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Santería as Informal Mental Health Support Among U.S. Latinos with Cancer

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Abstract

This article explores and examines Santería's function as a culturally congruent informal mental health support that assists U.S. Latinos to cope with the psychosocial sequelae of living with cancer. Research has demonstrated that Santería serves as a mediating institution for many Latinos. The tradition functions as both a religion and a health care system within various Latino subgroups and has functioned as an informal mental health service in occurrences of health versus illness.

Keywords

Santería; folk healing; Latino; cancer; psychosocial; mental health

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Research has consistently shown that chronic illness, such as cancer, causes people to seek out alternative, informal treatment options that are congruent with their values, culture, and worldview (Chang, Wallis, & Tiralongo, 2007). Additionally, Latinos in the United States experience an overall lack of access to culturally congruent mental health services. This has led U.S. Latinos to adopt alternative forms of care. Among Latinos, indigenous or folk healing traditions such as *Santería* have gained recognition for their poly-functional role not only as a religion, but also as an informal mental health care system offering a cultural reality that combines health, illness, and treatment options (Pasquali, 1994).

Latinos living with cancer face unique cultural and socioeconomic factors which increase their risk of developing psychosocial sequelae (i.e., depression, anxiety, shock, disbelief, uncertainty, fear, relational difficulties, decreased health-related quality of life, concern over lack of social support, etc.), which results in a greater need for mental health support (Napoles-Springer, Ortiz, O'Brien, & Diaz-Mendez, 2009); for chronically ill Latinos, the increased risk of psychosocial sequelae, combined with the general proclivity to not seek formal psychosocial treatment, creates a pressing need for culturally congruent psychosocial care that resonates with this population.

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Ortiz, Davis, and McNeill (2008) discuss that among various Latino subgroups, there is a popular collective worldview that illness and health are strongly influenced by spiritual and religious factors, which is a fundamental tenet of Santería. Santería is an amalgamation of popular Catholicism, 19th century French Kardecian spiritism, and a variety of African traditions that emerged as a result of Cuba's sociocultural and political colonial history (Brandon, 1997). Santería spread throughout the Caribbean and into other Latin American countries where African Diaspora traditions had already become commonplace (Murphy, 1994). Thus, the various Latino subgroups in the United States each possess a unique native religious heritage with similarities to Santería that can partially be explained "by tracing the history of transmission from Africa" (Murphy, 1994, p. 1). Aside from two other indigenous Latino folk healing traditions *Curanderismo* and *Espiritismo*, Santería is identified as a main healing system utilized by various Latino subgroups and communities in the United States (Gloria & Peregoy, 1996; Sandoval, 2008). As utilized by U.S. Latinos, Santería offers ethnic and cultural congruency because of its origin as an indigenous healing tradition (Insaf, Jurkowski, & Alomar, 2010).

LATINO CULTURE'S INFLUENCE ON PSYCHO-ONCOLOGICAL NEEDS

Despite the race or ethnicity of an individual, a cancer diagnosis marks an immediate passage from a condition of health to one characterized not only by physical changes, but also by uncertainty, threat of death, and social role disruption (Annunziata, Muzzatti, & Bidoli, 2011). Multiple emotions are experienced upon receipt of a diagnosis including shock, disbelief and despair, anger, fear, and sorrow, thus increasing the need for social support (Martinez, Aguado, Martinez, Flores, & Meade, 2008). Treatment following diagnosis is typically a physically challenging experience for patients, requiring some combination of surgery and adjuvant therapy such as radiation or chemotherapy for months or years (Institute of Medicine [IOM], 2008). The consequences of psychological and social distress caused by diagnosis and treatment are identified as the "psychosocial sequelae" of the cancer experience and recognized as components in the process of disease adjustment (Annunziata et al., 2011).

