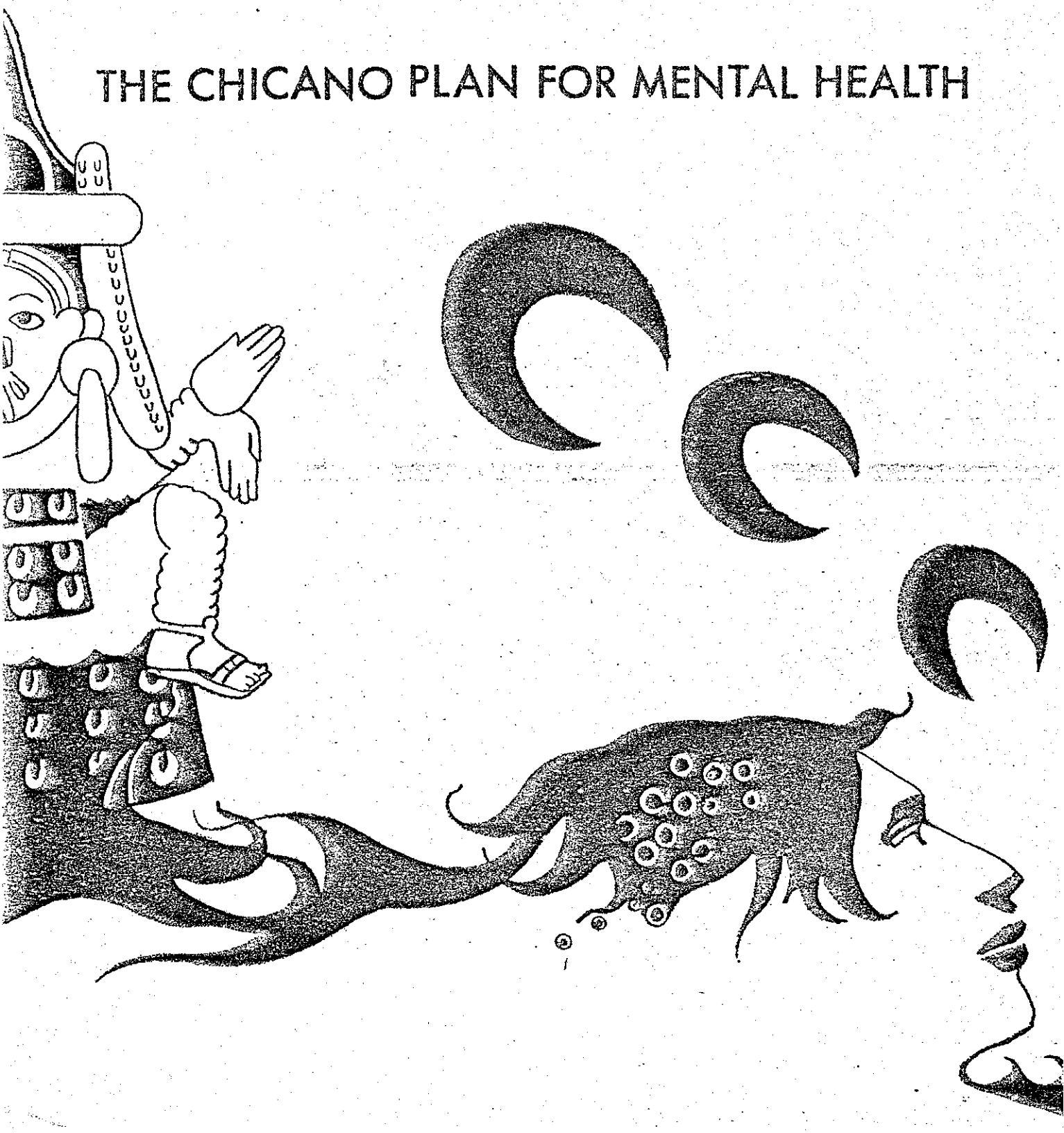
SALUBRIDAD CHICANA: SU PRESERVACIÓN Y MANTENIMIENTO

THE CHICANO PLAN FOR MENTAL HEALTH



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CHAPTER 3
MENTAL HEALTH NEEDS OF MIGRANT WORKERS

Even those familiar with rural mental health programs seldom know firsthand the difficulties that arise in attempting to provide mental health services to migrant farm workers. This section of the mental health plan identifies some of the problems that must be solved if migrants and their families are to receive adequate mental health services. Considering that such services are inadequate for the general population, they are even more so for migrant workers. Moreover, the fact that migrants are constantly on the move and the reluctance of service agencies to help them further exacerbate the problem of providing them with mental health services.

Statement of the Problem

In order to develop a good mental health program for migrants, it is necessary to define mental health from Chicanismo perspectives and, concomitantly, to consider the unique environmental circumstances in which migrants live. While no attempt will be made here to define Chicanismo as a cultural phenomenon, suffice it to say the term implies a militant sense of brotherhood and a desire to bring about social changes to improve the lot of Chicanos.

To the extent that Chicanos assume such a posture, they differ in their cultural and social outlook from those who identify with Mexican-Americans. The latter are more prone to favor assimilation, strive for acceptance into the dominant Anglo society, or be content with the status quo. Chicanos are more apt to be concerned with the problem of maintaining and reinforcing the Chicano culture, opposing assimilation, advocating cultural pluralism, and preserving the intrinsic cultural values of Chicanismo. Finally, Chicanos are vitally concerned with the problem of improving working conditions and increasing wages for farm workers through unionization.

While it may be argued that differences in sociopolitical outlook between Chicanos and Mexican-Americans are relative, Chicanos, in terms of culture, are distinct from Mexican-Americans and, hence, warrant special consideration in developing a system of mental health services for them.

Chicanos Defined Along Sociocultural Lines

