Silva- please feel free to critique. Thanks!

Independent Study
MIGRANT MENTAL HEALTH

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Gemma,
This is very well done. It's a big & complicated task to try to fit all the parts together into some meaningful whole, - but you did it. I hope you continue this work & include your perspective as therapist as well.

Lane

By tracing the roots and phenomenon of migrant farm work, and by exploring what it means to be Hispanic in America today, I attempt to highlight the particular life and mental health problems of Hispanic farm workers, and to make some initial recommendations for the provision of mental health services to this population and their families.

PART ONE -- MIGRANT FARM WORK

What is migration?

"A snail and a caterpillar went walking slowly
(because of the snail) in the evening sun.
Then the caterpillar halted and said,
"I have to go now."
"Why?" asked the snail.
"I have to go change into a beautiful butterfly."
So he walked away.
Then the snail murmured to himself,
"I will always stay with me."

(Carolina Garcia, Grade 6.
in Kafka and Coles 1982)

To migrate is to move from one place to another -- once, periodically, or continuously. For the context of this paper, we shall be looking at men, women and children for whom continuous migration is a way of life. For whom "home" means a place perhaps several thousand miles from where they spend most of the year, and a place in which they will be lucky to spend one quarter of their time.

Contemporary migrant farm workers form three streams of people, numbering in the hundreds of thousands, who fan northward from their homes around Florida, Texas and California to work in distant places where they will pick and pack crops in the rich agricultural holdings throughout the States.

For months they travel thousands of miles, stopping for brief periods - a few days, a week, maybe a little longer -- to work in the fields and sheds where the fruits and vegetables ripen ever northward. Men alone, or with families of several generations, they pick the fruit in Florida's citrus groves, the cucumbers in the Carolinas, the tobacco in Connecticut, the tomatoes in Delaware. They trim sugar beets in Colorado, collect cherries in Washington, gather avocados in California and prune and tie grape vines in the vast vineyards of that state.

The crops are varied, seasonal and totally weather-dependent, and become the pickers. Wedded to the earth for the growing season, the

people and the crops they gather are subject to the vicissitudes of weather and pests, human greed and competition. Some of the work is skilled, some of it is not, but in every respect the work is gruelingly hard. The work day is long when things are good -- from sun-up until past midnight and there is little rest. Whole families pitch in including the elderly and the children because a ripe crop cannot wait.

Working conditions are hard and subject to their own set of particular hardships and dangers: unsafe equipment, unhealthy sprays and pesticides, unsanitary living conditions and many forms of subtle and not-so-subtle exploitation by crew bosses and employers.

Their work, however, is crucial -- preparing, harvesting and readying for distribution the billion dollar a year food industry in [illegible], the richest agricultural nation in the world.

Why migration?

Historically there are roughly six interrelated reasons for the phenomenon of migration in the United States today: the decline in cropping; the mechanization of cotton picking; the demise of the family farm; the concentration of land in the hands of a few; the expansion of large scale labor-intensive commercial agriculture and improved transportation which enables workers to travel vast distances.

Many ex-slaves-turned-sharecroppers heeded the lure of the cities and left their land for false promises of riches. As urban flight, and consequent urban unemployment, rose these ex-farm workers turned back to the land. Finding their homes changed beyond recognition as simultaneously cotton became mechanized, they had to wander on, in search this time not of city lights, but of earth that still needed a human touch. As more farmers could afford heavy equipment, and could thereby achieve unheard-of productivity and "un-natural" prices, small farms went under. The snowball effect begun -- a neighbor farm mechanized and could out-produce and undercut the family owned farm next door. So, the family sold to their neighbor and America lost another family farm and watched a conglomerate grow.

> "In scale and structure, this industrialized agriculture was fundamentally unlike the family farming operation . . .Unlike the family farm, which typically depended on family members and an

> occasional hired man or two at harvest time to meet its labor needs, the industrialized farm was perennially dependent upon a large, cheap labor force which was abundantly available during seasons of peak labor need, and either sufficiently mobile to move on when that need no longer existed or to remain in the vicinity and sustain itself through other means, including public assistance, until such time as there was again work to be done on the farm."
> (Daniel,C. 1975)

Without the family farm, in which farm owner and farm worker lived on equal footing -- coming from the same class, living and eating together, marrying and intermarrying, working the same land side by side, and with equal stake in the success of the farm -- the new order of farm worker found a very different world. The new owners were often distant corporations and relationships with employees became remote and impersonal. Farm work was becoming a big profit business more than a way of life. Owners were interested in farms only as part of bigger, diversified holdings. Wages became matters to be calculated on ledgers, not personal contracts to be discussed and negotiated. Workers were laid off or imported for impersonal reasons governed only by economic considerations. Their welfare was neglected. Their social status became alienated from the agricultural community.

As more and more small farms sold out to fewer and fewer land owners, so there was a corresponding number of men and women--who knew nothing but farm life--cut lose from their land and needing work. As farms grew in size, and specialized equipment was purchased, farms had to concentrate to maximize the use of their equipment. No point in only growing a few acres of cotton when one had an expensive machine just waiting to cut hundreds of acres of cotton. And so slowly crop specialization took its toll, of the soil and of the human lives that must travel with the seasons' harvests. Not everything could be mechanized. People had to pick the beans, celery, peas and fruits. Now, as one farm's crop could be harvested in the month or so of its prime ripening, so could families not survive on one month's income per year. They had to move to the next state where a harvest was still ripening after the southern crops were safely in. And as men and women had to travel further and further for work, so the car played its role. A group cold gather together to buy some older auto and migrate as

whole families and groups of families, with nothing but a car and their labor, to make enough money to get them through a winter of unemployment.

Thus begun two perhaps irreversible trends in American agriculture
— the seasonal nature of the now-specialized American farm;
— the trend of farm workers to move from place to place in search of work when none was available locally.

Why do farm workers opt for such a grueling lifestyle? There are probable alternatives. One, the workers had no other way to earn a living; two, they preferred seasonal farm work. There are arguments with both points of view, though I tend to believe there is truth in both perspectives. William Friedland and Dorothy Nelkin, sociologists at Cornell University, indicated that for black migrants from Florida who were working in New York and New Jersey, the decisive factor was lack of alternatives:

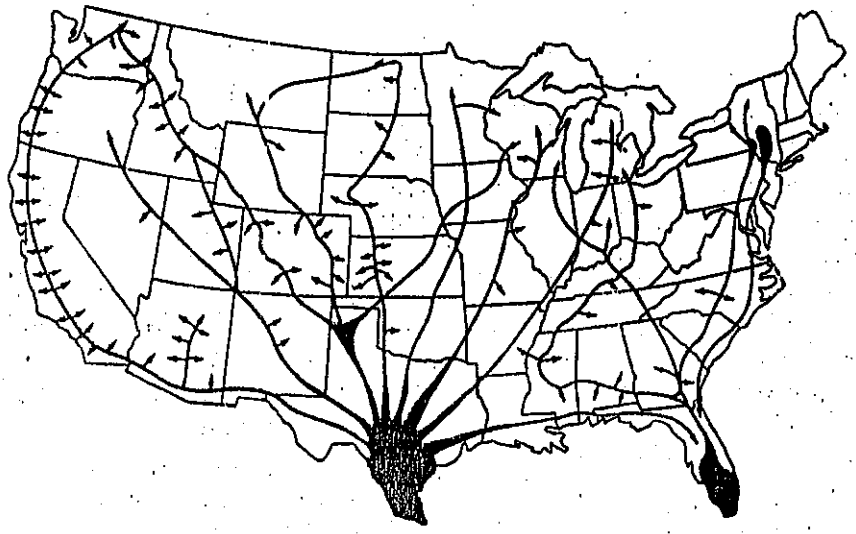
> "Why do people come north on the season? There are some who see the trip as a way to expand their horizons. Some are sucked into the system for the first time, believing the extravagant promises made by their crew leader. Others are restless and prefer the loose schedules of migrant work to the routine of more regular employment. Many are unable to hold other types of jobs. Some are physically handicapped, others are alcoholics and have jail records. Most have no alternative. They must subsist during the summer when there is no work in Florida. Most claim that their decision to come on the season was made spontaneously because opportunity presented itself at a convenient moment."
> (Friedland & Nelkin, 1971 pp.20)

Migrants might be resigned to farm work because they think they are fitted for nothing else. They may have a poor command of the language and little or no education, no idea of possible alternatives nor the money needed to settle in one place long enough to try. Much may be based on expectations. If the family has always farmed, how could they begin to think of anything else?

