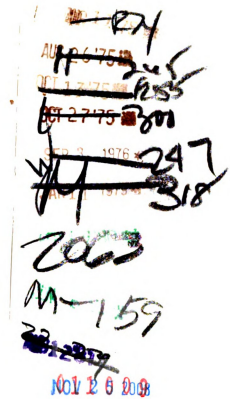
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ABSTRACT

HEALTH AND ILLNESS OF MEXICAN AMERICAN CHILDREN
IN AN UPPER MIDWEST URBAN SETTING

By

Carol J. Lindstrom

The existence and persistence of a well-defined, cohesive folk health care system in the Mexican American culture is well documented in the literature. However, the extent to which Mexican Americans in the midwest participate in the folk system has not been studied. This study focuses on health, illness and health care of young Mexican children in the context of their culture, including the folk health care system, and in articulation with the Anglo or Western scientific health care system. Utilization of preventive care at the Child Health Clinic in Lansing, Michigan is of particular interest.

The Child Health Clinic provides well child care, treatment for common childhood illnesses and referral to other sources for care for children under five in families who do not have access to private well child care. Twenty Mexican American families were selected from the Clinic clientele--ten who attended the Clinic consistently (good users) and ten who attended sporadically (poor users). Ten Mexican American families who had access to the Clinic but had never attended were selected from the community, providing a total of thirty families for the study. Factors which differentiate the three groups were explored.

An interview schedule was developed to obtain (1) demographic data, (2) mothers' perceptions of health and illness in their children, (3) sources of care for illness and (4) knowledge, belief and practice in the folk health care system. Most of the questions were open-ended, allowing the mother to express her views and the interviewer to pursue selected aspects of the responses. Interviews were conducted in the homes of the respondents. A minimum of two visits was made to each home. In addition, numerous visits were made to three families in each group.

There were many similarities in the thirty families. Very few of the parents had finished high school; the fathers had low skill, low income jobs. The mothers stayed home and cared for the children; they were socially isolated. Privacy was highly valued by all of the families. All of the parents and the majority of the children spoke Spanish. Skill in English ranged from good to none in parents and children both.

Family structure differentiated the good user and poor user groups. All children in the poor user group lived in a nuclear family. Only three families in the good user group were nuclear. The other seven were either headed by a female or composed of the mother, her children by a previous marriage, her husband and children of that union. The mothers in the two latter groups felt highly responsible for their children, since they did not have a man to share in the responsibility for some or all of the children.

All but one of the mothers recognized illness in a child by changes in his behavior, not by physical symptoms. They used home

remedies when a child first got sick and sought help from the doctor if what they did at home was not effective and they thought the child was very sick. Most of the families had a regular source of medical care. Many of them, including those who had a source of care, used the Emergency Room at one or more of the local hospitals for illnesses which were not medical emergencies.

The majority of the mothers were knowledgeable about the folk diseases, whether they believed in them or not. No mother volunteered information about the folk diseases. They did discuss them freely when the interviewer named the common diseases and asked if their children had ever had any of the diseases. A positive answer to this question constituted belief in the system. In the good user group, five mothers believed and five did not believe in the folk diseases. Eight poor users believed and two did not. In the non-user group, seven believed, one did not and two were not sure if they did or did not believe. The mothers who did believe either knew how to treat the diseases themselves or knew a Mexican American woman who did know how to treat them. Mexican diseases were not treated by physicians, because they do not believe in them and do not know how to treat them. The diseases and treatments described by the mothers are consistent with the description in the literature.

Only one mother said she knew of a curandera (a Mexican curer). The curandera told the interviewer that she received the gift of curing from God. She does not charge for her services. She has cured many people whom the doctors could not cure. She uses prayers, a number of rituals and a variety of herbs in her treatments.

Most of the families in this study participate in two insular systems of health care. Mexican folk diseases are treated within the Mexican culture. Non-Mexican diseases are treated by physicians. Families may participate in both systems separately or simultaneously.

HEALTH AND ILLNESS OF MEXICAN AMERICAN CHILDREN IN AN UPPER MIDWEST URBAN SETTING

By

Carol J. Lindstrom

A DISSERTATION

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to my parents

who appreciated my need

for this flight

"You are the bows from which your children as living arrows are sent forth--even as He loves the arrow that flies, so He loves also the bow that is stable."

--K. Gibran

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"*Work is love made visible.*"

This dissertation is the visible result of the work and love of many people. Those who provided assistance and support throughout the course of my graduate program know how important they are to me. I can express my gratitude here to only some of them.

"*If he is indeed wise, he does not bid you enter the house of his wisdom, but rather leads you to the threshold of your own mind.*"

To Dr. Charles Hughes--Chairman of my Guidance Committee, Director of my thesis, teacher, adviser, friend--who led me to the threshold of my mind. He understood quickly where I wanted to go, encouraged me willingly and consistently and shared the joys and pains of my growth.

"*For the vision of one man lends not its wings to another man.*"

To the other members of my Guidance Committee--Dr. Ruth Useem, Dr. Dozier Thornton and Dr. Arthur Kohrman--who helped me to find my vision and fly with my wings.

"The teacher . . . gives not of his wisdom but rather of his faith and lovingness."

To the parents and children in the Mexican families--my teachers and friends--who gave freely and warmly that I might learn.

"Your friend is your needs answered."

To my friends on the nursing staff of the Ingham County Health Department who answered my needs for information and the sharing of ideas.

"And in the sweetness of friendship let there be laughter and the sharing of pleasure."

To my many friends and my family who helped me to laugh when the road was rough and who shared with me their pleasures and strength.

"To work with love . . . is to charge all things you fashion with a breath of your own spirit."

To Grace Rutherford, who always knew how I wanted my papers typed--fashioned with a breath of perfection.

"It is well to give when asked. . . ."

To the Division of Nursing, U.S. Public Health Service, for the financial support of a special predoctoral fellowship (No. FO4-NU-27, 183-06) and Dr. Marie Bourgeois for her moral support.

(Words of K. Gibran throughout)

TABLE OF CONTENTS

	Page
LIST OF TABLES	x
Chapter	
I. INTRODUCTION AND RATIONALE	1
The Setting	1
The People	2
Cristo Rey Community Center	5
Child Health Clinic	7
Purpose	17
II. MEXICAN AMERICANS AS DESCRIBED IN THE LITERATURE	19
Terminology	19
Multiple Terms	19
Recent Terms	20
Present Interest	23
Descriptions by Anglo Writers	25
Family Relationships	26
Language	28
Acculturation	28
Social Class	29
Comments by Chicano Writers	30
Mexican Americans in the Midwest	33
Illinois, Wisconsin and Ohio	33
Michigan	35
Culture or Poverty?	37
Health and Illness	39
Specific Diseases	42
Curers	45
Recent Studies	46
Folk-Scientific Articulation	50
Socio-Cultural Factors	52
Poverty and Health	54
Preventive Care	56
Surveys of a Population	56
Surveys of Population of a Source of Care	59
Articulation with the Anglo System	66

Chapter		Page
III.	METHOD	76
	Introduction	76
	Preparation	76
	Process	78
	The Questionnaire	79
	Development	79
	Pre-Test with Migrant Families	81
	The Sample	83
	Selection	83
	Interviews	86
	Socioeconomic Status	89
	Limitations of the Study	93
IV.	MEXICAN AMERICANS AS MIGRANTS	95
	The Migrant Project	95
	The Migrants as the Outreach Worker Described Them	97
	Relationship with the Outreach Worker	97
	Relationship within the Group	99
	Relationships with Whites	100
	Personal Observations and Experiences	102
	Data from the Interviews	105
	Demographic Data	105
	Health and Illness Perceptions and Behavior	108
V.	MEXICAN AMERICANS IN LANSING: SOCIAL AND ECONOMIC DATA	114
	Introduction	114
	Family Structure	116
	Socioeconomic Status	126
	Migration and Mobility	135
	Summary	139
VI.	MEXICAN AMERICANS IN LANSING: HOME, FAMILY AND CULTURE	141
	Introduction	141
	Major Informants	142
	Families Who Attend the Clinic Consistently	142
	Families Who Attend the Clinic Sporadically	143
	Families Who Have Not Attended the Clinic	144
	Home and Family	146
	"The Mexican Is Always Remote"	146
	"A Clean House, Clean Wife, Clean Children"	148
	"Come Again, Any Time"	150
	"I Love My Children"	152
	"Families Are Like That"	154

Chapter Page

"Mexican Women Put Up With A Lot" 157
"Good Food Is Important" 159
"Five Children--That's Enough" 163
"Mexicans Should Know Spanish" 167
Outside the Home 169
"I Don't Bother Them; They Don't Bother Me" 169
"Those Other Mexicans Are 'Uppity'" 170
Summary 172

VII. MEXICAN AMERICANS IN LANSING: HEALTH AND ILLNESS 173

Introduction 173
Health Care at Home 174
"I Do Many Things To Keep Them Well" 174
"They Don't Get Sick Much" 176
"I Do the Best I Can" 179
"They're Quiet--They Don't Play" 179
"Colds" 184
"Aspirin" 188
"When What I Do At Home Doesn't Help" 189
Health Care in the Anglo System 192
Sick Care 192
Preventive Care 197
Better Health Care 207
Folk Health System 211
Belief 211
Source of Care 215
The Curandera 220
A Visit with the Curandera 222
Summary 228

VIII. IMPLICATIONS FOR PRACTICE 230

Introduction 230
Mexican Culture 231
Language 232
Dignity of the Individual 234
Home and Family 236
Mobility 241
Folk Illnesses and Treatments 242
Health Care In the Anglo System 244
Preventive Care 244
Child Health Clinic 247
Health Care Delivery 250
Summary 255

Chapter Page

IX. IMPLICATIONS FOR RESEARCH 257

Family Structure 257
Migration and Mobility 259
Sickness 261
Folk Health Care 263
"Battered Child Syndrome" 265
Child Health Clinic 266
Additional Data 268
Comparative Studies 270

Appendix

A. DATA FROM MICHIGAN HEALTH SURVEY 272

B. MENTALLY ILL ADULTS--FOLK BELIEF AND ANGLO CARE 284

C. QUESTIONNAIRE 287

D. CHILD HEALTH CLINIC RECORDS OF FAMILIES WITH SPANISH SURNAME 298

E. MIGRANT MOTHERS' RESPONSES TO QUESTIONNAIRE 301

REFERENCES 306

LIST OF TABLES

Table		Page
1.	Child health clinic appointments kept, broken and cancelled by Spanish-surname families in 1972	11
2.	Relationship betweek kept and broken appointments by location of child health clinic in 1972	12
3.	Relationship between clinic assignment (North and South) and records closed due to many broken appointments	13
4.	Language spoken at home by members of ten migrant agricultural worker families in Michigan	107
5.	Relationship between having check-ups and giving vitamins stated and practiced as health promotion-illness prevention measures	111
6.	Years of education of mothers by use of Child Health Clinic services	128
7.	Years of education of fathers by use of Child Health Clinic services	129
8.	Place of education of mothers by use of Child Health Clinic services	130
9.	Place of education of fathers by use of Child Health Clinic services	130
10.	Income of families by use of Child Health Clinic services	131
11.	Relationship between income and size of good user families	132
12.	Relationship between income and size of poor user families	133
13.	Relationship between income and size of non-user families	133
14.	Socioeconomic status scores of families by use of Child Health Clinic services	134

Table		Page
15.	Pattern of migration by use of Child Health Clinic services	137
16.	Length of time in present dwelling by use of Child Health Clinic services	139
17.	Other family members in Lansing by use of Child Health Clinic services	154
18.	Relationship between number of children and use of contraceptive	165
19.	Language spoken in the home by use of Child Health Clinic services	168
20.	Relationship between mothers' perception of own and children's health by recency of move	178
21.	Sources of help for illness by use of Child Health Clinic services	191
22.	Antepartum care by use of Child Health Clinic services	198
23.	Relationship between age on first visit and use of Child Health Clinic services	201
24.	Source of referral to Child Health Clinic by use of service	205
25.	Belief in folk diseases by use of Child Health Clinic services	213
A-1.	Age distribution of individuals of Mexican descent	273
A-2.	Percent of white population by age and area, Lansing-East Lansing	273
A-3.	Education of head of household in families of Mexican descent	274
A-4.	Population 19 years of age and older. Education by area, Lansing-East Lansing	274
A-5.	Relationship between age and education of head of household of families of Mexican descent	275
A-6.	Yearly income of families of Mexican descent	276

Table		Page
A-7.	Detailed yearly income of families of Mexican descent . . .	276
A-8.	Relationship between income and education of head of household of families of Mexican descent	277
A-9.	Relationship between income and size of household of families of Mexican descent	278
A-10.	Relationship between income and number of people working in families of Mexican descent	279
A-11.	Employment status of heads of household of families of Mexican descent	279
A-12.	Relationship between number of rooms and size of household of families of Mexican descent	280
A-13.	Ownership of dwelling units occupied by families of Mexican descent	281
A-14.	Length of time at present address by families of Mexican descent	282
A-15.	Relationship between home ownership and length of residence at present address by families of Mexican descent	282
A-16.	Maintenance of interior of dwelling unit occupied by families of Mexican descent	282
A-17.	Use of contraceptive measures by women, age 14-60, in families of Mexican descent	283

CHAPTER I

INTRODUCTION AND RATIONALE

The Setting

Lansing, the capital of Michigan, is an urban, industrial city with a population of 213,000 (United States Department of Commerce, 1972). The major industries are those involved, directly or indirectly, with the automotive industry. The city is surrounded by good agricultural land.

Like most urban industrial areas, Lansing has a number of families whose income is low. The Bureau of the Census reports that, in 1970, 7.5 percent of the population had an income below the poverty level (United States Department of Commerce, 1972). Unlike many cities of this size and character, Lansing has traditionally provided very little publicly supported medical care for those families who could not afford or obtain private care. The local Medical Society maintained that care was available for those who need it; there was no need for 'clinics for poor people.' Until 1968, there was no resource for preventive care for children in those families which could not afford private care.

At the present time (1974), it is difficult for any newcomer to Lansing, including those who can afford private care, to find a

source of care. No pediatricians and few general practitioners are taking new patients. Medical care is generally less accessible to families with a low income than to those with a high income. Low availability of medical care in the community serves to further decrease the accessibility to the low income families. Problems in obtaining care will be discussed more fully in a subsequent chapter.

The People

Much of the agricultural land in the area is devoted to crops which require hand labor, rather than machine labor. For a number of years, much of the labor was done by workers brought in from Mexico for that purpose. When this program was stopped, Mexican Americans from Texas came as migrant laborers every summer to work in agriculture here. Each year, and recently in increasing numbers, Mexican American families left the migrant stream and settled in Lansing or another of the urban industrial areas in southern Michigan. Their numbers increased rapidly in Lansing.

The actual size of the Mexican American population in Lansing now (1974) is not known. According to the Bureau of Census Report for 1970, there are 6,307 persons of Spanish language living in Lansing in Census Tracts with 400 or more persons of Spanish language. These figures are based on a sample of the population (United States Department of Commerce,1972).

This is an underestimation of population size. In October, 1970 there were 1,937 children of Spanish surname enrolled in the public

schools of Lansing (J. Brown, 1972). The designation of Spanish language would exclude those families in which English is the principal language. Families living in a Census Tract with fewer than 400 persons of Spanish language would not be counted.

Several Mexican American community leaders have said that the 1970 Census estimate would be low. Many families resented the census form because they felt overlooked as an ethnic minority. They do not want to be counted as Anglo (Caucasian), although by law they are classified as Caucasian. They would like a separate and specific classification. The form itself presented a problem to those who cannot read English. As a result, many families did not return the form (Benavidez, Martinez, personal interview).

The leaders estimate the population size at from 12,000 to 15,000 and increasing at about 100 to 150 families a year. The increase in the Spanish-surnamed population in Lansing is evident in the "student ethnic count" compiled by child accounting consultant for the Lansing School District.[1] Between November 1967 and October 1972, the number of Spanish-surnamed children in the Lansing elementary schools increased from 820 to 1,528 and in the secondary schools from 438 to 879. Both groups doubled in their percentage of the total student body, from 4 percent to 8 percent in the elementary schools and from 3 percent to 6 percent in the secondary (J. Brown, 1972).

According to the leaders, the population is characterized by families that are young, large and poor. Average family size is eight.

---

[1]Approximately 95 percent of the Spanish-surnamed population is Mexican American (Benavidez, personal interview).

Only about 1 percent of the population is 62 years of age or older. Their impressions are substantiated in several sources of demographic data.

The Michigan Health Survey, originally known as Project ECHO (Evidence for Community Health Organization), provided a source for information about the Mexican American population in Lansing. The survey was begun in 1967 in seven urban areas, including Lansing, and six small-town--rural areas in Michigan. The purpose of the study is to provide current information for planning and evaluating health services. The program, conducted in three phases, provides a continuous appraisal and up-date of environmental, demographic and health data.

The first phase consists of a block by block count and appraisal of dwelling units and their surrounding environment. In the second phase, a simple random sample of dwelling units is drawn. The residents in the selected units are interviewed to obtain health and demographic data. The interior condition of the unit is appraised and the blocks in which they are located are reappraised. All data are coded, keypunched and put on magnetic tape for computer retrieval. Phase three consists of an analysis and interpretation of the data to interested people in the local community. For purposes of interpretation and utilization, the city is divided into neighborhoods or areas with a high degree of internal homogeneity and external heterogeneity.

The questionnaire was revised several times. The version which was put into use in January 1970 included a question designed to determine ethnic background. "Considering both his parents, what is the

national origin or descent of (head of household)?" (Michigan Department of Public Health, 1970b). However, the responses were not coded for a specific category for people of Mexican descent. A hand sort of all Lansing questionnaires for the period from January 1970 through June 1971 yielded thirty-four families of Mexican descent.

In general, data from the Michigan Health Survey is consistent with the description of the Mexican American population given by the community leaders (Michigan Department of Public Health, n.d.). Although the 1970 Census (United States Department of Commerce, 1972) underestimates the size of the Mexican American population, the internal data are highly similar to that from the Michigan Health Survey. The population is young, with generally low incomes and low educational levels. (See Appendix A for detailed data.)

Cristo Rey Community Center

As the Mexican American population increased, the people wanted a church (Catholic) where they could have services in Spanish and English. In 1961, the Diocese of Lansing established Cristo Rey as a church for the Spanish speaking people. In 1965, the church had to relocate.

At this time, the community leaders decided that they needed a center which would provide more than religious services. The people needed help with credit, housing, employment and health care and felt that the church was not fulfilling that social role. They requested and were given funds for a building that would serve as a combination

of church and community center. Now, the Center is funded mostly by the Catholic Church (Diocese of Lansing), with some help from the Capital Area United Fund. Although the Center was established at the request of the Mexican Americans, the mandate from the bishop is that they serve anyone who is in need (Lehr, 1974).

The Community Center is located in north Lansing in an area characterized by deteriorating or dilapidated housing (Michigan Department of Public Health, 1970a). Many of the families are Mexican American. This is the area in which many of the newcomers first settle; it is the poorest of the several areas in which they live (Choldin and Trout, 1969). There are also many Black families and white families. Michigan Health Survey Area C includes Cristo Rey Community Center and the surrounding area (see Appendix A). The people in Area C are characterized by a relatively high percentage of households headed by a female, high mobility, low level of employment, low income, high infestation by rats, mice and cockroaches, comparatively low level of immunizations, low level of preventive health care and little dental care (Michigan Department of Public Health, n.d.). This constellation of characteristics describes a "poverty" population. (The relationship between poverty and health will be discussed in a subsequent chapter.) Public health nurses have observed that many of the people have an inadequate diet, inadequate health care, much illness and little preventive care. The children tend to have medical care primarily for severe, acute illnesses. The families cannot afford private preventive care; neither Medicaid nor the Department of Social Services pays for preventive care.

Child Health Clinic

When the present Community Center was in the early planning and building stage, the priest told the public health nurse who worked in the area that they would include a clinic room; she could decide how to use it. Since she had not had any experience in developing community services, she asked me for help. At that time, I was on the faculty of the Michigan State University School of Nursing. I was familiar with the area and had had experience in planning and developing community services. I assumed nursing leadership in contacting both professional and non-professional people in the area who might want to be involved in determining the need and deciding what service could be offered. I discussed the alternate plans with the Medical Director of the Ingham County Health Department and wrote the protocol for the implementation of the Child Health Clinic which was established.

The Ingham County Child Health Clinic began service to the community in July 1968, in the Cristo Rey Community Center. This Clinic was the first source of preventive health care for children in those families who did not have access to such care from a private physician. Many groups and individuals contributed time, money and effort to initiate and continue the service. It was a community effort; no federal funding was requested (C. Lindstrom, 1970a).

When the Clinic began operation at Cristo Rey, it was open twice a month. After eight months, the demand was great enough to necessitate a Clinic session every week. For about the first two years, all sessions were conducted at Cristo Rey. After that, the weekly

sessions alternated between Cristo Rey and the Health Department. Facilities in the Health Department were more spacious than those at Cristo Rey. The new location made the service more accessible to families in the south part of Lansing.

The Clinic provides well child care, treatment for the common childhood illnesses and referral to other sources of care for those problems which cannot be treated at the Clinic. Mothers in the community had expressed a need for some place where they could take their sick children for care. A traditional well child clinic would not have met the needs of the people in the area. Volunteers provided transportation for those who needed it and looked after the children while the mother was otherwise occupied. The professional staff recognized that lack of transportation and/or a baby sitter were major reasons for broken appointments.

Insofar as possible, the mothers and children saw the same doctor and nurse at each clinic visit. The staff hoped that this continuity would help to reduce the number of broken appointments. Nonetheless, there were some mothers who did not keep their appointments. Over time, it became possible for the nurses to look at the appointment book and predict that 'this mother will come because she always comes' and 'this mother will come only if the children are sick.'

I worked regularly in the Clinic during the first year and a half of operation. Some mothers brought their children consistently, whenever they had an appointment, whether the child was sick or well. Some mothers brought their children sporadically, usually only when

they were sick. This pattern prevailed in all three groups--white, Black and Mexican American. I became particularly interested in the Mexican American group.

The people of Mexican heritage with whom I worked in the Clinic and later in the course of this study referred to themselves simply as "Mexican." They referred to me and other light skinned Caucasians as "white" or occasionally as "American." For this reason, the terms "Mexican" and "white" will be used in the portions of this work which deal with contact between the writer and the people of Mexican heritage. The problems and issues of ethnic terminology and the differences from the now widely used term "Chicano" will be dealt with more fully in a subsequent chapter.

The Mexican mothers did not differ noticeably in pattern of attendance from the white and Black mothers--some attended consistently and some sporadically. Some children were receiving the best care that the Clinic could provide; some were receiving less than the best care. Concern for the children in the latter group prompted me to wonder what differentiated the two groups.

The problem of broken appointments and resultant less than good care raises several obvious questions. Who does not keep appointments? Why? It seemed to me that there were two equally salient, but seldom asked questions. Who does keep appointments? Why?

All of the mothers who attended the Clinic were part of the "low income" or "poverty" population; they could not afford private preventive care. In addition to low income, the Mexican mothers had

a cultural background different from the other two groups. The behavior of interest to me might be a function of social class, ethnicity or a combination of both.

Since the Cristo Rey area is heavily populated with Mexican Americans, more of these families attended the North Clinic (Cristo Rey) than the South (Health Department). Because Cristo Rey serves as a center for helping the Mexican American families in a variety of ways, and because there are always bilingual people there, I thought it likely that the attendance record would be better (fewer broken appointments) at Cristo Rey than at the Health Department. This was not the case, however.

I reviewed attendance records for both clinics, North and South, for 1972. During that time, Spanish-surnamed families were given 154 appointments at the North clinic, with a number of families having more than one. Of these 154, 86 (56%) were kept, 60 (39%) were broken and 8 (5%) were cancelled. In the South clinic, there were 65 appointments, with 42 (63%) kept, 18 (28%) broken and 6 (9%) cancelled. The rate of broken appointments was higher in the North than the South clinic (see Table 1).

Further study of the attendance record at the two clinics revealed some interesting information. Eighty-seven families (Spanish-surnamed) had appointments at the two clinics. Of these, forty-six regularly attended the North clinic, twenty-two regularly attended the South clinic and nineteen were new; they had never been to either clinic. These nineteen families account for thirteen broken appointments at the

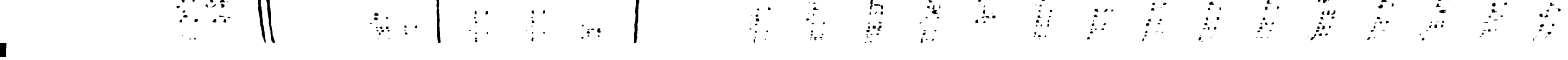

Table 1. Child health clinic appointments kept, broken and cancelled by Spanish-surname families in 1972

Child Health Clinic	Appointments							
	Kept		Broken		Cancelled		Total	
	No.	%	No.	%	No.	%	No.	%
North clinic	86	56	60	39	8	5	154	100
South clinic	41	63	18	28	6	9	65	100
Total	127	58	78	36	14	6	219	100

North clinic and seven at the South. (One mother broke an appointment at each clinic.) Eliminating these twenty broken appointments changes the rates somewhat, but the broken appointment rate at the South clinic remains lower (19%) than at the North (33%).

Families who never kept an appointment account for twenty-three broken appointments at the North clinic and nine at the South clinic. Eliminating these appointments does not change the rates. It is interesting to note, however, that one of these families broke three appointments and one broke five at the North clinic, whereas no family broke more than one at the South clinic (see Table 2). Another interesting difference in attendance pattern appears in Table 2. No family kept more than three appointments at the South clinic; three of the four families who kept three appointments account for seven broken ones. In the North clinic, the four families who kept three appointments account for only four of those broken. Also in the North clinic, the

four families who kept four or more appointments (a total of 25) account for only six of those broken. The pattern of attendance is different in the two clinics.

Table 2. Relationship between kept and broken appointments by location of child health clinic in 1972

Relationship	Location of Clinic	
	North	South
None kept--one broken	15	9
None kept--three broken	1	0
None kept--five broken	1	0
One kept--none broken	8	9
One kept--one broken	11	4
One kept--two broken	3	1
One kept--three broken	1	0
Two kept--none broken	6	4
Two kept--one broken	5	1
Two kept--two broken	1	0
Two kept--three broken	1	0
Three kept--none broken	1	1
Three kept--one broken	3	1
Three kept--two broken	0	1
Three kept--four broken	0	1
Four kept--one broken	2	0
Five kept--one broken	1	0
Five kept--two broken	2	0
Seven kept--one broken	1	0

The difference in attendance patterns raised the question of family records closed to clinic service because of many broken appointments. Since the rate of broken appointments was higher in the North clinic, one might expect that a higher percentage of records would be closed. However, more families established a record for good attendance in the North clinic than in the South. On this basis, one might expect that a higher percentage of records would be closed in the South clinic. The latter speculation proved to be correct. A review of Spanish-surnamed records closed to service in 1971 and 1972 revealed that four of the families attended the North clinic and ten the south. Although the active caseload was only available for 1972, I do not think that difference in times has any appreciable effect on the relationship shown in Table 3. There are always more Spanish-surnamed families attending the North clinic.

Table 3. Relationship between clinic assignment (North or South) and records closed due to many broken appointments

Clinic Assignment		Closed Due to Broken Appointments
North	46	4
South	22	10

Information from the Clinic records, observations and experience suggested some variables which did not seem to differentiate the two groups. There were mothers who spoke little or no English and mothers who spoke good English in both groups. Mothers who lived within several blocks of Cristo Rey and mothers who lived greater distances away were represented in both groups. There were young mothers with one or two children and older mothers with five, six or more children in both groups. Command of English, proximity to Cristo Rey, age of mother and family size did not seem to differentiate the two groups.

Language, the most readily observable cultural difference, did not distinguish those mothers who attended regularly from those who attended sporadically. However, language is only the "tip of the iceberg" of the cultural differences between whites and Mexicans. There are differences in family relationships, role expectations and child rearing practices. There are differences in orientation to the health-illness spectrum.

The existence of a well-defined, cohesive and persistent Mexican folk health-illness system has been well documented. Saunders (1954) describes the cause, symptoms and treatment of the most common folk illnesses and suggests that adherence to the folk system may be one reason why the Anglo system is not used extensively. Rubel (1960) also describes the folk illnesses; he suggests that they persist because they provide a strong cultural bond. Both of these studies were done with populations in the southwest.

Relatively few studies have been done of Mexican Americans in the midwest; fewer still have been done of those in Michigan. Those who

have settled in Michigan are a self-selected group. Choldin and Trout (1969), in a study of Mexican Americans in five Michigan cities, found that 60 percent of the men had been born in Texas and 11 percent in Mexico. Most of the men left Texas because of the massive poverty; 66 percent gave job related reasons for migration and settlement. In general, the men are better educated and have higher incomes than the men in the areas in Texas which they left.

The Mexican Americans in Lansing tend to live near other Mexican Americans; the general geographic areas in which they live can be described. However, there is not one area of any appreciable size peopled almost exclusively by Mexican Americans; no area which would be the equivalent of the "barrio" of cities in the southwest. It seems possible that these families who have left Mexico and/or Texas for better jobs might be more ready than those who stay to adapt to or accept some facets of Anglo culture.

To a greater or lesser degree, all of these families are exposed to Anglo culture. Most of the men have a continuing exposure at their place of employment. The children go to primarily Anglo schools. Many of them have white neighbors. All of the mothers who bring their children to Child Health Clinic are participating in the Anglo health care system.

To a very high degree, these families otherwise live in the Mexican culture. They speak Spanish, eat Mexican foods, play Mexican music, participate in Mexican festivals and return to Texas or Mexico to visit family members. They shop in stores which specialize in

Mexican foods and have bilingual staff members. There are a number of Mexican restaurants in north Lansing.

To some degree, they live in two cultures. They probably know more about the Anglo culture than Anglos know about the Mexican culture. Public health nurses who work with them in the Clinic and/or at home are aware of some of the cultural differences--language, if nothing else. However, the public health nurses probably do not know much about Mexican culture in general, or the folk health-illness system in particular. They see the mothers and children only in a contact with and in the context of the Anglo culture and system.

However, the Mexican mothers live in both systems and may participate in both systems of health care. The degree of participation and the relationship that the mothers see between the two systems are not known.

Goldkind (1959) compared folk health beliefs and practices of Ladino women in Saginaw, Michigan, and Denver, Colorado. He hypothesized that there would be more belief and practice in the group in Denver, because they live in the midst of the traditional Mexican-American culture. He administered a questionnaire to 36 women attending the General Medical Clinic of Denver General Hospital and 40 women attending the Guadalupe Health Center in Saginaw. The women in Saginaw were older and less well educated than those in Denver. He found no significant difference between the two groups in use of and belief in the effectiveness of curanderas, personal experience with witchcraft and use of a group of 21 folk medicines. He found less adherence in

the Saginaw group to having babies at home, admitting knowledge of cases of witchcraft and knowledge of a group of 21 folk medicines. He suggests that the aspects of folk medicine which seem to have been weakened by residence in Saginaw pertain to belief or knowledge rather than actual practice.

Purpose

Relatively little is known about the Mexican American population in Lansing. They are a self selected group; their life situation and circumstances are different from what they left. For these reasons, it does not seem reasonable to generalize to this group from studies done with those who live in the southwest, particularly Texas. It might be expected that there will be some culture change, some lessening of the traditionalism described by Saunders (1954), Rubel (1960, 1966), and others. However, what culture traits are changing and how rapidly is not known. More specifically, change in knowledge, belief and practice in the folk health-illness system is not known.

The purpose of this study is to explore, with a selected group of Mexican mothers, the extent of their knowledge of, belief in and participation in the folk health-illness system specifically as this relates to their children under five. The study will include their perceptions and behaviors in relation to their children under five, i.e., what they do to keep the children well, how they recognize illness, what they do and where they go for help once illness has been recognized. Participation in the Anglo system for both prevention and

treatment will also be explored. Health perceptions and behavior will be viewed in the context of significant aspects of the Mexican culture.

The mothers who bring their children to the Clinic will provide a group who have some articulation with the Anglo system. Some mothers attend sporadically; some attend consistently. The relationship between attendance pattern and participation in the folk system is not known. There are also many mothers in the community who have access to the Clinic, but have never attended. It seems safe to assume that these children have had no preventive care, with the possible exception of immunizations. An exploratory study of these three groups may point out some factors which differentiate them from each other. Increased understanding of the Mexicans may help health professionals provide better health care.

CHAPTER II

MEXICAN AMERICANS AS DESCRIBED IN THE LITERATURE

Terminology

Multiple Terms

A discussion of ethnic terminology is necessary prior to a review of the literature. Ramirez (1973) says, "The Census Bureau tabulates 9 million Spanish Americans in the United States. Of these, 57 percent are of Mexican origin; 17 percent Puerto Rican; 7 percent Cuban; 6 percent Central and South American and 13 percent 'other Spanish origin'" (p. 2). "Mexican-American," with or without the hyphen, is used frequently; it is descriptive and not likely to be confusing to the reader. "Spanish American," "Spanish speaking," "Spanish surname," "Latin," and "Latin American" are also used to refer to those of Mexican origin. Any one of these terms may also be used to describe any of the five groups above. Some authors do not define the specific group about which they write. "Hispanic American" and "Hispano" may also be used to describe those of Mexican origin or the descendants of those early Spanish settlers who had no Mexican heritage.

Burma (1970b) recognizes the lack of concensus in terminology. He provides a broad guide to current usage. In Texas, "Latin" or "Latin American" is preferred. In other areas these terms generally refer to people of Central or South American heritage. Mexican usually means a citizen of Mexico. In New Mexico and Colorado, Spanish American or Hispano refers to those of Spanish origin dating back some three hundred years. Elsewhere, these terms may be used to designate middle class Mexican Americans. In general, however, Mexican American is the preferred term (pp. xiii-xiv).

Recent Terms

Two terms, "La Raza" and "Chicano," have come into wide usage recently. Moore (1970) says "the idea of 'La Raza' permeates the Mexican American population. 'La Raza' does not refer to 'race' at all, but to a vague sense of ethnic identity, a compelling feeling of belonging--but to what is left relatively unconceptualized" (pp. 158-159).

La Raza apparently encompasses all Mexican Americans. Steiner's (1970) La Raza is sub-titled The Mexican Americans. Samora's (1966) La Raza is sub-titled Forgotten Americans. Both writers are concerned with Mexican Americans as a minority group.

"Chicano," used more frequently than La Raza, is still in the process of change in definition and usage. Simmen (1972) says that the origin of the word is unknown. Two plausible theories exist. One theory "ascribes the word to Nahuatl origin, suggesting that Indians pronounce Mexicano as 'Me-shi-ca-noh' . . ." (p. 54). The first

syllable was dropped, the "sh" was changed to "ch" and the term was used for ethnic identification. The other theory "asserts that the word was conventionally formed by suffixing ano to chico (young boy) exactly as one would form, for example, Mexicano from Mexico" (p. 54).

Simmen (1972) recognizes that a minority of Mexican Americans would like to use the term "Chicano" to replace all other labels presently used. Most Americans today would define Chicano as follows: "A dissatisfied American of Mexican descent whose ideas regarding his position in the social or economic order are, in general, considered to be liberal or radical and whose statements and actions are often extreme and often violent" (p. 55). However, he thinks that, in time, the word will mean "an American of Mexican descent who attempts through peaceful, reasonable, and responsible means to correct the image of the Mexican-American and to improve the position of this minority in the American social structure" (p. 56).

There is a curious blend of all three usages in the literature. Simmen (1972), on the back cover of his book, uses "Chicano" and "Mexican American" synonymously. Delgado (1971) writes about the Chicano movement, a movement by the young, particularly students, as a "refusal to acculturate or be absorbed, or assimilated into the dominant or larger society . . ." (p. 1). He speaks as a militant to provoke action. Carranza (1969) seems to see the Chicano as militant and/or intellectual who is actively engaged in a "cultural revolution" of self-determination for all Mexican Americans, with the Chicano as the agent of change (p. 8). He speaks as an intellectual, to arouse feeling

and provoke thought. Other books with "Chicano" in the title use the term to refer to all Mexican Americans (Simmen, 1972; Simmen, 1971; Ludwig and Santibañez, 1971; Wagner and Haug, 1971; Vasquez, 1970).

The bibliography compiled by Grebler, Moore and Guzman (1970) provides an interesting perspective on terminology. This bibliography contains about 1,500 entries and covers a span of more than fifty years. Most of the entries prior to the mid-forties use the term "Mexican" to refer to those of Mexican heritage. Beginning with the late forties and to the present, "Latin" is used frequently for studies done in Texas, "Mexican American" or some Spanish designation for those in other states. This change may reflect a change in Census Bureau terminology. In 1940, the Bureau dropped the Mexican classification and "used principal language other than English," using the classification Spanish speaking (Samora, 1966, p. xiii). It may also reflect a change in attitude toward the Mexican American. Servin (1969), in a brief description of the literature, says that during the twenties and thirties, most of the studies concluded that the plight of the Mexican American was the "result of his inherent lack of ambition, his innate violence, his racial make-up, or his religious beliefs" (p. vi). Following the Second World War, this attitude changed. "American writers began viewing the unhappy plight of the Mexican-American from a sociological viewpoint that exonerated him and attributed the cause of his downtrodden position to various aspects of American society" (p. vii).

The bibliography (Grebler, Moore and Guzman, 1970) also attests to the recency of the terms La Raza and Chicano--each term is represented by only one title in the entire collection.

In reviewing the literature, I will use the terminology used by the particular author. In some instances, I can only make an educated guess as to whether he refers to Mexican Americans or some other Spanish-speaking group.

Present Interest

National interest in and concern for the Mexican Americans is a fairly recent phenomenon. Grebler, Moore and Guzman (1970) state that they were first recognized in a national political campaign by John F. Kennedy in 1960. A decade of change began in the larger society, demonstrated in civil rights legislation, anti-poverty programs and Supreme Court decisions against discrimination in many spheres of life. At about the same time, the Mexican Americans began to recognize themselves as a "national minority" largely ignored, but perhaps capable of bringing about change in their situation (p. 4).

A spate of literature in the 1960s and on into the '70s attests to their having been ignored by the larger society. The writers, the majority of them Mexican American, refer to the group as "Forgotten Americans" (Samora, 1966), "An Awakening Minority" (Servin, 1969), "An Awakening People" (Haddox, 1970), "A Forgotten American" (Hernandez, 1969), and "Emerging Faces" (Cabrera, 1971).

Concomitant with having been ignored by the larger society are statements of having been ignored in the literature. Cabrera (1971) says, "We are in an era of ethnic cultural awareness today, and there is a demand for publications about Mexican-Americans. Not much is

available" (p. vii). Burma (1970b) says "until the last five years it was very difficult to secure information on this important ethnic group" (p. xi). Moore (1970) points out that Mexican Americans "have had almost no press whatsoever." Although they are the nation's second largest disadvantaged minority, Time magazine in 1968 "has yet no idea that Mexicans are a substantial part of the nation's poor" (p. 157). Heller (1966) says, "The meager literature about the Mexican Americans both reflects and contributes to their being unremembered and little known" (p. 4).

Grebler, Moore and Guzman (1970) disagree, however.

> Contrary to widespread impressions, a great deal has been written about Mexican-Americans by social scientists. (Our bibliography lists about 1,500 items ranging from books to magazine articles and government publications.) Much of the scholarly work is valuable. However, most of it is so local in scope that its impact on even the scholarly community has been limited. Moreover, many studies have focused on the rural Mexican American, or they were conducted in remote areas and urban ghettos where isolation allowed traditional culture traits to be preserved. These studies unwittingly helped to overemphasize the notion of a highly distinctive population. Many users of such research carelessly extended the notion of cultural uniqueness to the entire Mexican-American population regardless of differences in the social setting. Policy makers embraced this notion when it would help "explain" why American institutions failed to reach the population [pp. 6-7].

Their bibliography is indeed lengthy and comprehensive. The vast majority of the literature concerns Mexican Americans in the five southwestern states with large numbers of this population--Texas, Arizona, New Mexico, Colorado, and California. Little has been written about those who settled in the midwest. Education and language are consistently the topics of major interest.

The health-illness spectrum, with all of its ramifications, receives little attention. I counted seven books, two chapters in compilations, 29 journal articles, 11 unpublished dissertations and 15 other unpublished materials. In the meager total of 64, one--a Master's thesis--concerns Mexican Americans in the midwest. Health and illness as a topic and the midwest as an area have received relatively little attention in the literature.

Descriptions by Anglo Writers

There is a very high degree of similarity in the anthropological studies of the Mexican Americans. To all intents and purposes, Saunders (1954), Clark (1955), Madsen (1964) and Rubel (1966) say the same thing. Heller (1966) is concerned specifically with teen-aged boys. However, all five books present essentially the same picture of the culture of the Mexican Americans.

Knowledge, belief and practice related to health and illness can only be understood within the context of the culture of the group. Books written about health and medical care of the Mexican Americans include a study of the culture (Clark, 1959; Saunders, 1954); books written about the culture include chapters on health and illness (Rubel, 1966; Madsen, 1964). Clark (1959) points out the relationships between health/illness systems and the culture in which they are found.

> Since medical systems are integral parts of the cultures in which they occur, they cannot be understood simply in terms of curing practices, medical practitioners, hospital services, and the like. Medical systems are affected by most major categories of culture: economics, religion,

> social relationships, education, family structure, language. Only a partial understanding of a medical system can be gained unless other parts of culture can be studied and related to it [p. 1].

Some aspects of the culture and social position of the Mexican Americans have particular salience for public health nurses, both in themselves and as they interact with the health-illness system. These will be reviewed prior to a review of the folk health care system.

Family Relationships

"One cultural trait of the Spanish-speaking people that is constantly underevaluated by Anglo medical professionals in both rural and urban areas is the strong family relationship and the extent to which family affairs take precedence over matters that Anglos consider more important" (Saunders, 1954, p. 210).

The strength of family ties, both nuclear and extended, is emphasized in everything I read. Madsen (1964) describes the family as "the main focus of social identification in all classes of Mexican-American society." It is "a sanctuary in a hostile world" (p. 44). He states that a person is a member of a family first and an individual second. Children are valued and loved. Kinship ties extend to both sides of the family and over three generations. Kinship is further extended through the institution known as compadrazgo, or coparenthood. The coparents are sponsors, as in baptism, who assume carefully defined roles in establishing a ritual kinship.

Sex roles are clearly defined and children learn them early in life. The father is the head of the household, to be honored, respected

and obeyed. The mother is submissive to her husband; her responsibility is to her husband and children. The mother tends to be isolated in the home; visiting with other than real or ritual kin is discouraged.

Madsen (1964) concludes with the observation that the traditional strong family is best preserved in the lower classes and weakening as families rise in socioeconomic level and become more anglicized. However, the ties of the Mexican-American family are stronger than those of the Anglo family, regardless of degree of anglicization (p. 46).

Rubel (1966) likewise stresses the importance of the home and family. "The strength with which a person is bound to his family . . . overshadows all other bonds in importance . . ." (p. 55). Sex roles and interpersonal relationships are well defined. "The older order the younger and the men the women" (p. 100). The family is extended bilaterally and further extended through ritual kin. The nuclear family is isolated socially, if not spatially, from non-kin (p. 100).

Tuck (1946), a number of years prior to the previous writers, recognized the changes which were occurring in the Mexican-American home.

