

Mexican Culture
and Disability:
*Information for U.S.
Service Providers*

Sandra Santana and
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John Stone, Series Editor



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Center for
International
Rehabilitation
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Exchange

An Introduction to Mexican Culture:
For Rehabilitation Service Providers

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AN INTRODUCTION TO MEXICAN CULTURE: FOR REHABILITATION SERVICE PROVIDERS

Preface

Mexico is by far the leading country of origin of immigrants to the U.S. In 1997, there were more than seven million persons in the U.S. who were born in Mexico, which represented 28 percent of the foreign born population. The population from Mexico was about six times as large as the foreign-born population from the next highest country. The foreign-born population from Mexico increased from 0.8 million in 1970 to 2.2 million in 1980 to 4.3 million in 1990 to 7.0 million in 1997. (Schmidley and Campbell, 1999). In light of the large number of persons born in Mexico who live in the U.S., it is surprising that Mexican culture is not well understood by many Americans.

Persons from Mexico differ from other foreign-born groups in the U.S. Only 15 percent of U.S. residents born in Mexico are U.S. citizens. This contrasts sharply with the U.S. citizenship rates for persons born in Europe (53 percent) and Asia (44 percent) and even with persons from other parts of Latin America. Mexican-born persons in the U.S. tend to differ from other Latino groups in many ways. The proportion of persons with a high school education or higher was 47 percent among all Latin American-born persons, but was only 31 percent for persons born in Mexico. Only six percent of the Mexicans were employed in managerial and professional specialty occupations, as compared to 23 percent for those from South America. Among workers born in Mexico, the median earnings were below the median for workers born in the Caribbean or South America. The poverty rate for those born in Mexico was 34 percent, while for those born in South America it was 15 percent. Only 46 percent of the U.S. population that is Mexican-born had health insurance, as compared to 43 percent from South America. The size of the households was also larger for the Mexican-born (4.38 per household) in comparison with people born in South America (3.17). (Schmidley and Campbell, 1999).

This profile indicates that many persons in the U.S. who were born in Mexico are poor, not highly educated and lack access to many important services, even in contrast to other groups from Latin America. Persons in such circumstances may experience difficulty accessing and using health, rehabilitation, and human services. It is particularly important that these professionals gain at least some familiarity with Mexican culture.

The authors of this monograph are particularly well qualified to interpret Mexican culture for rehabilitation service providers in the U.S. Felipe Santana, Ph.D., is a clinical psychologist with 37 years of experience, including extensive

experience with clients of Mexican origin. He has worked for 24 years as a Senior Psychologist in Mental Health and Senior Program Administrator for the Department of Drugs and Alcohol, County of Ventura, California. He has been Director of Golden State Community Mental Health in San Fernando Valley. He has written on issues related to health care for Latinos, including a chapter "Dolor de Cabeza: Depression or Martyrdom" in the book, *Healing Latinos*.

Sandra Santana, Psy.D, did her dissertation on a community-based program aimed at Latino teenage mothers which had the goal of preventing childhood abuse and neglect. She has worked at the Kessler Institute for Rehabilitation in Chester, New Jersey and the Kaiser Permanente Medical Center in Los Angeles. She is currently working as a clinical psychologist in California.

The authors join me in acknowledging and thanking three anonymous reviewers who made many useful suggestions for strengthening the monograph.

This monograph is part of a series developed by CIRRIE - the Center for International Rehabilitation Research Information and Exchange at the University at Buffalo. The mission of CIRRIE is to assist rehabilitation researchers and practitioners in the U.S. to access international expertise. CIRRIE is supported by a grant from the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education. In addition to the monograph series, CIRRIE conducts workshops on providing rehabilitation services to foreign-born persons. We hope that this monograph will be useful to you in your work with persons born in Mexico. We welcome your comments that will enable us to deepen our understanding of ways to increase the effectiveness of rehabilitation services for persons born in other countries.

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Series Editor*

AN INTRODUCTION TO MEXICAN CULTURE FOR REHABILITATION SERVICE PROVIDERS

Introduction

My left arm felt like a dead branch hanging from a tree and I thought I would never be able to move it again. My shoulder was frozen from my diabetes; I had too many calcifications. When I tried to move it, excruciating pain resulted. My right arm was beginning to feel the same way. I recall feeling fearful, thinking I was going to be without movement in my arms. My doctor gave me painkillers and muscle relaxants to help with the pain. I went for a second opinion. I was getting scared. The new doctor did an MRI, which confirmed the calcifications. He referred me to a physical therapist close to my home with a good reputation for working with this medical problem. I still was not satisfied, especially being in the field of health care myself. I called an old friend of mine, an orthopedist, who confirmed the reputation of the physical therapist and of the rehabilitation center to which I was being sent. I made the appointment.

My wife had to take off work in order to drive me to the center because I was unable to drive at that point. By this time, my right arm was nearly as bad as my left. The little motion I did have in my right arm allowed me only to reach the bottom of the steering wheel. We arrived and waited in a typically cold room. I had been told the procedure was going to be painful and was scared. My wife held my hand to try to comfort me. The doctor looked over my medical records and said, "You have calcification and we need to take care of it right away. Let's see how *macho* you really are." He made a special reference to my Latino name and my heavy accent. "Let's see if you are *macho* enough to handle the pain that I am going to inflict upon you. We have to be very aggressive in breaking the adhesions as soon as possible."

"No pain, no gain" was his motto. He suggested he start with the left shoulder because it was the worst of the two. He said if he didn't do this, the shoulder would become immobilized and movement might be lost completely. He said all this with a smile on his face and laughed about it as if it were a funny statement. He took me to the treatment room and said, "I am going to take care of you."

First he suggested a heating pad and a massage to relax the muscles. Once those were completed he said, "Ok, are you ready?" Then he took me to another room where he grabbed my arm and said, "Let's hear how you scream in Spanish." And he literally jammed my arm into my shoulder. I screamed. He said, "Oh, I thought that you were able to handle pain! I thought you *macho* people didn't scream." I told him that I would continue to scream as loud and as much as I needed, as long as he continued to provoke that much pain. He continuously

made reference to my *macho* life and ancestors. With each pull, I screamed. With each scream, he laughed because a *macho* was screaming. I thought I would pass out.

It is worth noting here that I am someone who has trained myself to handle and block pain. I don't even take aspirin for headaches, no matter how extreme they are. In this case, I was unable to block anything.

He said, "Now that you have been through all the pain, let's go and relax you again and then you can go home." I asked him if my wife could be with me while they were working and relaxing my shoulder. He said, "No, she will wait for you." I needed someone with me at this point, but he made reference to regulations that no one could be in the treatment room with a patient. I waited, typical waiting. I really needed my wife. I didn't have my mother; I had my wife. If my mother had been there along with my wife, I would have asked for both of them. It was Monday, and we made appointments for three times a week. After I left, the pain was intolerable. Everything hurt. That night it was difficult for me to sleep because of the pressure in my left shoulder. I needed to lay down on my right shoulder, which still had adhesions. It hurt even to lay on my back. There was no position available to me that wasn't painful. I dozed between the bouts of pain. The following day, I woke up with more pain in my shoulder than I had the day before. My wife had to shower me, help me dress and drive me to work that day. Although I was still in pain, I wanted to be at work because this is what I love to do. At work as a psychologist by trade, I explained to my patients that I had excruciating pain in my shoulders, and that I might be somewhat distracted by it. If they choose, they could cancel their sessions, and reschedule for a day when I would be feeling better.

I left work early, since I was not doing well. I awoke the following morning still in pain. The mere thought of going back to physical therapy produced an anxiety that I had never experienced before. I finally understood what free-floating anxiety was. My hands became sweaty, I developed butterflies in my stomach, I was unable to eat and I continuously worried.

My wife drove me to therapy again, on Wednesday since I was still unable to reach the steering wheel. I waited in the cold waiting room. Again, they did not allow her to go inside with me. I was in agony filled with anxiety, waiting for the therapist. He went through the same process as he had the first time. The same laugh, the slogan "no pain no gain."

That was the last time I went to that clinic.

I was diagnosed with Type II Diabetes twenty years ago and was treated at the Samson Clinic in Santa Barbara, California by an Argentine doctor. I chose her,

not because she was Latina, but because she had a good reputation for the treatment of extreme diabetics. Even though I was a Type II diabetic, I was on insulin because I was not responding to any medication. I was also having some resistance to the insulin, however, and the doctor had developed a new treatment program for this problem. I was in the program to see if I would respond to the new regimen. During one of my regular visits, the doctor was surprised that I was unable to move my left arm and immediately called in one of the orthopedists. After a brief examination, he asked if my wife was with me. I responded, "yes". He said, "Tell her to come in".

"My wife came into the room where the doctor explained to both of us that an intervention needed to be done immediately. He was going to put me under anesthesia and "windmill" my left arm to break the adhesions in my shoulder. We agreed to the intervention. He really went out of his way to make us feel comfortable.