C. Who migrates?

Most migrants do not wander from state to state looking for work. Rather, they follow well-established migratory routes and barring disaster or unusual conditions, follow the same cycle year after year. By the middle of this century three distinct streams of people had

evolved: an east coast stream; a mid-continent stream; and a west coast stream.



Travel Patterns of seasonal migratory agricultural workers. (Office of Migrant Health, U.S. Public Health Service. In Goldfarb 1981, pp. 9)

The east coast stream was originally composed of Irish, Italians and Scandinavians who lived along the mid-Atlantic coast. More recently, the east coast stream has become peopled by native blacks [illegible] with imported Puerto Ricans and West Indians.

> "Each year when the harvest begins, thousands of buses and cars haul thousands of crews to fields across America as millions of migrant farm workers hit the road. They ride in flatbed trucks, on old condemned school buses patched together for just one more season. They go by car: old cars with engines knocking, laying a smoke screen of oil; old cars packed with bags, bundles, pots and pans, children crying. They go in pickups made into mobile tents- A home for the season . . . The circus and the college house parties leave Florida after Easter. The first week of April, the major league clubs wind up their spring training to go home and play ball. The snowbirds start back to the cities of the north with their tans. And the migrants and farm workers form crews and follow the sun. Sometimes a single bus will carry a crew; sometimes they pass in ragged convoys as the migrant battalions rumble out of Florida and up the Eastern Seaboard . . . The worker finds little to do in November. It is after a lean Thanksgiving and a bleak Christmas that hands are needed again in the fields and groves of the winter gardens."
> (Salvador Herrera, National Association of Farm workers Organizations official, in Goldfarb, 1981 pp.9-10)

The mid-continent stream is based in the Rio Grande valley in Southern California. Mostly composed of Texans and Mexicans, this stream was initiated in the late 1800's as ranchers imported men from Mexico and Texas to work as temporary herdsmen for their cattle and ranches. In the early 1900's Mexican and Chicano workers were used to pick cotton in Oklahoma, cut sugar cane in Louisiana, top sugar beets in Colorado, and harvest wheat in Kansas and Missouri. Their home bases are now in and around Texas where they can live for most of the year. For the other half they travel in large trucks as families in one of two basic patterns: one group travels through Texas working on the cotton crop from July to December, while the second group travels on to the great Lakes area after working in Texas on peppers, cabbages, cauliflowers and onions. A small minority makes its way to the Rocky mountains and the Pacific Northwest.

The west coast stream has its own unique ethnic base as well. With the abolition of slavery in the mid-nineteenth century a farm labor vacuum built up in the vast rich farmlands of California. This was filled in the 1860's by imported Chinese labor; in the early 1900's with imported Japanese labor; soon after with southern Europeans (many of whom settled to become land owners in their own right); in 1920's and 1930's Filipino laborers were brought in to California and in the midst of the depression hordes of men came to California from Oklahoma and Arkansas to find work. The primary migratory units in this third stream -- the West Coast stream which is the object of my particular focus -- are individual families and some single men. Most own their own car, and have a higher mobility than the individuals and families of the other streams.

> "Farm labor unions have been most successful in the West Coast growing areas, which has changed the dynamics between the growers and the migrants. Not all crops have been successfully unionized; wages and benefits vary by region and by the type of labor required. These factors have had a direct impact on the health of migrants and on their willingness to seek help.:
> Trotter, 1988, pp 23)

Are the men and women who travel throughout our fields today the sons and daughters of the men and women of yesterday? John Kleinert, professor of Education at the University of Florida, reported that this

relation holds for Mexican-American migrants with a home base in Texas:

> "Within the Florida migrant community . . . the Texas-Mexican family [who are] generally second or third generation Americans . . .have a family heritage of migrating with the crops."
> (Kleinert, J.E. 1970, in Sosnick, S. 1978, pp 46)

Sosnick conducted a series of interviews in 1966 with family men in California's Sacramento Valley. Seventy five male seasonal farm workers who had dependents living in the United States and whose main source of income was farm work told his team about their father's main source of work and income:

> "It was hired farm work for 43% of the 49 Mexican-Americans, 38% of 12 Anglo Americans, and 33% of the 12 Afro-Americans. Combining all ethnic groups, we find that the father's main occupation was hired farm work for 39%, farming for 15%, unskilled nonfarm labor for 19% and white collar work for 7%. A majority of the family men had fathers with different - and higher - status occupations."
> Sosnick, S. 1978. pp 47)

There is no single profile for a "typical" migrant farm worker as a New York Times writer captured well:

> The stereotype of the farm workers is of a Mexican-American stooped over a lettuce field in California, or weeding a row of cantaloupes in Texas or Arizona. Actually, a migrant farm worker is almost as likely to be a southern black who follows the harvest from Florida to upstate New York, or into Maine. The work is also varied: some farm workers are skilled equipment operators who drive combines through the wheat fields of Kansas; others tend sheep herds in Idaho or round up cattle in Texas or harvest corn in Iowa."

For the purposes of this paper I am proposing to focus on the Hispanic migrant farm worker who is principally unskilled, who travels to Washington State with his family or alone, and whose main source of annual income is derived from farm work. For these individuals and families, as well as for the variety of other farm workers such as those pictured in the New York Times article, there are a number of common problems inherent in the migratory lifestyle, and a number of consequences -- economic, physical and mental -- that ensue when the late twentieth-century "norm" of sedentary, community-based living is overturned, and people are forced into a highly stressful migratory lifestyle for economic survival.

C. Consequences of migration -

1. economic

Migrant farm workers are a uniquely impoverished, exploited and generally underserved group. The agricultural Labor Relations Act does not allow collective bargaining on the part of agricultural farm workers and until the new State minimum wage law goes into effect, they will continue to be denied a the right to a basic minimum wage and unemployment compensation. Given that farm workers cannot earn very much while they are employed, it is all the more devastating for them when unemployment hits. With increasing farm mechanization comes increasing layoffs among traditionally high density farm tasks, and as the same number of farm workers seeks an ever decreasing number of jobs, unemployment or under employment is on the rise.

The structure of work on the farm is also designed to keep the worker at an economic disadvantage. Individuals and families band together under the direction and "protection" of a crew boss. More or less honest, the crew bosses traditionally will keep the wages of all those under his "protection". From this total amount he will take his percentage, and then meter out small allocations as he thinks fit. The theory behind this child-like treatment is to prevent the men from drinking their wages immediately, and to ensure safekeeping of the money under less that ideal circumstances. It means however, that each individual picking has little feel for how much he or she is earning, and cannot discern whether he/she is being cheated out of his/her [illegible]es. It is also a demeaning method of maintaining grown men and [illegible] in a condition of dependence.

