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ORIGINAL PAPER

From "Shrinks" to "Urban Shamans": Argentine Immigrants' Therapeutic Eclecticism in New York City

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Abstract This article examines Argentine immigrants' reliance on informal networks of care that enable their access to a variety of health providers in New York City (NYC). These providers range from health brokers (doctors known on a personal basis) to urban shamans, including folk healers and fortunetellers of various disciplines. A conceptual framework, based on analysis of social capital categories, is proposed for the examination of immigrants' access to valuable health resources, which are based on relationships of reciprocity and trust among parties. Results revealed immigrants' diverse patterns of health-seeking practices, most importantly their reliance on health brokers, epitomized by Argentine and Latino doctors who provide informal health assistance on the basis of sharing immigrants' social fields and ethnic interests. While mental health providers constitute a health resource shared by Argentines' social webs, urban shamans represent a trigger for the activation of women's emotional support webs. Contrary to the familiar assumption that dense and homogenous networks are more beneficial to their members, this article underscores the advantages of heterogeneous and fluid social webs that connect immigrants to a variety of resources, including referrals to diverse health practitioners.

Keywords Argentines · Immigrants · Latinos in the US · Mental health · Social capital · Social networks · Brokers · Folk healing · Shamanism

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Introduction

From the groundbreaking therapist-Spirit project developed by Koss (1980) in the 1970s to the latest research on Latinos' use of folk healing practices in urban milieus (Gomez-Beloz and Chavez 2001; Jones et al. 2001), medical anthropologists have shown the synergetic liaisons between traditional and Western forms of treatment, as well as the collegial collaborations among practitioners from different disciplines. Some of the questions that still puzzle theorists and policy analysts alike refer to immigrants' ability to mobilize both domestic and transnational resources to satisfy their most immediate needs (Chávez 1992; Menjívar 2000), particularly given the increasing barriers to health care in the United States. To what extent do immigrants help each other on the basis of belonging to the same ethnic or national group or of sharing similar social interests? What is the role of social networks in connecting immigrants to diverse health resources? What are the ways through which immigrants access diverse health providers via their supportive webs?

This article addresses the above questions by exploring the overlapping nature of Argentine immigrants' social networks with biomedical services, on the one hand, and with alternative healing providers, on the other (see Fig. 1). The current work builds on previous research on medical pluralism and the intersection of different sectors (i.e., self-care, the folk healing realm, biomedical services) in providing diverse health care options to those in need (see Kleinman 1980; Young 1978). The literature on health-seeking behavior was pioneering in understanding the power of networks in channeling health needs, as shown early by studies on lay consultation and the referral system (see Chrisman 1977; Freidson 1970; Young 1981). Access to resourceful networks of care is one of the main paths that lead to other health options, namely, visiting a doctor or a folk practitioner (Chrisman 1977; Kleinman 1980). As noted by Kleinman (1980: 51) the popular sector, in which social networks are inscribed, becomes the main point of intersection of other health domains.

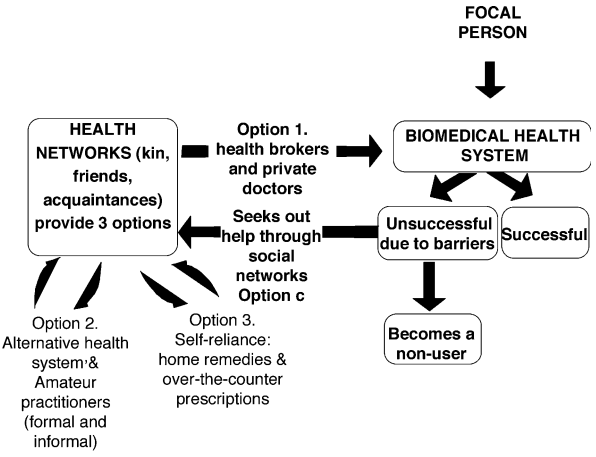

Fig. 1 Cultural model of immigrants' health-seeking behaviors. This model illustrates a conceptual framework based on the role of social networks in providing resources to Argentine immigrants, which allow them to access biomedical, alternative, and ethnomedical health systems

> The popular sector is the nexus of the boundaries between the different sectors, it contains the points of entrance into, exit from, and interaction between the different sectors. The popular sector interacts with each of the other sectors, whereas they frequently are isolated from each other. The customary view is that professionals organize health care for lay people. But typically lay people activate their health care by deciding when and whom to consult, whether or not to comply, when to switch between treatments alternatives, whether care is effective, and whether they are satisfied with its quality. In this sense, the popular sector functions as the chief source and most immediate determinant of care.

Community studies in anthropology early on examined the role of social networks in promoting social integration, social change, and mental health in urban milieus (see Garrison 1973; Lewis 1968). More recently, the literature on social capital has nurtured the theoretical body of research on social networks and social support by exploring the role of trust-based social relationships as main engines in the access to valuable resources. Although the fields of sociology and economy have been pioneers in developing theory and research on the notion of social capital, there has been increasing interest in this issue from anthropological perspectives (see Schneider 2006). In particular, the notion of social capital has been a contribution to our understanding of how social networks operate in situ, particularly by providing informal access to resources on the basis of trust and reciprocity (see Bourdieu 1985; Portes 1998). Ethnographic research, based on case studies, has explored the concept of social capital by studying the connections between individual and collective poverty, as well as the means through which informal webs and community organizations encourage the access to diverse social assets (see Flores and Rello 2003; Goetz 2003; Small 2004).

