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9

PENTECOSTAL HEALING: A FACET OF THE PERSONALISTIC HEALTH SYSTEM IN PAKAL-NA, A VILLAGE IN SOUTHERN MEXICO

A Dissertation

Presented for the

Doctor of Philosophy

Degree

The University of Tennessee, Knoxville

Murl Owen Dirksen

March 1984

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ABSTRACT

This research investigates the degree to which Pentecostals in Pakal-Na, Chiapas, Mexico, employ personalistic rather than naturalistic disease theory (Foster, 1976) in selecting curing methods, and it compares Pentecostal and non-Pentecostal employment of health resources. In naturalistic disease theory, illness results from impersonal, natural forces (i.e., cold, heat, wind and dampness) which cause an imbalance in natural body states. In personalistic disease theory, illness is caused by supernatural forces. Because of differences in believed sources of illness, these two theories of disease predispose individuals to select different therapies and curers.

For this study, personalistic/naturalistic categories were viewed as a continuum, and Pentecostal and non-Pentecostal curing practices were examined in terms of naturalistic and/or personalistic elements involved in each. Pakal-Na residents have access to three major healing resources: folk-traditional (including sorcerers, spiritists, herbalists, and herbs); modern-western (including medical professionals, pharamaceutical drugs, hospital, and clinic); and religious (including prayer, Bible, church, priests, evangelical pastors). The religious orientation is viewed as most personalistic; modern-western as most naturalistic; and folk-traditional as being at a midpoint on the continuum.

Four methods were used to collect data on healing methodology in Pakal-Na. Participant observation consisted of daily visits to local Pentecostal churches, attendance at a Pentecostal convention, and trips

with pastors while they prayed for the sick. The second method was a structured interview with 47 Pentecostals, covering motives for joining the movement and healing experiences. Through interviews, participants shared 123 healing narratives. Interviews were analyzed using Opler's thematic approach (1945) assuming that themes appearing frequently are significant in the culture. The third method was a semantic differential questionnaire distributed to 70 villagers. The questionnaire sampled attitudinal and behavioral involvement with healing elements from each of the three orientations. Responses to questionnaire items were cross-classified with Pentecostal and non-Pentecostal identification to determine the presence of differences between them. Cramer's V was used to measure the strength of difference. Key informants, including local health professionals, were interviewed to clarify other information.

The findings show that Pentecostals employ a more personalistic approach than non-Pentecostals. However, both groups showed little involvement with traditional curers, and both showed high confidence in religious elements including church, prayer, and Bible. Uniquely Pentecostal healing elements included a dedicated life style, visions, Holy Spirit possession, and sanctified oil. Non-Pentecostals had a more positive attitude toward modern medicine, but Pentecostals appear to be integrating modern medical techniques into their personalistic framework. The social aspects of Pentecostal healing appear important to villagers, and healing was cited as the reason for movement membership by 80% of the adherents interviewed. Pentecostals demonstrated

marked uniformity in responses, indicating an ideological framework underlying healing choices. The co-opting of certain folk-traditional health practices by socioreligious movements deserves further investigation, as do the functions and dysfunctions of these movements in the transition toward modern medicine. Pentecostalism has growth potential in Pakal-Na because it is a rapidly modernizing village in which Pentecostals provide personalistic healing through quasi-family relations and church/community integration. Pentecostalism offers a transition between traditional and modern medicine, but ambiguity in healing theology and stringent life-style commitments prevent complete acceptance of this religious ideology.

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CHAPTER I

INTRODUCTION

I. PENTECOSTALISM

The Pentecostal movement is an international association of Christian fundamentalists united by the belief that the Holy Spirit enters committed believers and endows them with power for healing, prophesying, preaching, gaining material wealth, and enduring crisis situations (Hollenweger, 1972). Spirit possession is initially evidenced by the phenomenon of glossolalia known to Pentecostals as "speaking in tongues." Conway (1980) and Glazier (1980) found that faith healing is an essential component of the Pentecostal message and a primary attraction for movement membership. Like other Pentecostals, those living in the mestizo village of Pakal-Na, Chiapas, Mexico, believe that Holy Spirit possession provides individuals with the ability to heal; and an estimated 80% of all Pentecostal villagers have joined the movement because of its healing emphasis. Pakal-Na villagers are in the process of incorporating this alternative into their health-care methodology. Margolies (1980) suggests that just as Catholics invoke the saints in conjunction with orthodox medical practices, Pentecostals use faith healing as a "back-up mechanism."

Disease etiology, curing methods, and curers of the Pentecostals' health orientation represent what Foster (1976) has termed the "personalistic" health model. To the Pentecostals, the Holy Spirit is a conduit through which God's healing power flows, and each individual

has potential for possession by the Holy Spirit. Furthermore, the church is a "caring" organization that provides support to members during critical periods of illness; and members are responsible for each other's health because sickness is a sign of weakness or sin in the corporate body. The purpose of this research is to describe and to analyze Pentecostal healing in Pakal-Na and to contrast Pentecostalism with other approaches to healing.

Pentecostal healing is inseparable from the wider context of the movement's ideology. When people join the movement for the purpose of solving a personal health problem, they are, immediately upon conversion, introduced to a rigid doctrine that attempts to reshape their personal values and beliefs. Therefore, a concomitant to the healing ritual is a strong commitment to a new religious ideology. To Pentecostals the strength of an individual's faith in God determines whether or not the person is cured, and failure to be healed indicates lack of spiritual commitment. Therefore, Pentecostalism addresses health problems and provides a belief framework to redirect one's life.

Although North American in origin, the Pentecostal movement has been particularly successful in areas affected by rapid modernization. In Brazil, for example, there are an estimated 3,000,000 Pentecostals; and Hoffnagel (1980) explains:

> The phenomenal growth of Pentecostalism has taken place during a period marked by increased pace of industrialization, a rationalization of export agriculture and a demographic shift from rural to urban areas (111).

It appears that Pentecostalism helps counteract the strain of industrialization; and many researchers view the movement as an indigenous

response to modernization (Birdwell-Pheasant, 1980; Conway, 1980; Flora, 1980; Glazier, 1980; Hoffnagel, 1980; Wedenoja, 1980).

Because the Pentecostal movement has only recently received the attention of social scientists, data on movement membership are sparse and often inaccurate. Many persons attend denominational and independent chapels but never join because membership requirements are rigid. Thus, official membership statistics may represent less than half the persons affiliated with Pentecostalism. Operation World (1980), an interdenominational missionary publication, estimates the size of the movement in Central and South America to be over 6,000,000. In the Caribbean, Trinidad has 200,000 Pentecostals (Glazier,1980), and Jamaica has over a quarter of a million (Wedenoja,1980). One-tenth of the Quiche Indians of the central Guatemalan highlands are movement participants, with one denomination claiming over 300 chapels in the western third of the country (McClain, 1983). Pentecostals can be found in simple societies such as the Otomi of Mexico (McGavran, 1963), the Toba Indians in Argentina (Miller, 1967), and the Mosquito Indians in the refugee camps in Honduras. Congregations are also common among the lower classes in Colombia (Flora, 1976) and Guatemala City (Roberts, 1968). Tribal, peasant, and urban societies all appear to possess conditions favorable to the beliefs and rituals of this unconventional religious movement.

In Mexico, Protestant Pentecostals are strongest in the northern states and the southern region of Tabasco, Chiapas, Veracruz, Quintana Roo, and Yucatan (McClain, 1983). The urbanized areas of central

Mexico are the territory of Catholic Pentecostals where Chordas (1980) found that 10,000 Catholics in the area around Mexico City had joined the Charismatic Renewal Movement between 1971 and 1975. It is particularly difficult to estimate the strength of the movement in southern Mexico because adherents may be either Protestant or Catholic and are found in various sized independent and denominational groups with missions, chapels and churches. One of the larger Protestant Pentecostal denominations in Mexico estimates its membership at 25,000 including over 13,000 in the southern region (McClain, 1983). Mexican Pentecostal leaders suggest a maximum estimate of 500,000 adherents (Castelo, 1983).

The present study was conducted in the village of Pakal-Na, located in the municipality of Palenque in the northern tip of the state of Chiapas. With 4,000 residents, Pakal-Na has only two religious groups, Catholic and Pentecostal. Two Pentecostal churches and one Catholic church are located in the community. Although some religious preference is reported by almost all villagers, regular religious involvement is minimal. Pentecostal attendance indicates about 200 devout adherents, and Sunday morning mass attendance ranges from 50 to 80 persons. In Pakal-Na, all Pentecostals are Protestants although most of them come from Catholic backgrounds.

Despite the fact that participation accounts for a small percentage of the village population, Pentecostalism in Pakal-Na has shown consistent growth over the past decade, and the community exhibits the elements of change, instability and modernization which appear to

promote Pentecostalism. Geographically, Pakal-Na is situated in a region that is experiencing rapid economic growth. On the edge of a jungle on the Usumacinta River, the village provides needed services for those involved in the exploration and extraction of natural resources from Mexico's last frontier, and dozens of families have moved into the area seeking employment. Politically, the village is not an independent community but a colony of Santo Domingo de Palenque, the municipal center. Pakal-Na has only one elected official and maintains a tenuous political identity. The village's massive in-migration, unclear political status, expanding job market, and location in a relatively resource rich area have made Pakal-Na an area of pronounced transition typical of those settings in which Pentecostalism has been most successful.

II. THEORETICAL FRAMEWORK

The principal objective of this research is to examine the relationship between medical systems and religion. Where and how does Pentecostalism fit into health-related culture? In a cross-cultural comparison of nonwestern medicine, Foster (1976) defines two main disease etiology systems: personalistic and naturalistic. The believed source of illness strongly influences the selection of curer, mode of diagnosis, and curing form. "While the terms refer specifically to causality concepts, I believe that they can be conveniently used to speak of entire systems" (Foster, 1976:775).

> A personalistic medical system is one in which disease is explained as due to the <u>active, purposeful intervention</u> of an

> agent, who can be human (a witch or sorcerer), non-human (a ghost, an ancestor, or evil spirit), or supernatural (a deity or other very powerful being) (1976:775, emphasis in the original).

In the naturalistic system, illness is explained by impersonal, natural forces:

> Disease is thought to stem, not from the machinations of an angry being, but rather from such natural forces or conditions as cold, heat, winds, dampness and above all, by an upset in the balance of the basic body elements (Foster, 1976:775).

Illness in the personalistic system is due to active agents; while in the naturalistic, it is due to a loss of equilibrium.

In personalistic health systems, illness is only one of life's misfortunes (see Table 1). The same active agents may also cause financial, marital, and interpersonal problems. In naturalistic systems, illness is largely unrelated to other personal problems. In personalistic systems, medicine, religion and magic are interrelated, while in naturalistic medical systems, religious rituals are not typically associated with curing. In personalistic systems there are several levels of meaning with interest in the who and why of disease etiology. Naturalistic etiology tries to answer the question how. According to Foster, prevention in the personalistic system is based on maintaining social networks; and naturalistic systems emphasize avoiding all natural elements that are known to cause illness. Because personalistic systems are complex, the responsibility of the individual is unclear. In contrast, specific avoidance rules in naturalistic systems require high individual responsibility (1976:781).

Table 1: Characteristics of Personalistic and Naturalistic Disease Etiology.

	Personalistic	Naturalistic
Causation:	Active agent	Equilibrium loss
Illness:	Special case of misfortune	Unrelated to other misfortunes
Religion, Magic:	Intimately tied to illness	Largely unrelated to illness
Causality:	Multiple levels	Single level
Prevention:	Positive action	Avoidance
Responsibility:	(At times) beyond patient control	Resides with patient

Source: George M. Foster, (1976), Disease Etiologies in Non-Western Medical Systems. American Anthropologist 78:781.

Foster's theoretical model is particularly useful in the investigation of Pentecostal healing in Mexico because it allows for the interrelationship of religion and medicine within a sociocultural context. Fitting the naturalistic/personalistic model into the modernization context of developing communities like Pakal-Na, one might consider Foster's two categories as opposite ends of a continuum and place the villagers' medical systems on a continuum from naturalistic to personalistic.

III. PERSONALIZED PENTECOSTAL HEALING

The folk-traditional medical orientation of Mesoamerica has both personalistic (sorcerers, divination, spiritualism) and naturalistic elements (herbs, hot-cold body states); thus, it could be placed in the mid range of the continuum. Modern western-medicine is the most

naturalistic of the three approaches. Pentecostals are oriented toward a personalistic approach because they believe:

1. Illness is the result of the maliciousness of Satan or the punishment of God.

2. Illness can be solved by the same methods (prayer, fasting, spirit baptism, faith) that are used to solve other life problems.

3. Illness is directly related to the spiritual state of the individual.

4. Illness diagnosis must first find the sin that is causing the symptoms to appear.

5. Public ritual (laying on of hands, testimony of healing, healing services) is important for curing and prevention of illness.

6. Illness prevention is best pursued through living a "sanctified, holy life."

7. Only God really knows why individuals get sick and die.

It is clear that Pentecostal healing emphasizes personalized disease theory to a greater extent than the folk-traditional or modern-western health approaches found in Pakal-Na.

Pentecostalism typically involves community responsibility for health restoration, a divine being who directly intervenes in an individual's state of health, and religious rituals. God must be petitioned for healing, and all community members are responsible to pray for the sick. When individuals are ill, they are prayed for by family and by Pentecostal neighbors. If they are unable to attend church services, the pastor and other healing specialists visit their

homes for special prayer. Church members assume responsibility for transporting the infirm to healing services when possible, and fellow believers may assume some of the patient's responsibilities until health is restored. All healing rituals are performed within the context of a supportive church community.

Many Pentecostals maintain the concept of an interacting, caring God who desires only good for believers. Personal commitment to God is directly correlated to healing blessings from him. Nevertheless, occasionally one must endure pain in order to recognize and appreciate a state of health or to demonstrate one's faith. Illness may be the direct result of evil spirits, for example the Devil, or it may be allowed by God as a test of one's commitment. While God is a personalized being who can be petitioned through prayer, he also responds directly to the health needs of believers by giving healing power through the Holy Spirit. Pentecostals believe that the power of the spirit possesses the individual and displaces any evil responsible for sickness.

IV. RESEARCH DESIGN

Data for this project were collected during three months of residence in the village of Pakal-Na. Pentecostal healing practices were observed by attending nightly worship services, by accompanying a Pentecostal pastor on his daily healing visits, and by participating in a regional Pentecostal convention which attracted over 5000 participants. In addition to participant observation; structured interviews

were conducted with 60 individuals in 47 Pentecostal households. These interviews were used to collect life-history material on healing experiences. In addition, open-ended interviews were conducted with local Pentecostal leaders, modern medical professionals, and the village political leader. Finally, a modified semantic differential instrument was given to 28 Pentecostal and 42 non-Pentecostal villagers. They were asked to evaluate 12 distinct health resources by giving the degree of their behavioral (use and correctness) and attitudinal (strength and confidence) commitment to each resource. These health resources represented traditional-folk, modern-western, and religious health orientation.

One hundred twenty-three case histories were collected during interviews in the 47 Pentecostal households. A thematic analysis was made of all life-history material focusing specifically on the patient, cause of ailment, type and number of healers consulted, healing resources employed, location of healing, and life changes which resulted from healing. A simple frequency distribution was made for each thematic category.

For the analysis of the responses to the semantic differential test, frequency distributions were constructed and percentages calculated. The semantic descriptors (strength, use, confidence, correctness) were evaluated, individually and collectively, by chi-square to determine whether the evaluative data on health-care resources were drawn from two distinct populations. Cramer's V was used to measure the strength of these differences.

V. GENERAL FINDINGS

Pentecostals employ a more personalistic healing approach than non-Pentecostals. However, both groups relate religion and curing in some ways. Both de-emphasize the importance of traditional folk practitioners such as the brujo, but members in each still recognize traditional illness categories such as the evil eye (mal de ojo) and spells as possible causes of sickness.

Non-Pentecostals

Pakal-Na villagers not affiliated with the Pentecostal movement tend to be more private and to place greater emphasis on naturalistic disease causation, such as environmental conditions and hot-cold body imbalance. Although they use modern therapy, including pharmaceutical drugs and doctors, more often than any other alternatives investigated in this study, they retain some personalistic orientation and are not generally opposed to being prayed for by Pentecostal family members or friends. Although they do not indicate strong involvement with traditional folk practitioners, non-Pentecostal villagers maintain relatively positive attitudes toward traditional religious healing elements such as the Bible, prayer, and church and make moderate use of herbal remedies.

Pentecostals

The healing orientation of Pentecostals contains strong public and religious components. The intensity with which Pentecostals emphasize and involve themselves in prayer for healing clearly illustrates their

personal approach to illness. They believe that God has the ability to expel all evil, including illness, and that power to cure can come through possession by the Holy Spirit. Although healing power can be acquired in private communion, public rituals involving family, neighborhood, and church prayer groups are considered to be most effective for curing. Although Pentecostals apparently do not make significant use of traditional healers such as the brujo, other traditional resources and modern medicine are used by Pentecostals if they can convince other believers that such methods have been approved by God. One's spiritual dedication and involvement in the Pentecostal movement usually provide the needed proof.

Pentecostal healing has found a receptive constituency in Pakal-Na due, in part, to the village's rapid social and economic change. Confidence in and use of folk healers and magical curing methods have deteriorated, and traditional Catholic healing methods such as prayer by the priest or the petitioning of saints have become secondary to western medicine and its practitioners. The attraction of Pentecostal healing is that it provides an important alternative, one which combines elements from the folk-traditional, religious, and modern healing approaches in a church/community system.

VI. IMPORTANCE OF THE STUDY

Despite advances in "Pentecostal studies," much is still to be learned about the dynamics and structure of the Pentecostal movement. The present study makes several specific contributions to on-going

research on Pentecostalism. First, the study extends anthropological research to Pentecostalism in southern Mexico by describing briefly some of the social functions Pentecostalism serves for uprooted traditional peoples in a village experiencing rapid modernization. Second, while most studies of Pentecostalism focus on the rapidly changing sociocultural contexts in which the movement is found or upon the psychological needs of people involved in intense emotional worship, this investigation focuses on healing, the reason most often cited by converts for joining a Pentecostal church. Third, this report investigates the relationship between the Pentecostal health approach and other medical orientations in Mesoamerica. The project explores whether Pentecostal healing is a permanent alternative to other healing forms or a passing form of collective behavior. Fourth, this research helps validate the theory that health approaches in Mesoamerica are flexible and adaptable.

CHAPTER II

THE SETTING

I. INTRODUCTION

Research Site

Pakal-Na, named for an ancient Maya ruler reportedly buried in the Temple of the Inscriptions at the nearby archaeological site of Palenque, is a satellite community just north of the tourist town of Santo Domingo de Palenque, six kilometers distant. Although the latter is familiar to international visitors for its Mayan ruins, the almost equal-sized village of Pakal-Na is known only for its train station and small airstrip. This village is the center of a strong Pentecostal healing movement.

Geographical location. Pakal-Na is a mestizo community of 4000 located on a hilly plain that rises toward the Sierras de Chiapas to the south. Figure 1 indicates the location of Pakal-Na within the state of Chiapas. The average temperature is 79°F, and the altitude of the surrounding area is 600 meters (1800 feet). The hydrographic system of the municipality includes numerous rivers: Chamak, Chacamax, Chancala and Chocolja, all draining into the Usumacinta or Grijalva systems. Precipitation ranges from 188 to 310 centimeters (74 to 122 inches) annually, giving the area a pronounced tropical climate. Pakal-Na possesses fertile soil and plentiful vegetation (Ruz, n.d.).

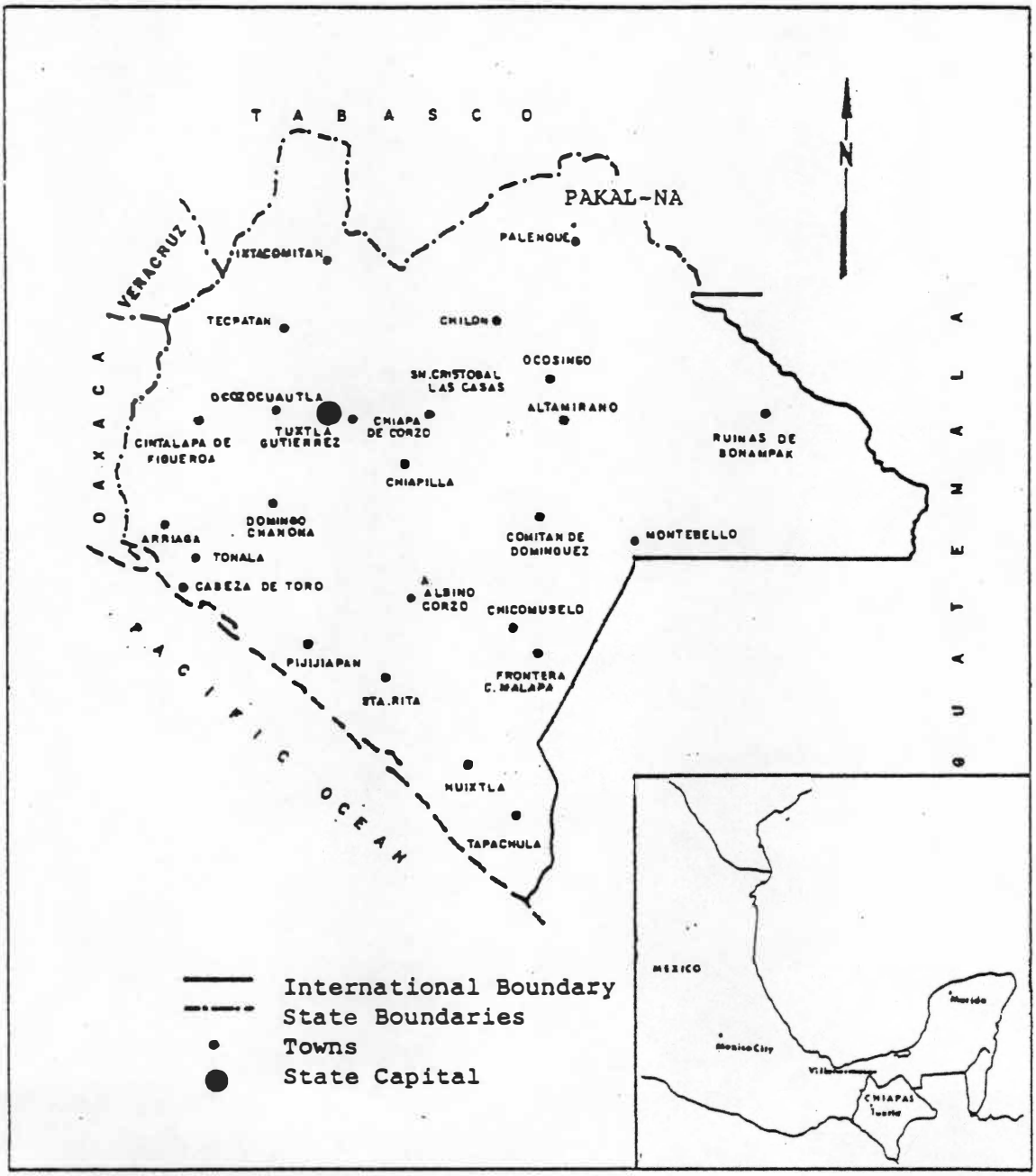


Figure 1. State of Chiapas

Source: Miguel De La Madrid, (1982), Chiapas--De La Madrid: Comitan y Palengue. Mexico, D.F.: Centro de Estudio Politicos Economicos y Sociales.

While ample rainfall and fertile soil contribute to the area's relative prosperity, they also favor a variety of tropical diseases and other health problems.

Pakal-Na's proximity to the archaeological site at Palenque insures easy accessibility. The village can be reached by car on a paved road from Villahermosa (146 kilometers). On the edge of the community is a small airport for chartered flights, military planes and a daily commercial flight from Tuxtla Gutierrez, the state capital. Commercial buses also make regular stops in Pakal-Na. The railroad station in the center of Pakal-Na is a daily stop for two passenger trains running between Villahermosa and Merida.

