6-1987

The Mexican American Elderly and Barriers to the Utilization of Health Care Services

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The utilization of health care services by the Mexican American elderly is low compared to the severity of their health problems. This thesis examines the sociocultural factors which affect the interaction of the Mexican American elderly and mainstream health professionals. Included is a brief history detailing discriminatory practices, a description of traditional Mexican cultural practices and attitudes, and an exploration of the cultural barriers which limit access to health care.
ACKNOWLEDGEMENTS

The writing of this thesis could not have been accomplished without the support and the assistance of many persons. It has benefited from the suggestions made by Dr. William Garland and Dr. Arthur W. Helweg, and I am grateful to them for their help. I am particularly indebted to Dr. Robert Jack Smith for his help, advice, and guidance in taking this project from idea to reality. My husband, Marv, and my children, Becky and Dan, were deeply involved in the day-to-day struggles and I am grateful to them for their unfailing encouragement and cooperation. And finally, thanks to Heidi and Kris for being there when I needed you.

Kathleen Anne Hoekstra
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The Mexican American elderly and barriers to the utilization of health care services

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Western Michigan University, 1987
# TABLE OF CONTENTS

**ACKNOWLEDGEMENTS** ............................................. 11

**CHAPTER**

I. INTRODUCTION .................................................. 1

II. WHO ARE THE MEXICAN AMERICAN ELDERLY? .................. 3

III. MEXICAN AMERICAN HISTORY AND ITS IMPLICATIONS ....... 9

   A Brief History of the Mexican American .................. 9

   Stereotypes and Discriminatory Practices .................. 12

IV. TRADITIONAL CULTURAL PRACTICES AND ONGOING CULTURAL CHANGES ................................................... 17

   Traditional Values and Attitudes of the Mexican American .. 18

   The Traditional Mexican American Concepts of Health and Illness .............. 22

V. HEALTH CARE SERVICES ......................................... 31

VI. SUMMARY AND CONCLUSIONS .................................... 39

BIBLIOGRAPHY ...................................................... 42
CHAPTER I

INTRODUCTION

This thesis will attempt to deal with the factors affecting the utilization of health services by the Mexican American elderly. The rapidly expanding population of Mexican American elderly can be, for the most part, characterized as having lower class, minority status. Poverty, poor housing conditions, a lack of job opportunities, and low educational levels all contribute to a situation in which poor health is prevalent. Although there is a great need for health care, the elderly Mexican American underutilizes health care services. The goals of this paper will be to uncover the reasons for this underutilization of services and to make recommendations for the purpose of reducing the barriers to health care and increasing utilization.

First, this paper will describe how the impact of Mexican American history and its story of migration, annexation, deportation, and discrimination relates to the Mexican American attitudes toward health care services. Various stereotypes and discriminatory practices will be discussed to show how they have shaped the attitudes of this people.

Second, a brief description will be given of the Mexican American family and its cultural attitudes, as a basic knowledge of Mexican American culture is vital for the health practitioner in understanding his client. The Mexican American cultural situation is constantly changing, as rapid assimilation into Anglo society takes place. The
results of these changes will be discussed, as well as the more traditional aspects of Mexican American life. This section will also include certain elements of Mexican folk medicine and its importance in the lives of the elderly. Folk medicine has been used by the Mexican community for hundreds of years and elements of it are still very popular. A knowledge of these practices is important for anyone working with Mexican Americans.

There are several cultural barriers to health care services which limit the availability and accessibility of these services to the elderly Mexican American. The third section will deal with some of these barriers and suggest ways in which to remove them. The majority of Mexican American elderly speak Spanish as a first language, and many of them are not fluent in spoken or written English. Language, therefore, creates a major barrier to communication, leading to difficulties in information dissemination, proper diagnosis of a physical illness, and cultural misunderstandings. Other barriers, such as low income, transportation and differences in the cultural perceptions of Anglo and Mexican American society, will be discussed.

The factors responsible for the underutilization of health services are many. The main goal of this paper is to reveal some of the reasons for the underutilization of these services by the elderly Mexican Americans, in the hope that utilization can be increased and that the older Mexican Americans can receive the medical care they greatly need.
CHAPTER II

WHO ARE THE MEXICAN AMERICAN ELDERLY?

The Hispanic population is one of the fastest growing minority groups in the United States and is expected to be the largest after the year 2000 (Torres-Gil 1986:140). They have become politically more sophisticated, increasingly urbanized, and more visible to the majority culture, making it more aware of the inequitable treatment given to most Hispanics. Discriminatory practices, particularly in employment and education, have been responsible for the low socio-economic status of the Hispanic population. The Hispanic elderly suffer from discrimination due to minority status and old age, placing them in multiple jeopardy.

Mexican Americans comprise the largest segment of the Hispanic population. The 1980 Bureau of the Census data recorded a total United States population of 226,545,805, a total Spanish population of 14,608,673, and a Mexican American population numbering 8,740,439 or 60% of the Hispanic population (United States Department of Commerce 1981). The number of Hispanics over 65 years of age represents over 4.9% of the total Hispanic population (United States Department of Commerce 1984). The small number of elderly is due to high mortality rates associated with lower class minority status.

Many Mexican American elderly are poor, with a mean income per year of $8,378 for a couple or $3,557 for a single person compared to $13,183 and $5,602 respectively for white persons over 62 (United
States Department of Commerce 1971). Their poverty and the proliferation of health problems due to minority status create a great need for health care and yet this group underutilizes health care services.

Before dealing with the complex issue of utilization of medical services by the Mexican American elderly, the population needs to be defined. Mexican Americans are a heterogeneous group with different socioeconomic levels, varying length of residency in the United States and different levels of assimilation into Anglo culture. Some Mexican American elderly are nearly indistinguishable from Anglos of the upper and middle classes. They hold good jobs, have reached high education levels, live in decent housing, speak English fluently, and in every facet of their lives have accepted American majority values and customs. Most Mexican American elderly are poor, have had little or no education, reside in low income barrios or isolated rural areas, speak, write and understand English poorly, if at all, and have resisted assimilation into Anglo culture. Other Mexican American elderly fall between these extremes.

