

Social Factors of Health-Seeking Behavior: On Medical Treatment for Elders With Dementia in Oaxaca, Mexico

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Abstract

This article presents data on family caregiving for elders with dementia in Oaxaca, Mexico. Drawing on a year of ethnographic research, this article explores how caregivers engage in health-seeking behaviors and how they choose between biomedical and traditional medical alternatives. While caregivers are primarily concerned to maintain elders' health, decisions about which medical providers to (not) consult invoke broader social factors that go beyond their relationships with elders, and concern socioeconomic realms of power, as well as broader ideals concerning local tradition and its maintenance in the contemporary world.

Keywords

health-seeking behavior, medical pluralism, dementia, caregiving, Oaxaca, Zapotec

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Introduction

With the exception of providers who might ally with a particular medical model, rarely are explanatory or treatment models of illness exclusive, and it is the norm across cultures that individuals and their caregivers draw on multiple and overlapping ideas to meet health care needs (Good, 2010; Kirmayer et al., 2004; Kleinman, 1988; Lewis-Fernández & Kleinman, 1995).¹ In Teotitlán del Valle (hereafter “Teotitlán”), a rural 5,500 Zapotec-speaking community in Oaxaca, Mexico, individuals regularly face choices about which medical providers to consult and which regimens of treatment to follow.

Drawing on 1 year of ethnographic data collected in Oaxaca, this article analyzes interviews among family caregivers for elders living with dementia. This article seeks to explore how caregivers make medical choices on behalf of elders, and how those choices not only involve deliberation about elders’ well-being but also caregivers’ broader concern about social cohesion. Health-seeking behavior involves issues pertaining to family and communal belonging, local tradition, and social stigma, and thus discloses how a local community responds to broader social change.

Like its neighboring communities, in Teotitlán medical pluralism influences much of how individuals in contemporary settings come to experience, understand, and respond to illness. As a topic of inquiry in the social sciences, medical pluralism was first studied by anthropologist Charles Leslie (1980) who demonstrated the existence of multiple medical systems in most societies. Leslie argued that, even in the wake of contemporary biomedicine, traditional medical treatments often continue to provide relevant, explanatory frameworks and meaningful responses to illness. More recently, as Lock and Nichter (2002) articulate, research in medical pluralism has revealed the vast range of medical practices that exist across and within varying cultural settings, and how those practices are expressive of the negotiation of broader social issues pertaining to the maintenance of local identity (see also Comaroff, 1981; Pigg, 1996). In Teotitlán, members of this community are situated within a “traditional” medical system (a syncretic blend of medical theories from different historical periods) and a biomedical one (an increasingly dominant perspective about health and illness associated locally with social modernization).²

The Case of Graciela

At 78 years old, Graciela (a pseudonym here and throughout the article) cared for her husband, Nicholas, after a series of strokes left him significantly debilitated. Since having his first stroke 7 years ago, Nicholas has

progressively lost functioning and is now completely dependent on family care. He is immobile, gestures to communicate, and needs to be fed. His family cuts his fingernails and shaves his beard, as well as other tasks like helping him eat and go to the restroom. “He does it at anytime,” Graciela’s adult son, Mario, said describing his father’s incontinence. Though Graciela and her family initially sought help from a *curandera* (“traditional healer”) to respond to Nicholas’ abrupt decline, they also turned to a physician at Teotitlán’s local hospital. “What a doctor relieves is fever and what a *curandera* relieves is *susto* (“fear” or “fright”),” said Isabelle, Graciela’s daughter-in-law.³ And she further explained her family’s engagement with multiple medical systems, “In this case both [traditional and biomedicine] work together. We believe in both of them.” Similar to research in other medically plural settings, notions about belief and believing in traditional medicine accounted for this family’s turn to a *curandera* as well as the broader community’s engagement with traditional healers (Pigg, 1996; Young & Garro, 1993). Indeed, there was something inherent about *believing in* medicine that justified its power to heal and be chosen among alternatives.⁴

A Humanistic Perspective on Medical Pluralism

Central to caregiving is how medical decisions are made on behalf of another given the plurality of options, invoking what Charles Nuckolls (1991) aptly terms “deciding how to decide,” and the way that such decisions involve deeply complicated and overlapping rationales. In many ways, appreciating this decision-making process is a matter of humanistic inquiry and addresses how caregivers come to “believe in” certain forms of medicine, and the significance of what subsequent medical decisions entail. As readers of this journal well know, Amadeus Giorgi (2000), a pioneer in humanistic psychology, reflects that approaching psychology as a human science involves studying human experience as a matter of description and interpretation, much like a text is understood in regards to the larger world that contextualizes it. This approach arose against tendencies to view individuals as determined and mechanical, people whose behavior and experience could be understood like the laws of the natural world (Burston & Frie, 2006). Most of research in psychology today is approached as a matter of natural science, with data that is operationalized, decontextualized, and statistically understood. This approach has certainly advanced a number of critical insights into human functioning and how to optimally treat human suffering. Yet it also risks missing something critical about human experience itself. As Leswin Laubscher (2016) writes, “Human beings operate in the realm of meanings, lived experience, and complex and complicated relationships with self and

others such that a simple and reductively predictive formula, law, or generalization misses that very experience of being human” (p. 61).

In response, humanistic psychology attends to those very dimensions of human experience that evade being understood without appreciating their context—the way that the word “Alzheimer’s,” for example, might evoke a sense of loss for the son who recently witnessed his father’s decline, or a sense of anxiety for the physician who knows its empirical facts as she becomes more forgetful herself. Alzheimer’s refers both to neurological facts as well as to experience, history, ethics and broader inter- and intra-subjective meaning (Yahalom, 2017). Anthropological research has shown that the meaning of Alzheimer’s is constituted within a broader cultural outlook. Indeed, the commonly embraced idea that Alzheimer’s is “a death that leaves the body behind” is only intelligible within a “hypercognitive” culture that equates selfhood with cognition (Post, 2000). This is compared with other studies in Japan (Traphagan, 1998), Vietnam (Braun & Browne, 1998), India (L. Cohen, 1998), Brazil (Leibing, 2002), U.S. Native American settings (Henderson & Henderson, 2002), and rural Mexico (Yahalom, 2019a, 2019b), which all demonstrate that the same symptoms of Alzheimer’s and dementia are varyingly interpreted, depending on surrounding cultural outlooks and values. This further means that, when it comes to understanding how people make medical decisions, it is not always a matter of rational decision-making regarding what treatment is optimal, nor how behavior can be predicted by surrounding social factors. Rather, medical decisions also involve how people engage with these broader factors as a matter of human agency (Cipolletta, Beccarello, & Galan, 2012). As researchers from this journal have recently argued, illness cannot be merely understood as something professionals must cure but also an experience that invokes personal meaning that extends beyond medical interpretation and intervention (Cipolletta, Consolaro & Horvath, 2014; see also Jenkins, 2015; Mattingly, 2014; Mattingly & Garro, 2000). It is this dimension of human experience, meaning, and choice that humanistic psychology attends to—and also what matters most in the case of Alzheimer’s given the fact that there exists no clinical cure.

