UNDERSTANDING THE DOMESTIC AGRICULTURAL MIGRANT OF MEXICAN AND SPANISH DESCENT: HIS CULTURAL HERITAGE, PERCEPTIONS OF HEALTH PROBLEMS, AND MEANS OF MEETING HEALTH NEEDS

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Meetings of this kind are dear to my heart because they bring together academic people, practitioners, administrators, and people in the various helping agencies.

In introducing me, Dr. Bowman has mentioned the Hildago County Project which was a study by anthropologists of the relationship between health practices and beliefs and other aspects of the culture of Mexican-Americans along the border. I think that it is appropriate to point out to you that the Hildago County Project could not possibly have been accomplished without the very real cooperation between the anthropologists and the Hildago County Health Department. I would like especially to cite the assistance of Mrs. Ruth McDonald who is head nurse of the Hildago County Health Department. I might add that there were many things that we did in Hildago County which had never been done before, and in order to do these things we had to have the help of people who were influential in the county. I am sure that there were a number of things that seemed completely without reason to people of the Hildago County Health Department and others in Hildago County, but Mrs. McDonald was unwavering in her support and I want to thank her.

Now we are here to discuss the culture of the Spanish-speaking people of the Southwest. We have a great deal of material as anthropologists, and public health workers have a good deal of material, from which we can derive some general principles about the culture of the Spanish-speaking people of the Southwest. We are accumulating a great deal more material, and the more we accumulate the more we realize how very similar is the culture of the Spanish-speaking people of New Mexico,Colorado, California, and Texas. Although there are variations, that is, regional variations from one state to another in the culture of the Spanish-speaking people, we can also speak in very general terms and in such a way that if a health worker who is in Texas, for example, understands the principles of the culture of the Spanish-speaking people of Texas, he or she can go to New Mexico, California, Colorado, South Dakota, or Illinois, or wherever there are Spanish-speaking migrants, and utilize these same principles.

Now what do I mean by culture? I think that it is very useful to think of culture as a kit-bag, or a bag of tools. It is the kit-bag that people who are members of a group possess and which they use to cope with the world, that is, to understand the world, to organize their behavior in relationship to the world, to get things done. One part of culture consists of health beliefs and health behavior. This means the way members of a group of people understand illness and the way in which they interpret symptoms. It means the kinds of ways in

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which they prevent illness, and the things they do to heal illness. It also means the kinds of specialists that they utilize.

A person is not born with a culture. A person is not born a Mexican-American. He learns to be a Mexican-American and I cannot stress this too strongly. Any individual, any infant, must learn a culture, and we find that infants who are born into different groups learn very different ways of behavior. Who does a person learn a culture from? The individual learns his culture primarily from his immediate family. He also learns his culture from the church he belongs to, from the formal educational institution which he attends, and from his or her friends.

Cultural Heritage of Spanish-Speaking Agricultural Migrants

We are here to talk not about culture in general but about the culture of the Spanish-speaking people of the Southwest. Who are they? I remember well the talk I gave in Washington just after leaving the Hildago County Project. I gave a talk on some of the more bizarre attitudes and behaviors of Mexican-Americans with regard to health, and there was a health worker present at that conference who kept insisting that people who held such exotic or bizarre beliefs, must be people who have just emigrated from Mexico and, secondly, that they must be of Indian descent. Nothing could be further from the truth.

Many of the Spanish-speaking people of the Southwest have lived in this country or on this side of the border since the middle of the eighteenth century. This is particularly true of those in Colorado and in New Mexico where they are a very stable population of resident citizens. It is less true in Texas where we have a tremendous influx each year of people fresh from Mexico. It is important to realize that these people who migrate to the U. S. are not from central and southern Mexico where we have sedentary Indian populations. These are people who come from the northern regions of Mexico; they are people whose culture ultimately derives from a Spanish peasant culture. These people derive their culture from western Europe just as the culture of most of us derives from western Europe. The difference is that the culture of these people derives from a Hispanic tradition, whereas, for most of those present, our culture derives from non-Hispanic sources.