Brief history of the community. Pakal-Na, like many other villages along the line between Villahermosa and Merida, originated as a railroad community when the government constructed houses for rail workers and ticketing agents. Pakal-Na residents refer to their community as Estación, suggesting the importance of the railroad to the village. In the 1960s the station and railroad houses comprised essentially the entire village with a few paths leading to nearby ranchos and homes of recently arrived mestizos. Figure 2 illustrates the layout of Pakal-Na in relation to the railroad demonstrating recent growth away from the earlier pattern. The early 1970s brought major changes to Pakal-Na's mother community of Santo Domingo de Palenque. The Mexican government, having decided to restore several archaeological sites as a means of attracting international tourism,

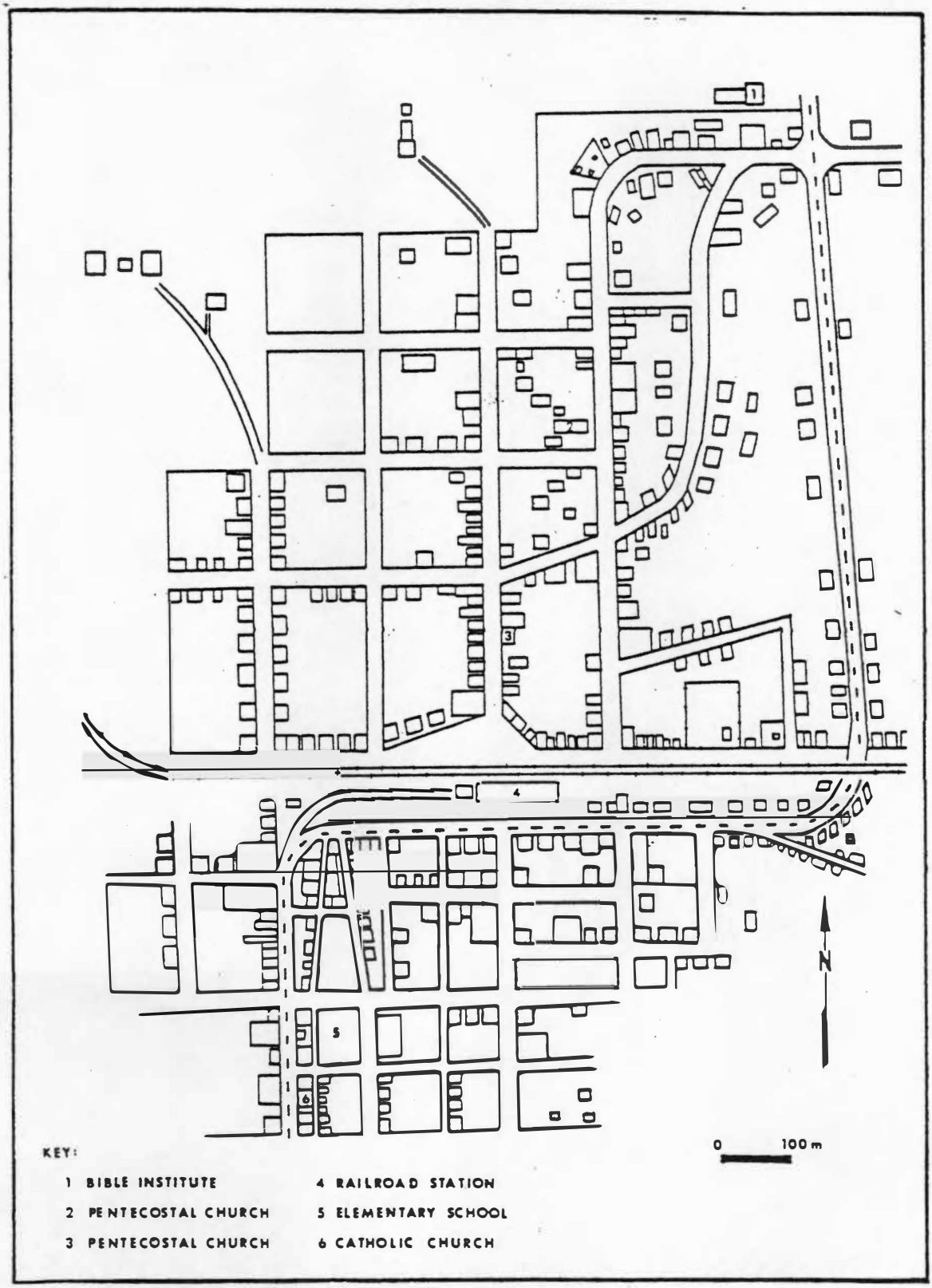


Figure 2. Village of Pakal-Na

selected the ruins at Palenque because of extensive reconstruction done between 1949 and 1958 by Alberto Ruz. Within the past 10 years, the Mexican government has provided Santo Domingo de Palenque with funds for street improvements, water, sewage, and electricity; and the small village of a decade ago is now a bustling tourist center with nine hotels and twice as many restaurants. These influences have also encouraged growth in Pakal-Na, most of whose residents have moved there within the past 20 years. Pakal-Na profits from development in Santo Domingo de Palenque because such economic expansion provides employment for many Pakal-Na residents. In 1960 the community had only 605 residents, but by 1980 it had grown to 3840, only slightly smaller than the municipal center with 4019 residents as indicated in Table 2. However, there are major differences between the colony of Pakal-Na and the town of Santo Domingo de Palenque: Pakal-Na has no indigenous Indian population, no tourist shops, only one hotel and two

Table 2. Population Growth from 1960-1980 for the Municipality of Palenque, Santo Domingo de Palenque, and Pakal-Na.

	1960	1970	%INC.	1980	%INC.
Municipality of Palenque	12,416	23,205	87%	35,689	187%
Santo Domingo De Palenque	1,611	2,595	61%	4,019	150%
Colony of Pakal-Na	605	1,364	126%	3,840	635%

Source: Censo General De Poblacion: 1960, 1970, 1980, Estados Unidos de Mexico, Secretaria de Industria y Comercio, Mexico D.F.

restaurants, and no paved streets, sewer system or water works. Some Pakal-Na residents have electric pumps which provide them with inside water. Other mestizo communities and traditional Chol speaking villages dot the area. However, none has experienced significant growth, while Pakal-Na has grown more rapidly than either the municipality as a whole or the commercial center of Palenque.

Importance of the municipality to the region. In addition to its importance as a tourist center, Santo Domingo de Palenque is also the center of the most successful cattle-producing municipality in the state, as well as the gateway to the lumber-rich forests. The future importance of the municipality rests in its rich oil and natural gas deposits and its promise as a site for hydroelectric development. Because of its present significance and promise for future development, the Mexican government has begun a concerted effort to modernize municipality communities.

Importance of the Community to the Research Problem

Several conditions in Pakal-Na make it an ideal research site for the observation of Pentecostal and non-Pentecostal healing systems. Most important, the village has a significant population of Pentecostals with the only two types of churches being Catholic and Pentecostal. Furthermore, the two Pentecostal churches in the village are affiliated with the largest international Pentecostal denominations: the Iglesia de Dios, Evangelio Completo, Church of God (Cleveland, Tennessee), and Asamblea de Dios, Assembly of God (Springfield, Missouri) (Hollenweger,

1972). An additional important consideration is the community-wide focus on Pentecostal healing. Each year a Pentecostal convention attended by 5000 people is held on the outskirts of the village. Lasting four days, the meeting draws participants from Chiapas, Veracruz, Tabasco, Quintana Roo, and Campeche. One service daily is devoted to healing, and several hundred people are prayed for during the convention. This meeting attracts devout believers, marginal members, and spectators, and involves the whole village with local residents setting up temporary restaurants, renting rooms, and selling a variety of goods to convention participants. Additional emphasis on Pentecostalism in the village comes from Instituto Lemuel, a Bible training school with 30 students sponsored by the Iglesia de Dios, Evangelio Completo.

II. VILLAGE OF PAKAL-NA

Home Construction

Residential construction reflects the rapidly expanding population of Pakal-Na and is a reliable indicator of affluence. It is relevant to the present study since an examination of home construction materials can help clarify the relative economic position of Pentecostals as community members (see Table 3). While generally, sectarian members are less affluent than their mainstream neighbors, a sampling of home construction materials in Pakal-Na indicates that Pentecostals are not over-represented among either the affluent or the indigent although they appear slightly more prosperous than the general population of

their community. (See Appendix A for an explanation of the collection of home construction materials.)

Concrete is the most expensive and modern roofing material for village homes, and only 7% of the overall population possess this luxury. However, the percentage of Pentecostals with cement roofs is almost twice the average at 13%. Corrugated metal is the next most desirable material, and 58% of Pakal-Na residents have roofs of this type. Felt paper, the least durable and cheapest material, is found on 31% of Pakal-Na homes with a slightly lower percentage among

Table 3. Comparison of Home Construction Materials for Sampling of Pentecostal and Non-Pentecostal Residents.

	Pentecostals		Non-Pentecostals		Combined	
	%	No.	%	No.	%	No.
Roof						
Concrete	13	(6)	6	(9)	7	(15)
Asbestos	7	(3)	4	(6)	4	(9)
Corrugated metal	59	(27)	58	(94)	58	(121)
Felt paper	22	(10)	33	(54)	31	(64)
Total	101	(46)	101	(163)	100	(209)*
Walls						
Block	30	(14)	34	(57)	33	(71)
Wood	59	(27)	35	(58)	40	(85)
Plywood	11	(5)	32	(53)	27	(58)
Total	100	(46)	101	(168)	100	(214)
Floor						
Ceramic tile	9	(4)	4	(6)	5	(10)
Concrete	80	(37)	82	(137)	81	(174)
Wood	0	(0)	2	(3)	1	(3)
Earthen	11	(5)	13	(22)	13	(27)
Total	100	(46)	101	(168)	100	(214)

* Homes with two or more roofing materials were deleted from category.

Pentecostals. No homes use the traditional thatch except on verandas. Walls are made of cement block, heavy wood or scrap plywood from the local lumber mill. Block is the preferred material used by 33%, and many residents are replacing wooden walls with concrete blocks made in the village. While 40% use heavy wood, 27% use scrap plywood. Again, Pentecostals appear slightly more affluent, using thin plywood scraps less frequently than the overall population.

Construction modernization has occurred most in the flooring. According to the 1970 census, 66% of the homes in Pakal-Na had dirt floors. Nevertheless, homes with cement floors were more common in Pakal-Na than elsewhere in the municipality. At present only 13% still have dirt floors. Affluent Pakal-Na residents place ceramic tile over cement flooring, but most villagers (81%) have only cement. This is the most popular flooring because of heat and humidity. Pentecostals do not differ from other residents in type of flooring.

Economic Activities

Living in a relatively new village, residents of Pakal-Na are more involved in industrial work and commercial services than the general population of southern Mexico. However, the percentage of villagers involved in income-producing activities is approximately the same as for the general population of the municipality. Pakal-Na employment is, nevertheless, unusual because certain types of occupations are more common here than in the surrounding area. Table 4 summarizes the types of work performed by Pakal-Na residents and compares them with work done by residents of the municipality of Palenque. The 1970 census

Table 4. Economic Activities of Municipality of Palenque and Colony of Pakal-Na in 1970.

	Municipality*	Pakal-Na
Economically active	23.9%	22.1%
Primary agriculture	81.4%	48.0%
Industry	6.0%	21.5%
Commercial services	8.8%	24.2%
Other	3.8%	6.3%

*Municipality figures include figures for Pakal-Na.
Source: Censo General De Poblacion, 1970, Resumen General, Mexico D.F.

distinguishes three categories of economic activities: agricultural work, industrial employment, and commercial services. In 1970, 48% of Pakal-Na's employed fell into the first category, working as campesinos, ganaderos, or vaqueros, while the municipality as a whole averaged approximately 80%. Some villagers find temporary work on ranches herding cattle, clearing brush, or mending fences. There is little cash cropping although fruit trees are being introduced.

Modernization of work in Pakal-Na is exemplified by the number of residents in industrial occupations. In 1970, 21% of Pakal-Na residents had industrial employment compared to 6% for the municipality. Five kilometers from the village is a lumber mill which offers good wages and steady work. The railroad also employs a number of men, and grocery and general merchandising chains hire Pakal-Na residents to work in warehouses. The most significant occupational difference is

the percentage of people involved in commerce. In 1970, 24.2% of the villagers were involved in selling goods and/or services, significantly higher than for the municipality as a whole with 8.8%. A variety of commercial activities is represented in the village including household enterprises such as leather working, tailoring, carpentry, hammock-making, and shopkeeping. Of the approximately 600 households, about every fifth house uses its front section for selling fruits, vegetables, medicines, and other items. Also classified as commercial are transportation services such as chauffeuring and taxi and truck driving which provide a major source of income in Pakal-Na, as do related activities such as the selling and maintenance of vehicles.

Another focus of commercial activity is the buying and selling of cattle, cattle transportation, and the arrangement of cattle investments. An additional important profession in the commmunity is construction work such as masonry. Most commercial occupations in Pakal-Na are blue-collar jobs which do not require special training. Therefore, one individual may work at a number of different jobs at the same time. However, some Pakal-Na residents commute to Palenque for more professional white-collar work as hotel administrators, government employees, or secretaries. Pakal-Na occupations are more typical of an urban than a rural society. Industry and commerce have expanded significantly in the past decade, and families move to Pakal-Na to find employment outside traditional agricultural work.

Standard of Living

Several occupations in Pakal-Na require a higher level of education than basic agricultural jobs and provide a higher standard of living. Pakal-Na has a preschool and elementary school going to sixth grade. Those continuing their education attend secondary school, levels seven through nine, in Palenque. After the ninth grade, Pakal-Na young people may go either to Tuxtla Gutierrez or Villahermosa to complete tenth through twelfth grades and university studies. There is also an agricultural/technical school between Pakal-Na and Palenque, and the Pentecostals have a Bible institute, as noted earlier. Table 5 compares the literacy rate and educational levels of Pakal-Na residents with residents of the municipality of Palenque. The 1970 census indicated that 77% of Pakal-Na residents were literate. Pakal-Na residents rank higher both in number of years of school completed and literacy than other municipality residents.

Table 5. Comparison of Educational Characteristics of Municipality of Palenque and Colony of Pakal-Na in 1970.

	Municipality*	Pakal-Na
Literate	50.1%	77.1%
Some elementary school	35.6%	58.9%
Some secondary school	7.9%	15.6%

*Municipality figures include figures for Pakal-Na.
Source: Censo General De Poblacion, 1970, Resumen General, Mexico D.F.

Occupation, education, and personal conveniences are highly correlated. Table 6 compares household conveniences of Pakal-Na homes to homes in the municipality in general. Electricity was installed in Pakal-Na 10 years ago, and all homes except those of the adjoining ejido have access to it. With electricity have come refrigerators, fans, blenders, televisions, radios, and stereos as indicated in Table 6. In areas such as education, home building materials, and appliances, where villagers have control, Pakal-Na villagers show a higher standard of living than other residents of the municipality. However, in areas such as public utilities, which depend upon governmental assistance, the village is not as well developed as other communities in the region. Although Pakal-Na has no public water works, 9.3% of the villagers have their own electric pumps providing inside water as indicated in Table 6. With more employment and higher incomes, people are able to maintain a higher standard of living and are now acting collectively to acquire clean public water and to improve sanitation through a community sewage disposal system. Occupation, education, and standard of living are relevant concerns to a study of Pentecostalism because rapid social development predisposes individuals to movement membership.

Family Structure and Womens' Roles

Family organization in Pakal-Na is relevant to the present study since the variety of forms rivaling the traditional extended family indicates rapid social change and a significant level of social instability. The same social forces which bring about new family

Table 6. Comparison of General Characteristics of Households in Municipality of Palenque and Colony of Pakal-Na in 1970.

	Municipality*	Pakal-Na
No. of total households	4,085	226
In percentage		
Self owned	82.6	74.3
Inside water	18.3	9.3
Outside water	1.2	4.0
Sewer	14.5	13.7
Floor other than dirt	20.1	44.2
Electricity	16.6	16.4
With radios	62.0	79.6
With televisions	8.2	.4

*Municipality figures include figures for Pakal-Na.
Source: Censo General De Poblacion, 1970, Resumen General, Mexico D.F.

structures may also result in changes in traditional religious beliefs and healing practices. The church itself may become a surrogate family for individuals uprooted from traditional extended-kin groups. Therefore, an examination of social change in the family has implications for the degree of change in other areas of the community's value structure.

A community less than 30 years old, Pakal-Na has social structures unlike those found in more traditional, stable communities because it possesses a larger than average number of families experiencing the strain of rapid culture change. The oldest families in the community are most likely to have the traditional extended form. One of Pakal-Na's original Pentecostal households is an extended family whose modest ranch was one of the first residences in the community. The

rancher, age 64, lives in a small rectangular dwelling to which rooms have been added for his daughter's family of seven. A second family structure in Pakal-Na is the modified extended family; i.e., nuclear families residing in individual dwellings as near to the parents' home as availability of land allows. For example, a 33-year-old married Pentecostal male lives with his brother and family in a cement block home adjacent to their parents' house. The independent nuclear family is also common, particularly among young married couples and recently arrived families. One example of an independent Pentecostal family is a young married couple with no children. The husband sells groceries and owns a restaurant. In their early twenties, they have a modern cement block home with contemporary furnishings and plan to have only two children because of the expense of raising a family.

Other deviations from traditional family forms arise from unusual life situations. One of the most luxurious homes in the community is owned by a female who has established a matrifocal family. A recent Pentecostal convert, she cannot become a church member because she has three children by a wealthy older man who has seven wives and families. Among the village Pentecostals one also finds a number of single women whose husbands have left them. This situation is exemplified by a middle-aged Pentecostal female living with her two daughters and a grandson in a sparsely furnished two-room apartment. Her husband beat her, and when he left her, she moved from their rancho to Pakal-Na and rented a room.

Although Pentecostal families represent most of the organizational variations present in Pakal-Na, the more traditional forms are found more frequently among families who have resided there for 30 years or more. Recent arrivals and younger members establish families more characteristic of the simple nuclear unit that is mobile and adaptable to a rapidly changing environment. Many young couples apparently compensate for the lack of extended kin through relationships formed in the church.

Like changes in family structure, sex role variation reveals information about social change. Sex segregation in Pakal-Na's mestizo society is readily apparent. Women's work is different from men's work; there are women's groups and men's groups; some areas are designated for men and others for women. The front of the home, for example, is reserved for men if they are present. If one wishes to communicate with someone's wife, the nature of the communication must first be explained to her husband. In local churches, men sit on the left and women on the right. This segregation is also observed at the altar during prayer times.

In matters of courtship the "double standard" is a well established tradition in the colony. Members of the community consider it their responsibility to see that "nice" girls remain nice. Dating is closely supervised and practiced only if marriage is being considered. A pastor in the village refused to marry one of his female members because she had been seen holding hands with her fiance..

Despite their segregated status and restricted treatment, women play an important economic role in the family as well as in the church. Meat from animals kept in the yard is important to the family diet. Women are responsible for chickens, ducks, turkeys and pigs, animals which most Pakal-Na families own. If a surplus exists, extras are sold to add cash to the household budget. A cleaned chicken brings 120 pesos ($2.50), and ducks bring about twice that amount. In addition to their poultry income, most village mothers make money selling foods prepared in their homes. Producing items such as pork rinds and rice cakes, they send younger children door-to-door selling foods. Through these home enterprises, Pentecostal Pakal-Na women supplement family income and earn money for church offerings.

In spite of conventional views about women, Pentecostal churches allow them a wide role in the community. Women have long been accepted as ministers and evangelists, and the Pentecostal movement was introduced into Mexico by a woman, Maria Atkinson, who began dozens of churches in Sonora (C. Dirksen, 1980). With a belief in the equality of all believers, Pentecostals have afforded women roles of unprecedented leadership. (For a similar process among Catholics, see Warren 1978.) In Pakal-Na the only female-controlled community organizations are Pentecostal women's groups offering members a variety of activities. Every Wednesday night is the culto de damas, and several times a week women meet in the morning for prayer. Periodically, women are responsible for a week of services. Such activities give women

leadership roles and help integrate them into a traditionally male-dominated community.

The importance of women in Pentecostalism is relevant to this study because affiliation with a Pentecostal church brings women into the community in ways not experienced before. They are freer in their interaction in the community and freer in their quest for healing. Because they move more openly about the community, Pentecostal women are at liberty to consult a wider range of possible healers and are freer to become healers themselves. In fact, Pentecostal women have healing groups that go from home to home praying for the sick. Because a large proportion of Pentecostals are women, their social roles are crucial to an understanding of healing within the Pentecostal movement.

III. THE PENTECOSTALS

General Characteristics of Pentecostal Congregations

Demographic characteristics. In Santo Domingo de Palenque, the Catholic church is still the largest congregation, but two Pentecostal churches are next in membership (see Appendix B). Of the Pentecostal churches, the Iglesia de Dios has the larger congregations in both town and colony. Attendance at the main Sunday night service exceeds 200 persons for the Palenque church, and over 100 individuals attend the Pakal-Na church each Sunday evening. The Asamblea congregations total close to 150 attenders in Palenque and about 40 in Pakal-Na. In addition to these two main Pentecostal groups, there is a moderate-sized independent Pentecostal church in Palenque.

In outlying communities Pentecostal denominations have either missions or small churches with local men as pastors. A mission usually consists of two to four families who meet in a member's home several times a week. Mission services are conducted by a male family head or a visiting member from an established church.

In the Pentecostal churches observed for this study, the preponderance of the congregation was comprised of children and teenagers. In some services, up to 50% of those attending were under 12; and up to 80% were under 20. Females of all ages outnumbered their male counterparts two to one. According to the pastors, men find it difficult to attend the nightly services and abide by all the church's life-style regulations, particularly in the areas of total alcohol abstinence and marital fidelity. Nevertheless, men almost equal women in number of believers; and they frequently utilize the church's services for healing. The typical situation is the adherence of the total household, with the father/husband either a member or strong believer. Women whose husbands are not members are continually instructed by their pastors that the "salvation" of their family members is their primary responsibility. Movement growth occurs by proselytizing relatives, working first with those in one's own household.

Ritual order of the church service. Pentecostal churches in Pakal-Na hold regularly scheduled services every night of the week. Services are planned by various groups within the congregation who are then responsible for congregational worship. Sunday night is an evangelistic service intended to win new converts. On Monday the

pastor teaches doctrine, and on Tuesday the men organize the service. Wednesday is the women's night, and a healing and prayer service is conducted each Thursday. Friday the youth lead in worship, and Saturday is children's night. Each service is referred to by the group's name, for example, culto de damas (women's service) or culto de jovenes (youth service). The pastor delivers a message each night, but the group in charge carries out the elements of the ritual order.

The Pakal-Na Pentecostals schedule their services for 7:00 pm and normally continue until 9:00 pm. At about 6:30 pm, members begin arriving to set the building in order. They sweep and pick up. Some conversation occurs; but, as the official time for the beginning of the service approaches, people begin to move to the altar to pray. All participants are expected to pray upon entering the tabernacle, but prayer time varies according to the individual. Some members spend several minutes, then return to their benches to sit solemnly and read their Bibles. Others spend up to half an hour in prayer and only return to their seats when the music begins, designating the opening of the congregational portion of the service. The formal part of the worship usually begins half an hour after the scheduled starting time. Late arrivals may either pray at the altar or kneel by their benches and pray privately. The preservice altar praying is verbal; and by the time the service is to begin, a large crowd has gathered, and the noise from their prayer is clearly recognizable from outside the church.

The first hour of worship alternates between singing and prayer. The repertoire of songs is small because some of the church members are

illiterate. The initial songs are simple choruses known by all participants and sung repeatedly while everyone claps to the strong beat emphasized by the guitar player. A single chorus may be sung for as long as 10 minutes. The longer the song is sung, the more involved the congregation becomes; and when a particular emotional level is detected by the lay leader, he either enters spontaneously into verbal prayer or directs the congregation to pray with him. When response to his direction seems to be decreasing, he initiates another activity. The lay leader may call upon one of his group to come to the small table in front of the stage to give a testimony and lead in singing. The testimony almost always refers to a recent healing.

After this sequence of singing, praying, and special testimony and songs, the group in charge is instructed to stand before the congregation. Group members sing a series of songs and recite scripture. At this point, the attendance statistics are recorded. First, the names of the members of the group responsible for that specific service are called out. They respond and present their nightly offering. While the group remains in front of the pulpit, the statistics of their weekly activities are collected. The leader asks the group how many chapters in the Bible each person has read, how many days each has fasted, how many home visits each has made, and how many religious brochures each has passed out. After this information has been recorded, the leader appoints someone to count those in attendance and asks all those with Bibles to hold them up so they can be counted. This ritual of data gathering is a regular part of each service.

It is at this point in the service that the pastor enters the pulpit, either to present a sermon or to introduce a special speaker. The message is presented with emotion and authority and usually contains numerous points on living a respectable and holy life. Throughout the sermon congregational members shout various phrases of approval, and if the speaker begins to arouse members of his audience emotionally, they will proceed to the front of the church to pray. The pastor then terminates the message and asks the remaining worshipers to join those already at the front or to pray at their benches. The next few minutes are occupied with loud emotional praying and wailing, with the pastor moving about the stage praying and viewing the scene. He might be asked to pray for a sick child or adult, laying his hands on the pained part of the body. When the intense emotional praying has subsided, the people return to their seats, and leadership in the service is passed from the pastor to the lay leader. He then asks the leader of the following night's service to come to the front and read the names of those who have been appointed to participate. After these announcements, there is another prayer, and the service is formally ended. The members then move about the church shaking hands and saying, "Dios le bendiga" (God bless you).

Movement Leadership

In any institutional arrangement the personality types that occupy positions of authority are significant in shaping organizational structure and atmosphere. The various leadership approaches in the movement are illustrated by contrasting leadership styles of

Pentecostal pastors in Santo Domingo de Palenque and Pakal-Na. The Palenque pastor believes that his destiny is to be a Pentecostal minister. Any other occupation he might wish to pursue will result in harm to himself or his family. He receives his daily direction from God through the Holy Spirit and spends days alone fasting and praying for the growth of his church. Not only does he feel that fasting is necessary for himself, but also for devout members. Visions are sought, and dreams may have spiritual significance. He believes the church will grow if members prove their devotion by rejecting things of the world. His leadership is based upon development of the mystical features of Pentecostalism.

In the colony of Pakal-Na, the pastor is a graduate of the local Bible institute and instructs part-time at the same institution. He is oriented toward education and spends a great deal of time studying books he has recently purchased. He believes that doctrinal instruction is important for a sound church and that the church that establishes an educated core of members will grow naturally. He is concerned, however, about the attrition of the youth from his church and visits the homes of members and nonmembers daily. He is very much aware of the behavior of his members and preaches constantly on the virtues of a Christian life.

The Palenque Pentecostal church reflects the orientation of its leader. The services are organized to move those in attendance to a highly expressive emotional level. Within 30 minutes, the audience is involved in fervent worship. Children go unattended and generally roam

about the church while parents engage in ecstatic prayer. The noise of the busy street is not disruptive because of the intense concentration of the worshipers.

A contrasting situation is found in the Pakal-Na church. The minister demands order, and from his position on stage, he scans the audience. When disruptive behavior is observed, he moves to the microphone and demands conformity. On one occasion a mother was standing holding her two-year-old child during the song service. The singing had exceeded half an hour, and the mother sat down. The pastor immediately moved to the pulpit and instructed her to return to her standing position. When the church lights fail (the electric service in the village is very erratic), the pastor walks up and down the aisle, placing the beam from his flash light on each worshiper to insure that he/she is praying. He proclaims that cleanliness of the church and orderliness of services represent purity of heart.

