

Project Demonstrating Excellence

An Integration of American Nontraditional and Mesoamerican Traditional Approaches as  
a Treatment Model for Traumatic Stress and Post-Traumatic Stress Disorder (PTSD)

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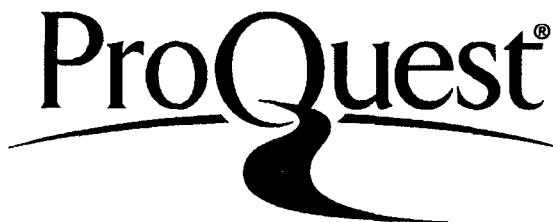
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## Abstract

Traumatic stress and Post-Traumatic Stress Disorder (PTSD) are rampant in American culture, even within nuclear families. This may cause disorganization of attachment bonds and increase the likelihood of PTSD when exposed to future traumatic events. The objective of this study is to assess the similarities and differences among psychotherapeutic treatment modalities employed in the United States, Cognitive Behavioral Therapy (CBT); Eye Movement Desensitization and Reprocessing (EMDR); Structured Intervention for Trauma for Children, Adolescents and Parents (SITCAP); Hypnosis; and finally Curanderismo, a Mesoamerican traditional treatment modality with similar practices to those found in Transpersonal Psychology for the treatment of PTSD. This heuristic study consists of interviews with co-researchers gathered in urban settings in the United States; urban, rural, and jungle settings in Mexico; and the personal and professional experiences of the researcher with both modalities. This study includes description of the therapeutic use of the temazcal (a Mesoamerican sweat lodge); limpiezas (a ritualized clearing of the subtle energy field); the medicinal and spiritual applications of herbalism; shamanic ritual; and the plática (a specific and highly interpersonal counseling style employed by curanderos), and the significance of holism and equilibrium in the Mesoamerican healing paradigm. In addition to these, this discussion also presents the role of prayer and interpersonal touch related to healing traumatic stress, and PTSD. An analysis of the results produced the development of an integrated healing model to reflect the positive aspects of all researched modalities toward efficacious treatments for traumatic stress and PTSD. Finally, this research examines and discusses

the implications, limitations, and future research of this model for trauma treatment and research.

*Keywords:* Curanderismo; Susto; Temazcal; Post-Traumatic Stress Disorder; Heuristic Research, Integrative Mental Health, Integrative Healing, Subtle Energy

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**Dedication**

*For my beloved husband Johnnie Almeida*



## Chapter I

### **Historical Relevance of Treatment Strategies**

Trauma negatively impacts an individual on mental, physical, developmental, emotional, social, and spiritual levels. An individual's genetic inheritance, the quality of early life experiences, and socioeconomic factors are stored in the right-brain's amygdala, the seat of emotions (Levine, 1997) and the hippocampus, the seat of memories. When emotions, including fear, overwhelm an individual, the neocortex—the seat of rational thought—is not in control, so the individual has difficulty attending to life's tasks and skills such as working and relating (Levine, 1997). Any experiences of early traumatic stress may be stored outside an individual's conscious awareness. However, suppressed, unresolved, or unprocessed traumas persist as emotional, unconscious memories, they are encoded in the human brain, awaiting a new sensory trigger to link the past with the present (Carey, 2008). The severity of the early trauma determines whether the individual's recovery from a later traumatic event will be facile (Reivich & Shatte, 2002). The linking of past traumas with current ones may account for why many men and women who served in the armed forces in Afghanistan and Iraq are experiencing PTSD while others are not.

Current treatments for trauma reflect the mores of the society in which they are created and the population they serve. Thus, in American allopathic mental health systems, treatments are left-brain-dominated, logical approaches that are cognitive-behavioral or drug-oriented. Physical symptoms are regarded as more legitimate in this system than subjective experience (Mehl-Madrona, 1997). Individuals are dehumanized and treated as "cases" developed from a specific constellation of diagnostic criteria.

(Mehl-Madrona, 1997). In this biomechanical model, the mind, body and its behaviors operate mechanically (Duncan, Miller, & Sparks, 2004), are subject to breakdowns, and are detached from the spirit (Dossey, 1993; Mehl-Madrona, 1997). When “cognitive” is presumed to include emotions and feelings, or when an individual’s left-brain processes are not modified by the right-brain’s input, Joseph LeDoux (2002), a neuroscientist at New York University, informs us that:

A mind without feelings and strivings (the kind of mind traditionally studied in cognitive science) might be able to solve certain problems given it by a cognitive psychologist, but it doesn’t stack up well as the mental foundation of a self. The kind of mind modeled by cognitive science can, for example, play chess very well and can even be programmed to cheat. But it is not plagued with guilt when it cheats, or distracted by love, anger, or fear. Nor is it self-motivated by a competitive stream or by envy or compassion. If we are to understand how the mind, through the brain, makes us who we are, we need to consider the *whole* mind, not just the parts that subserve thinking. (p. 23)

Thus, in our left-brain-dominated institutions and organizations, rarely does traumatology incorporate elements of treatment that lie outside the allopathic medical model, so attention is not paid to the entire person’s less measurable resources such as the soma, social supports, and spirituality. Spirituality in allopathic models is viewed through the lens of the mechanistic orientation of Western science (Grof, 1985). Wholeness is not a treatment priority, nor is it a treatment approach sanctioned by licensing boards. Rather, treatment is conducted from a left-brained perspective that is symptom-oriented and completed in a specified number of sessions. Counseling services that do not adhere to

allopathic treatment models charge a fee for service, so individuals must pay additional money to receive humanistic care.

Furthermore, the management of the right-brain's attributes is not taught in our public school systems even though both the left- and right-brains complement each other in all aspects of being human (Freed & Parsons, 1997). Whole-brain functioning correlates with increased intelligence, improved learning, enhanced moral reasoning, psychological stability, and emotional maturity (Hagelin, 2007).

Despite our culture's educating the left hemisphere only, "normally, the two hemispheres are in constant communication" (Doidge, 2007, p. 280). Brain research suggests that the plasticity of the human brain means that positive neuroplasticity may occur when optimum stimuli are present and the heart is engaged. We now know that "neurons that fire together wire together" and that "neurons that fire apart wire apart", or "neurons out of sync fail to link" (Doidge, 2007, p. 62). Thus, clients have the power to change their malleable brains for the better. In fact Doidge (2007) states:

Recent brain scans done before and after psychotherapy show both that the brain plastically reorganizes itself in treatment and that the more successful the treatment the greater the change. When patients relive their traumas and have flashbacks and uncontrollable emotions, the flow of blood to the prefrontal and frontal lobes, which help regulate our behavior decreases, indicating that these areas are less active. (p. 233)

State licensing agencies impose sanctions on what therapeutic approaches may be "legally" used by psychotherapists and counselors to treat traumatic stress and PTSD.

These sanctions, then, are reflections of our culture. Culture shapes perception, and often what is “natural” is actually “learned” (p. 300). Doidge avers:

civilization is a composite of the higher and lower brain functions [which] is seen when civilization breaks down in civil wars, and brutal instincts merge...Because the plastic brain can always allow brain functions that it has brought together to separate, a regression to barbarism is always possible, and civilization will always be a tenuous affair that must be taught in each generation and is always, at most, one generation deep. (p. 298)

Psychotherapy evokes data from both the higher and lower brains which is an opportunity to educate the emotional brain and integrate it with the logical brain for clients' optimum functioning. Psychotherapy can help individuals transform psychologically painful experiences into a wellspring of creativity, compassion, and greatness. When psychotherapy is conducted within a transpersonal psychotherapeutic approach, the potential for the evolution of the individual's consciousness through spirituality comes to the fore (Grof, 1985). Grof (1985) suggests:

Transpersonal experiences often have an unusual healing potential, and repressing them or not supporting them critically reduces the power of the therapeutic process. Important emotional, psychosomatic, or interpersonal difficulties that have plagued the client for many years and have resisted conventional therapeutic approaches can sometimes disappear after a full experience of a transpersonal nature, such as an authentic identification with an animal or plant form, surrender to the dynamic power of an archetype, experiential reenactment of a historical event, dramatic sequence from another culture, or reliving what appears to be a

scene of a past incarnation the basic strategy leading to the best therapeutic results requires that the therapist and the client temporarily suspend any conceptual frameworks, as well as any anticipations and expectations as to where the process should go They must become open and adventurous and simply follow the flow of energy and experience wherever it goes, with a deep sense of trust that the process will find its own way to the benefit of the client Any intellectual analysis during the experience usually turns out to be a sign of resistance and seriously impedes the progress (p 377)

Jung (1927) posited that there is a layer of the human personality that transcends individual experience, which he termed "The Collective Unconscious " According to Sharpe (1991), Jung conceptualized the collective unconscious as a means to explain psychological phenomena that could not be understood through an examination of personal experience In fact, according to Jung (1927), the collective unconscious "contains the whole spiritual heritage of mankind's evolution, born anew in the brain structure of every individual" (p 342) Archetypes, symbols, and the language of dreams reside in this realm of the human personality Jung (1927) said

In addition to our immediate consciousness, which is of a thoroughly personal nature and which we believe to be the only empirical psyche (even if we tack on the personal unconscious as an appendix), there exists a second psychic system of a collective, universal, and impersonal nature which is identical in all individuals This collective unconscious does not develop individually, but is inherited It consists of pre-existent forms, the archetypes, which can only become conscious secondarily and which give definite form to certain psychic contents (p 87)

Jung (2009) highly valued plumbing the depths of his psyche, spending six years of his life in contentious connection with his unconscious mind. Jung was able to tap into the collective unconscious while simultaneously flirting with creativity and insanity. Jung (1959) understood encounters with the collective unconscious as advantageous for the individual to transcend life. He acknowledged that these encounters happen during sacred rites, which:

Reveal[s] to (the observer/participant) the perpetual continuation of life through transformation and renewal. In these mystery-dramas the transcendence of life, as distinct from its momentary concrete manifestations, is usually represented by the fateful transformation – death and rebirth – of a god or godlike hero. The initiate may either be a mere witness of the divine drama or take part in it or be moved by it, or he may see himself identified through the ritual action with the god. In this case, what really matters is that an objective substance or form of life is ritually transformed through some process going on independently, while the initiate is influenced, impressed, “consecrated,” or granted “divine grace” on the mere ground of his presence or participation. (p. 117)

As a researcher with 10 years of experiences practicing psychotherapy, I have realized that the humane and transpersonal dimensions advocated by Jung are missing in those allopathic “head to head” therapeutic approaches for traumatized individuals. My study of and recent immersion in Curanderismo, a Mexican “heart to heart” approach for healing traumatized individuals, includes opportunities for the kinds of transpersonal encounters espoused by Jung. Therefore, this paper will argue that some aspects of

Curanderismo could fill in the “missing pieces” in allopathic therapeutic approaches for traumatic stress and PTSD.

Having a strong interest in Latin cultures, I undertook the research of how trauma is treated in traditional Mesoamerican communities to ascertain how it compared to my experience of working with the contemporary traditional and nontraditional treatment modalities. My interest in Latino culture stems directly from my life experiences: I am married to a Latino and have a daughter who is half Latina; I speak Spanish fluently; I have spent more than 20 years studying Central and South American through literature and travel; and for nearly a decade, I have been helping Latinos overcome trauma in professional settings.

For this study, I reviewed pertinent literature on both the antecedents of trauma and the human brain. In addition, I reviewed relevant literature on contemporary and Mesoamerican treatment modalities for traumatic stress and PTSD. I chose to research and analyze three cognitive/behavioral, solution-focused, brief therapeutic styles of intervention: a Cognitive Behavioral approach, Prolonged Exposure, Eye Movement Desensitization and Reprocessing (EMDR), Structured Sensory Intervention for Traumatized Children, Adolescents and Parents (SITCAP), and Hypnosis, which are a few contemporary, commonly utilized, nontraditional treatment modalities for traumatic stress and PTSD. I also researched a traditional Mesoamerican approach known as Curanderismo. Finally, interviews with my co-researchers supplemented my own experiences with both the contemporary and Mesoamerican treatment modalities.

I address the pros and cons of these modalities to ascertain an integrated approach for treating traumatic stress and PTSD in children and adults. The study of a traditional

Mesoamerican healing technique may provide data for the integration of right-brained treatment modalities that draw upon the strengths of traumatized individuals and their natural supports within the American mental health system. Allopathic psychological treatments for trauma often forfeit multiple assets of treatment which may benefit individuals with traumatic stress and PTSD. Therefore, incorporating humanizing, holistic methodologies that take advantage of all of the assets of the right- and left-brains for trauma resolution may have greater efficacy for the treatment of America's burgeoning problem of trauma and PTSD.

#### **Research Focus Questions**

Research on treatments for trauma that lie outside of the allopathic model has significant implications for individuals who may benefit from treatments which incorporate all aspects of healing beyond just mental. Trauma treatment from left-brain and right-brain perspectives that integrates contemporary cognitive approaches and Curanderismo, which includes cognitive, spiritual, somatic, and social elements, may possibly be an effective way to address traumatic stress and PTSD.

#### **Research Objective**

It is my research objective to illuminate the essential similarities and differences among three American nontraditional treatment modalities and one Mesoamerican traditional treatment modality for the benefit of individuals whose trauma experiences and PTSD afflictions negatively affect themselves, their families, friends, colleagues, and humanity in general.



### **Research Question**

The scope of this research hinges on the following question:

*Is it feasible to integrate American and Mesoamerican healing treatment approaches to design a model for healing traumatic stress and PTSD that would create a therapeutic, interpersonal environment whereby the model and the lived experiences of the psychotherapist/healer and of the client/patient are acknowledged, intertwined, and utilized for optimum healing?*

### **America's Current Response to Traumatic Stress and Post-Traumatic Stress Disorder (PTSD)**

Before attending to this study's specific research question, the allopathic model and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) definitions of and the influence on approaches to treating Traumatic stress and PTSD must be addressed as both of these influence state licensing boards who approve acceptable treatment modalities. Additionally, the influence of insurance companies and licensing agencies for practitioners on treatment modalities must also be addressed.

The predominant healing paradigm for psychological and behavioral problems in the United States of America is the allopathic medical model. Researchers are beginning to question the efficacy of this model for behavioral health (Hubble, Duncan, & Miller, 2006). People benefit from psychotherapy in ways that are unrelated to the medical model, which is a controversial stance, for such benefits challenge our cultural understanding of how people heal (Duncan, et al., 2004). Conducting research on holistic

trauma treatments is exceptionally significant to humanity, especially given the current warfare environment in the United States

Alvord and Cohen van Pelt (1999) suggested that American culture does not place importance on the things that most effectively heal, which include being heard by caregivers, family and friends, positive interpersonal relationships, and feeling a sense of wholeness and belonging. The allopathic system does not gently confront the defenses that protect individuals from feeling painful emotions, and it does not create environments where individuals may feel safe enough to experience their feelings (Sarno, 2006). Generally, clients are not encouraged to play a role in their own healing and are powerless against the institutions that were created to help them.

Recovery from traumatic stress or PTSD requires a complete socio-psychological work-up to comprehensively understand a patient's background and his or her needs. Treatment needs to include supportive psychological and somatic therapies. According to Duncan et al., (2004), "The benefits of psychotherapy are related to the explanation given to the clients, the rituals consistent with that explanation, which remoralize the client, the relationship between the therapist and the client, the skill of the therapist, the healing context, the client's expectation and hope" (p. ix-x).

Contemporary models for the treatment of trauma include three stages: establishing a sense of safety, reconstructing the trauma story, and restoring the connection between the victim and their natural supports (Herman, 1997, van der Kolk, 1996). Eckberg (2000) echoes this theme by suggesting that trauma resolution occurs in stages, beginning with education and stabilization, followed by renegotiation, reorganization, and finally, integration, which includes the ability to experience pleasure

For the victim, re-exposure to the trauma is a core component of trauma resolution and significantly reduces overall PTSD symptomatology (Steele, 2001) Trauma must be integrated as an aspect of the traumatized individual's personal history Also important to the integration of a traumatic event is the cultural context of the trauma because trauma can be culturally specific Thus, the social and spiritual milieu surrounding a traumatic event are important in healing both individual and community trauma (van der Kolk, 1996) There is little funding available in mental health systems to discover an individual's true needs, and as a result, develop a strong therapeutic relationship and complete the stages needed to reintegrate the traumatic memory Furthermore, insurance companies often allot a limited number of sessions and call it "managed care "

The importance of the client-therapist relationship in treatment was proposed by Mulhauser (2007) who suggested that the interpersonal skills of individual therapists may be more important in sustaining positive treatment outcomes than the therapeutic orientation of the psychotherapist Additionally, the match between an individual client's preferences and a particular style of counseling can influence the success of the treatment Lambert (1992) reports that 40% of the improvement clients experience in psychotherapy is related to extra-therapeutic factors, or the people, events, and beliefs that influence the client's life outside of therapy Factors such as a therapist's warmth, caring, empathy, and encouragement constitute 30% of the client's improvement in therapy Hopeful and positive expectations on the part of the client contribute 15% of the positive outcome of psychotherapy, and 15% of improvement in therapy is related to the specific technique utilized by the therapist

Mental health professionals' diagnoses of clients' problems are controlled by the American Psychiatric Association's DSM-IV-TR. Clinicians must use the DSM-IV-TR to label clients' behavioral and physiological symptoms in order to assign a numerical diagnostic code for insurance reimbursement. Symptom-focused diagnoses are limited because they do not target deeper issues, which, if left untreated, will emerge in maladaptive behaviors in the future (Stalker, Levene, & Coady, 1999)

In my experience, insurance administrators, not mental health professionals, determine the length of clients' treatment, though clients and therapists may choose to continue treatment without insurance benefits. The treatment of choice in managed care is often a solution-focused, brief therapeutic style of intervention that may not address the deeper issues. Instead of healing the trauma holistically, pharmaceuticals are routinely administered. This practice may result in individuals' continued repression of the trauma.

The allopathic medical and mental health systems rarely operate from an understanding that people's minds are divided into the conscious and the unconscious. This is unfortunate since very often out-of-awareness, embedded belief systems run the ego and the body (Damasio, 1999, Dossey, 1993, Freud, 1963, Jung, 1954; LeDoux, 2002, Lipton, 2005, Mandler, 2004; Scaer, 2001). Unaddressed negative life experiences remain in the unconscious ready to be triggered by later traumatic events.

In addition, American medical and educational systems do not acknowledge that human brains have two distinctly functioning hemispheres: the left- and the right-brain (Williams, 1983). The left-brain is revered, engaged, and educated while the negative aspects of the right-brain including fear, anger, guilt, and shame, are used to control, manipulate, and raise children in American society. The right-brain's positive aspects of

love, joy, compassion, conceptualizing the big picture, and maintaining quality interpersonal relationships are not fostered (Freed & Parsons, 1997). Whole-brain functioning and literacy is necessary to raise healthy children (Williams, 1983) and to attend to *in utero*, preverbal, and early childhood trauma experiences (Sarno, 1998).

**Schism in the Psychology Field: Empirically Supported Therapies (ESTs) and Field Practitioners.**

Furthermore, there is a gap in allopathic mental health practices between empirical researchers and field practitioners (Arkowitz and Lilienfeld, 2006).

Their differences focus on researchers' increasing use of empirically supported therapies (ESTs), which list specific therapies for the gamut of specific problems from depression to bulimia. The American Psychological Association's (APA) defines its "evidence-based" practice as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (Arkowitz & Lilienfeld, 2006, p. 49). However, standardized treatment techniques that emphasize ESTs ignore an individual's uniqueness and constrain therapists' flexibility to customize treatment to clients' needs (Arkowitz & Lilienfeld, 2006).

Mental health professionals are licensed by individual states in the United States after they successfully complete mandated coursework and internships that has been approved by the State Boards of Behavioral Health. Licensed professionals who use unsanctioned mental health treatment approaches are at risk of losing their licenses to practice therapy. This effectively reduces the types of treatments available and excludes individuals for whom board sanctioned treatments are not efficacious.

Therapy for trauma should be based on patients' experiences, losses, and needs (Eitinger & Major, 1993). Yet, in the American mental health care system, clinicians often have an overload of cases and are mandated to follow by-the-book approaches to treatment. The DSM-IV is based upon empirically supported diagnoses and grandfathered categories that will not be updated until 2010 (Ancis, 2004). Data continue to emerge that the contributors to and evaluators of the DSM-IV have had financial ties to pharmaceutical companies (Pachter, Zimbardo, & Antonuccio, 2007).

Appelbaum (2002), the President of the American Psychiatric Association, reported that America's mental health system is on the brink of a complete collapse. The bureaucratic system itself may be alive and well, but its mission appears to be numbers-oriented versus people-oriented, and its clients' recidivism record is similar to that of prison inmates' recidivism. How and where Americans spend their money is demonstrating that the time is ripe for change within America's mental health fields. Currently, as many as one in three Americans are going to alternative medical providers (Weil, 2004). Individuals are also spending their dollars on treatments other than what they are getting in allopathic psychotherapy.

Concurrently, interpersonal violence is rampant in our American culture and frequently occurs within nuclear families, resulting in traumatic stress, PTSD, and the disruption of attachment bonds. Homicide is the third leading cause of death in America for children between the ages of five and 14, and there was a 300% increase between 1986 and 1993 in the number of children seriously injured by maltreatment, mostly at the hands of violent, emotionally-illiterate parents (Levy & Orlans, 1998), increasing their victims' future vulnerability to PTSD. Traumatic experiences in early childhood may

weaken developing personalities, resulting in irreversible mental disturbances even in the absence of psychoses or organic damage (Eitinger & Major, 1993) Thus, traumatic stress and PTSD impact culture on micro and macro levels and must be successfully treated for these trends to abate

The number of PTSD diagnoses in American society is escalating, primarily in military personnel (Corbett, 2007) Much of what is known about traumatic stress is based on research on male combat veterans and civilian women who have been sexually assaulted (Corbett, 2007) A Pentagon report, released by the Army Surgeon General, Lt Gen Eric B Schoonmaker on May 27, 2008, indicates that nearly 40,000 military personnel have been given diagnoses of post-traumatic stress disorder since 2003 (AP, Washington, 2008, 28<sup>th</sup> May)

At the same time, more than 160,000 female soldiers have been deployed in Iraq and Afghanistan of which one in every ten is female A 2003 Department of Defense report on female veterans who sought health care through the Veterans Administration (VA) indicated that they had experienced sexual assault or attempted sexual assault during their service Women who had endured sexual assault (from fellow servicemen) were more likely to develop PTSD from the assault in conjunction with exposure to combat than those who were only exposed to combat (Corbett, 2007)

Clearly, traumatic events overwhelm ordinary the human ability to adapt to life (Herman, 1997, Levine, 1997, Scaer, 2001, van der Kolk, 1996, Walser & Westrup, 2007) During a traumatic event, individuals often experience intense fear, helplessness, or horror The exposure to the traumatic event may result in disorganized or agitated behavior, persistent re-experiencing of the traumatic event, avoidance of anything

associated with the trauma, numbing of general responsiveness, or hyper-vigilance. If these symptoms cause clinically significant impairment in social, occupational, or other important areas of functioning and are present for more than one month (American Psychological Association, 1994) the individual is diagnosed with PTSD.

Traumatic stress reaction is another response experienced by individuals exposed to violence. It encompasses subjective distress and disruption to normal functioning. Individual reactions after exposure to trauma may range from a heightened sense of vulnerability and helplessness to a specific constellation of symptoms resulting in psychiatric disturbance (Pynoos, Sorenson, & Steinberg, 1993).

During a traumatic event, individuals are highly aroused and dissociative, which helps the individual to survive the trauma (Scaer, 2007). However, these mechanisms result in dissociated fragmentation of the memory of the experience (van der Kolk, 1996). Intrusive thoughts or numbing symptoms related to the trauma disallow integration of the trauma because it affects an individual's ability to comprehend and integrate the experience (Herman, 1997).

In order to overcome traumatic stress, traumatic memories need to be modified and reintegrated into a meaningful narrative. Thus, individuals need to integrate the potent fragments of traumatic memory so the memory cannot trigger affects and behaviors related to the trauma, but unrelated to the present. The traumatic memory must be reframed and recreated rather than remain static in the psyche of the traumatized individual (van der Kolk, McFarlane, & Weisaeth, 1996). Unfortunately, Western culture has not given credence to the effects of trauma until the last century. The unusual symptoms exhibited by combat soldiers and World War II's Holocaust survivors



catalyzed the acknowledgment by Western Psychology of PTSD as a legitimate psychological issue requiring treatment.

### **DSM-IV Definition of Trauma and PTSD**

According to the DSM-IV-TR, PTSD often follows direct exposure to an extreme traumatic event which involves serious injury or actual or threatened death or a threat to one's physical integrity (American Psychiatric Association, 1994). Exposure to death, injury, or a serious risk to the physical stability of another person or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a loved one can also result in PTSD. The severity of an event or the nature of the exposure to it are not the only occurrences that can result in PTSD. Many trauma experts fault the DSM-IV as being severely limited in its guidelines (Levine, 1997; Scaer, 2001; van der Kolk, 1996).

The current DSM-IV was published in 1994 and laid the scientific foundation for the psychological field with standardized diagnoses as the basis for drug testing and short-term talk therapies. The DSM-IV is built on the principle that clients' symptoms are the way to classify their mental problems. It does not work with internal thoughts or unconscious assumptions, which are almost impossible to standardize scientifically (Levine, 1997; Scaer, 2001; van der Kolk, 1996).

The DSM-IV was updated as DSM-IV-TR in 2000 as a Text Revision. The DSM-IV-TR incorporates data culled from literature reviews of research about mental disorders that had been published after 1994.

The DSM-IV-TR does not take into account the human brain research that has evolved over the past decades; the update focused on a literature research of mental disorders. Since treatment modalities are mirrors of our culture, it appears that DSM-IV's and the DSM-IV-TR's contents are slow to respond to our culture's realities of escalating PTSD diagnoses and brain research.

#### **A Complementary Model: Psychodynamic Diagnostic Manual (2006)**

The *Psychodynamic Diagnostic Manual* (PDM), published by the American Psychoanalytic Association, is modeled on the DSM-IV in its format, but it asserts that “the D.S.M. is a taxonomy of disease or disorders of function. Ours is a taxonomy of people” (Carey, 2006, p. D1). Nevertheless, the PDM is intended to be complementary to the DSM-IV, which many psychotherapists believe is too superficial to capture the complexity of human motivation, the depth of emotional pain” (Carey, 2006, p. D1). Instead of focusing on diagnosing and treating the mental disorder as most psychiatrists do, “psychoanalysts focus their efforts on understanding the meaning and the psychological roots of mental suffering” (Carey, 2006, p. D1).

Working in collaboration, the PDM was developed by the American Psychoanalytic Association and the APA. The PDM incorporates new elements such as case histories and brief descriptions of what people with mental disorders are feeling. It also focuses on the importance of individual personality patterns, which are full-blown only at their extremes. The PDM's insistence that personality be evaluated first and symptoms second is a striking difference between itself and the DSM-IV. Proponents of the PDM think that working with underlying personality patterns is important in planning treatment and more important than describing symptoms. Dr. Nancy McWilliams, a

psychologist at Rutgers University and major contributor to the PDM says, “Many therapists out there already are familiar with these ideas, whether they use family systems approaches, or short-term cognitive therapies, but we wanted to provide some guide to the process” (p. D7).

The PDM, while considered complementary to the DSM-IV, is still a guide to diagnosis, not treatment, and it does not appear to be commonly utilized in the psychological field. “Honestly,” Dr. McWilliams said, “most of the people who come in for therapy do so for a kind of sickness of the soul, or for some interpersonal disaster. It’s very artificial to chop them up into these symptom syndromes” (p. D7).

### **Summary**

Allopathic psychological treatments for trauma often forfeit multiple assets to treatment which may benefit individuals with traumatic stress and PTSD. Therefore, I hypothesize that incorporating humanizing holistic methodologies that take advantage of all of the assets of the right and left brain for trauma resolution may have greater efficacy for the treatment of the burgeoning problem of trauma and PTSD for Americans.

It appears that the mandated allopathic method of diagnosis is deficit-based; it does not take into account all the possible assets a client brings to treatment. Diagnosis within the DSM-IV-TR model also does not consider previous trauma and subconscious material as it relates to a traumatized individual’s current situation. Thus, holistic, right-brain integrated with left-brain treatment modalities for PTSD and traumatic stress may be a viable treatment for the escalating number of individuals who are experiencing PTSD.

## **Chapter II**

### **Literature Review**

This literature review will describe how trauma has been addressed in Western culture to provide background about the thought that shaped Traumatology. A description of the impact of trauma on the adult brain will be presented, which demonstrates the importance of addressing the consequences of trauma. The impact of trauma on the developing brain will also be examined, which addresses the significance of secure attachment bonds between child and primary caregiver and demonstrates the pervasive, intergenerational negative potential of untreated traumatic stress and PTSD. Allopathic treatment approaches including CBT, EMDR, SITCAP, Hypnosis, and Mesoamerican Curanderismo will be presented.

#### **Historical Components of Trauma**

The study of trauma in Western culture has waxed and waned in popularity within the field of psychology since it was first described by neurologist Jean-Martin Charcot in 1887 (van der Kolk, Weisaeth, & van der Hart, 1996). Freud published accounts of incest and trauma reported by his patients, although he later succumbed to pressure from the affluent and powerful parents of his patients to recant his findings in that area of inquiry. Interestingly, Freud's Oedipus and Electra Complexes emerged after Freud rescinded the veracity of his patients' accounts of sexual abuse by their upper class parents, blaming instead subconscious sexual desire by the victim as the source of those reported "fantasies" (van der Kolk et al., 1996).

Societies shamed and blamed the victims who experienced the adverse impact of trauma during and after World Wars I and II. A soldier's inability to successfully manage combat stress was blamed on his moral weakness or lack of will. Studies of Nazi concentration camp survivors and Vietnam War veterans gave psychologists the opportunities to revisit earlier trauma concepts and to formulate new theories regarding the negative impact of trauma on the human organism. Even today, the idea that trauma profoundly impacts individuals continues to be socially unacceptable (van der Kolk, 2008). It is hoped that the effects of trauma will not be discredited or dismissed in the future (van der Kolk, 1996).

Traumatic stress and PTSD came to the fore after World War II when the Holocaust victims experienced symptoms that could not be attributed to weakness or will. Similar symptoms were observed in veterans of the Korean, Vietnam, and Gulf Wars. At the end of the 1960s, it was discovered that the children of Holocaust survivors also seemed to be adversely affected by their parents' Holocaust experiences (Baranowsky, Young, Johnson-Douglas, Williams-Keeler, & McCarrey, 1998), demonstrating that traumatic stress can be experienced secondarily. More recently, individuals and servicemen and women are experiencing traumatic stress and PTSD as a result of the 9/11/01 attacks and the ongoing wars in Afghanistan and Iraq.

According to a recent report from the Committee on Gulf War and Health (2006), service in the Persian Gulf places American veterans at increased risk for developing anxiety disorders, depression, and substance-abuse problems. Additionally, Gulf War veterans were more likely to experience transportation-related injuries or deaths in the first few years upon return from the war. Gulf War veterans also experienced a high

prevalence of fatigue, memory loss, muscle and joint pain, difficulties sleeping, and symptoms associated with chronic conditions such as fibromyalgia, chronic fatigue syndrome, and multiple chemical sensitivities. As previously noted, trauma affects behaviors and results in physically observable symptoms. These discernible characteristics may be far worse, including their impact of trauma on the human brain.