Still, there has been little application of social capital categories to ethnographic studies on health able to explain the processes through which provision and reception of valuable resources (from information to prescription drugs) take place between donors and recipients amid informal social liaisons. In addition, and despite the known importance of social networks in assisting with physical and emotional health needs, little is known about the overlapping nature of individuals' social webs over formal and informal systems, as in the case of "immigrants treating other immigrants" (see Messias and Hilfinger 2004). The importance of informal networks is even more conspicuous among immigrants in the United States, given the limitations that many encounter in accessing formal health services due to their undocumented status, limited English skills, and lack of health insurance, among other barriers (Freidenberg and Hammer 1998; Pitkin 2000). Furthermore, not all members of a web enjoy the same benefits in gaining access to the necessary resources (e.g., information about affordable practitioners, referrals to reliable doctors), as well as in developing informal relationships with those who can offer help.

This article particularly examines the role and importance of networks of care in providing Argentines with referrals and connections to health providers from different disciplines, many of whom share immigrants' informal webs. Building on

Kleinman's (1980) seminal work on the linkages among the three sectors of health (the professional, the folk, and the popular), this article describes the processes through which immigrants have access to providers belonging to different health domains. The notion of social capital is constrained to immigrants' access to resources on the basis of trust-based social relationships (see Bourdieu 1985). As examined in this article, immigrants' search for practitioners who "care" for them finds in their informal networks a main seeking and selection engine.

This study has granted visibility to Argentines in New York City (NYC), an understudied group that presents unique characteristics vis-à-vis other Latino populations including their widespread reliance on Western medicine, both in Argentina and in the United States. In addition, contrary to the stigma regarding mental health among other Latino groups, being *en terapia* (in psychological treatment) is a widespread feature among Argentines, particularly among those of middle-class origin, even if impoverished. This article discusses immigrants' access to diverse health providers ranging from health brokers (medical doctors belonging to immigrants' social webs) to psychologists and *urban shamans*—the latter representing a variety of folk healers who have become the quintessential counseling resource for women. The analysis of these healing options among Argentine immigrants will hopefully open new research avenues regarding the span of healing beliefs and practices among diverse Latino populations in the United States.

Argentines in the United States: Making a "Hidden" Minority Visible

For the past few decades, there has been a massive influx of Latino immigrants to NYC; they have become a main force in the ongoing transformation of the city's urban fabric. Nevertheless, little is known about many Latin American groups, which differ in terms of nationality, culture, race, and ethnicity among other characteristics, as well as regarding the distinctive ways through which they address their health issues via informal means (Alonso and Koreck 1989). Argentines are one of these groups, who, although members of the first Latino streams that came to America in the 1960s, have mostly remained an unstudied population in the United States.

Argentina, traditionally a nation of immigrants, at some points in its history received more visitors (mostly from Southern and Eastern Europe) in proportion to its native-born population than the United States (Plotkin 2001; Viladrich 2003). As a result, large groups of present-day Argentines are the children and grandchildren of European immigrants. Nevertheless, this trend began to be reversed in the late 1950s, when novel streams of Argentine migrants joined the first Latino American flows to the United States. These early waves largely recruited Argentine émigrés from the middle classes of European origin that soon entered the U.S. professional and academic fields. Boundless professional opportunities abroad and political persecution in Argentina made popular the image of middle-class political exiles who left their country in the 1970s and 1980s (Oteiza et al. 2000; Zuccotti 1987).

This picture, however, began to change in recent decades, partially as a result of Argentina's sociopolitical and economic crises, which have encouraged cyclical migratory exoduses of working-class and impoverished middle-class citizens. Nevertheless, most research on Argentine emigrants has been skewed toward portraying the successful "middle-class" individual who, sooner or later, will climb the status ladder. This picture was, until lately, a favorite staple in the academic literature as well as in the popular media (Baron et al. 1995; Boccanera 1999; Zuccotti 1987) and even in psychoanalytic writings (see Grinberg and Grinberg 1989). Although this literature has provided a unique contribution to our understanding of Argentines' migration patterns in the twentieth century, it has overrepresented the presence of the successful middle-class white fellow (Viladrich 2005b). Certainly, little is known about the paths of large numbers of Argentine immigrants who have steadily slipped down from the middle class, and who have become the most likely candidates to leave their country in recent decades (Viladrich 2007).

Although figures reporting the total number of Argentine immigrants in the United States are few in comparison with those on other Latino groups, estimates of the numbers of Argentines in irregular situations portray a much larger picture. According to the 2000 U.S. Census, 100,864 Argentines were living in the United States at that time, a figure that could increase to 400,000 when including estimates of undocumented immigrants (Rodríguez 2002). In NYC, the last U.S. Census counted 14,407 argentines, a number that rises to 22,116 residents when considering the metropolitan area (Wilman-Navarro and Davidziuk 2006). In addition, nonofficial figures assess the presence of 50,000 Argentines living in the metropolitan NYC area and almost 90,000 in Florida (Associated Press 2002; Wilman-Navarro and Davidziuk 2006).

Most Argentines in the United States have come from urban regions where access to advanced biomedicine has been accompanied by the popularity of Western psychotherapeutic treatments (Lloyd-Sherlock 2005). These features conspicuously distinguish Argentines from other Latino American groups, particularly those coming from rural milieus and who are less familiar with Western models of healing. Even though the recent privatization of health services in Argentina has excluded large portions of the population from affordable health services, universal access to health care has been the main model since the creation of the modern Argentine state by the turn of the twentieth century. As Finkler (2001) notes in the case of Mexico, biomedicine provides the mainstream delivery system in both the private and the public sector in Argentina, with a state-of-the-art technology that mirrors that developed in the United States and in Europe.