With regard to treatment, Annunziata and colleagues (2011), Sellick and Edwardson (2007), and Hopwood, Sumo, Mills, Haviland, and Bliss (2010) indicate that even though as much as 50% of oncology patients experience psychological distress, they do not seek or receive adequate mental health intervention for the psychosocial distress experienced. Factors that create barriers for oncology patients and prevent them from receiving adequate mental health care for their psychosocial sequelae include: (a) oncology or primary care providers overlooking psychosocial support as an integral part of care and/or their failure to identify and differentiate normal psychological responses from signs/symptoms of psychiatric malaise, (b) patients' inability to express their situation and needs, and (c) the scarce investment in the psychological sector on the part of institutions (Annunziata et al., 2011; IOM, 2008).

Additional barriers to receiving adequate mental health care for psychosocial oncology needs exist for Latinos. Latino oncology patients, particularly Latinas, are less likely than nonminority patients to access and receive culturally and linguistically appropriate

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formalized psychosocial services, which complicates the identification of their psychosocial needs (Ashing-Giwa, 2008; Galvan, Buki, & Garces, 2009; Napoles-Springer et al., 2009). Moreover, research has shown that culture and ethnic factors influence how an individual understands, explains, and responds to the facts and meaning surrounding life-threatening diseases such as cancer; how side effects will be understood and experienced; how emotions will be expressed; and which treatments will be sought (Kawaga-Singer, 1995). Cultural issues such as (a) reluctance to discuss emotional problems with strangers and (b) viewing psychosocial support as services for the mentally ill may further prevent the psychosocial needs of Latinos from being met through formal mental health services (Napoles-Springer et al., 2009).

MENTAL HEALTH SERVICE UTILIZATION BY LATINOS

Although mental health services reduce overall psychosocial sequelae and positively impact coping, psychological distress, and quality of life for those with cancer, these formal services are not adequately reaching Latinos. Evidence suggests that most oncology patients require assistance and encouragement in seeking and utilizing mental health services for their psychosocial needs (Moyer, Knapp-Oliver, Sohl, Schnieder, & Floyd, 2009). For Latinos, access and use of mental health services is further limited and influenced by financial, linguistic, institutional, and cultural factors (Galvan et al., 2009).

Research has consistently found that Latinos in the United States under-utilize formal psychological and mental health services (Carpenter-Song, Whitley, Lawson, Quimby, & Drake, 2011). Keefe and Casas (1980) discuss literature dating back to the 1930s which substantiates concerns regarding the underutilization of mental health services among Mexican Americans. Much of the current underutilization of mental health services is rooted in the institutional discrimination that still permeates the U.S. health care system (McBride, 2011). Latinos delay or refuse to seek needed mental health services as a result of experiences and expectations of mistreatment due to perceived prejudices and discrimination in overall interactions with the health care system and organizations (A. K. Smith, Sudore, & Perez-Stable, 2009). This discrimination is evident in the quality of mental health services Latinos receive, which is reportedly inferior resulting in worse outcomes than those experienced by non-Latino Whites (Elder, Ayala, Parra-Medina, & Talavera, 2009). There are also certain cultural characteristics found among Latinos that are “generally forgotten by or are unknown to mental health specialists who have received classical training” (Ruiz & Langrod, 1976, p. 393). The limited availability of mental health support and overall lack of quality formal support sources (i.e., mental health professional, support groups, research clinical trials, and community organizations) results in (a) Latinos’ decreased awareness and access to key information that can promote health adjustment to cancer and (b) Latinos overall underutilization of mental health treatment compared to non-Latino Whites (Cabassa, Zayas, & Hansen, 2006; Galvan et al., 2009; IOM, 2002). Furthermore, in a study by Pescosolido, Gardner, and Lubell (1998), Latinos were found to adopt different combinations of sources of care, including family members, friends, and spiritual leaders, indicating that there are factors beyond socioeconomic access barriers that contribute to the underutilization of formal mental health care (Lopez, 2002). This finding is expected, given that Cheung and Snowden (1990) explain that mental health exists as a culturally embedded

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notion where (a) beliefs about the nature of mental health problems are rooted in folk criteria, (b) expectations of the health care environment and provider/patient relationship are created, and (c) the acceptability of alternative solutions affects the utilization of formal services.