Immediately after the procedure, while still under the influence of some anesthesia, I was taken to the rehabilitation center where I received a massage and began to do some exercises there. When the procedure was completed, I left the clinic relieved, and was able to move my shoulder. That night I slept solidly. I never had problems at that clinic. Everyone was very pleasant and very sensitive to my request of having my wife with me. From that point on, I received rehabilitation therapy there three times a week and was trained on how to complete the exercises at home. While in therapy, I worked on the right shoulder as well. The doctor had not minded, in fact he had encouraged my wife to be with me during physical therapy. I recovered with few limitations in a culturally competent environment.

This experience that one of the authors (Felipe) went through is not uncommon. Many health care professionals have not been exposed to other cultures nor have they been trained to treat individuals from other cultures. Being culturally competent is extremely important so that the patient will be properly diagnosed and treated and the desired outcome will be achieved.

Competencies are attitudes, knowledge, and skills that health professionals, including rehabilitation specialists, must possess in order to deliver high quality care (Coursey, 1998). Competencies are attributes of individual providers, though it is unlikely that a single provider will have all of those necessary to treat all persons (Hartman, Young & Forquer, 2000). Having a general understanding of particular populations, however, is the first step in achieving this goal.

The purpose of this monograph is to offer information about Mexican culture to help rehabilitation service providers increase their competence in treating this growing population.

One must keep in mind, however, that the Mexican and Mexican-American cul-

tures are complex and heterogeneous. This monograph will present the "skeleton," or the basic foundation of the Mexican culture, with emphasis on the poor and uneducated. As with any community, change occurs and cultures fluctuate under the influences of migration, acculturation, oppression and change in socio-economic status.

HISTORY OF IMMIGRATION

The first step in understanding a culture is to know its history and the conditions that led its people to emigrate to this country. It is commonly known that most of the Mexicans of today are the descendants of the native Indians of that region and the Spaniards who conquered them. Some Mexicans are descended from French and Africans as well. Contrary to popular belief that "all" Mexicans have brown skin, there are Mexicans who have white skin and others who have black skin. Mexico is as diverse as the United States in terms of racial differences, dialects, political beliefs, etc. Mexico also has regions that have their own cultures which will be addressed later.

The present population of Mexico is 92 million, 40 million of whom live at or below the poverty line. Mexico City is the largest city in the world having surpassed Tokyo a few years ago. The population of metropolitan Mexico City is 22 million. The minimum wage is approximately five dollars (U.S.) per day, but few employers in the city pay the minimum wage.

Although factories and assembly plants raised income levels, Mexico has never really had a middle class. Approximately 20 percent of Mexicans live according to upper-class standards. They have heavy investments in the U.S. and buy goods imported from the north. Mexicans have a seasonal agricultural orientation and during the year work on the land for a certain length of time before returning home. This orientation makes factory work difficult for them to accommodate (Nelson & Rubi, 1999). Many Mexicans have migrated to the U.S. because of poverty, but this was not always the case.

As most know, the western and southwestern part of the United States was Mexican land until the war between U.S. and Mexico (1846-1848) when Mexico lost nearly half of its territory. Mexican inhabitants of ceded lands were offered U.S. citizenship with the promise of property rights. Some 80,000 Mexicans who originally lived in the new U.S. territory were ancestors of today's fourth-, fifth-, and sixth-generation Mexican Americans (De Paula, Lagana & Gonzalez-Ramirez, 1996). Some assimilated into the Anglo culture, while others retained their Mexican culture - a common occurrence with immigrants in a new country.

In the late 1800's, U.S. laborers imported Mexicans to build railroads. During the World War I labor shortage in the U.S., Mexicans were again recruited to help the labor force. Between 1921 and 1930, Mexico experienced endemic poverty and Christian religious persecutions. As a result, many migrated to the United States and laid the foundation for the growth of the Mexican American population. Before 1929, the movement of persons between border communities was relatively uninterrupted. After 1929, immigration policies created a divide between Mexicans and their Mexican-American kin based on whether or not they were "documented." During the Great Depression, about 458,000 Mexicans living in the U.S. were repatriated and deported to Mexico, and by 1940, there were more U.S.-born Mexican Americans than Mexican-born.

In 1965, the Border Industrialization Program (BIP) was established by the Mexican government, that established a zone for foreign companies on the Mexican side of the U.S.-Mexican border. These are known as the *Maquiladora* districts, in which the factory owners have special privileges such as freedom from tariffs, in-bond importation of parts and equipment and 100 percent ownership of the plant (Heyman, J. Mc. C., 1991). People from all over Mexico flocked to the *Maquiladoras* to find employment, but because of the large number of potential employees and a limited number of positions, a job shortage resulted, leading to an increase in undocumented immigration to the U.S.

The 1986 Reform and Control Act increased the likelihood of family reunification. More skilled persons settled in urban centers and competed for jobs in the U.S. service industry.

Currently, there appears to be less migrant activity than in the past. Overall, between 1900 and 1990, 2.5 million Mexicans legally crossed into the United States. An undetermined number of immigrants have crossed without documentation. Their immigration provoked by the political and economic instability in Mexico.

Many Mexican immigrants do find the better life in the U.S. They have the highest labor force participation of any ethnic group because they are willing to take the jobs that most Americans would not even think about doing. Migrant farmworkers constitute almost half (42 percent) of the population employed in seasonal agricultural work in the U.S. They work six, sometimes seven days a week, in the fields, their backs constantly bent for 10 hours a day on farms that often don't have bathrooms. The majority of the farmworkers (70 percent) are foreign born, and 90 percent of those are Mexicans. In California, half of the estimated one million farmworkers are migrants, and as many as 98 percent are Mexican. Unfortunately, for all their hard work, they are one of the poorest population segments with a median personal income of \$2,500 to \$5,000 a year (Alderete, Vega, Kolody & Aguilar-Gaxiola, 2000).

Latinos as a whole work just as hard as their non-Latino counterparts. Yet only 11.4 percent of Latino males and 16.4 percent of Latinas are employed in managerial/professional positions compared to 27.4 percent for male non-Latino whites and 28.2 percent of females. The annual median household income for Mexican Americans in 1993 was \$22,477 (U.S. Bureau of the Census, 1993). Not only do they comprise one of the poorest groups in this country, they are also the group most likely to not have health insurance. It is estimated that 41.6 percent of Mexican Americans are not insured (Valdez, 1993). Moreover, whether or not they have insurance they are less likely to utilize health services (Trevino, Moyer, Valdez & Stroup-Benham, 1992). The many reasons for this include language barriers, limited knowledge of systems and services, unfamiliarity with acceptable help-seeking behaviors, possible distrust of the professional service system, and perceived discrimination by agencies or service providers (Bailey, et. al, 1999). Some of these factors will be discussed in more detail later.

MEXICAN CULTURE

It is extremely important to note that that this monograph makes generalized statements about Mexican culture in order to identify common themes. Mexicans are a heterogeneous group, however, with different cultures in each region of the country. We will continue with Felipe's experience in the physical therapist's office as an example:

"I am back at the initial physical therapist's office where I realized that I was the only one in the place who was screaming. I felt discriminated against because it seemed as though he made me scream because I was supposed to be 'macho'.

I realized that ignorance was motivating him to make me scream and to create more pain than I should have endured. It wasn't malice, or insensitivity, it was just ignorance about how to approach the culture, my culture. I say this, because in my personal experience, I have learned to differentiate between a person who, with full knowledge, is attacking me with a racist statement and a person who is just plain ignorant of my culture. In this case, it was the latter.

Regardless, here I am, a doctor, well educated, high middle class, and sophisticated, and 'I', once again, was being treated in this manner. How would they treat someone less sophisticated? How is a person who is non-school educated with very limited knowledge of or no knowledge of the English language, and limited knowledge of Anglo culture able to deal with something of that nature?

I kept thinking about my knowledge of the Mexican culture, and I realized that there is an important point to make. Let's use someone from Yucatan, Mexico as an example. Can the rehabilitation center and the physical therapist be culturally aware enough to know the difference between the people from Yucatan and the people from Michuacan, Mexico? Aware enough to know there are cultural differences between the Guicholes in Mexico, and the people of Chiapas, Mexico? Although everyone is Mexican, each region in Mexico has its own idiosyncrasies.

The same applies in the United States with its own regions. Generalizing or assuming that everyone is the same because they are from "America" may lead to trouble. People who live in the south are different from those people who live in the north, and the same can be said for those that live in the east versus those that live in the western part of the United States. Similarly, there are subtle differences between the different regions of Mexico and within the Mexican culture at large. For example, the people from Yucatan, are mostly Aztec descendants, are known to be very stoic, mild, pleasant and able to handle pain. The people from Michuacan have a reputation of being very assertive and tough. Whereas the people from Chiapas will defend their rights and will never let the "White Mexican" conquer them. These three regions are all culturally different, but tend to be generalized under one culture, the 'Mexican culture.'