Economically, migrant farm work is a circular problem. A vicious [illegible] of bad economic conditions at home forces a migratory work [illegible], which continues to perpetuate bad economic conditions at home.

2. physical

Work conditions for migrant farm workers do not contribute to good [illegible]n. The hours are grueling, the work is back breaking, the pay is poor, the housing dilapidated and unsanitary, the surroundings often hostile and the exposure to life-threatening pesticides, fungicides and

herbicides is orders of magnitude higher than the non-farming majority culture.

Ironically, the population that is responsible for harvesting the nation's food baskets suffers from malnutrition. A Texas department of Health Resources Study (1970-72) revealed that a significant number of Mexican Americans in the categories of children under five years of age and elders over 74 years of age die of nutritional deficiencies. Tesler and Rodriguez (in Andrade, 1987) found that Mexican Americans die of undetermined causes often relating to nutritional deficiencies at a rate three times that of Anglos. Deaths relating to diabetes mellitus which is also attributable to dietary patterns was almost three times higher among Mexican Americans than Anglos.

The average life span for a farm worker is 49 years.

The New England Journal of Medicine has reported that:

> "Health problems cannot be solved without addressing other important aspects of the community's health such as housing . . . Programs that focus on curative medicine without major attention to these traditional non-medical areas will achieve at best a marginal success."
> (Danns and Johnson, 1975)

In other words, clinicians must pay attention to how the people live if they are to attempt to help.

While travelling, migrants often sleep whole families in cars, trucks and busses because they do not have the money to sleep elsewhere. Frequently they stop near a park, or sleep briefly by the side of a road and then push on for their destination. After reaching their place of work they must find cheap, temporary housing. If they cannot -- often the case -- they are at the mercy of their employer. In farm work, housing is commonly provided by the employers; the situation requires it. In Oregon and Washington 80% of their housing units are on the farms where they work.

What housing they do find is mostly atrocious. Conditions are often far below acceptable, civilized standards and are usually dilapidated, unsanitary and depressing. Without funds, without options and with few protections migrants, even though they work hard and adhere to traditional American values concerning family and industry, are forced to live like hoboes or ghetto dwellers.

One journalist described a migrant housing project he saw in Florida:

> "The houses . . . are in constant need of repair. [The] smell of backed-up toilets [and] odor of urine (is) everywhere. [The] water smells bad, tastes bad and sometimes is not potable. [There is an] absence of lighting. Wiring is exposed. Windows do not have screens. Pests, bugs, and rats are a problem. Said one foreman, these are homes "congressmen from Washington wouldn't keep their dogs in."
> (in Goldfarb, 1981 pp 42)

One Senate report warned that poor housing caused disproportionate cases of tuberculosis and other respiratory diseases, stomach disorders, accidents and children's diseases (mumps and measles) as well as psychological problems, juvenile delinquency and mortality.

Employers of migrant farm workers have no practical incentives to provide adequate housing. Decent living quarters cost money, the season is short, and employers' risks from maintaining bad housing is minimal. In addition, the laws of economics are perverse; if a farmer improved his workers' housing, property taxes would go up; yet if migrants are employed, overall real estate values go down and general taxes will rise to cover the social costs of additional poor people in the area.

A unique physical problem for the contemporary farm worker is exposure to pesticides. A senate subcommittee reported in 1970 despite incomplete medical records there was documentation that 300 workers are killed each year and over 800,000 are injured as a result of pesticides. In California alone a Department of Public Health study in 1960 revealed that 3,000 children received emergency or medical treatment for ingesting pesticides. (in Goldfarb 1981, pp 35)

Hearings in 1972 before the Senate Subcommittee on Migratory Labor and the House Interstate and Foreign Commerce Committee unearthed the deplorable health conditions that plague migrants. On the move and without funds, these workers have limited access to medical care. In 1977 a survey in Indiana revealed that only 6% of migrant farm workers there saw a doctor each year (77% of the general population does so). A Virginia Health Department study in 1974 found that 28% of the migrants in that state received no medical treatment for their serious

critical health needs. One witness reported:

> "Most of these people live constantly at the brink of medical disaster, hoping that the symptoms they have or the pain they feel will prove transient or can somehow be survived, for they know that no help is available to them."
> (Senate Hearings, 1972. In Goldfarb 1981, pp 34)

Health problems run the gamut; malnutrition, visual defects, ear infections, tooth decay, heart and parasitic diseases, skin and respiratory infections, and high rates of mental illness and preventable diseases such as polio and venereal disease. The infection and parasitic disease rates of migrants are 200-500% higher than the national averages. Their mortality rate is double the national average; life expectancy is about 30 years lower. (Senate Committee on Labor and Public Welfare, 1970, in Goldfarb 1981, pp 34)

Health problems start in infancy, or even before, in utero. Migrant children are born premature three times as often as others, 20% are born without proper medical assistance, they have 25% higher chance of dying in the first year and the infant mortality rate is at the 1930 level. As the migrant child grows and matures he or she has little preventative medical care and health care is rare when sickness occurs. They are subjected to atrocious, inhuman environmental conditions--water, food, housing, clothing, sanitation -- which contribute to poor health.

> "As we walked between the rows of dwelling units, many small children played around us, running about barefooted through mud and pools of stagnant, refuse-filled water - the perfect culture for intestinal parasites, polio, and bacteria - causing infections diarrhea which kills so many children . . . "
> (Department of Health, Education and Welfare Inspection Team, in Goldfarb 1981, pp 35)

Many of the communities where farm workers work and reside and are underserved, underserved or inappropriately served in the areas of mental health and social services because those communities do have facilities or personnel. The numbers of full time physicians, psychiatrists and psychologists and other specialists in the fields of health and mental health are declining in family health centers and community health centers. This is particularly true in rural areas where maldistribution of personnel has always existed. Clinics in

small towns and rural areas have also suffered from the "circuit-rider" syndrome where a service is provided one day or a half day per week.

iii. mental

One of the most destructive factors in the life and mental health (or ill-health) of the migrant population is their very powerlessness. One farm worker's conversation with Dr. Robert Coles (Coles 1972, pp 434):

> "Sometimes we'll be out there in the field. The grower will be on my back telling me the tomatoes have to be in by the end of the week of he's through, completely destroyed. I'll be pushing on my people to pull those tomatoes in. The sun will be beating down on us. And I'll be looking at my people and thinking to myself that half of them are in real bad trouble, the men and the women and the children. Maybe all of them are in trouble, and I should be taking all of them that day to the doctor. But if we don't get the tomatoes in pretty soon, not of us will be eating three meals a day and then we'll really need to see a doctor -- and he'll tell us to go and eat! And how, I ask you, will we go and do that except by getting those tomatoes in, right on time?"

It is this life style, characterized by poverty, poor health, low educational achievement, mounted upon a history of oppression, subjugation, exploitation and discrimination that gives rise to extremely high levels of stress which in turn lead to high rates of emotional and behavioral disorders. In fact a number of studies have shown that life conditions and experiences are similar to those that are highly correlated with high incidence rates of "mental illness", especially psychosis. (Hollinghead and Redlich, 1958; Leighton, 1959; Langer and Michael, 1963).