Latino cultural traditions emphasize the importance of collectivism, interdependence, and cooperation (Changrani et al., 2008). The ethnocentric tradition of Western "professional" psychology and mental health services stress the desirability of individualism, autonomy, and competition, which stands at odds with Latino cultural values (Changrani et al., 2008). Such service delivery has sociohistorically viewed Latino cultural values as "pathogenic and in need of reform" (De La Cancela & Martinez, 1983, p. 252). The cultural experience surrounding Latinos' illness and treatment needs is completely devalued and treatment options lack the incorporation of such foundational cultural values. Therefore, to find culturally congruent mental health services that effectively incorporate Latino/a worldview and cultural variables (such as language, norms, and religion), Latinas commonly turn to accepted, popular practices found in their community such as folk or traditional indigenous healing systems (Gonzalez, 2002).

LATINOS' USE OF INDIGENOUS FOLK HEALING

One of the most common indigenous systems found in the Caribbean and within the Americas is the Yoruba-based systems of *Ifá* and *Orisa* worship, both of which are African Diaspora traditions and promote spiritual balance by managing "health and mental health concerns via holistic approaches addressing mind-body-spirit connections" (Ojelade, McCray, Ashby, & Myers, 2011, p. 407). Latino indigenous folk healing systems vary, but conceptually, they focus on spiritual balance and harmony which affect an individual's spiritual, physical, and mental states (Balick et al., 2000). Latino traditional systems function as both healing and spiritual systems through the understanding that "the life system extends into a metaphysical belief system in which the worldly and other worldly operate conjointly on a daily basis" (Gloria & Peregoy, 1996, p. 123). Subsequently, there is value placed on the "whole" person, and the holistic orientation afforded by folk and traditional Latino healing systems is a quality sought when mitigating illness (Zapata & Shippee-Rice, 1999). In both the United States and throughout Latin America, traditional healers are typically well-known in the community; they share holistic concerns with their clients, along with similar experiences, geographic location, socioeconomic status, class, language, religion, and beliefs regarding the causes of pathology (McNeill & Cervantes, 2008).

Nearly three decades ago, Delgado and Humm-Delgado (1982) determined that five types of folk or traditional healers were used by the three largest Latino subgroups in the United States: (a) spiritist (*espiritista*), (b) *santero* (Santería traditional healer), (c) herbalist, (d) *santiguador*, and (e) *curandero*; additional variations of healers were found in other Latino subgroups, such as *parcheros* and *sobadores* among Central Americans. Spiritists (espiritistas), santeros (Santería traditional healer), herbalists, and santiguadores were utilized by Puerto Ricans; santeros were most visible among Cuban Americans; and curanderos were the primary healers in Mexican American communities. Over a decade later, Gloria and Peregoy (1996) reported that the three main traditional healing systems

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among Latinos in the United States were: (a) Curanderismo, (b) Espiritismo, and (c) Santería.

Santería

Santería is a traditional healing system utilized throughout Latin America and the Caribbean by a pan-ethnic population of Latinos (Murguia, Peterson, & Zea, 2003). Santería functions as both a religion and as a health care system with a substantial historical and contemporary role in the United States within various Latino subgroups and communities (McNeill, Esquivel, Carrasco, & Mendoza, 2008; Pasquali, 1994). As an organized religion, Santería emerged from Cuba in the late 19th century, directly resulting from the slave trade, which dated back to the 16th century, and the subsequent sociocultural shifts that occurred thereafter (Holliday, 2008). In the 1930s, Santería is recorded as entering the United States with the wealthy and urban educated Cubans; however, Santería's highly visible presence in the United States can be traced to the historically catalytic Cuban Revolution (1959–1962) and the immigration of Cubans to the United States, primarily to the East Coast (Holliday, 2008). However, McNeill and colleagues (2008) indicate Santería is well documented not only within the U.S. Cuban American community, but "has been noted for its spread across continents and cultures" (p. 70). In addition to its popularity in the United States (Miami, Chicago, New York, Los Angeles, and San Francisco), Santería has a strong presence in the Caribbean (Cuba, Puerto Rico, and Dominican Republic) as well as many other Latin American countries (McNeill et al., 2008). Gonzalez-Whippler (2001) estimates that over one hundred million people practice Santería in Latin America and the United States.