If we were to focus on the individual regions, however, this monograph would be extremely long. So, for the purposes of brevity, we will discuss the generic aspects of the Mexican culture. It should be used as a guideline, not as a complete assessment, given that each person is an individual, and the service provider must assess the person accordingly. The provider must also keep in mind the level of acculturation of the individual. This will have a great impact on cultural views and behaviors of that individual. As mentioned earlier, this monograph focuses on Mexicans who are poor, unacculturated, and non-school educated. These are typically the ones who migrate to the U.S. so they can make enough money to support themselves and their family back in Mexico. We also focus on them because, as stated earlier, they are the ones who have escaped other influences that would impact the basic influence of the Mexican culture. Before describing specific cultural habits, beliefs and behaviors, one of these "influences" needs to be clarified - how acculturation affects one's culture.

Acculturation

Acculturation is the degree in which a member of a culturally-diverse group, in this case, Mexicans, accepts and adheres to the values, attitudes, beliefs and behaviors of his or her own group and those of the dominant (majority) group,

in this case, the Anglo Americans (Berry et al., 1987). Berry and his colleagues divided acculturation into four categories:

- a) **Integration:** The person maintains his/her own culture but also incorporates many aspects of the majority culture. Integration produces a "bicultural identity."
- b) **Assimilation:** The person accepts the majority culture while relinquishing his/her own culture.
- c) **Separation:** The person withdraws from the dominant culture and accepts only his/her own culture.
- d) **Marginalization:** The person does not identify with either his/her own culture or the majority culture.

Knowing a client's level of acculturation is important because it may affect his treatment outcome. For example, those who are highly acculturated or assimilated into the Anglo culture may be more responsive to the therapeutic interventions commonly used in the U.S., whereas those not highly acculturated or assimilated, may require an approach more relevant to their native culture. We should note here that research has shown that Mexican Americans who try to "Americanize" or assimilate, have more psychological problems and drug use than those who retain their language, cultural ties and rituals (Falicov, 1996). So acculturation may not only affect one's cultural identity, but can also affect one's mental and physical health.

Now that acculturation factors have been discussed, let us look into general cultural beliefs and behaviors.

Eating Habits

Mexicans and Mexican Americans usually have three meals a day, with lunch and dinner bigger than breakfast. They prefer to eat as a family and if the extended family lives in the same household, the meal is usually prepared by the non-working grandmother. Traditionally, food belief is traced to Galen's (1916) humoral theory based on the notion that the body's four humors, blood, phlegm, yellow bile and black bile, must be kept in balance by using qualities of heat, cold, moisture, and dryness. Humoral theory does not refer to the temperature of the food but to the effects that certain substances have on the body. For example, certain illnesses are considered to have hot or cold states and are treated with foods that complement those states. Patients may refuse certain foods based on this belief (de Paula, Lagana & Gonzalez-Ramirez, 1996).

Meals are usually prepared with fresh natural ingredients. Beans and *tortillas* are the staples in most meals, in addition to rice. Corn tortillas are preferred over flour. Fresh fruits and vegetables are common and usually cooked. Tomatoes are

widely used for a variety of sauces and *salsa*. Chilies and Nopales cactus are also commonly used. Meat is served sparingly because of cost and fat content. Chicken is used most often, especially to make *caldo de pollo*, a soup given to recuperating individuals.

Tamales are another staple of the Mexican meal. They are usually made by women of the household cluster. The making of the tamales, however, constitutes a deeper meaning in the culture. For example, it is common for the women to freeze the tamales and later give them to friends and people outside the family network. This tradition broadens relationships inside and outside the personal clusters. This is of central importance for socialization - as this tradition, and other rituals managed by women, reflects the central contribution women make to household cultural and social stability (Velez-Ibanez, 1993).

Role of Religion

Eighty to ninety percent of Mexicans and Mexican Americans are Roman Catholic (de Paula, Lagana & Gonzalez-Ramirez, 1996; Falicov, 1996). The Virgin of Guadalupe, who is considered to be the dark-skinned mother of Christ, is a powerful popular religious image. She is perceived as the model of motherhood, peace, faith, strength and endurance. Many direct their religious promises and prayers to her (de Paula, et al., 1996).

For many, "religion is a private affair centered around commitment to marriage and fertility, the sanctity of mothers, the condemnation of premarital sex, abortion, contraception, and homosexuality" (Falicov, 1996, p. 172). Feelings of guilt and shame for one's actions are common.

In the United States, the church in the *barrio* also provides a strong support system. It provides a sanctuary for undocumented immigrants, crises counseling, space for activist groups and community celebrations. The priest has the utmost respect and officiates the life cycle celebrations such as communion, baptism, weddings and the *quinceanera* (celebration initiating a 15-year-old girl into adulthood). It appears, however, that some parishioners are leaving the Catholic parish and joining other groups, such as Pentacostalism, Jehovah's Witnesses and the Fundamentalist Protestantism (Falicov, 1996).

In general, many Mexicans believe that death and illness is the will of God and many will incorporate a Rite of Anointing of the Sick if the prognosis of a loved one is grave. When the person is sick, some may use folk healing measures as opposed to or in addition to biomedical treatment (de Paula et. al., 1996).

Empacho (intestinal obstruction) consists of abdominal pain, vomiting, constipation, loss of appetite, or bloating caused by adherence of food to intestinal walls.

Mal de Ojo (evil eye) is a sudden downturn in physical or emotional health of an infant or young child (and sometimes adults) caused by "admiration" (jealousy) of a person with powerful eyes. To admire an infant without touching puts the infant at increased risk for *mal de ojo*. Symptoms include fitful sleep, crying without apparent cause, diarrhea, vomiting, and fever.

Susto (fright, shock) manifests as malaise, insomnia, irritability, depression, nightmares and wasting away. The illness is attributed to a frightening event that causes the soul to leave the body. Symptoms may appear any time from days to years after the fright is experienced. Some believe that *susto* can result in death.

Antojos (cravings) is the failure to satisfy food craving in pregnant women that is believed to cause defect or injury to the fetus. For example, "strawberry nevus" may be explained by unsatisfied cravings for strawberries.

Nervios (nerves) refers both to a general state of vulnerability to stressful life events and to a syndrome brought on by difficult life circumstances. Symptoms include headaches, easy tearfulness, irritability, stomach disturbances, sleep difficulties, nervousness, inability to concentrate, trembling, tingling sensations and *mareos* (dizziness with occasional vertigo-like exacerbations).

Ataque de Nervios (attack of the nerves) is understood to occur as a direct result of a stressful event relating to the family (death, separation, divorce, conflicts, witness of trauma). Symptoms include uncontrollable shouting, attacks of crying, trembling, heat in the chest that rises into the head, and verbal and physical aggression. A general feature is a sense of being out of control. Some individuals report amnesia during the "event" but regain usual levels of functioning.

Depending on the individual, you may encounter a Mexican patient who is complaining of or describing symptoms of *nervios* or *ataque de nervios*. Out of ignorance, many service providers who hear of these symptoms or complaints dismiss the patient or looks at them as though the person were crazy. Subsequently, the person feels misunderstood, rejected and confused, and would probably never seek treatment from a "professional" again. Therefore, if you don't know what they are referring to, it is suggested that you look it up in a culturally relevant book or general article, or ask someone you know from that culture to explain it to you. In this way service providers can avoid hurting the pride of their clients through cultural incompetence.

In the Mexican culture, there is no clear separation of physical and mental illnesses. It is believed that there must be a balance between the individual and environment, otherwise one may get a disease. Emotional, spiritual, social and physical factors are major contributing forces to illness, in addition to the Humoral theory, God, spirituality, and interpersonal relationships. The causes are God's will or unacceptable behavior. Shame may be associated with genetic defects. Physical disability is usually more accepted than mental disabilities. Furthermore, illnesses are seen as a social crisis and are experienced by the entire group. Institutionalization is not common, rather the family cares for persons with disability. The following experience of our family is an example of this:

My (Felipe's) mother developed Alzheimer's disease many years ago. My father insisted that my mother stay at home so that he could take care of her. He was in his late 70's. They lived close to my wife, daughter and I, and we were able to help my father take care of her. As she progressively got worse, it was more difficult for him to care for her. I convinced him that he needed help and hired someone to clean and cook some meals, as well as a nurse to bathe my mother three times a week. My father would not allow "the helper" to cook because he wanted to cook for his wife, as well as to cook whatever he chose. Prior to this he was never in the kitchen. He learned how to do this because he felt he had to. As time went on, having the helpers in the apartment became more acceptable to him, as they became more familiar with the home and my father became more familiar with them. It was also a mental necessity for my father to have them in the apartment.

