

The shaman or the doctor? Disease categories, medical discourses and social positions

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The focus in this chapter is on the relationship between illness experience, disease categories, social class and ethnic relations. More specifically the chapter argues that through the use of disease categories and illness stories patients – here especially from the lower social strata – situate themselves within their social environment in connection with categories as ethnicity and class. From 2004-2005 I carried out fieldwork in the south of Chile among patients, doctors and shamans – the so-called *machis* – of the Mapuche Indians. The Mapuche Indians are an ethnic minority with a population of 1.3 million people. They live in the south of Chile in reservations (*comunidades*) as well as in the capital Santiago. The medical practice of their shamans has been revitalized over the last decades and has become a very popular medical choice both among Mapuche Indians and other Chileans – especially near urban centres (BACIGALUPO A. M. 2001). In their medical work the *machis* normally diagnose on the basis of observing urine (*willintun*) and through entering trance state; the medical practice consists of a combination of rituals and herbal remedies.

During my fieldwork I observed that in everyday conversation in Southern Chile knowledge and experience of illness and use of medicines – especially biomedicine and Mapuche medicine – were often-discussed topics among members of the family, neighbours and colleagues. Conversations about illness and medical practices frequently touched upon illnesses that involved symptoms with no apparent organic pathology. In particular, people shared stories of “strange” afflictions with quite similar symptoms: typically these were psychological symptoms like anxiety, lack of energy, loss of memory, constant desire to cry, combined with diffuse physical symptoms such as dizziness, nausea, swellings or intense pain, which most often were manifested in the head or stomach, but did also have a tendency to move location within the body. Some cases discussed, however, also

involved serious, and often terminal, diseases, which did have a biomedical diagnosis; the most common was cancer. These illness stories were, furthermore, accompanied by the complaint that the recent social changes and modernity hadn't brought much that was good, and many expressed a general feeling of being stuck in a rut without many opportunities to change the current social and economic situation. Others said they felt "crushed" and that they did not feel "alive". In addition, people complained of the cost of medical treatment, the long waiting for medical examinations as well as the failure of the medical doctors to detect a disease. A fundamental part of these stories was an evaluation of the medical diagnosis and treatment that the patients had received, from their medical doctor, as well as alternative practitioners.

In Southern Chile indigenous disease categories are part of a general repertoire of folk knowledge. Here the distinction between, on the one hand, natural illness, such as colds, wounds, infections and flues, and on the other, spiritual (or supernatural) illness, reflects popular talk on health matters. To the latter category – spiritual illness – belong those types of afflictions, where an external agent, a spirit, ancestor or witch, is believed to have affected both the body of the patient, as well as his surroundings, causing physical, psychological and social unbalances. In the anthropological and biomedical literature the bodily afflictions described, which are diagnosed by patients and practitioners within an alternative or indigenous medical traditions, have been referred, to as "folk-illnesses", "idioms of distress" (NICTER M. 1981) or "culture-bound syndromes" (SIMONS R. - HUGHES C. 1985). Locally they are referred to as "Mapuche-illnesses" or "spiritual illnesses", as alternative and Mapuche practitioners often explain illnesses through the Mapuche worldview, taking as a point of departure the belief in spiritual forces.

The underlying assumption, which stems from the observations expressed in these conversations about "folk-illnesses" and medical practices, was that these medical discourses might encapsulate issues not only related to health problems. Also, the notion of power and identity in relation to social and political processes seemed to be implied. Inspired by Paul Antze (ANTZE P. 1996), I assumed that these illness stories reflected general existential concerns and issues related to identity and power. According to Paul Antze, trivial stories, when told in groups, serve to translate shared ideas into experiential realities. He further proposes that stories "might be the chief means by which grand cultural discourses like Christianity or psychoanalysis find their way into something resembling self-knowledge" (ANTZE P. 1996: 6). Or, in other words, these stories reflect how people articulate and negotiate their sense of self in relation to the languages

available in a given context. In a similar vein Libbet Crandon (CRANDON-MALAMOUD L. 1986, 1991) argues that in a context of social change, medical discourses is a mechanism through which people can form alliances, manifest economic concerns and negotiate social status.

With this theoretical background this chapter will explore the question why many urban modern citizens in Southern Chile – who identify as mestizo and Mapuche – diagnose and treat themselves with Mapuche medicine for afflictions, the so-called Mapuche-illnesses or spiritual illnesses. Do they have a biomedical condition, which the doctors had not discovered? Or is something else going on? And what happens in those cases where patients actually do have a biomedically diagnosed disease, but still believed they had a spiritual or a Mapuche-illness. In most cases, both the diagnosis as well as the treatment of these afflictions take place within a pluralistic medical system, which means that the patient seeks a variety of practitioners such as, for instance, doctors, psychiatrists and Mapuche healers. Furthermore the patient's experience, diagnosis and management of illness embodies and reflects a larger socio-economic context. The aim of following is, consequently, to explore stories of folk-illness or Mapuche-illness by following the patients' articulation and management of illness in a context of medical pluralism.

Indigenous disease categories and cultural identity

During my fieldwork I found that the indigenous diagnosis of *susto* and *mal*⁽¹⁾ was very widespread among Mapuche Indians, but also among Chileans defining themselves as mestizo, that is, those with mixed Hispanic and Indian ancestry. Both types of diagnosis rely on the concept of *wekufe*, that is, the forces of evil (MONTECINO S. 1985: 18, CITARELLA L. 1995). A person is diagnosed with *mal* when the cause of symptoms is witchcraft, which has been performed through the introduction of objects in the body of the victims, such as insects/ vermin (*bichos*), reptiles or what is called a "living hair" (*pelo vivo*)⁽²⁾. *Susto* means, literally, "fright", and is also produced by an encounter with *wekufe*, the evil force, which is generally believed to have been sent by a sorcerer. In some cases *susto* can also be produced by a traumatic and frightening event. The symptoms of both include insomnia, bodily swellings, lack of energy and appetite, paleness, vomiting and often also visions of the evil forces, or *wekufes*.

