# HEALTH AND HEALING AT WORK:

# SOCIAL NEGOTIATIONS IN FAMILIES OF MEXICAN AMERICAN MIGRANT FARMWORKERS

by

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Health and Healing at Work: Social Negotiations in Families of Mexican American Migrant Farmworkers

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## ABSTRACT

Over the last century, families of Mexican American farmworkers have migrated from Texas or Mexico to northern U.S. harvests, enduring difficult work and living conditions as they follow the sun in search of a livelihood. The health of these workers is poor, and yet they make almost no use of health services, and little is known about their medical practices. This thesis applies ideas in critical medical anthropology -- the importance of wider political and economic processes in shaping everyday healing events -- in order to show how the organization of migrant work contributes to the development of ideas and practices about sickness.

This thesis combines qualitative methodology with a health and demographic survey of migrants conducted in Whatcom county, Washington in the summer of 1989. A second phase of participant observation fieldwork with a migrant family, the Leals, in Texas during the spring of 1990, provides comparative ethnographic data. The comparative methodology highlights the fact that workers may live in three places, but that health care and health beliefs take on meaning when examined as part of the single world of migratory family workers.

Whether at home in Texas and Mexico, or working in northern harvest towns, the Leals and other farmworkers depend on kin for information about medicine and medical help instead of using biomedical services that contradict their ideas about how doctors should treat patients. The male head of household often takes charge of medical matters because his family's

success at work depends on his ability to keep the family healthy and productive. Men are more likely to suffer *mortificaciones* [emotional outbursts] when at work because of the increased pressure on them to control their family. This thesis also highlights how migrants explain locations in terms of health and sickness, "the healthy north and the sick south," which suggests that families use healing symbols to describe how work gives them some measure of control over their lives.

Anthropology's strength has traditionally been in its ability to describe and analyse the minutiae of social life. However, in the case of migrant labour, the wider processes of international migration and the economic needs of U.S. agriculture provide a necessary structural framework for understanding the health and healing events of everyday life.

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I also acknowledge my debt to the organizations and people - all very patient - who assisted me through the many stages of this thesis: SeaMar clinic staff and directors; my supervisors Michael Kenny and Marilyn Gates; and my motley crew of friends: Allyson, Anne, Charlene, Chris, Delphius and Brother Dug.

Most of all I want to thank the Leals for showing me the ropes, giving me shelter and kindness, and opening themselves to my scrutiny. Their eldest daughter Alejandra commented as we parted: "Thanks for putting up with us". I want in turn to thank the Leals and dedicate this thesis to Alejandra, Doña Catalina, Ruben, Silvia and Imelda, with thanks for their patience and their good humour.

## TABLE OF CONTENTS

# INTRODUCTION

Any attempt to write ethnographically approaches fiction. Like a novel, ethnographies describe events and attitudes in order to gain insight into human behaviour. But this ethnographic study, although it seeks to tell a story about certain aspects of a migrant family's life, is not a novel. If it were, it might seek to colour the tale of how an extended family makes a yearly journey from south Texas to northwest Washington state, 'following the sun' as they pick crops along the well-used paths of migrating agricultural farmworkers in the United States. The vision is compelling. More than one million Mexicans and Mexican Americans classified as "migrants" move through the country every year, picking and sorting crops not mass-harvested by machine. Entire families, sometimes comprising three generations, bundle into automobiles in Texas and travel two thousand miles north to pick fruit and vegetable crops in Washington, Wisconsin, Oregon and New York state. Convoys of up to fifteen trucks and cars wind their way across the country to unload at labour camps; ubiquitous small barrack style or wood slat housing units set up on farmers' property. Families work hard, and together scrape up just enough money to make it through the winter. The consistent lack of opportunity, advancement and a way out of the migrant stream forces cohesion and cooperation among families and kin.

However, people today do not often write novels glorifying Mexican American agricultural labourers and their yearly work routine. In the 1930's during the dust-bowl depression, public interest in the white, dispossessed migrating farm family was spurred by Farm Securities Administration

photographs from 1932-1936, documents by Agee & Evans (1939), and Steinbeck novels. The photographs and stories resonated with the (mainly) white readers because many of the dispossessed workers were white, and not Black or Hispanic. Dust-bowl migrants inspired public interest and sympathy, and to this day there persists an ongoing fascination with documenting white migrant life, "a vanishing species,...the end of a line of agricultural labor, the closing of a chapter in American history" (Emmet 1989:xviii).

Meanwhile, Mexicans and Mexican Americans in the west and Blacks in the east have worked the crops since the late 1900's, travelling farther each year as harvest mechanization continues to eat up jobs closer to most workers' southern homes. Even though some journalists describe the Mexican American story (Geranios 1988, Mackie 1987), their poor working and living conditions generally holds little interest for the wider American population because there is no "plight," no anomaly. U.S. agriculture needs migrant workers to harvest crops, and has relied on Black and Hispanic people for 80 years to keep food costs affordable. The potential drama inherent in the story of their yearly journey lacks appeal in a country with a long history of discrimination against Hispanics, and immigrant workers in particular (Cockcroft 1986).

I do not wish to present the Mexican American family I worked with as a special or unique case, a glorified description of the "plight" of the contemporary migrant. Rather, I seek to describe order in the yearly work

patterns of one extended family, the Leals[1]. They tell me that going north is an organized, ongoing, generational process. I examine the social framework of informal networks upon which migration depends. Over and over again the Leals patiently explained to me how important family is to everything they do and how they do it. I focus on health and sickness because all the migrants I talk to assure me that the key to being a successful migrant is owning a strong, healthy body. I present normal work patterns and their relationship to social relations and to healing processes. This thesis seeks to move away from colorful descriptions of the poor work and living standards of 1970's ethnographies (Nelkin 1970, Friedland & Nelkin 1967) and 1930's novels on the subject -- and the inevitable comparisons with the reader's lifestyle -- to present instead the migrant's point of view, one that sees work and social life in much different terms.

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[1] All people in this report have been given pseudonyms and the names of the towns have been changed, although research was conducted in the counties described.

## RATIONALE

This thesis documents family-based circular labour migration and discusses how work patterns can affect the way migrants act around health and healing. Of all the ethnographic categories, medicine offers perhaps one of the most insightful views into a group's practices and beliefs. Medical practices, anthropologists argue, shed light on philosophical beliefs (Comaroff 1978); reinforce ideas about the self (Helman 1985); arise from wider political relationships (Singer 1990); and bring out fundamental relationships between kin and friends (Jacobson 1987). Practices surrounding health also cut across gender categories; across traditional ethnographic divisions of politics and economics; and across the public/private division of responsibilities. Within the limits of a short ethnographic study, health and healing practices offer penetrating insight into wider practices and ideas of a small social group.

Health practices can be examined in two different lights: firstly through the observable processes of seeking health such as using medical services or herbal medicines, or choosing to see a doctor for a cold but not a fever. Secondly health practices reflect action taken about wider beliefs: "sickness episodes also perform an ontological role - communicating and confirming important ideas about the real world" (Young 1976:5). Meaning and practice cross paths regularly. People do not act without a set of beliefs behind them, and beliefs arise from everyday events. In turn, the beliefs explain those everyday events. In short, health and healing are inevitably tied to the world in which they are given meaning; "dynamic entities whose adequacy is determined by their usefulness within the extra-medical social environment" (Hunt 1989:945). When patterns (both of process and of meaning) occur

differently across different groups, an analysis of the patterns can shed light on meaningful issues in the everyday world.

In the case of migrants, health practices are particularly important: their jobs depend on staying healthy. If they aren't well enough to bend over, pick, lift and carry fruit and vegetable crates, then they cannot find work. Health is central to work and work is central to a migrant's life. Because work takes the Leals and other families from Texas to Washington every year, health practices necessarily encompass the services available in all the locations the Leals travel through, as well as the people they come in contact with. The Leals travel 6,000 miles a year. To assume continuity in health practices across four homes and two countries is to downplay the significance that labour migration plays in shaping the structure and symbolic processes of healing.