Practically speaking, Chicano is a term used to identify individuals of Mexican descent who, in one way or another, are concerned and/or involved with the social struggle to improve the lives of Spanish-speaking people. How and where the term originated is relatively unimportant. It is important to note, however, that the term Chicano identifies a group of people involved in a social struggle that is hundreds of years old and that continues today.

The following excerpt from a Department of Labor report[1] identifies Chicanos in socioeconomic terms. That Chicanos continue to live under extremely unfavorable social and economic circumstances is implicit in the definition:

> **The Spanish-speaking minority of the United States of North America is the second largest minority in the United States. They share commonalities and differences as do any other groupings of people.**
>
> **They are primarily Spanish-surnamed, Spanish-speaking, primarily Catholic, they live in a land conquered by the predominate Anglo society and they live in close proximity to their native lands and customs that allow for retention of their culture and life style. The Spanish-speaking people experience poverty and denial of economic opportunity at a level little realized by the average American.**
>
> ***Spanish-speaking Americans make up roughly 5 percent of the population,* making them the second largest minority group—about half the size of the Negro population.**
>
> **In contrast with the widely held view that most Spanish-speaking are migrants or live on farms, *80 percent reside in urban areas,* 46 cities throughout the country have target populations over 10,000.**

[1] U.S. Department of Labor, Report on the Manpower Needs of Spanish-speaking Americans, prepared by S. Bell, L. Cardona, R. Ontiveros, and M. Ramirez (Washington, D.C.: U.S. Department of Labor, 1970), p. 5-6.

The largest and most impoverished Spanish-speaking groups are Mexican Americans (55 percent) and Puerto Ricans (16 percent); Cubans, Central and South Americans, and other persons of Spanish origin tend to be better educated and have relatively higher incomes.

Seventeen percent of Spanish-speaking incomes are below $3,000 poverty line, compared with 10 percent of all other Americans.

Unemployment is high: 16.0 percent compared with 10 percent for persons of other origin (in November 1969 when the overall level of economic activity was better).

The Spanish-speaking are concentrated in lower-paying occupations; only 25 percent of Spanish-speaking are in white collar jobs—41 percent for the rest of the population.