Adding to this line of research, this article attempts to address how the choice to engage with different types of providers in a medically pluralistic setting is similarly imbued with personal meaning. This article addresses themes pertaining to health-seeking behavior to explore how dementia caregivers make choices regarding which practitioners to consult and, by extension, which medical systems to engage with (for similar research in Mexican and other settings, see also Duncan, 2018; Ell & Castañeda, 1998; Finkler, 2001; Kleinman, 1980; Nichter, 1978; Sesia, 1996). In the context of Teotitlán’s particular historical and social circumstances, this article analyzes how caregivers’ health-seeking decisions are rooted in epistemological

assumptions—what Graciela’s family refers to as “beliefs”—and how what caregivers believe to be true is situated within broader social, political, and economic factors. These factors are not deterministic but provide context for how medical decisions are imbued with social and personal meaning. This is to say, caregivers’ decisions to consult with and adhere to medical providers are not just based on choosing among different medical options about what is held to be most effective but also based on how available options are representative of broader social issues at stake in the community. This article will argue that caregivers’ medical decisions are at once caught between alternative perspectives of “tradition” and “modernity”: either affirming idealized notions of what tradition means in contemporary life, or embracing notions of modernity via engagement with biomedicine. As this article will show, caregivers are further challenged for how their decisions are situated within a tension of being perceived as socially backward or jettisoning local traditional identity, and subject to concomitant stigma in either choice. These decisions about whom to (not) consult invoke broader social factors that go beyond their relationships with elders, and concern socioeconomic realms of power, as well as broader ideals concerning local tradition and its maintenance in the contemporary world.

Research Setting: Viewing Oaxaca as Juncture Between “Tradition” and “Modernity”

Teotitlán is a rural Zapotec-speaking community located in Oaxaca’s Central Valleys, known nationally and globally for its woven *tapetes* (“rugs”). Teotitlán’s physical location and economic positioning place it at the symbolic intersection between two idealized lifestyles: “traditional” life linked to ideas about local heritage involving notions of local custom and communal solidarity, and “modern” life associated with Oaxaca City, Mexico City, California, and other external locations represented by global capitalism and social independence.

In 2014, during the time of this study, Oaxaca was one of the poorest states in Mexico (second to Chiapas) with over 66% of the state’s population living in poverty and 28% meeting criteria for extreme poverty (CONEVAL, 2016). Systemic and social stigma against indigenous people that arose through postindependence and revolutionary ideology help begin to contextualize Oaxaca’s poverty, although it is an oversimplification to simply trace the origin of one phenomenon as the consequence of the other (see Knight, 1990; Lewis, 2006). Furthermore, Mexico’s neoliberal policies that were implemented during the 1980s have also exasperated these social disparities (Haber, Klein, Maurer, & Middlebrook, 2008). With the goal to create more fluid economic exchange across borders, privatize and deregulate industries,

and reduce government spending in social programs, Mexico's economic role has grown in the global sphere—but at a cost to the regions that did not (or could not) join. Across Mexico, indigenous communities like Teotitlán experienced these neoliberal trends as a larger campaign to jettison local traditions. Joining the global economy meant adopting national and international (nonindigenous) languages, adhering to foreign legal customs, migrating, and more generally replacing forms of life once centered on communal solidarity and subsistence farming for those premised on social independence and capital gain (see Katzenberger, 1995).

Teotitecos are similar to other Oaxacans who have responded to economic hardship through migration (J. H. Cohen, 2004; Holmes, 2013; Worthen, 2015). Apart from selling textiles, a significant amount of Teotitlán's economy derives from remittances sent by migrants. Many households and families are characterized by pursuing “transborder lives,” migrant lifestyles that maintain the “local” identity of the community while being stretched across municipal, state, and international borders (Stephen, 2007; see also Cruz-Manjarrez, 2013; Wood, 2008).

Migrants who leave are viewed to embrace foreign lifestyles, while members who remain face challenges about how to uphold local identity. Yet as Teotitecos themselves understand social life in terms of a binary between modernity and tradition, these temporal idioms implicitly reference notions of social progress and backwardness. And this, in turn, is based on larger political campaigns that define progress via engagement with capitalism and related forms of contemporary life (Pigg, 1996). This explains why any analysis of modernity is problematic; whenever it is mentioned, one inherently posits something it is not—the premodern, traditional, or archaic—thereby producing the category differences that define its meaning (Latour, 1993). Yet in this article both terms are referenced precisely because they are so commonly used by locals to make sense of everyday life. As will be shown, making medical choices is a matter of how one chooses to (dis)engage with capitalism and related forms of “modern” life. In this way, modernity and tradition are concomitant perspectives of the same contemporary experience. Yes, life is qualitatively different than it was in the past, but what is taken to be “traditional” in Teotitlán today is inextricably constituted within the features of contemporary life.

Method

Research Design

This article draws on dissertation research that sought to investigate the lived experience of caregiving for dementia in Oaxaca (Yahalom, 2016). Focus group research was conducted in partnership with a local translator to conduct

interviews in Zapotec knowing that, although a growing number of younger individuals speak Spanish, the majority of social life is carried out in Zapotec, and that most elders experience difficulty sustaining deep conversation in Spanish (see Stephen, 2005; for more on focus group research see Carey & Smith, 1994; Kidd & Parshall, 2000; Krueger, 2009). This was intended to avoid limiting which members of the community could be interviewed, and specifically anticipating interviewing husbands and wives of forgetful elders (many of whom were monolingual in Zapotec). Furthermore, this strategy also helped foster greater ecological validity as participants were studied conversing among each other (Temple & Edwards, 2008; Yahalom, in press).

Collected Data

Through the course of a year of ethnographic research in Teotitlán, 22 family caregivers for elders living with dementia across 9 households were interviewed (comprising over 15 hours of recorded interviews conducted in Zapotec). In conjunction with other observations made in the community, all interview data were subsequently transcribed and translated.

The resulting interview transcripts produced a rich set of texts that constitute this project's primary unit of analysis. These data (and all other supplementary data collected in the course of fieldwork) were viewed as "discourse," referencing a specific theoretical tradition that studies language and, more broadly, social practices (Foucault, 1972). To speak of discourse is to refer to three interrelated features: it is action-oriented in that it achieves a specific effect (J. L. Austin, 1975); it is constituted within a discursive event (following and responding to prior discourse, situated within local norms, etc.; Packer, 2010); and it is an act of construction (it is constructed from surrounding discourse, and *constructive* of the world; Potter, 2003). Thus, sensitivity to the nature discourse discloses awareness not just to talk endorsed by participants but also to institutional structures, power relations, and the way in which participants and the words they use are constituted and engaged with broader discursive practices.