I realize why that participant in the Washington conference felt so strongly that these people must be Indian and that they must be recent emigrants from Mexico in order to hold such beliefs. It is always easier to understand a way of life which is different from our own if we can simply describe it as alien and bizarre and thus don't really have to understand it. In fact, the belief systems which I am going to talk about today are belief systems which are part and parcel of the life of the people of the Southwest, people who have lived in this country for generations. It may be dismaying to you, but these are people who have been in intimate contact with orthodox professional health systems for at least two generations. One of the interesting things about the Spanish-speaking people of the Southwest is that they have been able to maintain and to utilize two parallel

health systems and to make use of both. One of these health systems we can speak of as the "professional referral system" and the other as the "lay-referral system."

There are also such things as sub-cultures. Professional health workers have a sub-culture. They have a system of beliefs, a system of attitudes, a system of behavior, all of which are logically consistent with one another. The totality of this sub-culture system differentiates them from other people in their culture. It is instructive to realize that we have among us today people who derive their culture from an "Anglo" tradition and others who derive theirs from an "Hispanic" tradition, but they hold in common a sub-culture, a professional health sub-culture.

The idea of culture may seem ethereal to you. It may seem very academic. But, you can put it to work as you can any other concept and find that things which were not understandable to you before now become understandable. Furthermore, it will help you by understanding yourself as a member of the professional health service sub-culture. It will help you to understand why you feel strongly about some of your own ways of behavior and why you feel so strongly that other people, in this case Spanish-American, should change.

Culture Characteristics

What about the culture of the Spanish-speaking people who actually move along the mid-continent stream and the west coast stream? In the first place I want to speak to you about the importance of the family among these people. There is no other unit in the culture of the Spanish-American which is more important than the family. The family is a small family. It consists of the father, the mother, and the children. At the head of the family is the father. In anything related to the family and which demands a decision by the family, that decision will be made by the father. This is not to say that the father is the only one who makes the decisions. Such a statement couldn't be further from the truth. But people act as if the father is the only one who can make the decisions in the family and, as a rule, health workers who require the cooperation of a Spanish-speaking family will need to take this into account.

It is very much like some clinics that I have known which everyone understands are run by the nurses. Nobody questions this, but Lord help us if we don't act as if the doctors are really running things, that is, if we don't go through the channels. It is the same way with the Spanish-speaking family. One must work through channels and the most appropriate channel in the decision-making process is the father.

In the Spanish-speaking family, the head of the family is the father and all the decisions normally are made by the father. Yet, when we investigated specific cases of decision making, the mother has been very instrumental in decisions. Should a child who is sick with diarrheal disease be taken on a trip when the family leaves Texas to go to South Dakota, or should the child remain home to follow later? If

we were to ask who made the decision, we would be told that his father said such and such. If we were there at the time, however, we would discover that there had been a dialogue between the father and the mother as to what the decision was to be. These considerations have to be taken into account.

The importance of the family among the Spanish-speaking people is related directly to the fact that these people do not organize themselves into such things as cooperatives, unions, parent-teacher associations, or extra-familial organizations. These people are organized to cope with problems in terms of family units. Often, when I am speaking to groups such as this one, the question comes up, why don't these people get out and do something? They are not saying why don't these people do something, however, they are saying: why don't they go out and organize a group who will do things the way we do things? But the Spanish-speaking people don't organize their behavior that way! This is not the same thing as saying that Spanish-speaking people aren't concerned about their problems and that they don't organize themselves to solve those problems. They do, but they do so in terms of families and not in terms of non-family groups.

There is another principle that I would like to introduce here about the culture of the Spanish-speaking group. That is, when a member of the family relates to people who are not members of his family, he seems to personalize that relationship. Unlike ourselves they fail to compartmentalize their behavior into behavior with regard to friends, in contrast to their behavior in regard to business associates, professional associates, doctors, nurses, etc. One of the sharp contrasts which can be drawn between the Spanish-speaking groups of the Southwest and the English-speaking groups of the Southwest is that the Spanish-speaking groups tend to personalize their society and the English-speaking groups try to depersonalize their society.