### **Traumatic Stress, PTSD, and the Brain**

The impact of traumatic experiences on human physiology is profound. Trauma negatively impacts the entire brain as memory is stored throughout the entire brain (van der Kolk & van der Hart, 1991), which is comprised of approximately one hundred billion neurons, each with an average of ten thousand connections that directly link to other neurons, resulting in nearly one million billion neural connections (Siegel, 1999). Trauma can affect an individual's ability to self-regulate biological and psychological processes, rendering the trauma victim susceptible to chronic affect dysregulation, learning disabilities, dissociative problems, somatization, conceptual distortions about self and others, and destructive social behavior (van der Kolk, 1996). Prolonged states of trauma-related stress can result in physical illness including cardiovascular disease and other leading causes of death among adults (Ziegler, 2002).

Traumatic events often contaminate an individual's perceptions of all subsequent experiences. Intrusive memories of the traumatic experience rob the individual of the ability to be fully present in the here and now as the trauma victim suffers from chronic arousal of the autonomic nervous system (Herman, 1997; van der Kolk, 1996).

The effects of traumatic stress are often co-morbid. Erickson et al., (2001) examined the relationship of PTSD and depression symptoms in a sample of Gulf War veterans. Evidence from their study supports a reciprocal relationship between PTSD and depression. Other studies have shown that PTSD tends to persist in the absence of treatment (Taylor et al., 2001; van Etten & Taylor, 1998).

That susceptibility to PTSD could be accurately predicted based on a combination of demographic and psychological data was demonstrated by Blake et al., (1990). That data demonstrated a correlation between pre-trauma risk factors (family instability and childhood antisocial behavior), war-zone stressors (combat exposure and perceived threat), post-trauma resilience-recovery variables (hardiness and social support), and PTSD symptom severity. It seems that without a preexisting, resilient personality, a strong social support, a positive physiological response and the meaning given to the traumatic event by the victim, traumatized individuals are more vulnerable to chronic PTSD (van der Kolk, 1996).

### **The Impact of Trauma on Brain Structures**

The brainstem, sometimes referred to as the body's thermostat, is the first portion of the brain to develop before birth. It is connected to the spinal cord and includes the cerebellum, the midbrain, the pons, the cerebellar vermis, and the medulla oblongata (Ziegler, 2002). The brain stem manages functions necessary for survival, such as breathing, regulation of blood pressure, temperature regulation, and the fight, flight or freeze response. The brainstem also produces and controls the release of neurotransmitters. Different types of memory are stored in different parts of the brain,

and what is stored in the brainstem is the condition needed for the body to survive (Ziegler, 2002)

The next most complex structure in the brain is the diencephalon, composed of the thalamus and hypothalamus. The diencephalon regulates appetite, arousal, motor skills, regulation of sleep patterns, and the body's ability to negotiate its environment. This part of the brain stores kinetic memory and helps the organism respond to threats to survival (Ziegler, 2002)

The brain becomes more complex within the limbic system, comprised of the amygdala, hippocampus, cingulate cortex, basal ganglia, and septum. This portion of the brain regulates emotions, motivation, sexual behavior, reproduction, and attachment. Self-regulation is carried out in the limbic regions of the brain (Seigel, 1999). Memory stored in the limbic system is primarily verbal and emotional memory. The hippocampus is very vulnerable to trauma because it develops slowly and has dense cortisol receptors (McEwen, 2000)

According to van der Kolk (2008), our right-brain's amygdala records traumatic events. Right-brained treatment modalities may be important to the resolution of traumatic experience because the limbic system is linked to both cortical and subcortical sections of the brain through the right orbitofrontal area where arousal, emotions, and behavior regulation occur (Ziegler, 2002). If a current situation resembles a past traumatic event, the amygdala responds. This reactivity can bypass and greatly distort rational thinking, helping ensure the individual's survival. This right-brain form of intelligence is intuitive, nonverbal, non-logically analytic, and deeply intelligent (Ziegler, 2002)



The neocortex is the most complex portion of the brain, overseeing brain functions such as initiating, inhibiting, shifting, planning, organizing, self-monitoring, emotional control, and working memory. The memory stored in the neocortex includes all aspects of cognitive memory such as facts, figures, faces, names, dates, and phone numbers (Ziegler, 2002).

According to van der Kolk and van der Hart (1991), traumatic memories are activated by autonomic arousal and are thought to be mediated via hyper-potentiated noradrenergic pathways originating in the locus coeruleus of the brain...the 'alarm bell' of the central nervous system, which properly goes off only under situations of threat, but which, in traumatized people, is liable to respond to any number of triggering conditions akin to the saliva in Pavlov's dogs. When the locus coeruleus alarm is activated, it secretes noreadrenaline, and if rung repeatedly, endogenous opioids. These in turn dampen perception of physical and psychological pain.. These neurotransmitters, which are activated by an alarm, affect the "hippocampus, the amygdala and the frontal lobes, where stress-induced neurochemical alterations affect the interpretation of incoming stimuli further in the direction of 'emergency' and fight/flight responses" (van der Kolk & van der Hart, 1991, p. 443)

Individuals with PTSD tend to experience their subjective reality as a hazardous venue rife with thoughts and feelings related to the traumatic memory. These individuals continuously avoid emotional triggers related to the trauma. In so doing, the significance of the here and now attenuates and creates the dilemma of increased attachment to the traumatic experience (Steele & Raider, 2001; van der Kolk et al., 1996).

### **Impact of Traumatic Stress on the Developing Brain**

Traumatic experiences early in life may have a more pervasive effect on the structures of the brain responsible for affect regulation and the management of stress (Siegel, 1999). The neonatal brain is the most undifferentiated organ in the body. Early experience, in addition to genetic predisposition, is crucial in organizing neuronal connectivity and the organization of basic brain structures and mental processes. Siegel (1999) reports that specific circuits within the brain may function as somewhat distinct subsystems that create their own predominant states of processing. For example, the left and right sides of the brain have distinct circuits that become predominant early in life even in the embryo. Each of these pathways has its dominant neurotransmitters and involves distinct evaluative components that serve to direct each hemisphere to process information in distinct areas. How each hemisphere is activated will directly shape subjective sensations and communication with others.

For the growing brain of a young child, interpersonal relationships influence the expression of genes, which in turn determines how neurons create the neuronal pathways and mental activity. How these pathways function is determined by their structure. Changes in genetic expression can impact brain structure and shape the developing mind. This is apparent in the production of corticosteroids as a response to stress, which directly impact gene function. A traumatized child will have large hormonal responses to small stressors and “thus both constitutional and experientially ‘acquired’ reactivity can lead to further physiological features that maintain the hypervigilant response over time” (Siegel, 1999, p. 20).

According to Siegel (1999)

The differentiation of circuits within the brain involves a number of processes including (1) the growth of axons into local and widely distributed regions; (2) the establishment of new and more extensive synaptic connections between neurons; (3) the growth of myelin along the length of neurons, which increases the speed of nerve conduction and thus 'functionally' enhances the linkage among synaptically connected nerve cells; (4) the modification of receptor density and sensitivity at the postsynaptic 'receiving' cell making connections more efficient; and (5) the balance of all these factors with the dying away or pruning of neurons and synapses resulting from disuse or toxic conditions such as chronic stress (p. 14).

Traumatized children experience complications in their personality development (Bowlby, 2000). Traumatic experience results in a dysfunction of the organizational system of the right hemisphere of the brain, which influences attachment, affect regulation, and stress management. The child with PTSD experiences difficulties maintaining a cohesive and unified sense of self. One disorder associated with PTSD is borderline personality disorder, which features a primary theme of an underdeveloped and insecure sense of self (Zeigler, 2002).

Mary Ainsworth's (1978) early studies suggest that healthy, secure attachment requires the caregiver to have the capacity to perceive and respond to a child's mental state. The mother-child bonding process is essential to the integration of the right- and left-brain attributes. Siegel (1999) reports that the flow of information during interpersonal experience shapes the structure and function of the brain and central nervous system. He states, "Human connections shape the neural connections from which the mind emerges" (p. 2). Throughout this process, a child's mind establishes a sense of

continuity across time, linking the past, present perceptions, expectations for the future, makes generalizations about the self, and the self with others (Siegel 1999).

The primary ingredient of secure attachment is in tune emotional communication and alignment between child and caregiver. Secure attachments involve the interchange of a wide range of representational processes from both side of the brain, resulting in the establishment of self-organizational abilities. In insecure attachment patterns, attunement between caregiver and child often lacks emotional interaction (Siegel, 1999).

Similarly, the way the mind places value on an experience is linked to social interactions. This connection between meaning and interpersonal experience occurs because these two processes are mediated by the same neural circuits responsible for initiating emotional processes. Emotion is important for the evolving identity and functioning of a child as well for setting the stage for the establishment of future adult relationships. Children who have had a lack of attachment to a primary caregiver during their formative years cannot establish intimate interpersonal relationships later on (Siegel, 1999) without considerable unlearning and relearning.

The brain has asymmetrical circuitry, which causes the specialization of functions on each side of the brain. This lateralization of function shapes the way the mind creates representations of experience. The right side of the brain senses the emotions of another person and the expression of emotions via facial cues and tone of voice. Experience shapes what information can enter the mind and the way the mind processes that information (Siegel, 1999).

Relationship experiences have a dominant influence on the brain, according to Siegel (1999). The circuits in the brain responsible for social perception are the same as,

or tightly linked to, those that integrate the important functions controlling the creation of meaning, the regulation of bodily states, the modulation of emotion, the organization of memory, and the capacity for interpersonal communication. Thus, interpersonal experience plays a special organizing role in shaping the emerging brain structure early in life and the ongoing development of brain function throughout the lifespan (Siegel, 1999).

Memory is what can consciously be recalled about the past as well as the way the brain is affected by the past; then an individual alters his/her future responses. Past events stored in memory directly influence how and what we learn even if we have no conscious memory of those events. Thus, our earliest experiences shape our future behavioral and interpersonal patterns. The development of pathways in the brain over time causes the formation of neural templates, which become automatic pathways for processing information. These neural templates develop the processes of brain activity, conscious awareness, and personality (Siegel, 1999; Zeigler, 2002).

According to Zeigler (2002):

The development of personality is influenced by the brain's process of states becoming traits. The brain adapts and builds itself around experiences and the body's response to situations (*states*), which become *ingrained within the future responses of the individual (traits)*... It could be said that the basic ingredients of what we refer to as the personality are formed by predispositions (formed by experience) first found in the neural templates of the brain. (p. 21-22)

Foster placement, divorce, a house fire, or other events where there is an absence of safety, whether perceived or actual, can be traumatic for a child (Steele, 1998).

According to Steele (1998), traumatic childhood events are especially devastating because the traumatic event negatively impacts social, emotional, cognitive, and behavioral development. Traumatic events can result in hyperactivity, increased aggression, impulsiveness, withdrawal, and learning problems. Terr (1988) suggests “physical symptoms may also result from trauma, including chronic physical discomfort and illness, unmodulated emotions, and the failure to engage fully, both physically and mentally, in the present” (p. 38).

Terr (1988) reports that children under the ages of 28 to 36 months cannot fully verbalize traumatic experiences, though females appear better able than boys to verbalize parts of traumas from before ages 28 to 36 months. Older children are able to recall short, single traumas verbally. Behavioral memories of trauma are accurate and true to the traumatic event regardless of the child’s age (Terr, 1988).

At birth, the brain has approximately 100 billion neurons, which by age three, connect and create 1,000 trillion synaptic connections. Neurons have incredible plasticity, as evidenced by the ability of auditory nerves in animals replacing and producing damaged visual nerves. Trauma in early childhood can be especially detrimental because at age three, the brain is three times more active than an adult brain and has many more neurons and synapses available than at any other time in life (Ziegler, 2002).

Gluckman and Hanson (2004) have linked osteoporosis, mood disorders, and psychoses to negative pre- and perinatal developmental influences. When a pregnant woman experiences trauma, it impacts her unborn baby (Lipton, 2005). The quality of life in the womb establishes the child’s susceptibility to coronary artery disease, stroke, diabetes, and obesity (Nathanielsz, 1999).

At birth, the infant's brain takes in, processes, and stores information essential to survival. Additionally, the brain makes structural changes in response to its environment. Brain scans of children from neglectful environments confirm physiological differences in the size and appearance of multiple areas of the brain when compared to children from nurturing homes (Zeigler, 2002). Neglectful environments and trauma impact the brain and neural pathways through the growth or atrophy of axons and synapses within the neuron. When a neuron is stimulated into activity, it becomes stronger. The level of use within a neuron encourages the axon to strengthen. Neurons that are seldom used atrophy and die. Trauma can grossly impact the nature of these neurological connections (Zeigler, 2002). Zeigler (2002) states:

In this use-dependent system related to trauma, this process becomes central. The neglect to the neurology of the brain from early years of deprivation cannot be made up for by over stimulating the child years later. By that time, the brain has adapted to a distant and unresponsive world, even if that world becomes stimulating. In fact, the child may lose some of his/her ability to autonomically tolerate stimulation. With prolonged neglectful pasts, children can lose their receptivity to others and attachment problems result (p. 19).

### **Trauma and the Disruption of Attachment Bonds**

Survival is an essential task for any organism, and attachment bonds between mother and child ensure the child's survival. The attachment bond between mother and infant provides an external modifier to the child's behavioral and emotional regulation and directly influences the right hemisphere of the infant's brain where the brain processes stress responses and has direct connections with the limbic and autonomic

nervous systems (Schoore, 1994; Zeigler, 2002). The right side of the brain also processes emotional and social information. An individual's environment becomes imprinted in the regions of the right hemisphere of the brain (Zeigler, 2002).

Schoore's (1994) research indicated that trauma has a significant negative impact on early bonding and maturation of the right brain during critical periods of development. Early relational trauma can result in the lack of self-regulation, affect regulation, and the organization of a healthy, functional self. Early trauma also increases sensitivity to stress later in life (Schoore, 1994).

Most individuals experience some form of trauma. In a study of 6,000 men and women, Kessler, Sonnega, Bromer, Huges, and Nelson (1995) found that the majority of individuals had experienced at least one traumatic event in their lifetime. Vrana and Lauterbach (1994) found that nearly 33% of a sample of undergraduates had experienced four or more traumatic events in their lifetime. Nearly 80% of people are resilient enough and able to recover from a wide range of traumatic events (Lynn & Krisch, 2006). Others suffer after a trauma with depression, anxiety, and PTSD. The lifetime prevalence of PTSD is 5% in men and 10% in women (Kessler et al., 1995). In high risk populations such as war veterans, the prevalence is as high as 30% (Lynn & Kirsch, 2006). Exacerbating the problem, after an individual is traumatized, the likelihood of experiencing a second trauma is nearly 50% (Kessler et al., 1995). In fact, 94% of traumatized individuals will develop symptomatology consistent with PTSD, depression, panic, and anxiety immediately following the event (Monson & Friedman, 2006). By three to six months after the event, these symptoms in most individuals abate (Foa & Riggs, 1995; Kessler et al., 1995; Marsella et al., 1996; Norris, Murphy, Baker, & Perilla,



2003; Schlenger et al, 2002). Approximately one-third of traumatized individuals continue to experience symptoms 10 years after the traumatic event (Monson & Friedman, 2006).

Traumatic memory has a long-lasting negative effect upon self and psyche because the trauma becomes dysfunctionally stored in the implicit/motoric rather than the explicit/narrative memory (Shapiro, 2001). However, the plasticity of the human brain means a return to normal brain functioning is possible if treatment is effective, medications are minimized, and all assets of the whole brain are exploited.

### **Summary**

Having barely begun to acknowledge PTSD as a legitimate psychological issue, allopathic psychology is clearly in its infancy. The foregoing literature review indicates that most individuals experience some form of trauma in the womb or during early childhood, making them vulnerable to future traumatic events in adulthood. Hence, there is a proliferation of PTSD cases that have grown out of our violent society and past and current wars. I hypothesize that a holistic, right-brained treatment modality needs to be integrated into current American treatment approaches. Therefore, this literature review includes a study of American Nontraditional approaches (EMDR, SITCAP, and Hypnosis) and Curanderismo, a Mesoamerican Traditional approach that has been used to treat traumatic stress for centuries (de Franklin, 2008; Navarro, 2008; Nuñez, 2008).

### **Contemporary American Treatment Approaches**

I have chosen to examine the CBT's approach of Prolonged Exposure, EMDR, SITCAP, and Hypnosis as representative of American nontraditional treatment approaches for trauma. These methods have been described in traumatology literature as efficacious treatment modalities, though the SITCAP method is not as well known as the other modalities. Talk therapy is the predominant treatment paradigm in our culture for the treatment of trauma, which usually begins with a period of orientating the client to the type of treatment and responses to trauma he or she can expect (Miller, 1998).

#### **Cognitive Behavioral Therapy (CBT)**

CBTs are commonly utilized treatment modalities for the treatment of trauma. In CBT, the client tells his or her trauma story, and a desensitization technique is utilized to mitigate the effects of the traumatic event. CBTs for trauma are time-limited and goal-oriented and focus on observable outcomes and symptom reduction. There is also an expectation that the client will be an active partner in his or her recovery from the traumatic event (Monson & Friedman, 2006). Cognitive-behavioral therapies generally include the phases of stabilization, engagement, psychoeducation, symptom management, exposure treatments, cognitive restructuring, and relapse prevention (Rothbaum, Meadows, Resick, & Foy, 2000).

The narrative process is essential to the functional integration of traumatic memory (Siegel, 1999), a process facilitated by CBT. One of the first components of CBT is Stabilization. Should the client be suicidal, homicidal, or in crisis, stabilization should be the primary focus before beginning treatment for PTSD (Flack, Litz, & Keane,

1998). Once stabilization has been achieved, engagement ensues. This entails the development of a therapeutic relationship in which the client feels safe and confident in the treatment (Flack et al., 1998). Providing psychoeducation about PTSD and the recovery process is also important and can reduce stress related to the symptoms of PTSD, improve the credibility of the therapist, and improve the therapeutic alliance (Flack et al., 1998).

The management of anxiety is the next important step in recovery from PTSD within the CBT paradigm. Anxiety management interventions such as relaxation techniques, controlled breathing, exercising, eliminating negative self statements, negative thought stopping, and behavioral changes such as daily-activity scheduling and social reintegration should be implemented.

Individuals with PTSD are vulnerable to relapse. Clients should be made aware of this possibility and have strategies to deal with relapse. Ongoing help from a mental health professional may be necessary for an extended period (Flack et al., 1998).

### **Prolonged exposure therapy for trauma.**

A common CBT treatment modality for PTSD and traumatic stress is Prolonged Exposure (PE) Therapy. In this treatment, the traumatized individual confronts the situations, activities, thoughts, and memories related to the trauma, thereby reducing his or her anxiety (Riggs, Cahill, & Foa, 2006). PE Therapy consists of 9-12 sessions, lasting 90 minutes, which incorporate the following four elements:

1. Psychoeducation about trauma, reactions to trauma and PTSD;
2. Breathing retraining;

3. In vivo exposure to the feared (but now safe) trauma-related situations that the client avoids; and
4. Imaginal exposure that consists of repeatedly recounting memories of the traumatic event. (Riggs et al., 2006, p.66)

PE to the traumatic memories is a central component of successful treatments for PTSD, supported by a large body of empirical research (Rothbaum et al., 2000). PE involves helping the individual to confront the painful memories and to remain engaged with the memory until the anxiety abates (Flack et al., 1998). Cognitive restructuring is also helpful for traumatized individuals. In this process, the individual identifies and changes dysfunctional thoughts and beliefs about the world, other people, or themselves resulting from the traumatic experience (Beck, Rush, Shaw, & Emery, 1979).

Each session of PE Therapy is budgeted to include time to examine thoughts and feelings that occur during the imaginal exposure, to review of the previous session's content, to continue processing the traumatic event through imaginal exposure with *substantial emphasis on the thoughts and feelings the client experienced during the traumatic event*, and to review the client's homework assignments. Homework consists of the client listening to tape recordings of the session, imaginal exposure exercises, and psychoeducational reading about traumatic stress and PTSD (Riggs et al., 2006).

In addition to specific aspects of the PE program, numerous nonspecific factors can facilitate treatment. Basic therapeutic skills such as empathy and active listening are invaluable. Perhaps most important is the therapist's ability to convey confidence in the effectiveness of therapy, the client's ability to complete the treatment program, and expertise in conducting the treatment (Riggs et al., 2006, p. 68).

Foa and Rauch (2004) found that treatment for PTSD that included PE resulted in clinically significant and lasting reductions in negative thoughts about the self, world, and self-blame as measured by the Post-traumatic Cognitions Inventory. The addition of cognitive restructuring for PTSD did not enhance treatment outcomes.

In 2005, Foa et al., reported that both PE alone and with cognitive restructuring reduced symptomatology and depression in individuals with PTSD. Cognitive Restructuring alone did not enhance treatment outcomes.

Bryant, Moulds, Guthrie, Dang, and Nixon (2003) found that administering cognitive restructuring along with Prolonged Imaginal Exposure, a process similar to PE Therapy, leads to greater symptom abatement in individuals with PTSD than imaginal exposure alone. Foa, Zoellner, Feeny, Hembree, and Alavarez-Conrad (2002) found that a minority of participants experienced a brief symptom worsening during prolonged exposure, which was independent of the outcome.

Foa et al., (1999) found that there was no representative difference in participant results when treated with prolonged exposure or stress inoculation training. The benefits continued throughout the follow-up period. Foa, Rothbaum, Riggs, and Murdock (1991) found that prolonged exposure therapy resulted in more cogent amelioration of PTSD symptoms than supportive counseling and stress inoculation training. Prolonged exposure therapy also created superior impact on PTSD symptoms at follow up.

Taylor et al., (2003) found that PE therapy, compared with EMDR and relaxation training, resulted in much larger and faster attrition in avoidance behaviors, reduced re-experiencing indicia, and a reduction in participants who met criteria for PTSD after

treatment. EMDR and relaxation techniques were similar to one another in speed or effectiveness.

### **Eye Movement Desensitization and Reprogramming (EMDR) for Trauma**

EMDR is widely successful in American culture for the treatment of trauma. EMDR utilizes mental and emotional patterning in tandem with eye movements or other forms of bilateral stimulation to achieve healing. EMDR effectively reduces the potency of triggers and the client's response to them by incorporating changing patterns of thought and working with implicit and explicit memories. Often, individuals are able to manage their traumatic memory significantly better after one or a few sessions.

EMDR has come to the fore as an effective treatment for traumatic stress. EMDR coalesces multiple psychological orientations including psychodynamic therapy, behavior therapy, cognitive therapy, experiential therapy, hypnosis, and systems theory, making it useful to diverse clinicians (Shapiro, 2001). EMDR attends to the foregoing modalities through attention to etiological events, conditioned responses, beliefs, emotions, imagery, and contextual understanding of the traumatic event.

Furthermore, EMDR incorporates dual attention stimuli to activate the traumatized individual's information processing system to achieve treatment effects (Shapiro, 2001). EMDR requires the traumatized individual to recall traumatic memories while also attending to some form of external bilateral stimulation. Shapiro (2001), the architect of this approach, states that:

[It] allows individuals to quickly metabolize the dysfunctional residue from the past and transform it into something useful. Essentially, with EMDR the dysfunctional information undergoes a spontaneous change in form and meaning

– incorporating insights and affects that are enhancing rather than self-denigrating. (p. xiv)

EMDR is reported to help traumatized individuals integrate the traumatic memory through the application of counterbalancing, ameliorative information. The eye movements, or other forms of bilateral stimulation, facilitate access to the imprinted multisensory and affective aspects of the trauma. Through EMDR, reciprocal interaction between the cognitive and affective subdivisions of the anterior cingulate cortex and the unilateral activation of right anterior cingulate become reinstated (Corrigan, 2002).

According to Shapiro (2001), the traumatic memory, negative images, emotions, and beliefs become less vivid through the process of EMDR. She suggests that the traumatic memory may become connected in the brain to information that helps the traumatized individual learn from the traumatic event. This necessary and useful information related to the trauma becomes integrated in the memory as an adaptive, healthy, nondistressing form. Shapiro (2001) also suggests that this reframing of the traumatic event is done on a continuum:

When the target is positive, such as an alternative desirable, imagined future, the imagery, beliefs, and affects become more vivid, more enhanced, and more valid. Therefore, EMDR is used to 1. help the client learn from the negative experiences of the past, 2. desensitize present triggers that are inappropriately distressing, and 3. incorporate templates for appropriate future action that allow the client to excel individually and within her interpersonal system. (p. 3)

Dual attention stimuli is one part of the procedures of EMDR. Careful attention is also given to images, beliefs, emotions, physical responses, increased awareness, and

interpersonal systems in achieving EMDR's effects. Shapiro (2001) suggests that EMDR practitioners use EMDR protocols customized to the needs of the client. Once the client's history has been taken, the client is prepared for treatment, and the trauma themes have been identified, there are 11 steps to EMDR, which include the following:

1. **Imagine:** Have the client access an image that represents the entire event.
2. **Negative cognition:** Develop the negative self-statement that conveys an underlying limiting self-belief. It should begin with "I am" and incorporate words that go with the image.
3. **Positive cognition:** Create a desirable positive self-statement that incorporates an internal locus of control.
4. **Validity of Cognition (VOC) level:** Determine a client rating of the gut-level validity of the positive cognition (one equals "completely false" and seven equals "completely true").
5. **Emotion:** Identify the name of the disturbing emotion that arises when the image and the negative cognition are linked.
6. **Subjective Units of Disturbance (SUD) level:** Determine a client rating of the degree of disturbance that arises when the memory is stimulated (where one equals "neutral" or "calm" and 10 equals "the worst disturbance imaginable").
7. **Localization of body sensation:** Identify where the physical sensations are felt when the disturbing information is accessed.
8. **Desensitization:** Inaugurate the process whereby all associated channels are cleared and the targeted event has a SUD rating of zero or one.
9. **Installation:** Infuse the positive cognition.



- a. Check the appropriateness and VOC of the original or new positive cognition.
  - b. Link the positive cognition with the target event.
  - c. Attain a VOC of seven or greater.
10. Body scan: Have the client mentally scan for residual physical sensation while holding the target event and positive cognition in mind.
11. Closure: End the treatment session in a way that gives the client feelings of self-efficacy and accomplishment as well as reasonable expectations.
- a. Visualization: Use guided imagery to dispel any disturbance that still remains.
  - b. Debriefing: Give post-treatment instructions to clients regarding potential ongoing processing, keeping a log, and using a relaxation tape and other self-control procedures (Shapiro, 1995, p. 217-218).

Shapiro (2001) reports that EMDR has been researched and evaluated by independent task forces such as the International Society for Traumatic Stress Studies and has been recognized as an effective treatment for trauma. An extensive base of controlled research has established EMDR as a standard and effective treatment for trauma.

Taylor et al., (2003) studied the effectiveness, pace, and incidence of symptom worsening for three types of treatments for PTSD. These treatments included prolonged exposure, relaxation training, which involves applying various relaxation practices during times of anxiety, and EMDR. Their study demonstrated that the regimes did not differ in attrition, the incidence of symptom worsening, or in their ramifications on numbing and hyperarousal symptoms. Exposure therapy resulted in significantly greater reductions in

avoidance and flashbacks, generally reduced avoidance behaviors more quickly, and resulted in the largest post-treatment portion of participants who no longer met the benchmark for PTSD. Relaxation therapy and EMDR did not differ from one another in speed or efficacy (Taylor, et al., 2003).

In a 2007 study by the Federal Department of Defense, in a survey of a treatment program implemented to treat PTSD with EMDR, the participants rated the program with high satisfaction and found significant results from EMDR treatment (Silver, Rogers, & Darnell, 2007). In another study, an estimated 1,500 earthquake trauma victims with PTSD were treated with EMDR. The researchers found that an average of five 90-minute sessions eliminated symptoms in 92.7% of participants. These gains were maintained at a six-month follow-up (Konuk et al., 2006). Clients treated with EMDR after the attacks on the World Trade Center in 2001 made highly significant positive gains on validated psychometrics and self-report scales (Silver, Rodgers, Knipe, & Colelli, 2005).

EMDR may be more effective for the treatment of traumatic stress than other nontraditional modalities. Marcus, Marquis, and Sakai (2004) studied individuals treated for PTSD with EMDR and with standard care. At three- and six-month follow-ups, there were significantly greater improvements in the individuals treated with EMDR. The researchers concluded that relatively few EMDR treatment sessions resulted in substantial outcomes that were maintained over time.

DiGiorgio, Arnkoff, Glass, Lyhus, and Walter (2004) analyzed therapists from psychodynamic, humanistic, and cognitive-behavioral orientations who also incorporated EMDR into their work with clients. All of the therapists varied the standard EMDR

protocol to some degree based on their theoretical orientation. All therapists from disparate orientations were able to successfully integrate EMDR into their work.

### **Structured Sensory Intervention for Traumatized Children, Adolescents and Parents (SITCAP) for Trauma**

SITCAP incorporates the right-brain through an art therapy component, making it a left-brain, right-brain integrative treatment modality. SITCAP sessions are highly structured and are a part of the overall goal of reducing traumatic stress. Through this process, the traumatized individual tells his or her trauma story, reframes it, and contains the memory symbolically within the drawings made through the course of treatment.

Steele (1998) purports that psychomotor activities should be a part of treatment for trauma resolution. Steele, who works predominantly with children, achieves trauma resolution through a structured sensory intervention program, which features processing trauma with art therapy. This treatment modality is especially interesting because it integrates both cognitive components and altered states and seamlessly helps individuals resolve trauma.

Steele's SITCAP program was conceived in 1990 and took 11 years to develop. The goal of the SITCAP program is to help traumatized individuals regain a sense of physical and emotional safety and the process "is based on an educational model of teaching, exploring, guiding, normalizing and reframing of experiences. Feelings are addressed in order to be normalized, not analyzed" (p. 33).

Although SITCAP is geared towards children and adolescents, it is also effective with adults. Steele has three age-specific programs: *What Color is Your Hurt* for children

ages three through six (Steele & Kordas, 1998); *I Feel Better Now!* for children ages six through twelve (Steele, 1995); and *Trauma Intervention for Children and Adolescents* for children ages thirteen through eighteen (Steele, 1997). Steele (2007) reports that his methods are successful with families and children exposed to domestic violence, murder, sexual or physical assault, suicide, and other violent acts such as car accidents, fires, critical injuries, drownings, terminal illness, divorce, and parental separation.

In trauma, Steel (2003) says that the avoidance efforts made by the individual support their fear and suggests that “when traumatic memories are not integrated into consciousness...the memories then continue to trigger the traumatic state or conditioned responses. (Steele, 2003, p. 14)

According to Steele (2003), two conditions are necessary to treat PTSD and reduce fear. The first component is a reactivation and controlled reliving of the traumatic memory in a safe environment in order to modify it. The next component is to provide corrective information to the traumatized individual, which helps to reframe the event into a new narrative that places the trauma to a time and event rather than a generalization to everyday life (Steele, 2003).

In his *Trauma and Loss in Children* (1990), Steele organized research featuring 150 mental health practitioners in seven Michigan counties. The practitioners worked with 150 traumatized children and instructed them to draw what happened and then draw themselves. Study-generated trauma questions were also asked while the children drew. Traumatic incidents were worked with that had occurred as recently as six weeks prior and as long as 14 years before the SITCAP intervention. Steele (2003) reports that the outcome of this study revealed the following:

- Trauma can be induced by either violent or non-assaultive incidents,
- Compared to assaultive incidents, levels of severity can be as high or higher with non-assaultive incidents,
- Duration from the time of the trauma to the intervention indicated greater levels of severity,
- Children were eager to draw about the details of their experience and thereafter tell their story (p 19)

The above study demonstrated the need to distinguish between grief and trauma reactions, how they show up in children, and how to assist children in telling their trauma stories. It also formulated questions about what kind of intervention should follow the first session and what focus that intervention should take (Steele, 2003)

After working with *Trauma and Loss in Children* and various trauma survivor groups, Steele created *I Feel Better Now!* (Steele, 1995), which is an eight-session trauma resolution program for children between the ages of six and twelve. The program features telling the trauma story and cognitive reframing and the primary strategies

All parents of the traumatized children who attended the program indicated that they would recommend the program to others. All parents also reported positive changes in the trauma-related behavior (Steele, 2003). Anecdotal feedback from the children indicated that most felt better, less afraid, and more tranquil overall, which parents and teachers confirmed. Further, all children completed the eight sessions. The *I Feel Better Now!* program is now utilized in schools and agencies in group settings across the country (Steele, 2003)

The outcome of this field test inspired the development of *Trauma and Loss in Children* (TLC), which is a structured, trauma-specific program that would serve children ages three to 18. TLC is an eight session intervention model. Seven of the eight sessions are individual; in the eighth session, the parent joins the child so the child can tell the trauma story (Steele, 2003).