A small percentage of Mexican Americans can trace their ancestry back to the inhabitants of the Southwest prior to annexation by the United States. Most are immigrants or the descendants of immigrants from Mexico—present-day boundaries. The large groups of Mexican American immigrants require further clarification. Many are legal immigrants, who arrived at different periods in Southwest United States history. Some are illegal immigrants whose children automatically became United States citizens at birth. Many Mexican Americans have temporary status of one type or another. Braceros
enter the United States with contracts to do seasonal farm work. "Green card" commuters live in Mexico but have official alien visas for daily work. Other "border crossers" have short-term permits to allow weekly or monthly stays (Feagin 1984:163).

The degree of assimilation among the Mexican American elderly varies greatly and depends on several variables. Upper or middle class status with its opportunities to mingle socially, educationally, and occupationally increases the rate of assimilation. Likewise, lower class status isolates the Mexican American from the Anglo society and slows the rate of acculturation. Another factor is length of tenure. Newly arrived immigrants do not adopt Anglo cultural norms as thoroughly as those who have resided here for decades. Age may also be a factor. The young tend to embrace new ideas quickly, while the old are generally more traditional.

We can further define the Mexican American population by comparing it to other populations using material from a variety of census data sets. United States census data provide the most complete statistical information available, but it is imperfect. The United States Bureau of the Census admits to undercounting Mexican Americans by as much as 38% in the 1970 census. There are several reasons why this margin of error is so high. As many as 7 million undocumented workers may have been uncounted (Cuellar 1980:III, p. 16). Families neglect to report family members without legal status for fear of deportation. Employers find illegal aliens a cheap, compliant source of labor and may fail to report them for economic reasons. A second major cause of undercounting has been due to "mislabeling." The 1930
United States census listed as Mexican all persons born in Mexico or of parents born there. The classification was placed in the category of "other races" which included Indian, Negro, and Oriental, and made it clear that Mexicans were not white (Grebler, Moore, and Guzman 1970:601). This definition of "Mexican" failed to include those with light skin, especially if they were from the upper or middle classes. The 1940 census substituted "Spanish-speaking" for "born in Mexico" (Meir and Rivera 1972:xiii). When many Mexicans reported English as their mother tongue, they were not counted in the proper category. The 1950 and 1960 census data used the "Spanish-surname" identification. Names of apparently Spanish origin were checked against a list of 7,000 surnames. This method resulted in undercounting by excluding those who had changed their names or those who had married Anglos (Grebler et al. 1970:603). The 1970 census used four identifiers of the Hispanic population. These were Spanish origin or descent, Spanish surname, Spanish mother tongue, and Spanish birth or parentage (United States Department of Commerce 1971). This method solved some of the problems caused by earlier forms of classification but did not break down different demographic units in the Hispanic populations. The 1980 census data did so with Mexican American, Cuban, and Puerto Rican subcategories. By making these distinctions among Hispanic populations, specific data for the Mexican American were made readily available, which was vital in developing programs and services for them. 

Most Mexican American elderly (80%) live in urban areas, mainly concentrated in the states of California, New Mexico, Texas, Arizona,
and Colorado. The majority live independently, while only 9% live with relatives. Sixty-seven percent are female and 33% male. The mean educational level for the elderly is 5.8 years, with 23.1% receiving no schooling. Fifty percent indicated they could speak English passably. The percentage was lower for written English (Valle and Mendoza 1978:40). Median income as reported in the 1978 census reports was $4,000–$5,000 for elderly Hispanic, as compared to $8,000 for the elderly white population. Twelve percent of the elderly white population is below the official government poverty level versus 23% of Hispanic elderly (Gelfand 1982:35).

The existing data on elderly Mexican Americans show the majority to be poor, urban, living independently, and with little formal education. The implications show a need for health care services to alleviate the problems of low class status.

The cultural diversity of the Mexican American is demonstrated by the problem of naming this group. Mexican American is commonly accepted by the majority, but others prefer Mexicano, Spanish-speaking, Hispanic, Latino, Chicano, or some other designation. Many of these names carry strong emotional content. For example, the name Chicano—a diminutive of Mexicano—is preferred by many young, politically active Mexican Americans. Many of the elderly fear negative consequences from this political activity and strongly reject the name. Regional differences also influence the name of choice.

The Mexican American population is such a very heterogeneous group, it is not possible to discuss every facet of this diversity.
Since the majority of Mexican American elderly are vulnerable and disadvantaged, they will be the focus of this paper.
CHAPTER III

MEXICAN AMERICAN HISTORY AND ITS IMPLICATIONS

When attempting to understand attitudes and behaviors of a particular ethnic group, it is vital to study them within a social, cultural, and historical framework. Only then can health care programs be developed which are appropriate and culturally sensitive. A brief history of the Mexican American will demonstrate how present-day attitudes are shaped by events which took place in Mexico and the United States within the last 300 years. Understanding these attitudes will show how the elderly Mexican American perceives the Anglo world in general and mainstream medicine in particular.

A Brief History of the Mexican American

Mexicans have a dual heritage derived primarily from a mixing of Spanish and Indian populations and resulting in a rich and complicated culture. An important Indian component came from the Aztec Indians whose culture had been built upon that of the Toltecs, Olmecs, and Mayans. The Spanish who conquered the Aztec in the 1500s brought in an equally rich heritage. Intermarriage, the keeping of concubines, and illicit sexual unions between the Spanish and the Indians resulted in a large, racially mixed population. These persons were called mestizo from the Spanish word mestizaje meaning "the mixing of Spanish and Indian bloods" (Nava 1970:22). The darker skinned mestizos and the Indians held low positions in the
social system. They were exploited by the Spanish for their labor in agricultural and mining communities. This subordination continued until 1824, when Mexico won its independence from Spain. Prior to this, in the early seventeenth century, Mexicans began moving north of the present-day boundaries of Mexico. Their first entry into the United States coincided with the first permanent English settlements in Jamestown and Plymouth. The Spanish authority over the mestizo was not as strong in the far north and many of these northern Mexicans were able to amass large areas of land for farming and herding in what is now California, New Mexico, and Texas.