To quote a Hispanic psychologist, working with the migrant population of Washington State:

> "In-house medical providers [ ] have frequently encountered high rates of major depression and other affective disorders; anxiety disorders, including panic disorder, phobias, generalized anxiety states, and obsessive-compulsive disorder; psychoses such as paranoia, the schizophrenias, and mania; a number of psychologically disabling personality disorders; several "non-typical" disorders such as impulse control disorders; child physical, sexual and mental abuse; spouse and other relative physical and mental abuse; and a number of other dysfunctional psychological conditions."
> (Arenas, S. 1988)

Most farm workers want their children to break out of the cycle of poverty and out of the migrant stream to better paying, stable jobs. Education is the classic route out of poverty, but the very conditions under which the migrant family labors makes this usual route even more difficult. How can the young be educated if they are constantly on the move? The children are in and out of different schools all through the school year and often find themselves in English speaking schools when all they know is Spanish. They are often without friends other than siblings. Often they are hungry and without the necessary school supplies -- books, paper, pens. They have no assistance at home because their parents are too busy and are often without the means and abilities to be helpful when they return.

The combination therefore of appalling living conditions, the inevitable stresses that accompany powerlessness, the difficulty of changing their situation, and the physically demanding work often combines to make the migrant particularly vulnerable to somatic complaints, depression and anger. There is little understanding on the part of the individual, or family members with mental problems and certainly little sympathy from a crew boss or employer when the "illness" is not tangible and "fixable". Any one problem in itself can render one's life less than meaningful, but when whole families are dealing a variety of mental and physical problems simultaneously, the stresses compound to make an already difficult life sometimes unbearable.

PART TWO -- HISPANIC CULTURAL CONSIDERATIONS

E. Descriptive highlights of Mexican American/Hispanic culture

Ethnically the contemporary Mexican-American or Chicano is an admixture of the Indian and Spaniard. The Spanish component is made up of a complex mixture of original Iberians, Latins, Visigoths, Moroccans, Phoenicians, Carthaginians and others. The heritage of the Indian component is equally complex, with a blend of Aztecs, Mayas, Incas, Otmis, Tarahumaras, Mixtecs and Zapotecs. Theirs is a culture that was born 400 years ago and is still intact in some areas of New Mexico and Colorado where the Castilian Spanish and culture are much as they were several centuries past. Indo-Hispanic enclaves still exist in many parts of the Southwest and Mexico in which people still adhere to the folkways, mores, culture and language of centuries past. Today the mestizo of Indo-Hispanic is known as Spanish American, Latino, Chicano, Mexican American, Hispano, Spanish-language/Spanish surnames and American of Spanish or Mexican descent, while others prefer to call themselves simply American. They may be monolingual in English or Spanish, or they may prefer to speak both languages mixed or singularly.

The Mexican-American population is the second oldest ethnic group in the United States today, second only to the Native Americans. The similarities between the two groups far outnumber the differences. Like the Native Americans, the Mexican Americans were given the option of saving their souls through Christianity or of being dealt with as beasts or burden to be managed and rented as slaves to perform cheap labor.

Even today this population is one of the most misunderstood and neglected groups in the United STates, with only very recently a sense of Hispanic/Chicano pride and specific culture beginning to find its voice. Chicanos have typically been portrayed as dumb, lazy, illiterate, violent, inebriated macho-type banditos.

> "The literature is replete with statistics which paint a grim picture of the status of Hispanic American in the United States today. Nationally, Hispanic American families exist in an untenable situation in comparison to other groups: high morbidity

and mortality rates, poor schools, lower pay for equal work, rampant unemployment, substandard housing, high dropout rates, poor nutrition, low educational attainment, high incidence of poverty, and a shortage of adequate, accessible health and mental health care services in their communities.

"On the whole, Hispanic families are large. The average size of the Hispanic family was 4.07 persons per family compared to 3.44 persons for the total population in 1973. Approximately one of every 20 families in the United Stated had seven or more members; one of every 10 Hispanic families had seven or more persons. A young population, about one of every eight Hispanos was under five years old in March, 1974, compared to one out of every 13 persons for the total U.S. populace. Only four percent of the Hispano population was 65 years old and over. In 1974, the median age for the total population was 20.1 years as compared to 28.5 years for the total population. In Los Angeles, the median age of Chicanos is about 17.5 years old."
(Andrade 1978, pp iv-vii).

In 1978 there were 11 million Americans of Hispanic descent living in the United States. Today that number has swelled to 15 million, [illegible] Chicanos the fastest growing minority in America today.

The most important thing these diverse peoples have in common is the Spanish language (though many are bi-lingual to some degree) and the influence of language is tremendous. It is, for example, a more formal language than our contemporary English tongue. Having both a formal and informal word for "You" (Usted-formal, Tu-informal) introduces a whole layer of interpersonal relations that English speaking persons have been ignoring since "Thee/Thou" went out of our tongue over one hundred years ago. This characteristic of the language, plus other factors, lead to a certain formality in interpersonal relations. Not to say that all Hispanics rigidly adhere to the above usages in daily discourse but with the Hispanic patient the clinician should be somewhat more formal and avoid too rapid a progression to a first name informal relationship.

In contrast to this degree of formality there is also a great deal of importance placed on "personalismo" - that is, concern about personal attention, personal contacts, and similar factors. Some writers have even indicated that "la platica" (the chat) be used to describe the interview with an Hispanic patient. Hispanics do appreciate informality, personal interest and chatting, but only after

the proper formal amenities have been considered and respected.

Two other important cultural characteristics are the great emphasis placed on close family ties and the stricter definition of roles, especially those of gender appropriate behavior. Much has been said and written about the importance of the family in Hispanic interpersonal relations. This is a key consideration in clinical work with Hispanics. When attempting to hospitalize someone, for example, or when trying to mobilize social support or to understand family dynamics the interconnectedness and interdependence of the Hispanic family should not be over-ridden in favor of the more streamlined efficiency with which Anglo clinicians may be used to expediting treatment and services. For example, if one is working with a poorly motivated client, locating a godparent (compadre or comadre) and soliciting his or her support in encouraging treatment can often mean the difference in getting the patient to accept needed care.

Despite rapid changes occurring in the definition of sex/gender roles in the American family, the Hispanic family tends to remain traditional. According to Diaz-Guerrero, "The word of the father should never be questioned." (1977) Diaz-Guerrero has also documented the enormous importance of the role of the father in the Mexican-American family, along with other culturally important values such as "The place for the woman is in the home," and "Men should wear the pants in the family." He also reports that the coping style is traditionally passive (Diaz-Guerrero 1977, pp 23) in that people accept or endure problems and prefer to actively modify themselves rather than try to modify the environment. The father's role is that of breadwinner. The mother's involves care of the home and children. Working outside the home is discouraged and these values are reinforced by the Catholic church. Adherence to traditional roles (large families, sex-role-dictated jobs, etc) does not mean belief in machismo, a term used to describe the male belief in his superiority. There is no more wife beating or home violence among Hispanic families than the national averages. This more traditional role does however set the stage for family conflicts resulting from changing modern role expectations. Intrafamily conflicts about values and behavior tend to

be more intense.

An example from our Sea-Mar case load:

> Pedro* is an eleven year old fifth grader in a rural Washington State school. The principal at the school is friends with Pedro and was alarmed to receive a suicide note from the boy. The Principal then asked for some professional mental health counseling. Pedro lives with his middle aged mother, a migrant farm worker now settled in this small town. She has seven children, all of whom are grown except Pedro and his sister Maria, older by two years. The mother lives with her second husband (the children's father died several years ago) who takes no responsibility for the children, but instead is disabled and spends his days before the television. Pedro is embarrassed by his mother. She is poor, spends her days hoeing the fields, she does not cook American food, does not speak English, does not understand how things are for Pedro growing up in America and does not want to take any smarts from Pedro. He is thoroughly Americanized having spent the past four years living here. He does help his mother hoe on weekends and after school, which he resents hugely and wants to be free to play with the other boys his age. The mother, for her part, cannot understand why her son is so unruly. The final straw occurred for her when Pedro ran away from home and took up residence at the house of a friend. In Hispanic culture, problems are best kept within family walls, and for Pedro to seek outside help was tantamount to rejecting the entire family structure which is all the mother had to offer. The school compounded the problem by encouraging Pedro to acquire American values -- independence, a lively, critical attitude, and through no one's fault, Pedro was allowed to become integrated in his adopted culture.
>
> Stalemate. Should the mother change her life's beliefs and permit Pedro to demand American food, stay out late, not help with the farm work, cultivate American friends, and assert himself? Should Pedro be encouraged to be a traditional Hispanic male, be obedient to his mother, forget trying to be an American?

