanding descriptives in methodology* (pp. 219-243). Washington, DC: APA.

Moodley, R. (1999). Challenges and transformations: Counselling in a multicultural context. *International Journal for the Advancement of Counselling*, 21, 139-152.

Moodley, R., & West, W. (2005). Introduction. In M. Moodley & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. xv-xxvii). Thousand Oaks, CA: Sage.

Morrow, S. L. (2007). Qualitative research in counseling psychology: Conceptual foundations. *The Counseling Psychologist, 35*, 209-235.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counselling psychology. *Journal of Counselling Psychology, 52*, 250-260.

Morrow, S. L., & Smith, M. L. (2000). Qualitative research for counseling psychology. In S. D. Brown & R. W. Lent (Eds.), Handbook of counseling psychology (3rd ed., pp. 199-230). New York: Wiley.

Namora, F. (1956). *Mountain Doctor* (D. Ball, Trans.). London: William Kimber.

Namora, F (1979). *Retalhos da vida de um medico* [Remnants of the life of a doctor]. (22nd ed.) Lisboa, Portugal: Livaria Bertrand.

Noivo, E. (1997). *Inside ethnic families: Three generations of Portuguese-Canadians.* Montreal/Kingston; McGill-Queens University Press.

Oquendo, M. (1996). Psychiatric evaluation and psychotherapy in the patient's second language. *Psychiatric Services, 47*, 614-618.

Patterson, C. H. (1996). Multicultural counseling: From diversity to universality. *Journal of Counseling and Development, 74*, 227-231.

Pedersen, P. B. (2001). Multiculturalism and the paradigm shift in counselling: Controversies and alternative futures. *Canadian Journal of Counselling*, 35, 15-25.

Pedersen, P. B. (1997a). Recent trends in cultural theories. *Applied & Preventive Psychology, 6*, 221-231.

Pederson, P. B. (1997b). The cultural context of the American Counseling Associations code of ethics. *Journal of Counseling and Development*, *76*, 23-28.

Pedersen, P. B. (1991). Multiculturalism as a fourth force in counseling [Special Issue]. *Journal of Counseling and Development, 70*, 4.

Pedersen, P. B., Crethar, H. C., & Carlson, J. (2008). *Inclusive cultural empathy: Making relationships central in counselling and psychotherapy*. Washington, DC: American Psychological Association.

Pelto, P., & Pelto, G. (1996). Research designs in medical anthropology. In C. F. Sargent & T. M. Johnson (Eds.), *Medical anthropology: Contemporary theory and method, revised edition.* Westport, CT: Praeger.

Perry, M. E., & Cruz, A. J. (Eds.), *Cultural encounters: The impact of the Inquisition in Spain and the New World* Berkeley, California: University of California.

Poelzl, V. (2004). *Culture shock! A guide to customs and etiquette, Portugal*. Portland, OR: Graphic Arts Center.

Ponterotto, J, G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52*, 126-136.

Ponterotto, J. G., Fuertes, J. N., & Chen, E. C. (2000). Models of multicultural counseling. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (pp. 639-669). New York: John Wiley.

Poonwassie, A. & A. Charter. (2001). An Aboriginal view of helping: Empowering approaches. *Canadian Journal of Counselling*, 35, 63-73

Pope-Davis, D. B., Ligiero, D. P., Liang, C., & Codrington, J. (2001). Fifteen years of the Journal of Multicultural Counseling and Development: A content analysis. *Journal of Multicultural Counseling and Development, 29*, 226-238.

Quezada, N. (1991). The Inquisition's repression of curandeiros. In M. E. Perry & A. J. Cruz (Eds.), *Cultural encounters: The impact of the Inquisition in Spain and the New World* (pp. 24-37). Berkeley, California: University of California.

Raimo, P. (1999). Abdul Qadir: a portrait of a Saudi healer. *Suomen Antropolgi, 4*, 131-141.

Raybeck, D. (2000). Getting below the surface. In P. R. DeVita (Ed.), *Stumbling towards truth: Anthropologists at work* (pp. 17-30). Prospect Heights, IL: Waveland.