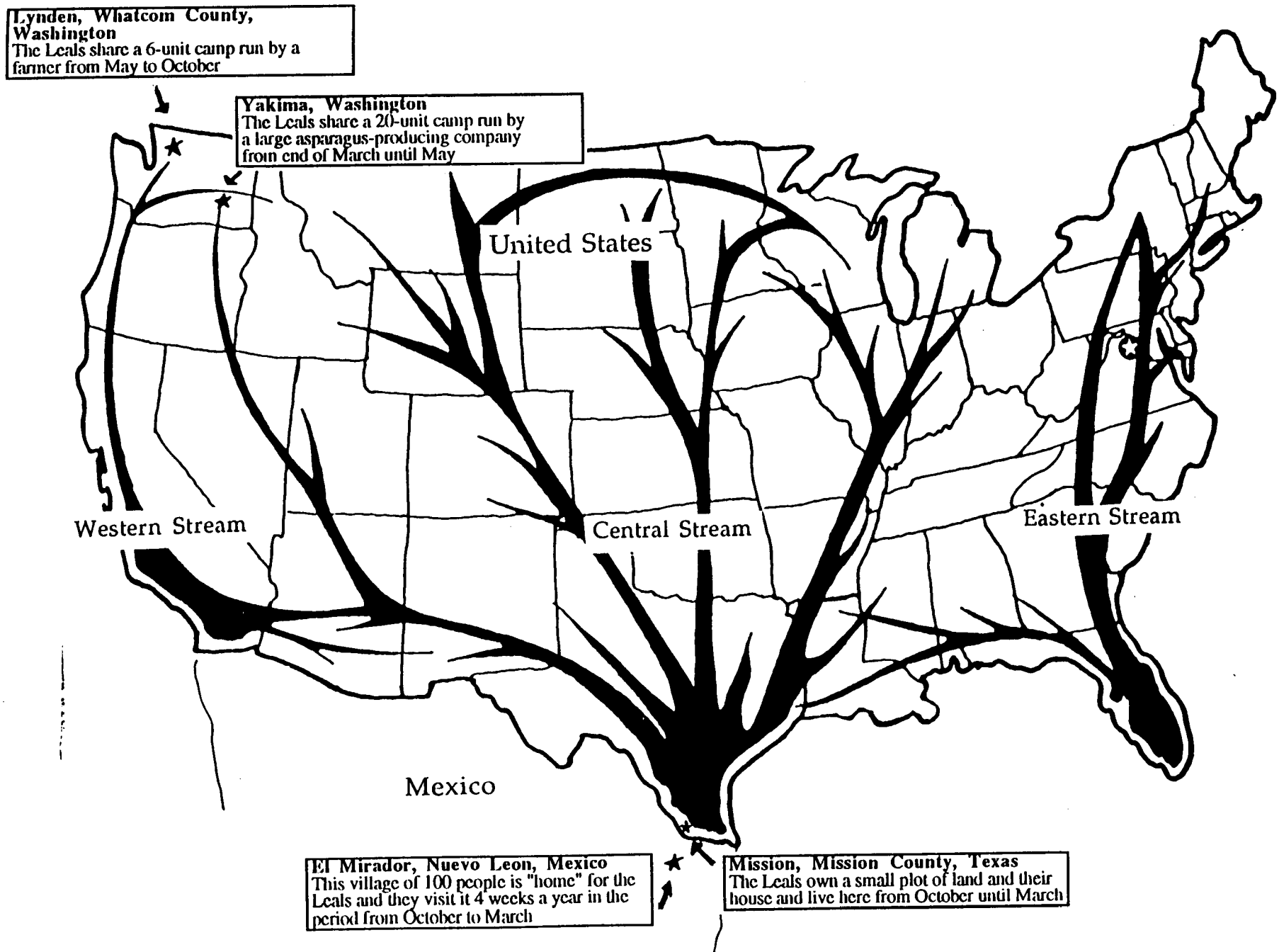
I argue that the healing processes that migrants adopt are tied fundamentally to the process of migration itself. I describe how symbolic explanations about health and sickness reflect the different geographical spaces migrants inhabit and the social relations within which they negotiate getting and keeping work in northern harvests. In order to argue that certain behaviour patterns and symbolic beliefs are specific to a migrant population, I need to define the term "migrant" and to suggest why migrant families form a closed social group, i.e. a "coherent form of social organization" (Barth 1978:13), within which unique patterns of healing and unique ideas about healings worlds can take recognizable shape.

WHAT IS A MIGRANT?

Many Americans term all agricultural workers "migrant", conjuring images of transient, unsettled people. While technically this is true -- workers do follow crops as they need harvesting --, the western stream of primarily Mexican American migrants [see Figure 1] more closely resembles a transhumant population. A transhumant social group makes one major seasonal move a year along a well-defined route instead of making random trips across the country. Migrants from Texas often spend seven months of the year in the north and five in the south, and do not traverse the country at whim for a few days of work. Many Americans also assume that most migrants are either illegal immigrants or Mexicans working on a temporary visa (Cockcroft 1986). While both groups are represented in workers in the western stream, many families that travel north through California and Oregon have lived in Texas or other southern states for a long time. While they may continue to have strong ties to northern Mexico or southern states like Jalisco, the U.S. is their home.

Many Mexicans crossing the border for the first time have no plans to work in agricultural labour but often unwillingly find themselves part of the migrating stream after five years in the U.S. (Portes & Bach 1985). Estimates on the number of Hispanic-origin agricultural workers in the U.S. range from less than 200,000 in the country (Slesinger & Okada 1984) to over 1 million in California alone (Vega et al 1985). Portes & Bach (1985) suggest that 6.5 % of the approximately 14 million Hispanics living in the U.S., or 900, 000 Spanish-speaking people, work as agricultural migrants. Most workers stick to a steady travel route. For example, Californians tend to stick close to home,

**Figure 1.**
**The U.S. Migrant Agricultural Stream**



whereas Texas residents are more likely to travel farther north to Washington or Wisconsin, and work longer shifts once they get there. Thus, even though the agricultural labour force is scattered all over the country (Mexican Americans form a significant percentage of the resident population in almost all northern agricultural states (Portes & Bach 1985)), workers tend to follow the same work route as others living in the same region.