Santería's traditions function as anchors to cultural identity and as an informal health care system that continues to prove resistant to formal biomedical health care because it has demonstrated its appeal to serve as a mediating institution for many Latinos (Sandoval, 1979). The acceptance and flourishing of Santería in Latin America was facilitated by: (a) the widespread influence of Kardecian spiritualist beliefs in the late 19th and early 20th century and the distinct "Mexican Spiritualism" popular in the 1920s; (b) the salience of unorthodox folk saints' veneration; and (c) the prevalent practice of curanderismo, which has ritual elements comparable to those found in Santería (Ortiz et al., 2008; Sandoval, 1979). Santería continues to draw individuals of non-Cuban extraction in the United States as well, appealing to Puerto Ricans, Nicaraguans, Venezuelans, Mexicans, Colombians, and other Latin Americans (Sandoval, 2008).

The evidence suggests that folk and traditional healing is prevalent among Latinos in the United States; however, Zapata and Shippee-Rice (1999) state that it is nearly impossible to calculate the number of curanderos in the United States because, fearing of health and legal authorities, they conceal their identities. They are instead known by word of mouth (Viladrich, 2006). The same complication exists when attempting to ascertain the prevalence of Santería healers in the United States. The inclination to limit their visibility is a historical trend dating back to the time when African slaves' religious practices were outlawed in Cuba by the Spanish colonizers, subsequently causing persecution for any related religious expression; Santería is a tradition that even today errs on the side of secrecy due to the history of persecution (Holliday, 2008). However, *botánicas* (i.e., principal retail outlets

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providing the religious supplies needed to support the practice of Santería) are material proof of Santería's presence as a religion and healing tradition. Because botánicas are prevalent, U.S. Latino clients can access healers in a public, unconcealed context (Viladrich, 2006). Botánicas are located in areas heavily populated with Latinos and function as "the visible door to the invisible world" of Latino folk healing and Santería practices, and serve as an informal network hub for Latinos as well (Viladrich, 2006).

Today, Latinos vary in their level of belief and practice, ranging from rejecting Santería beliefs openly but seeking consultations when faced with crisis or stress, to occasionally visiting botánicas, to formal initiation and full participation (McNeill et al., 2008). However, evidence suggests the tradition functions as a subsidiary of formal mental health services, with Viladrich and Abraido-Lanza (2009) documenting the modern-day role of such healers as informal counselors who fulfill the demand for psychological services among diverse subgroups of Latinos.

RELIGIOUS ELEMENTS

The word "Santería" emerged as a colonial Eurocentric, derogatory term to distinguish the stigmatized "corrupt" popular expressions of Catholicism from the Orthodox-Catholic practices in Spanish colonized Cuba. Today, it is a loose term, or label, that is assigned by outsiders to the African religious manifestations most associated with the strand of practice from southwestern Nigeria. Practitioners, however, identify themselves by the dominant tradition they practice: *Lukumí, Ifá, Abakuá, Arará, Espiritista, Regla de Ocha, Reglas Conga*, and so forth. Despite differing origins and theological epistemologies (i.e., various African influences, European spiritist beliefs, native precolonial Latin American and Caribbean Indian beliefs and practices, and the dominant African Yoruba dogma), there exists a reconciliation rooted in the notion of spiritual balance and its relationship to health and illness (Sandoval, 2008). In the individual systems comprising the Santería tradition, physical and mental health are not divorced from the metaphysical. An individual's life is viewed as a spiritual phenomenon that is maintained using healing practices based on the premise of mutual interdependence between the physical and spiritual dimensions (Ortiz et al., 2008).