> When it comes to the matter of family life, one's subject matter becomes at once less concrete and more unmanageable. The most common experience in talking with informants was to be given a description of "the Mexican home," drawn in bold, substantial, unequivocal outline, consistent in every detail. Just as I was feeling solid ground under my feet, the speaker would add, "But, of course, we don't do a lot of those things in our home. . . ." By the time I had gone through a dozen such interviews, that nice, neat structure labeled, "the Mexican home" had been partially torn down, remodeled, repartitioned, and even redecorated. . . . Still, through the mass of detail, outlines could be glimpsed which corresponded to that "Mexican home" which had originally been defined for me [p. 119].

Language

Tuck (1946) says, "There are three areas in which culture survival seems to be strongest: language, food habits, and family life. Even here, nothing is static" (p. 118). The Spanish language persists in the homes, but by the second generation it has become rather Anglicized. Few of the children can write good Spanish.

Twenty-two years later, Heller (1966) found that the principal language used by first, second and third generation Mexican American youths, particularly in interpersonal relationships, was a form of Anglicized Spanish. Saunders (1954), in commenting on the persistence of the Spanish language, says "language difference is both a cause and an effect of isolation, and as such exerts a strong influence in the perpetuation of other cultural traits . . ." (p. 111).

Acculturation

All writers agree that the Mexican Americans, as a group, are "assimilating" into the larger society very slowly.

> Today, the Mexican-Americans are undergoing acculturation in the American melting pot, but many seem to be well-insulated against the melting process. They cherish much of their Mexican cultural heritage as too precious and universally valid to be abandoned. . . . There is no general agreement on what mechanisms can best be utilized to hasten the remaking of the Mexican-American into a plain American. Many sincere individuals working with this problem are distressed that the Mexican-American fails to recognize the "inherent superiority" of the all-American way of life [Madsen, 1964, p. 1].

Heller (1966) says, "Both in the rate and degree of acculturation and assimilation Mexican Americans are among the least "Americanized" of all ethnic groups in the United States." She goes on to say,

"they display a marked lack of internal differentiation, whether in terms of schooling, occupation or income" (p. 4).

Social Class

All writers likewise agree that the vast majority of the Mexican American population falls in the low income or disadvantaged or poverty group. Glick (1966) says, "Two ethnic or racial groups in the United States are currently distinguished by their inferior economic status as compared with the nation as a whole" (p. 95). Barrett (1966) says, "The Spanish-speaking population in the five southwestern states has remained a socially and economically underprivileged group during the 117 years since the treaty of Guadalupe-Hidalgo" (p. 195).[1] Rubel (1966) describes the differences in life on the two sides of the tracks--the north or "Mexican town" side and the south or "American town." He says the differences in the two are due, in part, to the traditional cultures which guide the lives of the two groups and, in part, to the low income characteristics of those in Mexican Town (p. 23).

Cabrera (1971) summarizes the picture of Mexican-Americans presented by the Anglo writers. Historically, the Mexican-Americans inherit similarities which identify them as a group. The Spanish language unifies them, not only as a means of communication, but also as a symbol of their culture. Religion serves as a bond. The extended

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[1]There is a relatively small group of upper middle class Spanish speaking people, many of whom are descendents of the original Spanish land-grant families. They live apart from the majority of the Spanish speaking people whose background is Mexican (Madsen, 1964).

family, with its strong ties, provides security. Internal qualities are valued over material success. Frequently, Mexicans are described as having a present-time orientation. There are many ideologic contrasts between the concepts of the Mexican-American and the Anglo. The result is discrimination and prejudice. He concludes by stating that this "standard story or explanation of the Mexican American . . ." is likely to be accepted without question. "How much of this is true or how great are the contemporary variants are basic questions for exacting studies. . . . Today what passes as understanding the Mexican-American is at times distorted, polarized and absurd" (Cabrera, 1971, p. 4).

Comments by Chicano Writers

Other Chicano writers are not as kind as Cabrera in their evaluation of the Anglo social science literature about Mexican Americans. Chicano writers point out that the Anglo authors present a stereotyped view of the Mexican Americans as a people without a history, passive, non-changing and all alike. Romano (1971) writes a detailed critique of a number of the books mentioned above and concludes that "contemporary social science views of Mexican Americans are precisely those held by people during the days of the American frontier. In short, there has not been any significant change in views toward Mexican Americans for the past 100 years" (p. 37). He goes on to say that the social scientists are perpetuating opinions that are "pernicious, viscious, misleading, degrading and brainwashing in that they obliterate history and then re-write it in such a way as to eliminate the historical significance of Mexican Americans" (p. 37).

Rfos (1971) comments as follows on Romano's article:

> The question now arises as to what steps follows Romano's lethal thrust at the erroneous and prejudicial, but widely accepted concepts concerning the Mexican American advanced in the name of social science. Obviously the Mexican American must write his own perspective. Needless to say, this perspective must not be the half-digested excrement that current social scientists offer as intellectual nutrient [pp. 7-8].

Wagner and Haug (1971), in the preface to their book of readings, refer to Madsen's (1964) book as "stereotypic, supercilious, and unfortunately very influential . . ." (p. xi). Morales (1971), in an Introduction to the same book, points out that there are some Chicano writers who "echo Anglo-Saxon stereotypes of Mexican Americans." There are also non-Chicano writers who "have adopted a subordinate-group, i.e., a Chicano perspective" (p. xviii).

Galarza (1970) uses the continued stereotype of the extended family as an example of a hazard in language and in research. He says that sociologists still talk about the "extended family" when they describe the Mexican culture in the southwest. It may indeed still exist in isolated rural areas, but is no longer useful in the urban areas and most of this population now lives in urban areas. This leads to "dysfunctional research" as universities still send graduate students out to study the extended family. They might better put their efforts into defining and studying the areas of change in the Mexican family and community (p. 4).

One of the major points made by these Chicano writers (Romano, Rfos, Galarza) is that the Anglo writers (Tuck, Meller, Madsen, Saunders) say, implicitly or explicitly, that the problems of the Mexican American

are a result of his culture. The Chicano writers suggest that much of the problem lies in the social structure of the larger society. Galarza (1970) talks about the deviancy of American social institutions in relation to the Mexican--they are not geared to meet the needs of the Mexican as he sees the needs.

Grebler, Moore and Guzman (1970) deal with the theme and variation of a cultural distinctiveness in the social science literature. The study which they report is recent and comprehensive; their approach to treatment in the literature is less emotional than some of the Chicano writers (see quote on page 24). The purpose of their study was to "depict factually and analytically the present realities of life for Mexican Americans in our society. These realities depend largely on the minority's interaction with the dominant society." The study focuses on urban Mexican Americans interacting with the larger society in the southwest, primarily Texas and California. The study emphasizes change and diversity within the group, not the lack of change and high degree of similarity reported elsewhere. The Spanish language does persist strongly; other than that, the authors report change and diversity in the commonly mentioned cultural traits.[1]

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[1]A number of Chicano authors attest to the persistence of Spanish by using Spanish words, phrases and sentences in their writing. In the instances in which an English translation is not provided, the point the author is making is obscured.

Mexican Americans in the Midwest

Illinois, Wisconsin and Ohio

Samora and Lamanna (1967) report a study done in East Chicago as part of the Mexican American Study Project mentioned above. For the most part, the findings are the same as reported in other studies. They find little difference between those in East Chicago and those in the southwest, within the parameters discussed by Grebler, Moore and Guzman. Those in East Chicago are likewise "disadvantaged" by any yardstick. Moving to the industrial north apparently did not help them to improve their socioeconomic status. The population is young, with large families. The family continues to be a bulwark of tradition; the Spanish language persists; assimilation is largely limited to a few individuals who have moved out of the isolated areas in which most of the Mexican Americans live. In fact, this report sounded to me more like those of Madsen (1964) and Rubel (1966) than like Grebler, Moore and Guzman.

Shannon (1966) reports on a longitudinal study done in Racine, Wisconsin. He studied three low-income, immigrant groups--Anglo, Black and Mexican-American. Here, as in the other studies, the Mexican-Americans are part of the poorly educated, low-income group with poor housing and low-status occupations. The group is young with large families. Use of Spanish continues, with most of the children bilingual. However, many of the Mexican-Americans see their ethnic practices declining, although this is not what they want. Most of them feel that they have bettered their situation by moving from the Southwest (largely

Texas). This does not mean that they are satisfied to remain in the low-income group. Upward mobility is a slow process, however. Educational attainment does not function for the Mexican-American as it does for the Anglo in improving opportunity and status. One conclusion which they draw is that "variables completely beyond the immigrants' control have probably had more to do with what has happened to them than the individual or group characteristics that have so often been hypothesized to be the determinants of absorption and integration into the larger society" (p. 428). In a follow-up study ten years later, very few of the Mexican-Americans had improved their socioeconomic position (Shannon and Shannon, 1973).

Macklin (1963) studied the Mexican-American community in Toledo, Ohio. The people lived in three contiguous communities, all near the central city. Although the areas were not exclusively Mexican-American, there was almost no socialization between Mexican-Americans and non-Mexican neighbors. Almost all interaction took place between real, affinal and ritual kin; the women were socially isolated in the home. Family ties remain strong. Families are large, with an average of five children. Most of the men have low-skill, low-income jobs; the families live with "poor whites in a culture of poverty" (p. 42). Macklin suggests that the slow rate of acculturation is the result of some aspects of the Mexican-American culture, some factors in the dominant community and the fact that Anglo culture is mediated to the Mexican-Americans through Anglos in the lower socioeconomic classes.

Michigan

Goldkind (1963) studied factors in the acculturation of Mexican Americans in Lansing. He found the population, generally, to be young with low educational levels, employed in low skill occupations and having low incomes. He considered four dimensions of acculturation--position in the occupational structure, membership in organizations, contacts with Anglos and ethnic cultural traits. Those who were more acculturated had greater fluency in English, longer residence in the north, less experience in the migrant stream and higher education. He used knowledge of folk medicine as one of the ethnic cultural traits. He found recognition of Mexican folk medicine related significantly to "longer Mexico residence, older age, longer agricultural work experience, lower grade of school completed, less English fluency, and less pre-Lansing contact with Anglos. Also, a higher index of Mexican appearance is significantly related to a greater recognition of folk medicine" (p. 120). However, he did not consider belief or practice in the folk system, nor articulation with the Anglo system.

Choldin and Trout's (1969) study of Mexican Americans in Michigan (excluding Detroit) is similar to the Grebler, Moore, Guzman study in that it stresses change and interaction with the dominant society. They are struck by the diversity within the group, as were those involved in the former study. Much of the demographic data is the same as in any other study. The population is young, with large families. They are disproportionately represented in the low-income segment of the total population of Michigan. Their educational level

is low, by Anglo standards, but higher than the level achieved by those who live in Texas. They suggest that the "role of cultural variables in the migration, resettlement, employment, education and mobility of Mexican-Americans must be considered in the varying situational contexts into which migrants move and within which they and their children live" (p. 11).

Verway (1973) presents a profile of "Spanish Michigan" using data from the 1970 census. The census term "persons of Spanish language" includes all people in families where at least one parent gives Spanish as the native language. This designation encompasses Mexican, Cuban, Puerto Rican, Central and South American. His findings are essentially the same as Choldin and Trout's (1969) and Shannon's (1966). The population is young with large families. (All comparisons are made with total population of Michigan.) For the most part, they have settled together in certain areas of the state and in specific areas in cities. They are over-represented in low skill, low paying jobs. Unemployment is higher for both sexes and in nearly every age group. Women are under-represented in the labor force. In most occupations, the Spanish speaking earn less than their "other white" counterparts. However, they "are relatively better off than their national counterparts in both an absolute and a relative sense" (p. 7).

Culture or Poverty?

All writers agree that the Mexican Americans are a "disadvantaged minority" or part of the poverty population. Early writers, for the most part, suggest that their culture is responsible for their low social status. Later writers suggest that the poor Mexican American has much in common with all other poor people and much of his behavior is a function of poverty. Shannon (1966) and Choldin and Trout (1969) view the social situation as a crucial variable. Several Chicano writers point out that many of the attributes of the Mexican American are really attributes of most poverty groups.

Sotomayor (1971) attempts "to show how a significant number of weaknesses that had been attributed to the internal dynamics of the Mexican-American family can now, by the systems approach, be ascribed to the limitations placed upon the Mexican Americans by external systems . . . also . . . to point out how these limitations affect the internal integration of the family unity" (p. 320).

Casavantes (1971) presents a comprehensive discussion of eight qualities "invalidly attributed to Mexican Americans as part of their ethnicity" (p. 46). Briefly stated, the characteristics are (1) ethnocentricity, (2) non-participation in voluntary associations, (3) preference for the old and familiar, (4) anti-intellectual attitude, (5) male demonstration of manliness, (6) use of physical force to settle arguments or punish children, (7) inability to postpone gratification and (8) a fatalistic view of the world. He relates these to poverty, a context in which they do have validity, and concludes that these eight

qualities are "basically the qualities or attributes of people from the culture of poverty, not the culture of Mexico" (p. 49). He sees the essence of the Mexican American in the Spanish language and Mexican-Spanish ancestry. Most are Catholic and most have dark skins, although these qualities are not essential. He sees poverty as the major factor in the "impossible situation" of the Mexican American in this country today.

Burma (1970a) uses many of the above mentioned qualities in comparing the Mexican American subculture with Lewis' culture of poverty model. His comparison differs from Casavantes in that Burma recognizes both similarities and differences whereas Casavantes sees only similarities. For example, he says the existence of the "ideal" Mexican family, with a loving mother and a providing father who bring up their children to be respectful and courteous provides for a major family difference in the Mexican American subculture and the general subculture of poverty. Mexican Americans demonstrate more personal pride than the rest of the poverty population. He states that there is a qualitative difference in social interaction in the Mexican American subculture, with greater stress on courtesy and pleasantness. The Mexican American is not as materialistic in his goals and desires as the Anglo. Communication problems exist between those in the subculture of poverty and the dominant culture even when both have English as their native language; these problems are compounded for those who have Spanish as their first language.

In working with the Mexican families in Child Health Clinic, I had recognized that some of their behavior might well be a function of

poverty. I had also observed some differences between the poor Mexicans and the poor whites which might be attributed to cultural differences. Experience bade me accept the idea of diversity within the group, rather than lack of internal differentiation. Observation told me that they had large families and little money. No experience in the Clinic, however, told me anything about the existence of or adherence to a folk health care system. Did these mothers participate in the folk system? If they did, they did not mention it in the Clinic. Do the folk diseases and folk cures persist in the midwest? This will be the major focus of this dissertation.

Health and Illness

The existence of a well-defined, cohesive folk health care system within the Mexican American culture is amply described in the literature. Foster's article (1953), tracing much of the folk medicine of Mexico and other Central and South American countries to medieval Spain, is widely quoted.[1] In addition to this source, Saunders (1954)

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[1]Foster describes the "hot-cold" theory of disease as one aspect of folk medicine brought by the Spanish. Harwood (1971) describes the theory as part of the belief system of many Puerto Ricans in New York City. "The hot-cold system stems from Hippocratic humoral theories of disease . . ." in which the body humors are thought to be "hot" or "cold." Illness results from an imbalance and is treated by foods or herbs which are "hot" or "cold" to restore the balance (p. 1153). "Hot" and "cold" are inherent properties not related to temperature.

The "hot-cold theory" is not included in this study for several reasons. Very few of the writers refer to the theory in their description of the Mexican American folk system. Rubel mentions it briefly in his early report (1960), but not in the later publication (1966). Madsen (1964) states that some curanderos and recent migrants from Mexico subscribe to the theory. Clark (1959) found that very few of her informants knew which foods were inherently "hot" or "cold." Although they retained many of the dietary habits and treatments of the

says that the medical knowledge of the Spanish speaking people comes from one or more American Indian tribes, Anglo folk medicine and "scientific" medicine.

Saunders describes folk medicine as common knowledge within the group. The practices and beliefs are rooted in tradition; they are taken for granted as part of daily living. Folk medicine is integrated with and reinforced by other elements of the culture. It is accepted uncritically. Folk medicine "is rooted in belief, not knowledge, and it requires only occasional success to maintain its vigor" (Saunders, 1954, p. 146).

Health and illness are integral parts of social life in the Mexican American culture. Illness may be caused by disturbed interpersonal relationships within the kinship group, or outside it; it may be a punishment from God; it may be caused by forces over which the individual has no control, be they witches or bacteria.

Madsen (1964), Clark (1959) and Rubel (1960) give essentially the same description of the folk health-illness system, the causes, symptoms and treatments of folk diseases and the integration of

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system, foods were considered "hot" or "cold" according to temperature. Kay (1972) does not mention the theory in her comprehensive classification of the health-illness system of a barrio (Mexican American enclave) in Tucson. She does give examples of specific relationships between diet and health-illness conditions. Apparently the behavior persists; the underlying theory may be lost as part of the process of culture change.

None of my informants mentioned the theory as such, although they did allude to some of the behaviors. ("It is not good to drink something cold when you are all hot and sweaty.") The theory is not relevant to the four folk diseases in which I was particularly interested.

health-illness with the rest of the culture. All include examples of the various diseases as they were manifested, caused, diagnosed and treated in instances known to their informants.

Since my interest in this study is directed to children under five, I selected the four folk illnesses which commonly affect children (caída de mollera, mal de ojo, empacho and susto). Do Mexican children in Lansing get these diseases? If they do, how and where are they treated? Does belief in these diseases result in delay of medical treatment? Do mothers who believe in these diseases tend not to have preventive care for their children?

These four diseases "have remained firmly embedded in the socio-cultural framework, despite the introduction of an alternate system of belief and competing healing ways" (Rubel, 1960, p. 318). They are diseases that only people of Mexican heritage get and they are not amenable to treatment by scientifically trained physicians because they do not understand or believe in them. Rubel concludes that these four diseases will continue to be important to the traditionally oriented Mexican Americans because they "function to sustain some of the dominant values of the Mexican American culture" (Rubel, 1960, p. 813).

Macklin (1963) arrived at the same conclusion in her study of the Mexican-Americans in Toledo. She reports that most mothers know how to treat the common Mexican-American diseases; more serious problems are usually taken to a medical doctor. The Mexican-Americans feel that educated physicians are "adequate as far as their knowledge goes . . ." but laugh at or scoff at folk illness, therefore they are not equipped to

take care of them (p. 219). Many of the people visit a curandera who lives more than one hundred miles from Toledo. Macklin feels that the presence of this curandera serves to stabilize the social structure and inhibit culture change, since she "nearly always interprets illness in terms of deviation from approved Mexican-American behavior" (p. 222).

Specific Diseases

The following descriptions of the four diseases are condensed from Rubel (1960), Clark (1959) and Madsen (1964).

Caída de mollera (fallen fontanelle).--This is the only one of the diseases which afflicts only children, usually under six months of age. It is believed that the area of the head, directly beneath the anterior fontanelle and the hard palate balance each other. Anything which disturbs either the fontanelle or the palate can cause the fontanelle to fall, a condition which can be felt with the finger. Thus, a blow to the head or a fall can result in the fontanelle falling. Vigorously pulling the nipple from the baby's mouth while he is sucking can also cause the fontanelle to fall. In addition to the depression in the skull, a "little ball" can be felt in the palate. Symptoms include vomiting, diarrhea, fretfulness, inability to suck well and, usually, fever. There are four methods of treating fallen fontanelle, all designed to restore the balance between the fontanelle and palate. (1) The palate may be pushed up hard with the thumb in an effort to make the fontanelle "pop" back into place. (2) The curer may place her lips around the fontanelle and suck gently to bring the fontanelle back up. (3) The fontanelle may be covered with a thick soap suds or a solution

of egg white and water. This may be left to dry and pull the fontanelle up or the curer may cup her hand over the fontanelle and the solution, create a vacuum and pull upward. (4) The child may be held upside down by the ankles with the top of his head in a pan of warm water. Then he may be shaken gently, twirled, or the bottom of his feet may be slapped gently three times.

Mal de ojo (evil eye).--This disease may afflict anyone, although women and children are more susceptible, since they are weaker than men. It is believed that some people have "strong eyes" and can gain control over a weaker person. If a person with "strong eyes" admires or makes a fuss over a child, perhaps with envy, the child can get mal de ojo. There is no intent of evil on the part of the person causing it, and the spell will be broken if the person touches the child's head. If a mother suspects mal de ojo, she tries to determine who might have caused it and gets that person to touch the child. If this is not possible, other treatment is necessary. The illness has a sudden onset with intensive crying, trembling, insomnia and, usually, fever. Diagnosis is made by rubbing an unbroken egg over the body of the ill child, then breaking the egg into a glass of water. If a spot appears on the yolk, the diagnosis of mal de ojo is made. Treatment consists of rubbing an egg over the entire body in the shape of the cross while reciting prayers. The egg is then broken into a bowl of water, three small crosses are made on it with Holy Palm leaves (or broom straws) and the bowl is placed under the bed. In the morning, the child will be well. If the egg appears cooked, the fever has gone out of the child into the egg.

Empacho (a form of indigestion).--In this disease, a ball of undigested food gets stuck on the wall of the stomach or intestine. It causes pain, swelling, and loss of appetite; the hard ball may be felt. It may be caused by eating a food which disagrees with one, or by eating too much. Rice, bananas and soft white bread are particularly likely to cause empacho. It may also be caused by eating food one does not like or want to eat, or at a time when one does not want to eat. For example, if a guest eats food he does not want out of courtesy to the hostess, he may get empacho as a result. Treatment consists of rubbing the back and abdomen, pulling up the skin along the spine and letting it "snap" back, administering various herbal teas which have a laxative effect and maybe giving a dose of castor oil. (An Anglicized informant told Rubel (1966) that empacho is nothing but constipation and a good dose of epsom salts was all that was necessary.)

Susto (fright sickness).--This illness is caused by an experience which frightens the individual. Rubel (1960, 1966) says it occurs when the individual is in a situation in which he perceives himself to be helpless, frequently an inability or failure to meet social role expectations. The symptoms include fatigue, restlessness, loss of appetite and irregular pulse. There are many ways of treating susto. Most treatments utilize prayers, rituals using the sign of the cross, sweeping the body, and ingestion of herbal teas. They may extend over three or nine days. If not treated immediately, susto can be a serious and dangerous disease.

Madsen (1964), Clark (1959), Rubel (1960, 1966) and Saunders (1954) all stress the importance of interpersonal relationships as a

factor in the cause of disease and as a major factor in treatment of disease. Much of the success of treatment, they feel, derives from the concern, love and attention directed toward the patient. If the treatment is done by someone other than the mother, the family is consulted and participates in the rituals.

Curers

Rubel (1966) reports four levels of healers from whom the Mexican-Americans seek help when ill. The least specialized are housewives, who care for members of their own families. Next are neighborhood healers who usually are older women with experience in treating illness (señoras). "The most highly revered of all categories of healers, the curandero, is unlike any other" (p. 200). He or she cures by virtue of a gift from God. Finally, there are the certified physicians "whose technical skills and knowledge are accorded considerable respect by Chicanos" (p. 200).

Weaver (1970) describes the same categories of healers. He presented hypothetical illness situations to individual rural traditional Spanish Americans and to a group of acculturated urban Spanish Americans. All participants "were asked a series of direct questions about the symptoms, diagnosis, treatment, beliefs, and action associated with the particular ailment . . ." (p. 141). (Although Weaver's informants are Spanish American, their responses and behavior are the same as the Mexican Americans in other studies.) He describes four phases in the illness referral system. The first is the kinship phase, which includes consulting with members of the nuclear family and bilateral kin.

The second phase is the community phase, in which influenctial, knowledgeable and experienced people are consulted. The folk specialist phase, the third, includes culturally defined healers. The urban professional phase consisting of scientifically trained practitioners is fourth. The typical rural traditional patient goes from kinship to community to folk specialist to urban professional. The typical urban acculturated patient goes from kinship directly to urban professional, but may go to the folk specialist after the professional (p. 142).

There is concensus about these categories of healers. The traditionally oriented, unacculturated Mexican Americans are apt to have more contact with the folk healers and less with the physicians than are the acculturated. To a greater or lesser degree, some belief in the practice of folk medicine persists in both groups, on a continuum. It is not unusual to find people participating simultaneously in both systems in their search for a cure. Folk illnesses--those which only Mexicans get--are treated within the folk system. If a cure does not result, then perhaps it was not a folk illness, but something which a physician could treat. Conversely, if the physician does not cure the patient, then perhaps the problem should have been treated in the folk system in the first place.

Recent Studies

It is apparent from the foregoing discussion that the folk health care system has been studied within the context of the Mexican American culture. However, as stated earlier, the broad spectrum of health and illness has not been of major interest to those who have

studied this population.[1] The Mexican-American Study Project (Grebler, Moore and Guzman, 1970) produced an Advance Report related to health. Since the Study did not produce any original data, the Report is composed of existing materials, with some special tabulations (Moustafa and Weiss, 1968).

Shannon's (1966) study in Racine, Wisconsin, was initiated by a request from the State of Wisconsin Board of Health. They recognized a problem situation in the community peopled largely by Mexican-American immigrants. "Foremost among the problems were the poor physical health of the residents and their economic dependence or instability. Communicable disease rates were high and illnesses common. The children of the community were said to be ill-fed, ill-housed and ill-clothed by middle class standards" (p. 2). There were also problems of sanitation--no running water or sewers in the community. Professional people "experienced great difficulty in their attempts to reach this segment of the community and became aware of the fact that normal approaches were inadequate to deal with what they defined as an extremely desperate situation" (p. 2). The Department of Public Welfare and the Governor's Commission on Human Rights joined the discussions. It was decided that "research was urgently needed on processes of value assimilation and behavioral change among culturally separate immigrants to Midwestern

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[1]Locating what has been done recently in research into this area posed problems. Neither Med-Line nor Index Medicus has a category for Mexican Americans by any designation. Psychological Abstracts has no subject entry for Mexican Americans. Sociological Abstracts has an entry "Mexico (an) (ans)." Abstracts in Anthropology indexes by the terminology used by the author.

communities" (p. 2). However, the study did not include any questions related to health or illness. In the portion of the study dealing with respondents' perceptions of institutions in the community, the respondents were Anglo and Black, no Mexican-Americans, and no health institution was included.

The nursing literature offered little about the Mexican Americans. Baca (1969) presents a brief description of some of the concepts of health and illness held by the Spanish-speaking. She feels that it is important for nurses to know not only that these concepts exist, but that they persist. If the scientific measures and treatments which the nurses teach conflict with the folk system, the people "are apt to reject that which is foreign and contrary to their own tradition" (p. 2172).

More recently, Prattes (1973) provides a more comprehensive description of folk beliefs and practices. She, too, points out that they persist and will probably continue to persist because of the social isolation of the poor Mexican-Americans and the continuing in-migration from Mexico. She recognizes the frustration the nurse must feel "at their failure to see the benefits of scientific health care practices . . ." (p. 136). She points out that "scientific medical care is often not available to these people in a form that is meaningful to them, and many have seen little evidence of the benefits of modern medicine and nursing" (p. 137).

The persistence of the folk health care system is stressed also by ethnographers of the Mexican-Americans. They suggest that belief and

practice exist on a continuum, being strongest in the least acculturated and weaker in the more acculturated. However, they do not provide data on how many of any given group adhere to the beliefs and practices. Martinez and Martin (1966) report on an exploratory study "to determine the extent of knowledge about these (folk) concepts among Mexican-American women in a large Southwestern city; to obtain a detailed account of beliefs about etiology, symptomatology and modes of treatment . . ." (p. 161). They interviewed 75 Mexican-American women who lived in a public housing project. They found that "more than 97 percent of the women interviewed knew about each of the five diseases" (p. 162). The five diseases were mal ojo (evil eye), caída de mollera (fallen fontanelle), empacho (surfeit), susto (fright) and Mal puesto (hex). The causes and treatments reported by these women were essentially the same as those reported by others. "All but 5 percent of the women reported one or more instances of these illnesses in themselves, a family member, or in acquaintances" (p. 163). The respondents identified eight señoras and one curandera in the neighborhood. More than half reported having been treated by a señora, but only 20 percent had sought the services of a curandera. However, adherence to the folk system did not preclude visits to a physician. The authors conclude that "many Mexican-Americans participate in two insular systems of health beliefs and health care" (p. 164). Folk diseases are treated within the folk system because physicians do not believe in or understand these diseases.

Creson, McKinley and Evans (1969) report a study which, they state "replicated the work of Martinez and Martin" (p. 266). However,

their sample was smaller and was selected from a different group. "Twenty-five consecutive patients with Spanish surnames were interviewed in the Pediatric and Psychiatric Outpatient Clinics of a teaching hospital" (p. 264). Twenty of those interviewed were female, five were male. Since the care of the sick is culturally vested in the female, their findings may reflect lack of knowledge on the part of the males. They felt that twenty of the subjects had "a good knowledge of the tenets of folk medicine. This was defined as knowledge of at least four of the five syndromes . . . with some knowledge of symptoms and treatment procedures" (p. 265). Many of the subjects mentioned using folk remedies at home, particularly herbal preparations. Someone in twelve of the families had used the services of a curandera. The authors conclude that "the concept of folk illness was deeply entrenched and resistant to the influence of the Anglo culture and its scientific medicine" (p. 265).

Folk-Scientific Articulation

The relationship between adherence to the folk health-illness system and seeking and using care in the Anglo system has received little attention in the literature. Most of the studies relate to adults who have a mental illness which was diagnosed and treated in the Anglo system. Since this study is concerned with physical illness in children, the above body of literature has little relevance. (See Appendix B for a review.)

A recently reported study purports to examine the relationship between folk medical beliefs and health care of Mexican Americans in Nebraska.

> A sample of Mexican Americans was interviewed to ascertain their attitudes toward medical care and doctors and to determine what kinds of medical care they are receiving. Social characteristics of the respondents are examined to explain differences in "folk" medical beliefs. Beliefs are most strongly related to the size of the Mexican-American community the respondent lives in, but are not highly correlated with any characteristic [Welch, Comer, and Steinman, 1973, p. 205].

Nowhere in the article do the authors state that they asked any questions pertaining to the folk health system. Apparently they infer belief in the system from responses that seemed to indicate closeness to Mexican society and culture (use of Spanish, length of residence in the United States, birth place of respondent's parents and size of Mexican-American community). They conclude that "there seemed to be relatively little evidence of a prevailing 'folk' medical culture" (p. 212). In general, they found that social variables (income, age, sex, education) explained differences in health care to a much higher degree than did attachment to the Mexican culture. Their findings are similar to Suchman's (1965a and b, 1966) which are reviewed below.

Nall and Spielberg (1967) recognize that Mexican-Americans' conceptions of disease differ from Anglos, but do not accept the implication that "the presence of such folkways represents a causal dimension of the frequent rejection of modern medical practices by Mexican-Americans . . ." (p. 300). Acceptance or rejection of treatment for tuberculosis is the focus of their study. They inferred that commitment to the folk health system was not related to rejection of treatment for tuberculosis. Commitment to the folk system was defined as experiencing the illness or describing its occurrence in the family or in a close

friend. They did find that strong integration into the ethnic subcommunity favored rejection of treatment, and vice versa. They conclude that "the findings imply that the milieu of the Mexican-American sub-community is "unfavorable" to the . . . techniques embodied in the medical regime for tuberculosis treatment" (p. 306).

Socio-Cultural Factors

Nall and Spielberg's (1967) milieu is highly similar to the ethnocentrism described in several reports by Suchman (1964, 1965a, b, 1966), concerned with social patterns of medical care. He summarizes the findings as follows:

1. The lower socioeconomic and minority groups are significantly more socially isolated, parochial, or ethnocentric.

2. Ethnocentrism is, in turn, highly related to less knowledge about disease, unfavorable attitudes towards medical care and dependency upon group support during illness.

3. The lower socioeconomic and minority groups hold these "negative" health orientations to a significantly greater degree than the upper socioeconomic groups. The individual's degree of ethnocentrism strengthens or weakens his conformity to the overall medical orientation of his group [1966, p. 667].

Suchman (1964) found that the Puerto Ricans in his study were highly ethnocentric with families strongly oriented to tradition and authority and having a non-scientific or "popular" orientation to health and medical care. However, he did not ask any questions about specific folk illnesses. Since the Puerto Ricans, like the Mexican Americans, have a Spanish background, it is safe to assume that at least some of their folk beliefs would be similar (Foster, 1953).

Reeder and Berkanovic (1973) report on a "partial replication" of Suchman's study. They replicated Suchman's questions related to medical orientation. They were not able to replicate his questions pertaining to community orientation. However, they feel that their items "connote a theoretical dimension similar to Suchman's . . ." (p. 136).

Their argument of theoretical similarity seems to be weakest in the dimension of traditionalism. Suchman's items refer to family tradition and authority; Reeder and Berkanovic's do not. Since 15 percent of their sample was Mexican American, a group with strong family orientation and authority, the similarity may not be as great as the authors believe. Their findings did not support Suchman's. In fact, they state that their evidence "directly contradicts Suchman's findings . . ." (p. 142) with respect to the relationship between ethnocentrism and medical orientation. They suggest a number of reasons for the differences. They conclude, however, that the "relationship between medical orientations and health behavior remains to be established . . ." (p. 143).

Anderson (1971) reports on a comparative study of socio-cultural variations in response to illness. The study group consisted of 270 families--some Anglo-Americans and some Spanish-Americans--living in a rural area in southern New Mexico. He never mentions how many of the families were Anglo-American and how many Spanish-American. His Spanish-Americans were probably Mexican-Americans, since Spanish-Americans are more apt to live in northern New Mexico. The literature to which he refers all pertains to Mexican-Americans. He says that

Grebler, Moore and Guzman (1970) "have estimated that the 1970 U.S. Census will reveal about 5.6 million Spanish-Americans living within the United States" (p. 1). The work to which he refers is entitled The Mexican American People. In comparison with the Anglo-Americans, the Spanish-Americans were younger, had larger families, were more poorly educated and had more low status jobs. He says that the two groups "are somewhat comparable in socioeconomic conditions" (p. 16). They found that the Anglo-Americans resorted to self-treatment for illness as frequently as did the Spanish-Americans. However, "the utilization of existing health services by Spanish-Americans was found to be lower than that of Anglo-Americans" (p. 15). The Spanish-Americans had considerably more children born somewhere other than a hospital and delivered by someone other than a physician. Spanish-Americans had a higher level of anxiety about their health and tended to rate their health as fair or poor more often than did the Anglo-Americans, yet no differences in health were detected in the multiphasic screening. The author reports that preventive care is low, based on immunization levels.

Poverty and Health

The relationship between low socioeconomic status (poverty), poor health and inadequate health care has been well documented. James (1965), Commissioner of Health for New York City, compared the mortality rates for five of the ten leading causes of death in a middle class white area and a lower class, poor white, Black and Puerto Rican area.

If the poor area had had the same rates as the middle class area, there would have been 13,000 fewer deaths in the poor area. He concludes that "poverty is the third leading cause of death" (p. 1764).

Hochstim, Athanasopoulos and Larkin (1968), in a study in Oakland, found that people who lived in a poverty area, had low incomes and were members of a minority group had more health problems and less health care than high income whites in a non-poverty area.

Hurley (1971) presents an excellent review of the current literature related to poverty, illness and inadequate medical care. The poor are crowded into deteriorating or dilapidated housing in a physical environment inimical to good health. Little preventive health care is available to them. They have more illness and more serious illness than the non-poor. Mortality rates for a number of conditions are higher for the poor than for the nation as a whole. By any index, the poor need more health care than the non-poor, and have less.

Bice, Eichhorn and Fox (1972) review the literature related to socioeconomic status and the use of physician services. They conclude that "relationships between income and use have diminished considerably over the past four decades. Race and education remain consistently related to use" (p. 269). They found little evidence that socio-psychological variables accounted for a difference in use among socioeconomic groups. They suggest that "Medicare and Medicaid have probably played a major role in increasing access to physician services among the poor" (p. 269).

Olendzki, Grann and Goodrich (1972) studied the effect of Medicaid on the use of private care by the urban poor. Those who considered a private physician their major source of care increased from 1 percent prior to Medicaid to 10 percent after. The majority continued to use publicly supported clinics, some because they preferred them and some because there were too many barriers to private care.

The relationship between cultural-social-psychological factors, demographic variables and utilization of health care services remains cloudy. However, the advent of Medicaid would have no effect on the utilization of preventive care, since Medicaid does not pay for preventive services.

Preventive Care

Literature pertaining to preventive health care for Mexican American children in low-income families is limited indeed. However, there is a body of literature related to utilization of health care services, both preventive and curative, for children in low-income families. It can be divided into two broad categories--random sample surveys of a particular population and surveys of the population of a particular source of care.

Surveys of a Population

Mindlin and Densen (1969, 1971) conducted a survey on a random sample of new-borns in two areas of New York City. One area was an inter-racial slum with Negroes, whites and Spanish. (In New York City,

Spanish are Puerto Rican). The other area was composed largely of middle-class white families. They were interested in the illness and medical experiences of the babies during their first year of life. They reported separately on continuity of care (1969) and health supervision (1971).

The authors "have devised a numerical index which combines visits and immunizations to give a rating of the amount of health supervision an infant receives" (1971, p. 687). They object to immunization status alone because it ignores other aspects of care.

They found that infants in the middle class have markedly more care than infants in the lower class. Low education of the mother and low family income are associated with less care; however, ethnicity and residence have a higher influence. Infants in a single-parent family or a large family were apt to have poor care.

They define continuity of care as "having a single source of medical care during the year, or getting to subsequent sources only by referral from earlier ones . . ." (1969, p. 1295). They state that "continuity is considered an attribute of good medical care" (1969, p. 1294). Their findings were much the same as in the above study. There was generally less continuity for children in the lower socio-economic group. There was less continuity for Negro and Spanish babies than for white at the same education and income level in the same community. All infants with continuity of care scored better on the Health Supervision Index.

Schonfield, Schmidt and Sternfeld (1962) report a study conducted by the local health department in Cambridge for the purpose of

providing a community setting for health studies and health training for a variety of disciplines and to gather data for program development and improved health services. They selected a random sample of birth certificates and studied 163 mothers and infants (6.6% of annual births).

They found poor health supervision related to low educational level of the mother, lower social class, large family, clinic care and late antepartum care.

Gallagher (1967) studied 10 percent of the infants born during a ten month period in a three county urban area in the midwest. His objective was to get some basic facts about community health needs and behavior. The sample of 279 infants represented all social classes--he makes no mention of race of the infants.

No preventive health care for the infant was heavily concentrated in the lower clases, and correlated highly with no antepartum care. Reason for not seeking care were lack of knowledge of the value of health supervision, transportation problems, baby-sitting problems and expense. Free clinics were available, but some mothers preferred private care and sought care only for illness. The author points out that, although inadequate care was concentrated in the lower classes, this was not the norm for that group. Most of these infants had adequate care.

Smiley, Eyres, and Roberts (1972) studied a group of 403 mothers and infants who lived in high risk areas in Detroit--those areas with the highest maternal and infant mortality rates in the city. They wanted to learn if there were characteristics which would predict which

babies were most at risk of illness and death in a nominally high risk population. The babies who had at least one episode of sickness during the first three months of life tended to have unhappy mothers who lived in a socially isolated, non-supportive environment. The mother and baby had probably moved during the three-month period. The mothers had medical care either late in pregnancy or not at all.

The mothers' use of prenatal care was also predictive of her use of well-child care for the baby. Mothers who had prenatal care early tended to have well-child care for the infant. Those who had prenatal care late or never tended not to have well-child care for the baby. The latter group also tended to be older, unmarried, mobile, poorly educated mothers who had a low income and large family.

Surveys of Population of a Source of Care

Studies of families who utilize a particular source of care address themselves, for the most part, to differentiating between those families who make good use of the service and those who do not.

Stine et al. (1968) were interested in determining characteristics which might help to explain the frequency of broken appointments among the lower social class patients. They felt that "prediction of the likelihood of appointment breaking in a given family in the future . . . would provide a rationale for efforts to change parental information, attitudes or habits" (p. 333).

The study population consisted of the 203 low-income Negro families who received comprehensive child health care in the Maternal and Child Health Clinic of Johns Hopkins University School of Hygiene

and Public Health. There was no charge for the care which was provided in an attractive setting by a friendly staff.

They concluded that, with multiple factors considered, completion of high school by the mother explained the greatest proportion of variation between mothers in appointment keeping. Urban origin of the mother and poor marital relationships were associated with poor appointment keeping. "The concept of social disintegration of poorly educated urban families gave more meaning to these findings than the concept of social class" (p. 339).

Alpert et al. (1970) were interested in evaluating the effectiveness of a comprehensive health care program for children in low-income families. The study group was comprised of 250 low-income families receiving comprehensive care and a control group of 250 families receiving traditional fragmented care at Boston Children's Hospital Medical Center. Both groups of families were interviewed initially. The experimental group was interviewed at six-month intervals for three years. The control group was interviewed again at the end of three years.

Mothers' attitudes toward preventive practices, physicians and the relative importance of health showed no change over the three years. The mothers in the comprehensive group showed greater satisfaction with the care received, more use of the telephone in seeking help and a greater preference for a primary physician. They made more visits for health supervision.

Medicaid was initiated during the time period of the study. However, the authors state that "it is clear . . . that provision of

comprehensive services has a much greater impact than provision of a payment mechanism alone" (p. 505).

Nolan, Schwartz and Simonian (1967) report a study of utilization of pediatric services in the Kaiser Foundation Health Plan in Oakland. They wanted to determine whether social, ethnic and educational characteristics seem to influence the use of pre-paid medical services. The study group included all children who were seen in the Appointment Clinic (339), the Drop-In Clinic (367) and the Emergency Room (22) during a four day period.

Families in the upper social classes made significantly more visits for health supervision; those in the lower social classes made more visits to the Drop-In Clinic for acute care. With social class controlled, whites made more visits for health supervision than did Negroes. Whites were apt to have more continuity of physician care. Negroes made more evening and Saturday visits.

Belkin et al. (1964) interviewed a representative sample of 247 mothers who used the Child Health Stations in New York City. Their purpose was to determine what the mothers thought and felt about the clinics. All mothers were in the lower social classes; 55 percent were Negro, 23 percent Puerto Rican and 22 percent white. Younger, better educated and higher income mothers viewed the care at the Clinic less favorably than did the older, less educated and lower income group.

Gold, Stone and Rich (1969) report on a study of the Maternal and Infant Care Program in New York City. About 1,000 "super high-risk" pregnant women are selected each year and offered comprehensive care;

well-child care is offered for the infant. The Clinic population is overwhelmingly Negro and Puerto Rican.

In reviewing broken appointments during the first 19 months of operation, they found the rate to be 19 percent for antepartum appointments and 36 percent for well-child appointments. Home visits by public health nurses are said to be a major aspect of follow-up of broken appointments. However, the information given indicates home visits for this purpose only to maternity patients. They offer no explanation for the broken appointments (1968).

In the later report, two time periods are used with comparisons between the first thirteen months of operation and the next eighteen months. The broken appointment rate for antepartum visits remained stable at 19 percent. The rate for well-child care increased from 38 percent to 43 percent. The authors conclude that the patients "exemplify their traditional attunement to seek care for illness or catastrophe . . . they are, however, not so well attuned to seek preventive medical services . . ." (1969, p. 1853). They suggest a need for socio-cultural and motivational studies to determine the reasons for this disparity in motivation for care.

Morris, Hatch and Chipman made two reports (1966a, 1966b) of a study of 246 lower social class infants referred at birth for well-child care at the North Carolina Memorial Hospital Well-Baby Clinic. Over 75 percent of the families were Negro. The purpose of the study was to learn more about the factors which acted as deterrents to well-child care as a first step in decreasing broken appointments.