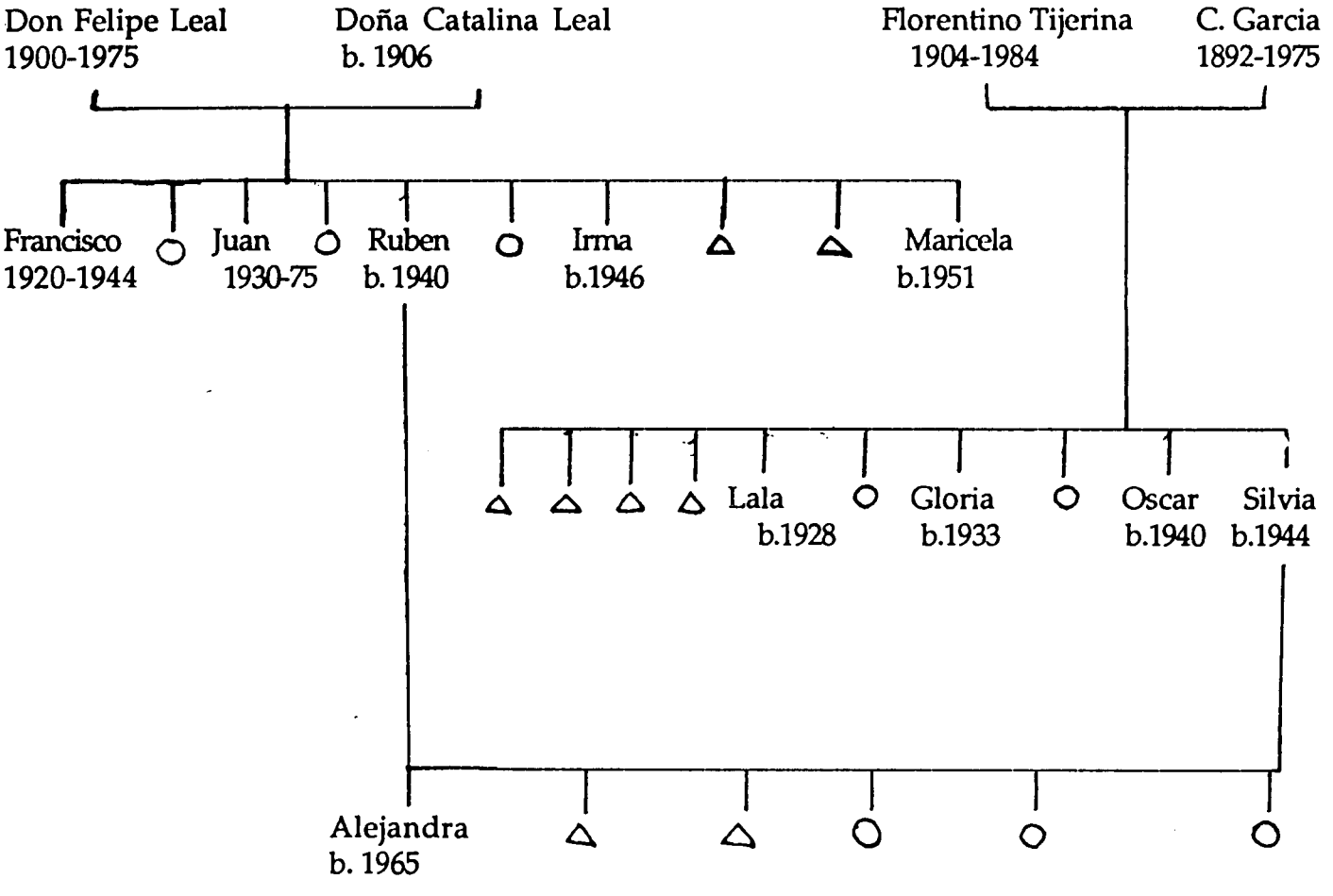
Some researchers and political advocates argue that all Hispanic agricultural workers are Chicanos -- Mexicans or Mexican Americans with a distinct cultural identity and political voice. The Chicano movement gained autonomy, in part, through the grape boycott and United Farmworker (UFW) activism of the 1960's and 1970's. It consolidated its presence as a movement through activism in areas that work to set up, for example, migrant clinics and advocacy groups (Sakala 1987). Because of the UFW's involvement in the early stages of the Chicano movement, farmworkers have been tied to the more political implications of Chicano ethnicity and identity, perhaps at the expense of ignoring the diversity within migrant families and within migrant streams (Montiel 1978). Migrants as a body of people, like Chicanos, come in all nationalities and political leanings. "Virtually every Mexican American family takes several forms and includes many types of people, from assimilationist to Chicano to cultural nationalist and through all varieties including *un español* thrown in every now and then" (Romano in Montiel:30). Agricultural workers include single men newly arrived from Mexico, their well-established relatives living in rural South Texas or Los Angeles barrios, northern Chicanos fighting for Spanish services but working as labourers in the summer months, and determinedly non-political families eking out a living for most of the year. The label Chicano, with its attendant

political implications and evolved sense of cultural identity, therefore applies only to some migrants.

The all-inclusive term "migrant" that researchers use is disputed by migrants themselves. Farmworkers may come from the same ethnic background, but they decide among themselves who fits into the categories of "Mexican American" or "migrant" or "Chicano" (Wallman 1984, Barth 1978). Migrants assert that race and Chicano ethnicity matter less than categories of place and people that they themselves define. For example, family units choose not to associate with single men, Texas-based farmworkers and local Hispanic residents ignore each other, and long-term workers distance themselves from first timers. In Whatcom county, the most northern county in the northwest corner of the United States, an estimated 38,000 Mexicans and Mexican American migrants pass through each year seeking work in summer fruit harvests (SeaMar 1987). Most of these workers live and travel in a nuclear family unit, and yet at the same time have a large number of friends and relatives that work and live nearby that they trust and rely upon. They define themselves as a group, help each other, look out for each other and are more interested in each other than in the lives of other migrants that they might work closely with.

Following the categories that the migrants themselves define, I limit my discussion of migrants to the family-based units that have made the long journey north from Texas, and that have done so for several years. The Leals are one such family that have been travelling for many years to northwest Washington to pick fruit crops in the summer [see Figure 2]. Members of the Leal clan have been working as migrants for three generations, and Silvia and

**Figure 2.**
**The Leal Family**



Ruben Leal and their six children, as well as many Texas friends and relatives, make one trip north that lasts for seven months. They are well-established in the northern communities and work for the same farmers picking the same crops year after year. They leave Texas in March to work asparagus crops in Yakima, Washington then move to Whatcom county for the fruit crops and potato harvest until mid-October. Their story, as well as the tales told by Doña Catalina, Ruben's mother, help to describe the nature of family migration and how they negotiate to keep work "in the family." I argue that the organization of family-based migration results in patterns which affect healing processes as much as their cultural heritage or their identity as Chicanos. The farmer needs cheap and plentiful labour, the migrant needs steady work and the family unit fulfills the needs of both. Migrant families come to depend heavily on other members of the family and on the informal social networks characteristic of family migration, and consequently rely less on formal services or on traditional healers. Men take a more active role in health care. These patterns are most evident in well-organized, long-term working families like the Leals and their extended kin.

WHY MIGRANT MEDICINE?

There is a dearth of ethnographic material on labour migration that deals with medical processes. Ethnographies by Nelkin (1970), Friedland (1970), and Friedland & Nelkin (1967) on migrant labour only focus on the social organization of work, paying little attention to the relationships between migrants and the outside world, and how migrants act to achieve some measure of control over work or healing. Ethnographies of Chicano and Mexican American populations that do discuss healing processes (Clark 1959, Madsen 1964) generally emphasize the cultural heritage behind health care patterns, or focus instead on some universal aspects of culturally specific behaviour patterns (Rubel 1984, Guarnaccia 1989) rather than examining the local context of sickness.

The cultural heritage behind many Hispanic theories of sickness has understandably intrigued many anthropologists. A unique syncretic blend of 17th century humoral theory carried over by early colonizers and re-interpreted within a local context leads to theories about bodily balances, and environmental balances. For example, imbalances are seen as taking the form of "hot" and "cold" in the weather, and "hot" and "cold" properties of foods. If a person gets sick, it is usually because she took in too much cold air, or ate an excess of "hot" foods, thus creating an imbalance in the body that leads to sickness (Young 1981, Willard & Arenas 1983).

Mexican Americans also carry with them a rich tradition of "folk illnesses." These are consistent behaviour patterns that most Spanish-speaking populations recognize by name, from *susto* which is a form of fright sickness, and *nervios* [nerves], to physical ailments such as *mollera caida* [fallen

fontanel] and *empacho* [blocked digestion]. Although the symptoms vary across countries and cultural groups, the interpretation and treatment remain more or less constant (Guarnaccia 1989, Low 1982). The illnesses have a basic structural etiology understood by all: sickness comes from the outside (Crandon 1986, Kay 1970). Factors such as witchcraft, sudden noises, and malevolent glances cause sickness, not the sick person herself or her behaviour. Thus there has been a powerful impetus to examine sickness from a universalistic perspective ignoring the effect of local events or the role of wider political forces in shaping diagnosis and treatment of sickness.

These generalizations about both the symptoms and causes of folk illnesses imply a cultural unity among all Mexicans and Americans of Mexican descent without allowing for variations incurred in everyday life. Anthropologists writing for clinical audiences frequently lay out "folk" illnesses as disease categories that carry a specific set of symptoms (Kay 1970, Schreiber & Homiak 1981). This form of presentation reinforces the notion of homogeneity in folk explanations of behaviour, as well as their inadmissibility in clinical contexts. It places the decisions as to what is a meaningful and appropriate way of looking at sickness into the hands of the medical profession who, however empathetic, generally use this knowledge to make it easier for patients to comply with a biomedical regimen (Anderson 1977, Willard & Arenas 1983). Perhaps, more importantly, it negates how wider political forces as well as local and family-based power games play a role in shaping ideas about sickness. And yet variations in lifestyle, work, family relationships, sociopolitical context, individual and group power and powerlessness can all contribute as much to different ways of explaining and healing the body as do culturally specific theories of balance and imbalance.

In the case of migrants, everyday actions and attitudes surrounding medicine are also shaped by the U.S. political and economic context and the provision of medical care. While migrants earlier in this century were forced to resort to their own devices when someone fell sick, since 1962 the Migrant Health Act allows migrants to receive low cost care, and migrant clinics now dot the countryside in harvest regions. One of the agencies that receives federal funding to operate migrant services, SeaMar clinics, has three different facilities in Washington's Northwest that provide inexpensive, accessible and non-threatening biomedical care. Yet migrant clinics provide services to only 17% of the target population. One reason for such low utilization rates, critics argue, is because federal funding averages $25 per migrant whereas the average American receives approximately $400 in funding (Sakala 1987). Both the quality and quantity of services provided are inadequate (Shenkin 1974). The Farmworkers Legal Action Program and the Farmworker Justice Fund work with groups like SeaMar to lobby the federal government for stricter pesticide regulations and more monitoring of work standards. The provision of health care, particularly for a group with such strong political ties, does not occur in a vacuum.

