FOREIGNERS IN THEIR OWN LAND:
THE MIGRANT AND MENTAL HEALTH

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INTRODUCTION

This paper attempts to present a brief overview of the complexities involved in trying to understand the mental health problems of Mexican American migrant fieldworkers and in developing mental health programs to meet their needs. Copies of this will be available for the various agencies and projects that are, or should be serving the mental health needs of migrant fieldworkers. Hopefully they will be alerted to the special needs of migrants in regard to mental health. A comprehensive study of migrant mental health would take up several volumes. Consequently the reader should be aware that in a brief paper of this nature many statements will tend to oversimplify and stereotype the migrant. Each person may know a migrant who doesn't fit the description portrayed or knows of instances where a community is meeting the special mental health needs of the migrant. The author does not deny that there are exceptions to some of the concepts addressed.

A summary of current research on mental health and the Spanish speaking is discussed along with a Mexican American's outlook on health compared to the Anglo viewpoint. Various problems underlying mental illness and stress will be outlined as well as the difficulties encountered in purveying mental health services to the Spanish speaking. A possible solution to the future improvement of some of these difficulties is proposed.

While much research has been done on the Spanish speaking which includes Mexican Americans, Puerto Ricans and other Latin Americans, the paper will address the specific needs of only Mexican American migrant fieldworkers while they are working on the farms and in the canneries of the Midwest. For definitional

purposes in this paper, the term Latino refers to all Spanish speaking persons or persons of Hispanic culture living in the United States. Mexican American refers to people of specifically Mexican origin living in the United States and the term migrant refers to a sub-culture of Mexican Americans who attempt to make their living by working in the vast agricultural industry of the United States as it varies by planting and harvesting a number of crops.

Biographical Sketch of the Migrant

The average migrant family that comes to Illinois each year, has a size of 3.7 members, and an income of $2,194 per year. The head of household has 6.2 years of formal education. Eighty percent of these Mexican American migrants are citizens of the United States. Their permanent homes are in the lower Rio Grande Valley of Texas. (Illinois Migrant Council, 1975). The typical migrant agricultural worker has a life expectancy of 49years; an infant mortality rate 25 per cent higher than the national average; mortality rates from tuberculosis and other infectious diseases two and one-half times the national rate; and for influenza and pneumonia, a 20 percent higher rate for migrants than for the general population (Schmitt, 1975).

The migrant's lifestyle fits into all the research done on the "culture of poverty", i.e. limited financial resources leading to inadequate nutrition, poor and unsanitary housing, extremely limited access to health care, inferior education, underemployment and general socio-political impotence. This vicious cycle keeps migrants from gaining upward economic and social mobility.

In addition to poverty the migrant's maintenance of various aspects of the parent Mexican culture clashes with the dominant Anglo/WASP culture. This further

isolates the migrants from the communities in which they work and keeps them confined to the labor camps in which they live when they come to the Midwest. The Mexican American culture derived from a northern Mexican rural background that was not influenced by industrialized Western ideology. This isolated agrarian society was primarily a two-class society with no upward social mobility for the lower class. There was no emphasis on the education and skills necessary to compete in Western society. In fact competition was actively discouraged. One study reveals that rural Mexican mothers reward their children whether they succeed or fail, whereas Anglo mothers tend to reinforce their children according to the child's achievement. Consequently Mexican children are socialized to learn that what they receive is not a function of what they do; the reverse is true of the Anglo child (Nelson,1972).

Simplistically the rural Mexican culture tends to reinforce a high individual regard for authority (migrants are easily intimidated by crew leaders, growers and cannery personnel,) adherence to tradition and a very religious orientation. Conversely, the Anglo culture is competitive and tends to replace tradition and religion with science. While the Mexican culture stresses a group/family centered orientation, the Anglo culture puts emphasis on the individual personality. The strict family roles of migrants instill a conservatisim and group values that support acceptance of the status quo, humility and non-agression. The reverse is true in the Anglo culture. Migrants live in the "here and now", hand-to mouth with the fatalistic view of life, "que sera sera" - a feeling of powerlessness in determining one's future.