Analytical Methods

Discourse Analysis Theory. As Linda McMullen (2011) points out, discourse analysis is a nonspecific term that does not denote any single research method. There exist a variety of analytic approaches that draw on Foucault's notion of discourse to achieve different methodological ends, and the approach used in this study was to strategically employ the analytic techniques that fit with the ethnographic parameters of fieldwork. Potter and Wetherell (1987) suggest identifying not only patterns found in discourse but also divergences that

provide insight into how and why differences exist. Kendall and Wickham (1998) encourage identifying contingencies (historical factors that situate the occurrence of discourse) and also eschew the search for hidden meaning. Serge Moscovici (2000, 2008), although not traditionally considered a discourse analyst, further helps explain the psychosocial process regarding how scientific ideas are appropriated in a culture, and the way in which those ideas become commonsense. His work reveals how representations are not just ways of seeing the world but that they also facilitate social cohesion. Together, these approaches draw attention to local medical history and see it as having constitutive power in local biomedical practice, as well as other sociocultural histories that shape discursive events.

Discourse Analysis Method. All transcript and field note data were coded using shorthand single word or short-phrase notations that identified specific sections of discourse (Saldaña, 2012). Drawing on focus-group literature, both the individual *and* the group were considered the primary unit of analysis (Kidd & Parshall, 2000). To this end, the study attended to the way in which participants interacted with each other, how meaning was collectively formulated, and also the points at which individuals disagreed, acquiesced, or abstained from participating.

After coding, a set of common themes was identified that resonated across interviews, again with attention to exceptions (L. A. Wood & Kroger, 2000). These themes grouped together different codes under a common notion such as “encounters with doctors” or “understanding of forgetfulness.” An interactive computer spreadsheet was then created to study different themes within and across interviews: over 400 excerpts of text was categorized by theme, and household, and allowed quick navigation and comparison across the broader interview set.

During, before, and after data collection and analysis, relevant literature was also studied with attention to how these themes engaged, challenged, and supported existing findings. Continual work with the research assistant and other local informants was also critical to clarify information about findings. Once a sufficient understanding of themes was acquired, returning to study transcripts was important to ensure reliability and verify how well each theme was consistent to the broader perspectives caregivers endorsed.

Analysis

Traditional Medical Options

Traditional Medicine in the Case of Graciela. When Graciela saw her husband immediately after his first stroke, she woke from her sleep to find Nicholas

holding his pants and wearing his sweater inside out. He was unable to speak or respond to her questions, and he stood absently staring in the distance. Graciela explained how she was frightened and wanted to find help, but was also worried that doing so would put others in jeopardy during an *hora mala*, a specific night hour where individuals are vulnerable to spirit intrusion. Eventually, she turned to her son, Fredrico, who at that time was visiting from California.

I went to Fredrico and told him that there's something wrong with his dad. And he asked me, "What's wrong?" And I told him that he just stares in one place, and I don't know what's happening. And he came running—holding a bag of eggs, about four of them. . . . And I told him, "I don't know what's wrong with that man. I didn't see when he went to the restroom." . . . And so [Fredrico] rubbed the eggs on him, over his entire body. And he said, "We're going to take these [eggs] to the curandera." It was around 4:00 in the morning. . . . So [Fredrico and Mario] went. They immediately went, so she could tell us what's wrong with him. Moments later, they returned and said it was the *hora mala*. He inhaled the air of the bad hour. And she said that he probably wouldn't survive.

Nicholas did survive, and Graciela's family interpreted this good fortune to be the result of their immediate action. Fredrico acted on common knowledge that eggs can be used to draw out negative energy, and subsequently turned to a curandera for further help (for more on the curative power of eggs, see Hunt, 1992; Rubel, 1960). As this example shows, traditional medicine continues to provide meaningful explanations of and responses to illness in contemporary life, and Graciela's words highlight the way in which caregivers might turn to traditional healers to attend to elders' immediate needs.

Local Background on Traditional Medicine. It is important to note that in Mexico, "traditional" (or natural) medicine does not refer to a codified system, but rather a general perspective of physical and spiritual health that emphasizes equilibrium among individual, social, and ecological domains (Rubel, 1960; Somolinos d'Ardois, 1973). In contrast to Western tendencies to separate mind from body, traditional medicine does not have a mind-body division and sees health as an expression of the harmonious functioning of the whole organism (Rubel & Browner, 1999). Moreover, when anthropologists and clinicians refer to traditional medicine, they also reference the shared and constructed knowledge of the local environment's curative properties (e.g., medicinal plants, healthy foods, therapeutic benefits of being in nature, etc.), and the larger social role held by healers in their respective communities (Sesia, 1996).

As Valentina Napolitano (2002) writes of her own study on medical pluralism in Mexico, “Complementary [i.e., traditional] medicines are part of a postmodern condition” that are not a vestige of the past, but “an emergent phenomenon that re-inscribes tradition into modernity” (p. 105). Indeed, this fact is even inherent in the historical roots of traditional medicine. However much traditional medicine might imply something in reference to “traditional” culture, it does not actually originate from “pure” pre-Hispanic origins, but is rather representative of Mexico’s broader syncretic history that combined humoral theory (introduced by the Spaniards), as well as other abroad sources (A. L. Austin, 1988). This variegated system became formalized into a distinct medical practice during the time of the Colonial period, distinguished in comparison with the humoral medical system introduced by the Spaniards (Treviño, 2001).

The most recognized traditional practitioner is the *curandera*, an expert with specialized knowledge who works to diagnose sites of disequilibrium and reestablish harmony (Ortiz, Davis, & McNeill, 2008; Young & Garro, 1993).⁵ *Curanderas* are often described as general practitioners in Mexican settings, yet in Teotitlán they are perceived with more specificity. The Zapotec word for *curandera*—*benny ni rusiak dxiby*—translates as “person who cures *susto*.” This means that, at least nominally, *curanderas* are not perceived as medical practitioners in a general sense, but as having expertise in a more specified arena. *Curanderas* are individuals who possess specialized knowledge about local plants and herbs, and use this knowledge for the treatment of *susto*. They administer teas and provide other traditional interventions (incantations, *limpias* [spiritual cleansings], card divination, and more). Nevertheless, and despite the specificity that this name conveys in Teotitlán, their practice is supple and wide ranging. *Curanderas* are often consulted for *mal de ojo* (“evil eye”), *hora mala* (“bad hour”), *pérdida del alma* (“soul loss”), spirit possession, divination, the common cold, and other maladies.⁶