However, active lobbying by groups who work with SeaMar clinic can affect whether or not a migrant uses medical service. For example, farmers are worried that when their employees go to SeaMar they will be encouraged to join the United Farm Workers and become politically involved in organizing labour movements. Some farmers oppose the clinic because of its political connections and they recommend their workers go elsewhere. Therefore, the politics of health care, as much as cultural heritage and negotiation among

kin, play into variations in health utilization as well as health beliefs across social groups.

I conducted ethnographic research in an attempt to see in what ways everyday work patterns can affect actions and beliefs surrounding health care. Instead of seeking out the rare mentions of *susto* and *nervios* in the migrants I studied, or looking exclusively at health and political organizations, I focused instead on daily health activities, common practices and preventive measures to see how work makes a difference in how people take care of themselves in ordinary circumstances. I argue that the migrants that travel as a family group to Northwest Washington state from South Texas do indeed have consistent patterns, ones which are shaped as much by the demands of work and travel as they are by access to biomedicine, or the long history of beliefs about disease that motivates most other research.

## ANALYTICAL ISSUES

In order to describe patterns of utilization and attitudes surrounding healing processes, I need to situate the family-based migrants in their own world. Their world includes three homes: Whatcom county, Washington; Mission, Texas; and their original home at a ranch called El Mirador in northern Mexico. They left El Mirador in 1982 but many extended family members still remain. Their world is also their kin and its networks. And their world is their work which, including the lengthy preparations for the trip north, takes up most of the year. Yet migrants do not create their world as they please. To a great extent, economic forces dictate the structure of U.S. agriculture. American farming is on the one hand highly mechanized and characterized by large farms and vertically-integrated production (farmers own and control the processes which get the crops from the field to the marketplace -- land, packaging and shipping). On the other side, agriculture still depends on hand-harvesting for delicate crops such as asparagus and strawberries and it is here that migrants play a central role in the production process. As a result, the migrant's world needs to be placed in the context of U.S. agriculture and immigration policy because work contains and channels migrants to the area and the seasons in which they are needed.

U.S. agricultural requirements provide the framework within which migrants construct meaningful systems of explanation and action surrounding health and healing. In other words, symbols of health and healing arise from a complex interplay between wider external forces, including international labour migration, as well as negotiations at the level of the individual (Comaroff 1985). Medical processes cannot be adequately

understood in isolation from the social context within which they are meaningful, and in migrant populations, the context is particularly wide.

Cultural Issues

Sickness[2] is seen by many as a cultural construct (Helman 1985, Low 1985, Kleinman 1986). The term "culture" is frequently cited in anthropological literature to explain variations in sickness processes such as definitions and appropriate treatment for sicknesses, and has generally been linked with the meaning that people give to physical processes (Rubel 1984). However, recent medical anthropology moves away from issues of meaning to look at the wider framework of political and economic processes and how these wider forces shape the sickness process (Singer 1990). For example, diabetes mellitus occurs almost five times more frequently among Mexican-American farmworkers than it does among higher income bracket groups (Scheder 1987). Farmworkers are twice as likely to get diabetes as other low-income groups. Not only does migration, poverty and poor diet appear to increase the incidence of diabetes, but cultural beliefs surrounding blood and blood sugar levels may also contribute to the high prevalence of the sickness in migrants. A central analytical and methodological issue therefore lies in deciding which cultural factors play important roles in shaping sickness -- are beliefs more important than political processes? -- , and how they are given meaning within a population.

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[2] Kleinman distinguishes between "disease" and "illness" on the basis of physiology. A "disease" is a biological process, and "illness" its social and cultural understanding. Such a distinction creates an unneccessary distinction between the social and the physiological. That distinction is of little use in this thesis which looks almost exclusively at the social aspects of medicine. For ease and simplicity, I use the term "sickness" to include both the symptom and the social response to it.

One of the most compelling sets of data on culture's role in sickness arises from theories of "culture-bound syndromes": symptom clusters which are given meaning only within a given population. Latino populations are renowned in the literature for their many culturally-specific explanations of behaviour. While earlier research was concerned with the underlying symptom patterns, or with simply describing incidence and treatment (Rubel 1966, Young 1981), medical anthropologists increasingly try to explain why Spanish-speaking populations bind a set of symptoms into a sickness loaded with meaning while other groups do not. Beginning originally with social explanations which looked closely at relations within the community -- witchcraft and sorcery were often indistinguishable from healing -- (Clark 1959), contemporary analysis examines local social relations within wider structurally defined positions of powerlessness. *Susto* [fright illness] and *ataques de nervio*s [nerve attacks] are "psychological", emotional incidents widely encountered across Central and South America, and in Latino immigrants in the U.S., but with differences in understanding and explanation across groups (Harwood 1977; Guarnaccia et al 1989). People of Puerto Rican descent living in the U.S. explain susto differently than do rural Mexican residents. Researchers increasingly argue that these differences can be understood within a wider frame of reference that includes social, political and economic processes that shape behaviour at the local level (Scheper-Hughes & Lock 1987).

Consequently, medical anthropologists argue that events and actions about sickness need to be placed both into the cultural context of meaning negotiation, and within a wider economic and political context (Singer 1990, Pappas 1990). The local context may include doctor/patient interaction and

community roles as well as ideas about the self (Kleinman 1986, 1980, Rubel et al 1984, Scheper-Hughes & Lock 1987). The wider political context can call up the colonial history of a people, medical policies and the state, and domination and control through the provision of primary health care (Crandon 1986, Comaroff 1985, Doyal 1979).

Political context

As politics can explain medicine, so too can medicine explain politics. Healing systems, by virtue of their boundedness to social, historical and economic processes, can convey a great deal of information about the wider system within which they acquire meaning. As Comaroff suggests, "ideas and practices concerning health, illness and death strike to the core of prevailing philosophical and moral beliefs" (Comaroff 1978:249). This thesis focuses on aspects of healing that are defined by relationships of power and domination. It examines migrant social relationships at the local kin-based level, as well as policy decisions about immigration and public health at the national level.

Across the country officials, employers and policy-makers set up systems to control and manipulate migrants into playing a "game" (Bourdieu 1977). Migrants retaliate by seizing the few available opportunities to get established as a reliable worker in the uncertain seesaw of employer/employee relations and immigration law negotiations. Sickness and health, too, fall into the patterns of domination -- and resistance to domination -- that are part of a migrant's everyday life.

Bourdieu (1977) cogently argues that domination is a game because the position of the dominator is so fragile. Those in control must maintain their

position through everyday practice as much as through systems of coercion. Domination occurs incessantly because "the continual redrawing of the boundaries of social closure and exclusion as new 'fronts' are opened up provides for a re-entry of the problematics of resistance" (Miller et al 1989:16). For example, farmers want smooth-running operations and need hardworking migrants to make that happen. Control must be continually maintained, but cannot always be maintained by force: "the dominant have only to let the system they dominate take its own course in order to exercise their domination; but until such a system exists, they have to work daily, personally, to produce and reproduce conditions of domination which are even then never entirely trustworthy" (Bourdieu 1977:190). For farmers, reproducing these conditions takes the forms that Bourdieu outlines: kindnesses, small favours, everyday manners, gifts and, in the current political climate, sanctioning the provision of health care. Medical aid, like other gifts, is "symbolic violence, the gentle, invisible form of violence" (Bourdieu 1977:192) that coerces and objectifies relationships even as it claims to heal people and improve lives. Without health care and the semblance of genial work relations, farmers would be less able to maintain their positions of control over the farmworker, less able to push for illegal work practices or to promote loyalty within the work force.