One night he awoke to the smell of gas in the apartment. My mother had apparently left the gas on in the apartment. Even after this, my father was not convinced that my mother needed care at a convalescent hospital for Alzheimer's patients. Although my wife and I were always around to help if it was necessary, my father did not want a lot of help. However, he just wanted someone to talk to. One Sunday, my wife and I went to Santa Barbara for the day. When we returned, the answering machine was filled with messages from my father. We literally flew over to my parent's home to find my mother in between the toilet and the bathtub. That morning when he took her to the washroom with her coordination faltering, she sat on an "empty object" that she thought was the toilet, and fell to the floor. My father was eighty-eight years of age at the time and unable to lift my mother off the floor. He spent the majority of the day attempting to pick her up off the floor. That night he asked me to place her in a convalescent hospital, where he spent every day with her, next to her bed. In his situation, it did not matter what the therapist, doctor or nurses had to say. He needed to know on his own that she was ok. She died only three months after being placed in the hospital.

This is a prime example of how the family feels they are responsible in taking care of other family members. In general, if there are other children in the family, and one is not working, the person with disability will move to the child's home. We offered to have my mother and father move in with us, even prior to her becoming ill, and they refused. They did not want to be a burden to us. They are the exception to the rule. In the Mexican and Latino culture it is expected that the parents will live with a child and be cared for by them in old age. Of course, there are exceptions in every case. That is why we stress that each individual must be assessed individually, but with the cultural context in mind. When my mother died, my father still refused to live with us. He stated he wanted his own space, his own routine and did not want to bother us. Most Mexican parents, and some Mexican American parents, move in with their children at some point in their lives. In general, children do not feel as though caring for the aging parent or a sibling with disability is a burden. They look upon it as a responsibility.

Given their holistic beliefs, some Mexicans use home and folk remedies to treat certain illnesses. *Curandismo* is the use of traditional Mexican healers who attempt to use imbalances by using prayer, pledges to religious and supernatural forces, and rituals involving candles, artifacts, and herbal baths. The *Curandera*, or female folk healer, is believed to be chosen by God to heal. *Yerbalistas* (herbalists) use herbs, usually in teas or broths, as home remedies. *Sobadoras* (masseuses) are female healers who use massage or manipulation of bones and joints to correct musculoskeletal imbalances. Humoral and herbal remedies are traditionally passed on from mother to daughter, and continue to be used in the U.S. by traditional Mexican Americans as an alternative to in conjunction with one another to treat minor medical, psychosocial and chronic problems.

Experiences of Pain

The meaning and expression of pain, as well as its control have been identified in the Mexican culture as originating from two predominant Mesoamerican civilizations, the Aztecs and the Mayas (Villarruel & Ortiz de Montellano, 1992). Attitudes toward the experience of pain include: a) pain as an accepted, anticipated, and necessary part of life, b) man has an obligation to endure pain in the performance of duties, c) pain is predetermined by the gods, d) pain is a consequence of immoral behavior; e) pain should be endured stoically; and f) maintaining balance was effective in alleviating pain. These findings can help the therapist understand current approaches to pain in Mexican culture. Villarruel (1995) studied how Mexican Americans experience pain. He found four prevailing common beliefs:

A) *Pain is an encompassing experience of suffering.* In other words, pain is synonymous with suffering. They viewed pain as not only a physical experience but also a personal, interpersonal, social and spiritual experience. Women tend to

keep emotional pain such as anger, hurt, disappointment and other negative feelings, to themselves but release it through physical symptoms such as headaches, chest pain, and muscle tightness. In addition to feeling their own pain in many dimensions, they feel the pain of others. Many informants in his study expressed that feeling the pain of others was an expression of care characteristic of the Mexican American culture. One female informant said:

Mexicans feel the pain more. The majority of Mexicans are sentimental. They feel the pain of another person. Their culture [American] is different, because here, to each his own (p. 431).

B) *Pain is an accepted obligation of life and of one's role within the family* - a burden one must bear so as not to inflict pain on others. "Villarruel said acceptance of pain was evident in statements such as "that's part of life," "I have to suffer," "you're supposed to live with it" and "it's something from God." Acceptance was not equated, however, with fatalism or resignation. Rather, informants expressed confidence in their ability to deal with pain and had hope that it could be resolved or overcome. The statement that associates pain with fulfilling one's role, embodies the belief that there is an obligation for the mother to support, nurture and provide for the family and for men in general, no matter what pain she is suffering.

C) *To endure pain stoically is expected and esteemed*. Villarruel found that accepted expressions of pain include withdrawing, going to bed, and a change in activity or demeanor. For women, efforts to hide pain were especially evident in the context of family:

When my family use to come to the hospital...I would be thinking, I hurt, but I wouldn't ask the nurse for anything...I would say everything was all right...because I didn't want them to worry (p. 432).

Enduring the pain is associated with pride, the willingness and ability to work despite pain, and the refusal to give in to personal weakness. Expectations are stronger for men to hide their pain, especially outside the family and in the presence of other men:

My brother-in-law, he's from Mexico...and he hurt his shoulder. He wouldn't act like he was in pain...He acted proud, like yes, I hurt my shoulder, but I can take it, I'm a man...When I'm with my friends...it's almost like a competition, a macho thing of 'who went through the most'...my Latino friends learned and have this 'I can take it attitude' (p. 432).

D) *The primacy of caring for others is the essence of the family*. They not only express their willingness to care for others, but also expect available care from others.

One informant in the study said:

People should take responsibility away from the one...who is in pain. Take care of them...When someone comes into your house, you don't ask them if they want anything, you just give them something to eat...When someone is sick, you don't ask them what they need to have done, you just do it (p.432).

In Villarruel's study, specific care identified by informants included protection of others, giving advice, being present and assisting with treatments and responsibilities. All informants said that seeking and receiving advice from family members for painful conditions was common practice.

Villarruel's study also measured the level of acculturation and found only subtle differences between acculturation levels in terms of the meaning of pain and the extent to which health systems were utilized. He suggested that the preponderance of similarities between persons at high and low levels of acculturation to American way of life meant that cultural aspects associated with pain were retained.

Value of Family

Possibly the most significant value of Mexicans (and most Latino cultures) is the value of *familismo* - family unity, welfare and honor. The emphasis is on the group, not the individual as in the Anglo culture, and on family commitment, obligation and responsibility (Garcia-Preto, 1996). Mexicans have a deep sense of familialism and family loyalty, are reliant on extended family and social support networks and emphasize interpersonal relatedness and mutual respect (Forehand and Kotchisk, 1996). Family comes first. Therefore, if a major decision needs to be made, the immediate and extended family are involved in the process. Traditionally, the father or oldest male is head of the household and holds ultimate decision-making authority. The mother, however, holds greater influence over their children throughout their lifespan.

Children are raised in a protective environment and are expected to be obedient and respectful. *Respeto* is extremely important to the Mexican people. It insures smooth interpersonal relationships by demonstrating respect for a given individual (De Paula, et al., 1996). Respect is given to elders, parents and people in authority and is expected in return. As De Paula and her colleagues stated, "Because of the implied social power that health care providers have as healers, failure to demonstrate *respeto* to Mexican American clients could be perceived as oppressive, classist or racist." (p. 214).

Children are also expected to work hard and "do better" than the previous generation. They usually live in their home until they are ready to get married and

start a family of their own. When their parents become older or sick, the children take care of them by having them move into their home (Bailey et al., 1999).

Family also provides a sense of community. Studies show that Mexican families tend to live near relatives and close friends, have frequent interactions with family members, and exchange a wide range of goods and services that include babysitting, temporary housing, personal advice, nursing during times of illness, and emotional support (Muller and Espenshade, 1985).

Family Structure

As mentioned earlier, men tend to have more power and control in the Mexican or Mexican-American home than do women. The men work and provide for the family, while the women are expected to stay home and care for the children, sick and elders. These traditional gender roles are known as *Machismo* and *Marianismo*. It should be understood that gender roles and expectations may often be somewhat different from those that are described here, due to differences in class, region and acculturation. However, the conceptual distinction between *Machismo* and *Marianismo* may be helpful as a starting point, but not an end point, in understanding family dynamics.

Machismo or *Macho* is a term that many non-Latinos use on a daily basis without understanding the cultural relevance. It is usually used negatively as demonstrated earlier by one of the authors' experiences. The positive connotation of *Machismo* is that the male is the provider and is responsible for the welfare and honor of his family. He protects his wife and family from all dangers, gives up his seat for women or the elderly and will sacrifice anything for the family's benefit. He is also very sensitive, romantic, responsible, has a keen sense of his own dignity and is always ready to respond to any real and fancied offense (Gil and Velasquez, 1999). The men have a lot of pride in taking care of their family and making them happy. The other side to this, however, is that the male is considered superior to the female based solely on his gender. He is associated with power over women, which is expressed in romanticism and jealousy of a fiancé or wife. Within this context, boys are given greater freedom of movement, are not expected to share in domestic responsibilities and are encouraged to be sexually aggressive. Boys are seen as strong in nature and not needful of the protection received by girls, who are seen as weak by nature. Males are expected to be strong, rational, intellectual, authoritarian, independent and brave. As can be expected, this is a difficult role to maintain.