Throughout Oaxaca and Mexico, *curanderas* and traditional medicine in general have been indexed against broader notions of social progress. Individuals experience stigma talking about their use of traditional medicine, and it has been documented in Mexico City that over 64% of patients did not report using traditional remedies to their physician (Argáez-López et al., 2003). This sensibility certainly extends to individuals in Oaxaca and is expressive of Mexico’s broader history. During Mexico’s 1910 Revolution, which occurred after the Spanish attempted to eradicate indigenous medical practices, indigenous cultures were seen as an obstacle to efforts of the new nationalism that sought to “mestizo-ize” (whiten) the indigenous population: *Indigenismo* was a core feature of revolutionary and postrevolutionary ideology, centering on an idea of Mexican national identity that romanticized indigenous culture as Mexico’s origin, while, in so doing, creating a construct

of the “Indian” as a figure of the past and at odds with modernity (Knight, 1990; Lewis, 2006). This widely affected the prevalence and perception of traditional medicine. For example, until the 1970s, national policy written by the *Instituto Nacional Indigenista* (National Indigenous Institute) aimed to eradicate indigenous healers and discourage traditional medical treatment (Duncan, 2017b). Yet culminating in the 1994 Zapatista movement that positively put indigenous issues in the political spotlight, national policy shifted to recognize Mexico as a multicultural nation with varied social (and medical) practices. For example, in comparison with the policy during the 1970s, a recent report written by the National Health Secretary writes that the national government “respects the free decision of citizens in choosing which medical model meets their needs” (Secretaría de Salud, 2007, p. 23). Since 2001, with the legal passing of Oaxaca’s Decreto 345, the state has come to recognize traditional medicine as a legitimate practice on the same legal footing as biomedicine (Gutmann, 2007). Yet these public policies have not translated to tangible cultural change. As Whitney Duncan (2018), Mathew Gutmann (2007), and Paola Sesia (1996) have shown in their respective research in Oaxaca, viewing traditional medicine as a “right” is different than it standing on par with biomedicine, and traditional medicine continues to be viewed with stigma and is associated to cultural “backwardness” in implicit reference to *indigenismo* ideology.

Analysis of Traditional Medical Options. This helps account for today’s varied appeal of traditional medicine in Teotitlán. Households like Graciela’s justified their decision to consult traditional specialists in reference to how traditional medicine is indexed to cultural identity. In the words of Graciela’s son, Mario, “We took him to the curandera because that’s our first choice before taking him to a doctor. . . . We took him to the curandera because it was susto.” Mario’s comments draw attention to how curanderas are called on because they are perceived to treat a certain category of illness that physicians cannot. Curanderas treat spiritual attacks (e.g. susto) that are considered different than physical ailments. In this way, medical systems are distinguished not only because of varying medical practices but also because of varying illness categories (see also Ayora-Díaz, 1998; Higgins, 1975; Hunt, 1992; Napolitano, 2002; Whiteford, 1995; Young & Garro, 1993).

But for caregivers like Graciela and family, recognizing these symptoms as a case of susto is also an implicit stance that affirms tradition over more “modern” interpretations. This was apparent when Graciela and family told me that the treatment provided by the curandera actually took a long time to take effect, and also when Mario’s wife, Isabelle, discussed the treatment Nicholas received, and why it was meaningful to the family:

What the curandera uses are materials from the earth like water, rocks, fire, and everything that belongs to the earth. And that's how they work—just like our ancestors used to work. And that's one of the reasons why we took him there, before taking him to a doctor. Because something else might happen to him that might be cured by a curandera. . . . [And so] she prescribed a natural medicine—she prepared some herbs for him to drink, and she left us some herbs to make drinks for him. And he was cleansed with an egg, and we were told to throw away the egg very far [because it contained dangerous energy].

Isabelle's description provides a glimpse of how curanderas work, and also about the way that their work is perceived to serve as a bridge between idealized notions about cultural origins and modern experience. Curiously, after they state that the curandera was slow to ameliorate Nicholas' symptoms, their description is nevertheless positive. They describe how curanderas use timeworn remedies, "just like our ancestors," and state that this is their first choice when seeking medical assistance. This is not just a description of traditional medicine, but also a justification of it. The family turns to traditional medicine *because* it is part and parcel of their views of cultural identity.

Another participant to this study, Juanita, cared for her husband recovering from a series of debilitating strokes. She also happened to be a curandera. Juanita worked from home and gained recognition in the community for treating cases of epilepsy. She was also proud of curing an individual who temporarily resided in Teotitlán from Mexico City; this individual did not initially believe in traditional medicine but was nevertheless cured from abrupt symptoms involving weight loss and fearfulness. Juanita understood this to be a case of *susto* related to his being victim of a highway robbery. She treated him with a series of local plants, and also advised him to return to the site of the robbery. Within weeks, he regained his health. Similar to Graciela's experience, after the stroke Juanita witnessed in her own husband, she noticed that he could hardly speak or ambulate. Juanita drew on local understandings of illness regarding disequilibrium. She explained her husband's condition as caused by the psychological stress that he had experienced earlier. "I believe it was due to a lot of stress and the anger that he had. That's what I believe caused everything. And I think it goes back to his childhood." Juanita explained how a dispute between her husband and his father about who would inherit the family property rendered the family disjointed. As a result, her husband endured stress throughout his life. Throughout their marriage, Juanita tried to get her husband to go on walks and engage with their own children, implicitly reinvoking the sense of family that he felt he had lost with his parents. Initially, Juanita and her husband consulted physicians at the *Centro de Salud* (local health clinic) and later a neurologist in the wake of her

husband's first stroke. Yet they found the medications they received to be ineffective. "The doctor's medication didn't work. And even now, I don't think it's working. So I plan to start giving him natural medicines so he can get better. That's why I take walks with him." Although she knows her husband is not suffering from *susto*, Juanita said that related medicines will likely be effective towards treating his condition. She described local plants—respective ones for men and women—and how she uses them in conjunction with other remedies, like walking in nature, *limpias* ("cleansings"), and other restorative measures. At once, Juanita's approach illustrates how traditional medicine is viewed as an alternative to biomedical options, as well as how it leads to locally meaningful responses to social disequilibrium.

Similar to how *susto* and traditional medical concepts are a matter of belief for Graciela and Juanita, *not* pursuing traditional medicine is analogously related to disbelief. Over and over, among different caregivers and across various households (and also with other individuals surveyed in the community), people continued to say that they do (not) visit *curanderas* as a matter of belief. Whenever traditional medicine was discussed, people invoked the Zapotec word *relilaz*, "to believe" (e.g., *Kety relilaza rumedý kan*, meaning "I don't believe in that treatment"). Yet as anthropologists have noted, justifying (or dismissing) something as a matter of belief carries subtle implications. Pouillon (2016) reminds us that the notion of belief is "paradoxical in that it expresses doubt as well as assurance" (p. 485). To say that one believes in something implies a conviction, but it also conveys awareness of doubt about that conviction. To further this point, Byron Good (1994) turns to etymology to highlight how belief is a "modern idea" that differs from its original meaning. Originally, writes Good, the concept of belief was linked to notions of affection and a relationship with something held dear, and only later came to imply a presupposition tentatively held to be true in contrast to higher, absolute knowledge. That is why today, across many cultures, to say one "believes" in a given entity like medicine means something different than saying one has "knowledge" of it; the former is marked by tentative faith and the latter by unwavering certitude.⁷

Discussion of Traditional Medicine. In medically plural settings like Teotitlán, the dichotomy between belief and knowledge is adapted to rationalize the difference between "traditional" and "modern" medicines, where the notion of belief is used to describe traditional medicine and knowledge is used in reference to biomedicine. This distinction creates a further division among how epistemological claims divide geographical territories. *Curanderas* are seen to work in a setting concerned with local dimensions of human life—drawing on local medicinal knowledge, local illness concepts, and local

ecological harmony—while allopathic doctors, in comparison, are trained in institutions that represent the modern world with knowledge purported to transcend local custom. When belief is appealed to justify traditional medicine, it is done so in the context of the wide-ranging authority biomedicine has over local perspectives. And, conversely, as Stacy Pigg (1996) acutely observes in her own fieldwork in a different medically plural setting, claiming to not believe in traditional medicine only makes sense if you have somewhere else to go—namely, the modern, cosmopolitan world.

