



CULTURAL

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Family, Culture, and Health Practices Among Migrant Farmworkers

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Migrant farmworkers and their families have restricted access to health and human services because of their frequent relocation between states, language and cultural barriers, and limited economic and political resources. Living and working in substandard environments, these families are at greater risk for developing chronic and communicable disease. In an assessment of health patterns among 225 migrant workers and their families, using personal observations, unstructured interviews, and individual and state health records, children's immunizations were found to be current, but dental caries and head lice were epidemic. Among adults, almost one third tested positive for tuberculosis exposure. Urinary tract infections were the most common health problem among women. Primary and secondary prevention were almost nonexistent because funds for these services were not readily available. The patriarchal system contributes to these problems by limiting access to family-health and social service needs. Although providing comprehensive health care to migrant communities presents unique challenges, nurses can demonstrate their effectiveness in reducing morbidity through strategic interventions and alternative uses of health delivery systems.

Health practices among migrant farmworkers represent a challenge to health care providers due to the magnitude of environmental stressors that compromise this aggregate's economic and health care resources. Migrant farmwork is normally multi-generational, following a family history of working in the fields and often returning to the same locations each year (Schneider, 1986). Under the duress of poor housing, limited sanitation facilities, inadequate diet, and substandard health care, migrant farmworkers and their families are at greater risk for communicable and chronic health problems than the U.S. population (Dever, 1991). Furthermore, the adverse environmental, social, and economic circumstances associated with the life-

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style of migrant farm families suggest a high risk for domestic violence in this group (Korosick & Rodriguez, 1994; National Migrant Resource Program, 1990). The purpose of this article is to describe health patterns, family systems, and culture among a group of migrant farmworkers and to assess the impact of these findings on nursing practice.

SETTING

Beginning in late May of each year, migrant farmworkers and their families move north from Florida into south-central Georgia to pick bell peppers, squash, and cucumbers. A majority of these workers originally come from the southern area of the United States via Mexico and Texas and move to the northern states as crops ripen and become available for harvest. A crew chief, who acts as a middleman between the migrant worker and the farmer, alerts the migrants to available positions, and the workers and their families relocate in groups. They are often required to drive day and night to move from one camp to another as crops ripen. The cycle repeats itself annually, with workers and their families bringing only the most essential possessions in aging cars, vans, and trucks. For children of these families, these conditions directly interfere with their educational processes and social development (Diaz, Trotter, & Rivera, 1989). Occasionally, van-loads of "solos"—single men traveling without families—embark on this migratory journey. Their status is even more precarious because their family support systems are absent.

Living predominately in rent-free trailers furnished by the farmer, the workers harvest crops at \$.40 per 5-gallon bushel. On a good day, workers can make up to \$100.00, but rain, poor harvest, injuries, and disease can prevent maximum earnings. They average \$30.00 to \$60.00, based on a 4- to 6-hr workday. The abbreviated work schedule is due to both the intense weather and the inconsistent ripening of crops. Both women and men work in the fields, although women with children may either remain at home or arrange for a sitter. The sitter, who earns \$5.00 per day per child, is normally a teenage girl or young mother. Because family vehicles are used to transport the workers to the fields, those people left in the camp are generally without transportation.

RESEARCH DESIGN

Employing unstructured interviews, personal observations, and individual and state health records, data were collected for 225 men, women, and children in five migrant health camps in southern Georgia. This research was compiled over a 2-week period by senior baccalaureate nursing students as part of their community health nursing rotation. Assessment variables included status of immunizations, occupation-related health factors, barriers to health access, and issues related specifically to women's and children's health. Confidentiality of data was secured in compliance

with the university Institutional Review Board and the state's district health office. Analysis of the findings and a description of the interventions follow.

Immunizations

Preventive health practices are an indication of both risk and control. In this study, immunizations assessed included diphtheria-tetanus-pertussis, measles-mumps-rubella (MMR), *Hemophilus influenzae* Type B (HiB), polio, and tetanus. All of the children under 17 ($n = 91$) had immunization records, and of this group, 95% were adequately immunized. The most frequent missing immunization was the last MMR and HiB series, which was subsequently provided to the children free of charge, following state guidelines. The majority of prior immunizations had been furnished to the children by the public health department of their permanent residence in Florida.

The vast majority of adults ($n = 134$) did not have health or immunization records available. Although tetanus boosters were offered, only 17 adults accepted the immunizations. Convincing the crew chief to receive the first injection encouraged some of the other workers to overcome their reluctance. To maximize participation, the tetanus booster was offered at no cost in camp during lunch breaks and in the fields while people were working. Many stated they had received the booster within the past 10 years, although this could not be confirmed. Others stated they did not want the injection due to the possibility of a sore arm, which would interfere with picking crops. Foreign-born migrant workers may never have received an adequate primary series vaccine against tetanus, and thus this booster may have been insufficient protection against the disease.

Tb remains a major health problem among migrant farmworkers (Centers for Disease Control, 1992). Workers tend to live in close proximity to one another during the harvest period, often with two or three families sharing one single-wide trailer. At one camp, 16 men slept in a single trailer. Sanitary facilities are strained under these conditions, and transmission of disease—particularly tuberculosis (Tb)—became inevitable.

Of the 126 adults who requested tuberculin screening, 39 had positive purified-protein derivative (PPD) skin reactions greater than 10 mm. None of those screened were under prophylactic treatment. This finding suggests a higher risk of exposure in the migrant worker community than is prevalent in the general population.

Although Tb screening is necessary in the migrant community because of the high prevalence of the disease, essential follow-up procedures and treatment must also be available for those with positive skin reactions. In this study, inaccessibility to the state Tb chest x-ray van delayed confirmation of active cases, and financial constraints further prohibited prophylactic treatment. Furthermore, those with a positive PPD often relocated before the state-run mobile unit arrived. Because physical signs and symptoms were generally absent, the infected person often did not believe the infection was present, thus adversely affecting compliance with treat-

ment. Understanding the need for lengthy treatment when no signs or symptoms were apparent was further aggravated by language and cultural barriers.

Although court-ordered compliance is required for active Tb cases, it is often an ineffective process for this segment of the population due to the workers' migratory patterns and the absence of a nationwide tracking system. Because of the financial cost to the state and the problems with compliance already inherent in the migrant population, those diagnosed with active Tb were provided with only a 1-month supply of medication.

Occupational Health

Although migrant workers may suffer from exposure to pesticides and chemicals, extreme heat and dehydration, unsanitary and unsafe working and living conditions, and on-the-job injuries, health-resource availability and use are low among this group compared to the general population (Sakala, 1988). Monitoring labor conditions is a function of several state and governmental agencies, including the Occupational Safety and Health Administration, the Department of Labor, and the Department of Agriculture. However, specific barriers, such as job loss, often prohibit the migrant worker from discussing working conditions or reporting minor injuries. Thus, an accurate determination of the incidence of occupational injuries among migrant workers does not exist.

In this setting, crew leaders affirmed that injuries were few and were treated promptly and effectively, although the only visible evidence of health care supplies were basic first aid kits. Minor injuries received superficial treatment in the field from either fellow workers or the crew chief, although each crew chief had access to a cellular phone to be used in case of emergencies. Non-emergency and chronic health conditions, however, received minimal attention and were the responsibility of the worker. Leaving the fields resulted in a loss of pay because workers were compensated on the amount of crops picked. Farmers were not required to pay for health insurance or worker's compensation.

Barriers to Health Access

The multiple and complex barriers to accessible health care identified in this study include (a) dissimilarities in language and culture, (b) low levels of income, (c) powerlessness in the political arena, and (d) limitations of health resources. In south-central Georgia, there were no paid bilingual staff members at the hospital, the Department of Family and Children's Services, or the sheriff's department. However, the primary care center provided bilingual workers who not only visited the camps, but advocated for the migrant workers with local and state authorities as well. Additionally, minimal educational levels further hindered workers' understanding of health maintenance and restoration concepts. Finally, migrant populations relocate constantly, limiting the determination of specific health patterns and indices.

Most of the school-age children in the camps spoke English and Spanish fluently.

but the adults generally had limited proficiency in speaking and understanding English. Although certain reading materials were available in Spanish, most were poorly translated.

The average annual income for migrant families in this assessment was \$7,000 per year, well below national poverty levels. In the migrant families interviewed, only 5 were receiving Medicaid, 9 were receiving food stamps, and 10 were enrolled in the Women, Infants and Children (WIC) program. Identified barriers to receiving food stamps included the waiting period, the cost and inconvenience of renting a permanent post office box, and the restricted hours during which the agency was open for applications. The agency's office hours conflicted with the migrant workers' availability of personal transportation and breaks away from the field. Many of the migrant workers stated they were unwilling to use the system because they could not afford the loss of a day's pay. In addition, the migrant's inherent suspicion of strangers can impede communicating basic needs to health and social service agencies.

Many migrant families reside in their state of legal residence fewer than 4 months each year. The number of illegal residents in this setting was minimal, but because the population moved among several communities, the workers had little voice and limited influence in the local political decision-making process. Consequently, few avenues were available for changing working and living conditions, which in some cases could be compared to those in Third World countries. Moreover, state and federal agencies were severely understaffed and unable to provide adequate enforcement of health regulations and labor laws.

Access to health agencies can be a formidable barrier for migrant workers. Office hours for these agencies were normally 9:00 a.m. to 5:00 p.m. Monday through Friday, which parallels the time migrants are in the fields. Unfortunately, the limited amount of available professionals in the area also prohibits taking health care to the migrants. When the nurse practitioner from the clinic visited the camps, then no one was available to see clients at the primary health center. Thus, the emergency room at the community hospital was considered the most accessible and, unfortunately, the most expensive health care facility for this population.

If the migrant families accessed available health services, the primary care center did provide well child examinations, hearing and vision screenings, and immunizations on a sliding-scale fee basis. In addition, prenatal and family planning services were available from the public health department, but routine dental care was essentially nonexistent, although several dentists in the area did offer emergency services for a reduced fee.

Women and Children's Health

Hispanic migrant culture is patriarchal, with men playing the dominant role in decision making and income dispersment. Hence, money was available for alcoholic beverages and snacks but not necessarily for nutritious food, dental care, and over-the-counter medications.

Women in this culture frequently marry at an early age and often have begun to

bear children by the time they are 13 to 17 years old. Because of the transitory nature of the work, continuous prenatal care is usually difficult to attain. Although no pregnant women were observed in the five migrant farm camps involved, progress is occurring with the implementation of the "Right from the Start" Medicaid program.

Due to their constant relocation, children of migrant workers received fragmented health care. Many of these children subsequently withdrew from the educational system, and, equipped with little more than a sixth-grade education, have limited future job opportunities. Thus, they are forced into the repetitious migratory patterns of their ancestors.

Health problems most frequently found in women and children during this survey included nutritional deficiencies, urinary tract infections, diabetes, hypertension, dental caries, skin infections, and head lice. A 3-day screening of hemoglobin in children at a migrant summer-school program revealed that 24% of the children screened ($n = 46$) fell below WIC standards. Part of this deficiency may be attributed to the discarding of iron skillets and kettles, which were a rich source of minerals. The more portable, lightweight, and modern aluminum pans represent affluence.

Among migrant women, urinary tract infections were frequently encountered. Due to the demanding working conditions and the absence of facilities in the fields, many of the women stated that they did not have the time or the opportunity to urinate when needed. Overcrowding in the camps further hindered hygienic practices, and the work in the hot Georgia sun perpetuated dehydration.

Diabetes and hypertension were exacerbated by poor diet and high levels of stress in the camps and fields. Funds for treatment of chronic health conditions were very limited, and families did not have ready access to or knowledge of preventive or routine health measures. There was no access to urine dipsticks or glucometers, and knowledge of appropriate foot care and opportunities to practice hygienic measures for skin integrity were minimal.

Dental caries were epidemic within this community. Almost all the children screened had dental caries and plaque accumulations, and a majority of the adults had missing and decayed teeth. Refined sugars and soft drinks are not normally a part of a traditional Mexican diet, but migrant children are frequently exposed to these foods in the migratory life cycle. Furthermore, most of the families did not own a single toothbrush, and routine maintenance and preventive dental care was either unavailable or unsought. As a general rule, visits to a dental care provider were sought only when the pain became severe.

Another frequently observed condition among the migrant children was the presence of head lice and the picking of nits. Barriers to the effective treatment of this condition included cost, the time and work considerations of the parents, and the lack of a perceived need for treatment. Although funds for prescription drugs were allocated by the primary care center, some families did not believe the situation warranted spending their dollars for medications to treat head lice.

DISCUSSION

Based on the assessment data in this study, the community health nurse who attempts to provide quality care to migrant communities will find (a) multiple health problems and minimal resources, (b) limited accessibility to other health professionals, and (c) multigenerational and interfamilial factors that create a difficult framework to change. Because of their distrust of outsiders, migrant workers may perceive health providers as having policing powers. Consequently, a reluctance to respond to questions has become an integral part of their relationship with health providers. Even when distrust is not a factor, the health care professional must be aware that for the migrant, each minute away from the fields translates into lost income. With almost no advance knowledge of how long or when the worker will be in the fields, preparation for other activities may be restricted.

Health care providers should be more cognizant of differing cultural values and should employ every effort to bridge this gap with bilingual outreach workers from the migrant community. Instituting a Spanish language requirement with multicultural sensitivity training for those health professionals who work with migrants could enhance their trust-building ability as well as their skills in communicating with this population. In addition, user-friendly services, such as mobile units or extended health center hours, would increase accessibility to health care, although the perceived priorities of the migrant workers may still limit the effectiveness of some interventions. Integrating the farmer or employer into the health and social concerns of the migrant families may also be helpful. Due to their own financial constraints, farmers traditionally have not been consulted concerning migrant health care. However, collective discussions during program planning involving the farmers, local health and human services agencies, and crew chiefs from each camp could positively impact the quality of life of the migrant family. They could also increase utilization of primary (rather than secondary and tertiary) services.

Continued investigation to improve the health care of migrant farmworkers and their families is needed. This commitment will necessitate a prolonged period of assessment, intervention, and evaluation—areas in which community health nurses excel. Increased federal funding for migrant health projects is essential to develop outreach and primary care services. Regulations that limit reimbursement for dental and eye examinations, mammograms, and preventive health care should be reevaluated.

In this assessment, migrant farmworkers traveled significant distances to avail themselves of the services of the primary care center rather than visit the public health department which was much closer to both the camps and fields. Further reduction of the need for secondary and tertiary interventions was accomplished through efforts of a nurse practitioner, the initiation of weekend health-education classes, and the hiring of a bilingual health care worker from the migrant farm community.

When exposed to this unique population, nursing and allied health students can provide high-quality health care to migrant workers and their families. In addition,

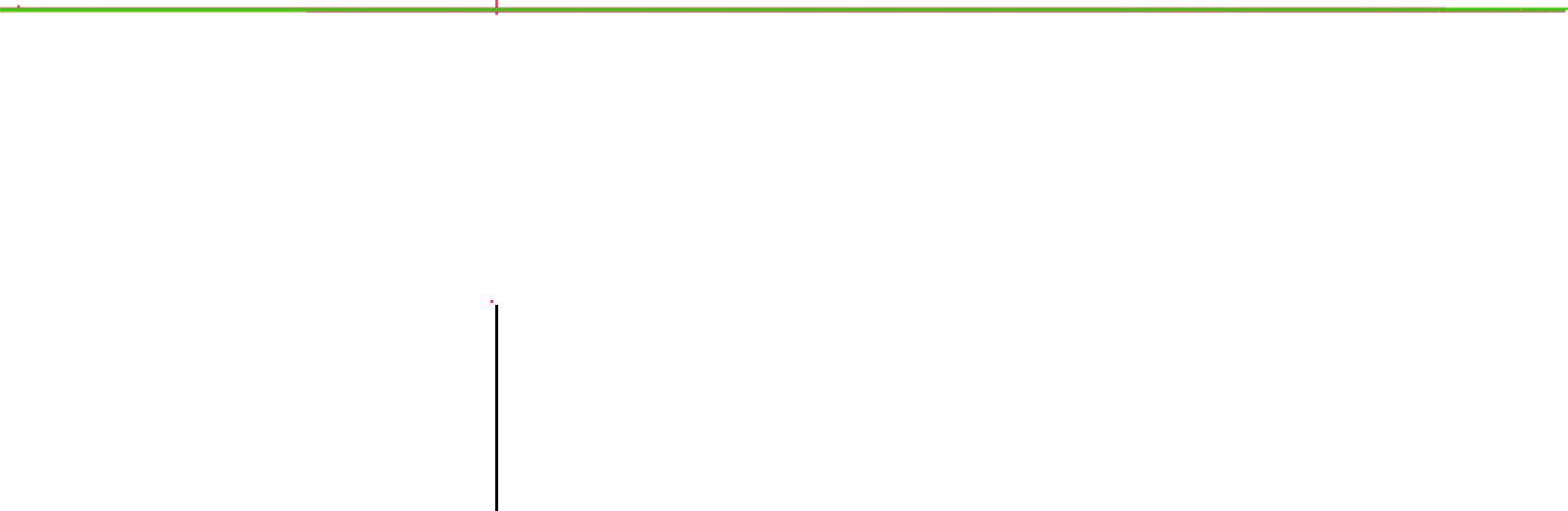
the development of community partnerships, involving the farmer, local health and human service organizations, and migrant farm families, can be instrumental in reducing morbidity and increasing quality of life. Providing quality health care, reasonable living accommodations, and opportunities for personal growth for the migrant worker and his family can be attained when communities unite to reach a common goal.

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 Back**Culture and Gender Sensitive AIDS Prevention with Mexican Migrant Laborers: A Primer for Counselors****Record: 4**

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CULTURE AND GENDER SENSITIVE AIDS PREVENTION WITH MEXICAN MIGRANT LABORERS: A PRIMER FOR COUNSELORS

The purpose of this article is to explicate research-informed culture and gender sensitive AIDS prevention strategies aimed at Mexican migrant laborers living and working in the United States for extended time. This unique and extremely marginalized Latino population is yet another emerging high risk group for contracting the HIV virus. Counselors interested in applying their knowledge of psychology and minority groups to preventing such an AIDS epidemic will be challenged by the complex factors that frame this problem.

This article addresses the following questions based on pertinent literature and original research by the authors and their associates: (a) What is the risk of contracting HIV/AIDS for Mexican migrant laborers living and working in the United States? (b) What are the factors related to culture, gender, and migratory labor that need to be considered by counselors? and (c) How can professional counselors use this information to assist them in providing effective HIV/AIDS prevention strategies with this unique Latino population?

Counselors working with a population at risk for HIV infection are often responsible for the delivery of prevention services in nontraditional settings, including primary health care centers (Kaplan, 1991; Myers, 1992). In particular, Mexican migrant laborers are a new at-risk population that counselors may encounter in federally funded and nonprofit rural health and mental health centers as well as urban county hospitals. In addition, counselors may assume the roles of consultants and case managers as they consult with other health care providers (Dworkin & Pincu, 1993).

MEXICAN MIGRANT LABORERS' RISK FOR HIV/AIDS

It is hard to imagine a Latino group in the United States that is more socially and geographically marginalized than Mexican migrant laborers. The Department of Health and Human Services (DHHS) estimated that there are over 4 million migrant laborers and seasonal farmworkers (including family members) in the United States, and they are predominantly of Mexican origin (DHHS, 1990). Recent reviews of the literature on the threat of AIDS to migrant laborers indicated considerable risk in this unique population (National Commission to Prevent Infant Mortality, 1993; Organista & Balls Organista, 1997).

Certain primary risk factors include significant prostitution use, susceptibility to sexually transmitted diseases (STDs), male homosexual contact, and female migrants having high-risk sexual partners (Carrier & Magana, 1991; Lafferty, 1991; Lopez & Ruiz, 1995; Magana, 1991). In addition, problems in actual knowledge regarding HIV transmission and proper condom use

have been reported (Organista et al., in press).

Prostitution use. In one survey we conducted in-depth interviews with 501 Mexican migrants that have lived and worked in the United States during the past 15 years (Organista et al., in press). Female as well as male migrants were surveyed in five prototypical "sending communities" in Jalisco, Mexico, with historically high rates of out-migration to the United States. Findings revealed that 43% of the 342 men surveyed reported using prostitutes while in the United States. In fact, compared with single men, married men were as likely to use prostitutes, but were less likely to use condoms.

STDs. Susceptibility to STDs has been documented in a limited number of studies. Lopez and Ruiz (1995) reported a 9% lifetime history of STDs and two active syphilis cases in a sample of 176 Northern California Mexican farmworkers. Carrier and Magana (1991) found that epidemics of syphilis and chancroid had recently occurred in migrant laborers and the prostitutes they used in Orange County, California. In both of these studies, either no active cases of HIV or a very low number of HIV cases were identified. However, researchers cautioned that because of the high rates of unsafe sex practices and resultant high number of STDs, prevention efforts must be taken with this population to impede a likely HIV epidemic in the near future.