Marianismo is based on Catholic veneration of the Virgin Mary, who is both a virgin and a mother. The concept underlying *Marianismo* is that females are spiritually superior to men and therefore capable of enduring all sufferings inflicted by men (Gil and Velasquez, 1996). In keeping with the values associated with

the Virgin Mary, they are expected to remain virgins until they are married. As mothers, they are to be like the Madonna and to deny themselves on behalf of their children and husbands. In other words, they are to be like martyrs. This concept goes hand in hand with *hembriso*, characterized by a women's devotion to home and family. It is about sacred duty, self-sacrifice and chastity. Women must dispense care and pleasure but not receive them. When women become mothers, they gain a significant amount of respect and hold a great deal of power despite their outward submissive. Boyd-Franklin and Garcia-Preto (1995) identified Latinas as living "cultural paradoxes" since they are "morally and spiritually superior to men, while...they are expected to accept male authority" (p.253). To add to the paradox, expression of female sexuality is considered negative. If a woman has sex before she is married or overtly talks about her enjoyment of sex, she is considered "*una mala mujer*," a bad woman, and risks social censorship and feelings of guilt and shame. This dichotomy is known as the Madonna-Whore Complex.

As mentioned earlier, acculturation greatly affects these cultural norms. Research has shown that when Mexicans arrive in this country, the more acculturated they are, the more health and mental problems they acquire, to a degree equal to that of the Anglo culture (Alderete, et al., 2000). Among many hypotheses that attempts to explain this phenomenon, one is that it is difficult to maintain these traditional roles in the United States. Mexican women tend to find work in the U.S. easier than the men because they can use their sewing skills in factories or their "homemaker" skills in cleaning homes or hotels. The men, who traditionally worked on farms, cannot use that expertise in the U.S. because of the scarcity of such jobs. They either have difficulty finding a job or they find employment in hard labor. As a result, the woman is working outside of the home since the man is not able to provide enough for the family. So she is exposed to the "non-traditional" female role of empowerment and independence. This often causes problems in her marriage if she becomes more assertive and demands certain rights. This doesn't make things better for the man who is unable to provide for his family like a "good man should." Alcohol rates among Mexican-American men significantly increase with acculturation (Vega, Kolody, Aguilar-Gaxiola, Alderete, Catalano & Caraveo-Anduaga, 1998) and the change in roles appears to be a factor (Gloria & Peregoy, 1996). In addition, the children of the traditional family also are exposed to the American way of life and may rebel against their parents, which in the Mexican culture, is not acceptable. Therefore, while the parents are trying hard to hold on to their cultural beliefs, the children are trying to reject them. This can cause turmoil in the house and possibly lead to mental and medical problems.

How do these cultural norms affect rehabilitation treatment? They affect it greatly because if you do not assess these norms accurately, you can lose your patient. In the Mexican culture a patient who is temporarily disabled is going to

be supported by the family, if the disability does not last for a prolonged period of time. This is important because family support is a major contributor to improved physical health.

One such study was conducted by the World Health Organization's International Pilot Study of Schizophrenia (IPSS), in which 1,202 patients from Nigeria, India, Columbia, Taiwan, United Kingdom, United States, USSR, Czechoslovakia and Denmark were followed for five years. Findings at a three year follow-up indicated a markedly superior course of illness for patients from developing countries, relative to outcomes observed for patients residing in more industrialized nations (World Health Organizations, 1979).

It was concluded that the observed difference in course and outcome could be explained by features of the sociocultural environment (Sartorius, Jablensky, & Shapiro, 1978). Additional observations have been recorded in subsequent studies. It has been suggested that familial and societal patterns of response to an ill individual may influence the course of illness. For example, it has been hypothesized that families who respond to an ill family member with tolerance and acceptance may contribute to a more benign course of the illness.

Another contributing factor to improvement in health is the level of "Expressed Emotion" (EE) - the criticism, hostility, or over-involvement - shown by a family member toward a relative with disability, specifically schizophrenics. When the primary caretaker becomes too involved and protective, but is not critical, the patient can become completely dependent on family and friends. If they are critical, the patient may become angry and hostile but is unconsciously unwilling to get better because of the additional attention. Research has shown that in developed countries Expressed Emotion in the families of schizophrenics is high and critical, while in underdeveloped countries it is extremely low. They also showed that Mexican-Americans had lower Expressed Emotion than Anglo Americans, resulting in significantly better clinical outcomes in Mexicans with schizophrenia (Jenkins, Karno, de la Selva, Santana, Telles, Lopez and Mintz, 1986). These results apply to any disability in that family support, not overprotectiveness, greatly increases the chances of a patient regaining an optimal level of function.

In the Mexican culture, when someone is temporarily disabled, the Expressed Emotion is low with minimal criticisms and significant support. If the disability goes on too long, a great amount of covert criticism may begin to emerge. In the Mexican culture this criticism is expressed in a joking way. "Hey, you are having a good time staying home from work because of your back pain, I am going to injure myself in order not to work." It is critical and covert, but obvious to the patient. A family member may continue to criticize until the mother intervenes. She is the only one who can keep Expressed Emotion low. As mentioned earlier, the reason is because it is her duty to care for the sick and her children, and to

sacrifice everything for that person. But she may also use the disability to become a martyr and instill guilt: "Look how I am sacrificing for my son who is disabled." "No one wants to believe you my son, but I believe you and I will take care of you."

If it is the daughter who is injured, generally speaking, things are a little different. She is also to follow the Marianismo norm by taking care of the household and children, unless she is permanently disabled or in extreme amounts of pain. Initially, the family will be empathetic and sympathetic to the female. But if the disability continues and there appears to be no basis for it, it will be made known that she'd "better start taking care of her responsibilities." On the other hand if the son has a disability, he will probably be pampered.

When you speak to the mother, compare her to her daughter. Always show respect and focus on their strengths. In order to get her daughter to practice some therapeutic techniques at home, you can say something such as, "she is as strong as you are and you did a very good job in raising her, but at this time she needs your assistance. Your daughter is not asking for this, I am." This takes the responsibility off the daughter by using your level of authority to make a request. In summary, if the injury results in a temporary disability, the family will be empathic and supportive. But if it appears that the disability is used as a secondary gain, the family will not allow it, except for the mother who will do her sacred duty.

In rehabilitation treatment, it is recommended that these factors be taken into consideration. The goal is to see the entire family and assess their level of acculturation. If they are traditional, the father will have the final say but usually with the mother's approval. The therapist should also be aware of the mother's level of Marianismo. If she becomes too involved in the treatment, it may prolong the illness or disability. Remember, she is not only taking care of her child for his or her own welfare, she is also doing it to express her role as the sacrificing mother. If the mother is not incorporated as an ally she may sabotage the treatment. In general, allow the mother to be a part of the treatment process. Let her know that she is the one who can help you with the recovery of her son or daughter. In physical therapy, for example, tell her that that her son needs someone to push him to do the exercises. Depending on your assessment of the mother and/or family dynamics and history, you can remind her, for example, that when he was a child she disciplined him and made him do things for his own well being, and that you are sure that if you, as a rehabilitation therapist, are concerned for his illness, she must be twice as concerned. Do not minimize the illness. Do not exaggerate the illness and the disability. Explain that she needs to take things into her own hands, giving her son the courage he needs to recover quickly, just as she did when he was a child. Then his chances of a fast recovery are higher.

If the patient is female and married, and you see that she is not getting support from the husband, it is recommended that you bring him into the treatment process and present him with the advantages of helping his wife, and how his help will accelerate her recovery. If they are a traditional family, for example, let him know that if she begins to do her household duties before she is fully recovered, her recovery will be twice as long and he, the husband, will have to do the house chores himself. Remember, we are presenting a sub-group who are unacculturated and who are usually non-school educated with little social and intellectual sophistication. This is their culture and it is best that it is respected. In addition, the respect will generally be mutual because in the Mexican culture, a health care professional is usually second only to a priest.

This is a significant point. As mentioned earlier, *respeto* or respect is very important in Mexican culture. This not only means that they will respect you because of your level of authority and expertise, but they also expect respect from you. It is very important to call adults by their last name prefacing it with *Señor* or *Señora*. The Spanish language reflects the importance of respect as demonstrated by the word *Usted* (formal you) that replaces the informal word of *tu* (informal you). For example, if they ask you how you are in Spanish, you would respond with "*Muy bien, y usted?*" (I am fine, and you?). This will greatly increase your chance of establishing a strong rapport with them.