They found that whites made more visits than Negroes. Less preventive care was associated with lower educational level of both mother and father, low status occupation, big families, distance from the Clinic, little knowledge of purposes of well-child care and alienation (1966, p. 1).

The second report deals specifically with alienation as a deterrent to well-child care. Social isolation predicted care-seeking behavior in whites in low status occupations. Powerlessness predicted care-seeking behavior in whites in the lowest educational group. Alienation did not predict care-seeking in the Negro families. With race and occupational status controlled, there was no significant relationship between agreement on the purpose of well-child care and care seeking behavior. It cannot be assumed that people act according to what they know (1966, p. 2).

Triplett (1969, 1970) studied perceptions of well-child clinic services held by 40 white women in a midwestern city. Twenty of the women were good users of the service, twenty were poor users as defined by public health nurses. Her purpose was to discover if there were demographic or personal characteristics which differentiated the two groups. Her particular concern was with threat and disparity perceived by the women in inter-relationships with health professionals.

She found no relationship between use and age, social class or education. Poor users were more apt to be heads of households, receiving welfare and have more children. Good users tended to have lower self-esteem, be more socially isolated, express feeling lonely, and feel more threat (1969).

In another report of the same study, she hypothesizes that the poor users have built up strong defenses for their inadequacies and tend to avoid failure. The good users attend clinic, despite threat, because they get some positive support and it provides them with some socialization (1970).

Brinton (1972) and LaFargue (1972) report separate but related studies done in the Maternal and Infant Care Pediatric Clinic in Seattle. More than 60 percent of the mothers failed to keep their appointments for follow-up health care for their infants. The studies "were undertaken to determine factors which might be limiting the program's effectiveness" (Brinton, p. 46).

Brinton studied differences in values pertaining to health and health care between public health nurses and low income families. The study group consisted of ten black mothers, five of whom kept their appointments and five who failed to keep their appointments; ten white mothers, six of whom kept their appointments but four who failed to keep their appointments; and 23 public health nurses. All infants were "recognized as having certain high-risk conditions, medical or social" (p. 48). All the nurses were white, well educated, middle class and young.

Questionnaires designed to determine the degree of importance attached to health concerns, value priorities and value orientation were administered to the mothers and the nurses. In addition, the nurses were asked to respond as they thought the mothers would. The nurses and the mothers gave similar replies to the importance of health,

except for the importance of home remedies and luck, which more mothers saw as important. However, the nurses perceived the mothers as having quite different values from theirs in regard to health.

Of the mothers who kept appointments, 82 percent felt that it was important to take a child to the doctor when he was sick. Of those who failed appointments, only 44 percent felt it was important.

The author devised a "preventive care score" for the mothers, based on when the mother began prenatal care, whether she had a post-partum check, and immunization status of the infant and other children, if any (Brinton, page 49). Of those who kept appointments, 91 percent were oriented to preventive care. Of those who failed appointments, 45 percent had a preventive care orientation; they had obtained preventive care from a source(s) other than the Clinic. The 55 percent who failed appointments were not oriented to preventive care and had not received preventive care from an alternative source.

LaFargue (1972) studied the same 23 nurses and the ten black mothers in an effort to determine whether prejudice prevents black mothers from seeking health care. Racial prejudice among the nurses (all white) was relatively low. All of the families felt that they had been discriminated against, at some time, because of their color. All five who failed appointments and three of those who kept them felt that there was discrimination in the health care field. The families felt that they had been treated unfairly by doctors, clinic nurses, social workers and hospital clerks.

The only study I found which specifically includes Mexican American children (Wingert, Friedman and Larsen, 1968) is concerned

with illness care, not preventive care. The authors interviewed the parent(s) of 3,058 children who were brought to the Pediatric Emergency Room of the Los Angeles General Hospital. They reported on three ethnic groups--Caucasian, Negro and Mexican-American. Mexican-Americans comprise 8.5 percent of the population of Los Angeles County; however, they accounted for 29.6 percent of the visits to the Emergency Room. Mexican-American families were the largest and the most intact. The fathers had the highest employment rate and the mothers the lowest of the three groups. The families were characterized by low income, low educational level, low status occupation and poor or no relationship with private physicians. Immunization levels were rather low in all three groups, with no appreciable difference between groups.

Articulation with the Anglo System

It is apparent that Mexican Americans have some contact with the Anglo health care system, and that the amount of contact is increasing. However, according to a number of authors, much of the contact results in negative experiences which serve to discourage further contact. Although Rubel (1966) says that the "technical skills and knowledge . . . [of physicians] are accorded considerable respect by Chicanos" (p. 200), he does not give any examples of a positive relationship or experience.

Rubel (1966) does give some examples of negative experiences and points out a number of reasons why the Mexican-Americans do not use the health care available to them. One reason is the tremendous

social distance between the poor, poorly educated Mexican-Americans and the upper-class, well educated physicians with their professional culture and vocabulary. The communication gap is increased when the patient has a poor command of English; very few physicians speak Spanish. The Mexican-Americans object to the fee for service, which is not part of their traditional curing system. They feel that doctors are only interested in getting paid and do not care about the person. Physicians are ignorant of the health concepts of the Mexican-Americans and do not listen to their complaints.

The physicians who provide medical care to the Mexican-Americans with whom Rubel (1966) worked see their role as both health care providers and as teachers. They recognize changes in the traditional patterns of health behavior of the Mexican-Americans, but are dismayed and puzzled because the people do not accept the whole complex of scientific treatment and prevention. The physicians feel that treatment by the traditional curers delays the beginning of medical care to the detriment of the patient.

Saunders (1954) provides examples of negative experiences of Spanish speaking people in contact with the Anglo health care system. He, too, suggests a number of reasons for the limited use of Anglo medical care.

> The most important differences between Spanish-American folk medicine and Anglo scientific medicine that influences the choice of one or the other are these: Anglo scientific medicine involves largely impersonal relations, procedures unfamiliar to laymen, a passive role for family members, hospital care, considerable control of the situation by professional healers, and high costs; by contrast the folk medicine of Spanish-American villagers is largely

> a matter of personal relations, familiar procedures, active family participation, home care, a large degree of control of the situation by the patient or his family, and relatively low costs. Given these differences, it is easy to understand why a considerable motivation would be necessary for a Spanish-American to have any strong preference for Anglo medicine over that which is not only more familiar and possibly psychologically more rewarding--or at least less punishing--but also less expensive [p. 168].

Madsen (1964) likewise relates negative experiences. A bustling, efficient public health nurse was unwelcome in the homes because she had "strong eyes" and spread sickness (mal de ojo) among the children. The people could not believe her statements that she understood sickness and wanted to help them because she did not even know enough to touch (prevent mal de ojo) the children she admired. One of Madsen's informants comments on the differences between being treated by a curandero and a physician. "A curer cures because he cares. The doctor cures because he likes money and power. . . . A curer admits there are things he cannot cure and helps you find someone to treat it. Have you ever had a doctor send you to a curer because your sickness was susto?" (p. 91).

Clark (1959) describes several situations in which the Anglo physician displayed sympathy and understanding which resulted in a positive experience. These experiences are the exception rather than the rule, however. Physicians are generally viewed as cold, impersonal and efficient, more interested in money than in people. They are authoritarian; curers have no authority in the Mexican-American culture. Nurses may be criticized more harshly than physicians, perhaps because they come to the home and work directly with the family, much as the curandera does.

Cabrera (1971) discusses the poor health and poor health care suffered by the poor, many of whom are Mexican American. In an agricultural area, one physician reported that 100 to 200 farm workers suffered each year from pesticide poisoning. He objected to the lack of enforcement of safety regulations regarding pesticides. Another doctor in the same community "expressed a pride in the effectiveness of the hospitals. He believed the hospitals, as well as the doctors' offices, were open to all regardless of economic means" (p. 22). The prevailing sentiment in the community was that the gringos "do not understand the embarrassment Mexicans feel when they are unable to pay their bills" (p. 22). Lack of money makes Anglo health resources unavailable to many Mexican Americans. Folk treatment is better than no treatment at all.

Moore (1970) suggests a different reason for the lack of use of Anglo health agencies by Mexican Americans. "Officials in public agencies almost always comment on the passive 'hard-to-reach' character of the Mexican approach to public agencies. . . . Mexicans are not responsive; they withdraw; they are uninterested; they lack aggressiveness" (p. 94). Cultural explanations are advanced; however, Moore considers it equally logical that the Mexicans are suspicious and do not trust the government. In studies done by health agencies, the conclusion reached is that Mexican Americans avoid using the services because of cultural conflicts. "But some of the studies also note, sometimes almost in passing, that the public health worker is greeted in the Mexican American home just as is any other government worker, as somebody coming to cause trouble" (Moore, 1971, p. 95).

As mentioned in an earlier discussion of Shannon's (1966) study in Racine, he did not gather any information about health status, health practices, or contact with any health professionals. He studied economic absorption and cultural integration and approaches the area of health from this frame of reference. "The fact that public health nurses found it difficult to establish rapport with immigrant workers or their families suggests that they were not defined as part of the overall change which the Mexican-Americans and Negroes sought as a consequence of their moves from the South and Southwest" (pp. 441-2). He suggests that the Mexican Americans could not communicate with the public health nurse because they could not identify with an English speaking, uniformed, middle class Anglo. The formal, bureaucratic structure of any social agency serves to impede its utilization by the immigrant groups.

It is apparent that there are many factors involved in the relationship between Mexican Americans and the health professionals and institutions of the Anglo health care system. There is misunderstanding and lack of understanding of concepts, practices, methods and goals on the part of both groups. Problems of communication are compounded when the person who is seeking care does not have a good command of English.

A recent article in the Journal of the American Medical Association exemplifies many of the problems. A local pediatrician who knows of my interest in the Mexican American folk health care system asked me if I had read the article in JAMA which told about treating a baby by

holding his head in boiling water. At that time, I had the reference (Guarnaschelli, Lee and Pitts, 1972) but had not read the article. I proceeded forthwith to read it. A Mexican-American baby, two months old, was admitted to the Pediatric Unit of the hospital. "The patient exhibited areflexia, paleness, and lack of spontaneous respirations. Although no external signs of trauma were noted, the anterior fontanelle was full and moderately tense . . ." (p. 1545, italics mine). The initial history obtained from the parents indicated a normal birth and uneventful development. Two days before admission, the baby

> became irritable, listless, and vomited forcefully. Diagnostic studies included a retrograde femoral angiogram demonstrating bilateral, large subdural mantles. Deliberate questioning then revealed that the infant had had a sunken fontanelle. In order to reverse the effects of the fallen fontanelle, or caída de mollera, his grandmother subjected the infant to a series of therapeutic maneuvers. The last of these consisted of holding the infant upside down by his ankles with his head partially immersed in boiling water, shaking him vigorously three times while slapping the soles of his feet [p. 1545, italics mine].

The authors comment on the persistence and importance of folk concepts of disease to Mexican-Americans. They describe the cause and treatment of caída de mollera, giving Foster (1953) and Clark (1970) as references. (Clark's book, originally published in 1959, was reissued, unchanged, in 1970.) Four maneuvers in treating caída de mollera are described by the authors. I was familiar with the first three, but not the fourth "the child is held by his ankles, with the crown of his head dipped into a pan of boiling water. After two to three minutes, the curandero pounds or slaps the soles of the infant's feet while the child is still in an inverted position" (p. 1545). They do not cite a direct quote for the treatment.

The authors state that it is difficult to determine the frequency of folk treatment of caída de mollera in southern California. They refer to the survey done by Martinez and Martin (1966) in which 97 percent of the mothers interviewed knew of the sickness caída de mollera, but "only 33 percent would admit knowledge of its treatment. This trend is consistent with the extreme reluctance on the part of our patient's family in relating the grandmother's role as curandero" (p. 1546).

They cite examples of subdural hematoma occurring without visible signs of head injury, as in whiplash injuries and in "severe rotational acceleration/deceleration injuries produced in monkeys" (p. 1546). They conclude that "it is conceivable that the folk treatment of caída de mollera served as a whiplash injury, resulting in a rotational/acceleration mechanism for this infant's subdural hematoma" (p. 1546).

I was familiar with the literature on folk treatment of caída de mollera; nowhere had I seen boiling water mentioned. Further, I was familiar with how the Mexicans felt and behaved toward their children; it was inconceivable to me that any Mexican would subject a child to anything as painful as boiling water. Completely apart from any knowledge of Mexican American folk concepts, it did not seem possible to me that a baby could have his head boiled, yet have no external signs of trauma two days later.

I checked Foster and Clark for treatment of caída de mollera. Foster (1953) does not mention water at all in the treatment of this

condition. Clark (1970) says that the infant "may be held up by the ankles, head down, with the crown of the head dipped into a pan of tepid water" (p. 171). I wrote a letter to the editor of JAMA in which I quoted the treatment directly from the references given by Guarnaschelli, Lee and Pitts (C. Lindstrom, 1973).

The negative bias of the authors is apparent in their translation of curandero as "quack" (p. 1545). It is also apparent in their acceptance of the "boiling water treatment," in view of the fact that the baby had no evidence of burns.

The authors misinterpret the findings of Martinez and Martin (1966). Martinez and Martin did find that more than 97 percent of the women knew about the diseases, caída de mollera included. However "85 percent of the women reported therapeutic measures for all the males except for mal puesto, but only one-third could or would admit knowledge about its treatment" (p. 162). Males are sicknesses; mal puesto is a hex--a sickness or evil "put on someone willfully by another. This putting of an evil or hex can be done either by a curandera or bruja (witch) upon request, or by any person knowing the intricacies of witchcraft" (Martinez and Martin, 1966, p. 163). Thus, 85 percent of the women knew about the treatment for caída de mollera. Guarnaschelli, Lee and Pitts do not say "could or would admit knowledge," only "would admit knowledge" with the implication of "extreme reluctance" which they noted in the baby's family.

Guarnaschelli, Lee and Pitts consider the folk treatment for caída de mollera to be a variant of the battered child syndrome. If one defines the battered child syndrome as any injury done by an adult

to a child, then perhaps this situation is a variant. An expert in the field of child abuse does not think it is, however (Helfer, personal interview).

Caffey, a pioneer in the field of child abuse, says, "Many cerebrovascular injuries attributed to prenatal infection or congenital malformation may actually have been caused by undetected whiplash shakings during the first weeks or months of life" (Caffey, 1973, p. 151). Cerebrovascular injuries of infants and young children as a result of rough handling, including shaking, are being studied by pediatricians in this country and Great Britain. Subdural hematoma is the same injury, whether caused by shaking or treatment of caída de mollera. However, the mechanics of the injury are different, requiring different approaches for prevention or recurrence.

I cannot explain why Guarneschelli, Lee and Pitts believed the boiling water treatment. I can offer an explanation of why they were told boiling water was used in the treatment. The authors do not mention how much command of English the family had; neither do they mention using an interpreter. It seems probable that the parents of the baby had some knowledge of English, but not a great deal. They knew that their baby was very sick; their anxiety level must have been high indeed. With this stress, their ability in English would decrease. The "deliberate questioning" which elicited "with great reluctance" the information about the folk treatment was probably done by an angry Anglo speaking rapidly. Under these circumstances, the frightened, anxious parents may have translated aqua caliente (warm water) as boiling water (aqua herviendo) instead of warm water. On the basis of my experience

with Mexicans whose English is not very good, this explanation is reasonable and highly probable.

After I had read the article, I talked with the pediatrician who had mentioned it to me. I asked him if he believed the part about the boiling water. He said yes, he did. When I pointed out that the baby did not have a burned scalp, he agreed that the boiling water was unlikely. He said he scanned the article, which is what most pediatricians would do. Since this man, who has more interest in and knowledge of Mexicans than most pediatricians, believed it, I expect that any physician who read it would believe that the baby's head had been held in boiling water.

Articles like Guarneschelli's, with its strong negative bias, lack of understanding of Mexicans and Spanish and misrepresentation of some of the pertinent literature, can only serve to widen the gap between the Anglo health professional and the Mexican people who need health care.

CHAPTER III

METHOD

Introduction

Preparation

> A celebrated malariologist who worked on the Panama Canal project made a remark which lingers in the memory of his public health disciples. "If you wish to control mosquitoes," he said, "you must learn to think like a mosquito." The cogency of this advice is evident. It applies, however, not only to mosquito populations one seeks to damage, but also to human populations one hopes to benefit. If you wish to help a community improve its health, you must learn to think like the people of that community. Before asking a group of people to assume new health habits, it is wise to ascertain the existing habits, how these habits are linked to one another, what functions they perform and what they mean to those who practice them [Paul, 1955, p. 1].

I learned, in the first course I took in public health nursing, that I was supposed to be able to 'think like a mosquito' in order to practice public health nursing successfully. As long as I worked only with English-speaking people, I could 'think' in English.

When I began working with Spanish-speaking people, I was frustrated, initially and overwhelmingly, by my inability to communicate with them. At Cristo Rey, there was usually someone available to interpret for the professional and the mother. I was never completely satisfied with this, however, because I did not know if the translator's bilingual vocabulary was adequate for the task. Some knowledge of

Spanish would have enabled me to use the interpreter's help to better advantage.

A knowledge of Spanish was also necessary for some understanding of how the Mexicans with whom I work do think. We think primarily in words--language--the same words we use to communicate our thoughts, ideas, feelings and to describe our experiences and the world within which we live.

However, language does more than provide us with the symbolic tools which we use to describe experience. The Sapir-Whorf hypothesis suggests that "language functions, not simply as a device for reporting experience, but also, and more significantly, as a way of defining experience for its speakers" (Hoijer, 1954, p. 93). In an intensive course in Spanish, I learned the structure of the language and developed some verbal skill. This proved invaluable in my contacts with the families during the data collection process.

In addition to knowing the language, I needed a good background in the culture of the Mexican Americans. I needed to know something of their family life and child rearing practices; something of their values and attitudes, particularly in relation to health and illness; something of their reactions to Anglo health professionals. With this knowledge, I would be able to relate to them in a manner acceptable and meaningful to them.

Ethnographies about the Mexican Americans provided me with a picture of their life style, their values and how health and illness fit into their perception of life and living (Clark, 1959; Madsen, 1964; Saunders, 1954; Macklin, 1963; Rubel, 1966). Kiev (1968) provided

particular insight into the relationship between interpersonal relationships, expected behavior, mental illness and folk curing methods.

When I was ready to begin interviewing, I knew something about acceptable and unacceptable behavior in Mexican homes. I knew the Spanish names for diseases, something of their causes, symptoms and cures. I knew what specific aspects of family life, values and behavior I wanted to observe and learn more about.

Process

As a public health nurse, I was accustomed to interviewing, observing and recording. However, my objectives as a public health nurse were different from my objectives as a social scientist. With some reading and guided practice, I learned to observe, interview and record like an anthropologist (Wax, 1960; Whyte, 1960).

With some modifications, I followed the traditional anthropological method of participant observation and interviewing key informants in the community. I had frequent and continuing contact with the Mexican American families from November 1972 through August 1973. However, I did not live in the Mexican American community.

Observations included maintenance of housing (interior and exterior) and yard and characteristics of the neighborhood as described in the Michigan Health Survey (Michigan Department of Public Health, 1970a) and in Appendix A. While I was in the homes, I made a number of observations related to homemaking practices. I also observed family members interacting with each other and with people other than immediate family members, both at home and in other settings.

Conversations covered a wide range of topics not included in the interview. Informants talked about their relationships with their parents and siblings, their husbands, in-laws, children and neighbors. They described experiences and aspects of life in Texas and in the migrant stream. My open-ended questions usually elicited a lengthy response.

To facilitate ease and completeness of recall, I seldom had contact with more than two families in one day. I made copious notes both on the questionnaire form and in a notebook. Following a visit with a family, I wrote detailed field notes. When the field work was completed, I had about 150 pages of notes, excluding those on the questionnaire forms. The notes provided the data for the following chapters.

The Questionnaire

Development

Since no one has studied the perceptions and behaviors of Mexican mothers regarding health and illness in their preschool children in relation to their utilization of preventive care in the Anglo system, it was necessary for me to develop a tool specifically for use in this study.

I gained ideas for the design of the questionnaire from a number of sources. During the time that I worked as a public health nursing consultant for the Michigan Health Survey, we revised the questionnaire several times. The revisions were the result of long and at times

heated discussions among those who conducted the interviews, program directors from the health departments involved, the nursing consultants, the director at the state level and the consultant in questionnaire design. During the process, I learned a great deal about designing a health information questionnaire, particularly in the areas of the order and wording of the questions.

Other ideas for the questionnaire came from two major sources. The study done by Smiley, Eyres and Roberts (1972) in Detroit resulted in information about utilization of preventive care for infants in low-income families. Although the families involved were not Mexican, they were low-income; lack of money presents a common barrier to utilization of health care. Smiley is a public health nurse; we have many interests in common. We spent an afternoon discussing my proposed study, her study, methodology and some of the problems she had encountered and I might anticipate.

Smiley shared with me a copy of Steckert's paper reporting a study of the medical beliefs and behaviors of southern mountain women living in Detroit. This paper was published later (Steckert, 1971). It was of particular interest to me for several reasons. The southern mountain people have migrated to Detroit from a poverty stricken rural area and come from "a culture alien to that of our large urban centers" (p. 95). They bring with them folk health beliefs and practices which persist and are glorified--"the way things were done back home in the past was far superior to the present" (p. 103). Medical knowledge and treatment are culturally the role of the women. Steckert used a loosely

structured questionnaire with open-ended questions and had repeated contact with a small number of women. Her study resulted in descriptive data similar to that which I wanted to gather.[1]

Using the above sources for ideas, my knowledge of the culture and folk health system of the Mexicans and my knowledge as a public health nurse, I developed the first draft of the questionnaire. I discussed the questions and format with the nursing supervisor responsible for the Child Health Clinic, my adviser and a Chicano friend who is bilingual and bicultural. After some changes, the questionnaire was ready for pre-testing. A copy of the questionnaire is in Appendix B.

Pre-Test with Migrant Families

The questionnaire was pre-tested with Mexican American migrant agricultural workers for several reasons. More than half of the male heads-of-household of the stable or settled Mexican American population in Michigan come from a migrant agricultural worker background. Twenty-five percent were born in Mexico and 60 percent were born in Texas (Choldin and Trout, 1969). Some contact with those presently in the migrant stream would give me a basis of comparison for the stable population and some background information about the life which those who "settled out" had left. The reactions and responses of the mothers would provide valuable information both about the migrant families and the acceptability and adequacy of the questionnaire.

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[1]Both Smiley and Steckert provided me with a copy of the questionnaire used in their respective studies.

The opportunity for contact with the migrant population was offered to me fortuitously. I met a Chicano graduate student, an education major, who wanted to do some independent study in sociology during the summer. Since he spent the summer as an outreach worker with the migrant families, he wanted to do something related to this group. He was interested in pretesting my questionnaire and in providing me with some contact with the migrant families. He felt that gaining some knowledge about the health and health problems of the migrant families would give him an additional dimension of understanding.

Originally, we planned to pre-test with thirty families, the same number I planned to interview in Lansing. The only criterion I set was that the family have at least one child under five years of age.

As things turned out, he was able to interview only ten families. The summer of 1972, when the interviewing was done, was a bad summer for the migrants and the growers. There were many days of rain, followed by many days when the fields were too wet to work. Many families left early, either for another agricultural area in Michigan or to return to Texas because there was no work in the Lansing area. On the days when they could not work, the family might leave the camp. If they did not leave, the father was at home and the mother would not talk with the outreach worker. He said that the people, especially the men, get very suspicious when they see papers being filled out. He could not even interview on Friday nights, when the men usually went to town to drink beer. This year, they could not afford their night out.

As an example of how bad things were, one woman told me that they had been on the farm for five weeks and only worked eight days.

With seven of them working, they only made about $20.00 a day, sometimes less; ordinarily, they made about $40.00 a day. One grower said he had replanted this year, the first time he had done that in twenty years of growing pickles. Another said that the first check he got from the buyer was about half of what he usually gets.

Although the number of interviews was small, the information obtained was valuable. I made some changes in the questionnaire as a result of the pre-test and conferences with the Chicano worker. Specific findings will be presented in a subsequent chapter.

The Sample

Selection

The sample was composed of ten families who attended Child Health Clinic consistently, ten who attended sporadically and ten who had never attended. A sample size of ten in each group was large enough to provide some clues to factors which might differentiate the three groups. A total of thirty families provided a data base large enough for some generalizations in those factors which were common to the entire group. It was possible for me to interview thirty families and obtain the kind of in-depth information I wanted. Although the sample was not large enough for any tests of statistical significance, it was large enough for the purposes of this study.

Before selecting the sample I talked with Mrs. Ellyn Preas, Nursing Director and Mrs. Marilyn Lee, Nursing Supervisor in the Ingham County Health Department. They were both aware of my interest in the

Mexican families who attended the Child Health Clinic. I explained the purpose and plan of my study; they gave me permission to review the records of Spanish surname families. Thereafter, most of my contact was with Mrs. Lee, since she was responsible for the Clinic. I told her that I would visit ten mothers who attended consistently and ten who attended sporadically; I would provide her with the names of the families I was seeing.

Since I planned to introduce myself as a public health nurse, I fully expected that I would provide some nursing service to the families. I could not, in good conscience, refuse if there was a need which I could help the family meet. In addition, service involvement with the families would provide me with information which I would not get through the interview itself. I planned to have at least two contacts with each family and to work intensively with a few families in each group.

Mrs. Lee concurred with these plans. I would keep the staff nurses who had agency responsibility for the families informed of problems and actions taken; the staff nurses would continue to provide service when it was no longer feasible for me to do so. It was agreed that I would function as an "ex-officio" staff nurse while working with the families.

Since I had worked in the Child Health Clinic for about a year and a half, I was familiar with the information which would be contained in the records. I developed a form on which to record the pertinent information. A copy of the form is in Appendix C.

I reviewed the record of every Spanish surname family receiving health care in the Clinic. Records which indicated that the family was not Mexican or that the mother was not Mexican were rejected as not meeting the criteria for my study. Information from the remaining records was noted on the form in preparation for selecting the families which I would visit.

The records were divided into three groups--those families who attended consistently, those who attended sporadically and those who had not been attending long enough to establish a pattern.

The families who attended consistently met the following criteria: (1) There was at least one child under five years of age. (2) The mother had made at least five visits to the Clinic. (3) There was no more than one broken appointment. (4) At least one visit other than the initial one was a well-child visit--that is, a visit in which the mother stated that the child did not have a health problem.

The families who attended sporadically met the following criteria: (1) There was at least one child under five years of age. (2) The mother had made at least two visits to the Clinic. (3) The mother had failed to keep at least two appointments. Some of the families in this group were no longer attending the Clinic. According to Health Department policy, records of families with a history of broken appointments are made inactive--no more appointments are given to the child.

The families who had never attended the Clinic met the following criteria: (1) There was at least one child under five years of age. (2) The mother had not attended the Child Health Clinic. (3) The child/children under five did not receive well-child care. (4) The mother had

access to the Clinic, either by living within walking distance or having transportation available.

I did not have any specific method for selecting the families in this third group. I had considered two possibilities. I was reasonably certain that some of the public health nurses would be visiting families who met the criteria. I also thought that the mothers whom I visited might give me the names of mothers who did not go to the Clinic. I had not considered that I might locate some families by accident--a method which provided me with four of the ten families in the third group. In addition, two families were referred by the public health nurse, two were relatives and two were friends of mothers who attended the Clinic.

Interviews

Before I began interviewing the mothers, I talked with two of the leaders in the Mexican community: the Executive Director of the Cristo Rey Community Center and one of the leaders in Quinto Sol, a Mexican organization. I wanted both men (Benavidez and Martinez, personal interviews) to know and approve what I planned to do. I did not anticipate any objections from them, nor from people in the community. However, if anyone did question or object to what I was doing, one or both men would hear about it.

Both expressed interest in and approval of the study. They offered to help in any way they could, including locating families for me to interview. Both felt that I would be accepted into the homes readily because people respect public health nurses. I appreciated

their interest and willingness to help. However, if possible, I wanted to find all of the families myself. If I could do it, then it was possible for another public health nurse to do so, too.

I conducted all of the interviews myself in the homes of the families. I did not make any contact with the families to make an appointment for the first visit. Experience had taught me that I was more likely to receive a positive response from the mother if the first contact was face to face.

I introduced myself by name as a public health nurse and asked whoever answered the door if this was the family I expected to find. I know that poor people move frequently. This was the "accidental" means by which I met some of the families who met the criteria for the third group.

With this introduction, I was invited to come in, whether or not this was the family I had named. I then explained to the mother that I was doing a special study because I was particularly interested in Mexican families; I knew that they had some ways of thinking about and doing things that were different from the ways of white people and that public health nurses needed more information and better understanding of Mexican families in order to work well with them. I asked the mother if she would be willing to talk with me and answer some questions about herself and her children. Every mother whom I contacted agreed to participate. If the time of my first visit was inconvenient for the mother, we agreed on time when she would have time to talk with me. I kept every appointment and always found the mother ready for me when I came.

With the exception of one family, I had at least two contacts with each family. This enabled me to conduct the interview at a leisurely pace, follow clues for further information, make some pertinent observations in the home and of the mother's interactions with the children. I had repeated contacts over a period of months with three families in each of the three groups.

All of the mothers talked to me willingly and freely. The interviews were conducted informally, frequently at the kitchen table. The fact that I was writing things down did not seem to bother them. I never had the feeling that they were telling me what they thought I wanted to hear rather than what they thought or felt or did. They had the option of refusing the interview, or of refusing to answer any of the questions; none did. I assumed, as was assumed in the Michigan Health Survey, that if the mother agreed to participate, she would answer the questions truthfully. A number of mothers volunteered information of a highly personal nature which I had not requested; to me, this was an indication that they trusted me. Their comments will be discussed fully with the findings from the interviews.

I met the father in 17 of the families. Twelve of them participated actively in the interview, expressed interest in what I was doing and in some instances displayed more knowledge of the folk cures than the mother did.

The families were delighted that I spoke some Spanish and were impressed with my accent. We frequently used a mixture of Spanish and English. I could conduct the interview in Spanish, but my vocabulary

was not always adequate for the answers. My Spanish-English dictionary helped immensely. In the situations in which neither parent spoke any English, we did use an interpreter, always provided by the family.

I was very pleased with the strongly positive response of the families. I think that there are a number of factors involved in their acceptance of me and what I was doing. Mexicans are a courteous people; consideration for others is an aspect of their culture which has been retained. I could carry on a conversation in Spanish; very few white health professionals can do so. I was asking them to help me learn about them; I was interested in what they believed and did. I was not telling them what to do. More specifically, I was encouraging mothers to tell me about their children; this is a favorite topic of conversation for mothers. I like and relate easily to children; I frequently had a child on my lap when I was in a home. Knowledge of their culture enabled me to do many things their way rather than mine. Their experiences with the public health nurses in Lansing had been positive; I was probably accepted and respected initially because I am a public health nurse. All of these things probably contributed to the fact that every mother thanked me for coming and invited me to come back any time I wanted to.

Socioeconomic Status

At the time I began this study, I knew that the families with whom I would have contact were part of the poor or low-income segment of the population. Anything that I read about Mexican Americans told me that they were poorly educated and largely employed in very low skill,

low-pay occupations. Few of the women are employed outside the home, with the result that most families rely on one income. The families are large, which increases the dependency ratio. My experience with the families in the Child Health Clinic supported what I read.

The most widely used measure of socioeconomic status is the two-factor index of social position developed by Hollingshead (1957), which consists of occupation and education of the male head of household. I did not want to use the Hollingshead index for several reasons. It was over ten years old and had not been updated to keep pace with changes in status symbols and the deletion and addition of occupations. It had not been standardized to preventive health behavior. Education of the father is one of the factors. Education of the mother has been demonstrated to be a more sensitive index of health care and decisions (Mindlin and Densen, 1969, 1971; Peters and Chase, 1967; Schonfield, Schmidt and Sternfeld, 1962; Stine et al., 1968). These studies were all reported after the Hollingshead index was developed.

A relationship between ethnicity and health care behavior is pointed out in the literature; Blacks, Mexican Americans and Puerto Ricans generally have less care and less adequate care than whites in the lower social classes (Mindlin and Densen, 1969, 1971; Hochstim, 1968; Morris, Hatch and Chipman, 1966; Nolan, 1967; Peters and Chase, 1967; Wingert, Friedman and Larsen, 1968). The Hollingshead Index does not allow for ethnic differences.

Green (1970) developed a method for scoring socioeconomic status which is well suited to public health programs and planning. He gathered

data from over 1,500 families with at least one child under five years of age, using nine items of preventive health behavior as the dependent variable. He presents a three-factor index of occupation, income and education of the mother, also a two-factor index of income and education of the mother. The scoring is standardized to preventive health behavior.

He found that the relationship between income, education of the mother and preventive health behavior was different for whites and non-whites. Education of the mother was the predominant variable in the white majority; however, in the non-white population, income was "more important than education in accounting for the variations in the preventive health behavior . . ." (Green, 1970, p. 826). His scoring system allows for the difference through the use of different weights assigned to the two variables for the two population groups.

Using Green's system, a family will fall somewhere on a scale ranging from 0 to 55. He does not define a discrete set of social classes as Hollingshead does. He states that the "only essential feature of any index of socioeconomic status is that it places individuals, families or neighborhoods on a hierarchy according to their social status relative to others in the same community" (Green, 1970, p. 816).

Green has established scores for coding education, income and occupation. The range for education of females is from 28 for no education to 73 for five or more years of college. Income scores for the North-Central region range from 25 for an income of less than $1,000 to 81 for an income of $50,000 or more. The scores are weighted

differently for white and non-whites. SES is determined as follows, using the two-factor index:

SES (non-white) = (0.5 x education) + (0.6 x income);

SES (white) = (0.7 x education) + (0.4 x income) (p. 826).

For example, a Mexican family (here considered non-white) in which the mother has six years of education and the family income is $6,000 would obtain an SES score as shown:

0.5 x 34 (education) = 17.0

0.6 x 44 (income) = 26.4

SES score = 43.4

The weighted scores will fall on a scale between 30 and 85. Subtracting thirty from each score permits scoring from 0 to 55 and does not affect the statistical properties of the scale. The above family would have an SES score of 13.4 or 13.

I used Green's two-factor index for non-whites to score socio-economic status for all families in this study. I had specific data on income and education of the mother, but not on occupation. I chose to use the scoring for non-white since poor Mexican Americans more closely resemble poor Blacks than poor whites (Shannon, 1966; Wingert, 1968). For the purposes of this study alone, either index for either population would have given essentially the same information. The choice I made seems to provide more precision for purposes of comparison with other studies.

Limitations of the Study

The most obvious limitation, of course, is the size of the sample. The sample size of ten in each group makes the drawing of conclusions or generalizations rather risky. The total of thirty is probably adequate for generalization in those things which are common to the entire group.

The good and poor users were selected from those families which met the criteria. The ten good users selected were the first ten whom I could locate. A different group of ten families might have resulted in different information. The pool of poor users was considerably smaller than good users. However, these families, too, were the first ten I was able to locate. There was no selection process in finding the non-users. As mentioned earlier, I found many of them by accident. A defined method of identifying the non-users might have produced different families and different results.

I began data collection with two mothers whom I had known when I worked in the Clinic. Since I was not entirely sure of a positive reception, it seemed wise to begin with the known and move to the unknown. Had there been glaring errors in the questionnaire, from the point of view of the Mexican mother, these two women would have told me about them and helped me to correct them.

The fact that I had known some of the women previously might have resulted in some bias in those interviews. I made every effort to avoid differentiating between those mothers and the ones whom I had not known. Since I conducted all of the interviews myself, all of the bias

should be in the same direction; the findings should not be biased differently.

I have no way of knowing whether the information given me by the mothers reflects their true feelings, beliefs and behaviors. Neither do I have any indication that it was not. I gave them the option of not participating; whether they felt free to exercise the option I do not know. I assume the truth of their responses for several reasons. The mothers talked to me freely. Many of them volunteered information of a much more personal nature than any of the questions I asked. They did not volunteer information about the Mexican diseases. They did talk about them at length when I asked, even though they had every reason to think that I did not believe in what they were describing.

I wanted to explore the possibility of differences among families with three different degrees of contact with the services offered by the Child Health Clinic. Information in depth, time to return to each home several times, time to follow leads the mothers might give were necessary to obtain the information I wanted. I think that the richness of detail and wealth of data compensate for the limits imposed by the small sample size.

CHAPTER IV

MEXICAN AMERICANS AS MIGRANTS

The Migrant Project

As stated earlier, the questionnaire was pre-tested with migrant agricultural workers for a number of reasons. Although I did not conduct the interviews, the responses and reactions of the mothers would give me some information about the adequacy and acceptability of the questions. I knew that many of the families I would be visiting in Lansing had a migrant agricultural background. Contact with families presently in the migrant stream would give me information about their background. Had the outreach worker been able to interview thirty families, comparisons between the two groups would have been possible.

The Migrant Project with which I had contact was one of many throughout the state, established to help the migrant families during their stay in Michigan. A number of services were provided by staff members who were employed specifically to work with the migrants.

Social Service workers helped the families fill in the forms necessary for them to get Food Stamps. They also provided transportation, if necessary, for people to go to the Social Services office, the Clinic or elsewhere for medical care.

The Migrant Clinic, staffed by volunteer doctors and nurses, was open one evening a week. Bilingual aides on the Project staff served as

interpreters. The Project nurse worked in the Clinic and was in the school during the day. She was not a public health nurse and did not speak Spanish.

The school was in session Monday through Friday. All of the teachers but one spoke some Spanish. The Project Director did not consider ability to speak Spanish important--the children were supposed to learn English. The nursery, for children under three, was equipped with about 14 cribs. There were a number of toys appropriate for small children. The children on formula were given enfamil with iron. The staff kept a chart for each child, noting meals and medications if any were given.

The room for three to six year olds seemed small for the 23 who were registered. The teacher said that there were never 23 in attendance. The children were learning primary colors, shapes and numbers. In the six to nine year old group, 18 were registered. The classrooms showed evidence of drawing and story telling.

The children in the nine and over age group attended school sporadically. Many of them worked in the fields with their parents when weather permitted. These children produced a weekly newspaper in both English and Spanish. At least one of the children in this group spoke very little English.

The outreach worker was the only staff member who spent much time in the camps. He interpreted the Project program to the families, provided transportation, served as interpreter, helped the families get household things they needed and served as a liaison person between the

migrants, the Project and the growers. He said that the Project nurse had gone to the camps with him once for a little while, but she had to go home and take a shower.

The Migrants as the Outreach Worker Described Them

I learned a great deal about Mexicans in general and the migrant population in particular as I talked with the worker between visits to the migrant camps. He was the only Chicano on the Migrant Project staff; he was also the only one who had had experience as a migrant agricultural worker. He and his family were in the migrant stream until he was twelve.

Relationship with the Outreach Worker

The migrant families accept him readily. He speaks Spanish; he is a Chicano; he comes from a migrant background. He is also a Chicano who had "made it"; this affects his relationship with them in several ways. They look up to him; what he says and does carries weight. He convinced one family to hospitalize a very sick baby; no one else had been able to. He does have to be careful in his relationships with the girls and women, particularly those who are not married, lest someone think he is "interested" in them as a man. For example, there was one one young woman who was in the camp with her parents and her illegitimate baby. The worker knew that she had had two previous pregnancies which had terminated with premature babies who died. He felt that the girl needed some counseling on birth control, but he could not provide

it for fear she would think that he was "interested" in her. Neither could he discuss it with her parents. They claimed the child as their daughter, not their granddaughter. The birth of an illegitimate child brought shame to the family. If he discussed contraceptive measures with the parents, it would be with the assumption that the girl would continue the behavior which was unacceptable to the parents. The subject was one which he could not bring up.

The worker could only do the health interview with the women if the husband was away; they would not talk with him if the husband was present. The man still rules in the migrant families. The woman usually obtained permission from her husband before she would participate in the health interview. She also asked him what their income was. None of the women knew. No one refused to participate, which in itself is a measure of their trust.

The interview could only be done satisfactorily on a one to one basis with no other adults around. The housing did not permit any privacy. The worker concluded that the best way to get the interviews done would be for the interviewer to travel with the migrants and obtain the information as the opportunity presented itself. An alternative which he recognized but could not use was to take the women someplace else, for example, the school. This would not have been acceptable to the husbands, however.

The interview schedule which was used did not include the question about use of contraceptive measures. This was a question which the worker, being a male, could not ask. He felt that, for the most part, the women answered the questions freely and honestly. He did feel,

however, that they might not have wanted to admit to him that they used the services of a curandera in Texas for fear that he would "look down on them."

Relationships Within the Group

The worker mentioned several times that Mexicans fight a lot among themselves. He thinks that is one reason why they cannot get together, present a united front to the Anglo community and "fight" for their rights; they are too busy fighting each other.

One afternoon, he was going to try the role of arbitrator for two women who had engaged in a hitting, hair-pulling fight over the use of the clotheslines. He feared that, if the active animosity continued, the rest of the families in the camp would "take sides" and the entire camp would be in an uproar.

In another camp, there were two brothers and their families who had come to Michigan from Texas together. The two families shared a small cabin. The men had a fight and put up a partition in the middle of the cabin, making two woefully small living quarters. The brother with the car refused to take the other family back to Texas. Fortunately, the wife in the family without the car had relatives in a camp in another part of Michigan. The relatives came to get them to work with them and later return to Texas with them.

Project staff members often asked the worker how come the kids were so mean and tough and fought so much. He said they had to, to survive. Frequently there was not enough food. In that situation, those who were the toughest and got there first got the food; the rest

often went hungry. He has observed that the boys are tough and remain tough as men until they are about forty or so; then the toughness seems to dissipate and they are just "beat down old men." The life of a migrant agricultural worker is hard and "does things to people."

Mexican parents love and value their children; caring for and protecting the children has high priority for these parents. The worker got pressure from the Project staff members to get the parents to send the children to the school every day. The Project staff members do not recognize or understand the reluctance of the mothers to send their little ones--infants and pre-schoolers--away for a whole day. It is a long day--from 7:00 A.M. until 5:00 P.M. They may have to ride as much as 30 miles each way on the bus. The mothers want their children with them.

The older children usually work in the fields with their parents. Project staff members want them in school, too. They do not realize that even the children are an economic asset. They might contribute one to two hundred dollars to the family income. This is important when the yearly income is only about $3,000. Those who have not been in the migrant stream do not know what it is like and do not understand the economics of the migrant families.

Relationships with Whites

The worker said that many of the people had had bad experiences with whites, particularly in Texas. In general, they felt that they were treated better in Michigan than in Texas. This statement was supported by the comments they made during the interviews.

Many of these families have been coming to Michigan to the same farms for many years. One grower has had the same group for nearly ten years. Everyone in this group belongs to the same family. However, they may not come back next year because they are making so little money this year. The grower said if they do not return, he will stop growing pickles rather than go to mechanized picking. He likes "his families" and they like him. He is pleased that they bring the whole family. He helps them with things like transportation if they ask, otherwise he leaves them alone. The worker says that this man has the best camp and treats the families very well.

One day about mid-summer, a Project staff member (female) spanked an eleven month old baby. The worker said this woman is big, loses her temper easily and spanks because she does not know what else to do. The parents learned about it and were very angry. They would not spank a baby of that age and did not think that anyone else should. They refused to send him back to the school, but did not want to "make trouble for anyone." They returned to Texas shortly after the spanking episode.