The Project

Data for this article were drawn from the first ethnographic study on Argentines living in NYC, which combined in-depth qualitative techniques with participant observation and field notes. The study received approval from the Columbia-Presbyterian Medical Center Institutional Review Board (CPMCIRB), which

aims to protect the integrity and identity of study participants. To that end, the project sought informed consent from study participants and guaranteed the confidentiality of the information provided by excluding all types of personal information (such as names or initials, Social Security numbers, phone numbers, and addresses) from all interviewing materials. Therefore, all names used in this article are fictitious.

Ethnographic mapping, launched during the first stage of the project, led to the identification of a variety of social venues and activities attracting Argentines in NYC, which contributed to disseminating the project among a variety of potential informants (Schatzman 1973).[1] More importantly, by examining Argentines' interactions in different social settings it was possible to explore how information on health issues circulates, what type of material assistance social networks provide, and who the donors and recipients of such assistance are. Finally, my status as an Argentine immigrant eased my entry into Argentine social fields (e.g., community gatherings, Argentine festivals and clubs), providing me with a first-hand impression of the subtle issues related to participants' interpersonal negotiations when addressing their everyday needs.

Unstructured (guided and informal) interviews were conducted with community leaders, members of Argentine gatherings, and immigrants participating in ethnic social fields. Some of the venues visited on a regular basis, and that are relevant to this analysis, were the enclave of "Little Argentina," in Queens, and the nomadic world of tango *milongas* (dancing halls). Semistructured interviews and life histories were drawn from a purposive sample (50 interviewees) of immigrants who lived and worked in the United States. Study participants were recruited via flyers handed out at social events as well as through referrals. Sample participants were chosen from a cohort of elderly immigrants, who arrived in NYC several decades ago, by the end of the 1950s and early 1960s, and from newcomers belonging to middle- and lower-income groups, who have mostly lived in the city for the past 10 years. Most sample participants had a primary or high school education, and only a few recent immigrants had a college degree from Argentina.

As the study was aimed at examining the health needs of those in vulnerable situations, the project design excluded from the sample Argentines belonging to "privileged" strata, a group represented by executives and professionals of corporations, visa-sponsored graduate students, and members of academic institutions. Systematic field notes were written throughout the research process, recording participant observation activities as well as informal conversations held with about 100 informants. Therefore, the findings reported here reflect immigrants' experiences being clients of diverse types of health practitioners, as well as my observations of the interactions that took place in diverse ethnic fields.

[1] The following maps were defined in this project: (a) the *geographic* map, which refers to the identification of Argentines in NYC, as well as their geographical enclaves; (b) the *institutional* map that is represented by ethnic organizations run by Argentine immigrants; and (c) the *social* map, which includes the main social activities (e.g., festivals, community gathering) involving the Argentine minority in NYC.

Health Brokers: Doctors Sharing Fields

As noted in the literature, cultural brokers have been paramount in performing as interpreters in their communities, as well as in serving as liaisons between formal organizations and informal webs, particularly regarding the treatment of mental health conditions among immigrants (see Kaufert and Koolage 1984; Kirmayer et al. 2003; Schwab et al. 1988; Weidman 1973). Among Latino populations, the importance of *los promotores de salud* (lay health advisors or bridge persons) has been critical in connecting vulnerable populations with available health services (see Wasserman et al. 2006). The notion of the health broker in this study builds on this body of research, while adding properties related to the overlapping characteristics of mainstream health services over immigrants' social webs.

In this article, health brokers are defined as first-generation immigrants who participate in Argentines' social webs, on the basis of sharing ethnic interests that go beyond the biomedical field. Doctors/brokers are mostly successful providers of Argentine and Latino origin, who have made a career via United States accreditation and practice, a fact that facilitates their untailored role as bridges between the biomedical field and immigrants' informal networks. Nevertheless, this model differs from community-health paradigms in the sense that clients benefit from services provided mostly in nonmedical settings, on the basis of sharing codes of reciprocity as members of the same lay-ethnic world. Therefore, the health broker model somehow refers to a parallel biomedical system that grants informal access to those who otherwise would encounter several barriers to get the help they need. Clinical practice is virtually removed from "clinical reality" (see Kleinman 1980) and becomes embedded in shared common interests involving medical practitioners and their patients. Medical doctors turn into health brokers by providing their acquaintances and friends with accessible, affordable, and even free health care, even if limited, usually by bypassing some of the cumbersome formal requirements of the health care delivery system in the United States. As their relationships are supported by extraclinical features, doctors and patients are drawn to health brokering transactions by somehow skipping the inequalities of the medical encounter (see Finkler 2001).

During the fieldwork, I had several opportunities to witness informal exchanges between immigrants and these doctors, which involved the provision of health resources in specific social milieus. The tango field was one of the venues where Argentines gathered with an international crowd of artists, professionals, and business people who got together to dance, eat, and mingle with others (Viladrich 2005a). For example, Carmin, a talented Argentine tango dancer, was close to Dr. Larry, a biomedical practitioner also from Argentina. Dr. Larry provided her with free prescription drugs in exchange for becoming her informal tango partner at the *milongas* (tango dancing halls). As somebody who intersected two worlds, Dr. Larry shared his patients' cultural allegiance while being, at the same time, a formal player in the biomedical American system. Therefore, he was in a unique position to perform as a link between the health care system and immigrants' informal social webs.