I will here focus on the case of Albina, a middle aged mestizo rural woman, who suffered from *susto*. Albina's illness story during the military regime of

Augusto Pinochet (1973-1989) was a theme that she liked to bring up in conversation. She related how she had suffered from an affliction related to the work of evil forces (*wekufes*) or witches (*brujos*). It began when she suddenly one day collapsed and fell unconscious. Afterwards she did not remember anything about the incident, but woke up at three in the morning vomiting dramatically without being able to move; later she could only raise herself from the bed with the help of her mother. After the collapse she began having illness attacks, which she described as *susto*. It normally started with a sudden loss of the ability to speak, at which point she would try desperately to find someone nearby who could support her, because she knew that she could collapse at any instant. Her family described the expression of her face and eyes as “total terror”. The attack came in weekly intervals and lasted around five minutes. She went to a doctor who diagnosed her as suffering from *nerves*, and was treated for a while by the “kind doctor” Cordero in the public hospital in individual therapy sessions. Dr. Cordero, however, was killed during Augusto Pinochet’s military coup in 1973, and Albina didn’t have the means to continue to attend private therapy sessions. Instead, she was assigned Dr. Silva, the head of the psychiatric ward in the public hospital. Here the resources for treating the patients were scarce and, according to Albina, mostly consisted in the prescribing of medicine and hospitalization or, as she put it, the offer to take her to the psychiatric ward to be “locked up with the mad ones”. Although she felt that Dr. Silva’s treatment did decrease the number of attacks she was terrified of being accused of being psychologically “bad” or “insane”, or being told that she was imagining things which were not there. At this point, she explained to me, she started treating herself with indigenous medicine, with a completely successful outcome: her attacks stopped.

Albina as a mestizo with symptoms of *susto* and *mal* - represented a group of patients who were very dominant among all those who consulted the Mapuche shamans. By doing this she, just like many other I’d met who identified themselves as Chilean and mestizo, challenged my original assumption that having a Mapuche-illness had something to do with the intention of strengthening their cultural identity as indigenous. Albina did not acknowledge herself as Mapuche, nor did she pretend to share the Mapuche lifestyle; however, she shared the idiom of indigenous disease categories with knowledge and intensity, and actively showed and expressed her alliance with Mapuche medicine in opposition to Western medicine.

The case of Albina is interesting because, although a mestizo, she suffered from symptoms derived from indigenous disease categories, which apparently could not be linked to either a biomedical condition nor to her self-

ascribed ethnicity. The question to be explored is this: if having a Mapuche-illness is not connected to a set of organic symptoms nor reflects an ethnic identity, why does Albina then suffer from an indigenous illness? In what follows, by analyzing Albina's case and comparing it to cases of two Mapuche Indians⁽³⁾ – Rosario and Alvaro – I will suggest that the value of indigenous diagnosis is that it serves as a means for expressing and negotiating a vulnerable position: that of belonging to a downwardly mobile group in a context characterized by modernization and privatization of the health system (SONTAG S. 1991, CRANDON-MALAMUD L. 1986). To do this I will explore experiences of categories such as class and culture, which highlight aspects of *olvidos*, the Spanish word for forgetting – in this case related to inequalities in relation to class and ethnicity. I will also explore how medical discourses and medical practices are a means to negotiate and establish alliances between persons who share social positions. This serves as a counter strategy to the asymmetrical and hierarchal relationship perceived by the patient to exist between the poor and the medical doctor; thus the mestizos' choice of an indigenous diagnosis and medicine reflects a social and political struggle. Here the use of Mapuche medicine serves to establish social bonds among what are considered social equals, in this case Mapuche Indians, the landless and unemployed mestizo. In this way illness experience and Mapuche medicine become a resource through which patients navigate and make allies across interethnic boundaries with individuals in a similar social position, despite a perceived difference in ethnicity.

Medicine, modernity and power relations

A general position within development theory is that modernization destroys, or at least changes, indigenous culture. As pointed out by several authors, exactly the opposite has been taking place in a number of cultural contexts, where the use of indigenous medicine has increased (KOSS-CHIONINO *et al.* 2003; NICHTER M. - LOCK M. 2002). In a similar vein, by focusing on Albina as well as other cases of patients with *susto* this chapter describes the widespread use of indigenous disease categories and medical practice among a section of the society in southern Chile, that is the lower social strata. Some authors have suggested that *susto* is an idiom of distress for expressing psycho-social distress (RUBEL A. *et al.* 1984). In contrast it is here proposed that the diagnosis of *susto* connects the patient with an indigenous medical practice, which serves as a means for negotiating ethnic relations and social positions within the framework of the state.

According to Libbet Crandon the articulation of illness experience and medical choices are connected to social and political processes and embedded in political power relations (CRANDON-MALAMOUD L. 1991). The notion of power in relation to medical practice has been addressed by Michel Foucault. In his work, the *History of Sexuality* (FOUCAULT M. 1979), Foucault argued that through patients' confession with medical experts biomedical practices become a way to discipline and position subjects within certain structures of power. In a similar vein inspired by Michel Foucault Bryan Turner argues that practices and politics of the body serve to regulate and control the individual body and the population, but might also be regarded a site for resistance to the process of standardization, regulation and control of the State (TURNER T. 1992: 10). I here take Libbet Crandon's point that medicine can be considered a resource through which people negotiate social positions, power and cultural identity (CRANDON-MALAMOUD L. 1991: 139). This is founded on the classic anthropological problem of the relationship between body and society (DOUGLAS M. 1973). That means that a -vision of the body – and in this case, of bodily practices and medical practices – can be regarded as a reflection of social relations and the social world. In this way a medical diagnosis such as *susto* might represent a symbolic statement and negotiation of a social position and power relations.

I also use Libbet Crandon's (1986) concept of medical dialogue to explore how people negotiate power relations through the use of medicine. Libbet Crandon argued that medical dialogues (or what people say about their social world through the idiom of medicine), are statements about political and economic realities (CRANDON-MALAMOUD L. 1986: 463). The diagnostic process that takes place in medical dialogue can therefore be considered a social arena, where the construction of identity and the negotiation of social and power relations take place. In this way, these dialogues can be regarded as a window to the social processes taking place as well as a means by which they take place (CRANDON-MALAMOUD L. 1986: 463, 473). The medical dialogues described in this chapter, however, stand as a kind of anti-discipline – as a dialogue between equals – which serves as an alternative type of confession or biopower to the official biomedical version. In other words, when patients suspect that they have a “folk-illness” or a “Mapuche-illness” they are implying that they find biomedical categories inadequate to explain their bodily symptoms. Already here the link between local notions of illness and universal categories of illness – in this case biomedical categories – appears to be relevant. A person who has *susto* or *mal* is consequently making a statement about his place in

society, marking distance to the official biomedical solution and alliances with indigenous explanations involving witchcraft and the work of magical forces.