Things were in a turmoil at the Project for a while after the spanking. This was not the first time that this woman had spanked a child, but it was the first time that there had been repercussions. Social Services and Migrant Project people at the state level became involved. The outreach worker commented that this woman was being more careful about how she treated the children. He was afraid that her behavior would give the children a negative impression of school and

white women. Their general feeling about school anywhere was negative; they did not need anything to reinforce this attitude.

Personal Observations and Experiences

I visited the six migrant camps served by the Project. The worker introduced me as his friend, a nurse. I greeted the people in Spanish, which pleased them. I felt accepted. Two of the women said to me, when we were leaving, "Mi casa es su casa." (My house is your house.) He said they would not say that if they did not mean it--I was welcome to return.

The housing for the migrants was inadequate by many standards. Several years ago the State Legislature passed a law establishing some minimum standards for housing for the migrant workers. I do not know if these camps met the requirements. I do know that many of the growers objected violently to the requirements and that the State Health Department had difficulty in enforcing them. Some growers stopped hiring migrant workers. The worker said that the living conditions were much better than they were when he and his family were in the migrant stream.

Five of the camps had small, individual dwelling units for the families. I hesitate to call them houses--shacks or cabins would be more descriptive. At the best place, the units were the largest--maybe 18 x 40 feet--set in a semi-circle, well separated from each other. The buildings and the yard looked well-kept. The front part of the unit served as living room and kitchen. It was equipped with a space heater, stove, refrigerator, and sink. The family had a table and chairs and a davenport. The back part of the unit contained two bedrooms. They were

separated from the living area by a full wall, but no doors; the doorways were covered by curtains. We were there on a cold, damp day. The cabin was clean, rather crowded, warm and comfortable. There was a pot of beans simmering on the stove and a stack of home made flour tortillas on the table.

In the other four camps, the units were smaller, closer together and did not look as well kept. Some did not have running water. Some did not have stoves, just a two burner gas plate. All of the camps had a community toilet, shower room and washing machines, but no dryers. I often saw clothes hanging on the lines even when it was raining.

The camp that had the worst housing, in my estimation, did not have individual units. There was a very large metal shed, like the kind a farmer might build to store big machinery during the winter. This was subdivided into apartments. We visited one apartment in the shed, again on a cold, damp day. That place was cold. The ceiling was high; there was no insulation, just the metal building. The only means they had to heat the apartment was a two-burner gas plate, also used for cooking. Both parents commented on how cold it was and had been all summer. A low partition set apart the sleeping area; however, I could see over the top of it. There were two beds and two or three mattresses on the floor. The furniture consisted of a table and two chairs. The cooking area had some cupboards and shelves, and counter space big enough to hold the gas burner. There was no refrigerator. The parents and seven children lived here. (The worker said that that farmer did not take very good care of his fields, his own place or the workers.)

Although none of the housing could be classified as good, it certainly was not the worst I have been in. The women kept the units, their clothes, themselves and the children clean, and they struggled against high odds to do so. There were no offensive odors; I did not observe any "bugs" other than house flies. (I think that the Project nurse must have led a very sheltered life if she had to go home and take a shower after visiting a couple of camps.)

One night I went to a dinner at the school, given by the Project staff. They invited all of the families to come and eat, meet the teachers and see what the children were doing in school. They served very good Mexican food in large quantities. The worker estimated that about 200 people came. Transportation was provided by the buses. He said that he got a lot of pressure from the Project Director to get the people to come--people at the state level were impressed by a large turnout. They did not seem to realize that these people had been up at 5:00 A.M., had worked ten or twelve hours in the fields and had to get up the next day at 5:00 A.M. to work another ten or twelve hours.

I held four month old Reynaldo while his mother ate. He was a responsive, well-nourished baby who seemed to be normal in growth and development. I observed another baby who looked to be about a month old. His mother (?) was holding him against her side, facing outward. He looked like a "failure to thrive." My experienced eye told me that there was something wrong with the baby. I could not locate the worker to find out if he knew anything about the baby. I did describe the baby to him after we left. He thought he knew which family it was, but would find out.

Later, he told me that the baby I had observed was the illegitimate baby I mentioned earlier. The baby was four months old. He was so small and looked like a "failure to thrive" because he was a premature suffering from malnutrition and diarrhea. He was hospitalized shortly after the dinner. Another baby in the same camp (the big shed) was hospitalized for diarrhea at the same time.

Data from the Interviews

The ten interviews were all conducted by the outreach worker. The only criterion was that the family have at least one child under five years of age. Additional pertinent information which I obtained from the mothers as I talked with them will be presented with the interview data, but identified as additional.

Demographic Data

The families all have very low incomes. Yearly income ranged from a low of $1,500 to a high of $4,000, with an average of $2,575. Nine of the families had a male head of household, one had a female head. The number of children ranged from one to six, with a mean of 3.6. The high dependency ratio puts additional stress on available financial resources.

Educational level was also low. Average years of education of the fathers was 4.9, with a range of no schooling to a high of seven years. The mothers were better educated, with a range of none to eleven years and an average of 7.7 years. Four of the men and five of the women went to school in Texas. I have heard repeatedly from poorly

educated and well educated Mexican Americans that they get an inferior education in Texas.

As would be expected, these families all scored low on Green's two-factor index of socioeconomic status. On the scale of 0-55, these families scored from a low of four (two families) to a high of 15 (one family). All the families but one scored in the lowest quartile; all but two scored ten or below. The two scores above ten reflect the education of the mothers, one of whom finished tenth grade and one eleventh.

Since these families live, work and attend school in an English speaking world, I wanted some information about their skill in and use of English. Language spoken at home by parent to parent, parents to children and children to children was determined by asking the mother which language was used in each instance. Skill in English was determined in conversation, using the following definitions:

> Good--Able to carry on a conversation in English without groping for words; easily understood by an Anglo.
>
> Fair--Able to carry on a conversation in English, but has a limited vocabulary, slurs words, accents poorly; understood by an Anglo who makes an effort.
>
> Poor--Knows some words, but can barely carry on a conversation with an Anglo.
>
> None--Does not know any English.

One family was composed of a Mexican American father and an Anglo mother. They spoke English to each other; the father spoke English well and the mother did not speak Spanish. The father spoke Spanish, the mother English, to their child.

In the other nine families, four spoke only Spanish at home. In another four, the parents spoke only Spanish to each other and to the children; the children spoke both Spanish and English to each other. In the family which consisted of just mother and children, all of them used both Spanish and English. This mother spoke good English. The predominant pattern--four families--was parents speaking only Spanish to each other and to the children, with the children using both languages in talking with each other (see Table 4).

Table 4. Language spoken at home by members of ten migrant agricultural worker families in Michigan

	Spanish	English	Both	Total
Parent to parent	8	1	0	9*
Parent to children	8	0	2	10
Children to children	4	1	4	9**
Total	20	2	6	28

*One family had only one parent.

**One family had only one child, not old enough to talk.

In two families, neither parent spoke any English. In two families, excluding the family with the Anglo mother, both parents spoke good English. In the remaining four families, skill in English was distributed as follows: father fair, mother none (two families); father none, mother good; father poor, mother none.

Nine of the families lived in Texas during the winter; one lived in Idaho. Length of time in the migrant stream ranged from a low of one year to a high of thirty years, with an average of 8.7 years. The number of years as a migrant worker in Michigan ranged from a low of one year to a high of twenty-five years, with a mean of six years. Only one of the families had any kin (a niece) settled in Michigan.

Three of the families had considered settling in Michigan because the employment opportunities were better. One family did stay in Michigan after the agricultural season was over. This family was not included in the study; I visited them with the worker. The oldest girl had a job as a nurses' aid in one of the local hospitals. The father did not speak English; the six children were bilingual. The outreach worker planned to help with finding housing and a job for the father. They had no kin in Michigan. They decided to stay because the children could get a better education here than in Texas. I talked with three of the girls; they were pleased to be staying because they liked the school. The worker said they are all good students.

Health and Illness Perceptions and Behavior

These mothers recognize illness in their children by changes in their behavior. They know a child is sick when he is "sad," doesn't eat, cries a lot and is restless or is quiet and inactive, sleeps more or doesn't sleep as much. The only mention of a physical symptom, fever, was by the Anglo mother.

Upper respiratory infections were the frequently mentioned sicknesses--cough, colds, sore throat, flu. Six mothers included fever as a sickness. Treatment at home, when the child first got sick, included aspirin, herb tea, alcohol rub, lemon juice, hot tea, lemonade and egg treatment for mal do ojo. They sought help if the child was "really sick," had a "hard fever," a sickness that lasted or if none of the home remedies helped. In five families, the mother made the decision to seek help; in the other five, both parents made the decision.

All of the mothers said that they would go to the doctor or the clinic first, the hospital, clinic or doctor next. They would seek care from an Anglo doctor for any sickness; there was none for which they would not seek care from an Anglo doctor. Seven mothers reported having a family doctor.

When talking about the differences in health, illness and health care in Michigan and Texas, four mothers said that the children had less sickness here because they had more and better food in Michigan. Social workers help them get food stamps here; they do not get food stamps in Texas. Three mothers said that there are more services and more help here. Three mothers make more clinic visits here. Two mothers reported no difference.

The Anglo mother was the only one who said that she had problems when she wanted to see an Anglo doctor. She had the same problems with Anglo social workers--said that they were rude and inconsiderate. She thought that people disapproved of their mixed marriage. Two mothers

felt that Anglo doctors and nurses treated them differently from the way they treated Anglos; both felt that the health professionals "looked down on Mexicans." One mother said that she did not know if there was any difference, because they "don't mix with Anglos."

Eight mothers reported that their children's health was generally good. The same eight also said that their own health was good. The two mothers who said that their children's health was fair said that their own health was fair.

All of the mothers knew of some place in both Texas and Michigan where they could take their children for well child care. One mother commented that the clinics in Texas were only for "welfare people." Only three of the mothers took their children for well child care. The two who answered with an unqualified "yes" were the two with the highest education. The other mother went as often as she could, but said that she missed some appointments because the cards telling her when to come were in English and she could not read them. She had not attended school at all. This mother and one of the other two whose children had well child care mentioned check-ups as one means of keeping the child well or preventing illness; the other mother replied "nothing" to both questions.

Seven mothers stated that they did not take their children anywhere for well child care. Three said that they could not afford to go, three said that it was not necessary or they only took the children to the doctor for sickness and one did not respond. Two of these mothers mentioned check-ups as a means of keeping the children well or preventing illness (see Table 5).

Table 5. Relationship between having check-ups and giving vitamins stated and practiced as health promotion-illness prevention measures

	Stated Check-Ups			Stated Vitamins		
Practice	Yes	No	Total	Yes	No	Total
Yes	2	1	3	2	1	3
No	3	4	7	2	4	6
Total	5	5	10	4	5	9*

*One did not respond.

Four mothers mentioned giving vitamins as a means of keeping the child well or preventing illness. However, only two of these mothers reported giving vitamins. One mother said she gave vitamins only when prescribed by the doctor (see Table 5).

In addition to check-ups and vitamins as means of maintaining health or preventing illness, five mothers said "watch them and take care of them." Only one mother gave shots as a preventive measure. However, all of the children were immunized as part of the Migrant Program. Since I was not able to talk with the Project nurse, I did not see the immunization records. However, one mother showed me her baby's record and asked if he needed any shots. His immunization was complete for his age. I told her he should have the shot for measles when he was a year old.

All of the women reported some pre-natal care, although it was minimal for one. She had made two visits with the second pregnancy,

none with the first and third. She "thinks it's good to go." This is the mother who took her children for well child care when she remembered the appointment. The other two mothers who reported well child care had regular pre-natal care. Two other mothers also had care during the entire pregnancy. The other mothers had care irregularly and tended to start later, at about the sixth month. All mothers felt that pre-natal care was important. Reasons given were to relieve their doubts, be sure the baby was all right and because it was better for the baby.

Eight of the mothers had transportation when they needed to go to the doctor. Four had baby sitters available (grandmother or older children), one always took the children with her, the other five said that it was hard for them to get a baby sitter.

All of the mothers used disposable diapers while in Michigan and cloth diapers in Texas. One mother washed the diapers by hand, the others either had a washing machine or went to the laundromat.

All of the mothers were aware of the health care facilities provided in Michigan. Five women found them satisfactory. The others found them too crowded, the wait too long and the once a week availability too infrequent. Suggestions for improving the health care included more clinic dates, more money and clinics in the migrant rest areas.

All of the mothers had ideas of things they could do to help their children have better health. Suggestions included check-ups, vitamins, good food and a good education.

All mothers stated that there was not a curandera in the group. One said that there had been one the year before. The only mention made

of any aspect of the folk health/illness system was the egg treatment for mal de ojo. No mother named mal de ojo as an illness which the children got. They may have done so indirectly, since some did name fever as an illness and fever is a symptom of mal de ojo. There is no evidence of a lay referral system in the responses given by these mothers. I do not think that this reflects an actual absence of such a system. I think, rather, that it is the result of the wording of the questions and the fact that the interviewer did not ask any probing questions.

I found the lack of information about the folk system interesting and important. I could only speculate about the possible reasons. The questions were worded as I wanted to ask them; they were not designed for an interviewer without a background in health and health care. The worker asked them as worded without following any clues to other possible responses. He, as a male, is not expected to have much knowledge of sickness and cures; this is the woman's role. However, he does speak fluent Spanish and had been taken to a curandera as a child. He thought that his position as a "Mexican who had made it" deterred the mothers from telling him about their practices in the folk system. I did not change the wording of the questions because I wanted to know if the mothers would volunteer information about the folk system. A summary of the responses given by the migrant mothers is in Appendix E.

CHAPTER V

MEXICAN AMERICANS IN LANSING: SOCIAL AND ECONOMIC DATA

Introduction

There is no single area of Lansing in which the Mexican Americans are concentrated. The largest group, those with the poorest living conditions, live on the near west side, the north side and in a deteriorating area near East Lansing. Cristo Rey Community Center is located on the north side. Here, also, are grocery stores which carry many Mexican foods and a number of Mexican restaurants. The business establishments have bilingual staff members.

Those with the best living conditions live in the southwest part of Lansing. Also in the southwest, but closer to the center of town, are those whose living conditions fall between the poverty of the north side and the relative affluence of the far southwest. There are also Mexican stores and restaurants on the southwest side.

The thirty families whom I visited were scattered throughout the city; one family lived in the country. I had continuing contact with nine families, four on the north side, four on the east side and one in a low-cost housing project on the southwest side.

These nine families, three in each group, were selected on the basis of need for public health nursing service not currently being met

and for variety in family size and age and background of the parents. Some of the differences will be apparent in the descriptions of the families in Chapter VI. The names have been changed in all of the families mentioned in this study. However, I have maintained internal consistency with names, following the mother's pattern of using Spanish or English names.

The thirty families included in this study shared many demographic characteristics. Most of them are young, which is to be expected, given that each family has at least one child under five. Incomes are low; only two of the families had an income of $10,000 or more. This, too, is to be expected, since twenty of the families have (or had) much of their child health care at the Clinic and ten have had no well child care. Educational level is low. Six fathers and one mother had completed high school; none has any education beyond high school. The majority live in housing that is deteriorating; only eleven families live in housing that is well maintained. Over all, the housing was not as crowded as I had anticipated. Seventeen of the families have more than one person per room.

Within these aspects of generally low socioeconomic status, common, not only to these families but to all poor families, there are some differences among the three groups. In a number of ways, those who had never attended the Clinic are more like those who attended consistently than like those who attended sporadically. The differences and similarities within the three groups will be presented and discussed. For purposes of brevity, those who attended the Clinic consistenly will

be designated "good users," those who attended sporadically "poor users" and those who had never attended "non-users."

Family Structure

As I was meeting the families and conducting the interviews, the large number of households headed by the mother surprised me. Mexican Americans are largely Roman Catholic, place a high value on the home and family and discourage independence in the women. These factors would seem to support the maintenance of stable nuclear families, which they are reputed to have. However, in the thirty families I visited, nine (30%) had a female head. This is a much higher percentage than I found mentioned anywhere in the literature.

Kay (1972) reports that 5.5 percent of the Mexican American families in Tucson have a female head. She cited this figure in pointing out the relative rarity of the matrifocal family. Choldin and Trout (1969), in their study of Mexican Americans in Michigan, found about 10 percent of the families headed by a female. The median age of these women was 43; many were widows.

The female heads of household in this study are young; the median age is 29, with only two over forty. One of the latter is a widow, two are divorced, the remaining six are separated. The young, matrifocal family is more common than I had anticipated in this group.

When I began to analyze and interpret the data I had about the families in relation to their utilization of the Child Health Clinic services, one difference between the good users and the poor users

became apparent immediately. In the group of good users, there were only three nuclear families--father, mother and children of that union. By contrast, in the group of poor users, there were nine nuclear families. The tenth was a young divorced woman with one child. On that basis, she would be classified as a female head of household. In fact, however, she did not function as a female head of household. She had only lived with her husband for five months. Before the baby was born, she returned to her parents' home, where she and her son still lived at the time of the interviews. In terms of life style, they were part of a nuclear family with her father functioning as father to her son.

Four of the women in the good user group were in fact and function female heads of household. Mrs. Centino is a widow. Mrs. Zamora's husband "just took off and left." She does not know where he is, nor does she care. Mrs. Naranja's husband is in prison. Mrs. Dominguez and her husband are legally separated. Three of the women in this group are married for the second time; each has children from the first marriage living with them. For want of a better term, I will call these families modified nuclear families.[1]

These seven women have in common a feeling of complete responsibility for their children, those without a husband in residence for all of the children, those with a husband for the children who are theirs but not their husbands'.

Mrs. Cabrera takes the children to the Model Cities Clinic when they are sick, even if they are not very sick. She said the doctor

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[1]The term was suggested by Dr. Ruth Useem.

asked her one time why she brought them in so often, like when they had a cold and they really would not have to see a doctor. She told him, "Listen, Doctor, I myself alone have the responsibility for these children. If anything happens to them, it is my responsibility. No one helps me. I have to take care of them alone, as best I can, and I get scared when they get sick." She said he did not ask her that again.

Two of the women in the modified nuclear families are employed. Mrs. Flores works so she won't have to ask her husband for things for her children. He works full time and pays all of the household expenses. She helps with the expenses sometimes, but says her money is hers, for her children. "I don't like to ask him for things for my kids. He shouldn't have to pay. This way, I can buy Alberto a pair of shoes or give Robert money for a football. I could give Anselmo money when he needed it for school." (Anselmo graduated from high school, a source of great pride to his mother.) She works nights, cleaning offices. That way, she does not have to have a baby sitter, she is home to get them off to school in the morning, to fix the evening meal and be sure they go to bed when they should.

Mrs. Cabrera went to work, cleaning offices in the evening, while the study was in process. Margaret, her oldest daughter, needed clothes for school; Miguel needed a new coat; and they would need boots when winter came. She, too, expressed her feeling of responsibility for her children. She also commented that her husband did not get along well with her children. She wanted to move back to Texas, where her father and brothers would help her with Miguel.

Rachel Bermudez was having marital problems and thinking about divorcing Jack. She went to Texas for a few weeks to visit her mother, and told her that she was considering a divorce. Her mother did not approve. Rachel said, "She told me, 'there are lots of men--you can always find another man--but you will never find another father for your children.' Mexican men aren't so nice to somebody else's children. Look at the way Elba's man treats Martha (Elba's daughter). He doesn't even let her have enough to eat!" (Elba lives behind Rachel.)

The mother's acceptance of responsibility for her children, not shared with her husband, implies his non-acceptance of responsibility. The mother's statement, "They are not his children," explains the relationship for her. She did not expect her husband to assume full responsibility for children not his.[1] No husband adopted the children of her first marriage.

This joint acceptance of a relatively minor role for the husband in relation to his wife's children probably results from a combination of machismo (manliness or maleness), strong identification with one's family of origin and the role of the father in the educación (proper up-bringing) of his children. Indeed, it could be argued that the role of the father in bringing his children up properly is part of machismo.

Machismo is often thought of primarily in terms of sexual prowess. Machismo has a "dominant theme of sexual virility . . ."

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[1]Lewis describes a similar situation in the Jesús Sanchez family in Mexico. Jesús' common-law wife said, "Once he told me, 'I'll give you money for my own daughters, but not for those others. They are not my daughters'. . . . The day never came when he gave me money for them. . . . I don't ask him for anything either" (Lewis, 1959, p. 209).

(Grebler, Moore and Guzman, 1970, p. 363). "The most convincing way of proving machismo and financial ability is to keep a mistress in a second household . . ." (Madsen, 1964, p. 49). Machismo is cited as a major factor in the large size of the typical Mexican American family. "Masculine potency and dominance are symbolized by the fact that men can get women pregnant" (Grebler, Moore and Guzman, 1970, p. 364). Several Chicanos told me that machismo would present a major barrier to the use of contraceptive measures. To the degree that fathering children demonstrates machismo, children fathered by another man would do nothing to enhance the status of the present husband.

Kay questions machismo "i.e., the need for a man to demonstrate his virility by having many children" as a major factor in the high fertility of Spanish speaking women. "Such a reason is not considered influential in Kroeger Lane, if indeed it really obtains anywhere" (Kay, 1972, p. 196). More broadly viewed, machismo encompasses much more than virility. It "is intertwined with the traditional patriarchy . . . by domination over the affairs of his family and especially over his wife" (Grebler, Moore and Guzman, 1970, p. 363).

Olguin, narrator of a series of television programs describing the culture of Mexicans, does not mention virility as an aspect of machismo. It "means something very, very special to the Mexican people." The Mexican boy learns about machismo from his father, beginning at a very early age. He is taught to be "tough . . . tough-minded . . . tough in self discipline . . . tough physically." There is more involved than toughness, however.

> A Mexican child's earliest memories will very likely center around his father representing the epitome of machismo--a strong, firm man who was most certainly the master in his home. The wife and children were definitely subservient to him. They . . . never, never questioned his decisions. . . . And from the time they were babies, the sons of this strong, virile father were taught, by word and example, to imitate his machismo.

The daughters were not taught to be tough, but to be loving, gentle and patient. The father had a role in caring for the girls, too (California State Department of Education, n.d., pp. 13, 14).[1]

The father plays a major role in the proper up-bringing of the children. Children are taught "proper" behavior, including courtesy, respect for adults and obedience (particularly of the father), beginning at an early age. The father "holds himself responsible for the behavior of individual family members both within the home and in society as a whole" (Madsen, 1964, p. 51). Although the relationship between fathers and little children is relatively permissive, it is not entirely so. In the families I visited, a stern look from the father, a snap of his fingers or a few words were sufficient to indicate his disapproval of a child's behavior. The child responded to the first indication of the father's displeasure.

The husband in the modified nuclear families did not have any role in the "proper upbringing" of his wife's children. In the interactions I observed between fathers and little children, the firmness in controlling behavior was generously tempered with affection and gentleness. Rachel Bermudez said, "Jack expects the boys to mind him,

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[1]WKAR Channel 23 in East Lansing presented the series in June and July, 1973.

but he never hits them." Angela Flores still wet the bed when she was seven. Mrs. Flores wanted to punish her. "But," she said, "her father won't let me hit her. She is 'his girl' and he has always spoiled her." The step-fathers had no input in shaping their step-children's behavior during their crucial early years. They could not accept credit if the children were well behaved; neither were they at fault if the children behaved badly.

Madsen says, "Next to devotion to the family, the male's "manliness" outweighs all other aspects of prestige. The Latin male always represents his family and he must represent it with honor and devotion" (Madsen, 1964, p. 18). Blood ties carry an obligation. Step-children carry the blood and the name of their biological father; they cannot bring dishonor to the name and family of the stepfather.

This complex of the father's blood ties, family honor and role in the rearing of children may also play a part in adoptions. Olguin says "you will very, very rarely find a Mexican child available" in an adoption agency.

> Babies born into this culture are simply not given away. Should the parents die, other relatives or even friends will welcome the children of that family into their own home. And to a Mexican mother, wed or unwed, the stigma of giving up her own flesh and blood would be much, much worse than having the child and keeping it. She simply does not do it [California State Department of Education, n.d., p. 33].

Rubel presents a different picture. An orphan, in Mexican-American usage, is a child who has lost one or both parents.

> The lot of the orphaned child is universally averred to be incalculably difficult. Not only is the orphan to be pitied, but his lot scarcely improves as a consequence of his surviving parent's remarriage, or of his own adoption by relatives or strangers. (. . . There is no record of the adoption of orphaned children by their godparents.) Instead orphans are appended to the families of relatives.

Following this statement, Rubel gives a brief description of the bitter and often hostile relationships between a stepfather and his wife's children (Rubel, 1966, p. 70).[1]

The relationships I observed in the modified nuclear families were similar to Rubel's description. Mrs. Cabrera's oldest daughter is living in Texas with her grandparents because she "doesn't get along with" her step-father. She expects that the others will leave too, when they get a little older.

The adoptions I am aware of seem to be more similar to Olguin's description. Three of the families either had adopted or were in the process of adopting a child. In each instance, one parent was a member of the adoptive father's family. The children (two boys, one girl) carried his blood; the boys bore his name. In the other adoption, Anselmo Lopez is adopting Tomaso, his wife Maria's illegitimate son. Tomaso never knew his biological father. Maria and Anselmo began living together when Tomaso was a baby; Anselmo is the only father he knows. Anselmo was very much involved in Tomaso's rearing. There was an observable difference in Anselmo's relationship with Tomaso and Ricardo Cabrera's relationship with Miguel. When Tomaso behaved badly, Anselmo

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[1]This is the only reference I found to relationships in a Mexican American modified nuclear family.

corrected him. When Miguel behaved badly, his mother spoke to him even if her husband was in the same room.

These seven women who are good users of the Child Health Clinic services feel keenly the lack of support and help of a father in rearing either all or some of their children. They either are now or have been a female head of household. In this situation, they were forced to assume more responsibility than the mother in a nuclear family. None moved in with her parents. (Only one has a father living in Lansing.) Rather, they seem to have responded to the additional responsibility by becoming more independent than the mothers in the nuclear families. Those in the modified nuclear families continue to make the decisions about health care for all of the children. Mrs. Cabrera and Mrs. Flores are employed. Mrs. Dominguez is a room mother for José's kindergarten class. Mrs. Flores said, "When my husband died, I had to do things." In general, all of the women in the study who are or were a female head of household demonstrated more independence than those who have always lived in a nuclear family. This independence, coupled with increased responsibility in the care of their children, may account in large part for their consistent utilization of Child Health Clinic services. Since they lack the support of a husband, in full or in part, they turn to other sources for help.

Family structure in the non-user group resembled that of the good users more closely than that of the poor users. The non-user group consisted of five nuclear families, one modified nuclear family and four families headed by a female. Mrs. Ramos thought she would not

have so much trouble with her children if she had a husband. She thought that the schools should take more responsibility in controlling the children. Maria Lopez felt highly responsible for Tomaso, even though Anselmo functioned as his father. Consuelo, Maria's sister, felt "helpless" without a man. Maria and Anselmo said she would be "better off" when she got married. From several other comments the women made, it seemed that being married was preferable to being the head of the household.

Family structure is not often considered as a variable in the studies of utilization of child health care services. When it is, some form of single parent family is used most frequently. Smiley, Eyers and Roberts (1972) found that babies born to unmarried women tended to have poor health care. By unmarried, they apparently meant never married, since mothers were also classified as widowed, separated or divorces. Mindlin and Densen (1971) found that infants in a single parent family had little health supervision. Triplett (1970) found that the low income white mother who was head of the household was apt to make poor use of preventive care.

One study included a comprehensive breakdown of family structure in the Caucasian, Negro and Mexican-American families who brought their children to a large pediatric emergency room. Mexican-American families were described as the most stable, with 65 percent of the children living with both parents, compared with 45 percent of the Negro and 55 percent of the Caucasian. The other large difference occurred in the percentage of children living with the mother only. Twenty-eight percent

of the Mexican-American children lived with the mother only, compared with 48 percent of the Negro and 36 percent of the Caucasian. There was essentially no difference in the percentage living with father only or one of either step-parents. However, family structure was not used as a variable in utilization (Wingert, Friedman and Larsen, 1968).

Family structure was used as a variable by Nall and Spielberg (1967) in their study of acceptance or rejection of the medical regime for tuberculosis. They found that being single, widowed, separated or divorced favored the acceptance of the Anglo regime. It may be that these people are viewed, or view themselves (or both), as not a part of the Mexican social system, which centers so strongly around the nuclear family home. The same may hold true for the good users in the present study.

Socioeconomic Status

Occupation, education and income are closely related and are generally used as indices of socioeconomic status. The low-skill occupations of those who are employed reflect the low level of education and result in low incomes.

Nine of the households are headed by a female. Of these nine, one works as a cashier in a Mexican restaurant owned by a relative. She also gets ADC (Aid to Dependent Children), as do the other eight. Mrs. Centino said, with some disdain, "Those women who can't get along on ADC are just lazy--they don't want to work." As mentioned above, two of the women in the modified nuclear families work. One woman in

the poor user group works in the kitchen of one of the hospitals. She and her husband bought a home recently and she is earning money to "fix it up so it looks nice."

Twenty-one of the households are headed by a male. Of these, twelve are employed full time, all in low skill jobs, most in construction or heavy industry. Two work part-time in seasonal jobs. Three are unemployed, looking for work. Four are disabled, two with chronic illnesses and two with injuries.

The educational level of the parents is, on the whole, low. One of the fathers and five of the mothers have not attended school at all. However, only the father and one of the mothers are functionally illiterate. The other mothers learned to read and write both Spanish and English on their own, with the help of their children and, for one mother, the help of "Sesame Street."

The mothers in the non-user group are the most poorly educated; four had no formal education, none finished high school. They have a mean of 5.1 years and a median of 6.5 years of school. The mothers in the poor user group are the best educated. Although none finished high school, all but one have more than a grade school education. This group has a mean of 8.8 and a median of 9.0 years. The mothers in the good user group fall between the other two, with a mean of 6.7 and a median of 6.5 years. (Table 6 depicts the education of the mothers by use.) In this group of thirty mothers, a higher level of education is not predictive of good use of preventive services. The three mothers in the good user group who live in nuclear families are not the best educated in the group; two have six and one seven years of education.

Table 6. Years of education of mothers by use of Child Health Clinic services

Years of Education	Mothers			
	Good Users	Poor Users	Non-Users	Total
None	1	0	4	5
1-6 years	4	1	0	5
7-11 years	4	9	6	19
12 years	1	0	0	1
Mean	6.7	8.8	5.1	6.9
Median	6.5	9.0	6.5	8.0

The educational level of the fathers is likewise low, although, as a group, they are better educated than the mothers. Only one has never attended school and seven finished high school. The fathers in the non-user group have the highest mean (9.5) and median (10) years of education. However, this is probably an artifact of the small number (6) and the fact that three of them finished tenth grade. Educational level of the fathers is shown in Table 7. Although the mean and median years seem to indicate that the fathers in the good user group are a bit better educated, there is little difference in the overall distribution.

According to a number of the parents, the place where they were educated is important. Mexicans get a poor education in Texas. Rachel Bermudez told me that she did not start school until she was ten, then dropped out of the sixth grade when she was fourteen. She explained, "Nobody cared if you went to school. Mexicans don't think school is important and schools don't think Mexicans are important. I was just

Table 7. Years of education of fathers by use of Child Health Clinic services

	Fathers			
Years of Education	Good Users	Poor Users	Non-Users	Total
None	0	1	0	1
1-6 years	2	1	1	4
7-11 years	4	4	4	12
12 years	3	3	1	7
Mean	9.0	7.0	9.5	8.5
Median	9.0	8.0	10.0	9.0

'passed along' even though I didn't know much. My older sisters can't even read or write. My little sister went to tenth grade and she knows a lot!" One family moved to Lansing specifically for a good education for the children.

The place where the parents, particularly the mothers, were educated may have a relationship to the use of preventive care for the children. In the good user group, four mothers and four fathers were educated in Texas. In the poor user group, seven mothers and six fathers were educated in Texas. Tables 8 and 9 depict the place of education of mothers and fathers.

Family income is generally low, with eleven families having an income under $5,000 and only two having $10,000. For half of the families, ADC is the only income. Only one mother supplements her ADC by working. The ADC budget is based primarily on family size, age and sex

Table 8. Place of education of mothers by use of Child Health Clinic services

	Mothers			
Place	Good Users	Poor Users	Non-Users	Total
Mexico	3	1	4	8
Texas	4	7	4	15
Michigan	3	2	2	7
Total	10	10	10	30

Table 9. Place of education of fathers by use of Child Health Clinic services

	Fathers			
Place	Good Users	Poor Users	Non-Users	Total
Mexico	1	2	2	5
Texas	4	6	3	13
Michigan	4	1	1	6
Total	9	9	6	24

of the children. For example, Dolores Dominguez and her three children, ages five, four and one, get $4,300 a year. Jaime and Concepción Almaguer and their ten children (ages 16 years to six months), get $9,256 a year. Families who receive ADC may buy food stamps every two weeks. The number of free or extra food stamps depends on family size, income and some expenditures. Dolores pays $38.50 for $56.00 worth of

food stamps; Concepción pays $79.00 for $122.00 in food stamps. Medicaid pays for medical care for sickness and prescription drugs for families on ADC.

The dollar value of food stamps is not included in the incomes in Table 10, for several reasons. A number of the families did not buy food stamps every two weeks because sometimes they did not have enough money for the stamps. (They do not have the option of buying fewer than their allotment.) Assuming that every family bought the stamps every two weeks, only Jaime and Concepción would have a large enough increase in income to move to the next highest income bracket.

Table 10. Income of families by use of Child Health Clinic services

	Families			
Income	Good Users	Poor Users	Non-Users	Total
Under $2,000	0	1	0	1
$2,000-$2,999	0	1	1	2
$3,000-$3,999	1	0	2	3
$4,000-$4,999	1	1	3	5
$5,000-$5,999	1	3	0	4
$6,000-$6,999	1	0	2	3
$7,000-$7,999	2	2	0	4
$8,000-$8,999	2	0	0	2
$9,000-$9,999	2	0	2	4
$10,000 and over	0	2	0	2
Mean	$6,881	$5,992	$5,325	$6,033
Median	$7,150	$5,700	$4,321	$5,942

As can be seen in Table 10, the families in the non-user group have the lowest incomes. Six have incomes below $5,000, compared with three and two in the poor user and good user groups. The families in the good user group have the highest incomes, with no family having an income under $3,000 and four having incomes of $8,000 or above.

How "poor" a family is depends not only on income, but also on how many people that income must support. Since Mexicans tend to have low incomes, only one wage earner and larger-than-average families, the relationship between family size and income has a crucial bearing on their life style. In Tables 11, 12, and 13, it is evident that the families in the non-user group tend to have lower incomes and smaller families than the other two groups. Family size does not differ appreciably between the good and poor users; however, the good user group seems to be the best off, with four families in the highest income bracket and no families larger than nine members. Average family size of both good and poor users is 6.0; the non-user group has an average family size of 5.3.

Table 11. Relationship between income and size of good user families

	Family Size				
Income	2 or 3	4 or 5	6 or 7	8 or 9	10 or More
Under $5,000	1	1	0	0	0
$5,000-$7,999	0	1	2	1	0
$8,000 and above	0	1	1	2	0
Total	1	3	3	3	0

Table 12. Relationship between income and size of poor user families

Income	Family Size				
	2 or 3	4 or 5	6 or 7	8 or 9	10 or More
Under $5,000	1	2	0	0	0
$5,000-$7,999	0	1	3	1	0
$8,000 and above	0	0	1	0	1
Total	1	3	4	1	1

Table 13. Relationship between income and size of non-user families

Income	Family Size				
	2 or 3	4 or 5	6 or 7	8 or 9	10 or More
Under $5,000	2	3	0	0	0
$5,000-$7,999	0	2	0	1	0
$8,000 and above	0	0	1	0	1
Total	2	5	1	1	1

These are, of course, young families. The mothers generally are younger than the fathers. Three of the mothers are under twenty. The mothers in the poor user group are the youngest, with seven under thirty and none over forty, compared with five under thirty and two over forty in each of the other groups.

The fathers likewise are young, with one under twenty, nineteen under forty and five over forty. Data are available on only six fathers in the non-user group. There is no appreciable difference in age distribution of the fathers in the three groups.

Given the low incomes and low educational level of the mothers, low scores on Green's (1970) two factor index of socioeconomic status follow naturally. Although Green does not specify any social classes, a range of scores from zero to fifty-five subdivides neatly into five groups with eleven points per group. Using this separation, five families fall into the lowest group, twenty-three into the second, and two into the third, with 25 the highest score attained (see Table 14). The non-user group has the greatest number of families (4) in the lowest score range; there are four women with no schooling in this group.

Table 14. Socioeconomic status scores of families by use of Child Health Clinic services

	Families			
Scores	Good Users	Poor Users	Non-Users	Total
11 and under	0	1	4	5
12-21	10	8	5	23
22-25	0	1	1	2

Migration and Mobility

Better jobs and family members already here are the major reasons given by these families for the move to Michigan. This is consistent with other studies of migration of Mexican Americans (Choldin and Trout, 1969; Shannon, 1966). Eight mentioned job opportunities as the only reason, four gave family members here and three said both job and family. The latter three were all in the poor user group. Other than that, the reasons are fairly evenly distributed. Some of the women in the modified nuclear families did not know why their present husband came. Some of the men were born here or came as children. Three of the women who are heads of household in the non-user group and one good user in a modified nuclear family came to get away from family problems in Texas.

The "chain migration" described by Choldin and Trout (1969) is quite common in these families. The Almaguer family provides a typical example. Leon and his wife dropped out of the migrant stream and settled In Michigan when Leon got a job in a chicken processing plant. About a year later, Leon's younger brother Martin and his family moved to Michigan and Martin went to work in the same plant. When Leon got a job in construction in Lansing, he and his family moved into a duplex near Cristo Rey. When they were settled, Martin and his family moved in with them. Leon helped Martin find a job and separate housing. About a year later, Leon's older brother Jaime and his family moved to Lansing from Mexico and lived with Leon until they could find housing. At the onset of this study, Martin and Leon lived next door to each other and Jaime lived across the street. Leon has since moved.

In the past several months, two of Leon's nephews, Paco and Esteban, came here from Texas to look for work. Paco's wife and daughter came a bit later. All of them live with Leon and his family. In time, Paco and Esteban will find jobs and move into separate housing, probably on the north side. Settling first on the north side, the area with the largest concentration of Mexicans, and later moving to another area of Lansing, is a common pattern of mobility.

Leon's home is the gathering place or stopping place for those who come to Lansing, though he is not the oldest of the brothers. There are a number of factors which account for his home being the family headquarters. He and his family have been in Michigan and in Lansing for the longest time. Leon and Evalina both have a fairly good command of English. Martin's English is very poor, Irma's a bit better, Jaime knows a few words and Concepción does not speak English at all.

Leon has a truck and a station wagon. Evalina has a driver's license; she provides transportation and serves as interpreter. She also makes the contacts with people and agencies in the community. Leon has had a variety of jobs and has some knowledge of the job market. In general, Leon and Evalina are the most aggressive and knowledgeable about Anglo ways.

The pattern of family migration is interesting and seems to have some relationship to use of Clinic services. In the poor user group, eight of the families came to Michigan as families. In the two remaining families, both parents were born in Michigan. This pattern is noticeably different from that of the other two groups (see Table 15).

Table 15. Pattern of migration by use of Child Health Clinic services

Pattern	Use			
	Good Users	Poor Users	Non-Users	Total
Parents came together	1	8	4	14
Parents came separately	4	0	0	3
One parent grew up in Michigan	3	0	2	5
Both parents grew up in Michigan	2	2	1	5

Fewer of the families in the good and non-user groups came as families (one and four, respectively). Some form of separate migration appears in both of the latter groups, but not in the poor user group.

This pattern of either migrating to Michigan as a family or never migrating, seen only in the poor user group, seems to emphasize the family stability apparent in this group. These mothers have not had the opportunity or the necessity, as the case may be, to develop much independence. In the migration pattern, as in family structure, the good users and the non-users have similarities which tend to separate them from the poor users.

Whether or not the mother has had experience as a migrant agricultural worker also serves to differentiate the poor users from the good and non-users. Seven of the mothers in the poor user group have had experience; four in the good user and three in the non-user groups have.

The seasonal mobility of the migrant family may serve to reduce both exposure to the Anglo health care system and the opportunity to participate consistently in a preventive care program. Health care programs for the migrant worker families in Michigan are a fairly new development. According to my informants, health care was not as available to them in Texas as it is here. Also, those with a migrant background have to adapt both to living in the same place and to living in a different place.

It may be that the mobile life of the migrant serves to retard adaptation to various Anglo ways. For example, Choldin and Trout (1969) found that age-grade retardation of children was highly related to migrant experience, socialization in Texas and recency of arrival in Michigan of the head of the household. They do not offer an explanation for the relationship.

More of the mothers in the poor user group were socialized in Texas than in Michigan (see Table 8). Recency of arrival in Michigan does not have any apparent relationship to use of Clinic services. There are two possible explanations for this. Of the mothers who migrated to Michigan only the two over forty have been here for more than nine years. In that respect, they are all fairly recent arrivals. Also, since the Clinic has only been in existence since July 1968, it was available on arrival only to the mothers who came most recently.

Mobility within the city is quite common in all of these families. Only two have not moved at all since they came. Only three have lived in their present dwelling more than five years, the longest

period being nine years. More of the non-users (7) and the good users (6) have moved recently than the poor users (4) (see Table 16). Frequency of moves is not remarkably different in the three groups.

Table 16. Length of time in present dwelling by use of Child Health Clinic services

Time in Present Dwelling	Use			
	Good Users	Poor Users	Non-Users	Total
One year or less	6	4	7	17
Two-three years	3	5	2	10
More than five years	1	1	1	3

Home ownership, a good indicator of some financial stability, does separate the non-users from the users, both good and poor. In the latter two groups, five and six of the families own their homes in the sense that they make house payments rather than paying rent. One mother told me with obvious pride, "We give money to the bank every month." In contrast, nine of the non-users rent their present dwelling.

Summary

On a number of indices, the families in the poor user group seem to be the most stable. This group has the highest number of nuclear families, the best educated mothers, the highest socioeconomic scores, the highest home ownership and the least number of families receiving Aid to Dependent Children. The parents either migrated to Michigan together or were brought up here.

The families in the non-user group seem to be the least stable. This group has the highest number of households headed by a female and receiving Aid to Dependent Children. The mothers have the lowest level of education, the families have the lowest incomes and the lowest socio-economic scores. Only one family owns their home.

In general, the families in the good user group are more similar to those in the non-user than poor user group. The good user group has the highest incomes, but falls between the other two groups on most other indices. The greatest similarity to the non-users is noted in the small number of nuclear families and pattern of migration.

CHAPTER VI

MEXICAN AMERICANS IN LANSING: HOME, FAMILY AND CULTURE

Introduction

During the months I spent conducting the interviews and having frequent contact with the Mexican families, I was struck by the many similarities in their behavior and way of living. The public health nurses who work with Mexican families here have observed many of the aspects of their life style described below. The behaviors which are common to the thirty families I visited apparently are common to many more families as well.

The extensive reading I did about the culture of the Mexicans prepared me for some of the consistencies I found. Despite the objections which many Chicano writers raise about the "stereotyped picture" presented in the literature, I found many aspects of that picture reflected in the families I met and came to know here. Because of their objections, I approached the families with an open mind and was prepared for the many differences I found. Some of the similarities and differences I expected, some I did not. In general, the differences did not seem to follow a pattern, nor did they serve to differentiate the three groups.