Riley, M. (2001). The Traditional Medicine Research Center (TMRC): A potential tool for protecting traditional and tribal medicinal knowledge in Laos. *Cultural Survival Quarterly, 24*, 21-24.

Robinson, D. T, & Morris, J. R. (2000). Multicultural counseling: Historical context and current training considerations. *The Western Journal of Black Studies, 24*, 239-253.

Sadeghi, M., Fischer, J. M., & House, S. G (2003). Ethical dilemmas in multicultural counseling. *Journal of Multicultural Counseling and Development*, *31*, 179-191.

Salvendy, J, T. (1999). Ethnocultural considerations in group psychotherapy. *International Journal of Group Psychotherapy, 49*, 429- 464.

Saramago, J. (2000). *Journey to Portugal: In pursuit of Portugal's history and culture* (A. Hopkinson & N. Caistor, Trans.) New York: Harcourt. (Original work published 1990).

Sayers, D. (2004). *Azores: The Bradt travel guide*. Guildford, CT: Globe Pequot.

Shweder, R. (2003). *Why do men barbeque?: Recipes for cultural psychology.* Cambridge, MA: Harvard University Press.

Stake, R. E. (2003). Case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 134-164). Thousand Oaks, CA: Sage.

Silva, S (2003). Romeiras ocultas: a mulher num ritual masculine de São Miguel; Hidden religious pilgrims: Women in a masculine ritual of São Miguel. In Rosa Maria Neven Simas (Ed.), *A mulher nos Açores e nas communidades; Women in the Azores and the immigrant community* (pp. 251-261). Ponta Delgada, Sao Miguel: Empresa Gráfica Açoreana.

Spanierman, L. B. & Poteat, V. P. (2005). Moving beyond complacency to commitment: Multicultural research in counseling psychology. *The Counseling Psychologist, 33*, 513-523.

Statistics Canada (2003). *Canada's ethnocultural portrait: The changing mosaic.* Retrieved May 2, 2007, from http://www12.statcan.ca/english/census01/products/analytic/companion/etoimm/ pdf/96F0030XIE2001008.pdf

Statistics Canada. (2001). *Census of population: Ethnic origin*. Retrieved June 8, 2005, from http://www12.statcan.ca/english/census01/products/highlight/ETO/Table1.cfm?Lang=E&T=501&GV=1&GID=0

Stewart, A. (1998). *The ethnographer's method*. Thousand Oaks. CA: Sage

Struthers, R. (2003). The artistry and ability of traditional women healers. Health Care for Women International, 24, 340-354.

Sue, D. W., Arrendondo, P., & McDavis, R. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development*, 70, 477-486.

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice*. New York: John Wiley.

Suzuki, L. A., Ahluwalia, M. K., Mattis, J. S., & Quizon, C. A. (2005). Ethnogrpahy in counseling psychology research: Possibilities for application. *Journal of Counseling Psychology, 52,* 206-214.

Sabatier, P. (1894). The road to Assisi: The essential biography of St. Francis (J. M. Sweeney, Editor). Brewster, MA: Paraclete.

Tedlock, B. (2000). Ethnography and ethnographic representation. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 455-486). Thousand Oaks, CA: Sage.

The Green Guide: Portugal, Madeira, The Azores, (2001). Herts, UK: Michelin Travel Publications.

Tierney, G. (2002). Becoming a participant observer. In M. V. Angrosino (Ed.), *Doing cultural anthropology: Projects for ethnographic data collection* (pp. 9-18). Prospect Heights, IL: Waveland.

Torrey, E. F. (1972). *The mind game: Witchdoctors and psychiatrists*. New York: Emerson Hall.

Turner, E. (2004) Editorial. *Expedition, 46,* 13-15.

Vontress, C. E. (2001). Cross-cultural counseling in the 21st century. *International Journal for the Advancement of Counseling, 23*, 83-97.

Vontress, C. (1999). Interview with a traditional African healer. *Journal of Mental Health Counseling, 24*, 326-336.