However, by the 1830s the large influx of European American settlers had outnumbered the Mexicans. Through the United States expansionist policy, Texas was annexed in 1845 and that event precipitated the Mexican War. In 1848, the United States annexed New Mexico. In 1850, California, New Mexico, and Utah were designated United States territories by the United States. From the north, south, and east, Spanish American landholdings were threatened by Anglo cattlemen. The Spanish Americans were no match for Anglo lawyers and the Anglo system of property ownership replaced the Indian-Hispano system of possession or use (Stoddard 1973:10). The final blow occurred in 1892 when grazing privileges were denied to the Spanish Americans from whom the land had been taken.

These early Mexicans were assimilated more or less into American culture. The other largest segment of Mexican Americans arrived through a series of immigrations. Migration into the United States on a massive scale began in 1910. That year marked the beginning of
the Mexican Revolution. There was a great political upheaval in Mexico as the common people rebelled against the upper classes and the hacienda system. The economic situation was difficult for many, and job opportunities in the fields and factories of the United States beckoned thousands. In 1917, World War I military demands further diminished local labor supplies and the government issued special regulations to admit temporary workers. By 1930, the Bureau of the Census reported nearly 1.5 million persons of Mexican extraction in the United States (Stoddard 1973:23).

During the Depression years industry slowed or halted and the demand for farm labor decreased. Many Mexican immigrants were not eligible for welfare assistance, and thousands were shipped back to Mexico. Among those repatriated were documented and undocumented workers, some of whom had been in the United States for decades.

The return to Mexico was halted in 1940 with the growing pressure of World War II. A shortage in local labor and a needed increase in industrial production created a demand for an imported labor supply and the bracero program was born. This program recruited and redistributed labor from poverty areas in Mexico to United States farms. These workers were legally protected from exploitation and dangerous work environments. This protection of the "foreign Mexican bracero" was viewed bitterly by Mexican American citizens who did not receive equal protection (Stoddard 1973:24). The bracero program ended in 1964. As early as 1960, Mexican American workers in the Southwest had united to organize politically against exploitation and inequality.
The post-war boom in the United States and a corresponding economic slump in Mexico caused the number of migrants to mushroom. The number of those entering the United States illegally increased and in 1954 the Special Force Operation was implemented. Its purpose was to trap "wetbacks," a name given to those who entered the United States illegally by crossing the Rio Grande. "Operation Wetback," as it was commonly called, also snared many former immigrants who had entered the United States without proper credentials. Their deportation, along with that of the wetbacks, caused much tension between the United States and Mexico.

Migration declined after 1964 due to administrative restrictions designed to curb unlimited immigration. A ceiling of 120,000 was put on immigration from countries in the Western Hemisphere (Stoddard 1973:29). However, additional Mexicans have been issued various temporary permits to allow for short-term stays in the United States.

Stereotypes and Discriminatory Practices

This brief historical description is meaningless unless the implications for Mexican American attitudes are discussed. For hundreds of years the Mexican and Mexican American experience has been one of subordination. The Spanish conquerors, who helped create the dual heritage of the mestizo, also kept him in a subordinate position. The Mexican American experience in this country includes conquest, conflict, and minority status. Like other minorities, the Mexican American has been negatively stereotyped and discriminated against in every sphere.
In the 1800s, Americans of European descent entering the South­west looked at the Mexican as an inferior creature. The Protestant work ethic, developing out of Calvinism and its doctrine of election, exalted "labour, with its taboo on idleness of every kind, with its utilization of every chance of gain" (Troeltsch 1931:645). The Mexican, viewing work as a means to an end, was seen as lazy and lacking in discipline. Imperialistic America, with its dogma of Manifest Destiny, felt it had a "right and duty" to develop an area which the "lazy" Mexican had failed to develop (Feagin 1984:266). The dark skin color of many Mexicans triggered racism from many levels of Anglo society. In the early 1900s Mexican labor camps were raided by the Ku Klux Klan. In 1850 John Monroe called the Mexican Americans "thoroughly debased and totally incapable of self­government" (Feagin 1984:267). In 1928 an expert for the House Immigration Committee spoke vehemently about the racial inferiority of the Mexican, calling the "Mexican race" a threat to the "white race" (Feagin 1984:267).

The Mexican Americans have long been subjected to a stereotype of excessive criminal activity. The Zoot Suit Riots in California in 1942 are just one example of negative attitudes toward the Mexican American. Anglo sailors attacked Mexican American youths, especially those who dressed in baggy "zoot suits" and wore long hair. The Mexican Americans retaliated, arousing intense anti-Mexican sentiment. Police harassment and biased trials stirred up local prejudice. Years later the unjust treatment given to the youths was condemned, but the damage to the Mexican American image had been done (Feagin
1984:270). The role of the Texas Ranger in the Southwest has traditionally been that of the hero. The role is being reinterpreted by many historians and the Texas Ranger is now seen as a kind of gestapo force used by the Anglos to exploit the Mexican population in Texas (Samora, Bernal, and Pena 1979). These are but two examples of the mistreatment of the Mexican American by law enforcement agencies and help explain his mistrust of them.

The inferior mental capacity of the Mexican American is a negative stereotype which was "proven" by the results of I.Q. tests. These tests are culturally biased and measure social class skills rather than intelligence, but low scores have been used by racists to "substantiate" the belief that dark skin color and low mentality are inseparable (Feagin 1984:79; Stoddard 1973:82).

The Mexican American heritage includes a close affiliation with the Catholic Church. In Mexico, during the Spanish conquest, the Catholic Church was a powerful landowner, interested in maintaining the stability of the New World. For economic reasons this stability could only be kept by protecting the caste system. Although the Catholic Church was hated for its role in subordinating the Mexican, its heritage remains in the Mexican love for ritual ceremonies, especially those accompanying the major sacraments. These rituals, mingled with elements of the preconquest faith, are the basis of Folk Catholicism. Folk Catholicism is still practiced, especially in rural areas, however, most Mexican Americans are more accurately classified as nominal Catholics, implying a loose, independent relationship with the Church (Stoddard 1973:89).
White Anglo-Saxon Americans have had a deep-seated aversion to Catholics since colonial times. Since most Mexican Americans are Catholics, the stigma of Catholicism contributes to prejudicial treatment and has resulted in restrictions on place of residence, the holding of political office, and on the right to vote (Nava 1970:14).

The "special" history—the collective experiences of the Mexican American—entails subordination and has been and is accompanied by discrimination. Unequal treatment in education, employment, and housing have kept many Mexican Americans in low socioeconomic slots. Although discriminatory practices have abated to a degree, the elderly Mexican American, with whom this paper is concerned, grew up with the full impact of discrimination.