More specific to this paper are the cultural differences in the migrant's perception of health. The Mexican agrarian culture does not have clearly defined

lines between physical health, mental health and religion. For example, the Spanish expressions, "estoy sano y fuerte" and "siento como un cañon", contain physical as well as psychological conotations. Additionally there is the belief that medicines and other medical treatments will cure only if "it is the will of God". Folk diseases such as "Susto" (the soul leaving the body or fright), "Mal Ojo" (the evil eye), "embrujada" (a witches spell) to name only a few, are examples of diseases which may start with a physical symptom and cause subsequent anxiety and guilt or the guilt and anxiety cause the physical system to break down. A Curandero (folk healer) may be called in to treat the sufferer of a folk disease. Curanderos usually cure with the combination of religious rites, herbs and the physical "laying on of the hands". Religious confession plays an important role in relieving the components of guilt and anxiety.

Typically, a migrant in the early stages of illness is self-treated or treated by members of the family. If the condition persists, the family consults with someone with more knowledge (an older person or neighbor). If no relief is obtained they may consult someone with a knowledge of herbs. When all else fails they will consult a physician, clinic, or the emergency room of a hospital. For minor illnesses, chronic untreatable conditions and conditions which arouse anxiety and are feared as supernatural, many Mexican Americans consult the Curandero. Migrants traveling the Midwest have less access to "Curanderos" and Herbolarios" (herb doctors) and thus make more use of emergency rooms, company doctors or the special clinics for migrants funded by the United States Department of Health, Education and Welfare.

Use of health care facilities by migrants in the midwest is generally only for acute care. Unfortunately, even the acute illnesses are not brought to the attention of health professionals until they have become life threatening. The sick role

is an acceptable role in the Mexican culture, but migrants are initially reluctant to be classified as "sick" for fear that illness may lead to a loss of respect. This attitude accounts for the value placed on "machismo" and female stoicism. To the Anglo, illness is a less personal event brought about by neutral, unemotional natural agents, such as germs. For Mexican Americans, illness relates to the individual's life, the community, interpersonal relationships and God.

As mentioned in the introduction, it has been necessary to greatly stereotype the rural Mexican and migrant culture in order to give the reader a brief overview of some cultural differences that might impact on the way in which the Anglo views the migrant. For detailed information refer to the Bibliography.

THE PROBLEM

Factors Causing Mental Health Problems in Migrants

There are two categories of problems which may put migrants at greater mental health risk than the Anglo. The universal mental health problems faced by the entire population will not be discussed. The first category is in the area of culture-specific illnesses as partially discussed in the previous section. The theory that people learn not only socially and culturally acceptable ways of "going crazy", but also culturally sanctioned defenses that are reinforced by the beliefs and attitudes of others must be kept firmly in mind.

Curanderismo, a type of folk psychiatry, may be defined as a culture specific method of diagnosis and treatment of the culture specific disorders such as "susto", mal ojo, embrujada" and "caida de la mollera" (when the hole in the front of a babies head falls down). An example of the dynamics of folk disorder and treatment might go as follows:

"In caida de la mollera, the mother becomes anxious that her child might have fallen when the child is inattentive, has diarrhea and fever, or is crying and restless. Since a mother is criticized if her child is sick or harmed

through neglect, it is not unreasonable that mothers become anxious and seek to explain the child's problem and their distress in a culturally meaningful way. Illness in a child also causes hostility toward the child, on whom the mother is dependent for her status and toward whom she may also have many unconscious hostile feelings. Labeling the child's problem as caida enables the real or imagined blame to be focused away from the mother. At the same time she has the opportunity to relieve her guilt by following certain culturally prescribed patterns. If the illness is more severe, the child older and the mother more dependent, the same situation may be labeled differently." (Kiev, 1968)