Some of the differences will be apparent in the following brief descriptions of the nine families with whom I had close and continuing contact. Other differences and many similarities will be discussed in this chapter and the chapter which follows.

Major Informants

Families Who Attend the Clinic Consistently

The Cabrera family lives within walking distance of Cristo Rey. Both parents were born and educated in Texas. She has a fifth grade education; he finished sixth grade. She has lived in Lansing for seven years; she says she has moved "many times--about seven" since coming. Prior to moving to Lansing, she worked "in the fields" in Texas and, for two summers, in Michigan. She moved to Lansing because she liked it better here and her first husband "bothered her" in Texas. She has six children, three by her first husband and three by her present husband.

The Flores family also lives within walking distance of Cristo Rey. Mrs. Flores was born in Detroit, but the family moved back to Mexico when she was four. She lived in Mexico until she was 18, when she got married and moved to Michigan. She never went to school; her father did not think it important for girls to go. She has taught herself to read and write both Spanish and English. She has lived in Michigan for more than twenty years and in Lansing for thirteen or fourteen years.

This is her second marriage. Her first husband died when she was pregnant with her fifth child. She had two children following her second marriage. Her oldest child, Anselmo, is twenty-four; her youngest, James, is four.

The Dominguez family lives on the east side of Lansing. This is a young family, with parents in the mid-twenties and children ages five, four and one. The parents are separated but not divorced. Mr. Dominguez sees the children almost every day and participates in some of the decision making. Mrs. Dominguez does not want the separation to have a negative effect on the children; she says, "They need to know they have a father."

Mrs. Dominguez was born in Michigan. Mr. Dominguez was born in Texas, but moved to Michigan when he was four. Both have family in Lansing.

Families Who Attend the Clinic Sporadically

The Leonirdes (Leon) Almaguer family lived on the east side when I began visiting, but moved to the north side during the study. Leon was born and educated in Mexico. He finished high school. Evalina, his wife, was born and educated in Texas, where she finished ninth grade. They worked "in the fields" for a few years, including one summer in Michigan, but did not like that life. They wanted something better for their children. They have been in Michigan for six years.

They have six children, ranging in age from eight to two. In addition, Leon's 18 year old son lives with them and they are adopting a one year old girl whose father is a member of Leon's family.

Martin Almaguer, Leon's brother, and his wife Irma live on the east side. Before Leon moved, they were next door to each other. Martin and Irma were both born in Mexico and finished the eighth grade there. They have five children ranging in age from 12 years to eight months. The baby was born while the study was in process.

They worked "in the fields" in Texas for a few years. Like Leon and Evalina, they did not like it; they, too, wanted a better life for their children. They moved from Texas to Michigan about five years ago.

Domingo (Jack) and Refugia (Rachel) Bermudez live southeast in a small subdivision in the shadow of the Expressway. When I asked Mrs. Bermudez for their names, she gave me Domingo and Refugia. However, that was the only time I heard their Spanish names. They use Jack and Rachel. Both were born and educated in Texas. Rachel quit school in the eighth grade because she was pregnant. Jack finished high school in the Army.

Both Jack and Rachel worked "in the fields" in Texas as children. Rachel was fourteen when she got pregnant. After Richard was born, they continued to work as agricultural laborers. They have been in Lansing about four years. Their second son, Rudolph, was born here.

Families Who Have Not Attended the Clinic

I met Anselmo and Maria Lopez and Maria's sister, Consuelo Martinez, when I was looking for the Martinez family that had lived at Consuelo's address. Both women agreed to participate after we discovered the error. Each has a pre-school child; neither had had any well child care.

Maria was born in Mexico. She has never attended school, but is able to read and write in both Spanish and English. Her son, Tomaso, is eight; he was born just after she came to Lansing. Anselmo was born in Texas and went to the tenth grade there. He is adopting Tomaso, who is illegitimate. He and Maria are adopting Juan (also illegitimate), the three year old son of Anselmo's sister. They have had Juan since he was a month old. They have no children of their own.

Consuelo Martinez and her three children had only been in Lansing six months when I met them. She left Mexico shortly after Maria did. Like Maria, she has never attended school, but is able to read and write in both languages. When I met them, Anselmo was functioning in some ways as a father for Consuelo's children.

Several months later, Consuelo married a Lansing man also named Martinez. He works full time and 'is making a good life for her and the children.' When the study concluded, she was pregnant and "very happy."

Esmeralda Ramos and her family live in a large apartment in one of the low-cost housing projects. She was born in Texas and worked "in the fields" there for many years, both as a child and an adult. She came here six years ago to get away from relatives who were always "interfering and gossiping." She does not know where her husband is.

Mrs. Ramos has never attended school. She is the only woman in the study who is functionally illiterate. Eight of her children live with her. Laura, her oldest daughter, is married. She, her husband Carlos and their two children live with Mrs. Ramos. Laura brings her children to the Clinic sporadically. Joy, Mrs. Ramos' youngest child, is just four.

Home and Family

"The Mexican Is Always Remote"

Paz says of the Mexican, "He is jealous of his own privacy and that of others, and he is even afraid to glance at his neighbor. . . . The Mexican is always remote, from the world and from other people" (Paz, 1961, p. 29). Ubaldo Patino, a Chicano who works in the federal program for migrants, says of the Mexicans in Lansing, "The families stay locked in their homes" (McAleenan, 1973a, p. 1).

All of the Mexicans I met do value their privacy and stay closed, if not locked, in their homes. Every home I visited had all of the front and some side windows covered with draperies, blinds or heavy curtains of some kind. If there was a window in the door, it was covered with a curtain or masking tape. When I approached the house or knocked on the door, there was no way I could look inside. This was completely consistent and highly indicative of whether a Mexican family lived in the house. I tried it on the street where Rachel Bermudez lives, by observing which houses were closed and then asking Rachel which houses had Mexican families. I did not miss on any of them. As I drove around in the areas where the Mexican families lived, I observed houses that were closed and some that were not.

The fact that the houses had a closed look did not mean that no one was home. Neither, in my experience, did it serve as a means of pretending not to be at home when I knocked. (I have had the experience, in the past, of knocking, knowing someone was at home, but not getting a response.) When I knocked, someone usually looked out first, then opened the door and asked me to come in.

I asked Rachel why Mexicans always have the windows and doors covered. She said, "We don't want people looking in, Mexicans are like that." Mexican women do a lot of gossiping, she told me, but they do not like to be the subject of gossip. If people looked in, they might see that sometimes her house is messy or her boys run around without any pants on or anything else they could talk about. What goes on in her house is her business and not anyone else's.

The closed curtains make the houses dark inside. This was not compensated for by having lights on. The mother usually turned a light on for me when she realized that I would be reading and writing.

The other major indication of a desire for privacy was the high number of unlisted phone numbers. Twenty-four of the households had phones. Twenty of them had unlisted numbers. Three had the phone listed to the head of the household. Esperanza Flores had the number listed in her name, using her first husband's surname. Five of the families who did not have a phone were in the group who had never been to Child Health Clinic. Two of those with listed phone numbers attended Clinic sporadically. Esperanza Flores and the other family with a listed number attended Clinic consistently.

I discovered the unlisted numbers because I did not initially ask for their phone number; I just asked if they had a phone. I soon discovered that I could not get the number from the phone book or the operator. After that, I asked each woman if she would give me her phone number. No one refused or even hesitated. I also asked if the number was listed, since no one volunteered the information. Some of women did not know how they learned about unlisted numbers--they

"always had it that way." Others said, "My husband knew" or "It was like that in Texas, too."

The women did not all give the same reason for having the private number. Only Mrs. Zamora said it was because of bill collectors. When her husband left Lansing, he left many debts. She told the people she would pay them when she could, but they kept bothering her. When she moved, she got a new, private number. Esperanza Flores told me, "It is my phone and my people know how to find me." Rachel Bermudez said, "Mexicans don't like to have a lot of people call them. Too much gossip." The most common reason was some form of "So people won't bother us." The underlying reason, although not explicitly stated, seemed to be that the families wanted control over who called them as one means of maintaining their privacy.[1]

"A Clean House, Clean Wife, Clean Children"

Lupe Santos commented that taking care of her home and children was her biggest job. "Juan works hard. He should have a clean house, clean wife, clean children and a good meal when he comes home." She thought that if she did not provide those things for him, he might get angry and maybe even leave her.

Cleanliness of home and family was a value of all of the mothers. Rachel Bermudez was the only one who honored it more in the breach than in the keeping. She made a valiant effort to have the house clean when

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[1]Kay observed the same phenomenon in Tucson. The most frequent reason given to her was to avoid being dunned by creditors. She concluded that the underlying reason seemed to be "no one is entitled to have access to your phone number who is not close enough to get it from you" (Kay, 1972, p. 81).

her husband came home, but did not always succeed. With very few exceptions, the homes were clean and uncluttered when I visited, whether I was expected or not. Most of the women did their cleaning in the morning. Many of them asked me to come in the afternoon, when they had finished cleaning.

In addition to keeping the home clean, the women made it attractive. If the couch and chairs were old and worn, they were covered by a bright throw. The walls were not bare. There might be a knick-knack shelf with a vase of artificial flowers, framed pictures of the children or religious pictures or statuettes. A bright calendar, pictures of the family, the children's art work, a Mexican sombrero or serape, a picture cut from a magazine might be hanging on the wall. Ricardo Cabrera's certificate for finishing a course in basic education was framed and given a prominent spot on the wall. Every home had something.

These homes did not have the bleak, barren, cluttered, dirty appearance so common to the homes of low-income white families in my experience. Neither did the Mexican homes have the smell of poverty--a distinctive and offensive odor, probably a combination of old grease, unwashed bodies and poorly washed clothes, particularly diapers. Neither the homes nor the people had an offensive odor. The children were often dirty as a result of playing out of doors, but it was "new" dirt, not "old" dirt.

The women did not like to have anyone see their home when it was not clean and "picked up." Irma Almaguer could not clean as often or as well as she wanted to at the end of her pregnancy. The children

tried, but did not do a very good job. Martin, her husband, did much of the cleaning, but was hampered by a "bad back." More than once when I came, Martin was dusting or running the vacuum cleaner. He referred to himself, in Spanish, as "the woman of the house."

One morning during this time, a young woman employed by the Board of Education came to make arrangements to visit Irma and Martin three times a week to help them learn English. Several weeks later, I asked Irma how the English lessons were progressing. She said the teacher never came back. I asked if she had called; I knew she had the teacher's name and phone number and she wanted to learn English. She answered, "No. After the baby comes. I don't like to have people see my house when it is not clean." I was accepted as one permitted to see her house when it was not clean.

"Come Again, Any Time"

Olguin (1973) describes the Mexican people as gentle, sensitive, courteous people who learn respect for and consideration of others as part of their way of life. Anglo and Chicano writers alike comment on the importance of inter-personal relations, the preservation of the dignity of the individual, as characteristic of the Mexican people (Murillo, 1971; Haddox, 1970; Madsen, 1964; Paz, 1961). This courtesy was shown to me from the time I was invited to come in and sit down until the time I left, when the mother thanked me for coming and said, "Come again, any time."

The consideration was demonstrated in many ways. I never had to compete with the television when the mother and I were talking.

If it was on when I came, it was turned down or off or we went into the kitchen. If the children were present, they were quiet; they did not intrude into the conversation. When David Abelardo walked in front of me, his mother said, "David! You know better than that."

Consideration for the feelings of others may be manifested in another way which has particular importance for public health nurses. They find it very difficult, if not impossible, to say "No," even though they do not want to do whatever is being suggested or requested. They may offer excuses or they may agree, even though a negative response would express their feeling. Irma Bermudez did not tell the teacher she would rather wait until after the baby was born; she just did not pursue the matter when the teacher did not come.

For a while, case workers from the Department of Social Services were making appointments at Child Health Clinic for their clients. The rate of broken appointments in this group was extremely high. As a result, a policy was established that only the nurses could refer families to the Clinic. The families with whom I had contact had only negative things to say about "those welfare people," for whom they had little respect.

I do not think that the acceptance accorded me was based on a reluctance to refuse. I frequently made an appointment to return; the mother was always expecting me when I did. Several times, a mother called to change an appointment because "something came up." Not being home is an accepted way of avoiding someone.

Every mother who had had public health nursing service at home knew the name of the nurse who visited her. Several mothers knew the

names of two or three. It was apparent from their comments that their experiences with public health nurses had been positive. Seldom did the mother know the name of her "welfare worker," although she might have it written down.

I was frequently offered something to drink--coffee, tea, lemonade--and something to eat--a homemade tortilla or other Mexican food. My Chicano friends tell me that this is an indication of acceptance. I was given the ultimate in acceptance by the three women with whom I had the most contact. They said, "You don't have to knock--just come in and say 'It's Carol.'" That is a privilege usually accorded only family members.

"I Love My Children"

Both parents verbalize and demonstrate love for their children. Leon Almaguer had Evalina, his littlest one (18 months) on his lap, sharing his beans and tortillas. Mark, the four year old, came and leaned against his father. Leon put his arm around Mark and said to me, "I love my children." When he was sitting down, he usually had a child or two on his lap or curled up against him. When Miguel's puppy was killed, Leon comforted him.

Martin Almaguer took the little ones into the bedroom while Irma and I talked. I could hear them talking, laughing and singing softly. He fed the baby, Angelita, several times and grinned broadly when she produced a lour "burp."

While we were talking, the mother always maintained an awareness of where the children were and what they were doing. If one was

hurt, he was held and comforted. If necessary, she excused herself to meet the child's needs. I never saw a child ignored or brushed aside. Most of the mothers and fathers spoke quietly to the children, with an added note of firmness if their behavior was unacceptable. Rachel Bermudez was the only mother who quite consistently "yelled at" her children.

The most frequent response to the question, "What do you do to keep the children well?" was, "Take care of them--watch them." Leon and Evalina Almaguer said parents should stay home and take care of their children. "Parents who go out all the time and leave the children with a sitter have sick children." Evalina worked for awhile, as a teacher aid. She liked the work, but her children were always sick. When she quit and stayed home with them, they were better. Leon gets up in the night to be sure the children are all right.

As I interacted with the parents and children, observed them interacting with each other and listened to the parents talk about their children, it was easy for me to understand why the Mexican home is described as a source of security for the family members and a source of identity for the children. I observed the development of the close family bonds as I saw the older children looking after the little ones. I learned about the close family feeling as the parents talked about their relationships with their parents and siblings.

"Families Are Like That"

Leon Almaguer's house is always crowded, but for several months it was worse than usual. Anna, her husband Robert and their little girl lived there "temporarily" while Robert looked for work. Anna's mother is Evalina's comadre and she could not refuse a request for help. Two of Leon's nephews, Paco and Esteban, came from Texas to look for work. Paco's wife and little girl came a bit later. They all lived at Leon's. The noise, confusion, crowding and cost were making Evalina nervous. No one was contributing to the budget. Evalina could not ask any of them for money nor could she ask them to move, because they were "family, and families are like that."

Strong family ties are apparent in the number of families who migrated to Michigan because other family members were here and in the number of parents who have family members here (see Table 17). In only two of the thirty families, neither parent has any other family member in Lansing. In ten families, both parents have relatives here.

Table 17. Other family members in Lansing by use of Child Health Clinic services

Family Members in Lansing	Use			
	Good Users	Poor Users	Non-Users	Total
Only mother	2	3*	5*	10
Only father	3	2	3	8
Both parents	4	4	2	10
Neither parent	1	1	0	2

*Includes female heads of household whose husbands are not in Lansing.

Most of the women who do not have any family here, or those who have only male relatives, express great loneliness. They do not have anyone to talk to. Irma Almaguer, who only has a brother here, said, "I don't have any friends, Mexican or white--only Evalina and Concepción to talk to and they are always so busy." When I asked why she did not have any friends, she said, "Martin doesn't let me. He gets jealous." Mrs. Cabrera wants to return to Texas, with or without her husband. She says she has been away from her family long enough. Mrs. Zamora says her phone bills are pretty high sometimes because she calls her mother in Texas quite often. Maria Lopez was very happy when Consuelo moved to Lansing because now she has someone to talk to. Most of the women in these families are quite isolated at home; they socialize only with relatives. Those without family members here feel keenly the lack of companionship and support provided in Mexican families.

The Almaguer families offer a good example of the mutual support system of the Mexican family. When I began visiting, Leon was recovering from a serious accident with the truck; the family was getting Aid to Dependent Children. They had some savings and Leon went back to work in about three months. Martin was on sick leave from his job in an automobile plant. His sick pay was a little less than ADC would be for a family of the same size. They had no savings, were making house payments and were having financial problems. Jaime has a physical disability. They have been getting ADC for over a year and manage well.

Martin was the one who needed help. Irma told me, "Martin is the baby and they have always spoiled him." Leon could usually provide

a few dollars for gas for Martin's car. Evalina provided transportation frequently. She had "extra" milk, eggs and beans, as did Concepción. Sometimes, all three families were short on food.

Irma did not like to ask Martin's family for help. She said, "Husband's and wive's families never get along." She could ask her brother Horacio for help. He lived with Irma and Martin from the time he was ten until he was a man and on his own. Irma says he is more like a son than a brother. He works full time in one of the automobile plants. He is single and sends money to his mother every month. Periodically, when the financial problems were worse than usual, Irma would say, "I go to my banker [Horacio]." When they were threatened with losing their home because they missed two payments before they got some help from Credit Counseling, Horacio said to Irma, "Not to worry [about] the $287.00."

The children of all three families play together and are in and out of all three homes freely and frequently. Apparently they learn sharing and caring early. I took four of the children to the circus one afternoon. Lydia and Miguel, Leon's children, each had two quarters. Leon was working in construction. Evalina and Maria, Martin's children did not have any money. When we got to the circus, each child had one quarter.

Mrs. Zamora's husband deserted her and the children. She has no family in Lansing; his family lives here. They "care for" her and the children by providing transportation, outings for the children and help with things she is unable to do around the house.

There were many examples of families helping each other. There were also some examples of families who did not get along well together. Esmerelda Ramos has a sister in Lansing, but they have no contact with each other. "You might as well say I have no family here," she told me. She left Texas to get away from relatives who were "always interfering and gossiping." Several others also came to Lansing to get away from family problems of one kind or another in Texas.

"Mexican Women Put Up With A Lot"

Life was not all love and consideration in all of the Mexican homes. I observed relatively little husband-wife interaction during my visits. I heard about some problems from the women with whom I had a close relationship. Evalina said, "Mexican women put up with a lot. They just have to suffer in silence, no matter what their men do--more in Mexico and Texas, but some here, too. They are afraid of gossip, so they can't talk to anyone about it. Their husbands can beat them up and they can't do anything about it."

I knew from three of the women that their husbands "beat them up." None claimed to like it, though.[1] Rachel Bermudez said that Jack used to "beat her up" but he had not since she called the police. That shamed him to the other Mexican men. That she would "call the cops--that really took away from his macho [maleness]."

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[1]Madsen's statement that "some wives assert that they are grateful for punishment at the hands of their husbands for such concern for shortcomings indicates profound love" has called forth the wrath of many Chicano writers (Madsen, 1964, p. 20).

Rachel told me of two other women she knew whose men "beat them up all the time." "Why do they put up with it?" she asked. "They don't have to--I don't." As she described their situation and we discussed the circumstances of their lives, we could speculate on why they did not do anything. Neither woman was married to the man with whom she lived, although they had lived together for a number of years and had born "their man's" children. Neither woman spoke much English, neither had transportation other than that provided by her man. One woman was in this country illegally, had no family here and was threatened with exposure which would lead to deportation. The other woman had family here, but they accepted the union as legitimate. It was apparent from the way Rachel talked that she too, accepted the union as legitimate.[1]

Rachel concluded that there was not much these women could do without help. The language barrier was not the major barrier as she saw the situation. "Mexicans don't like to ask for help from outsiders because it puts them down and people gossip. Besides, their men would only beat them worse if they found out. Most Mexican women are afraid of their man. I guess I'm different."

I do not know how common "free union" is among the Mexicans in Lansing. I do know that it exists. Rachel and Jack were not married until just before the second of their two children was born. To "outsiders," Rachel dates her marriage from the time she became pregnant with her first child. Two other women in the study had lived with

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[1]Lewis describes these "free unions" as being fairly common in Mexico and "on the local community level . . . socially acceptable" (Lewis, 1959, p. 29).

their present husband for an extended time prior to marriage. Another woman was living in a "free union" with the father of her youngest child.

The interactions I observed between husband and wife were calm and almost, at times, impersonal. There was never any display of affection between them. The three women who discussed their marital relationships with me were the three with whom I had the most contact. All were having marital problems; all felt helpless in the situation. Several times, I observed bruises on one of the women, but neither of us mentioned them. One does not ask about such things; each of the women volunteered information. To some degree, in almost every family, there was evidence of the authoritarian male-submissive female relationship described in the literature.

"Good Food Is Important"

All of the mothers recognized the importance of a good diet; twenty-nine of the thirty named good food as one means of keeping the children well. All of them knew what foods constitute a good diet and did their best to provide them for their children. Some managed better than others.

I was interested in the dietary patterns of the families for several reasons. Good nutrition is basic to good health. In observing the Mexican children in the Clinic, I had seen several rather severe cases of nutritional anemia. In general, however, the Mexican children appeared well-nourished. None of them had the observable indicators of prolonged malnutrition.[1]

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[1]In a nutrition survey done recently in ten states, Spanish-Americans (Puerto Ricans and Mexican Americans) in the high-income-ratio

Overall, I was impressed with the mothers' ability to provide a fairly decent diet, particularly those who had a low income. Low income families were stretching their food dollars with beans, cheese, eggs and other meat substitutes before the escalation in the cost of food. Between September 1972 and September 1973, the year during which I conducted the study, the cost of food increased by 21 percent. No family had a comparable increase in income or in food stamps.

All of the mothers commented on how expensive food was. They shopped in the supermarkets because food was less costly there, the variety was good and many of them carry Mexican foods. If not, they went to the smaller stores only for Mexican foods. Many of the mothers watched for sales and used the coupons from the paper.[1] They did the grocery shopping once a week or once every two weeks, depending on when the check came.

These mothers, as a group, provide better nutrition for their families than the low income white mothers with whom I have worked. I think that there are several reasons for this. The Mexican ethnic diet includes pinto beans, a good source of protein, as a staple. Every family had beans once a day, many had them twice a day. They use tripe and beef head, two inexpensive sources of animal protein I had not seen

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states (including Michigan) had fewer important nutritional problems than Blacks or whites (U.S. Department of Health, Education and Welfare, 1972b). They also had the highest adequacy of nutrient intake of calories, protein, iron, thiamine and riboflavin and second highest in calcium. They were lowest in Vitamins A and C (U.S. Department of Health, Education and Welfare, 1972a).

[1]According to a survey done by the staff of Cristo Rey, 78 percent of the Mexican families read the daily paper (Benavidez, personal interview).

used before I knew the Mexican families. The other major sources of animal protein are hamburger and chicken. Their diet also includes a great deal of cheese. Many of their national dishes are what whites would call "one-dish meals." These foods are part of the way they eat traditionally, not things they do to economize.

The mothers place a high priority on a good diet. Several of them told me that, when the check comes, they buy food first. They spend very little money on what nutritionists call "empty calories" and public health nurses call "junk food." I very seldom saw pop, potato chips, Fritos, pretzels or sweets other than cookies in the homes. My evaluation of their diet is not based solely on what the mothers told me. I spent quite a bit of time in quite a few kitchens. I was there when they were putting away food after the weekly shopping trip, or before or after a meal. The children snacked on fruit, a baloney or peanut butter sandwich, a glass of Tang or a bowl of cereal.[1] One afternoon when I was at Irma's, the children were sharing a large bottle of Coke, a bag of pretzels and some candy. Irma said, "I don't buy that. Horacio brings it for a treat."

Very few of the women work outside of their home. Three were employed at the time I conducted the interviews. Amada Cabrera went to work cleaning offices in the evening after I had been visiting her for

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[1]Between-meal foods and beverages provided a substantial amount of Vitamins A and C to the diets of Spanish-Americans in the high-income-ratio states in a recent survey. Spanish Americans had a lower intake of calories between meals than did Blacks or whites (U.S. Department of Health, Education and Welfare, 1972a).

about six weeks. She only planned to work for a few months. The women stay home and "make a good home' for their family. All of the women make their own flour tortillas, because the ones in the store are not good. A few of them do buy corn tortillas; they are not very expensive and not bad tasting. They cook, they do not buy frozen dinners.

Rachel Bermudez made flour tortillas one day while I was visiting. She scooped some flour out of the bag with a coffee cup and put it in a mixing bowl. She put in a little salt, then poured some baking powder into her palm, looked at it, added a little more and it went into the bowl. Last, she scooped some shortening out of the can with her fingers, mixed it in with the rest of the ingredients, added a bit more and continued to mix with her hands. While she was doing this, she said, "Tortillas are the hardest thing for white people to make because they always have to measure. You can't measure for tortillas, you have to go by the feel." She let the dough "rest" for a little while, then formed small balls, rolled them very thin with a rolling pin and fried them on a hot, ungreased griddle. Mrs. Aguilar told me how to make tortillas, using the same method of measuring that Rachel used, and added that I could use a fruit jar filled with water if I didn't have a rolling pin. I never saw a cook book, a measuring cup or spoon--but I ate some mighty good food!

In many poor white families, a three meal recall done just before the check came would be very different from one done just after the check came. They do not manage to maintain a fairly similar diet, be it adequate or inadequate, from pay check to pay check. The same is

true of the Mexican families I visited. Fifteen of them reported no change, fifteen said they ran out of some foods, usually meat and milk. Five mothers in each of the three groups ran out, five did not.

The distribution in the group attending the Clinic sporadically would have been different had I done the interviews two months earlier. Leon and Martin Almaguer were both unable to work because of injuries. Aid to Dependent Children and sick pay provided considerably less money than the men earned when working. Both Evalina and Irma said that they managed fine with a working husband. At the conclusion of this study, Leon was working part time, Martin had not returned to work.

Ability to manage was not related to family or per capita income, education of the mother, family size, skill in English, length of time in Lansing or experience in the migrant stream. It may be related to overall quality of the diet, particularly in relation to meat protein. Several of the mothers who managed with no change in diet said they did not serve meat every day. Some of those who ran out mentioned meat as the item which they could not serve just before the check came.

"Five Children--That's Enough"

I was surprised at the high usage of contraceptive measures in the families I visited. Nothing in the literature had prepared me for this. As mentioned above, several Chicano friends expressed the opinion that the combination of religion (Roman Catholic) and machismo would deter the use of contraceptive measures. However, Irma Almaguer's fifth pregnancy was planned because she wanted another boy. When Nancy was born, Martin said, "I love my girls. Five children--that's enough."

In the Michigan Health Survey sample of families of Mexican descent, 26 percent of the women were using some method of preventing pregnancy, 47 percent were not (see Appendix A, Table A-17). Grebler, Moore and Guzman (1970) report attitudinal acceptance of birth control practice at 64 percent in the Los Angeles sample and 50 percent in the San Antonio sample. Verbal acceptance was higher in the women in the child bearing years, the higher income group and in those living in predominantly Anglo areas, regardless of income.

Kay's study (1972) in Tucson was composed of a small number of women, some over fifty who did not accept the idea of birth control. She stated that some of the younger women were using some method of preventing pregnancy, against the wishes of their mothers and the priest. She concluded that, on the basis of her information, it was difficult to generalize on the use of contraceptives.

O'Grady's study (1973) of Mexican-American and Anglo women in Tucson did result in some conclusions. The major difference she found between the two groups was in the timing and ultimate purpose of utilization of contraceptive measures. The Anglo women tended to begin use of contraception early and use it for spacing of children, whereas the Mexican-American women began use of birth control after they considered their family complete. She reported that 70 percent of the Mexican-American women used some means of contraception.

O'Grady (1973) found that the Mexican-American women wanted more children than the Anglo women. José Almaguer's wife Gloria, age seventeen and pregnant for the first time, told me, "Mexicans like to have big families. It is part of our tradition and our image." Some of the

women whom I interviewed followed the pattern described by O'Grady, but the number was small.

Evalina Almaguer had six children in six years. She said the doctor told her it wasn't good for her to have babies so close together and she should talk to her husband about it. She said, "I told the doctor my husband is a hard man and he likes for me to have lots of babies. I can't do anything about it." However, she did have a tubal ligation after the sixth baby. Concepción Almaguer had a tubal ligation after her tenth child. Generally, the women over forty with big families did not use any form of birth control until after the birth of the last child, when they tend to use a permanent method. As can be seen in Table 18, tubal ligation and hysterectomy appear predominantly where there are six or more children.

Table 18. Relationship between number of children and use of contraceptive

	Number of Children						
Contraceptive Used	One	Two	Three	Four	Five	Six or More	Total
Pill	0	6	2	2	2	0	12
IUD	1	0	1	0	2	0	4
Foam and condom	0	1	0	1	0	1	3
Tubal ligation	0	0	1	1	0	3	5
Hysterectomy	0	0	0	0	0	3	3
Abstinence	0	1	0	0	0	0	1
Nothing	0	1	1	0	0	0	2
Total	1	9	5	4	4	7	30

The pill, used by twelve of the women, is the most commonly employed means of preventing pregnancy. Several of the women who have an IUD or use foam and condom would prefer the pill, but have too many negative side effects. Eight women with only two children and four with three are using some means of birth control. No one is using rhythm. Only two women are not doing anything. Maria Lopez wants to get pregnant; Anselmo wants children that are his. Consuelo Martinez did not know where to go here in Lansing to get the pill; she had taken it prior to coming to Lansing (see Table 18).

As I talked with the mothers, it was apparent that they were using contraceptives to space their children. Jack and Rachel Bermudez have two boys, ages four and two. Jack would like to have a girl, but Rachel said, "Two is all I can handle right now. Maybe we'll try for a girl later." Another young mother of two told me that they could only afford two right now.

Only one mother said that her mother would object to her using a contraceptive if she knew. None of the women hesitated in answering the question nor did they seem to object to my asking. In a number of instances, the father was present and participating in the interview. No woman said she was taking the pill without her husband's knowledge. Maria Lopez said that Anselmo had accused her of "taking something" because she did not get pregnant, but Maria wants a baby, too.

"Mexicans Should Know Spanish"

Spanish is spoken to some degree in all but four of the homes. Irma Almaguer, who speaks only Spanish to her children, told me she had heard about a Mexican family that was not teaching their children any Spanish at all. She said, "That is very bad. They are Mexican, and Mexicans should know Spanish."

English is spoken to some degree in all but five of the homes. The most common pattern is one of the parents speaking Spanish to each other (19), both languages to the children (16) and the children speaking primarily English to each other (17) (see Table 19). Several of the mothers said they spoke only English to the children so they would know the language when they started school. A large number of mothers indicated that they wanted the children to be bilingual. In families with school age children, the older ones teach the little ones English.

In general, the children learn English quickly. When Jaime Almaguer and his family moved here from Mexico three years ago, no one spoke any English. Now, the school age children speak good English without an accent. Neither parent speaks much English, but Concepción can read and understand it well. Only two mothers reported children having difficulty learning English. Evalina Almaguer said that Gloria was not "picking up English fast, like the others did." As a result, she is repeating kindergarten, much to Leon's chagrin. Maria Lopez said they were worried about Anna, Consuelo's oldest girl, because she was not "picking up English" as fast as her younger sister. Maria said Anna was "slow to learn."

Table 19. Language spoken in the home by use of Child Health Clinic services

	Language Spoken in the Home								
	Parent to Parent			Parent to Children			Children to Children		
Use	Span.	Eng.	Both	Span.	Eng.	Both	Span.	Eng.	Both
Good users	6	2	2	2	2	6	2	7	1
Poor users	8	0	2	3	1	6	1	5	4
Non-users	5	2	3	3	3	4	2	5	3
Total	19	4	7	8	6	16	5	17	8

In half of the families, both parents (or the mother in the one parent families) have a good command of English; only six parents (five in the non-user group) are unable to speak English at all. The parents generally have about equal skill in English, be it good or poor. Two of the mothers are going to school to learn English; one has a teacher who comes to the house to teach English. Parents in both the good and poor user group tend to have a better command of English than those in the non-user group.

Use of the Spanish or English pronunciation of the children's names is closely related to skill in English. The seven mothers who used only Spanish names are those with the least skill in English. The remaining mothers used either only English names or Spanish and English interchangeably, usually related to which they were speaking, but not always. Anselmo and Maria used the Spanish when the children were

misbehaving. The children generally used the English pronunciation, even in those families in which the parents did not speak English.

Outside the Home

"I Don't Bother Them; They Don't Bother Me"

The descriptions in the literature of the relative isolation of the Mexican women are born out by what I heard and observed in families I visited. Mrs. Flores and I were talking one day about the neighborhood and neighbors. She said that when they moved into this house, they were the only Mexican family on the block, but that has changed in the nine years they have lived here. She said, "The neighbors are nice, both the white and Mexican. They seem to like my kids. We get along fine--I don't bother them; they don't bother me."

Martin Almaguer said their white neighbors are "beautiful people" but "we don't talk to them--they can't understand us." This seemed to be the prevailing attitude on the part of the Mexican women. They stayed home and minded their own business and expected others to do likewise. A few of the families lived in predominantly white neighborhoods. However, only one reported any troubles with white neighbors.

Family members visited quite frequently. However, it was rare indeed to find anyone but family members visiting. The only exception I found was at Rachel's. She and Elba, who lives behind her, visit back and forth, interspersed with periods when they are not speaking to each other. (Neither has any family here.) I met Elba at Rachel's and later visited her for an interview. I also met a neighbor at Mrs. Cabrera's;

she came over because she knew I was a nurse and wanted to talk to me. I visited her at home later for an interview.

I learned early in the study that the families whom I visited were not likely to serve as a source of referrals for other families to be included in the study. The two mentioned above I met at one home where they learned what I was doing and why. Later, when I contacted them in their homes, they agreed to participate. Twice, I asked a young mother if she thought that the Señora who treated her children for Mexican diseases would talk to me about Mexican diseases. The first one answered that the Señora only spoke Spanish. The second said her husband didn't like for her to give someone's name to anyone else, because the Señora might talk to me even if she didn't want to and then be mad at her. I talked about this with Rachel. She gave me the name of a curandera, but would not consent to being named as a source of information. She said, "Mexicans don't do that. Maybe she won't want to talk to you and then she'll be mad at me." The underlying attitude of "minding your own business" was associated with the fear of gossip and was quite apparent as I became better acquainted with the families.

"Those Other Mexicans Are 'Uppity'"

I first heard about "'uppity' other Mexicans" a number of years ago when I made a home visit with a nursing student to a Mexican family. Mrs. Cordero's husband was in the hospital with tuberculosis and she was having many problems in adapting to her temporary role of the head of the household. At that time, the Lansing School Board had a number of Family Helpers who helped women in ways related to managing a home and

family. A Mexican Family Helper was visiting Mrs. Cordero and making her "nervous." She said, "I don't like that other Mexican. She's uppity--thinks she is so good because she has a job. She says I have too many kids. What she wants me to do--kill some of them?"

Relationships with other Mexicans are constrained in part because of fear of gossip, in part because of the feeling that those who have jobs "look down on" those who need help. Eight of the women whom I interviewed do not like to go to Cristo Rey for help, giving both gossip and "uppity Mexicans" as reasons. One father commented that the whites at Cristo Rey are nicer to them than the Mexicans are. Several have asked for help in vain. One young mother said she "just doesn't have any faith" in Cristo Rey.

The negative comments about other Mexicans are not confined to those at Cristo Rey. Several families expressed similar feelings about a Mexican "welfare worker" whom they would not call again. They would prefer a white worker, but would not ask that a change be made.

Madsen (1964) comments on the Anglicized Latin doctors who look back on their folk origin with a contempt which is communicated to the Mexican patients, thus increasing both the barrier between physician and patient and the Mexicans' resentment of the Anglo society. The same phenomenon may obtain regarding those Mexicans who have jobs and look down on those who need help. Those with jobs may be becoming Anglicized and denying their low Mexican beginnings.

The other possible explanation may be envy, which Madsen (1964) among others, cites as a leveling mechanism. The man who is successful

expects to be envied by those who are less successful; he becomes defensive as a result.[1] Rachel said, "Mexicans don't try to get ahead. If they have a place to live and enough to eat, that is enough. They don't want others to get ahead, either." Because Jack is going to school, her brother-in-law thought she was married to a white.

Summary

There are many similarities in behavior and way of life of these thirty families. All place a high value on privacy. Family ties are close; children are valued and cared for. Few of the women are employed; their role is to provide a good home for their husband and children. The homes are clean and cheerful looking, although some are crowded. Although Mexicans traditionally have large families, many of the younger women are using some means of contraception to limit family size.

The mothers particularly are socially isolated. Usually the only visitors are members of the family--immediate, extended or ritual. Independence and responsibility outside of the home are not encouraged. The families have little contact with neighbors, either Mexican or white. They 'mind their own business' and expect others to do likewise. This is accomplished by maintaining their own privacy and respecting the privacy and dignity of others.

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[1]Although the phenomenon of the "uppity Mexicans" can be explained by aspects of Mexican culture, hostility between adjacent social classes in general and toward the class immediately below in particular is a class-bound phenomenon not peculiar to any ethnic group. For example, see Parker (1972) for a discussion of hostility of the lower middle class toward the lower class.

CHAPTER VII

MEXICAN AMERICANS IN LANSING: HEALTH AND ILLNESS

Introduction

All questions in regard to health, illness and health care were asked before I told the mothers specifically that I was interested in the folk diseases and cures and indicated that I knew something about them. When I introduced the study, I merely said that I knew that Mexicans had ways of thinking about and doing some things that were different from what whites thought and did.

There were several reasons for taking this approach. In reviewing the Child Health Clinic records, I had not seen any reference to folk diseases or cures. I had reviewed some family records, also. I found only one reference to folk illness. The public health nurse commented that this mother had "many peculiar Spanish beliefs" and gave a pretty good description of one of the folk diseases. The public health nurses did not know that a Mexican folk health-illness system existed. It seemed reasonable to suppose that the Mexican mothers were highly unlikely to volunteer information about the system.

This supposition was supported in the pre-test of the questionnaire with the mothers in the migrant worker families. The outreach worker, a Chicano who spoke fluent Spanish, might be expected to have

some knowledge of the system. On the other hand, his education might have served as a barrier to obtaining the information. For whatever reason, these mothers did not volunteer information about the system.

In the face of these experiences, it seemed important to know whether the Mexican mothers would tell me about folk illnesses and treatments on the basis of a very general interest in things Mexicans thought and did. My supposition that the information would not be volunteered was supported.

Health Care at Home

"I Do Many Things To Keep Them Well"

In perceptions of health and illness, as in many other aspects of this study, there are more similarities than differences in the groups. All of the mothers viewed good health for their children as very important. All mothers could name things they did to maintain the childrens' health, although a common response was, "I do many things to keep them well," followed by some specific things.

Good diet was the most commonly named health maintenance measure; twenty-seven mothers gave some version of "feed them good" or "see that they eat right" as a response, often the first. "Take care of them" or "watch them" ranked second, named by fifteen mothers. Other responses included "keep them clean" (nine), "play outside" (eight), "dress them right" (five), and "enough sleep" (five). There was no remarkable difference in distribution in the responses. Only one mother mentioned

giving a laxative once a month.[1] Only four mothers mentioned giving vitamins as a means of maintaining health, two in the poor and two in the non-user group. They gave vitamins 'because they thought it might help.'[2]

In addition to these four, eighteen mothers were giving or had given vitamins to one or more of the children. However, they gave them specifically because a child did not eat well, or because a doctor or nurse recommended or prescribed vitamins. In these instances, then, the mother was giving the vitamins for a specific reason, usually on the advice of a professional, not on her own initiative. Several mothers commented that the children don't need vitamins if they 'eat right.'

There was much evidence that these mothers did indeed 'care for' and 'watch over' their children. If the children were not within the mother's sight, she knew where they were and what they were doing. It was apparent both in actions and in conversations that the mothers wanted the children to stay close to home so they 'could keep an eye on them.'

I heard very few reports of accidents or injuries involving the children. Martin, Jr., fell in the laundromat and had a trip to the Emergency Room for stitches. Robert Flores broke his arm playing football. The fact that the homes were "picked up" reduced the danger of

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[1]Kay (1972) found that giving a laxative once a week was a fairly common health practice.

[2]Brinton (1972) reports that many low income mothers associated health with keeping clean, eating right and taking vitamins.

falls. Medicine was quite consistently kept out of reach of the children, on a high shelf, on top of the refrigerator, or often, in the mother's purse.

Few of the mothers mentioned any safety measures as a preventive measure. There was one mention each of keeping medicines out of reach, keeping them out of the trash, not using 'old food' and keeping the child away from the river.

These were mentioned in relation to preventing illness. This question posed a problem for a number of mothers. To many, I seemed to be asking the same question I had just asked, about maintaining health (question no. 033 and 034, Appendix C). Three replied, "The same things," and seven said "Nothing special." Mrs. Flores said "If you gonna get sick, you gonna get sick." That may summarize the problem with the question. Olguin says that the Mexicans do the best they can, but recognize that God is "running the show" and, "should God have other plans, then there is nothing whatsoever that any man can do to change the course of his life" (emphasis his, California State Department of Education, n.d., p. 12).

Other responses to means of preventing illness included keeping them in when it is cold or at night (seven), keeping them away from sick people (four) and 'don't let them overeat' (two). Only two mentioned "shots" although practically all of the children are fully immunized.

"They Don't Get Sick Much"

Half of the mothers (15) rated both their health and that of their children as good. An additional eight rated the children's health

as good, theirs as fair or poor. A number of mothers said, "They don't get sick much." Four mothers rated both as fair. There were no remarkable differences in the three groups.

Four mothers, three in the non-user group, rated their health as poor. Of these four, one had just had a radical mastectomy, one had diabetes and heart trouble, and one was scheduled for a hysterectomy. The fourth mother, Maria Lopez, said she 'just felt tired all of the time.'

Although perception of health is not apparently related to use of Clinic services, it may be related to recency of moving. As can be seen in Table 20, those who rate their health, their children's health or both as fair or poor are pretty well concentrated within the group which has been in their present dwelling for the shortest time. Moving tends to be a stressful experience and some of these families move frequently.

Mechanic (1964) reports that mothers under stress tend to report more illness both in themselves and in their children. Smiley, Eyres and Roberts (1972), found that babies in families which had moved had more illnesses than those in families which had not. They suggest that moving is a disrupting, stressful factor in the life of a family.

Arthur (1971) presents a concise summary of the relationship between social factors and the onset of disease. The "Social Readjustment Rating Scale" developed by Thomas and Rahe has particular relevance to this study (Arthur, 1971, pp. 87-88). Stressful life events are assigned a numerical value on a scale from 11 (minor violations of the

Table 20. Relationship between mothers' perception of own and children's health by recency of move

In Present Dwelling	Perception of Health								
	Children's Health			Mothers' Health			Total		
	Good	Fair	Poor	Good	Fair	Poor	Good	Fair	Poor
Less than one year	5	3	0	5	3	0	10	6	0
One-two years	10	4	0	5	6	3	15	10	3
Three years or more	8	0	0	6	1*	1*	14	1*	1*
Total	23	7	0	16	10	4	39	17	4

*Mother has a chronic illness.

law) to 100 (death of spouse). Studies done by Thomas, Rahe and others suggest that people who have experienced many stressful events (high life crisis score) over a relatively short span of time (one or two years) are more likely to develop a major health change than those with few stressful events (low life crisis score) during the same period of time (Arthur, 1971).