Leaders manipulate their followers to achieve those ideals they consider of greatest importance. A more mystical oriented leader will de-emphasize the mundane factors of everyday life while emphasizing communion with the Spirit. The more rational leader in the Pentecostal church will preach the ideology of the proper, conservative life style, as well as the importance of rules he himself has established. Pentecostal leaders, however, generally are extremely authoritarian and expect members to follow their spiritual and practical mandates. The churches in both Pakal-Na and in Palenque have

grown rapidly within the past year, indicating that both leadership orientations can be successful in this region of Mexico.

IV. VILLAGE HEALING ORIENTATIONS

Villagers in Pakal-Na have access to three healing approaches: folk-traditional, modern-western, and Pentecostal-religious. The folk-traditional approach categorizes illnesses as caused either by natural or supernatural forces, and therapy may be shamanic or based on herbal remedies. Several different types of folk healers participate in this approach (Higgins, 1975:33-34). The modern-western orientation interprets virtually all disease as naturalistic in origin. The most common curing method is use of antibiotics and surgery, and services are provided by doctors and nurses in government hospitals. In the Pentecostal-religious healing orientation, the ultimate cause of illness is usually supernatural. Evil forces, one cause of misfortune, can only be subverted by faith in God. In curing, the afflicted individual or another believer uses Bible reading, solitary or group prayer, or sanctified oil to restore health. Spirit possession and visions may also accompany healing.

Traditional Healing

Disease causation. Many Pakal-Na villagers believe that supernatural forces cause certain types of illness and sickness can result from the evil someone sends through the rituals of a hired sorcerer. The local nurse explains, "Sometimes they come and tell the doctors

that a sorcerer has given them something to eat or drink that has a curse on it." A man, explaining the cause of his wife's illness, said, "I think they put a curse on her. . . . This sorcerer put something inside her throat like hairs, and she began to dry up." Even accidents are sometimes attributed to supernatural causes. For example, a worker at the local lumber mill explained that he knew he was going to be injured because someone had put a curse on him.

In the traditional view, many health problems affecting infants and children are supernaturally caused. High infant mortality rates give rise to an assortment of folk explanations. The most common explanation for vomiting, diarrhea, and fever among children is evil eye (mal de ojo) or dry eye (ojo seco). It is widely believed that certain people have the ability to make children sick by looking at them or playing with them (Ingham, 1970: 80-81). One father explained that his child had been sick for months with an upset stomach and fever, but the doctors had been unable to provide successful treatment. Finally, he realized that his child had been affected by the evil eye and cured the infant using a water ritual.

Disease etiology in the traditional approach also includes naturalistic explanations. Excessive heat, cold, wind, and wetness are often given as causes of sickness. During the summer of 1982, for example, a flu epidemic swept the community. Almost every household had at least one member who became ill with an extremely high fever, and several older people in the community died. Local residents called the disease denge and commonly associated it with the intense heat and

dust produced by the recent eruption of El Chichon. Pakal-Na was directly in the path of ash fallout even though the volcano is over 60 kilometers away.

Curers. Traditional healers in the community include a variety of folk practitioners who employ herbal, magicoreligious, and pharmaceutical methods. Three main categories in Pakal-Na are herbalists, sorcerers, and spiritists. All three types of healers use a variety of curing techniques and usually specialize in certain types of illnesses (Cosminsky and Scrimshaw, 1980: 275). On the naturalistic/ personalistic continuum, herbalists are more naturalistic than either sorcerers or spiritists. Herbalists are individuals, usually trained by mentors, who are skilled in identifying, processing, and prescribing non-patent remedies. Herbs themselves are used by a variety of practitioners, both naturalistic and personalistic; and some herbalists may also function as sorcerers or spiritists. However, the skill of the herbalist is analogous to that of the pharmacist, and most herbalists in Pakal-Na and the surrounding region are naturalistic practitioners not involved in sorcery.

Explaining the curing method of the herbalist, one man stated:

> The herbalist will hold your hand and see if you are scared and then give you whatever remedy he has for you. He gives you a bottle and tells you how many hours to drink it for and when to come back. . . . Going to the herbalist is all right because . . . the herb doctor will give some medicine, some herbs. The drugs that the herbalist gives you are more natural than what the doctors give you.

In Pakal-Na the sorcerer category includes practitioners referred to as brujos, hechiceros, and curanderos. These three are classified

as sorcerers because of their use of spells and hexes. Brujos and hechiceros differ from curanderos in that they are consulted for a variety of problems in addition to illness. For example, they may be employed to recover lost articles, to counteract the spell of one of their counterparts, or to cause an injury to another individual. Curanderos are only consulted for healing, but they are similar to sorcerers because of their use of magic and spells. The involvement of the curandero in magic is illustrated by one Pakal-Na villager as follows:

> This other man was telling me about what happened to him. He had gone to the doctors and had to spend all his money, and someone told him about this curandera. She told him that she would cure him and that it would be cheap. . . . What happened was that, as time went by, this man got worse in his illness. He quit going to the curandera, and she got mad and came to him and said, "If you don't pay me, we are going to cast a spell on you. We are going to embrujar you."

All three types here classified as sorcerers use a variety of methods and materials in curing, including herbs, modern medicine, oil, baths, the Bible, and effigies of saints. In spite of this eclectic approach, however, they are essentially personalistic healers, employed to counteract evil by whatever means they deem necessary.

The final traditional healing alternative that Pakal-Na villagers have available is spiritualism or spiritism (cf. Finkler, 1981). There are conflicting reports among villagers as to whether a center exists in Pakal-Na, but people reported visiting centers in several regional cities. Those who report that the village has a center say that it is located in a private household. Centers are locations of religious services where mediums perform rituals, and the congregation engages in

public worship. Any local establishment, from a home to a temple, can be referred to as a spiritist center. Spiritism has been used for over a century as a Mexican curing alternative (Kearney,1978). Spiritists are highly personalistic, and although they use some religious rituals, they are also closely associated with sorcerers. Villagers indicated that some individuals are both sorcerers and espiritistas.

Modern-Western Medical System

The village has its own clinic, established by the government originally for the railroad workers and their families when the train station was built. The clinic is now open to the public. The clinic nurse reports seeing approximately 20 people a day. Santo Domingo de Palenque also has several clinics in addition to a small government hospital, and Pakal-Na villagers have access to a number of mestizo doctors and pharmacists in Palenque. Accessibility of medical facilities and cost of the services seem to influence the use of clinics and doctors (Young and Garro, 1982). An older man who works at the lumber mill three kilometers from Pakal-Na claimed that all the men he works with go to the hospital in Palenque when they are sick. "They don't go to the brujos, hechiceros, or hierbateros any more because they have insurance with the Social Security Hospital." The nurse at the Pakal-Na clinic confirms the observation that most patients are company or government employees. "We see people from Triply (the local lumber mill), the railroad, the federal government people, people who are insured."

The nurse also commented that the infant and child death rates had gone down dramatically in the past few years because of immunization and other preventive techniques. From observation of the amount of modern medicines in villagers' homes and the availability of drugs and patent medicines at small shops throughout the community, it can be concluded that few people are hesitant about taking western medicine. Although the pharmacist might be included in a discussion of modern medical practitioners, there is no pharmacist in Pakal-Na, and none was mentioned in any interview data; therefore, this category of practitioner was not investigated.

Attitudes of Pentecostals

Folk-traditional. Pentecostals in Pakal-Na generally agree with other villagers that diseases result from both natural and supernatural causes. In interviews, they indicated that diseases are frequently brought on by curses or the evil eye; but they also attributed many illnesses to natural causes, such as the volcanic eruption. Pentecostals attribute a higher percentage of illnesses to supernatural forces than do non-Pentecostals, and they much more frequently find and interpret the ultimate cause of illness as evil in one's personal behavior or attitude. Pentecostals frequently explain disease causation on more than one level. They often recognize an immediate naturalistic cause, but they also believe that a spiritual cause ultimately lies behind the illness. For example, an individual might become ill because of the heat, but he was allowed to become ill because of his

failure to live up to the standard of holiness set by the Pentecostals. Despite some similarity between Pentecostals and non-Pentecostals in attitudes toward the cause of disease, Pentecostals use traditional healers less frequently than others in the village; and the movement generally prohibits members from expressing favorable attitudes about folk healing forms and healers.

Modern-western. Pentecostals have mixed attitudes toward modern medical practitioners and medication. A Pentecostal member and father of several small children said:

> Up until now my children haven't had serious diseases. We take them to the doctors if it is needed. The doctors are good; we have faith in them. We have faith in the director of the hospital; he is evangelical.

In contrast, the nurse, a member of the local Pentecostal church, stated, "I work in the clinic here and to be honest, I don't have faith in the doctors." Numerous Pentecostals indicated that they had consulted a doctor, and he had sent them home because their illnesses were too advanced to be treated. The Pentecostal nurse explained the attitude of fellow church members.

> I believe that 50% of the church brothers and sisters don't go to the doctor or take medication when they get sick; 25% don't do it because they have faith that God can heal them, and the other 25% because they are afraid of the shots, the medication tasting bad, or just afraid. They say that they don't go because God can heal them. I believe that God can heal them, but I think they are far away from God; they don't want to accept the healing he has for them.

Traditionally, the Pentecostals were opposed to any form of healing other than prayer, Bible reading, fasting, and use of sanctified oil; but younger church members, including the village pastor, now frequent

the local clinic and those in Palenque. They also make trips to specialists in Villahermosa and Merida. Overt opposition to modern medicine exists mainly among the older, long-time church members. Therefore, Pentecostals, like other village residents, appear to be in a transition period in relation to health and curing. While they generally retain the attitude common in personalistic approaches that disease can be supernaturally caused, they have largely rejected traditional curers. Modern medicine addresses illnesses which are caused by naturalistic forces, but for both Pentecostals and non-Pentecostals, there are supernaturally caused illnesses which are resistant to this naturalistic treatment. Pentecostals have, therefore, adopted the third alternative--the Pentecostal-religious approach--which restores the role of the personalistic curer to the overall healing strategy.

CHAPTER III

REVIEW OF LITERATURE

A review of descriptive and scientific literature concerned with Pentecostalism is important to an understanding of the historical and sociocultural context of the movement in Pakal-Na. Areas covered by the review include Pentecostal ideological characteristics, major theoretical models, debated research findings, general movement characteristics, the Pentecostal movement in Mesoamerica, and investigations of the interaction between folk-traditional healing and Pentecostal healing.

I. PENTECOSTAL BELIEFS AND PRACTICES

To understand Pentecostal beliefs and practices, one must understand the centrality of the Holy Spirit in Pentecostal theology (Damboriena, 1966; Hollenweger, 1972). In Pentecostal worldview, God is the ultimate source of spiritual power. This power can be acquired and controlled, and it can be used as a dynamic force to bring about Holy Spirit possession and healing (Hine, 1969; Abell, 1976). Despite a common perspective concerning its source, Pentecostals hold divergent views concerning functions of spiritual power. Traditional Pentecostals consider God's spirit to be a functional power providing subsistence in a "daily bread" fashion, while more progressive Pentecostals view spirit possession as a means of achieving the good life so that "daily bread" prayers become unnecessary (M. Dirksen, 1979).

Characteristic Pentecostal beliefs and practices include fundamental biblical interpretation, crisis conversion, anticipation of the second coming of Christ, baptism by immersion, divine healing, "washing the saints' feet," expressive religious services, and active seeking of Holy Spirit possession (LaRuffa, 1980:49). These traits aptly identify Pentecostals in Pakal-Na. In addition to spirit possession, many Pentecostals believe in an intermediate stage between conversion and true spirit possession referred to as "sanctification." This stage indicates a major change in one's life style. Thus, members must avoid tobacco, liquor, "worldly" entertainments, and extravagant or immodest attire (Conn, 1977). The sanctified life style of Pentecostals in Pakal-Na identifies members as a distinct village subculture and contributes to solidarity within the group.

Pentecostal worship is "atmospheric communication," where interacting members communicate more through common sentiment than words. The enthusiastic worship style practiced among U. S. Pentecostals was adopted from American black culture, and it is reflected in spontaneous singing, dancing, speaking in tongues, and interpretation of tongues (Hollenweger, 1972). Indigenous roots are found also in Mexico in the music used in Pentecostal worship. For example, an electric guitar or even a mariachi style band may accompany religious services, during which participants clap and sing while others pray out loud. The adoption by Pentecostals of indigenous music is also reported by Castro (1972: 956).

> Pentecostal worship is an authentic experience. In the Caribbean world it makes use of Afro-Caribbean percussion instruments; in Chile, of the guitar; in Brazil, of the string orchestra. In one way or another, Pentecostal worship is always an expression of the people's overflowing feeling.

II. THEORETICAL APPROACHES TO THE STUDY OF PENTECOSTALISM

Models commonly applied to socioreligious movements include the disorganization/disruption model, the deprivation model, and the individual deviant model (Hine, 1974). The disorganization model focuses upon disruptions in the social setting; for example, rapid social and cultural change and its relationship to the rise of religious movements (Wallace, 1956). The deprivation model concentrates to a greater extent on the individual's feelings of personal inadequacies resulting from such inequities in the social system as economic, status, ethical, or worth deprivation (Aberle, 1965). Applying the disorganization framework, one immediately recognizes that residents of Pakal-Na are experiencing rapid modernization and community development and that the people of Pakal-Na are part of a national migration from smaller rural communities to more urbanized locations. These conditions are partially responsible for the growth of Pentecostalism with its quasi-kin relations and strong community-church emphasis, but the question of why specific people join the movement is more appropriately addressed by the deprivation model. The transition from traditional to modern health care has caused certain Pakal-Na residents to feel powerless during periods of health crisis, and thus

they are in the process of creating a new personalistic health-care system.

Research from the Disorganization Approach

There appears to be a set of culture change variables closely associated with the growth and spread of Pentecostalism, not only in southern Mexico but internationally as well. In the American South, Pentecostalism can be viewed as a product of social disorganization and cultural conflict stemming from rapid urban migration. Rural southerners migrating to urban centers were generally socially alienated individuals who sought to restore a sense of security through religious revival and reform. Industrialization and commercialization precipitated the growth of Pentecostalism by loosening mores; encouraging individualism, impersonalism and mobility; and accentuating segregation, socioeconomic status, and emotional instability (Holt, 1940: 747-48). Many of these same factors confront Pakal-Na villagers who have migrated in from the rural countryside or are part of the reverse migration from larger urban centers such as Villahermosa and Mexico City.

Pakal-Na attracts newcomers because of its economic viability, and modern types of employment are becoming more available. What is occurring here can be compared to the situation in Puerto Rico after 1899 where the spread of capitalism caused significant change and facilitated the growth of Pentecostalism. Such changes included the rise of industrial production in cane fields, standardization of wages and hours for field hands, and capitalization of farmable land

(Mintz, 1960). Taso, Mintz's primary informant, was a displaced sugar worker who joined the Pentecostals because of illness (for which he received help), but it was the acculturational aspect of the church that was most beneficial during Taso's life crisis. Mintz concludes that "conversion to a revivalist sect may be viewed as a way of increasing one's social and economic mobility" (1960: 266).

In Pakal-Na, villagers have found ample opportunity to practice their entrepreneurial skills, and upward mobility has been a common phenomenon for both Pentecostals and non-Pentecostals. Early descriptions of American Pentecostals emphasized their sectarian characteristics: uninhibited emotionalism, fundamentalist theology, and legalistic approach to morals. But Johnson (1961) theorizes that the Pentecostals' emotionalism was not an erratic release but evidence of strong commitment to a particular belief system and life style. Such positive orientation produced upward mobility among poor Pentecostal white southerners. While the disorganization model is useful for investigating social and cultural disruption caused by migration, urbanization, industrialization, and mobility, it is not particularly useful in explaining information concerning health-care systems.

Research Using the Deprivation Model

The basic postulate for the deprivation model is that an individual's motivation to join a socioreligious movement arises from a need to restore meaning and order in some critical area of life. Many of the earlier studies employing this approach focused on the relationship between socioeconomic hardship and religious movement affiliation

(cf. Aberle, 1965). The concept of anomie can be expanded to apply to any social institution that is not meeting the expectations of some members. A sense of power deprivation leads individuals into movements which bring about personal and social change (Hine, 1974). For example, case histories of Pakal-Na Pentecostals' preconversion healing quests showed that, in most cases, Pentecostals were contacted only after traditional and/or modern healing methods had been tried.

Among West Indian Pentecostal sects in England, it was found that the attractiveness of these fundamentalist sects stems from the formation of a community for people who are personally and/or socially alienated. Personal problems included difficult adjustment to climatic conditions and employment discrimination. However, instead of being socially integrating, Calley found that Pentecostal sects in England inhibited assimilation. "Saints are much further from assimilation than non-Pentecostal West Indians because they erect cultural barriers to assimilation. . . "(1965: 144).

Various studies of Pentecostals have dealt with the subject of personal need fulfillment and community reorganization. Comparing Puerto Rican Pentecostals and Catholics in a slum area of the South Bronx, it was discovered that Pentecostalism assists "individuals in times of acute distress" and produces stronger patrilineal ties, greater familial cohesiveness, more social mobility, and greater community involvement (Garrison, 1974). Similarly, the Zion Holiness Church of Pittsburgh helped to re-establish a personal community for Black southern migrants. Psychological needs were met through

prophecies, testimonies, and spiritual possession; and social requirements were satisfied through church organization (Williams, 1974). In Colombia, Pentecostal affiliation is more common among individuals of low socioeconomic status and those who have experienced personal dislocation in terms of migration and employment, moving to an area where they had no kin network to assist in their adjustment (Flora, 1976). All the above researchers stress the important personal needs met by the Pentecostal church community.

For the purpose of this study, the traditional deprivation model is modified to include powerless feelings toward the institution of health care. Emphasis is placed on the social and psychological factors that personalize the health process among Mexican Pentecostals. This study is interested in the characteristics and the means by which the Pentecostal healing system fulfills the personal needs of Pakal-Na villagers and attracts them into church/community membership.

III. PENTECOSTALISM AS AN INDIGENOUS OR INTRODUCED MOVEMENT

In any discussion concerning social religious movements, a number of questions arise: Is the movement indigenous or introduced? Is it modernizing or resistant to modernization? Is it revolutionary or conservative? Researchers are not in total agreement as to the nature and direction of the Pentecostal movement cross-culturally (cf. Glazier 1980). The introduced/indigenous controversy is widely discussed by researchers in the Caribbean and Central America. In Jamaica, Pentecostalism is an indigenous expression in the context and needs of

Jamaicans (Wedenoja, 1980). In Haiti, Pentecostalism is very Haitian and comparable to Vodoun. While the church polity is definitely American in origin, the Haitian Pentecostal employment of traditional animistic beliefs and rituals is not (Conway, 1980). In a Belizean village Pentecostals are marginal members from strong patrifamily units, and Pentecostalism draws from traditional rather than modern social systems (Birdwell-Pheasant, 1980). In Trinidad, "Pentecostalism is a more salutary means of exorcism than found in Rada or Shango cults, or private techniques of the Obeahman" (Glazier, 1980:67).

Pentecostalism is a flexible movement that adapts to each culture a bit differently by fulfilling various social and psychological needs. Pentecostals in Brazil are attempting to reinstate the old organizational form of the patriarchal family. In Pentecostal churches, the pastor assumes the role of patriarchal family head exercising absolute power and control over the congregation (Hoffnagel, 1980). Colombian Pentecostalism has a distinct proletarian orientation. Colombians believe that the Holy Spirit will help them in their confrontation with the power structure because of the biblical passage, "The first shall be last and the last first" (Flora, 1980:85). Having studied Pentecostalism extensively in various cultural settings, Gerlach concludes that it is a "spontaneous revolutionary movement whose impressive growth is linked to the rupture of anachronistic social forms and consequences of socioeconomic modernization" (1974:212). In contrast, a study from Puerto Rico contends that Pentecostalism is an accommodating movement that reinforces the Americanization process and

statehood alternative (LaRuffa, 1980). Most researchers argue for strong indigenous elements in the Caribbean and Central American Pentecostal movement. Although Pentecostal theology is of foreign origin, its healing system is basically indigenous and an expression of local cultural traditions. What has been added is an organizational framework that controls the healing system with the church/community becoming responsible for the health of individual members.

IV. SOCIORELIGIOUS MOVEMENT CHARACTERISTICS

A review of general Pentecostal movement characteristics is essential to an understanding of the relationship of Pentecostal healing to the rest of the movement. The following characteristics, which will be illustrated in later chapters, are clearly present among villagers of Pakal-Na: 1) Faith healing is facilitated by the open organizational forms that allow individuals who show healing ability to become leaders in the Pentecostal movement. 2) Recruitment along family and friendship lines often is done by introducing the sick person to the pastor, bringing the family member to the church to be prayed for, or inviting the evangelical healer to the home to pray for a relative. 3) If healing should occur, testimony is required. This serves to enhance one's commitment to Pentecostalism. 4) Many times healing solves physical, psychological, and social problems, and the person may develop an ideology of action that facilitates achievement of higher status in the community. 5) To Pentecostals, health is that state where positive forces predominate over negative forces. Imagined

opposition from evil is always present, and sickness is evidence that evil is predominating. These five aspects of recruitment through healing parallel the findings of Gerlach and Hine (1968:23-24).

Organization

Pentecostal movement organization is likely to be characterized by a cell-like network of organizations (Gerlach and Hine, 1970: 33-38). A Black Pentecostal congregation in Pittsburgh formed extended interaction networks in the Black community (Williams, 1974). Among West Indians in England there was a network of visiting evangelists who preached and held revivals in various Jamaican fellowship groups. Personal association between the individuals from different groups, networks of leaders who exchange services, and large international membership associations are all part of this "reticulate" organizational structure (Calley, 1965). Thus demonstrating this cell-like network, the two Pakal-Na Pentecostal congregations interact with other Pentecostals during special church services and regional conventions, by exchanging pastors and inviting leaders from other Pentecostal groups to conduct services.

Recruitment

Most Pakal-Na Pentecostals reported that a family member first introduced them to Pentecostal healing (cf. Gerlach and Hine, 1970: 96-97). Mintz (1960) found that his main informant, a Puerto Rican cane worker, was recruited to Pentecostalism by his wife while in search of a cure for his illness. In Venezuela, nominal Catholics

experiencing an emotional crisis were considered to be excellent prospects for membership by Pentecostal family members, friends, or neighbors (Pollak Eltz, 1978). Forty percent of Colombian Pentecostals in Flora's study (1980) were recruited by friends or family, and a large number of adherents were contacted through visits to their homes and work places.

Commitment

Pentecostal movement participation is often addressed by analyzing commitment by experience (i.e., glossolalia) and commitment by act (i.e., the break with non-Pentecostal church or family) (Gerlach and Hine, 1968). Studies on glossolalia in the Yucatan of Mexico found that "speaking in tongues" manifests itself during the "period of revitalization," using Wallace's (1956) revitalization model (Goodman, 1974). Glossolalia was a common phenomenon during the prayer portion of Pakal-Na Pentecostal church services. The salient and functional factors of glossolalia are that it significantly changes personal attitudes and social behaviors, affects cognitive organization, and causes a break in association with non-Pentecostal religious groups or with other secular groups (Hine, 1969).

Testimony is another indicator of one's commitment to a given movement. While glossolalia was a private prayer matter, public testimonies of one's healing were a necessary part of the healing ritual at each service among Pakal-Na Pentecostals. It can be seen as a public form of identity, in which one's aspired status is ritually addressed. Ritual testimony ". . . confirms a present social position

and reaffirms commitment to change positions" (Kroll-Smith, 1980: 25). The commitment act sets participants apart by demanding that they perform bridge-burning acts of glossolalia and testimony.

Ideology

Movement ideology is characterized by a dogmatic quality, rejection of the ideal/real gap, serious involvement, and positive fatalism (Gerlach and Hine, 1968: 34-35). An example of closure between the ideal and the real is illustrated by the emergence of a new cosmology among Toba Pentecostals. The traditional concept held by these Argentinian Indians was that spirits were both malevolent and benevolent, but the introduction of the benevolent Holy Spirit meant a rearrangement of traditional existential postulates (Miller, 1967). Ideological characteristics such as "serious involvement" are functional for healing, and appear in such Pentecostal terms as "faith," "belief," and "the dedicated life." The militant ideology is exemplified by the dogmatic quality of Haitian conversion which demands nonuse of ancestral spirits and vodoun healing specialists (Conway, 1978). In Puerto Rico, the modernization process demands the development of a changing ideology; and Pentecostalism serves this purpose by demanding total commitment to a specific set of ideas (Mintz, 1960).

Another characteristic of movement ideology is positive fatalism. Pentecostalism, according to Damboriena (1966), encourages striving, and even situations involving failure are interpreted as opportunities or challenges. Pentecostals strengthen their ideology by ignoring instances of failure and elaborately proclaiming their cases of success

(Gerlach and Hine, 1968). This attitude extends to long periods of illness in which the patient feels that God is testing him for some higher calling. Reference is continually made by Mexican Pentecostals to the suffering of Job in the Old Testament before God healed and richly blessed him.

Opposition

Movements generally have a clear perception of the "enemy." Opponents are either real or imaginary. Castro (1972), pastor of the Central Methodist Church in Montevideo, Uruguay, admits that the growth of the Pentecostal movement has caused tension with the Catholic and Protestant churches. Imagined opposition is illustrated by the spiritual struggle in Haiti between the Pentecostals' Holy Spirit and the Vodouns' ancestral spirits. The militancy of the Pentecostal imagery supports the ideology that sees the "Pentecostal healer locked in combat with an evil spirit" (Conway, 1978: 240). Pakal-Na Pentecostals have received unflattering names such as "the noisy ones" and "the evangelizers," and they perceive illness and accidents as ultimately caused by an evil supernatural force.

V. STUDIES FROM MESOAMERICA

Although Pentecostalism is distinct in many ways, it adopts significant traits from the cultures in which the movement is found. Research on Pentecostalism in Mesoamerica has been relatively sparse because only in the past decade has the movement shown growth sufficient for social scientists to accept it as a significant sociocultural

force. Over 70% of all Protestants in Central America are Pentecostal, but actual Pentecostal membership accounts for a small percentage of the total population (Johnson, 1980).