Vontress, C. E. (1991). Traditional healing in Africa: Implications for cross-cultural counseling. *Journal of Counseling and Development, 70*, 242-249.

Vontress, C. E. (1969a). Counseling the culturally different in our society. *Journal of Employment Counseling, 6*, 9-16.

Vontress, C. E. (1969b). Cultural barriers in the counseling relationship. *Personnel and Guidance Journal, 48*, 83-97.

Vontress, C. E. (1967a). The culturally different. *Employment Services, 4*, 35-36.

Vontress, C. E. (1967b). Counseling negro adolescents. *The School Counselor, 15*, 86-91.

Vontress, C. E. (1966). The negro personality reconsidered. *The Journal of Negro Education, 35*, 210-217.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods and findings*. Mahwah, NJ: Erlbaum.

Whitehead, H. (2000). The hunt for Quesalid: tracking Levi-Strauss' shaman. *Anthropology & Medicine*, 7, 149-168.

Williams, J. (1982). *And yet they come: Portuguese immigration from the Azores to the United States.* NY: Center for Migration Studies.

Wolcott, H. F. (2005). *The art of fieldwork*. Walnut Creek, CA: AltaMira.

World Health Organization. (1995). *Bridging the gaps*. Geneva, Switzerland: Author.

Worthington, R. L., Mobley, M., Franks, R. P., & Tan, J. A. (2000). Multicultural counseling competencies: Verbal content, counselor attributions, and social desirability. *Journal of Counseling Psychology, 47*, 460-468.

Wrenn, C. G. (1962). The culturally encapsulated counselor. *Harvard Educational Review*, *32*, 444-449.

Yen, J. & Wilbraham, L. (2003). Discourses of culture and illness in South African mental health care and indigenous healing, part I: Western psychiatric power. *Transcultural Psychiatry, 40*, 542-561.

Young, R. A., & Nicol, J. J. (2007). Counselling psychology in Canada: Advancing psychology for all. *Applied Psychology: an International Review, 56*, 20-32.

APPENDIX A

Ethics Approval

The University of British Columbia
Office of Research Services and Administration
Behavioural Research Ethics Board

Certificate of Approval

PRINCIPAL INVESTIGATOR	DEPARTMENT	NUMBER
James, S.	Educ & Couns Psych & Spec Educ	**B02-0778**

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT

Waterloo University ,

CO-INVESTIGATORS:

Beiser, Morton, ; Bezanson, Birdie Jane, Educ Psych/Spec Educ; Clarke, Juanne, ; Mcintyre, Teresa,

SPONSORING AGENCIES

Canadian Institutes of Health Research

TITLE:

Investigating the Discrepency Between Immigrant and Medical Conceptualizations of Symptoms

APPROVAL DATE (yr/mo/day)	TERM (YEARS)	AMENDMENT:	AMENDMENT APPROVED:
05-08-08	1	Dec. 8, 2005, Co-PI / Subjects / Consent form	JAN 04 2006

CERTIFICATION:

The protocol describing the above-named project has been reviewed by the Committee and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approved on behalf of the Behavioural Research Ethics Board
by one of the following:
Dr. Peter Suedfeld, Chair,
Dr. Susan Rowley, Associate Chair

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures

APPENDIX B

Photographs

Figure 2: Lagoa das Furnas on São Miguel

Figure 3: Biscoitos on Terceira

Figure 4: Cozido nas Caldeiras [Stew of the Caldeiras]

Figure 5: Ramarias on São Miguel

Figure 6: Preparations for the celebration of Senhor Santo Cristo dos Milgares

Figure 7: The celebration of Senhor Santo Cristo dos Milgares

Figure 8: The celebration of Senhor Santo Cristo dos Milgares

Figure 9: The image of Christ

Figure 10: The celebration continues at night

Figure 11: The dramatic coast of São Miguel

Figure 12: The lush flora on São Miguel

Figure 13: A village on Terceira showing the central position of the church

Figure 14: Cows crossing the road on São Miguel

Figure 15: Stone fences crisscrossing the hills of Terceira