Medicine, culture and social class

In this section I will briefly focus on neoliberal politics in connection with issues relating to indigenous territory and health services, as these affect both interethnic relations and medical practices. Since the foundation of the Chilean republic the mestizo has been considered the ethnic base of Chile, while the indigenous population was regarded merely as remnants of the old Chile, who should be subjected to a process of civilization and integration into the modern nation-state. However, as a consequence of state politics, the indigenous and poor mestizo populations share and compete for the same scarce resources, with regard to both land and medicine.

Since their “pacification” between 1881 and 1884 the Mapuche Indians have increasingly been integrated into national society; this process has been accelerated through a continuous loss of territory. From 1970-1973, during the agrarian reform programme of the Unidad Popular government of Salvador Allende, the Mapuche recovered some of their lost territories. With the military coup in 1973, the process of agrarian reform was reversed; the indigenous land became private property, which was transferred to mestizos in order to create economic development (AYLWIN J. 1995, 2000). With the democratic governments of Eduardo Frei (1994-2000) and Ricardo Lagos (2000-2006) some of the indigenous territories were returned to indigenous owners, but this did not even come close to satisfying the needs of the rural Mapuche population. In this way mestizo farmers and Mapuche Indians have increasingly been forced to co-exist and to share the same resources in rural areas (KRISTENSEN D. 1999, 2000).

With regard to medicine, poor mestizo and Mapuche Indians have also increasingly come to share the same resources. The official health system today consists of a combination of private and public services. The proclaimed goal of the creation of this mixed system was to provide the user the possibility to freely choose between public and private health services. Having a good income became a means of providing oneself a good health insurance, and, in other words, maintaining one’s health. In this way “good health” was regulated by the politics of the state through the relation between income and health insurance. As suggested by Nicolas Rose (ROSE N. 2006), a state politics based on the idea of individual freedom also

paves the way for state control over the medical practices of the population. The health system created in Chile became a system that was based on the user's possibilities of obtaining health insurance. Private insurance became part of this (obligatory) model of the state for the worker to keep in good health. In reality, the public health system was assigned the lower social strata in Chile. The public health system is, furthermore, characterized by insufficient resources, limited services in rural areas, poor and decaying infrastructure, low salaries, lack of medical devices and medicine and a long waiting period (BORZUTSKY S. 2006: 150-151). This system has, in some aspects, failed to fulfil the expectations and needs of the user, which Albina's case is an example of. Choosing a doctor or a shaman is therefore interwoven into a complex web of meanings of what it means to be poor and/or Indian in modern Chile. This also explains that Albina by choosing the shaman might get improved health care, while in the same breath she refuses the identity as indigenous.

Albina and Alvaro

The first time I met Albina was in a medical centre in connection with a so-called Mapuche pharmacy in an urban setting. The Mapuche pharmacy sold Mapuche herbs and medicine made on ancestral recites, furthermore Mapuche practitioner offered here the service of diagnosis and treatment. On the day of the consultation Albina had brought her Mapuche neighbour whose son, Alvaro, was seriously ill; she also wanted a medical check-up for her father and herself. In her case it seemed that the reason for visiting the Mapuche pharmacy was more to socialize with her Mapuche neighbours than for actually solving a serious health problem. Where a typical rural Mapuche would wear a long skirt and silver jewellery to keep away evil spirits, Albina, with her nice knee-length skirt, pageboy haircut, gold teeth and gold jewellery, signalled the lifestyle of a typically well-off mestizo woman. She talked in a lively way with everyone in the waiting room, commenting on her visits to different shamans, most recently to seek treatment for her father's illness.

At the consultation she greeted the shaman Sebastian cordially, just like an old friend or relative, and commented on his performance and participation at the military parade at the Independence Day celebrations (on September 18th), which had been broadcast on national television. She had brought the urine of her father, and entered the consultation room with her small plastic bottle containing the urine sample. When Sebastian made

the diagnosis (nervous stomach ulcer, pains in spine, waist and bladder) she seemed more interested in knowing what medicine to take for her migraines. Sebastian advised her to take *pila pila*, a medicinal plant, and told her that she could buy it in the countryside. “No problem”, she replied, “I can easily obtain it, I am a very dear friend to my Mapuche acquaintances”.

After the consultation, she told about another *machi*, Jose Caripan, whom she also knew very well, and commented on his difficulties with the tax authorities as something “which should not happen, the *machi* ought not to pay tax. Yes, they have even entered his house and caused problems there”. Her manner was self-assured as a real knower of Mapuche culture, in a position of having intimate, inside information. The neighbour also knew Jose Caripan, and joined the conversation, revealing that her son was affected by witchcraft (a *mal*) when he was 15 year old. Now he was 22 year old and, according to his mother, had a relapse once a year, when he would have a serious panic attack and stop eating and sleeping. At such times they had to perform a ceremony to treat him for this affliction. Albina, due to her concern for the neighbours, had offered to accompany the neighbour to her “favourite” *machi*, Sebastian. The boy himself just sat, speechless and apathetic, while Albina and his mother told people in the waiting room about his afflictions and experience of being bewitched. What I found interesting was that Albina, as a self-identified mestizo, acted as the knower of Mapuche culture, and especially as one who knew where to find treatment for a so-called *mal*.