Guatemala

It is estimated that over 20% of Guatemala's population is associated with the Pentecostal movement. More Guatemalans attended the evangelical centennial celebration in the capital in 1982 than turned out for the visit of the Pope several months later (Minay, 1983). Those individuals who moved to Guatemala City without a strong social network and had high social expectations were most receptive to Protestant Pentecostal affiliation (Roberts, 1968).

Some communities in the northern Peten area of Guatemala were more receptive than others to religious innovation (Reina and Schwartz, 1974). Pentecostals differed from other Protestant sects in that they were indigenous; leadership training was less rigid; and religious services were intensely emotional. The researchers concluded that populations most receptive to new religious influences are not the very poor peasants or local elite, but socially frustrated peasants and small merchants with "resources to fall back on" (1974: 190).

In the western part of Guatemala bordering on Chiapas, Mexico, the influence of Pentecostalism is extensive. In this highland Maya area, one Pentecostal organization claims to have over 400 chapels among the the Mam, Quiche, Tzutuhil and Cakchiquel speakers (Minay, 1983). A study of Pentecostal Indians in two towns along the shores of Lake Atitlan shows that the relationship of Protestants to modernization is

multivariate, including feelings of religious and moral superiority, greater material wealth, more cognizance of a changing environment, and increased willingness to take advantage of opportunities even when they involve risks. Protestant conversion and individual modernization are complementary (Sexton, 1978). Tax and Hinshaw (1970) argue that an inherent Protestant ethic predisposed the Indians of Lake Atitlan to accept Protestantism.

Rios Montt, past president of Guatemala, is a Pentecostal associated with a charismatic group from California. In the fall of 1982, he gave a sermon at a rally celebrating the centennial of evangelicalism in Guatemala that attracted over 500,000 Guatemalans. Each Sunday Montt made a televised speech on a political, economic, or spiritual topic (Crossette, 1983: 4B). In the village of Pakal-Na, Chiapas, one frequently hears Pentecostal radio broadcasts from Guatemala, and evangelists from Guatemala are invited to conduct revivals in the village. There is an obvious spill-over effect of Guatemalan Pentecostalism into southern Mexico.

Belize

Belize has also experienced the diffusion of Pentecostalism from Guatemala. In a small village in northern Belize, Birdwell-Pheasant (1980) focused on Pentecostalism as a motivating force behind increasing an individual's or group's sense of power in the community. The collapse of the sugar ranchos, disintegrating family structures, a hurricane and epidemic, and cultural loss from missionary efforts had caused tremendous social and economic disruption. The function of the

Pentecostal congregation was not upward mobility, as in the local Catholic brotherhood, but it was "a substitute for the family itself, an alliance of individuals marginalized by the local village in terms of the family" (1980: 104).

Mexico

Few studies can be found that deal exclusively with Pentecostalism in Mexico. One of the first references to Pentecostalism in Mexico was made by Erasmus (1961) in Man Takes Control, dealing with the strength of Pentecostalism among the Mayo Indians of Sonora. Later research compared two religious movements among the Mayo Indians: the Protestant Pentecostals (all Protestant churches were of the Pentecostal type) and a Mayo nativistic movement called Diospaskos, a quasi-Catholic movement. The Diospaskos view the mestizo world as pagan, while the Pentecostals encourage participation in Mexican national culture. Pentecostalism is classified as a redemptive movement because it focuses on the individual, particularly his economic improvement, rather than on changing the system (O'Conner, 1979).

The only other study of Pentecostalism in northern Mexico was completed by Elliott (1971), a religious educator, who describes sociocultural change brought about by the socialization of formal religious education. Elliott's pilot study proposes several socialization hypotheses: Pentecostal groups provide positive political socialization for people from the "culture of poverty;" Pentecostals focus on personal improvement; and Pentecostalism provides individuals

who under normal conditions would not be leaders with potential for religious leadership.

Again, comprehensive research on Pentecostalism in central and southern Mexico is lacking. Goodman (1972) has done fieldwork in Apostalic congregations in Mexico City and among the Maya of the Yucatan. Her research is concerned mainly with phonological patterns and suprasegmental features of glossolalia and provides few insights into the structure or function of Pentecostal congregations.

VI. PENTECOSTALISM AND TRADITIONAL HEALING SYSTEMS

The appeal of Pentecostalism to people in developing countries can be attributed, in part, to the emphasis it places on restoring members to good health. Pentecostal ideology contends that illnesses result from disturbances in the metaphysical or spiritual realm of life, as well as in the physical realm. Although conversion to Pentecostalism calls for a rejection of the old ways, Pakal-Na members have been able to incorporate many traditional features into their new religious healing system. The same can be said for individuals of other traditional cultures that have accepted Pentecostalism.

A variety of conditions predispose Navajos of the American Southwest to convert. Some type of sickness, usually tuberculosis, is associated with Navajo conversion. Also, several Pentecostal males had wanted to be traditional folk healers but were unqualified because they were alcoholics. Joining the Pentecostal movement, they stopped

drinking and became evangelists, fulfilling their desire to be healers through this circuitous method (Hodge, 1953).

Healing is the major concern in two recent research projects in the Caribbean concerning Haitian healing (Conway, 1980) and exorcism in Trinidad (Glazier, 1980). Traditional Haitian religion is a complex of ancestral spirits that possess individuals and make them ill. Haitian Pentecostal rituals are designed to protect members against spiritual and human enemies and do not cost anything; whereas the traditional healers charge large sums of money. Three-fourths of the Pentecostals interviewed by Conway were converted during a period of illness when they had visited a Pentecostal service seeking a healing alternative. Three forms of healing were distinguished: laying on of hands, prayer, and/or conversion; and, according to Conway, when healing fails, cognitive dissonance is lessened by requiring members actively to proselytize and demonstrate power through glossolalia.

In Trinidad, Pentecostalism contributes to the concept of traditional healing. The rapid growth of the movement is attributed to the Pentecostal handling of traditional beliefs concerning Obeah and demon possession. Pentecostal rites of exorcism are performed at the end of a long service of preaching, prayer/glossolalia, and testimonies of previous healing. The Pentecostal rites are free and are advantageous to the people of Trinidad because Pentecostal healers do "not interfere with their daily life" (Glazier, 1980: 75) as the Obeahman does. Pentecostal ceremonies are public, and the pastor encourages participants to seek medical attention.

In Chile and Brazil, Pentecostalism has become the largest Protestant church in South America by picking up the mystical healing traditions of Latin American folk Catholicism, particularly in the case of visions, healing miracles, and medieval beliefs in evil spirits (Willems, 1967). Collectively, the studies above demonstrate that Pentecostalism fulfills a diverse set of human needs arising from cultural change where traditional patterns blend with new ones.

Pentecostal healing in Pakal-Na is partially a spiritual process that demands that one understand beliefs and practices of the religious movement (Damboriena, 1966; Hollenweger, 1972; M. Dirksen, 1979; LaRuffa, 1980). This study views Pentecostal healing in Pakal-Na from a "withdrawal" orientation (Holt, 1940; Calley, 1965) and from a social psychological perspective (Hine, 1974). Most researchers found Pentecostalism to "resonate with indigenous symbols and interests" (Manning, 1980); thus, this project has paid particular attention to the presence of folk-traditional healing forms among Pakal-Na Pentecostals. Understanding movement characteristics such as organization, recruitment, commitment, ideology, and opposition and their function in Pentecostalism (Gerlach and Hine, 1968) allows one to see the interrelationship between Pentecostal healing and the overall movement.

Pentecostalism in Pakal-Na is related to general cultural change in Mesoamerica. It is associated with religious revivalism in Guatemala (Roberts, 1968; Reina and Schwartz, 1974) which has spilled over into Belize (Birdwell-Pheasant, 1980) and southern Mexico. Much of the growth in northern Mexico (Elliott, 1971; O'Conner, 1979) has been

influenced by the United States. Traditional areas coming under modernizing influences are fertile ground for Pentecostal growth, thus Pentecostalism picks up elements from traditional folk healing (Conway, 1980; Glazier, 1980) as well as from traditional religious forms (Willems, 1967).

Pentecostalism in Pakal-Na is indigenous to the extent that it incorportes elements from the traditional culture. In healing this is demonstrated by the use of the Bible, the church, and prayer--all elements from Catholicism which are also found in the practices of folk-traditional curers. The Pakal-Na Pentecostal movement assists individuals in adjusting to modernization, but it also retards total assimilation because of the rigid life-style requirements of membership. Therefore, like Pentecostal groups reported in the literature, Pakal-Na Pentecostals are generally transitional, and their religion is both an assimilating force and one which prevents assimilation.

CHAPTER IV

METHODS OF DATA COLLECTION

I. SELECTION OF RESEARCH SITE

Pakal-Na is a regional center for Pentecostalism. Research in Pakal-Na is facilitated by the fact that people in the community are somewhat familiar with outsiders due to the community's proximity to the tourist town of Palenque. Pakal-Na is a rapidly developing village but, as yet, has not been influenced by government projects such as improved streets and public water although some residents have their own electric water pumps.

Specific factors facilitating the study of Pentecostalism include the convention, the Bible institute, and the presence of two Pentecostal congregations, one from each of the largest Pentecostal denominations in the United States. The convention is especially important to the investigation of healing because one of four daily services during the meeting is dedicated to prayer for the sick. The presence of the institute allows for key informant interviews with young men and women in training for movement leadership. The two Pentecostal congregations in the village allow comparison of denominational similarities. Because the only other church in the community is Catholic, Pakal-Na is ideal for comparing Pentecostal and non-Pentecostal healing resources and describing beliefs and rituals of Pentecostal healing.

Two unanticipated factors contributed significantly to informants' willingness to talk about their beliefs regarding sickness. El Chichon erupted in March 1982, and for over 24 hours the skies over Pakal-Na were obscured by clouds of ash. This experience was recounted over and over by the villagers, relating how the local Pentecostal churches were full of people praying for forgiveness because they thought it was the end of the world. The presence of the ash, which did not disappear until mid-July, resulted in a number of respiratory problems. The second factor, concurrent with the effects of volcanic dust, was a flu epidemic that ravaged the village. Symptoms included high fever, loss of appetite, extreme headaches, and chills. For two months virtually every Pakal-Na household had at least one severely ill person. Although these incidents were unfortunate for the villagers, the volcanic eruption and epidemic contributed to gathering of information of village reaction to illness.

I. LENGTH OF RESEARCH

The present research on the Pentecostal movement in Mexico began during the summer of 1981 with a general orientation to the area and final selection of the research site. The actual fieldwork period extended from May through July 1982, and was terminated then because the investigator contracted hepatitis. During the period, 67 interviews were completed, 46 with village Pentecostals and 21 with key informants familiar with the movement. In addition 70 questionnaires on healing practices were completed by both Pentecostal (28) and

non-Pentecostal (42) residents, and 135 Pentecostal healing rituals were observed. Other research activities included mapping the village and sampling materials used in home construction in order to compare the relative affluence of Pentecostals and non-Pentecostals.

III. RESEARCH ASSISTANTS

Four assistants were used during the field research, with their selection based upon religious affiliation, position in the community, and ability to perform needed data collecting functions. They included a translator/interviewer (a Pentecostal), two questionnaire assistants (one Pentecostal, the other a nonmember), and a community contact person. The main assistant, the translator/interviewer, spent two months on the project. A teacher at the Bible institute, he is originally from Monterrey but spent four years in the United States completing a college degree. His introduction to Pentecostalism came when his mother took him to a Pentecostal group for healing. Since age 12, he has been a Pentecostal and has pastored and evangelized since age 17. A very gregarious and well-respected person, he was quick to understand the nature of the research, and he assisted with most of the interviews.

The female assistant distributed questionnaires to non-Pentecostal villagers. A mother in her late 20s, she sells household and personal items door-to-door throughout the village. Because she grew up in the village and sells door-to-door, she is well known in the area. She distributed questionnaires individually, explaining the purpose and

method of completion. She then returned to pick up the sealed envelopes containing the completed forms. She understood instructions well and gathered responses to 40 questionnaires within several weeks.

Another questionnaire assistant helped in mapping the village. A member of one of the oldest families in the community, he lives with his parents and grandparents on a small ranch that borders Pakal-Na. He was born in the village and presently attends the Instituto Lemuel. His first assignment was to map the village since no government maps were available. Next, he made a selection of Pakal-Na homes (each third house) and noted the type of flooring, roofing, and wall material. He specified which homes were owned or occupied by Pentecostals. His final assignment was to distribute and collect the questionnaire on healing among village Pentecostals.

The final individual contributing to the research was a local Pentecostal minister. His assistance was not originally anticipated, but it soon became apparent that interviews with Pentecostals were facilitated by his participation, so he was included. He made daily rounds in the village, praying for the sick and attending to church business. His easy nature and concern for people made him welcome in Pentecostal and non-Pentecostal homes alike. He introduced the researcher to community members and helped to clarify the purpose of the proposed research.

IV. RESEARCH METHODOLOGY

Participant Observation

Information about healing was gathered by regularly attending Pentecostal worship services, participating in a regional convention with healing services, and accompanying a pastor on his home visits to pray for the sick. To the Pakal-Na Pentecostals, most daily activities are oriented around the church schedule. Attendance at evening services is expected of all members; therefore, church services provide a location for regular social interaction.

Several goals were reached by participant observation in evening services. Perhaps most important was the establishment of the role of the researcher in the community. The support of the pastor, accompanied by regular interaction with townspeople at church, allowed the development of rapport with individuals who were to be interviewed. In addition, regular attendance made it possible to understand the organization of the church as a community institution and to trace its relationship to the town of Pakal-Na. It also allowed for more comprehensive understanding of the rituals used in group prayer for healing, and testimonies given at church gave greater exposure to a full range of healing strategies. During the research period, 135 healing rituals were observed. In a more practical vein, church services provided a context for scheduling interviews and reinforcing contacts made through interviews. The pastor formally introduced the researcher to the congregation, describing the purpose of his stay in the community. On

several occasions throughout the fieldwork, the researcher was allowed to address various Pentecostal congregations to thank them for their cooperation.

Structured Interviews

After rapport had been established with Pentecostals through participation in church services for one month, structured interviews were begun. The structured interview technique allowed for focused conversation to elicit information on specific topics. Tape recordings of conversations provided data for later analysis. The interview process had several stages: First, informants were selected. Approximately 60 households in Pakal-Na contained at least one Pentecostal member. The original intent was to contact one member from each household. Although that goal was not achieved because of limitations in time, 60 individuals, 27 males and 33 females, were interviewed from 47 Pentecostal households. More females than males were interviewed because Pentecostal membership is predominantly female.

The second stage consisted of construction of an interview schedule and training of the research assistant (translator/ interviewer) mentioned above. The schedule was intended to elicit life-history material on healing experiences and contained four main areas of information: biography, Pentecostal movement membership, healing, and community attitudes (see Appendix C). Questions moved from general to specific information, and the assistant was instructed to ask more probing questions when the informant initiated healing or health related topics.

The third stage was the actual interview. Contacts were made at evening church services, with informants selecting the most convenient day and time to be interviewed. Approximately two interviews were completed per day. Each interview lasted approximately 45 minutes, with additional time spent in casual conversation and/or eating. Interviews seemed to cause no apprehension among informants because they were seen as an opportunity to entertain guests and to give a personal testimony. Public testimonies are very common among Pentecostals, and members are generally eager to talk about conversion, healing, and the sanctified life.

Key-Informant Interviews

Key informants included four Pentecostal pastors, five students from the Bible institute, two Pentecostals who formerly had been folk healers, the municipal agent and others. One very important key informant was the nurse at the local clinic. Because she is a Pentecostal as well as a primary health-care professional in Pakal-Na, her insights and information were invaluable. Information from these interviews gave a broader perspective on healing methods in the village. Information on the importance of a healing-centered religious ideology gathered from other sources was confirmed by these interviews.

Modified Semantic Differential Questionnaire

Questionnaire construction. The purpose of the questionnaire was to provide quantitative data for comparison with qualitative interview responses and to allow for comparison between Pentecostals and

non-Pentecostals. Behavioral and attitudinal data were needed on healers, healing materials, and healing places. Healing resources frequently mentioned in interviews formed the basis of the questionnaire (see Appendix D). Four descriptors pertaining to health resources were used; two were attitudinal, confianza (confidence) and poder (strength) and two behavioral, justo (correctness) and util (use). The healing resources included two from the modern-western system--hospital and medicine; three from the folk-traditional system--herbs (self procured and employed), herbalist, and brujo; and six religious forms: one strictly Pentecostal--pastor; two exclusively Catholic--priest and cathedral; and three which might be either Pentecostal or Catholic--Bible, prayer, and church.

The semantic differential responses to the descriptors were placed on a Likert scale of 0-4. (These five divisions were based on the local school grading scale.) The most negative response was indicated by 0 indicating no acreditada, 1 was defined as regular, 2 as bien , 3 as muy bien , and 4, excelente. The use of this scale was suggested by local youths who assisted in the development and pretesting of the questionnaire. They contended that all adults in the village were aware of this scaling device. The questionnaire contained some brief instructions concerning the answering procedure, but instructions were also given verbally. The back of the questionnaire requested general demographic information: age, sex, religious affiliation, marital status, and employment.

Questionnaire distribution. Research assistants were carefully instructed on the distribution of the instrument. Assistants were to distribute 75 questionnaires, one assistant was assigned to distribute 30 to Pentecostals and the other to 45 non-Pentecostals. The sample of respondents was to be selected from all villagers over 18, with an equal number of male and female respondents from a variety of age groups. The community, consisting of approximately 600 households, was divided into three nearly equal sectors, one south of the railroad station, and one east and one west of the main street from the station to the intersection near the Bible institute (see Figure 2, p. 17). An equal number of questionnaires was to be distributed in each sector with only one per household. Demographic information was requested on the questionnaire to determine whether respondents represented the intended sample population. Table 7 illustrates questionnaire respondents in terms of sex, religious affiliation, and number. Research assistants explained the purpose of the questionnaire to potential informants, emphasizing the importance of respondents' opinions. Respondents were then instructed to answer the questions without

Table 7: Questionnaire Respondents by Sex and Religion.

	Male	Female	Total Returned
Pentecostal	13	15	28
Non-Pentecostal	22	20	42
- Catholic	(9)	(18)	(27)
- no affiliation	(13)	(2)	(15)
Total	35	35	70

indicating their names, taking no longer than 15 minutes. They were requested to complete the project in private if possible. However, 22.9% of the villagers are illiterate (see Table 5, p. 25) and these were encouraged to seek assistance in reading from a family member. The semantic questionnaire was written on an elementary reading level to facilitate communication with marginally literate respondents. Completed forms were to be placed in envelopes provided by the assistants who returned the following day to pick up the forms. The total sample size for the three groups was 28 Pentecostals, and 42 non-Pentecostals of which 27 were Catholics, and 15 designated no religious affiliation.

In summary, four methods of data collection were used for this study: participant observation, structured interviews, key-informant interviews, and a modified semantic differential questionnaire. Participant observation at local Pentecostal services and a regional convention introduced the researcher to Pentecostal healing rituals and provided an avenue for his validation in the community. Structured interviews provided case histories of healing experiences. From these case histories, categories were derived for the formulation of the semantic differential questionnaire. The questionnaire itself allowed for the gathering of data from both Pentecostals and non-Pentecostals and provided a comparison of attitudes toward healing resources extracted from interviews. Key-informant interviews were used primarily to provide clarification of material from structured interviews and observations and to add information about the healing orientations of villagers.

CHAPTER V

METHODS OF DATA ANALYSIS

I. ANALYSIS OF STRUCTURED INTERVIEWS

In addition to providing a general orientation to healing beliefs, structured interviews revealed specific information about healing practices among Pakal-Na Pentecostals through thematic analysis. Some 123 health-related case histories excerpted from 47 interviews were examined using character/theme analysis or "themal approach" (Opler, 1945) which attempts to determine the importance of a specific behavior to the culture by the frequency of its appearance in case histories.

> The term "theme" is used here in a technical sense to denote a postulate or position declared or implied, and usually controlling behavior or stimulating activity, which is tacitly approved or openly promoted in a society (Opler, 1945:198).

Thus, by delineating the themes of a culture, one can describe the implicit value system from an emic perspective. In the same way, by applying themal/thematic analysis to health related case histories, one can isolate culturally relevant attitudes. This study used a thematic healing schedule developed by the researcher to analyze life-history material from the interviews. Frequency distributions and percentages were calculated for each thematic category on the assumption that frequency of appearance indicates cultural significance. Five categories were delineated: 1) cause of illness, 2) healer(s) consulted, 3) method, 4) location of healing, and 5) resulting life-pattern changes.

Cause

To Pakal-Na villagers, illness may originate from natural and supernatural causes (cf. Higgins, 1975; Fabrega and Manning, 1973a and 1973b). Natural causes include wind, wetness, cold, heat, and other phenomena; supernatural illnesses result from the will of God or malevolent spirit forces. The category "accident" has been added because it was mentioned in some narratives as a source of illness. The following excerpts quoted directly from case history material illustrate each category.

1. Natural: I was out working in the field, and I didn't think that it was going to rain, and I got very wet, and I got sick in my lungs.

2. Supernatural: A friend of mine said that maybe my husband had cast a spell on me.

3. Accident: I had an accident at work and was incapacitated for three days.

The supernatural category was only applied to cases in which the informant specifically mentioned the cause as being a spiritual force or agent. If a villager mentioned the symptoms of illness as being headache, stomach ache, etc., the case was categorized as natural illness unless the informant specifically explained that the symptoms resulted from a spiritual force. Thus, the natural category is much more extensive than the supernatural.

Healer

Eleven categories of healers emerged from the analysis, ranging from western medical doctor to sorcerer. Pakal-Na villagers refer to sorcerers by a variety of titles including brujo, hechicero, and

curandero. (Although in some cultures the curanderos are not sorcerers, Pakal-Na villagers place them in this category. Data gathered through structured interviews and material checked with key informants indicate that these three types, although referred to by different names, are indeed similar.) Since persons often go to more than one type of healer for an illness, it was possible to assign the same story to several categories. In the following list, 5, 6, and 11 are an example of this multiple assignment.

1. Self: I took the baby from her hands and started praying like I have never prayed before.
(Note: The healer is classified as self if the individual relating the story played the role of healer regardless of whether he/she was the main character. Therefore, all cases in which the healer is classified as self are related in first person.)

2. Doctor: My girl here was sick, and we had to take her to the doctor.

3. Pastor: They anointed me with oil, and I drank it, and the pastor prayed for me. . . .

4. Evangelical member: Many brothers and sisters from the church prayed outside because they wouldn't let them come into the hospital room where I was.

5. Sorcerers: So I went to find a cure for this with brujos and hechiceros and spiritists.

6. Herbalist: We know Lorenz, and so we went to him. He is an herbalist and a brujo.

7. Evangelist: One day I was listening to a program from Guatemala, and the preacher told all those who wanted healing to put our hands on the radio.

8. Family member: When his children are sick, he prays for them.

9. Saint: When I got to where the saint was, nothing happened.

10. Nurse: I took her to the clinic to see the nurse.

11. Spiritist: During the seven years I was sick, I went to doctors, herbalists, and spiritists.

Methods

Pentecostal informants indicated that their healings had been accomplished by a variety of methods, including prayers offered either in solitude, by the family, or by a group through the practice of "laying on of hands." Medications such as herbs, oils, and pharmaceutical drugs were sometimes combined with prayer; and healings were often reported to be concomitants of other religious experiences such as conversion, sanctification, spirit baptism, and visions. Fasting, the Bible, and dedication to an austere life style also reportedly brought about effective cures. In many cases, several methods were combined to produce the desired results.

The purpose of investigating the methods of healing indicated in the interviews was to determine how often various methods were used. If a case history indicated the combination of more than one method, each was counted. Each method is listed below in the order of its frequency of appearance in the data. (Exact frequencies will be described in the next chapter.) Following is a list of the healing methods and illustrations quoted from interview data:

1. Solitary prayer: One night a little boy died of the same sickness that my little girl had, an infection in his kidneys. I was alone in the room, and I prayed. . . .

2. Group prayer/laying on of hands: They prayed for me especially at the end of the service. When someone put their hands on me, I felt a great comfort. . . .

3. Fasting: My daughter was very sick, and we thought that she was going to die. So I told my oldest son to go see Lorenz and see if he can do something about this. . . . My daughter got healed. . . . Brother Lorenz didn't use anything; he didn't use any herbs or anything. The only thing that he did was to pray and fast for the situation.
(Note: Lorenz is also mentioned in example 6, p.78, where he is classified as an herbalist. Although he was a well-known herbalist and brujo, Lorenz was converted to Pentecostalism. He has continued to serve as a curer, but according to interview data, he now uses only prayer, fasting, and other Pentecostal healing rituals, operating within the context of the Pentecostal church. Because of his prominence in the village, he was mentioned in several narratives, and the story of his conversion was related by one informant.)

4. Medicine: I do have faith in the medical doctors; I take medicine and go to the doctors.

5. Family prayer: We don't use any herbs or anything like that. We use our faith in the Lord. When our children get sick, we go to the church and pray for them.

6. Bible: I went and lay down on the cot, and I had my Bible with me. I began to read the Bible, and I became sleepy, and I put the Bible on top of me. I went to sleep, and the pain was gone when I woke up.

7. Oil: One day I listened to the program from Guatemala, and I put this small jar with oil in it on the radio, and I told him to put this oil on the sick parts of his body and to do it every day.

8. Herbs: When my baby was sick, I knelt down and prayed, "Reveal to me what will heal my child." At about three that morning a man came in a vision and said, "With this starch from the yucca plant your child will be well." It was night time, and I got dressed and got my machete, and when I came home with the yucca plant, it was still night, and I peeled it. While I peeled it, my wife ground it up. I picked up my child and pried open his mouth, and the moment he swallowed it, he started to move.