[* names have been changed to protect identities.]

It has been suggested that the strong family means Hispanics do not need to use mental health services as much as less cohesive groups, but on the other hand, stricter definitions of family roles can have pathological interpersonal effects, such as excessive dependency.

An individual Hispanic may be more or less acculturated, depending upon generation of birth, place of upbringing, immigration patterns, parental habits, socioeconomic status and personal choice. Variations in the use of the Spanish language often identify where a person sits in the scale of Anglo American through Mexican American. It is thought

that the more a person is assimilated into the American culture, the less he is likely to use Spanish, but it is not so simple for two reasons. One, Spanish is one of the most tenacious languages in the world and Hispanics, unlike European groups, are being continuously replenished by Spanish speaking immigrants from Puerto Rico, Mexico and Cuba. Secondly, since a great deal of what is "cultural" is tied up in language (some have even said that language IS culture) it is important to state a few generalizations about the Spanish language as a prelude to other considerations. Hispanics are making a conscious effort to maintain their cultural and linguistic identity and individuality.

PART THREE -- MENTAL HEALTH SERVICES FOR HISPANIC MIGRANTS

F. Particular needs of Hispanic migrants in the delivery of mental health care systems.

1. Particulars of Hispanic psychopathology --

There is general agreement that most psychiatric disorders have roughly the same incidence and prevalence throughout the world.

> "Studies, however, have demonstrated underutilization of psychiatric services (both inpatient and outpatient) by Hispanics. Underutilization of services does not necessarily mean a lower incidence and prevalence, but more likely reflects institutional barriers (language, racism), better family supports, uses of other resources (folk healers, priests) data gathering methods, or shunting into the penal systems. These many epidemiologic questions continue to remain unanswered.
>
> "There is no doubt, however, that the form the functional psychoses and other disorders take among Hispanics is different from that among other Americans. It has been fairly well demonstrated that sociocultural events weave themselves into patient's delusions - for example religious and scientific themes. Among Hispanics, elements of the Catholic faith and folk medical beliefs are incorporated into the content of thinking of disturbed individuals. In addition, there is evidence that there may be specific "culture bound" syndromes among Hispanics:
> (see Puerto Rican syndrome below)
>
> "This is a syndrome of a hysterical nature, characterized by sudden seizurelike activity and thought to serve to defend against overwhelming aggressive impulses. Various clinicians have stated that this type of conversion symptom pattern is more common among Puerto Ricans, but no quantitative studies to support this clinical impression have been done."
> (Wilkinson, C.B. 1986, pp 69-73)

With regards to other problems in the realms of mental health, Mexican Americans seem to be over-represented among numbers for alcoholism and drug addiction, but the explanation, again, is not so simple. Hispanics are also over represented among the poor in this country, and it is typically among the poor that problems with alcoholism go untreated through generations. Also, as far as drug addiction is concerned, the problem may exist because of the culture's long history with psychotropic drugs. Finally, toxic inhalant abuse (spray paint, aerosols) is particularly high among Hispanic children and is becoming a serious mental health, school and community problem.

Bilingualism

For those individuals for whom Spanish is the preferred language, the clinician needs to be careful of the effect of language on the diagnostic process. When a person thinks in one language and speaks in another there occur certain changes that can be interpreted as psychopatholigical. There is a hesitation, a groping for words that can appear as a blocking, thought derailment, or loosening of association. A limited vocabulary in a new language results in simpler restricted verbal output. This may be seen as impoverishment of thought or concreteness. The expression of a complex thought is blunted and the clinician may be tempted to allow these impressions to effect judgments about intelligence and cognition.

The language spoken can also have significant effects on the description, expression and manifestation of emotions. It is hard enough even when both patient and clinician speak the same language to express and understand emotions. Simply identifying and labeling an emotional response may prove difficult across a language gulf. The expression of an emotion may likewise be affected by the process of translation and expression into another language. To have to undergo psychiatric evaluation and treatment in a language other than one's own is probably distressing to most individuals. This situational anxiety is a further complicating factor. It may effect the expression of thought and emotion and it may bring out certain behavioral or "state" changes that can also lead to mishandling.

Symptomatology among Hispanics e.g., somatic complaints.

Wilkinson (1986) reports that Hispanic patients differ from non-Hispanic patients in the type of presenting symptomatology they demonstrate. Specifically mentioned are somatic symptoms such as headaches, and pain in the back of the neck (la nuca). It is not clear however whether this is particularly an Hispanic complaint or has more to do with socioeconomic levels. In large scale mental health surveys (e.g., The Midtown Manhatten Study) it was found that people from the lower socioeconomic brackets have a grater tendency to manifest anxiety through some form of somatic symptom. The poor are also more likely to

experience stress through overcrowding, lack of material necessities and financial uncertainty.

Among some Hispanic women, hysterical traits may become evident, such as coyness, negativism, and denial. Among Hispanic males one may see negativism, hostility, or excessive passivity. In addition, it has been noted that Mexican males must wear a mask to hide their vulnerability.

iv Beliefs in folk medicine

Willard and Arenas (1983) maintain that one reason Chicanos are underrepresented in mental health services is because of their use of the indigenous folk-medical system known as curanderismo for treatment of emotional and behavioral disorders.

> "The term curanderismo comes from the Spanish word curar, which means "to cure." Individuals who are trained in its concepts and curing techniques, and are sanctioned as practitioners within the traditional Chicano community, are known as curanderos. Curanderismo is a comprehensive and viable system of folk medicine with its own theoretical, diagnostic and therapeutic aspects. It consists of a large body of folk medical beliefs, materials, rituals, and practices that have evolved over the centuries to meet the physical, psychological, and social needs of the traditional Chicano people. Curanderismo is conceptually holistic in nature; no separation is made between the body, the mind, the spirit, and the social and physical environment as in the standard health care system."
> (Willard & Arenas, 1983 pp. 270)

The complicating factor for the clinician is the degree to which one particular client might be availing him or herself of traditional folk medicine while at the same time coming for more standard, society-culture cures. Curandos are used flexibly for both physical and mental/emotional problems and may be participating in both systems of health care simultaneously, without informing one practitioner of the other.

Although detailed well in Willard and Arenas (1983), a brief summary of folk medical beliefs follows:

> In the traditional Chicano world view, the natural and supernatural are not divided into separate compartments. Harmony between these two conceptual realities is considered essential to health and stability; disharmony causes illness and instability.