Another case is epitomized by Dr. Kant, another Argentine doctor, who, although he lived in Long Island, used to visit the well-known Argentine barbershop located in Queens where a myriad of Argentines, including the ethnographer, gathered on a regular basis. During these visits, Dr. Kant mingled with his Argentine compatriots to join heated discussions about Argentine soccer, national politics, and the latest gossip about Argentines in NYC. He also distributed samples of prescription drugs or prescribed them on demand. What made Dr. Larry and Dr. Kant unique was their shared networks of contacts and friends with whom they interacted as "one of them," while retaining their status as formal health practitioners.

By sharing social fields, such as tango dancing and soccer playing, doctors not only nurture their own informal social relationships, but also solidify their reputation as biomedical practitioners while increasing their opportunities for client recruitment and referrals. Most of all, immigrants and their doctors exchange "favor per favor" in a reciprocal bartering of services and symbolic goods. In the words of an informant "nothing comes without a price," as informal arrangements are not without (even symbolic) returns. Social relationships based on sharing job venues or community interests often turn out to be fertile grounds for a diverse array of goods to be exchanged between medical doctors and their informal clientele. Rather than mimicking the clinical encounter in which doctor-patient relationships unfold their own interpersonal drama (Finkler 2001), the health broker model somehow contests the expected doctor-patient roles of the medical office, and quite often not without costs. Indeed, as noted in Fig. 2, the health broker model also presents disadvantages based on the nature of its informal arrangements, such as lack of supervision and absence of contractual terms, superficial examinations of underlying health conditions, and uncertain follow-ups. In addition, the importance of

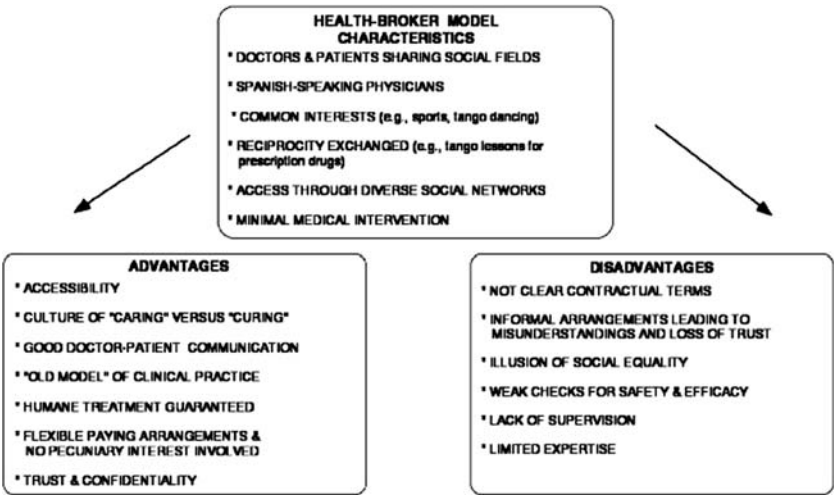

Fig. 2 Health broker model. This figure summarizes the main features characterizing the health broker model including its advantages and disadvantages

interpersonal relationships (e.g., good communication, equal treatment, and sharing of diverse interests) often supersedes immigrants' checks for accuracy and efficacy.

For most participants, finding health brokers was not an easy task, unless they counted on job-related connections or on diversified social networks where people with different skills, professions, and interests interacted on the basis of sharing common goals and activities, as in the case of the salsa and tango fields. Some immigrants became disenchanted with their health brokers' performance, based on their lack of consistency or dismissive behavior, and even stopped seeing them when they changed occupations or moved to other neighborhoods (see Viladrich 2003). In most cases, immigrants' reliance on health brokers presupposes considerable investments of time and social resources due to their informal agreements, which are often subjected to unexpected modifications. Among study participants, access to health brokers was also more plausible among long-term immigrants who had been embedded in steady relationships with Argentine or Latino practitioners with whom they shared ethnic interests, as in the case of senior residents congregating in the Argentine enclave in Queens. In addition, for most uninsured interviewees, including undocumented ones, health crises became the catalyst that activated their health-related networks. In most cases, participants did not visit their health brokers for screening tests and checkups, but did so in the event of emergencies, often due to their inability to perform their everyday tasks.

Health brokers also become health consultants by providing second opinions on medical procedures prescribed by other colleagues. Hortensia (a 39-year-old woman) had medical insurance that she paid out-of-pocket, although she had experienced many hurdles in trying to obtain the health care she needed. During our interviews, she often mentioned experiences with American doctors whom she characterized as impersonal and uncaring with their patients. On one occasion, she was talking about a serious back problem that had incapacitated her for a while, and upon my insistence to learn more details, she suddenly began mentioning Latino doctors who had helped her "off the books." Once I began to probe these practitioners' realm, an array of resources emerged in Hortensia's narrative. She had met Latino doctors in the salsa dancing arena in NYC, one of whom had become her physician-friend and had taught her how to "trick" the system in order to get the services she, and some of her friends, needed. On one occasion, she was terrified upon receiving a diagnosis of cancer from her HMO primary doctor, which turned out to be a *falsa alarma* (false alarm). Right after receiving this diagnosis, she went to her doctor-friend to seek a second opinion:

> You see, this doctor [her health broker] prescribes me things without seeing me *de onda* [spontaneously, as a good gesture]. He calls the drugstore when I need an anti-inflammatory drug or something else, and has done that also for my friends. This guy has been very good to me and to my friends whom he did not even know. When this doctor [the American doctor] told me I could have cancer, my friend told me: *"Chica, que tu no tienes nada; hierba mala nunca muere"* ["Girl, you don't have anything; bad herb never dies"].