Though from different ethnic backgrounds, Alvaro and Albina shared biographical backgrounds, namely, having been placed in the specific community due to political processes. Albina’s father, who used to be a poor landless worker, received his small plot of land during the time of Pinochet, where the *contra* agrarian reform from 1973-1976 resulted in the transfer of indigenous land to landless mestizo with the aim of producing economic growth. Now the process had been reversed, and Alvaro’s parents had received a plot of land from CONADI (National Institution of Indigenous Peoples), that had been bought by governmental funds from a mestizo owner. In this way Albina and Alvaro’s shared rural lifestyle was a result of shifting governmental policies, which had placed them in similar a social position. While they identified themselves as belonging to two different ethnic groups, however, they acted with apparent solidarity in the sharing of the scarce resources in an indigenous community. Alvaro was obliged to migrate to Santiago, and Albina’s son now lived and worked in town nearby. It was the son who gave Albina the gold jewellery, which created a some-

how false impression of her lifestyle, as her estate was, in fact, quite modest. The jewellery, however, helped her to signal a successful *mestizo* lifestyle. Albina and Alvaro both commented on the impact that changing governments had had on their lives. Politics as a theme in itself was, however, apparently not of much interest as a topic of conversation; in contrast, the medical dialogue was the idiom through which they articulated their everyday existence.

Since the treatment of her own sickness the *machi* Sebastian had treated her father, mother and son. Her son had been suffering from *mal*. Albina related how he had been really well-off, the owner of a house and four cars, when suddenly he started losing his cars one by one; at the same time, he started to feel unwell when in his house, and suffered from insomnia, apathy and constant weeping. He also often saw a black man appearing beside him during the nights and heard the sound of strange birds. She explains all this as products of human evil and envy – of *wekufes*. However, with Sebastian's medicine her son had recovered his health (and his cars).

Why susto? Or, why is Albina a mestizo?

When Libbet Crandon enters the discussion of culture-bound syndromes with her study on *susto* she does so by switching the question from what is *susto* to why *susto*. Libbet Crandon describes *susto* as a common illness throughout Latin America, with the following symptoms: “restlessness in sleep, listlessness, loss of appetite, weight loss, disinterest in dress and personal hygiene, loss of energy and strength, depression, introversion, paleness, and lethargy”; *susto* can also lead to “high fever, diarrhoea, and vomiting, occasionally it can lead to paralysis and convulsion” (CRANDON MALAMUD L. 1983: 156).

Libbet Crandon revises earlier research on *susto* and outlines two approaches to the study of “culture-bound syndromes”. One approach considers such syndromes as psychological/ psychosocial, as a culturally appropriate way to express hysterical anxiety (GILLIN J. 1948) or as social role stress within a cultural context (RUBEL A. *et al* 1964). The second approach is based on the assumption that culture-bound syndromes have organic causes, in this case hypoglycemia (BOLTON R. 1981), which are hidden “in the mists and mires of exotic cultural expression” (CRANDON MALAMUD L. 1983: 153). As a starting point Crandon points to the problematic in deciding whether culture-bound syndromes are psychosocial or physiological, as both fail to acknowledge the significance of the indigenous system of logic. She

dismisses the first explanation (social role stress) due to the fact that so many infants apparently suffer from *susto*: in the area where she worked *susto* was reported as the second highest cause of death of infants under age one. In other words, she finds it unlikely that an infant can die of role stress (CRANDON MALAMUD L. 1983: 156). A purely psychological approach, she warns, obviates the assumption that culture, mediated through symbolic systems, plays an active role in the illness process.

Crandon also argues against the theory of *susto* as the exotic manifestation of an authentic medical disease, namely hypoglycaemia. This is not to deny the possibility that *susto* might have physiological causes; on the contrary, she holds that physiological causes in relation to the symptoms of *susto* might be relevant, not only in connection with hypoglycemia, but with a range of other biomedical diagnoses such as gastroenteritis and malnutrition. However, she observes, studies of *susto* had showed that no single pathology could be identified. This argument is identical with that of an interdisciplinary study published the year after Libbet Crandon's article, which concluded that patients who were diagnosed with *susto* could be considered as being ill from a biomedical point of view, mainly suffering from infective and parasitic diseases or anemia; however, no single organic syndrome or disturbance was found. The study concluded that *susto* could not be regarded as a syndrome or be classified as a disease in a medical sense, but rather as a local way of articulating and dealing with social stress. It was therefore concluded that much of what is known as culture-bound syndromes are, in fact, not syndromes in the strict medical sense but were, rather, local ways of explaining and dealing with illness (RUBEL *et al.* 1984: 87).

Consequently Libbet Crandon notes that Bolton's (BOLTON R. 981) search for organic causes does not explain why people with such a wide range of symptoms and pathologies are diagnosed with the same disease category. If, however, "culture-bound syndromes" (in this case *susto*) cannot be linked to a biomedical condition then, she concludes, something else is going on. She proposes that the reason that people choose the diagnosis of *susto* has to do with a negotiation of social inequalities and power relations, due to the fact that "any diagnosis of an illness, perhaps especially *susto*, is a social process that depends on and affects social, economic, political and ethnic relations" As a consequence, she suggests that rather than focusing on "why certain classes of people are diagnosed with *susto* rather than other classes of people" the focus can be switched to "why certain classes of people are diagnosed as suffering from *susto* rather than from some other illness category" (CRANDON-MALAMOUD L. 1983: 154). She proposes three levels of analysis in the diagnosis of any illness and here more specially

susto: What causes the symptoms diagnosed as *susto* within a given environment? What is its underlying meaning? and, finally, What is the relationship between its meaning and the socio-cultural context, which leads people to diagnose symptoms as *susto*?

In the following I will follow Crandon's suggestion and compare the case of Albina with that of a Mapuche woman – Rosario – in order to explore the relationship between illness experience, social class and ethnic identity. I will consequently focus on the symptoms of *susto* and *mal*, the underlying meaning of the cause of the affliction, as well as the relationship between the social and cultural context of people suffering from *susto* and *mal* and the meaning they attach to it.

Different lives, shared experiences

Albina and Rosario are in many ways in a similar life stage and share, to a large extent, a certain socio-economic reality. They are both in their late fifties, have grown-up children who have moved to a larger city and they have both lived in rural as well as urban areas. Both live a very modest life, surviving as itinerant vendors of home-produced products, in this case cheese and flowers. The financial support of their children helps them to make ends meet. Although without any formal education, they both appear to be very strong, independent and articulate women, who managed to break out of violent marriages to alcoholic men.