Homosexual behavior. Despite limited research on homosexuality in Mexican migrants, reports have indicated that homosexual/bisexual contact accounts for 65% of AIDS cases in immigrant Latinos born in Mexico, Central America, Cuba, and South America (Diaz, Buehler, Castro, & Ward, 1993). Based on interviews with Mexican migrants, Bronfman and Minello (1992) concluded that homosexual contact is more likely to occur with migration as a result of loneliness, isolation, and fewer sexual restrictions in the United States.

Needle sharing. Another risk factor, needle sharing, is practiced by some Mexican migrants. Although intravenous illicit drug use poses an obvious threat of HIV infection, therapeutic injections of vitamins and antibiotics may present an even greater danger. Lafferty (1991) reported that 2.9% of 411 predominantly Mexican farmworkers reported intravenous illegal drug use, however, 20.3% reported therapeutic self-injection of vitamins and antibiotics. Of these, 3.5% reported sharing needles for therapeutic injections.

Risky sex partners. As stated earlier, our survey (Organista et al., in press) showed no difference in the rate of prostitute use by married men and single men. Yet, married men were less likely to use condoms with prostitutes than were single men. The risk to the wives of these men is obvious and consistent with other studies substantiating other risk factors placing Mexican migrant women at risk. For example, Lopez and Ruiz (1995) found that 9.1% of women in their Mexican farmworkers sample reported having sex with someone who injected drugs during the past year.

AIDS and condom knowledge. Findings from our surveys indicated that AIDS-related knowledge by Mexican migrants show mixed knowledge of AIDS transmission and low and inconsistent condom use (Organista, Balls Organista, Garcia de Alba G., & Castillo Moran, 1996; Organista et al., in press). For example, migrants were very knowledgeable about the major modes of AIDS transmission, but held many misconceptions about contracting AIDS from casual sources (e.g., public bathrooms, kissing on the mouth, taking the AIDS test). Misconceptions about casual modes of transmission could compromise supportive responses to friends or family members within the Mexican migrant population who are infected with HIV. Also, the fact that 50% of the sample believed they could contract HIV from the AIDS test would suggest high inhibition to obtain such screening.

We also found that knowledge of proper condom use is poor, and actual condom use is significantly higher with occasional sex partners than with a regular sex partner. Problematic knowledge about AIDS and condom use is exacerbated by cultural and migratory labor factors that must be considered in prevention strategies, such as limited education; cultural, linguistic, and geographical barriers to health services; and constant mobility.

GUIDELINES FOR AIDS PREVENTION SERVICES

Wyatt (1994) stated that an ideal AIDS prevention program would be based on an understanding of the normative sex practices for a target group as influenced by variables such as cultural values, gender, socioeconomic status, sexual orientation, and the group's degree of social marginality within society.

Addressing Acculturation, Education, and Migratory Labor Issues

As counselors attempt culturally responsive prevention intervention efforts targeting Mexican migrants, they will need to address the following pragmatic needs:

1. Basic AIDS and condom information must be disseminated in Spanish. For example, 81% of our sample spoke only or mostly Spanish (Organista et al., in press).
2. Literature should be geared to appropriate reading levels and should also include nonreading-based (i.e., hands-on) education.
3. To increase the likelihood of health and counseling service use, extensive outreach to where migrants live and work (e.g., labor camps, sending communities) must occur.
4. Because this is a transient group, counselors and other service providers should consider that most contacts will be brief, possibly only a single session. This reality presses the counselor to develop interventions that are accessible, concise, and problem-solving oriented.

Addressing Gender and Other Cultural Issues

If attempts are made to provide group psychoeducational interventions or workshops, attention needs to be given toward the tendency for traditional Latino men and women not to talk directly about sexual matters. De la Vega (1990) suggested that sex education for Latinos may necessitate placing men and women in separate rooms with same-sex sex educators, and then reuniting them afterward to begin a dialogue about preventing AIDS. Indeed, we recommend that counselors consider a number of gender- and culture-sensitive intervention issues informed by relevant research and outlined as the following:

Male-focused interventions. Our research has led us to conclude that the highest priority in prevention work is to focus on getting male migrant men to use condoms consistently with occasional sex partners, including prostitutes, in the event that these men pursue extramarital sexual relationships. Although proper and consistent condom use does not give 100% assurance against HIV transmission, it is one of the best preventative behaviors for decreasing the spread of AIDS. Furthermore, married as well as single migrant laborers need to be included in such prevention efforts, especially in view of lower condom use reported by married men.

In a rare intervention study with migrant farmworkers, Connor (1992) evaluated the effectiveness of a program designed to increase condom use with prostitutes, as well as improve AIDS-related knowledge and attitudes, in Mexican male farmworkers (N = 193). Participants in this study were provided AIDS prevention information in the form of Mexican style *fotonovelas* (photo novellas) and *radionovelas* (radio novellas) that were broadcasted daily on a local Spanish language station (participants were given radios and program times). These *novellas* depicted scenarios in which three male farmworkers used a condom with a prostitute, abstained from sex, and infected his wife and child with HIV, respectively. Also included were instructions on proper condom use and information on the risks of needle sharing.

All participants were given pre- and post-tests. Results showed that these participants made significant gains in AIDS knowledge and related attitudes, and in reported use of condoms with prostitutes. For example, of those men who used prostitutes during the course of the study, 20 of 37 reported condom use after participation in the study, versus 1 of 32 prior to participation.

Because our research reveals poor knowledge of proper condom use (Organista et al., 1996; Organista et al., in press), migrants should be provided with demonstrations and practice with phallic replicas. Furthermore, because carrying condoms has been found to predict condom use with occasional sex partners (Organista, Ball's Organista, Garcia de Alba G., & Castilla Moran, in press), migrants should also be given condoms and urged to carry them, given their impoverished and transient lifestyles. In particular, married migrants should be urged to carry condoms because they seem less prepared for safe sex, despite rates of prostitute use comparable to single migrants.

For Latinos, the issue of homosexual contact is complicated by the cultural factor that some Latino men who occasionally have sex with men do not consider themselves homosexual. Research in Mexico has indicated for some time that masculine men who occasionally play the active inserter role with passive, effeminate men may continue to identify themselves as heterosexual and lead predominantly heterosexual lifestyles (Carrier, 1995). In focus groups conducted by the authors, Mexican migrants commonly acknowledged the practice of macho men having sex with men, as previously described, but stopped short of admitting any such personal experience. In fact, only 2% of Mexican migrant men interviewed admitted to homosexual contact (Organista et al., in press).

AIDS prevention interventions with Mexican migrant men must directly address homosexual transmission, via unprotected anal sex, whether or not participants admit to such behavior. In addition, the risk to the females of male sex partners who engage in high risk, unprotected sex with other men needs to be acknowledged. The culture-based responsibility of "protecting one's woman" from contracting a fatal disease should be stressed. One study showed that using condoms to protect one's female partner was a more powerful predictor of condom use than self-protection in Mexican immigrants (Mikawa et al., 1992).

Female-focused interventions. Although Mexican migrants historically have been almost exclusively male, the number of women participating in migratory labor has increased over the last two decades. For example, Massey, Alarcon, Durand, and Gonzalez (1987) found that women comprised 15% to 20% of migrant laborers in four Mexican sending communities surveyed. Within the last two decades, 50% of all Mexican immigrants have been women (Vernez & Ronfeldt, 1991).

We have found that Mexican migrants in general and migrant women in particular believe that women who carry condoms would be seen as promiscuous (Balls Organista & Organista, in press; Organista et al., in press). As such, this strategy, as well as discussing condom use with male partners, runs contrary to culture and gender norms. Although the power differential in traditional Mexican gender roles places women at a disadvantage, female-focused prevention strategies should not be totally abandoned.

Strategies that activate self-protection against AIDS in Mexican migrant women may be consistent with the gender role expansion experienced by these women. Guendelman (1987) has found that seasonal migration to the United States expands the traditional roles of Mexican women to include earning wages, greater purchasing power, more involvement in family decision making, more division of household responsibility with husbands, greater feelings of autonomy, and even lower stress levels than nonworking migrant women. Perhaps the central, culture-based role of being a protective mother can be used to persuade Latinas to think about precautions to prevent the congenital transmission of AIDS to children. Furthermore, an appeal can be made to the woman's role as primary caretaker within the family, and the strong relation between her health and her ability to attend to the family's welfare.

Counselors will need to develop innovative methods of assisting traditional Latinas with the process of verbally negotiating, with their male sex partners, the use of condoms. For example, Comas-Diaz (1985) and Comas-Diaz and Duncan (1985) discussed guidelines for culturally sensitive assertiveness training with Latinas that begins by teaching women to preface their requests to men with qualifiers such as *Con todo respeto* (With all due respect), or *¿Me permite decir algo? (Will you permit me to say something?)*. These statements acknowledge the status differential between traditional men and women in a respectful manner and increase the probability of more open communication. In the event that the man does not want to discuss condom use or becomes angry, a counselor can instruct the woman to say something like "I am going to feel very hurt if you do not allow me my say" or "It makes it difficult to feel close to you if you do not consider my view." Women can also remind their male partners of their responsibility to protect them, in this case by using condoms to prevent the possibility of AIDS. Counselors should liberally apply their knowledge of role playing and role reversal to provide practice for such new communication behavior.

These suggestions break new ground in Mexican gender roles, and as such can be challenging interventions. However, in the United States, Latinas represent 21% of all adult female AIDS cases (Amaro, 1988) and Latino children comprise 24% of all pediatric AIDS cases (Centers for Disease Control and Prevention, 1993). These alarming rates warrant serious thinking about the development of gender- and culture-sensitive interventions for Latinas in general, and Mexican migrant women in particular.

CONCLUSION

The counseling profession's mandate to provide culturally responsive mental health services now extends to health care issues, given the increasingly popular subspecialties of behavioral medicine and health psychology (Dworkin & Pincu, 1993; Keeling, 1993). The threat of an imminent AIDS epidemic in the Mexican migrant labor population represents a formidable yet stimulating challenge to counselors interested in applying their knowledge of counseling and ethnic minorities to the complex intersection of AIDS, sexual behavior, culture norms, gender roles, and migratory labor. Although AIDS-related data on Mexican migrant laborers are scarce, we have developed a survey data base with implications for conducting culture and gender sensitive prevention interventions with this unique and extremely marginalized population of Latinas.

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Survey of Condom-Related Beliefs, Behaviors, and
Perceived Social Norms in Mexican Migrant
Laborers

SURVEY OF CONDOM-RELATED BELIEFS, BEHAVIORS
AND PERCEIVED SOCIAL NORMS IN MEXICAN MIGRANT LABORERS

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Running head: MEXICAN MIGRANT CONDOM NORMS

ABSTRACT

This study reports findings from a survey of condom-related beliefs, behaviors, and perceived social norms in Mexican migrant laborers that live and work in the United States for extended periods of time. Snowball sampling was used to recruit 501 Mexican migrants from five "sending towns" in Jalisco, Mexico, with historically high rates of out-migration to the United States. Results showed that subjects reported few negative beliefs about condom use and high efficacy to use condoms in challenging sexual situations but social norms sanctioning condoms were limited. Results also revealed mixed knowledge of HIV transmission, poor knowledge of condom use, and higher condom use with occasional versus regular sex partners. Forty-four percent of male migrants reported sex with prostitutes while in the U.S. with married men reporting less condom use with prostitutes than single men. It was concluded that condom promotion efforts with Mexican migrants should concentrate on men to encourage consistent use with occasional sex partners, including prostitutes. AIDS prevention education should be provided with sensitivity to the language needs, limited education, and extreme social and geographic marginality of this highly underresearched Latino population.

Key words: AIDS, CONDOMS, MEXICAN MIGRANTS, LATINOS, SOCIAL
NORMS

INTRODUCTION

In Mexico, there is growing concern regarding the potential for an AIDS epidemic in small, rural "sending towns" with historically high rates of seasonal, out-migration to the United States^{1,2}. In the U.S., reviews of the literature on AIDS and migrant laborers revealed substantial risk for exposure to HIV mixed knowledge of AIDS transmission, poor knowledge of condom use and inconsistent condom use in predominantly Mexican and Black migrant laborers^{3,4}. For example, HIV screening at migrant farmworker labor camps revealed prevalence rates that ranged from 3.5% to 13%⁵⁻⁸.

There are an estimated 4.1 million migrant laborers and seasonal farmworkers in the United States, predominantly of Mexican background⁹. Risk factors especially relevant to Mexican migrant laborers include prostitution use, susceptibility to sexually transmitted diseases, male homosexual contact, and female migrants having high risk sexual partners¹⁰⁻¹³. For example, a recent survey found female prostitution use to be as high as 30% on the part of male Mexican farmworkers¹² in California.

Conditions of prolonged loneliness, isolation, and deprivation of affection are believed to precipitate prostitution use in male Mexican migrants in the U.S. and it is not uncommon for inexpensive, intravenous drug using prostitutes to solicit male migrants near their place of work¹⁴. In fact, one study reported

on the occasional practice of several migrant men having sex with the same prostitute in succession without condom use¹³. Hence, there is considerable need to better understand this significant HIV exposure category in the Mexican migration experience

Unfortunately, AIDS-related data on Mexican migrants are scarce. In December of 1992, the authors conducted a small, pilot survey of 87 Mexican migrants to assess AIDS and condom-related knowledge, attitudes, and behaviors¹⁵. Results revealed high knowledgeable of the major modes of AIDS transmission (e.g., blood semen) but a third to half of the respondents also believed that they could contract AIDS from various casual modes such as mosquito bites, using public bathrooms, and kissing on the mouth. Poor knowledge of proper condom use was also found.

With regard to frequency of condom use, one study found that 64% of their single and sexually active male respondents reported no condom use¹². Our pilot study showed that condom use, during the past year, was "Half of the time" with occasional sex partners and "Less than half of the time" with a regular sex partner¹⁵. A qualitative study of 60 Mexican migrants found almost no condom use due to the belief that condoms reduce sexual pleasure and that (according to female respondents) their spouses were faithful¹⁴.

In view of the above findings, much more AIDS-related research with Mexican migrants is warranted. The purpose of the current

study was to assess condom-related attitudes, efficacy, and perceived condom social norms in a multi-site sample of Mexican migrants that have lived and worked in the U.S. during the major years of the AIDS epidemic. The survey also assessed AIDS and condom knowledge, frequency of condom use, and sex with prostitutes while in the U.S

METHODS

Subjects

Subjects were 501 Mexican migrant laborers that have lived and worked in the United States since 1982. The sample consisted of 342 men and 159 women with a mean age of 31.6 (SD=11.4) years, 7.8 (SD=3.8) years of education, and 5 (SD=4.2) years spent in the U.S. Subjects also averaged 6 trips to the U.S. from 1982 to December 1994. Fifty-six percent of subjects reported being married/living with someone, 39% were single, and 5% were divorced or widowed. One-third of the sample reported currently residing in the U.S

Procedures

In collaboration with the School of Public Health at the University of Guadalajara, the survey was conducted in five "sending towns", in Jalisco, Mexico, selected for their long histories of high out-migration to the U.S. At each survey site, a coordinator and interview team of Mexican medical students spent five days in the field conducting interviews. Because no other sampling strategy was feasible in these small, remote, rural towns,

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getting AIDS from blood and from public toilets, respectively) To get some sense of perceived vulnerability, subjects were also asked, "How often do you worry about contracting AIDS?" and "Have you personally known someone with AIDS or infected with the AIDS virus?"

Knowledge of proper condom use was assessed by three items: "Do you think vaseline is a good lubricant for condoms?" "Is it necessary to unroll a condom before putting it on the penis?", and "Is it necessary to grab the condom while withdrawing the penis after ejaculating?"

Condom use. Subjects were asked how frequently they had used condoms in the past 12 months with a regular and with occasional sex partners, and how frequently they carried condoms.

Condom-Related Beliefs and Social Norms

Negative beliefs about condom use. Negative beliefs about the consequences of using condoms were assessed with a five-item scale: Would you feel embarrassed; would you feel less sexual pleasure; would your partner feel less sexual pleasure; would it interrupt the sex act to put on a condom; and would you feel an emotional barrier ($\alpha=.67$)

Condom efficacy. The condom efficacy subscale consisted of 20 items that assessed how capable respondents felt about negotiating condom use with partners in a variety of challenging sexual situations. For example, subjects were asked how capable they would be of insisting on condom use if a sex partner was to:

get angry; not want to use a condom, threaten to leave, etc. Other items assessed condom use capability with a sex partner that the respondent was in love with, that was using another form of birth control, that wanted to have a baby, etc. These items were arranged on five-point scales ranging from 1 (Definitely yes) to 5 (Definitely no) with 3 (Maybe) as a midpoint. This scale had high internal consistency reliability ($\alpha=.91$)

Condom social norms. A 19-item subscale was created to assess the frequency with which respondents, as well as their friends and family members, sanctioned condom use. For example, subjects were asked how frequently they have told friends or family members that they use condoms. Subjects were then asked how frequently friends or family members have told them that they use condoms. Other items assessed the frequency of recommending, criticizing, giving, asking for condoms, etc. Items were arranged on scales ranging from 1 (Very frequently) to 4 (Never) and the scale had satisfactory internal consistency reliability ($\alpha=.80$).

Respondents were asked if they believed that their friends would think badly of them if they were to carry condoms; did they believe that a woman carrying condoms was ready to have sex with someone she just met; and female subjects were asked if they thought men would perceive them as ready to have sex with acquaintances if they were to carry condom. Item scales ranged from 1 (Yes) to 4 (No).

Prostitution Use in The United States

An 11-item subscale was constructed to assess prostitute use in the U.S.. In addition to the frequency of sex with prostitutes male subjects were also asked the frequency with which they solicit, are solicited by, encourage friends to use, are encouraged by friends to use, use condoms with prostitutes, etc. Subjects were also asked the frequency with which they had participated in the practice of several men "taking turns" having sex with the same prostitute ($\alpha=.70$).

Acculturation and other background information.

The HCQ contains an acculturation subscale consisting of four language-related items from the Short Acculturation Scale¹⁹. Items are arranged on five-point scales ranging from Only Spanish 1) to Only English (5) with Both Equally (3) as a mid-point. As expected, this factor had a mean of 1.5 (SD=.71 indicating very low acculturation ($\alpha=.85$). Various other sociodemographic background data were also collected

Sending towns. According to the 11th Mexican census of 1990 the five towns are small, rural, agricultural locals where approximately 40% of the population are 14 years old and younger. It is estimated that an average of two members per family have lived or are currently living in the U.S. Descriptions of subjects and sending towns are summarized in Table 1. While variance in acculturation was small in the study sample, a one-way Analysis of

Variance (ANOVA) used to compare sending towns revealed Concepción de Buenos Aires (CBA) was higher in acculturation ($M=1.9$) than all four other towns and that Jalostitlán was higher than Teuchitlán ($M_s=1.6$ & 1.3 , respectively), $F(1,4)=10.2$, $p<.000$ (Tukey-HSD used to conduct post-hoc, pair-wise comparisons of mean acculturation scores across towns).

RESULTS

AIDS and Condom Knowledge

As can be seen in Table 2, over 90% of respondents were accurate in identifying actual major modes of HIV transmission but a third of the sample thought that AIDS could be contracted from casual sources such as a mosquito bite and kissing on the mouth, and half of the sample believed they could contract AIDS from the AIDS test. A series of one-way ANOVAs were conducted to compare subjects on selected socio-demographic variables. Using average percentage correct across all 10 AIDS transmission items as dependent variable, it was found that younger subjects (aged 31 were more accurate in their knowledge of AIDS transmission than older subjects (aged 32-83) (78% & 71% accurate, respectively), $F(1,499)=18$, $p<.000$; subjects with seven or more years of education were more accurate than subjects with six or less years of education (80% and 71%, respectively), $F(1,489)=4.34$, $p<.05$; single subjects were more correct than married subjects (80% and 72.1%, respectively), $F(1,498)=23.1$, $p<.000$; and subjects with two or more sex partners were more accurate than subjects with one sex partner

(78% and 74%, respectively), $F(1,378)=5.9$, $p<.05$. While no gender differences were found, a one-way ANOVA used to compare sending towns revealed that subjects from Jalostitlán were more accurate in AIDS transmission knowledge than subjects from Teuchitlán (79% & 71%, respectively), $F(1,4)=2.4$, $p<.05$.

Subjects reported generally not knowing someone with AIDS ($M=3.1$ or "Probably not") and also reported that they "Sometimes" worry about contracting AIDS ($M=2.8$ where 3="sometimes"). No differences in worry were found between subjects differing by age, gender, marital status, education, number of sex partners, or sending town.

With regard to knowledge of proper condom use, only 69 subjects in study (13.8%) answered all three condom knowledge items correctly. Two-thirds of the sample said either "Yes" or "Don't know" to the items asking if vaseline was a good lubricant for condoms and 48.1% answered similarly to the question asking if one should unroll a condom before putting it on the penis. Only slightly more than half of the sample knew to grab a condom while withdrawing from a partner after ejaculation.