The intervention process focuses on incorporating the following techniques:

- Normalization through education;
- Understand through cognitive restructuring;
- Anxiety management through psychomotor activities;
- Empowerment through discovery and reframing of responses; and
- Relief through telling and showing, restructuring, and replacement. (Steele, 2003, p. 23)

The goals of the intervention included

- Stabilization (return to previous level of functioning or prevention of further dysfunction;
- Identification of PTSD reactions;
- Reduction of level of severity of trauma reaction identifies in the three subcategories of the DSM-IV (APA, 1994);
- The opportunity to revisit the trauma in the supportive, reassuring presence of an adult (professional) who understood the value of providing this opportunity;
- An opportunity to find relief from the terror of the experience;
- An opportunity to re-establish a positive “connectedness” to an adult;

- Normalization of current and future reactions;
- Support of the child's heroic efforts to become a survivor rather than a victim of the experience;
- Replacement of the child's traumatic sensory experience with positive sensory experiences;
- Identification of additional needs and involvement of the parent to help meet these needs. (Steele, 2003, pp. 23-24)

Steel (2003) has identified 10 major trauma themes, which include terror, fear, anger, revenge, hurt, worry, accountability, powerlessness, absence of safety, and victim thinking versus survivor thinking. His programs focus on these themes rather than on the symptoms of PTSD. Steele has identified events which may result in PTSD symptoms in children. They include:

- Separation from a parent due to the parent's substance abuse problem;
- Physical/sexual abuse, neglect or abandonment;
- The murder of a sibling, parent or friend;
- Witnessing the killing of a sibling, parent, or friend, including the witnessing of a suicide;
- The discovery of a body;
- Witnessing the rape or physical abuse of a family member or friend;
- Death of family members by fire, car accident or drowning;
- Terminal illness and death of a family member or peer;
- Critical injuries;

- Divorce/Adoption; or
- Neither witnessing nor actually being involved in any of the above, but simply being a friend or peer of someone who was exposed to a traumatic incident. (p. 36)

When children are traumatized, they may suffer cognitive impairment in memory and in learning, be unable to concentrate, experience hypervigilance, exhibit increased aggressive behaviors, have survivor guilt, experience flashbacks, report disturbing dreams, undergo regressive behavior, experience increased startle reactions, and emotional detachment. Some children experience grief in brief episodes and often seem not to be grieving at all. Verbal expressions of sadness related to the loss are often related without emotion (Steele, 2003).

The first stage intervention strategies include exposure, trauma narrative and cognitive reframing. Steele (2003) asserts:

Drawing is used as the major component of exposure. The trauma narrative is facilitated with the use of trauma-specific questions, and educational materials facilitate cognitive reframing. Each intervention is structured for the purpose of creating a sense of safety and power for the child, adolescent or parent while re-experiencing, re-telling, and reframing of major trauma reactions. The restoration of a sense of safety and power is of primary concern in each program. The activities are primarily sensory activities, as trauma is experienced at a sensory level, not a cognitive level. The structure of the intervention, however, directs those sensory experiences into a cognitive framework, which can then be reordered in a way that is manageable and empowering. (p. 910)



Clearly, thought drives emotion (Beck, 1976). Disturbing states are driven by dysfunctional thinking. By changing the thoughts, the emotional state also changes. The application of cognitive restructuring in Steele's intervention allows the traumatized individual to identify and then evaluate the traumatic memory, challenge incorrect or self-defeating thoughts, and then reframe them to support a positive mental state. In SITCAP, thoughts associated with the trauma are reorganized to incorporate the current life situation and thereby become manageable.

Memories determine the interpretation of the present moment even if they are subconscious (Mihaescu & Baettig, 1996). "Children experience trauma in a sensorimotor level then shift to a perceptual (iconic) representation to a symbolic level" (p. 239). Later in life, traumatic memories can be ordered linguistically. In order to work with the traumatic memory, it must be given a language and integrated into consciousness and expunged in its symbolic form (Steele, 2003).

Steele (2003) asserts that drawing is an effective form of exposure therapy which can also help the traumatized individual to create a narrative that describes the trauma. Traumatized individuals simultaneously create a symbolic representation of the traumatic memory. Through strategic questioning, this intervention allows the individual to externalize the memory, give the memory a language and thereby make the trauma manageable.

The SITCAP intervention helps through the following:

- Initiating focused psychomotor activity to assist in triggering traumatic memories stored at the sensory level;

- Moving the victim from a passive to an active involvement in the healing process;
- Providing a vehicle to safely communicate what children and even adults do not have the words to adequately describe;
- Providing for the externalization for the trauma into a “container” (8 x 11 sheet of paper) that has boundaries, is concrete and tangible and assists in bringing about a renewed sense of power over that experience;
- Creating a focal or impetus to tell the story;
- Giving the intervener a visual representation of the way the trauma was experienced so the intervener, as a witness, can see what the victim sees as he now looks at himself and the world around him following the trauma;
- Allowing trauma sensations to be replaced with positive sensations;
- Re-establishing a connectedness to the adult world which leads to a greater sense of safety and hope as a survivor;
- The major intervention components of SITCAP are exposure by; by drawing about the specific sensations of the trauma itself; telling the story, or developing a trauma narrative through trauma specific questions, and cognitive reframing to move from victim thinking to survivor thinking.

(Steele, 2003, p. 17-18)

Steele (2003) conducted a multivariate study of the SITCAP Method and reports that t children could experience severe levels of PTSD symptoms following non-assaultive as well as violent incidents. It further documented that levels of trauma could continue to exist years after exposure without trauma-specific intervention. It

demonstrated that the use of the Trauma Response Kit by trained trauma specialists and consultants did, in fact, assist in the reduction of symptoms across all diagnostic subcategories and, for most, continues that reduction three months after the last intervention. “It demonstrated that the most severe (multiple traumas) saw the greatest reduction in reactions, contrary to the myth that little can be done to help those exposed to multiple traumas” (p. 30).

Steele (2003) also reports that a child does not have to witness a traumatic event in order to be traumatized by it through his internal images and fantasies of what happened. Sudden, unexpected events can be traumatic for a child, such as witnessing an anticipated death, or hearing details about the traumatic event.

During SITCAP Session One, the therapist explains why the child is meeting with the therapist, is shown a video about trauma entitled “You Are Not Alone,” and is asked to draw about the traumatic event. The drawing is child directed without order or sequence. Steele (2003) recommends asking the following types of questions:

- Who is this person?
- What is your relationship to each?
- What are they doing, saying, thinking, feeling?
- Who else was there when this happened?
- Were you there?
- When this happened, what were you doing?
- What sounds do you remember hearing when this happened or when you heard about what happened?

- Is there anything that you touch or that sometimes touches you that reminds you of what happened?
- What did you see?
- What worries you most about what happened?
- What else do you think might happen?
- What worries you most now?
- What scared you the most about what happened?
- What scares you now since this happened?
- What do you do now when you are scared?
- What was the worst part for you?
- What is the worst part for you now?
- What would you like to see happen to the person who caused this?
- What makes you mad now?
- What do you do when you get mad now?
- Is there anything you wish you would have said to the person before he died, was killed?
- Is there anything you wish you would not have done? What would you have done?
- What exactly happened?
- What do you think this person (or you) was thinking when this happened?
- If this person could have talked what do you think he/she would have said (or did say)?

- Where did you feel it most in your body?
- What worried you the most?
- What did you like most about this person who died or was injured?
- (If the child was the victim) What did you like most about yourself before this happened? (p 120-124)

After the drawing is put away, Steele (2003) recommends making reframing statements, such as “It is okay to remember and talk about the person who died or about your Mom and Dad who doesn’t live with you now,” or “It is okay for us to have fun even through we miss the person and their being gone makes us sad sometimes” (p 124)

The Second SITCAP session deals with the fear and worry a traumatized child experiences. The child draws a monster or scary person and a treasure box. The therapist draws himself/herself in the picture and then has the child describe the details of the monster/scary person. The therapist then describes what he or she would do to get around the monster/scary person (Steele, 2003). The therapist also asks questions about the worrisome monster, such as “Sometimes what scares us worries us a lot. We think about it and dream about it. Tell me, since this happened, what worries you the most?” (p 140). The therapist then reframes the worry through a rain metaphor that suggests that feelings of worry do not last forever, like the rain, and helps the child think of things he or she could do when feeling worried (Steele, 2003).

The Third SITCAP session works with hurt and anger by having the child draw herself/himself and describe where in their drawing they feel the hurt and what color it is (Steele, 2003). The therapist asks questions such as “What happens now that makes you feel the hurt?” and “What makes the hurt go away?” (p 148). Next, the child draws the

person who caused the trauma and describes what he or she knows about that individual. The therapist reframes the desire for revenge by suggesting that it is okay to feel angry and want to hurt the person, but it is not okay to actually do it. The session ends with the child drawing a picture of the family before the traumatic event happened and what the child can share about the picture (Steele, 2003).

The Fourth SITCAP session is designed to help the child identify what he or she can do when he or she feels angry. The therapist has the child draw a happy memory and teaches the child that he or she can change uncomfortable feelings by thinking about happy memories. The therapist also dispenses clay for the child to beat or to cover the drawing of the traumatic event (Steele, 2003).

SITCAP session five focuses on accountability, the worst part of the traumatic memory, saying goodbye to the bad, and creating hope for the future. These objectives are cultivated through the incorporation of a ritual that involves attaching a list of bad memories to a helium filled balloon and letting it go, then making a list of hopes and dreams for the future (Steele, 2003).

SITCAP Session Six readies the traumatized child for the end of treatment, prepares them for a meeting with his or her parents to discuss the traumatic event, and to define the child's relationships to other adults in his or her life and what he or she may need in order to feel better. During this session, the counselor recapitulates the work done with the child and the child determines what he or she wants to share with the parents (Steele, 2003).

Steele's (2003) method encourages parental interaction and allows the parent to discern how the trauma has impacted their child. Before Session Seven, Steele suggests

that the parent of the traumatized child meet with the therapist to support the information presented to the parent at the initial session, to discuss changes in the child, to discuss the issues faced by the child, and to prepare the parent for ways to respond to the child's story at the next session. According to Vickerman and Margolin (2007), including a safe caregiver in therapy can reinforce the therapeutic goals set by the child's therapist. Parenting interventions may also include psychoeducation about child development and the exploration of the caregiver's worries (Vickerman & Margolin, 2007).

During SITCAP Session Seven, the child and parent re-establish the trust that may have been damaged due to the trauma, the parent understands how the child perceives him or herself and the world differently as a result of the trauma, and the parents are provided with responses that can be most helpful to the child. The child presents the parent with a book of all the drawings made throughout the process and reviews it with the parent. Debriefing the parent after the presentation of the trauma may be necessary (Steele, 2003).

The last and Eighth SITCAP session provides the child the opportunity for closure with the therapist. During this session, the therapist helps the child understand that saying goodbye does not mean abandoning what was learned or happy memories; reinforces the positive relationship established with the care giver; and encourages returning to counseling if needed (Steele, 2003).

Vickerman and Margolin (2007) suggest that most trauma-focused treatments are based on cognitive behavioral models and include a combination of trauma reexposure, violence education, cognitive restructuring, emotion expression and regulation, social problem solving, and parent training. Exposure interventions help the child think about

the trauma without becoming emotionally overwhelmed; understand their reactions during and after the traumatic event; and create and practice adaptive responses.

Cognitive interventions dovetail with the goals of reexposure and include reconceptualizing the trauma, developing vocabulary to describe the trauma, gaining support and validation related to the trauma, and developing coping strategies to respond to trauma. Reexposure to a traumatic event may work as an informal desensitization process. By discussing the event without retraumatization, conditioned responses and painful emotions become extinguished. When physiological and psychological reactions to trauma are reduced, individuals no longer need to avoid triggers or thoughts related to the trauma (Vickerman & Margolin, 2007).

The trauma interview is a commonly used form of reexposure, which assists the child to work with the details of the trauma and consider the details of the traumatic event in a safe setting. This interview allows the child to reframe and integrate the trauma, increase his or her tolerance for negative emotions associated with the trauma, understand traumatic reactions, and discover personal meaning to the traumatic event (Pynoos & Eth, 1986; Vickerman & Margolin, 2007).

Treating trauma in children through the application of a written trauma narrative is described by Cohen, Mannarino, and Deblinger (2006). The child first describes the details and facts of the trauma, then shares his or her thoughts and feelings about the trauma, and eventually discloses the worst part of the traumatic event previously too difficult to discuss.

Interventions that address emotional regulation associated with the trauma include learning to identify and express emotions, recognizing emotions in others, the



development of empathy, interrupting anxiety, and identifying connections between emotions, automatic thoughts, and behaviors. Social problem-solving often includes learning how to open conversations, take turns, listen to one another, be polite, and use assertive rather than aggressive or passive behaviors to solve problems (Vickerman & Margolin, 2007). Deep breathing, relaxation, guided imagery, and visualization can be taught so that traumatized individuals can disrupt the reliving of the traumatic event (Vickerman & Margolin, 2007)

Rachman (1966), Marks (1972), and Saigh (1987) recommend exposure to the traumatic event is necessary for a successful integration of traumatic events. Saigh and Bremner (1999) have conducted several studies that support the use of exposure and cognitive based interventions for trauma work with children

### **Hypnosis as a Trauma Intervention**

Hypnosis is another contemporary treatment modality for trauma. This approach involves imaginal exposure to the traumatic memory, cognitive restructuring, and the utilization of relaxation techniques to diminish the individual's reactivity to traumatic memories

This sample of American treatment modalities does not represent all treatment modalities currently used by practitioners. These methods are similar, but have unique approaches to mitigate the pervasive negative impact of a traumatic event. Other methods utilize flooding, the reduction of emotional triggers and flashbacks, and grief work

Hypnosis is one effective contemporary treatment modality for traumatic stress (Poon, 2007, Solomon & Johnson, 2002) Hypnosis can assist traumatized individuals to overcome affect dysregulation, stabilize overwhelming traumatic stress, improve the sense of self-worth, and allow for re-processing of the traumatic memories in a safe environment (Poon, 2007)

A few common definitions of hypnosis, according to Gafner and Benson (2003) include

Guided daydreaming, believed-in imagination, controlled dissociation, a relaxed, hypersuggestible state, a halfway point between sleep and consciousness, and a narrowing of conscious attention and facilitation of unconscious receptivity (p 119)

According to the APA, hypnosis is an approach where a clinician assists a client to experience changes in sensations, perceptions, thoughts, or behavior Hypnotic states are generally established through an induction procedure that usually includes suggestions for relaxation, calmness, and well-being The range of induction techniques that induce hypnosis suggests that the only common factor is the label “hypnosis ” Hypnosis may be an expectancy of manipulation or placebo because the effects of the induction are independent of specific components or ingredients (Lynn & Kirsch, 2006)

Hypnosis is not a type of therapy in and of itself, rather, it is an adjunct to facilitate therapy Hypnosis has been used in the treatment of pain, depression, anxiety, stress, habit disorders, and varied psychological problems (Kirsch, 1994) Hypnosis has been empirically validated in the treatment of pain, smoking cessation, anxiety, stress-

related physical and psychological disorders, dermatological conditions, asthma, obesity, and eating disorders (Lynn & Kirsch, 2006).

Traumatic memories are preserved in an abnormal state, set apart from ordinary consciousness (Herman, 1997; Levine, 1997; Scaer, 2001). Herman (1997) argues that this abnormal state of detachment is similar to hypnotic trance states in that they “share the same features of surrender of voluntary action, suspension of initiative and critical judgment, subjective detachment or calm, enhanced perception of imagery, altered sensation, including numbness and analgesia, and distortion of reality, including depersonalization, derealization, and change in the sense of time” (p. 43).

Patient characteristics that may contraindicate the use of hypnosis include vulnerability to psychotic decompensation, paranoia, and unstabilized dissociative or post-traumatic patients (Lynn & Kirsch, 2006). Lynn and Kirsch (2006) suggest that “placebo effects reveal a basic principal of human experience and behavior: When people expect changes in their own responses and reactions, [they] can produce...self-fulfilling response expectancies [that] are a cause of psychological problems and an essential part of psychological treatment” (p. 38).

Lynn and Kirsch (2006) aver that hypnosis is comprised of three components, which include preparation, induction, and application. Responding to hypnosis has more to do with the abilities, anticipations, and attitudes of the patient than with the skill of the hypnotist. Part of the preparation phase is to create in the patient an expectation of positive outcomes of the hypnosis, building a positive therapeutic alliance, debunking hypnosis myths, describing hypnosis completely, and helping the client to understand that hypnotic experience can take place even without a hypnotic induction.

Patients with PTSD are more hypnotically suggestible than most other patient populations (Spiegel, Hunt, & Dondershine, 1988; Stutman & Bliss, 1985) and are likely to benefit from hypnosis (Cardena, 2000; Cardena, Maldono, van der Hart, & Spiegel, 2000). Flashbacks respond best to hypnosis and desensitization. Avoidance behaviors respond best to psychodynamic therapy (Lynn & Kirsch, 2006). Hypnosis is a useful adjunct to exposure therapies and CBT (Lynn & Kirsch, 2006).

Lynn and Kirsch (2006) suggest that before using hypnosis with a patient, the clinician should obtain detailed information about the trauma including the age of the patient when the trauma occurred; the perceived life threat, injury or harm, frequency and duration of the trauma and behaviors; and feelings and thoughts that happened before, during and after the trauma. Personal resources and limitations, social support, comorbid psychological diagnoses, previous trauma history, alterations in the individual's sense of self and worldview, triggers, memory problems, flashbacks and context of flashbacks, and previous successful and unsuccessful strategies should be explored.

Lynn and Kirsch (2006) report that traumatic experiences create fear networks or structures in memory. Exposure therapy may be effective in the treatment of PTSD because it allows for the opportunity to alter these structures and minimize avoidance.

A correlation between PTSD and hypnotizability among Vietnam veterans was found by Stutman and Bliss (1985); individuals with low or no PTSD scores had normal hypnotizability scores and individuals with high PTSD scores had high hypnotizability scores. The authors concluded that either combat traumas enhanced hypnotic potential or individuals with excellent hypnotic potential to begin with were more susceptible to

PTSD. They suggested that individuals may revert to spontaneous self-hypnosis as a coping technique (Stutman & Bliss, 1985).

Theoreticians debate whether hypnosis can be explained in socio-psychological terms, or as a special process; whether it is a state or a trait; or merely dissociation. Yapko (1993) describes hypnosis as a meaningful interaction in which the clinician and the client are responsive to each other. Gafner and Benson (2003) suggest that:

The therapist is a guide who helps people elicit experiences of which we are all capable, whether it is a heaviness in one hand or the other, subjective mental and bodily relaxation, pleasant imagery, an improved sense of well-being, an overall meaningful experience, or some other therapeutic objective. (p. 120)

Dissociation, which is an altered state, prevents the individual from integrating the traumatic event. Integration is necessary for healing (Herman, 1997). Swerdfeger (2008) also believes that when a trauma occurs, the individual begins to operate in an altered state in order to survive the trauma. A return to the altered state in which the traumatic event occurred is necessary for the resolution and integration of that event, and hypnotic techniques facilitate that process.

Exposure to traumatic memories causes a shift to an altered state of consciousness (Levine, 1997; Steele, 2001; van der Kolk, 1996). A return to a non-ordinary state of consciousness experienced by the individual at the time of the original trauma helps the individual integrate the experience into ordinary consciousness (Levine, 1997; Marks, 1972; Rachman, 1966; Saigh, 1987; Scaer, 2007; Steele, 2001). The return to the altered state for the resolution of trauma is implied, but not asserted, in American treatment models.

Gravitz (1994) found that when traumatic experiences were retrieved and restructured during hypnotic regression and revivification, therapeutic suggestions effectively modified recollections of the prior traumatic events so that their meaning and impact were changed. A follow-up inquiry indicated that the memory alterations and posthypnotic improvement of the presenting problems were maintained.

Hypnosis may be effective in facilitating the treatment effects of CBT for treating traumatic stress, according to Bryant, Moulds, Guthrie, and Nixon (2005). In their study, CBT in combination with hypnosis resulted in greater reduction in the re-experiencing symptoms associated with traumatic stress than CBT alone (Bryant et al., 2005).

Solomon and Johnson (2002) also found that treatments that combine cognitive and behavioral techniques are most effective in the treatment of traumatic stress. Mental exposure to traumatic memories through hypnosis decrease intrusive memories associated with PTSD, while cognitive and psychodynamic approaches may better address the numbing and avoidance symptoms.

Conversely, there may be unwanted consequences associated with hypnosis for the treatment of traumatic stress. Serious consequences have included chronic psychopathology, seizure, stupor, spontaneous dissociative episodes, and the resurrection of memories of previous trauma. Individuals with schizophrenia may not be appropriate candidates for hypnosis because there are related neurophysiological mechanisms between hypnosis and schizophrenia (Gruzelier, 2000).

Hypnosis is not a reliable technique to recover historically accurate memories in psychotherapy (Lynn, Lock, Myers, & Payne, 1997). The inability to recover accurate memories may be due to the possibility that clients and clinicians may not be able to

differentiate between accurate and inaccurate memories. However, the authors suggest that hypnosis is an effective treatment for individuals who recall traumatic events without the application of hypnosis (Lynn et al., 1997).

Meditation and guided imagery may also be helpful to traumatized individuals. Germain et al., (2004) found that imagery rehearsal therapy can reduce nightmares associated with traumatic events. When traumatized individuals experiencing nightmares scripted new dreams, they experienced fewer nightmares and negative elements in their dreams. Germain et al., (2004) also suggest that lucid dreaming and hypnosis techniques can be effective in trauma processing because these processes access the patient's ability to direct the content of his or her dreams. An increase in mastery over dream content may also result in the reduction of other intrusive symptoms in PTSD, such as flashbacks.

### **Mesoamerican Curanderismo**

While there are counselors, psychologists, and psychiatrists who practice allopathically in Latin countries or American Latino communities, an individual suffering from severe *susto* or *desasombro* will visit a *curandero* for treatment that involves a ritual for energy healing, increasing social support, and *platicas*. Such an encounter allows the traumatized individual to heal and return to his or her community as a functional, contributing member. Jung (1969) described "loss of soul" as a possible transformation of the personality common within "primitive psychology" (p. 119).

Curanderismo integrates mind, body, spirit and community support in treatment of *susto* and *desasombro*, resulting in highly integrated outcomes rather than mere treatment of the mind in isolation. Curanderismo focuses on maintaining a state of harmony within the individual, "produc[ing] and protect[ing] a holistic relationship

between the individual and his total environment” (Trotter & Chaveria, 1997, pp. 29 – 30), and

places a strong emphasis on the social, psychological, and spiritual factors contributing to illness and poor health. In the first place the work of a curandero is sanctioned by the community where he practices. Second, most healing procedures involve an evaluation of a patient’s family and support systems (for example, co-workers, friends, and schoolmates). Third, there is always the ritual petition to God or other spiritual beings to help with the healing process. The spiritual factors involved in Curanderismo are beyond the normal limits of social science. However, we cannot deny that the violation of certain moral codes and the development of guilt complexes do constitute threats to good health. In the same vein, once a person becomes ill, faith can become an important factor in his recovery. (Trotter & Chavira, 1997, p. 44)

In 1968, Ari Kiev documented the practice of Curanderismo in Texas as a treatment for psychological concerns. Few books about Curanderismo have been written in English. Kiev’s book is the only one which focuses on the psychological aspects of this treatment modality. He discusses the role culture plays in personality formation; psychic conflict; and the development, patterning perpetuation, and management of mental illness. Unfortunately, Kiev’s book is difficult in tone regarding his research subject and participants, and his book is strongly rooted in left-brained thinking. Since there is a dearth of information about Curanderismo, the literature review for this Project Demonstrating Excellence consisted of three visits to Mexico over the course of this



study wherein I immersed myself in the Curanderismo culture there. Additionally, I worked closely with an Azteca and Apache cuandera in Albuquerque, New Mexico.

Curanderos are part doctor, psychologist, and priest. In the majority of cases, their treatment is hands-on and friendly. Generally, the curandero treats individuals of his or her social strata. Illness is believed to be related to everything that surrounds it. Usually, the consultation is a collective meeting of the ill person with his or her family. Patients do not attend sessions alone. The operating belief system is that *corazón cura corazón*, or that heart cures heart (de Franklin, 2008). Psychological issues such as PTSD, anxiety, or depression are treated with spiritual cleansings with a sahumerio, candle magic, various rituals, limpieas, and temascales. The healing process in Curanderismo incorporates pre-Hispanic, native therapies (de Franklin, 2008; Hurlong, 2001; Nuñez, 2008; Ornelas, 2008) and, at times, includes ancient ceremonies and ritual practices kept alive by the healers and shamans. Mexican Curanderismo's pedigree stems predominantly from Aztec/Nahuatl medicine.

According to de Franklin (2008), the Aztecs had three types of therapy, which included Natural Therapy, Religious-Psychological Therapy, and a mixture of Natural and Religious-Psychological Therapy. Natural treatments included the application of plants, animals, and minerals. Religious-Psychological Therapy healed through calling on the intervention of Spirit. The mixture of Natural, Religious-Psychological Therapy included limpieas with herb bundles to extract ill wind from the patient while invoking Spirit to heal the patient's body through the use of the sahumerio.

Curanderismo has also incorporated elements from other cultures into its system (Nuñez, 2008; Ornelas, 2008), such as Spanish contributions from the conquest, African

systems, and modern Eastern practices. For example, traditional medicine utilizes plants such as basil and rosemary, which are European, and Sábila, which is African in origin. Present day Curanderismo is also influenced by Christianity (as healing being a “don” or gift from God and a belief in God); Greek (for the humoral concept and balance of hot and cold), Arabic (for directing psychic energy), Wiccan (for a belief in supernatural forces), African (for Santeria blend of Catholic saints and African deities), spiritualism, psychic communication with spirits, trances, science for germ theory, psychology, and biomedicine (de Franklin, 2008).

An important aspect of Curanderismo is the cosmovision in which this practice is understood. In Curanderismo, everything in the universe is interconnected. All elements of nature are sacred, have their own personality, and are more important than the human being. The human being is connected to everything including other people, plants, animals, objects, the air, water, earth, divinity, the planets, and all in the cosmos. It is not possible for human beings to control or dominate nature; rather, human beings should strive to understand, respect, and harmonize with the natural world. Actions that lack respect for these elements break familiar, social, natural, cosmic, and divine equilibrium. Illness is a consequence of a rupture in equilibrium between the individual and social, spiritual, and environmental relationships (Macina, 2007; Mexican Secretary of Health, 2006). Conversely, the equilibrium of the universe is also contingent upon the equilibrium of humans (Mexican Secretary of Health, 2006).

Confident in the efficacy of Curanderismo, the Mexican government is officially promoting the construction and use of temascales. The Mexican Secretary of Health (2006) has also documented, incorporated, and legitimized Curanderismo as a

complementary medicine within the allopathic model. Traditional medicine is “a conglomeration of medical systems that contains profound knowledge about health and illness that different Indian and rural pueblos have accumulated over the course of their history” (p. 7), similar to alternative Western treatments, Chinese medicine, Japanese medicine, and Ayurvedic medicine.

In Curanderismo, psychological illness occurs when the individual experiences emotional extremes. These extremes include exposure to traumatic events, following whims/cravings, abdominal trauma, and external influences that impact the tonalli. The tonalli is the force that gives the body breath, appetite, causes waking states, thought faculty, and strength. The tonalli, according to L. de Franklin (personal communication, December 11, 2008), is established when an individual is born and links the individual to the cosmos. Everything that is alive has tonalli and it can be borrowed to cure. The tonalli can become adversely impacted through the evil eye, strong winds, hexes, rages, preoccupation, and events that cause strong impressions such as children seeing their parents having sex, thinking overmuch, being overly nervous, and guisha (A. Ornelas, personal communication, December 13, 2008).

Two illnesses similar to the symptomatology of traumatic stress and PTSD within the Curanderismo cosmovision are susto and desasombro. Susto approximates a severe fright in English (Navarrete, 2008; Nuñez, 2008; Ornelas, 2008; Ramírez, 2008; Romero, 2008; Rubel, O’Neill & Collado-Ardón, 1984), resulting in a part of the tonalli, or vital force, fragmenting away from the individual during the shocking event. Desasombro, another variety of susto, also closely approximates PTSD. Desasombro occurs after a frightening encounter with the supernatural or possession by evil forces (Ornelas, 2008).

Susto and desasombro occur when an individual experiences something frightening, which can be as simple as being startled to profound traumatic experience, such as witnessing the murder of a family member (Rubel et al., 1984).

Rubel et al., (1984) report that an individual is “diagnosed with susto if they are restless during sleep, and (the patient is) otherwise listless, debilitated, depressed, and indifferent to food and to dress and to personal hygiene” (pp. 6–7). Sandra Hurlong (2001) describes susto as “soul loss or fright” (p. 19), and Elena Avila (2000) also defines susto as “soul loss” (p. 63), caused by a frightening or traumatic event. Avila suggests “when we suffer from susto we do not feel fully present or as if we are really ourselves. We experience a feeling that ‘something is missing’ because our spirit, the energetic aura that surrounds us, has been violated” (p. 64).

Treatment for susto involves the recuperation of the tonalli through spiritual practices (Avila, 2000; de Franklin, 2008; Kiev, 1968; Navarrete, 2008; Ornelas, 2008; Torres, 2005; Trotter & Chavira, 1997). Treatments include modalities such as pláticas (heart to heart chats), limpiezas (spiritual cleansings), and other ritualistic practices, prayer, temazcales (vapor baths), herbology, and interpersonal touch (Avila, 2000; Nuñez, 2008).

### **Temascales.**

Another consequential treatment modality utilized by curanderos is the temazcal, a vapor bath similar to the Native American sweat lodge. The word temazcal comes from the Aztec word *temazcalli*, which means bathing house (Macina, 2007). The temazcal has religious and therapeutic character throughout Mesoamerica. It is sometimes known as the Mother of the Gods and Heart of the Earth, Creator of the Gods and of humans, of medicine, doctors, surgeons, midwives, and psychics. In the past, the temazcal was a

medical-religious institution, and was utilized in association with other forms of healing (Macina, 2007). The vapor bath is utilized throughout Mesoamerica, Mexico, Guatemala, parts of North America with the exception of Eskimo groups, Yuma and Pima Indians, and groups in the northern regions of Mexico (Macina, 2007).

The temazcal, a permanent igloo-shaped building, represents the womb of the Great Mother and the belief is that a return to the womb results in a healing rebirth (de Franklin, 2008). An experience in the temazcal is an encounter with the Great Mother archetype, making this practice transpersonal. Jung (1969) described rebirthing as a psychic reality that includes an experience of renewal or improvement experienced by the individual through magical practices. Jung (1969) said:

Rebirth is an affirmation that must be counted among the primordial affirmations of mankind. These primordial affirmations are based on what I call archetypes. In view of the fact that all affirmations relating to the sphere of the supranatural are, in the last analysis, invariably determined by archetypes, it is not surprising that a concurrence of affirmations concerning rebirth can be found among the most widely differing peoples. (p. 116)

Plants are employed in the temascales, either to line the floor of the structure or for switching bundles. Plants utilized in temascales are common in the states of Morelos, Puebla, Estado de México and Distrito Federal and include rue, tarragon, white sapote, wild cherry, elder flower, oak, willow, rosemary, sage, mugwort, pepper tree, Castilian rose, and arnica (Davidow, 1999; Macina, 2007).