This vision is harsh. It depicts those being dominated as coerced into having to eternally play the "game." Yet there is another side to dominance, and that is the effectiveness of resistance, of opposition to games of power and control. Thus, at the same time that medical practice can act as a mechanism for control, medicine can also provide a vehicle for opposition to control. Medical symbols used in healing can come to take on specific meaning within

a historical, political context of domination (Comaroff 1985, Crandon 1986). Comaroff (1985) argues that sickness and health reflect changing political powers. She places sickness and health front and center in an historical account of the effects of colonial intervention on South African chiefdoms. In Tswana social systems, healing rituals and the symbols inherent in ritual processes changed over time in opposition to increased colonial power, and came in turn to act as explicitly expressed opposition to the outside political forces that were reshaping Tswana social structure. In another work on the political context of medical beliefs, Crandon (1986) examines peasants in Bolivia and the ways they give symbolic meaning to sickness as a means to reinforce opposition to colonial powers. Sickness symbols also act as a means to set ethnic boundaries -- to define the community as distinct from the outsider. In both the Bolivian and the Tswana cases, healing processes give ideological meaning to a certain set of symbols, which arise out of a dialectical framework: "the determining force of sociocultural structures upon these processes; [and] the transformative practice of human actors" (Comaroff 1985:5).

The presence of political structures in medical belief systems is also found, I argue, in migrant populations. While there is very little research which looks at migration from the theoretical perspective of medical anthropology, contemporary migration studies provide a compelling framework for studying the relationship between the structure of migration and the healing symbols and patterns it generates. In particular, work by Eades (1987) and E. Marx (1987) argue that dialectical processes are inherent to migrant labour systems. Rather than look at causes of migration, as earlier social anthropologists had done (Mitchell 1961), Eades looks at the process, the

variations in migration brought about by varying political and economic contexts within which population movements occur.

Kinship and Migration

Kinship patterns are particularly susceptible to change wrought by repeated migration. The static view of kinship as a consistent and describable system found within defined social groups is being challenged by recent work which looks at variations in kin processes within groups. For example, farmworkers see themselves as different from third generation urban Mexican Americans, even though they might define themselves as part of the same group. Migrating groups generally take on some unusual characteristics, such as an increased focus on helping siblings rather than helping people by generation (Gonzalez 1969). Migrants may send money to their mothers at home in Mexico, but they are more likely to travel with, and have a consistent helping relationship with their brother or sister who works alongside them. Women are more likely to stay at home while husbands work, leading more than one theorist to suggest that the home resembles more matrilineal societies (Gonzalez 1969). Extended households, where nuclear family households are the exception rather than the norm, occur more frequently when people move (Lomnitz 1977). However, over time the home and the work community come to resemble each other more and more, as people are able to acquire some means of control over their work situation. For example, mothers may join families at work and single men may acquire the financial stability to bring their wives and children along with them. In the case of Mexican Americans, overwhelming evidence suggests that keeping the family together is a key goal (Montiel 1978, Keefe & Padilla 1987, Keefe 1979).

Eades (1987) suggests that kinship relations and kin terms are particularly susceptible to change when groups have steady migration patterns. The ideology of kinship is central to analysis. Labour migration is often dependent upon kin for knowledge about work and resources, and changes reflecting external pressures, and resistance to these pressures most often take form in altered kin patterns (E. Marx 1987, Massey 1985). Migration is a process which encourages the development of ideologies different from those of stable populations.

This thesis intends to demonstrate that healing processes, like kinship, take shape within the framework of migration. Healing can also provide a means for migrants to articulate their identity and to resist the many limitations that migrant labour imposes on their behaviour. Migration creates its own set of beliefs and practices: one of the most important is beliefs and practices about health and healing. In order to describe beliefs [what Wolf (1990) calls signification] and practices [organization (ibid.)], that arise from the dialectical processes of the interplay between worker, systems of control and healing, I begin this thesis by placing healing into the wider context of work. Chapter one introduces the Leals and other Whatcom migrants, and places their history of migration into the context of U.S. immigration policy and its impact on the social organization of agricultural work. Chapter two highlights the organized healing systems and processes available. This chapter stresses that healing in migrant families is fundamentally social in nature and that this characteristic becomes stronger as a form of opposition to formal systems. Finally, Chapter three argues that symbolic meanings given to healing processes are polysemic, that symbols can express ideas about the

social nature of migrant work, and the family's understanding of systems of power within the workplace.

## METHODOLOGY

Trying to get reliable information about Mexican American migrants in Whatcom county is next to impossible. As one researcher commented despairingly, "there are so many migrants out there you wouldn't believe it, but you never see the same ones twice." Rather than work with the idea of migrants as a nameless, faceless and rather elusive group of people [as do locals and quantitatively oriented medical researchers], I attempted to get the workers' point of view through participant observation and surveys. I wanted to get close enough to a family to get their opinions on a wide range of topics, but I also wanted to ensure that the Leals were in some measure representative of what appeared to be the norm of family-based migrants choosing to work in Washington.

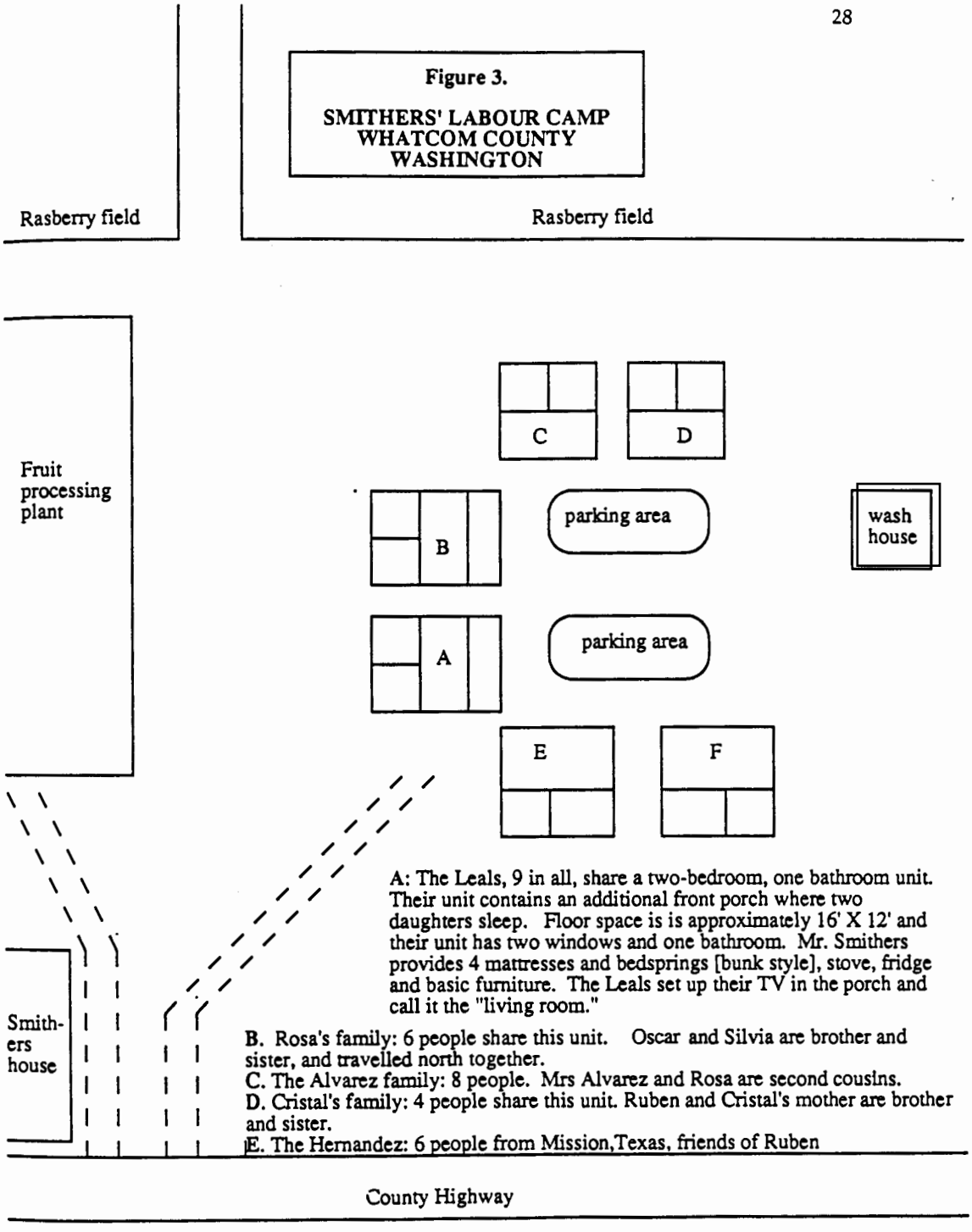
Despite the commitment of social service agencies in Whatcom county, they record virtually no information on the migrants themselves; who they are and where they come from. The agencies' concern lies mostly with distinguishing between a seasonal worker [one who does not leave the state on a yearly basis], and official migrants [those who come in and out of the state to work] and their concomitant eligibility for social services. The first research objectives, then, were to find out who Whatcom farmworkers are, their place of origin, their "home" base, the number of dependents, the number of years travelling, and where, when and why they seek health care. I question local agencies' tendency to view the nuclear families working in Whatcom county as closed social units, and suggest instead that the nuclear family is a boundary artificially constructed from the outside on the basis of ethnicity, work and income.