In almost all participants' narratives, the idealized figure of the doctor-broker was opposed to either the image of the HMO doctor-employee or the private

doctor motivated by pecuniary interests. According to these representations, typical HMO practitioners treat patients as part of their job, while trying to save time, effort, and care as much as possible. Doctors considered to be "friendly brokers," on the other hand, genuinely look after their patients' health and spend the necessary resources (including time) to treat them. Even among interviewees who generally disliked the idea of visiting doctors' offices (as in Hortensia's case, above), practitioners seen as friends were a guarantee of being *en buenas manos* (in good hands).

Participants' quest for *caring* practitioners often led them to rely on their webs of acquaintances and friends to look for Latino and Argentine doctors, whom they often identified as belonging to the "old model" of medical practice, in which physicians are assumed to spend quality time with their patients while encouraging them to ask questions and talk about their health problems and concerns. These findings reveal a dual relationship between Argentine immigrants and U.S. health services in general: on the one hand, study participants believed in the efficacy of Western medicine as well as in the excellence of its technology, while on the other, many doubted the quality of U.S. service delivery. Therefore, finding doctors they could trust, typically through their informal webs, became a guarantee of being in "good hands." Indirectly, participants alluded to the pervasive aspects of a globalized culture of medicine, which most perceived as distant from the patient-centered paradigm (DelVecchio Good and Good 2000; Good and DelVecchio Good 1993). This concurs with ongoing changes in medical practice that value clinical performance over human interaction and doctors' verbal skills (Ong et al. 1995).[2]

Counting on lay or amateur practitioners became the next best thing for many study participants, particularly when health brokers were unavailable. As noted in the literature, self-diagnosis and self-treatment are two of the most relevant nonbiomedical options worldwide, which are typically performed with the advice of relatives and acquaintances (Finkler 2001; Kleinman et al. 1978). As pointed out by Young (1981), self-treatment combines the use of a diverse variety of remedies, from herbs to legal drugs, usually prescribed by diverse lay providers. In addition, health brokers and lay practitioners represent the epitome of the health-related capital, as they are known and shared by word-of-mouth within ethnic social networks on the basis of trust and reciprocal liaisons. Nevertheless, these practitioners are not an enduring substitute for formal biomedical services. As noted by Kleinman (1980), and illustrated in Fig. 1, people often return to their social networks to evaluate the results, to explore possible next steps, and even to get referrals for new providers when their health problems continue (see also Finkler 2001; Young 1978).

[2] Care and cure reflect two aspects of patients' needs. While "cure" systems measure instrumental (task-focused) behaviors, "care" systems refer to affective (socioemotional) behaviors (DelVeccio Good and Good 2000). Good and DelVeccio Good (1993) observe that caring and competence (cure) become a dual message addressed to medical students in the United States.

Looking for a Good Shrink

When it comes to dealing with mental health issues, psychiatrists are the least preferred among immigrants, mostly due to stigma (Chadda et al. 2001; Chen et al. 2005; Thiel de Bocanegra 2006). Nevertheless, this is not the case among most Argentines, for whom acknowledging mental health problems, and looking for professional help, reveals a shared explanatory model that mostly encompasses nonsomatic ailments. Indeed, contrary to the stigma of mental health practices among other immigrants groups, including Latinos (see, e.g., Jenkins 1988; Yeung and Chang 2000), being *en terapia* (in therapy) constitutes an accepted indicator of self-awareness among many Argentines.[3] The literature has emphasized the uniqueness of the Argentine case when it comes to the widespread acceptance of a psychotherapeutic culture both at home and abroad (see Plotkin 2001; Vezzetti 1996). As Plotkin (2001) observes, a psychoanalytic lingo pervades most Argentines' everyday life, which has also influenced the lexicon of other therapies including New Age practices.

Nevertheless, the popularity of psychoanalysis in Argentina has not prevented the domestic market from being saturated by an increasing number of young professionals looking for jobs in both mainstream and alternative mental health domains. As a result, NYC has become an attractive destination for Argentine psychologists who travel there looking for jobs, while also running away from rampant unemployment and an increasingly impoverished clientele. Certainly, the growing presence of young and middle-aged Argentine therapists in NYC correlates with the fact that Argentina presents the highest density of psychologists per capita (La Nación 2002). In Buenos Aires, Argentina's capital, there are 500 registered psychologists for every 100,000 people (Alonso 2001; Shapira 2002). Psychologists' strenuous living and working conditions, which have been prominently featured in the media, have encouraged their migration abroad.

Some of my respondents had received in the past, and were still receiving at the time of the interview, counseling support from Argentine and other Latino psychologists in NYC. In most cases, they were recent immigrants who had been influenced by Buenos Aires' psychotherapeutic culture. During the fieldwork, I met at least ten Argentine psychotherapists who not only shared with me some of their informal networks, but also attended with me seminars and events organized by Argentine associations, including the Argentine Consulate in NYC. As with their search for health brokers, immigrants try to find trustful psychotherapists via their social webs. In turn, these therapists recruit potential clients through the acquaintances and friends they meet at social outings and ethnic events. The following notes, based on my visit to one of the tango *milongas*, describe this trend.

> Everybody seems to be related to everybody else, they are like a network of people and needs, where everyone has something to offer and take in return. Carmin (a female tango dancer) was telling me yesterday about her complex relationship with this psychologist friend, who at the same time "treats"

[3] For example, Jenkins (1988) observed that Mexican-American families tend to counteract the stigma associated with a mental illness by reinforcing the strength of solidarity and family bonds.