Although neither Mechanic (1964) nor Arthur (1971) mentions perception of health, it seems reasonable to assume that mothers under high stress would be likely to perceive their health, or their children's health, to be less than good.

The mothers in this study who rated their health, their children's health, or both, as fair or poor and who have moved within the past two years all have high life crisis scores. A change in residence

has a score of 20. These mothers have had two or three additional changes which carry scores higher than 20. For example, one mother was pregnant (40), her husband had been injured (44) and their income was reduced (38). Another mother had recently been divorced (73) and her husband had the two oldest children (this would probably be more stressful than the 29 assigned to a son or daughter leaving home). The stress of moving, added to the other stresses of these mothers, may provide a partial explanation of their perceptions of less than good health (see Arthur, 1971, pp. 87-88, for events and scores).

"I Do the Best I Can"

Few of the mothers had any ideas of things they might do to help their children have better health. Twenty-two answered "Nothing" frequently followed by "Only what I do" or "I do the best I can." When I put the question to Mrs. Cabrera, she just sighed and said, "I don't know--I wish I did." Mrs. Ramos, whose girls are all very overweight, said, "Eat less sweets." Only one mother suggested dental care, although few of the children had dental care, and many had carious teeth. Evalina Almaguer said, "Don't let them get their feet wet. Mexicans believe it is very bad to get your feet wet." Maria Lopez, who did not know about the Child Health Clinic, suggested regular check-ups. No one suggested vitamins. In general, these mothers feel that they are doing all they can to maintain their children's health.

"They're Quiet--They Don't Play"

I was particularly interested in the answers to the question regarding recognition of illness. Twenty-nine of the thirty mothers

answered in terms of behavioral changes, not physical symptoms. Twenty-four mothers said, "They don't play--they are quiet--not active." Ten mothers said the children cry a lot, eight said they don't eat much. Four said they "look different"; four said they "feel warm." Most of the mothers named more than one behavioral change. Only one mother named physical symptoms--nausea, vomiting, diarrhea, rash and fever, with no behavioral changes. This mother, a non-user, had recently begun taking her children to a pediatrician. She spoke practically no English, but could tell me in English how she recognized illness. That was the only question she could answer in English. A reasonable explanation for her answer, so different from all of the rest, is that this is the information the pediatrician expects when she calls him and she has learned to say it in English.

Eight of the women have a fever thermometer, including the mother mentioned above. The remainder of the mothers recognize fever by feeling the child. One mother said she could not learn to read a thermometer. Several commented that they did not need one--they knew when a child was sick.

One afternoon when I arrived at Rachel's, she was rocking Rudolph, who was half asleep. This was very unusual--he was usually playing actively and ran to greet me with a hug. I asked Rachel what was wrong with him. She said, "I don't know. He's so fussy--he won't eat anything--he just wants to be held and rocked." I asked if he had a fever. She said, "He felt warm last night, but doesn't seem to now." There was no evidence of nasal congestion or cough. I asked if he had been vomiting. No. I asked if he had had any diarrhea. "Yes, he

started yesterday afternoon and is still having it. He has gone through a box of Pampers already and I'm about out now." The physical symptoms existed, but Rachel did not tell me about them until I asked specifically.

I was only able to find one reference to behavioral changes in children prior to the onset of symptoms. Mattsson and Weisberg (1970) studied behavioral reactions of preschool children to minor illnesses. Among other things, information was gathered about "first behavioral clues that the child may be ill" (p. 605).

> Under the age of 4, 6 of the 35 children were said to show irritability and tiredness for several hours before any specific physical symptoms had appeared. Such behavioral clues that an illness was pending became almost the rule as the children reached the age of five [p. 606].

All of the children showed behavioral changes after the onset of symptoms. The children in this study were all from the private practice of one pediatrician and practically all of the families were of the upper middle class.

The above finding is in keeping with the responses I got when I asked my middle class friends how they know when a young child is sick. The only one who answered in terms of behavior change apologized for doing so. She said she had to because her youngest did not vomit or "run a fever" easily.

The Mexican mothers in the present study would not agree with the finding that only one out of six children (under the age of four) exhibit changes in behavior prior to the onset of symptoms. They would say all of the children do.

There may be several explanations for the difference between the responses of upper middle class white mothers and lower class Mexican mothers. The Mexican mothers may be more closely attuned to their children. Taking care of the home and children is not only the most important thing that these Mexican mothers do, it is practically the only thing they do. It seems highly probable that they have more contact hours with their children, either collectively or individually, than do the middle class white mothers, even though the Mexican mothers have more children. They very seldom leave the children with a sitter. When they do, it is with a relative, someone else who is closely attuned to the children. The Mexican mothers may be more aware of their children's "normal" behavior and more sensitive to subtle changes in it. This may well be part of "watching over them."

The persistence of the Mexican folk health system presents a possible explanation. In their system, disease is generally recognized as a change in behavior, with some physical symptoms. They have no sophisticated means of diagnosing disease. They have only behavior change, objective and subjective symptoms, history and a few diagnostic rituals. Different diseases produce different changes in behavior. Thus behavior change is important not only in recognizing illness, but also in diagnosing it. (This will be discussed more fully later.)

Another possible explanation is the relative lack of availability of medical care. Medical care is generally less available and less accessible to poor people; the poor Mexicans in Lansing are certainly no exception. Those who have come from Texas or Mexico recently bring with

them a background in which medical care was difficult, if not impossible, to obtain. It was available only to those who were middle class, or approaching it, in Mexico; they are in a distinct minority in this particular group. They have had to, and probably still do, rely more on themselves and less on medical care than do the middle class whites.

Reliance on, or consistent use of medical care for sickness suggests that the middle class mothers may recognize illness in terms of symptoms which will enable her to decide whether to call the physician and what information he will want, should she call. Initial changes in behavior do not give her any of this information. The child is sick in terms of facts she can present to the doctor. A fussy child who just wants to be held and rocked does not tell him much. A temperature of 101°F and six loose yellow-green stools in the past six hours do tell him something. At this point, behavioral changes such as not eating or drinking also tell him something.

Only one mother related an experience with taking a child to the doctor with behavioral changes the only signs of sickness. Mrs. Cabrera told me she took Dina to the doctor (in the Emergency Room) because she "knew something was wrong with her." The doctor "got mad at her" for bringing Dina in and told Mrs. Cabrera that she was "only spoiled." Mrs. Cabrera ended the story with some satisfaction. Dina broke out with the chicken pox the next day. She said, "I knew she was sick, but he wouldn't listen to me."

It is possible that other mothers have had similar experiences. Whether they have had or not, the difference between the mothers' definition of sickness and the doctors' recognition of sickness is

a fertile breeding ground for communication problems between mother and doctor. The end result would be a diminished faith on the part of the mother and disdain on the part of the doctor. In such a situation, the mother may turn to the folk system as the only resource for help.

"Colds"

The responses to the question regarding what sicknesses the children get were the responses one would expect from any group of mothers with infants and preschoolers. The most frequently mentioned (nineteen) was "colds." Upper respiratory problems were the most common, with sore throat (nine), cough (eight), fever (seven), and flu, chicken pox and ear ache (six each). (Chicken pox was 'going around' while the study was in process.) No mother mentioned a Mexican disease.

The sicknesses mentioned were those common to children and, for the most part, those with overt symptoms. Upper respiratory problems and nutritional anemia were the most common of the health problems diagnosed in all of the children seen in Child Health Clinic during the first year and a half of operation (C. Lindstrom, 1969, 1970b).

No mother reported anemia or "low or thin blood" as a sickness the children got, although I know that many of them had been told that one or more of their children was anemic. Several mothers mentioned anemia in connection with giving the children vitamins--they gave vitamins with iron because of the anemia.

It may be that the mothers did not mention anemia because it was likely to have been a one-time occurrence. However, they did mention other one-time conditions, such as pneumonia, bronchitis and

and cervical adenitis. The latter are acute, more serious, at least to the mother, and have overt symptoms. Anemia is chronic, not viewed as dangerous and has no overt symptoms until it is rather severe. It develops slowly, does not produce "behavioral changes" early and may not fall within the mothers' classification of illness.

In Child Health Clinic, hemoglobin is checked at six months of age or on the first visit, whichever occurs first. Thereafter, it is checked on a flexible schedule, depending on age, history and other factors. The instrument used to determine hemoglobin is not accurate; rather, it might be considered a good screening device. Blood studies done by one of the pediatricians suggested that the instrument used tended to register somewhat low. However, since the screening instrument is all that is consistently available, a reading below ten was considered indicative of iron deficient or nutritional anemia. Treatment and diet counseling were begun at the Clinic; help with diet was continued at home if necessary and the child was given a return appointment to determine whether the treatment was successful.

During the first year of operation, 29 percent (51) of all children seen (176) had a hemoglobin reading below ten (C. Lindstrom, 1969). During the next six months, the comparable figure was 25 percent (40) of all children seen (159) (C. Lindstrom, 1970a). In the same two time periods, 37 percent and 34 percent of the children seen were Mexican.

The incidence of nutritional anemia is high in the children in this study, particularly those in the good user group. Even though the instrument used to measure hemoglobin may result in a relatively high

number of children with a low reading, all children were tested with the same instrument, therefore all of the bias would be in the same direction. Of the ten families in the good user group, only two were free of nutritional anemia. In the twenty-six children in this group, fifteen of them (66%) had a low hemoglobin at least once during the time they were being seen in the Clinic. In the poor user group, six families had no incidents of low hemoglobin. One child in each of the remaining four families did have a low hemoglobin. About 25 percent (four) of all children in this group (seventeen) were anemic. The incidence in the poor user group is comparable to that in the total Clinic population; the incidence in the good user group is much higher.

The most apparent explanation for this difference is the difference in attendance. Children in the good user group are seen more frequently and over a longer period of time than are those in the poor user group. The opportunity for discovering a low hemoglobin is greater for these children. If this is true, then one must wonder about the incidence of anemia in the Mexican population. A multiphasic screening program of preschool Spanish-American children in New Mexico found only 3 percent to be anemic (H. Brown, 1972). A study of the nutritional status of children in migrant farm worker families showed a number of nutritional deficiencies, most notably Vitamin A; however, anemia was not included as an indicator (Chase et al., 1971).

The presence or absence of anemia is not related to income; it occurs in both the lower and higher income families. Neither is it related to ability to maintain essentially the same diet from pay check

to pay check; it is evenly distributed between those who manage and those who run out of food. It may be related to family size, however. All but one case of anemia occurred in families composed of five or more people. It may be that the amount of food purchased is not adequate for the number of people to be fed. It is difficult to determine whether it might be related to family structure, since the difference between the two groups is so great. In the good user group, however, the anemia tends to occur in the female head of household or modified nuclear family. In this context, anemia may be related to general stress.

Certainly some of the anemia can be explained by the extended period of time these children take milk from the bottle. It is not unusual to see a two or three year old child with constant access to a bottle of milk which is filled as often as necessary by the mother or an older sibling. The high milk intake would reduce the intake of other foods. It may be easier for the mother to provide the bottle than to offer solid foods. Leon Almaguer says, "Give them the bottle whenever they want it."

Leon also said that Mexicans don't believe in giving meat until the child is three years old. I do not know how common this is in practice. I do know that a number of the families did not use baby foods, but started the child on table foods. These two practices could contribute to the incidence of low hemoglobin. Fear of <u>empacho</u> could also contribute, since this disease can be caused by overeating or eating something one does not like or does not want to eat. One mother

said she did not let her children get empacho. Many of the Mexican mothers would tend to let a child eat what he wanted, without urging or forcing anything. (They treated me the same way--food was offered, but never pressed upon me.) These practices could account for the incidence of anemia generally, but not for the difference between the two groups.

Anemia was not mentioned as a condition which the mothers feared their children might get. The common answers to that question were "nothing" and "only what they get" (seven each). Mumps and chicken pox were mentioned because they were "going around." Mothers with a previous experience with pneumonia feared a recurrence. Two mothers mentioned tuberculosis because someone in the family had had it.

Although these mothers are not fearful that their children will get sick, they get very upset and frightened when they do. Many mothers said, "I get so scared when they get sick!" Some of the fathers made the same comment. One mother said she made the decision to seek care because her husband "got panicky and wasn't any good." They value good health for their children, do the best they can to keep them healthy and become upset when they are sick. I doubt that sickness in a Mexican child is ever ignored.

"Aspirin"

The ubiquitous aspirin is as much used in these Mexican homes as it is on television. Twenty-nine of the mothers responded "Aspirin" first as a home remedy when a child is sick. Eleven use Vicks for a cold; eleven give fluids. Nine said they put the child to bed or to

rest. Two use alcohol sponge baths, one a cool enema and one covers the child with leaves soaked in cool water to reduce a fever. Several mentioned rice water for diarrhea. Two described the treatment for empacho. One each mentioned manzanilla tea, comino seed tea and cinnamon tea.

The teas are given both for fluid and for the curative properties they have. They may be used for a 'stomach infection' or cramps, a cold or a cough. There are several stores in the area which carry some of the herbs necessary for the teas. Women who use these remedies can buy them locally. The mothers generally try home remedies before they seek help from any other source.

With a few exceptions, the home remedies are those commonly used in white homes. "Baby aspirin" is part of the medical armamentarium of most mothers. Vicks also is commonly used. The use of herbal teas probably provides an increase in fluids, which is a good practice, particularly if the child has a fever. Rice water for diarrhea is helpful, since rice is constipating. The last mentioned method of reducing a fever is not common to white homes, but would be effective. The home remedies used are not harmful and, indeed, may be helpful.

"When What I Do At Home Doesn't Help"

When I asked the mothers for what sicknesses they sought help, they did not answer with changes in behavior. The most common answer, given by twenty-two of the mothers, was some form of "When what I do at home doesn't help." Twenty of the mothers said they sought help for a fever that was very high or lasted a long time. Leon Almaguer said,

"Take to the doctor if the fever last three days." Other answers included "When I don't know what's wrong" (five), and injury (four) and "When they are really sick" (five). The general pattern seems to be that of trying to cure the child at home and seeking outside help if the home treatment is not successful. The danger in using home remedies may lie in using them for an extended period of time rather than seeking medical care.

The above pattern of seeking medical care late in the course of an illness is not peculiar to the Mexican families. It seems to be a function of poverty and its attendant problems rather than a function of ethnicity (Wingert, Friedman and Larsen, 1968). In my experience in working with poor white families, I observed the same pattern of "crisis care" orientation.

Seeking advice from someone other than the doctor is an integral part of the Mexican health care system (Rubel, 1960; Weaver, 1970). Shannon states that when the Mexican-Americans in Racine were asked who advised them on their children's health, the ratio of Mexican to non-Mexican surnames was twenty-five to one (Shannon, 1966, p. 277). This behavior is not confined to this population, however. Friedson describes the "casual exploring of diagnoses . . ." as taking the "form of referrals through a hierarchy of authority" (Friedson, 1960, p. 216). Suchman describes the "lay referral system" as part of the sociology of the sick individual having particular relevance to the public health professional (Suchman, 1963, p. 67). Wingert, Friedman and Larsen (1968) found that poor Blacks, whites and Mexican-Americans all sought help from a variety of sources, with no apparent ethnic differences in the sources of help.

I was surprised at the large number (fourteen) of the mothers who responded that the doctor was their first and only source of help. Fifteen asked a relative first. Two asked a neighbor. Eight named the public health nurse as a source in conjunction with a relative or neighbor (see Table 21). Those who did not name the doctor first named him second; no one responded with a series of three sources of help. The reason for going to the doctor was always some form of 'he knows what to do.'

Table 21. Sources of help for illness by use of Child Health Clinic services

	Use			
Source of Help	Good Users	Poor Users	Non-Users	Total
Only doctor	5	4	5	14
Relative	5	6	4	15
Neighbor	0	0	2	2
Public health nurse	2	4	2	8
Total	12	14	13	39*

*Some mothers named more than one source.

Health Care in the Anglo System

Sick Care

I was surprised at the number of families who have a family doctor or some regular source of care, such as the Family Practice Unit or the Model Cities Health Clinic. Nine non-users, eight good and eight poor users named a regular source of medical care. One non-user family had just begun to take the children to a pediatrician; the rest of the families all went to a general practitioner.

It does not seem to me that they utilize the services of a family doctor in the same way that middle class white families do. They only call him during office hours. At any other time, they go to the Emergency Room of one of the hospitals, where they see whoever is available. Many of the families have an osteopathic physician as their regular source of care, but tend not to go to the Emergency Room of the Osteopathic Hospital. Martin Almaguer's family used the Emergency Room at three different hospitals while the study was in process.

One afternoon when I visited Evalina Almaguer, I noticed that Miguel had some stitches on his cheek. I asked what had happened; he had been bitten by a dog and she took him to "Emergency at XX Hospital." I asked why XX Hospital, since I knew they had had several bad experiences there, and it is not "their" doctor's hospital. She said, "Well when someone else is driving, I can't tell him where to go." Martin took her. When he started for XX Hospital, she could not tell him to go the other way.

Another mother went to the Emergency Room after office hours because she 'didn't want to bother the doctor.' When Mrs. Cabrera goes

to the Emergency Room, she doesn't even tell them that she has a family doctor; she says, "He won't come anyhow." Evalina said, "What are you supposed to do? If you call and your doctor doesn't have time to see you, they say 'go to Emergency.' If you go to Emergency, they yell at you for coming and say you should go to your doctor." Almaguers (all three families) go to an osteopathic physician, but seldom go to the osteopathic hospital Emergency Room. For the most part, it seems that the families go to their family doctor for an acute illness if he can see them the day that they call.

I think there are several possible explanations for this behavior. Leon Almaguer said, "These doctors! I don't like to go to them. They don't talk to you--ask you anything. They just listen to what you tell them, write something down on a little piece of paper and say 'Go take some pills.' I don't like that. Maybe what I say is wrong isn't what's wrong at all." Saunders (1954) and Rubel (1966), among others, describe the same basic problem in communication and orientation between the Anglo physician and Mexican patient.

Evalina does not like to call for an appointment. Even though her English is good, she finds it difficult to explain the problem over the phone. She does not like to make an appointment ahead, either. She said, "Then you have to plan, and something might come up, or you might forget. I would rather just put the kids in the wagon and go!" (Only one mother made a note of appointments on a calendar.)

If Evalina goes to the Emergency Room, she can 'just put the kids in the car and go.' Families who have Medicaid or Blue Cross-Blue Shield through employment have an erroneous understanding of coverage. Both

Medicaid and Blue Cross-Blue Shield will cover care for an emergency. Families go to the Emergency Room and present the card with the full expectation that the care will be paid for. In fact, however, the coverage is only for conditions deemed emergencies by the attending physician. The parents do not understand this. A number of times I was asked why they got a bill when they had Medicaid or insurance. What constitutes an emergency for a mother with a sick child does not necessarily constitute an emergency to the physician.

Mr. Robert Niblock, United Auto Workers International Council, said that the emergency care clause in their coverage presents many problems. The men do not understand the "medical emergency" restriction--an emergency is an emergency. He said that the insurance company only pays about 5 percent of the emergency care claims, usually only if the person is admitted to the hospital as an in-patient or has sustained a severe injury. The men just don't understand, even though they conduct classes on the coverage (only in English).[1] The families have a false sense of security about payment for care in the Emergency Room.

Whether it is an 'emergency' or not, the mother is involved in making the decision to seek care. This is logical, since matters of health and illness are culturally vested in the women. As stated earlier, the mother makes the decision in the modified nuclear families and, of course, in those families which are headed by a woman. In most of the other families, the decision is made jointly. No mother said

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[1]Personal interview.

that the father alone made the decision. The differences in decision making are related to family structure, not to use of Clinic services.

According to the mothers and some of the fathers, overt discrimination against them by Anglo health professionals is not common. None of them feels generally discriminated against because they are Mexican. Twelve of the mothers said, "They treat us like they treat anyone else." Mrs. Fuentes said, "We pay our bills. They better treat us nice!" I helped Rachel Bermudez find a doctor who was taking new patients. When she called for an appointment, the secretary asked if she was on Medicaid. Rachel told me, "I old her 'No. We aren't like some disadvantaged--we can pay.'"

Some of the mothers say they have problems because they cannot speak English well and there are so few doctors who speak Spanish. They see the problem only as language, however. A number of mothers related specific experiences and incidents of discrimination in the Emergency Room and clinics of one of the hospitals. Mrs. Centino said, "I can take it when they talk bad to me--but they acted as if I wasn't even there. I can't take that--I just walked out." However, the mothers tend to view these experiences as isolated and confined to the particular hospital; they do not generalize to discrimination by all Anglo health professionals. Other than the problems with language, their experiences could as well be a function of poverty as a function of "Mexicanness." Some of them related the "shabby treatment" to the fact that they are "on Welfare."

The mothers who had had experience with the Anglo health care system in Texas are unanimous in their statements that "things are much

better here." It was difficult, if not impossibe for them to get medical care there. One mother summarized the situation by saying, "In Texas, the whites have money and say, 'She's only a dirty Mexican.'" These mothers have a background of negative experiences with the Anglo system; contact in Texas was largely confined to life-threatening situations. It will take time, help and some positive experiences to enable these mothers to develop a different pattern of utilization of health care.

All of the mothers are familiar with the Emergency Room of at least one of the local hospitals and would take a child there in the event of serious illness or injury. Only one of the mothers has never taken her child to one of the Emergency Rooms. They know that there is always someone there and they will be seen if they wait long enough.

Nine mothers related at least one instance of thinking a child needed medical care, but they were unable to go to the doctor. Lack of money and/or lack of transportation were the reasons given for not going. One mother in the good user group, three in the poor and five in the non-user groups reported such an occurrence. None of these health problems was life-threatening in the view of the mother. In such a situation, all mothers would 'manage somehow, even if I had to call a cop.' The recognition of a need for care coupled with the inability to meet the need is not related to whether they have a family doctor. Neither was it always related to inability to pay; three mothers with Medicaid could not find transportation. It does seem to be related to degree of use of Clinic services, which may represent degree of contact with the Anglo system.

The remainder of the mothers (nine good, seven poor and five non-users) said they 'always managed' to get the child to the doctor when they thought it necessary. Availability of transportation may be a major factor in whether or not the mother 'manages' to get care. Finding transportation is always a problem for only one mother in the good user group, whereas it is always or usually a problem for six in the poor and seven in the non-user group. A combination of more contact with the system and the availability of transportation may explain much of the difference in whether or not the mother manages to get the child to the doctor.

Finding a baby sitter is not as much a problem as finding transportation. Only five mothers reported that a baby sitter was generally available (one good, three poor, and one non-user). Four mothers report that they never use a baby sitter; they take all of the children with them if anyone needs to go to the doctor. Twenty-one of the mothers have a baby sitter readily available, usually an older child or a relative.

Preventive Care

Several studies have shown a high correlation between the mother's use of antepartum care and use of preventive health care for her children (Schonfield, Schmidt and Sternfeld, 1962; Peters and Chase, 1967; Smiley, Eyres and Roberts, 1972). This study, likewise, shows a correlation. Mothers in the good user group began antepartum care earlier than those in the other two groups. There is no appreciable difference between the other two groups. Only one mother has never had

prenatal care. Of particular interest to me was the pattern described by nine mothers (three in each group) of having little, late or no prenatal care in Texas, but beginning care early in the pregnancies they had after moving to Lansing. This seems to me a good indication of change in pattern of health care concomitant with the move (see Table 22).

Table 22. Antepartum care by use of Child Health Clinic services

	Use			
Antepartum Care	Good Users	Poor Users	Non-Users	Total
Two months	6	3	3	12
Three months	0	1	0	1
Four months	1	2	2	5
Seven months	0	1	1	2
None or late in Texas, early here	3	3	3	9
None	0	0	1	1

One mother in each group had at least one baby delivered at home by a midwife in Texas. Mrs. Ramos had her first six delivered at home. Mrs. Zamora's first four were born at home in Texas, the last two in a hospital here. She went to the doctor and delivered in the hospital here because she could not find a midwife. The other mothers delivered in a hospital in Texas, even though they frequently did not have a doctor.

The mother who had not had any prenatal care knows about the Jean Grainger Prenatal Clinic in Lansing, but she does not like to go to the doctor. Only two mothers said they began care early and continued regularly because they were sick during the pregnancy. One mother began early and continued because 'it's what you're supposed to do.' Another went regularly because the doctor told her to. The rest of the mothers went because they thought it best to be sure they and the baby were all right. The responses were worded differently, but the general idea the same. This is in sharp contrast to Watkins' (1968) study of low income Negro women. Most of them decided to have prenatal care either because they did not feel good or because someone in the family, usually their husband, pressured them into going. In the families in this study, early and continuing prenatal care is a fairly good indicator of use of preventive health care, particularly if one considers only the later pregnancies.

Completeness of immunization appropriate for age has been used frequently by public health professionals as an indicator of use of preventive health care. Triplett (1970) used this as the sole criterion to corroborate the staff nurses' judgment of good or poor use of well child care. Mindlin and Densen, however, feel that a description of immunization status "ignores other aspects of health supervision." They developed a health supervision index combining immunizations and health supervision visits (Mindlin and Densen, 1971, p. 687).

Kay reports that most Mexican American women in Tucson are reluctant to have their children immunized until they are school age.

She found that "the age at which a baby is brought for immunization to the serious communicable diseases of childhood is the best single indicator . . . for acculturation to western scientific medicine" (Kay, 1972, p. 194).

In this study, I found a relationship between fact, completeness and age of immunization, degree of use of Child Health Clinic service and the age at which the child was first seen in the Clinic. Only three children, all in the non-user group, had not had any immunization. In general, the children in this group began immunizations after their first birthday. Completion took longer than the prescribed schedule. If they were incomplete, measles was most likely to be lacking. Five of the mothers in this group did not have any record of the immunizations; they just knew that the children had or had not had "their shots."

By contrast, in the good user group, every mother had a record of each child's immunizations, even the oldest ones. Considering the age when the immunizations were begun, they were complete for age and generally followed the Clinic schedule for spacing. The general pattern was for the immunizations to begin on the first visit to the Clinic, regardless of age of first visit. When the mother began coming to the Clinic, she usually brought all of the children who were eligible, thus the older children started immunizations later than the younger ones. Babies who were born after the mother had established a pattern of care were brought within the first few months of life and began immunization early.

Those in the poor user group fell between the good and non-users in completeness and age of beginning. All of the children except those born during the course of the study had had some immunizations. These mothers, too, tended to bring all children who were eligible on the first visit and to begin immunizations at that time. However, they brought the younger children at a later age than did the good users, thus delaying the start of immunizations. Several of these mothers had not brought the youngest one or two children to Child Health Clinic at all, but had begun to take them to immunization clinic. Nine of the mothers had immunization records for the children. Six children had incomplete immunizations (see Table 23).

Table 23. Relationship between age on first visit and use of Child Health Clinic services

	Use		
Age on First Visit	Good Users	Poor Users	Total
Under three months	5	1	6
Three-six months	4	5	9
Seven-twelve months	1	4	5
One-two years	9	4	13
Over two years	7	3	10
Total	26	17	43

The good users all knew that they were attending Clinic for both preventive care--"to be sure they are okay--" as well as for treatment of common illnesses. Mrs. Flores was very glad she took James regularly because one time she found out his blood was "thin" and that "scared" her. They gave her some medicine, though, and told her what he should eat. When she took him back, it was better, which made her feel good. Both good and poor users were consistent in returning for a check on a low hemoglobin; all but one of the children showed improvement.

Seven of the mothers in the poor user group said that they had brought the child(ren) to "Baby clinic" to see how they were. Three of these mothers only wanted "shots" and thought they were going to immunization clinic. Some of the mothers in the non-user group also confused immunization clinic and Child Health Clinic. Both clinics are held in the same place, at the Health Department and Cristo Rey, but on different days.

The mothers gave various reasons for the broken appointments. Evalina and Irma Almaguer did not think more check-ups were necessary, once they knew the child was all right. Evalina was overwhelmed with her large family and all of the things she had to do. She had all she could to to take them to the doctor when they were sick. Transportation was a problem for Irma. In addition, these two did not like to go to Cristo Rey if they could avoid it. In all, four women named transportation as one or the only reason for not keeping appointments. One family moves back to Texas every winter. One young mother said she

never knew when to go; she had not been receiving the appointment cards. She was the only mother who wrote appointments down on a calendar. One mother worked days and had to arrange to get off work early to go. She went only for the shots or if one of the children was sick.

Mothers in both groups were pleased with the care the children got at Clinic. All of the nurses and most of the doctors were described as good, kind, nice. They appreciated the time the nurses spent with them and their patience with poor English. The nurses "listen good" and "help to understand." They particularly liked to see the same nurse every time.

Six of the good users went to the Clinic at Cristo Rey, four went to the Health Department. The Health Department was always referred to as "that place down by Yankee." Of the poor users, seven went to Cristo Rey, two to the Health Department and one had just changed from Cristo Rey to Health Department. Six mothers in each group had never been to the Health Department. Seven had had experience with both; five felt that there was no difference in the two. The other two preferred the Health Department, one because it was less crowded than Cristo Rey, the other did not like to go to Cristo Rey because "a church is a church."

Only two of the mothers did not have a relative or friend who also attended Child Health Clinic. Ten had a relative who attended Clinic at the same place the mother did. However, they seldom had appointments at the same time.

Three of the mothers in the non-user group had had, in the past, preventive care for their children from a private physician. Now, none

could afford it. Only one of the mothers in this group knew of the services at Child Health Clinic. The public health nurse had told her, but she had no transportation. (The public health nurse had also told one of the mothers with previous experience; the mother may have interpreted it as a referral to immunization clinic.) These four mothers will probably attend the Child Health Clinic as good users if transportation is provided when necessary. Elba, Rachel's neighbor, might go with some support and further explanation from a public health nurse. When we talked about a check-up for her baby, she said it 'might be a good idea.' She needs transportation, as does Rachel. If they are speaking, taking both at the same time would be a good idea. Rachel, for all her youth, is fairly knowledgeable and assertive in the world of the white, much more so than Elba.

The other five mothers in the non-user group do not think it necessary to take a child to the doctor unless he is sick. Mrs. Blanco has gone to Child Health Clinic with her daughter-in-law to help with her two children. When I asked if she had ever taken Rafael, her four year old, she looked at me in surprise and said, "Oh, no. Why would I do that? Rafael is <u>healthy</u>. No need to take away time from children who aren't." Her daughter-in-law is a good user. However, since she is not Mexican, she did not meet the first requirement for inclusion in the study.

There is no remarkable difference in the source of referral to Child Health Clinic. Two women in each group were referred by a relative who attended. Three good users and four poor users were referred by the public health nurse (see Table 24).

Table 24. Source of referral to Child Health Clinic by use of service

Source of Referral	Use	
	Good Users	Poor Users
Relative	2	2
Public health nurse	3	4
Hospital staff	2	1
Cristo Rey staff	1	1
Case worker	1	0
Neighbor	0	1
Not known	1	1

Home visiting by the public health nurse does not make any apparent difference in Clinic attendance. Six mothers in each group were visited at home both before and after the mother began attending Clinic. Four good users and two poor users have never been seen at home by the public health nurse. Public health nurses tend to have contact at home with families who have a number of problems, regardless of Clinic attendance.

I was particularly interested in two aspects of preventive care at home. Safe preparation of formula has been part of helping the mother to care for and cope with her infant for as long as I have been a public health nurse. It is included in classes for expectant parents, taught in obstetrics in the hospitals and taught or reviewed in home visits by public health nurses. Although there is equipment available

now which is safe and easy to use, it is expensive; it did not seem likely that many, if any, of these mothers would have a sterilizer. None did.

The practice was instituted to prevent infant diarrhea. Whether it is still necessary is a moot question. I know that some pediatricians are telling their middle class white mothers to just wash the bottles and nipples in hot soapy water, rinse them well and use tap water. I was interested in learning what the Mexican mothers did and why.

Every mother who gave her baby formula told me that she boiled the bottles and nipples so they would be clean or sterile. "One mother said, "You never know what gets on them." Eight of the mothers said that the nurse at the hospital told them to do it and showed them how. The others learned from their mother or another relative.

Smiley, Eyres and Robers (1972) found that method of formula preparation had no relationship to illness in the baby during the first three months. My observations in the Mexican homes suggest that thorough washing and rinsing would probably be adequate care for the infants. It seems to me that the greater danger lies with the toddler who carries a bottle of milk around most of the time, drops it any place and has it refilled numerous times without any washing and often before it is completely empty.

Eight of the mothers breast fed all of their children. This number was smaller than I had expected, given the traditionally close bond between mother and child and the major role of motherhood for the

women. The distribution is interesting--one good user, three poor users and four non-users. This behavior may be an indication of acculturation to Anglo ways. Even though breast feeding is gaining in popularity with middle class white mothers, the cultural change would filter down to the lower income groups slowly. Acosta (1972) reports that breast feeding declined as families moved from Mexico to the border areas. It may decline even more as families move from the border areas of Texas to Michigan.

Since diaper rash was a problem which occurred frequently in the children seen in the Clinic during the time I worked there, I was interested in how the mothers cared for the diapers. Practically all of them use the disposable diapers all of the time because "it is so easy." Most of those who use cloth diapers do so because the child "breaks out" when they use a disposable diaper. Concepción Almaguer is the only one who uses cloth diapers by choice. She has so many she could go for a week without washing any, although she did wash them twice a week. She had a washer and hung them out to dry. I saw them on the line--it was apparent that she used bleach. However, it did not irritate the baby's skin.

Better Health Care

For the most part, the mothers who have a regular source of medical care are satisfied with the health care they receive. They could not think of anything that could be done to improve the health care delivery system. Three of the mothers who have a Medicaid card have to travel a long way to see a doctor who takes patients on Medicaid.

The mothers who do not have a regular source of medical care just wish that there were more doctors.

In Lansing, at the present time, it is difficult for middle class newcomers to find a physician who is taking new patients. The Ingham County Medical Society maintains a list of doctors who are taking new patients. At present, no pediatricians are taking new patients. Six doctors in general practice are taking new patients; however, only two of them are taking new patients who are on Medicaid.

I was also interested in how many of the osteopathic physicians are taking new patients. There is no listing in the telephone book for the Ingham County Society of Osteopathic Physicians and Surgeons. I called the Osteopathic Physicians Answering Service. The person who answered the phone did not know anything about the Osteopathic Society; she referred me to the Ingham County Medical Society. I called the College of Osteopathic Medicine at Michigan State University. The secretary gave me the name of the President of the Osteopathic Society. I called his office. His secretary did not have any information; she referred me to the Medical Society. I told her that I thought the Medical Society would only have information about the medical doctors. She thought they would have information about all physicians in the area, whether they were medical or osteopathic. I called the Medical Society. The secretary confirmed my belief that she only had information about the medical doctors. She suggested that I call the Osteopathic Hospital. I did; the person who answered the phone referred my call to the Emergency Room. The person who answered the phone in the

Emergency Room gave me the names of three doctors in general practice who might be accepting new patients--one in Lansing, one in East Lansing, and one in a small town about thirty miles away. One is accepting new private pay patients only. One is accepting new private pay patients who are having a medical emergency. One, in a small town about thirty miles away, is accepting new patients who are on Medicaid.

The discrimination by medical and osteopathic physicians against people on Medicaid has been documented. A research group in Michigan found that half of the physicians (both medical and osteopathic) "were refusing to treat Medicaid patients." About 10 percent of the physicians who have Medicaid patients "are now trying to phase these patients out of their practice." The report also "alleges that the Michigan State Medical Society has urged its members to refuse service to Medicaid patients." The doctors do not like the document they must sign and all of the paper work required for reimbursement (J. Lindstrom, 1973).

I doubt that any of the women included in this study would know how to find out which doctors are taking new patients. I made five telephone calls to obtain the information about the osteopathic physicians and I am familiar with the system. For both groups of doctors, I had to call each individual office to determine if the new patients included those on Medicaid. The new patient on Medicaid, if she could get the information, had a choice of two medical physicians in Lansing and one osteopathic physician some thirty miles away.

The situation was not much better in the publicly or semi-publicly supported sources of medical care. The eligibility requirements

for care at the Model Cities Clinic are stringent and the waiting time for new patients is long. The Family Practice Unit, which charges on a sliding scale according to ability to pay, would accept new patients if the mother called at eight in the morning and there was an opening. She could not call at eight one morning and make an appointment for the next day; only patients already established could do that.

Most of the mothers who have a family doctor found out about him through a relative or another Mexican, or with the help of the public health nurse. Those who have care at the Model Cities Clinic or the Family Practice Unit learned about the resource from a public health nurse or a Department of Social Services caseworker. To the best of my knowledge, no mother found a source of medical care completely on her own initiative.

The Mexican mother who does not now have a source of care faces many barriers to finding a source. Low income is one; this is made worse if she is on Medicaid. Low assertiveness poses a barrier. Inability to speak English is, of course, a major problem. Even those whose command of English is fairly good are reluctant to use it on the phone with someone whom they do not know. For the most part, they do not know what services are available nor do they know how to obtain the necessary information.

Evalina recognizes the problems that Mexicans have in not knowing where to go. She said, "I know where to go, but most Mexicans don't know. It [health care] would be better if they did." The Ingham County Board of Commissioners is making an effort to inform the Spanish

speaking people of the availability of county resources. They will defray the cost of five pull-out sections printed in Spanish to be included in the Spanish language newspaper. The intent is to provide information about the services the county offers (Leach, 1973). Most of the Mexicans have access to the paper. It seems likely that they are more apt to read and understand something in Spanish in their newspaper than the same material in English from any other source.

Folk Health System

Belief

When we had completed all of the questions which dealt with health, illness and health care in general, I told each mother that I knew that there were some sicknesses that Mexicans got but whites did not get. For example, Mexican children might get susto, mal de ojo, caída de mollera and empacho. I then asked each mother if any of her children had ever had any of these diseases, or if she knew of children who had. Knowledge of an occurrence of one or more of the diseases constituted belief in the system.

The mothers were surprised that I knew about the Mexican diseases. Since I was knowledgeable and interested, they talked freely and at length about the diseases, their causes, symptoms and treatments. The descriptions the mothers gave are those found in the literature (Rubel, 1960; Clark, 1959).

Three of the mothers said they did not know much about the Mexican diseases. The remaining twenty-seven knew a great deal about them, whether they believed in them or not. As the mothers described

episodes of the diseases, the relationship between changes in behavior and recognition or definition of illness became apparent. Changes in behavior are almost always the first, and sometimes the only, symptoms of the disease. Physical symptoms often occur rather late in the course of the disease; they suggest that the condition is severe and has not been treated properly.

When a mother whose children get Mexican diseases observes behavioral changes which indicate that the child is sick, she may suspect a Mexican disease. If the behavior does suggest a Mexican disease, she "thinks back" to what the child has done, where he has been, whom he has seen over the past several days to determine if there has been cause for a Mexican disease. If there has been cause, she either treats the child herself or takes him to some Mexican woman who can treat him. If the treatment does not work, the mother concludes that the child does not have a Mexican disease. At this point, she takes him to a white doctor. This pattern was consistent for all mothers whose children had had a Mexican disease.

Table 25 depicts the pattern of belief in the folk diseases. There are some differences in the three groups. In the good user group, five women believe and five do not believe in the Mexican diseases. One mother said maybe she does not believe in them because she lives here, not in Texas or Mexico. There are good doctors here who 'don't care if you are a Mexican.' Another mother said maybe she does not believe because she was brought up here and Mexican diseases are "way back." Mrs. Flores said she did not even believe in them when she lived in

Table 25. Belief in folk diseases by use of Child Health Clinic services

Belief	Use			
	Good Users	Poor Users	Non-Users	Total
Yes	5	8	7	20
Hardly	0	0	2	2
No	5	2	1	8

Mexico, nor did her parents. They had a family doctor there, too. The women in this group either believed in all of the diseases or did not believe in any.

Eight mothers in the poor user group believe and two do not believe in the folk health diseases. Two of these eight each named one disease in which they do not believe, however. Evalina does not believe in mal de ojo because she doesn't really think that a person can look at a child and make him get sick. The other sicknesses are real, though, because her children have had them. Rachel does not believe in caída de mollera. Once, when Richard had it and was very sick, she did take him to the doctor and showed him that the mollera was "sunk in." He said, yes, it was, but that happened because Richard had a high fever. He showed her that there was a bone between his mollera and his mouth; pulling the nipple out too fast could not do anything. (The doctor is a native Spanish speaker, but not a Mexican.) The other diseases are real; both boys had mal de ojo while the study was in process and were treated successfully by Jack's aunt.

In the non-user group, seven of the mothers believe in the diseases, two "hardly believe" and one does not believe (see Table 25). It was particularly interesting to listen to the two who are beginning to wonder if the Mexican diseases are "real" or not. Both mothers are under thirty, were born in Texas and came to Michigan as adults. One said she doesn't know much about Mexican diseases and "hardly believes in them." When she was living in Texas, her daughter (now eleven) got sick once and the mother did not know what was wrong with her. Her aunt said she had ojo and cured her with an egg. After that she didn't know what to believe. Neither child has had a Mexican disease since that episode. This mother does not have any family living in Lansing, does not have any transportation and does not know many people, either Mexican or white.

I talked with both parents in the other family in which the "realness" of Mexican diseases is being questioned. This family was interesting for several reasons. When I arrived, I noticed that the mother had lighter skin and hair than any of the other Mexicans I had met. If the mother was white, the family would not meet the crucial criterion for the study. I introduced myself, explained my purpose and asked if they were Mexican. Mrs. Gutierrez answered in the affirmative. Later, she told me that her mother is white and her father Mexican. They lived with her father's family. She was brought up Mexican, learned Spanish as her first language and learned about Mexican diseases from her grandmother. She does not know much about treatment, however. Now that they are in Michigan and can go to a 'real doctor,' both are

wondering if they 'really believe' in the Mexican diseases. Mr. Gutierrez said that, in Texas, the Mexicans don't go to doctors very much. They don't have any money, and besides, doctors don't like Mexicans. They do the best they can with what they have. Mexicans believe in "natural ways"; for example, not many boys are circumcised. (I had observed this in Clinic.) Both of his boys have been circumcised. He commented that Mexicans don't understand and don't want to learn new ways.

His mother believes that children will have trouble learning to talk if their hair is cut before they are three. He doesn't believe this, but neither boy has had a hair cut. His mother is coming to visit them next month and she would get 'all upset and nervous' if she saw the boys with short hair.

When we were talking about curanderas, he said he went to one once in Laredo because he thought he was embrujado (made sick by a witch). It turned out that he wasn't, though--he had only lost his good luck charm. She gave him another one and he was fine.

Source of Care

Many of the mothers know how to treat the common folk diseases. Some of the younger ones (under thirty) do not know how to treat, although they do know the causes and symptoms. These mothers know someone who does know how to treat the diseases, either a female relative or an older, unrelated Mexican woman. Folk diseases are treated in the folk system.

The mothers talked very freely about the diseases in general and described in detail instances of the various diseases in their

children. Dina Cabrera got susto "very bad" when she was frightened by a big dog. Mrs. Cabrera and a Señora who knew more about susto worked very hard so she would get better. Dina is still afraid of big dogs.

Jack Bermudez' mother died while the study was in process. She lived in Lansing; the boys knew and loved her. The family came from Texas; there were many people and much confusion. Rachel and Jack took the boys to the funeral parlor one evening for a few hours. When they came home, rather later, both boys were sick--crying, warm, fretful and irritable. Rachel remembered all of the relatives who "made a big fuss over the boys." She said, "They did look cute, in their new clothes and all clean, with their hair combed nice. With so many people saying how cute they were and all, I figured they probably had ojo. I treated them with an egg, like you're supposed to do, and they were fine--stopped fussing and went right to sleep."