> Individuals are said to be composed of a corporeal being (cuerpo) and an immaterial soul or spirit (espiritu) that may wander freely at times, especially during sleep and after death. This soul can be dislodged through physical and supernatural trauma, allowing other spirits to enter the vacant bodies. Some individuals are said to be unusually sensitive or receptive to acquiring alien spirits, either as victims that become possessed by evil entities or as mediums whose bodies serve as "boxes" (cajitas) or empty "vessels" through which good spirits can exercise their benevolent missions. [...] Communication with the spirit world is possible; the living can talk with the dead and the dead can influence life on earth [ ]. Magic (magia) and witchcraft (brujeria) are important concepts in traditional Chicano life. Individuals are said to be able to cause illnesses and misfortune in others (i.e., hex them) as well as help them, through various means. Imitative and contagious magic are used to harm enemies, to control peoples' behavior, or to cure illness and "neutralize" evil forces [ ] Imitative magic involves the use of images or figures that represent the victim (e.g., dolls, molded wax, pictures, etc.) or the manipulation of certain objects or materials (e.g., magical powders, perfumes, amulets, etc.) In contagious magic, objects that were once in contact with the victims (e.g., personal belongings, locks of hair, fingernail trimmings, etc.) are used for the same purposes. Bewitchment (embrujamiento) can also be accomplished byu introducing or directing various objects and substances into victims' bodies (e.g., powders, potions, negative energy, etc. Religion, especially Catholicism, also plays an important role in traditional Chicano life. A violation of religious and moral standards is believed to lead to illness or misfortune. God is believed to intervene directly in the affairs of humans. A variety of saints, both formal (e.g., St, Jude, St, Martin, the Virgin Mary, etc.) and folk (e.g., el nino Fidencio, Don Pedrito Jaramillo, Santa Teresa, etc) are also believed to cure illnesses and remove obstacles in life."
> (Willard & Arenas, 1983 pp 271-272)

Examples of some types of culture-specific illnesses (i.e., illnesses not recognized by the majority culture) include:

SUSTO - fright, soul loss. Believed to be caused by a sudden and traumatic experience such as a near miss by a speeding truck. Symptoms include: a trance-like state, apathy, listlessness, restlessness, sleep disturbances, anxiety, depression, indigestion, withdrawal and irritability.

MAL OJO - "evil eye". Results when a person with strong vision admiringly or enviously looks at a patient. Children are more susceptible than adults. Symptoms include: crying spells, headaches, irritability, fever, diarrhea.

MAL PUESTO - hex/bewitchment. Catch-all term for variety of behaviors. Symptoms include: visual and auditory hallucinations, strange or bizarre behavior, anxiety states, disassociative states, conversion reactions and phobias. Most of what would be considered to be psychotic reactions are included in this category.

Types of cures include - 1) material level--use of common objects like plants, herbs, eggs, lemons, and religiously or mystically symbolic materials like crucifixes, oils, incense etc. Rituals and cleansings or sweepings and other magico-religious rituals.

2) Spiritual level -- healings are organized around the church or temple and the healer is usually possessed by a formal or folk saint during their healings.

3) mental level -- the least researched or common cure, this level involves processes and activities that can be referred to as "psychic healing". In this level it is believed that mental energy can be directly channeled from a curandro's mind to a client. Healers engage in activities like precognition, clairvoyance, telepathy, psychokenesis etc.

7. <u>Problems and special considerations in the delivery of mental health care systems to Hispanic migrants.</u>

a. <u>Clinics need to be in rural areas and be culturally welcoming.</u>

Because the migrating farm working family cannot take time to travel long distances for their physical or mental health services, clinics must come to them. The more accessible the clinic, the more likely it is to attract the men and women it is trying to serve.

> Standard mental health facilities with their office-like and tightly organized settings are felt to be cold and personally sterile...and not places where one goes to talk about emotions, life, family, personal relations, and intimate secrets. The way a place is decorated and even furnished, in fact, determines whether or not a person can relax or feel safe enough to "open up" and focus on the issues at hand. The more a setting includes familiar decorations, furniture, odds-end-ends, seating arrangements, and space relationships, the better."
> (Arenas, S. 1988)

ii Clinics need to have sliding scales/free services

This most usually means the clinics should operate on a non-profit basis and apply for federal, state and county funds to operate, thus enabling them to have little or no charge for the patients who already afford no insurance and would otherwise again be barred from the clinic's services.

Clinics for mental health services need to be attached to medical clinics

The Hispanic migrant is unlikely to seek out services specifically for mental health problems. Having a medical clinic to attract patients for their more urgent physical cases can permit of a flow between medical and psychological providers without stigmatizing a client as "loco" or forcing them to feel in any way different from their friends and families.

iv Providers need to be bi-lingual and bi-cultural for best effect.

It is not impossible for a provider from one culture to work with a client from another, but as the preceding pages will attest, learning the language and a minimum of the customs and cultural mores will go a long way towards facilitating a more accurate relationship between provider and patient.

However, even if equipped with this minimum, barriers to communication do not lie only in one's inability to speak good Spanish. Barna (1970) cited five barriers to accurate intercultural communication:

1) Language is not just about learning new sound symbols. You can learn just enough to make a "fluent fool" of oneself if you do not understand the nuances of that culture;
2) Non-verbal communication, all that we say to one another by gesture, posture and our other megamessages are generally different between cultures, more emotional and hard to learn;
3) Pre-existing stereotypes we may have of another culture or person can get in the way, for we tend to se what we look for;
4) We have a tendency to evaluate what others say or do as intrinsically good or bad. This evaluation tends to interfere with understanding the other person's point of view of himself and leads the counselor into patronizing the counselee;
5) There is a high level of anxiety that is particularly obvious in intercultural encounters where neither person is certain what is expected of him or her.
(from Pederson 1976, pp 26)

Using an interpreter in the diagnostic and therapeutic situation is controversial. For several reasons traditional wisdom has advised against the use of the interpreter except when absolutely necessary. (Wilkinson, C.B. 1986. pp 72) The interpreter brings a third person into the process which has usually been seen as producing negative effects because it supposes a greater likelihood for distortion and misrepresentation. Also, patients are reported to find it disagreeable. A report (Klein, Acosta, Austin & Johnson, 1980) questions whether the use of the interpreter invariably has negative effects. The patients studied by these workers saw the use of an interpreter positively, as evidence of interest and concern for better communication and understanding. It seems reasonable to conclude that like another tool used in diagnosis, the interpreter may have variable effects and these need to be taken into account in the interpretation of clinical findings.

- Providers need to be aware of a patient's simultaneous use of western science with their folk medical beliefs.

Not knowing, for example, that certain teas act as laxatives might be cause for concern when a western anti-diarrheal medicine has no effect, or a mild laxative prescribed by the doctor has violent results with the client because it is being augmented by herb teas.

- Clinicians of the majority culture need to be aware of problems when representatives of one culture think they can "fix" members of another.

In a review of the social psychology literature, Amir (1969) concluded that merely getting members of different groups together is not enough to produce understanding and harmony. The direction of change depends on whether it occurs under favorable conditions that tend to reduce prejudice, or unfavorable conditions that tend to increase it. Amir's review of the literature on intercultural relationships suggested that favorable conditions occur under six circumstances: (1) when there is equal status contact between members of the various ethnic groups; (2) when the contact is between members of majority group and higher status members of a minority group; (3) when the social climate is likely to promote intergroup contact; (4) when the contact is intimate rather than casual; (5) when the contact

pleasant or rewarding; and (6) when the members of both groups act in functionally important activities toward superordinate goals. Amir also listed six unfavorable conditions which apply: (1) when the contact situation produces competition between the groups; (2) when the contact is unpleasant or involuntary; (3) when the prestige or status of one group is lowered as a result of the contact; (4) when members of a group perceive themselves as being victims of ethnic "scapegoating"; (5) when one group in the contact has moral standards that are objectionable to the other; (6) when the minority group members are of lower status in their own community." (in Pederson 1976, pp 25-26).

In the context of the anglo therapist working with a non-Anglo client, the more unfavorable circumstances for effective communication may be present (particularly points numbers #2,3,5 & 6) and special effort should then be taken to ameliorate those conditions.