Condom Use

Seventy-five percent of subjects reported being sexually active during the past year. During this time period, 61% of these subjects reported only one sex partner and 38% reported two or more. Only 5 male subjects (2%) reported sex with men during the

past year, making this important risk factor too small for meaningful analysis.

The frequency of condom use during the past year was approximately "Less than half of the time" ($M=3.7$), with a regular sex partner, and "More than half of the time" ($M=2.2$) with occasional sex partners items on five-point scales ranging from 1 [Always] to 5 [Never] with 3=Half of the time), and this difference was significant ($t(223)=10.15$, $p<.000$)

Men reported more condom use with occasional partners than did women ($M_s=1.9$ and 3.1 , respectively), $t(235)=-4.7$, $p<.000$, but there was no gender difference with regard to condom use with regular partners ($M_s=3.6$ and 3.9 , respectively). Compared to married migrants, single subjects reported more condom use with a regular sex partner ($M_s=2.9$ & 4.1 , respectively), $t(369)=-7.42$, $p<.000$, and with occasional sex partners ($M_s=1.75$ & 2.5 , respectively), $t(235)=-3.65$, $p<.000$. Table 3 lists the percentages of male and female migrants that reported "Always" and "Never" using condoms with regular and occasional sex partners during the past year.

Sixty-six percent of subjects reported that they "Never" or "Almost never" carry condoms while only 17.6% "Always" carry them. Men reported carrying condoms more frequently than did women ($M_s=2.7$ & 3.6 , respectively) on this four-point scale ranging from 1 (Always) to 4 (Never), $t(492)=-8.11$, $p<.000$. In fact, 76.6% of women reported that they "Never" carry condoms as compared to 41.4%

of men. A one-way ANOVA used to compare sending towns showed that subjects from Teuchitlán carried condoms less often than subjects from Jalostitlán ($M_s=3.3$ & 2.8 , respectively) $F(1,4)=3.2$, $p<.01$

Condom-Related Beliefs and Social Norms

Negative beliefs about condom use. Negative beliefs about the consequences of condom use were generally low in the current sample. A mean score of 2.7 on this scale indicated that when subjects were asked if they believed that various negative consequences would occur with condom use, they generally said "Probably not". Subjects higher in education had less negative beliefs than subjects lower in education ($M_s=2.8$ & 2.65 , respectively; $t(452)=-2.61$, $p<.01$), but there were no other differences between by age, gender, number of sex partners, marital status, or sending town.

Condom efficacy: When subjects were asked how capable they were of insisting on condom use in a variety of challenging sexual situations, they reported high condom efficacy as indicated by a mean score of 2 (Probably yes) on this 5 point scale ranging from 1 (Definitely yes) to 5 (Definitely no). There were no differences by age, gender, education, marital status, or number of sex partners on this scale. However, subjects from Teocaltiche and Cuautla reported higher condom efficacy than subjects from CBA ($M_s=1.9$, 1.9 , & 2.3 , respectively), $F(1,4)=4$, $p<.005$.

Condom social norms. Subjects reported that they themselves, as well as their friends and relatives, "Sometimes" sanction

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condoms, in a variety of ways, as indicated by a mean score of 2.3 on this four-point scale ranging from 1 (Never) to 4 (Very Frequently). Sanctioning condoms was more true of men than women ($M_s=2.5$ & 2 , respectively; $t(436)=10.8$, $p < .000$), younger subjects than older subjects ($M_s=2.4$ & 2.2 , respectively; $t(435)=4.35$, $p < .000$), more educated than less educated subjects ($M_s=2.4$ & 2.2 , respectively; $t(428)=-4.54$, $p < .000$), subjects with multiple sex partners as compared to subjects with one sex partners ($M_s=2.6$ & 2.2 , respectively; $t(344)=-8.1$, $p < .000$), and single subjects as compared to married subjects ($M_s=2.5$ & 2.3 , respectively; $t(435)=4.96$, $p < .000$). A one-way ANOVA used to compare sending towns showed that subjects from Teuchitlán were lower in social sanctioning condoms ($M=2.1$ than subjects from the four other communities (M_s ranged between 2.3 & 2.5) $F(1,4)=11.8$, $p < .000$.

Beliefs about carrying condoms. Male subjects considered it the man's responsibility to carry condoms more than did female subjects as indicated by their respective mean scores of 2.5 and 2.7 , $t(83)=-3.56$, $p < .001$, on this five-point item ranging from 1 (Always the man) to 5 (Always the woman) with a midpoint of 3 (Both). Further, while subjects generally reported that their friends would probably not think badly of them for carrying condoms ($M=3$ or "Probably no"), a breakdown by gender revealed that women answered "Probably yes" ($M=2.2$) to this item while men answered "Probably no" ($M=3.4$), $t(472)=10.2$, $p < .000$. Also, female subjects answered "Probably yes" when asked if men would perceive them as

ready to have sex with acquaintances if they were to carry condoms (Mean=2.2).

Prostitution Use in the United States

Male subjects reported that they are "Sometimes" involved with prostitutes in a variety of ways (e.g., solicit and are solicited by prostitutes, encourage friends and are encouraged by friends to use prostitutes, etc. as indicated by a mean score of 3.2 on this 11-item scale ranging from 1 (Very frequently) to 4 (Never). Involvement with prostitutes was higher in single versus married men ($M_s=3.1$ and 3.2 , respectively; $t(314)=-2.04$, $p<.05$), younger versus older men ($M_s=3.1$ and 3.2 , respectively; $t(315)=-2.74$, $p<.01$), men with multiple sex partners versus one sex partner ($M_s=3.0$ and 3.3 , respectively; $t(258)=6.2$, $p<.05$), and in men with lower versus higher education ($M_s=3.1$ and 3.2 , respectively; $t(310)=1.95$, $p<.05$). Also, migrants from Cuautla reported less prostitution use than subjects from CBA ($M_s=3.3$ & 3 , respectively), $F(1,4)=3.8$, $p<.005$

An examination of selected individual items from the prostitution use subscale revealed that 44% of male subjects reported having sex with prostitutes while in the U.S., and 70% of these men reported frequent to very frequent condom use. Twenty-four of the 144 men reporting prostitution use said that they never used condoms with prostitutes. Married and single migrants did not differ in frequency of prostitute use ($M_s=3.5$ & 3.4 , respectively) but married men did report less condom use with prostitutes than

did single men ($M_s=2.3$ & 1.6 , respectively), $t(142)=-3.43$, $p<.001$. Thirteen percent of male migrants reported participating in the practice of several men sharing the same prostitute in succession.

DISCUSSION

While the Mexican migrant laborers surveyed were very knowledgeable about the major modes of AIDS transmission, their many misconceptions about contracting AIDS from casual sources could compromise supportive responses to friends or family members infected with HIV. In addition, the fact that 50% of the sample believed that they could contract HIV from the AIDS test would suggest high inhibition to obtaining such screening.

Low concern about contracting AIDS and the finding that most subjects reported not knowing someone with AIDS warrants efforts to increase perceived vulnerability in Mexican migrants as a way of motivating precautionary behaviors. Such efforts should include educational outreach by Mexican migrants with HIV/AIDS because knowing someone with AIDS has been shown to predict carrying and using condoms with occasional sex partners in Mexican migrants¹⁸.

It has been found that U.S. Latinos low in acculturation and education are in high need of receiving basic AIDS and condom-related education²⁰. Similarly, between half and two-thirds of the survey sample were unaware of basic knowledge of condom use. In fact, subjects from the least acculturated and least educated

sending town of Teuchitlán were significantly lower in knowledge of AIDS transmission, social sanctioning of condoms, and carrying condoms as compared to subjects from the more acculturated and educated town of Jalostitlán

Culturally responsive prevention efforts targeting Mexican migrants will need to provide AIDS and condom information in Spanish (81% of current sample spoke only or mostly Spanish) with literature geared to appropriate reading levels (subjects averaged 7.8 years of education) and should also include non-reading-based (i.e., "hands on") education and extensive outreach to where migrants live and work (e.g., labor camps, sending towns).

Subjects reported few negative beliefs about condom use consistent with our pilot research¹⁵ but in contrast to qualitative studies claiming that Mexicans dislike condoms because they decrease sexual pleasure¹⁴ and because condoms are associated with venereal disease and condemnation by the Catholic Church²¹ With regard to religion, results from our pilot study¹⁵, and research on Mexican immigrants²² and U.S. Latinos^{17,23} consistently show that being Catholic and considering one's religion as important are unrelated to condom use. Further, religion has also been found to be unrelated to general contraceptive use in Mexican American women²⁴. In the current study, 95% of subjects were Catholic yet 46% of the women surveyed reported using some type of contraceptive during the past year. Hence, the pervasive view of Catholicism as

an obstacle to condom and other contraceptive use appears greatly overestimated.

While subjects reported few negative attitudes towards condoms as well as high condom efficacy, the analysis of condom-related norms indicated that within the interpersonal, social world of Mexican migrant laborers, condoms are only sanctioned and promoted to a limited degree. In addition, there was a pronounced gender bias against women carrying condoms based on the widespread belief that such women are promiscuous. As such, it is not surprising that 75% of female respondents reported never carrying condoms.

In the current study, 27% of married men and 82% of single migrant men reported multiple sex partners during the past year. These figures are considerably higher than the rates of 18% and 60% reported for married and single U.S. Latino men, respectively¹⁷. On a related note, one survey found that the rate of married Latino men with multiple sex partners was twice as high as the rate for non-Hispanic whites (i.e., 18% & 9% respectively)¹⁷. Therefore, it appears that while most married Latino men do not report extramarital sexual relations, their higher rates relative to non-Hispanic whites support the much discussed culture-based norm sanctioning sex outside of marriage for men²⁵. Our data suggest that extramarital sexual relations are especially pronounced for Mexican migrants men who frequently leave their spouses/primary sex partners while in the U.S.

The finding that condom use was significantly higher with occasional sex partners than it was with regular sex partners is consistent with our pilot study¹⁵ and with research on U.S. Latinos^{17, 26}. These findings suggest that for Latinos generally, and Mexican migrants in particular, condom use is implicitly sanctioned for occasional but not primary sex partners. As such, condom promotion efforts with Mexican migrants need to primarily target men to promote consistent condoms use with secondary partners. Further, married as well as single migrant men need to be included in such prevention efforts in view of lower condom use reported by the former in this study.

It should be noted that only 2% of male subjects survey admitted to having had sexual relations with other men. This figure is consistent with the rate 3.5% in a survey of Mexican farmworkers¹² and the figure of 2% found in U.S. Latinos¹⁶. It is presently unclear whether these low rates represent accurate prevalence or whether the considerable stigma associated with homosexuality in Latino culture in general²⁷ and Mexican culture in particular²⁵ leads to under reporting. In survey research in which subjects are interviewed by a same sex interviewer

The current study provides important baseline data on prostitution use by Mexican migrant men in the United States. It was found that 44% of the men surveyed reported sex with prostitutes as compared to 30% reported in a smaller survey of

Mexican farmworkers and 18% in a survey of "predominantly Latino" migrant farmworkers¹¹

Interestingly, married and single migrants did not differ in reported frequency of prostitution use yet married men reported significantly less condom use with prostitutes as compared to single migrants. Married men may use condoms less than single men for a variety of reasons including less planning around having sex, more inhibition to have condoms on hand, and perhaps even denial that they will have sexual relations while away from spouses. The risk to the spouses of married migrants is an area of concern warranting further research.

The current study is the first relatively large survey of Mexican migrant laborers to examine condom-related knowledge, behaviors, beliefs, efficacy, and perceived social norms; as well as migration-related prostitution use while in the United States. Considering the extreme social, cultural, and geographical marginality of Mexican migrant laborers, the development of culturally responsive HIV prevention services and health policies remains a formidable challenge, but one assisted by the baseline descriptive data provided by this report

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MEXICAN MIGRANT CONDOM NORMS

24

Table 1 Comparison of Subjects from Five Sending Towns in Jalisco Mexico

	<u>CAB</u>	<u>Jalos</u>	<u>Teocal</u>	<u>Cuautla</u>	<u>Teuchit</u>
N	101	101	124	69	106
Age (M)	32	28	30	34	35
Male (%)	64.4	79.2	75.8	70	52
Years of Education (M)	7.9	8.8	9	6.8	6.2
Married (%)	49.5	40.6	51.2	71	72.6
Acculturation (M) ^a	1.9	1.6	1.5	1.4	1.3
Spanish only or Mostly Spanish Spanish (%)	74.3	76.2	80.6	82.6	89.6
Years in U.S. (M)	6.3	4.9	5.4	4.9	3.0
Catholic (%)	91	97	96	97	98
Total town population	5,294	24,497	36,379	2,905	7,778
Number of households	1,164	4,693	7,154	588	1,666

Note: CBA=Concepción de Buenos Aires; Jalos=Jalostitlán; Teocal=Teocaltiche; Teuchit=Teuchitlán.

^afive point scale where 1=Traditional Latino; 3=Bicultural; and 5=Anglo Oriented

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Table 3 Percentages of Male and Female Migrants That Always and Never Use Condoms with Regular and Occasional Sex Partners (n=378)^a

	Sex Partner			
	Occasional		Regular	
	Always	Never	Always	Never
Male migrants	70.7%	15%	20.8%	48.3%
Female migrants	40.8%	49%	15%	56.1%

^a75% of subjects reported being sexually active during the last year

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TESOL and health
People who are ill:
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about his education.
ahead in life. But he

Resource ID#: 4931

Culturally Appropriate Health Care: Lessons From an Outreach to Hispanic Clients

math lesson when you've got a savage tooth ache? Or to write an essay when your teeth are rotting in your jaw? I thought maybe the best contribution I could make to educating these kids would be to keep them healthy enough to get something out of school." No doubt we all aspire for our students to become wealthy and wise. But healthy comes first.

The articles included in this special issue of *TESOL in Action* address many of these objectives. They are contributed by health care providers, health administrators, communication specialists, TESOL professionals, and social activists

rs wear several of those hats). My hope is will help move us forward—at least by t—as teachers and as contributors to a the health of all her members. My hope 1 will help move us to reshape the re to become a discourse of inclusion

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CULTURALLY APPROPRIATE HEALTH CARE: LESSONS FROM AN OUTREACH TO HISPANIC CLIENTS.

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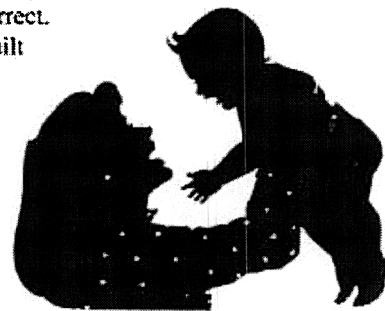
Culture is the mirror in which we see ourselves and through which we view the world around us. Culture represents a particular set of values, norms, attitudes, beliefs, and expectations about the world that shapes the lives of those who belong to that culture. As the cultural landscape of the United States continues to diversify, it is estimated that by the year 2000, Hispanics will make up nearly 11% of the population. These changes and the diversity of people seeking health care services has challenged both the providers of these services as well as those seeking these services themselves.

Consider the term "Hispanic." This term is often used to refer to anyone whose native language is Spanish. But it is essential for an accurate cultural understanding to recognize the tremendous diversity that exists within this term. For example, the rural Mexican is uniquely different from the urban Columbian or the indigenous Guatemalan who all might be categorized as Hispanic. Each group has a unique historical, linguistic, political, and social evolution that has contributed to their cultural identity. Thus it is easy to understand the importance of cultural literacy on the part of health care providers as an important element in providing culturally appropriate health care services to Hispanic clients. Lack of such cultural knowledge and skills has all too frequently resulted in many traditional health care settings reflecting values and norms that are inadequate or inappropriate for Hispanic clients.

It is the purpose of this article to acknowledge the diversity that exists within the term "Hispanic," and then to examine specific cultural similarities that exist and are relevant in providing culturally appropriate health care services to the Hispanic client.

Early Lessons Learned

Although there are cultural differences within the Hispanic population, there are also some important similarities that can be identified. Practicing as a Pediatric Nurse Practitioner over the last 26 years, I had the opportunity of working with Hispanic families both in the United States and in Central and South America. It was during this time I learned the importance of Spanish language competency for myself as a health care provider. Language competency I believed was the key to success in working with Hispanic clients. I was partially correct. Language competency built the bridge over which I would travel to learn very important lessons. These lessons were taught to me over time by my Hispanic colleagues and friends as well as by years of



experience working with diverse Hispanic clients and their families.

The lessons began with the understanding that *Confianza* (trust and confidence) was a critical element to interpersonal relationships within the Hispanic community. Working directly with Hispanic families in their community was important in establishing trust and confidence. So when in 1993 the Grady Health System began providing pediatric health services in the northern part of greater Atlanta, I had the opportunity to put what I had learned regarding *Confianza* into practice. As a part of these pediatric services I began a postpartum home visiting program which laid the first steps in establishing a trusting relationship with the largely Hispanic community that we were to serve. This program allowed for a postpartum home visit to each family discharged from Grady Health System that had received prenatal care at our clinic. It allowed me to meet families in their own homes with extended family present. It was a culturally appropriate way to build trust and confidence with that community. One cultural principle had been well learned.

Another important cultural principal was that of *Respeto* (respect). *Respeto* is practiced commonly in both personal and professional relationships. *Respeto* requires that a person's sense of integrity be maintained in interactions with others. For example, it would be appropriate during my home visits or in my examining room to greet the eldest member of the family present or to pay appropriate respect to the head of a particular household before dealing with the purpose of the visit.

Simpatia (congenial attitude), which has no direct translation in English, is another important principle that can best be described as a practical approach to social interaction. *Simpatia* avoids direct conflict or confrontation. Sometimes this meant that my plan or intervention could be accepted politely by a family with the nod of the head or a smile, but in reality not be accepted at all. It was crucial that further communication take place to reveal the degree of understanding present and whether agreement was mutual or just a reflection of *Simpatia*.

Challenges of Culturally Appropriate Care

There were, however, certain particular cultural lessons and principles that led me from the original postpartum home visiting program to a much larger community outreach involving other community agencies and resources. One of these cultural principles was that of *Personalismo* (good character and the personal use of self). This principle consists of using your best interpersonal qualities to help accomplish a task. In practice this means that families may be more likely to trust and cooperate with health care providers whom they know personally and with whom they have had meaningful conversation. It would be expected that such a health care provider would ask about clients and their families and would remember details of their lives. For example, *Personalismo* would require that I ask about the family or the health of the person with whom I was speaking before addressing any other

subject that was of importance to me. Here was the challenge. After asking about the family and their health, I then had to consider the full range of information that I had been given. I was responsible in my relationship with the Hispanic family to pay attention to all that I now knew. In other words, how would I respond to the needs of the larger family?

Personalismo is closely related to another important cultural value that was essential to any understanding of Hispanic culture. *Familialismo* (familialism) refers to the centrality of the family within the Hispanic culture. This cultural value is demonstrated in the need that Hispanic family members have to consult with each other before making decisions and to help others in the family both economically and emotionally. An important consequence of *Familialismo* is the fact that Hispanics may be highly motivated to talk with other family members about their health related needs or the relevance of particular health care service programs available to them. This is a strength within the culture to be understood and built upon. It is an opportunity to reach extended family members within the Hispanic community with needed health related programs. It is also a challenge to health care providers to build this *Familialismo* knowledge when designing health service plans for Hispanic clients.

The principle of *Familialismo* is also closely related to another important cultural value, *Colectivismo* (collectivism). *Colectivismo* speaks to the importance of personal interdependence, conformity, and sacrifice for the good of the group. As *Familialismo* requires consultation with the family prior to decision making, *Colectivismo* requires that decisions be made interdependently and cooperatively for the well-being of family or community. The concept of individualism, as is highly valued in Western culture, may be of less importance to the Hispanic client because it is incompatible with the predominant tendency toward collectivism and may be perceived as selfish. This has important implications when asking individual Hispanic clients for an immediate response to a given therapeutic option. They will want to consider how that medical treatment will affect others in their families or communities (e.g., economic impact on others, need for others to take on household chores).

Later Lessons from the Field

Perhaps the most important lesson learned in working with Hispanic clients is that neglecting to consider the needs of the family or the interdependent ways decisions are made could result in ineffective as well as a



culturally inappropriate health care services. This is a challenge for our health care systems, systems that have traditionally valued the individual, self-care, and taking responsibility for one's own individual decisions. This is not about judging one set of values as being better than the other. It is about recognizing and respecting the differences and being able to build upon the strengths of these values and thus provide culturally appropriate health care services.

It was the recognition of these cultural values as cultural strengths that transformed the postpartum home visiting program which was focused on the mother and infant into a much larger outreach program that targeted the needs of the larger community. This community outreach and research project was called MICO (Mobilizing Interagency Comprehensive Outreach).