Every mother but one newcomer knew where to go for treatment of a Mexican disease if she could not treat the child herself. Those who used the various herbal teas, whether they believed in the folk diseases or not, knew where they could buy them in Lansing. However, when I asked about a curandera, only Rachel told me that she knew one. The other mothers said they did not know of one in Lansing. Mrs. Flores called the curanderas "witch doctors." Mrs. Cabrera said she didn't believe in "those old ladies." All but two of the women said they would not go to a curandera if they did know of one. Mrs. Zamora would go if she knew of one; Mrs. Valasquez "probably would go!"

Lack of knowledge of a curandera in Lansing coupled with the high degree of belief in the folk diseases surprised me. There are several possible explanations for the stated low level of knowledge and use of the curandera. The mothers may have withheld the information from me. One young mother who does not know how to treat the Mexican diseases her children get told me that the lady next door is real nice and treats the children for her. I learned later that the lady next door is a curandera. I doubt if the young mother is unaware of this.

If the mothers did know of a curandera and did not tell me, they may have been protecting her from the possibility of legal action against her and the resulting loss of her services. A public health nurse who was educated and practiced in a hospital in Texas suggested this as one explanation. In Texas, she said, the nurses were encouraged to try to get information from the Mexicans about the "folk healers" so they could be arrested and prosecuted for practicing medicine without a license. The Mexicans, of course, did not reveal any information; they protected their source of help and care. Given this background, it is not remarkable that the mothers do not volunteer any information and may withhold some when asked.

During the time that I was conducting the study, a Black "spiritual healer" was arrested and forced to leave town on the charge of obtaining money under false pretenses. Three or four of the mothers mentioned this occurrence to me. They may have been afraid that I had an ulterior motive in asking about a curandera. I accepted the negative answer at face value and proceeded to the next question.

The curandera does much more than cure the common folk illnesses. The ability to diagnose and cure many sicknesses is a gift from God. The healer, male or female, is a charismatic individual who effects magical and miraculous cures (Rubel, 1966; Romano, 1965). Since I was only asking about the common diseases, the mothers may have answered in the context of these diseases, for which they did not need the help of a curandera.

It is possible, of course, that these particular mothers indeed do not know of a curandera and would not go to one for help. Some of the mothers do not believe in any of the folk diseases I mentioned, several believe in some but not all, several are beginning to wonder if they 'really believe' in them. It may be that, as belief in the folk system diminishes, the more exotic elements, such as witchcraft and magical curing and curers, is lost first. Rubel (1960) suggests that the four diseases which I asked about will persist in the event of increasing Anglicization because they serve to reinforce the traditional culture. In this study, I found that the diseases persist and are treated without reference to a curandera.

These mothers who believe in the folk diseases participate in two separate health care systems. They answered my first questions about sources of help when a child was sick in the context of the Anglo system of sickness and care. When I asked if there were any sicknesses for which they would not seek care from a white doctor, every mother answered no--she would take her child to a white doctor for any sickness because he knows what to do.

Within the context of the Anglo system, fourteen mothers named the doctor as their first source of care (see Table 21). Seven of these mothers do not have a female relative available to help them. Within the context of the Mexican system, most of the mothers who believe in the folk diseases find a Mexican to treat them. The doctor is always the first source of care only for those mothers who do not believe in the Mexican diseases.

The mothers did not expect a white nurse to be interested in or knowledgeable about the folk diseases; they were surprised that I was. No white professional in their experience had expressed a non-judgmental interest in Mexican diseases. When I asked if they would take a child to a white doctor if the child had a Mexican disease, the answer was no, they would not. White doctors do not believe in these diseases and do not know how to treat them; they would just laugh.

The two mothers who said they would take a child to the doctor for a Mexican disease qualified their response. Mrs. Guitierrez is not sure if she believes in them or not. She said if one of the children did get a Mexican disease, she would have to take him to a white doctor anyway, because they have not been here very long and she does not know any Mexican women who could treat the child. Maria Lopez took Tomaso to a white doctor once when she thought he had empacho. She was curious; she wanted to see what he would say. She told him about empacho. He laughed, but said, "Well, maybe. But try this and see if it helps." She did not know what the medicine was, but it did help. Maybe she would go the doctor again.

When I asked the mothers if they would talk to a white doctor or nurse about Mexican diseases, the only ones who said they would not were those who do not know much about them. They were afraid they would give wrong information. The others said they would, or probably would, if the doctor or nurse asked specifically for information. Asking would indicate that they were interested and would allow the mother to give information without necessarily indicating whether she believed in them.

The Curandera

Rachel talked freely and volubly about Mrs. Abelardo, the curandera. She told me her name and approximately where she lived. However, she did not want me to tell Mrs. Abelardo that she was the one who told me. Rachel met her through Jack's mother, who went to her frequently for many things.

Jack's mother was particularly insistent that Rachel take Richard for treatment of his drooping eyelids. She was certain that Mrs. Abelardo could cure him. Rachel finally took Richard to satisfy her mother-in-law. Mrs. Abelardo gave Rachel a picture of Santa Lucia, the saint who would help Richard. In the picture, Santa Lucia was holding a platter with what looked a human eye on it. (Rachel showed me the picture.) She told Rachel to make Richard a gown like the one Santa Lucia was wearing; he was to wear only the gown during the day, every day, until it was so worn out it just fell off. During this time, all three women would follow a prescribed pattern of prayers and other rituals. When the gown fell off, Richard's eyes would be cured.

Rachel did not believe this and refused to follow the advice. Jack's mother got angry, but Rachel said she was not going to have Richard "running around in a silly looking gown to satisfy Jack's mother. People would laugh at both Richard and her."

Jack's mother (Anna) was discovered to have far advanced abdominal cancer during the time I was visiting Rachel. Rachel talked at length about the care Anna had had in both systems. When Anna began to feel sick, she went to Mrs. Abelardo. She did not have any money to go to a doctor. She was living with a man, but not married to him. They did not get any public assistance. He would not give her money to go to the doctor. When she did not get better, Jack borrowed money from the Credit Union so she could go to a doctor. She went, three months prior to the diagnosis of advanced cancer. Rachel said the doctor told her she did not have cancer, she had high blood pressure, constipation and "female problems." He gave her some prescriptions which she had filled. (Rachel showed me the pill bottles to prove that Anna had gone to the doctor three months ago.)

She took the pills, but did not get better. She went back to Mrs. Abelardo, who told her she had cancer and began the treatments which she said would cure her. When Anna continued to get worse, she went back to the doctor. At that time, he arranged for her to be admitted to the hospital and requested that someone from Social Service see her to arrange for financial help.

Rachel was very upset and angry at both the doctor and Mrs. Abelardo. The doctor should have found out the first time that Anna

had cancer. They spent all that money for nothing. Mrs. Abelardo made the right diagnosis, but Rachel knew she could not cure cancer. Anna believed she could. Mrs. Abelardo's explanation was that Anna came to her too late. Both systems failed Anna; she died in September, six months after her first visit to the doctor.

Mrs. Abelardo does more than treat many kinds of sicknesses. Rachel says she also says she can cast spells on people. She cast a spell on Anna's man when he was seeing another woman and threatening to leave Anna. She offered the same service to Rachel when she was having marital problems. Rachel refused; she said, "If I can't handle it myself, there is nothing she can do."

When Rachel told me Mrs. Abelardo's name and something about her and her family, I realized that the family had been known to the Health Department for a number of years. I told the nurse who was visiting them that I planned to visit because Mrs. Abelardo was a curandera. The nurse suggested that I wait for a while. Mr. Abelardo was in the hospital and the family was in a turmoil. The nurse did not know that she was a curandera. When I talked with the nurse later, she told me that on her last visit, Mrs. Abelardo had just finished treating a little boy. That information gave me the entre I needed for my visit.

A Visit with the Curandera

I was not sure what kind of reception I would get from Mrs. Abelardo. Only Rachel had told me she knew a curandera, yet one mother lived next door to Mrs. Abelardo and went to her for help. If other mothers did know of her, it was possible they were protecting her from me and what I might do or say.

I introduced myself, in Spanish, by name and profession to Mrs. Abelardo; she invited me in immediately. Mr. Abelardo, several of the children and an unidentified woman (who soon left) were in the living room. The house is small for the number of people (parents and eight children) who live in it. There were stacks of neatly folded towels and wash clothes on one chair, shoes gathered together under another chair. The living room appeared neat, clean and attractive, with bright serapes on the sofa and chairs, pictures on the walls and curtains and drapes (drawn) at the windows. A knick-knack shelf on the far wall was crowded with religious articles.

Since I knew that Mr. Abelardo had been discharged from the hospital recently, I asked how he was. He told me at length about his problems with the doctors, the hospital and the problems he was having in getting some financial help and finding a job. I relayed the information to the staff nurse.

I told Mr. and Mrs. Abelardo about my interest in Mexican diseases, my desire to talk to a specialist in curing Mexican diseases, and the suggestion from the nurse that I talk with her. I named the diseases, in Spanish; she said she knew how to treat them. (The entire interview was conducted in a combination of Spanish and English.)

She talked freely and at length about her role as a <u>curandera</u>. She has the gift of curing from God. She was born with it, indicated by the fact that she had two <u>molleras</u> (fontanelles). When she was nine, an old woman who was a curandera told her that she would be able to cure people when she was older. Mrs. Abelardo said she had to learn how to

treat the children when they got sick. In Texas, there was no help for poor Mexicans and she could not afford to take them to a doctor. She and her husband both worked, but 'the babies came too fast.'

Several times, she mentioned the low availability and high cost of medical care in Texas. She said, "You had to do something when someone got sick. You did what you knew to do and used what you had." She does not charge for her services; God gave her the gift so she could help people and she likes to help people. She does ask them to pay for the things she uses, so she can buy more. She does not refuse if people want to give her something more; she has many children to feed and care for.

The cures and treatments she uses are basically those described in the literature. She rubs camphorated oil (or Vicks) on the chest or stomach when either one hurts. The oil comes from a Holy Shrine in Texas. She gave me the bottle, which I opened and identified by the odor. Mr. Abelardo gave me a napkin so I could wipe the oil off my fingers. He brought me a mint leaf from the garden; she makes a tea of them for stomach cramps. She grows a few herbs, but gets most of them from her mother in Texas. She uses herbal teas to help people with many different sicknesses. One is particularly good for people who are "nervous"; another, used in conjunction with a special diet, helps those with hemorrhoids.

She has treated many babies for <u>caída de mollera</u>. They get it from falling, having the nipple pulled out too fast when they are sucking, or from being handled too roughly by brothers and sisters. Babies

especially little ones, should be handled gently.[1] The symptoms are poor sucking, vomiting, diarrhea and fever. The treatment consists of pushing the palate up gently three times, sucking the mollera up or holding the baby upside down by the ankles and lightly slapping the bottom of the feet three times. When I asked if she had heard of holding the top of the baby's head in boiling water, she gasped and said, "Oh, no'"[2] She does not put the baby's head in water at all--it is better to put a little oil on the head and pull up on the hair gently. In all treatments, she stressed the need to be gentle with small babies.[3]

Many times she has cured people, especially children, when the doctor could not help them. When her son David was about six months old, he was in the hospital for a while, very sick, thin, not eating, vomiting his milk. The doctor could not make him better. Since they could not afford to leave him in the hospital, the doctor told them to take him home. At home, she prayed and got some help from the curandera. David was better in a few days. White doctors don't know how to treat Mexican diseases. All they want to do is get out the paper and write (prescriptions).

Prayer and ritual are a major part of her treatments. She asked if I thought she was going against the law by praying for people

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[1]Caffey (1973) suggests that repeated shaking or rough handling of small babies may result in subdural hematoma.

[2]Guarneschelli, Lee and Pitts (1972) describe this as a treatment for caída de mollera.

[3]Kay (1972, p. 180) reports that the curandero in Tucson is "especially gentle with mollera."

like she does. She does not think so; it is good to pray always to stay healthy or to get better. One old lady was in the hospital with cancer. She was very sick; the doctor said she would die in three months. Her daughter came and asked Mrs. Abelardo to go to the hospital and pray for her mother. Mrs. Abelardo was reluctant to go because the nurses might not like it and she could get into trouble. The daughter pleaded with her and said she would pay her $50 if she would go and pray and make her mother better. She went and prayed three times and the lady got better. She is very grateful; she has made four blankets and the living room drapes at no charge. The daughter never paid the $50 though.

Some people think she is a bruja (witch), but she isn't. Some people can do bad things; they get their power from the devil. Her gift is from God; she does only good things. Some things are bad and some are good; some people are bad and some are good. If you do bad things, God will punish you and you will get sick. If God wants you to die then you die. He decides and there is nothing you can do about it.

She knows of many instances in which people do "bad things" which make them get sick. For example, she said that "fucking" a woman who is not your wife is a "bad thing to do" and God punishes these men by making them sick.[1] Sometimes the other woman puts an "evil spell"

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[1]When these women are talking about a sexual relationship which they deem legitimate, they use the term "with me" or "with her." "My husband is not with me very often" or "He wants to be with her every night." When they consider the relationship not legitimate, they use the term "fuck." Sexual relationships outside of marriage or a free union are not legitimate.

on the man; that is a bad thing to do, too. One man who "fucked a lot of women" got real sick and died from it."

She knows that there are some things that she cannot cure. Specifically, she named boils or anything with pus. She took David to the doctor when he had an infected mosquito bite; she knew she could not cure that. Doctors have penicillin and other strong medicine for pus. If anyone comes to her with that kind of a problem, she just tells them to go to the doctor.

Mostly, her children are healthy. They eat good food--raw vegetables, and meat when she can afford it. They are poor, but well, thanks be to God. It is very difficult for her to take anyone to the Clinic (Model Cities). They do not have transportation; she has to call a cab or pay someone else to take them. Then she has to wait four or five hours to see the doctor. She has much to do at home. She likes to clean her house in the morning. There is much washing, ironing and cooking to do for her large family; she does not have time to spend all day "just sitting, doing nothing."

As I was preparing to leave, Mrs. Abelardo asked if I was 'Mexican or white or what.' (Apparently a white nurse who spoke Spanish and knew about Mexican diseases was a new experience for her.) I replied that I was white, but interested in Mexicans. She said, "Oh. Well, you come back any time you want to. I can help you to know many things; I tell you anything you want to know."

The pattern of care which Mrs. Abelardo described was that of people going to the doctor first, then coming to her when they did not get better. The mothers described treatment at home first; they go to

the doctor if their treatment is not effective. One mentioned a curandera; most said they would not go to one. Rachel's mother-in-law participated in both systems. Kay (1972) describes very similar attitudes and behavior on the part of the Mexican women she interviewed in Tucson. It is quite probable that many families participate in both systems, either alternately or simultaneously.[1]

Summary

These Mexican mothers value good health for their children and do their best to keep them well. On the whole, they feel that the children are healthy. The mothers recognize illness in their children by changes in their behavior rather than by the onset of physical symptoms. They treat them at home first, using the common home remedies. If the home treatment is not successful, they seek medical care.

Most of the families have a regular source for medical care. Those who do not wish that there were more doctors who took patients who were on Medicaid. All of the families are familiar with the Emergency Room as a source of care.

The majority of the mothers had antepartum care 'to be sure everything was all right.' Preventive care for the children is less common, for a variety of reasons.

No mother volunteered information about the folk health care system. Most of them are knowledgeable about the folk illnesses and

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[1]Rubel (1966) and Olguin (California State Department of Education, n.d.) both suggest that the Mexicans will seek help from any source available to them.

many know how to treat them. Folk diseases are treated within the folk system, not in the Anglo system. Only one mother said she knew of a curandera. The curandera said she treats many Mexicans for illnesses that the doctor could not cure.

The mothers who believe in the folk illnesses participate in two insular systems of health care. If they suspect a folk disease, it is treated in the folk system. If that treatment fails, they seek care from an Anglo doctor because apparently the disease was not a folk disease.

CHAPTER VIII

IMPLICATIONS FOR PRACTICE

Introduction

The results of this study present a number of implications for nursing practice, delivery of health care and further research. Since the study was exploratory and descriptive in nature, with the major emphasis on depth in content and contact with a relatively small number of people, the findings and implications can be generalized only to the extent that the people, services and basic milieu are similar to those described here. For example, they would probably be applicable to low-income Mexican families in another medium-sized Michigan city with heavy industry.

The implications and suggestions for nursing practice and delivery of health care will, in large part, be discussed together. In the context of this study, public health nursing service comprises a large part of the delivery of care, either directly or indirectly. I believe that the public health nurse has a role and responsibility in effecting change in the delivery system. Suggestions for further research will be discussed separately, although many of the ideas for research are inherent in the implications for practice.

This study focused on health, illness and health care of young Mexican children in the context of their culture, including the health-illness system, and in articulation with the Anglo health care system. Utilization of preventive care at the Child Health Clinic was of particular interest. Implications will be discussed in relation to each of these four facets.

Suggestions for nursing practice and health care delivery are based on the assumption that the over-all purpose of the health care system, with nursing practice as a major component, is to provide good health care to those who need it. In the event that the needs are not being met, I believe that the health professionals have a major role and responsibility in determining why the needs are unmet, and implementing means of meeting them. Barriers to health care exist in the attitudes and situations of those who need care and in the attitudes and systems of those who provide care. Those who provide care have full responsibility for the latter two; they also have a role in helping those who need care to use it effectively. Implications will be discussed within this framework.

Mexican Culture

Very broadly, health professionals, particularly public health nurses, need to have some understanding of Mexican culture, beginning with the fact that it does exist and has implications for practice. One of the nurses who works with Mexican families commented that it had never occurred to her that Mexicans were different from any other families. I doubt that this nurse is alone in not realizing that there are

differences. It is true that many of the problems and behaviors of poor Mexicans are a function of poverty; in this respect, they do not differ appreciably from poor whites or Blacks. Some behavior may appear the same in all three groups, but have a different basis, thereby requiring a different approcah. Some behavior is uniquely Mexican and needs to be understood and accepted as such.

Language

The use of Spanish is, of course, the most obvious cultural difference. The communication barrier between the Spanish speaking patient and the English speaking nurse (or other health worker) is formidable. A barrier exists not only in the words themselves, but also in the perception and structure of the world embodied in the language. In the latter instance, a barrier exists even when the native Spanish speaker has a fairly good command of English. A different kind of barrier exists for the patient whose poor English is interpreted incorrectly by the professional. The last two barriers are less likely to be recognized by the English (only) speaking health professional.

The obvious implication, of course, is for the nurses who work with Spanish-speaking families to learn some Spanish. One of the nurses said that was not necessary; she gets along fine with the mothers and their broken English. She may not get along as fine as she thinks, to the detriment of the family. Two examples will suffice. The physician who was caring for Martin Almaguer wanted to hospitalize him. Martin did not want to go into the hospital until after Irma had the baby, but said the doctor did not understand. I called, at his request. The

nurse said, "But he told us last week that she had the baby!" Martin gets verb tenses confused. Irma showed me a letter she received from the Department of Social Services, instructing her to make an appointment before a certain date to renew her Food Stamp authorization. She pointed to the word "before" and asked, in Spanish, "Is that "before" or "after?"

Communication would be improved in a number of ways for the nurse who knows some Spanish. First, the Mexican mother would know that the nurse was making an effort to understand her. The mother would be more likely to use her poor English if the nurse was using her poor Spanish. Mothers who know some English will frequently present themselves as not knowing English rather than risk being laughed at.

With some knowledge of vocabulary and structure of Spanish, the nurse will have a better understanding of how the Mexican thinks. Spanish is a personal language, with use of the familiar form of address, many reflexive verbs and things happening to people. The English "my ear hurts" translates literally to "the ear hurts me" in Spanish. "I missed the bus" translates to "the buss missed me."

Some knowledge of Spanish will enable the nurse and the mother to use a Spanish-English dictionary, which I think should be standard equipment for every nurse working with Mexicans. None of the families had a bilingual dictionary, but they did become accustomed to mine. They would ask for it when their English vocabulary was inadequate; I used it to find the word I wanted in Spanish.

Within one week, I heard two physicians, both influential in the delivery of health care to low-income families, express opposite

opinions on the subject of health professionals learning some Spanish. One was very frustrated because he was unable to communicate with a mother whose child had a chronic illness. He thought it might be a good idea to require some Spanish as a pre-requisite to medical school in those areas with a large number of Spanish speaking people. The other said he had no sympathy or patience with these people who did not learn English. If they were going to live here, they could learn the language. I think that the latter opinion is much more common than the former. A nursing student who visited one of the clinics at Cristo Rey reported that the nurses and doctors were not interested in learning Spanish. They felt that having a Spanish speaking aid to interpret was adequate.

Sole reliance on an interpreter presents some problems. In the above situation, there is only one interpreter. Those who need her help have to wait, sometimes for hours. This could discourage returning or even coming at all. The interpreter's vocabulary, English or Spanish or both, may not be adequate for the task at hand, with resultant misunderstanding. Given the Mexican women's fear of and propensity to gossip, the patient may withhold much important information from another Mexican who, in addition, may be "uppity."

Dignity of the Individual

The respect for the dignity of the individual has many ramifications, including the strong need for privacy and the role of gossip. All of these suggest implicitly that the nurse be particularly careful to maintain the confidentiality of information. A woman may ask for

information about someone because she does enjoy a bit of good gossip. However, if the nurse gives the information, she will probably get a reputation as a gossip.

The nurses were not aware of the high number of unlisted phone numbers. The nurse is given the phone number because she is in a position of trust; however, she is not given the information that the number is not listed. The implication is that she will not give the number to anyone without the consent of the family.

Appearing stupid, being "put down" or laughed at is a particularly demeaning experience for the Mexican. It is for most people, but it seems to be more so for the Mexicans. Their language does not have a word which translates adequately into "embarrass." (Embarazo means pregnant.) When I would use embarrass, they use shame. Rachel explained the difference. Embarrass is a small, weak feeling; shame is a deep, strong feeling and shame is what they feel. They do what they can to avoid being laughed at, including avoiding situations. When I took the children to the circus, they had been bathed, shampooed, combed and dressed in their best. Lydia (age eight) said, "My mamma said we better get dressed up so people won't laugh at us." Rachel did not send Richard to Head Start because she was afraid that the children would laugh at his drooping eyelids.

Rachel wanted to have Richard's eyes "fixed" before he started kindergarten. He had had some private care, but had not returned because they could not afford it. I told her about the Medical Eye Care Program; I was fairly sure that they would be eligible. She

discussed it with Jack and they decided to apply. When I took her to the office for the appointment, I knew she was very nervous. She told me later that she was 'so afraid that the lady would put her down because she was asking for help--but she was real nice.'

The women seem more likely to be a bit assertive and willing to risk being laughed at if a child needs care than if they themselves need care. I heard of a number of instances in which a mother or father needed medical care but did not get it because they did not have any money. Many mothers, and fathers, said, "I don't like to ask for favors" or "I don't like to ask for help." They lose dignity in so doing. The public health nurses' statement "call me if you need a ride" is not apt to elicit a call for a ride. That constitutes asking a favor. However, if the nurse were to call the day before the appointment, ascertain if they had a ride and offer one if necessary, they would probably accept. Accepting an offer of help is not the same as asking for help.

The courtesy which protects an individual's dignity goes both ways. A Mexican mother may agree to do something, if pressured by a nurse, in order to preserve the nurse's dignity. If that is her reason for agreeing, however, she is not likely to do it. This suggests a "soft-sell" asking rather than telling approach.

Home and Family

The social isolation and lack of independence of the mother have particular significance for the public health nurse. Many of these women, especially those in a nuclear family, have had little

experience away from home alone. When I took Rachel downtown for her interview, I parked in the parking ramp, rather high. When we got out of the car, she asked how we got down. She had never been in a ramp.

Triplett (1969) and others have suggested a reaching-out program by the nurses to low-income mothers who do not use preventive services. For these Mexican mothers, just a reaching-out would probably not be enough. A reaching-out and going with or taking might be more effective. Aspects of the health care system can be overwhelming in their complexity for these women with limited skill in English and little experience away from home.

These mothers stay home and care for their children. The fathers also participate in caring for the children. The children are given much love and attention by both parents and by other family members. They are held, rocked, played with, generally given a great deal of physical contact. This was consistent in the families I visited; it is also reported in the literature (Clark, 1959; Madsen, 1964). I had a great deal of physical contact with the children because that is my usual behavior pattern in relating to children. However, for many people, physical contact--touch--is not a usual behavior for relating or communicating. Touch means different things to different people, in both giving and receiving. In these families, particularly in the parent-child relationship, touching seems to be part of caring and communicating love. I think that my physical contact with the children enhanced my relationship with their parents. This meaning and use of touch has implications not only for nurses but for all health professionals.

Little contact with the neighbors, another aspect of the social isolation of these women, also has implications for nursing. It is not uncommon for the nurse to suggest to a woman who does not have transportation that she ask if she can ride with a neighbor down the street who does have a car and attends the same clinic. The Mexican woman may agree, but not ask. She may also be reluctant to ask to use a neighbor's phone. Maria Lopez walked four blocks and used a pay phone to call me rather than use the neighbor's phone. When Evalina's phone was disconnected, she waited until she went to Irma's to call me. Not asking favors and fear of gossip are both relevant to this situation.

The fact that visiting in the home is largely confined to relatives and, for the women, to female relatives, suggests that a male nurse would not be acceptable. Although I did not inquire about this directly, several of the women commented that their husband did not like it if men came to the house when they were not at home. When a male out-reach worker from the Action Center was coming to see Irma, and Martin had to go to the doctor, she asked me if I could come, too. One afternoon, Concepción came over to discuss with Irma the propriety of her going over to Evalina's. There were several "strange men" there with Leon; she decided to wait until they left. These behaviors all suggest that a male nurse might not be acceptable in the home.

A goal of independence in seeking, finding and using health care seems to me unrealistic, particularly for the women in nuclear families. Independence and going places alone are discouraged. One afternoon when Evalina was feeling overwhelmed by all of the family and problems, I

asked if she would like to come home with me for a cup of coffee and some quiet conversation. She said, "No, thank you--Leon would not like it." She is one of the more independent ones! The mother who is head of her household may be more willing and ready to attain some independence, since she does not have a man to whom she can turn.

The woman who does have a man to whom she can turn will probably discuss health related decisions with him. Although the women in modified nuclear families in this study made the health decisions regarding the children, they did discuss the situation with their husbands. If they disagreed, the mother usually made the final decision. Parents frequently consult with other family members about health problems and decisions. If a decision about a course of action is necessary, it would be well to allow the mother time to talk with the father and other family members. The nurse might offer to talk with those who are involved in the decision making process. Pressure for an immediate decision could result in rejection or in verbal compliance with no action intended immediately by the mother.

The Mexican family has many strengths which the nurse can utilize. Care, safety, what is best for the children can be powerful motivators. There are many areas in which the nurse can give positive support and make suggestions within the framework of what the mother knows and does. This assumes that the nurse first finds out what the mother thinks and does. The toddler with the constant bottle, milk anemia and the risk of diarrhea will serve as an example. Telling the mother to take the bottle away will probably not be effective. Would

she consider limiting the times when the child has the bottle? Would she consider water, dilute fruit juice or something other than milk in the bottle? She boiled the bottle and nipples for cleanliness for the baby; she would probably accept the need for frequent washing now. What foods high in iron might she add?

What sources of vitamin C might she add? For example, many of the families use Tang, not orange juice. Determining with the mother what is feasible may not result in as much change as the nurse sees as desirable; it will probably result in more change than telling the mother to take the child off the bottle, give him orange juice and make him eat meat. The high incidence of anemia in these children suggests the need for exploration of possible causes and the implementation of preventive measures.

The traditional Mexican diet, on the whole, provides fairly good nutrition. Most of the families I visited have retained a large portion of the traditional diet. If dietary changes are indicated, every effort should be made to suggest the changes within the framework of the family's present eating pattern. For example, the Anglo diet and exchange list for people with diabetes has limited usefulness for the person who eats a traditional Mexican diet. Translating the food exchange list into Spanish accomplishes little, since the diet remains Anglo. A food exchange list based on the traditional Mexican diet would have considerably more usefulness and acceptance.

Mobility

Much of the mobility within the city is probably a function of poverty; poor people tend to move frequently. Some of the in-migration from Texas is related to the poverty and ethnic discrimination these families experienced in Texas and as migrant agricultural workers. The chain migration described earlier is facilitated by the strong family ties. To a degree, then, mobility is related to ethnicity and culture.

The possibility of a relationship between a recent move and a perception of less than good health and/or an increased risk of illness has implications for nursing practice. A study now in process in Seattle suggests a relationship between moving and the birth of a premature infant.[1] Smiley, Eyres and Robers (1972) found a strong relationship between moving and illness in the infant within the first three months.

Moving is a stressful, disruptive change for any family. Most of the mothers in this study who had changed residence within the past two years were also coping with other stress-inducing changes. A number of stressful changes in a short period of time results in a high "life-crisis" score which is predictive of increased risk of illness.[2] Frequently, a major or high-score change such as divorce or marital separation, or change in income or job, precipitates a change in

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[1]Hutchins, personal interview.

[2]See description and discussion of the work of Holmes and others in relation to change and illness in Arthur (1971) and in Chapter VII, pp. 177-178 above.

residence. This was true for a number of families in this study. The move may suggest that the family is undergoing other changes which are stressful.

A concerted effort should be made to locate families who have moved recently. Smiley, Eyres and Robers (1972) demonstrated that they can be located in Detroit; it is probably possible to locate them in Lansing using the same means. An effort should also be made to locate families who have moved into the city recently. The staff at Cristo Rey and those who work in the programs for migrant families would be good resources for this information. The people in these families are at risk of illness. The stress of moving, probably combined with other stressful change, may result in a perception of less than good health. This perception, in turn, may result in increased receptivity to health care. A reaching-out, personal contact program would probably be more fruitful than any program based on the expectation that the families will actively seek out the help.

Folk Illnesses and Treatments

The persistence of folk illnesses suggests that the nurse needs to know something about them. If she admires a Mexican child, she can touch him on the face and head. If she has strong eyes, she has guarded the child against mal de ojo. With an understanding of empacho, the nurse will realize that the mother's knowledge and ideas about diet and eating habits are vital to any discussion of dietary change.

In view of my experiences, it seems reasonable to suppose that a Mexican mother will discuss folk diseases with a public health nurse

who displays some knowledge of and non-judgmental attitude toward them. Determining what the mother thinks the sickness is and what she is doing for the child will enable the nurse to build on or add on to what the mother is already doing. She may have to ask specific questions, as I did with Rachel when Rudolph had diarrhea, to learn if there are physical symptoms. If medical care seems indicated, it might be put on the basis that the doctor, too, might be able to help. In that situation, it is important that the mother tell the doctor the physical symptoms as well as the behavioral ones. He needs to know these, just as the Mexican curer (mother, señora, curandera) needs to know the behavioral changes.

Finding out what the mother is doing will enable the nurse to determine whether the home treatment is innocuous, helpful or dangerous. The home treatments which the mothers described to me are largely helpful. Rest, fluids, aspirin and observation are frequently recommended by the physician. Most of the rituals, in themselves, are harmless. Rough handling in treating caída de mollera may be harmful (see Caffey, 1973). The major danger in the folk system, as I see it, lies in delaying or never seeking medical care. According to the mothers, they do seek medical care if the home remedies, whatever they are, are ineffective. According to Mrs. Abelardo, the children she sees have usually been seen and treated unsuccessfully by a doctor. Use of the curandera to the exclusion of medical care may be more prevalent in the adult Mexican population. Use of the curandura may also be more prevalent in those problems which Anglos call emotional or behavioral

problems. In the folk system, they are the result of disturbed interpersonal relationships or deviation from cultural norms. Within this context, treatment by a curandera will probably be more successful than treatment by a physician (Kiev, 1968).

Delay in seeking care is more likely a function of poverty than of belief in the folk system. My past experience with poor white families supports this assumption. A recent large study of poor whites, Blacks and Mexicans found "no remarkable ethnic difference in delay in seeking treatment" (Wingert, Friedman and Larsen, 1968, p. 869). Lack of money and/or transportation, and unavailability, inaccessibility or unacceptability of sources of care may be greater barriers than the folk system.

Health Care in the Anglo System

Preventive Care

The similarities and differences in the three groups in use of preventive care have implications for nursing practice. Although level of education is not a predictor of use of preventive care for the children, place of education may be. The mother who was educated in Michigan was more likely to bring her children to the Clinic consistently than was the mother who was educated in Texas. The Michigan-educated mother may have had more exposure to Anglo health ways and teaching and thus be more receptive to preventive care. For the most part, the mothers who grew up in Texas had had no experience with well child care; their limited experience with care in the Anglo system tended to be negative.

Prenatal care is a good predictor of preventive health care for the children. The mothers in the good user group tended to have care early and regularly for their pregnancies. However, the majority of the thirty mothers had early and regular prenatal care for the babies born in Michigan. A few went to the doctor "because it is what you are supposed to do." Most of them went "to be sure everything is all right."

Seeking health care 'to be sure everything is all right' suggests that these women are dealing with this aspect of health care at a rather high level of abstraction. The end result of preventive health care is (or should be) good health--an absence of illness. There is no immediate result or gratification. This behavior seems to be at odds with the often mentioned inability to delay gratification which is common to those who live in a "culture of poverty."[1] The birth of a healthy baby to a healthy mother is gratifying; however, the gratification is delayed.

Early and regular prenatal care "because it is what you are supposed to do" suggests that the mother is familiar with the middle class pattern of prenatal care. Care "to be sure everything is all right" suggests that the mother sees value in the preventive care. For either reason, it is an example of preventive care with which the mother is familiar. Either reason can be equally cogent for preventive care for the children.

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[1]See Lewis (1966) and Kosa (1969) for descriptions and Parker and Kleiner (1970) for a discussion of the 'culture of poverty.'

The woman who is or has been the head of the household is more likely to use preventive care than the woman who has always been in a nuclear family. The former may need an explanation of purpose; she may need concrete help with transportation. Neither Maria Lopez nor Consuelo Garcia has missed an appointment since they began attending Child Health Clinic eight months ago. Both are in modified nuclear families. Maria had previously had experience with well-child care from a private physician. Several other mothers in the non-user group would probably become good users with support from the public health nurse, continuity of nurse from home to clinic and transportation.

Perhaps a goal of early and regular well-child care is unrealistic for those children whose mothers 'do not believe in taking a child to the doctor unless he is sick.' Early and complete immunizations might be more feasible. This, in itself, might represent the first step in preventive health care and be as much change as can reasonably be expected of the mother who was brought up in Texas.

Most of the children in this study have been immunized. Those in the poor and non-user groups are more likely to have begun late and to be incompletely immunized. For these mothers, the value of good health and the importance they attach to keeping their children well might serve as reasons, particularly if emphasis is put on the diseases with which they are familiar, such as polio and measles. The same rationale may hold true for the mothers like Evalina, who are overwhelmed with maintaining the home and caring for many young children.

Child Health Clinic

The mothers who are overwhelmed and those who do not see any reason for well-child care do want to have their children immunized. It might be possible to combine immunizations with visits for broader preventive care. The mothers do take their children to Immunization Clinic at Cristo Rey or the Health Department. The waiting time is about equal for the two clinics.

Often, these children are not immunized according to the recommended schedule, but rather over a longer period of time. The mothers might be willing to bring the child to Child Health Clinic for immunizations. The visits then might be scheduled for the critical periods of growth and development. This would mean spacing the visits further apart than is recommended for either initial immunizations or good well-child care. However, it might also result in these children having some well-child care rather than none, without jeopardizing the ultimate adequacy of immunizations. Discovering a health problem, such as nutritional anemia, in an apparently well child might help the mother see the value of well-child care.

Both the fact and the rate of broken appointments have implications for those who provide care as well as for those who need care. The latter are not getting as good care as is available to them. The former become frustrated with the large number of "no-shows." Their solution is to over-schedule each clinic to assure a full afternoon. As a result, the mothers frequently wait several hours to see the doctor. This long wait was the only negative comment I heard about the Clinic. It could deter a mother from going if her child was not sick.

Lack of transportation could account for broken appointments at either clinic. It could be a bigger problem for those attending South clinic, since those families are less likely to live within walking distance. Data from the appointment sheets for 1972 suggest that more families need transportation than ask for it. Only seven of the eighty-seven families who had an appointment had requested transportation. Fourteen of the thirty families I visited reported that transportation was always or usually a problem. The difference between 8 percent and 47 percent is great enough to support the clinic supervisor's statement that only the aggressive ones will ask to have transportation provided. Asking the mother, shortly before the appointment, if she needs transportation rather than waiting for her to request it may reduce the number of broken appointments.

At present, Lansing does not have a good public transportation system. Development of such a system would ease the problem for some of these mothers. For some it would not, however. Some could not afford it. The woman who has had little experience away from home alone, little experience with public transportation and does not speak English might find the barriers to use public transportation insurmountable. The mother with an infant, two or three preschoolers and a diaper bag could foresee many problems in using public transportation, particularly if she had to transfer. Public transportation would be a realistic solution for some of these mothers only if the above barriers were reduced or removed.

A conflict between the husbands' working hours and the afternoon clinic hours could account for broken appointments at either clinic.

For many mothers, transportation is available when the husband is not working. Many of the husbands work afternoons or nights, never days. A mid-afternoon appointment would be impossible for the man who works afternoons; an early afternoon one would be difficult for the man who works nights. An afternoon appointment is out of the question for the man who works days.

Scheduling appointments in accord with the husbands' working hours might reduce the number of broken appointments. Observing attendance patterns and the predictors of preventive care suggests the possibility of early appointments for those likely to come and late ones for those not likely to come. Offering the service in the morning and evening would increase the availability to those who need care. Providing a choice of times might reduce the number of broken appointments.

The number of broken appointments might also be reduced if the nurses knew why the mothers did not keep the appointment. Home visits to those who have not come would demonstrate interest on the part of the nurse, an important aspect of the Mexican mothers' expectation of those who provide health care. The reason for non-attendance would direct the approach the nurse used and the solution or alternative action she suggested. This might be an effective method of finding families who need help at a time when they are ready to use it. At present, many records are closed for non-attendance without any indication that an effort was made to determine the reasons for the non-attendance.

Health Care Delivery

All of the families included in this study have had some contact with the Anglo care system. Most of them have a family doctor. Those who do not have a family doctor would like to have one. However, few doctors in the area are taking new patients; fewer still will take new patients on Medicaid. The families do not have enough familiarity with the system to ascertain, on their own, which doctors are taking new patients.

These families, and probably most poor families, want a family doctor. This is, and has been for years, the traditional pattern of care for middle class families. The traditional clinic care provided for those who cannot afford private care is fragmented and generally inadequate to meet their needs. Health care is delivered to and used by the poor in a manner different from the non-poor.

However, utilization patterns may change if the delivery system changes to resemble middle class care. Mothers in a demonstration program of comprehensive care in a hospital clinic setting used the care in a manner resembling middle class behavior. The authors concluded that providing comprehensive care has a greater impact than providing a payment mechanism alone (Medicaid) on the use of care (Alpert et al., 1970). The Kaiser Foundation Medical Care Program provided comprehensive health care to a group of indigent families with the Office of Economic Opportunity paying the fees. Costs and utilization rates did not differ greatly for the public-pay and private-pay groups. The staff concluded that comprehensive health

care can be provided to the poor within currently established group practice, pre-payment plans at a reasonable cost (Colombo, 1969).

Pre-paid group practice plans to provide comprehensive health care (Health Maintenance Organizations) are being discussed and developed with increasing frequency in an effort to improve health care and make better use of facilities and manpower. Some rather radical changes are likely to occur in health care delivery to all groups of people (Mechanic, 1972). A Health Maintenance Organization of some kind which provided care to the poor and the non-poor together might be a good means of helping the poor learn to use health care to better advantage. If they aspire to middle class care and see middle class families having care in a non-private physician setting, perhaps some culture lag can be by-passed.

At present, however, there are few sources of care available to those in Lansing who cannot afford private care. The few that do exist are not adequate to meet the needs. The new adult clinic at Cristo Rey, open one day a week, is an example (Lehr, 1974). Physicians in private practice in this community have told me that anyone who needs care can get it. They provide care for "poor people." What they do not realize, or recognize, is that there are many "poor people" who do not get care.

Recently, the President of American Medical Association stated that "Health care is not a major national problem because such care in the United States . . . already is socialized." He cites Medicare, Medicaid and health insurance paid for by industry as socialization.

The President, a urologist, said, "In my experience, it's rare that I see a patient who doesn't have insurance coverage" ("Sick Care . . ." 1973). This attitude on the part of physicians creates a major barrier to health care for low-income families.

The last, and for some, the only resource for people in this community is the hospital Emergency Room. In a number of cities, Emergency Rooms are over-used and mis-used by families who belong to an ethnic minority, have low incomes and little or no relationship with a private physician. The result is Emergency Rooms crowded with people who need medical care but are not having a medical emergency. Some have no place else to go; some view the hospital as their "family doctor." The definition of an "emergency" by a mother with a sick child and by a frustrated physician can be vastly different. The care is crisis-oriented and fragmented, with no consideration of prevention or follow-up (Alpert, Kosa and Haggerty, 1969; Perkoff and Anderson, 1970; Wingert, Friedman and Larsen, 1968; McAleenan, 1973b). There is some indication that decisions regarding treatment are based on factors other than the presenting problem (Perkoff and Anderson, 1970).

The problems and patterns described above are, by and large, common to all poor people. They are compounded for the Mexican who lacks skill in English, may have had little experience in the Anglo system and may present the problem in terms of behavioral changes rather than physical symptoms.

Expanding and changing the character of service in the Emergency Room has been suggested by several people. Wingert, Friedman and Larsen (1968) suggest expanding the service to include some preventive care,

counseling and follow-up. Jacobs and Gavett (1973) suggest a bi-partite service, with separate areas for medical emergencies and clinic-type care. Meyers (1973) suggests expansion and change in the hospital out-patient departments because of the over-use of Emergency Rooms for non-emergency care.

Some change of the nature suggested above is applicable to the situation in Lansing. The families with whom I had contact are all familiar with the Emergency Room as a source of care. Many of them have been to more than one. One hospital usually has a bilingual person available. Since the service is always available, the families can go when they have transportation or an interpreter. Change of this kind seems to me a viable alternative to establishing more new, limited facilities for care. Many of the necessary services are already available in the hospital. The people will undoubtedly continue to come. Changing the services to meet the demand could result in reduced frustration for both users and providers of care.

Over-use of the Emergency Room may result, in some part, from a misunderstanding of the "emergency care" clause in Medicaid and Blue Cross-Blue Shield coverage. I know that the families do not understand why they are billed for care when they have coverage. To them, an emergency is an emergency. It is possible that the doctor's secretary who tells families to go to the Emergency Room thinks that the visit will be covered. The Medical Director at Oldsmobile thinks that the workers' insurance covers all costs for all care in the Emergency Room.[1]

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[1]Bangs, personal interview.

He apparently does not realize that the family is billed both by the hospital and by the doctor, and that the insurance covers only conditions defined by the doctor as emergencies. There is implication for a program of some kind to educate both the families and the health professionals about the limitations of coverage for emergency care.