<u>Clinicians need to define "norm" within the Hispanic migrant culture in their search for a vision of health for each particular client.</u>

"Many of the basic assumptions of counseling and therapy reflect the social, economic and political context of Western cultures as well as imply the universal applicability of these assumptions in non-western cultures. Challenging the universality of Western-based psychology is not to deny psychology's scientific character but rather to recognize alternative assumptions from other cultural perspectives. Sampson (1977) for example cites the androgynous ideal of normality as reflecting an individualistic social science in which persons need to be self-contained and self-sufficient to be successful. Rotenberg (1974) and Draguns (1974) describe how the influence of the Protestant ethic's enhancement of a scientific, rational approach to psychotherapy in Western psychology idealizes active adjustment rather than passive acceptance in striving for success. The acceptance of the Protestant ethic has contributed historically to the separation of people into categories of good/bad or sick/healthy, predestined by the dualistic labels of therapy to reject the mentally ill. Hsu (1972) rejects individualism and describes mental health in terms of an interpersonal nexus in his theory of psychosocial homeostasis as an alternative which emphasizes the individual-in-context and the relationship between persons as primary."
(in Pederson 1976, pp 27)

viii <u>Clinicians need flexibility to cope with charts scattered throughout the country, an average one third "no-show" rate, and the difficulty of follow-up with clients.</u>

Might seem like a small point, but there are some individuals for whom life in a migrant health center would prove too uncertain. Charts made up for a one-time visit, and then never used again for the client, though sick, has moved on; clients who come again and again and never manage to follow advise; clients who come and then fail repeatedly to keep appointments. It demands a person who has a deep reservoir of concern, but who can allow the client to go freely, and to act as best he or she can under the circumstances.

t. Clinicians need to be aware of the degree of acculturation of the individuals whom they are seeing.

Clients who are seen virtually straight from Mexico have their own particular set of problems, some of which have already been identified in this paper. However, for the client who is fluent in English, is middle class in orientation and quite acculturated, there is another set of problems. The more acculturated individual may develop serious identity problems, anxiety, and other symptomatic behavior as a result of too rapidly shedding his or her traditional Hispanic cultural values, beliefs and habits. Some of these traditional attitudes include the belief in the father and males as dominant in the family, and the expectation that children remain close to the home. Also included are a host of cultural traditions ranging from those dealing with the use of the language to others having to do with eating. Particularly now that there is heightened consciousness about ethnic identity among Hispanics, those that have acculturated in too rapid and perhaps too extreme a fashion may feel acutely conflicted and make desperate efforts to re-embrace their culture or flee from it. Both extremes can be problematic.

Rapid acculturation also leaves the individual susceptible to serious conflict with parents, and other less acculturated relatives, with resulting interpersonal friction and possible alienation from a valuable support system. It has been demonstrated among other ethnic groups that second generation immigrants have higher suicide rates than the first. Thus when working with the more acculturated Hispanics the therapist should not assume that ethnicity and cultural identification are not longer issues; they obviously can very much be issues of

central concern and should be explored. Often the client experiences a great deal of remorse and longing for the lost culture and language. Frustration and shame are common especially in the presence of more traditional Spanish speaking peers, and sometimes there is a great deal of anger, resentment and misunderstanding of parents who did not teach their children Spanish in the home believing they were helping them to become fluent in English, only to find that Spanish is now valued and as a result they are held to blame for their way of upbringing. Often second generation Hispanics particularly Mexican Americans are not only aware of the racism and other pressures on their parents during the 1930, 1940's and 1950's that made them try to deny their language and heritage.

x Clinicians need to be reasonable in their proscriptions for healing and change.

Again, a rather obvious point, but it would do little good to tell a family who were not at all acculturated into western foods and lifestyles to go away and lower their cholesterol when all they could afford were tortillas and lard. A sensitivity to the type of healing the client is prepared to adopt is a necessary prerequisite for effective treatment.

II. Some How-To recommendations for the delivery of quality mental health services to Hispanic migrants.

Look at the individual in context.

Regardless of what social psychiatric studies suggest about the prevalence of various disorders among Hispanics the clinician is still ultimately faced with the task of evaluating the single individual in his or her social and cultural environment, and responding therapeutically. In the process of this work, the clinician is presented with two basic intervening variables: language and culture. But paramount in the tension of these two poles, is the life experience of the individual.

ii Understand, and research if necessary, the relevant cultural differences of the client with whom you are to be faced.

Understanding aspects of the culture of the client, even when he

...she seems well acculturated, is important. It is especially important that the therapist remember strong traditional beliefs still prevalent among Hispanics, especially those beliefs having to do with ...definitions of family roles, sex roles and health. In practice ...means the therapist must be aware that suggestions for change ...ally in the women in the direction of greater personal freedom ...tonomy may be met by strong resistance and conflict. The spouse ...other family members may also be opposed to such movement. It is a common error for therapists working with Hispanic women to encourage too eagerly a sense of independence in a woman and family who are still deeply caught up in traditional beliefs about the roles of men and women.

iii Employ the "Explanatory Model."

There are several approaches or perspectives that can be used when working with persons from a different cultural group. One approach that seems particularly useful is the "Explanatory Model approach" (Kleinman, Eisenberg & Good, 1978). Using this approach the therapist explores and works to understands the patient's "explanation" for his or her condition. Therapy then departs from and utilizes the patient's explanatory model. Psychotherapy involving a therapist and patient from roughly the same sociocultural group usually proceeds on the basis of certain shared assumptions: that previous historical events influence present behavior, that talking helps, that emotional conflict may produce physical symptoms, that certain emotional problems are health problems. In working across cultural boundaries there may be fewer or different shared assumptions, e.g., Hispanics commonly believe that certain symptoms (anxiety, insomnia) are due to hexes or bad spirits. In other cases symptoms may be attributed to an episode of uncontrolled anger or a demonstration of disrespect for elders. Therapeutic wisdom says that therapist-patient expectations should be properly aligned and congruent for therapy to work. When one is working across cultures this alignment of perspectives may not always be possible. The therapist may have to be satisfied with simply understanding the patient's explanatory model of dysfunction, or the therapist may need to utilize the patients' explanatory language to more effectively

produce change.

Likewise many Hispanics may simultaneously use two modes of [illegible]ng (explaining) -- the folk and the scientific -- and be prepared to function within both systems.

iv Employ a "Multimodal" approach.

A comprehensive and systematic approach to the treatment of human problems, the "Multimodal" approach was developed by Arnold Lazarus (1976, 1981). In brief, the theory is that each personality consists of seven specific and interrelated modalities. All individuals manifest behavior, experience emotions, have physical sensations, create pictures, think to themselves, relate to others, and manifest biological mechanisms (e.g., eating). Labeled more concisely as Behavior, Affect, Sensations, Images, Cognitions, Interpersonal [illegible]ions and Drugs/Diet (biological), this list forms the familiar acronym BASIC ID. An essential tenet of multimodal therapy that makes it especially appropriate for Mexican-American clients is that the [illegible]each is flexible, multifaceted, and fully comprehensive. Unlike more traditional modes of therapy which concentrate on just one or [illegible]f the aforementioned modalities (e.g., Gestalt with the Affect mode, Cognitive therapists with the Cognitive mode etc), multimodal therapy deals with each modality in every therapeutic encounter. The therapist and client draw up a modality profile in which an exploration [illegible]ch of the modalities should reveal exactly where the particular client is having difficulties, e.g., what behavior is being manifest that could be troublesome? and how does this behavior influence the client's affect and physical sensations? What about interpersonal [illegible]ions etc.? For a full summary of the multimodal approach with the Mexican American client I refer the reader to J. Ponterotto, (1987) and the original works of Lazarus (1976, 1981.)

v Work with dual systems of scientific and folk medical beliefs.