Another common feature is their perception and use of the Chilean health system. Both make use of biomedicine in case of illness, and make sure that they and those close to them do not miss any medical check-ups. Rosario suffers from high blood pressure and rheumatism, Albina from varicose veins. The consequences of distancing themselves from the biomedical system would be too fatal, they claim: they would thereby risk being denied the opportunity to be treated in case of an emergency, as well as the opportunity to get a medical certificate in case of illness or death. Dying in the house of one of the "clandestine" practitioners, the *machis* – means risking putting both the practitioner and the family in a difficult situation, such as a law suit. This is the reason – they both explain to me – that they continue to attend their regular medical check-ups. They do, however, take at face value the diagnosis they get from the medical doctor, and do also take the medicine they have been given, even though this is often not considered "good medicine" (*buen medicina*), often due to what they consider is an insufficient diagnosis. The doctor's medicine might alleviate the physical

symptoms, but it does not provide any acceptance of nor explanation for the complex combination of symptoms, physical, psychological, social and often also spiritual, which the patient experiences.

In other words, the loyalty of the women is not with the Chilean doctors and their medicine; far from it. The following phrase was often repeated: “I really do not trust doctors”. This distrust stands in contrast to the almost blind confidence in Mapuche medicine; of course, not in all of the practitioners of Mapuche medicine, but in the medicine in itself, when it is well practiced. Who is a good practitioner, who has treated whom for what and on which occasion, and what was the cause of the illness – these are themes that are constantly commented upon. As with most other patients I met, they had their “favourite” practitioner of Mapuche medicine, who was sought on those occasions when the biomedical doctors could not provide a sufficient diagnosis. The relationship with this practitioner was one of generations, and also included the illness stories of several family members and neighbours; in this way one could almost say that the practitioners of Mapuche medicine were granted a status as the family doctor. Everyday conversations often concerned illness stories; in these medial dialogues trust and mistrust in social relations was expressed through the identification of good and constructive or evil and deconstructive forces. In other words, magical forces and witchcraft were a crucial part of the reality of the women in their social relations. Here they expressed, especially, the fear of witches (*brujos*) who used evil forces – the *wekufe* – as their intermediaries. The experience of having been influenced by *wekufes* was one that both women revealed in medical dialogues.

“Por eso tengo fe” – *the reason why I have faith*

Both Albina and Rosario can be considered what could be called “medical resource persons”. Their way of making a social entrée is characterized by illness stories, which contains success stories of healing by a Mapuche practitioner. In other words, they make use of their experiences and knowledge of medicine and especially Mapuche medicine, as a social resource; they happily convey their medical knowledge and their own illness experiences and are often consulted in situations of illness; they also most happily volunteer to accompany relatives and neighbours to their “favourite” medical practitioner. Due to the many years of consulting *machis*, they have also actually gained a solid knowledge of Mapuche medicine and medicinal plants, so they are often asked for medical advice. In their gardens they

grow those medicinal plants that are considered an important source for maintaining good health.

Hardly surprisingly, I met them when they were accompanying a patient: in the case of Albina, a young Mapuche neighbour, in the case of Rosario, her sister-in-law Nancy, a 50-year-old mestizo woman. Through medical dialogue between mestizo and Mapuche they both reflected on the nature of illness, mostly on whether the patient was affected by a natural or spiritual illness and its social implications. In this way medicine served as a symbol of a social position that also provided an idiom through which they expressed values, evaluated social relationships and explored different options of actions (CRANDON MALAMUD L. 1991: 151).

In the case of both women a “spiritual” suffering, what some would call a “Mapuche-illness”, was the reason for consulting their favourite practitioner; that is, they suffered from an illness with both physical and psychological symptoms, which did not fit a biomedical diagnosis, especially in relation to the pains, which had no organic explanation; further, the illness was characterized by extreme lack of energy, nervous attacks and sudden speechlessness. The affliction did not only manifest itself in the body of the sufferer, both the sufferer and those close to her or him had unusual dreams and visions. In addition, strange occurrences took place in the house.

In the case of Rosario, she suffered for 14 years from an affliction which did not have a biomedical explanation. The stomach became enormously swollen, even though her only nourishment was soup; at the same time, she suffered from what she called an intense “pain in the bones”, in knees, legs, waist and brain and especially in the intestines, which felt as though they were falling out, or as if something was moving around inside them. She felt totally drained and exhausted and also suffered from insomnia. Furthermore, she describes an extreme paleness produced by “the lack of blood”. At home strange occurrences started to happen – the house started creaking, although it was totally new, and she constantly had the feeling of being haunted by something, but when she turned around, nothing could be seen. She went to a doctor who diagnosed her as suffering from swellings, which might be the beginning of rheumatism. On a later occasion he diagnosed her as suffering from cold, with high blood pressure, and gave her aspirin and vitamins. However, the symptoms of exhaustion and swellings continued, and her search for another diagnosis and treatment started.

During my fieldwork I often heard stories similar to these, of all types of illnesses, which doctors often discard as problems with the nervous system,

anxiety or as depressions, or simply treat with aspirins. Among patients in southern Chile, when illness occurs which cannot be treated with biomedicine or herbs, there is always a lurking fear that it is produced by a spirit or human being, a witch, who has used spiritual powers to produce misfortune and sickness. To the practitioners of indigenous medicine sickness is considered as a sign of imbalance, and is often diagnosed as afflictions produced by external forces, spiritual as well as human, that have made a pact with evil forces, the so-called *wekufe*. While patients do consult Mapuche practitioners for many different types of illness, among them a number of so-called natural illnesses⁽⁴⁾, the so-called supernatural/ spiritual illnesses (*males*) or Mapuche illnesses (*mapuche kutran*) like *kalku kutran*, *infintun*, *trafentun*, *perrimonton* or *susto* are the most common cause for consulting a Mapuche practitioner. These illnesses are thought to be caused by an unbalance or conflict between the patient and his/ her social environment and/ or transgression of a social norm. Health practices – including practices for bewitching or preventing and counteracting – are often used to explain the patient's trust and preference for Mapuche practitioners. The signs that are used to identify a witch are often articulated and shared.