9. Dedicated life: Finally, I came to and found myself in the weeds, and I got up and went back to the house. Then I made a promise with God. If he would give me back the life that was escaping me, I would serve him and I would seek his word. I promised him that I wouldn't drink anymore or go to any more dances and go to church. . . and that was the change in me.

10. Visions: One time a brother in the church had a little girl that was sick. . . . And one morning, at five in the morning, they came to find me to pray for her. . . . When I was praying, I saw a vision. I saw a man in black leave the house. And when we had finished praying, we were surprised to see that the child was completely healed.

11. Spirit baptism: The pastor came right away . . . and prayed for me, a fervent prayer . . . and right there I was baptized with the Holy Spirit. When I got up, I was speaking with other tongues, and I was healed.

Location

The location index classifies the physical context of healing (location was mentioned in 94 of the 123 narratives). Informants included home, church, and clinic/hospital as locations of healings.

1. Home: The young men of the church came and prayed in my house. . . . After they prayed for my son, he was healed, he was fine after that.

2. Church: Finally I went to church, and it was only the second prayer that they did on me that everything went away.

3. Hospital-clinic: I was in the Social Security Hospital in Villahermosa. Many brothers were praying for me and at last God willed. They prayed over oil, and at last I began to move my mouth. A doctor came to see me and asked me how I felt. And I said, "Thanks to God I feel fine." He was surprised.

Associated Experiences

Conversion or subsequent affiliation with an evangelical group resulted from healing in 33 of the 123 narratives. The following excerpts illustrate subsequent life-style changes for the main character and/or family members:

1. Main character: We became members right away after I was healed because we couldn't stay away from the church after we had received these healings; we couldn't leave the church.

2. Family member: After our daughter's sickness was passed, he kept on talking to us about the church, and he wanted us to become Christians. All kind of sickness was going through our family and through our cattle, and it was kind of scary. He said he would bring his pastor to talk to us. And that is the way we were converted.

Failure

It is uncommon for Pentecostal believers to admit that the prescribed Pentecostal healing rituals have been ineffective. The cognitive dissonance that results from healing failure jeopardizes the whole Pentecostal healing approach. Nevertheless, in ten examples the individual remained sick or died while seeking divine healing.

II. SEMANTIC DIFFERENTIAL QUESTIONNAIRE ANALYSIS

Questionnaire data were collected from a sampling of Pentecostal and non-Pentecostal villagers. Religious preference was determined both by the research assistants' selection and by the informants' responses on the questionnaires. Responses from the completed forms were categorized as follows: Pentecostals (evangelico, pentecostal, Asamblea, Iglesia de Dios), and non-Pentecostals (catholico and nada). The semantic differential scale of descriptors and numbers 0-4 were condensed into three categories. Data were analyzed statistically before and after restructuring the categories, and restructuring did not distort significantly the pattern of data. The restructuring was accomplished as follows: no acreditada (0) has been translated low; regular and bien (1 and 2) have been translated moderate, and muy bien and excelente (3 and 4) have been translated high. Descriptors were

analyzed individually and collectively on all 12 healing resources. (See Appendix E: Tables 22-69.) With two religious groups (Pentecostal, non-Pentecostal) and three levels of response (low, moderate, high), the data are presented in 2 x 3 tables for analysis and description.

Both descriptive and inferential techniques were used to analyze modified semantic differential responses. The types of analysis included frequency distributions, percentages, chi square, and Cramer's V. Descriptive analysis included only the calculations and comparison of number and percentage of frequency distributions. Inferential techniques included the use of chi-square technique to determine whether there was a difference between Pentecostals and non-Pentecostals and Cramer's V to determine the strength of that difference. Necessary assumptions for chi square were met as follows: the level of measurement was nominal; samples were independently drawn, and the method tested for the null hypothesis with two degrees of freedom.

The null hypothesis tested by the chi-square analysis is that there is no difference between the Pentecostal and non-Pentecostal responses to various healing forms. Using a .01 level of significance, the chi-square test was used to measure whether there was a difference between the frequencies that were obtained empirically and the attitudes and behaviors expected if the Pentecostals and non-Pentecostals had been from the same population. The size of chi square indicates nothing about the strength of that difference. Cramer's V is a measurement of strength of difference between groups.

III. LIMITATIONS OF DESIGN

Participant Observation

Although participant observation was a most successful research tool for this project, it was limited--as were other techniques--by time restrictions. A much longer research period would have produced more reliable findings, especially through the use of participant observation. Furthermore, in order to gather needed information among Pentecostals, it was necessary to become strongly identified with the local churches and pastors. This affiliation, although quite helpful in most respects, limited contact with and acceptance by non-Pentecostals.

Structured Interviews

An increasingly apparent language barrier limited the effectiveness of the interview technique. This was overcome partially through growing familiarity with the local idiom and partially through the use of an excellent translator who understood the research project and was well-acquainted with the community. Nevertheless, the use of a translator even on a limited basis complicated interaction with participants. Again, because of the translator's close affiliation with the Pentecostals, responses may have been biased in favor of the predominant Pentecostal perspective.

There was also some difficulty resulting from the fact that the interviewer was male and many of the interview subjects were female. The strict codes regulating male and female behavior in Pakal-Na made

it necessary for the husband to be present during interviews with the wife. Since some of the husbands were not Pentecostal, their presence may have affected the responses.

Semantic Differential Questionnaire

Respondents omitted questions they found confusing or too sensitive to answer. As a result, the nonresponse rate on some questions was high; for example, only 19 out of 28 Pentecostals answered questions on the healing correctness of the cathedral. Five Catholics omitted the question concerning the correctness of the pastor in healing.

The use of multiple research techniques including participant observation, key-informant interviews, structured interviews, and modified semantic differential questionnaires allowed data to be collected on several different levels. The technique with the greatest limitation for research in developing countries is the questionnaire. Many of the people of Pakal-Na have only recently become literate, and the reading level necessary for filling out forms is still somewhat uncommon. Writing responses to questions and having opinions preserved in permanent form are strange activities to some older people in the village.

Younger villagers were quickest to understand instructions, and some older people never understood well enough to complete the forms. To overcome the problem of limited literacy, assistants attempted to give extensive verbal instructions with mixed results. Some validity may have been lost through extended examples of how one could respond.

Close relatives were allowed to read the questionnaire to illiterate respondents. Thus, it was difficult to ascertain whether the responses were those of the informant or the reader. Although limitations were difficult to overcome, the questionnaire proved to be an excellent tool for collecting data in a short period of time, and responses to it were validited by use of other techniques.

CHAPTER VI

THE FINDINGS

The degree to which Pentecostals in Pakal-Na employ personalistic approaches to healing was compared to their selection of other curing methods, and Pentecostal and non-Pentecostal employment of health resources was compared. Three data sources are presented in the development of a healing methods profile for Pentecostal and non-Pentecostal village residents. First, quantitative information is examined from a modified semantic differential questionnaire distributed to 70 villagers. Chi-square values were calculated individually for each of the four descriptors on the questionnaire: confidence, strength, use, and correctness. Information concerning individual descriptors is presented in Appendix E: Tables 22-69. For the following presentation and discussion, however, the four descriptors have been combined in order to provide a composite of attitudinal and behavioral responses to various healing resources. Second, results are given from a thematic analysis of 123 separate case histories, and finally, excerpts from interview material are presented to illustrate findings from these two analyses.

Data are organized in terms of specific health resources. Folk-traditional methods, including herbs, herbalists, spiritists, and sorcerers, are presented first. The category of herbs includes healing materials only, while the category of herbalists includes only practitioners. These categories are considered separately since Pakal-Na

villagers sometimes identify and process their own herbs without consulting an herbalist. Modern-western healing resources, presented second, include over-the-counter and prescription drugs, doctors, and hospitals. Finally, specifically religious forms such as church, Bible, prayer, pastor, priest, and cathedral are compared for the two populations. Within each general category (folk-traditional, modern-western, and religious) resources are discussed in order of their positive assessment by Pakal-Na residents; i.e., the resource within each category which received the most positive response from villagers in the survey is discussed first, etc. The second section of this chapter presents a discussion and analysis of these findings including an interpretation of the rankings of degree of difference among healing resources as measured by Cramer's V.

I. PRESENTATION OF DATA

Folk-Traditional Curing Strategies

On the personalistic/naturalistic continuum of disease etiology and cures, modern-western medicine is predominantly naturalistic, and the healing practices and disease theories of Pentecostals are typically personalistic. Folk-traditional medicine is partly naturalistic and partly personalistic, placing this health care system somewhere in between modern medicine and the Pentecostal system. Although sometimes used by sorcerers, herbs are essentially naturalistic. In the view of most Pakal-Na residents, herbs have much the same characteristics as pharmaceutical drugs; i.e., they work directly on an illness caused by

natural forces. They do not counteract evil or dispel hexes. In spite of their naturalistic characteristics, however, herbs are frequently used by personalistic practitioners including brujos. Similarly, the herbalist himself may be a naturalistic curer. In such cases, he is a specialist who has been trained by a mentor to identify and process herbs and is not involved in conflict between good and evil. Many herbalists, however, also act as sorcerers, moving toward the personalistic end of the continuum. Nevertheless, for the community of Pakal-Na, there is not enough overlap between herbs, herbalists and sorcerers to justify combining these categories. In contrast to herbs and herbalists, sorcerers and spiritists are essentially personalistic. Their curing powers are based on an assumption of good vs. evil, and both sorcerers and spiritists invoke supernatural powers.

Herbs. Most individuals possess some knowledge of herbs and their associated uses, and some residents collect and process their own herbal remedies. Although knowledge and skill in collecting herbs is decreasing among the younger generation, most older residents can still identify numerous medicinal plants and specify their healing uses. In Pakal-Na, herbs can be collected and processed by individuals, or purchased from door-to-door vendors or the herbalist in the market square in Palenque. Use of herbal remedies in the village is still relatively high, as illustrated in Table 8, with 69% of all respondents expressing moderate to high confidence in herbs as a health resource. Nevertheless, there is a significant difference between the two populations. Pentecostal villagers express a greater uncertainty about the

healing quality of herbs: 47% of the Pentecostals expressed negative attitudes toward herbs compared to 21% of the non-Pentecostal villagers. The null hypothesis that there is no difference between Pentecostals' and non-Pentecostals' attitudes toward herbs must be rejected at the .01 level of significance. However, herbs ranked 10th out of 12 resources in terms of degree of difference as measured by Cramer's V; i.e., relative to other resources examined, Pentecostals and non-Pentecostals were more similar in their attitude toward herbs than toward any resources besides the spiritist and the sorcerer.

In the 123 healing case histories collected, Pentecostals mentioned employing herbs as a resource on 8 occasions, or in 5% of the cases (see Appendix F). A few narratives, however, did indicate that

Table 8. Comparison of Attitudes Toward Use of Herbs by Pentecostal and Non-Pentecostal Residents of Pakal-Na.*

	Level of Confidence/Strength/Use/Correctness		
	Low	Moderate	High
Pentecostals (n=100)	47%	50%	3%
Non-Pentecostals (n=164)	21%	46%	34%
Total (N=264)+	31%	47%	22%

Chi Square = 12.249, df=2, $P(x^2)$= .0027, Cramer's V = 0.215

* Each table in the text summarizes 4 tables in Appendix E.
\+ Totals vary from table to table because not all respondents answered every question.

curing resulted from the use of herbs when such was directed by God or combined with prayer.

The above data reveal that Pentecostals have confidence in and use herbs significantly less than non-Pentecostals, but that Pentecostals' confidence/use remains somewhat high with 53% indicating a positive reaction. The negative assessment of herbs by Pentecostals is an aspect of the total healing ideology of the movement; i.e., that all healing should come from God and that use of any other curing resource constitutes a lack of faith. However, not all Pentecostals are completely doctrinaire on this point, and some do use resources outside the Pentecostal tradition. One Pentecostal explained the church's position as follows, "The people in the church don't use herbs any more. . . . They tell us we shouldn't."

Again, despite the fact that Pentecostals use herbs significantly less than non-Pentecostals, 53% responded to this resource with some degree of acceptance. This degree of confidence/use might be explained in two ways: First, some Pentecostals consider herbs to be natural remedies and, therefore, safer than drugs prescribed by a doctor. As indicated by the nurse, Pentecostal villagers are sometimes afraid of prescribed medication. A second important factor is that an individual can procure herbs without consulting a healer. Pentecostals responded with some degree of negative sentiment toward each of the healers included on the questionnaire except the pastor, and they were particularly reluctant to consult practitioners even remotely connected with sorcerery. Therefore, a remedy which would allow individuals to

diagnose and treat their own illnesses would be more acceptable to Pentecostals than remedies requiring the intervention of a healing specialist. The nurse commented, "Pentecostals use herbs for teas and . . . other minor medical purposes, but they don't go to the people who sell herbs and rely on herbs for healing."

Herbalists. Herbalists are considered separately from herbs because herbs themselves are available to villagers without the assistance of the herbalist. The herbalist is a practitioner skilled in the art of processing and prescribing herbs and engaged in this practice for pay. Although some herbalists are sorcerers, in most cases, the herbalist's ability to heal is not supernatural. Table 9 indicates reactions to the herbalist as a folk practitioner.

Almost 67% of all villagers showed no attitudinal or behavioral involvement with the herbalist, and only 33% indicated some degree of positive feeling. On the specific semantic descriptor of confidence in

Table 9. Comparison of Attitudes Toward Use of Herbalist by Pentecostal and Non-Pentecostal Residents of Pakal-Na.

	Level of Confidence/Strength/Use/Correctness		
	Low	Moderate	High
Pentecostals (n=89)	92%	8%	0%
Non-Pentecostals (n=159)	53%	33%	14%
Total (N=248)	67%	24%	9%

Chi Square = 40.782 df=2, $P(x^2)$= .0000 Cramer's V = 0.406

the healing ability of an herbalist, the Pentecostals gave no positive responses. However, 45% of the non-Pentecostals indicated either moderate or high confidence in the herbalist (see Appendix E: Table 28.) In the combined percentages on all four descriptors--strength, use, confidence, and correctness--the two populations showed a significant difference as presented in Table 9. Only 8% of all Pentecostal informants designated the herbalist as a possible healing resource compared to 47% of the non-Pentecostals. Further, in healing case histories, Pentecostals indicated the use of an herbalist only 8 times out of a total of 189 times healers were mentioned (4%). (See Appendix F.) The herbalist ranked seventh in degree of difference between Pentecostals and non-Pentecostals as measured by Cramer's V.

Although both populations demonstrated a somewhat negative assessment of the herbalist as a curer, Pentecostals were significantly more negative than non-Pentecostals. This negative reaction has at least two sources. First, as indicated above, the curing ideal for Pentecostals is divine healing without the intervention of nonreligious practitioners. The particularly negative response to the herbalist may be partly derived from the fact that some sorcerers in the Pakal-Na are also herbalists, and Pentecostals almost completely reject sorcerers. A second, less idealistic factor in the negative assessment of the herbalist is his fee. It appears that some residents think herbalists charge too much for their services since many nonspecialists in Pakal-Na have some ability to process and administer herbal remedies. One informant summarized these two sources of negative assessment as

follows: "I don't think it is good to go to an herbalist and spend the money there and forget about Jesus' power."

Spiritists. Pakal-Na villagers recognize espiritistas as folk healers although their presence in the community is not conspicuous. There are conflicting reports as to whether a spiritist center exists in Pakal-Na, but probably, a spiritist occasionally visits the village and holds meetings in a private residence. Data from Table 10 support the conclusion that these folk healers are not a primary curing resource in Pakal-Na.

Overall, only 14% of the respondents reported moderate to high confidence and involvement. The hypothesis that the groups differ significantly in attitudes and behavior regarding spiritists must be rejected, however, because neither the combined scores nor the individual semantic descriptors indicate a important difference

Table 10. Comparison of Attitudes Toward Use of Spiritists by Pentecostal and Non-Pentecostal Residents of Pakal-Na.

	Level of Confidence/Strength/Use/Correctness		
	Low	Moderate	High
Pentecostals (n=98)	93%	4%	2%
Non-Pentecostals (n=158)	82%	13%	4%
Total (N=256)	87%	10%	4%

Chi Square = 7.174 df=2, $P(x^2)= .0272$ Cramer's V = 0.167

(see Appendix E: Tables 30-33). The value of Cramer's V for spiritists is the smallest of any of the 12 healing resources, indicating that Pentecostals and non-Pentecostals are more similar in their attitudes toward spiritists than toward any other healing resource investigated. In healing case histories, Pentecostals mentioned employing spiritists on only three occasions, and only one Pentecostal related hearing about successful healing by a spiritist.

One reason for the limited use of spiritists by Pakal-Na residents is that spiritism tends to be somewhat regional, and Pakal-Na is simply not an area where the movement is strong. Again, there may not be a center in Pakal-Na, and if there is, it is not widely attended nor is its presence a matter of general knowledge. Pentecostals react negatively to spiritism because the Pentecostal churches strongly advise against participation in its rituals. Pentecostals sometimes classify spiritists as sorcerers because of the cross-over between these two groups, and Pentecostals avoid spiritist meetings partly because sorcerers frequently attend them. This association between sorcerers and spiritists repels Pentecostals because spiritist healing rituals are similar to their own. Rather than providing affinity, the similarity of practices causes dissonance for Pentecostals because the spiritists appear to juxtapose sorcery and Pentecostal ideology in a way Pentecostals find dangerous. Any misuse of the power of the Holy Spirit can result in death or irrevocable damnation according to Pentecostal theology.

Sorcerers. Curing is only one activity practiced by sorcerers. In healing, they are usually contacted to counteract a curse the victim (or sorcerer) believes is causing his sickness. Sorcerers are the least used health resource in Pakal-Na, as indicated in Table 11. Less than 9% of the villagers considered sorcerers a possible healing resource. For non-Pentecostals the percentage was 12%. The local nurse claims, "I know only one person in the Pentecostal church who goes to the brujo for healing." The data show no significant difference between the responses of Pentecostals and non-Pentecostals. Of the four semantic descriptors, none was significant at .01; therefore, the null hypothesis must be accepted that there is no intergroup difference on villagers' attitudes toward and use of sorcerers for healing. Neither group admits to frequent use or high confidence.

Information from the thematic analysis of healing case histories indicates that sorcerers were visited 7 of the 189 times healers were

Table 11. Comparison of Attitudes Toward Use of Sorcerers by Pentecostal and Non-Pentecostal Residents of Pakal-Na.

	Level of Confidence/Strength/Use/Correctness		
	Low	Moderate	High
Pentecostals (n=98)	98%	1%	1%
Non-Pentecostals (n=161)	88%	9%	3%
Total (N=259)	92%	6%	2%

Chi Square = 7.900 df=2, $P(x^2)= .0191$ Cramer's V = 0.175

consulted (see Appendix F). In each of these, however, the individual was relating an experience which occurred before his membership in the movement. Several factors inhibit Pentecostals from utilizing the sorcerer as a health resource: prohibition by the church, lack of trust, cost, and negative experiences. Again, because of their theology, Pentecostals avoid association with what they term "powers of evil." Any power which does not come from God must come from Satan, and Pentecostals are admonished to shun any association with such power. Lack of trust stems from the fact that sorcerers are used to counteract evil, usually by enacting some evil of their own. Because they are involved in the use of malevolent spells and hexes, they are mistrusted, even by their clients.

Cost is an additional negative factor in the use of sorcerers. Pentecostal healing rituals are free, and by comparison, the services of a sorcerer seem expensive. Also, there is concern that the sorcerer will use extortionist tactics to collect fees and that the client will be powerless against his skill. Some informants indicated that fees are somewhat nebulous, and an individual is not sure how much he will have to pay for a ritual before it is performed. Finally, each of the seven case histories involving sorcerers related a negative experience. In some cases the ritual was ineffective; in some it had negative side effects; and in others, the interaction with the sorcerer was frightening.

Modern Medical Practices

Medicine and drugs. Nonprescription western medicines are becoming common health resources in village homes, as indicated in Table 12. In Pakal-Na several sources dispense information on appropriate pharmaceutical drugs for minor illnesses including folk curers, the nurse at the village clinic, and trained modern physicians. Attitudes toward western medicine are positive for Pakal-Na villagers, with almost 94% of the villagers indicating use. Although village use overall is high, there is a significant difference between Pentecostals and non-Pentecostals. While 15% of the Pentecostals expressed high use and confidence, 74% of the non-Pentecostal villagers reported high positive feeling toward and employment of medicines and drugs. The degree of difference between the groups as measured by Cramer's V was the strongest of any of the 12 healing resources; therefore,

Table 12. Comparison of Attitudes Toward Use of Modern Medicine by Pentecostal and Non-Pentecostal Residents of Pakal-Na.

	Level of Confidence/Strength/Use/Correctness		
	Low	Moderate	High
Pentecostals (n=105)	9%	76%	15%
Non-Pentecostals (n=164)	5%	21%	74%
Total (N=269)	6%	43%	51%

Chi Square = 89.507, df=2, $P(x^2)= .0000$ Cramer's V = 0.577

Pentecostals and non-Pentecostals were more different in their use of medicine than in their use of any other health resource investigated. All four semantic descriptors showed significant difference, with the use descriptor indicating the strongest contrast (see Appendix E: Table 39). In summary, both Pentecostals and non-Pentecostals make considerable use of modern medicine, but non-Pentecostals use it significantly more than Pentecostals.

The discussion of use/nonuse of western medicine is continually carried on in the Pakal-Na Pentecostal churches. According to the nurse, several Pentecostals have died because they refused to employ modern medicine. During the course of fieldwork, one of the oldest Pentecostal women in the village died because her illness advanced too far before her family demanded that she accept western medicine. The husband of the deceased expressed a viewpoint common among many Pentecostals:

> I was a little confused because I thought that all the Christians were going to die without suffering. I remember the story of Job about his suffering. We tried to make her deny her belief in God because we couldn't deal with the fact that she had been lying there for five months suffering and in great pain.

Further evidence of Pentecostal indecision over the use of medicine is provided by the nurse. "When someone dies because they didn't take medicine until the very end, some church members say it is because they used medicine. The others say it is because they didn't take it soon enough." Among Pentecostals there is cognitive dissonance concerning use of medicine and faith in the healing power of God. The nurse related several stories of members' deaths she had witnessed,

having been consulted too late to be of any help. Nevertheless, she herself holds to her belief in the power of the supernatural to heal:

> I think that if God doesn't want you to get healed and you take a lot of medicine, you still won't get well. If he wants you to get healed, just one pill or someone putting their hand on you, you will get healed. This is what I believe.

The attitudes of Pentecostals appear to be changing, and in the homes of the Pentecostal pastors, for example, boxes of medicine are on open display. The nurse concludes, "Maybe it is a teaching that they got long ago. Most of the people that I observe are people who have been in the church 20 years or more. The younger people don't have this attitude."

Doctors and hospitals. As indicated in Chapter II, medical facilities and doctors are generally available to Pakal-Na residents. Nevertheless, treatment by medical professionals in a hospital or clinic is relatively uncommon for many villagers. As shown in Table 13, only 37% of the sample population claimed to make use of doctors' services and feel comfortable in doing so. Pentecostals and non-Pentecostals show the same high contrast on doctors and hospitals that they do on modern medicine and drugs. The difference exceeds the .01 level necessary to reject the assumption that the informants are members of the same population, and Cramer's V indicates significant strength, .600 on the descriptors of use and confidence (see Appendix E: Tables 43 and 44).

Pentecostals were more negative toward doctors and hospitals than toward medicine, with 17% rejection compared to 9% on the previous

Table 13. Comparison of Attitudes Toward Use of Hospitals and Doctors by Pentecostal and Non-Pentecostal Residents of Pakal-Na.

	Level of Confidence/Strength/Use/Correctness		
	Low	Moderate	High
Pentecostals (n=104)	17%	77%	6%
Non-Pentecostals (n=161)	9%	34%	57%
Total (N=265)	12%	50%	37%

Chi Square = 75.521 df=2, $P(x^2)= .0000$ Cramer's V = 0.534

scale. Some 57% of the non-Pentecostals claimed a high degree of confidence in doctors and hospitals compared to only 6% for Pentecostals.

Nevertheless, consultation with a doctor during the course of an illness was mentioned in 24% of the Pentecostal healing case histories; i.e., on 46 occasions (see Appendix F). However, despite this comparatively frequent indication of consultation, Pentecostals exhibited considerable ambivalence in their attitude toward doctors and hospitals, and many of the case histories came from narratives relating preconversion experiences. Pentecostals complained that doctors had no cure for their illnesses; they sometimes consulted a physician but refused to follow his instructions; and even when they followed the doctor's advice, they attributed their healing to God and were embarrassed or confused over the doctor's role in their recovery. Luis

Montejo, a Pentecostal believer, illustrated this contradictory attitude.

> I had a terrible backache, painful backache, and I went to Palenque to see the doctors. The doctors gave me some medicine for that, but I didn't take it. I trusted the Lord, and I still have the medicines in there. I refused to take the medicine and I trusted God. I don't trust the doctors.

In spite of their attitudes about doctors and hospitals, Pentecostals are beginning to incorporate modern medicine into their religious healing framework, largely due to its availability. An anecdote by Teresa Monteja reveals the dilemma faced by Pentecostals during this transition period.

> Since we didn't see any changes in my condition, people started telling him that they should take me to the doctor. And he decided to take me to the doctor. And that is why I feel uneasy about going to the altar to give my testimony because people are going to say that I went to the doctor to seek help instead of God and that it wasn't God who healed me; it was the doctors. I feel that I am a little confused about this. Before, we didn't go to the doctor at all, and we only trusted in prayers, and we prayed until we got healed from whatever sickness we had.

Religious Approaches to Healing

Because both Pentecostal and Catholic healing resources were mentioned in the structured interviews, both were included in the questionnaire and in the analysis. As indicated above, most Pentecostals were Catholic before their conversion, and since Pakal-Na has only two types of churches, Pentecostal and Catholic, forms from both traditions were investigated. The priest and cathedral are exclusively Catholic approaches while Bible, prayer and church might be used by either group. Only evangelical pastor is exclusively Pentecostal.