Now, when we understand these two principles, that is, that Spanish-speaking groups organize their behavior in terms of family, and they try to personalize social relationships, we understand a great deal about the life of the Spanish-speaking groups. This is just as true of Spanish-speaking migrants as it is of Spanish-speaking people who remain sedentary.

There is logic, there is an internal consistency between their beliefs and their behavior. There is also a logic that has to do with the way that they look upon health problems and the avenues which they take to resolve those problems. What I want to stress here, and I am certainly not going to minimize the differences between the attitudes and behaviors of Spanish-speaking people and English-speaking people, is the logical consistency of their attitudes and their behavior. I think that this is very much in our favor. That is, speaking as professional health workers, this is very much in our favor because it means that if we can understand the principles of those attitudes and behaviors, we can understand their ramifications. Moreover, if we can discover the logic of those beliefs and behaviors, we can put them to our own use.

Illness and Perceptions of Health Problems

Now I am going to discuss with you two kinds of illnesses which among the Spanish-speaking people of the Southwest probably have the highest rates of incidence and prevalence of all the illnesses understood by these people. It is strange that I should think this, because I am saying on the one hand that from the point of view of these people those illnesses which have the highest rate of incidence and prevalence are the very illnesses which professional health workers dismiss as superstition. I think it behooves us to take this into account, because when we interpret illnesses, or rather when we as professional health workers interpret illness in one way and the patient, or the potential patient, interprets the illness in another way, we find that instead of going down the track together we come to a switch, and we go one way while they go another.

I have said that the Spanish-speaking people of the Southwest have a culture, and I have said that professional health workers and members of the helping professions have a sub-culture. This means that we not only have attitudes about certain problems and that those attitudes give rise to behavior, it also means that we feel very strongly about the way we feel and we feel very strongly about the correctness of our behavior.

There have been a considerable number of studies of the attitudes and behavior of Spanish-speaking people of the Southwest with particular relevance to health and illness. I think particularly of Lyle Saunders' excellent study Cultural Differences and Medical Care,[1] and William Madsen's study Society and Health in the Lower Rio Grande Valley.[2] The studies also have pointed out the differences between the Spanish-speaking people and the so-called Anglo. Today I am not going to minimize the sharp differences but I am going to stress that there are areas of congruence between their attitudes and our attitudes. I think that where we find congruences, where we find that they and we share attitudes, it is here that we can begin the building of a good, potentially successful, public health program.

In the Southwest one of the most prevalent illnesses (according to the Spanish-speaking people) is one which is called "mal de ojo," which in English is translated as "evil eye" which, incidentally, is a very bad translation. (Parenthetically, "evil eye" is a bad translation of mal de ojo because there is nothing evil about it.) The other is "susto" which we speak of as "soul loss."

In the Southwest mal de ojo simply refers to the fact that some people are born with strong eyes, meaning that if they look at someone who is weak such as a little child, they will affect that child in a

1. Russell Sage Foundation, New York, 1954
2. Hogg Foundation for Mental Health, University of Texas, Austin, 1961

bad way, meaning that the child will become sick. The person doesn't do this malevolently, he doesn't do it with intent, he can't help it. Some people are born that way just as some people are born left-handed. There is not only a strong belief in mal de ojo, there is also a very logical system of behavior which relates to its use.

Now what are the symptoms of mal de ojo? In the first place, the most common symptom, the most easily recognized symptom, is diarrhea which is known as "correncia." There are other symptoms of mal de ojo. They consist of the child crying incessantly, of the child being fitful and not sleepint well. As soon as these symptoms appear, the mother takes action. There is no waiting around on the part of the mother because this is a dangerous illness. Given the fact that the mother's primary responsibility is the care of her family particularly, she cannot afford to take chances, that is, she can't take the chance that the illness might run its course. She can't wait, so what does she do?