In order to get a wide-angle view of the families working in Whatcom county, I began research by gathering as much information about migrants as possible over three weeks in the summer of 1989. In a previous undergraduate field research course the class had interviewed farmers, workers, county advocacy and resource agencies. As a result, I was able to tap into some of the more active community organizers for help and information on labour camps and farmers in Whatcom county. The first phase of research in August 1989 in Whatcom county involved visiting all county camps and administering at least two household surveys per labour camp as well as interviewing local agencies such as the Food Bank, the employment office, the county health department, child care centres and medical services like SeaMar clinic and other low-cost medical facilities that migrants use.

Migrant populations embody the difficulties in trying to obtain a representative sample by household units. Housing units can change hands every couple of weeks and household composition varies from single men to three generation families. Additionally, people who work illegally generally prefer no contact whatsoever with people outside the labour camps. Rather than attempting to obtain a statistically significant sample of families working in Whatcom county over the summer, I worked towards obtaining a "judgement sampling" (Honigmann 1973) of families based in labour camps only. Camps differ in quality and in size, and consequently attract different types of families [see Figure 3]. As a result, I attempted to interview families at every labour camp in the county. I surveyed a minimum of two adult heads of family in 15 of the 16 camps in the county, working with the assumption that "even when controlled sampling methods are impossible or

**Figure 3.**

**SMITHERS' LABOUR CAMP
WHATCOM COUNTY
WASHINGTON**




A: The Leals, 9 in all, share a two-bedroom, one bathroom unit. Their unit contains an additional front porch where two daughters sleep. Floor space is is approximately 16' X 12' and their unit has two windows and one bathroom. Mr. Smithers provides 4 mattresses and bedsprings [bunk style], stove, fridge and basic furniture. The Leals set up their TV in the porch and call it the "living room."

B. Rosa's family: 6 people share this unit. Oscar and Silvia are brother and sister, and travelled north together.
C. The Alvarez family: 8 people. Mrs Alvarez and Rosa are second cousins.
D. Cristal's family: 4 people share this unit. Ruben and Cristal's mother are brother and sister.
E. The Hernandez: 6 people from Mission,Texas, friends of Ruben
F. A family from Texas that Mr. Smithers recruited himself in Yakima during asparagus season.

Note: 4 of the 6 families living at Mr. Smithers' labour camp come from El Mirador, Mexico.

inappropriate, the logical link between representativeness and generalizability still holds" (Blabbie 1986:247). I administered 43 questionnaires to adults residing in labour camps at the time of visit, but only 37 of these were completed. Men were initially reluctant to participate in the survey, passing me over to their wives. But once the interviews began, men frequently joined in and often tried to dominate the interview process. Thus the overall information reflects a family consensus on work patterns and medical processes, rather than the opinion of one individual.

By focusing on families instead of looking at the whole community in some detail, I apply E. Marx's (1987) assertion that the social unit in migrant groups includes home and the place of work, and not merely the social group that lives together at the labour camps. Consequently, the focus on one family does not imply that no community is being studied, but rather that the community extends across the country: that social relations occuring across distances by telephone or by mail may matter more than casual encounters over the laundry sinks at labour camps. Additionally, selecting a single family for further research makes it possible to discuss in detail the role of healing practices within the wider structures of work and family life, whereas attempts to conduct participant observation in a camp or at a health center can shed light only on what occurs at that place, and at that time.

As a result, the last phase of fieldwork in Whatcom county involved conducting more informal interviews with a family that appeared to reflect some of the patterns highlighted in the survey I conducted. The Leals and their extended kin are in many ways "typical" migrants: a large, Texas-based family, they spend seven months in Washington state. They travel in a

convoy with relatives and have a large number of kin that also travel through Whatcom county although not necessarily with them. They may appear at first glance to be an isolated nuclear family, in their single-family unit dwelling and in their truck that carries one family only [see Figure 3], and yet informal discussions reveal a huge network of close and distant kin that find the Leals related to someone in almost every camp in the county, in many other parts of the state, and with many ongoing and enduring ties to relatives in Texas. My original sense that groups could be defined by labour camp housing units disappeared and it became increasingly clear that a strong helping infrastructure of predominantly kin relations played a key role in defining social groups. Kin relations and obligations cross county, state, and national boundaries. Just how strong and influential kinship networks are to all facets of migration, including health and healing, became clear to me only in the second phase of my fieldwork, in Texas the following spring.

Over a three week period, I spent time with the Leals and their family in Mission, Texas, although we also visited their ranch called El Mirador in northern Mexico for four days. Most research during this phase concentrated on semi-structured interviews about the social practices of healing; on obtaining life histories; on conducting informal interviews with the Leals, their friends and their relatives; and in participating as much as possible in the family's daily life and in their preparations to go north. I taped what they called "serious" interviews with Doña Catalina and Silvia about their history and their medical strategies. As tape-recording really embarrassed most people, I relied heavily on my ubiquitous notebook, writing down key quotes or words and fleshing these out whenever I was able to sneak a few minutes away from the ever busy Leal household. As one of four women sharing a

bedroom, spare time and privacy was a precious commodity that only I seemed to care about.

The three weeks of participant observation research in Texas provides a comparative perspective which can highlight continuities in processes over space, but also play out the differences. In working with the same people in three different locations -- Whatcom county, Texas, and Mexico --, their comments on these locations provided first-hand explanations of the links between health, space and social relationships. Comparison also allows for triangulation: validating what occurs in one area by comparing it with what occurs in another. While the process of triangulation in itself can create difficulties during the fieldwork process [creating doubt that one person's word is not good enough but needs be checked by another], it strengthens the validity of the research results (Hammersley & Atkinson 1986). While I compiled some of the interviews for ease of presentation in the following chapters, many others are transcribed more or less as they happened, with some editing. I attempted to verify the statements that people gave me, but tried not to alter them beyond recognition in the processes of translating, reducing, and polishing informants' words to meet the standards of academic presentation (see Appendix C for an unedited transcript of a taped conversation with Silvia Leal).

Not surprisingly, I was given the role of outsider throughout the research process. I am a white woman, a Spanish-speaking "American" woman, and therefore unorthodox and independent in the eyes of the migrants. In Whatcom county, armed with my survey and notebook and looking much like the many other outsiders who invade the camps over the summer to

In Texas, where I stayed with the Leal family and close kin for three weeks, my status as a woman became a more significant issue. Because I behave differently, and hold to so few of the traditional norms of Mexican women's behaviour ["She showed up, just like all those American girls do, all by herself, in jeans, with a big pack strapped to her back!", commented one key informant upon my arrival in Texas], my non-traditional curiosity took some explaining. I wanted to talk to the men about farming and how they organize trips north as much as I wanted to talk to the women about food and coping with children's illnesses. Given that all the men I talked to care deeply about family health, the majority of my questions might have been profitably directed towards them, but conforming to expected patterns of behaviour forbade any but the most casual, low-key discussions with men. I constantly came up hard against the wall of *tradiçion*, the normative family behaviour script the Leals follow scrupulously, and even define for others. Thus Wax's argument that women fare better than men in conducting fieldwork because women fieldworkers are allowed greater freedom in crossing local gender boundaries is only valid to a point (Wax 1986). Strict local codes and ethnic barriers can seriously limit a woman anthropologist's behaviour, and define her as an outsider merely by virtue of her presence. As Moore suggests, "the power relations in the ethnographic encounter are not necessarily ones which are erased simply by commonalities of sex" (Moore 1988:9).