Healing resources are presented in the order of their positive assessment by Pakal-Na residents.

Bible. The healing resource from the religious category receiving the most favorable response from Pakal-Na residents was the Bible. As indicated in Table 14, the Bible is an indispensable healing resource for Pentecostals (96%), and among non-Pentecostals strong positive attitudes and high use are evident (61%). However, there was a significant difference between Pentecostal and non-Pentecostal responses, with Pentecostals indicating more frequent use and a more positive attitude. Each of the individual semantic descriptors exceeded the .01 level of significance (see Appendix E: Tables 46-49). Cramer's V indicates that the strength of this difference is

Table 14. Comparison of Attitudes Toward Use of The Bible by Pentecostal and Non-Pentecostal Residents of Pakal-Na.

	Level of Confidence/Strength/Use/Correctness		
	Low	Moderate	High
Pentecostals (n=104)	0%	4%	96%
Non-Pentecostals (n=162)	16%	23%	61%
Total (N=266)	10%	15%	75%
Chi Square = 41.912 df=2, $P(x^2) = .0000$ Cramer's V = 0.397			

approximately in the middle of the twelve categories investigated. The Bible was given healing credit in 12 case histories (8%). (See Appendix F.)

The shared high regard for the Bible as a healing resource in Pakal-Na can be attributed to its general use in the community by Catholics, Pentecostals, and folk healers. Holding the Bible, placing it on the ailing portion of the body, and reading scriptures are all traditional methods of health restoration in Mexican culture. As part of their repertoire, folk healers commonly perform a ritual known as ensalmando or psalming, using Psalms 86 and 91. Psalming is not restricted to traditional curers, however, but is also commonly used by Pentecostals and Catholics.

The greater use of the Bible by Pentecostals can be explained in two ways. First, the Bible is the center of the Pentecostal belief system. It is literally interpreted, and every word in it is to be believed unequivocally. Each Pentecostal believer is expected to have a Bible and to bring it to all services, even if he/she is unable to read. In addition, the Bible is part of most Pentecostal healing rituals. Pentecostals do not make new uses of the Bible in healing, nor do they interpret its use in novel ways. However, they do intensify the importance of the Bible as central to religious activity of any kind, including healing.

Secondly, the Bible may be used more by Pentecostals than by non-Pentecostals because, again, there is no cost involved in the Pentecostal ritual. In the traditional healing system, there is a fee

for psalming, and some residents resent this charge. As one man indicated, "There are a lot of people that just make a business out of it. They read a Psalm so that you will get healed, and then they ask you to pay them for it." The Pentecostal pastor and other believers perform psalming and use the Bible in other ways to bring about healing, but there is never a charge.

Church. A second healing resource that has significance for both Pentecostals and Catholics in Pakal-Na is the iglesia, as shown in Table 15. Despite the use of this resource in both religions, however, there was a significant difference in the responses of the two groups with Pentecostals expressing a more positive attitude. Over 91% of the Pentecostals and 59% of the non-Pentecostals indicated a high degree of confidence in the church. None of the Pentecostals and only 13% of the non-Pentecostals expressed low confidence regarding this resource. Pentecostals designated the location of their healing 94 times in their case histories, and 34 of these healings (36%) took place in the church.

Although both groups expressed generally favorable attitudes toward the church as a location of healing, there are several reasons for the greater degree of acceptance expressed by Pentecostals. One factor is availability of the church as a resource. Because the Catholic church does not have a resident priest, masses are held only once a week. As mentioned above, Pentecostals have church services nightly, and the building is open for prayer several days a week. Secondly, unlike the clinic or hospital, the church is a familiar and

Table 15. Comparison of Attitudes Toward Use of The Church by Pentecostal and Non-Pentecostal Residents of Pakal-Na.

	Level of Confidence/Strength/Use/Correctness		
	Low	Moderate	High
Pentecostals (n=106)	0%	9%	92%
Non-Pentecostals (n=160)	13%	28%	59%
Total (N=266)	8%	20%	72%

Chi Square = 34.479 df=2, $P(x^2)= .0000$ Cramer's V = 0.360

comfortable setting for Pentecostals; thus, if they are ill, the church provides a nonthreatening environment for the restoration of health. The Catholic church might also be a nonthreatening environment, but the infrequency of services prevents it from being as familiar to Catholics as the Pentecostal church is to its members. Finally, corporate prayer is an important feature of Pentecostal healing, and prayer by a group can best be carried out at the church. Prayer for the sick is a regular part of many services, and the community aspect of "the body of believers" is an appealing feature of the Pentecostal approach.

Prayer. Combined results of the semantic descriptors again evidence the significance of prayer in the Pakal-Na health system. A contrast exists between the very large number of high responses (90%) given by Pentecostals, and the more moderate number (60%) given by non-Pentecostals. Nevertheless, only 13% of the combined populations

completely rejected prayer as a healing form, indicating that prayer plays a major role in the village healing system (see Table 16). The chi-square value exceeds the established level of significance and allows the conclusion that the groups are independent. This conclusion must be made with caution, however, because none of the individual semantic descriptors indicates significantly different responses for the two groups (see Appendix E: Tables 54-57). Cramer's V shows only a weak difference between Pentecostals and non-Pentecostals, the weakest difference among all the religious healing forms. It can be concluded, therefore, that the two groups do not differ greatly on the importance of prayer as a healing resource and that there is a strong cultural tradition of healing by means of prayer.

In the thematic analysis of Pentecostal healing case histories, three types of prayer were distinguished: solitary (i.e., an individual praying while alone), family, and group prayer (laying on of hands). Of the 161 successful cases of healing mentioned, one of the above prayer types was used on 96 occasions (60%); solitary prayer accounted for 30%, group prayer for 21%, and family prayer for 8% (see Appendix F).

Similarity of responses regarding prayer is predictable. Like church and the Bible, the religious ritual of prayer is customary for many Mexicans. The difference that does exist between the two groups may be accounted for by differences in the types of prayer used by Pentecostals and non-Pentecostals. Traditionally, Catholics pray to

Table 16. Comparison of Attitudes Toward Use of Prayer by Pentecostal and Non-Pentecostal Residents of Pakal-Na.

	Level of Confidence/Strength/Use/Correctness		
	Low	Moderate	High
Pentecostals (n=104)	1%	9%	90%
Non-Pentecostals (n=166)	21%	19%	60%
Total (N=270)	13%	15%	72%
Chi Square = 31.092 df=2, $P(x^2)= .0000$ Cramer's V = 0.339			

saints, the Virgin Mary, or Jesus, and prayers are performed in a solemn, contemplative manner. However, Pentecostals practice loud, public prayer directed toward the needs of one or more specific individuals in the congregation, and they exercise the ritual of "laying on of hands," in which a group of believers surrounds the sick individual placing hands on him while praying for his recovery. Pentecostals also sponsor prayer groups which travel from home to home praying for the sick. Again, Pentecostals have not introduced a new element into the religious healing ritual; however, they have increased the intensity of prayer as part of the ritual and have transformed it into a group process.

Evangelical pastor. Because pastor is a strictly Pentecostal category, it was expected that Pentecostals and non-Pentecostals would differ significantly in their use of this healing resource. As expected, the .01 level of significance was exceeded on all four

descriptors, indicating a significant difference in responses for the two groups (see Appendix E: Tables 58-61). Cramer's V is also strong, indicating that differences in attitudes toward and use of the pastor for healing constitute a major contrast between Pentecostals and non-Pentecostals, ranking as the third strongest difference of the 12 healing forms measured. However, combined scores on the four semantic descriptors attest to a generally positive attitude toward the pastor as a healing resource by both populations (see Table 17). Almost 75% of all respondents attributed some importance to his contribution to healing, and, even among non-Pentecostals, the percentage was high (59%). Pentecostals mentioned consulting the pastor in their healing case histories 21 times (11%). (See Appendix F.)

No Pentecostals expressed low confidence in their pastor, and the strong positive response is predictable based on the centrality of the pastor to the Pentecostal congregation and on his emphasis on healing

Table 17. Comparison of Attitudes Toward Use of the Pastor by Pentecostal and Non-Pentecostal Residents of Pakal-Na.

	Level of Confidence/Strength/Use/Correctness		
	Low	Moderate	High
Pentecostals (n=102)	0%	25%	76%
Non-Pentecostals (n=155)	41%	34%	24%
Total (N=257)	25%	31%	44%

Chi Square = 80.838 df=2, $P(x^2)$= .0000 Cramer's V = 0.561

and availability for healing prayer. His general acceptance by 59% of the non-Pentecostals was less predictable, however. This generally positive attitude may be explained in terms of familiarity, availability and cost.

Two Protestant ministers live in the village, and both are Pentecostal. Neither minister has an occupation other than pastoring, and both spend a considerable portion of the day visiting in the community. The pastor of the larger church (Iglesia de Dios) spends an estimated six hours a day visiting in village homes. Because of these daily rounds, pastors are familiar figures in the village. Everyone knows them, and most people are pleased to have them visit, especially to pray for the sick. Pastors are readily available to come to residents' homes, whether or not the residents are members. Compared to all other healers, pastors are the most available. Also, unlike folk healers and medical professionals, pastors do not charge for their services.

Catholic priest. Priests are held in fairly high regard for their ability to act as a healing resource. Over 55% of the sample of community members regarded them so, with 74% of non-Pentecostals responding with some degree of favor to the importance of priests in the health system (see Table 18). In a combined ranking of the 12 healing resources, however, the priest ranked 8th, below both the doctor and the evangelical pastor. Among the six resources from the religious system, priests ranked fifth. This ranking may have been influenced by the fact that Pakal-Na has no resident priest. Instead, a father from Santo Domingo de Palenque holds regular Sunday morning mass in the

Catholic church on the edge of the community. (The church in Pakal-Na is not a cathedral.) The priest is also available for fiestas, weddings, baptisms, and funerals, but he must be reimbursed for special services. Priests are not usually available to the sick, so villagers must wait till Sunday or travel to Palenque to the cathedral to receive the healing blessing. One informant commented:

> Priests don't come to pray for you when you are sick. If you want them to come, you have to pay. If you want a mass, you have to pay. You have to pay for almost everything. To solve the problems of especially the rich they say masses and charge them a lot of money. For the poor they send them to the altar to pray for several hours.

In contrast, Pentecostal ministers are readily available to pray for the sick, and their services do not involve a fee.

A significant difference between Pentecostals and non-Pentecostals was evident in responses combining semantic descriptors. Nevertheless, 23% of the Pentecostals viewed the priest positively as a healer.

Table 18. Comparison of Attitudes Toward Use of The Priest by Pentecostal and Non-Pentecostal Residents of Pakal-Na.

	Level of Confidence/Strength/Use/Correctness		
	Low	Moderate	High
Pentecostals (n=94)	77%	7%	16%
Non-Pentecostals (n=162)	27%	43%	31%
Total (N=256)	45%	30%	25%
Chi Square = 63.130 df=2, $P(x^2)$= .0000 Cramer's V = 0.497			

More than 26% of the Pentecostals and 67% of the non-Pentecostals expressed confidence in the healing ability of the priest (see Appendix E: Table 64). Such a high percentage indicates that Pentecostals have not rejected the priest as an element of the health-resource system; however, the priest was not listed as a successful healer in the Pentecostal illustrations of healing episodes.

Cathedral. Due to the religious specificity of this healing resource, a significant difference between Pentecostals and non-Pentecostals was expected regarding this resource. Religious affiliation was obviously a significant factor in informants' responses to the cathedral, as indicated in Table 19. The closest cathedral for villagers of Pakal-Na is in the town of Santo Domingo de Palenque. The cathedral was identified as a healing resource because it is a location to which one goes to receive the priest's blessing, to petition the

Table 19. Comparison of Attitudes Toward Use of The Cathedral by Pentecostal and Non-Pentecostal Residents of Pakal-Na.

	Level of Confidence/Strength/Use/Correctness		
	Low	Moderate	High
Pentecostals (n=91)	85%	15%	0%
Non-Pentecostals (n=158)	27%	39%	34%
Total (N=249)	48%	31%	22%

Chi Square = 82.559 df=2, $P(x^2)= .0000$ Cramer's V = 0.576

healing power of the saints, and to ask for divine intervention for illness. Over 52% of the villagers indicated moderate to high confidence in the Catholic cathedral. Among non-Pentecostals the percentage increases to 73%. The strength of the difference between Pentecostals and non-Pentecostals is high, producing the second strongest Cramer's V score. The level of significance of the chi-square value surpassed the .01 level. Therefore, the null hypothesis was rejected on all four descriptors (see Appendix E: Tables 66-69). Pentecostals show a slightly favorable attitude (15%) toward the importance of the cathedral for healing purposes, but their responses still contrast sharply with their Catholic and nominal Catholic neighbors.

Pakal-Na Pentecostals' marginal acceptance of the cathedral as a healing resource results from their religious heritage in the Catholic church. Pentecostals do not overtly criticize the Catholic religion since all of them have Catholic family members, and Pentecostals are still very much a part of the Catholic religious culture. As one Pentecostal villager explained: "When we were in the Catholic church, we also believed in Christ. We would go to the cathedral, pray to Christ, and he would hear us."

II. DISCUSSION

Several characteristics of Mesoamerican healing are illustrated by these findings. Like other communities in Mesoamerica, Pakal-Na appears to have several healing orientations operating simultaneously; religious rituals and leaders are an important part of all healing

systems; disease causation may be interpreted as either naturalistic, personalistic or both; acceptance of modern medical elements is apparently based on availablility and on the severity of illness; and traditional folk resources are undergoing critical evaluation and a decline in use.

Table 20 indicates the rank order of Cramer's V values for the healing resources included in the semantic differential questionnaire and is, therefore, a good indicator of differences between groups. Pentecostals and non-Pentecostals show the greatest difference in their attitudes and behaviors toward modern medicine, cathedral, pastor, hospital/doctor, and priest. Some difference is recognizable between the two groups' responses to herbalist, Bible, and church. The remainder of the resources (herbs, sorcerer, and spiritist) show only slight contrast.

Table 20. Rank Order of Cramer's V Values for Semantic Questionnaire Responses.

Healing Resources	Cramer's V Values
Modern Medicine	.5768
Cathedral	.5758
Pastor	.5608
Hospital/Doctor	.5338
Priest	.4966
Herbalist	.4055
Bible	.3969
Church	.3600
Prayer	.3393
Herbs	.2158
Sorcerer	.1746
Spiritist	.1674

Table 21 indicates the relative importance of various healing resources in the Pentecostal and non-Pentecostal approaches. The 12 items on the semantic differential questionnaire have been ranked by the percentage of Pentecostals indicating high confidence/use. Responses of moderate or low confidence/use have not been considered in this ranking. As indicated in Chapter IV, the original semantic differential questionnaire had a range of five responses (0-4). The two highest (3-4) were combined for data analysis as were responses 1 and 2. Because of this combination, only high responses were used for the ranking. Rankings by non-Pentecostals appear in column 4 of Table 21. Both Pentecostals and non-Pentecostals indicated significant use of and confidence in the Bible, church and prayer, with the Bible ranked by both groups as the most important religious healing resource.

Table 21. Rank Order and Combined Percentage of High* Confidence/ Strength/Use/Correctness Responses by Pentecostals/Non-Pentecostals.

Healing Resources	Pentecostal		Non-Pentecostal	
	Rank Order	Percentage	Rank Order	Percentage
Bible	1	96%	2	61%
Church	2	92%	4	59%
Prayer	3	90%	3	60%
Pastor	4	76%	9	24%
Priest	5	16%	8	31%
Modern Medicine	6	15%	1	74%
Doctor-Hospital	7	6%	5	57%
Herbs	8	3%	7	34%
Spiritist	9	2%	11	4%
Sorcerer	10	1%	12	3%
Cathedral	11	0%	6	34%
Herbalist	11	0%	10	14%

* This table uses only the upper part (3-4) of the Likert scale (0-4).

Significant differences between the groups may be summarized as follows:

1. Pentecostals have much less confidence in modern medicine.

2. Pentecostals have less confidence, as would be expected, in essentially Catholic resources such as priest and cathedral.

3. Pentecostals have more confidence in the evangelical pastor. Despite the denominational differences between the two groups, however, Pentecostals exhibited relatively high confidence in the priest, and non-Pentecostals exhibited relatively high confidence in the evangelical pastor.

Judging from Table 21 and previous tables, the groups have the following similarities:

1. Neither has great confidence in sorcerers or spiritists as viable healers.

2. Both have high confidence in religious elements such as the church, the Bible and prayer.

These data strongly suggest that religious healing forms are major elements in both Pentecostal and non-Pentecostal approaches to healing. Religious forms are essentially personalistic since they identify with the forces of good in combat with the forces of evil. Nevertheless, there is a strong, though limited, naturalistic component in both orientations as well. Although Pentecostals report little confidence in modern medicine and/or doctors and hospitals, data reveal frequent use of these naturalistic alternatives. From the data, it appears that Pentecostals are attempting to integrate the essentially naturalistic

elements of the modern-western approach into their personalistic system. The result, for some Pentecostals, is the cognitive dissonance and confusion expressed by Teresa Montejo on page 102. Dissonance appears to be disspelled if the use of medicine (or herbs) can be worked into the Pentecostal ideology; i.e., if medicine is prayed for and "sanctified" before use or if its use is directed by God through visions. Non-Pentecostals also appear to be in transition although they evidence much higher acceptance of modern-western approaches.

What appears to be most appealing about Pentecostal healing ideology is that the sick person is not isolated, such as is generally true in hospitals. Instead, the patient is the focus of attention from a concerned church community. The practice of "laying on of hands" is emblematic of the involvement of the Pentecostal group with those who are sick, and data from this research support the idea that group prayer and prayer by one individual for another are very common, and in the minds of the Pakal-Na Pentecostals, very effective.

The personal healing approach forms the basis of rituals still performed among Pakal-Na Pentecostals. Largely marginal to the main stream of society, early Pentecostals characteristically had less knowledge about and access to adequate modern medical care. To compensate they accepted biblical passages on healing literally as curing information. As members experience upward mobility and greater access to western medicine, uncertainty concerning the healing ideology begins, yet rituals which emphasize personal elements of physical touching, home visitation, and mutual aid persist.

CHAPTER VII

PENTECOSTAL HEALING: A LOCAL PHENOMENON WITH INTERNATIONAL IMPLICATIONS

In this chapter, specific behaviors and attitudes associated with healing among members of each group are reviewed followed by a recapitulation of the findings. Advantages and disadvantages of movement membership for the villagers of Pakal-Na are presented. Finally, seven conclusions from the research are presented as they relate to modern medical practices, community development, church growth, and the need for further research.

I. COMPARISION OF PENTECOSTAL AND NON-PENTECOSTAL HEALING

Healing Among Non-Pentecostals

Despite favorable responses to religious healing resources, non-Pentecostals in Pakal-Na emphasize naturalistic healing to a greater extent than do Pentecostals. The non-Pentecostal perspective has several naturalistic characteristics. First, 74% of the non-Pentecostal population indicated high confidence in and use of modern medicine, ranking it highest of the 12 resources investigated. This confidence that modern medicine can cure implies belief that illness is caused primarily by natural forces. The second indication of a naturalistic perspective is the relatively high rating of hospitals/doctors with 57% indicating high confidence and use.

A third indication of a naturalistic orientation is the relatively low evaluation of all practitioners except the doctor. In the naturalistic system, an important share of responsibility for curing rests with the individual (Foster, 1976: 781). It is apparent from the non-Pentecostal questionnaire responses that respondents are assuming that responsibility. Non-Pentecostals ranked priests, pastors, herbalists, spiritists, and sorcerers last in terms of confidence and use (see Table 21 , p.115). Significantly, all practitioners ranked well below the resources or rituals usually associated with them. While the priest elicited confidence from 31%, prayer elicited confidence from 61%. Although only 14% had confidence in the herbalist, 34% had confidence in herbs. Even the medical doctor, who elicited confidence from 57% did not receive as favorable a rating as modern medicine, at 74%. The fact that non-Pentecostal respondents evaluate rituals and resources more positively than practitioners implies that they are demonstrating individual responsibility for curing rather than relying exclusively on healers, be they traditional, religious, or western.

A fourth naturalistic characteristic of Pakal-Na non-Pentecostals is that they have some confidence in herbs (34%). Although used by a variety of practitioners, herbs are usually associated with naturalistic perspectives. Fifth, a dramatic indicator of naturalistic orientation is found in the low confidence afforded traditional personalistic curers. The spiritist elicited high confidence from only 4% of the non-Pentecostals surveyed, and sorcerers elicited favorable responses from only 3%.

Despite this strong evidence of a naturalistic orientation, however, non-Pentecostals also demonstrated some inclination toward personalistic disease theory. Bible, prayer, and church--all closely associated with a personalistic perspective--received very positive ratings from the respondents to the questionnaire, with only modern medicine eliciting a higher degree of confidence; 61% exhibited confidence in the Bible, 60% in prayer, and 60% in the church. The Catholic cathedral also elicited a fairly positive rating with a confidence response of 34%, and the priest rated highest of the nonmedical curers with 31%. This high confidence in religious curing is sharply contrasted with the lack of confidence in traditional personalistic curers as indicated above.

The non-Pentecostal responses also indicate a high degree of experimentation. On the average each respondent expressed high confidence in 4 of the 12 resources investigated, and 9 of the 12 resources elicited high confidence from more than 30% of the respondents. This relatively favorable reaction to a variety of resources indicates that non-Pentecostals in Pakal-Na experiment selectively with cures from modern-western medicine, the religious tradition, and folk- traditional curing approaches.

The above findings concerning non-Pentecostal orientation to healing reinforce the idea that Pakal-Na is a rapidly modernizing village. As indicated in Chapter II, individuals in Pakal-Na are generally better educated than their counterparts in neighboring

communities, are employed more frequently in industry and commerce, and earn higher salaries with more fringe benefits. This modernization is reflected in their apparent acceptance of modern medicine, doctors and hospitals. Nevertheless, the healing methods profile drawn by these data does not indicate that Pakal-Na is totally modern. Just beneath the acceptance of depersonalized, naturalistic medicine lies strong adherence to traditional religious ideology. The ranking of the 12 healing resources by non-Pentecostals reveals high confidence in medicine, hospitals, and doctors; but equally high confidence in the Bible, church, prayer, and the cathedral. The intertwining of these resources in the rankings indicates experimentation but also confirms the impression of Pakal-Na as a village in transition. Interestingly, personalistic curers from the folk-traditional orientation are the only resources eliciting low confidence from a majority of respondents. The acceptance of naturalistic approaches in conjunction with modernization, the rejection of personalistic resources from the folk-traditional orientation, and retention of religious resources from the Catholic-cultural tradition indicate that Pakal-Na is the type of transitional culture in which Pentecostalism flourishes.

Pentecostal Healing

As indicated above, Pentecostal healing has an essentially personalistic orientation. Table 21 (p. 115) indicates that at least 75% of the Pentecostals responded with high confidence regarding Bible, church, prayer, and pastor. Each of these resources is personalistic in that each assumes the possibility of supernatural intervention in

curing. The 96% positive response to the Bible indicates almost universal reliance on scripture in health restoration, a particularly interesting statistic since approximately 25% of Pakal-Na Pentecostals are either illiterate or marginally literate. This high confidence among people who cannot read well indicates belief in the power of the scripture itself whether or not it is read and understood; i.e., Pentecostals who cannot read well enough to understand the Bible still carry it and use it in healing rituals. Structured interview material only partially supported this high confidence response to scripture, however. In case history data, the Bible was mentioned as bringing about successful healing 12 times. In some of these case histories, Pentecostals practiced psalming, but in others, the Bible was placed on the portion of the body causing pain. The Bible was also used as part of a healing ritual involving prayer, oil, and other resources in additional stories. Part of the discrepancy between the limited appearance of the Bible in narratives and the high percentage of positive responses toward it may be explained in terms of how the questionnaire was interpreted. In narratives, the Bible was counted as the healing resource if the actual book itself brought about healing either by direct application to the body or through reading. It may be that individuals responding to the questionnaire interpreted its use more broadly. Pentecostals believe that the Bible contains answers to all life's problems, including illness. High confidence in the Bible indicates belief that the resolution to one's illness might be found in its pages. Many healing narratives indicated that the cause of ill

health was an unholy life. Therefore, living according to the Bible can restore health, and the Bible is seen as an important health resource.

The evangelical church, as would be expected, received positive responses from 92% of the Pentecostals in the survey and was mentioned as the location of healing in 34 narratives. Again, church was interpreted more narrowly in the narratives than on the questionnaire. In the narratives, it was seen specifically as a healing location contrasted to home or hospital. On the questionnaire the concept included the church as a body of believers as well as a location. Therefore, an individual might be healed by the prayers of the church as well as in the church.

Prayer received positive responses from 90% of the Pentecostals surveyed. In healing narratives, curing resulted from prayer in 96 instances. In additional narratives, prayer was implied as part of a healing ritual even though it was not mentioned. The evangelical pastor was the only exclusively Pentecostal resource on the questionnaire. Rating high confidence from 76% of the Pentecostals surveyed, the pastor was mentioned as a successful curer in 21 healing narratives. Although the pastor elicited high confidence from a majority of the respondents, there is good reason why his rating did not approximate that of the Bible and the church. Pentecostals believe that the pastor's power to heal is derived from his dedicated and austere life style. As one man explained:

> I have seen that when there is a minister that is "used of the Holy Spirit," you can feel it; you might even cry. But if we have a minister in the church who is a ball player or a card player, or someone who spends all his time in social and physical life, I feel that God is not there because in the simple churches. . . we feel the presence of the Lord, and people are healed. The minister is not someone who just plays around; he is a formal person, a serious person.

It is difficult for a pastor to live up to his congregation's expectations, and their confidence in his healing abilities is directly related to the holiness of his life. Therefore, it is not surprising that only 76% of the respondents expressed high confidence in his ability to bring about healing.