Medical practices, social position and cultural identity

The belief in and concern for practices of health and illness, among them practices for preventing witchcraft (so-called *contras*), are facets of everyday life that Rosario and Albina share, and they make up a fundamental part of their reality. Rosario told me how she had been diagnosed as having an insect (*a bicho*) or a living hair inside her, feeding on her. This was a product of witchcraft. Or, in other words, she suffered from a so-called *mal*, which is the popular or mestizo term for *kalkutun*, an illness caused by witches (*kalkus*, *brujos*). This diagnosis was first made by a herbalist, Rosario did not, however, follow her treatment. Later she heard rumours about a famous shaman and went to José Caripan, who made the same diagnosis and succeeded in treating and curing her. As already described, Albina had also been diagnosed as having *mal*, in this case *kalkutun* caused by *infintun*, or poison given in drink or food. Albina is sure that she was poisoned through a glass of red wine. Consequently, in their articulation of illness the women move in a similar universe with similar diagnoses, where external forces are considered the actors when other more natural factors fail to provide any explanation.

In many ways, however, Albina and Rosario also differ in their life situations. While Rosario has remarried and now lives an urban life with her new husband, Albina continues her rural life, sharing a house with her parents. What is even more interesting is that Rosario identifies herself as pure “Mapuche”, and Albina as “mestizo” or “Chilean”. This did not, however, seem to make any difference to their medical choices, though some differences could be traced in the role that medicine plays in their self-identification. In this chapter I seek to argue that this is due to the fact that disease categories – here especially indigenous types of diagnosis – represent a possibility for the articulation and management of certain social experiences, which the women share. By discussing their symptoms in medical dialogue within their social relations they draw on disease categories that shape their self-perception and identification.

Applying Libbet Crandon’s approach the question of why Albina is *mestizo* becomes especially interesting. In her own research she too had wondered why so many mestizo adults in Bolivia suffer from an indigenous disease, which is mainly thought to affect indigenous people. In the case of this present research, one could pose a similar question: Why do mestizo women suffer from diseases which are framed with an indigenous logic, the so-called “Mapuche-illness”, which explain sickness as soul loss: that is, as a product of fright, spirit attack (*susto, trafentun*) or as witchcraft (*mal, kalku kutrún, infintun*)? Why does the medical dialogue of Rosario, Albina and Alvaro’s mother contain such similar statements about the nature of certain afflictions as inherently magical? During my fieldwork it became clear that it is quite common that people who identify themselves as *mestizo* accuse Mapuche culture for being “backward” but, in the same breath, ally with Mapuche culture and the indigenous cosmology when it comes to medical choice. This was especially salient – as will be explored later in the chapter – in the case of mestizo Chileans who refer to themselves as “marginal”, “poor” and/or “exploited”.

This points to an assumption, which Libbet Crandon has already proposed, namely that biomedicine cannot accommodate the psychological needs of, particularly, the downwardly mobile, the “victims” of “modernization” (CRANDON MALAMUD L. 2002: 28). To these people, who perceive themselves as marginal and even “betrayed” by the Chilean health care system, Western biomedical care seems to offer no solution. Consequently, when Alvaro, Rosario and Albina share a medical choice they are making a statement about their social reality on several levels. Similarly, the question as to why people choose a certain disease category could, as Libbet Crandon proposed, be answered on different levels.

Firstly, by sharing their experiences of *susto* and *mal* the women are making a statement about their social relationship and their use of indigenous medicine as a means of the establishing and strengthening social bonds. In other words, choosing an indigenous disease, a magical versus a Western aetiology, has different social and ethnic implications. While Albina tried to project herself as a well-off mestizo city dweller, her lifestyle is in fact much more modest and characterized by a daily struggle to make the most of scarce resources. In this way establishing egalitarian social bonds with her Mapuche neighbours is a logical strategy to try to constitute herself within her present reality in an indigenous community. Through the use of indigenous medicine she adopts aspects of indigenous identity. The diagnosis of *susto* and *mal* linked the women together in a shared idiom of being possible victims of external forces, an idiom of social vulnerability and “loss” of control. The women preferred Mapuche medicine due to the horizontal relationship between practitioner and patient that made it possible to establish bonds of solidarity both with the practitioner as with his group of patients. The result is that though ethnically identifying with two different cultural categories (*mestizo* versus Mapuche) the women share, to some extent, a similar social position. Secondly, the use of a Mapuche disease category points to the inefficiency of biomedicine and thereby marks a distancing to official ways of explaining and treating illness. By rather sharing their symptoms in medical dialogue than in “confessions” to their medical doctors, the women manage, to a certain degree, to negotiate the asymmetrical power relations between doctor and patient.

An interesting question is whether Albina’s apparent downward mobility (in the direction of her poor indigenous neighbours) does in fact lead to improved health care (CRANDON-MALAMUD L. 1986: 472). In her own viewpoint that was definitely the case. In this way she shared Rosario’s perception that Mapuche medicine was the only available medical alternative for availing of health care. Rosario phrased it the following way:

So many people have died. The people do not know how to get medicine, they have no places to go, then the sickness gets worse and then that is just the end. But at least – thanks to God – thanks to don Jose (her *machi*) I have recovered to last a couple of years more.

While I have emphasized the connection between *susto* and *mal* and a vulnerable social position, it is important to stress that ethnicity does play a role in the diagnosis of *susto* and *mal*. That is, vulnerability was associated with being indigenous, being Indian. In contrast, being Chilean white was associated with a more secure and untouchable position. Thus, Rosario commented:

Do you know what, miss? The Chilean people are much stronger than the Mapuche, if a Mapuche knows about this [witchcraft practices] and uses it against a Chilean it will not be that effective, than if a Chilean person performs witchcraft against a Mapuche. The Mapuche are much more vulnerable.

In other words, vulnerability is connected to being poor but also to being indigenous. However, in the case of the indigenous, this vulnerability is also connected to practices to counteract destructive, evil forces. That is, indigenous practitioners are considered experts on witchcraft, as “knowers of the secrets of nature”. This is why Albina stressed the importance of maintaining good relations with her Mapuche neighbours:

I tell you, we have never been racist, we have never discriminated against the Mapuche, we are completely surrounded by Mapuche, and I hope they one day will look upon us as kind people. We feel equal with the Mapuche, we have never looked down upon these people. And they are so good to us, when they perform their rituals, we don't even have time to go to all the places where they invite us.

This means that sharing medical practices was not associated with shared ethnicity; rather, Albina constantly opposed herself ethnically to her Mapuche neighbours. However, through shared experiences of social position, Mapuche medicine became a resource, both as a symbol for a social vulnerable situation, as well as a resource to create social bonds and to gain access to health service.