The MICO Project

The MICO Project was created in 1994 in collaboration with talented and dedicated colleagues who worked in partnership over the course of two years until the project was completed in 1996. The purpose of this project was to promote access to and appropriate utilization of available health care resources by a largely Hispanic community. The project also sought to improve communication and build collaboration among the many agencies serving (or potentially serving) this community. These agencies included the Atlanta Prevention Connection, North Fulton Grady Health Center, Fulton-Atlanta Community Action Authority, Fulton County Health Department, and EMSTAR Research Inc. These partners were committed to the task of creating an outreach program that would be executed in a culturally appropriate way. This meant that Spanish language use, although important, could not be considered in isolation from other important cultural concepts in the design and implementation of this project. Consideration was given to the decision making process in Hispanic families as well as to the structure of family decision making, traditional concepts, communication styles, and roles. The project was initiated with a community health needs assessment. This assessment was accomplished by providing a culturally appropriate outreach to community residents, including door-to-door home visits, and both in-person and phone follow-up to identify needs and referrals. Community outreach workers were recruited from the community, were bilingual, and received extensive training on conducting community health assessments. Working directly with the community in this way fostered trust and confidence toward the local service agencies. Upon completion of the community health assessment, strategies were designed and implemented to assist the community in meeting their identified health related needs and to increase the community's competence and confidence in using available resources.

The next important task was working with the local health and social service agencies in the community. Culturally appropriate education and training programs directed toward working competently with the Hispanic families were designed and presented to the community agencies' staff and

health service providers in order to increase their comfort and ability in providing care for the larger Hispanic community. The comfort and ability of the service providers in working with their Hispanic clients was measured immediately following the training and again one month later. Project evaluation showed significant increases in both knowledge and use of community resources by the Hispanic community. The program evaluation also revealed significant improvement in the community service providers' level of comfort and ability in working with their Hispanic clients that was still significant one month after training.

Lessons for the Future

Effective strategies for providing culturally appropriate health care services to Hispanic clients must look beyond traditional approaches and models of the delivery of health care services. Language competency, although an essential element in any successful health related program, can not be considered in isolation from the cultural values and principles that create the template on which all communication will take place. Effective health care programs directed at serving the Hispanic community must consider the challenge of building their programs on the strengths of the cultural values and principles found within that community. By integrating cultural values and beliefs with conventional health care services we can best improve the quality of health care services in Hispanic communities.

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the 1990s, the number of people with a mental health problem has increased in the UK (Mental Health Act 1983, 1990, 1994).

There is a growing awareness of the need to improve the lives of people with mental health problems. The Department of Health (1999) has set out a vision for mental health care in the UK. This vision is based on the following principles:

• People with mental health problems should be treated as individuals, with their own needs and wishes.

• People with mental health problems should be given the opportunity to participate in decisions about their care and treatment.

• People with mental health problems should be given the opportunity to live in their own homes and communities.

• People with mental health problems should be given the opportunity to work and to contribute to society.

• People with mental health problems should be given the opportunity to lead a full and active life.

• People with mental health problems should be given the opportunity to be treated with respect and dignity.

• People with mental health problems should be given the opportunity to be treated as equal citizens.

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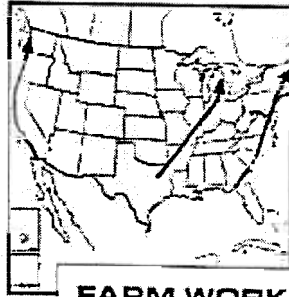
• People with mental health problems should be given the opportunity to be treated with respect and dignity.

• People with mental health problems should be given the opportunity to be treated as equal citizens.

Cross-cultural Medicine A Decade Later

Occupational Health Problems Among Migrant and Seasonal Farm Workers

KETTY MOBED, MSPH; ELLEN B. GOLD, PhD; and
MARC B. SCHENKER, MD, MPH, *Davis, California*



FARM WORKERS

The total population of migrant and seasonal farm workers in the US is estimated to be as large as 5 million. In 1987, the all-cause work-related death rate (49 per 100,000 workers) for farm workers was the highest for all occupations (compared to 11 deaths per 100,000 workers for all jobs).

Migrant and seasonal farm workers are one of the most underserved and understudied populations in the United States. The total US population of such farm workers has been estimated at 5 million, of whom about 20% live or work in California. Farm workers perform strenuous tasks and are exposed to a wide variety of occupational risks and hazards. Low socioeconomic status and poor access to health care also contribute to existing health problems in this population. Potential farm work-related health problems include accidents, pesticide-related illnesses, musculoskeletal and soft-tissue disorders, dermatitis, noninfectious respiratory conditions, reproductive health problems, health problems of children of farm workers, climate-caused illnesses, communicable diseases, bladder and kidney disorders, and eye and ear problems. Few epidemiologic studies exist of these occupational health problems. No comprehensive epidemiologic studies have assessed the magnitude of occupational health problems among migrant and seasonal farm workers and their dependents. Although the migratory nature of this population makes long-term studies difficult, the development of standardized data collection instruments for health consequences and scientific assessment of farm work exposures and working conditions are vital to characterize and reduce the occupational health risks in farm workers.

(Mobed K, Gold EB, Schenker MB: Occupational health problems among migrant and seasonal farm workers, *In Cross-cultural Medicine—A Decade Later* (Special Issue). *West J Med* 1992 Sep; 157:367-373)

They come with the dust, and go with the wind.¹

Agriculture is a major industrial sector in the United States and relies heavily on migrant and seasonal farm labor, especially in California where many of the labor-intensive crops, such as fruits and vegetables, are grown. Migrant and seasonal farm workers are one of the most underserved and understudied occupational populations in the US, even though they are working in one of the most, if not the most, hazardous occupations in this country.^{2,3} In 1987 the three highest all-cause work-related death rates per 100,000 workers were 35 for construction workers, 38 for miners, and 49 for agricultural workers, compared with a rate of approximately 11 deaths per 100,000 workers for all occupations.⁴

The US agricultural work force was estimated in 1986 to number about 6.5 million, 5.4 million of whom lived on farms⁵ and 1.1 million of whom were hired workers.⁶ Migrant and seasonal farm workers are not counted separately from other farm workers by most agricultural surveys. Recent estimates indicate that as many as 5.0 million migrant and seasonal agricultural workers live and work in the US.⁷ Statistics generally underestimate the dependence of agriculture on hired workers.

Among the migrant and seasonal farm-worker populations, basic health data—such as crude maternal and infant mortality, survival, and disability—are lacking, in part because of the absence of a precise denominator. This results

from the transient nature of the population, their migration into and out of the US, undercounting of those workers who meet the legal definition of a migrant but who do not fit ethnic and demographic stereotypes or occupational classifications, and the desire of many immigrant workers to avoid contact with government agencies.⁸ Language barriers, the seasonal nature of the work, and the large distances between camps or farms in rural, often remote, areas create further difficulties in obtaining reliable data on this population.

There is no uniform definition of migrant and seasonal farm workers among government agencies. The US Departments of Agriculture, Labor, Health and Human Services, and Education all use different standards for counting the farm-worker population, making data across agencies not strictly comparable. Currently the only national reporting system that tracks farm worker health data is the Migrant Student Record Transfer System maintained by the Office of Migrant Education of the US Department of Education. This computerized system contains the health and academic records of children of migrant farm workers in the US and Puerto Rico, but there exists no such collection of national health data on adult farm workers.⁹

Background

Agricultural labor in the United States began in the plantation days, when imported slaves worked the cotton, sugar cane, and tobacco fields of the southern states. With migra-

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Cross-Cultural Medicine: A Decade Later
Occupational Health Problems Among Migrant and
Seasonal Farm Workers.

nal Medicine, University of California, Davis, and the Agricultural Health

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years, with a combined overall rate of 25.8 work-related injuries per million work hours. Work-associated injury fatality was relatively high for those younger than 15 years (7.4%, when only 4.3% of the combined working hours by the whole farming population was contributed by this age group) and for those older than 64 years (11.1%, with 5.5% total work-hour contribution by this age group). Agricultural machinery was the single leading source of occupational injury (17.6%), followed by animal-related injuries (16.9%). Other surveillance studies of occupational injuries and mortality in farmers and their dependents have shown similar results,^{19,20} but again no distinctions were made between farmers and farm workers.

Surveillance of occupational injury in migrant and seasonal farm workers poses even greater challenges than that of farmers and permanent farm help. There are difficulties in locating and identifying farm workers and gaining their cooperation in a study after a long workday. Underreporting might also be prominent if symptoms are mild, short-lived, or both. Symptoms might be ignored by a temporary farm worker, who is fearful of losing his or her job or of being reported to immigration authorities.

In 1981 a study was done of 467 families comprising 1,888 persons in Tulare County, California.²¹ An aim of the survey was to gather data on the relationship between work and health. The most frequently reported work-related health problems were injuries, which accounted for 56% of all health problems reported. Falling stacks of crates, overturning gondolas, and other accidents associated with farm machinery—forklifts and tractors—were the most frequent causes of farm accidents for those who worked with field crops. Tree accidents, which included falling down from or through ladders with bags full of fruit, caused fractures, sprains, contusions, puncture wounds, and lacerations.

Of 287 migrant farm workers studied in North Carolina, 24 (8.4%) reported an occupational injury during the previous three years.²² Broken bones, sprains, and cuts accounted for 80% of the injuries. Vehicles or machinery caused 21% of the injuries, which often resulted in time lost from work. The relatively small number of reported injuries limits the interpretation of the results. The incidence rate of injury (8.4% for a 3-year period) is, however, probably an underestimate. The use of recall rather than surveillance strategies and the exclusion of previously injured workers from the current work force could also contribute to the underascertainment.

More population-based research is necessary to characterize fully the nature, frequency, and consequences of occupational injuries in farm workers. Most of the occupational injury categories outlined by the National Safety Council have rarely been studied in migrant and seasonal farm workers. This scarcity of data limits our understanding of work-related injuries in this population.

Pesticide-Related Illness

Pesticides are a major source of public concern because of their known toxicity, their pervasiveness in the environment, and their possible association with delayed health effects, such as cancer and adverse reproductive consequences.^{23,24} Pesticides, used extensively in US agriculture, include compounds such as insecticides, herbicides, defoliants, molluscicides, nematocides, algicides, and acari-

cides.²⁵ Agricultural workers can be exposed to pesticides in a variety of ways (Table 1).^{9,25,26}

Labor-intensive crops, such as fruits and vegetables, are treated extensively with pesticides. Most (more than 50%) farm workers are hired for harvesting operations, during which they might be exposed to different chemical compounds when handling and touching the foliage.²⁶ Pesticides are absorbed into the human body through the skin, by inhalation, and by ingestion. Exposure can result in acute systemic poisoning—abdominal pain, ataxia, nausea, dizziness, vomiting, headache, and malaise—or skin or eye problems, such as rashes, inflammation, or corneal ulceration. Chronic health problems may include chronic dermatitis, fatigue, headaches, sleep disturbances, anxiety, memory problems, and different kinds of cancers, birth defects, sterility, blood disorders, and abnormalities in liver and kidney function.^{9,17,26,27}

The number of workers in the United States affected by pesticides is unknown; California and Washington are the only states with mandatory reporting of pesticide-related illnesses. In the 1987 summary document of pesticide-related illnesses in California, 372 of 1,507 (25%) reported occupational cases of pesticide illness were in agricultural field workers.²⁸ Even in California, underreporting is likely to occur because many of the migrant and seasonal farm workers never see a physician or are never properly diagnosed.

Little is known about the extent or magnitude of chronic health problems related to occupational exposure to pesticides. Few population-based studies of such effects exist. Although several studies have addressed the association of cancer and pesticide exposure among farmers and permanent farm help,²⁹⁻³⁴ few population-based studies have been published about the effect of pesticides in migrant and seasonal farm workers. In California, a case study of a childhood cancer cluster,³⁵ a hospital record-based study of birth defects,^{36,37} and a health survey²¹ examined some of the effects. These investigations suggest that increased chronic health problems occur. All of these studies have been limited in size and scope, however, and have not reached clear conclusions about the magnitude of pesticide-related health effects among migrant and seasonal farm workers.

Although difficult, it is important to carry out further studies on the adverse health effects associated with pesticides among farm workers. Although cohort studies of cancer or other chronic diseases would be exceedingly difficult and costly, studies of hazardous exposures, such as case-control studies of acute exposures to pesticides, are possible and appropriate. An important problem to consider is assessing exposure. Estimates of human exposure must be considered in conjunction with results of the dose-response determination to obtain quantitative estimates of risk. Appropriately designed studies could measure pesticide residues among farm workers and compare their exposure to that in other populations. Developmental toxicity and cancer from pesticides are other important areas for assessment. Pesticides have been associated with adverse acute and chronic health effects in farmers, but much additional work is necessary to characterize the nature and magnitude of this problem in migrant and seasonal farm workers.

Musculoskeletal and Soft-Tissue Problems

Heavy physical labor contributes to a variety of musculoskeletal problems, including traumatic injuries, soft-tissue

TABLE 1.—Opportunities for Exposure to Pesticides

Usually an avoidable exposure	Diluting and mixing; loading into applicators; applying to crop; flagging during cropdusting
Often an unavoidable exposure	Drift; contact with residues during harvesting, weeding, pruning
Frequently an unknown exposure	Eating or smoking in field; drinking, bathing, cooking with contaminated water

disorders, and degenerative joint disease of the hands, knees, and hips.⁹ Few formal studies of the risk of musculoskeletal and soft-tissue conditions have dealt with agricultural populations; none have examined this in migrant and seasonal farm workers. Published articles, however, show that farm workers are exposed to many of the risk factors associated with musculoskeletal injury. For example, occupational factors that contribute to back strain include previous back injury, heavy lifting and carrying, difficult work positions, an excessively fast work pace, whole-body vibration, and work in cold or hot climates.³⁸

Farm workers carry heavy bushels and buckets of produce, often lifting them above their heads to empty into trucks. Orchard workers wear canvas bags held with straps over their shoulders that they fill with as much as 30 to 35 kg of fruit as they climb up and down ladders. Mushroom workers stand on catwalks 1.5 m high that are stretched across beds so that the workers can pick mushrooms and load and unload the beds with dirt. Farm workers also spend long hours bent over low-lying crops such as cucumbers, beans, strawberries, and squash.⁹

Only a few studies of ergonomic stress and health problems in farm labor populations exist. One study in Japan examined posture patterns and musculoskeletal problems in strawberry and eggplant growers.³⁹ Another Japanese study compared the overhead working posture of pear and apple workers.⁴⁰ An increased number of physical symptoms such as fatigue and pain in the lower back and shoulders and tiredness, stiffness, and pain in the neck, shoulders, and arms was reported, respectively, for the two different studies. (Statistical analyses were not presented in either article.) Swedish investigators compared the frequency of hip joint operations in the Swedish population and found that more agricultural workers (36%) underwent this operation than the general population (23%).⁴¹

Although no formal studies of musculoskeletal problems have been carried out among migrant and seasonal farm workers, in two different health surveys of farm workers, musculoskeletal complaints ranked second and third, 21% and 27%, respectively, of all physical problems experienced.^{31,42} Future epidemiologic studies on musculoskeletal problems in farm workers should focus on changes of working conditions and equipment design needed to reduce work-related musculoskeletal symptoms and disabilities among these workers.

Dermatitis

Agriculture has consistently been identified as the major industrial division with the highest risk of occupational skin disease.^{43,44} In 1984 skin disorders made up more than two thirds of occupational illnesses reported to the Bureau of Labor Statistics among crop production workers.⁴⁵ Reported rates for occupational skin disease (in California) might underestimate the actual rate by 10-fold to 50-fold.⁴⁴ Table 2 shows the agents that may affect the occurrence of dermatitis in farm workers.^{47,48}

The prevalence of dermatitis in general populations has been estimated in several large studies, including some in Western Europe,⁴⁹ the United States,⁵⁰ and the Netherlands.⁵¹ Dermatitis has also been studied in Hispanics in the United States,⁵² but few data exist concerning the prevalence of dermatitis in any agricultural populations, including predominantly Hispanic California farm workers. Several outbreak investigations—related primarily to pesticides—in California and Tennessee have been reported.⁵²⁻⁵⁵ California grape, tomato, and citrus workers were investigated for risk factors contributing to dermatitis.^{48,56,57} These surveys found that grape workers were more likely than citrus or tomato workers to report rashes and to have contact dermatitis and lichenified hand dermatitis, possibly because of crop-specific work patterns and exposures.

The future study of specific risk factors for occupational skin disease in agricultural workers could be addressed by case-control studies. The transient nature of some skin varia-

TABLE 2.—Agents Causing or Exacerbating Dermatitis

Environmental	UV radiation Soil Climate—heat, cold, wind, moisture Zoonoses Other physical agents, such as materials for protective devices
Chemical	Pesticides, including residues on foliage Fertilizers Other chemicals, such as machinery lubricants
Crop-related	Specific crop type Specific job activities, such as hoeing Plant materials
Personal	Hygiene Personal allergy history Use of protective devices

tions, however, raises issues of selection and recall bias in this type of study. To determine actual incidence, active surveillance and prospective cohort studies are necessary. The development of standardized data collection instruments is also necessary to improve the ability to compare results between populations.

Noninfectious Respiratory Illness

Respiratory illness from agricultural exposures has been well documented.⁵⁸⁻⁶⁰ Studies have shown increased mortality from nonmalignant lung disease⁶¹⁻⁶³ and an increased number of respiratory symptoms in agricultural workers compared with nonagricultural controls.⁶⁴⁻⁶⁹ In one study, the relative risk for pulmonary problems among farmers was found to be 1.92 compared with nonfarming controls.⁶⁶ The distinction between nonoccupational and occupational respi-

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ratory exposure, however, is most difficult to draw on farms. For example, fungi that colonize growing crops predominate in the air, both by day and by night, are dispersed during haymaking, harvesting, and other agricultural operations, and affect farm workers and other rural dwellers alike.⁵⁸

Respiratory health problems have a complex profile: One or more specific respiratory tract problems can develop at the same time. Obstructive airway disease (such as bronchitis) caused by biologic and physical agents and occupational asthma, caused generally by organic antigens contained in dusts from plant and animal sources, are major occupational health problems for farmers and farm workers. Restrictive lung disease is a less recognized result. Although continually inhaling organic dust represents a known risk for restrictive lung disease, recent studies suggest that inorganic dusts in the agricultural workplace may be hazardous as well.⁷⁰⁻⁷³ "Farmer's lung" (hypersensitivity pneumonitis), probably the best known respiratory disease of farmers, is generally associated with exposure to fungal spores in moldy hay. "Organic dust toxic syndrome" resembles farmer's lung disease but is distinguished primarily by the lack of reactivity to farmer's lung antigens and by bronchoalveolar lavage findings. Often the only significant objective findings are fever and an elevated leukocyte count.⁵⁹

Agricultural workers also may have exposure to a multitude of potential respiratory toxins, including hydrogen sulfide, fumigants such as phosphide and phosgene, ammonia, oxides of nitrogen from decomposing silage, herbicides, and pesticides.⁶⁰

Pulmonary function has been analyzed with prediction equations developed for several populations in the United States, and ethnicity may be an important predictor of lung function.⁷⁴⁻⁷⁸ Despite the fact that Hispanics are one of the largest and most rapidly growing ethnic groups in the US, few studies have been done of their pulmonary function. Specifically, only one comprehensive study of respiratory health in migrant and seasonal farm workers in California has been undertaken so far.^{79,80} This survey found that Hispanic farm workers in California had similar prevalences of smoking to other Hispanic populations. Grape workers in this study had reduced forced vital capacities, consistent with crop-specific agricultural exposures such as inorganic dusts, organic agents, and pesticides. Furthermore, the effect of agricultural work on respiratory disorders in this population was equal in magnitude to that of cigarette smoking.

Further epidemiologic investigations on farm workers should specifically attempt to identify activities or processes associated with increased respiratory tract symptoms. Physicians caring for agricultural workers should be alert for respiratory tract symptoms and attempt to familiarize themselves with the work in which their patients are involved. Work-site evaluations by industrial hygienists, although time consuming, may help clinicians assess exposures and provide insight for recommendations regarding treatment or preventive interventions. Longitudinal assessment of lung function in populations of exposed workers will be important to determine the persistence of changes in lung function, if any, and their clinical significance.

Reproductive Health Problems

Reproductive health problems have not been well studied in either men or women working in agriculture. Case reports of sterility or low sperm counts in men who worked in manu-

facturing the agricultural fumigant dibromochloropropane (DBCP) have been reported from California and from six southern states.^{81,82} In general, there are little or no data on reproductive problems in male farm workers.