The strength of the positive responses to these four resources (Bible, prayer, church, pastor) provides three important insights into Pentecostal healing. First, it underscores Pentecostal commitment to personalistic curing. Naturalistic resources (modern medicine, doctor/hospital, herbs and herbalist) elicited significantly less confidence than the four resource from the Pentecostal-religious perspective. In fact, the highest ranked naturalistic resource (modern medicine) elicited high confidence from only 15% of the respondents compared to the lowest ranked Pentecostal-religious resource (pastor) at 76%.

The second insight to be gained from the strength of the positive responses to Bible, church, prayer, and pastor is that Pentecostal healing is apparently part of a larger religious ideology which gives their healing perspective internal consistency. It is unlikely that Pentecostals surveyed would be in such significant agreement on healing resources if the Pentecostal healing orientation were not part of an integrated religious ideology. As indicated above, healing is often a

first step toward movement adherence; and individuals who come to the church for healing frequently become members, quickly socialized into the life-style requirements and theological orientations of the group. In 33 of the healing case histories, church membership resulted from a healing experience. In this integrated network, individuals seek healing, become members, and receive indoctrination concerning healing ideology. They are taught that illness can be caused by malevolent forces, allowed by God, or brought on by an unholy life style and that illness can be cured through prayer, belief in the Bible, and a sanctified life. Immediately after conversion, members become involved in the church which becomes the focal point of their lives.

Third, the clustering of high percentages around Bible, church, prayer, and pastor indicates that Pentecostals are much less experimental than their non-Pentecostal counterparts. These responses indicate that the Bible, prayer, the church, and the pastor comprise the principal healing repertoire among Pentecostals, at least within the context of the 12 resources indentified on the questionnaire. There is little experimentation with the herbalist or the cathedral and minimal use of and confidence in hospitals, herbs, spiritists, and sorcerers. Only the priest and modern medicine received a rating of confidence from more than 10% of the Pentecostal population. The priest is a respected religious leader, firmly established in the Mexican religious tradition, and Pentecostals have not completely rejected their preconversion religious orientation. Pentecostal dissonance over the use of medicine is indicated above. Some individuals may face death because they

believe healing must come from God; some consult physicians but refuse to take the medicines prescribed; some are cured by western medicine but subsequently feel ostracized from the church; and some attempt to integrate medicine into the Pentecostal framework by praying before taking it or by consulting a physician only if directed to do so in a vision from God.

While the Bible, church, prayer, and the pastor comprise the core of the Pentecostal healing methodology, several other significant resources were mentioned in interviews. Fasting, for example, brought about a successful cure in 14 narratives (11%). Pentecostals view fasting as a chastening experience that purifies the body of physical desires, and it serves to focus one's attention on spiritual matters. Fasting is useful in bringing about the holy life considered necessary for healing. Interestingly, it was not always the main character (patient) who fasted. In several case histories, fasting was done by the healer, reinforcing the idea that the pastor or prayer leader must be holy in order to be a conduit of God's power.

Sanctified oil (olive oil) also appears to be an important part of the Pentecostal healing ritual. Mentioned as bringing about successful healing in 11 narratives (9%), oil was central to most of the healing rituals observed. It is used in three primary ways. The leader of the group praying for an individual's healing places a small amount of oil on the sick person's forehead before group prayer begins. On some occasions the oil is prayed for first then placed on the part of the body which is in pain (see illustration on p. 80). A third use of oil

is internal. In this use, oil takes the place of herbs and is drunk in relatively small amounts after it has been blessed.

In contrast to questionnaire responses, interviews indicated some use of herbs as a healing resource. Eight individuals (7%) recounted healings brought about by herbal remedies. However, each of these narratives showed an interesting method of justifying the use of herbs within the Pentecostal framework. In one case (see p. 80.), a man was told in a vision sent from God to use yucca starch to cure his child. In other narratives, individuals prayed over herbs much as they prayed to sanctify the oil. In each case, the herbs were used as part of the Pentecostal healing orientation, and in no instance were they acquired from an herbalist. Thus, the naturalistic aspect of herbal curing is removed and use of herbal remedies is justified within the personalistic Pentecostal perspective.

A dedicated life style, visions, and Holy Spirit possession were also mentioned by informants as resources bringing about cures. The necessity of a holy life underlies much of Pentecostal ideology, and holiness is seen as a prerequisite for any "blessing" from God. Therefore, an austere life style underlies accessibility to healing whether or not individuals specifically mentioned it in narratives. (The only exception to this occurred when nonbelievers were healed and subsequently joined the church.) Three individuals indicated that their healing came about as a direct result of a dedicated life style. That is, their illness dissipated when they began to live in a more holy fashion. Two individuals indicated that they were healed as a result

of having a vision, and two others were healed when they received the baptism of the Holy Spirit.

As mentioned previously, healing narratives in the interviews often related experiences which occurred, at least in part, prior to movement membership. Therefore, case-history materials for Pentecostals exhibit more diverse health-care selection than indicated by questionnaire data. Only 1 healer was consulted in 68 of the case histories; 2 healers were consulted in 27 instances; 3 healers in 10 cases; and 4 healers were consulted in 3 case histories. The fact that more than one type of curer was employed suggests that only the final selection proved successful. Despite such experimentation, however, in 87 of the 123 narratives (71%), successful healing was brought about by a member of the Pentecostal fellowship.

The personalistic nature of Pentecostal healing is demonstrated by the importance placed on group prayer and church/community involvement. In 53 narratives (43%), individuals indicated that healing was accomplished through prayer by members of the church. In 34 of these illustrations a group of believers brought about the healing, and in 13 narratives the prayer was among family members. Forty-seven narratives (38%) indicated that the individual was cured when he prayed for himself (without the active assistance of other believers). Nevertheless, group support in illness/curing is essential to Pentecostals. Each evening, healing testimonies are given in church services; and Pentecostals believe that if an individual fails to announce his healing to others in the fellowship, he may become ill once again. This group

concern and involvement blend well with the integrated Pentecostal life style, with the church/community at its center.

Commitment to the group and to the Pentecostal identity is also seen in reactions of Pentecostals to modern medicine. Although the doctor received a rating of high confidence from only 6% of the questionnaire respondents, he was mentioned as a consulted healer in 46 interviews (37%), more than twice as often as the evangelical pastor. However, the pastor was successful in 100% of his attempts at healing, while the doctor was successful in only 11 consultations (25%). In several case histories, the point of the narrative was that even though the patient consulted a doctor, he was ultimately healed by God. Therefore, the doctor was mentioned whether or not he was successful, but the pastor was mentioned apparently only when he was successful. In fact, doctors are probably used widely by Pakal-Na Pentecostals, but their reluctance to express high confidence in modern medical services is explained in part by their commitment to the Pentecostal group. For the Pentecostals interviewed, a "physical" cure is often insufficient for complete recovery. Because illness is a church/community concern, the entire church congregation becomes involved in the search for health. If health is restored by forces outside the church, the cured individual typically feels isolated from the prayer group. There is hesitancy to testify about the cure or even to go to the altar (see quote on p. 102). Frequently, in order to be reintegrated into the fellowship of believers, the individual will seek group prayer in the church by the pastor and fellow believers after physical health has

been restored. This second "healing" is a spiritual or at least a social necessity quite apart from physical recovery.

Recapitulation

In drawing together information gathered from the three major research methods employed in this study (participant observation, structured interviews, and semantic differential questionnaire), a profile of healing perspectives for Pentecostals and non-Pentecostals in Pakal-Na emerges. The two populations appear to share a hesitancy toward the use of traditional folk healers, primarily sorcerers and spiritists, and each exhibits similarly high regard for religious sources of healing power, notably the Bible, the church, and prayer. Non-Pentecostals, however, are more oriented toward a naturalistic perspective, with confidence in modern medicine and herbs. The transitional nature of the village can be seen in non-Pentecostals' willingness to experiment with personalistic resources from the religious orientation. The village is modernizing to a significant extent, as demonstrated by educational level, type of employment, and type of home construction used in Pakal-Na; and modernization can be seen in non-Pentecostals' use of western medicine. Nevertheless, non-Pentecostals express a somewhat eclectic perspective in their relatively high confidence in personalistic/religious elements, notably the Bible, prayer, and church.

Pentecostals express strong commitment to personalistic/religious elements such as the pastor, church, Bible, and prayer, but they

express only minimal confidence in naturalistic resources including modern medicine. The high similarity of responses among Pentecostals indicates that an ideological framework for healing underlies their health-seeking behavior. However, their negative attitudes concerning modern medicine seem to contradict their relatively high use of and consultation with medical professionals. This contrast suggests transition in the Pentecostal orientation and points to increased use of naturalistic resources. The dissonance created by use of modern medicine has led to attempts to integrate it into Pentecostal ideology.

Both Pentecostal and non-Pentecostal orientations appear to be in transition. Non-Pentecostals are incorporating modern western medicine faster and with less cognitive dissonance than are Pentecostals. Nevertheless, non-Pentecostals are demonstrably experimental and have not entirely rejected religious sources of curing. The most important factor in the Pentecostal perspective appears to be the support and encouragement of the church community, a factor which apparently appeals to many residents. Since healing of nonbelievers frequently results in movement membership, and since non-Pentecostals are highly experimental in their search for healing, the healing resources of the Pentecostal movement appear to be a primary factor underlying its growth in Pakal-Na.

II. POSITIVE AND NEGATIVE FUNCTIONS OF PENTECOSTALISM

Studies on Pentecostalism indicate that it flourishes in rapidly developing areas because it aids individuals in adjusting to new

elements in their environment (cf. Glazier, 1980). The study of Pentecostal healing in Pakal-Na bears out this assessment in the following ways. First, Pakal-Na is a modernizing village in transition. Despite industrial-type employment, education, and a rising standard of living, many residents place confidence in personalized elements such as the church, the Bible, and prayer. In short, Pakal-Na is the type of community in which Pentecostalism flourishes.

Secondly, Pentecostalism has significant growth potential in Pakal-Na since individuals utilize its resources for social integration. Many families move to Pakal-Na without the support of extended kin, and find that the Pentecostal church provides aid and quasi-family relationships. Furthermore, Pentecostalism offers group identity for new comers and positions of leadership to individuals (including women) not normally afforded such opportunities.

Third, the Pentecostal healing orientation enhances community integration. Villagers are in transition between personalistic and modern-western curing. Their confidence in traditional healers appears to be declining, yet they do not totally accept modern-western practices which may isolate the individual from his family. Also, many Pakal-Na residents consider some diseases susceptible to natural cures, but they also believe that some are curable only by supernatural means. Pentecostalism provides the transition between traditional and modern approaches. In Pentecostal healing, the individual is integrated into the group rather than being isolated, and in some instances, Pentecostal practices validate modern medicine by implying that it is approved

by God. Finally, Pentecostalism provides an available, personalistic curer who treats supernaturally caused illness without a fee.

Despite its positive aspects, Pentecostalism has specific dysfunctions. Neither Pentecostal denomination in the village has a theological statement regarding modern medicine, and believers are divided in their opinions regarding this resource. As a result, some individuals may have died because they did not consult a physician; some have used medicine claiming they were directed by God; and some have been cured through medicine but feared ostracism from the group.

Pentecostalism requires stringent life-style commitments, and while the movement integrates community members on one hand, it also slows integration by enveloping individuals in a group with inflexible membership requirements. In the same manner, while Pentecostalism moves some individuals from traditional to modern medical practices, it may also retard acceptance of western medicine. Individuals who believe only in Pentecostal healing will not accept medicine or doctors.

Pentecostalism offers an ideological framework for rapid partial assimilation into a modernizing society, but it also prevents complete assimilation because of its rigid membership requirements. It offers a transition between traditional and western medicine, yet without a clear theology, it also prevents complete acceptance of medicine, doctors, and hospitals. It has provided Pakal-Na with an integrated supportive religious community and an available, inexpensive personalistic healer; but in return it has demanded a strict life-style

commitment of the recipients of his services. The success of Pentecostalism as an integrating force and as a bridge between traditional and modern health care systems will depend on the willingness of individuals to make the life-style concessions demanded, the ability of the Pentecostals to clarify their theology, and the continued need of Pakal-Na residents to be incorporated into a church community.

III. CONCLUSIONS

Data from this study have seven significant conclusions. The first four relate primarily to the practice of modern medicine in a transitional village like Pakal-Na; the fifth is a community development concern relevant to both community and Pentecostal church leaders; the sixth is primarily of concern to individuals interested in church growth and religious movements; and the seventh conclusion addresses the need for further research.

The first conclusion of the data suggests that social interaction is important to the recovery of the ill person in Pakal-Na. For Pentecostals, illness is socially integrating rather than socially isolating, and this quality has implications for the practice of modern medicine. When a critically ill person consults a doctor, he is usually hospitalized, taken away from his kin and social groups, and placed in an alien environment. In sharp contrast, a critically ill Pentecostal is integrated into the social network of the congregation. In fact, illness intensifies social interaction in the Pentecostal healing orientation. Even very sick people are brought to church

services where they are prayed for by the entire congregation. During this prayer, all the individuals in attendance gather around, and as many as possible place their hands on the subject. Rather than being isolated, the patient is literally embraced by the body of believers. Outside of the church service, the intensified social interaction continues with daily visits from members, the pastor, and the prayer group.

Many village residents expressed fear and concern over being separated from their families and placed in distant hospitals. Medical professionals in Pakal-Na explained that some Pentecostals did not use their services because of religious beliefs, but that a larger number avoided them because of fear of being put in the hospital. The desire of Pakal-Na residents to remain in familiar surroundings during illness suggests that modern-western practitioners might need to look for alternatives to hospitalization for villagers. In-hospital alternatives could include more liberal visiting hours and permission for a family member to live with the patient and carry out tasks usually performed by practical nurses. Several Pentecostals indicated that believers from the church were not allowed to come into their hospital rooms to pray for them; it would be helpful to allow such prayer. Integration of fellow believers into an individual's medical curing would lessen present tension between the desire to seek professional medical attention and the desire to remain an accepted member of the fellowship.

Secondly, the data suggest that Pentecostal denominations represented in Pakal-Na might assist in the integration of villagers into the modern-western health care system by clarifying their theological position on the use of modern medicine. Given the existing dissonance among many Pentecostals over the appropriateness of using doctors and medicine, it would appear that such a clarification would be helpful to local residents. If these denominations supported the use of medicine, Pentecostal curing resources could be utilized in a number of ways to facilitate health among both Pentecostal and non-Pentecostal villagers. Because the church is viewed as an important location for healing, the religious aspects of Pentecostal curing might be expanded to include resources from the modern-western approach. Pentecostal churches have served successfully as clinics in Haiti, South Africa, and Guatemala, for example. Since villagers already come to the church to seek healing, the church itself could dispense medicine and medical advice. The use of the church for this purpose would reduce tension among villagers not accustomed to modern-western practices. This might be an important step in personalizing the naturalistic elements in the modern-western system, a meaningful integration for both Pentecostals and non-Pentecostals.

The pastor might also play an important role in health restoration. Again, villagers frequently contact the evangelical pastor for healing, and he is a respected member of the community. Because he is in daily contact with the ill people in the village, he could serve as a valuable resource person. For minor illnesses, he could refer people

to the church clinic; for more serious illnesses, he could refer individuals to doctors familiar with Pentecostal ideology. Because Pentecostals already attempt to integrate the naturalistic resources of western medicine into their personalistic framework, this use of the pastor might be accepted readily. The community view of healing shared by Pentecostals could also be meaningfully integrated into modern-western approaches. Both Pentecostal and non-Pentecostal villagers would benefit from local church sponsorship of clinics, a program to establish lines of communication between religious leaders and nearby medical personnel, and a clearly expressed theological position on healing by local Pentecostals.

The third conclusion drawn from the research data is that Pentecostalism appears to be filling a gap created by the rejection of certain personalistic curers (sorcerers and spiritists). Data reveal that non-Pentecostals in Pakal-Na no longer express great confidence in these folk healers and that they have largely turned to modern-western medicine in their more naturalistic approach to healing. Nevertheless, they have not abandoned a personalistic perspective, as evidenced by their high confidence in the religious resources of church, prayer, and the Bible. However, in this blend of personalistic/religious and naturalistic/modern resources, there remains no personalistic curer who elicits high confidence from a majority of non-Pentecostals. Sorcerers and spiritists have probably been rejected, at least in part, because villagers are becoming increasingly modernized and educated, and the number of traditional healers is rapidly declining. However, reduced

use and confidence in sorcerers as part of the traditional healing repertoire leaves a gap. As indicated earlier, the use of modern medicine often results in the disruptive experience of hospitalization. This disruption cannot be avoided through the use of any of the curers remaining in the non-Pentecostal orientation except the priest who is not readily available. Further, none of the curers in the naturalistic system can combat diseases with personalistic causes. Therefore, individuals may be turning to Pentecostalism to fill the vacancy left by the declining acceptance of personalistic folk-traditional curers.

The fourth conclusion is that, as Margolies (1980) suggests, Pentecostal healing serves a "back-up mechanism" to both folk-traditional and modern-western approaches. Narratives and questionnaire responses indicated that Pakal-Na residents are experimental in seeking cures. For 40 of the individuals interviewed (85%), other resources were tried before Pentecostal healers were consulted. Some individuals tried as many as three other curers before turning to the Pentecostals.

The fifth conclusion is that Pentecostalism appears to be providing strong identity, community focus, and quasi-kin relationships for the transitional population of Pakal-Na, and that its healing orientation is one important resource in that framework. As discussed in Chapter II, residents of Pakal-Na are typically somewhat new to the area and tend to be neolocal nuclear families without strong kinship ties in the village. In events of crisis, including illness, individuals become more aware of their isolation from extended kin, but

Pentecostalism offers quasi-kin relationships. As stated earlier, Pentecostals intensify social interaction during illness. In addition to group prayer, they also provide assistance and emotional support during crisis periods. Pakal-Na Pentecostal churches have committees which prepare food; assist with housework, laundry and child care; and generally fulfill the functions of the family when someone is ill. Significantly, Pentecostals refer to each other as hermanos and hermanas, brothers and sisters. Nightly Pentecostal services offer leadership to individuals (many of whom are women) who would not otherwise be placed in such positions. Membership in the movement provides an individual with an identity, usually a very positive one.

Pentecostals, however, require firm commitment to the church in return for public support and concern. As one is embraced by the community, he surrenders a significant portion of his individuality and is indoctrinated into the ideology and behavior of the group. Once a person is accepted as a group member, a high standard of behavior is required. Individuals in the Pakal-Na churches who fail to live up to the standards of the group are placed on probation for a minimum of one year. During this time, they must attend all church services, but they are not allowed to take an active part. They continue to support the church financially, but some of its benefits (e.g., accessibility to leadership roles) are withheld. If a second violation of behavioral standards occurs during the probationary period, the person is excommunicated. Probation is fairly common; however, excommunication is

less common since individuals on probation generally either conform or withdraw from the church community voluntarily.

A sixth conclusion drawn from the data is that the growth potential for the Pentecostal movement in Pakal-Na is promising but uncertain. Although the potential for attracting new members is great, second generation attrition appears to be high. One reason for the growth potential is the transitional nature of the community. Pentecostalism flourishes where rapid modernization is taking place because it provides the type of support and community integration mentioned previously. Other reasons for its growth potential can be traced directly to the healing orientation of Pentecostalism. Almost 80% of the Pentecostals interviewed indicated that they joined the movement because of the role that the church played in healing. Even non-Pentecostals demonstrate an appreciation of characteristically Pentecostal healing resources. Since the Pentecostal pastor is readily available as a healer in the community, and since his services are free, it is likely that many non-Pentecostals will continue to employ his services. The present data suggest strongly that healing as a motive for membership will continue, and that the movement will possibly grow in the Pakal-Na area.

The data, however, also suggest that the movement might suffer significant attrition. If healing is the primary motive for membership, an individual's enthusiasm may wane after healing has been achieved. Even though the group offers community identity and group support, its life-style requirements are rigid and demanding. While a

miraculous cure might be sufficient justification for someone to join the movement, interviews indicated that initial enthusiasm did not carry over to dependents. When the children of converts reached an age of individual decision, many of them chose not to remain in the movement. They were already integrated into the community and had kinship ties in Pakal-Na. The healing which originally brought the family into the church had become a distant memory to the younger generation, and they lacked their parents' mistrust of modern medicine and hospitals. Therefore, just as the healing orientation provides a strong motive for movement membership and portends movement growth, it also implies some difficulty in maintaining movement permanence from generation to generation and suggests that--unless other motives for membership are developed-- Pentecostalism in this area might be limited primarily to new converts.

The final conclusion of the reseach data indicates areas for further research. Within the past decade research on the international Pentecostal movement has begun to proliferate. Glazier (1980) suggests that interest has reached a level justifying the development of an area of concentration in "Pentecostal studies." Research into the causes and dynamics of this religious organization is much needed. Several countries in which the movement deserves immediate investigation include Mexico, Guatemala, Brazil, Chile, South Africa, Nigeria, Romania, Indonesia, and Korea. These countries claim a significant and rapidly growing Pentecostal population.

Most research into Pentecostalism has concentrated on the expressive participatory worship style and the function of glossolalia for cognitive reorganization, but these features occur after movement involvement. What attracts new adherents to the Pentecostal movement? Investigations of this topic suggest that unresolved personal crises tend to drive a person to alternatives ordinarily not considered. Illness, particularly long-term sickness, has this effect. Therefore, the search for healing, as indicated in this study, is frequently a motive for Pentecostal membership. This phenomenon, however, deserves greater attention than it has received to date.

Because Pentecostalism is healing-oriented, it would also be profitable to investigate the clinical health status of Pentecostals. That is, are Pentecostals more frequently ill than their counterparts? Do they carry a greater disease load than nonmembers? Does the movement focus so heavily on healing that it enhances psychological stress? To what extent does reliance on Pentecostal healing deter individuals from seeking western medical treatment?

A final topic concerning Pentecostals and health would be what are the physiological reactions to Pentecostal prayer and healing rituals? Can such reactions be explained? Moreover, what types of diseases are most frequently treated successfully by prayer, use of oil, fasting, laying on of hands, etc.? Is the type of disease related to the apparent, though differential, success of Pentecostal healing?

In modernizing cultures, disease etiology is redefined, and diseases are reclassified according to both indigenous and

modern-western categories. In Pakal-Na, living conditions are improving, and community health should be enhanced by the products of modernization. Village residents, nevertheless, contend that there is more disease now than ever before. Because they are in transition, the residents classify some diseases as naturally caused and some as supernaturally caused. As they move toward increased use of modern-western approaches, it would be interesting to ascertain whether their assessment of disease etiology also moves toward a more naturalistic orientation. Research on "holistic health" has brought renewed attention to the importance of a variety of curing forms. Holistic healing offers a fruitful area of investigation to the anthropologist because --in several ways--it appears to be a return to healing orientations common in preindustrial societies.

Anthropologists need to give greater research attention to health related issues because of the significant role healing plays in several socioreligious movements including Pentecostalism. A more traditional view of health addresses the social, emotional, and physical components of the individual; and, thus, illness is a symptom of some imbalance. Personalistic healing is a response to a wide variety of problems. Socioreligious movements that focus on healing may be an attempt on the part of individuals under the stress of modernization to redefine their relationship to their total environment. As anthropologists are more and more drawn into areas associated with modernization and culture change, they should be aware of the relationship between new

healing forms and social movements. This surely seems to be the case with Pentecostals in Pakal-Na.

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APPENDICES

APPENDIX A

METHOD OF HOME CONSTRUCTION MATERIALS DATA COLLECTION

The specific responsibilities of one of the research assistants was to map the village and note the roof, wall, and floor materials that were used in the construction of the village houses. First, a map was drawn of the village including the location of each edifice, specifying the residences of the Pentecostals. Second, the assistant selected a sample of 214 homes (every third house) of the approximately 600 family dwellings in the village and listed the house materials. The data collected on a sample of village homes were compared to the materials in Pentecostal homes as noted by the researcher during the interview portion of the project. Finally, the researcher's data on home construction materials were checked by comparison to the homes that were identified as being residences of Pentecostal members on the map constructed by the research assistant. The results of comparison of Pentecostal to non-Pentecostal home construction materials are given in Table 3.

APPENDIX B

PENTECOSTAL MEMBERSHIP

It is difficult to determine total Pentecostal participation for the municipality due to unreliable church rolls, and even accurate membership lists underestimate total involvement in the movement because strict behavioral standards discourage some individuals from becoming members. For example, members must give 10% of their income to the church and refrain from drinking, smoking, dancing, attending movies, wearing jewelry, or swimming with members of the opposite sex. In addition, female members are not permitted to use cosmetics, cut their hair, or wear immodest clothing including shorts, slacks, and short sleeved dresses. Individuals who have been divorced and remarried are permanently ineligible for membership although they may be active participants. An adherent serves a year's probation after conversion before being considered for placement on the roll, and any behavioral infraction, even by long-time members can cause return to probationary status and loss of membership rights. Further, both excommunication and reaffirmation of membership make the rolls somewhat fluid. To further confuse the issue, each pastor may establish his own criteria for membership as long as they are not more lenient than those of the denomination. Finally, individual pastors sometimes discard existing rolls and establish their own lists based on current active participation. It is more profitable, therefore, to concentrate on

attendance than on membership for an understanding of the impact of the movement on the community.

Average combined Sunday night attendance for the two Pentecostal congregations in Pakal-Na is 185. The size of the congregations fluctuates radically. In Pakal-Na, the Iglesia de Dios averaged over 150 before internal disputes reduced the congregation to 50 or less. This significant decrease indicates that many more villagers have been part of the movement than the present attendance statistics indicate.