In the first place she makes sure that it is what she thinks it to be, that is, mal de ojo. She diagnoses. She does this by taking a glass, filling it half full of water, and then breaking an egg into the glass. If the egg floats up to the top of the glass in the form of an eye, then she diagnoses the case as being due to mal de ojo. If the egg takes an elongated form, she sees that the agent of illness is a man. If the egg is round in form, the agent is seen as a female.

Now what do you do in such a case? Well, let us say that my own child had been coveted by someone who was not a member of the family. That is, if my child is dressed up in her party dress and walking along the street and a neighbor comes up to me and says, "Your child looks lovely today," then, if that neighbor has good intentions, that is, if he wants to utilize preventive medicine, he will touch my child on the forehead so as to break the bond which he has established between himself and my child. (My wife and I didn't learn this until we had been in Texas a year. We couldn't understand why when we walked with my child who is very blond and very blue-eyed, complete strangers came up on the sidewalk and asked if they might touch my child on the head. We thought it was a very friendly neighborhood and we left it at that. We didn't understand the implication until we realized after I had gathered a number of cases of mal de ojo that these people were practicing preventive medicine.) That is, in a situation of which mal de ojo is a possible outcome, illness can be prevented by preventive measures.

Now suppose one can't find the person who coveted or admired the child. Then one must take the glass of water and place it under the head of the bed and leave it there overnight. The intention is that the glass of water will draw out the alien power from the child. This is logical if you believe that a child can be made sick by a stranger having admired the child. And if you believe that the illness is caused by the power of the stranger intruding into the child, then it is logical to think that a cure effects the removal of that alien power from the patient.

The same symptoms I have described above would seem to a physician or to a nurse, as diagnostic of shigellosis or salmonella. Given such a diagnosis as this, the physician takes action. The action is logically consistent with the diagnosis and his understanding of the etiology. Given the high incidence of shigella-salmonella infection in the Southwest among the Spanish-speaking people, the diagnostician, that is, the nurse or the physician, has every right to assume that when a child suffers from diarrhea, it is likely to be due to the presence of one of these micro-organisms, and to act logically on that assumption.

In much the same way, a Spanish-speaking mother whose child displays these symptoms, knows what is wrong with the child. She knows what is the correct thing to do, and not to do so would imply that she was acting irresponsibly. It is unfortunate, and we will return to this later, that a mother who knows what is wrong with her child, and who acts in a responsible manner, and gets no immediate result from her cure, and who then brings her child to a nurse or physician saying that the child has mal de ojo, that when the physician dismisses her diagnosis of mal de ojo, he is also dismissing the symptoms as not being there.

The high incidence and potential lethal effects of the symptoms which Mexican-Americans or Spanish-Americans associate with mal de ojo constitute neither naivete nor mere figments of the imagination. In fact, whether one elects to call the condition mal de ojo or acute diarrheal infection, a serious health problem exists, a problem which causes nurses, physicians, and sanitarians as much concern as it causes Spanish-speaking Americans.

I submit to you that the phenomenon of mal de ojo is not a figment of the imagination, and I would like to demonstrate to you why it is not a figment of the imagination. Some years ago, there was an excellent epidemiological study of infectious diarrhea in Fresno, California, in Georgia, and in the lower Rio Grande Valley of Texas. It is a study which I recommend highly to you because it very cogently points out and demonstrates the relationship between a dense fly population and a high rate of shigella-salmonella type diarrhea diseases. Now what did these researchers find? I'm not going to talk to you about the epidemiological aspects of the study itself, but I am going to discuss with you only the rate of illness they discerned and the relationship between age and the rate of attack. The study goes back to March, 1945 and February, 1948. They reported the following age-rate of attack relationships:* (see next page) Note that the peak is reached in the very young and that as soon as a child reaches the period of 5-9 years, the peak drops off sharply.

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*Watt, James; Hollister, A.C., Jr., Beck, M. D., and Hemphill, E.C. "Diarrheal Disease in Fresno County, California." American Journal of Public Health, 43,6: 728-741.