Medical practices and social class: unfulfilled dreams of modernity

In the following section I will compare Albina's *susto* to other cases of *susto* and *mal* in order to analyze why mestizo women so often appear among the patients of the Mapuche shamans. I will also discuss several themes, among which is the social experiences that seem to unite Mapuche and mestizo patients in their use of medicine and in the medical dialogue. In her work Libbet Crandon proposed that medical dialogues are statements of social and political reality; however, her focus is primarily on interethnic relations and she is not very concerned with an analysis of class relations (CRANDON MALAMUD L. 1983, 1986). In contrast, in my material, the diagnosis of *susto* and *mal* appears to be connected with articulation and negotiation of a social position and of class relations.

In the article “Susto: An Illness of the Poor” Avis Mysik (MYSIK A. 1998), suggests that *susto* is closely connected to class relations, and observes that *susto* victims are primarily poor peasants and landless labourers, the working poor and the downwardly mobile. Mysik furthermore stresses that this conclusion in no way challenges the hypothesis that *susto* involves some

combination of psychological, physiological and social factors. However, he points out that most research has not addressed the relationship between *susto* and class position. Mysik regards *susto* as a symbolic statement of an individual's position in the community, whether self- or other-perceived. In addition, he argues that the symbolic statement made by mestizo is their downward mobility. In the following I will explore this argument by comparing Albina's case in connection with other cases of *susto* and *mal* in my material in order to identify the themes that might unite them as a group. Albina, as a mestizo woman with *susto* and *mal*, was quite typical of many patients I met. The hypothesis that I want to explore further in the following is whether having an indigenous diagnosis might be linked to a negotiation of social positions, values and class relations.

Generally, Mapuche medicine is characterized by the users as the medicine of the "modest people" (*gente humilde*). A 40-year-old landless mestizo woman said that "the majority of the rich people go to the doctor, that might be the reason that they tell us that they cannot give us medicine, because we cannot afford to buy it". A woman who worked together with her husband as a shoemaker also suffered from *susto* and depression; she explained to me that as urban modern citizen she had felt "obliged to" go to a doctor. This was part of the package offered by the government of access to education and health for the workers. The shoemaker analyzed the situation in the following way:

After the introduction of the public health system the population grew so much that the medicine they offered became insufficient, and now they offer medicine in a way where they just greet you and then tell you to leave. No, for the poor they do not offer good medicine.

Another mestizo woman working at a market selling fruits and vegetable said:

It ought to be more complete, but the fact is that medicine today is too expensive, an operation costs you so much, just to have a medical examination costs you so much, I believe that many people just die because they cannot afford a biomedical examination, in the end what is left to us is the natural medicine [Mapuche medicine]. So many people are just left to die because they cannot afford to have an operation. I believe that the government is responsible for this, because they do not provide for and take care of the poor people, so many people are left without work, and then they cannot afford health insurance and so they cannot provide health to the family. In the end the family suffers, because there is no greater pain to a mother than to have a sick child and not be able to solve the problem. I know this from my own experience.

This woman's statement is similar to that of many others, and indicates that the prospects of gaining guarantees for health and education became limited to one section of society, while others were completely left out,

after the introduction of neoliberal politics. The shoemaker complained of having her dreams of getting an education and a good life destroyed due to her very limited income. Furthermore, she felt obliged to continue living with her alcoholic and violent husband due to her lack of economic freedom. Now she sees her life as quite hopeless:

How awful is this life of mine. But that is how it is. Perhaps I did choose this life myself, there is a saying that each person chooses his life, perhaps I did choose it myself, but I did not choose this situation, I wanted to progress in life, I wanted my family to progress, I wanted many people to progress together with me, but that did not become a reality.

In these statements the effect of the privatization of social security becomes clear. Firstly, a division was created between social strata in their access to medicine, and secondly, one's entire life situation became a private matter, to be solved, if at all, by the core family. If an expectation is not fulfilled it is the individual who is regarded as responsible. This corresponds to the neoliberal model of Pinochet, with its emphasis on personal freedom. On the other side of this vision are the experiences of social isolation and lack of confidence in social authorities, namely, biomedical doctors and priests. This particular woman told me very private details of her life, as did many other patients I interviewed. Furthermore, she claimed to hardly ever confess her inner thoughts. Many other women had similar comments. Although identifying herself as catholic one woman said about catholic absolution: "I simply don't like to go there to confess". Another woman said that "you cannot tell the doctor what you think might cause your sickness, nor report all your symptoms, as they do not believe the same things as us". Another woman advised me never to tell personal things to a medical doctor because "they might use it against you afterwards". As mentioned in an earlier chapter, one woman even said this about the medical doctors: "If you don't leave a cheque of guarantee to pay for the medical treatment, they just let you die at the entrance [to the building, without letting you in]". To this a man commented, "The doctors have made a huge business of our bodies". Furthermore, due to the lack of social security, the consequences of being ill were, in many cases, almost disastrous. A woman told of how medical neglect in the operation of her husband's appendicitis had left him unable to work for a year, leaving the family to survive on savings and charities. Today she treats her own *susto*, a condition which she thinks is caused by her desperate social situation, through the *machi*, Sebastian.

Hardly surprisingly my work as a medical anthropologist collecting illness stories was easy. The interviews were shaped as a medical dialogue, which stood as these women's statement of their social situation. Furthermore, the medical dialogues represented strategy and a social resource. When

choosing to tell their illness stories in medical dialogues rather than in confession to medical doctors, the women negotiated their social position, avoiding entering into the hierarchical relationship with the authorities. In this way the medical dialogue becomes a way to creatively negotiate power relations by establishing social bonds.

Furthermore, rather than adopting a political strategy, medicine became a strategy for action. In other words, in their individual version of the reasons for their unfulfilled dreams of a good life, no political action was imagined. A landless mestizo woman and her husband had dreamt of becoming owners of a small plot of land, now they only had a shelter provided by their patron, in return for services such as looking after livestock. I asked if the situation would change if a socialist president was elected. They responded: "If only it would change, but that would be like trying to get a star down from heaven". Furthermore, they even claimed that it might get worse with a socialist president, as the effects might include fewer industries and, as a consequence, less work. In a similar vein another woman said, "We just stick to our work, to what we can do; I do not understand much of politics, not much, I only vote because I am supposed to vote, but I am not really into politics". A taxi driver said, "No matter who is elected, we just have to work like hell".