Female farm workers also are exposed to reproductive hazards, such as prolonged standing and bending when working at conveyor belts, hoeing, thinning, or harvesting, as well as to overexertion and fatigue, pesticides and other agricultural chemicals, and insufficient sanitary facilities in the fields. These exposures might have adverse effects on reproductive health, possibly resulting in menstrual cycle disorders, infertility, spontaneous abortion, premature birth, pregnancy complications, fetal malformation or growth retardation, cancer among offspring, or abnormal postnatal development of infants from exposure to chemicals transmitted in breast milk.⁹

Some studies have analyzed the association of occupational exposures and reproductive outcomes of women employed in different occupations, including agriculture,⁸³⁻⁸⁵ although none of these large studies have been designed specifically to include migrant farm workers. In a Quebec study of spontaneous abortions, statistically significant excesses of stillbirth were noted in agricultural and horticultural workers compared with other women employed in different occupations (odds ratio 5.65, $P < .01$).⁸⁴ Prematurity and occupational activity of women were investigated in two separate studies.^{86,87} The rate of premature births was higher among women with jobs requiring prolonged standing (7.7%) than those with sedentary (4.2%) or active jobs (2.8%).⁸⁶ Few population-based surveys have studied infant mortality rates in this population.⁸⁸⁻⁹⁰ In a recent study conducted in migrant clinics in California, maternal occupation in agriculture was not significantly associated with the birth weight of infants born to Hispanic mothers.⁹¹ In other California studies,^{36,37} the relative risk (RR) of giving birth to a child with limb reduction defects was significantly elevated among women who resided in a county of high agricultural productivity compared with the general population in California (RR = 1.7, 95% confidence interval 1.1 to 2.7).³⁷

Many questions remain unanswered regarding possible reproductive health problems among farm workers. Future investigations might be directed at risks for fetal loss, pregnancy complications, reduced fertility, and menstrual cycle dysfunction in this population and the degree to which these risks are modified by such factors as nutritional status and access to medical care.

Health Problems of Children of Farm Workers

Children of farm workers are exposed to hazards in various ways: by doing field work (children are legally allowed to work on farms with parental consent at the age of 12, and exemptions may be granted by the US Department of Labor for 10- and 11-year-olds to harvest potatoes and strawberries), by accompanying their parents to the fields and playing in or near the fields, by living adjacent to the fields where they work, and by having contact with family members wearing contaminated clothing.⁹ Indirectly, the socioeconomic and migratory or seasonal status of the parents intensifies the health problems of these children.

The lack of sanitary facilities and the unsanitary, substandard housing contribute to the spread of communicable diseases. A lack of basic health care frequently results in these children not receiving the usual childhood vaccina-

tions. Furthermore, because family income levels are often below the poverty line, many farm-worker children suffer from malnutrition.⁸⁸ In 1989 a general health screening project was carried out on 1,717 children aged 1 through 12 years in McFarland, California, following the observation of a cancer cluster among children there.⁹² Of the children screened, most (71%) were referred for at least one health problem, most commonly for vision problems (40% of referrals), followed closely by dental problems (37%) and anemia (24%).

Few studies have assessed the causes and rates of injury and fatal accidents in farm children.^{20,93-95} In two studies an association was noted of childhood brain tumors and leukemia with pesticide exposure, although not necessarily among children of farm workers.^{95,96}

Information on the children of farm workers and their health is limited. To make any concrete assessments and recommendations, it is essential to continue studying the health problems of these children, including the health effects of short- and long-term exposure to pesticides.

Other Important Occupational Health Problems

Migrant and seasonal farm workers have exposure to other hazards that may increase their risk of health problems: climate-dependent problems, such as heat stroke or cold shock,⁹⁷ and occupationally caused infections such as anthrax, ascariasis, encephalitis, leptospirosis, rabies, salmonellosis, tetanus, and coccidioidomycosis.⁹⁸ Sensory problems are common: eye problems, caused by irritation, infection, or injury from the wind, sun, dust or soil, agricultural chemicals, debris ejected from farm machinery, and allergic reactions to plants,⁹⁹ and hearing problems due to noise from farm machinery and cannery work.¹⁰⁰ A lack of proper sanitary facilities in the field and crowded and unsanitary living conditions are responsible for spreading many infectious diseases such as tuberculosis and other communicable diseases.¹⁰¹ Urinary tract infections and kidney disorders also occur frequently, especially in women.⁹

Despite these risks, few population-based studies have been done to assess the frequency of occupational health problems in these workers.

Conclusion

Although a number of occupational health risks have been identified through studies of agricultural workers, many gaps remain in our knowledge of the level of exposures and magnitude of specific health risks. An investigation of occupational health risks in agricultural workers must also include a consideration of general health status and access to medical care of migrant and seasonal workers. Some of the usual approaches in occupational health investigations may not be possible in this population owing to the demographic, economic, cultural, and life-style realities of the study population. The migratory nature of this population precludes serious consideration of long-term cohort studies without enormous resources, but case-control and cross-sectional studies should be considered for some health effects.

The development of standardized data collection instruments for assessing health consequences and exposures will improve the ability to compare results between populations. The application of these instruments to agricultural workers must also distinguish between the usual "farmer" category and the large population of migrant and seasonal farm workers for the results to be informative.²³

Farm workers, their employers, and their community leaders must be approached directly to address health issues in this population. In addition, rigorous survey sampling methods involving a complete enumeration of all types of households and living quarters of migrant and seasonal farm workers in different agricultural areas during the peak agricultural work seasons must be implemented in future studies of participants who accurately represent the larger population of farm workers. Furthermore, the different languages and cultural and demographic factors inherent in these workers must also be carefully addressed in any scientific investigation.

These approaches are necessary to obtain the cooperation of farm workers and their employers so that occupational exposures and protection as well as health consequences are accurately and completely ascertained. In addition, information about health effects should be obtained in a way that is not only culturally sensitive but also meaningful to study participants and yet comparable to that obtained through standardized instruments. Undertaking studies of occupational health risks in this population with these considerations will not only contribute to the understanding of such risks but can also further preventive efforts and lead to better health in this high-risk population. Effective prevention can reduce suffering and death and contribute to enhanced productivity in the workplace. In this way, both the employers and the employees gain.

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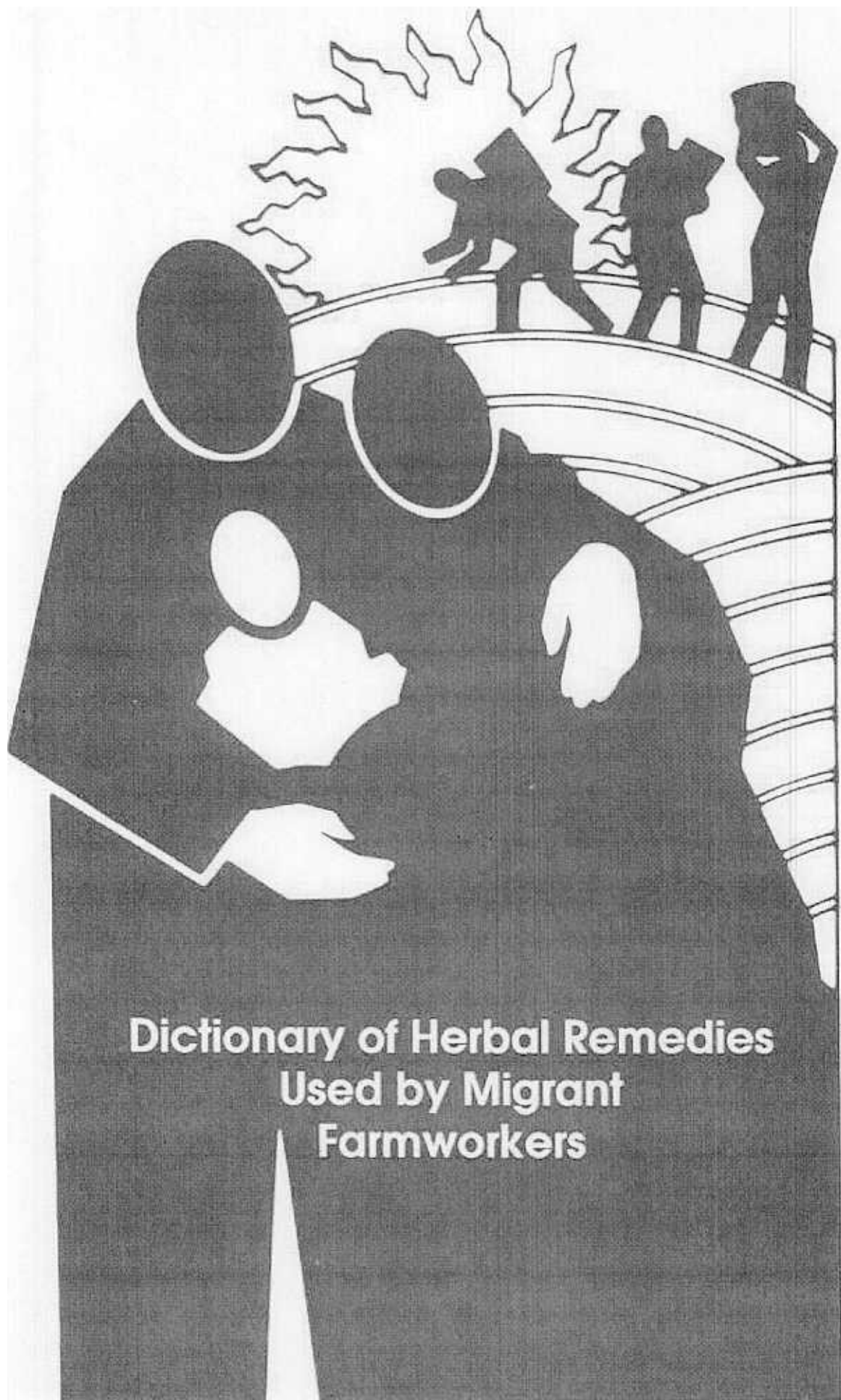
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By

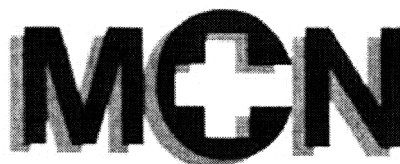
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Introduction

Herbal remedies have been used to treat every illness known to man for longer than there have been written records. Herbal treatments are still the traditional medicine in a major portion of the world. The recent trend toward more natural products has spurred growth in this area, and this trend is expected to increase in the future.

Some concern exists about the safety of these products. Most herbal remedies have not been studied very extensively due to the cost of research. Herbs are natural products which cannot be patented, so it is difficult to capture significant return on capital invested in research. Therefore, companies find little financial incentive to study herbs. Consequently, not enough is known about many herbs to be able to determine safe or toxic doses.

There are many variables that affect the quality of an herbal remedy. Many distributors do not have strict quality control, so potency can vary greatly. Other factors that affect the quality of these herbs are purity, climate where they are grown, time period when they are harvested, storage conditions, and method of preparation. Contaminants in these products include molds that can cause allergic reactions, insects, and poisons such as arsenic and lead from the soil. Other areas of concern are nomenclature and appearance. One plant may be known by several names, or various plants may have similar-sounding names. Serious consequences could result due to confusion caused by similar appearances between a safe plant and a more dangerous one.

Studies indicate that migrant and seasonal farmworkers often use herbal, home, or folk remedies instead of or simultaneously with conventional medical treatment. Many modern medications, such as digoxin, warfarin, and vinca alkaloids, are derived from plant sources. These examples of herbs highlight the fact that many herbs are not innocuous, and they should not be ignored. While some herbs have positive therapeutic effects, there are some which cause adverse reactions, and could even have drug interactions with conventional medications. Some herbs may potentiate the effect of prescribed medications, while others may nullify these effects. In some cases the herbs are safe but ineffectual, causing a deterioration of the patient's condition due to ineffective treatment. Patients do not always tell their doctor or pharmacist that they are using herbal remedies. They may not think of them as medications, or they may feel embarrassed to admit using them. Not telling their health care provider of their use of herbal remedies could have negative results, since it is possible to dangerously ignore or delay effective treatment.

It is important to know when an herbal remedy should be discontinued, as well as those that need not be. Health care providers can gain substantial rapport with their patients by being open to the use of herbal remedies when appropriate.

Many clinicians have expressed a need for an herbal formulary as a guide to prevent interactions between herbal and prescribed medications. The Migrant Clinicians Network conducted a survey of migrant health centers to gather information about herbal remedies which had been used by patients of these health centers. The resulting dictionary of herbs contains both English and Spanish names for each herb, in addition to other pertinent information.

This booklet is designed as a reference tool only. It is not intended as an instruction manual, and does not claim to be complete since so little scientific information is available on this subject. No responsibility can be assumed by the author or the publisher for the application of any of the information contained herein.

Alfalfa

Spanish Name: Alfalfa

Scientific Name: *Medicago sativa*

Form

Tea

Constituents

Saponins (2-3%), sterols, high molecular weight alcohols and paraffins

Therapeutic Effects

None proven

Safety/Toxicity

Safe in moderation; no evidence of any toxicity

Adverse Effects

Persons predisposed to systemic lupus erythematosus (SLE) should avoid this product since it may induce this condition. Large amounts could induce SLE in normal persons.

Potential Drug Interactions

None known

Comments

Reputed to relieve arthritic conditions and to stimulate appetite, thereby inducing an increase in weight. The vitamin P or rutin contained in alfalfa builds capillary strength and reduces inflammation of the stomach lining; vitamin A helps maintain stomach health; enzymes present aid in food assimilation.

Perceived Use by Patient

Used as a nutrient to increase vitality, appetite, and weight in humans; also as a diuretic and for ulcers.

Where Obtained

Health food stores

Aloe, Aloe Vera Gel (Lotion)

Spanish Name: Sabila

Scientific Name: *Aloe barbadensis*

Form

Topical lotion

Constituents

Various carbohydrate polymers (glucomannans or pectic acid)

Therapeutic Effects

Moisturizer, emollient, promotion of w healing, promotion of cell growth

Safety/Toxicity

Safe for topical use

Adverse Effects

None known

Potential Drug Interactions

None known

Comments

Gel from freshly cut leaves is efficacious, while commercial aloe gel products are not. The peeled fresh gel is applied to inflamed eyes and on all kinds of skin inflammations, sores, and burns. It has been recommended in the treatment of third degree x-ray and atomic radiation burns.

Perceived Use by Patient

Swelling of extremities, burns, marks, scars, asthma, cancer

Where Obtained

Home gardens

Aloe, Aloe Vera Latex (Juice)

Spanish Name: Sabila

Scientific Name: *Aloe barbadensis*

Form

Tea

Constituents

Anthraquinone glycosides, barbaloin

Therapeutic Effects

Cathartic properties acting on the colon

Safety/Toxicity

Aloe is safe as a tea for moderate ingestion, but is contraindicated in pregnancy and in individuals afflicted with hemorrhoids; also is apt to cause kidney irritation.

Adverse Effects

Overdosage causes abdominal pain, bloody diarrhea, hemorrhagic gastritis, and sometimes nephritis.

Potential Drug Interactions

None known

Comments

The laxative action of aloe occurs 8 to 12 hours after ingestion

Perceived Use by Patient

Purgative, anthelmintic

Where Obtained

Home gardens

Anise

Spanish Name: Anis

Scientific Name: *Pimpinella anisum*

Form

Tea

Constituents

1-3% volatile oils (80-90% anethole), 3-4% fixed oils, calcium oxalate, coumarins

Therapeutic Effects

Carminative, diuretic, diaphoretic, expectorant, stimulant, pesticide (topically for body lice), moisturizer

Safety/Toxicity

Its major component, anethole, has been reported to be the cause of dermatitis (erythema, scaling, and vesiculation) in some people

Adverse Effects

1-5 ml of the oil may cause nausea, vomiting, seizures, pulmonary edema, and skin irritation

Potential Drug Interactions

Tetracyclines, verapamil, thiazide-type diuretics, phenytoin, iron salts, quinidine, salicylates, sodium polystyrene sulfonate

Comments

Commonly used as a flavoring agent. Helpful in the relief of cough and congestion symptoms. Its healing properties emanate from its seeds.

Perceived Use by Patient

Stomach cramps, colic, to sweeten the breath, to increase mother's milk

Where Obtained

Mexican grocery or pharmacy, grocery store, herb store

Basil

Spanish Name: Albahaca

Scientific Name: *Ocimum basilicum*

Form

Infusion

Constituents

Essential oil (mainly estragol), eugenol, linalol, linalol, thymol, tannins

Therapeutic Effects

Antispasmodic, carminative, antiseptic, mild nervine, emmenagogue

Safety/Toxicity

Inbibed as an infusion by nursing mothers, basil is considered a safe, gentle tonic that helps expel gas in the infant and increases lactation in the mother.

Adverse Effects

None known

Potential Drug Interactions

Chloral hydrate, quinine sulfate, alkaloids, salts of heavy metals, albumin, oxidizing substances (permanganates, chlorates)

Comments

Commonly used as a flavoring agent. It is especially recommended for use before and after parturition to promote blood circulation.

Perceived Use by Patient

Gastric distress, headaches, colds, suppressed menstruation

Where Obtained

Grocery store, herb store, home garden

Black Cohosh

Spanish Name: Unknown

Scientific Name: *Cimicifuga racemosa*, *Actaea racemosa*, *Macrotys actaeoides*

Form

Tea

Constituents

Triterpene glycosides, isoferulic acid, tannins and volatile oils

Therapeutic Effects

None known

Safety/Toxicity

Adverse affects are very toxic.

Adverse Effects

Bradycardia, tremors, vertigo

Potential Drug Interactions

Digoxin

Comments

There is no rationale for the use of this remedy due to its lack of efficacy and its toxicity

Perceived Use by Patient

Used for second trimester abortion, rheumatism, bronchitis, uterine disorders, high blood pressure, and as a sedative.

Where Obtained

Health food store, curandero

Borage

Spanish Name: Borraja

Scientific Name: *Borago officinalis*

Form

Tea

Constituents

Tannins (very low concentrations)

Therapeutic Effects

Slight expectorant, slightly constipating, astringent

Safety/Toxicity

Safe in general; however, borage contains small amounts of two toxins (lycopsamine unsaturated pyrrolizidine alkaloids and supindine viridiflorate). Excessive or long-term consumption should be avoided

Adverse Effects

None known

Potential Drug Interactions

Alkaloids, salts of heavy metals, albumin, oxidizing substances (permanganates, chlorates)

Comments

Relatively ineffective. Has calming and cooling effects and can help break fevers. In Europe, borage tea has been used traditionally as a strengthening tonic for convulsing patients. It is suggested as a good herb for high blood pressure or for persons who are apprehensive or worry a lot.

Perceived Use by Patient

Upset stomach, fever

Where Obtained

Herb store

Chamomile

Spanish Name: Manzanilla

Scientific Name: *Anthemis nobilis*

Form

Tea, extracts, volatile oil preparations

Constituents

Volatile oils (chamazulene and (-)- α -bisabolol), bisabololoxides A and B, spiroethers, various flavones (especially apigenin, luteolin, patuletin, and quercetin coumarin derivatives)

Therapeutic Effects

Anti-inflammatory, spasmolytic, carminative, protection against peptic ulcers, antibacterial, antifungal, nervine

Safety/Toxicity

As a nervine, chamomile is safe and effective. It is gentle to the stomach, so it can also be used to treat indigestion.

Adverse Effects

May cause anaphylaxis, other severe hypersensitivity reactions, and contact dermatitis in persons allergic to ragweeds, asters, chrysanthemums, or related plants.

Potential Drug Interactions

Aspirin, warfarin (coumadin)—same as those for warfarin

Comments

A cup of chamomile tea is a classic remedy for nervous or hysterical conditions. Persons allergic to any plant in the compositae family should avoid this herb. Roman chamomile is emetic in large doses. Roman chamomile has been reported to exhibit anti-tumor activities *in vitro* against human tumor cells.

Perceived Use by Patient

Diarrhea, menstrual cramps, colic, upset stomach, insomnia, infantile convulsions, toothache, bleeding, and swollen gums.

Where Obtained

Mexican pharmacy, herb store, home garden

Camphor

Spanish Name: Alcanfor

Scientific Name: *Cinnamomun camphora*

Form

Topical lotion, tea

Constituents

Camphor oil contains camphor (2-bornanone), safrole, borneol, heliotropin, vanillin, terpineol, sesquiterpene alcohols

Therapeutic Effects

Antipruritic (external only), rubefacient (external only), counter-irritant (external only), antiseptic and carminative (internal)

Safety/Toxicity

Toxic doses of camphor taken internally result in convulsions accompanied by vertigo and mental confusion, and may lead to delirium and even coma and death. 700 mg can cause narcosis.

Adverse Effects

Camphor phenol lotions have caused skin ulceration.

Potential Drug Interactions

Phenol

Comments

Camphor oil is frequently used for ear-aches.

Perceived Use by Patient

Colds, inflammation, gout, rheumatic joints. Taken internally to calm hysteria; abate convulsions and epileptic attacks; also as a carminative and respiratory and cardiac stimulant.