I divided fieldnotes into three sections: what actually occurred -- or at least, what I saw and understood as occurring --, what I understood by what I saw, and how I felt about it. In other words, I organized my fieldnotes to appear in order of increasing subjectivity, and made sure that I always began with an

attempt to objectively record conversations and events, rather than emphasizing my feelings on the matter. I did begin some preliminary analysis in the field, which Hammersley and Atkinson (1988; see also Holy & Stuchik 1983) consider an integral part of anthropological analysis but attempted mostly to create categories and codes which I could use later for more in-depth analysis. When I transcribed my fieldnotes I used some of the categories I had devised in the field as well as those which formed the basis of my research questions; the social aspects of sickness, responses to clinical encounters and the role of work in shaping both of these. While I compiled some of the interviews for ease of presentation in the following chapters, many others are transcribed more or less as they happened, with some editing (see Appendix C for an unedited transcript of a taped conversation with Silvia Leal).

Therefore, the boundaries of the social unit under study (Barth 1978) is the extended migrant family. The field of analysis is a description and commentary on social processes across their three homes, and how health and sickness as process and as symbol evolves within the spatial diversity and work patterns of the extended family. I present normal work patterns and their relationship to social relations and to healing processes. If, in the end, consistencies in health and healing practices surface, even though they may sometimes seem far removed from the subject under discussion, I wish to suggest that the context within which medical events occur needs to be examined and discussed as thoroughly as do the processes of health and healing themselves.

# CHAPTER ONE

## POLITICS AND PROCESSES OF LABOUR MIGRATION

*"One needs to study what kind of body the current society needs"*
*(Foucault 1980:58.)*

Migrant agricultural labour holds a specific and important niche within U.S. agricultural production. Landowners need large numbers of temporary workers on a seasonal basis that will withstand difficult working conditions. They consequently organize their harvests to make full use of a temporary supply of healthy labourers. Workers, on the other hand, want good jobs and some measure of control over the workplace. They use their social networks of friends and relatives to improve their working lives. I provide an extensive discussion of both immigration policy and social networks in order to lay the foundations for discussions about health. I argue that health care and health choices are directly influenced by the reality that no worker can afford to ignore her health status. There is no room for a sick person on a harvest field. I present both the structural and the social aspects of work in order to argue that the context these frameworks describe are crucial to understanding how family farmworkers respond to health issues.

This chapter is divided into two parts; the first describes the structural conditions of migrant labour. I begin with a description of family migrants in Whatcom county Washington and detail how immigration policy affects workers' lives, using the Leal's story as a framework for discussion. The second section discusses how family migrants structure their lives in response to the demands of cross-country labour migration and how central family and networks are to the success of workers.

## A: MIGRANTS AS A STRUCTURAL NECESSITY

The Leals, like other long-standing migrants, are responding to the consistent demand for their labour in northern U.S. states. Over the course of the 20th century, U.S. farmers have consistently needed individuals with the physical stamina and willingness to hand-harvest crops. Delicate foods such as asparagus, strawberries and other soft fruits require dexterous handling and packaging, preferably by experienced workers who can assess when fruits and vegetables are ripe and ready to be picked. Farmers also need workers willing to accept piece-work wages. Farmers, however, only require large numbers of people with these skills for a very short time -- the duration of the harvest -- and cannot provide steady work for the remainder of the year. In short, U.S. agriculture depends on people who are willing to enter an area for a short time to work for low wages and leave when their presence is no longer required. "The harvest work force [is] ideally migratory and only semi-captive. That is, a captive work force [is] of use to growers only for the duration of the harvest" (Pfeffer 1980).

U.S. immigration policy in the 20th century reflects the time-specific, skill-specific needs of American agricultural production. At its most basic, U.S. immigration policy generally allows Mexicans legal entry into the country with no further provisos as to which areas of the country need harvest workers. Once inside the U.S. border, Mexicans scatter across the country seeking work on their own initiative. Not surprisingly, agricultural workers have responded to this open field by developing strong informal networks that cross national boundaries. Finding "good" work means seeking out

responsible employers who offer long harvest seasons. Informal networks cross national borders (Wells 1984), and frequently sidestep the categories of "legal," "illegal" and "temporary" workers that policies like the Bracero progam [1942-1964] and the Amnesty program [1986-1988] attempt to establish. Mexican and Mexican American farmworkers use social networks to establish routes across the country that follow harvests as they ripen, year after year. Worker initiative plays a crucial role in giving shape and character to the migrant stream.

The survey I conducted in Whatcom county in 1989 suggests that migrants do not wander aimlessly across the country looking for work. There are a number of consistencies in terms of work and social organization that suggests that migrants are a unified group. While there are some exceptions -- an uncle and nephew from Mexico city, tales of a busload of Guatemalans -- most migrants that work in Whatcom county fit into a fairly consistent pattern of work, travel, and family life. Contrary to local perception that migrants move in from all over the country for the berry harvest, my data suggests that workers follow a steady, recognizable route from Texas. While the number of surveys conducted does not allow for inferential statistics, the consistency of responses suggests that the migrant stream from South Texas to Northwest Washington displays remarkable structural consistencies.

Of the 37 families I interviewed, 24 lived in Texas, and the others were from Mexico (6), Washington state (5), California (1) and Guatemala (1). 65% of the families interviewed live in Texas, and of those, none was a single worker or a couple without children. All Texas residents travelled and lived with kin [see Table 1].

Table 1
Family Organization:

| Type of Family | Number of Families | Number of Texas-based Families |
|---|---|---|
| Single workers travelling alone | 3 | 0 |
| Couples without children | 0 | 0 |
| Couples with children | 26 | 21 |
| Couples with children and other kin [parents, sisters, nephews, etc] | 8 | 3 |
| TOTAL: | 37 families | 24 families |

While not all Whatcom migrants work as family units, it is interesting to note that no single person makes the trip north. In the county just below Whatcom, some farmers are organized to recruit single men and the percentage of single men from Texas there may be considerably higher (Tongue, n.d.). However, Whatcom appears to attract family migrants even though in the rest of the U.S. single workers, or a combination of family/single workers is the norm. For example, migrants in Florida are 80% single men; in Wisconsin, they form 60% of workers (Bleweis 1977, Slesinger & Cautley 1981).

Texas migrants, like other families in the county, work approximately half the year at harvests [see Table 2]. Some manage to work the entire year, but few work less than 10 weeks a year. Migrants often told me that they wanted to turn agricultural work into a full-time job, but that 26 weeks of work would at least get them unemployment insurance for the winter months.

Table 2
Number of weeks adults in family worked in agricultural labour in 1988:

| Weeks worked | Number of Families | Number of Texas-based Families |
|---|---|---|
| 0 -10 weeks | 0 | 0 |
| 11-20 weeks | 4 | 1 |
| 21-30 weeks | 23 | 19 |
| 31-40 weeks | 5 | 1 |
| 41-52 weeks | 5 | 3 |
| Total | 37 | 24 |

Average number of weeks worked by adults in all families: 28 weeks per year

Average number of weeks worked by adults in Texas-based families: 26.7 weeks per year

The range in number of years worked for Texas migrants and for all families interviewed is considerable. More than half of the families have worked for more than five years as agricultural labourers. Most of the families working 11 years and over have their home base in Texas [see table 3]. Two families have been working for 40 and 60 years respectively. Table 3 suggests that Texas-based families form the majority of long-term migrants working in Washington.

Table 3
Number of years worked as migrant labour:

| Years worked | Number of Families | Number of Texas-based Families |
|---|---|---|
| 0 - 5 years | 17 | 11 |
| 6 -10 years | 11 | 5 |
| 11-15 years | 4 | 4 |
| 16-20 years | 3 | 2 |
| 21+ years | 2 | 2 |
| TOTAL | 37 families | 24 families |

Most adults bring along at least one child with them, and 90% of Texas families are larger than four people [see table 4]. Most of the larger families are workers from Texas, and most of the smaller families [1-3 persons], live elsewhere. This reinforces the general trend of large families travelling north to work a long harvest season. 65% of Texas workers travel north in a convoy, and of those who travel with others, 87% say they make the journey with relatives they trust.