All these people shared experiences of social and economic marginalization in such a way that they could be said to be "downwardly mobile", where the good life of Chilean citizens, including access to work, health and education were not fulfilled. In that way both self-identified Mapuche or mestizo shared social experiences of being marginalized in relation to the state and the health system. This observation apparently confirms the hypothesis of *susto* and *mal* as an expression of role-stress and as a product of psychological and social stress. However, I have here shown that Mapuche diagnosis and medical practice is a valid alternative to biomedicine, because it also provides a sense of agency, that is, social values that help them to cope with their situation, a strategy for dealing with a social situation that is less than ideal.

Indigenous medical practice: a means to cope with a social situation

"The forces of evil always go after the most fragile, the most weak", many people told me. Therefore, lack of work and good health were regarded as circumstances that increased the possibility that a person might be affected by *wekufes*. In the same breath, it was also an explanation of misfortune, with its emphasis on how human greed and envy often result in actions of witchcraft. The indigenous cosmology, however, also provided a

means of experiencing and acting in relation to a social situation, firstly through the establishment of social bonds, secondly by creating a space for action in the negotiation of power relations.

Albina's is an example of how indigenous medical practice facilitates the establishing of social bonds. As a medical resource person, Albina is constantly in contact with her favourite health practitioners, which makes her feel well: many of the women whom I met reported that the search for medicine makes them feel better, or that they feel better even just being on their way to meet the Mapuche practitioner, or on arrival, before having being given any medicine at all. A mestizo woman described the effect of indigenous medicine "as having been in foggy mist, and then you just see everything clearly again". Another said that on her way to her *machi* (don Jose) she already felt better:

His medicine makes me feel good, it helped counter the *susto* I had, though of course it [the *susto*] still hits me but not as [much as] in that time when I felt really so bad, that I did not feel like me, when I lost the affection for my home, for everything; it feels as though when I am leaving to go there (to don Jose) I already begin feeling better, I arrive and it is as though things just went calm.

The indigenous medical knowledge is, however, often misused. Many told me that the Mapuche often curse a Chilean, causing them misfortune; in other cases Chileans pay the indigenous to send *witranalwe*, a *wekufe* which is described as a black man on a horse with a large hat and shining spurs. The *witranalwe* is impossible to catch as it often changes shape and manifestation: it might appear as an animal, a cat, a dog or a bird. It might also appear as the skin of a sheep which turns out to be alive. Or as the crying of a baby or the sound of a bird singing (*twu twu*). Often this destructive force inserts itself into the victim's body, where it starts growing. In other words, birds, insects, cats and dogs are regarded as possible messengers of evil forces, sent by a sorcerer or witch.

The idiom of *wekufes* represents a statement of the loss of life force and energy, associated with destruction and death. The victims often talk about the smell of soil or putrid flowers from the cemetery, which are also associated with witchcraft, as the soil is used as a means of bewitching. *Mal* due to witchcraft is often associated with the person described becoming completely pale and skinny. A man explained to me that this is because the *wekufes*, the evil spirits, live on human blood, which they suck out of their victims. However, the belief in *wekufes* also has its counteraction, as shown in the cases of Albina and Rosario. In both cases the women use the Christian cross to ward off evil. Other commonly used antidotes are salt and silver jewellery. Most patients also attend healing rituals of their favourite *machi*.

Conclusion: negotiating social positions and power relations

In this chapter I have explored the relationship between illness experience, disease categories and social positions. The case of Albina, a mestizo woman who has an indigenous diagnosis raised the question of why mestizo women often believe that they have a Mapuche-illness. I have compared the case of Albina to that of two Mapuche – Alvaro and Rosario – in order to explore the role of ethnicity and class in illness experiences. It has been shown that Rosario and Albina, though from different ethnic backgrounds, do in fact share many common experiences and a common social arena. They also share and negotiate the same resources, in this case land, work and medicine. These resources were considered scarce especially, their access to biomedical care. In other words, in a context of privatization and modernization the relationship to official medicine and medical doctors was characterized by a feeling of marginalization and lack of influence.

In this way the women shared a vulnerable social position, which they negotiated in medical dialogue. The use of indigenous medicine became a symbol for a social position, and a resource for negotiating social and power relations. Through medical dialogue they established egalitarian bonds and expressed social values; being “indigenous” was associated with vulnerability and loss of control and became a means to express a socially difficult situation. Furthermore, indigenous medical practice involved a negotiation of power relations and an explanation for sickness and misfortune through the vision of a duality of good and destructive forces. What is more, it provided social bonds and medical knowledge, which were both means to counteract the influence that evil forces have on human lives.

Notes

⁽¹⁾ Out of 30 patients interviewed during my fieldwork, 10 reported symptoms which they identified as *susto*. 3 of these were male or female. 5 were mestizo women, 2 were children. All had other diagnoses, mostly depression / nerves and in two cases they also suspected witchcraft to have been involved. The diagnosis of *mal* is even more widespread: out of 30 patients, 26 believed or had suspected that witchcraft was involved in their affliction. In this group 9 were mestizo women.

⁽²⁾ These objects enter the body through eating food or beverages bewitched by a sorcerer. The evil force then installs itself inside the victim's body, most commonly in the stomach, and from it sucks the blood and life force.

⁽³⁾ *Susto* and *mal* among patients in Southern Chile are quite widespread. According to the findings in my survey, 22% percent of the respondents reported having suffered from *susto*, and 17% said they had suffered from *mal*. I was intrigued to see how many mestizo women attended the medical consultations of the *machis*. The survey supported a negligible gender bias in the spread of *susto*, as women were only slightly overrepresented. Of the 26 persons who reported that they were suffering

from *susto*, 12 were men and 14 women. That mestizo women apparently dominated in the medical consultation might not be an indication of a higher prevalence of these illnesses and diagnosis among women, but due to the simple fact that women often consult the medical consultations on behalf of their family members. Furthermore – as I argue in this chapter – it serves as a strategy to position themselves within their social environment.

⁽⁴⁾ For instance *pasmo*, a suffering caused by sudden change of temperature, or *empacho*, diarrherra caused by improper balance between hot and cold food.

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