Where Obtained

Mexican pharmacy, herb store

Chaparral

Spanish Name: Unknown

Scientific Name: *Larrea tridentata*

Form

Tea

Constituents

Nordihydroguaijaretic acid (NDGA)

Therapeutic Effects

None known

Safety/Toxicity

This product has caused lesions in the mesenteric lymph nodes in rat studies.

Adverse Effects

None known

Potential Drug Interactions

None known

Comments

None

Perceived Use by Patient

Unknown

Where Obtained

Unknown

Cinnamon

Spanish Name: Canela

Scientific Name: *Cinnamomum verum*

Form

Tea

Constituents

60-75% cinnamic aldehyde, 4-10% phenols, hydrocarbons, ketones, alcohols, esters

Therapeutic Effects

Carminative, astringent, local stimulant

Safety/Toxicity

Doses of the oil greater than 0.5 mg/kg may cause renal damage or coma. There have been a number of reports of sensitivity to cinnamon. Acceptable daily intake is 700 mg/kg body weight.

Adverse Effects

Ingestion of the oil may cause nausea and vomiting. Contact with skin or eyes may cause redness or burning.

Potential Drug Interactions

Diuretics, digoxin, alkaloids, salts of heavy metals, albumin, oxidizing substances (permanganates, chlorates)

Comments

Commonly used as a flavoring agent. Cinnamon oil has exhibited antifungal, antiviral, bactericidal, and larvicidal activities.

Perceived Use by Patient

Cramps, colic, chronic diarrhea, colds, kidney troubles, hypertension, to stimulate appetite.

Where Obtained

Grocery store, herb store

Coffee

Spanish Name: Café

Scientific Name: *Coffea arabica*

Form

Ground, roasted beans

Constituents

1-2% caffeine, 10-13% fatty oil, 25% trigonelline, 3-5% tannin, 15% glucose and dextrin, 10-13% proteins

Therapeutic Effects

Caffeine is a powerful stimulant of the central nervous system, respiration, and skeletal muscles; other activities include cardiac stimulation, coronary dilation, smooth muscle relaxation, and diuresis.

Safety/Toxicity

Caffeine is teratogenic and should be avoided or limited during pregnancy. It may be linked to esophageal cancer. It has been definitely determined that coffee is capable of producing allergic response. Various symptoms have been reported, including severe migraine, gastroenteritis, headache, and widespread hives.

Adverse Effects

Nervousness, arrhythmias, increased blood glucose, increased cholesterol levels, excess stomach acid, heartburn, insomnia.

Potential Drug Interactions

Theophylline, iron

Comments

Caffeine should be used in moderation. Non-pregnant adults should limit their consumption to 250 mg per day. Range of caffeine contact: 40-80 mg per 5-8 oz. brewed; 30-120 mg per 5-8 oz. instant. Coffee is reported to stimulate gastric reaction and should be taken only with proper precautions by individuals with peptic ulcer.

Perceived Use by Patient

Laxative

Where Obtained

Grocery store

Coriander

Spanish Name: Cilantro

Scientific Name: *Coriandrum sativum*

Form

Tea, infusion

Constituents

1% volatile oils (including borneol, coriandrol, α -pinene, β -pinene, terpinen, geraniol, and decylaldehyde)

Therapeutic Effects

Stimulant, carminative

Safety/Toxicity

Coriander oil is reported to have weak cytotoxic activity.

Adverse Effects

Excess amounts can cause narcotic-like effects, nausea, vomiting, mental confusion, dizziness, convulsions.

Potential Drug Interactions

None known

Comments

Occasionally used in medications as a flavoring agent. Coriander has been reported to have strong lipolytic activity. Coriander possesses hypoglycemic qualities in experimental animals.

Perceived Use by Patient

Stomach cramps, stomach tonic, laxative and purgative, to expel gas from the bowels.

Where Obtained

Mexican pharmacy, herb store, home garden

Corn Silk

Spanish Name: Cabellos de elote, pelos de elote

Scientific Name: *Zea mays*

Form

Tea

Constituents

Starch, gluten

Therapeutic Effects

Diuretic, hypoglycemic, anti-hypertensive, demulcent

Safety/Toxicity

Generally recognized as safe.

Adverse Effects

None known

Potential Drug Interactions

None known

Comments

Corn oil is used as a solvent for injections, as well as for irradiated ergosterol.

Perceived Use by Patient

Kidneys, urinary infection, enuresis, and calculus

Where Obtained

Grocery store

Perceived Use by Patient

Coughs, headaches, earaches, and sinusitis. Also used as a mouthwash and gargle for inflammations of the mouth and throat

Where Obtained

Unknown

Flax Seed

Spanish Name: Lino

Scientific Name: *Linum usitatissimum*

Form

Tea

Constituents

30-40% fixed oils, mucilage, wax, tannins, gum, nitrates, linamarin (a cyanogenic glycoside)

Therapeutic Effects

Expectorant, emollient, demulcent, laxative

Safety/Toxicity

Flax leaves and seed chaff contain the cyanogenic glycoside linamarine from which the enzyme linamarase is capable of releasing cyanide

Adverse Effects

Symptoms of overdose include increased respiratory rate, excitement, gasping, staggering, weakness, paralysis, and convulsions

Potential Drug Interactions

Alkaloids, salts of heavy metals, albumin, oxidizing substances (permanganates, chlorates)

Perceived Use by Patient

Stomach irritation

Where Obtained

Unknown

Garlic

Spanish Name: Ajo

Scientific Name: *Allium sativum*

Form

Garlic water

Constituents

Allium (s-allyl-L-cysteine sulfoxide) converted to allicin (diallyldisulfide-s-oxide); converted to ajoene

Therapeutic Effects

Potent antibacterial, antithrombotic, antifungal, decreases plasma fibrinogen, decreases serum triglycerides, decreases beta lipoproteins, decreases phospholipids, decreases blood pressure, decreases serum glucose, expectorant, diaphoretic, diuretic

Safety/Toxicity

Unknown

Adverse Effects

Allergic contact dermatitis due to garlic has been reported

Potential Drug Interactions

None known

Comments

Garlic has considerable potential; however, more studies are needed before the therapeutic value can be determined with certainty

Perceived Use by Patient

Blood pressure, worms, weight loss, tuberculosis, emphysema, asthma

Where Obtained

Grocery store, home garden

Horsetail (Shave Grass)

Spanish Name: Cola de Caballo

Scientific Name: *Equisetum arvense*

Form

Tea, infusion

Constituents

Flavone glycosides, saponins

Therapeutic Effects

Weak diuretic, astringent

Safety/Toxicity

Unknown

Adverse Effects

None known

Potential Drug Interactions

None known

Comments

Horsetail has been a traditional herbal treatment for mending broken bones. It is also used as an infusion to help build kidney strength. In Europe, horsetail tea was also used to stop bleeding both internally and externally.

Perceived Use by Patient

Diarrhea in children, polyps, abdominal and oral cancer

Where Obtained

Unknown

Lemon

Spanish Name: Limón

Scientific Name: Citrus limonum

Form

Tea

Constituents

Peel: oil, bitter principle, glucoside hesperidin

Juice: 6.7-8.6% citric acid, sugar, gum

Oil: 7-8% citral, pinene, citronellal

Therapeutic Effects

Oil internally: carminative, stimulant

Oil topically: rubefacient

Juice: antiscorvy, astringent

Safety/Toxicity

Lemon oil has been reported to promote tumor formation on the skin of mice by the primary carcinogen 9,10-dimethyl-1,2-benzanthracene. Acceptable daily intake up to 500 mg/kg of body weight.

Adverse Effects

Volatile oils may cause photosensitization

Potential Drug Interactions

None known

Comments

None

Perceived Use by Patient

Inflammation or infection of the mouth, throat, etc; refreshment; to suppress menstruation

Where Obtained

Mexican pharmacy, grocery store

Linden Tree (Lime Tree)

Spanish Name: Tilo

Scientific Name: Tilia cordata (Tilia platyphyllos)

Form

Tea, infusion

Constituents

Flavonoid compounds (especially derivatives of quercetin and kaemferol), p-coumaric acid

Therapeutic Effects

Weak diaphoretic, diuretic

Safety/Toxicity

Using old flowers may induce narcotic intoxication.

Adverse Effects

Using this tea too often could lead to heart damage.

Potential Drug Interactions

None known

Comments

This product should not be used by anyone with any cardiac condition. Recommended for nervousness, insomnia, cramps, and indigestion which arises from an inability to relax while eating. Used as an infusion at the onset of cold symptoms

Perceived Use by Patient

To promote sleep, treat nervousness, for burns and colds

Where Obtained

Mexican pharmacy

Marijuana

Spanish Name: Marijuana

Scientific Name: Cannabis sativa

Form

Inhalant

Constituents

Cannabinone (a resin), tetrahydrocannabinol

Therapeutic Effects

Cerebral sedative, analgesic, antispasmodic, antiemetic in patients receiving cancer chemotherapy

Safety/Toxicity

Unknown

Adverse Effects

Possible change in blood pressure, impotence, increased heart rate

Potential Drug Interactions

Theophylline, tricyclic antidepressants, anticholinergics, ethanol, antipyrene, pentobarbital, disulfiram

Comments

Possession is illegal. Marijuana affects the hepatic metabolism of some drugs. THC enhances the CNS depressant action of ethanol and reduces the metabolism of antipyrine, pentobarbital, and ethanol.

Perceived Use by Patient

Antiemetic, asthma, insomnia, alcoholism

Where Obtained

Individual dealer, home garden

Mormon Tea

Spanish Name: Canntillo

Scientific Name: *Ephedra nevadensis*

Form

Tea, infusion

Constituents

Tannins, resins, volatile oils

Therapeutic Effects

Very mild diuretic, astringent

Safety/Toxicity

Unknown

Adverse Effects

Mild constipation, frequent use may result in nervousness and restlessness.

Potential Drug Interactions

Alkaloids, salts of heavy metals, albumin, oxidizing substances (permanganates, chlorates)

Comments

No significant therapeutic effect. It should only be used on the advice of a physician particularly if patient suffers from high blood pressure, heart disease, diabetes, or thyroid trouble.

Perceived Use by Patient

Colds, gonorrhea, headache, nephritis, syphilis

Where Obtained

Unknown

Olive Oil

Spanish Name: Olivo (aceite de olivo)

Scientific Name: *Olea europea*

Form

Oil

Constituents

Fatty acids: 2% myristic, 9.5% palmitic, 1.4% stearic, 0.2% arachidic, 81.6% oleic, 7.0% linoleic

Therapeutic Effects

Internally: laxative, demulcent, externally: lubricant. Vehicle for topical preparations; vehicle for injections

Safety/Toxicity

Unknown

Adverse Effects

None known

Potential Drug Interactions

None known

Comments

Used to soften the skin and crusts in eczema and psoriasis and as a lubricant for massage. Also used to soften car wax.

Perceived Use by Patient

Burns, constipation, fever

Where Obtained

Grocery store

Onion

Spanish Name: Cebolla

Scientific Name: *Allium cepa*

Form

As food; topically (mashed)

Constituents

Organic sulfur compounds, phenolic acids, flavonoids, sterols, saponins, sugars, vitamins

Therapeutic Effects

Antifungal, antithrombotic, decreases plasma fibrinogen, decreases serum triglycerides, decreases beta lipoproteins, decreases phospholipids

Safety/Toxicity

Unknown

Adverse Effects

Onions stimulate digestion and clean the intestines but they should not be eaten by those with sensitive stomachs.

Potential Drug Interactions

None known

Comments

Onion has considerable potential; however, more studies are needed before the therapeutic value can be determined with certainty.

Perceived Use by Patient

To make hair grow, asthma, burns, empty sella, to soothe coughs, to induce urination.

Where Obtained

Grocery store, home garden.

Orange (Sweet)

Spanish Name: Naranja

Scientific Name: *Citrus aurantium*

Form

Tea

Constituents

Oil of the peel, at least 90% d-limonene, 10% citral and citronella.

Therapeutic Effects

Antibacterial, antifungal, antiinflammatory, antihypercholesterolemic, carminative.

Safety/Toxicity

Bitter orange oil is reported to have distinct phototoxic activity.

Adverse Effects

Ingestion of large amounts of orange peel by children has been reported to cause intestinal colic, convulsions, and even death.

Potential Drug Interactions

None known.

Comments

The essential oil is commonly used as a flavoring agent.

Perceived Use by Patient

For sleep, nerves, shock, dyspepsia, diarrhea, blood in feces, and elevated blood pressure.

Where Obtained

Grocery store.

Peppermint

Spanish Name: Hierba buena

Scientific Name: *Mentha piperita*

Form

Tea, infusion.

Constituents

56% free menthol, α and β pinene, limonene, cineole, ethyl amylcarbinol, menthone, carvacrol, thymol.

Therapeutic Effects

Antiseptic, carminative, spasmolytic, GIT and menstrual cramping, decreases tone of esophageal sphincter to facilitate belching.

Safety/Toxicity

This product should be avoided in infants and small children because the menthol may cause a choking sensation.

Adverse Effects

Peppermint oil can be an irritant and may cause allergic reactions. Heartburn has been reported.

Potential Drug Interactions

None known.

Comments

A strong infusion of the herb will produce copious perspiration, so it has been used in breaking fevers.

Perceived Use by Patient

Stomach ache, dysmenorrhea, colic, baby diarrhea, colic in babies, cramps, backaches, heartburn, sore throat, wash wounds, colds, fever, hysteria.

Where Obtained

Mexican pharmacy, home garden, grows wild in some areas.

Potato

Spanish Name: Papa

Scientific Name: *Solanum tuberosum*

Form

Food, topically (mashed).

Constituents

78-80% water, 14-18% starch, 2% protein, 1% minerals, 0.1% fat, sugar, organic acids.

Therapeutic Effects

Cardiotonic activity, hypotensive, myotropic, spasmolytic, soothing effect on GI musculature, antimicrobial activity (against gram- and gram+ bacteria).

Safety/Toxicity

The green shoots, leaves, and fruits contain toxic steroidal glycoalkaloids (solanine, emissine, and others). These can lead to dulling of the senses and death.

Adverse Effects

If ingested, solanine can cause symptoms such as headaches, vomiting, diarrhea, fever, apathy, restlessness, confusion, and hallucinations.

Potential Drug Interactions

None known

Comments

None

Perceived Use by Patient

Burns, headache, coughs, spasm, tumors and warts

Where Obtained

Mexican pharmacy, grocery store

Rose

Spanish Name: Rosa de Castilla

Scientific Name: Rosaceae (family)

Form

Tea (from hips)

Constituents

Ascorbic acid, 11% pectin, 3% malic and citric acid

Therapeutic Effects

Laxative, diuretic, antiscorvy

Safety/Toxicity

Unknown

Adverse Effects

Large amounts may cause diarrhea.

Potential Drug Interactions

Warfarin, dicumarol, erythromycin (parenteral), ethinyl estradiol, iron, sulfonamides, basic drugs (amphetamines, tricyclic antidepressants)

Comments

Vitamin C (ascorbic acid) is equally efficacious regardless of whether it is from rose hips or from synthetic sources. Vitamin C from rose hips costs about 25 times as much as from synthetic sources.

Perceived Use by Patient

Gastritis, stomach ache

Where Obtained

Health food store, home garden

Rue

Spanish Name: Ruda

Scientific Name: Ruta graveolus

Form

Tea

Constituents

Mixture of quinoline alkaloids, coumarin derivatives, volatile oils (including methylmethylketone, ketones, esters, and phenols), bitter principle, glycoside rutin, tannins

Therapeutic Effects

Antispasmodic, antihistaminic, anti-inflammatory, emmenagogues

Safety/Toxicity

Avoid during pregnancy due to abortifacient properties; photosensitization (may cause skin to blister after exposure to sunlight). There is much doubt about the safety and medical value of rue.

Adverse Effects

Kidney irritation and degeneration of the liver have been reported. Large doses may cause violent gastric pain, vomiting, and prostration.

Potential Drug Interactions

Aspirin, warfarin (coumadin)—same as those for warfarin, alkaloids, salts of heavy metals, albumin, oxidizing substances (permanganates, chlorates)

Comments

Rue oil has been reported to have anthelmintic properties.

Perceived Use by Patient

Menstrual cramps, headache, earache, aborting during first and second months, nervousness, hysteria, convulsions, insanity

Where Obtained

Mexican pharmacy

Sage

Spanish Name: Salvia

Scientific Name: Salvia officinalis

Form

Tea, infusion

Constituents

α and β thujines (volatile oils), linoleic, bornoni, 2-methyl-3-methylene-5-heptene, sesquiterpenes

Therapeutic Effects

Antiseptic mouthwash used to treat toothaches, sore throats, inflammations of the mouth and throat. Stimulates blood flow through local irritant effect. Hypoglycaemic in diabetes, especially on an empty stomach. Anhidrotic (anti-perspirant), carminative.

Safety/Toxicity

Not recommended for use due to its high thujone content. Can cause convulsions and loss of consciousness.

Adverse Effects

Mothers breast-feeding their babies should not use sage, as it will dry up their milk.

Potential Drug Interactions

Alkaloids, salts of heavy metals, albumin, oxidizing substances (permanganates, chlorates)

Comments

Regarded as a tonic that keeps the stomach, intestines, kidneys, liver, spleen, and sexual organs healthy. Hot tea has been used to help lessen excessively heavy menstrual flow. The infusion is used to wash wounds.

Perceived Use by Patient

Gastric distress, kidneys, nerves, sore throat, worms, bleeding, fever, headache, colds.

Where Obtained

Herb store, home garden.

Sarsaparilla

Spanish Name: Cocolmeca

Scientific Name: Several of the species *Smilax*

Form

Tea

Constituents

Saponins derived from sarsapogenin and smilagenin, sitosterol, stigmasterol, pollinastanol.

Therapeutic Effects

Astringent, strong diuretic, diaphoretic, expectorant, laxative, tonic.

Safety/Toxicity

Unknown

Adverse Effects

None known

Potential Drug Interactions

Sarsaparilla facilitates the absorption by the body of other drugs.

Comments

Commonly used as a flavoring agent. It does not cure syphilis as was once thought. Used to increase flow of urine, as an eyewash, and to promote perspiration.

Perceived Use by Patient

Burns, cramps, dyspepsia, rheumatism, athlete's foot, gonorrhea, indigestion, syphilis, fever.

Where Obtained

Herb store

Sassafras

Spanish Name:

Scientific Name: *Sassafras albidum*

Form

Tea

Constituents

Up to 9% volatile oil (contains 80% safrole), .02% alkaloids, resin, two ligans, starch, sitosterol, tannins.

Therapeutic Effects

Sassafras oil has rubefacient properties and was formerly used as a pediculocide.

Safety/Toxicity

Safrole and other constituents have proven carcinogenic and hepatotoxic in rats and mice.

Adverse Effects

None known

Potential Drug Interactions

None known

Comments

Sassafras has a pleasant taste and aroma which may affect its reputation. This product should not be recommended because of its potential carcinogenic effects and its lack of therapeutic efficacy.

Perceived Use by Patient

High blood pressure, bronchitis, burns, colds, dyspepsia, chicken pox, diarrhea, fever, and rheumatism.

Where Obtained

Herb store

Tea

Spanish Name: Té negro

Scientific Name: *Camellia sinensis*

Form

Tea

Constituents

1-4% caffeine, catechin tannins, 15% gallic acid

Therapeutic Effects

CNS stimulant

Safety/Toxicity

Caffeine is teratogenic and should be avoided or limited during pregnancy. The condensed tannins are linked to esophageal cancer in areas where large amounts are consumed.

Adverse Effects

Arrhythmias, nervousness, insomnia, increased blood glucose, increased cholesterol levels, excess stomach acid, heartburn

Potential Drug Interactions

Theophylline, alkaloids, salts of heavy metals, albumin, oxidizing substances (permanganates, chlorates)

Comments

Caffeine should be used in moderation. Non-pregnant adults should limit their consumption to 250 mg per day or less. Range of caffeine content: 20-110 mg per 5-8 oz. brewed; 25-50 mg per 5-8 oz. instant

Perceived Use by Patient

High cholesterol, headache, dysentery, excess phlegm, stomach ache

Where Obtained

Herb store, grocery store, health food store

Witch Hazel

Spanish Name: Unknown

Scientific Name: *Hamamelis virginiana*

Form

Tea, topical lotion

Constituents

Tannins, gallic acid, hamamelose, saponins, choline, resins, flavonoids

Therapeutic Effects

Tea: very slight constriction of varicose veins

Topically: astringent, used to treat hemorrhoids

Safety/Toxicity

Unknown

Adverse Effects

None known

Potential Drug Interactions

Alkaloids, salts of heavy metals, albumin, oxidizing substances (permanganates, chlorates)

Comments

It is applied externally by rubbing or fomentation to relieve congestions, bruises, hemorrhoids, and other skin irritations.