Age in Years	Rate
-1	608
1	784
2-4	247
5-9	60
10-14	33
15-34	31
35+	39

Now what do the Mexican-Americans contend, that is the Mexican-Americans who live in the same area in which this study was done? They hold the belief system that some people are inherently weak, and thereby more susceptible than other people to the illness which they know as mal de ojo. Who do they find to be the most susceptible? The very young! Very young children are inherently weak and are thereby inherently susceptible to mal de ojo.

What I am pointing out to you is that their observations of attack rates and the relationship between differential attack rates and relative age of the patient population, is such that it is supported by very sophisticated epidemiological studies. Mind you, we are not saying anything whatsoever about the truth value of mal de ojo. We are talking about observations people make of attack rates. And I repeat to you, from this evidence we determine that mal de ojo (which is the same syndrome attributed to shigella-salmonella infection) and the correspondence between relative age and susceptibility (as observed by the Spanish-speaking Americans) is similar to that which is observed and demonstrated by sophisticated and epidemiological studies. I am pointing out to you the logic of the attitudes these people have and the logic of their behavior.

I am happy to say that physicians and nurses, when they discover or diagnose a condition as being infectious diarrhea, have a system of curing which flows logically from their diagnosis. Given our belief in the presence of shigella-salmonella type organisms, and given our belief that they are causes of illness, what the health professionals try to do is heal the illness by removing or killing the organism, which they do by the use of antibiotics.

I spoke to you before about another illness which is known as susto. I said that this means in English, "soul loss or loss of a soul." Spanish-speaking Americans believe very firmly that the body consists of a number of parts, and that in a healthy person one finds all the parts of the body in their proper positions. This is a very important principle for understanding the health beliefs of the Spanish people. In their belief system the soul is detachable, and when a person is frightened, or when a person is indisposed by a disagreeable situation, it is believed that the soul will take flight. We're not talking about the truth value of their belief. We are interested in the behavior that logically follows.

If I were to believe that my soul could become detached under circumstances that were disagreeable or frightening, and if I believed that the loss of my soul caused me to be ill, then it would be a perfectly logical belief to attempt to rejoin the soul with the body. This is precisely what these people believe.

There is a very elaborate ceremony in which a healer is called in, or if the mother understands the procedure, she will do it. The mother, or healer, will request the soul to return to the body and, in fact, will cajole and beg the soul to return to the body. When the patient gets well it is believed that the soul has, in fact, rejoined the body. What are the symptoms of soul loss among the people? Well, let me give you another term to use, one which is applied to the same illness "mal de delgadito." Mal de delgadito refers to the "thin man's disease" or the "wasting disease," for which we find a high incidence rate, a high prevalence rate, in this area according to the perceptions of the Mexican-Americans. We also find an extraordinarily high rate of tuberculosis in this region. Although no studies have been done (and certainly this is an area in which we want to do studies), we suspect that people who are suffering from advanced states of mal de delgadito disease are the very people who are suffering from the advanced stages of tuberculosis.

Once again, we are not questioning the truth value of a belief in susto. We are suggesting that people who have these belief systems act logically upon them. And what is the logic here? The logic here is to bring patients who suffer from mal de ojo and susto, to people who know how to cure them, and the people who know how to cure them are not physicians and nurses. Now it seems to me, that given that kind of a belief, these people follow the path of what we call a lay-referral system. The mother will try to cure the child, or whoever is ill, and if this is not successful she will go to someone who is more skilled in this, i.e., a lay healer. If he is unsuccessful, the mother will go to someone who has prominence in her region - the regional corandero.

Most anthropologists and sociologists, myself included, have harped on the differences between the health culture of the Spanish-speaking people and that of professional health workers in this area. Most of us have harped on the contrast between the lay-referral system and the professional referral system. What I would like to do today is to point out to you that the more chronic an illness - the longer the illness lasts - the more likely that a person from the lay-referral system will pass over into the professional health or referral system. The more chronic the illness, the more likely a person who has been introduced into the professional health system, will sooner or later enter into the lay-referral system, because these people are less interested in the credentials of a healer than they are in being healed. These people couldn't care less about the competence of professional health workers or of the lay healers. What they want, first of all, is to be healed! They will leave no stone unturned in their search for an effective agent. On the other hand, this process means that people become "shoppers" and they shop not only among

professional healers but they shop also among lay healers.