This epistemological dichotomy is present throughout Teotitlán, both among caregivers who professed to believe in traditional medicine and those who did not. For example, in his experience caring for his wife with late stage Alzheimer's disease, Carlos and his adult son, Francisco, highlighted an interesting intergenerational contrast about their respective beliefs in traditional medicine.

Carlos: I'm not very into natural medicines. And the way we live nowadays, natural medicine worked before. But also it killed a lot of people. And also a lot of people lived because of it. And when it works, it works slowly. Compared to the doctor's [medicine], it's quicker. That's why I'm not really into natural medicine.

Francisco: No, we're not into it. [Moments later Francisco adds:] We don't really believe in that.

For Carlos, it is not the case that traditional medicine is ineffective. He clearly states that he knows it can work (albeit slowly). Yet he also recognizes that it can cause harm. These comments are not merely about medical efficacy per se; they rather point toward a broader idea about the community to explain why he does not utilize traditional medicine. Life has changed. The circumstances of living in Teotitlán are different such that traditional medicine and traditional illness categories no longer seem relevant. This is what Carlos means when he says that it “worked before” and when he compares it with “the way we live nowadays.” Carlos' comments stand in contrast to Francisco, a generation younger, who affirms that traditional medicine is not something he or his family believe in at all. Indeed, whereas Carlos implies he does believe in traditional medicine, Francisco's concluding words highlight a generational difference about how traditional medicine is perceived as something relegated to the cultural past. To further understand this point, they were asked whether traditional medical concepts like *pérdida del alma* (“soul loss”) could be mobilized to explain the severe forgetfulness Francisco observed in his mother. “No, that's not the case,” Francisco said. “Because if it were the case we would have visited a natural healer. But this is just not the

case.” This further builds on Francisco’s comments regarding how traditional illness categories are no longer relevant. If he happened to believe that his mother’s forgetfulness was due to soul loss (or a related traditional illness category), then he would have sought relevant help. But he does not. Hence, Francisco explains, curanderas are relevant for treating traditional illnesses—yet he maintains that those illnesses no longer exist.

Francisco’s professed disbelief in traditional medicine is revealing of local dynamics given the prevalence of traditional ideas about illness (e.g., this family understood Alzheimer’s to be caused from stress). Indeed, traditional ideas about illness permeate most understandings of forgetfulness (Yahalom, 2019b). Yet many caregivers also stopped short of endorsing traditional illness categories like *susto* or *pérdida del alma*. Perhaps one reason for this is accounted for through the logic of belief. Like Francisco stated, *if* he believed, he would go. There is a commitment implied in this statement, and for this reason he does not believe. Similar to Stacy Pigg (1996) who writes in her study of shamans in Nepal, “your attitude towards shamans communicates who you are” (p. 160), curanderas in Oaxaca are caught up in the negotiation of what modernity means, and how individuals decide to position themselves with regard to it and concomitant notions of tradition. This sheds further light on the way traditional medicine is indexed to broader stigma that some Teotitecos attempt to navigate and avoid. Francisco’s statement that he does not believe in traditional medicine is situated in this understanding. Indeed, there were many instances during fieldwork when acquaintances stated that they did not believe in traditional medicine, only to later share that they had recently consulted a curandera for specific illnesses. People seemed to experience stigma and embarrassment for engaging with traditional medicine—and perhaps even more on talking about this subject with a researcher who was foreign to the community. In this way, individuals’ avoidance of traditional medicine is embedded within broader power structures that render it a matter of belief maintained in juxtaposition to biomedicine. In the process, traditional medicine becomes a symbol of backwardness or the maintenance of local identity—depending on one’s belief—highlighting the perceived tension between ideals concerning local tradition and contemporary life.

Biomedical Options

Biomedicine in the Case of Graciela. The night of Nicholas’ first stroke, his family thought he was dead. After appearing disheveled and unable to speak, Nicholas grew immobile and eventually lost vital signs of life. “He looked like he was dying,” Mario said. And Isabelle added, while standing over a loom and taking a break from the rug she had been weaving:

He *was* dead—when we touched him, he wasn't breathing at all, his blood wasn't circulating, his nose wasn't passing air. He got cold, and that's when we realized what it was. So they took him to the *Centro de Salud* [Teotitlán's local hospital], but our assumption was that he got scared of something. That's what we believe in.

This was their first description of what happened that fateful night, and it took time to piece together the details of how Graciela's family came to bring Nicholas to the local hospital. Because they believed Nicholas was suffering from *susto*, they initially sought help from a *curandera*. But they were later advised by this healer to go to the hospital. "We took him to the *curandera* because that's our first choice before taking him to a doctor," Mario said. "However, afterwards, we went to the doctor because she told us to take him." Indeed, while allopathic providers might be averse in referring patients to "alternative" treatments due to stigma and perceived inferiority, there existed other similar instances where *curanderas* advised families to visit doctors. In this case, Nicholas was first treated by the *curandera* for *susto*, and was subsequently referred to visit the hospital for high blood pressure. As Graciela's family made clear, both providers were seen as integral to keeping Nicholas alive.

Local Background on Allopathic Medicine. In Teotitlán, allopathic doctors are locally known and respected individuals who have specialized knowledge to cure illness. The Zapotec term for doctor, *benny ni rusiak*, literally means "a person who cures." As this phrase suggests, doctors are known to treat a variety of ailments and have been present in Teotitlán for centuries, embedded in extended histories of conquest, colonialism and, as will be argued, contemporary regimes of power.

The arrival of the Spaniards who conquered Oaxaca in 1521 signified what Kristen Norget (2006) rightly calls "cultural rupture," shattering and displacing dominated orders of meaning, and remaking the entire sociopolitical landscape (p. 91). While the actual conquest of Oaxaca lasted just under 1 week—and the Zapotecs capitulated without engaging in battle—the consequences were devastating (Murphy & Stepick, 1991, p. 16). The New World Conquistadores significantly changed the social landscape not only by exertion of power but also through introduction of disease; they brought measles, smallpox, typhus, and other infectious diseases against which the indigenous population had no immunity. The numbers alone are staggering, giving pause for the magnitude of losses. Whereas at the eve of the Conquest there were an estimated 350,000 indigenous people living in Oaxaca Valley, by 1568 the population dwindled to 150,000 and, by 1630 only 40,000

remained—a 90% drop in less than a 100-year period (Murphy & Stepick, 1991).