A Curandero is not always available for consultation, consequently the migrant either goes without treatment or is forced into an Anglo system that doesn't understand the culture-specific problems of Mexican Americans. Cultural conflict makes it difficult for Anglo mental health professionals to diagnose and treat cultural illnesses. For example, "hearing voices" has a different and less pathological connotation among Mexican Americans. Thus a woman who says to an Anglo psychiatrist that she "heard voices" telling her to become a nun is having auditory hallucinations with religious content. This interpretation, however, is inaccurate for the Mexican American. The statement is no more pathological than the Anglo counterpart of "having the call" to join a particular religious sect. Similarly, a Latino fairy tale, "La Llorona", about a mythical folk figure who roams at night crying aloud in a perpetual and futile search for the child she abandoned, may cause Latino children to hear her cries. If they tell this to an Anglo psychiatrist they would most probably be diagnosed as having "unusual beliefs which appear to include delusional and hallucinatory elements suggesting severe impairment in thinking". The same psychiatrist would probably see no problem with the Anglo child who heard a fat, bearded man in a red suit yell "Merry Christmas to all and to all a good night" (Padilla, 1973).

The second category of problems arises from the stress that is caused by discrimination, acculturation and as previously mentioned, the poverty cycle.

The prejudice voiced by a large part of the dominant Anglo society is that Latinos possess a pattern of negatively valued traits. Usually prejudice toward others is learned from contact with prejudiced prople. Discrimination is the end result of prejudice. Some studies have indicated that prejudice and discrimination have forced the migrant into a position of low esteem and inferior status (Bloombaum, 1968).

Another study (Fabrega, 1968) used Mexican American psychiatric patient interviews to evaluate the influence acculturation has on mental stress. The inference from this study is that the transition from one culture to another produces a condition of marginality which is stressful and thereby conducive to mental breakdown.

In the Midwest, migrant housing is deplorable and thus stress producing in itself. Some housing units still in use were once World War II prison camps used to incarcerate German prisoners of war. The migrants truly become "Foreigners in Their Own Land" - far from their culture and friends. The following quotations are taken from the testimony of a nurse who works at a migrant health clinic. This testimony was given at the United States Department of Labor hearings held in Toledo, Ohio on migrant housing (O.S.H.A. 1974). The quotations from her testimony suggest areas where mental problems are caused by poor housing:

"Safe and healthful housing must address the physical, mental and social needs of the occupant as well as provide protection against accidents and communicable disease."

"Of course, we all know that historically the migrant has not been entitled to any of the esthetic considerations afforded most human beings in the United States, so, in fact, there is no concern that he has a nose to nose relationship with livestock."

"Also deleted is the requirement that where there are small children in the family there be a partition of rigid material installed so as to provide reasonable privacy between parent and children. Ladies and gentlemen, would you like to live and sleep in the same room as your children, or perhaps the mental health implications of such an arrangement are less significant to the farm worker.

There are certain needs people have besides eating and sleeping. Sexual gratification is a basic physiological need. One way society recognizes these needs in an affirmative manner is by marriage. However, there can be negative reactions to this where children are subjected to observing these acts by being forced to sleep in the same room with their parents." (Empasis is the author's).

The entire testimony of Evelyn Gomez, a former migrant worker, at these same hearings is included below in its entirety because it summarizes the plight of the migrant in a particularly vivid manner. It is easy to interpret the mental health implications in her testimony:

"My family for the past 22 years have been migrant farmworkers, an occupation which we have been forced to follow because of a variety of social, cultural and similar factors. The seasonal nature and low-income level of this type of work has resulted in a typical annual income which has, in itself, forced us into a particular life style and has been the basis for acceptance of conditions affecting every aspect of our lives.

Probably the easiest way to provide you with an idea of these conditions and particularly with reference to legal housing requirements, is to tell you of some of my experiences during a typical season.