According to Macina (2007), the physical form of the temazcal is a representation of sacred imagery of the Mother Goddess who is the patrona, or patron saint, of the temazcal ceremonies. Macina (2007) describes the temazcal as follows:

In the tradition of the temazcal, an unspoken, unconscious symbolism is revealed. The relation of symbolism between form and its significance, the ancient knowledge of this ritual which has cut across the centuries and didn't fall into oblivion, the threads of memory that have crossed centuries in spite of religious persecution and acculturation, are expressed in the ritual of temazcal. The temazcal is a representation of the interior of the earth, it is a cave. Like the cracks in the earth – ravines, pits and caves – it puts the superficial world in communication with the subterranean world. It is a place of transitions, traditionally a site for rites of passage such as giving birth. Transformation is possible in this space, physical and spiritual rebirth. It was and is a place where individuals were and are birthed, thanks to contact with water and fire, in the interior of the earth. It was and is a place where individuals enter to purify themselves, it is a place of *limpia*. Periodically, people enter the vapor bath (temazcal) in order to clean themselves with fire and water, in order to purify themselves and to celebrate another time the return to the uterus, in a continual cycle of rejuvenation, in agreement with the cyclic regeneration of the world. It is a return to ourselves, to the most profound part of existence, a break from every day living, from immediate and daily experience (p. 18).

The temazcal is a place of social encounter (Macina, 2007) in addition to healing purposes. People prepare for transitions or rites of passage in the temazcal. Community

and family members engage in temazcales together, which fosters their familial and community bonds. Women give birth in temazcales, attended to by parteras (midwives). After giving birth, women will sit in temazcales to help the body heal from the trauma of birthing. In some communities, a post partum mother and her child will remain together in the temazcal for six weeks, allowing the child an easy transition in to the outside world (Nuñez, 2008). The temazcal is a sacred edifice, bringing healing and ritual within the realm of common, frequent experience. The temazcal heals on a symbolic level for Mesoamericans as it connects individuals to meaning within the collective unconscious (Macina, 2007).

The temazcal works on a spiritual and religious level of healing and is utilized for the treatment of susto. Macina (2007) describes this treatment as follows:

For susto, you give the person a massage and later have them [sic] enter the temazcal. After leaving the temazcal, the individual should rest for an hour. With the sahumario you smudge the individual. You give them flowers and 12 pieces of corn, which you place on the joints. The individual shouts their name and calls the name, saying, "Come back, \_\_\_! Don't be frightened!" Before entering the temazcal, the individual should take a tea of anis, peony, basil and Brazil stick. The individual should do this treatment three times, resting an hour between each temazcal. After, you give the individual *atole* (a drink made of corn meal, milk and sugar) and herbs and chicken, *clemole* and *betónica* soup. The temazcal is often utilized in association with individuals' drinking teas, taking medicinal plants, rubdowns, cupping, spinal adjustments, and massage, in addition to

applying moist heat to medicinal plants to create therapeutic vapor in the atmosphere of the temazcal. (Macina, 2007, p. 97)

After a temazcal, individuals sometimes receive massages by the temazcalero. In Curanderismo, there is fluidity to the role of the healer, seamlessly moving from psychologist within the temazcal to massage therapist outside.

### **Rituals.**

Rituals in Curanderismo may incorporate burying an egg that has captured negative energy from the individual, burying or scattering a symbolic article, fasting, praying, using religious artifacts, chanting, and drumming, among others. Limpias, or spiritual cleansings, are a common ritual practice which involves sweeping bundles of herbs or an eagle feather over the body to remove negative energies. Limpias are a form of spiritual work and are both preventative and reactive.

Additionally, an egg can be rubbed over the body to absorb negative energy (de Franklin, 2008; Navarrete, 2008; Nuñez, 2008; Ornelas, 2008; Ramírez, 2008; Romero, 2008). Sometimes, limpieas involve the symbolic application of corn kernels and copal, a tree resin. No matter what materials are employed, curanderos focus on being in flow with the energy of the patient and of nature. The application of sensation and energy enables curanderos to give each patient what he or she needs in the cleansing process (Rapahel, 2003).

Raphael (2003) suggests that the positive intent of the curandero is the most potent tool a healer has at her or his disposal. The client must be open to the healing, and the healer connects with his or her “sabiduria”, which is a state of connectedness with



deep knowingness. Raphael (2003) suggests that rituals work because through the repetition of whatever act is involved in doing the spiritual healing, it creates an energetic path. Raphael (2003) states:

By repeating the same act, we can create a path in structure for the energy to follow to the cleansing session. Holding rituals is a very important part of the healing process. It allows the energy coming in to grow, and become stronger and more refined through repetition. Like a morning routine, or ritual, a ritualized prayer will help to carry and add to our intent. A prayer is an important aspect of our ritual because it carries the power of our word. Our word is the first manifestation of our intent and is the quickest manifestation we create. By using a prayer, we are using the power of our word to carry our intention (p. 29).

#### **A Comparison of Contemporary American Treatment Modalities and Mesoamerican Curanderismo**

Mesoamerican Curanderismo and American nontraditional treatment modalities both have organizational precepts for healing similar conditions: susto and PTSD. Traumatology is well-documented and is continuously being scrutinized for newer, better scientific data regarding the efficacy of various treatment modalities. The efficacy of Curanderismo for trauma is, by comparison, not well-documented. This may be because the practitioners, the curanderos, serve the underserved in society and often do not charge for their treatments. Typical therapeutic treatments and procedures in Curanderismo include prayer, herbology, massage, hot humidity through the temazcal, the application of cold, and the reestablishment of tonalli through spiritual cleansings and rituals.

### Shared Characteristics

American nontraditional treatment modalities and Curanderismo often involve a return to the altered states of consciousness the individual experienced at the time of the traumatic event. In contemporary Traumatology, this altered state is accomplished through hypnotic induction, bilateral stimulation or flooding techniques. In Curanderismo, the altered state is accomplished through participation in rituals or through intense heat in the temazcal, similar to a Native American sweat lodge. Jung (1959) noted the significance of the rebirthing experience, suggesting that experiences which impact the psyche, similar to the transpersonal environment of the temazcal, are “the most tremendous fact of human life” (p. 116). Often the intense heat of a temazcal will cause a flashback, allowing the individual to process the traumatic experience.

The altered state of consciousness initially experienced when the traumatic event occurred probably allowed the individual to survive it. Levine (1997) reports that mammals spontaneously enter altered states of consciousness, including the freeze response. He states that when an animal plays dead, “it has instinctively entered an altered state of consciousness shared by all mammals when death appears imminent. Many indigenous peoples view this phenomenon as a surrender of the spirit of the prey to the predator, which, in a manner of speaking, it is” (Levine, 1997, pp. 15-16).

Levine’s description of the surrender of the spirit echoes the Curanderismo belief that during a traumatic event, a piece of the soul fragments away from the individual. Though it appears that American traumatologists understand this metaphor for the fight, flight or freeze response, contemporary treatment for traumatic stress does not directly address or acknowledge treatment of the spirit or other integrative approaches.

In American nontraditional treatment modalities for trauma there is also burgeoning interest in engaging the soma in the treatment of traumatic stress. Thus, in allopathic traumatology, the soma is accessed through guided imagery, meditations, or acute focus on the experience of the body, all of which allow the individual access to his or her bodily experience of the trauma. Curanderismo also engages the soma in treatment for *susto* through the practice of *limpias* and *temascales*, whereby, the focus of the experience is firmly grounded in body memories.

Another similarity Curanderismo and allopathic traumatology share is an acceptance of the efficacy of the treatments by the people who receive them. In American culture, people are invested in what is scientific and proven. Curanderismo works in Mesoamerica and South America because that is the system of healing that has worked and been in place for centuries. Most people readily accept treatments for *susto* that worked for their parents and grandparents. American treatments for traumatic stress help individuals gain insight into their suffering, give voice to the unspeakable, and provide support to face horrific realities (van der Kolk, 2008). These tasks are accomplished primarily through talk therapy and meaning-making of the trauma. Traumatized individuals benefit from self-revelation, disclosure about the traumatic event, and social communication. Those are important factors that decrease the psychosomatic repercussions of trauma (Pennebaker, 1997).

Practices in Curanderismo also seek to make meaning of the trauma, give the victim a voice, and help the traumatized individual to come to terms with the traumatic experience. These tasks are often accomplished through *pláticas*, community involvement, and rituals. In Curanderismo, all parts of the individual must be

acknowledged in treatment, often through the application of ritual. Torres (2005) suggests a strong link between the state of the mind and the state of the body, and chides his readers to “never underestimate the power of ritual” (p. 40).

### **Divergent Characteristics**

There are significant conceptual differences between allopathic and Mesoamerican approaches. In allopathic traumatology, mental and physical health is understood to be a result of correct functioning of the body. Our symptom-oriented approach to disease has a rational, scientifically provable cause such as viruses, bacteria, old age, cancer, inherited defects, and accidents, though there is some acceptance that stress or depression can cause sickness. There is also an understanding that ailments may be psychosomatic. However, allopathic scientific models do not accept that illness may stem from a problem of the soul or one of its parts (St. Pierre & Long Solider, 1995).

In Curanderismo, physical and mental health is a dynamic state of internal equilibrium among the body, the mind, and the spirit, and good health depends on a state of external harmony with other human beings, nature, and the cosmos in general. Illness comes from a rupture in the equilibrium of heat and cold, which is derived from individual behavior and social, environmental and spiritual relations (de Franklin, 2009; Ornelas, 2009).

Maintaining mental and physical health and treating mental and physical illness are also conceptualized differently in Curanderismo and contemporary models. Health and illness are managed as individual phenomenon in contemporary models. In

Curanderismo, there is an internal relationship of every human being with everything that surrounds the individual, including people, animals, objects, planets, the cosmos; everything can affect the human being. The actions of an individual can also impact everything else.

There is also a cultural difference between how people experience and understand the significance of the body in Latin and American communities. The language used to describe the body and its experiences reflects these fundamental attitudes. In English, people say, “My stomach hurts,” or “The chemicals in my brain aren’t firing correctly.” The body is experienced and conceptualized as “me”, who I fundamentally am. In Spanish, people don’t use “my” when referring to the body. Instead, they report “The stomach ails me,” or “The chemicals in the brain don’t function correctly.” Though subtle, this idiomatic difference reflects that in American culture, there is no separation between the individual and the body, whereas in Latin culture, the body is animated by what the individual truly is. This linguistic nuance demonstrates that the spiritual orientation and focus is fundamental to how Latin peoples understand the cosmos and their place in it.

Medical or mental health treatments are also conceptualized differently. In contemporary traditional and nontraditional models, illness is attended to as if the individual is only the body. In Curanderismo, illness is attended to inside of a collective family and environmental context. At times, the illness is attended to by inclusion of the entire social group. Additionally, Curanderismo utilizes medicinal plants for their hot and cold properties for their abilities to reestablish equilibrium within the mental, physical, and spiritual body, whereas in contemporary traumatology, plants are used for their

chemical properties and as a primary material to make commercialized medication (Mexican Secretary of Health, 2006).

Curanderos often have a dedicated healing space which contains religious and spiritual icons with significance to the healer and patient. Fresh flowers and candles are often found in these spaces. Curanderos may also take a patient to a natural or historical location renowned for healing energies to enhance the curandero's healing ritual. Psychologists also have dedicated healing spaces in the form of an office with icons significant to the healer and patient from contemporary culture in the form of books and degrees. The emphasis on the secular symbols of power, status, and formalized learning in allopathic offices differ significantly from the spiritual icons found in the healing spaces of curanderos.

In allopathic traumatology, the spiritual belief systems of patients can vary and not interfere with efficacy of the treatment. In Curanderismo, the belief system of the people is a fairly homogenized, Catholic-based system, and/or a pre-Christian system with Catholic names and ideas transposed onto them. These belief systems are significant to the efficacy of treatment modalities involved with Curanderismo.

There are strengths associated with contemporary models for the treatment of traumatic stress including the ability of the clinician to select a specific treatment for a specific personality, religious, and philosophical backgrounds. Additionally, there are multiple methods which produce the altered state necessary for healing such as art therapy, hypnosis or somatic treatments. Perhaps the most exciting and interesting contribution to the treatment of traumatic stress in allopathic traumatology is understanding of neuroplasticity. Studies in this area demonstrate that the brain has

amazing capacities to repair itself and overcome adversities, which was a concept inconceivable under the old localizationism paradigm (Doidge, 2007).

Another difference between the healing systems of Curanderismo and allopathic traumatology is the belief systems surrounding the healer. In American culture, individuals drawn to healing arts such as Psychology go to school to formally learn how to practice within a certain theoretic orientation as the guiding principle for all treatment. In Curanderismo, the healer is an individual who has a “don,” or healing gift. An individual can have the don through a calling to heal, through familial inheritance, or through a God-given ability to heal, which often comes to the individual after a life threatening event. No healing session is undertaken by an individual with the “don” without first acknowledging a divine force, and most curanderos operate with the understanding that they are merely conduits for the work of Spirit (de Franklin, 2008).

In both systems, the ability to heal gives the healer respect and sets that individual apart from others in the community. However, the origins of the respect differ greatly. In contemporary culture, the psychologist is understood to be an expert, as evidenced by his or her degree. In Curanderismo, healers are both respected and feared because they are influenced and have interaction with unseen powers. Though curanderos often claim no special gift and acknowledge that they merely serve as a conduit for God’s work, curanderos are sometimes treated with suspicion by their community. This is because the healer’s don may actually be related to dark arts and not a God-given gift. The motivation of the healer is often questioned by those seeking the services of the curandero, whereas in contemporary culture, the motivation of the psychologist in doing their work is rarely considered by the traumatized individual.

Psychopharmacology is also vastly different in Curanderismo and allopathic traumatology. The curandero works with plants for healing, and the curandero has a spiritual connection with the medicinal plant, which he or she gathers and picks him or herself. At the moment of picking the plant, the curandero will ask permission of the plant to take it for the healing of another. The curandero may also give thanks, make an offering, or give a blessing to the plant.

Some curanderos treat *susto* through shamanic trance induced by the use of *salvia divinorum*, a psychoactive plant. Under the effects of *salvia divinorum*, the curandero engages in a soul retrieval, returning the fragmented part of the spirit to the traumatized individual (Ratsch, 1998). In contemporary psychopharmacology, healing substances are highly controlled and regulated and come from factories as pills.

Medicinal plants may be under-utilized in allopathic medicine because pharmacy manufactures cannot get a patent for the rights to a plant. Thus, there is no profit motivation for using plants. Additionally, the dosage and quality of a medicinal plant is difficult to monitor and quantify in allopathic medicine. In settings with curanderos, the patient is likely to have daily interaction with the healer, who can closely monitor the effects of the dosage and make recommendations for the dosage based on multiple interactions with the patient. Curanderos, who make their own salves, tinctures, blended herbal teas and medicinal soaps, work very closely with the herbs and can know the potency of a particular plant based on its smell, color, or texture, for example.

Another significant difference between Curanderismo and American nontraditional treatment modalities for trauma is the use of supportive substances to help the individual cope with the traumatic stress. In our culture, an individual with PTSD and





severe flashbacks will likely be placed on anti-anxiety/antidepressant medications as possibly, “as needed” tranquilizers. Unfortunately, there are many side effects associated with these medications such as potential damage to a fetus in a pregnant patient, decreased memory functioning and verbal recall, decreased ability to achieve orgasm, among others. In Curanderismo, acute shock is treated with herbal teas. Linden tea, or *te de tila*, for example, is very effective for managing anxiety and has no known side effects (de Franklin, 2008). Nuñez (2008) reported that an herb commonly used in Oaxaca is *Lengua de Gailena* (Chicken’s tongue), and this herb has no side effects and is very effective. Valerian can also be used for the long term as a calming tea if needed with little or no side effects (Nuñez, 2008).

In allopathic traumatology, psychologists maintain a professional distance from the patient. This professional distance includes a guiding paradigm of limited or no self-disclosure to the patient. In Curanderismo, there is no governing body dictating what can and cannot be discussed between patient and healer, and the healer may choose to self-disclose for a multitude of reasons. American psychologists must always be vigilant to not give the client any reason to sue them, including crossing professional boundaries.

Perhaps the most significant difference between Curanderismo and American healing models is the professional attitude of the healer towards the patient. In allopathic traumatology, the healer is a professional expert and must maintain objectiveness and avoid becoming emotionally involved with the patient’s issues. Healing sessions are time limited as the healer has a tight schedule, likely due to the expenses associated with running a practice. In Curanderismo, the healer is playful and a part of the same social stratus and community of the patient. Healing sessions take as long as they take.

Curanderos also pray for and with their patients, which is not commonly a part of American psychotherapy.

### **Allopathic and Mesoamerican Modalities and Prayer**

A growing body of scientific evidence suggests that people can be healed through power of the mind. Larry Dossey, M.D. has examined the interaction of the mind, spirit, and body for more than three decades. Dossey (2007) reports that there are 19 major, randomized, controlled clinical trials demonstrating the power of intercessory prayer, 11 of which are statistically significant. Those studies provide evidence that thoughts, emotions, attitudes, feelings, intentions, and prayers influence the physical world. These studies suggest that consciousness is not confined to the brain and body. He states, “Consciousness can do something that individual brains and bodies can’t do; it can operate at a distance outside the limits of space and time” (Dossey, 2007, p.15). This is in alignment with the healing paradigm in Curanderismo.

#### **The power of prayer in healing.**

The positive effects of prayer are being researched and documented. Achterberg, Cooke, Richards et al., (2005) found that compassionate, healing intentions can exert measurable effects on the patient and that an empathic bond between the healer and the patient is an important part of the process. In their study, 11 healers from Hawaii selected a person with whom they felt a compassionate, bonded connection to be the receiver of their healing efforts. Each receiver was placed in an MRI scanner and was isolated from the healer. The healers sent healing at two-minute, random intervals that were unknown to

the receiver. In 11 of the 12 receivers, significant changes in brain function were found during the intervals in which the healer was sending healing.

Byrd (1988) found that heart attack patients receiving assigned prayer needed less CPR, less potent medications, and had a lower incidence of pulmonary edema and pneumonia than the control group during a randomized, controlled study at UCSF School of Medicine/San Francisco General Hospital. In another study at the Mid-America Heart Institute in Kansas City, Kansas and the University of Kansas School of Medicine, coronary patients who received remote, intercessory prayer had a statistically significant, better clinical score than the control group (Harris et al., 1999).

Tloczynski and Fritzch (2002) demonstrated that intercessory prayer significantly reduced the anxiety levels of the participants in the experimental group. There was no reduction in anxiety for those in the control group who were not prayed for during their study. In a triple-blind, controlled study by Cha, Wirth, and Lobo (2001), involving women undergoing in vitro fertilization and embryo transfer in a fertility clinic, the group receiving prayer was two times more successful with pregnancy than the women in the control group.

**Interpersonal touch.** Van der Kolk (2008) reports that treatments that emphasize working with bodily states affect the mind and help individuals “have physical experiences that directly contradict past feelings of helplessness, frustration and terror” (p. 79). Van der Kolk (2008) furthers his argument by stating the importance of engaging the body in treatment for traumatic stress and PTSD.

The medial prefrontal cortex and insula are linked to the brain’s emotional center (the amygdala) and arousal centers and, finally, to the hormonal and muscular

output centers. In this way working with deep sensations and feelings have the potential to achieve a sense of internal equilibrium and balance. Only after being able to quiet and master one's physical experiences does one regain the capacity to use speech and language to convey, in detail, feelings and memories. The process of psychological change involves regaining a healthy relationship with our internal feeling states. In contrast to understanding, paying close attention to one's internal life – the flow of physical sensations, feelings, internal images and patterns of thought – can make an enormous difference in how we feel and act (p. 3).

Touch is grossly underutilized in contemporary traumatology models. Touch is a basic behavioral and physical need that allows humans to grow, develop socially, and maintain contact with others (Caplan, 1998). Touch with pressure may stimulate the nervous system, decrease levels of cortisol, and stimulate the production of hormones, which help the organism feel good (Davis, 1999). Heart rates change when people are touched, and holding the hand of an individual in a coma or paralyzed produces significant cardiovascular responses (Davis, 1999). Touch can also help alleviate pain, decrease fear, aggravation, and feelings of helplessness that often accompanies illness. (Davis, 1999) Abnormal behavior will result when the need for touch goes unmet. The human need for touch for healing is advocated and supported by multiple researchers. Animal research demonstrates that lab animals that are handled die less frequently than animals left in isolation (Montagu, 1986).

In therapeutic touch, the healer should be “focused, fully present, heart-centered, attuned to the recipient, holding the intention for the highest good of the receiving person,

unattached to the outcome, and able to serve as a facilitator of healing energy” (Davis, 1999, p. 168), which sounds similar to the healer practicing prayer in action.

Massage therapy could easily be an adjunct to treatment for traumatic stress and PTSD in contemporary traumatology. Somatic processing through massage therapy assists the dissociative patient in experiencing his or her body and emotions while staying present with the experience. Cathartic release can happen during massage therapy, which is therapeutic if the patient remains present and aware of his or her surroundings. A bodywork session may include nothing more than holding or touching a spot, no touch at all, or maintaining a focus exclusively on how the patient feels in the body. It can also include deep tissue massage (Mowen, 2001).

The healer determines the work based on the needs of the patient, requiring the patient to think about his or her soma. For example, the patient can mentally scan the body and identify a place on the body where he or she feels the need to work. Patients may notice a sense of pain, hollowness, tension, or a place that feels happy and light - a feeling to work with and expand. In addition to providing muscle manipulation, the healer supports and comforts the patient, acting as a compassionate witness, similar to Rogerian counseling techniques (Mowen, 2001).

There are significant biochemical differences between individuals who have had adequate touch and those who have not. Lowen (1969) states, “An ego that is not grounded in the reality of body feeling becomes desperate” (p. 102). Montagu (1986) suggests that there is likely to be a biochemical difference between individuals who have been adequately touched and those who have not, regardless of life stage. For the resolution of trauma in an individual, van der Kolk (2008) suggests:

Must *physically* come to terms with the remnants of the defensiveness lodged in our physical reality; otherwise, the imprints of the past may permanently determine whether we feel at home in our bodies and whether we can be open to and learn from experience (p. 1).

Perhaps the most significant reason why clinicians don't touch their patients is because of the litigious nature of American culture. Touching a client violates professional boundaries and can have serious professional and financial consequences for the healer. I know a former licensed professional counselor in Arizona who lost her license, which she held for 25 years, because she hugged a client. Not being able to touch a client creates an environment that is not conducive for healing.

The American preoccupation with sexual harassment and abuse in schools and workplaces results in touch being taboo. Davis (1999) suggests that the implication of this new taboo for children may significantly impact their growth, development, and emotional well-being. Davis (1999) compares Americans to "cold fish" and states:

U.S. friends in a coffee shop tend to touch each other an average of only twice an hour – but French friends touch 110 times, and Puerto Ricans friends, 180 times. While a handshake pushes the limit on the comfort for American men, Hispanic men routinely embrace, and French men exchange cheek kisses in salutation as an accepted, even expected behavior. Except within the area of sports, touch is seen as homosexually threatening for American men (p. 81).

Davis (1999) notes professional touch is also performed without emotional attachment. He suggests:

The intent of touching here is to perform some service or accomplish some task. In order to prevent any possible intimate or sexual messages from interfering, the person to be touched is usually treated as a non-person or object. This objectivity becomes necessary in order to allow this touching, whether it be a gynecological, genital or prostate exam; a tailoring measurement; or a session with a golf or tennis pro. Barbers, chiropractors, hairdressers, physicians, massage therapists, athletic trainers, and foot reflexologists all fall into the professional touch category. Some people are never touched except vicariously or by professionals. Some people make unnecessary trips to doctors just to be touched, although they often do so on an unconscious level... I suggest that if your touching needs must be satisfied by professionals, then massage therapy, foot reflexology, or some other bodywork provide the most honest, direct, and gratifying methods. Some chiropractors run a close third. Not only can touch needs be satisfied to some extent, but this type of touching is also extremely healthful. Please note that the further we move from a strictly task-orientated professional touching behavior, the less socially sanctioned the profession becomes. Thus, the professional areas that best meet touch needs are less socially sanctioned (p. 93).

According to Davis (1999), we can create change in society completely based on how a child is nurtured and treated in early life. One study of 49 primitive cultures found a correlation between low levels of infant affection and high levels of violence. Davis states:

Primitive societies that prohibit or punish early touching behaviors and premarital sex also exhibit such social trends as slavery, wife purchasing, fears of castration,

theft, exhibitionistic dancing, sexual disabilities, and the killing of enemies. Apparently the restriction of outlets for physical pleasure and skin stimulation results in frustration and efforts to seek other forms of stimulation, most of which are counterproductive to a society (p. 109).

In truth, lack of touch shows up in our bones. During growth periods where an individual has not been sufficiently touched, there will be retarded bone growth in the tibia and radius. This phenomenon also shows up in x-rays of the metacarpal bones of newborns whose mothers encountered unusual stress during their pregnancies (Davis, 1999; Montagu, 1997). Davis suggests:

Touching communicates love, consciously or unconsciously, and can trigger metabolic and chemical changes in the body that help in healing. Tactile stimulation and emotions may control endorphins, which are natural body hormones that control pain and our sense of well being...Our body is our subconscious mind, and we can't heal it with talk alone. Besides the brain, we must involve the body. We must touch. We do store some memories in the brain, but the older, deeper, and more intense messages – the very ones we most need to access and release – are stored in the body (1999, pp. 143-144).

### **Ritual.**

Ritual plays a vital role in healing in Curanderismo, and is conceptualized as an activity for change in energy. Ritual acknowledges and creates change, and reveres that which is greater than humanity. It can also be used to acknowledge the growth and development of all levels of our being. L. de Franklin posits:



In order for the change to be genuine and lasting, there must be Spirit intervention. This requires a lot of trust and the willingness to let go of control. Healing happens when we surrender our control to Spirit, who is the real healer. Doing ritual helps people, reconnecting them to the ancestors and to their own deepest purpose. Because ritual is so deeply connected to our human nature, anytime it is missing there will be a lack of transformation and healing. Ritual is a dance with Spirit, the soul's way of interacting with the Other World, the human psyche's opportunity to develop relationship with the symbols of this world and the spirits of the other (2008).

According to de Franklin (2008), there are two parts to a ritual. The first part is planned through the preparation of the space for the ritual and through the choreography of the process. The latter part of ritual cannot be planned because it is the part that Spirit is in charge of. It is an unpredictable interaction with Spirit. Franklin asserts, "Before you get started, you own the journey. After you start, the journey owns you."

Burning incense in a sahumero is another ritual practice which encourages a meditative state. A common practice with a sahumero is to burn copal (an aromatic pine resin), offer it to the four cardinal directions, and ask permission from the supernatural to cleanse creation, the patient's surroundings, homes, and to heal the patient. The sahumero is the symbol of purifying fire, which is very strong within the Aztec/Nahua tradition because fire contains all four elements. The earthen bowl represents the earth, the charcoal represents the fire, the copal represents the water, and the smoke represents the air. The use of a sahumero burns and dissolves any harmful energies and the ill will

that might attach itself to the body and the subtle energy of the patient (de Franklin, 2008).

I encountered Curanderismo rituals with similar elements for the treatment of susto from southern Mexico north to Albuquerque. L de Franklin describes one such ritual:

First you need five corn kernels, five small pieces of white copal, a clear glass and filtered water. You might want to get rosemary oil or fresh rosemary. Set a small altar. Follow your intuition but try to open your intention to the four directions plus Mother Earth and Father Sky. You commence by the person facing East and you facing the person but in the West direction. Ask permission to do this limpia. If you are given permission, then you pour water in the glass half way. Take one corn kernel and one piece of copal. You have the person hold them for a few seconds with the intention of letting go of the fear or the feelings of trauma. Then take two kernels and start at the top of the head either in a form of the cross or clockwise circle three times saying something from your religion or spiritual beliefs. What matters is the intention of the ritual. Place them in the glass with the water. Take another set and do the right hand, same method, either a cross or clockwise circle praying or chanting three times. Then move up to the elbow point, inside of it, and do the same, afterwards placing them in the glass. Take another set and do the left hand and elbow in the same way. Place them in the glass. Turn the person around for his back to face you and do the back area of the neck with the same method and place the grains in the glass. When all the corn and copal are in the glass, hold a candle, incense or smudge stick or something

that represents fire to you and smudge the glass and its contents to purify the energy removed from the person. Set the glass on the altar. Then energetically sweep the person with the rosemary or rosemary oil from top to bottom. When you are done sweeping the body, blow gently on your hands to remove the energy. Next, the glass and sprigs are placed under the patient's bed. In the morning the person must drink the water one sip at a time representing each cardinal direction and Mother Earth and Father Sky. The water and corn with copal and rosemary sprigs should be sprinkled around on the outside of their home as protection, as a shield. Continue the candle burning for 9 days as a *velorio* (wake) for their little soul and nurturing them for as much time as you can. Gently touch them, let them feel safe, massage them, bathe them in lavender. Surround them with peace. Play soft music and make a cocoon in your home for them. (2008)

R. Navarrete (personal communication, October 26, 2008) also described the above, among others, and followed the ritual through the use of the copal and corn on the body and the *limpia*. However, she suggested scattering the corn and copal at a crossroads or pouring them into a running stream. R. Navarrete suggests that watching the corn kernels float away can be therapeutic for some individuals, while, for others, it is better that they toss the items over their head, not seeing them leave their possession. A similar method was also described by C. Ramirez (personal communication, October 28, 2008).

Treatment for trauma in American nontraditional settings may be fortified by practices found in Curanderismo such as the inclusion of the individual's community

rather than being treated in isolation. In Curanderismo, Curanderos perform their work either in their home or in the patient's home, and the appointment takes however long it takes versus limited time allotted in an office setting. The family, extended family and community members are often included in the treatment of the patient. Curanderismo relies heavily on the intuition of the healer rather than on a specific protocol. It also draws upon ritual, spirituality, social resources, and informal pláticas. Curanderos come from the same social stratus as the patient, often from the same pueblo, and are trained by elders from their pueblo rather than in the university. Curanderismo also relies heavily on interpersonal touch.

Both Mesoamerican Curanderismo and allopathic traumatology have organizational precepts for treating similar conditions--susto and PTSD. Traumatology is well-documented and is continuously being scrutinized for newer, better, scientific data regarding the efficacy of various treatment modalities that meet the DSM-IV guidelines. The efficacy of Curanderismo for trauma is, by comparison, not well-documented. This may be because the practitioners, the curanderos, serve the underserved in society and often do not charge for their treatments.

### **Curanderismo and Quantum Healing**

It appears that the concepts of Curanderismo are similar to those of quantum mechanics, or quantum physics as it is commonly known today. The physics of the subatomic realm refers to everything in the world that is smaller than an atom. "The laws that govern the classical (allopathic Newtonian) realm are in direct opposition to how things work at a subatomic level of the universe" (Shelton, 1999, p. 2). Shelton (1999) asserts:

From a quantum physics perspective, there are two worldviews. The Newtonian world is material, visible, concrete, static, stable, passive inert, predictable, reality is objective, controllable, a machine, the parts determine the whole, and cause and effect are clearly discerned. Whereas, the Quantum world is intangible, invisible, abstract, dynamic, vibrating, continuously changing, unpredictable, reality is subjective, everything is part of an interrelated whole, the whole determines the parts, and energy is intrinsic to life and its systems. (p. 5)

Shelton suggests that Newtonian thinking is highly valued in American culture, as it has been inculcated with it since Aristotle's (394 B.C. – 322 B.C.) teachings. That the world is obvious, logical, and clear cut is a difficult worldview to abandon. It is becoming apparent that our logical and rational thought processes and our treatment modalities are inadequate to cope with life's stressors.