Lowest level of educational attainment of any Americans; 8.5 median years of schooling for Spanish-speaking persons 35 years and older, 12.0 years for others; less than 12 percent of Spanish-speaking adults have attended college with the exception of Nati Americans.

Language barriers are severe with one adult in th illiterate in English and perhaps one in ten unable speak the language necessary for economic viabili

Major obstacles are posed by cultural characteris and differing value orientation of Spanish-speak persons due to the lack of understanding of the lar society coupled with a partially self-imposed eth isolation of the group itself.

La Raza, pride in a unique ethnic heritage of Span speaking peoples, has yet to be creatively linked with economic promise of our society in ways that enr the cultural heritage of all Americans.

It was also found that in California 40 percent of th convicted of narcotic offenses were Chicanos, t alcoholics still constitute a disproportionate num of arrests in barrio areas. The services offered in area of mental health are still not commensurate w the needs of Chicanos.

Ernesto Galarza launches the Goleta conference in 1970. In the midst of a police-student riot outside, he brings history, warnings, a definition of mental illness. (See p. 14 below).

The medley of definitions alluded to above serves specifically to describe Chicanos in terms of economics, life style, cultural values, and sociopolitical outlook. This characterization has been viewed with suspicion by those who contend that mental health problems among Chicanos stem from their unwillingness to conform to Anglo standards of assimilation.

Mental health problems among Chicanos have either been diagnosed along clinical lines or attributed to structural inadequacies in the social system. Clinical statements include those that profess to show that Chicanos are genetically inferior.[2] In fact, there seems to be a propensity among clinical psychologists to attribute mental unbalance and dysfunction among Chicanos to genetic makeup. Other clinicians hypothesize that Chicanos come from an environment deficient in intellectual stimuli, particularly during formative years.[3] Other theories indicate that socialization patterns among Chicanos are inadequate, compared to those of the Anglo nuclear family,[4] or that Chicanos come from a culture that is hostile to technical progress.[5] Such analyses have definite racist connotations, and they are wholly unacceptable to Chicanos and Third World people.

Mental health problems among Chicanos are more rationally and logically attributable to structural deficiencies in the social system, i.e., lack of access to the opportunity structure. This assumes many forms, such as denial of access to professional accreditation and educational opportunities. Nowhere is denial more obvious than in the educational system. At all levels, schools and colleges operate in a manner that tends overtly or covertly to deny Chicanos sponsorship in everything from student clubs to programs in Chicano studies. Chicanos, moreover, are falling further behind in their understanding of what it takes to survive in a complex capitalistic system. Other frustrating problems that affect the mental well-being of Chicanos include discrimination in hiring practices and debasement of the Chicano culture by the dominant society.

The point to be made here is that the varied assortment of clinical terms used to describe mental health problems among Chicanos, such as "mental unbalance," and "dysfunction," are more realistically manifestations of distrust for a socioeconomic and political system that Chicanos see as grossly unfair. In other words, adequate health programs can be developed only if the complex of factors that exacerbate mental health problems among Chicanos are clearly understood in terms of cause and effect.

The points indicated below are related directly or indirectly to the lack of access to the opportunity structure. As such, they serve to summarize why Chicanos often feel frustrated with life in a predominantly Anglo society that purports to give everyone equal opportunity. Among these may be listed (1) extremely limited potential for economic security, compared to other citizens, (2) general unwillingness of the dominant society to restructure the job market to increase employment opportunities for Chicanos at professional and subprofessional levels (despite federal affirmative-action guidelines), (3) lack of political power, (4) lack of opportunities for creative expression because of economic constraints, (5) lack of respect among white middle-class America for the Chicano people, their customs, beliefs, etc., and (6) an economic stranglehold tantamount to feudalism as a result of Chicanos being forced into barrios following the economic obsolescence of urban society.