In addition to *respeto*, *personalismo* is also important in the Mexican culture. *Personalismo* is having the ability to be personal. It emphasizes the personal quality of an interaction, and is used to relate to and maintain a relationship with an individual. In other words, it is important to be warm, kind, and show some interest in them. In general, they do not respond well to people who have no sense of humor, who are cold, who act superior to them and who have no time for them. This is illustrated by the first hand experience of a Mexican mother whose son was permanently disabled:

I would like for [the doctor] to really take his time to evaluate [my son] orthopedically...to sit him up, to touch him, to really notice what is happening. He only looks him over. I do not know. I believe he spends more time choosing a shirt he is going to buy or a pair of shoes than the time he spends on Miguel...Why doesn't he take the time to examine my son and give him quality care? I do not doubt his capacity as a doctor, as a specialist, but I sometimes doubt his humane qualifications (Larson, 1998, p. 869).

The first step in establishing a relationship with a traditional Mexican family is to immediately show respect, warmth, modesty and interest. It is important to note that given your high status of a health care provider, they may expect you to be highly directive and they may exhibit what appears to be a level of

dependency behavior that may become puzzling. As mentioned earlier, use your status to encourage empowerment and assistance by focusing on their strengths, not weaknesses.

Concept of Disability

In general, disability in the Mexican culture is viewed as either an act of God or as punishment for something one has done. Physical disability is more accepted than a mental disability, probably because the parents, especially the mother, blames herself if her child is not "normal." In general, a physical disability is viewed as "normal." There appears to be a complete naturalness with which the people with physical disabilities are treated.

In the U.S. disability is viewed as a limitation on the person's impaired ability to take part in economic and social life. The goal in rehabilitation is to enable the individual to be as independent as possible so that he or she can have a "normal" life.

This is in great contrast with the view in Mexico. In Yucatan, Mexico, the native language of *Zapotec*, does not even have a word for "disability" (Holzer, 1999). Since persons with disability contribute as much to society as anyone else. People in Yucatan do not need to work with the sole aim of making money in order to be valued by family and society. There is a broad range of activities that earn recognition and are considered as important as work at the market, the economic center of the town. The activities include giving each other time and attention, massaging one another, paying mutual visits, taking part of festivities, helping neighbors and simply sitting with others and exchanging views. Those who need support are supervised and cared for by the family. In Yucatan, there are no "retirement" homes, nursing homes or homes for the persons with disability (Holzer, 1999).

The difference between the Western and Yucatan society is summarized best by Holzer (1999). She says that Western societies, in a global sense, are patriarchal in that work is correlated with money and the economy. In the Yucatan culture, and others in Mexico, the society is more matriarchal. In other words, what is most important is the *mother's work* - preservation and creation of life. Money and a commodity-based economy are viewed as ideals that remove one from what is most essential in life.

As such, the patriarchal world ignores the mother's work, which makes it difficult for someone in that society to be accepted as a dependent being whose needs must be met by others. In the matriarchal world, being dependent and cared for is part of life. In addition, the women's production and distribution of food is considered "work" and "economy." Therefore someone with a disability in Yucatan is viewed as someone who contributes to society, not only because of

his/her sheer existence but also because the activities in which they can participate, including cooking, are valued. Persons with disability view themselves as part of a community. In addition, being dependent is not viewed as a negative attribute; but as a way of life.

In a town in Yucatan, a program for persons with disability aims to make them more independent as members of the family. Holzer states, "Each member of the family does something that can contribute to the family staying together as a social unit. Particular attention is paid to the mother, because she and the house she lives in are the center of the small community. A member of the family with disability almost always sees her or himself as a person who cannot contribute to the family's livelihood. This is what creates the acute sense of total dependence. At this point the person with the disability experiences him or herself as unequal and different" (1999, p.271). The rehabilitation program in question, emphasizes a self-reliant and independent life within the family.

In summary, views of disability in Mexico are quite different than those held in the U.S. In Mexico, someone with a disability is accepted by society and family. It is the community's and family's role to take care of them. The pressure is not for them to become more independent; it is for them to be more functional within the family.

Rehabilitation Services in Mexico

In general, rehabilitation services are scarce in Mexico, especially in rural areas. The scarcity is not a result of cultural belief, but of ignorance and lack of awareness of the politicians and social upper-class (Nelson & Rubi, 1999). It must be remembered that Mexico City is very modern and heavily influenced by American culture. Therefore, people in the city are more exposed to the American way of life, than people in the rest of Mexico, which is largely rural. Through the media, people are beginning to pay attention to the needs of people with disability, but therapy has yet to achieve the status it enjoys in the U.S. (Nelson & Rubi, 1999).

In 1986 American influence led the Mexican government to make it mandatory that all newly constructed buildings provide access to everyone, regardless of disability. Respect for the law is uneven. Architects argue that ramps interfere with the aesthetics of their design and building owners find ways to avoid the extra expense of accessible construction. Mexico is proud of its history, but older established buildings that are renovated to house public facilities, museums, stores, restaurants and schools often remain inaccessible to persons in wheelchairs.

Transportation is also an issue. Although bus and metro transportations are subsidized by the federal government, there is little push to make them more accessible. Buses have high steps and many metro stops do not have ramps. This is an

issue for the *campesinos* who do not have cars and who generally live in rural *pueblos* (small towns) that necessitate walking. The compensating factor is that Mexicans are notorious for their willingness to assist anyone with a special problem, and it is not uncommon to see two young men hoist a wheelchair and its occupant up five or six steps.

Health services are just as limited. In general, Mexicans receive health services through specialized hospital systems for workers of various types. The problem is that these systems are strongly influenced by politics and their quality of care varies according to the local forces that determine community government. New administrators are appointed with each new election (Nelson & Rubi, 1999).

Although many hospitals and treatment centers offer rehabilitation, such services are poorly represented and sometimes offered by untrained persons. Socioeconomic structures in Mexico do not encourage the achievement of expertise, nor does society reward professionals who develop special skills. In addition, salaries are very poor, so it is difficult to find such experts. Rehabilitation therapists in Mexico are usually confused by the public with teachers or masseuses.

The training programs for physical therapists (PT) and occupational therapists (OT) are traditionally offered at a technical level through a 3-year program sponsored by the federal government or large institutions. Schools are concentrated in Mexico City, and there are more practicing therapists in the metropolitan areas. Speech and language therapists are trained in a program at the University of the Americas, just south of Mexico City.

In an effort to provide more services to a wider population, there has been a move in Mexico to train "therapy technicians" at the high school or secondary school level. Government agencies are seeking to place such people who can be of some functional help to families with a family member with disability. The training courses run about six months, and are sponsored by the federal government. It appears that this practice has caused even more public confusion about services that might be expected from someone with the title of "therapist."

These therapy technicians often work with no professional supervision, serving clients in their homes. In addition, many physiatrists and other physicians prefer to employ their own assistants who have no formal training. Parents unaware of the differences in quality of care for their child with disability or adult member would likely welcome someone to come into the house two or three times a week to help out in their care. Currently there are no laws in Mexico to prevent this type of misrepresentation (Nelson & Rubi, 1999). Therapy associations exist, but meet in Mexico City and have little influence on the ongoing educational process. There is no formal licensure of either OTs or PTs and little professional

encouragement for continuing education.

Some changes are currently being made. The Centro de Aprendizaje (Learning Center) of Cuernavaca is a private treatment and education center begun by Mexican psychologist Raquel M. de Benabib, M.S., in response to expressed needs of the community (Nelson & Rubi, 1999). The center is based upon an interdisciplinary model, and intervention efforts are closely coordinated to work toward goals agreed upon by family and staff. The center stresses the problem-solving approach of neurodevelopmental treatment (NDT), with the addition of manual therapies, myotherapy and other preparatory treatments. The client (usually a child) is helped to change physically and behaviorally while plans are made with the family to meet his needs when he returns home. The staff finds local therapists or appropriate local programs if possible, and provides the family with videotapes and written material to take home. Families are encouraged to bring photos of home seating and typical activities so staff can understand better the challenges faced in home care.

This program sets priorities based on the age of the child and the wishes of the family. Feeding programs, for instance, must take into account the cultural, religious, and medical beliefs of the family and child. The process of taking in food is perhaps the most intensive cultural behavior encountered. In Mexico, babies often get sweets very early, and parents have difficulty understanding the need to restrict sugar. Respect for these individual preferences has been found to assist the bonding process between the family and professional staff.

The extended family is usually involved in the rehabilitation process, as they are an important resource for families with a member who has a disability. It is not uncommon to find that members of the extended family have pooled their money to help pay for a needed device, such as a wheelchair. Nor is it uncommon that a family member with greater economic resources than another will volunteer to provide resources for treatment services. This is extremely helpful, given that medical insurance is very expensive in Mexico. Insurance programs are being established in Mexico, but it will take years for the services provided to equal those of the United States. This makes it even more important for our rehabilitation staff to become culturally competent with the Mexican population so they can receive the care that has eluded them for most of their lives.