This history also had a significant impact on local medical practice. While Spaniards were initially fascinated by the knowledge indigenous populations had accumulated of medicinal plants, they soon came to prohibit much of it because they found it threatening and heretical.⁸ From the time of the Conquest, the Spaniards introduced European-trained *médicos* whose practice was initially based on classical Greek humoral medical theory. As already discussed, these practitioners and other Conquistadores challenged and eventually subverted indigenous medical treatment, leading to the eventual undermining of pre-Hispanic medicine as a legitimate treatment option (Somolinos d'Ardois, 1976; Treviño, 2001). Nevertheless, New World physicians began to selectively incorporate humoral medicine with parts of what remained of local knowledge of medicinal plants, leading to a *mestizo* (“mixed”) medical practice (Hernández Sáenz & Foster, 2001). This persisted until the early 19th century when French-based biomedicine was introduced to Mexico, leading to the contemporary dominant approach of distinguishing between underlying objective (biological) causes and subjective (psychosocial) experiences of illness (Good, 1994; Somolinos d'Ardois, 1976).

Today, the purported objectivity associated with biomedical knowledge stands in contrast to the beliefs people have toward traditional medicine. Biomedicine has come to be defined by a specific orientation that posits illness to have underlying, universal features, and medical knowledge as consisting in objectively accounting for those features. Yet however much we take biomedicine to be an objective “mirror of nature,” it is a cultural activity like any other social phenomenon, constituted by specific outlooks and values (Rorty, 1979). Yes, biomedicine is able to make critical observations and interventions to maintain a quality of life that should not be dismissed or minimized. But the point made by Rorty and other social scientists is that biomedicine is also steeped within cultural values that shape how people interpret and respond to them. As Good (1994) argues, we have been seduced into thinking that biomedical “knowledge” is somehow less cultural and contingent than traditional “belief,” and thus fail to appreciate how biomedicine is also socially constructed; in the United States, he argues, biomedicine is often situated within notions of salvation and purity and linked to broader forms of state power. This is Foucault's (1975) point when he reminds us that the purported objectivity of the “clinical gaze” did not arise from technological innovation or the unavoidable development of a neutral standpoint—from simply detecting somatic signs that were waiting to be seen. Rather, Foucault argues, the clinical gaze originated from within a specific cultural epoch that prioritized depth, such that it made sense to detect underlying signs of illness. Again,

the point is not to dismiss the unquestionable utility and efficacy of biomedicine, but to situate it within a specific cultural landscape and unsettle the way it is commonly viewed to be objective and free from cultural influence.

Analysis of Biomedical Options. In Mexico, congruent with how traditional medicine is linked to notions of backwardness, biomedicine is indexed to notions of economic development and social modernization. State campaigns meant to raise public awareness about health care invariably aim to also instill citizens with “modern” health behaviors that facilitate economic and social ends (Wentzell, 2015). This is written in federal policy as, for example, when the National Health Secretary has extended concern about health to include mental health, whose “importance . . . [is recognized] not only as a health issue, but also because of its impact on socioeconomic development for nations” (Secretaría de Salud, 2010, p. 13; see also Duncan, 2017b). Such statements testify to how biomedicine is contextualized within national efforts toward “modernization” and, conversely, how choosing to forgo biomedical treatment is viewed as a larger stance against national progress.

As other caregivers came to share their experiences of engaging with biomedicine, it became apparent that no household consulted a physician for forgetfulness itself, but rather due to other somatic complaints. This reveals biomedicine’s social power, as well as how it comes to introduce new perspectives of age-related forgetfulness. For example, Alberto, Beatrice, and Cecilia (caregivers whose mother was diagnosed with senile dementia, a local illness category of progressive forgetfulness considered less severe than Alzheimer’s disease) reflected on how they came to learn their mother had an illness pertaining to forgetfulness, when they had initially considered forgetfulness as normal. Beatrice explained why they initially turned to a doctor:

It was because of the pain in her feet, and her knees, her waist, and she would always complain about her pain. Everything happened gradually. It first started with her feet, then she used a cane. And then the cane wasn’t able to support her weight anymore, so she used a walker. And then we thought that the pain was probably in her knee. And then we took her to the doctor and he told us that she had severe osteoporosis. And he said that she needed a study, but the study she needed was for her whole body [including her brain]. So then they realized that she had it [referring to senile dementia]. And they asked her some questions. According to the answer of the questions, they also diagnosed the illness she has [senile dementia].

In congruence with the fact that this household viewed forgetfulness as non-problematic, Alberto and his family did not visit a doctor because of it. Instead, they initially sought consultation because of the elder’s pain. At first

tolerable, the elder's pain increasingly grew more acute, such that at a decisive point they decided to seek medical help. This line of reasoning illustrates a preliminary reason for why doctors are considered useful—they cure pain that has a physical origin, resonating with prior research that shows how other Mexican indigenous communities perceive doctors as treating physical, not mental or spiritual ailments (Ayora-Diaz, 1998). But, in the process of visiting the doctor to treat her knee, the consultation ends with an answer to a question they had not raised. It was through visiting a doctor for somatic pain that the family learns about senile dementia, an illness wholly different from her presenting problem.

Whereas Alberto and his family consulted a doctor because of physical pain, caregivers also consulted doctors due to knowledge about other somatic symptoms that do not involve pain at all. Pablo and Vanessa are a married couple who care for an elder diagnosed with Alzheimer's disease. They similarly described how they consulted a physician for symptoms not related to forgetfulness and came to learn the elder had Alzheimer's disease. Vanessa described why they initially turned to a physician:

Because of her high blood pressure, that's why we took her . . . That's when they asked her [if she was taking her medication]. And at that time I already knew that she wasn't taking the medication anymore. . . . And so when I took her to the clinic, she told the doctor that she was still taking her medicine. That's when they [the doctors] realized that she forgets. And that's when they told me that there is this disease that's called [Alzheimer's disease], and perhaps that's what she has.

This excerpt again demonstrates that forgetfulness is not caregivers' reason to seek medical help. Vanessa's description mirrors much of what Beatrice says—even how the diagnosis pertaining to forgetfulness is discovered accidentally. But here Vanessa reveals that there exist other symptoms that lead caregivers to seek help. Previous awareness about high blood pressure—and Vanessa's knowledge that medical doctors are the appropriate individuals to treat this condition—justified their visit.

The observation that caregivers visit doctors for reasons other than forgetfulness holds even for more severe cases. Caring for his wife with Alzheimer's disease, Carlos and his son Francisco described how their attentiveness to his wife's "thinking too much" after her finger amputation led them to consult a physician (for more on thinking too much as a local idiom of distress, see Kohrt et al., 2013; Yahalom, 2019b; Yarris, 2017). Francisco explained,

Well, she started to forget very often. And consequently her behavior wasn't normal anymore. . . . What depressed her the most was that she lost a finger.