These are some of the underlying causes of so-called mental "inadequacies, unbalances, and dysfunctions," among the Chicano people. Lacking full access to the opportunity structure, Chicanos see themselves as pawns in a racist society in which white skin is a prerequisite to social and economic success. We see, moreover, that to provide for the mental health of Chicanos requires that their needs be specifically identified, irrespective of whether those needs are similar or dissimilar to those of other minorities. For example, Chicanos and Mexican-Americans have certain problems in common, although each group may adopt different styles to solve these common problems. Strategies for survival adopted by Chicanos are Chicanismo oriented

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[2]A. Jensen, *Social Class, Race and Psychological Development* (New York: Holt, Rinehart & Winston, 1968).

[3]R. Hess, *Compensatory Education for Cultural Deprivation* (New York: Holt, Rinehart & Winston, 1965); M. Deutsch, "The Disadvantaged Child and the Learning Process," in *Education in Deprived Areas* (New York: Teachers' College Press, Columbia University, 1963); J. McV. Hunt, "Graduate Training: Some Dissents and Suggestions," *The Clinical Psychologist*, 1969.

[4]D.P. Moynihan, *Maximum Feasible Misunderstanding: Community Action in the War on Poverty* (New York: Free Press, 1969).

[5]O. Lewis, *Five Families* (New York: Basic Books, 1959).

and, hence, are perceived to be entirely appropriate in terms of mental health, particularly since Chicanos persist in their struggle for equality despite tremendous odds. Nowhere is this spirit more aptly expressed than in the slogan adopted by many Chicanos: "Nosotros venceremos." Such a slogan is indeed a tribute to the mental health and perseverance of the Chicano people.

Training Programs Consonant with the Principles of Chicanismo

Given that Chicanismo is a positive social phenomenon, there is need to develop mental health programs that espouse this concept. For example, in terms of Chicanismo, what attitude should Chicanos have regarding alcoholism, drug addiction, violence, religion, male-female relationships, child rearing, machismo, feminismo, self-esteem, etc.? These are questions of vital concern to mental health specialists in the United States, particularly those who work in barrios. Inasmuch as parteras, curanderos, brujas, yerberos, and other lay practitioners have been used in folk medicine since time immemorial, their place in the overall scheme of mental health programs also must be researched and defined.

In keeping with the spirit of self-determination, there also is need to intensify training of Chicano mental health specialists along cultural lines. All training programs should emphasize cultural values rather than excluding or minimizing them. Given the opportunity, Chicanos will again demonstrate their ability to efficiently and judiciously assume responsibility for mental health programs with which they are charged.

We have alluded above to the desirability of utilizing the cultural values of Chicanismo in training Chicanos in the mental health sciences. The Santa Clara Social Action Research Center (SARC) in California has carefully considered this possibility. In this regard, SARC concluded that the most important questions are (1) What is the extent of emotional and mental health problems among Chicanos? and (2) How should future programs be tailored to meet mental health needs of Chicanos? Adequate data to answer the first question must be compiled strictly by Chicanos, to keep Anglos from extrapolating perceptions of mental health that are not applicable to the Chicano community. Simply stated, Chicanos know what menta health is all about in their communities and ar no longer willing to let Anglos be the judges. Hov programs should be tailored depends to a grea extent on assessment of bona fide mental healt problems in specific communities. Mental healt services should be designed to meet real needs i terms of mental dysfunction, unbalance, etc among Chicanos—not to solve what Angl practitioners term the "Chicano problem."

An adequate definition of mental health *from Chicano perspective* is at the crux of the matte Dr. Ernesto Galarza, in his paper presented at th Goleta Conference sponsored by the Wester Interstate Commission for Higher Educatior discussed mental health of Chicanos as follows