### **Chapter III**

#### **Method**

##### **Rationale for Heuristics**

Heuristic qualitative research is a qualitative approach that is a combination of heuristics and building a theoretical model. I used heuristics in an unusual way, not just to record the lived experience of individuals, but also to get at the experience of the curanderos to arrive at the integrative model. The heuristic method became the philosophical touchstone for my observation, participation, interviewing, presentation of the data, and data analysis.

Heuristic research includes an internal search to discover the meaning and nature of the phenomenon studied (Moustakas, 1990). Along with personal experience, I focused on the experience of the co-researchers in non-allopathic, traditional methods of working with trauma in order to develop an integrative model. I chose the heuristic method in order to ask and to observe my co-researchers about their personal experiences in working with trauma unfolded from a different philosophical model.

In the creation of this research project, my goals were to research the antecedents of human traumatic stress and PTSD, to interview co-researchers who have knowledge and experience in using non-traditional American and traditional Mesoamerican approaches to heal traumatic stress and PTSD, to utilize my ten years of experience with three nontraditional American treatment modalities that are sanctioned by the American Psychiatric Association's DSM-IV-TR, and to observe and participate in the healing methods for trauma in a Mesoamerican traditional treatment modality known as Curanderismo. Since I have considerable personal and professional experiences with

traumatic stress and with my immersion in the Mexican culture, I chose the heuristic method of research to complement the literature review for this study.

### **The Heuristic Method**

In this study, I embraced Patton's (2002) "emergent design flexibility" (p. 40). The study remained open to adapting inquiry as understanding deepened or situations related to the study changed, allowing my studies to be responsive to new paths of discovery as they emerged.

The heuristic approach incorporates immersion in the research setting to begin the inductive process. A period of processing the experience follows the immersion experience and allows the researcher to digest, become aware of nuance and meaning in the setting, capture intuitive insights, expand awareness, and achieve understanding. The researcher then describes and explains the experience of individuals in the study. Finally, creative synthesis enables the researcher bring together as a whole the individual's story, including the meaning of the lived experience (Moustakas, 1990). Moustakas (1990) tells us:

The heuristic process requires a return to the self, a recognition of self-awareness, and valuing of one's own experience. The heuristic process challenges me to rely on my own resources, and to gather within myself the full scope of my observations, thoughts, feelings, senses, and intuitions; to accept as authentic and valid whatever will open new channels for clarifying a topic...the story of a crucial human experience must be told in such a way that in itself it enables self-transformation (p. 13).

Patton's (2002) question, "What is my experience of this phenomenon and the essential experience of others who also experience this phenomenon intensely?" (p. 132) will be responded to in Chapter 4. Heuristic research focuses on the essence, meanings, quality and experience of a research question and demands and allows for interactive and integrative experience by the researcher. The outcome of the heuristic process is a synergistic union of personal awareness and revelation with concrete knowing. According to Patton (1990), heuristic research

Epitomizes the phenomenological emphasis on meanings and knowing through personal experience, it exemplifies and places at the fore the way in which the researcher is the primary instrument in qualitative inquiry, and it challenges in the extreme traditional scientific concerns about the researcher's objectivity and detachment (p. 73).

Thus, in heuristic inquiry, my insights and experiences form the central point for creative synthesis and result from contemplation, research, discussion, personal experience, and investigation. Along with being process-orientated and highly descriptive, heuristic research relies on self-inquiry, dialogue, dreams, reflections, and personal exploration to comprehend human understanding through direct experience and recollection (Moustakas, 1990). Heuristic research is experiential in nature and seeks to illuminate the meaning in human experience. What the researcher ponders, senses, or has an intuitive hunch about are valid areas of inquiry. In heuristic methodology, there are no external methodological structures, nor is there a formal hypothesis that limits or directs the research in an effort to prove or disprove the hypothesis. In heuristic research, the



data analysis involves looking for themes and patterns in the data and then reporting an individual depiction of the experience (Moustakas, 1990)

My rationale for choosing this format is three-fold. First, I do not believe that research data can be separate from the researcher. Secondly, this format will allow me to examine the overarching and underlying themes that emerge as a result of this study. Finally, this format will afford me the opportunity to not only express personal passions, feelings, ideas, and subjective experience, but also play with ideas, present them in fresh ways, and challenge them with others.

### **Stages of the Heuristic Research Process**

There are six stages of heuristic research (Moustakas, 1990), which include the initial engagement, immersion, incubation, illumination, explication, and creative synthesis. The following narrative describes the six stages along with my experience of each stage. Careful reflection in each of these stages allowed me to discover the nuances of my research inquiry.

The first stage of *initial engagement* involves a willingness on the part of the researcher to discover, think, and intuit about the area of interest until an important theme that has personal and social meaning emerges. This step emerges from the lived experience of the researcher and the individuals researched (Moustakas, 1990).

I found this part of the research process uncomfortable, because I was not able to force the immersion of the research topic. This stage of the process requires putting myself out in the field and keeping my fingers crossed that my inquiries in to the subject will be responded to. I was pleasantly surprised with the quick responses I received to my inquiries and the generosity of the individuals I contacted regarding Curanderismo. I

quickly purchased the few existing books in English on Curanderismo that my contacts had recommended, consumed them, and found myself very eager for hands on learning. I was able to participate in several research trips in Mexico, and the first-hand exposure to Curanderismo transformed my life and my psychotherapeutic practice.

The next stage of *immersion* involves the researcher becoming engrossed with the research question. This absorption helps the researcher remain open to all possibilities that may define or elucidate the research investigation. This stage also involves locating pertinent information through books, networking, interviews, tacit knowing, intuitive leads, and reflection (Moustakas, 1990). This part of the heuristic research process was very exciting for me as it allowed me the opportunity to travel and network with curanderos in Mexico and New Mexico. I also found it interesting that there is very little written on the subject of Curanderismo in English, which may reflect a scientific, left-brained cultural bias in American society.

The *incubation* stage allows the researcher to withdraw from intense involvement with the research subject. Incubation allows for insights to spontaneously emerge from both the conscious and unconscious mind while the researcher detaches from intense absorption from the subject (Moustakas, 1990).

This stage of the process is paramount, and difficult to let happen naturally, given that I was working on a timeline. This part of the process is the most creative and spontaneous, and nothing kills creativity quicker than trying to force it to come. I had moments of insight in to trauma when I was quiet and contemplative, not necessarily focused on the subject. Often, early morning, before I really become awake, is the best time to allow what thoughts may come.

According to Moustakas (1990), the *illumination* stage or breakthroughs to tacit or implied knowledge occurs when the researcher does not apply intense focus on the subject. In this stage, breakthroughs focus on the conscious awareness of the direction or outcome of the study. Moustakas (1990) asserts that illuminations are intrinsic to creative scientific discoveries. In my personal process, I found painting and drawing helpful as these activities allowed me to take a break from my analytical mind and be with my synthesizing, creative mind. During these activities, I became aware that the outcome of this study would be a model that integrated Curanderismo and American Traumatology methodology.

This stage of the process is difficult for the same reasons as the incubation phase. I have grown to tolerate these periods of seeming intellectual hibernation and trust that what I will need will come to the fore of my psyche when I need it or when I am able to hear or receive it.

In the *explication* stage, the researcher concentrates on the information that has emerged in the conscious mind with the intent of further explanation and analysis (Moustakas, 1990). Moustakas (1990) describes this stage of the research process as follows:

In the explication process, the heuristic researcher utilizes focusing, indwelling, self-searching, and self-disclosure and recognizes that meanings are unique and distinctive to an experience and depend upon internal frames of reference (p. 31).

This stage of the process was joyous for me, because it allowed me to acknowledge and assert my personal experience related to trauma. This approach is a

departure from what I have traditionally done in academia, and I have grown as an academic for this experience.

In the final stage of *creative synthesis*, all levels of knowledge are synthesized through the exploration of an explanation of the phenomena according to specific themes. The themes are creatively expressed to capture all the crucial components of a descriptive depiction. The import of the study is clarified. The result of this stage is this document (Moustakas, 1990).

I first conducted a literature review about traumatic stress and contemporary treatment modalities in addition to observing and interviewing a Union Institute and University graduate and hypnotherapist. I also reviewed literature on Curanderismo and susto, which provided information and a historical context for my research in the field. I then engaged in fieldwork through open-ended, ethnographic interview and observation of curanderos. Throughout this research process, quotations, descriptions, and documentations were gathered to illuminate the lived experience.

### **Co-Researchers**

The co-researchers in the observations and interviews were Latinos or Latinas: four men and three women ranging in age of 35 to 89. Because the practice of Curanderismo extends beyond Mexico's borders, curanderos not born in Mexico were included in this study. In Curanderismo, the community bestows the title of "Curandero" on their healers rather than the healer self-promoting and self-entitling. Thus, the curanderos were chosen based upon their recognition by the communities in which they

live as curanderos. Non-curanderos were chosen based upon their historical expertise in Curanderismo or upon expertise in traumatology. The names of the co-researchers have been changed to maintain anonymity, as expressed in Table 1 below.

Table 1

*Co-Researcher Description*

Name	Occupation	Location
Roberta	Curandera and Temazcalera	Mexico City, Mexico
Alberto	Curandero and Dean	Cuernavaca, Mexico
Evita	Curandera and Temazcalera	Albuquerque, New Mexico, U.S.
Don Miguel	Curandero and Temazcalero	Oaxaca City, Mexico
Leonela	Curandera	Cuernavaca, Mexico
Bill	Consulting Hypnotist	Scottsdale, Arizona, U.S.
Juan	Linguist, Educator, and Aztec Culture Expert	Mexico City, Mexico

**Research Questions**

Throughout my 10 years of experience as a psychotherapist, I have used the American “head to head” healing approaches for traumatized individuals. However, this experience combined with my immersion and interactions with my above co-researchers has made me realize that the humane dimension is missing in American therapeutic approaches.

I hypothesize that my study of and recent immersion in Curanderismo, a Mexican “heart to heart” approach for healing traumatized individuals, could fill in the “missing” piece in American nontraditional treatment modalities for traumatic stress and PTSD.

My research-in-progress questions thus became:

- What are the lived experiences of my Mesoamerican Curanderos co-researchers, pertaining to healing trauma?
- What differences exist between American Traumatology approaches and Mesoamerican Curanderismo approaches to the experience of being healed of trauma?
- What messages about the sustainability of humanity are being transmitted by adhering to contemporary or Curanderismo approaches in isolation?
- What would a healing model consist of that integrates the head and heart (the left-brain and the right brain’s attributes) to heal traumatized individuals with PTSD?
- How could such an integrative model impact the psychotherapist’s experience of being a healer and the client’s experience of being healed?
- What impact could an integrative approach to healing have upon the healing profession and society?

I pondered these questions internally, with family, friends and colleagues, attempting to integrate these healing modalities. Ultimately, my final research question became:

- ***How could Western Traumatology and Curanderismo be integrated to create a more holistic approach to the lived experience of healing PTSD and traumatic stress?***

I also considered the larger picture of why we treat trauma from a left-brained perspective through the course of this study. Through personal reflection and dialogue with curanderos, it became apparent that the practice of healing in Mesoamerica was profoundly influenced by the Spanish conquest. Because Mesoamericans are still very much devastated by the Spanish Conquest, this study seeks to challenge the worldview of the victors, not the conquest. The worldview of the dominant culture is questioned and deconstructed in this study while it simultaneously, framing this research within a much larger social, historical, and political context.

#### **Data Collection**

Each participant and co-researcher reviewed and signed an informed consent forms before the interviews (Appendix D). All interviews were conducted face-to-face at either their homes or work location. The duration of the interviews varied from two to five hours. Observations of the curanderos in action lasted from half a day to a week. The questions and direction of the interviews were unstructured, though each curandero was asked to describe their treatment for susto. I also gathered information during observation and participatory experiences.

#### **Data Analysis**

After the field work for this research project was complete, I sat with the content of the interviews, participatory experiences, and observations for reflection. I then generated themes based upon what I discovered during the interviews, participatory experiences, and observations, and created a model for the treatment of trauma that integrates American Traumatology and Mesoamerican Curanderismo, which are described and graphed in Chapter Four.





## Chapter IV

### Results

Recognizing the importance for developing a holistic treatment model, it is equally vital to discuss my rationale for its development with the inclusion of Traumatic Stress and PTSD.

My final research question evolved to ask, “Is it feasible to integrate American and Mesoamerican healing treatment approaches to design a model for healing traumatic stress and PTSD whereby the model and the lived experiences of the psychotherapist/healer and of the client/patient are acknowledged, intertwined, and utilized for optimum healing?” I employed the word “feasible,” which, according to *Webster’s New World Dictionary*, means “capable of being carried out; practicable; possible; within reason; likely; probable” This is because American state licensing agencies have strict guidelines for helping professionals to follow when working with clients. Thus, under these guidelines, some aspects of the model would not be permissible, such as the incorporation of interpersonal touch.

The Treatment Model that I have designed goes beyond the allopathic orientation of symptoms and hands-on to focus on the whole persons’ bodies, minds, and souls. My model is practicable for all parties in the healing process, and it is possible that as the medical field changes to include emerging research on the brain that whole-brain and whole-person approaches may be sanctioned. My ten years of experience as a psychotherapist working with traumatized individuals, using American traditional and nontraditional treatment approaches (sanctioned by the American Psychiatric

Association's DSM-IV-TR), taught me that working with the head's data only, and not the heart's, worked for some clients but not for others. I pondered the larger issue, "What messages about humanity are being transmitted when we adhere to Western treatment modalities that do not consider that people's heads and hearts are interconnected?"

My research concentrates on an analysis of the similarities and differences between the experiences of three nontraditional American treatment modalities for trauma and Mesoamerican Curanderismo, a Mexican healing modality that engages whole human beings in their cultural context. My co-researchers' data presented and my analyses of those interviews, the literature review, and my own lived experiences are the bases for developing an integrative treatment model that encompasses the best of both treatment approaches for my work with traumatized patients. Attention will be paid to the complex interdependencies and systems dynamics that cannot be meaningfully reduced to linear cause and effect relationships (Patton, 2002).

In allopathic psychotherapy, the "client" and "psychotherapist" dyad implies a business relationship governed by laws rather than an authentic relationship in which healing occurs. In Mesoamerica's Curanderismo, the role of the psychotherapist is "healer" and the role of the traumatized individual is "patient." I will employ healer and patient in my Integrated Model to honor the un-institutionalized, informally educated path of my extremely knowledgeable teachers within the Curanderismo traditions.

I observed and interviewed five curanderos over the course of this study. I discovered, based on these interviews and observations, that the Curanderismo treatment modality for *susto* in central and southern Mexico is a fairly standardized treatment process; therefore, I present three interviews: Roberta/Juan, Leonela, and Alberto.

**Individual Portraits Roberta and Juan.**

The following interview took place in a microbus in Mexico City. Roberta, her nephew Juan (who was acting as translator for the non-Spanish speaking individuals in our group and Aztec culture expert), me, and others from the Albuquerque Curanderismo group had just visited the archeological ruins of Teotihuacan, north of Mexico City. I have translated Roberta's words and included Juan's translation to the group of Roberta's words in Appendix C. The words are transcribed as they were spoken, and include grammatical translation errors and a literal, direct translation of Roberta's words in Spanish, which adds to the authenticity of the recounting of the lived experience (Appendix C).

**Leonela.**

Leonela resides in a small pueblo approximately 40 miles East of Cuernavaca. The pueblo is so small that it is not identified on maps. It is nestled near the mythic birthplace of Quetzalcoatl, the Aztec winged serpent god, backing up against reddish brown cliffs spotted with pine trees. One dirt road passes through the village, which consists of a store, a restaurant, a 12-Step center, a basketball court, and a cemetery.

When I visited this village, homes were decorated with an even ended cross made of dried pericón, a yellow flower, signifying a connection with the Great Mother, corn, and the four cardinal directions. Los Días de Los Muertos, or the Days of the Dead celebrations were being observed. The cemetery was adorned with marigolds, the smell of which is said to attract the dead back to their gravesites. Once returned, the deceased spend time enjoying the company of living family members and earthly pleasures at a

picnic. High mass is also celebrated with the dead and their families in the cemetery. People attract their deceased loved ones to the mass through burning copal in their *sahumaríos* at the gravesites.

This small community does not have access to allopathic medicine. The people of the pueblo are served by a community clinic which provides affordable, natural treatment for common ailments, which have been handed down through the generations. Through this clinic, I was connected with Leonela who was identified as a *curandera* specializing in the treatment of *susto*.

Leonela resides about a quarter of a mile from the clinic. When I knocked on her fence, she came to the gate and stood on an upside down five gallon bucket and peered at me over her wall. I explained why I was at her doorstep, but she seemed reluctant to give me an interview. I explained that I was a doctoral student studying *Curanderismo*, and that she had been identified by her community as a specialist in treating *susto*. She continued to appear hesitant in talking with me. We chatted for about 20 minutes, and after I explained that I worked with poor children in Phoenix Arizona, she became interested in talking with me about her work.

I was led into her small courtyard where chickens and cats cohabitate. Leonela's home appeared to be a one room made of adobe. There was little room inside the house, which is probably why she gave me the interview on her patio. After bringing me a chair to sit, she told me that corn is intrinsic to the healing process for *susto*.

Leonela described a healing treatment similar to what I had heard from other *curanderos*, in which dried corn kernels are placed upon all the major joints of the patient to remove the energy of the *susto*. Some healers will make even armed crosses with the

kernels; others have their patients hold the kernels in the joints by bending the elbow, for example. This practice is said to reopen blocked energy caused by the traumatic event. Prayer is said by the curandero while the treatment is in process.

Leonela, along with other curanderos, sometimes diagnose the cause of the susto by placing the kernels in a glass of water. If the kernels sink, the susto is caused by something earthly; if they float, the susto is of a spiritual nature or from a hex. After the treatment is complete, the curandero will have the patient dispose of the corn in a way that supports the treatment and rids the patient of the cause of the susto. For example, if the susto is caused by a sexual assault, the curandero will have the patient disperse the energy of the assault now contained in the kernels through throwing them into a running body of water, placing them at a crossroad, or tossing them over a cliff. If the susto is something the patient needs to reintegrate, the curandero may have the patient bury the kernel in their yard or carry it in their pocket.

It appears that a theme common in Curanderismo is making a connection between the patient and the Great Mother, symbolized by corn in Leonela's treatment. There are many Latino Catholics in the United States with whom the Virgin of Guadalupe is firmly entrenched as the Great Mother energy. For people outside of this spiritual tradition, a connection with something loving and larger than themselves, perhaps spiritual, may be significant to overcoming trauma. This may be accomplished through the introduction of the temazcal and its symbolism. A connection with the Great Mother energy may also be accomplished through the establishment of a sincere relationship between the patient and a loving mentor.

**Alberto.**

I first encountered Alberto in Albuquerque where he was speaking on traditional healing and Curanderismo at a University of New Mexico, Albuquerque. Alberto is a fluent English speaker, but chose to speak to the group in Spanish through an English translator. Alberto is very passionate about traditional medicine, as evidenced by dramatic gesticulations and vocal crescendos throughout his lecture.

At the end of his lecture, he made an impassioned plea to those interested in Curanderismo to help restore the body of knowledge to its rightful place alongside other healing modalities. Before the translator could complete the translation, Alberto had dropped his microphone and briskly walked off stage. He said, “We must end the colonialization of medicine,” a provocative idea, indeed.

Alberto is very well educated and quick to laugh. On his property in Cuernavaca, he runs an institute that fosters and teaches traditional healing. At his school, students learn various Mesoamerican styles of massage, pláticas, acupuncture, herbalism, limpieas, and traditional spirituality. Alberto’s character is playful and simultaneously intellectual.

At the age of seven, Alberto was sent alone to Cuernavaca to make his way in the world. He began to shine shoes, until a priest, who had become a regular customer, was drawn to Alberto’s intellect and took him under his wing. Alberto ended up attending an exclusive Catholic school in Cuernavaca, and in exchange for his education, was required to assist the priest during exorcisms. Alberto attended three exorcisms during his years with the priest and learned about negative energy in the process. After participating in

these extreme experiences with spirituality, Alberto now takes seriously the spiritual component of illness.

I asked Alberto to describe an exorcism he attended. He chose a particular one because it was funny, or at least had a funny component. The priest was called to attend to a mentally ill or possessed woman who had severely beaten a child in her pueblo. Alberto and the priest found the woman in her bed, naked, except for a pair of flip flops on her feet. The priest covered her with a blanket and began the exorcism rite. Alberto, who was responsible for burning incense throughout the rite, reported that it was obvious to him that the woman was possessed by an evil spirit because she growled and bared her teeth in a non-human fashion. She also levitated about six inches off her bed at one point during the exorcism. Alberto, laughing heartily, pointed out that the funny part of the exorcism was when the woman let out an “enormous fart,” which was extremely foul. The exorcism lasted about 12 hours, and the spirit left the woman when her flip flops flew off her feet, began walking on their own up the adjacent wall, leaving behind footprints of a foul smelling substance. Alberto and the priest attended the woman for several hours after the evil spirit left her so that it would not have the opportunity to re-enter her body.

Alberto believes that everything is interconnected. Illness stems from disequilibrium in the environment, the organism, the spirit, and interpersonal relationships. Treatment for an illness, be it psychological or physical, must address the spiritual cause of the illness along with other components of the treatment. The spiritual cause of illness may be addressed through ritual, limpieas, prayer, and/or the temazcal. Additionally, medicinal plants help transform illness on a physical level (when ingested

or applied to the body) and on a spiritual level through the transference of the plant's healing energy. Spiritual practice is also paramount to maintaining a healthy equilibrium.

Alberto believes that the ancient Mesoamerican people had an intimate knowledge of energy medicine, and that it was lost during the Spanish conquest. He believes that traditional medicine is very potent, that good physical and mental health is a God-given right, and that any illness can be treated successfully through the application of medicinal plants, which are abundant and readily available to everyone. He is disgusted by allopathic medicine which seeks to make money and cause dependence on costly drugs rather than healing holistically.

Playfulness is a characteristic I have noticed among many curanderos, but is especially apparent in Alberto. I believe being playful helps put people at ease. In allopathic medicine, doctors are supposed to be very serious scientists with all the answers. Americans are conditioned to believe that playfulness is equivalent to incompetence. This is unfortunate because the seriousness displayed by allopathic doctors disables authentic relational connection between healer and patient.

### **Personal, Contrasting Experiences in American Healing Settings and Curanderismo Settings**

Over the course of my studies and immersion in Curanderismo, I have participated in multiple temascales. While I am certain that the sacred healing space of the temazcal enhanced my healing experience, it was my strong connection with the healer that had the greatest impact. This healer had given me multiple massages before the temazcal, and I perceived that she had genuine concern and caring for my mental, spiritual, and physical well-being. Throughout the healing process, I found myself



thinking that I had never been treated with such kindness, compassion, and love in my life. At one point in my work with the curandera, she held me while I sobbed over experiences of which I had no conscious recollection, but that remained embedded in my memory until that moment of physical contact.

One temazcal process I experienced included acknowledging the four cardinal directions, Mother Earth and Father Sky, and the energy that binds all of these entities together. Prayers were offered in each direction. Each participant was smudged and then entered the temazcal naked. Temazcales are undertaken by the participants in the nude (R. Navarro, 2008; Ornelas, 2008; C. Romero, 2008) or in very little clothing. The interior of a temazcal is a small, dark space where it is very difficult for participants to not bump into one another. There is no visible embarrassment about the lack of space or the nudity of the participants.

The floor of the temazcal was lined with herbs and plants, and we were given bundles with which to switch ourselves with, similar to Swedish sauna practices. We were invited to consider a life event that needed healing and the memory became intensified with the addition of steam resulting from water being poured on heated rocks. As the heat became intense, so did the feelings and emotional work. We were directed to cry and scream. Then we were directed to call back the fragment of our soul which left when we suffered the trauma. The temazcalera sprayed the participants with cold water from a hose, to shock the fragmented pieces of the soul back into the body. Songs were then sung, and we were invited to leave the temazcal to receive a massage.

Ornelas (2008), Navarrete (2008) and, Romero (2008) all suggest that American culture places an overemphasis on sexuality and that this is confusing to Mesoamericans

who are very proud of their bodies. Montagu (1986) suggests that in Western culture, the fixation on sexual stimuli may not be about sexual interest, but rather about satisfying the need for touch. This is unfortunate because, according to Davis (1999), touch is stronger than verbal or emotional contact. One temazcal I participated in the nude included both genders. This experience pushed my boundaries of comfort as my culture has taught me that being with a naked man other than my husband is a form of infidelity.

I witnessed a healing temazcal where the individual became emotionally out of control while remembering her trauma. The curandero held the patient while she screamed through the memory of her trauma and helped her regain control over herself. Screaming for this individual was a very empowering experience. Due to the nature of her trauma, she was unable to scream or verbalize anything when the experience originally occurred. If this event had occurred in American counseling, the therapist could have been held liable for multiple infractions of professional boundaries, most importantly for touching the patient.

Interpersonal contact and massage are very important in Curanderismo to the recovery of an individual suffering from susto (de Franklin, 2008; Navarrete, 2008; Ornelas, 2008), and it is liberally applied. In Curanderismo, the body is merely the body--an adjunct to the spirit--and pales in comparison. Massages by curanderos are conducted with the patient being naked and all parts of the body are massaged, with the exception of the nipples and genitals. Patients also disrobe in front of the curandero, which is significantly different from our culture's protocol for massage in the United States. Massage in Mesoamerica is not regulated by the government, though many massage professionals voluntarily attend school to learn traditional massage techniques.

During a massage from a curandero, I was asked to disrobe in a room that had 30 other people in it. I contemplated my embarrassment during this situation and after the massage, discussed this experience with the other healers and patients in the room. I am uncertain why I found this situation difficult other than for reasons of my cultural conditioning. It was also difficult to allow a man other than my husband put his hands on my naked body, though clearly the experience was non-sexual. In my culture, being touched while naked by a male other than my husband could be construed as a form of infidelity.

One of the many things I sincerely enjoy about Mexican culture is the generosity of the people to share what they have. This holds true with food, company, traditions and knowledge. In my research gathering in Mexico, I did not encounter one stingy individual. In fact, all of my research participants seemed flattered that I was interested in and honored their work; they were also impressed that I spoke their language. One curandera was reluctant to speak with me about treatments for susto until I convinced her through description of my trauma work with children. When I mentioned that I work with impoverished children in Arizona, I was welcomed with open arms.

Another remarkable experience I had related to being open to the culture and what came my way was being invited to dance with Native Mexicans in a ritualized dance. I have attended American Indian pow-wows in Arizona, and my experience has been that people outside of the tribal community are not welcome to join in the dancing. Again, my experience with Mexicans demonstrates that they are eager to share what they have, perhaps because of a belief in being the positive change they wish to help birth in the world.

Once I became clear that I wanted to study Curanderismo to examine and integrate its healing techniques into a treatment for trauma, I contacted Dr. Torres at the University of New Mexico and received an e-mail response from him in less than 24 hours. Dr. Torres, who organizes a Curanderismo healing fair in Albuquerque once a year and has also written several books on the subject, provided me with contact information for de Franklin. Within a week, I was generously invited to go to Albuquerque to attend Curanderismo healing fairs, to audit Dr. Torres' coursework in Curanderismo, and became affiliated with de Franklin. As an outsider, the ease with which I entered this community was staggering as was the welcome I received.

**Don Miguel.**

Don Miguel resides in Oaxaca City and spends part of his professional energies as an amazing curandero, sobadoro, herbalist, and temazcalero. His other vocation supports improving the health and subsistence lifestyles of people in rural Mexican pueblos. A current project Don Miguel is working on in a pueblo called La Luz includes the creation of a community bakery and the establishment of enough dry toilets in the community to eliminate diseases associated with open sewage systems and parasitic infections which were killing small children in the community. He also works with the women of La Luz to be less reliant on the males in the community for economic support through their work in the community bakery. Don Miguel is also an environmentalist, and "closing the circle of consumption and elimination" is a part of his work. The people of La Luz use the waste from the dry toilets as fertilizer, and consequently, they have such large crops in their community gardens that they are able to sell the surplus outside of the community.

In Oaxaca City, Don Miguel has a temazcal in which he uses with people by appointment. He is an extremely gentle and generous man of about 50 years. When I first met Don Miguel, I was in some pain from having been in a car for two days. He offered to give me a massage, which he refused payment for. After much insistence, he finally took it when I suggested that he donate it to one of the La Luz projects.

Near La Luz, on the shore of the Pacific Ocean, Don Miguel has built an amazing temazcal that he uses with the people of La Luz and other visiting groups, including my own through the University of New Mexico. Don Miguel's temazcal is cone-shaped, and its entryway faces the surf. Before entering Don Miguel's temazcal, the participants received a *limpia* and were also given candy to make an offering to the energies associated with the location. Don Miguel said that the candy would distract negative energies while the participants were in the temazcal, and would also bribe positive energies into helping the participants.

Because participation in Don Miguel's temazcal was associated with UNM, participants entered it in bathing suits. Don Miguel's suit was Speedo style, and he is a very hairy man. He also has a long, bushy beard. In spite of his obvious physical masculinity, his character or charisma is not sexualized. He is able to work with both genders seamlessly. I did not feel threatened by him sexually and felt as safe with him as I did Roberta.

Participants entered and exited the temazcal in traditional fashion, clockwise upon entry to enclose the energy, and counterclockwise to release it. Don Miguel's temazcal has sand for its foundation, upon which he had set up blankets. He also heats this temazcal with a wood fire, which gives it a unique wood-fire smell. Don Miguel swung a

bundle of plants on a string along the ceiling of the temazcal to bring the heat down to the participants. He sang gentle, soothing lullabies inside the temazcal and frequently checked in with the group to see how we were feeling. Don Miguel did not direct the participants to work with any particular emotional material inside the temazcal. However, many participants spontaneously cried while inside the temazcal.

The wood-fire smell triggered a flashback to a house fire for one of the temazcal participants. When she exited the temazcal she was hysterical. Don Miguel held her in his arms while she sobbed. He helped her calm herself down, and later she told Don Miguel and me about the traumatic memory, which she believed she had overcome prior to her participation in the temazcal.

**Evita.**

Evita completed a temazcal in her backyard in a subdivision in Belén, New Mexico. Our Curanderismo group initiated it on December 12, 2008--the feast day of the Virgin of Guadalupe. As part of the initiation, Evita and Roberta from Mexico City took our group to make a pilgrimage and ritual. Tomé Hill, or El Cerro de Tomé, is used as a religious site, a refuge, and as an observation point. People make the long, arduous trek to the top of Tomé Hill where several large crosses are placed for spiritual reasons and the amazing view.

Before we began the climb, Evita instructed me to pick up two stones—one to represent something I needed to rid myself of and the other something I wanted to gain. I had been feeling upset about some traumatic experiences a client had described to me, and I found a stone which represented this story for me. I wanted to gain commitment to my spiritual path and found a stone representing this as well. The walk up the hill was

long, and I would have been sweating profusely if not for the forceful, cold wind that blew throughout the trek. The sun barely warmed me, and my clothing was inadequate against the wind. At the top of Tomé Hill, Evita instructed me to toss the stone representing what I wanted to gain off the east side of the hill, the place of new beginnings. I was also instructed to throw the stone representing the story of my client to the west, the place of endings and letting go.

After I completed these tasks, I sat in isolation and contemplated the views. When I became very quiet, I noticed a strong sense of grief permeating the site. The group engaged in a few rituals, including a blessing of our *sahumaríos* by Roberta. Then we exchanged embraces. I was overcome by grief when Roberta embraced me, and she held space for me to sob until the grief passed. I wasn't consciously aware of carrying grief when I began the pilgrimage, though I knew I was angry about the history my client had revealed. I didn't think that the traumatic story, or any other traumatic material I am exposed to through my work, had impacted me so deeply. It all came to the surface on top of Tomé Hill in the arms of my beloved teacher Roberta.