[And] due to that situation, it started to get worse. . . . So we took her to a neurologist [because of the depression]. . . . Yes, he is the one that diagnosed her with Alzheimer's.

Here, Carlos and his family are aware of forgetfulness—they know that the elder has begun to forget in a concerning, not “normal” way—but their decision to visit a doctor is again not due to forgetfulness *per se*. They visited a neurologist for the elder's sadness and, again, it is through this encounter they learned that she has Alzheimer's disease. The family's turn to a physician for mental health concerns (and Pablo and Vanessa's turn for high blood pressure) illustrate how medical doctors are perceived to treat nonphysical symptoms beyond somatic pain—and also how these consultations lead to new perspectives of forgetfulness itself.

Discussion of Biomedical Options. In each of these instances it is instructive to note that no caregiver thought to consult a doctor because of memory complaints—nor did they consider visiting a doctor to assess memory—but elders nevertheless left being diagnosed with an illness concerning it. In a setting where doctors are not the only individuals known to cure illness, one must pause and consider the vast power this shows them to have. Indeed, whereas indigenous (or traditional) medicines have been historically delegitimized, biomedical practice continues to be embedded and reaffirmed through government programs, standardized medical procedures, and broader economic and political parameters. Teotitlán's *Centro de Salud* is symbolically situated with prestige, at the base of the community's main arterial motorway, to serve the Teotiteco and neighboring communities. Many of the doctors are not from Teotitlán, but other parts of Mexico, and are carrying out temporary residency programs. These doctors are routinely consulted to monitor somatic complaints—conditions like high blood pressure and diabetes.⁹ Yet for the majority in Teotitlán who receive a pension, this is not a personal choice one makes, but something required by government policy. The government-sponsored pension program, *70 y Más*, gives elders a pension *on the condition that they biannually visit doctors and attend bimonthly pláticas* (informational workshops on biomedical health and treatment; see also Sesia, 2001). In so doing, the state legitimizes and transforms one medical system over another, illustrating how power relations shape healing in local contexts (Connor, 2001; Menéndez, 1994; Rose, 2007). The power represented by allopathic providers at once demonstrates the regularity and legitimization of medical consultation—what Foucault (2003) calls the “politics of health”—and the way biomedical information about conditions like diabetes and Alzheimer's disease is circulated as a matter of public concern. Moreover, it illustrates limitations in explaining health-seeking behavior as solely

motivated by a pragmatism for what is best for elders. Yes, the decision to seek medical help is, in part, motivated by caregivers' pragmatic concern to ensure elders' well-being. Yet these encounters also reveal how health-seeking behavior is simultaneously constituted within broader power structures that influence with whom and how consultations occur.

These observations go beyond initial visits with physicians and include their recommendations for follow-up care. After Graciela and her sons took Nicholas to the *Centro de Salud* to address his high blood pressure, they were advised to go to a specialist in Oaxaca City for further diagnostic testing. Mario said,

They told us that we had to have a study on him in Oaxaca. But they also told us that all they would be able to tell us is what's wrong with his brain and that he wasn't going to get any better. And that [the study] is going to be expensive.

Like other households, when caregivers consult local doctors, they are given a tentative diagnosis that they are then told can only be confirmed through subsequent consultation with a specialist. This was a consistent finding across all the households interviewed who had met with a doctor that had suspected or diagnosed dementia. In Graciela's case, she and her family decided to forgo the tests, reasoning that the additional knowledge that they would have gained about Nicholas' condition did not justify the financial burden they would incur in the process.

Economic restrictions. While previous research has shown that health-seeking behavior among populations with dementia is related to cultural outlooks on forgetfulness (Hinton, Franz, & Friend, 2004), this perspective alone is insufficient to address the structural factors that contextualize what these decisions entail. Just as Graciela and her family reasoned that it was not financially viable to see a specialist in Oaxaca City, many other households held similar rationales, questioning whether receiving a definitive diagnosis from a specialist would improve how they provided care. For example, Pablo and Vanessa had a similar experience on their visit at the *Centro de Salud*. In Pablo's words, "They told us that if we took her to a specialist, we could be certain. But . . . we're doing the best we can. And to take her to a specialist is more expensive." And later he clarified what sort of information he could be certain of, if he managed to afford a visit with a specialist:

Well first of all, we'll get our questions answered, and what probability [she has to recover] . . . I hope that he will tell us the truth, whether it's really because of her age that she cannot get better, and if it's going to get worse until the day she passes away. Or if there is a way to save her if I had the money.

Those are the questions I want answered. But I'm hoping to have money in the near future. . . . Even if I don't buy the medication [the doctor might prescribe], at least I'd get my questions answered.

Pablo's words shed light onto the way specialized doctors are perceived and the type of services they are thought to provide. Though Pablo and his family cannot afford it, they speculate on how specialists might offer more definitive diagnostic answers than general doctors. He begins to wonder about the expected course of Alzheimer's, and whether there might be available medications or other treatment options. He wants this information so he can know how to plan for the future, and also so that he might provide better care, but he knows it is outside his financial means. This brings up the resources Pablo knows are available—but just not to people like him with financial limitations, further highlighting structural economic inequalities implicit within everyday caregiving experience. In the end, although Pablo suspects that specialists could help, and although he personally wants to consult one, he and his family decide to not pursue this option. In so doing, Pablo's comments also point toward how biomedicine is locally understood to hold a perspective of truth that might stand at odds with other, traditional perspectives. "I hope that he will tell us the truth," implies that specialists and, by extension, allopathic doctors have access to an underlying truth about illness that might not otherwise be known. Believing that the truth about illness exists—despite not being able to financially access it—is a stance that highlights one medical system at the expense of the other. It again reveals the local difference between "belief" and "knowledge," where physicians hold epistemological authority over other medical traditions. But here, even when that authority is recognized, biomedicine is perceived within financial constraints that limit Pablo's ability to pursue it.

Respect as foregoing care. In addition to financial reasons, caregivers also chose not to consult (specialist or generalist) physicians because it was against what elders wanted for themselves. This came up during a conversation with Sergio, Manuel, and Linda, another caregiving household, about why they have yet to gain diagnostic clarification about an elder's progressively impactful forgetfulness.

Linda: No, he hasn't been diagnosed with anything because he doesn't want to go.

Sergio: He doesn't want to go to the doctor. And even if he were to go, if they were to prescribe any medications, he would just take it all at once. So I don't see how there's a point to take him to the doctor since he won't take his medications the way he's supposed to.