A comparison of membership records to census data indicates that only 5% of the villagers are Pentecostal church members. Yet, as earlier stated, the mayor or municipal agent claimed that one-half the residents were Pentecostal. This discrepancy can be accounted for in three ways. First, as indicated above, membership lists are often inaccurate. Second, the agent was no doubt referring to the number of individuals who are sympathetic to the Pentecostals rather than to actual members; and third, he apparently over-estimated the number of adherents. One conclusion that can be drawn concerning the influence of Pentecostalism in Pakal-Na is that membership and attendance statistics under represent the extent of its influence, and the estimate of the municipal agent over estimates the number of people directly involved in the movement.

APPENDIX C

PENTECOSTAL INTERVIEW FORMAT

Instructions: Interview questions must cover all the following information.

Biographical Data:
1. Age
2. Marital status
3. Number of children
4. Educational level
5. Length of time lived in Pakal-Na
6. Type(s) of employment and length

Testimonial Information:
1. First contact with Pentecostalism
2. Believer or member: length of each
3. Involvement in church
4. Spirit baptism
5. Number of family members also in church
6. Visions or revelations
7. Instances of healings- yourself, family or friends

Specific Healing Questions:
1. What type of healers are there in the village?
2. How much confidence do you have in medicine, doctors and hospitals to heal?
3. Do you ever use herbs or go to the herbalist for healing?
4. Have your children been sick a lot? What do they get most often? How do you cure them?
5. Have you had any periods of major sickness in the past several years? What did you use or how did you get well?
6. Why do people go to the Pentecostal church for healing? What do they do that heals those that go?
7. Are there any sicknesses that a sorcerer can heal?

Other Questions:
1. From what location did you move to come to Pakal-Na?
2. Has the community gotten better or worse in the past ten years?
3. Are you better off financially since coming to this community?
4. What do you think your life will be like ten years from now?

APPENDIX D

SEMANTIC DIFFERENTIAL QUESTIONNAIRE ON HEALING FORMS

INSTRUCCIONES: Encierre en un circulo el numero que represente mejor su sentir, segun su opinion, de la columna de palabras escritas en mayuscula. (Instructions: Circle the number that represents best your feelings about the associated capitalized word.)
Los numeros equivalen asi: (The numbers are equivalent to:)

0= NO ACREDITADA- NA
1= REGULAR- R
2= BIEN- B
3= MUY BIEN- MB
4= EXCELENTE- E

Que numero represente mejor el PODER en un(a):
(What number represents best the HEALING STRENGHTH in a:)

	NA	R	B	MB	E
Hospital(Hospital)------	0	1	2	3	4
Hierbas(Herbs)----------	0	1	2	3	4
Medicina(Medicine)------	0	1	2	3	4
Pastor(Pastor)----------	0	1	2	3	4
Brujo(Sorcerer)---------	0	1	2	3	4
Oraciones(Prayers)------	0	1	2	3	4
Catedral(Cathedral)-----	0	1	2	3	4
El Sacerdote(Priest)----	0	1	2	3	4
Iglesia(Church)---------	0	1	2	3	4
Hierbero(Herbalist)-----	0	1	2	3	4
Espiritista(Spiritist)--	0	1	2	3	4
La Biblia(Bible)--------	0	1	2	3	4

Que numero representa mejor lo JUSTO en un(a):
(What number represents best the HEALING CORRECTNESS in a:)

	NA	R	B	MB	E
Hospital------	0	1	2	3	4
Hierbas-------	0	1	2	3	4
Medicina------	0	1	2	3	4
Pastor--------	0	1	2	3	4
Brujo---------	0	1	2	3	4
Oraciones-----	0	1	2	3	4
Catedral------	0	1	2	3	4
El Sacerdote--	0	1	2	3	4
Iglesia-------	0	1	2	3	4
Hierbero------	0	1	2	3	4
Espiritista---	0	1	2	3	4
La Biblia-----	0	1	2	3	4

Que numero representa mejor lo UTIL en un(a):
(What number represents best the HEALING USEFULNESS in a:)

	NA	R	B	MB	E
Hospital------	0	1	2	3	4
Hierbas-------	0	1	2	3	4
Pastor--------	0	1	2	3	4
Medicina------	0	1	2	3	4
Brujo---------	0	1	2	3	4
Oraciones-----	0	1	2	3	4
Catedral------	0	1	2	3	4
El Sacerdote--	0	1	2	3	4
Iglesia-------	0	1	2	3	4
Hierbero------	0	1	2	3	4
Espiritista---	0	1	2	3	4
La Biblia-----	0	1	2	3	4

Que numero representa mejor su CONFIANZA en un(a):
(What number represents best your HEALING CONFIDENCE in a:)

	NA	R	B	MB	E
Hospital------	0	1	2	3	4
Hierbas-------	0	1	2	3	4
Pastor--------	0	1	2	3	4
Medicina------	0	1	2	3	4
Brujo---------	0	1	2	3	4
Oraciones-----	0	1	2	3	4
Catedral------	0	1	2	3	4
El Sacerdote--	0	1	2	3	4
Iglesia-------	0	1	2	3	4
Hierbero------	0	1	2	3	4
Espiritista---	0	1	2	3	4
La Biblia-----	0	1	2	3	4

Edad (Age):_____ Sexo (Sex): M F
Afiliacion Religiosa (Religious Affiliation):_____
Estado Civil (Marital Status):_____
Empleo (Employment):_____

APPENDIX E

STATISTICAL DATA

Table 22. Comparison of Attitudes Toward the Strength of Herbs.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=24)	13	54.2	11	45.8	0	0.0
Non-Pentecostals (n=41)	8	19.5	22	53.7	11	26.8
Total (N=65)	21	32.3	33	50.8	11	16.9

Chi Square = 12.249 df=2, $P(x^2)$= .0027 Cramer's V = 0.434

Table 23. Comparison of Attitudes Toward the Use of Herbs.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=28)	12	42.9	14	50.0	2	7.1
Non-Pentecostals (n=42)	8	19.0	19	45.2	15	35.7
Total (N=70)	20	28.6	33	47.1	17	24.3

Chi Square = 9.062 df=2, $P(x^2)$= .0110 Cramer's V = 0.360

Table 24. Comparison of Degree of Confidence in Herbs.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=26)	13	50.0	13	50.0	0	0.0
Non-Pentecostals (n=39)	10	25.6	16	41.0	13	33.3
Total (N=65)	23	35.4	29	44.6	13	20.0

Chi Square = 11.564 df=2, $P(x^2)$= .0036 Cramer's V = 0.422

Table 25. Comparison of Attitudes Toward the Correctness of Herbs.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=22)	9	40.9	12	54.5	1	4.5
Non-Pentecostals (n=42)	9	21.4	18	42.9	15	35.7
Total (N=64)	18	28.1	30	46.9	16	25.0

Chi Square = 7.980 df=2, $P(x^2)$= .0184 Cramer's V = 0.353

Table 26. Comparison of Attitudes Toward the Strength of Herbalists.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=22)	19	86.4	3	13.6	0	0.0
Non-Pentecostals (n=40)	20	50.0	15	37.5	5	12.5
Total (N=62)	39	62.9	18	29.0	5	8.1

Chi Square = 8.518 df=2, $P(x^2)= .0142$ Cramer's V = 0.371

Table 27. Comparison of Attitudes Toward the Use of Herbalists.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=24)	21	87.5	3	12.5	0	0.0
Non-Pentecostals (n=41)	20	48.8	14	34.1	7	17.1
Total (N=65)	41	63.1	17	26.2	7	10.8

Chi Square = 10.408 df=2, $P(x^2)= .0060$ Cramer's V = 0.400

Table 28. Comparison of Degree of Confidence in Herbalists.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=22)	22	100.0	0	0.0	0	0.0
Non-Pentecostals (n=40)	22	55.0	14	35.0	4	10.0
Total (N=62)	44	71.0	14	22.6	4	6.5

Chi Square = 13.950 df=2, $P(x^2)$= .0014 Cramer's V = 0.474

Table 29. Comparison of Attitudes Toward the Correctness of Herbalists.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=21)	20	95.2	1	5.0	0	0.0
Non-Pentecostals (n=38)	22	57.9	10	26.3	6	15.8
Total (N=59)	42	71.2	11	18.6	6	10.2

Chi Square = 9.336 df=2, $P(x^2)$= .0097 Cramer's V = 0.398

Table 30. Comparison of Attitudes Toward the Strength of Spiritists.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=24)	22	91.7	2	8.3	0	0.0
Non-Pentecostals (n=39)	30	76.9	7	17.9	2	5.1
Total (N=63)	52	82.5	9	14.3	2	3.2

Chi Square = 2.584 df=2, $P(x^2)$= .2743 Cramer's V = 0.203

Table 31. Comparison of Attitudes Toward the Use of Spiritists.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=28)	27	96.4	1	3.6	0	0.0
Non-Pentecostals (n=41)	34	82.9	5	12.2	2	4.9
Total (N=69)	61	88.4	6	8.7	2	2.9

Chi Square = 3.132 df=2, $P(x^2)$= .2076 Cramer's V = 0.213

Table 32. Comparison of Degree of Confidence in Spiritists.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=24)	23	95.8	0	0.0	1	4.2
Non-Pentecostals (n=40)	36	90.0	3	7.5	1	2.5
Total (N=64)	59	92.2	3	4.7	2	3.1

Chi Square = 1.989 df=2, $P(x^2)$= .6280 Cramer's V = 0.176

Table 33. Comparison of Attitudes Toward the Correctness of Spiritists.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=22)	20	90.6	1	4.5	1	4.5
Non-Pentecostals (n=38)	30	78.9	6	15.8	2	5.3
Total (N=60)	50	83.3	7	11.7	3	5.0

Chi Square = 1.764 df=2, $P(x^2)$= .5828 Cramer's V = 0.172

Table 34. Comparison of Attitudes Toward the Strength of Sorcerers.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=24)	24	100.0	0	0.0	0	0.0
Non-Pentecostals (n=40)	36	90.0	2	5.0	2	5.0
Total (N=64)	60	93.8	2	3.1	2	3.1

Chi Square = 2.560 df=2, $P(x^2)$= .2780 Cramer's V = 0.200

Table 35. Comparison of Attitudes Toward the Use of Sorcerers.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=27)	27	100.0	0	0.0	0	0.0
Non-Pentecostals (n=42)	34	81.0	6	14.3	2	4.7
Total (N=69)	61	88.4	6	8.7	2	2.9

Chi Square = 5.817 df=2, $P(x^2)$= .0534 Cramer's V = 0.290

Table 36. Comparison of Degree of Confidence in Sorcerers.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=25)	23	92.0	1	4.0	1	4.0
Non-Pentecostals (n=39)	37	94.9	2	5.1	0	0.0
Total (N=64)	60	93.8	3	4.7	1	1.6

Chi Square = 1.615 df=2, $P(x^2)$= .5500 Cramer's V = 0.159

Table 37. Comparison of Attitudes Toward the Correctness of Sorcerers.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=22)	22	100.0	0	0.0	0	0.0
Non-Pentecostals (n=40)	35	87.5	4	10.0	1	2.5
Total (N=62)	57	91.9	4	6.5	1	1.6

Chi Square = 2.991 df=2, $P(x^2)$= .2229 Cramer's V = 0.220

Table 38. Comparison of Attitudes Toward the Strength of Modern Medicine.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=27)	2	7.4	23	85.2	2	7.4
Non-Pentecostals (n=42)	2	4.8	11	26.2	29	69.0
Total (N=69)	4	5.8	34	49.3	31	44.9

Chi Square = 25.705 df=2, $P(x^2)$= .0000 Cramer's V = 0.610

Table 39. Comparison of Attitudes Toward the Use of Modern Medicine.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=28)	3	10.7	21	75.0	4	14.3
Non-Pentecostals (n=41)	1	2.4	6	14.6	34	82.9
Total (N=69)	4	5.8	27	39.1	38	55.1

Chi Square = 31.693 df=2, $P(x^2)$= .0000 Cramer's V = 0.678

Table 40. Comparison of Degree of Confidence in Modern Medicine.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=28)	2	7.1	20	71.4	6	21.4
Non-Pentecostals (n=41)	2	4.9	8	19.5	31	75.6
Total (N=69)	4	5.8	28	40.6	37	53.6

Chi Square = 20.306 df=2, $P(x^2)$= .0002 Cramer's V = 0.543

Table 41. Comparison of Attitudes Toward the Correctness of Modern Medicine.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=22)	2	9.1	16	72.7	4	18.2
Non-Pentecostals (n=40)	3	7.5	10	25.0	27	67.5
Total (N=62)	5	8.1	26	41.9	31	50.0

Chi Square = 14.659 df=2, $P(x^2)$= .0001 Cramer's V = 0.486

Table 42. Comparison of Attitudes Toward the Strength of Hospitals/Doctors.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=26)	6	23.1	20	76.9	0	0.0
Non-Pentecostals (n=40)	5	12.5	15	37.5	20	50.0
Total (N=66)	11	16.7	35	53.0	20	30.3

Chi Square = 18.676 df=2, $P(x^2)$= .0003 Cramer's V = 0.532

Table 43. Comparison of Attitudes Toward the Use of Hospitals/Doctors.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=28)	4	14.3	21	75.0	3	10.7
Non-Pentecostals (n=42)	1	2.4	11	26.2	30	71.4
Total (N=70)	5	7.1	32	45.7	33	47.1

Chi Square = 25.225 df=2, $P(x^2)$= .0000 Cramer's V = 0.600

Table 44. Comparison of Degree of Confidence in Hospitals/Doctors.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=27)	4	14.8	22	81.5	1	3.7
Non-Pentecostals (n=40)	1	2.5	14	35.0	25	62.5
Total (N=67)	5	7.5	36	53.7	26	38.8

Chi Square = 24.117 df=2, $P(x^2)$= .0001 Cramer's V = 0.600

Table 45. Comparison of Attitudes Toward the Correctness of Hospitals/Doctors.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=23)	4	17.4	17	60.9	2	8.9
Non-Pentecostals (n=39)	3	7.6	16	41.0	20	51.3
Total (N=62)	7	11.3	33	53.2	22	35.5

Chi Square = 11.540 df=2, $P(x^2)$= .0036 Cramer's V = 0.431

Table 46. Comparison of Attitudes Toward the Strength of the Bible.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=25)	0	0.0	1	4.0	24	96.0
Non-Pentecostals (n=40)	7	17.5	9	22.5	24	60.0
Total (N=65)	7	10.8	10	15.4	48	73.8

Chi Square = 10.498 df=2, $P(x^2)=$ .0057 Cramer's V = 0.402

Table 47. Comparison of Attitudes Toward the Use of the Bible.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=29)	0	0.0	1	3.4	28	96.6
Non-Pentecostals (n=41)	6	14.6	9	22.0	26	63.4
Total (N=70)	6	8.6	10	14.3	54	77.1

Chi Square = 10.732 df=2, $P(x^2)=$ .0052 Cramer's V = 0.392

Table 48. Comparison of Degree of Confidence in the Bible.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=25)	0	0.0	1	4.0	24	96.0
Non-Pentecostals (n=40)	6	15.0	9	22.5	25	62.5
Total (N=65)	6	9.2	10	15.4	49	75.4

Chi Square = 9.463 df=2, $P(x^2)$= .0091 Cramer's V = 0.382

Table 49. Comparison of Attitudes Toward the Correctness of the Bible.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=25)	0	0.0	1	4.0	24	96.0
Non-Pentecostals (n=41)	7	17.1	10	24.4	24	58.5
Total (N=66)	7	10.6	11	16.7	48	72.7

Chi Square = 11.140 df=2, $P(x^2)$= .0043 Cramer's V = 0.411

Table 50. Comparison of Attitudes Toward the Strength of the Church.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=24)	0	0.0	2	8.3	22	91.7
Non-Pentecostals n=39) 4 10.3	15	38.5	20	51.3		
Total (N=63)	4	6.3	17	27.0	42	66.7

Chi Square = 11.094 df=2, $P(x^2)$= .0044 Cramer's V = 0.420

Table 51. Comparison of Attitudes Toward the Use of the Church.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=28)	0	0.0	1	3.6	27	96.4
Non-Pentecostals (n=40)	5	12.5	10	25.0	25	62.5
Total (N=68)	5	7.4	11	16.2	52	76.5

Chi Square = 10.655 df=2, $P(x^2)$= .0053 Cramer's V = 0.396

Table 52. Comparison of Degree of Confidence in the Church.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=28)	0	0.0	3	10.7	25	89.3
Non-Pentecostals (n=41)	5	12.2	10	24.4	26	63.4
Total (N=69)	5	7.2	13	18.8	51	73.9

Chi Square = 6.5730 df=2, $P(x^2)$= .0366 Cramer's V = 0.309

Table 53. Comparison of Attitudes Toward the Correctness of the Church.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=26)	0	0.0	3	11.5	23	88.5
Non-Pentecostals (n=40)	6	15.0	10	25.0	24	60.0
Total (N=66)	6	9.1	13	19.7	47	71.2

Chi Square = 7.1420 df=2, $P(x^2)$= .0276 Cramer's V = 0.329

Table 54. Comparison of Attitudes Toward the Strength of Prayer.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=25)	1	4.0	2	8.0	22	88.0
Non-Pentecostals (n=41)	8	19.5	9	22.0	24	58.5
Total (N=66)	9	13.6	11	16.7	46	69.7

Chi Square = 6.488 df=2, $P(x^2)$= .0382 Cramer's V = 0.314

Table 55. Comparison of Attitudes Toward the Use of Prayer.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=26)	0	0.0	3	10.3	23	89.7
Non-Pentecostals (n=42)	8	19.0	7	16.7	27	64.3
Total (N=68)	8	13.1	10	16.4	43	70.5

Chi Square = 7.490 df=2, $P(x^2)$= .0233 Cramer's V = 0.332

Table 56. Comparison of Degree of Confidence in Prayer.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=27)	0	0.0	2	7.4	25	92.6
Non-Pentecostals (n=41)	8	19.5	6	14.6	27	65.9
Total (n=68)	8	11.8	8	11.8	52	76.5

Chi Square = 7.513 df=2, $P(x^2)= .0230$ Cramer's V = 0.332

Table 57. Comparison of Attitudes Toward the Correctness of Prayer.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=26)	0	0.0	3	11.5	23	88.5
Non-Pentecostals (n=42)	8	19.0	8	19.0	26	61.9
Total (N=68)	8	11.8	11	16.8	49	72.1

Chi Square = 7.992 df=2, $P(x^2)= .0183$ Cramer's V = 0.343

Table 58. Comparison of Attitudes Toward the Strength of the Pastor.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=24)	0	0.0	5	20.8	19	79.2
Non-Pentecostals (n=38)	14	36.8	18	47.4	6	15.8
Total (N=62)	14	22.6	23	37.1	25	40.3

Chi Square = 26.287 df=2, $P(x^2)$= .0000 Cramer's V = 0.651

Table 59. Comparison of Attitudes Toward the Use of the Pastor.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=28)	0	0.0	8	28.6	20	71.4
Non-Pentecostals (n=42)	17	40.5	14	33.3	11	26.2
Total (N=70)	17	24.3	22	31.4	31	44.3

Chi Square = 19.218 df=2, $P(x^2)$= .0002 Cramer's V = 0.524

Table 60. Comparison of Degree of Confidence in the Pastor.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=26)	0	0.0	8	30.8	18	69.2
Non-Pentecostals (n=38)	18	47.4	9	23.7	11	28.9
Total (N=64)	14	28.1	17	26.6	29	45.3

Chi Square = 18.136 df=2, $P(x^2)$= .0003 Cramer's V = 0.532

Table 61. Comparison of Attitudes Toward the Correctness of the Pastor.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=24)	0	0.0	4	16.7	20	83.3
Non-Pentecostals (n=37)	16	43.2	11	29.7	10	27.0
Total (N=61)	16	26.2	15	24.6	30	49.2

Chi Square = 20.773 df=2, $P(x^2)$= .0001 Cramer's V = 0.584

Table 62. Comparison of Attitudes Toward the Strength of the Priest.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=23)	18	78.3	0	0.0	5	21.7
Non-Pentecostals (n=40)	11	27.5	19	47.5	10	25.0
Total (N=63)	29	46.0	19	30.2	15	23.8

Chi Square = 19.165 df=2, $P(x^2)$= .0002 Cramer's V = 0.552

Table 63. Comparison of Attitudes Toward the Use of the Priest.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=27)	21	77.8	3	11.1	3	11.1
Non-Pentecostals (n=42)	9	21.4	17	40.5	16	38.1
Total (N=69)	30	43.5	20	29.0	19	27.5

Chi Square = 21.238 df=2, $P(x^2)$= .0001 Cramer's V = 0.555

Table 64. Comparison of Degree of Confidence in the Priest.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=23)	17	73.9	2	8.7	4	17.4
Non-Pentecostals (n=39)	13	33.3	14	36.0	12	30.8
Total (N=62)	30	48.4	16	25.8	16	25.8

Chi Square = 10.075 df=2, $P(x^2)$= .0070 Cramer's V = 0.403

Table 65. Comparison of Attitudes Toward the Correctness of the Priest.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=21)	16	76.2	2	9.5	3	14.3
Non-Pentecostals (n=41)	10	24.4	19	46.3	12	29.3
Total (N=62)	26	41.9	21	33.9	15	24.2

Chi Square = 15.732 df=2, $P(x^2)$= .0007 Cramer's V = 0.504

Table 66. Comparison of Attitudes Toward the Strength of the Cathedral.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=22)	21	95.5	1	4.5	0	0.0
Non-Pentecostals (n=37)	10	27.0	13	35.1	14	37.8
Total (N=59)	31	52.5	14	23.7	14	23.7

Chi Square = 26.060 df=2, $P(x^2)$= .0000 Cramer's V = 0.442

Table 67. Comparison of Attitudes Toward the Use of the Cathedral.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=27)	21	77.8	6	22.2	0	0.0
Non-Pentecostals (n=42)	10	23.8	17	40.5	15	35.7
Total (N=59)	31	44.9	23	33.3	15	21.7

Chi Square = 21.940 df=2, $P(x^2)$= .0001 Cramer's V = 0.564

Table 68. Comparison of Degree of Confidence in the Cathedral.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=23)	19	82.6	4	15.4	0	0.0
Non-Pentecostals (n=40)	11	27.5	17	42.5	12	30.0
Total (N=63)	30	47.6	21	33.3	12	19.1

Chi Square = 18.975 df=2, $P(x^2)$= .0002 Cramer's V = 0.549

Table 69. Comparison of Attitudes Toward the Correctness of the Cathedral.

	Low		Moderate		High	
	No.	%	No.	%	No.	%
Pentecostals (n=19)	16	84.2	3	18.8	0	0.0
Non-Pentecostals (n=39)	11	28.2	15	38.5	13	33.3
Total (N=58)	27	46.6	18	31.0	13	22.4

Chi Square = 17.058 df=2, $P(x^2)$= .0004 Cramer's V = 0.547

APPENDIX F

THEMATIC ANALYSIS OF INTERVIEWS

Table 70. Number and Percent of Themes From 123 Case Histories in 47 Interviews of Pentecostal Pakal-Na Residents

Category	Type	Number	Percentage
Person	Self	51	41.5
	Family member	63	51.2
	Acquaintance	9	7.3
	Total	123	100.0
Cause	Natural	86	77.5
	Supernatural	17	15.3
	Accident	8	7.2
	Total	111	100.0
Length	O-2 weeks	25	33.8
	2 weeks-1 year	31	41.9
	1 year-5 years	8	10.8
	Over 5 years	10	13.5
	Total	74	100.0
Degree	Mild	20	20.8
	Moderate severe	43	44.8
	Severe	33	34.4
	Total	96	100.0
Healers Consulted	Self healing	47	24.9
	Doctor	46	24.3
	Evangelical member(s)	46	24.3
	Pastor	21	11.1
	Herbalist	8	4.2
	Brujo	7	3.7
	Evangelist	5	2.6
	Family member	4	2.1
	Spiritist	3	1.6
	Saint	1	.5
	Nurse	1	.5
	Total	189	99.8

Table 70. (continued)

Category	Type	Number	Percentage
Healing Methods			
	Solitary prayer	49	30.4
	Group prayer	34	21.1
	Fasting	14	8.7
	Medicine	13	8.1
	Family prayer	13	8.1
	Bible reading	12	7.5
	Oil	11	6.8
	Herbs	8	5.0
	Dedicated life	3	1.9
	Visions	2	1.3
	Spirit baptism	2	1.3
	Total	161	100.1
Location			
	Home	54	57.4
	Church	34	36.2
	Hospital-clinic	6	6.4
	Total	94	100.0
Converted as Result			
	Self	22	17.9
	Family member	11	8.9
	Total	33	26.8 % of total stories
Victim Not Healed			
	Died	6	
	Method unsuccessful	3	
	Remained sick	1	
	Total	10	8.1 % of total stories

VITA

Murl O. Dirksen was born on September 3, 1947, in the small rural farming community of Goessel, Kansas. Most of his childhood was spent in the Hopi village of Oraibi, Arizona. After graduation from Flagstaff High School in 1965, he completed 2 years in forestry at Northern Arizona University. Interrupting his undergraduate studies, he worked several years as an agricultural advisor with the Yugoslavian Red Cross under the auspices of the Mennonite Central Committee.

On returning to this country in 1969, he enrolled in the Department of Sociology/Anthropology at the University of Tennessee at Chattanooga and in 1971 met the requirements for the Bachelor of Arts degree. He continued his graduate education at the same university while employed by the Centenary Methodist Church as director of their inner-city programs. In the fall of 1972, he completed a Master of Arts in Teaching (Sociology/Anthropology) and accepted a position in the Department of Behavioral and Social Sciences at Lee College in Cleveland, Tennessee, where he is presently employed. On leave from Lee during 1977-78, he was a visiting professor at the University of Florida, Gainesville, under a grant from the National Endowment for the Humanities. Between 1973 and 1977, he did graduate work in anthropology at University of Arizona and University of Tennessee at Knoxville where he enrolled full-time in 1978. Areas of academic concentration include socioreligious movements and cultural change. Professional memberships include the Southern Anthropological Society and the Society for the Scientific Study of Religion.