REHABILITATION TREATMENT

Before describing preferred treatment for Mexicans and Mexican Americans, one important issue must be discussed - discrimination. As mentioned earlier in this chapter, many Mexicans do not seek professional treatment for health or

emotional problems. There has been many speculations as to why, but in addition to the difference in cultural beliefs, one obvious factor is the discrimination that Mexicans (or for that matter, all ethnic minorities) experience in this country.

"Healthy cultural suspicion" is a term that was initially used in reference to the attitudes of black families but has been generalized to refer to those of other ethnic minorities (Boyd-Franklin, 1989). This suspicion of intent has developed over generations in response to racism, oppression, and discrimination. It often takes the form of their refusal to identify with and trust persons who differ from themselves in color, life-style, class values and so forth.

Given that most agencies are owned and run by Caucasians, the suspicion extends to these "white institutions." As a result, minorities, in this case Mexicans and Mexican Americans, confuse the relationship between social service agencies (e.g., welfare system, child protective service) and medical facilities (e.g., community and rehabilitation clinics). Undocumented Mexicans, in particular, fear that the system will "find them," report them to the immigration office and later deport them. In fact, although Mexicans comprise only 18 percent of all undocumented immigrants, they constitute 86 percent of all Immigration and Naturalization Services (INS) detentions (Bustamante, 1995). Therefore, engaging the Mexican and Latino community in treatment is difficult and challenging. Once they are in treatment, it is important to keep them there by not discriminating against them or offending them.

Another factor that prevents Mexicans from entering treatment is the linguistic barrier. How can they expect to get help when their doctor or therapist cannot understand them? The consumer may say to him or herself, "They may act like they understand, but do they? Am I really getting the best treatment available? How will they answer any of my questions?" Many first generation Mexicans speak very little English. They should not be punished for this; instead there should be steps taken so that this is not a barrier to treatment.

I (Sandra) was working at a rehabilitation center whose staff and clientele were primarily Caucasian. One day I saw a Latino male being evaluated for his traumatic brain injury. It was obvious that his primary language was Spanish, but with his disability (he had mild aphasia) and poor English, the staff were having a difficult time communicating with him. They finally had one of the assistants, and later one of his family members translate for him, but it is questionable how much of the communication was accurate.

It is common knowledge that a lot of information is lost in translation, and, if a family member is the translator, they may tend to omit crucial information to avoid "hurting" the patient. In addition, research has shown that medical translation is ineffective if performed mechanically or without understanding of

client's cultural background (Wardin, 1996). The man was sent to speech therapy twice a week, but he eventually stopped coming. I'm sure he became frustrated because the Spanish and English language are very different, not only in how you say the words, but also in how you move your mouth to form those words. There are certain combinations in English, for instance, that are not used in Spanish, such as S-T. There is usually a vowel before the S, but to say it without a vowel is almost impossible. Another is the SH sounds, which does not exist at all in Spanish. How, then, can an English-speaking speech therapist teach a person who does not speak English how to improve his or her speech?

Wardin (1996) did a study in which she compared verbal evaluations of clients with limited English proficiency (LEP) and English-speaking clients in a physical rehabilitation setting. She surveyed 200 occupational therapists and asked them about their experiences. They reported that limited translation service was seen to be the most common barrier to verbal evaluation for clients with LEP, followed by cultural differences, limited time and limited resources. Respondents said that during the evaluations, they often misinterpreted the client's behavior because they were unaware of its cultural importance. In addition, they had difficulty understanding the role of family members who performed activities for the client instead of encouraging the clients independence. They found that this "help" and lack of will to return to work inhibited therapy.

They also noticed that when family members were used to translate, they were perceived as not being able to accurately translate medical information or they were not sharing the informant's goals for the client. When a translator was not available, some of the respondents said they used gestural communication or body language to communicate, but the emphasis was on the client understanding the therapist, not the therapist understanding the client. The respondents said that picture books and language-free videos seemed to aid in communication.

In contrast, bilingual therapists reported understanding the client's needs better. They not only used the client's primary language and met with the family, but they also understood the culture-specific role performances of each member. Overall, results indicate that the most effective way of understanding the client with limited or no English skills, is to know the language and the culture. The next best effective strategy is to use a medically-trained translator and to keep the culture of the client in mind so that cultural gestures or expressions will be noticed. If you use a translator, explain your expectations to him or her ahead of time (e.g., keeping a distance between you and the patient so the conversation flows naturally; don't omit anything). If all else fails, use other tools such as videos and books to facilitate the treatment process.

In terms of assessment tools, it is most important to use an instrument that has been culturally validated. Some service providers directly translate instruments,

with which to assess their Spanish-speaking clientele. The problem is that these instruments are usually normed on the white-American population, with the resulting likelihood of error and misinterpretation. It is important to produce or find an instrument that is validated for and normed on the Mexican community or the Latino community as a whole.

Given the heterogeneity of the Latino culture as a whole, the instrument should 1) be written in grammatically correct, simple language 2) contain vocabulary in common usage across all reference groups 3) be translated to retain the meaning of the original instrument 4) be translated to convey the same intent as the original instrument and 5) be culturally relevant (Cella, Hernandez, Bonomi, Corona, Vaquero, Shiomoto & Baez, 1998). When you use any assessment tool, explain why you are testing the client and what you expect from him or her. Many of them are not used to "taking tests," such as those taken in the U.S. and may become quite anxious when being assessed.

Education appears to be another important factor in treating persons with disability. Not only is it recommended that the client be educated about his/her disability, but so should the immediate and extended family. This can be done by having Spanish-speaking educational groups, using culturally-relevant videotapes, allowing group members to share recipes (if nutrition is involved) and using easily-explained written material to take home (Brown & Hanis, 1995).

If the patient has been in your facility for some time, but this is the first time you will see him or her, the best way to gather information is from staff members who have worked with that patient. If you need to know his or her level of cognitive function, ask the speech therapist. Speech therapists offer the best cognitive assessments of patients because language is the best indicator of cognitive function.

The importance of including the family cannot be stressed enough. If you incorporate the family throughout the rehabilitation process from inception to completion, then you will have a greater probability of achieving improvement in the condition of the consumer. We feel quite strongly about obtaining a complete history from the consumer. Obtaining the consumer's physical history, of course, is important, but equally significant is understanding the family medical history and the social history of the entire family in order to treat the case in a holistic manner.

Understanding the roles of the extended family, as mentioned earlier, is of great value. The extended family is an important element in the effectiveness of service. In addition, identify who lives in the home, because people who live in their house may be considered family, even though they are not true blood relatives. Understanding the social and cultural history of the family will aid in your decision of who to involve in the process.

When working with Mexican middle-class professionals, there are similar considerations involved. Although the client may be sophisticated intellectually, occupationally and perhaps financially, the mother will probably remain the central figure. Here too, however, the degree of involvement and participation by the family will depend on its level of acculturation.

I (Felipe) was involved at the University of California, Los Angeles in a research project for families who had a member with schizophrenia (Lieberman, Cardin, McGill, Falloon & Evans, 1987). We incorporated behavioral family therapy into the project in order to educate the family as much as possible about the illness that afflicting their loved one. In-home family therapy was compared with individual supportive therapy in 36 randomized patients. We found that family therapy was significantly more effective in decreasing exacerbations, hospitalizations, and overall treatment costs, than individual therapy. The patients in the family group also functioned better in the home and were given lower dosages of neuroleptic drugs than the patients in the individual therapy group.

We followed that research with the Course of Schizophrenia Among Mexican Americans (COSAMA) research project headed by Dr. Marvin Karno (1987). We evaluated the level of Expressed Emotion in Mexican American families who had a family member with schizophrenia. We found that among the low-income families, relatively high levels of Expressed Emotion (EE) and high levels of relapse among remitted schizophrenic patients who returned to live in those households after hospital discharge. We also found a significantly lower prevalence of high levels of EE among Mexican-American households than among Anglo American households. Mexican-American family members appear to be less critical of ill relatives than their Anglo counterparts. We suggested that intra-familial behaviors may account for different prognoses for schizophrenic outcome in different cultural settings. Both of these studies demonstrated the power and influence that Mexican families have over the treatment of ill family members.

I incorporate family therapy into my own practice when treating Mexican families with a member who has a chronic emotional or mental illness. I invite the entire family into the therapy process. There are times when I will explain the biological processes that are taking place, for example, in a person who is suffering from a major depressive episode. I explain this in simple terms and at the patient's and family's level of understanding. I like to use analogies and examples from daily life with patients so they understand more easily. It is not a lecture. Participation and interaction are greatly emphasized. As mentioned earlier, the education component is important so family members understand their role in the treatment of chronic illness, as well as the progress of that illness.