Santería, as practiced today in U.S. cities, developed from the circumstances of migration and pressures of a new environment during Cuba's historic-sociocultural transformation (Sandoval, 2008). Spanish colonial dominance over Cuba at the turn of the 16th century warranted the importation of African slaves. For three centuries thereafter, African slaves were an integral part of the Spanish colonial enterprise, working themselves into a social hierarchy constantly in flux; they arrived continuously into the island both legally and illegally carrying their distinct regional cosmologies (Dodson & Batista, 2008).

DISCUSSION

Santería provides Latinos with a cultural conceptualization of health, well-being, disease, and illness, constructing the experiences associated with each in addition to determining appropriate types of treatment (Holliday, 2008). Folk and traditional healers have historically

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fulfilled the roles of physician, apothecarist, and counselor, as well as that of religious and spiritual authority (McNeill & Cervantes, 2008). Folk healing traditions inclusive of Santería function in much the same way as mental health services, serving as "informal counseling" with spirituality as an added dimension offering explanations for the "why" in regard to the occurrence of health versus illness (McNeill et al., 2008; Viladrich & Abraido-Lanza, 2009).

These healers have historically played an important role in society and were held to many of the same standards of practice as modern-day health care professionals (Tafur, Crowe, & Torres, 2009). Folk or traditional healers are said to possess the same four common components that render a formal mental health professional as effective: (a) shared worldview with client, (b) the personal qualities of the healer/therapist, (c) patient expectations regarding the healer/therapist's capacities, and (d) and the training and employing of specific techniques (McNeill & Cervantes, 2008). In addition, all healing practices share: (a) an emotionally charged, confiding relationship with a healer; (b) a healing context in which the therapist/healer has the power and expertise to help by holding a socially sanctioned role to provide such services; (c) a rationale or conceptual schema to explain problems; and (d) "a ritual or procedure consistent with the treatment rationale" (McNeill & Cervantes, 2008, p. xxvi). These common qualities create the most culturally specific context for service delivery, theoretically rendering the services provided by folk or traditional healers culturally congruent to their clients' understanding of health and illness and thus, highly effective (McNeill & Cervantes, 2008).

SOCIAL WORK IMPLICATIONS

The social work profession is committed to meeting the needs of the most vulnerable and oppressed members of society, which is particularly important in the context of cancer given that there are significant disparities among various U.S. minority groups, including Latinos, compared to non-Latino Whites. Since the early days of the profession, social workers have played a crucial role in providing the earliest notions of culturally sensitive care within the highly Eurocentric U.S. health care system that discriminated against minorities (Cabot, 1909). Social work continues to hold the responsibility of alleviating the obstacles that exist in Latinos' access to culturally congruent psychosocial oncology care. Recommendations for future practice and research include: (a) development of client-centered service models and culturally tailored services for Latinos, (b) utilizing the community's significant role as a natural support, and (c) advocating for federal and local policies that expand the scope of culturally and linguistically appropriate services.

Micro Level–Service Delivery

Social work, with its holistic focus, has long acknowledged the importance of spirituality (E. D. Smith, 1998). It is no coincidence that social workers in end of life and palliative care were among the first in the profession to explore the significance of religion and spirituality as a means of relieving psychological distress. Soon after, mental health social workers implemented models of practice that included spiritual elements (E. D. Smith, 1998). Because social work is such a broadly based profession in which all social workers will inevitably encounter clients facing life-limiting illnesses such as cancer, expertise in

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culturally congruent palliative care will weigh heavily on social workers' capacity to intervene appropriately (National Association of Social Workers [NASW], 2004).