Educational opportunities prior to World War II were very poor. Most Mexican Americans went to segregated schools, the segregation of which was justified by the inability of these children to speak English fluently and by the necessity of keeping these alleged dirty, disease-ridden children separate from Anglo children (Feagin 1984:283). The teachers in these schools were for the most part poorly equipped for their positions. Most could not speak Spanish, nor were they culturally sensitive to Mexican American values and customs. From 1855 to 1968 many states ruled that teaching in any language other than English was illegal. In many schools, students were forbidden to speak Spanish while on the school grounds. The Anglo school system is but one American institution which violated the right of Mexicans to maintain their culture, a right promised
by the 1848 Treaty of Guadalupe Hidalgo between the United States and Mexico (Schaeffer 1984:289).

The poor educational experiences of the majority of Mexican American elderly have had severe consequences. Ninety percent of Mexican Americans over 65 years of age have had eight or less years of schooling, compared to 57% of the aged Anglo population (Moore 1971:31). With so few years of schooling and an education of very poor quality, the Mexican American elderly of today are ill prepared for the American job market. Consequently, many elderly Mexican Americans are unemployed or are found in low status, low paying jobs. Many of these jobs do not provide benefits or pay enough to prepare for retirement. Many of these jobs are hazardous or physically demanding. Consequently, a large number of Mexican American elderly are in poor health without the financial resources they need for private medical care.
CHAPTER IV

TRADITIONAL CULTURAL PRACTICES AND ONGOING CULTURAL CHANGES

The typical perception of the Mexican American family is of a multigenerational family living in close proximity to kin and giving support to one another. In some rural areas of the Southwest United States this description would be accurate, but the lifestyle of the Mexican American is changing rapidly and becoming more like that of the majority culture. With the decline of the extended family, many elderly have lost their traditional support system and more nontraditional agencies such as social service facilities are needed to take up the gap.

Since many elderly Mexican Americans still subscribe to the "old ways" it is important for agencies dealing with them to be aware of traditional Mexican American characteristics. The knowledge is important for program planning and also for offering culturally appropriate health care. A complicating factor is the great diversity among the aged, particularly in the degree of assimilation.

These different degrees of assimilation into Anglo culture affect the strength with which an individual holds onto his traditional beliefs. The elderly, generally more isolated from majority culture, tend to be culturally retentive, holding on to their language and Mexican cultural traditions. Their way of viewing the world should be seen as different from Anglo culture not as an aberration.
Traditional Values and Attitudes of the Mexican American

The family, not the individual, is of greatest importance. Decisions are based on what is best for the whole family. The family traditionally includes the father, mother, children, grandparents, aunts, uncles, and cousins. These persons do not all live under the same roof but live near one another and visit often.

One's role in the family is clearly defined, and the lines of authority clearly drawn. The father is the head of the house and is responsible for protecting his family and providing for them (Gelfand and Kutzik 1979:179). The mother is subordinate to him, but is valued and respected in her role as wife and mother. The children in a traditional Mexican American family do not have much authority or power, but are taught to be obedient and respectful to their elders. Age confers authority, and the elderly are valued and respected. They have an important role in safeguarding and teaching Mexican American cultural traditions (Salcedo 1955:24).

A profound change in the last few decades has been in the decline of the extended family. There are many reasons for this decline. The young are often the first to move to urban areas and this divides the family. High unemployment rates, low pay, overcrowded housing, and a high degree of mobility are easier to handle with a nuclear family and the extended family may never reunite.

Conflict occurs between generations, as acculturation progresses at varying rates (Falicov 1982:144). The young often have the greatest contact with Anglo society and act as social and language
intermediaries for their parents and grandparents. A resulting switch in authority roles weakens the position of the parents as heads of the household. This decrease in authority is often accompanied by a decrease in the amount of respect given to elder family members. Widening socioeconomic differences also widen the gap between generations and further fragments the family. The elderly, with their lack of education and job skills and their adherence to "the old ways," fare the worst in this breakdown of the family. With the erosion of traditional support systems, many elderly are left in poverty, in ill health, isolated from mainstream American culture.

Other persons outside the family are seen as authority figures. These would include social workers, medical personnel, governmental officials, and teachers. The basis for this conferring of authority is a history of subordination; and therefore, although the authority is recognized, it may also be resented.

The traditional Mexican American attitude toward time and the implications for planning differ from the attitudes of the majority culture. The Mexican American has been called "fatalistic," that is, embracing the philosophy of life that there is little a person can do to manipulate the future. Events are perceived as inevitable, with little room for individual responsibility. The common Anglo saying, "Early to bed, early to rise makes you healthy, wealthy, and wise," is not as real for them as the Mexican saying, "All your early rising will not make the sun get up one moment sooner" (Salcedo 1955: 27). This fatalistic view of life has been reinforced by Mexican
American minority group status in America, a status which offered little motivation to expect change. The roots of fatalism can be found in the Mexican cultural background where for hundreds of years there were few radical changes. The future promised nothing, it was the present that was the important reality. If it is the present that is important, then there is little need to plan for the future (Lewis 1970:69).

This powerlessness to change the future is shown in the attitude toward politics. Politically, the Mexican American has been passive. His alienation from the political system, both in Mexico and in the United States, has led to what Torres-Gil calls the "politics of indifference" (1982:40). Historically, the hacienda-peon environment prior to the Mexican Revolution in 1910 left him little political control. The Mexican American is no longer physically bound to an authority but is politically powerless due to his social and economic position. His failure to effectively participate in the institutions of the larger society is due to a number of factors which include "lack of economic resources, segregation and discrimination, fear, suspicion or apathy" (Lewis 1970:70).

The Mexican American tends to see himself in terms of his family and his immediate community. His allegiance is with them rather than the larger sphere of civic duty. His experience with the Anglo political system has actively discouraged his participation. The educational system does little to equip the Mexican American for political action. Unpleasant contact with law enforcement agencies and their often discriminatory and repressive practices contribute to a "cult
of suspicion" (Torres-Gils 1982:45). Gerrymandering of districts, laws requiring fluency in written English, discriminatory voter registration practices, and intimidation of prospective candidates are but some of the practices which have discouraged the Mexican American from political involvement (Nava 1970:30). To be motivated politically, one must feel the possibility of being effective. The older Mexican American usually has not felt this possibility.