Religion is an essential component of treatment with a Mexican family. As has been pointed out, in general, God has the last word. Your religious belief is irrel-

evant at this point, and, as a therapist, it is your responsibility to use any ethical and professional tool that will enable the person to recover as much of his/her previous level of functioning as possible.

"Only God knows the level of improvement this patient will reach." This common statement takes away the patients and family's responsibility for the recovery process and replaces it with the notion that they are helpers - "God's helpers". You are the professional and have the ability to empower the family and the patient by educating them about how they can "help" with the recovery process. For example, explain the reasoning behind the massage, physical exercises or pressure points that aid in reducing pain. Visual aids and hands-on experience can be beneficial. Remember you are not giving a lecture to professionals. Many of your patients may not even be able to read and/or write. Share your knowledge, but offer simple explanations.

By prefacing a recommendation with "as you know" allows the family to maintain their pride, because you are respecting their knowledge and "expertise". A phrase that is close to my heart, spoken by my mother is "hunger bends you, pride straightens you up." Do not touch the pride. MANY TIMES, PRIDE IS ALL THEY HAVE. We want to enhance what the person already knows. Ask family members to be your assistants. Use handouts for all involved and use simple statements. If you do not speak Spanish, involve a good translator to show your respect toward the family. Remember to speak at their level and try to understand their history. It is recommended that you thank them for coming to the sessions and working so hard. Shake hands and call each person by their last name. Encourage them and acknowledge to them that their hard work is what is going to help their family member improve. Tell them there is a level of involvement that is necessary from them and that you will keep training them to help facilitate the recovery process. If you feel comfortable and if religion is important to them, you may want to add "God will do the rest." If saying "God" is difficult for you as a therapist, use a spiritual term instead, such as "something higher than us is involved in the process."

If possible, provide ethnic food to eat when they arrive. This will show them that you respect their culture and make it easier for them to feel at ease with you and the organization you represent. If you are going to remove your jacket, warn the patient and family ahead of time. For example, you can say, "I am most comfortable speaking without my suit jacket on. Is it ok with you that I remove it?" They may respect the fact that you are sensitive to their feelings and when they arrive for subsequent appointments, they may be more relaxed. Make sure you always leave room for questions. Encourage them to ask. You may also want to assess what their situation is like at home. How is each person reacting to the situation? What are they doing? Not doing? Are they doing the prescribed exercises or recommendations? If there appears to be some resistance, reemphasize the impor-

tance of these activities and make sure that the family understands. Anatomical dolls can be used to educate the client on how to massage, for example.

Try to socialize with them, when possible. When you socialize in a relaxed manner, as if having a conversation, you can discover a great deal about their lifestyle - more than you ever realized. Remember, to them a "doctor" is anyone in the medical field and it will be a great honor for them to have socialized with you. Even if you do not have a doctoral degree, and you let them know that, do not be surprised when they repeatedly address you as a "doctor." In Mexico, a doctor is second only to a priest. When you converse with them, share cultural knowledge and express interest in their homeland. Express your desire to be educated about their country (Santana, 1999). Remember the Mexicans, in general, are nationalists, from the poorest to the richest. Do not align yourself with a particular soccer team. Do not speak of what you do not know. Always begin by addressing the father and the mother. Prior to starting the sessions, try to learn as much as possible about them. Inquire about Mexican food and how you would like to try something special. Ask them to share something from their menu with you. Joking without offending anyone is a wonderful way of developing allies and support from the family.

Ethically, a service provider is not supposed to accept gifts. If they give you a gift, graciously accept it as a small token of appreciation, and place it in your office - remember the pride factor. They may be looking for their gift in your office, so its recommended that you place it in there, otherwise they may be offended. If you need to go to the home, do not sit until you have been asked. If food is offered and you do not feel like eating, don't say "No thank you." That can be very insulting to them. Instead, use a valid excuse, such as "I already ate - thanks". Or take a small bite and don't eat the rest. Again, the goal is to establish rapport and to keep it.

It is important to be culturally sensitive to your client's culture and background, but half-hearted efforts can be damaging. Sergio Aguilar-Gaxiola (2000), one of the principal investigators for a large grant-funded study known as the Mexican American Prevalent and Services Study (MAPPS), presented the overall results of the study at a local training seminar. In his presentation he provided examples of well intentioned efforts in cultural sensitivity that were not effective. (These examples are taken verbatim from his presentation):

- When General Motors introduced the Chevy Nova in South America, it was apparently unaware that "no va" means "it won't go". After the company figured out why it wasn't selling any cars, it renamed the car "Caribe" in its Spanish markets.

- When Parker Pen marketed a ballpoint pen in Mexico, its ads were supposed to say "It won't leak in your pocket and embarrass you". However, the company mistakenly thought the Spanish word "embarazar" meant "embarrass." Instead, the ads said "It won't leak in your pocket and make you pregnant."
- An American t-shirt maker in Miami printed shirts for the Spanish market to promote the Pope's visit. Instead of the desired "I saw the Pope" (el Papa), the shirts proclaimed "I saw the Potato" (la papa).

We strongly suggest you avoid similar mistakes.

CONCLUSION

"Culture is a society's style, its way of living and dying. It embraces the erotic and the culinary arts; dancing and burial; courtesy and cures; work and leisure; rituals and festivals; punishments and rewards...[It is] dealing with the dead and with the ghosts who people our dreams; attitudes toward women, children, old people and strangers, enemies, and allies; eternity and the present; the here and now and the beyond."
- Octavio Paz

Within each culture there are subcultures. The subcultures are marked by socioeconomic, gender, race, sexual preferences and by different environmental factors. The purpose of this monograph is to deal specifically with the Mexican culture. We focus on the less acculturated who tend to be less educated, sophisticated and are immigrants who work in menial jobs, doing what other groups choose not to do. Due to the nature of their jobs, they are more likely to have incidents that render them either temporarily or permanently disabled. At this time we would like to provide you with a menu outlining the cultural issues we discussed, so that you can provide them the most effective treatment available to them.

- The Mexican culture is a heterogenous culture.
- Religion may be an essential component to doing therapy with a Mexican family. God has the last word.
- When it comes to rehabilitation, the family may use other resources such as "Curanderos", "Sobadores" or use herbal remedies for their folk illnesses. Inquire about the treatment to make sure it will not interfere with any medications or cause further health problems. Otherwise, allow them to pursue it.
- Mexicans have their own meanings for and expressions of pain.
- The roles of the immediate and extended family are important. Include them if possible.
- Cooperation comes from empowering the family and educating them about

what their role is in the recovery of the family member.

- In the Mexican and Latino culture, it is expected that the parents will live with and be cared for by their children when they age. Children generally do not feel as though caring for the aging parent or family member with disability is a burden. They may look upon it as a responsibility.
- If the person with disability is placed in a hospital, the mother, in most cases will want to stay in the hospital with him/her.
- If you show respect and *personalismo*, the chances are that the family will not try to sabotage or drop-out of treatment .
- Shake hands and call each person by their last name. Use the word *Usted* if using Spanish.
- Always address the father and mother first.
- Being a person with disability is "part of life" or of "God's will."
- In general, count on somebody always being at home to take care of persons with disability. Relatives or close family friends may insist that can care for the injured person at home.
- Learn Spanish or basic medical and cultural terms in Spanish. If you don't know Spanish, involve a good translator whom you trust.
- Remember to speak at "their" level.
- Use culturally-normed assessment tools.
- Educate the family through the use of videos, role-playing, dolls and written material
- In Mexican culture, a professional in the health care field is second only to a priest.
- Using the phrase "as you know" allows the family to keep their pride. Many times, pride is all they have.
- Share cultural knowledge and express interest in their homeland and your desire to be educated about their country. Remember, Mexicans are usually nationalists from the poorest to the richest.
- Ethically, a therapist is not supposed to accept a gift. If offered, accept them but place them in your office. Remember the pride factor.
- If going to their home is required, do not go in without being asked, do not sit until you are asked and if food is offered and you don't feel like eating, do not say "no thank you." Make up an excuse.
- Assess the level of the family's acculturation as some traditional beliefs may no longer apply. The level of acculturation will determine the family's degree of involvement and participation in the treatment and recovery process.
- Double the appointment time for your sessions with the patient and the family. You will need the extra time to apply techniques.
- Most important, put on your "cultural glasses" when you meet with Mexican clients and families, but focus your lenses on the individual.

We hope that this monograph was helpful in increasing your understanding of Mexican culture. The fact that you have read this material shows that you are

willing to learn and explore a new culture. But don't stop here. You may wish to take classes about Mexican language and culture, read books by Mexican authors or watch an independent Mexican movie, or go to museums and cultural centers. Becoming culturally aware is a life-long process that never ends, and should not end with this monograph. Become aware of your own stereotypes, and try to challenge them by finding evidence that does not support it. It takes work and a great deal of insight, but the result is rewarding - not only for the people for whom you provide services, but also for yourself.

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