> (psychologically speaking) all her friends and I could not stop thinking… *'Only among Argentines!'* Not only does this seem to be cool, but it also appears to be part of a mélange in which professionals and amateurs overlap spaces of privacy, professionalism, and real life. How much do they know about each other? How much do they share while relying on this psychologist as their channel/catalyst? It may not matter at all: he is there to be responsive, at least in theory, to their psychological problems. But he is also doing much more than that…. He has become a sort of needed figure that provides un *espacio de contención* [a supportive space] to a group of immigrant women in need of advice and care….

As stated in my field notes above, *ir a terapia* (going to therapy) was a practice that many of my informants not only acknowledged publicly but also shared with others. Given the fact that standard mental treatments in the United States are expensive, most Argentines turn to their informal networks to find suitable professionals who are well trained, culturally grounded, trustworthy, and affordable. To a certain extent, talking about one's issues in psychoanalytical lingo reveals the authority to diagnose both oneself and others, while keeping up the standards of the "*habitus*" that reveals a symbolic membership to an intellectual social group (Bourdieu 1984). Although among my respondents not all therapists were found through the grapevine, Argentine venues (store fronts and community media, including radio shows and magazines) were a good starting point for those looking for professionals of various sorts. Cristal, a 30-year-old undocumented tango practitioner, describes how she found her current psychologist:

> I found this guy in this magazine [an Argentine publication], and I called him up to ask where I could get a cheap consultation because I couldn't pay, and the guy did not let me go…. He kept me talking and talking, and he saw me for free. You see NYC is a city where you feel alone…. Okay, the city welcomes you but you are still alone. I had friends at that time who were telling me that I should see somebody who could help me, so I saw this guy. Then I went back to Argentina [for a while] and I quit. But some months ago I got very depressed and I started again with the same guy…. Everything got together: being illegal, not doing what I wanted, and on top my partner was also depressed, so he could not help me either….

Interestingly, Cristal's discovery of this therapist became a health resource that she shared with her tango friends and acquaintances, for whom the provider arranged lower fees. For many Argentines, finding a "good" Argentine or Latino psychologist had many advantages including counting on somebody who spoke the same language and shared the same slang and cultural codes; conveying their concerns to a practitioner who had probably experienced similar migratory experiences and would understand them better; and, finally, being able to negotiate lower fees and flexible schedules. As noted earlier, within ethnic social networks, the information circulating among immigrants is an important vehicle for professional reputation, since providers' prestige is based on clients' opinions and satisfaction. Among study participants, person-to-person referrals of medical

providers and therapists were a common, well-known, and acceptable marketing strategy, which became even more evident when trying to find and choose mental health providers. If trust is the currency for interpersonal exchanges, this becomes more conspicuous when seeking psychotherapists able to treat uninsured patients (if not undocumented), who often resist being labeled with culturally bound categories (for a critique see Guarnaccia and Rogler 1999) and therefore bring their own explanatory models of symptoms and etiology (see Kleinman et al. 1978).

Urban Shamans and the Gendered Construction of Hope

As noted by Wallis (1999), shamanism, as a term constructed in the West, has become one of the most used and abused notions in anthropology, as it has been applied to heterogeneous faiths and religious practices among which lack of consensus exists regarding its origins as well as its common properties (Price-Williams and Hughes 1994). Literature on shamanism has evolved from the study of ecstatic experiences (Harwood 1970) to New Age forms of spiritual renaissance in contemporary societies (see Fraherty 1992; Halifax 1982; Harner 1980). The term *urban shaman* has been used by a variety of practitioners and genres, from those who describe avant-garde females with supernatural powers in fictional writing (Murphy 2005) to those who examine the changing contexts in which traditional folk healing practices are influenced by urbanization, migration, family changes, and disruption (Dobkin De Rios 1992). The term urban shaman has also been exchanged with the notion of *neoshamans* or New Age shamanism, to refer to the work of spiritual and holistic healers who rely on nontraditional forms of meditation, spiritual cleansing, and self-search for knowledge and harmony with the self and others (see Jakobsen 1999; King 1990; Roth and Loudon 1989).

In this study, the choice of the term urban shaman is aimed at acknowledging the cosmopolitan mélange of traditional healing practices with newer spiritual traditions taking place in the NYC's globalized milieu. Cosmopolitan cities in the United States offer a panoply of services in storefronts that advertise psyches and clairvoyants, as well as in botánicas' consultation rooms (Viladrich 2005c). In this article urban shamans are mostly represented by multidisciplinary practitioners, primarily of Latino origin, who combine features of *neoshamanism* described above, with religious-healing practices rooted in folk-belief systems from the Americas (mostly Santeria and Spiritism) as well as with other psychic disciplines. Spiritism and Santeria in urban centers, although related to different bodies of knowledge, have remained as polyfunctional faiths, an issue noted by Harwood (1977a, b). As reported by Garrison (1977), Koss-Chioino (1992), and Singer and Garcia (1995), Spiritism and Santeria have an enormous potential for change and adaptability, which have been characterized more recently by their importance as commoditized products (see Romberg 2003). In fact, these faiths have become ubiquitous in cosmopolitan centers, representing the quintessential combination of the old and the

new (see Singer and Borrero 1984; Singer and Garcia 1995; Singer and Baer 1995; Viladrich 2006).[4]

Kleinman (1980:34) observed that although folk healers are "the most popular subject for cross-cultural research," studies have failed to report patients' motivations for consulting with them. To account for this omission, this article examines the perceptions of Argentine immigrants regarding urban shamans' roles in providing hope in their lives as well as in triggering their emotional support networks. Almost all study participants who acknowledged having relied on urban shamans' services were women, who had done so at different times during their migratory experiences. As in the case of Finkler's (2001) study, women more than men expressed conflicting situations that evolved into anger, anguish, and depression. They were also more prone to acknowledge the difficult issues related to the immigrant experience, which forced them to juggle different roles both within their communities and in the outside world.[5] No matter how much they seemed to endorse biomedical practices or how psychologically savvy they appeared to be, their adherence to self-analytical trends would not stop them from consulting urban shamans, both at home and abroad. This phenomenon is partially related to the commercialization of the occult, which is not unique to Argentina, and has its continuity in the rising tourism worldwide.