> . . . But first I want to define what *mental illness* mean to a layman. I don't pretend that it has any psy chological insight but it is my working rule. First means the *inability of the individual as he grows older years to overcome the experiences of early childhood th prevented him from becoming an integrated personality.* W have to reckon with the experiences which prevente us from becoming better-intergrated persons than w are today. Mental illness is the inability to reckon wi and overcome the damage that was done when w were young by family life, institutions, and all sorts agents. Second, it is the *inability of the individual to supp himself with the essentials of biological satisfaction.* I a taking the word "biological" in its broade meaning: decent housing, healthy sexual relatio with a partner, a mature ability to deal with both th young and old. If the adult cannot supply himself wi minimum response to meet these biological needs, the he is mentally ill. Finally, mental illness *is the inabili of the individual to find in society the reflection of self-estee which he needs.* With this working definition of ment illness, I find myself about to distinguish among th causes of anxiety and stress of individuals whom meet in my work.[6]

The following is another excerpt, from a pape read by Dr. Octavio I. Romano-V. at the Golet Conference:

> I am not a specialist in mental health. I think that i were, I would give a very high priority to launching a intensive investigation into the mental health of th people who have tested Spanish-speaking students English and then labeled them mentally retarde Such a distortion of reality is absurd. Somehow, as w go through the figures, we find that in 1966 there we 30,000 Chicano students in mentally retarded class in California alone. Individuals involved in th absurdity were counselors, psychologists, and scho teachers. It is unbelievable that anything like th

[6] Ernesto Galarza, "Institutional Deviancy: The Mexica American Experience," in *Mexican-American Mental Heal Issues: Present Realities and Future Strategies*, ed. Stanley W. Boucher (Boulder, Colo.: WICHE, 1970), p. 8.

could happen in a technological, urbanized, scientific, industrial society—and yet, it has happened.

What I have to say today really represents a further pursuit of this theme. If I am to pursue the subject of mental health among Chicanos, I cannot help but draw parallels between the peculiar beliefs of the Anglo culture which surrounds them. It seems, for example, absolutely idiotic to have a book like *Mexican-Americans: A Subculture* focus so strongly on witchcraft, and never once refer to Anglo-American witchcraft, which most of us know is a major industry. If I were going to study Chicano witchcraft, I would want to compare it to the Anglo witchcraft. Only in that way would we get some kind of balanced picture. Or suppose I was to focus on such a concept as "fatalism." It seems useless to me to discuss Latino fatalism and ignore fatalism as it exists in the United States as a whole. When the Latino shrugs his shoulders and says, "What the hell!" this is fatalism. When the Anglo does it, then it is alienation. If you read the literature of alienation and then go through the literature of fatalism, you will find that the words describing the conditions are almost identical. Only a different set of semantics is employed. . . . .

What I am saying, of course, is that fatalism, witchcraft, folk medicine, strong family ties, even machismo, are very strong Anglo-American characteristics. But in dealing with the Chicano, these characteristics are isolated and handled as if Chicanos were unique. Being unique, they are different. Being different, they must be deviant. Or, as Celia Heller, the Hunter College sociologist, is so fond of saying, they are "less Americanized." Or as Lyle Saunders likes to say, "unacculturated." Or as Florence Kluckhohn would have us believe, "steeped in a traditional culture of fifteenth-century Spain." The Chicano orders his universe along "affective lines," whereas the Anglo orders his universe along "instrumental lines." Translated into English, this means "We are rational, they are not. They are emotional people." So if I were a specialist in mental health, not only would I study the high school counselors who label Chicanos mentally retarded, but I would also study the mental health of the social scientists who have written about the Chicano.

Perhaps I would select another route. I would go through the categories that one encounters in the field of mental health, such words as deviant, irrational, pathological, dysfunctional, neurotic, and so on. I was talking to Armand Sanchez not long ago, and it dawned on us that these words do not exist in the barrio. How many times have you heard the word deviant or neurotic? This is quite interesting. If such words are not used in the barrio, does that mean that Chicanos behave differently, so that there is no need for these words? It seems to me that there is certain behavior that could be labeled "not acceptable" in the barrio. What are the words used to describe this? And this is crucial—the labels you use to describe human beings are very crucial indeed, because everybody knows that in medicine the label denotes the treatment. So what do you have in the barrio? You have words like *esta loquito; es sonso;* even *menso, esta zafado.* What are the differences between the barrio terms and the technical terms? The technical terms like "dysfunctional," "irrational," "pathological," are separating terms. By a word or label you separate them out. But the counterparts in the barrio are not separating terms; they are descriptive terms through which a whole series of incorporating mechanisms takes place. What I am trying to say is that, in the barrio, you don't have a polarized duality—rational/irrational, functional/dysfunctional. To put it in other terms, what I am saying is that a Western European model is dysfunctional when studying the Chicano, possibly irrational.