In April of each year, my family has been recruited for farm work, usually in Illinois. Usually an important consideration on our part has been the availability of housing since the income levels and transportation problems have forced us to consider this as a necessity to survival. Without the housing, we simply could not have lasted in farmwork. Never, that I can remember, has housing at the worksite been presented as an attraction to, or a condition of, employment by the recruiters who realize very well that no matter what type of housing is provided, we migrants are forced to use it.

The usual housing site for us was located anywhere from 18 to 33 miles from any community or stores for the purchase of food, recreation or anything else you might want. Our people even had to go that far to get gas for their cars. This isolation kept us in a very limited and confined area and my life centered around the campsite.

The five members of my family usually lived in a single room with a concrete floor and wooden walls. When I look back, though, I guess this wasn't too bad, because I remember once living in a house with wooden floors and few times my family and friends in camp would fall through them because they would rot from all the dampness.

We had very little ventilation. Once we had a house with no windows, only a door with a screen with holes in it. We would try to cover the holes with cardboard or stuff them with paper because we could never get anyone to fix them.

We had very little floor space. Once my brother and sister got all of us together and we tried to all lie down on the floor without touching anything in the room and we couldn't do it. We only had one bench and one chair to sit on so two of us used to take turns sitting on the bed to eat.

The open ceilings where each room of the housing unit was connected did not limit noise, cooking odors and particularly flies. Much of our food had to be stored on the floor because we only had 2 wooden shelves for storage of any kind. Our clothing was hung on the rafters of the house and our personal articles were left in our suitcases under our bed.

It was so bad that I couldn't eat for quite a while. We used to use flour and lard a lot and had to store them on the floor. The cockroaches and some awful looking black bugs used to get into it. My mother would still use it but I couldn't eat knowing that they had been in it.

For quite a few years my uncle and cousins lived with us. We only had a two burner, butane hot plate. My mother was diabetic and she was not allowed to eat very many fried foods, we tried to get a stove but never did. It was awfully hard for her to eat food that she needed.

It wasn't until a few years ago that the houses had any heat. We usually just left the two burner cook stove on. We stayed at the campsite until the end of November and it used to get awfully cold. The little gas heaters didn't do much good because the houses were built with big spaces between the sides of the house and roof. We also were afraid of the gas fumes in the house and would shut them off at night.

As migrant workers our family constantly worried about the no-work-no pay condition of employment, because of its' terrible meaning. Illness to us was a loss of income and also medical care was usually not available and, if it was available, we usually couldn't afford it.

My uncle who was also a migrant, finally had to move in with us because he could no longer work. He had emphysema and high blood pressure and couldn't get help anywhere because he was never eligible for any aid.

When we children grew up and were able to help in the fields or be in school all day my mother used to work in the fields. She never could when we were little because she was constantly watching us.

Our favorite games used to be hide and seek under the cars or in washing machines and refrigerators and anything else we could get into.

I guess I sound as though everything was bad, well it wasn't I guess, because my dad managed to get us food and clothing most of the time without being on public aid and we were really lucky because my aunts' house blew over with her in it last year during a summer storm. That never happened to us.

About eight months ago I was lucky enough to be able to leave the migrant

stream but for the memories I have of bugs constantly crawling on me and never being able to go to the bathroom or take a shower without 5 other people doing the same thing in the same room and the knowledge of the conditions to which my family are still subjected. I would certainly hope that these hearings could improve the awful conditions which still exist.

I really feel very limited in my ability to accurately describe the existing situation for my verbal description is no substitute for direct observation." (OSHA 1974)

In summary, high stress indicators prevalent among migrants are correlated with mental breakdown, self distructive behavior (alcoholism, drug addition, or suicide) and the subsequent need for treatment (Padilla, 1973). These indicators include poor communication skills in English, the poverty cycle, lack of acculturation from the rural Mexican culture into Midwestern Anglo/W.A.S.P. culture, prejudice and the economic pressures which necessitate seasonal migration.

THE PRESENT SYSTEM

Entrance into the present Midwest mental health system by migrants is primarily through attempted suicide or the manifestation of other severe disorders. Karno's research has demonstrated that Mexican Americans are under-represented in utilization of mental health facilities (1969). While this study was carried out in California, other localities also report low utilization (Jaco 1959).