Defying misfortune, women in this study had experienced unseen challenges in their paths to the American dream. As in Finkler's (1994) study on Mexican women's subjective experiences of pain and disease, many Argentine women seemed to be prey to the ongoing burden of their uncertain migratory journeys amid the emotional affliction that uncovered their everyday stressors. Participants usually sought urban shamans' services to satisfy a specific emotional or health need, including to get a loved one to come back, to neutralize bad energies from coworkers, or to foresee the future regarding jobs and family. They referred to their practitioners as being "multivaried" in the sense of being able to deal with different therapeutic domains: mental stress, marital problems, stomachache, and different forms of anxiety, karma, or misfortune. As is the case with users of cult practices such as Spiritism (see Koss 1987, 1980), women's consultations were aimed at immediately solving their emotional and psychological problems by complementing or replacing formal mental health services.[6]

By relying on explanatory models that count on supernatural forces, ranging from spirit possession to spells cast by a witch on an envious relative's behalf,

[4] As reported by Singer and Garcia (1995: 159): From the black spiritual churches of the American South (Baer 1984) to Candomble, Batuque, Umbanda, and Macumba of Brazil (Leacock and Leacock 1975) and from Mexican Spiritualismo (Finkler 1985; Kearney 1978) to Vodun in Haiti (Metraux 1959) and Santeria in Cuba (Sandoval 1979), the circum-Caribbean region supports a rich diversity of spiritist cults. These religio-therapeutic movements, primarily and traditionally centered among dominated populations, urban and rural poor, and the descendants of slaves, share a common belief in communication with and possession by an array of incorporeal spirits.

[5] The fact that the ethnographer was a woman could also have been at stake here, an issue discussed in other writings (Viladrich 2005b).

[6] Kleinman (1980) also notes that fortune-telling and other clairvoyant practices provide similar ends as do psychotherapy and supportive care, as they contribute to diminishing anxiety by providing advice and practical solutions.

participants reported a variety of conditions that had a common denominator in works attributed to *envidia* (envy), *venganza* (vengeance), and *karma* (old lingering souls from previous lives). As Finkler (2001) notes in her study in Mexico, people tend to find in witchcraft the source of their problems when other treatments have failed to release either physical or emotional pain. In a study of 50 clients at a Spiritist Center, Singer and Garcia (1995) found that half of the clients feared that sorcery or witchcraft was the source of their problems. Nevertheless, and contrary to schools of thought in which clients become enrolled in faith-belief schools upon consultation (see Garrison 1977), participants in this study did not adopt their practitioners' faith or practice. In most cases, their return to the consultation was triggered by critical circumstances, particularly when conventional resources seemed not to work. Indeed, most participants' requests responded to what has been called the "first level of spirit intervention" (see Garrison 1977), in which diagnoses are quite often attributed to *brujería* (witchcraft).

According to study participants, the typical encounter between *urban shamans* and their clients followed a routine, which started with the appraisal of their main problems (normally assessed through divination), accompanied by an explanation of the source (e.g., self-inflicted damage or damage caused by someone else), followed by a healing plan that usually consisted of several steps. Serena, a psychologist who worked at a mental health center, had become a habitué of one of these healers. Afflicted by several stress-related issues, which ranged from overweight and loneliness to physical extenuation, she and some of her coworkers spent Saturday afternoons waiting at a *curandera*'s office (literally meaning "woman who heals"), whose appointments were typically delayed. Before and after each encounter, she would sit with others to discuss "*los aciertos de la bruja*" ("the witch's correct assessments") and the potential effect that an upcoming session would have on her prognosis. For a period of months, the healer had channeled Serena into a routine of practices aimed at cleaning both her *aura* (the electromagnetic field surrounding one's body) and her physical environment through a combination of incenses, *agua florida* (flowered water), and candles. Although Serena was seeing an Argentine psychologist in NYC at the time (who did not have a U.S. license and therefore charged her a very moderate amount), she justified her visits to *la bruja* (the witch) by her need for additional help to cope with her everyday stressors.

Curiously, although some study participants doubted the veracity of their urban shamans' therapies, this did not stop them from either continuing to seek their services or searching for new practitioners in the field. As noted by Kleinman (1980), even in cases where bad news is delivered, clients are usually advised on how to change their fate by following the healer's prescribed rituals. Kleinman and Sung (1979) also argue that failure among traditional healers is not an option, as they must heal either the physical or the spiritual realm. And indeed, although participants in this study did not necessarily assess the efficacy of urban shamans' diagnoses and treatments, they did not question their overall ability to deal with untamed metaphysical powers that exceed the mind-body Cartesian distinction, typical of Western therapies. The underlying assumption is that urban shamans were able to tap into areas where others would fail. Therefore, reliance on their services was not supported by an ideological adherence to a specific body of knowledge, but

to the treatment process that would endorse practitioners' uncanny abilities. As Romberg (2003) notes in the case of practitioners of Spiritism in Puerto Rico, the idea that "I don't believe in witches, but they exist" suggests a critical oxymoron repeated by more than one informant in this study, thus emphasizing the notion that reliance on less conventional (and nonscientific) practices can lead to very satisfying outcomes.