The traditional American Protestant work ethic views work as a way to avoid the danger of idleness, as an end in itself. The Mexican American sees work as a way to get something done. He realizes no social rewards by being employed merely to avoid idleness (Leonard 1967:248). A lack of good job opportunities for the Mexican American reinforces his feelings toward work and helps explain his tendency to retire at a relatively early age. Other factors which lead to early retirement are the physically demanding jobs commonly available and the often dangerous working conditions which result in a high accident rate for Mexican Americans.

The Spanish language has important social meaning especially for the elderly. It is an integral part of Mexican American culture and is a factor in social cohesion. The elderly Mexican American may feel that he has been despoiled of nearly everything by Anglo society, and his continued usage of Spanish is often used in resentment against the dominant group. He may use the difference in language and culture to isolate himself from a threatening culture (Torres-Gil 1982:47).
A more specific application of the Mexican American views on life, time, responsibility, and authority can be shown by how these views apply specifically to the Mexican American conception of illness and health.

The Traditional Mexican American Concepts of Health and Illness

In varying degrees the Mexican American elderly subscribe to both "folk" and scientific conceptions of illness. Even the most traditional members of this group "share some knowledge and acceptance of biomedical concepts but tend to maintain separate cognitive categories for 'folk' and 'scientific' disorders" (Schreiber and Homiak 1981:299). Various ethnic groups perceive illness and its treatment in different ways. Sociocultural factors influence people's interactions with health professions. Therefore, a knowledge of these factors is important for the health care professional in treating patients of an ethnic group.

Historically, the Mexican American in America has been seen primarily as a source of surplus labor, and American society in general was not particularly concerned with his housing conditions, poor schooling, or the availability of health services. This lack of concern, along with a history of prejudice and discrimination, encouraged many Mexican Americans to isolate themselves from Anglo culture. The Mexican American elderly grew up during a period in history when these discriminatory practices were at their worst. Locked into the role of second class citizens, they were effectively
isolated from Anglo culture. A continuing deep-seated wariness of American society perpetuates their isolation, making it more extreme than that of younger generations. Seen as part of Anglo culture, American mainstream medical services are mistrusted and this mistrust affects the utilization of these services by the Mexican American elderly.

Another factor affecting utilization has been the high rate of mobility for many Mexican Americans. Over the past few decades there has been a major migration from rural to urban areas. In the 1980 Bureau of Census data, 7,659,041 Mexican American persons out of 8,740,439 lived in urban or suburban areas (United States Department of Commerce 1981). This massive population movement was a notable factor in the breakdown of the extended family. Job opportunities which would support nuclear family groups often could not support an entire extended family, and the elderly Mexican American was denied his traditional support system (Stoddard 1973:102). Out of a total of 367,476 Mexican American persons 65 years of age or older, 108,177 males headed a household (31,021 females), 64,028 live with a spouse, 61,349 reside with other relatives. Those who live with nonrelatives number 7,164 and the elderly who live alone are 25,698 male persons and 57,247 females (United States Department of Commerce 1981). The rest live in institutions or other group quarters. These figures destroy the myth that the majority of the elderly live in extended families. Although accurate data for health service utilization are sparse, those available show that more Mexican American elderly now do use mainstream medical services, often after consulting
with friends, neighbors, and relatives, but utilization is still low compared to the need (Valle and Mendoza 1978:73).

A high degree of mobility, especially for migratory workers or newly migrating families, affects utilization of medical services by making it difficult to make referrals and follow-ups on patients. Mobility would also limit a knowledge of available services (Schreiber and Homiak 1981:268).

A general picture of the elderly Mexican Americans can be extrapolated from these demographic characteristics. It has already been pointed out that most Mexican American elderly have low socioeconomic status. This results in low income, poor living conditions, little schooling, and ethnic segregation. The implications of these for the aged Mexican American are several. He has an increased exposure to disease. Access to health care services may be limited due to distance and an inability to pay. Often health care practitioners show prejudice against caring for those of a different ethnic group. This ethnic discrimination may bar or discourage him from seeking health care. His ethnic background, with a limited degree of scientific knowledge, may result in a decreased awareness of preventative medicine and disease control (Schreiber and Homiak 1981:272).

Mortality data show the most common causes of death for Mexican Americans, like the general United States population, to be from heart disease or cancer; however, their death rates from these diseases are not quite as high as that for the Anglo population. But Mexican Americans die more frequently than Anglos from cirrhosis of
the liver, tuberculosis, diabetes, infectious and parasitic diseases, circulatory disease, and accidents (Schreiber and Homiak 1981:279). The high rate of death from these causes can be related to low socio-economic status and conditions of overcrowding, poor nutrition, lack of pure water, and other results of poverty.

Traditional folk concepts of disease are still important to many Mexican Americans and continue to influence their health behavior and particularly that of the elderly. Present-day Mexican American folk medicine had its origins in Mexico in the sixteenth century, when Spanish medical knowledge blended with Indian beliefs during the Spanish conquest. The Spanish element contributed a simplified Hippocratic humoral pathology (Schreiber and Homiak 1981:289). This theory of disease postulated that the human body contains four "humours," some of which are "hot" and others "cold." A healthy body is in equilibrium in terms of contrasting qualities of "hot" and "cold," and illness reflects a disequilibrium reached after exposure, internally or externally, to excessive amounts of "heat" or "cold." Traditionally, illness, or a humoral imbalance, was treated with "hot" or "cold" foods or substances. Today most people are unsure of what constitutes a "hot" substance or a "cold" substance, and treatment usually consists of herbal remedies or topical applications (Schreiber and Homiak 1981:289).

Both Spanish and American beliefs lie behind the concept of disease caused by the dislocation of internal body parts (Clark 1959:170). Each part of the body is perceived as having a specific place and function, and a change in its position can cause illness.
Treatment consists of restoring harmony in the body by attempting to return the body part to its proper position.