The differences between the Mexican mother and the Anglo health professional in orientation to and definition of sickness (behavioral changes versus physical symptoms) suggest the need for education of both parties. Mexican mothers could learn to observe for and report physical symptoms as well as behavioral changes, since these are things the doctor will want to know. They are his clues, just as the behavioral changes are the mothers. Nurses, physicians and their secretaries who have contact with Mexican families might be more patient and use a different approach if they were aware of the method the mothers use to define sickness. For example, one Mexican child seen frequently in the Child Health Clinic is very subject to ear infections. The mother always knows that he is sick, but does not recognize it as an ear infection until it is far advanced. She does not call the doctor because she 'doesn't know what is wrong.' With some understanding on the part of the doctor and his secretary, she might call and bring the child in for care, on the basis of behavioral changes.

Summary

These implications for practice have generally been made in the context of public health nurses working with Mexican families. Most of them are more broadly applicable to health professionals working with any low-income group. Preservation of privacy, respect for the dignity of the individual, involving the family in planning for care or making changes are aspects of good health care for any people in any setting.

The implications that are specific to the Mexicans suggest that health professionals adapt their behavior when necessary to the patterns of behavior and belief that are part of the Mexican culture. An understanding of the culture and the language are vital to those who would provide health care which is meaningful and acceptable to the Mexicans. Ideally, this should be incorporated into the curriculum for health professionals in an area with a large Mexican population.

The Mexican families have many strengths which the health professionals can use constructively. Their traditional diet is good; help them to make changes within it. They give their children a great deal of love through physical contact; hold and touch the children. They value good health for their children; help them to learn about and value preventive care. Parents make decisions together, sometimes in consultation with other family members; include the others in the discussions and allow them time to arrive at a decision.

Mexicans do not like to ask for help; offer assistance rather than expecting them to request it. They find it difficult to say "no" even though they may want to; keep the pressure low. The women have

little experience away from home; reach out and go with them for a new experience. They move frequently; find them and offer help at a time when their stress level may be high.

Many of the Mexicans participate in both the folk and the Anglo health care systems. Learn about the folk system and discuss it with them. Evaluate what they are doing in terms of practice, not belief. Much of what they do is good; synthesize folk care and Anglo care whenever possible. Finally, consider that there may be situations in which the curandera can be more effective than the physician.

CHAPTER IX

IMPLICATIONS FOR RESEARCH

This study was exploratory in nature. The purpose was to gather information which would raise questions and generate hypotheses which could be tested. In that it has succeeded; the study has raised more questions than it answered. The particular question of factors that differentiate good, poor and non-users of preventive health services proved to be fruitful both in providing some possible answers and suggesting avenues for further research.

Family Structure

The difference in family structure between the good and poor user groups was striking. It was of particular interest because the difference was the opposite of findings in other studies. Triplett (1970), Smiley, Eyres and Roberts (1972), and Mindlin and Densen (1971) all found that children in a single female parent household were likely to have little preventive care. In this study, children in a family in which the mother is or has been the head of the household were more likely to have preventive care than children in a nuclear family.

The difference between the two groups may be a function of the small number of families and the particular families selected. Selection of different families may have yielded different results. The

inclusion of modified nuclear families with families headed by a female increases the difference between the two groups. I did not find any other study which considered the modified nuclear family as a variable in use of health care.

This raises several interesting questions. Is the poor Mexican woman more likely to enter a second marriage than the poor white or the poor Black? The relatively high dependence of a Mexican woman on a man suggests that this may be true. In good or poor use of preventive health care, would the poor white woman in a modified nuclear family resemble the poor white woman in a nuclear family or in a female head of household family?

Of primary interest, however, and crucial to an exploration of the above questions, is a determination of whether the difference in family structure related to use found in this study obtains for a large group of Mexican families. The information to answer this question is available in the Health Department records. The Child Health Clinic has now been in operation for five and a half years. A study of the total population of Mexican families who have had contact with Child Health Clinic is possible. The criteria for good and poor use developed for this study are objective and are applicable to all records of attendance at the Clinic. Determination of whether or not a relationship exists between family structure and use is possible, not only for the Mexican families, but for the entire Clinic population. Marital status is determined and recorded; female head of household status will be easy to determine. Modified nuclear family status may not be recorded, particularly if the children of the first marriage are all over five.

If a study of use by a large number of Mexican families supports the finding that mothers who are or have been heads of household tend to be good users, the hypothesis suggested earlier in this paper can be explored. Do they tend to be more independent, assume more responsibility, make more decisions than the mothers in nuclear families? What reasons do they give for attending consistently? Do they also seek medical care more frequently and earlier in the course of an illness? Although these questions were not asked in this study, some clues to the answers were offered by the mothers in talking about health, illness and their role as mother.

Is the relationship between family structure and preventive care different for poor Mexicans than for poor Blacks and/or whites? If yes, why? Are there things we can learn from and about the good users that are applicable across ethnic groups? The clientele of Child Health Clinic offers opportunities for comparative studies of three ethnic groups in many aspects of preventive care.

Migration and Mobility

The findings of this study suggest that the mother who was socialized in Texas and/or has a background as a migrant agricultural worker is less likely to use preventive care services. These mothers say they had little contact and negative experiences with the Anglo health care system. This could be verified with a comparative study of larger numbers of families who have settled out of the migrant stream and further study of migrant families, again in larger number.

If it is proven true, these mothers will need more and different help in learning to use the Anglo system.

It would be particularly interesting to do a follow-up study of migrants who have settled out of the migrant stream after they have had some positive experiences with the Anglo system in the clinics recently established for migrant families. Has this exposure had any effect on their health care seeking behavior? Are they more likely to use preventive care seeking behavior? Are they more likely to use preventive care services than the mother who has not had such an experience as a migrant laborer?

Is there a relationship between urban mobility and poor health? Smiley, Eyres and Roberts (1972) report that there is; Hutchins'[1] early findings and this study suggest that there may be. Further study may reveal that those families that have moved should be found and followed actively, rather than closed to service with the notation "Moved. Unable to locate."

Migration and mobility raises another interesting question not dealt with in this study. What adaptive mechanisms do the in-migrants to this community use, particularly those who have come from a life as migratory farm laborers? The changes are numerous and great; the move cannot help but be stressful. Can those who have adapted with a reasonable degree of success describe what their problems were and how they learned to cope with a settled life in an urban area? Could this information, in turn, be used to help the newly arrived in-migrant? If there

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[1]Personal interview.

is a relationship between mobility and illness, this group may benefit from some intensive help on arrival.

Sickness

Research into the amount and kind of sickness in the Mexican children is suggested by the many cases of anemia found, particularly in the good user group. What is the incidence in the entire group of Mexican children seen in the Clinic? Is it more frequent in any particular age group? How does the incidence compare with that found in the children in the other two groups? If the incidence is higher in the Mexican children, why? If it is higher in the good user group, either Mexican or all three, why? Is it a function of frequency and length of contact with the Clinic? Is it the cultural pattern of very late weaning and adding meat to the diet late? Could it be related to stress?

Mindlin (1970) found that Spanish (Puerto Rican) infants had more illnesses and more serious illnesses and had a lower ratio of visits to a physician per episode of illness than the Caucasian or Negro infants. Anemia was not mentioned. If the incidence of anemia is disproportionately high in children in Spanish-speaking families, is their resistance to disease lower? Could this account for the finding of more illnesses in the group Mindlin studied? Do the Mexican children here have more illness than the whites and Blacks? Are they seen less frequently by a physician? If they are, why? Research is needed to answer these questions. The answers may have major implications for nursing practice and planning for delivery of health care services.

The Mexican mothers' definition of sickness in terms of behavioral changes suggests several areas for research. How would poor white and poor Black mothers answer the same question? How would middle class mothers in the three groups answer it? Do behavioral changes precede the onset of physical symptoms in most young children? If they do, why did so few of the middle class mothers report them? (Mattsson and Weisberg, 1970). Is the difference a function of the Mexican folk illness system with its high reliance on interpersonal relationships as cause, and behavior change as symptoms? Is it a function of orientation to seek or not seek medical care early in the course of an illness? Is it a function of the mother-child relationship, regardless of orientation to medical care? What effect does the definition of sickness have on the decision of whether or when to seek medical care? Answers to these questions could result in better understanding of care seeking behavior and improved communication between Mexican mothers and health professionals.

The mothers who did not believe in Mexican diseases responded the same way as those who did. This suggests that the definition in behavioral changes does not lie entirely in making a differential diagnosis of Mexican or non-Mexican disease. Is this part of an orderly process of culture change or culture loss? This question should be studied in conjunction with the questions related to how other groups of mothers define illness.

The one mother who takes her child to a pediatrician was the only one who answered with physical symptoms. Had she learned, very quickly, what the pediatrician expected from her? Certainly her answer

would be functional for the busy pediatrician. How functional was it in terms of early intervention in the course of an illness? What role might early behavioral changes play in the early diagnosis and treatment, or prevention, of illness in children? Behavioral changes might suggest that the child primarily needs attention and affection. In the Mexican folk system, this need is met quickly and consistently. Did the pediatrician sensitize this mother to observe and behave in a manner which is functional for him, but may be dysfunctional for the child? These questions could be explored in the framework of pediatric practice.

Folk Health Care

The curandera apparently plays a major role in the health care of at least some of the Mexicans here. Is she, for some, the only resource they have for health care? Are the barriers to care in the Anglo system insurmountable, as they perceive them? Under different circumstances, would they participate in both systems?

The majority of mothers with whom I had contact said they would not take their child to a curandera. Only one mother told me she knew of a curandera. The pattern described to me by these mothers was treatment of a Mexican disease in the Mexican system, but not by a curandera. If that failed, they went to a doctor. Mrs. Abelardo described a different pattern. Many of the children whom she treats have been seen but not cured by a doctor. The two patterns raise several questions.

Were the mothers with whom I talked protecting the curandera or did they indeed not know of one? What would they have answered had I asked, "What do you do if your child does not get better with treatment

by the doctor?" Since no one knew of a curandera, they probably would have answered within the context of what they had already told me.

Are the patterns of care consistent with those described by Weaver (1970)? He found that the relatively non-acculturated Mexicans went through the entire folk system first and resorted to Anglo care when all else failed, whereas the relatively acculturated had care in the Anglo system early and resorted to the folk system when Anglo care failed. Some of the mothers described the latter pattern to me; some disclaimed belief and participation in the folk system. Would the mothers in the latter group resort to the folk system if Anglo care was unsuccessful and another Mexican diagnosed a folk illness? (One mother reported such an instance.) This behavior would be particularly supportive of the concept that some of the folk illnesses persist because they serve to retain some of the focal values of the Mexican culture (Rubel, 1960, 1966; Macklin, 1963).

What are the outcomes of treatment in the two systems and in the various patterns of care? If the pattern of care seeking behavior and the outcome of treatment could be predicted, planning for intervention would be facilitated. Would an Anglo physician consider a referral to a curandera as a valid and viable intervention?

Mrs. Abelardo does refer some people to the doctor. She has a better understanding of the Anglo system than the Anglos have of hers. Of the things that she does, which are harmful, which are harmless and which are helpful? Could knowledgeable health professionals, Anglo or Mexican, help to reduce the harmful aspects and utilize those that are

helpful? Kiev (1968) points out the value and success of the curandera in treating emotional health problems of Mexicans. Leininger (1969) compares the experiences of an Anglo girl treated by a psychiatrist and a Mexican girl treated by a curandera. The Mexican girl made better progress. Evalina's doctor referred her to Mental Health Clinic. Evalina will not go. She and Larry think she has a folk illness. Given this perception, a referral to a curandera might have been better. The Mexican people have contact with both systems, but keep the systems separate. Would their health care be improved if, in some situations or conditions, the two systems could articulate? The role of curandera in the total health care of the Mexicans needs further study.

"Battered Child Syndrome"

The article by Guarneschelli, Lee and Pitts (1972) raised for me the question of the "battered child syndrome" in Mexican families. The injury described by these authors comes under the general rubric of accidental injury to children at the hands of adults. However, according to an expert[1] in the field of child abuse, it does not follow the pattern of the "battered child syndrome." He is not aware of any studies of this problem in the Mexican population.

In the limited search of the literature which I did, I found one footnote which referred to this group.

> It would be hard to find a group more deprived and in more socioeconomic difficulty than the Spanish-American migrant agricultural workers. We spent some time

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[1]Helfer, personal interview.

> running down rumors of child abuse in this group and were unable to document a single instance. Possibly some cases do occur, but we were unable to find them [Steele and Pollock, 1968, p. 108].

My knowledge of and experience with Mexican families leads me to believe that the incidence of 'battered child syndrome' would be lower in the Mexican population than in the white population. Cases that do occur would probably be found in those families that were actively upwardly mobile and denying much of their Mexican heritage and/or those Mexican families in which the mother did not have a female relative (either hers or her husband's) on whom she could call for help in times of stress.

I do not know if much research has been done in this field. Very recently, the Child Abuse Coordinating Council in San Diego studied a random sample of 103 reported cases of child abuse in San Diego County.[1] In this study, Mexican Americans contributed a disproportionately small number of cases of battered children. Incidence and dynamics of child abuse in the Mexican American population would be an interesting question to pursue, both in the southwest and the midwest.

Child Health Clinic

A review of the Child Health Clinic appointment book and the active and inactive Clinic records revealed some interesting differences in attendance patterns at the North (Cristo Rey) and South (Health Department) Clinics. These differences seem to be directly related to

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[1]Chadwick, personal communication.

the specific Clinic and its attendant population and indirectly related to good or poor use of the services.

The differences between the two clinics in attendance patterns and records closed for lack of attendance raise some interesting possibilities for further research. Do the differences obtain over time? Would a review of appointments for 1973 reveal the same patterns? What accounts for the differences?

There are a number of variables which could be operating in some as yet undetermined combination. Some families do not like to go to Cristo Rey for anything; they may not keep North Clinic appointments unless the child is sick. Some families like to go to Cristo Rey because there is always someone bilingual there; they may not keep appointments at the South Clinic. What would happen if the mother were allowed to decide which Clinic she would attend? (Clinic assignments are presently made according to where the family lives.)

The large number of broken first appointments raises the question of pressure by the nurse (or someone else) to attend. The mother may agree, without any desire or intent to keep the appointment. She may want to attend, but not tell the nurse that she does not have transportation. How much follow-up is done with these mothers? Who decides whether or how much follow-up? On what basis?

Families who kept more than four appointments all attended the North Clinic. Perhaps these families have more babies with more illnesses; these children may need more frequent appointments and more follow-up. Are these families coping with many stressful experiences?

In general, the families who live in south Lansing and attend South Clinic live in better housing and a better neighborhood than those in north Lansing. They may have older children, less sickness and more private care. They may also be experiencing less stress.

At this point, no one knows what factors account for the differences in attendance patterns. Exploration of the above questions could provide information which could lead to better care for the families and less frustration for the professionals.

Additional Data

The interview schedule and method used in this study yielded a great deal of information both apart from and in conjunction with the utilization of the services provided by the Child Health Clinic. The schedule, as it is or with some minor revisions, could be used to gather the same information for a larger group of Mexican families who attend or do not attend Child Health Clinic. This could serve several purposes.

A larger data base would confirm or deny the trends or tendencies noted in the thirty families of this study. If these findings are confirmed with families who have established an attendance pattern, predictability of pattern will be enhanced. Use of the interview schedule with families who are just beginning contact with Child Health Clinic could help the nurse determine a course of action designed to reduce broken appointments.

The interview could be used with Mexican families in other cities in Michigan. Can we generalize from city to city? Are patterns

of preventive care similar in areas with similar services? Would the information be of value in planning for and developing health care delivery?

The interview could easily be adapted for use with older children or adults. At the present time, very little is known about health, illness and health care of the adult Mexican population. Their articulation with the Anglo system and the Mexican system should be studied. Such a study could begin with the parents of children seen in Child Health Clinic or with those who attend the Adult Clinic at Cristo Rey.

In any study of the persistence of the folk health system and articulation with the Anglo system, care should be taken to avoid drawing inferences on the basis of inadequate or inconclusive evidence. For example, Welch, Comer and Steinman (1973) infer belief or non-belief in the folk system from indications of closeness to Mexican society and culture (see Chapter II, p. 51). In view of my experiences and findings, their inference might well be an erroneous one. No mother in my study, either in Lansing or in the migrant families, volunteered any information about belief or practice in the folk system. I would not have known it existed if I had not asked specifically. The Mexicans who participate in two systems answer questions in accord with their perception of the orientation of the interviewer. They answer Anglo questions about health care in the context of the Anglo system. On this basis, I do not consider it safe to infer belief or non-belief from anything except a direct question about participation in the folk system.

Comparative Studies

At several points in this paper, I have made comparisons between Texas and Michigan. The Mexicans who move here from Texas are self-selected; they are, in general, better educated than those in Texas. One could argue that, to a degree, those who move here are all upwardly mobile. Many of the mothers and fathers commented that Michigan was better than Texas for the Mexicans; there is less discrimination; medical care is more available and better. Use of the questionnaire with Mexicans in urban areas in Texas might provide some interesting comparative data. Use with Mexicans newly arrived in Lansing could also provide interesting comparative data, particularly in a longitudinal study of the same families as they adapt or do not adapt to living here.

I have alluded several times to the possibility of cross-ethnic studies. The Child Health Clinic serves poor whites, Blacks and Mexicans. After five and a half years of operation, the Clinic records contain a wealth of information about all three groups in substantial numbers. Tabulating and comparing this data could yield valuable information about similarities and differences in the three groups.

With minor modifications, the interview used in this study could be used with families of all three ethnic groups and the three groups according to use of Child Health Clinic services. Do the good, poor and non-users in the three ethnic groups resemble each other? What are the similarities and differences by use? By ethnicity?

Perhaps the answers to some of these questions will provide some help in determining what behavior is a function of poverty and what is a function of ethnicity.

"Start where the patient is" is still a good precept for nursing practice. Behavioral science research will help us to understand where he is. Increased understanding of where he is and how he got there should enable us to determine and understand where he wants to go and why, whether or not it is the direction and means we would have him take. We can then help him to reach his goal or to find alternative goals and means which are acceptable to him.

APPENDICES

APPENDIX A

DATA FROM MICHIGAN HEALTH SURVEY

APPENDIX A

DATA FROM MICHIGAN HEALTH SURVEY

The following data are from the Michigan Health Survey (MHS), unless otherwise noted. Data pertaining to the thirty-four families of Mexican descent (Mexican American) were retrieved by hand tabulation; they are not available in any published document. Data relating to the City of Lansing as a whole and to Area C, the area with the highest concentration of Mexican Americans, are from the Michigan Health Survey Report, Lansing-East Lansing, September 1970-December 1971 (Michigan Department of Public Health, n.d.). Ruiz, who prepared the report, feels that the data for Area C and the City of Lansing as a whole are fairly accurate. A comparison of the age-sex distribution for Lansing from the 1970 Census and the Michigan Health Survey sample shows a "high level of agreement . . ." (Michigan Department of Public Health, n.d., p. 2).

The Mexican American population is growing; four of the women were pregnant. Nineteen of the families had at least one child under five. It is young, with 16 percent under five and 45 percent between five and nineteen (see Table A-1). It is younger than the population of Area C and Lansing (see Table A-2).

The majority of the families lived in a nuclear family household. Five of the families (15%) had a female head, one widowed, two divorced

and two separated. Comparable data for Area C and Lansing are 28.6 and 29.2 percent, respectively (p. 20). Three of the Mexican American families had someone other than a member of the nuclear family living in the household.

Table A-1. Age distribution of individuals of Mexican descent (N = 178)

Age	Number	Percent of Total
Under 5	28	16
5 through 19	81	45
20 through 44	51	29
45 through 64	17	9.5
65 and older	1	0.5
Total	178	100

Table A-2. Percent of white population by age and area, Lansing-East Lansing

	Areas	
Age	C	Lansing
Under 5	11.6	10.5
5 through 19	31.5	28.5
20 through 44	28.7	31.6
45 through 64	15.6	15.8
65 and older	10.5	7.1

Source: MHS, September 1970-December 1971, p. 14.

The educational level of the head of the household tends to be low. Twelve had less than eight years of schooling, six finished high school and five had some education beyond high school (see Table A-3). Educational level in Area C, although generally higher than that of the Mexican Americans, is lower than the level for Lansing (see Table A-4).

Table A-3. Education of head of household in families of Mexican descent

Education	Number	Percent of Total
Less than eight years	12	35
Eight through eleven years	9	26
Twelve years	6	18
More than twelve years	5	15
Unknown	2	6
Total	34	100

Table A-4. Population 19 years of age and older. Education by area, Lansing-East Lansing

	Areas	
Education	C	Lansing
0-7	9.8	4.2
8-12	39.7	27.2
High school graduate	34.1	40.4
College	15.4	19.5
College degree	0.6	4.0
Graduate work	0.3	4.7

Source: MHS, September 1970-December 1971.

Age and education are related, with the younger men (or women) generally having more education than the older ones. Only one of those under thirty had less than eight years of education; four of those under thirty had more than twelve years (see Table A-5).

Table A-5. Relationship between age and education of head of household of families of Mexican descent (N = 34)

Education	Under Thirty	Thirty-Forty-Four	Forty-Five or More	Total
Less than eight years	1	4	7	12
Eight through eleven years	2	6	1	9
Twelve years	4	1	1	6
More than twelve years	4	1	0	5
Unknown	1	1	0	2
Total	11	13	9	34

Yearly income varied greatly, from three families with an income under $2,000 to three families with an income of $15,000 or more. In six families, the interviewer was unable to obtain the income. The respondent was the wife of the head of the household (or head, if female) (see Tables A-6 and A-7). Area C has the highest percentage of families with a yearly income under $5,000 (34.8%) and the lowest with a yearly income of $12,000 or more (14.8%) of all areas in the city. Comparable percentage for Lansing are 20.6 and 22.3, respectively (p. 26).

Table A-6. Yearly income of families of Mexican descent (N = 34)

Income	Number	Percent of Total
Under $5,000	8	24
$5,000-$7,999	7	20
$8,000-$11,999	8	24
$12,000 or more	5	15
Unknown	6	6
Total	34	101*

*Total of other than 100 percent due to rounding.

Table A-7. Detailed yearly income of families of Mexican descent

Income	Number of Families
Under $2,000	2
$2,000-$3,999	4
$4,000-$4,999	2
$5,000-$5,999	2
$6,000-$6,999	3
$7,000-$7,999	2
$8,000-$8,999	5
$9,000-$9,999	1
$10,000-$11,999	2
$12,000-$14,999	2
$15,000 and over	3
Unknown	6
Total	34

As can be seen in Table A-8, there does not seem to be much relationship between income and education of the head of the household. In the families with an income of $12,000 or more, no head of household finished high school. Five of those in the lowest income group likewise did not finish high school. It is interesting to note that three of the household heads are students.

Table A-8. Relationship between income and education of head of household of families of Mexican descent (N = 34)

Education of Head of Household	Income					
	Under $5,000	$5,000-$7,999	$8,000-$11,999	$12,000- or More	Not Known	Total
Less than eight years	2	4	1	3	1	11
Nine through eleven years	3	0	3	2	2	10
Twelve years	0	2	3	0	1	6
More than twelve years	3*	0	1	0	1	5
Unknown	0	1	0	0	1	2
Total	8	7	8	5	6	34

*These three household heads are all students.

Income has more meaning when considered in relation to the number of people the income must support. As can be seen in Table A-9, income does not increase in proportion to family size. The largest households (more than eight people) are in the two lowest income brackets; two of the smallest households (two people) are in the highest.

Table A-9. Relationship between income and size of household of families of Mexican descent (N = 34)

Size of Household	Income					Total
	Under $5,000	$5,000-$7,999	$8,000-$11,999	$12,000 or More	Not Known	
Two	2	0	1	1	1	5
Three-four	4	1	4	0	1	10
Five-six	0	2	1	2	0	8
Seven-eight	1	2	2	2	0	7
More than eight	1	2	0	0	1	4
Total	8	7	8	5	6	34

In twelve of the households, no one was working. (The time span covered by the questionnaires included the strike at General Motors in 1970.) In eight of the families, two people were working; in one, three were working. The relationship between income and number of people working can be seen in Table A-10. In the families with a male head of household, three women worked full time, three women worked part-time and one was off because of the strike.

Only eighteen of the household heads were employed full time, four were laid off and three were not working because of a labor dispute (see Table A-11).

Table A-10. Relationship between income and number of people working in families of Mexican descent (N = 34)

People Working	Income					Total
	Under $5,000	$5,000-$7,999	$8,000-$11,999	$12,000 or More	Not Known	
None	6	4	1	0	1	12
One	1	3	3	2	4	11
Two	1	0	4	2	1	8
Three	0	0	0	1	0	1
Total	8	7	8	5	6	34

Table A-11. Employment status of heads of household of families of Mexican descent (N = 34)

Employment Status	Number	Percent of Total
Full time	18	52
Part time	1	3
Housewife	4	12
Laid off	4	12
Labor dispute	3	9
Disability	1	3
Student	2	6
Other	1	3
Total	34	100

The number of rooms in the dwelling unit did increase somewhat in proportion to family size, as shown in Table A-12. However, if one accepts crowding as more than one person per room, ten of these families (30%), lived in crowded conditions. In Lansing as a whole, 7 percent of all families live in a dwelling unit with more than one person per room (U.S. Department of Commerce, 1972).

Table A-12. Relationship between number of rooms and size of household of families of Mexican descent (N = 34)

	Number of Rooms								
Size of Household	1	2	3	4	5	6	7	8	Total
Two	0	1	2	1	1	0	0	0	5
Three-four	0	0	0	3	4	3	9	9	10
Five-six	0	0	0	0	2	3	2	1	7
Seven-eight	0	0	0	0	2	3	1	1	7
More than eight	0	0	0	0	1	2	1	0	4
Total	0	1	2	4	9	11	4	2	34

Eighteen of the families (53%) owned their home; sixteen (47%) were renting (see Table A-13). Home ownership is higher than this in both Area C (61.7%) and Lansing (73.2%) (p. 27).

Table A-13. Ownership of dwelling units occupied by families of Mexican descent (N = 34)

Dwelling Unit	Number	Percent of Total
Owned	18	53
Rented	16	47
Total	34	100

Geographic mobility is depicted in Table A-14. Five of the Mexican American families (15%) had lived at their present address for less than one year. In Area C and Lansing, 22 percent and 17.7 percent, respectively, had lived at their present address for less than one year (p. 22). Eighteen of the Mexican American families had been at their present address for two years or more. These families tended to own their homes; those who had moved within the last two years tended to rent (see Table A-15). Twenty-four of the dwelling units were well maintained on the interior (see Table A-16). Maintenance of the exterior was not readily available.

Since the number of families was small, I only tabulated health and illness information that seemed to be particularly pertinent to this study. All of the children under nine had been immunized. However, there was no way of determining at what age they were immunized. In some instances, there was no way of determining if the immunizations were complete, since some mothers only knew that the child had had the "baby shots." In Area C, no immunization level reached 100 percent. For children from five through nine, polio immunization was the highest (98.1%) and rubella was the lowest (43.1%) (p. 30).

Table A-14. Length of time at present address by families of Mexican descent (N = 34)

Length of Time	Number	Percent of Total
Less than one year	5	15
One year-less than two years	11	33
Two years-less than four years	11	33
More than four years	7	20
Total	34	100

Table A-15. Relationship between home ownership and length of residence at present address by families of Mexican descent (N = 34)

Length of Time	Owned	Rented	Total
Less than one year	1	4	5
One year-less than two years	4	9	13
Two years-less than four years	8	1	9
More than four years	5	2	7
Total	18	19	34

Table A-16. Maintenance of interior of dwelling unit occupied by families of Mexican descent* (N = 34)

Maintenance	Number	Percent of Total
Good	24	71
Fair	7	20
Poor	2	6
Unknown	1	3
Total	34	100

*Refers to structural maintenance, not housekeeping.

There were twenty-eight children under five years of age. Six of them (21%) had been seen for well child care in the past year. These children tended to be in the families with younger, better educated parents. Of the children under six, 21 percent had had an examination within the past year. In Area C and Lansing, respectively, 42.1 and 59.0 percent of the children under six had had a medical examination in the past year (p. 31). Twenty of the Mexican American children (71%) had not had any well child care in the past year. Two of the mothers thought that their child might have had a physical examination at Head Start.

Since Mexican Americans have large families and are frequently presumed to be opposed to any form of birth control, I was interested in the use of contraceptive measures by the women in this group. As can be seen in Table A-17, nine of the women used some means of contraception, sixteen did not. Use of contraceptive measures is not tabulated in the Michigan Health Survey, Lansing-East-Lansing, September 1970-December 1971.

Table A-17. Use of contraceptive measures by women, age 14-60, in families of Mexican descent (N = 34)

Use of Contraception	Number	Percent of Total
Yes	9	26
No	16	47
Not applicable	3	9
Not known	6	18
Total	34	100

APPENDIX B

MENTALLY ILL ADULTS--FOLK BELIEF AND ANGLO CARE

APPENDIX B

MENTALLY ILL ADULTS--FOLK BELIEF AND ANGLO CARE

The relationship between adherence to the folk health-illness system and seeking and using care in the Anglo system has been explored in relation to mental illness. Fabrega, Swartz and Wallace (1968) report a study of hospitalized schizophrenic patients from three ethnic groups--Mexican American, Anglo and Negro. The groups were matched "on the variables of sex, age, I.Q. estimate, number of previous psychiatric hospitalizations, and, when possible, education" (p. 225). However, matching on educational level was not successful; the Mexican Americans had a much lower educational rating. They do not explain how the I.Q. estimate was obtained nor do they consider that it might be non-valid. However, given the cultural bias (white middle class) of the standard I.Q. tests, they may have had as poor a match as they had on education, but in the opposite direction. Their findings "seem to suggest that the Mexican American schizophrenics are clinically more disorganized and regressed" (p. 230) than the Anglo and Black patients. They do suggest that the Mexican Americans might have felt culturally alienated in the Anglo institution and have a poor command of English, thus presenting an appearance of more severe illness. However, they conclude that the clinical evaluations were not greatly biased by culture-language considerations. They state that the findings "can be interpreted to

support the hypothesis that the Mexican Americans as compared to their Negro and Anglo counterparts, may be hospitalized at a point in their illness when more symptoms of this type are manifest" (p. 231). This, in turn, suggests that the Mexican American families may be more tolerant of "deviant psychotic behavior" than the Anglo or Negro families. They may cope with the behavior at home for a longer period of time, with help and support from family and community, including folk healers. They state that they do not know if the present findings "are the result of the process of hospitalization or reflect patient adjustment at a time preceding hospitalization" (p. 232).

In a later study, Fabrega and Wallace (n.d.) sought an answer to the above question. They studied all patients who came for outpatient care at an adult mental health clinic during a six-month period. The patients were divided into three groups--Anglo, acculturated and unacculturated Mexican Americans. Their hypothesis was that the unacculturated Mexican Americans would have more severe symptoms, greater reliance on folk beliefs and stronger family ties than the acculturated group. Degree of acculturation was measured by amount of education in the Anglo system, citizenship, fluency in English and living situation--with nuclear family or extended family. The hypothesis was supported. In addition, the unacculturateds made fewer visits during the course of treatment and were treated more often by drugs than the other two groups. The authors suggest that these findings are conceptually linked. They suggest further studies related to clinical status, attitudes toward psychiatric treatment and attitudes of psychiatrists.

Kline (1969) also considered some aspects of the psychiatric treatment of Spanish-Americans. He suggests that this group makes little use of psychiatric services and has problems in treatment because they perceive Anglos to be cold, exploitative and insincere; they identify psychiatrists as Anglo and therefore not a source of help and support. He concludes that the feelings of both the Anglo psychiatrist and the Spanish-American patient may present obstacles to care. He suggests that mental health services be developed with the participation of community leaders and that the treatment team include a curandera. He suggests that some of the Spanish-Americans' traditional ideas about cause and treatment of mental illness are probably not very different from some of the Anglo ideas.

Karno and Edgerton (1969) approached the low utilization of mental health facilities by Mexican-Americans from a different view point. They sought an answer to the question "how do Anglo-Americans and Mexican-Americans of similar socioeconomic status, living in the same community at the same time, perceive, define, and respond to mental illness" (p. 234). They found few significant differences between the two groups in perception and definition of mental illness. They believe that the low utilization of psychiatric treatment by Mexican-Americans "is to be accounted for by a complex of social and cultural factors" (p. 237). Factors with relatively high influence include the language barrier, an active role by the family physician, lack of facilities in the community and the self-esteem reducing experience of Mexican-Americans in the Anglo agency. They give relatively little weight to the folk system, folk curers and "Mexican culture" in general (p. 237).

APPENDIX C

QUESTIONNAIRE

APPENDIX C

QUESTIONNAIRE

Family Number _____

Family (Household) Members:

Name	Sex	Birth Date	Relationship	Education	Grade and/or Place
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12					

Source of Income: _____

Language spoken in the home:

Parent to parent _____

Parent to children _____

Children to children _____

Command of English

	Good	Fair	Poor	None
Father				
Mother				
Children				

019 Length of time in Lansing _____

020 Length of time in this dwelling _____

021 Number of moves since coming to Lansing _____

022 Residence prior to coming to Lansing _____

023 Occupation prior to coming to Lansing _____

024 Reason for moving to Lansing _____

_____

025 Other family members in Lansing area _____No _____Yes

If yes, identify by relationship and location:

026 Exterior condition of housing unit

_____Well maintained _____Deteriorating _____Dilapidated

027 Condition of premises:

_____ garbage

_____miscellaneous junk

_____ abandoned auto

_____ unstacked lumber

028 Housing is _____owned or being bought _____rented

_____other (specify) _____

029 Interior condition of dwelling unit:

_____good _____fair _____poor

030 Number of rooms _____

031 Number of rooms used for sleeping _____

032 Do you consider good health for your children to be

_____ very important

_____ somewhat important

_____ not very important

033 What do you do to keep the children well?

034 What do you do to prevent the children from getting sick?

035 How do you know when a child is sick?

036 What do you do when a child first gets sick--home remedies?

037 What sicknesses do the children get?

038 For what sicknesses do you seek help? (Why?)

039 To whom do you go first? (Why?)

040 To whom do you go next? (Why?)

041 Who makes the decision to seek help?

042 Does what you do here differ from what you did (or is done) in in Texas (or elsewhere)? _____No _____Yes If yes, in what way?

043 What sicknesses do you think the children might get?

044 For what sicknesses would you take you child to an Anglo doctor? Why?

045 Are there sicknesses for which you would not take your child to an Anglo doctor? _____No _____Yes Why? If yes, what ones?

046 Do you have a family doctor? _____No _____Yes If yes,
_____Anglo _____Chicano _____Spanish speaking

047 Where would you take your child if he were seriously sick or injured? Why?

048 Have there been times when you thought one of the children should go to a doctor, but you couldn't take him? _____No _____Yes
If yes, what sickness did he have? Why couldn't you take him?

049 Where could you go, or whom could you ask for help, for health problems?

050 Do you have any difficulty when you want or try to see an Anglo doctor? _____No _____Yes If yes, what are they? If no, why?

051 Do Anglo doctors and nurses behave differently toward you than they behave toward Anglos? _____No _____Yes If yes, in what way?

052 Would you say that your children's health is generally
_____good _____fair _____poor?

053 Some mothers take their babies and small children to a doctor when they are not sick. Have you ever done this? _____No _____Yes Why?

054 Is there some place here where you could take your children for this kind of care? _____No _____Yes If yes, where?

055 Some women, when they are pregnant, go to a doctor early, some go late in pregnancy, some do not go at all. What have you done? Why?

057 Would you say your health is generally _____good _____fair ____poor?

057 How available is transportation when you want to go to the doctor?

058 How available is a baby sitter when you want to go to the doctor?

059 What do you eat? (Three meal recall)

060 Is your diet different just before pay day from just after pay day?
_____No _____Yes Why?

061 Do you have trouble getting the foods you want? _____No _____Yes
Why?

062 Where do you shop? Why?

063 Have you given any of the children vitamins? _____No _____Yes Why?

064 How do you wash the diapers? Why?

065 How do you prepare formula? Why?

066 Immunization status of children:

Name	Age When Started	Completed

067 What do you think you could do to help your children have better health?

068 What do you think might be done so you could have better health care?

069 Have any of your children ever had one of the Mexican diseases?
If yes, which ones?

070 Do you know of any curanderas in Lansing? _____No _____Yes
If no, have there been any that you know of? _____No _____Yes
If yes, have you or the children gone to her?

071 Would you take your child to a white doctor if you thought he had a Mexican disease? Why?

072 Do you know of places where you can buy Mexican home remedies?
_____No _____Yes If no, would you buy them if you could, here?
If yes, have you bought any?

Child Health Clinic

073 Who suggested that you go to Child Health Clinic? Why?

074 Which clinic do you go to _____Cristo Rey _____Health Dept. Why?

075 Would you rather go to the other one? _____No _____Yes Why?

076 Do you have friends or relatives who go to the Clinic--either the same one or the other one?
_____No _____Yes _____Same _____Other

077 Is there any difference in the two? _____No _____Yes If yes, what?

078 How do the people who work at the clinic behave towards you? Why?

079 What things do you like about the clinic?

080 What things do you not like about the clinic?

081 Are you doing anything to prevent pregnancy? _____No _____Yes
If yes, what? If no, why?

082 Approximate yearly income _____

083 Would you talk to an Anglo doctor or nurse about Mexican sickness and Mexican cures? _____No _____Yes Why?

APPENDIX D

CHILD HEALTH CLINIC RECORDS OF FAMILIES

WITH SPANISH SURNAME

APPENDIX D

CHILD HEALTH CLINIC RECORDS OF FAMILIES

WITH SPANISH SURNAME

Family number _____

Head of Household

_____ male

_____ female

Age of mother _____

Source of income

_____ employment

_____ assistance

Number of children _____

Children born alive, now dead

_____ no

_____ yes (specify number)

_____ unknown

MOTHER

Antepartal care

_____ first trimester

_____ second trimester

_____ third trimester

_____ none

_____ unknown

Problems during pregnancy

_____ no

_____ yes (specify) _____

CHILD

Birth weight

_____ under 5 pounds, 8 ounces

_____ 5 pounds 8 ounces to 7 pounds 15 ounces

_____ 8 pounds or over

_____ unknown

Place of birth

_____ hospital

_____ home

_____ unknown

History of illness

_____ no

_____ yes (specify) _____

Immunizations

_____ age when started

_____ unknown when started

Complete for age

_____ yes

_____ no (specify) _____

FIRST VISIT

Age _____

Health problem stated by mother

_____ no

_____ yes (specify) _____

SUBSEQUENT VISITS

Number _____

Appointments not kept (number) _____

Interim health problems

_____ no

_____ yes (specify) _____

New health problem stated by mother

_____ no

_____ yes (specify) _____

New health problem found by physician/nurse

_____ no

_____ yes (specify) _____

HEALTH PROBLEMS

Suspected nutritional anemia

_____ no improvement

_____ improvement

_____ outcome unknown (specify reason) _____

Referred elsewhere for care

where _____

_____ did go

_____ did not go (specify reason, if known) _____

Seen by public health nurse at home

_____ no

_____ yes

APPENDIX E

MIGRANT MOTHERS' RESPONSES TO QUESTIONNAIRE

APPENDIX E

MIGRANT MOTHERS' RESPONSES TO QUESTIONNAIRE

Summary

What do you do to keep the children well?

- check-ups 4
- give vitamins 3
- watch them 2
- nothing 2
- take to the doctor when sick 2
- yearly shots 1

What do you do to prevent the children from getting sick?

- give vitamins 4
- watch and take care of them 3
- check-ups 2
- nothing 2

How do you know when a child is sick?

- sad 4
- won't eat 4
- cries a lot, restless 4
- quiet, inactive 4
- behavior or mood different 2
- sleeps more 1
- doesn't sleep much 1
- fever 1

What sicknesses do the children get?

- cough 8
- fever 6
- colds 5
- flu 3
- sore throat 2
- earache, measles, allergies 1 each

Do they get different sicknesses here and in Texas? If yes, what?

no difference 2
sick more often in Texas 4
not sick in Michigan 2
sick more often in Michigan 1
more colds, runny nose, allergies here 2

What sicknesses do you think the children might get--here--in Texas?

no difference 5

Michigan	Texas
more healthy, fatter 2	more sickness 1
more colds, allergies 2	anything 1
God decides 1	stomach problems 1

What do you do when a child first gets sick--(home remedies)?

egg treatment (for mal ojo) 6
aspirin 7
herb tea 3
alcohol rub 2
lemon juice 2
hot tea or lemonade 2
sweep with broom 1
no old ways 1

For what sicknesses or symptoms do you seek help?

hard fever 6
nothing else works 2
really sick, sickness that lasts 2
vomiting, dizzy, broken bones 1 each

Who makes the decision to seek help?

mother 5
both 5

To whom do you go first?

doctor 7
clinic 4

To whom do you go next?

maybe hospital 7
clinic 2
doctor 2

For what sicknesses would you seek care from an Anglo doctor?

any of them 10

For what sicknesses would you not seek care from an Anglo doctor?

none 10

How does what you do here differ from what you do in Texas?

more food here 4
more help and services here 3
more clinic visits here 3
more clinics in Texas 1
no difference 2

Do you have a family doctor? 3 No 7 Yes

If yes, 4 Anglo 5 Chicano

(two families mentioned both Anglo and Chicano)

Where would you take your child if he were seriously sick or injured?

doctor 10

Do you have any problems when you want or try to see an Anglo doctor?

no 8
no response 1
yes 1 in Idaho, but not in Michigan

Do Anglo doctors and nurses treat you differently from the way they treat Anglos? 7 No 2 Yes

If yes, in what way?

don't know; don't mix with Anglos 1
rude and inconsiderate
look down on Mexicans

Would you say your children's health is generally

8 good 2 fair ____ poor

Some mothers take their babies and small children to a doctor when they are not sick. Have you ever done this?

7 No 3 Yes

Why:	No	Yes
	no money 3	wants to be sure baby is OK
	not necessary 2	important to have check-ups
	only when sick 1	likes to know weight
	no response 1	

Is there some place you could take your child for this kind of care?

_____No __10__Yes here in Lansing or Michigan

_____No __10__Yes in Texas

Some women, when they are pregnant, go to a doctor early, some go late in pregnancy, some do not go at all. What have you done? Why?

Have gone, but not regularly 2
Try to go as regularly as possible 2
All nine months--better for the baby 2
3 or 4 months, then monthly--it is important 1
6 months--to relieve doubts 2
Twice with second baby, never with first and third--thinks it is important to go 1

Would you say your health is generally __8__good __2__fair _____poor?

How available is transportation when you want to go to the doctor?

have a car or truck 8
hardly available 2

How available is a baby sitter when you want to go to the doctor?

hard to get--no money 5
no problem--grandmother sits 2
no problem--older children 2
always take the children 1

Do you have trouble getting the foods you want?

local store has Mexican food 2
no 3
sometimes 1
yes--expensive 4

Have you given any of the children vitamins? __5__No __3__Yes

when prescribed 1

How do you wash the diapers while migrating? How often?

use disposable diapers 8

What arrangements are there for providing health care for you here?

Clinics 8
doctors 2
migrant school 5

Is this satisfactory for you?

no 3
yes 5
too crowded and wait too long 1
only once a week 2
better than Texas--more help--provide transportation

Is there a curandera in the group?

no 10
last year there was one 1

What do you think you could do to help your children have better health?

check-ups 6
vitamins 3
good food 2
good education 1

What do you think might be done so you could have better health care while migrating--in Texas?

more clinic dates 2
more money 2
more money for emergency health needs 1
clinics in migrant rest areas 2
inexpensive places to buy food 1
better heated car 1

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