Some basic theories explaining the under representation of Mexican Americans in the usage of mental health facilities have been developed. They are a lower frequency of mental illness because of the extended family's role in reducing stress (Madsen 1964); the utilization of Curanderos and folk psychiatry (Kiev 1968) and the inadequacy of the present mental health delivery system to meet the special needs of Mexican Americans (Padilla 1973). Evidence that the extended family system of Mexican Americans provides more support than an Anglo family during periods of

emotional stress is readily apparent to those agencies working with migrants. This familial support system apparently reduces the referral rate of mental illness into the established system. However as stated in the previous section, migrants routinely operate under extremely stressful conditions and it would be naive to assume the family is able to supply all the therapy and treatment needed. The author observes that migrants discourage referral of family members to mental health centers because these centers are perceived as alien and hostile. Little health education concerning mental health has been available to migrants.

Culture specific treatment for a culture specific disorder is apparently beneficial and curative in some unknown manner. Curanderos know the culture and how to use the powers of suggestion and faith to alleviate the culture specific illnesses mentioned earlier. Curanderos are probably more successful than mental health centers in dealing with these minor disorders. However, even the Curandero is not always readily accessible to all migrants, especially in the Midwest.

Both the Curandero and the extended family may offer symptomatic relief from anxiety, guilt and religious tensions, but they have difficulty in reaching the roots of severe disorders. Both are also lacking in access to the powerful psychotropic drugs available to psychiatrists and dispensed at mental health centers. However, the Curandero and family are at present the only culturally acceptable programs and will have to suffice until the established delivery system is sensitive to migrant needs.

According to Padilla (1973), there are four primary factors that keep migrants out of the existing system. One of these is the geographic isolation which prevents the migrant from obtaining existing services. Not only are migrants frequently located outside the community in labor camps, but the mental health services are also geographically inaccesible and do not offer services at hour convenient to the migrant. Lack of transportation and child care contribute to geographic

isolation.

Additionally, the language barrier often prohibits the communication necessary to serve the non-English speaking client. The importance of this point is self-evident and this will not be dealth with in detail at this time. The use of translators is often the only way to facilitate communication, albeit translation is not cost effective, may not communicate nuances successfully and frequently estranges both the patient and the professional.

Culture bound values also prevent adequate diagnosis and treatment in mental health centers. As discussed earlier, lack of knowledge of the client culture and prejudice will tend to discourage use of the Anglo facilities.

Finally, class bound values may be associated with underutilization of mental health facilities by migrants. Studies have shown that therapists and the whole mental health system conduct diagnoses and treatment with the value system of the Anglo middle class (Karno, 1969). Another study found that the negative attitudes held by psychotherapists are the same as those found among the general public and that these prejudices motivate and mantain social distance with Mexican American patients (Blocmbaum, 1968).

Some progress has been made however. Special mental health projects have been developed in urban areas of high Mexican American concentration. These projects have broken the four barriers mentioned above by adapting staffing (bi-lingual and bi-cultural), service quarters and treatment programs to meet the special needs of their Mexican American clientel (Karno 1971). These innovative programs have taken the comprehensive approach of providing preventive and prophalactic services, crisis intervention, group and individual therapy, drug therapy and follow up treatment with individuals, families, groups. Bilingual and bicultural para-professionals who are sensitive to and know first hand of the plight of Mexican

Americans have proven successful in crisis intervention. These para-professionals also work closely with other agencies (welfare, employment and education)in order to provide a wide range of services and support to their clients. Innovative approaches of this nature in mental health need to be developed in rural areas of high migrant concentration.

DISCUSSION

One Possible Solution

Enough research has been done to identify problems and special needs in migrant mental health to warrant the establishment of special migrant mental health programs. Such programs should meet the comprehensive health needs, both physical and mental of the migrant agricultural worker. They should be patterned after the successful urban program that have been able to bridge the barriers of language, culture, logistics and class.