Since many Mexican American elderly still subscribe to folk concepts of disease and its treatment, it is important for the health professional to be aware of what a patient means when he refers to one of the following folk terms. Mollera caida (fallen fontanelle), a condition of the very young, is thought to occur when part of the head—the anterior fontanelle—drops, leaving a depression. The displaced part presses down and forms a lump or bolita in the roof of the mouth (Clark 1959:171). The bolita inhibits sucking. The symptoms of the disorder are diarrhea, vomiting, and high fevers, and the treatment is aimed at getting the mollera back in place. This can be done in several ways. Pressure can be applied to the bolita. Sucking on the mollera or the application of an egg or topical plasters may put it in its original position. Mollera caida clinically resembles dehydration caused by infant diarrhea. However, there often seems to be confusion in folk concepts of disease over cause and effect, and the depressed fontanelle is thought to cause the diarrhea, not the other way around (Schreiber and Homiak 1981:292).

Although mollera caida is a condition affecting only infants, it has been included in this discussion of folk medicine and the elderly because it is an excellent example of how cause and effect can unwittingly be reversed and confused. It also shows clearly what is meant by a disorder caused by the dislocation of internal body parts. A second condition related to displacement is described as
lumps or bolitas (little balls) in the tissue of the arms and legs. These masses, probably due to varicosities, are treated by massage (Clark 1959:172).

**Mal aire** (bad air) is sometimes linked to the hot/cold theory of disease. It is thought that air, especially night air, can enter the body and make it ill. The body is particularly susceptible when it has been weakened by stress or overheating (Schreiber and Homiak 1981:296). Other Mexican Americans feel that mal aire causes disease because the air is inhabited by evil spirits which take over the body and cause illness (Clark 1959:173). In either case, the symptoms produced by mal aire are facial twisting or paralysis and are treated by herbal applications.

**Latido** (palpitation) is a serious, often fatal disease characterized by "severe emaciation with loss of abdominal fat and an empty stomach and intestines. This makes it possible to feel the normal pulsation of the abdominal aorta on deep palpation" (Clark 1959:178). It is caused when a person goes without food for a long time and then experiences severe abdominal pains which make it difficult to eat.

**Empacho** (surfeit) also involves the digestive system and is caused by a failure to pass food through the digestive tract. It is believed to be caused by overeating of certain foods (Clark 1959:179) or by being forced to eat against one's will. In other words, it is a disorder caused by one individual exerting his authority over another and throwing the victim's personal autonomy out of balance (Schreiber and Homiak 1981:293). The condition can cause severe
constipation, cramping, diarrhea, and vomiting, and is treated by herbal remedies and purges.

The term *bile* does not always mean a disease, but often refers to an emotional state caused by severe anger. This folk belief comes from the classical humoral theory that bile, one of the four humours, must remain in balance if the body is to be healthy. Extreme emotion causes bile to pour into the bloodstream producing symptoms of acute nervous tension and fatigue. It is usually treated by herbal remedies which reduce tension (Clark 1959:175-176; Schreiber and Homiak 1981:285).

*Susto* (fright) is a physical and emotional disorder which is thought to be caused by a traumatic experience of a physical or social nature. There are indications that some Mexican Americans relate the disease to the concept of "soul loss." The soul is jarred loose from the body by fright and the loss of the soul causes illness. The symptoms, regardless of cause, are varied and in the early stages include stomachache, diarrhea, high temperatures, and vomiting. Persons who are *asustado* may experience loss of appetite, restlessness, weight loss, listlessness, and a lack of motivation. Severe cases are usually fatal and the body wastes away (Schreiber and Homiak 1981:294). There are various cures for susto. In its early stages a hot coal can be placed in a glass of water and a little sugar added. The mixture is then drunk. For a more severe case of susto a ritual is performed using two branches from a sweet-pepper tree and a lighted candle in a saucer of water. The afflicted person walks over the candle while the curer sweeps the branches over his
head in the sign of the cross while reciting the Apostles' Creed three times (Clark 1959:177). Advanced susto is considered nearly impossible to treat. Susto may be a "culturally meaningful type of anxiety hysteria linked to role conflicts and self-perceived social inadequacies," but it may also have a physical component (Schreiber and Homiak 1981:295). It is important, therefore, that the physician consider each case individually when seeking an appropriate treatment, as the disease may be caused by many factors.

Traditionally, before exposure to modern medicine, a curandero (or curandera) was used to treat illness of a physical or emotional nature. The curandero is a specialist in the diagnosis and treatment of folk syndromes. Curanderos are not thought to possess supernatural powers but to have more medical knowledge than the average person. Their repertoire of cures includes herbal remedies, manipulation, poultices, purges, and incantations. There is some indication that aspects of modern medicine (i.e., use of stethoscopes and administration of antibiotics and vitamins) have been adapted by a number of contemporary curanderos (Schreiber and Homiak 1981:310), and that they will often refer their clients to mainstream medical care if the illness is severe. Other more traditional curanderos increasingly find their role to be in conflict with that of the medical professional, and if there is a conflict in advice, many elderly will choose to disregard professional medical advice (Tames and Hyslin 1980:17).

Illness and its treatment has cultural significance for many Mexican Americans, and folk medicine continues to flourish because it
is a functional part of their lives. Although illness is mostly negative in that it causes discomfort and disruption in normal routine and is costly in terms of time and money, its treatment, traditionally at least, involves the whole family. In a positive way it consolidates the family, and by continuing the time-honored folk treatments it confirms their ideas about life and reality. Folk medical beliefs are the framework into which new ideas must fit. If a new idea does not appear to be consistent with the old beliefs, it is rejected or put into a special category (Clark 1959:210).

The framework of medical beliefs is but part of the total framework of traditional Mexican American life. A change, a new concept, threatens the stability, the equilibrium of the traditional Mexican American way of life and may explain why many elderly fear even small changes. The changes are inevitable, however, and have resulted in the rapid assimilation of the Mexican American into Anglo culture. This assimilation has been most dramatic for those who migrated to the cities and experienced exposure to white middle class values and systems. An increase in assimilation and the decline of the extended family should lead to an increase in seeking outside assistance in providing basic health needs.
CHAPTER V

HEALTH CARE SERVICES

Most Mexican American elderly meet multiple socioeconomic and sociocultural barriers to adequate health care. Some of these obstacles are due to the lower class status of the majority of Mexican Americans and are common to other minorities and poor Anglos. Other barriers stem from cultural differences between the Mexican American and the Anglo, differences in attitudes toward, perceptions of, and ways of dealing with illness. Modern medical services and programs have often ignored cultural differences and not been aware of the socioeconomic barriers to those services. Vital to lowering all these barriers is a cultural sensitivity toward traditional Mexican American culture on the part of all involved in mainstream medicine.