I have dwelt to a slight degree on what the Chicano is not. He is certainly not what appears in Celia Heller's book on Mexican-American youth. What I think of when I think of that book is a quote in which she says, "it may be suspected by some that the high degree of delinquency in the Mexican-American community stems from deviance, but this is not the case. It stems rather from over-conformity to the culture." I think in that one quote you find the reason why such books persist in being so popular. What they essentially say, of course, is that the Chicano culture is a major cause of crime among its people. When you wonder why that book is in its fifth printing, it becomes very plain that it is because it tells people what they want to hear. Such books grossly over-rely on such ideas as *el campesino* (the field worker) and the agrarian society. Their authors go into a Chicano area like South Texas, New Mexico, or Arizona and see Chicanos working in the fields—therefore, they must all be agriculture types. This then becomes the basis for constructing the study. In actuality, of course, in the migrations that have taken place from Mexico to the United States, there have been musicians, bartenders, blacksmiths, jewelers, carpenters, Indians, religious people, atheists, masons, counter-revolutionaries, philosophers, and just about every other category of human occupation and existence that you can think of. For many the only work available was in the fields; ergo, they must all be agricultural.[7]

* One of the authors of this paper was recently personally involved in retesting a Chicano prisoner jailed in the Marysville jail on a charge of first-degree murder. He had been tested and declared fit to stand trial by an Anglo psychologist. In retesting the prisoner, who spoke no English, he remarked that the psychologist who had tested him before spoke no Spanish. Our results indicated that the prisoner was not fit to stand trial. He suffered from symptoms of schizophrenia and was clearly losing touch with reality. He was judged not able to stand trial and has been sent to the state hospital in Napa for treatment.

[7]Octavio I. Romano-V., "The Impact of the Mental Health of Anglo Social Institutions upon the Mexican-American," in *Mexican-American Mental Health Issues: Present Realities and Future Strategies*, ed. by Stanley W. Boucher (Boulder, Colo.: WICHE, 1970). p. 41-42.

General Health Status and Care-Seeking Patterns of Migrant Workers

Some of the best research dealing with migrant health studies has been published by Dr. H. Peter Chase, pediatrician at the University of Colorado Medical Center. Chase has noted the following facts about the health characteristics of the itinerant farm-worker family (based on representative samples): (1) an infant mortality rate of 6.3 percent, which is about twice that of the U.S. national average, (2) a life expectancy of approximately 49 years, (3) general lack of prenatal care (less than one-third of the pregnant women receive prenatal care), and (4) serious vitamin A and folic acid deficiencies comparable to conditions found in children from 11 developing nations in Asia, Africa, and Latin America.

The foregoing serves to indicate the plight of migrant workers in terms of malnutrition. Moreover, because of malnutrition, squalid housing, and pesticides poisoning, migrants are strongly predisposed to diseases in general, particularly respiratory and gastrointestinal diseases. The same may be said of other migrant workers, including Puerto Ricans, Blacks, Filipinos, and Native Americans.

In terms of seeking health care, migrant workers display a crisis-oriented pattern, which should be corrected. Limited by economics, and often unaware of the nature and value of preventive medicine, migrant workers for the most part do not enter the health care system except in cases of acute emergency. Preventive medicine is generally foreign to them, much as is holding funds in escrow for projected tax purposes. Moreover, few farm workers, particularly those who follow the migrant stream, purchase health insurance, nor are they eligible for such as seasonal employees. In addition, medical practitioners in rural areas are often reluctant to treat indigent farm workers.