Perceived Use by Patient

To stop excessive menstruation, hemorrhages from the lungs, stomach, uterus, and bowels; to treat nosebleeds, hemorrhoids, and diarrhea

Where Obtained

Grocery store, pharmacy

Worm Seed

Spanish Name: Epazote

Scientific Name: *Chenopodium ambrosioides*

Form

Tea

Constituents

Santonin, cineole, thujone, camphene, terpin

Therapeutic Effects

Anthelmintic, diaphoretic, diuretic, fungicide, stomachic

Safety/Toxicity

This oil is quite poisonous, causing fatalities in overdoses preceded by cardiac disturbance, convulsions, respiratory disturbances, sleepiness, vomiting, and weakness

Adverse Effects

None known

Potential Drug Interactions

None known

Comments

Epazote is used as a carminative, but no scientific studies have proven this effect. It has been discontinued because of toxicity in effective doses.

Perceived Use by Patients

Analgesic, nervine, antispasmodic, to treat asthma

Where Obtained

Unknown

Wormwood

Spanish Name: Estafiate

Scientific Name: *Artemisia absinthium*

Form

Tea

Constituents

Absinthin, anabsinthin, 0.25-1.32% volatile oils (containing thujone)

Therapeutic Effects

None proven

Safety/Toxicity

Thujone is a toxin and can cause effects similar to THC.

Adverse Effects

Habitual use or large doses cause absinthism, which is characterized by restlessness, vomiting, vertigo, tremors, and convulsions.

Potential Drug Interactions

THC

Comments

Commonly used as a flavoring agent and a fragrance.

Perceived Use by Patient

To sleep

Where Obtained

Unknown



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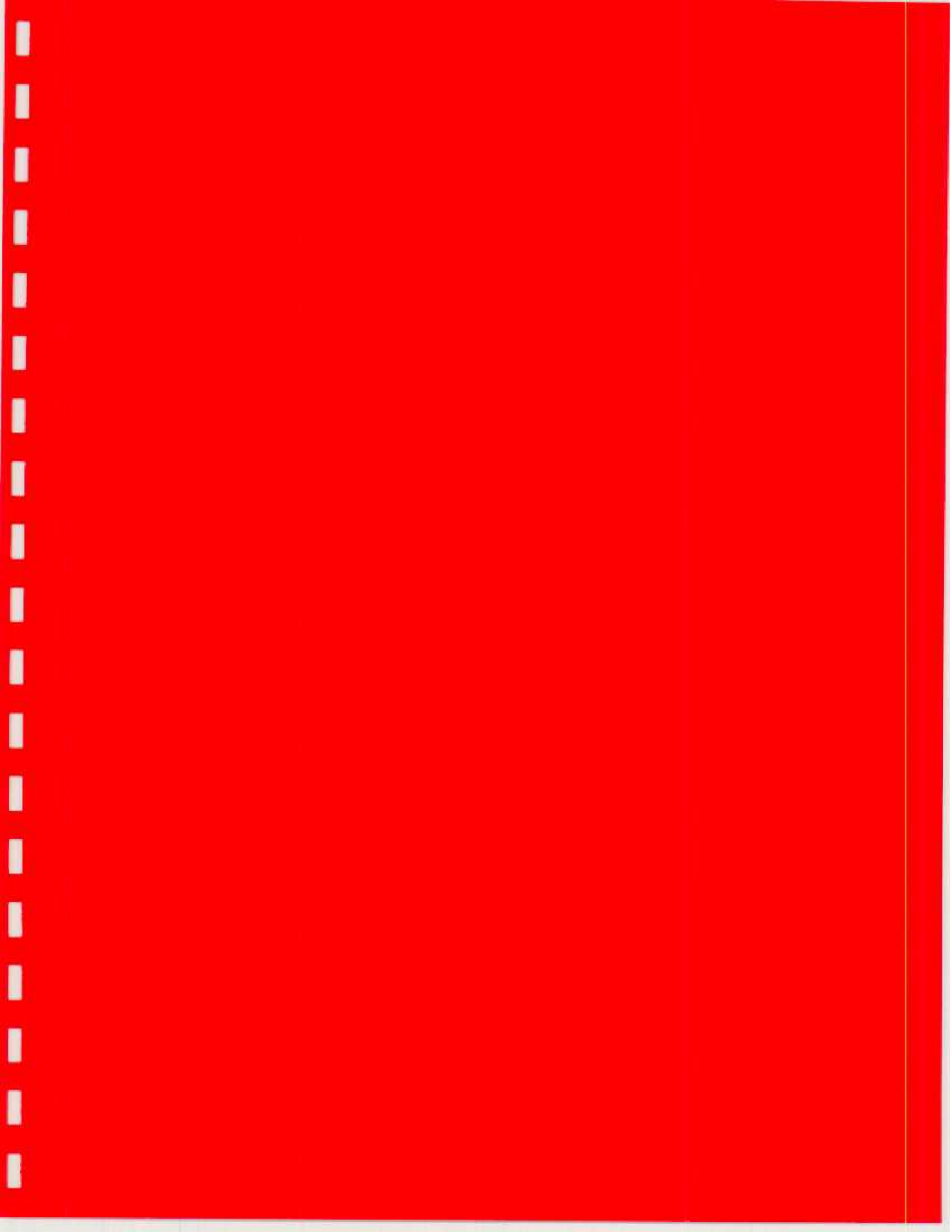


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An herb for what ails you

Curanderismo fuels tradition

By Carlos Vidal Greth
American-Statesman Staff

The most intriguing remedies in town are prescribed in front of home altars, burning candles and smoking incense.

- To attract customers and repel red ink, place a picture of San Martín Caballero on your cash register. Every Friday, set a glass of water and a few blades of grass nearby for the saint's horse. Business will blossom.

- If your ears burn and your reputation suffers, tape a dime over San Ramón Nonato's mouth and recite a special prayer. He will silence your critic.

- Hemorrhoids can't stand up to *alta misa*, an herbal concoction that when boiled can shrink the most obstinate swelling.

- When your lover's attention strays, light a candle (the most effective are made in Mexico of sebo, or animal fat) to *Santísima Muerte* (Holy Death). Then chant a prayer for her intercession.

So say the curanderos, folk healers who are as much a part of Mexican-American culture as tortillas and mariachi music.

Their "medical bags" contain herbs, bark, roots, candles, perfumed oils, crucifixes, amulets, statuettes, "sanctified" aerosol sprays and, most importantly, prayer. There is said to be a cure for every imaginable problem: bad luck, impotence, depression, diabetes, stomach aches, cancer and love sickness.

Curanderismo is much more than sincere faith healers or snake oil salesmen with a collection of remedies that do not stand (or haven't been put to) the test of medical effectiveness in the lab.

The practitioners of the centuries-old folk tradition have acquired cultural icon status for Mexican Americans seeking to preserve a rich, varied heritage. A mosaic of Mexican



Rudy Castanon, owner of the yerberia El Porvenir

Indian and Roman Catholic practice sprinkled with voodoo, Buddhist, Hindu and Egyptian religious elements, curanderismo provides a patchwork record of outside influences on and contacts with the Mexican people.

Jose Limon, associate professor of anthropology and director of the Folklore Center at the University of Texas, cites two popular explanations for the persistence of curanderismo in the barrio.

"Some believe that Mexican Americans need it because institutional medicine doesn't fit their cultural expectations," Limon said. "They supposedly experience diseases such as *empacho* (nonspecific gastrointestinal disturbances), *mal de ojo* (evil eye) and *susto* (an enduring feeling of fright) that American doctors don't recognize."

In Limon's view, people with roots in the Mexican culture go to curanderos because they don't (or feel as if they don't) have access to modern medicine. Curanderismo is particularly strong in South Texas, for exam-

See Curanderos, Page C8

for Mexican Americans seeking to preserve a rich, varied heritage. A mosaic of Mexican

particularly strong in South Texas, for example. See Curanderos, Page C8

of curanderismo.

Tools of the trade: herbs, prayers and a little mystery



Pictures of saints dot the curandera's bedroom altar, guarded by El Prieto, a black cat.

By Carlos Vidal Greth
American-Statesman Staff

It doesn't look much like a place of healing. The modest frame house in East Austin rests behind two mature cottonwood trees and a dirt yard cluttered with children's toys and discarded auto parts.

At the torn screen door, a waiting toddler, scuttling chickens and a woman with a suspicious mien greet a visitor.

When she learns you've come to see the curandera, a small, mysterious smile comes to her lips. She says in Spanish to wait a moment, but not to worry. The doctor is in.

Estrella, a slight, middle-aged woman with bushy hair, doesn't seem out of the ordinary. Her face, however, has the power to turn a Longhorn stampede. It is the ravaged, knowing look of someone who has visited a place where most mortals dare not go.

Estrella is not her real name. Like most curanderas, she maintains a low profile for legal and trade reasons. She doesn't want her face in the newspaper, she said, because enemies could use it to work spells against her.

She discovered a knack for curanderismo as a young girl in San Marcos. When people angered her, Estrella made little rag dolls of her tormentors and stuck the figures with pins. Her grandmother, a curandera, noted the child's propensities for the art.

'I can tell what someone's problem is even before he tells me.'

—Estrella

"My abuelita, Concha, taught me curanderismo so I wouldn't continue to create trouble," Estrella said, chuckling. "If you don't know what you're doing, you'll end up flat on your back in bed." By the time she was 18, people began consulting her with their pains and troubles.

Her bedroom doubles as a treatment room. A crude portrait of an alluring Mexican woman outfitted in revolutionary style with bandoliers and sombrero hangs above the king-size bed, which occupies most of the room.

The corners are piled with hard-to-identify objects, some tools of the trade obtained from El Porvenir in East Austin.

A brittle rattlesnake skin, she explained, can be used to dominate others, cure arthritis or close sores. On the bedstand rests a plastic bag of dried horned toads brought from Guadalajara, a powerful invitation to love and good luck.

At the opposite end of the room, a tiered altar dressed in a white sheet like a Halloween ghost supports a small, candle-powered village of Catholic saints: St. Ignatius Loyola, St. Anthony of Padua, St. Peter, St. Francis of Assisi and a host of lesser-known holy men. At the base of the altar, a foot-thick,

worn Bible lies open at Revelations.

Christian paraphernalia predominate, but folk tradition is well-represented. Scarified lemons floating in a water tank and El Prieto, a lively black cat, provide protection from those spirits who would do Estrella harm. A statue of curandero Don Pedrito Jaramillo sits in a corner, a puzzled expression on its little, bearded face.

Her clients are mainly poor to lower-middle-class Mexican Americans, she said, though Mexican nationals also frequent her home. Customers come mainly from the Austin barrio, but a handful of faithful followers come from Houston and Laredo.

When people come to her with tumors, broken bones and other visibly serious medical problems, Estrella said she sends them to a physician. There's plenty of work left for her to do.

"Men come to me to help them get jobs," she said. "Women come to me to bring back loved ones: boyfriends, husbands or sons.

"I pray to the saints or spirits for help. Don Pedrito or San Cipriano enters my body. My voice becomes brasa (smouldering like red-hot coals). I can tell what someone's problem is even before he tells me."

Estrella doesn't ask or set fees for her services. But you can bet that most of her clients gladly make a contribution.

"I can give clients the power to control people," she said, flashing a crafty, dark smile. "I can take away bad spirits. I can put bad spirits on others. I mostly do good things, but I work both ways."

I do — if you do

Prenuptial agreements attempt to guarantee wedded bliss

By Beth Ann Krier
Los Angeles Times Service

The man's fiancée was slim. He liked her that way. She was determined to do everything within his power to remain in his pre-

weeks of vacation her husband is to take and how many nights per week he must take her out to dinner.

Though no one knows how many premarital contracts are being negotiated today, attorneys say they are unquestionably seeing rising demand for prenuptial agreements, both the financial variety and those with unusual lifestyle clauses.

Coming Sunday



Gridiron clash

Small towns and big cities in Texas share one thing on Friday nights: high school football. Reports from Granger and Austin.

Lifestyle

Also . . .

for Mexican Americans seeking to preserve a rich, varied heritage. A mosaic of Mexican

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weeks of vacation her husband is to take and how many nights per week he must take her out to dinner.

Though no one knows how many premarital contracts are being negotiated today, attorneys say they are unquestionably seeing rising demand for prenuptial agreements, both the financial variety and those with unusual lifestyle clauses.

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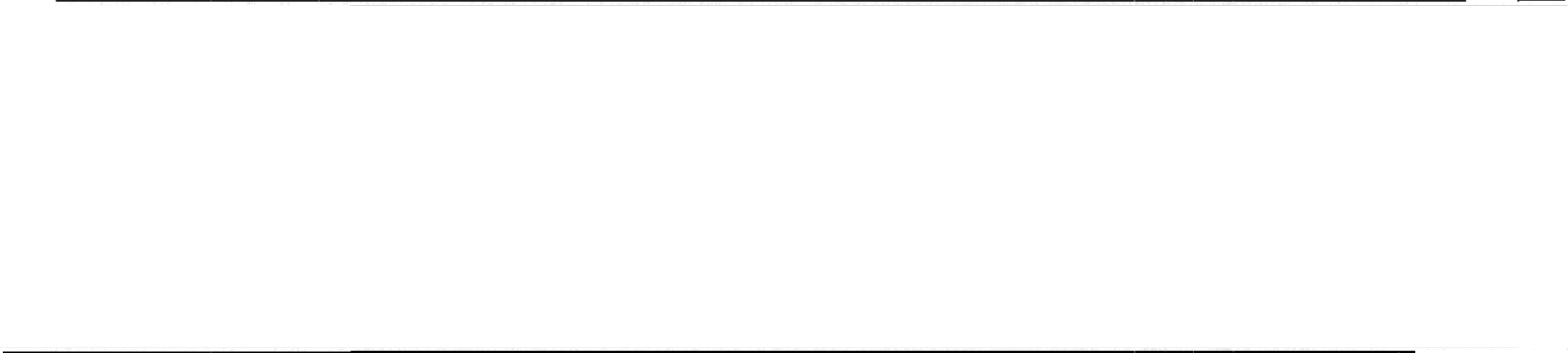


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Curanderismo and the DSM-IV: Diagnostic and Treatment Implications for the Mexican American Client

Occasional Paper No. 45
Occasional Paper Series

**Curanderismo and the DSM-IV:
Diagnostic and Treatment Implications
for the Mexican American Client**

*by Martin L. Harris, Ph.D.
Southern California College*

Occasional Paper No. 45
September 1998



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Abstract: When the Mexican American family's attempt to heal a troubled member fails, either by seeking out western medicine, psychotherapy, or the saints, curanderismo may be considered as a viable alternative form of intervention. However, opportunity for efficacious care may be thwarted by a psychologist/psychiatrist trying to "sell" their system of treatment and disease classification. Some challenges with traditional psychiatry and psychology are rooted in the nosological system used for assessment, diagnosis and treatment recommendations. Although the symptom profile for a culture-bound syndrome may mimic the clinical profile of a "standard" DSM disorder, the sequale of the disorder as well as the diagnostic, assessment and treatment protocol may differ significantly. The DSM-IV has made strides in terms of mentioning some cultural syndromes, however differential diagnosis, etiological considerations, and appropriate treatment protocols continue to be a challenging theme for mental health care providers. This paper seeks to overview some of the cultural stepping stones in the current classification system. Issues of family support, curanderismo, and differential diagnoses will also be discussed.

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Curanderismo and the DSM-IV: Diagnostic and Treatment Implications for the Mexican American Client

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The Julian Samora Research Institute is the Midwest's premier policy research and outreach center to the Hispanic community. The Institute's mission includes:

- *Generation of a program of research and evaluation to examine the social, economic, educational, and political condition of Latino communities.*
- *Transmission of research findings to academic institutions, government officials, community leaders, and private sector executives through publications, public policy seminars, workshops, and consultations.*
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- *Development of Latino faculty, including support for the development of curriculum and scholarship for Chicano/Latino Studies.*

Curanderismo and the DSM-IV: Diagnostic and Treatment Implications for the Mexican American Client

Basic Clinical and Research Questions

The participation in cross-cultural assessment, diagnosis and treatment intervention is a task that may seem intangible at times. In an attempt to provide a foundation for the understanding of the implications of cultural differences, Tharp (1991) suggests that theory and practice have converged on four basic research questions that must be considered in therapy and should be the focus of research. The first question provides a useful level of developmental analysis: what is the significance of the ethnogenesis for understanding and treating a client's present condition? The answer may be of significance when examining the higher prevalence of depression among African American inner-city youth, as compared to youth with different demographic composites. What is the causal agent for this increase in prevalence of depression? Is it a result of the cultural history of the ethnic group (i.e. oppression, discrimination, and minority status as a stressor), or is it a result of the cultural history of the youth himself or herself?

The next question Tharp asks is "How much weight should cultural psychosocial features be given?" If a Hispanic male drinks excessively and is abusive to his family, how much can we attribute behaviors such as this to culture and how much of it should we label psychopathology?

Tharp's third question is practice-oriented: How should therapy be applied to minority clients? Are there culturally specific and culturally unique treatments? Are there certain therapies that have been developed to work well with particular ethnic groups?

The final, and perhaps most controversial question raised by Tharp is: Are cultural members more effective in treating or investigating the treatment of members of their own culture? Many researchers on this topic have extremist views.

Tharp asks some insightful and thought provoking questions which are relevant to the challenges faced by psychologists who assess, diagnose and treat cultural clients, especially with regard to the utility and application of the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition

(1994) (DSM) with cultural clients. The DSM system fails to include many cultural disorders that have different etiological pathways. Subsequently research and treatment paradigms continue to be negatively affected, and "culture bound syndromes," unique phenomena that can pose challenges in assessment and treatment planning are not recognized. Being able to distinguish these etiological and cultural pathways to a disorder will allow the therapist and client to work together in recognizing the origins of the disorder, and subsequently facilitate treatment options.

Evidence of the need for cultural relevance in the delivery of mental health care is reflected in the very nature of concerns echoed by past and present researchers, mental health care providers and government agencies. However, the current assessment system is an impediment, rather than enhancement to improving the delivery of culturally sensitive care, as it too often serves as a conceptual starting point in the appropriation of treatment. In addition, the current system of disease classification is invalid, misunderstood and at times neglectful in recognizing cultural illnesses as unique syndromes. This chapter will serve to overview some of the progress and pitfalls the current diagnostic system has encountered in assessing Mexican American clients. In addition, issues of underutilization of mental health care services, family support, and alternative medicine, as well as an outline for cultural integration in psychotherapy, will be discussed.

The Epidemiological Paradox and the Underutilization of Psychological Services

Large-scale psychiatric studies have repeatedly indicated that oppression, racism, economic struggles, separation from family support, and other stressors are associated with a high incidence of mental illness. Paradoxically, however Mexican Americans tend not to utilize mental health care with the same frequency as other groups. Cuellar and Schneec (1987) state that, regarding the underutilization of services by Mexican Americans, "Perhaps no single issue in the mental health care field has generated so

much concern and raised more questions concerning care and treatment."

Regarding the underutilization of traditional services by Mexican Americans, research studies have fostered three central themes. One theory suggests that Mexican Americans may utilize alternative treatment modalities (Torrey 1986; Alegria, Guerra, Martinez, and Meyer 1977). This theory proposes that Mexican Americans afflicted with a mental illness will seek out a folk-oriented treatment such as those offered by *Curanderos* (Mexican American-Faith healers). A second explanation argues that the Mexican American family serves to buffer or neutralize psychological distress (Jaco 1959; Hoppe and Heller 1975; Becerra, Karno and Escobar 1982; Meadow 1982). A third theme suggests that traditional services are culturally incompatible with the mental health care needs of Mexican Americans. This theory identifies as obstacles and such elements as language, acculturation, and intracultural diversity issues (Yamamoto 1968; Burruel and Chavez 1974; Padilla 1975; Cuellar and Gonzalez 1983; Ramirez 1991).

Language and Acculturation

When discussing the theories as to why Mexican Americans underutilize services, cultural barriers influencing these patterns should be considered. These barriers include: language, acculturation, and intracultural diversity.

When a therapist is interviewing, assessing or appropriating treatment for Mexican American clients, the language barrier should be given special consideration. Among the Mexican people there is no one single encompassing culture which exemplifies all of its constituents. Errors relating to diagnoses can create problems both for the client in need of treatment and the therapist, who may be inappropriately providing services for an unwarranted diagnosis. Marcos and his colleagues (1979) noted that when patients were given critical psychiatric evaluations, the clinicians concluded that the patients who were interviewed in a non-dominant language, even when the interviews were conducted by professionals, were considered to have a greater degree of pathology than when the clients were interviewed in their own language.

Intra-cultural diversity and varying degrees of acculturation within the Mexican culture are factors that should also be considered when appraising mental health care. Traditional and attraditional Mexicans both need to be recognized as unique sub-groups. The Mexican culture, like other cultures, encompasses a continuous change of cultural, political, socioeconomic and familial ideologies. For example, generational differences among Mexican Americans may present a unique challenge for the transcultural psychotherapist.