Evita has a very different presence from other *curanderos* I have encountered. Evita has a very colorful background, which includes being born in the United States and raised by her grandmother in Mexico, where she was first exposed to *Curanderismo*. Evita entered the military as a young adult, and became a drill sergeant. Probably because of her military days, in addition to many challenging life experiences, Evita has a forceful presence. Evita's forcefulness is her strength as a healer. I feel confident in her treatments because of her strong bearing and if I were to do something I was afraid of, I

would want her at my side to lend me some of her strength. I feel empowered by her confidence in me.

**Roberta.**

Roberta embodies the energy of the Great Mother for me. With her, I feel safe to purge grief I often am unaware of carrying. With Roberta, I am precious no matter what I have experienced. Because of this unconditional acceptance, I feel safe to sob with her. I feel like she can contain the grief for me while I experience it.

Like Alberto, Roberta is very playful. One of my favorite rituals to participate in with Roberta is similar to a game called Whiplash that I used to play as a child with large groups of people. Basically, the players all hold hands and make a long line. The leader then runs around, making fast zigzags, which all the players eventually experience as they follow the leader. In Roberta's version of this "game," she gently leads the group around, and the last person in line becomes the center point where everyone wraps themselves around, forming a barrel shape. Roberta then holds the group with wide arms and gently rocks the collection of bodies. She also has the participants let out deep sighs. My experiences with this activity have been very soothing and simultaneously playful. It feels really wonderful to be supported physically and emotionally by other people and rocked.

Roberta is an outstanding temascalera with nearly 30 years experience. She has a temazcal as part of her home, which is in Mexico City. She runs temascales seven days a week, sometimes four or five on Saturdays and Sundays. This is hard, hot, and sweaty work.



Roberta begins each day with a swim before the sun comes up at a fitness center near her home. On Wednesdays, market day, she heads to a market where people bring medicinal plants into the city from the rural areas surrounding Mexico City. Roberta pays better than average for the medicinal plants she uses in her temascales and remedies to ease the difficult life of the people who bring the plants. Roberta is well known in the market, and when she took me, we filled the trunk of her car with plants she planned on using for the temascales I would participate in while staying with her.

Roberta lines the floor of her temazcal with herbs for aromatherapy to evoke what the patient needs to experience inside the temazcal. She uses roses, rosemary, and pepper tree branches, along with other herbs as indicated by what the patient needs from the temazcal. Roberta removes every plant after each temazcal, when it is then washed down and lined with fresh plants.

The first temazcal I participated in with Roberta was what she described as “gentle.” This referred to the temperature achieved inside the temazcal, which was lower than a “stronger” one. This temazcal was taken in the company of females only, and we were all naked. It was dark inside the temazcal, and I was aware of the nearness of the other women. However, there was enough space inside to not bump into one another.

Before entering the temazcal, Roberta gave each participant a *limpia*, and also gently dropped rose petals over their heads. She also blew her conch shell to the four cardinal directions to open a healing circle. The participants entered the temazcal in a clockwise direction. Once we were situated inside the temazcal, Roberta began to pour herb infused water on the rocks she had heated from outside the temazcal. She continued to do this until the steam built up to the intensity she wanted inside the temazcal. Roberta

had a bundle of herbs on a string, which she swung in a rotating manner along the dome ceiling of the temazcal, which brought the heat down to the participants. The bundle and string made an otherworldly humming when she did this, which helped to set the event apart from ordinary reality for me.

Once I began to sweat and was wet all over from the steam, Roberta instructed us to repeat the words of a song she was singing. The words essentially said that our desire was to be reborn and renewed inside the temazcal. We repeated the song several times until the emotion of the participants was elevated through the song.

Roberta then took her herb bundle and dipped it into a vat of warm, herb infused water and slapped each of the participants on the back with it. We were also given bundles to switch ourselves with and instructed to do so. This further increased the emotional pitch of the temazcal.

Once Roberta felt that the participants were emotionally receptive, Roberta had us to call out to our parents and ask them for what we needed from them, to heal our deep emotional wounds. We screamed their names several times. This struck me deeply as I had some emotional stuff going on with my parents, and I cried. Then we were instructed to think beyond our parents to include others we needed healing with, and I thought of a relationship I experienced that was very painful. Roberta instructed us to scream out the names of the person we were thinking of, which was also emotionally cathartic. Everyone was sobbing, and the protective shell around my ego dissolved. I was not self-conscious of the noise I was making as it was only a part of the cacophony, nor was I concerned about how foolish I might appear because I was in the dark. I was surprised by what

thoughts and emotions came up for me because when I entered the temazcal, I had no idea that I was carrying the emotional baggage with me.

When the participants appeared to be cried out, Roberta sang another song to help quiet the emotional state of the participants. A helper outside of the temazcal handed in small buckets with washcloths and warm, herb-infused water. We washed ourselves, and Roberta instructed us to understand that with this washing we were removing any negativity or shame we might be carrying. We were rinsed again by Roberta and her bundle of herbs dipped in herb infused water. Roberta sang another soothing song while she did this process.

The helper then tucked a hose into the temazcal, under the blanket that was covering the entryway. The participants were unaware of what was coming. Roberta began spraying us with cold water, which was shocking and reviving. This was done to bring our spirits and thoughts back to the present. It was also a playful part of the temazcal, and everyone ended up laughing and screaming while being sprayed. Then we exited the temazcal in a counterclockwise direction.

Outside of the temazcal, helpers were waiting for us, wrapped us in large sheets of terrycloth, and gave us *te de compuesto*, a soothing herbal tea, to drink. We were then ushered to massage table and given gentle massages.

The next day, Roberta took our group to the Basilica of the Virgin of Guadalupe and Teotihuacan, an Aztec ruin north of Mexico City. During the bus ride, Roberta explained that the temazcal is a very old practice that people in Mexico use for a variety of reasons. Sometimes the temazcal is used as a vapor bath for health purposes. Other

times, there is an emotional intention to the temazcal such as preparation for a rite of passage, birthing, or as preparation before entering battle.

Roberta explained that the temazcal is sacred because it is a representation of the womb of the Great Mother. The entryway to the temazcal represent the vagina, the rocks inside, adjacent to the entryway, are the ovaries, and the fire which heats the rocks represents the penis and masculine, creative energy. The dome ceiling inside the temazcal represents the universe, and outside represents a pregnant belly.

### **Queta.**

Another curandera I was too afraid of to ask for a formal interview and to ask to sign a release of information is named Queta. Queta is a curandera “total,” which means that she performs all functions of the curandero. She told me that she has delivered more than 4000 babies in Oaxaca, usually without compensation. I was introduced to her when I first went to Mexico for Union Institute and University coursework. Queta is a very shrewd business woman, and she travels throughout Mexico and the Southwestern United States as a curandera. Since first meeting Queta, I have encountered her several times in Mexico and Albuquerque. I have even been to her home twice, and in spite of all these interactions, I am still too afraid of her to ask her for a formal interview and release. She has very direct energy, similar to Evita’s personality. If I were experiencing a difficult labor and delivery, I would absolutely want Queta at my side, as her directiveness would inspire confidence in me.

Similar to my feelings about Queta, I have felt fear in the presence of other curanderos. I was introduced to a curandera who lived near Leonela by Alberto. I was too afraid of her to ask her for an interview and also to ask her to sign a release of

information for the interview. Alberto, who I find to be a very credible source, reported that the first time he met this particular curandera, he saw her pass through a solid wall. When I met her, she was married to her fourth husband who was half her age. She also had a pair of esquinques, which are smelly, hairless, black dogs. Esquinques were kept by the Aztecs as pets and were sometimes offered to the gods as sacrifices. Because esquinques eat only plants, they have no front canine teeth, only molars.

Queta does not censure her thoughts and feelings in public settings. In front of a group of people I was traveling with, I volunteered to give feedback on a limpia Queta had performed on another person. While Queta was doing the limpia, I felt nauseated, and I shared this. She abruptly and strongly replied that I am too afraid of everything, and that I need to overcome this. While I have received this feedback from other curanderas and was okay with it, I was embarrassed by Queta's public assessment and declaration.

The first time I went to Queta's home, I was with a small group of Union learners. One learner, who was married to an allopathic doctor, had a very rare, debilitating disease. Because of her connection with the medical community through her marriage, she had been to several doctors for treatment, and because they were unable to diagnose and treat her, they told her that the illness was psychosomatic. Meanwhile, this learner suffered for years in terrible, constant pain.

Finally, in France, the learner found a doctor who was familiar with her condition and provided her with enough relief that she was able to continue functioning and living a normal life. When this learner presented the symptoms she was still contending with to Queta, Queta believed her. Queta examined her, noted unusual physical symptoms of the disease that had been ignored in allopathic medicine and prescribed several exercises

which treated neurological symptoms. The learner said that when she performed the exercises, she could immediately feel relief of her symptoms.

The rest of the learners at Queta's home were there for limpieas. There was one man in the group who decided to get the first limpia. Queta has a room dedicated to limpieas in her home, which contains an altar with hundreds of icons from multiple religious traditions and fresh plants. While the learner was getting his limpia, the remainder of the group waited outside the room in a courtyard where Queta's temazcal is located. We heard Queta singing and the man sobbing in the healing room, and when the limpia was completed and Queta opened the door, steam poured out of the room. The man was holding a bunch of herbs, complete with roots and dirt, and was trembling. I was next, and after seeing this man's condition, I was afraid.

I entered the room and was instructed by Queta to sit on a chair in front of her altar naked from the waist up. Queta began the limpia with a prayer. She then circled me, stopping in each cardinal direction, where she spit a mouthful of alcohol on me. Next she scrubbed me vigorously with a bundle of herbs, including roots and dirt. When she was finished scrubbing me, she again encircled me, stopping at each cardinal direction and spitting alcohol on me. When she was finished, she gave me the bundle of herbs and sang a song in a language that was not Spanish. I was instructed to put my shirt back on and left the healing room. I did not experience the emotional catharsis the man appeared to have, perhaps because I am more likely to become emotionally vulnerable when I feel protected rather than directed.

I met another curandera who performed limpieas in a dedicated healing space in a shed behind her home. She used agua florida, or flower scented water, as her primary

prop in the limpia. She prayed for the person in front of the altar, poured some of the water into her hands, and then wiped the water over the individual while chanting.

One curandera I met told me that being a healer in a pueblo is a precarious position because people may perceive her as a witch and shun her. Thus, healers often practice their skill under the table.

Unfortunately, not all people I encountered in the limited American Curanderismo community are as generous and welcoming as Dr. Torres and Evita. During Dr. Torres's Curanderismo course, many curanderos came from Mexico and New Mexico to participate in the health fairs affiliated with the course. Elena Avila presented a lecture during this course, but notes of any kind were not allowed to be taken. Avila indicated that she felt angry that her version of Curanderismo was appearing in other peoples' work. I found this mind-set confusing because it is so opposed to what I encountered from most curanderos in Mexico regarding sharing the medicine.

A comadre (close friend) of Avila's seemed overly interested in me throughout the two week course I attended in Albuquerque, making sure I took no notes at Avila's lecture and had limited access to the curanderos at the healing fairs. I came across this comadre at a healing event held in a small Native American pueblo outside of Albuquerque. She was guarding the entrance to the room in a community center where the healers had set themselves up and vendors were selling herbs and other items. The comadre would not let me in to assist the healers or purchase herbs, despite the fact I had been given permission to do so by Dr. Torres, "unless I spoke Spanish and could translate." After I reported that I do speak Spanish, I was still not granted access to the healers. At another healing fair at the National Hispanic Cultural Center, I was again not

allowed access to the healers and was escorted from the building by the same comadre, though other students of various ethnicities and Spanish skills were allowed to assist the curanderos.

Again, I found the stance of this comadre to be odd, due to the overwhelming desire of healers in Mexico to share their knowledge with eager students. Fortunately, this experience has been the exception rather than the norm. Perhaps I had this experience because I am non-Latino, and my Native American heritage is not visibly apparent. Another possible reason for this treatment is that I am associated with Evita, who used to be one of Avila's students. Perhaps I was unknowingly rude, though I strove to be polite, as I was an invited guest at these events and it was important to me that my behavior didn't reflect poorly on those who had invited me to Albuquerque. This experience with Curanderismo in an American setting is reflective of American culture, where power and profit, not kindness to people, are the major motivators.

The sharp contrast between how people are treated in American "healing" settings and Curanderismo are illustrated by the following personal experiences. I went to a doctor in Arizona for a routine procedure, and when I arrived, I was officiously asked up sign in and then to sit down and wait. The receptionist spoke this request from behind a window she quickly opened and closed. While waiting, the receptionist barked out a question and the request to come to the window was implied. When she was satisfied, the window slammed shut once again. I took this cue to mean that I was to return to my seat and patiently wait to see the doctor's assistant. I was seeing the doctor's assistant and not the doctor because meeting with the doctor would have meant waiting seven months for an appointment.



After waiting half an hour, I was directed to one of a dozen appointment rooms, where I answered more questions and was told to disrobe and put on a large paper sheet. I waited another 20 minutes before the physician's assistant entered. After she introduced herself, we discussed the procedure, and the doctor's assistant provided me with a paper describing what I should expect while healing from the procedure. I spent about 10 minutes with the physician's assistant and was charged about 250 dollars.

In another doctor's office, the receptionist had difficulty finding my appointment in the schedule, did not welcome me, and only spoke to me to tell me to fill out paperwork. After an hour of waiting to be seen by the doctor, I gave up and left without being seen. I wrote the doctor a letter describing how frustrating and difficult it was for me to wait, as I was in abject fear over why I was there. He replied, but blamed me for the long wait, as I was 15 minutes early for the appointment. I don't feel comfortable trusting someone with my health who has so little regard for my time and emotional state.

I had a similar experience in a counselor's office. Though she was considerably warmer than the people at the doctors' offices, and I was seen in her home, she had an agenda: I had to sign a treatment plan, and the counseling hour was closely monitored, though there was no one waiting to see her after me. In my psychiatrist's office, I usually wait a half hour to forty-five minutes for my 10 minute medications check appointment, and my doctor closely follows her questioning protocol to monitor my mental health.

Curanderos appear to be very skilled at building rapport and patient confidence in their skills. In Mexico, I went to see a curandero known as a *huesero*, or bone setter. I was suffering from a hip injury from birthing my daughter. The *huesero* practiced out of a room in his multigenerational home and was his own receptionist; indeed, he did not

have an appointment book. People came to him when the need arose, or he went to them if they were unable to come to his home. The *huesero* offered me a drink and while I rested, he described work he had successfully accomplished with former patients. As he described his work, I met members of his family as they wandered in and out of the area where we were sitting. I described my injury to the *huesero* and he described a theoretical framework for treatment of the injury. When I was in agreement with his treatment modality and didn't have any questions, he performed a chiropractic maneuver on my hip and showed me how to perform the maneuver on myself at home. When I had no further questions, the session was complete. This session lasted about an hour. The *huesero* did not have a set fee for his services; instead, he asked for a donation.

### **Major Themes**

During the course of my study, I noted several common personal characteristics among Curanderos that appear to positively impact the process of healing trauma. Most Curanderos exude compassion for the individual patient, often crying with them as the patient tells the trauma story. I witnessed several Curanderos cry with patients over the patient's trauma and hold and rock the patient as if the patient were a small child. Often, this nurturing, physical contact results in emotional release. This release can only be achieved when the patient needs to feel safe enough to be re-exposed to the memory and somatic experience of the trauma.

Curanderos tend to have some spiritual or philosophical precept regarding the experience of trauma, which helps them remain intact in spite of constant exposure to human misery. Curanderos sometimes conceptualize themselves as a tool or conduit for

the healing power of God or other forces. It is rare for a curandero to take personal credit for a healing, and, in fact, if the ego of the curandero becomes attached to or involved with the outcome of the healing, the curandero may physically take on the patient's state of disequilibrium.

The curandero also practices a great deal of care for the physical body as the body itself is understood to be a healing tool which must be kept in prime condition. Sometimes care for the body with diet and exercise happens as a matter of ordinary life through subsistence diets and walking to collect medicinal plants for the curandero's practice. Other healers practice more contemporary forms of exercise such as daily swimming at a pool. Curanderos take great care with their diets; some cannot eat before they do spiritual or healing work. Many curanderos recommend not eating meat for at least 24 hours before participating in a temazcal or before practicing healing work. Others become ravenous, while doing healing work. Regardless of which end of the spectrum the healer's dietary needs fall upon, most curanderos know and honor their physical needs during their healing work.

Curanderos also teach their patients to recover from traumatic events by their own response to the exposure to the traumatic material. The curandero's resilient response becomes a model of behavior for the traumatized individual. Curanderos also incorporate the patient's community in the healing process to support patient. Many times, the curandero has direct and intimate knowledge of members of the patient's family and community.

Curanderos also practice spirituality as a part of the healing process both for self-care and for the recovery of the patient. Spiritual components are always incorporated in

treatment. The spiritual orientation of the curandero varies from individual to individual, but discourse with the Great Mother in the form of the Virgin of Guadalupe or a goddess energy is usually a component of treatment.

Curanderos are generous and would never turn away a patient due to an inability to pay for services. For example, Queta reported that she has delivered more than 4,000 babies in rural Oaxaca, most without compensation. She sustains herself and her family economically by selling salves and medicine to people who can afford to pay well for the medicines. Others cannot practice openly due to superstition within their community and provide healings, medicinal plants and advice in trade rather than monetary compensation.

Curanderos also develop strong interpersonal relationships with their patients, whereas in contemporary psychotherapy counselors are bound by professional ethics to keep a professional distance from the client. Curanderos in small pueblos can be biologically related to most of the people in their community. Other curanderos do not hold back about their personal experience, again teaching recovery from trauma through modeling. For example, Roberta shared that she had experienced multiple sexual assaults as a child, that one of her own children had died, and that she also experienced the loss of a spouse and brother. In spite of these debilitating traumas, Roberta remains strong. Roberta has saved money for the last 20 years in order to build a clinic in Jilotepec, a rural area north of Mexico City. In addition to bringing medicine to a community without access to healthcare, Roberta's goal is to teach healing skills to women who are tolerating domestic violence so they can have financial means to leave abusive situations. I find myself thinking if Roberta can survive all of these massive traumas and transform her

tragic history into a humanitarian stance, I, too, can survive anything and passionately help others.

Curanderos conceptualize trauma and illness as a state of disequilibrium between the physical body, the spiritual body, and the emotional body and the environment. Allopathic practice conceptualizes of illness and the results of a traumatic event as something that must be fought and contained, similar to the psychology of the Spanish Conquest and colonialization. Curanderismo seeks to gently restore the body, mind, and spirit to a state of balance within itself and with the environment and spiritual forces therein. Curanderos may use medicinal plants and altered states of consciousness to treat states of disequilibrium. Allopathic practice applies head only treatment to integrate traumatic experience.

Additionally, allopathic practice is often an adjunct for psychopharmacology, wherein the psychotherapist becomes a sales representative for the pharmaceutical industry. Curanderos rely on treatments that are found in a natural state in nature. The application of these naturally occurring materials helps align the patient with nature and is thereby a return to equilibrium in the body, mind, and spirit and with the natural environment.

## **Chapter V**

### **Discussion and Summary**

In reviewing the positive and negative aspects of American traditional and nontraditional traumatology models and Mesoamerican traditional Curanderismo, these two paradigms can be synthesized into a model that may benefit individuals who need cognitive, emotional, and spiritual components for the resolution of their traumatic stress. This kind of holistic approach would be very difficult to practice under current laws and codes of ethics in allopathic practice in the United States. The practitioner would find him or herself vulnerable to law suits if he or she worked with individuals outside of sanctioned scopes of practice, even if this is what the patient wants or needs. However, if a practitioner is truly interested in treating the whole individual, laws can be circumvented through the practitioner obtaining a ministerial ordination and practicing “Spiritual Counseling” rather than “Psychotherapy.”

### **Treatment Modalities**

Though American treatment modalities for traumatic stress and PTSD do not incorporate spirituality, therapeutic touch, ritual, or community, there are many positive aspects of these modalities. Cognitive models for the treatment of trauma are very effective for the cognitive aspects of trauma, and are documented in the literature as such. In my work with trauma survivors, there is always an element of CBT in treatment. I usually present some form of psychoeducation to the client that describes the impact of trauma on the human organism. The scientific verification of these modalities has

meaning for many traumatized personalities who are comfortable with left-brain conceptualization of how healing occurs.

Within the nontraditional treatment paradigms, I am particularly impressed with EMDR. Over the course of my studies and practice, I have employed it successfully in multiple circumstances. I became Level One Certified in EMDR approximately three years ago in preparation for this Project Demonstrating Excellence. Since my certification, I have successfully used EMDR in multiple settings, both formal and informal. I was first introduced to EMDR in my own therapy and experienced a great deal of relief from the treatment. It is quick and effective with the cognitive portion of healing trauma.

In my professional experience, I have engaged many clients between the ages of three to seventy in EMDR and have witnessed dramatic results within a very short period of time. However, the Shapiro protocol does not align well with most traumatized individuals' cultures and belief systems, or the system may be too sophisticated for the age of the traumatized individual; therefore, I prefer to not follow Shapiro's strict protocol. Instead, I choose to work with the traumatized individual's eyes closed so that I can attune to the nuances of the individual's soma as they process the traumatic memory.

When an individual is processing trauma, his or her eyes move in ways similar to the way eyes move during REM sleep. Additionally, working with individuals with closed eyes allows me to read facial twitches and expressions and to also read body language. Part of what happens during EMDR may be a flooding of the individual's psyche, coupled with a stimulus that disrupts the neuropathway of the traumatic memory.

I have noticed that EMDR is more effective with individuals with single episode trauma rather than with multiple traumatic incidents.

I facilitated a successful EMDR session with a 19 year-old Latina female who had been sexually assaulted by her boyfriend in her family home, while her baby was present. Details of the traumatic event can be especially useful during EMDR because incorporating details brings the event to the fore of the individual's thought processes. Interestingly, during the processing, I could observe, through her body language, that her somatic memory was being re-experienced. She had been beaten on the right side of her body, which had winced in that direction. At one point, she got "stuck" in the processing, so I asked her turn into the trauma, or physically turn to the right. She quickly became "unstuck," which is not, to my knowledge, a method suggested by Shapiro.

At the onset of our session, the Latina female had a self-reported level of disturbance of the assault as a 10, the highest level of disturbance. After an hour and a half of processing, she self-reported being at a one, the lowest level of disturbance.

After our session, the Latina continued processing her trauma in her dreams. She returned to my office a few days later and we discussed a strange dream she had, which was related to her trauma. She continues to feel comfortable with her traumatic memories. While she wishes the event had not taken place, the event does not interfere with living her life.

The SITCAP model also works well with some individuals, and it provides a visual interpretation and metaphor for the traumatic event. Confining a symbol of the trauma within the parameters of a piece of paper is, in itself, therapeutic. I was trained in the SITCAP method approximately three years ago in preparation for this Project



Demonstrating Excellence and have used the SITCAP program with traumatized children in formal settings several times. I have successfully incorporated the SITCAP method into my work with children and adolescents in formal settings. In one case, a boy had been physically abused by his stepfather, and he suffered PTSD as a result of that abuse. After working through the SITCAP program with him, I noticed a decrease in anxiety and noncompliance with adult requests. I also engaged this boy in EMDR around his traumatic memories, because EMDR is the modality I feel most confident in. After the EMDR, the boy reported decreased disturbance in sleep, which was not accomplished with the SITCAP method alone.

Hypnosis helps the individual relax into the traumatic memory and to understand it as only that – a memory. I attended an Eriksonian International Congress in preparation for this Project Demonstrating Excellence and have applied some of the techniques garnered there in formal settings with limited success. Furthermore, cognitive work around the meaning-making related to the traumatic event is significant, in addition to the desensitization associated with frequent exposure to the traumatic material.

I have liberally applied hypnotic techniques with clients, though I have not incorporated formal inductions. It is my belief that the efficacy of the treatment is substantially supported by the faith of the client in the efficacy of this process. I have also found that many people are suspicious and fearful of hypnosis, so not doing a formal induction allows them to feel safe with their guided imagery.

I have successfully worked with many clients through the somatic experience stemming from traumatic memory. I teach traumatized individuals muscle relaxation, breathing, and guided imagery techniques and invite them to practice the skills on their

own. One client was extremely anxious because she was diagnosed with cancer of the liver, and she was fearful of death and what would happen to her small children if she did not survive. Through relaxation techniques, I was able to help her to slow down, release her anxiety, and identify her priorities during this uncertain stage of her life.

An element shared by CBT techniques and Curanderismo that lends itself nicely to the creation of an integrated treatment approach is that both techniques result in a non-ordinary state of consciousness. When the traumatic event originally took place, the individual experienced an altered state of consciousness, and part of the process in Curanderismo and many CBT techniques is to return to that altered state; therefore, these modalities are compatible adjuncts.

### **Traumatology**

CBT techniques also address aspects of healing that may be missing in Curanderismo, including the cognitive work and meaning-making of the trauma. CBT techniques work specifically with traumatic memories and mental images, intrusive thoughts, flashbacks, and nightmares, which is an aspect not addressed in Curanderismo. Curanderismo includes all the resources and practices that CBT techniques ignore. Curanderismo techniques tie in nicely with Jungian Psychological principles, making the practices in Curanderismo psychologically sound. The aspects of Curanderismo that are significant to healing trauma which are not exploited in CBT techniques include the liberal application of interpersonal touch, temazcales to provoke suppressed memories and to utilize somatic healing, spiritual practices, and the inclusion of community for support. Curanderismo also heals the community of the patient because they are included in the healing process.

### **Summary of the Results**

I determined from the literature search and personal experience that there are positive and missing elements in both CBT and Curanderismo techniques. That finding led me to develop an integrated model based upon both the American nontraditional and the Mesoamerican traditional healing modalities. My synthesis of those approaches integrates what I deem to be the best of both practices.

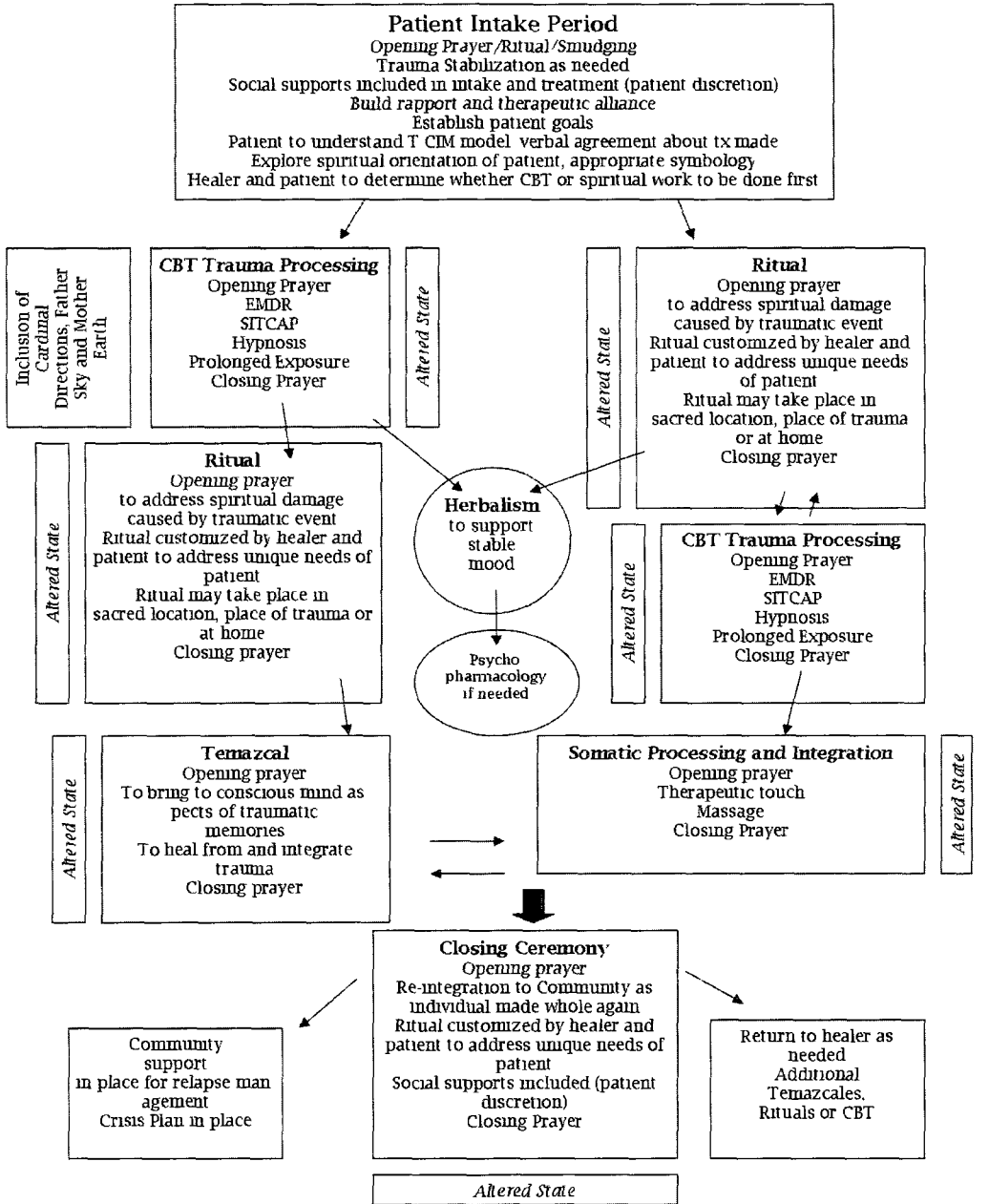
Allopathic trauma treatments may also be improved through the incorporation of the understanding that there is no separation between a human being's mental, physical and spiritual selves. American traumatologists treat the mind in isolation when the entire individual could be treated, including mental, physical, and spiritual. Curanderos don't consider any aspect of the patient in isolation.

American traumatologists follow the 400-year-old teachings of Rene Descartes whose separation of mind and body has been handed down to our culture (Doidge, 2007). Our culture may eventually embrace the scientifically proven fact that the mind, body, and spirit are intimately connected. In American culture, the shift away from organized religion in to nondenominational spirituality has created a vacuum in spirituality that counselors have filled. Increasingly, psychotherapists are spiritual leaders for their patients. Curanderos apply spiritual practices for curing (de Franklin, 2008; Navarrete, 2008; Nuñez, 2008; Ornelas, 2008). The application of spiritual healing could be easily incorporated into the practice of counselors if the counselors have a spiritual orientation.

**Traumatology-Curanderismo Integrated Model**

Based upon a similarities-differences analysis of the literature on American and Mesoamerican approaches to healing trauma and on my clinical and immersion experiences in both approaches, I developed a Traumatology-Curanderismo Integrated Model (T-CIM). My integrative model may impact the psychotherapist's experience as a healer and the patient's experience of healing on multiple levels. A graph of my T-CIM follows:

**TRAUMATOLOGY-CURANDERISMO INTEGRATION MODEL  
(T-CIM)**



**Narrative Description of the Above Model Prior to Initial Session**

The healer initiates rapport by personally scheduling the patient's sessions and by answering briefly any questions the patient has in person or by telephone. The healer warmly encourages the patient to bring family members and friends to the initial session, if the patient is comfortable with that suggestion.

**Initial session.**

The first goal of this session is to assess if the patient is a danger to self or others. If the patient presents a threat to self or others, the healer will refer the patient to a hospital if the patient is an immediate threat or counsel the patient, create a crisis plan, and release the patient into the 24-hour care of family and friends. If no friends or family attend the initial session and the patient is a danger to self or others, regardless of the risk, the patient will be referred to a hospital. If the patient is released to the care of family or friends, a crisis plan will be provided in a written format delineating the responsibilities of all involved, and everyone will be asked to sign the document.