Even more appalling, some physicians, particularly older practitioners, look with disdain or condescension on farm workers as patients because they lack the language skills and cultural knowledge required to communicate with them.

Health Insurance

Farm workers are rarely in a position to afford even low-cost insurance, given that most of their earnings go to provide the basic necessities of life. There is nothing to indicate, however, that migrant farm workers and/or those who have settled out of the migrant stream would not be willing to take advantage of a low-cost system of health care. Like anyone else, they would have to be convinced that the overall benefits of health insurance warrant the cost, particularly since migrant farm workers practice a form of survival economics unlike that of the general population.

Any proposed system of health care would require that migrants have access to counselors trained in health care to help them interpret complex instructions for submitting application forms, filing insurance claims, etc. Even in exceptional cases where migrant workers have participated in health insurance plans, e.g., in certain agricultural processing plants, they have deplored the task of filing claims and applications, and they are convinced that the benefits of health insurance are not commensurate with the cost.

Three specific program goals for mental health are proposed for the migrant and rural poor:

1. Delivery of health care (physical and mental): We propose multipurpose health centers, Centros Familiares, in which all necessary services are under one roof. Such centers should be linked with extant medical facilities where possible. Components of social welfare, education, economic, and legal services should be part of the one-roof concept approach. It is further proposed that a thorough assessment of existing services for migrants and rural poor be made in specific regions, accompanied by qualitiative and quantitative descriptions of specific available services. Such assessments should include modalities of who, how, where, and when migrants and/or rural poor enter health care systems. Factors that prevent migrant workers from entering the health care system tend also to dissuade urban Chicanos from seeking health services. Two facts account for this: First, systems of health care with which Chicanos can identify are virtually nonexistent, and, second, the mobility of migrant workers poses an extremely difficult problem in terms of logistics. The question becomes how best to offer health care services to a large number of Chicanos many of whom are constantly on the move. Extant programs of health care should be monitored and a feedback system used as a ba

for modification and necessary change. Such an approach would insure that mechanisms for changes come about as a result of input from recipients of health care. Consumer representation must be assured if substantive changes are to become a reality.

2. **Health education:** There is a need to disseminate health training information in Spanish and/or English to migrant workers, rural residents, and Chicanos living in urban areas. Responsibility for synthesis of health information and dissemination of printed material should be assumed by professional and paraprofessional workers in the barrios, colegios, and Centros Familiares. It is important that in all cases information be relevant to the target population.

Equally important is the establishment of a health linkage system, i.e., a system of constant intercommunication between Centros Familiares, to create solidarity of purpose. Such a system would not only promote interchange of ideas, but would encourage development in due course of a sound theoretical base and strengthen capacity for innovative health delivery systems that Chicanos so urgently need.

3. **Career development:** There is definite need to attract more Chicanos into the mental health field at all levels of specialization. Provision must also be made for the identification and certification of curanderos, sobadores, parteras, yerberos, etc., to assist in the work of the Centros Familiares. The various techniques and general expertise of these practitioners should be made known to all concerned, so that adequate referrals can be made to fit the needs of individual patients. The practitioners referred to above should be an integral part of the staff in the Centros Familiares. Moreover, such individuals, as practitioners and members of the barrios and communities, would serve admirably as role models for students and others who wish to enter the mental health field.

Through the one-roof concept of health care, staff members of the Centros Familiares, including the curanderos, sobadores, etc., would participate in an outreach program of health care services. Folk practitioners and other paraprofessionals would be encouraged to move up the professional ladder under this system. The means to do so would be made available by matriculation at Chicano-affiliated colleges and universities, particularly those with strong Chicano studies programs that offer courses in folk medicine and related fields. Such a plan would not only help develop a relevant system of health care but would also provide a strong framework for career development.

Mariano Aguilar describes a new kind of Chicano organization—the paraprofessionals organize and run it, hiring experts when they need them.