Furthermore, unlike traditional verbal therapies in which subjects typically are confronted with self-exploration, urban shamans tend to place the origin and responsibility of people's suffering in external causes epitomized by either magical or social agents (see Wedel 2004). Surely, urban shamans' practices contribute to immigrants' construction of hope by usually anticipating a future that is better than the present, while reassuring their clients' personal projection onto upcoming life paths, particularly among those experiencing important life transitions (see Viladrich 2003, 2006). Although in some cases it was clear that participants were more interested in having a *trabajo* done or overcome (e.g., to get a loved one back or to stop envy by friends or relatives), the routine practice of urban shamans' visits contributed to calming the anxiety stirred up by their everyday tribulations.

Many valued having a place where somebody would listen to their personal worries and uncertainties, despite the urban shamans' imprecise, and often inaccurate, predictions. For example, one informant would compare predictions from different practitioners both in Argentina and in the United States, in order to reach a consensual agreement on issues that would validate her options via self-verification (see Lillqvist and Lindeman 1998). In addition, not only were urban shamans recommended by word of mouth, but also they often belonged to immigrants' social webs, and in some cases they did not charge for the consultation. For example, Lean (a 40-year-old woman), who was having marital problems at the time, visited different tarot readers recommended by friends *para que le tiraran las cartas* (to read the Tarot).

> They were right in all occasions. You see, they charged me once, but I did not pay the following ones as they did it as a sign of good faith, favor by favor, knowing that I was not a case to make money from. I always went there through people who referred me. They saw everything I was going through, the fights and pain [with her former husband]. It was a relief for me because I was in the middle of my divorce and needed some help to deal with it.

In summary, for Lean, Serena, and others, urban shamans' sessions provided a channel for the activation of their networks of care, where talking about personal worries would continue even after the consultation was over. Attending a shaman's session was part of a socialization process in which the supernatural was involved in the ordinary uncertainties of life. As in the case of Serena, other female psychologists I met during the fieldwork also acknowledged having consulted with *brujas* (witches), fortunetellers, and clairvoyants for the same reasons that many of their clients would: to search for solutions to problems that failed to be solved by more conventional therapies. When visiting a diviner, women had the opportunity to share love stories, as well as marital and job problems, with individuals who would be willing to listen to them. The formality of a supernatural consultation was

transformed into an outing that bonded friends in a common healing adventure. The therapeutic process, which included the healer, the client, and her significant others, formed a social triad of meaning that exceeded any individual intervention. Urban shamans' verdicts were often discussed, shared, and even contested by other friends and healers, with whom immigrants had developed relations of friendship and comradeship. In sum, consultations with these practitioners seemed to be a trigger for the activation of women's emotional support networks, since respondents almost always attended these services accompanied by friends and relatives.

Beyond Biomedicine: Immigrants' Therapeutic Eclecticism

This essay has brought Argentine immigrants' stories alive by illustrating the creative ways in which study participants obtained the health resources they needed by relying on their networks of care. As shown by the pioneering research of medical anthropologists (Kleinman 1978; Kleinman et al. 1978; Young 1981), biomedical practice in most societies, rather than being exclusive, is combined with other treatment alternatives. Argentines offer a unique case of medical pluralism, as they not only subscribe to a wide range of healing disciplines, from psychoanalysis to tarot, but also engage in diverse informal social webs in order to reach healers from different realms. Belonging to similar social niches, such as tango dancing or soccer playing, provides a gateway to informal networks in which both practitioners and patients benefit from each other's company.

This article, based on Kleinman's (1980) model of the interrelation of different health sectors, has drawn innovative data to understand the overlapping effect of immigrants' social webs over diverse healing domains. Argentines acknowledge health brokers as providers-friends who spontaneously switch from the clinical codes of "doing medicine" into the terrain of informal social networks in which explanatory models of illness are basically shared. And by participating in common social fields, health brokers move from the clinical realm of ritualized hierarchy to one that equalizes social differences. The meaning of trust, which is the basis of social capital exchanges, achieves here dual connotations. Although it refers to having confidence on the accuracy and efficacy of biomedical science and technology, it does not imply reliance on medical practitioners per se. And it is precisely because of their sharing of informal networks of care that participants felt able to find accountable practitioners, both within and outside the biomedical profession. In addition, the notion of trust is twofold, as it refers to the fact that people develop reliable relationships with those who refer them to diverse health practitioners, as well as with the providers themselves.

Argentines' *therapeutic eclecticism*, characterized by their utilization of whatever seems to work best, also becomes the tip of the iceberg of immigrants' unmet needs and not a rationale to replace affordable health services. While mental health providers become a health resource shared by immigrants' social networks, urban shamans constitute a trigger for the activation of women's emotional support webs. Reliance on both groups of practitioners discloses immigrants' active attempts to deal with their everyday stressors. In fact, the successful stories reported

in this article should not lead us to conclude that any of these providers are an effective long-term substitute for comprehensive medical care, as immigrants combine them while searching for the most effective (and often fastest and cheapest) resolution to their ailments. Certainly, health brokers are not necessarily the best professionals for immigrants' specific health conditions, nor do they provide the best advice in all circumstances. To a certain extent, counting exclusively on a health broker becomes a symptom of immigrants' *hidden* demand for health care, particularly among the undocumented and the uninsured, who have very few alternatives to choose from. Future research could test the existence of the health broker model among other immigrant populations, including assessing providers' similarities and differences. If, as this study suggests, health brokers are playing the role of informal primary care practitioners, efforts should be made to support their role in promoting preventive practices among disadvantaged populations.

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