La Familia (The Family)

The Mexican family has long been considered a valuable mental health resource alternative for members of the community suffering from psychological stress. Jaco concluded from studies conducted in Texas (1959) that the Mexican family provided considerable emotional support in mental health crises. When family members were considered to have some form of mental distress, the family would comfort and console the afflicted member, creating a natural and loving support system. Regarding the capacity for emotional support in a Mexican family, Hoppe and Heller (1975) state:

Family ties serve supportive and protective functions against risk of failure, economic loss, embarrassment, and vulnerability to criticism encountered in the broader society. Such ties serve as a buffer between the objectively alienated Mexican American and the Anglo middle-class society. (306)

Becerra, Karno and Escobar (1982) concur that in the Mexican community "The natural support system, the family, has been viewed as one of the primary sources of sustaining the individual when he or she is experiencing emotional problems."

Origins of Mental Illness

According to Western culture, the origin of mental illness can be attributed to two main sources, psychological/psychiatric trauma, and organic causes that lead to the manifestation of a disease, for example, the dopamine theory to schizophrenia or the serotonin theories of depression. Within the Mexican culture, however, there are a multitude of causes for psychopathology and its related behavior. Torrey (1972) describes three etiological pathways:

Psychopathology that is influenced by natural causes. For example the *curandero* disorder *empacho* is usually caused by some food that has not digested properly.

2. Psychopathology that has been influenced by emotional causes. For example *susto*, which is often caused by a severe fright, or *Envidia*, which may be caused by a severe desire or jealousy.
3. Psychopathology that might be influenced by supernatural causes. For example those influenced by God as punishment for a particular behavior.

In attempting to explore the differences in *curanderismo* and psychiatry, one can begin with E.F. Torrey's *A Shared Worldview The Principle of Rumpelstiltskin*. In this important book, Torrey uses the story of Rumpelstiltskin to illustrate an important cultural assumption — that the therapist knows the right name to assign a disorder. But, according to Torrey, in order to know the proper name the therapist must share some of the patient's worldview concerning the disorder itself.

Torrey characterizes a shared worldview as a demonstrated awareness and an appreciation for the diversity of cultures, specifically the concept of a shared worldview between the therapist and patient. This concept implies that therapists will examine their own cultural perspective, and also familiarize with the cultures of patients.

Torrey recommends that therapists be flexible in their therapeutic approaches in order to develop a set of techniques that is consonant with the cultural belief system of their patients. Other cultures have alternative equivalents to psychotherapy, and although the means may differ, the fundamental ends of helping the patient feel better, remains the same.

El Curandero (The Healer)

When the Mexican family's attempt to heal the troubled member fails or becomes overwhelming, spiritually guided/therapeutic intervention may be an option. These faith healers are common in many Mexican communities, and often go by the name of *curandero* or *curandera*. This traditional and well-respected folk healer may take the place of a psychi-

atrist, psychologist, or even general practitioner when ailments of the body and mind are regarded as too sacred for contemporary remedies.

In their study on *curanderismo*, Alegria and his colleagues (1977) interviewed several *curanderos* in order to explore the reasons people utilize these folk healers. On visiting one *curanderos* office (his home) — *el hospital invisible* (the invisible hospital) — they found a unique contrast to traditional practices in the *curanderos* practicing environment.

"The setting for the *curanderos* practice is invariably their homes. There is a waiting area as well as a room for private consultation... The curers all practice in the community they serve. In this respect they are completely integrated with their clients" (Algeria et. al. 1977). These researchers also describe the culturally relevant and appropriate nature of the *curanderos* relationships with their patients. In addition to sharing their clients' geographic location, the curers share patients' social/economic, class, background, language, and religion, as well as a system of disease classification.

Case Example: Esperanza

The following is an example of someone seeking out assistance of a *curandero*.

Esperanza is a 16-year-old Mexican female from the Yucatan peninsula. She is single, attractive, standing about five feet in height with a medium build. Her long black hair is woven into a single thick braid which she carries over her shoulder. Her family comes from a long history of Mayan Indians, and both her parents and maternal grandparents raised her. Her father is a *campesino* (fieldworker) and her mother stays at home. Esperanza is the youngest of 10 children (six brothers and four sisters). All of her siblings work in the fields. Esperanza went to public schools until about the fifth grade. At that point her parents decided that she had been educated enough, adding that "too much education would ruin her for a good man."

Esperanza, bright and energetic, longed to continue her education. She continued friendships with schoolmates, borrow their books, and spend hours reading discarded books from the library and bookshops. Esperanza wanted to experience more, but felt

that her life situation was doomed by history, racism, and by pressure from her traditional family. Esperanza had dreams for something besides the seemingly timeless cycle of life amongst the Mayan people.

In the Fall of her sixteenth year, she began to experience a host of problems: she would begin to feel that her heart was racing at tremendous speeds, she might lose consciousness, vomit profusely, or have considerable trouble breathing. At first her parents were not aware of these symptoms as Esperanza did not want to worry them with what she called "mild fainting spells." However, as the illness progressed and she began to have these attacks more frequently the family became alarmed. Esperanza's mother took her to a local clinic staffed with occasional medical personnel, nurses, and a priest. The clinical evaluation revealed no medical condition and referred the family to a psychologist in the city. The family, wanting to avoid the hint that there was something "crazy" going on with their daughter, chose to seek the advice, wisdom, and treatment of one of the towns *curanderos*, Don Wicho.

Don Wicho is a gentleman in his early seventies, with wrinkled hands and gray and white hair. His office is his backyard, with no books, waiting rooms, medicine, or magazines. He had one chair resting under a tree that looked older than Don Wicho himself. He also had one candle that he carried under his left arm, a rosary in his mouth, and a few olive branches in his right hand. Don Wicho sat Esperanza down, asking no questions, and began to pray and light his candle. He occasionally waved the branches over her face and body as she sat motionless in her chair, arms extended outward.

Upon completion of the "intervention" which took about 20 minutes, Don Wicho informed the parents that the situation involved a boy, and that she should consider marriage if the parents approved. On her next visit to Don Wicho (a day later) Esperanza confessed to the *Curandero* that she was pregnant and felt she could not tell her parents about the pregnancy, and was reluctant to admit to herself that she would have to continue her role in the Indian cycle of life. However, she added that she loved her boyfriend very much, and knew she must get married. Don Wicho prescribed some tea to help her with her nausea and told her to pray for her developing child and for her soon-to-be marriage. In addition, he provided a special healing intervention to assist in her

plans to move away from her family and start her new home.

The symptoms and treatment for Esperanza were complicated by a host of medical, psychological, and cultural twists. Esperanza's belief in the healer aided her recovery.

Another *curandero* case history involves a 12-year-old boy named Lorenzo. Lorenzo, although born in Michoacan, Mexico, was sent to live with some relatives in the United States at the age of five.

Case Example: Lorenzo

Lorenzo was raised for the most part by his maternal aunt and uncle in a rural agricultural community in the Southwest United States. His aunt and uncle are first generation Mexicans who migrated to the United States illegally during the 1950's. Lorenzo was sent to live with this family because of his own parent's financial and emotional troubles. There were rumors that the family in Mexico was going to break up.

Lorenzo adjusted to his new environment and to the cultural norms of an American child as well. He was into video games, fast food, and sports. Everything seemed to be going well for him: he had many friends, both Mexican American and Anglo. He was very popular at school and was very close to his aunt and uncle. There were, however, occasional problems with his biological family which distressed him, but he continued to do well socially and academically.

All was well until he reached the summer before he was to begin junior high school. He was now 12 years old and began to worry about the next level of his education and the challenges therein. Would he be able to fit in, would the other students accept him, would he be able to compete academically? These worries began to transfer to worries about his aunt and uncle. He began to worry that they might reject him if he did not do well academically or socially. Would they be there for him, or would they abandon him? These worries eventually translated into nightmares of being left behind or abandoned by his aunt and uncle. He would wake up with night sweats, his heart racing, experiencing intense fear, and anxiety. During these episodes Lorenzo wished to be consoled and reassured by his *tios* that they would not leave him behind. These worries eventually began to affect

his sleep, social life, and mood. He became less interested in sports, his friends, and his appearance. The aunt, feeling she was untrained to help her nephew, called upon a local *curandera* to assist with the situation. Down the block from her home lived a locally-known faith healer: Angelita.

Angelita is a chubby sixty-ish woman with black and gray hair. She is soft-spoken and calm and came to the home to assess the situation. She was welcomed with *café con leche* (coffee and cream) and *pan dulce* (Mexican sweet bread). Angelita brought with her a special concoction of herbs, teas, and a rosary. She had Lorenzo dress down to his shorts and lie on the living room floor, crushed some leaves over his body, and began to pray with the rosary, calling on the saints and angels to protect the child and remove his fears. The treatment lasted about 15 minutes. Later, she prepared a special tea from crushed leaves she carried in a small plastic sandwich bag. She told the aunt to prepare this tea twice a day for Lorenzo until the bag was empty. Angelita was paid a small donation for her services. The boy's fears returned that night and continued for the next several days.

The aunt, worried about the child's well-being, consulted with a priest and a doctor who recommended she take the boy to a psychologist, which she reluctantly did. The psychologist began by having Lorenzo explain his fears, subsequently tracing them to the problems in Mexico with his biological family. After the course of about two months of visits, by exploring the origins of the child's fear, and reassuring him, the psychologist was able to successfully treat Lorenzo.

These cases illustrate the need for diverse and complex approaches to emotional crisis in the Mexican/Mexican American community which may include utilizing psychological or *curandero* treatment interventions, or both. Both adolescents were of Mexican ancestry and accustomed to the *curandero* tradition. Trust and belief in the power of the healer, the diagnostic system and treatment protocol are critical components to a viable intervention program.

The most common types of *curandero* diagnoses include *Mal De Ojo*, *Envidia*, *Susto*, and *Mal Puesto*. In table 1, I've discussed symptom profiles for each.

Table 1. Symptom Profiles for Common Curandero Syndromes

CURANDERO	SYNDROME
MALDE OJO <i>The Evil Eye</i>	One may interpret the behavior of a (The Evil Eye) look, glance, or stare of someone who is an enemy or a stranger as an attempt to inoculate someone with this illness. Headaches, crying, irritability, and restlessness are common symptoms, accompanied by stomach ailments.
ENVIDIA <i>Extreme Jealousy</i>	Envidia translates as a desire (Extreme Jealousy) or jealousy that results from an extreme anger toward, or a dislike or jealousy of another. Symptoms often mimic a number of anxiety syndromes, or may even resemble a more common illness such as a severe cold or fever.
SUSTO <i>Extreme Fright/Fear</i>	(Extreme Susto is typically the result of Fright/Fear) a traumatic experience. In particular the symptoms of this disorder mimic those of Post-Traumatic Stress Disorder. These symptoms include feeling keyed up or on edge, fatigue, restlessness, a significant change in appetite, anhedonia, bodily complaints, withdrawal and other symptoms of depression.
MALPUESTO <i>Hexing</i>	Hexes may be placed by someone (Hexing) who is familiar with witchcraft. Symptoms may include a host of somatic complaints and gastrointestinal problems. Paranoia and anxiety may be symptoms.

In addition to the differences in etiological pathways and symptom profiles of *curandero* versus western syndromes, treatment interventions also vary. Some of the common interventions used by *curanderos* include herbal tea treatments, which have long been used to treat a variety of maladies from the common cold to several types of cancer, as well as for psychological or emotional symptoms as anxiety is the most common form of mental illness not only among Mexican Americans, but in the world. (Hough et al. 1987). *Curanderos* have developed a myriad of herbal treatment options to cover the variety of anxiety type disorders, particularly significant is the fact that the following table illustrates some common *curandero* syndromes as well as the Western disorders they may mimic. In addition, common treatment interventions are illustrated in Table 2.

<i>Curandero Syndrome</i>	<i>Curandero Treatment</i>	<i>Similar Western Syndrome</i>	<i>Western Treatment</i>
Nervios	Herbal Tea Spiritual Healing	Generalized Anxiety	Medication Psychotherapy
Ataque De Nervios	Herbal Tea Spiritual Healing	Panic Attack Disorder	Medication Psychotherapy
Empacho	Herbal Tea Spiritual Healing Abdominal Massage	Stomach Ailment	Medication Diet Exercise
Mal Puesto	Spiritual Healing	Paranoia	Medication Psychotherapy
Susto	Spiritual Healing Herbal Tea	Panic Attack Phobic Disorder Extreme Fear	Medication Psychotherapy
Mal De Ojo	Spiritual Healing	Paranoia	Medication Psychotherapy
Tos	Herbal Tea Spiritual Healing	Cold Cough	Medication

Cultural Stepping Stones and the DSM

With respect to cultural issues, the DSM has been lacking. There is no mention of culture-bound issues until the 1987 DSM-III-R which states:

Culture specific symptoms of distress may create difficulties in the use of the DSM-III-R because a psychopathology is unique to that culture or because the DSM-III-R is not based on extensive research with non-Western populations.

<i>Anxiety Disorder</i>	<i>Specific Cultural Issues</i>
Panic Disorder	Found in EPA studies worldwide Culture bound syndromes may be related
Agoraphobia	Some cultures restrict women in public
Specific Phobia	Varies with culture and ethnicity
Obsessive Compulsive Disorder	Cultural rituals not necessarily OCD
Post Traumatic Stress Disorder	Immigrants from war-torn countries
Generalized Anxiety Disorder	Cultural variations in expression of anxiety
Social Phobia	Presentation or impairment may differ

The DSM-IV (1994) took a positive step by incorporating four small sections to its edition. These additions include cautionary statements, culture specific issues, (Table 3) an outline for cultural formulation, and a glossary of culture bound syndromes.

Although these sections contributed more to cultural issues than all other editions combined, each section is extremely limited, non-specific, and may in fact do more harm than good. Specifically, the psychologist who may have expertise in culture-bound syndromes, differential diagnoses of cultural disorders and cultural formulations would more than likely disregard all of these additions. On the other hand, psychologists with limited cultural experience or training who use the DSM-IV as their primary assessment tool may do more harm than good by diagnosing and treating a client based solely on this criteria.

It is important to outline each new "cultural" section of the DSM-IV in order to exemplify the potential dilemmas.

Section 1. Cultural and Ethnic Considerations: Located in the introduction of the DSM-IV this section includes a series of cautionary statements regarding how challenging it may be to work with clients from different cultures. This section includes approximately one page of text to discuss the new "three types of information regarding cultural considerations." Within the content of this single page it also mentions that psychopathology can be misdiagnosed cross-culturally.

Section 2. Culturally Specific Variations: Discussion of cultural variations within the symptom profile of disorders. This by far was the least effective of the new additions. Most of the "specific cultural issues" included in the profiles were non-specific with no breadth, depth, or culture specificity. Within Table 3 is an outline and summation of the anxiety spectrum of disorders as included in the DSM-IV for illustration.

Section 3. Outline for Cultural Formulation: Located in Appendix-I, this section is also less than effective. The cultural formulation outlines five important steps that need be taken when making an assessment with a client of a different culture. These include:

- Step 1.** Note the cultural identity of the individual, acculturation, language use and assimilation.
- Step 2.** Note client's explanation and cultural explanation with regard to symptoms and treatment.
- Step 3.** Note cultural stressors, social support, and level of functioning and disability.
- Step 4.** Note differences in culture/social status between client and clinician and possible problems in diagnoses and treatment.
- Step 5.** The formulation concludes with a discussion of how cultural considerations specifically influence a comprehensive program of diagnoses and care.

Step	Assessment Issue	Significance Stated	Clearly Measurable
I	Cultural Identity	No	No
I	Acculturation	No	No
I	Language	No	No
I	Assimilation	No	No
II	Worldview	No	No
III	Cultural Stressors	No	No
III	Social Support	No	No
III	Functioning	No	No
IV	S.E.S. Disparity	No	No
V	Formulation	No	No

CULTURAL SYNDROME	COMPARABLE SYNDROMES	DIFFERENTIAL DIAGNOSIS
<i>Ataque de Nervios</i>	Panic Disorder	None
<i>Bilis</i>	None	None
<i>Mal De Ojo</i>	None	None
<i>Nervios</i>	Adjustment, Anxiety, Depressive, Dissociative, Somatoform, Psychotic Disorders	None
<i>Susto</i>	Depression, PTSD	None

This section lists some very important steps, but offers no mention of how to carry them out, how to gauge their utility, how to conduct differential diagnosis, or how to recognize the impact on a treatment protocol. Once again, psychologists with experience in working cross-culturally would most likely ignore this section and defer to more reliable methods.

Within Table 4 is a summary of the shortcomings of the "cultural formulation" section of the DSM-IV.

Section 4. Glossary of Culture-Bound Syndromes in the DSM-IV: This section includes a glossary of 25 culture-bound syndromes. The glossary only sparsely defines the disorders, providing little to no mention of how to differentially diagnose from standard clinical syndromes. In Table 5 are five culture-bound syndromes of Mexican origin. This table illustrates some of the problems that may arise in assessment, differential diagnosis and treatment implementation.

The DSM has yet to recognize cultural disorders as clear syndromes, which meet criteria for a clinical profile. Cultural disorders such as *Mal Puesto*, *Empacho*, *Susto* and *Mal De Ojo* oftentimes mimic symptoms of Western mental illness. Making an appropriate assessment and differential diagnosis is crucial for providing treatment.

Assessment Model

The following paradigm (Table 6) is presented as a culturally sensitive approach to working with cultural clients, especially clients who might hold differing cultural beliefs regarding both the origin of mental illness, and what kind of intervention is appropriate.

Of the 3-part model essential for cross cultural intervention, Component 1, encourages sensitivity toward the client's culture, language, empowerment issues, and belief systems. This includes being sensitive to the many stages of acculturation and intra-cultural diversity which exist within the Mexican culture.

Language is another issue that needs special attention, as it can be an obvious barrier for communication both for the client as well as for the therapist. Problems that may arise as a result of the inter-lan-

guage barriers include issues of assessment, diagnosis and treatment. Intra-language barriers may also create special problems. Mexican Americans sometimes create a secondary composite language used with family, friends, or in daily communications with society. These may include, *mocha* (Mixed-English and Spanish) or variations therein.

This model is a framework for approaching, assessing and treating the Mexican patient. It involves exploring the reasons and motives behind wanting to work with this population. It also requires one to respect the worldview of the patient one is treating, and to factor this worldview into assessment and treatment approaches.

Table 6. A Paradigm for the Assessment and Treatment Approaches with the Mexican American Client

I.		II.		III.	
<i>Understanding, and Respect for Client's:</i>		<i>Self Analysis of Racial:</i>		<i>Promotion of:</i>	
A)	Culture/Acculturation	A)	Motives	A)	Traditional Psychotherapy
B)	Language	B)	Tendencies	B)	Culturally Integrative
C)	Empowerment	C)	Biases	Approach, Including use of	
D)	Belief System	D)	Prejudices	<i>Curanderismo</i>	

Understanding a client's perception of his or her own degree of empowerment is another fundamental element for the therapist working with Mexican Americans. Understanding the client's personal degree of conflict with the majority culture may help orient the direction and approach to treatment.

The fourth issue comprising Component I is essential for all psychologists: it involves understanding the level of discordance in belief systems between the therapist and client. For example to what extent does the client's understanding of mental illness, mental health, and the provider of care, differ from that of the therapist.

Component II represents one of the most important steps in modifying traditional treatment. It involves therapists' self-analysis regarding their motives in doing therapy with the client, as well as their feelings about working with people of color, in order to uncover and recognize any prejudices, biases, or tendencies. Dealing with the etiology and maintenance of these feelings is difficult and personal, but also crucial for honest communication.

Finally, Component III suggests the promotion of traditional psychology/psychological care as a viable treatment (alternative). This component is valid only in the presence and effective implementation of the other components of the model. If possible and appropriate, the traditional approach may include therapeutic approaches and techniques which integrate the client's cultural/psychological treatment system.

Summary and Conclusion

Past research has attempted to understand and explain the reasons and motives behind the underutilization patterns in the field of psychology exhibited by Mexicans. These theories have suggested that Mexicans may have less need for traditional psychotherapy, or that this group may make use of alternative treatments. Torrey (1986), Alegria et al. (1977), and others found significant use of *curanderos* among Mexicans. Family buffers have also been considered as a viable explanation for why Mexicans do not seek traditional forms of psychological care.

Differences in perceiving psychopathology have also been considered as a possible explanation regarding the underutilization phenomenon. This theory suggests that Mexicans may have a different worldview with respect to perceiving psychological disorders and psychological care.

Models for providing care should also include the three components of the model included. Those include a sensitivity and respect for the clients culture and belief system, an analysis of the therapists own motives and racial biases, coupled with a promotion of traditional or cultural integrative treatments.

Identifying and understanding the cultural differences that exist among the Mexican people may offer more concrete evidence to support a change in the delivery of services to this group. More importantly, understanding these issues may offer Mexican Americans treatment options/approaches that are more commensurate with their needs.

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