Two major socioeconomic obstacles are money and time. Medical care and medicine are expensive, and many Mexican American elderly are not covered by medical insurance. Time is a factor if the person is still employed or if medical facilities are quite a distance away. The situation is improving, but still many clinics are far from the communities they serve.

Transportation can be a major barrier for some persons. Few Mexican American elderly own their own cars (Cuellar 1980:III, p. 39). They may need to rely on friends or relatives who own cars but while they would be willing to ask for occasional help, many would hesitate...
to continue asking for rides on a regular basis if continuous treat-
ment was needed. Many must rely on public transportation which
produces its own set of problems. It may be cost prohibitive. Bus
or train stops may still be quite a distance from the person's desti-
nation. Use of public transportation is difficult when a wheelchair
or walker is needed. Boarding a bus with its high stairs may be
impossible for a weak or ill person. Hearing and sight impairments,
common among the elderly, may make even short trips frightening and
difficult (Gelfand and Olsen 1980:86).

Although some Mexican American elderly speak only Spanish, most
are bilingual, with varying degrees of proficiency in English.
Language and subsequent communication difficulties present formidable
barriers to medical services. Every discipline has its own "foreign"
language, and the Anglo medical profession is no exception. Often
unintelligible to middle class English-speaking Anglos, medical lingo
may be totally baffling even for the bilingual Mexican American. The
unfamiliar words and unfamiliar concepts may bewilder the patient,
who out of politeness will pretend to comprehend what the doctor is
saying. A basic knowledge of Spanish for the health professional is
helpful but is not really adequate for getting into the emotional
aspects of illness (Schreiber and Homiak 1981:315). To eliminate the
barrier language presents, personnel fluent in Spanish, and prefer-
ably from the Mexican American community itself, are needed.

Neglect in having Spanish-speaking personnel on a medical staff
serving Mexican American persons is but one culturally insensitive
action they often suffer. A general lack of sensitivity can give
rise to many sociocultural barriers. Modern medical practitioners tend to be efficient and impersonal, whereas, the Mexican American expects a personalistic, sympathetic approach and may feel that the doctor does not understand his problem or really care about him (Harwood 1981:9). Being ill is a very frightening experience in Mexican American culture and patients and their families need concerned, reassuring care. The Anglo doctor tends to be very authoritarian and expects to have his expertise acknowledged and his plan of treatment followed. He may find his authority resisted for the lines of authority in the Mexican American family are clearly defined and the doctor as an authority is outside those lines (Clark 1959: 213). The wise doctor treating Mexican American elderly will be careful to suggest, not order. While it is true many Anglos also resent this type of treatment by doctors, this feeling is intensified for the Mexican American by contrast with treatment by curanderos.

The fatalistic philosophy of life previously discussed shapes Mexican American attitudes toward health and health practices. Illness and the disabilities of old age are considered inevitable and something to be dealt with courageously and with dignity. A person is not responsible for getting sick; it just happens. As awareness of preventative medicine, germ theory, and hygiene increases, this fatalistic outlook may change among Mexican Americans in general, but not among many elderly for whom the fatalistic view is likely to persist. In Anglo society one often hears such a remark: "You don't take care of yourself. No wonder you're sick." There is a sense of guilt, a feeling of responsibility involved. This sense of
responsibility for illness is totally foreign to most Mexican American elderly, and they are very offended if a medical provider implies that they are somehow to blame for their condition. A patient should never be blamed for his illness; rather a practitioner can suggest how to avoid a recurrence (Clark 1959:196, 232; Schreiber and Homiak 1981:320).

In Mexican American culture a person is healthy, if he is strong and robust and free from symptoms. When he is ill, the symptoms and their alleviation are the main concern. He may not understand that a person can be sick and in need of treatment, when there are no tangible signs of ill health. If symptoms are present, he expects quick relief. This "health seeking" behavior is frustrating for medical personnel who feel that long-term care and prevention of illness are important (Schreiber and Homiak 1981:323).

The elderly patient, who may have had a lifelong experience of consulting curanderos, expects to be given something—an herbal remedy, a massage, a purge. He may feel the doctor is not doing his job if he does not receive a shot, a prescription, or vitamins. He also "knows" that the herbal cures, ritual applications, and other folk treatments work, he has "seen" the results. Wise medical personnel realize that many elements of folk medicine have real therapeutic value, and rather than criticizing folk medicine will incorporate it into his treatment. For example, an elderly patient suffering from dehydration may not see the value of drinking much water but might be willing to drink large quantities of herbal teas (Clark 1959:226).
During required hospital stays other problems due to cultural differences may arise. Hospital foods can be disturbing on two levels. First, the food may not be to the liking of a person accustomed to tortillas, beans, and rice. Mexican American foods should be served more frequently. On a more emotional level, hospital dietary practices often violate the Mexican American concern with "hot" and "cold" foods. Many elderly complain that the foods given to them were "bad" for them because they were too "hot" or too "cold." Patients with such a concern should be offered a variety of foods so that they can avoid unacceptable dietary items (Clark 1959: 227; Schreiber and Homiak 1981:323).

The entire Mexican American family plays a role in health care. In most cases, the family consults together after receiving a diagnosis and plan of treatment. Often the decision of what to do is made by the family for the patient. A Mexican American patient who is pressured for an immediate response to a doctor's suggestions may resist treatment or politely comply and then leave never to return. Because the Mexican American puts such importance on the involvement of family members, it is vital to include them in medical discussions (Schreiber and Homiak 1981:327).

Hospitalization is often resisted, as it may entail isolation from the rest of the family. On the other hand, conflict with the hospital staff can arise when the aged patient expects and receives a great number of visitors. If the patient feels he is being denied the support of the family, he may leave the hospital against medical advice (Schreiber and Homiak 1981:322; Clark 1959:231).
Other difficulties arise from differing attitudes concerning modesty. The Mexican American is very modest and finds the hospital or clinic experience embarrassing. A reluctance to undress or a refusal to give a urine specimen may be seen as a lack of cooperation, while the patient is merely seeking to preserve his/her dignity. The elderly Mexican American patient should be given privacy and treated with respect. Problems of a sexual nature should be handled by medical personnel of the same sex if possible and should not be discussed in a mixed group (Clark 1959:229-230; Schreiber and Homiak 1981:319).