Areas of Congruence in Health Beliefs

I said before, that anthropologists harp on cultural differences, on things that differentiate between groups - in this case those features which separate Spanish-speaking Americans from professional health workers. However, today I would like to concentrate on those areas of congruence, on those areas in which we share beliefs because I think it is here that we can build good, effective, public health programs. What are some of these features?

In the first place there are the warning signs or symptoms. Given the divergence of opinion and interpretation by professional health workers on the one hand, and Spanish-speaking Americans on the other, of the symptoms of mal de ojo, or infectious diarrhea (call it what you will), it is amazing that given these differences, both recognize the warning signs and, secondly, both interpret them as being indicative of bad health and as requiring attention. These are things that work in our favor with respect to systems in which we find predominantly displayed, a wasting away, a loss of weight, loss of appetite, and an unwillingness to work or carry out one's normal functions. In most cases, from the point of view of the health worker as well as from the point or view of the Spanish-speaking mother, these are indicative of danger signs. They require that something be done and they require that someone who knows how, who is considered competent, should be the one in charge.

Now I want to stress again, that aside from the area of beliefs that we share with Spanish-speaking people, in other words, each of us understanding the implications of the warning signs, I want to make plain that, they, as well as we, are seriously concerned about illness. When they see symptoms which they interpret as illness, they become deeply concerned.

Secondly, they are by no means resigned when face-to-face with a condition of illness, and I myself know of people who were once in the migrant stream and have settled down in the area of Toledo, Ohio, who, when confronted with a case of illness in the family, used every means available in the Toledo area. When those facilities did not suffice, they traveled whatever thousands of miles it is to northern Mexico where there is a renowned curer. I also know of people who now live in Texas, who remember healers whom they had met while passing in the migrant stream in the Lubbock area, who will return there. I know of people who have been told by doctors that they don't have a chance to live. They have since visited a series of lay healers who have told them that "you're not long for this world," and they have not accepted this decision as definitive. Let me give a case example of this.

Once when I was in the lower Rio Grande valley, I was introduced to a family in which a young boy, about 15 years old, suffered from epilepsy (I wouldn't be exactly sure it was epilepsy since I am not a

physician, but he had had symptoms of epileptoid fits). He said that he had been diagnosed by a physician as an epileptic. During his life he had been to a series of lay healers and when I met him he seemed to be resigned to his fate and his family, also, seemed resigned to his fate.

I had come to his home with another couple. The woman also suffered from epileptic fits and that very morning this couple had learned of a cure for his type of illness by a lay healer. Mind you, I wasn't advancing the cause of lay healers, it just came up in the course of our conversation. After that the two couples engaged in conversation about the work of this healer (they hadn't known about him before) and they made preparations to leave the next day to consult with him. It would have been a trip of several hundred miles up the Rio Grande to this healer. The point here is that they were not apathetic, that they exploited every opportunity available to them to find healing measures, and they were perfectly amenable to new suggestions.

The last point I wish to make is that it seems to me, for example, that where we have people who believe that a set of symptoms are symptomatic of an illness to which they give the label mal de ojo, and when we have the professional health worker whose mandate it is to provide these people a cure and who interprets that very same syndrome as infectious diarrhea, it seems to me of little importance to them or to us whether we call this syndrome mal de ojo or infectious diarrhea. What is important is that we find (1) a syndrome which people of both cultures recognize, and (2) an instance in which the parents would not have brought a child to us unless they thought that there was some chance that the nurse or physician could be of assistance with this kind of syndrome. To call it infectious diarrhea is really beside the point, it really doesn't matter what you call the illness, it's the syndrome that we are interested in!

I submit to you that for people interested in the health education of the Spanish-speaking people of the Southwest, one of the best things that one can do to advance our programs is to disregard the labels that we or they place on the syndrome, and that we all concentrate on symptoms and the syndromes themselves. I think that when we do this, we will find that more and more people will be taking advantage of the really excellent, and already available health services that we have to offer.