If there is no danger to self or others, the primary goal of the initial session is to begin to establish a trusting relationship between the patient and healer. In American traumatology, the psychologist may spend a portion of the session establishing rapport. Often, this is accomplished through empathetic listening skills and asking guiding questions to elicit information about what outcome the patient is seeking from therapy. In Curanderismo, the patient may already know or know of the curandero through interactions within the community, because the curandero successfully treated a family member or friend, or because the individual was involved with treatment for someone

else. This would likely not be the case in our American society, so the therapist could rely on his or her traumatology techniques to build the therapeutic alliance.

The healer also explains the T-CIM treatment model to the patient and answers any questions the patient may have. If the patient is uncomfortable with including spirituality and ritual into treatment, CBT or other contemporary trauma treatment will be offered, or a referral will be given to the patient for a more compatible psychotherapist. The healer will explain various cognitive treatment modalities, such as EMDR or CBT's Prolonged Exposure, and offer psycho-education about the nature of PTSD and trauma. The healer answers any questions about himself or herself and the treatment model, and gain information about the patient and the nature of his or her problem. The healer asks for a brief description of the trauma which would be explored more fully in another session.

If the patient responds that the T-CIM model may be a good treatment fit, the healer's rationale for opening a healing space, as beautifully described by Villoldo (2000) may be shared with the patient:

*Shamans always begin healing ceremonies by opening sacred space. In this space we leave behind the affairs of ordinary life, the bustling world of meetings and schedules, and prepare to meet the divine. Sacred space allows us to enter our quiet inner world where healing takes place. Here the mundane cannot distract us, and every act is hallowed and deliberate; yet sacred space is neither serious nor ponderous. Shamans take their work very seriously, but they do not take themselves very seriously at all, and there is often laughter and playfulness during healing ceremonies. Within sacred space we experience the lightness of our being.*

Both laughter and tears come easily. Alan Watts used to say that the reason angels could fly was because they took themselves so lightly. Within sacred space our burdens become lighter, and we can be touched by the hand of Spirit. After we finish our healing work, sacred space must be closed by again acknowledging the four directions, Heaven and Earth. When the shaman does this, she releases the archetypal energies she summoned, and they reintegrate into nature. (pp. 136-137)

If the patient is in agreement with participating in opening healing space for the session, the healer will perform the following ritual:

1. The healer lights *sahumario* and burns copal over coals.
2. With *sahumario* in hand, the healer faces East, the direction of beginnings, offers smoke to that direction, and releases darkness, pain, and acknowledges a new start.
3. The healer then faces West, the direction of endings, offers smoke to that direction, and acknowledges endings, and releases that which no longer serves the patient.
4. The healer then faces South, the direction of innocence and beauty, offers smoke to that direction, and acknowledges childlike innocence, playfulness and beauty, and claims these characteristics for the patient.
5. The healer then faces North, the direction of the Ancestors, offers smoke in that direction, and acknowledging the Ancestors, asking for their guidance and blessings during the healing session.



6. The healer then faces the sky, offers smoke in that direction, and acknowledges Father/Sky and asks for His blessings and guidance during the healing sessions.
7. The healer then touches the ground, offers smoke to and acknowledges Mother Earth, asking for Her blessings and guidance during the healing session.
8. The healer then thanks all energies for their presence and then blesses/cleanses the patient with smoke.

The healer and patient then sit and discuss treatment goals, and individualize a treatment plan, which will be a verbal contract. The healer and patient discuss the patient's spiritual orientation, and discover what symbols, icons, or spiritual figures are important to the patient. The healer incorporates those elements into treatment and ritual as much as possible. The healer will provide the patient with a guided meditation (American Hypnosis) that connects the patient emotionally and spiritually to the symbol most closely identified by the patient. The healer and patient determine the form of treatment for the next session: spiritual work or cognitive work.

**Closing ceremony.**

1. The healer faces East, gives thanks for the new beginning offers that direction a gift, such as corn meal, copal smoke, tobacco, chocolate, rum or mescal, which the healer blows from the mouth in that direction.
2. The healer then faces West and gives thanks for the release experienced during the healing session. The healer offers the gift to that direction.

3. The healer then faces South and gives thanks for the reconnection with childlike innocence, playfulness and beauty, and offers the gift in that direction.
4. The healer then faces North and gives thanks for the presence of the Ancestors and their guidance during the healing session, and offers the gift in that direction.
5. The healer then faces the sky and gives thanks to Father Sky and His blessings and guidance during the healing session. The healer offers the gift to Father Sky.
6. The healer then touches the ground, and gives thanks to Mother Earth, and Her blessings and guidance during the healing session. The healer offers the gift to Mother Earth.
7. The healer then thanks the patient for participation in the healing, and closes the healing space.

### **Description of an Initial Trauma Session**

The healer engages in the opening ritual, if the patient is comfortable with the practice. The patient describes the traumatic event in detail, taking as long as necessary. Additional sessions may be necessary. The patient may desire psychopharmacology or herbology to manage the anxiety associated with the traumatic event. If the patient wants psychopharmacology, the healer will give the patient a referral to a psychiatrist. If the patient wants to manage the anxiety related to the trauma through herbology, the healer will make recommendations or give the patient a referral to a herbologist. The patient and healer will determine the direction of treatment at this point. If the patient feels that he or

she would benefit from cognitive work, the healer will follow CBT protocols. The choice of which CBT modality will be determined by the patient and the healer, based upon which modality appears to be the best fit for the needs of the patient.

If the patient feels he or she would benefit from ritual, the healer and patient will create a ritual to begin to overcome *susto*, or the feeling that the patient is not whole spiritually because of the trauma. For example, one common Curanderismo practice for victims of sexual assault is to bury the patient's feet or legs into the dirt, which is believed to be a grounding experience, bringing the fragmented parts of the spirit back into the body. This ritual may include a *limpia*, or a *limpia* could be given in isolation as treatment for the trauma. The depth and breadth of the ritual is contingent upon the needs of the patient. This healer will follow up with the patient regarding the impact of the ritual at future sessions in order to determine if more ritual work needs to be done. The healer will perform the closing ritual.

**Ritual or CBT session(s).** The healer will ritually open a healing space. Depending on the needs of the patient, this session will focus either on performing the pre-designed ritual or involve CBT work, EMDR or SITCAP. If the patient chooses cognitive work first, the SITCAP method may be a powerful choice for cognitive work because the drawing produced describing the trauma can be burned during a ritual at a later session. If the patient chooses EMDR, Hypnosis, SITCAP or Prolonged Exposure, the treatment protocols will be followed as described in the Literature Review, Chapter Two. Those procedures may take several sessions.

If the patient chooses to engage in ritual work, the healer, patient, and family and friends, if the patient wants to include them, will meet at a predetermined time and

location for the ritual. The location may be at a sacred healing space or where the trauma took place. The ritual can also be performed in the healer's healing space. The healing space will be ritually closed when the healing work is complete.

Once the patient and healer arrive at a consensus that either the patient is stuck in some aspect of his or her trauma, or that the cognitive portion of the trauma work has been completed, the patient may opt to participate in a temazcal. The healer will explain what a temazcal is, that it is an ancient and sacred practice, and what the patient can expect during and after the process.

**Somatic integration session(s).** Prior to the temazcal session, the healer will prepare the temazcal, which includes heating the stones and gathering the necessary herbs for the ritual. When the patient, family and friends arrive at the temazcal, the healer will explain the temazcal and answer any questions about the process. The healer will then perform the opening ritual and smudge the participants prior to their entering the temazcal.

Smudging is a practice similar to a *limpia*, and is a practice suitable for groups because it is quicker than a complete *limpia*. Smudging involves either lighting copal in a *sahumerio* and cleaning an individual's spiritual self with the smoke, or using smoke from a bundle of herbs, such as sage, and performing the same process. The healer may choose to perform a complete *limpia* for each participant, depending on the individualized needs of the patient and other participants. The healer may also require the patient and participants to make an offering to Spirit prior to entering the temazcal, such as burying chocolate or other sweets near to or away from the temazcal, depending on the nature of the trauma and what aspects of the trauma the patient is working with. For

example, if the patient feels that support from Spirit or an ancestor would be beneficial, the patient will encourage their presence by making the offering near the temazcal. If the patient feels that the purpose of the temazcal is to purge an unpleasant aspect of the trauma, the patient can distract or divert any negative energies associated with the trauma to the offering.

Once inside the temazcal, the healer will guide the patient and other participants as determined by the patient through the temazcal process. The process will be individualized to the needs of the patient. For example, for some kinds of traumas, such as those related to grief, the patient will need to feel more healing at a deeper level. In these circumstances, the temazcal will be gentler, not involving severely intense heat. Other kinds of trauma, such as a physical and sexual assault, may require intense heat and stronger herbs such as eucalyptus and pepper tree to provoke the healing. Another benefit of the temazcal is that it can unlock suppressed memories related to the trauma, and the temazcal becomes a symbolic container for these aspects of the trauma.

The healer will place herbs on the floor of the temazcal which are specific to the kind of healing needed by the patient, and infuse a bucket of water with the same healing herbs. Temazcales are conducted over multiple “rounds,” which involves pouring water infused with healing herbs on to heated rocks. The healer monitors the progress of the patient by asking how the participants are faring, possibly singing, and, if necessary, shocking the patient back into themselves by unexpectedly pouring cold water on the patient. Another task of the temazcalero is to keep the motion and energy of the temezcal strong by whirling bundles of herbs along the ceiling of the temazcal. This acts to bring the heat down, and encourages the confluence of energy within the temazcal. Participants

can also swish their skin with bundles of herbs during the temazcal to aid the physical detoxification process, which is a benefit of vapor baths.

Once the temazcal is complete, participants will leave the temazcal either as they are ready or as directed by the temazcalero. Outside of the temazcal, the participants will rinse off or towel off and sit and rest for a moment. If appropriate, the participants may choose to describe their experiences inside the temazcal with the healer. An important aspect of healing from trauma is making meaning out of the traumatic event. Following a temazcal may be the perfect opportunity to do this, as individuals may have connected with some aspect of the trauma that they had not prior to the temazcal. This processing and meaning making may be done in private, in a follow-up session, as per patient preference. The healer then performs the closing ritual.

An alternative to the above method to incorporate somatic healing is through therapeutic touch. Massage performed by a licensed and gifted massage therapist can access additional information about the nature of the trauma and help heal it. For example, if an individual had been injured on a specific area of the body during the trauma, therapeutic touch can help release shame, create a sense of physical safety, and be physiologically beneficial. Ideally, the massage would immediately follow the temezcal because the defenses of the participants would be lower and muscles would be more easily manipulated because of their exposure to strong heat. If a massage follows a temezcal, cognitive processing and meaning making about the traumatic event would be done at a later session.

**Typical Session in T-CIM Model**

I recently engaged a woman who had been sexually assaulted in a treatment modality similar to the T-CIM model. I know this woman from professional and social interaction, so the establishment of a rapport was unnecessary. The woman told me about the traumatic event, which she knew had happened, but she had repressed the details of the event. While she processed her trauma through EMDR, the details of the event surfaced, and she successfully processed them. After the EMDR, the woman reported that she felt no emotional charge from the traumatic memory. However, she did notice pain in a leg that was injured when the sexual assault occurred 26 years prior to the processing.

After the cognitive work was complete, and because I know the spiritual orientation of this woman, we held a small ritual wherein we burned the notes taken to complete the EMDR, in a symbolic gesture of releasing the traumatic memory, and also did an invocation to the four cardinal directions, Mother Earth and Father Sky, thanking *them for the healing that happened.*

This particular woman is a sophisticated healer who is connected with many wonderful massage therapists. She will seek out their help with the somatic piece of this memory on her own.

**Ceremonial Reintegration Session(s).** The final portion of the T-CIM protocol involves the healer assisting the patient in designing a celebratory ritual to either publicly or privately symbolize the patient's reintegration of the Self. This celebratory ritual may also serve as a welcoming back in to the community as an individual who is changed for the better by the traumatic event. The healer and patient design this ceremony during one session, and it may include symbolic actions such as burning drawings created through

the SITCAP method in a fire. The healer helps the patient determine who, if anyone, should be present, both spiritually and physically, at the ritual, and determine how to include these people and energies. The healer and patient also determine natural supports for the patient for relapse prevention, and the patient will ask those individuals for their support either in or outside of the session. The patient will also understand that he or she may return to the healer as necessary for additional CBT, temazcales or other forms of support as needed. The ritual is individualized according to the needs of the patient, and the patient is strongly encouraged to design the ceremony with elements that have deep personal meaning. The healer's role is to facilitate the creation of the ceremony, not to create it for the patient.

The healer, patient, and whomever the patient wants to include then meet and perform the ceremony. The healer opens and closes the healing space ritually, and the patient can choose to conduct the portions of the ceremony between the opening and closing if deemed empowering. After the healer has ritually closed the healing space, the participants welcome the patient back into the community as a whole individual with a celebratory dinner or other social, welcoming event.

### **Connection to the Scholarly Literature**

This study is connected to the scholarly literature I reviewed in multiple ways. Dossey (1993), Achterberg, Cooke, Richards, Standish, Kozak, and Lake (2005) acknowledge the role of prayer in healing, which is also a component of healing in Curanderismo. Mulhauser (2007) acknowledged the significance of the interpersonal relationship between therapists and clients, the warmth and compassion demonstrated by the therapist towards the client, and a match between the client's preference of style of



counseling is significant as it influences on the outcome of psychotherapy. Curanderismo practices seamlessly address these factors and support the research. Lambert (1992) acknowledged that improvement from traumatic stress is related people, events, and beliefs outside of therapy. Curanderos also utilize these elements in practice.

Curanderos also create healing spaces outside of ordinary reality through the use of the *temazcal*. An altered state of consciousness for healing traumatic stress is acknowledged by expert traumatologists (Levine, 1997; Poon, 2007; Riggs et al., 2006; Scaer, 2001, 2007; Shapiro, 2001; Spiegel, Hunt, & Dondershine, 1988; Steele & Raider, 2001; Stutman & Bliss, 1985; van der Kolk, McFarlane, & Weisaeth, 1996; Villoldo, 2000; Ziegler, 2002). Contemporary nontraditional modalities create the altered state through flooding techniques, art therapy, somatic integration, and hypnosis. Unique to Curanderismo is the use of heat to bring emotions to the surface quickly within the *temazcal* where altered states are created.

### **Significance of Research**

*There are a number of themes common to the practice of Curanderismo. These include a strong sense of compassion for others; the ability to quickly recover from exposure to traumatic material; community involvement in the healing process; the ability to be direct with a patient; consistent spiritual practice; care for the physical body; the desire to help others is stronger than the desire for personal economic gain; authenticity of relationship between healer and patient; a sharing of self with the patient; and a strong sense of playfulness.*

Incorporating alternative healing modalities into psychotherapeutic practice can increase the overall impact of treatment. These methods are holistic and not driven by

economic gain. Additionally, psychotherapists in the United States come from a place of fear, and are always on the guard with their clients, fearful of a malpractice lawsuit. Being sued for trying to help someone is a foreign concept in Curanderismo. Curanderos are able to witness and help transform traumatic material, experience their emotions along with the patient, and able to release the traumatic event through spiritual practice.

Another significant component to working with traumatized individuals on a spiritual level is that the healer must attend closely to his or her personal spiritual needs. The healer must have a spiritual practice, which will provide the healer an increased sense of intuition about what types of healing practices need to take place. A consistent spiritual practice also fortifies the healer to be able to do spiritual healing, which is often exhausting work.

All of my Mesoamerican teachers have also warned me about making sure I am spiritually protected before I begin any healing ritual. The belief is that negative energies can attach themselves to unprotected individuals. All teachers indicated that wearing something red and maintaining mindfulness during the healing will protect the healer from taking on the negative energies released during the healing process.

Because the spiritual components of healing work are not well understood, a healer must also work closely and collaborate with an experienced teacher, often for decades. Like traditional supervision, the healer must also have a place where he or she can process transference, counter-transference, and spiritual components of working with traumatized individuals. The healer must understand that this work is done in scientifically uncharted territory and thus, the healer is a pioneer, at least within

allopathic traumatology. This places significant ethical responsibility on the healer as others will build upon the work, findings, and techniques of the healer.

With individuals I have worked with utilizing the Curanderismo model, I have felt simultaneously uncomfortable and satisfied. Throughout the research process, I noted similarities between coursework in Transpersonal Psychology and Curanderismo, which is likely why I was compelled to study Curanderismo. I felt very effective knowing that I helped heal trauma on a deep, spiritual level while also attending to the cognitive needs of the patient. I felt the work was solid and the patients report feeling significantly better, which is the ultimate goal. The patients reported that incorporating elements from their cultural belief systems made the trauma work feel more real for them, that it touched them on levels beyond the head, that they felt safer, more understood by me than other psychotherapists, and that the work was more complete because it incorporated spiritual elements. Despite those reported effective outcomes, I was uncomfortable and fearful because I was engaging in professionally “risky” behavior including interpersonal touch through performing limpiezas and also giving hugs when the work was complete.

Despite my fears, one of the fundamental questions I uncovered over the course of my study was, “Why are the traditions, guiding principles and operating methods of our culture guided by the belief systems of those who conquered America? It has been 500 years since the colonization of the Americas, and the traditional medicines of the conquered (Curanderismo, for example) have not been incorporated into our American body of knowledge about human beings. The colonialization of medicine is a tragedy. In my opinion, the native peoples of Mesoamerica have vast stores of knowledge that have practical application for healing people’s traumas.

Of course, there are aspects of Curanderismo that counter the belief systems of most Anglo-Americans; however, it is the creativity of the psychotherapist who intuits what will and will not work for him or her and for the client. I may not believe, for example, that corn kernels can carry away a *susto*, but if this metaphor is something that will work for the ultimate benefit of the patient, applying this practice in a therapeutic setting is meeting the patient where they are at. This is a sharp contrast to the icons frequently employed by American traumatologists and curanderos.

In my experience, I have found that some of the Curanderismo methods, such as herbology or ritual, work as well as allopathic medicine, both for mental and physical illness. There appears to be fewer side-effects associated with the Curanderismo approach to medicine, and it incorporates many assets at the patient's disposal that are ignored in the allopathic model.

### **Contributions to the Field of Psychology**

This study contributes to the field of Psychology through the creation of the T-CIM, which incorporates contemporary, nontraditional psychotherapeutic practices with traditional healing practices found in Curanderismo. The integration of all of these practices results in a holistic approach to the treatment of PTSD and traumatic stress.

An integrative approach to healing could impact the healing profession and society on multiple levels. If healers are willing to risk possible ridicule from others in the field for working within uncharted territory, new learning can take place about the nature of healing from trauma. If individuals with graduate degrees begin to integrate left- and the right-brained aspects of treatment for trauma in practice including attending to the spiritual aspects of healing seriously, holistic thinking and spiritual practices may

become mainstream. It may become difficult for people to harm the environment and one another if they think holistically, realizing that what one does on a micro level quickly impacts the macro level, since we are all connected on planet Earth.

### **Summary and Conclusions**

My research question was:

*“Is it feasible to integrate American and Mesoamerican healing treatment approaches to design a model for healing traumatic stress and PTSD that would create a therapeutic, interpersonal environment whereby the model and the lived experiences of the psychotherapist/healer and of the client/patient are acknowledged, intertwined, and utilized for optimum healing?”*

I designed a treatment model for traumatic stress and PTSD that is feasible for those whose culture or mind-sets allow them to participate in activating their right- and left-brains, their emotional and cognitive selves, for it works with their past and present experiences of being human. It is not feasible for those psychotherapists who do not believe that the best tool they bring to a client is themselves, not their toolbox of American traditional and nontraditional treatment modalities. Research has shown the importance of the healer-patient relationship as the single most important therapeutic factor impacting the outcome of the treatment (Hubble, Duncan, & Miller, 2006).

### **Limitations of My Study**

Unfortunately, current American professional counseling ethical guidelines disallow many aspects of Curanderismo because they violate professional boundaries. In order to incorporate the positive aspects of Curanderismo into allopathic traumatology, or to utilize my model, the clinician must currently operate outside of state sanctioned

practice or become an ordained minister and market him or herself as a “Ministerial” or “Pastoral” counselor. Since psychotherapy is a form of re-education, I propose that psychotherapists are educators since the word *education* derives from *educare*, meaning to draw out, rather than, to use Carl Rogers’ metaphor, the educator being the jug and the students the mugs.

In this study, I sought to shed light on Mesoamerican healing practices and to acknowledge and integrate them as strong, effective healing modalities. Curanderismo may be an important adjunct for American approaches to Traumatology and hopefully, may broaden our society’s attitude toward mental illness and recovery. Jung (1969) described rites that follow prescribed actions to achieve a specific purpose, such as recovery from soul loss or rebirthing. These procedures are designed to create in the participant a specific “psychic effect” (Jung, p. 129). Practices in Curanderismo, such as the use of the *temazcal*, engender transpersonal experience, which assists the individual to recover from *susto*, traumatic stress, and PTSD.

Ancient and modern approaches to the treatment of mental illness can be integrated in a way that offers the patient the benefits of both. It is my sincere hope that others will try these age-old healing techniques or learn to practice them with others so that the ancient tradition will no longer be overshadowed by colonization. At the very least, the use of rituals could be an adjunct to healing sessions.

It is important to note that while the curanderos in my study are from specific regions of Mexico or New Mexico, they do not represent all curanderos in Latin America. Additional research in South and Central America related to Curanderismo and other

shamanic practices may offer contributions to the incorporation of whole-person approaches to treating traumatic stress.

Because I am an Anglo-middle-class American, the interpretation of the data may be skewed. I do not live in the poverty that is common in rural Mexico, and I can take advantage of a myriad of options for mental health concerns, unlike many Mexicans whose only option is the curandero. In spite of the open arms of the Mexican curanderos, I remain an outsider looking in, with a multitude of beliefs and biases that stem from being American. I am likely unaware of many biases of participants towards me as a female, Anglo and middle class American. Some participants were willing to explore their preconceptions of me and mine of them in an effort to establish a person to person dialogue rather than stereotype to stereotype. As a researcher, I was fortunate in studying the healer, as many are self actualized and able to look deeply in to their motivations.

The application of my Integrated Model to someone outside of traditional Latino communities may be limited due to cultural orientation. However, with psychoeducation, *individuals outside of traditional Latino communities may benefit from the model.* In casual conversation with Latinos, I have found that Latinos who are acculturated to the United States or are from Northern Mexico are unfamiliar with the temazcal, while people from Mexico City and southern Mexico are aware of the temazcal and its benefits for mental and physical health. The American nontraditional trauma treatments included in this study were chosen based upon their reputations as efficacious treatments and because each approach is unique.

### **Implications and Suggestions for Future Research**

There is a paucity of literature and research on Curanderismo available for English speakers. While there is limited research and documentation of Curanderismo practices in Spanish, translation of Curanderismo practices into English is necessary to allow English speakers to be aware of and to consider Curanderismo practices. Additionally, if not written down, these rich traditions are likely to disappear because many modern Mexicans have been acculturated to discredit traditional healing. There are fewer young Mexicans studying Curanderismo; thus individuals from other cultures interested in the tradition are openly welcomed by curanderos who want future generations to benefit from this vast body of knowledge.

Research in Curanderismo may be more substantial if conducted by researchers from Mexico, Central and South America, individuals who speak Spanish as their maternal tongue, or with the assistance of someone with those attributes. These individuals may be aware of cultural nuances that I may not understand, as a non-Latino.

Future research might include sharing contemporary Traumatology techniques with Curanderos to be integrated into Curanderismo healing practices. Heuristic papers and case studies by Curanderos and other shamanic practitioners would greatly add to the body of knowledge relating to spiritual healing practices.

Future studies could expand on this study. For example, researchers could examine other traditional healing modalities and compare and contrast it with Curanderismo. Future studies should assess other aspects of recovery from trauma, including the role of the physiological in recovery from trauma, the impact of spiritual



practices such as meditation, prayer, and community healing from trauma, and ways to integrate these seemingly disparate aspects. Researchers should also consider how the intellectual investment in a specific treatment modality may limit the integration of treatments

### **Implications for Practice**

Counselors should refrain from having expectations of individual's being open to treatment not familiar within their own culture. Practitioners may need to engage in psychoeducation and elicit buy-in from the patient in order for an integrated treatment to be efficacious. Additionally, counselors have their own biases and assumptions about spirituality and its role in healing and everyday life. Counselors should examine their beliefs and values about spirituality in order to prevent inadvertent imposition of these values and assumptions on the people they work with. Counselors also need to examine their biases related to what kind of work is efficacious and whether a spiritual component fits within their healing paradigm. American counselors should also guard against discrimination against a modality that is passed along by informally educated, and in some cases illiterate, individuals. Not all great learning takes place in the classroom or from books. The hands-on, life-long learning, based on multigenerational wisdom should be respected and honored. Curanderos are successful because they work with a like-minded population. For curanderos to work successfully with a more cognitive population, my treatment model is a source of integrative possibilities.

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*Appendix A*

**Definition of Terms**

- Allopathic** – American medicine, biomedicine, or modern medicine.
- Allopathic**
- Traumatology**- trauma intervention based on the model of allopathic medicine.
- Client** – the recipient of services in American psychotherapy.
- Counselor** – a psychotherapist in American culture with a graduate degree in psychology, counseling or related field, requiring licensure to practice or working under a licensed practitioner.
- Curanderismo** –a traditional Mesoamerican healing system which incorporates the physical, psychological, social and spiritual in the treatment of individuals
- Curandero** – a practitioner of Curandersimo. There are several types of curanderos, including herbalists, midwives, bone setters, and spiritualists, to name a few.
- Desombro** – a susto resulting from an encounter with the paranormal.
- Guisha** – a type of susto which occurs upon encountering a close friend cheating on her or his spouse.
- Healer** – a practitioner who helps a traumatized individual to integrate a traumatic experience.
- Left-brain**

- Dominant** - an individual's mindset or culture's institutions and organizations that function primarily through logic, analysis and exactness; the left-hemisphere "seems to be the repository of all fully developed structures of knowledge, handling all learning [and treatments of trauma] that is stabilized and firm" (Pearce, 2002, p. 37).
- Limpia** - a practice commonly utilized by curanderos which restores the individual to equilibrium on spiritual levels.
- Mesoamerican** – Central American in origin.
- Plática** – heart to heart chats, or unstructured counseling.
- Post-Traumatic Stress Disorder (PTSD)** - an anxiety disorder which may occur after exposure to terrifying events that threatened or caused grave physical harm to self or others. PTSD occurs more often in those who have knowingly or unknowingly experienced earlier trauma, so the current event is enhanced because remembering is like reliving.
- Pueblo** – a small, rural community in Mexico

**Right-brain**

- dominant** – an individual or culture that functions through holism, relatedness and intuition. “The right hemisphere, with its rich connections to the two lower regions [of the brain and the heart], is involved in new learning...” (Pearce, 2002, p. 37).
- Sahumerio** – a ritual vessel used to burn purifying herbs
- Soma** - the physical experience of an event
- Susto** – a psychological condition common in Latino communities which comes from being severely frightened. An individual’s belief system holds that when he or she experiences trauma, a portion of the soul fragments away, resulting in a feeling of not being complete, not whole.
- Temazcal** – a traditional vapor bath. This term refers to the specialized building and the ritual vapor bath.
- Temazcalero/a**- an individual who organizes and runs the *temazcal*.
- Tonalli** - a vital force that gives the individual animation, vigor, heat and stimulates growth.
- Trauma** – a shocking event that results in impairment of mental, emotional, social and spiritual functioning.
- Traumatology** – a specialized field within Psychology that focuses on the treatment of PTSD.
- Whole-Brain** – an individual who incorporates the best of left- and right-brain attributes in decision making.

**Wholeness** – a sense of integration experienced by a traumatized individual related to recovery from PTSD and traumatic stress.

*Appendix B***DSM-IV Descriptor**

The DSM-IV (1994) established criteria for Acute Stress Disorder and Posttraumatic Stress Disorder. The DSM-IV describes Acute Stress Disorder as follows:

- A. The person has been exposed to a traumatic event in which both of the following were present:
  - (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and
  - (2) The person's response involved intense fear, helplessness, or horror.
  
- B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following symptoms:
  - (1) A subjective sense of numbing, detachment, or absence of emotional responsiveness
  - (2) A reduction in awareness of his or her surroundings (e.g., 'being in a daze')
  - (3) Derealization
  - (4) Depersonalization
  - (5) Dissociative amnesia (i.e., inability to recall an important aspect of the trauma)
  
- C. The traumatic event is persistently re-experienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes,

or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

H. The disturbance is not due to the direct physiological effects of a substance (e.g., drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder. (pp. 431-432)

The DSM-IV describes PTSD as follows:

A. The person has been exposed to a traumatic event in which both of the following have been present:



(1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others;

(2) The person's response involved intense fear, helplessness, or horror.

Note: In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

(3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.

(4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- (1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma
- (2) Efforts to avoid activities, places, or people that arouse recollections of the trauma
- (3) Inability to recall an important aspect of the trauma
- (4) Markedly diminished interest or participation in significant activities
- (5) Feeling of detachment or estrangement from others
- (6) Restricted range of affect (e.g., unable to have loving feelings)
- (7) Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- (1) Difficulty falling or staying asleep
- (2) Irritability or outbursts of anger
- (3) Difficulty concentrating
- (4) Hypervigilance
- (5) Exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. (pp. 428-429)

*Appendix C***Interview Transcriptions****Roberta and Juan**

The following interview took place in a microbus in Mexico City. Roberta, her nephew Juan (who was acting as translator for the non-Spanish speaking individuals in our group and Aztec culture expert), me, and others from the Albuquerque Curanderismo group had just visited the archeological ruins of Teotihuacan, north of Mexico City. I have translated Roberta's words and included Juan's translation to the group of Roberta's words. The words are transcribed as they were spoken, and include grammatical translation errors and a literal, direct translation of Roberta's words in Spanish, which adds to the authenticity of the recounting of the lived experience.

**Juan** (*in English, to the group*)

People who took the temazcal did so for many, many reasons. For example, ladies who have had the baby, they purify themselves, and they try to sweat out all the bad things around them, purifying before or after the birth of the baby. That's one kind of reason to go to temazcal in ancient Mexico. Another way that the temazcal was used was the players of the ballgame (ancient ritualistic ballgame played in Mexico and Central America, and usually included human sacrifice), used to go to the temazcal before the games to purify themselves before the offering to the gods, so they were clean inside and out of them. Also, they used the temazcal after playing the game as a ritual to allow the gods to help them to be healthy, to be champions again. Remember I told you that some of the players were killed every time, so the others went to the temazcal to be grateful to the

gods for being still alive. In ancient Mexico, the healers used the temazcal first to help people to sweat their illness, their problems, mental problems, emotional problems, etc.

*Juan turned to Roberta and told her he had said the following to the group:*

**Juan** *(to Roberta in Spanish)*

The temazcal represents the uterus of nature, where we return to rebirth ourselves, but healthy, without emotional problems. Prehispanic peoples used the temazcal, for example pregnant women, the players of the ballgame, and the healers used it to allow the people to put their problems in their proper place.

**Juan** *(to group in English)*

The temazcal is usual in Central Mexico, but the Mayans had something similar. The temazcal is so common in pre-Hispanic cultures. In the culture of the pre-Hispanic period, the classical and post classical periods, all of them, had temazcal. The people from each place, from each town, used their temazcal. It was a reason, to be in a temazcal, to prepare for some activities they had. For example, before a marriage, they used to go to a temazcal, or after being married. So there are many ways the people went to use the temazcal. Sometimes they gave birth in them.