According to NASW guidelines (2004), a significant component of effective palliative care includes integrating the psychological and spiritual aspects of patient care so to offer "the prevention and relief of suffering by means of early identification and comprehensive assessment and treatment" (p. 10). Incorporating a client-centered service delivery model would afford clinicians the ability to provide such care and offer therapeutic approaches with flexible parameters that can be modified to include each client's cultural concepts, values, and belief system. As Baez and Hernandez (2001) indicate, traditional Latino spiritual and healing systems have long been noted as mental health support. Nearly 30 years ago, folk healers could be included in formal mental health treatment networks or teams providing services to Latinos (Schwartz, 1985). Therefore, a client centered therapeutic approach inclusive of spirituality and elements from traditional belief systems such as Santería can contribute to the quality of understanding between clinicians and clients and remains a goal in formal mental health care service delivery to Latinos (Baez & Hernandez, 2001). Treatments and interventions that incorporate cultural values, spirituality, and elements of clients' traditional belief systems, have been shown to be effective as well. In a systematic review conducted by this researcher on psychosocial interventions for women with breast cancer, only two of the 15 studies, Chan et al. (2006) and McKiernan, Steggles, Guerin, and Carr (2010) incorporated cultural relativity into the intervention, with only Chan and colleagues (2006) reporting robust effects. In addition, Camp Alegria, a camp for Latina oncology patients established by Martinez et al. (2008) that focused on cultural relativity, proved successful. Additional research in the area of culturally tailored psychosocial services for Latinos inclusive of spirituality and elements of their traditional belief systems could further inform effective service delivery models for this population.

Meso Level–The Community

The inclusion and involvement of community members and informal community networks in an effort to meet Latinos psycho-oncological needs is critical. Much of the informal support Latinos with cancer have been receiving is from the community and through the informal networking accomplished in the community. Changrani and colleagues (2008) and Gonzalez (2002) offer examples of how the community itself acts as an informal support. Therefore, integrating community into efforts aimed at reaching Latinos is fundamental in meeting their psycho-oncological needs.

Cultural congruence and staff development trainings can include consultations by folk or traditional healers, as recommended by Delgado and Humm-Delgado based on their extensive work in this area (1982). Further research could also test the effectiveness of (a) embedding resource information on cancer, services, support, and so forth within informal community networks (i.e., botánicas, folk or traditional healers, etc.) and (b) promoting services, treatments, interventions, and so forth through informal community networks.

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Macro Level–Policy

Cultural congruence efforts began as a guide for interpersonal interaction between provider and patient, and later expanded to consider health systems. Demands for culturally congruent health and mental health services grew out of the failure of service delivery systems to be responsive to all segments of the population (Chin, 2000). The federal response was the development of the Culturally and Linguistically Appropriate Services, or National CLAS Standards, by the U.S. Department of Health and Human Services' Office of Minority Health, to provide a common understanding and consistent definition of culturally and linguistically appropriate health care services (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003). These standards were set forth to respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner (Hoffman, 2011).

In an attempt to promote cultural congruence, the American Psychological Association's DSM-IV and the World Health Organization's ICD-10 call for additional awareness of culture-bound syndromes (Quinlan, 2011), further necessitating knowledge of cultural beliefs, values, and practices. Otherwise, practitioners can easily make errors of diagnosis, provide inappropriate care, and be in poor compliance with offering culturally congruent care (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007). Therefore, Schim and Doorenbos (2010) recommend an expansion of thinking in regard to cultural variables, going beyond strictly racial and ethnic boundaries and instead approaching cultural variables as a "socially-constructed and transmitted constellation consisting of such things as practices, competencies, ideas, schemas, symbols, values, norms, institutions, goals, constitutive rules, artifacts and modifications of the personal environment" (Fiske, 2002, p. 85). By advocating and lobbying for federal and local policies with an expanded scope of what is considered culturally appropriate, programs funded from such public resources will be obligated to diagnose minority patients, particularly in regard to culture bound syndromes, from a more flexible perspective.

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