Despite the fact that Sergio's father cannot recall his name and the risks involved in the elder's dangerous tendency to wander, Sergio and his family decide not to consult a doctor—or any medical specialist. Their reason is simple: the elder does not want to go. This helps show how, even if caregivers were interested in consulting doctors, they overlook their own desires to honor what elders want. While this decision may appear to be a negation of caregiving responsibilities, there is also good reason to understand it as a mechanism that upholds them. Research on Latino elders shows that social and familial support is more important to elders' sense of well-being than medical attention (Beyene, Becker, & Mayen, 2002). Hence, by respecting elders' wishes not to visit a doctor, caregivers are perceived as attending to them in a significant way. Sergio and his family highlight how listening to elders and demonstrating respect—and, in some instances, eclipsing their own inclinations to seek professional help—is central to the tenets of caregiving itself.

Biomedicalization of aging. The most obvious impact medical consultations have on caregivers is the way in which consultations transform “normal” forgetfulness into a diagnosed biomedical disease. This is representative of what Carroll Estes and Elizabeth Binney (1989) term the “biomedicalization of aging,” a process whereby perceived normal physical and mental decline is placed under the domain and control of biomedicine.¹⁰ All of the caregivers who consulted doctors made their decisions on the basis of previously known biomedical illness categories, or because visits were required by the state's pension program. Yet in the process, they were introduced to a new illness category—senile dementia, Alzheimer's disease, stroke, or vascular dementia—thereby expanding the scope and power of biomedicine. This finding, implicit throughout the previous pages, is important with regards to how the perception of elders is changing in Teotitlán. Following Duncan (2018), who observes how Oaxacan mental health professionals go beyond the provision of treatment to actively foment local culture change in the way mental health is understood and pursued, the above discussion demonstrates how doctors, nurses, and other stakeholders in biomedicine are equally integral to a type of “cultural change”—initiating not only a change in the scope of biomedical practice but a more fundamental reconstruction of how the aging process is understood.

Conclusion

This article has advanced a number of observations about the choices caregivers face in engaging with medical specialists in a rural Oaxacan setting. The implicit distinction between “knowledge” in biomedicine and “belief” in traditional medicine implicitly presupposes power structures that

legitimize one system at the expense of the other. Health-seeking decisions are rooted in epistemological assumptions that are structured by broader social, political, and economic factors. This is not only based in perceptual differences between medical systems but broader idealized notions of modernization and social progress. When caregivers seek traditional medical providers, they do so as part of a larger stance that engages with notions of tradition and local identity in the context of modern alternatives. Conversely, when caregivers engage with biomedical providers, this choice is representative of a larger affirmation of ideas about modernization. This latter perspective is rooted in the power attributed to biomedical providers—from government policy and fiscal programs that require engagement. The regularity of consulting physicians comes to change how age-related forgetfulness is understood and contrasts with broader representations of aging that view illness as a normal part of the lifecycle.

As a whole, the choices that caregivers make in consulting physicians, specialists, and traditional healers concern—and are responsive to—factors that go beyond the provision of care for elders, and involve broader ideas about how to maintain tradition in a setting perceived to be increasingly “modern.” This helps situate how medical decisions ought to be studied with regard to humanistic inquiry, where, in the words of Giorgi (2000), “the human being is an embodied being” whose experience is, in part, not only embodied by immediate, corporeal life, but also social factors that shape larger values and meaning (p. 65). The medical pluralism described in this article is not just about a set of choices one has between different types of providers, but a broader “arena for the negotiation of social difference” (Pigg, 1995, p. 19). This is a negotiation situated between socioeconomic spectrums and cultural differences, and also between the opposite idealized poles represented by “tradition” and “modernity” that inscribe those differences, including the inhabited grey zones in which most caregivers are situated as they make medical choices. Caregivers’ medical decisions engage with broader concerns about their cultural heritage in a world perceived to be increasingly modern.


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Notes

1. The Duquesne University Institutional Review Board approved the research conducted in this article (Protocol #2014-02-18). This article is adapted from a chapter in the book *Caring for the People of the Clouds: Aging and Dementia in Oaxaca* (University of Oklahoma Press, 2019). The author would like to thank Scott Churchill and two anonymous reviewers from this journal, Duquesne University for a generous Dissertation Fellowship, UCLA's Chicano Studies Research Center, the Centro de Investigaciones y Estudios Superiores en Antropología Social in Oaxaca (CIESAS), La Biblioteca de Investigación Juan de Córdova, Janet Chavez Santiago, Taurino Alexandro Mendoza Martínez, and the many other individuals and research institutions that contributed to this study.
2. In addition to traditional and biomedicine, Oaxaca is also home to homeopathic medicine (see Finkler, 2001; Hunt, 1992; Whiteford, 1995) and new psychological perspectives of personhood (see Duncan, 2017a, 2017b, 2018). These forms of treatment are not included in the following article because they were irrelevant to how individuals conceptualized dementia.
3. Susto is a medical condition common across Latin American settings (see also American Psychiatric Association, 2013; Rubel, 1960).
4. Representing other people's worldviews as a matter of "belief" is delegitimizing and authorizes one's power as observer (Good, 1994, p. 20). Yet in this article the word "belief" is used to account for people's (dis)engagements with traditional medicine because, as will be shown, this concept (and its juxtaposition to statements about "knowledge" of other forms of medicine) best account for how and why individuals justify their health-seeking behaviors.
5. Curanderas are referred to in the feminine form because all practicing folk healers encountered in Teotitlán were women. Yet there exist many male curanderos throughout Oaxaca, Mexico, and Latin America. In Teotitlán, curanderas do not typically rely on medical practice as a primary means of income. Most have other professions and practice traditional medicine on the side.
6. As Good (1994) notes, biomedical practice operates with a distinct hermeneutic that is primarily oriented toward diagnosis. Other medical systems like traditional perspectives in Oaxaca are less concerned with differentiating symptoms and illness types, and instead focused on establishing personal and ecological harmony.
7. In Zapotec this diction is valid, but carries more sophisticated differences among other verbs. The Zapotec verb to know with certainty, *nanna*, is used in sentences like "*Nanna kety raku xhii*" which translates to mean "I know that you do not have a cold." The Zapotec verb to think something is the case, *rizak*, is used in sentences like "*Txa rizaka zia b nisie*," which translates to mean "I think it will rain." While *rinii* is a Zapotec word to refer to knowledge, one would not use it

to refer to make a sentence like “the doctor knows I am sick.” Instead, a Zapotec speaker would attribute this information to the authority of the doctor himself or herself, as in sentences like “Doctor gunii na yuu dxabaa” which translates to mean “The doctor told me I am sick.”

8. However, it is rumored that Cortes wrote to King Charles V not to send Spanish doctors because indigenous medics were more than competent (Hernández Sáenz & Foster, 2001). Whether the anecdote is true, it reflects the highly developed medical tradition that existed prior to the Spaniard’s arrival. Furthermore, it shows how even Cortes found value in local culture and healing practices.
9. Medical visits are free for elders on the state pension program, and are subsidized to \$20 pesos for those who pay out of pocket.
10. This also touches on what Kitwood (1997) calls the “Alzheimerization of dementia,” the way in which symptoms of dementia are increasingly viewed through notions about Alzheimer’s disease in the U.S. and other biomedical-oriented settings (p. 22).

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