The Mexican American is a proud person despite his deprived state. He may show a great reluctance to seek the medical assistance he needs and to which he is entitled (Trinidad 1977:31). He often meets medical personnel who are resentful at having to deal with a Mexican American person. Elderly patients of any ethnic background are often considered less desirable patients due to an abundance of chronic illness and a resulting lack of satisfaction in treating them. The aged Mexican American patient may feel this double dose of resentment as an affront to his dignity and seek to avoid mainstream medical care as long as possible (Davis 1973:84).

Medical personnel are often offensive in their social interactions with the Mexican American. The Mexican American prefers an initial encounter to be polite, formal, and reserved. He resents direct personal questions and the informal usage of his first name so both of these should be avoided by the physician (Falicov 1982: 148).
Another factor which limits access to medical services is a lack of information. Elderly Mexican Americans, isolated by language and social barriers, may not be aware of services that are available to them. The news media send most information in English, but even Spanish language newspapers and magazines are not effective for disseminating information to elderly Mexican American people as 60% said they never read either. Although this percentage may increase for future generations of the aged, the poor reading skills of this group eliminate information gathering through the printed word (Carp 1970: 131).

Use of the telephone is important for Anglo elderly. Nearly three-quarters use the telephone weekly and over one-third use it daily. Although telephones are available to most Mexican American elderly, they do not want to use them—preferring personal face-to-face communication (Carp 1970:130). This aversion to the telephone rules it out as an effective way of communicating with elderly Mexican Americans.

Other media are more promising. Most Mexican Americans listen to the radio, and over 80% watch television frequently (Carp 1970: 131). Radio and television are very effective in informing elderly Mexican Americans when the information is given in Spanish and by Mexican American announcers.

The most effective way to pass information, however, is through family, friends, and neighbors. Despite changes in the extended family, kinship and friendship ties continue to be strong and the elderly Mexican American learns much about the broader society through
them. Ninety-eight percent still have active family networks, with 66% of the elderly reporting daily or weekly contacts (Valle and Mendoza 1978:52). When experiencing medical difficulties, the community of family, friends, and neighbors is first consulted by four-fifths of the elderly Mexican Americans (Carp 1970:130; Valle and Mendoza 1978:52), and it is only when the illness becomes acute that many Mexican Americans consult with mainstream medical services. Although the frequency of contact with family members increases for Anglos with age, the Mexican American experiences the most frequency at any age (Bengtson 1979:23). Personnel in health care programs should realize the importance of the family and utilize kin and other community ties when seeking to inform the elderly Mexican American.
CHAPTER VI

SUMMARY AND CONCLUSIONS

Interest in the health status of older Mexican Americans has grown in the last decade. A body of information now exists that describes the multiple jeopardies that result from racial status, age, ethnicity, and (for some) language. The elderly Mexican American is viewed as a member of a group that is vulnerable and disadvantaged, struggling to cope with multiple problems. Not all elderly Mexican Americans have these problems, but relative to non-minority elderly, most "are faced with disadvantages that can be traced to a lifetime of deprivation, discrimination, and a lack of opportunities" (Torres-Gil 1986:140).

The minority status of the Mexican American has made him more vulnerable to health problems, yet the elderly continue to underutilize health care services. There are many reasons for this underutilization. This paper has attempted to discuss several of them.

The Mexican American experience in the United States has been one of subordination and oppression. Most Mexican Americans are immigrants or the offspring of immigrants from Mexico. They have entered at various times when it was economically advantageous to United States labor concerns and have often been deported when the labor market was not in need. A lack of job opportunities and low educational attainment have kept most Mexican American elderly in low paying, low status jobs. Most are poor, with 26% of the aged
persons of Hispanic origin below the poverty level (United States Department of Commerce 1982). Many elderly Mexican Americans are not proficient in written or spoken English. All of these factors have kept most Mexican Americans in a lower class position.

Like other minority groups, Mexican Americans have been subjected to stereotyping. They are seen as dirty, dishonest, lazy, and of low intelligence. They have also been discriminated against on the basis of their small size and dark color. Their traditional Mexican values have been unacceptable to many espousing Anglo-Saxon American values. These prejudices have isolated the Mexican American from majority white culture and have made him wary of its institutions, including mainstream medicine.

The Mexican American's needs have traditionally been met by family support systems. However, these support networks are rapidly eroding, as the extended family declines in significance (Torres-Gil and Negm 1980:3). Community and kinship ties remain strong but as a nuclear family structure becomes more common the elderly Mexican American will increasingly need to go outside his isolated community network to receive assistance. Agencies that serve the Mexican American should realize, however, that the family continues to be of great importance and that it should be involved in any decision making.

The Mexican American views illness and its treatment differently from members of the Anglo society. Illness is seen as inevitable, a matter of chance, and treatment is geared toward alleviating its symptoms. He believes in many folk illness categories, such as susto
or surfeit, which may be unfamiliar to the modern practitioner. The Mexican American's views regarding time, responsibility, and work also may be unfamiliar to members of the majority. Therefore, a basic knowledge of these and other cultural differences are vital in understanding this group.

Attitudes can also influence utilization of services, and Mexican American attitudes toward Anglo society and Anglo prejudice toward Mexican American cultural aspects do present formidable barriers to medical services. The language barrier prevents communication and reduces the effectiveness of medical care. It becomes difficult to disseminate information about where to receive care. It is also difficult to teach preventative care or to explain a medical treatment. Other barriers are caused by the prohibitive expense of medical care. Many of the elderly are poor and without medical insurance. Their poverty often discourages them from seeking the care to which they are entitled. Geographic location and a lack of transportation to medical facilities also limit the accessibility of medical care.

The barriers to mainstream medicine are many and the relationship between them is complex. The agencies that are responsible for aiding the Mexican American elderly "must consider not only geographic, economic, and demographic variables but the elderly's cultural and social needs" (Tames and Hyslin 1980:15). Eliminating the physical and psychological barriers which limit access to these services will increase utilization and upgrade the health status of the elderly Mexican Americans.
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