As explained in the fuller discussion of folk medical beliefs on [illegible] 20-23, knowledge and understanding of the particular Hispanic [illegible]'s folk medical belief system is very important. By using the explanatory model discussed above, it might become clear that a woman feels she has been hexed by a dead uncle to whom she showed disrespect,

thing but a cleansing ritual is likely to heal her, from her perspective. In this case, no amount of "talking therapy" is likely to bring her peace of mind, and it would be best to bring in a cuarando to perform the desired ritual.

vi. Initiate self-help groups among the clients.

One of the main problems for the women who travel in the migrant streams is the loss of their traditional social organizations from their original villages and towns. Women are used to gathering together for child raising, companionship, gossip and healing. One interesting example of how recreating a little of this lost companionship can make a big difference was told to me by Dr. Silverio Arenas, and demonstrates the efforts of the La Clinica in Eastern Washington State to help their female clients. With grant money, the clinic bought a small house not far from their main location, furnished it in traditional Hispanic style, provided comfortable chairs, a kitchen, plates and enough money to keep the fridge and larder well stocked. When a woman would come to the clinic, and seemed to be above all depressed and without female companionship, Dr. Arenas would tell her about a new group of women --las Comadres -- (the god mothers) who had started to meet at this little house. The woman would then be encouraged to attend some informal gatherings and slowly slowly the reputation of the Comadres' group grew, enticing many single and married women to gather there regularly, and thus alleviate much depression, fear, loneliness and even sickness, through the regular interaction of an intergenerational group of women sharing similar burdens and with tried and true remedies they had found through personal experience.

vii. Include the family in treatment, or find a comadre or compadre (Godparent).

It is particularly important when working with clients from a split family background to ensure that the patient, and his or her family develop a reasonable degree of understanding about the nature of the patient's condition. A not uncommon finding is guilt among family members over the cause of the illness. The guilt may be displaced and projected through the use of a hex system onto "jealous" in-laws or

friends. It is important that this possibility be explored and alternative explanations be offered. Sometimes because of Hispanic patient's difficulty with English there is a reluctance to ask questions or seek clarification. A more aggressive approach is then required on the part of the therapist.

viii Employ pharmacotherapy when necessary.

Pharmacotherapy has a position of importance with Hispanics. [illegible] Americans appear to be disposed for historical reasons to [illegible] to pharmacological means to alleviate suffering. Mexico during [illegible] times had an extensive pharmacologically active pharmacopeia. To [illegible] day, curandos prescribe herbs and other ingestible substances for [illegible] variety of physical and emotional maladies. Also until recently all [illegible] of drugs were easily available from pharmacies in Mexico without a physician's prescription. These traditions incline Chicanos to some degree to accept pharmaceutical intervention more readily.

ix Consider the pathology of the environment.

There is a tendency to look for pathology in the individual while overlooking the pathology that might exist in the environment. No-one can make a strong case for the health benefits enjoyed by the lifestyle of a migrant farm worker!

x Learn the language of your clients.

Not speaking the language of one's clients is a major drawback. [illegible] are numerous in the United States, and yet the number of bi-lingual/bi-cultural therapists is not sufficiently great. Schools have dealt with this dilemma by means of bi-lingual programs. No such large [illegible] effort has been started in the field of mental health -- an area [illegible] proper communication is paramount. Some efforts to recruit more Hispanic health professionals are underway, but despite this effort and with existing Spanish speaking psychiatrists, there is still the problem of uneven distribution. The problems encountered in making an accurate diagnosis when working with a bi-lingual client have already been discussed, and the situation is even harder in the area of psychiatric treatment where the cure is either talk or drugs. It should be self-evident that the efficacy of a verbal therapy whether it is counseling, analytically oriented psychotherapy or group

psychotherapy, is compromised if adequate communication does not take place. If communication is poor, even pharmacotherapy is liable to be less effective through diminution of the placebo effect or poor compliance due to faulty explanation of the correct drug use.

xi) Use an interpreter when necessary.

If the therapist if faced with a Spanish speaking client, and there is no other suitable provider in the vicinity, the use of an interpreter would be advisable. At the very least however, even when employing an interpreter, it is courteous to learn the correct pronunciation of the client's first and last name. Correct pronunciation of a patient's name shows interest and concern. Some Hispanic patients, due to anxiety, fear, shame or anger may present themselves as able to speak less English than is actually the case. The sensitive interviewer should not let the patient's demurral lead to the conclusion that further communication is not possible.

xii) What makes a good cross-cultural counselor?

Torrey (1972) has pulled together some common themes shared and practiced by therapists across cultures to illuminate those underlying techniques that have relevance for all of us --

a) The therapist names the illness, and thereby dispels the unknown quality of the illness. Also, an illness cannot be treated until identified.

b) The therapist lessens the ambiguity of the situation by identifying a cause for the illness that has some relevance within the patient's particular culture.

c) The therapist depends upon culturally determined criteria for establishing his credibility. Using this culturally sanctioned role, he or she establishes a rapport with the patient for without the support of the person seeking help most therapists will agree, there is little that can be done.

d) The therapist forms a coalition between herself as help giver, and the patient as help-receiver, for a joint approach toward the problem.

e) The therapist knows that much of the client's healing will depend upon the client's belief in the healer. She therefore demonstrates -- whether by diplomas hanging on the wall, years of training, or certain magical acts, that she or he is qualified and will indeed be able to help this client.

But what makes a good cross-cultural counselor? According to Sanard (1970), a good counselor is one who is secure enough in his or her own culture to be able to leave its security and understand the

world of another culture without falling prey to the dangers of encapsulation" or "seeing everything through the eyes of a white, middle class individual." Traditional theories of psychoanalysis emphasize the individual as an isolated biosocial unit, but these theories do not touch upon the complexity of personality development in pluralistic society in which each person is in a feedback relationship with several cultures at the same time.

And what is to be avoided?

1) Defining reality according to a monocultural set of assumptions and stereotypes which then become more important than the real world.
2) Becoming insensitive to cultural variations among individuals and assuming that our views correspond to reality. The assumption that "I know better than they do what is good for them" is, not surprisingly, offensive to the target audience.
3) Harboring unreasoned assumptions that we accept without proof. When those assumptions are threatened by an alternative religion, political view or cultural value, we can easily become fearful or defensive. When the minority culture is perceived as threatening, it quickly becomes the enemy to be opposed and ultimately defeated for the sake of self-preservation.
4) Clinging to a technique-oriented job-definition which further contributes toward and perpetuates the process of encapsulation. Each relationship should be evaluated according to whether or not it contributes toward solving problems. However, when counselors seek to escape encapsulation by blindly accepting the problem as resulting from the client's culture they only succeed in absolving themselves of any responsibility to interpret the behavior of others as being relevant and meaningful.

I) CONCLUSION

Maybe, in a more perfect world, every client could be seen therapeutically by a professional of similar culture and therapeutic background. However, in the world of today, we would do well to simply inform ourselves of the issues that are appropriate when one culture attempts to "help" a member from another, different, culture.

Counselors are increasingly confronted with pressures from culturally different clients who challenge their basic assumptions about mental health. Questions of racial and ethnic identity have increased consumer demand for awareness of special mental health needs from many cultural perspectives.

Basic issues of mental health focus on the adjustment of

individuals within their own sociocultural context, requiring that we examine basic assumptions of our own culturally biased perspectives.

Still, in spite of all the caveats and complications, says Lonner (1976) "intercultural counseling is an exciting and promising area of study. It brings to psychology and other social sciences many opportunities for important learning - how different peoples might understand each other better, how one culture is viewed by another, and new ways of observing our basic human commonalities, similarities, and uniqueness."