It is hoped that further research done in the area of Mexican American mental health will not follow the course of research in the area of Mexican American education and intelligence testing. The early studies, among them Garth (1923), Sheldon (1924), Paschal (1925) and Manuel (1932) indicated that I.Q. type testing was culturally and linguistically biased and thus tended to indicate that children of Mexican heritage were of lower intelligence than Anglo childr[redacted] and in many cases mentally retarded. Now, fifty years later, there is more awareness of the inaccuracy of intelligence tests in measuring I.Q. in children of the non dominant culture. However, there are still many Mexican Americans who are labelled as unintelligent or retarded by these tests. This is not to say that there is no need for further research in the mental health field, but merely to emphasize that there is enough evidence to start new types of mental health programs immediately.

This paper further concludes that agencies like the Illinois Migrant Council (I.M.C.) have the greatest potential to meet the special needs of migrants. I.M.C. is a community based organization with a consumer dominated board of directors, migrants and their representatives,with input from health providers. The comprehensive services provided by I.M.C. at the present include emergency assistance, legal services, social services, English as a second language, pre-vocational education, vocational training and other secondary and post-secondary education programs. In the area of health, the Illinois Migrant Health Project, a subdivision of I.M.C., makes personal and public health services as well as nutritional programs,providing both nutritional foods and nutrition education,available to migrants. Consequently an expansion of services in the area of mental health for migrant fieldworkers should be done through I.M.C. and similar organizations in the Midwestern states. Because these organizations offer a multitude of services to migrants, these agencies would be in the best position to restore equilibrium in a crisis by clarifying perceptions of the event, providing available situational support and strengthing the coping mechanism.

This does not mean that migrant health projects work in a vacuum. These agencies work closely with other health providers,local agencies, church groups, growers and governmental entities. In health,these include local hospitals, health departments, private practitioners, medical schools and graduate medical programs, family planning agencies, and school health programs. A migrant mental health project through I.M.C.or their counterparts in other states would work closely with existing mental health agencies to avoid unnecessary duplication and to be mutually supportive in areas of overlaping responsibilities.

The author is biased toward the solution presented above. However, in a non-biased research project done by a graduate student of Public Health, a simila

conclusion was derived:

> "It may be concluded, therefore, that the level of planning for migrants is, with one promising exception, non-existent. This is due not only to lack of understanding of the migrants problems, but is also due to inadequate funding, organizational instability because of the recent federal Health Planning Act, and due to the current state of the act of health planning. Health planning has addressed itself much more to hospital construction and bed capacities than to rural health care delivery. Only with the development of the art and science of health planning will we be able to deal more effectively with the problems of migrant health.
>
> At the current time most of the health planning for migrant workers is that done by the Illinois Migrant Council. (The Illinois Migrant Council is a federally-funded agency which works to improve conditions for Illinois' 32,000 migrants. It was founded in 1966, and has its central adminstrative office in Chicago). An examination of the IMC program will reveal utilization of many planning concepts used by CHP agencies: consumer control of activities (their Regional Advisory Board are composed of 51% migrants); continuity of care (referrals are sent ahead to migrant clinics in other mid-western states or to Texas); accessibility of care (Mobile Health Clinic in southern Illinois, transportation from migrant camps provided by some other clinics); shared services (all clinics buy drugs from same source to save money); outreach (outreach paraprofessionals are extensively used); evaluation of care (formal and informal means of evaluation are being implemented); ongoing education of staff (in-service education is an important part of the program); and prevention (immunizations, improvement of housing conditions, health education, and regular screening for common conditions is done). Thus it may be concluded that the Illinois Migrant Council is the de facto CHP agency for the 32,000 Illinois migrants." (Bartlett, 1975)

The names have changed but the situation is as true today as it was in 1975. The C.H.P.'s are now H.S.A.'s but they are still unable to deal effectively with issues regarding migrant health, both physical and mental.

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