**Roberta** *(to group, in Spanish, translated)*

I have personally investigated, in the Curanderismo, the temazcal. It is a very, very necessary importance to encounter the health, because of the emotional effect it provokes.

**Juan** *(to group in English, translating)*

People need to get health through emotions, through emotional changes.

**Roberta** *(to group, in Spanish)*

We have discovered that the temazcal had uses apart from the thing Carlos mentioned, but also to close cycles in many ways. These cycles normally...

*(inaudible)*

**Juan** *(translating to English, to group)*

Okay. These cycles, I am going to give you an example. When we lose a relative, something near us, in Mexico we have a “duelo,” a great pain. So that he closing of a life cycle. When someone has a trauma, it’s another cycle. You break something that is okay, and the trauma finishes that cycle. So you begin with another cycle, where you are trying to make the trauma go away, to start over another cycle.

**Roberta** *(to group, in Spanish)*

Because, they say, in these traumas, like in an accident, the spirit, yes, it leaves.

**Juan** *(translating to English, to group)*

When you have a problem or a trauma, your spirit goes off, out of you.

**Roberta** *(to group, in Spanish)*

In this moment, the person loses concentration, the state of health in equilibrium.

**Juan** *(translating to English, to group)*

Your equilibrium is lost when you have a trauma, when you have an accident, you can’t concentrate in anything, so you need to restart that cycle.

**Roberta** *(to group, in Spanish)*

This (temazcal) provokes that the human being doesn’t suffer alone emotionally.

**Juan** *(translating to English, to group)*

The pain is not only suffered physically, also mentally, and mentally you can become a mad (crazy) person.

**Roberta** *(to group, in Spanish)*

This is a level (of understanding) of Curanderismo. But on a scientific level it's when the person has encountered a psychological problem, such as a problem of depression, low self-esteem, flashbacks, and distraction.

**Juan** *(translating to English, to group)*

The first explanations are from the point of view of the healers. Scientists explain the same thing talking about psychological problems like depression, like feeling themselves as someone who doesn't have value, and ... *(inaudible)*

**Roberta** *(to group, in Spanish)*

After a trauma, the state of animation (animo) lowers, self esteem lowers, and the person falls into a state of automatic functioning. And there is a physical reaction that affects the central nervous system.

**Juan** *(translating to English, to group)*

Psychological problems impact the immunological system, it goes down, so you immediately get sick, so you need to reactive that system. But your mental problem doesn't let you to do that.

**Roberta** *(to group, in Spanish)*

It (the trauma) begins to somatize, mental turns into a real physical consequence.

**Juan** *(translating to English, to group)*

So the illness is controlled by the mind, the physical illness comes from the mental.

**Roberta** (*to group, in Spanish*)

It begins the necessity to treat yourself with chemicals, you can become dependent on the medicines, on drugs, on other substances people use to get themselves to feel good.

**Juan** (*translating to English, to group*)

People, like who we are talking about, begin looking for chemical health, but that isn't health. They are then dependent on it, not just physically dependent, but psychologically dependent.

**Roberta** (*to group, in Spanish*)

We know that this, after a trauma, is subconscious, because it is like a fight, these things become necessities for the body.

**Juan** (*translating to English, to group*)

This process is unconscious. We don't know how we are dependent on that chemical product, but it's a need for the person to get well, to be healthy, to be healed.

**Roberta** (*to group, in Spanish*)

The human body is like a vessel, it wants to be filled, but it encounters this disequilibrium, and then comes the desire to cry, to suffer or to harm someone else, too, make someone else suffer, too.

**Juan** (*translating to English, to group*)

This loss of health is like emptiness. When people feel this emptiness, they try to right it through an act of self-compassion, they try to get someone else to pay for the pain, to pay for that problem, their own problem.



**Roberta** (*to group, in Spanish*)

Without a doubt, it takes a while for medicine, chemicals, to serve the people.

These effects aren't immediate, which is what the people want.

**Juan** (*translating to English, to group*)

People go to the psychiatrist trying to solve their problem, but they, in most cases, don't solve the problem.

**Roberta** (*to group, in Spanish*)

Without a doubt, therapies of the temazcal, one after another, will lower the emotional parts of the trauma, after the songs, after the poems, after the feelings.

**Juan** (*translating to English, to group*)

Having frequently the temazcal, through singing, through dancing, through reading, is more effective than the other ways to treat an illness, a trauma. When you go to a temazcal, there is a flashback, a rebirth, that lets you fight against the trauma.

**Roberta** (*to group, in Spanish*)

Because of this, to curanderos it represents (the temazcal) something extremely sacred.

**Juan** (*translating to English, to group*)

That's why the temazcal is so scared to the temazcaleros.

**Roberta** (*to group, in Spanish*)

The temazcal is like a universal uterus...

**Juan** (*translating to English, to group*)

The temazcal is like a uterus

**Roberta** (*to group, in Spanish*)

The entrance is the vagina...

**Juan** (*translating to English, to group*)

The entrance is the vagina of that uterus

**Roberta** (*to group, in Spanish*)

The rocks are the ovaries...

**Juan** (*translating to English, to group*)

The ovaries are the rocks inside the temazcal, the rocks, they are representing the human ovaries.

**Roberta** (*to group, in Spanish*)

The fire that enters from outside represents the force of the male

**Juan** (*translating to English, to group*)

Fire represents men.

**Roberta** (*to group, in Spanish*)

It also represents the penetration into the ovaries. This penetration provokes a pregnancy. It is for this reason that we are in the temazcal completely naked, like a fetus.

**Juan** (*translating to English, to group*)

That is why you must be nude, like a fetus, inside the temazcal.

**Roberta** (*to group, in Spanish*)

In the center of the temazcal is the belly button.

**Juan** (*translating to English, to group*)

In the center hole of the temazcal is the belly button.

**Roberta** *(to group, in Spanish)*

And the environment of the temazcal, with the humidity and darkness, contact with the Earth, is like the environment of the womb.

**Juan** *(translating to English, to group)*

As you talked about last night, the humidity and darkness...

**Roberta** *(to group, in Spanish)*

This provokes the feeling in us that we begin to feel this movement.

**Juan** *(translating to English, to group)*

That humidity, that darkness, begins in you that emotional movement. That your emotions began moving.

**Roberta** *(to group, in Spanish)*

In this, all the four sacred elements combine, the earth, the fire, the water and the air. And for our ancestors, having all the sacred elements together was very important.

**Juan** *(translating to English, to group)*

All four sacred elements for our grandparents are inside the temazcal. There is fire, there is water, there is earth and there is air.

**Roberta** *(to group, in Spanish)*

I can talk in particular about what I have learned and what I am interested to incorporate in the temazcal.

**Juan** *(translating to English, to group)*

That is what Roberta has learned and what she wants to teach to you about the temazcal.

**Roberta** (*to group, in Spanish*)

To me, it has called my attention to incorporate inside the temazcal the music

**Juan** (*translating to English, to group*)

Roberta is interested in using sounds and music, something like that, inside the temazcal practice.

**Roberta** (*to group, in Spanish*)

Because this provokes and moves all thought and more profoundly the feelings, along with the help of the music therapy.

**Juan** (*translating to English, to group*)

This is called musical therapy and it moves feelings, emotions strongly.

**Roberta** (*to group, in Spanish*)

The music, to me they say give me the words to the song, and on some occasions I have told them that it's the words (the therapeutic effect) of the songs, but there are many songs that can never be recreated or repeated, that it is the energy of what she feels inside the temazcal.

**Juan** (*translating to English, to group*)

Many people have asked Rita to write them, the lyrics from that songs. She hasn't because she just feel what to sing every time.

**Roberta** (*to group, in Spanish*)

This is an example of what we did in front of the mural (group had sung a spontaneous song in front of an ancient mural at an archeological site).

**Juan** (*translating to English, to group*)

The exercise she invited to make with her in front of the mural inside the palace (the ruin), she didn't do it before. She hasn't done it before.

**Roberta** (*to group, in Spanish*)

Like this, it is inside the temazcal. It depends on the feelings that inspire me from every one of you.

**Juan** (*translating to English, to group*)

Depending on her feelings and inspiration, she...her mood, she decides what to do inside the temazcal.

**Roberta** (*to group, in Spanish*)

I have seen people who arrive with violations, with the death of children, with the soul feeling abandoned.

**Juan** (*translating to English, to group*)

She has received people at her temazcal, like raped men, people who have lost a child, have a died child, people who have killed someone else, she has to keep those secrets with her. Its important to the temazcalero.

**Roberta** (*to group, in Spanish*)

And, in it, I don't know what happens to me, but I can't say what I do because the only thing that I feel is the desire to secure with songs, with words, with contact, so that the person cries, in this moment, the person accompanying one another who are there and they cry, yell, and work hard with...*(inaudible)*

**Juan** (*translating to English, to group*)

She tries to make these people to cry just to keep them from forgetting themselves. That's the way she wants to help them.

**Roberta** *(to group, in Spanish)*

At times, they vomit, at times they shout and vomit, they have diarrhea and vomit.

**Juan** *(translating to English, to group)*

Many times they shout, they throw up, they have diarrhea.

**Roberta** *(to group, in Spanish)*

This is a treatment that lasts 2 or 3 hours, or until whatever time.

**Juan** *(translating to English, to group)*

This healing process, this helping process took from 2 to 3 hours.

**Roberta** *(to group, in Spanish)*

Because in this, the person cries out for their mother, their father, or someone really close, begging them, please to deliver them or to forgive them.

**Juan** *(translating to English, to group)*

Sometimes they shout to their parents or their mates, asking them to let them be in health or to forgive them.

**Roberta** *(to group, in Spanish)*

And, in there, we enter something that is really important in Curanderismo, that the curandero is a psychologist, we encounter trauma very, very serious. The person has evaded extremely grave situations, and they are there to resolve these traumas.

**Juan** *(translating to English, to group)*

Roberta thinks that if the healer works together with a psychologist, they could heal the people sooner than one of them alone.

**Roberta** *(to group, in Spanish)*

Overall, there are people who are not responsible enough to continue with a therapy, or because they don't have the money or they don't have the time, and if we, the curandero and the psychologist incorporate these therapies, very quickly we can resolve this problem.

**Juan** (*translating to English, to group*)

For example here, in Mexico, there are a lot of people who don't have a lot of money for a psychologist, so if a psychologist and a healer work together it can reach in a few times, the health.

**Roberta** (*to group, in Spanish*)

I have noted that this process works because the human organism requires crying, shouting, to say that they don't like something and to give a desperate cry. This can be done through songs, through shouts, through sounds.

**Juan** (*translating to English, to group*)

Human beings need to shout, to say what they don't like, and not only to shout. Singing is a way to say what we like and what we don't.

**Roberta** (*to group, in Spanish*)

It is important that I learn English so that I don't have to interrupt this relation. Without a doubt, you are seeing that to be a curandero, you have to have a deep sensibility to make ideas.

**Juan** (*translating to English, to group*)

Last night I was telling Rita that she has to learn some English, but she say that instead of this, she has a lot of awareness and sensitivity, and that is the way a healer communicates with other people.

**Roberta** (*to group, in Spanish*)

Without a doubt, I have never done what we did last night (temazcal with English speakers), because normally I have to be in profound communication with the people in the temezcal, that we understand one another and are united in the temezcal.

**Juan** (*translating to English, to group*)

Last night you all understood Roberta. She felt that you all were only one person, as one woman.

**Roberta** (*to group, in Spanish*)

And I felt that I did this communication, these sincere techniques, to take out feelings.

**Juan** (*translating to English, to group*)

There was a communication using feelings, your feelings communicated something.

**Roberta** (*to group, in Spanish*)

For me, it is like this, like a triumph, a step up in my practice of curanderismo when I hear that someone begins to cry.

**Juan** (*translating to English, to group*)

She feels good, she feels she is going up one level more when someone in the session of temazcal begins to cry.

**Roberta** (*to group, in Spanish*)

I believe in this practice, I have realized that it is something very noble, very humble, but also very grandiose.



**Juan** (*translating to English, to group*)

Being a healer, as Rita has felt like herself, its not a great profession, but it is enormous and important for her.

**Roberta** (*to group, in Spanish*)

This is speaking about the therapies.

**Juan** (*translating to English, to group*)

This is what she has to say to you about psychotherapy with temazcal.

**Roberta** (*to group, in Spanish*)

But speaking about the temazcal is a result of what I have investigated, that they style of temazcal that dominates is the warrior style, which are temazcales VERY strong, VERY hot, like 70 or 80 centigrade.

**Juan** (*translating to English, to group*)

Another style of temazcal is called the warrior temazcal. Basically a warrior temazcal is 70 or 80 centigrade...Does anyone know how to convert that to degrees? (*someone suggests 140 degrees*). Hot. Very hot. Okay. (*Someone asks Juan to ask Roberta about how many rocks are used in the temazcal*). Okay.

**Juan** (*to Roberta, in Spanish*)

Someone asked how many rocks are used in the temazcal.

**Juan** (*to group, in English*)

I supposed you also want to know which type of rock is used in the temazcal.

**Juan** (*to Roberta, in Spanish*)

Volcanic rocks?

**Roberta** (*to group, in Spanish*)

Yes, volcanic rocks. The kind in my temazcal are from (*name of place inaudible*).

**Juan** (*translating to English, to group*)

Volcanic rocks are used. Not necessarily lava rocks, but it is a type of volcanic rock.

**Juan** (*to Roberta, in Spanish*)

And how many rocks are used?

**Roberta** (*to group, in Spanish*)

Traditionally, there are 54 rocks used. I don't recall how many I have in my temazcal.

**Juan** (*translating to English, to group*)

She disagrees with the rest of the healers, she doesn't feel that there will be only a specific number...

**Roberta** (*to group, in Spanish*)

Because the actual temazcal divides itself in three parts. The temazcal pre-Hispanic, indigenous, the warrior temazcal, and the mixed style of temazcal, and actually the temazcal combines itself with modernism, this form has arrived as well.

**Juan** (*to Roberta, in Spanish*)

Can you give us an example?

**Roberta** (*to group, in Spanish*)

An example is that you can make a great importance about the number of rocks used...

**Juan** (*translating to English, to group*)

She says it is more important than the number of rocks and how you are going to heat them. In traditional temazcal, they had 54 rocks. In warrior temazcal they used too many rocks, more than 54, and Roberta has used about 40 rocks. And there are other techniques like using gas or other techniques to heat the rocks.

**Roberta** *(to group, in Spanish)*

In respect to the part that is about the rocks, the construction, the use of gas, I have walked in these parts, and other healers have broke with tradition.

**Juan** *(translating to English, to group)*

Other temazcal mates from Roberta disagree with her, with this thing about the number of rocks, using of gas for heating the rocks, for giving the heat to the rocks.

**Roberta** *(to group, in Spanish)*

Few people who use the temazcal seem concerned with how I constructed my temazcal, because I used my own hands and heart in its construction.

**Juan** *(translating to English, to group)*

No temazcalero mate from Rita let her to see their temazcal, so she got something just feeling and asking to her heart and the little she could see from the other temazcaleros. No one taught her how to make the temazcal.

**Roberta** *(to group, in Spanish)*

Because of this, people have told me that my temazcal is not correct in its use.

Without a doubt, I feel and believe it is full of spirit, and of my heart, more than of my head.

**Juan** *(translating to English, to group)*

Many temazcaleros criticize Roberta's way to having a temazcal. She is still trying to hear her soul and her heart, not her brain.

**Roberta** *(to group, in Spanish)*

Temazcaleros say it is important inside the temazcal where people sit, for example.

**Juan** *(translating to English, to group)*

Many temazcaleros don't like to have a seat inside the temazcal, as you could see last night, you could sit inside the temazcal *(there is a small curb that follows the circumference of Roberta's temazcal, upon which people can sit)*.

**Roberta** *(to group, in Spanish)*

Another thing is that they aren't in agreement that I use the gas, but I believe that also, the gas is something of Earth.

**Juan** *(translating to English, to group)*

Roberta says that natural gas is another resource from Earth. So she uses it as another natural thing for heating her rocks.

**Roberta** *(to group, in Spanish)*

Also, I am inside the city, I can't burn wood, I would be depriving people (of clean air to breathe), so I can't make a temazcal like other temazcaleros.

**Juan** *(translating to English, to group)*

Making her fire with wood, here in the city, it would be more dangerous to the earth and people around, that using gas, for example.

**Roberta** *(to group, in Spanish)*

Of course, I feel very content because I have returned a little to the practice of the warrior temazcal. This has required me to work hard with this internal part of me.

**Juan** (*translating to English, to group*)

She is so proud because she work more with the inside of people, their souls.

**Roberta** (*to group, in Spanish*)

Because I have seen in the warrior temazcales the tradition was for giant warriors, representatives or chiefs of communities, or for people who had a strong tolerance for the fire, they were for many hours inside the temazcal.

**Juan** (*translating to English, to group*)

At first the warrior temazcales were only for fighters, warriors, for people who had a great braveness, and had a big force to resist that heat.

**Roberta** (*to group, in Spanish*)

Without a doubt, I have considered for me the significance of the warrior temazcal, it is to go to work with in the temazcal with the crazy war we have going on inside the mind, impotency, fears, serious things, my poverty, the stupid things I have done that are taking up room in my head.

**Juan** (*translating to English, to group*)

She understands the warrior as a person who needs to fight with madness or the mad ideas that we have inside us, like envy and things like that.

**Roberta** (*to group, in Spanish*)

To me there is a lot of rabid energy with injustices. For me these are dirty wars inside the head and you have to work with them.

**Juan** (*translating to English, to group*)

She is angry against injustice and she wants to work with them.

**Roberta** *(to group, in Spanish)*

Because I have arrived at considering that the man has a representation of physical and powerful force over women, but we are warriors, too, before my community, before my family, before my country.

**Juan** *(translating to English, to group)*

Normally, great warriors were men. She wants that women should be, could be, great warriors, in front their society, in front of their men, in front of all the humanity.

*(Participant asks Juan to tell Roberta that she has participated in many sweat lodges in the past and they were are very masculine. Last night was the first sweat lodge that was for the woman, and that felt very, very powerful. And tell her that when I was singing, I knew what she was going to sing. Or she knew what I was going to sing)*

**Juan** *(to Roberta, in Spanish)*

She comments that last night some very interesting things. Something important is that she felt that you knew what she was going to sing before she sang it.

**Kathy** *(to Roberta in Spanish)*

Also, she has attended many sweat lodges in the past and they have all been very masculine in their energy. This was the first time that the sweat lodge was for THE WOMAN.

**Juan** *(to group, in English)*

That's why, last night, I didn't get in to the temazcal with you, trying to be alone. I waited so you could enjoy it for yourselves.

**Roberta** (*to group, in Spanish*)

I understand what you are saying, but the truth is that what happens is an aggrandizement of me because you allowed me to enter your heart.

**Juan** (*translating to English, to group*)

She is grateful to you because you are letting Rita get in to your hearts. Many people have asked her if she feels in herself as a higher person, more important person. She only wants to feel wanted by the people she helps.

**Roberta** (*to group, in Spanish*)

I listen in the temazcal first to what I have divined. I sometimes feel violated, like a girl of 5, 8, 9 years of age, I sometimes feel the perdition of a child that has died, of a mate, brothers or sisters, mothers, fathers...

**Juan** (*translating to English, to group*)

She has wept for many things since she was a child. For example, she was raped when she was 7, when she was 9 years old. She also lost a mate, she also lost a daughter, so she feels many of the things that people who come to her temazcal.

**Roberta** (*to group, in Spanish*)

To not have something to eat, this is to suffer in the moment. I have gone through many, many tragedies. From these things I have cried and shouted and today I am satisfied for these experiences, that they have permitted me to understand, to arrive at the understanding of what I am supposed to do with my hands.

**Juan** (*translating to English, to group*)

She has suffered a lot with those experiences, she cried a lot, but she is proud because of that suffering, and today she can help people with similar problems. She has felt them herself.

**Roberta** (*to group, in Spanish*)

An important part is that I can feel the contact of whoever arrives at my temezcal because I put myself in their place, I believe in their pain, I feel their pain. The difference today is the intent to understand and transform this pain.

**Juan** (*translating to English, to group*)

When someone gets inside Roberta's temazcal, she tries to get in to their place, to their body, so she can feel their pain, their suffering, and that's the way she tries to help them. Like if she were they.

**Roberta** (*to group, in Spanish*)

For this I consider, in theory, that now I am very documented in the concept and conducting of the temazcal, music, plants, everything that is needed.

**Juan** (*translating to English, to group*)

Roberta has a lot of information about how to do a temazcal. She started after she built the one she has. She also has information about the plants, how to ask permission to take them for healing, and that kind of information is what she wants to tell to you.

**Roberta** (*to group, in Spanish*)

What I have is information about everything related to the temazcal. You can't have a connection with others, with their suffering, if you have not experimented with how to conduct them, like a warrior.



**Juan** (*translating to English, to group*)

Sometimes knowledge isn't enough if you don't try to practice it, being a warrior.

**Roberta** (*to group, in Spanish*)

It has been 5 years I have been working with the temazcal, I have done meetings with about 5000 people.

**Juan** (*translating to English, to group*)

Almost 5000 people have been in her temazcal in 5 years.

**Roberta** (*to group, in Spanish*)

And it is for this that that when I go to a course about temascales, I listen, and I respect the teacher, but I think it is important to enter the temazcal from the bottom of your heart, and with this spirit engage in an exchange of energy of the moment inside the temazcal.

**Juan** (*translating to English, to group*)

One thing in the temazcal is that you must use your heart, your soul and you have to be wanting to exchange your energy with the others.

**Roberta** (*to group, in Spanish*)

It is interesting, one time I discovered that for me (the temazcal) is a very practical thing, but it is also a deeply beautiful thing, why have I not incorporated a part of beauty?

**Juan** (*translating to English, to group*)

One of the last things she has discovered is... Temazcal originally helped people to heal themselves. So why not include beauty in this practice? Why not to include beauty treatments in the temazcal?

**Roberta** *(to group, in Spanish)*

So I have started to include (in my practice) treatments with oils, honey, oils for the hair, aromatherapy during massage.

**Juan** *(translating to English, to group)*

Now Roberta includes in her treatments things like hair oils, facials of honey and other things.

**Roberta** *(to group, in Spanish)*

Because, after the temazcal, it is a moment of rebirth, to the human organism, contact with the skin, it is very agreeable the touch, like a greeting to a new born baby.

**Juan** *(translating to English, to group)*

When people goes out of the temazcal, they feel like a new baby. So they want hugs, they want to be loved, so that is the reason why she wants to give them some love.

**Roberta** *(to group, in Spanish)*

So we go with this part, a recognizing that the physical part is very important, taking care with it, when you leave with your clean face. This is significant to the rebirth of self-esteem.

**Juan** *(translating to English, to group)*

When someone goes out from the temazcal, perhaps the eyes have some redness or hesitation because of crying, the heat, but they are also self-conscious of themselves, so it is important to let them care for themselves.

**Roberta** *(to group, in Spanish)*

For this the importance of the curandero to amplify the understanding of medicinal plants, massage, chiropractics, trauma therapy, music therapy, aromatherapy, and everything that you can do in relation to every type of massage.

**Juan** (*translating to English, to group*)

That is what Roberta has learned in her therapies, many kinds of them, like chiropractics, aromatherapy, music therapy and others.

**Roberta** (*to group, in Spanish*)

Because to give a massage is to listen...there are many kinds of massage, just a typical massage, or energetic, hot rocks, honey, pregnancy, for the baby, shitazu, Swedish...all these kinds of massages are important.

**Juan** (*translating to English, to group*)

The massage is so simple. So you must explain to people you help to know a lot of types of massage. She mentioned about 10 different types.

**Roberta** (*to group, in Spanish*)

I have considered that for me, it is a compromise to capacitate me to resolve the needs that arrive at my practice.

**Juan** (*translating to English, to group*)

She has compromised with learning to help people who come to her.

**Roberta** (*to group, in Spanish*)

The temascales are also used to celebrate birthdays, marriages,

**Juan** (*translating to English, to group*)

There is another type of temazcal, for example to celebrate a birth, a wedding, or to give someone a name. To give a baby a new name. She calls it “Siembra de nombre,” or “to pull out a name.” And they use the temazcal for this.

**Roberta** *(to group, in Spanish)*

After the delivery of a baby, there is a very strong emotional problem (depression) and this can be helped with massage.

**Juan** *(translating to English, to group)*

Women feel bad, depressed, so you can fight depression through chanting songs.

**Roberta** *(to group, in Spanish)*

You give the woman a “manteada” (blanket massage), where you move the body while it is resting against a blanket, to put everything back in place.

**Juan** *(translating to English, to group)*

You can give her a “manteada,” which means to shake her with a blanket, to keep her waist well.

**Roberta** *(to group, in Spanish)*

The manteada is very noble because there is little contact with the naked body, it is done with clothes on.

**Juan** *(translating to English, to group)*

Manteada allows having the clothes on you.

**Kathy** *(to Roberta and Juan, in English)*

This could be something very useful, because in the United States, we cannot have a lot of contact with the body.

**Juan** *(translating to English, to group)*

That is why she is telling you, so you can learn to use it in the States.

**Roberta** *(to group, in Spanish)*

Tonight we will do a temazcal with much force, and you will see that this produces a very different effect.

**Juan** *(translating to English, to group)*

Tonight you are going to have a strong temazcal, so you can feel it is different from the one last night, so you can feel the differences between the two styles.

**Roberta** *(to group, in Spanish)*

If you all are in agreement, I would like to include Juan, so we can sample a mixed temazcal. It is very different, for the force of the man reaffirms that, in the temazcal, the body is like a temple, that it deserves respect, that nothing will happen, like in the United States they interpret that it could be something not permitted.

**Juan** *(translating to English, to group)*

Roberta is inviting you to let me to get in to the temazcal tonight to prove to you that nothing will happen like the North Americans believe that could happen if men and women are all inside in this kind of therapy.

**Roberta** *(to group, in Spanish)*

For us, when we do temascales in groups, and there are 3 or 4 men, we put them between the women so the energy flows well.

**Juan** *(translating to English, to group)*

She says that when some men are in to a temazcal with a lot of girls, they share the men to have energy that is strongest or stronger than hers, and to share this energy among women. Among girls.

**Kathy** *(to Juan, in English)*

That is totally not what she said! No. She said that it isn't that men's energy is stronger, it got to have a confluence of energy that combines the masculine and feminine, which are very different.

**Juan** *(translating to English, to group)*

Also she said that when there are 3 men and a lot of girls, that they have to share the force of the man among the women. She has to share among 3 or 4 women the strength of one man.

**Kathy** *(to Juan, in English)*

I heard Roberta say that it is every other one, man, woman, man, woman.

**Roberta** *(to group, in Spanish)*

Yes. In the temazcal, the differences in chests can call attention, so you have to be respectful, have your eyes closed, with lots of concentration, and it is something very beautiful because the force of the woman centers and says I am by him, I am not with anyone. Everyone is equal, the same. And this is a form of showing and exercising respect to the body. Because it is sacred.

**Juan** *(translating to English, to group)*

During daily life, usually men looks at boobs or specific parts of women. Inside the temazcal, things can't be like that because of two things. Roberta didn't say, but because of the darkness, it doesn't allow them to do that, but the women force

to be concentrated only in himself. Yes. Only with him, not with them. I explain it well?

**Roberta** *(to group, in Spanish)*

Without a doubt, it is something very beautiful because here, in the bus, there are fears and embarrassment.

**Juan** *(translating to English, to group)*

Temazcal also lets people to break, to fight against embarrassment, fears and taboos.

**Roberta** *(to group, in Spanish)*

But, something that is very important, something that I carry in to the practice, is that twice mates have come to my temazcal to make love with one another. And I permitted it, and I prepared the temazcal for this with petals of flowers, for an ambiance very pretty, and it was a very beautiful practice, and some others and I made music outside of the temazcal so they could make love inside.

**Juan** *(translating to English, to group)*

A couple came once to make love themselves. They asked for it from Roberta. So went out of the temazcal, let them to themselves, and they made music for them to make love. When they go out the temazcal, Roberta and her mates offered rose petals for the couple after having made love.

**Roberta** *(to group, in Spanish)*

Another couple asked me permission to have the sexual act inside the temazcal, because they were suffering strongly because they couldn't get pregnant. So I gave them permission to hold a ritual to become pregnant, and it happened.

**Juan** (*translating to English, to group*)

Another couple asked Roberta for permission because they couldn't have a baby.  
So they asked Roberta for permission to make love in the temazcal and the girl  
became pregnant by that sexual act.

**Roberta** (*to group, in Spanish*)

So, it is something very, very beautiful.

**Juan** (*translating to English, to group*)

Those two experiences were very, very beautiful for Roberta.

**Roberta** (*to group, in Spanish*)

Well, this is what I can tell you about it and now we will practice it.

**Juan** (*translating to English, to group*)

is inviting you to practice...

**Roberta** (*to group, in Spanish*)

With a lot of force, something much stronger than yesterday, and if you want to  
shout, laugh, cry, don't limit yourself, because you can let it all go in the temazcal  
between the songs, the heat, water that purifies me, wind (from the bundles being  
swung around the top of the temazcal), saying Mother Earth, I want to be reborn,  
so that we can leave the temazcal in the manner of a new born baby.

**Juan** (*translating to English, to group*)

She is inviting you to prepare for a strong temazcal. She is also to shout, cry, sing,  
because she thinks that water is going to wash you, heat is going to help you to  
suffer and win against fear and other things and the wind is purifying you and gets  
you to an alter. Morning wind, please get me to an alter.



**Roberta** (*to group, in Spanish*)

Because I want to be reborn in the temazcal.

**Juan** (*translating to English, to group*)

Because I want to be born again inside this temazcal.

**Leonela**

The following interview took place in Tepoztlan with Leonela, who was indentified by several locals as a curandera. Leocadia appeared to be very old, probably in her 80s. When I knocked on the door to her property, she stood on a bucket to look over her fence. After explaining who I was and what I wanted, she didn't appear to be interested in allowing me an interview. I told her that I work with traumatized children in Arizona, which struck a chord with her, and I was then allowed inside. We sat outside her two room adobe house, among chickens and kittens, throughout the interview.

**Kathy** (in Spanish, to Leonela)

How do you treat susto?

**Leonela** (in Spanish, to Kathy)

Well, we are people of the corn, so we heal with using corn. After you talk about the traumatic event, the person, she stands up, and you give her a limpia. It is this, like this. A handful of (dried corn) the person she holds some seeds in her left hand. You remove one seed and put it on her elbow, inside the arm, like this. You do the same with the other (elbow). With the rest (of the seeds), you clean the person by rubbing the seeds over their body. Then you take the seeds of corn and put them in a glass of water. If they sink, the susto has been removed.

**Kathy**

What if they don't sink?

**Leonela**

The limpia is done again until they all sink.

**Kathy**

Ah...

**Leonela**

The person puts the glass with the seeds in it under their bed for the night, when they sleep.

**Kathy**

How does that work?

**Leonela**

The spirit of the corn carries away the susto.

*Appendix D***Abbreviated Written Consent Form and Consent for  
Audio Recordings**

**Project Title: Traumatic Stress and Curanderismo: An Integration of  
Scientific and Humanistic Approaches to Treatment**

**Principal Investigator:** Kathy Mohr-Almeida  
48 West Hillside Street, Mesa, AZ 85201 USA  
(c) 480-329-8503                      (h) 480-969-7482

All elements of the comprehensive informed consent form have been provided to research participants in a nonwritten form.

**Signatures:**

Participant Name (Printed): \_\_\_\_\_

Participant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Principal Researcher's Name: Kathy Mohr-Almeida

Principal Researcher's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Name (printed): \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

***Witness Statement***

*My signature attests that I was present during the informed consent discussion of this research for the above named participant and that the information in the consent form and any other written information was accurately explained to, and*

*apparently understood by the prospective participant, or his/her representative and that the informed consent decision was made freely by the participant or the participant's representative.*