Table 4
Size of families sharing housing unit:

| Persons sharing Housing unit | Number of Families | Number of Texas-based Families |
|---|---|---|
| 0-3 persons | 8 | 2 |
| 4-6 persons | 21 | 16 |
| 7-9 persons | 8 | 6 |
| TOTAL: | 37 families | 24 families |

A typical worker in a Whatcom county migrant camp is a Mexican American who lives in Texas, is part of a large family, travels north with family and friends in a convoy, and works approximately half the year in the northwest. A typical Texas family lives and travels as a "nuclear" family. While family contact may be strong, Texas migrants don't appear to share living quarters with people who are not part of a parent/child relationship. Many Texas migrants work in eastern Washington, then move to Whatcom county for the berry season, and return home in time to enrol children at school in early September. Most families live 4 to 6 people in a cabin, in camps ranging in size from three cabins to over 50. Most share public washrooms and washing facilities, and families often try to return to the same housing unit each year.

The Leals structurally resemble most other Texas migrants. Mr Leal has been working all his life in the crops, but he has been bringing his wife and his 6 children north with him for the past 8 years. They stay somewhat longer than the average family does, and harvest the potato crops in September and early October for a total of 28 weeks of work a year. They travel with other relatives that share the same camp with them, and know many people in other camps in the county that hail from Mission or that are related to either Ruben or Silvia.

Yet upon closer scrutiny the Leals differ from most families in many respects. Mr Leal's lifelong association with this type of work makes him adept at establishing profitable contacts. The family manages to find work to keep them earning money longer than most families. They live in one of the few camps that have washrooms inside the cabin. Mr. Leal often holds the job of supervisor which pays more and carries more status than regular harvest work. Mr. Leal speaks English, which gives him a competitive edge over most other workers. In a sense, the Leals are a "desirable" migrant family, and their story reflects their ability to get the best jobs, the best housing and the best job security of just about any family that works in Whatcom county.

The Leals provide an example of how networks and knowledge of U.S. harvests shape their choice to work in Washington for the entire harvest season. The Leals' chosen route takes them up the western stream from Texas straight up to Washington state, where they stay for seven months. "We don't go to California, they don't like families there and the work isn't steady. You work for three days and rest for ten in California. We go to Washington, there you can work steady because they have many different

types of crops. We know we have a good *troquero* [worker supervisor] who gets us good work in the asparagus crops. We've always travelled with him. In Whatcom county, I know lots of farmers that I could work with but we always stay with Mr. Smithers because he gives us steady work for many months", says Ruben, explaining his decisions.

The Leals live in three main stopping places. The ranch in Nuevo Leon, Northern Mexico where Ruben's mother Doña Catalina, Silvia Leal, and many others were born and grew up, is a tiny unincorporated village about 110 miles south of the U.S. border [see Figure 1]. El Mirador has only one main road. The cantina and the school with broken windows form the centre of town; houses cling to the side of the road with fields of corn and sorghum spreading out behind them. Dogs, chickens and pigs compete for dust and dirt to roll in; and people compete for the few jobs remaining in the village that most left ten years ago. There used to be over one hundred children in the school, but now less than fifteen children attend school and there is no community spirit to keep improvements going. "First came electricity, then came the T.V., and now everyone has left to live the better life they suddenly learned about," says Lala, Silvia's sister. Apart from the occasional job harvesting someone's crops there is little work to be found in this once prosperous village. Despite the ghost town appearance, the Leals call the ranch "home" and they return to visit whenever possible.

The Leals' second home is in Mission, Texas, a small town of 2,000 people 15 miles north of the border. Mission is 90% Spanish speaking and most people live on small plots of land they bought themselves, in houses they build themselves from the profits they saved by working up north. Many Rio

Grande residents are migrants. Half of the high school student body is made up of migrant kids who get special dispensations and free books, but can't stick around in the spring to participate in school activities or join clubs and sports. Almost everyone in the valley that can afford to builds a fence around their house, and some construct 8 feet high barbed wire barriers. The Leals take their outside tap off when they go north because otherwise they worry someone will steal their water in the county that rates as the second poorest in the U.S. (Weintraub 1989). Many houses hold more than the formal residents: the back suburbs of the valley appear to act as a holding place for many illegal Mexicans who wait for a chance to get established before travelling north in the U.S., and the area swarms with police at all hours of the day. Yet the social networks of Mexico survive in South Texas too, and visiting goes on all day with relatives showing up from the ranch and friends from other villages actively watch out for others. Families help sick people with housecleaning and help others find jobs. Many are related, and many from El Mirador moved to the same Texas town.

The Leals' third home is in Whatcom county, Washington. There they share a labour camp from June to October with five other families in a pine grove off a secondary road [see Figure 3]. They pick strawberries, raspberries, blueberries, and finish with a month of full-time work sorting potatoes. Like their other homes, this is in the country, but the greenery and trees create an altogether different atmosphere. Too busy to have fun most of the time, the Leals put in seven day work weeks whenever they can. The housing units are not much smaller than their homes in Texas but they spend much of their days outdoors in the field, something that everybody likes. Although they live in Washington seven months of the year, they are usually too busy

working to get out and visit or explore the area. When in the north they socialize with their friends from the south. [1]

Ruben's mother, Doña Catalina and her daughter Irma, tell a tale of opportunities and restrictions in family-based labour migration over the century [see Figure 2]. Sitting in the home in Mission, Texas that she and her husband built in 1942, Doña Catalina, at 80, gratefully accepts the help of her nieces and daughters in keeping the house clean, all the portraits in the living room dusted. Three of her children bought land and houses surrounding her home in Mission, Texas, making Doña Catalina and her home the center of the family and a source of unity. Doña Catalina is the Leal matriarch, and her children and grandchildren watch over her accordingly. Through her tales of life as a migrant in the first half of the century, the family comes to define their history, taking pride in their many successful years of work.

Doña Catalina was born in El Mirador. Pancho Villa apparently passed through El Mirador, she claims, during the height of the Mexican Revolution [1910-1916] when Doña Catalina was a teenager, just before she made her first trip across the Rio Grande River.

"After all the soldiers left we were able to concentrate on harvesting crops, but the crops were bad many years in a row. We wouldn't have gone to

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[1] The Leals also spend 2 months working in Yakima, Washington picking asparagus before they move west to the coast to pick berries, yet they never in my hearing called Yakima 'home'. The labour camp there is large, new and although filled with amenities, very impersonal. Asparagus work is physically demanding. The company also requires workers to sign a contract that they will stay until the end of the season, which often overlaps with the lucrative early days of the strawberry season. Perhaps for all these reasons, Yakima doesn't feel like 'home' and consequently doesn't earn that distinction, even though they spend more time there than they do on the ranch in Mexico.

Texas to pick at all except our family harvest was ruined, the cows got skinny and didn't produce milk for us to sell. I married my husband and that allowed us to leave together. If I was 16 when I got married, then the first crossing must have been in 1922. I must have crossed the river six or seven times those first few years. The first time we went by the river, but the second trip was official. We even had to have our pictures taken so if we caused trouble in the States they could track us down. All six of us, my husband and the four people we travelled with, we are all in the photograph together. My face is so small in the photo that even if I killed someone in the U.S. they would never be able to trace me using that photograph. But that's what we had to do to get work the second year."

"My first four children were born in the U.S., I made sure of that! It is better for them to be American citizens. Ruben is my fourth child. The first year we did fieldwork we lived in a tent, but after that the farmers provided cabins, not that you could live in them. They were just shells, no mattresses, nothing. Workers nowadays have so much; food stamps, beds, stoves, even washing machines. Sometimes my husband and I would sleep under the truck, and let the kids stay in the cabin, that's how small the cabin was. We used to do all our cooking outside, under the 10-ton trucks we travelled in, because there was no room inside the cabins for our stove and the buckets of water for cooking and washing."

"We used to travel in big convoys of canvas-topped trucks. My husband was a *troquero* - a truck owner who was responsible for transporting and supervising workers -, so he had to find the work and decide when and where we would go. There was always lots of work then, we hardly ever

had to leave Texas to find work; now they have to travel to the other end of the world. It's a good thing work was close by because there were forty of us sitting in the back of the truck on wooden benches, being bounced around, sometimes for a whole week."

Irma laughs at the memory, and describes how much fun it was as a child to travel in the trucks.

"We were pretty squashed in the trucks because there were only two benches on the truck sides and the rest had to sit or lie on the floor, so as kids we would spend a lot of time trying to climb up the slats and peer out over the canvas top. Of course we weren't supposed to because we could easily fall out if we climbed too high, but because the truck travelled so slowly we didn't worry. Working wasn't much fun, because we had to help out the family, but travelling in the truck was like a holiday".

Doña Catalina remembers little of the actual locations they worked at, but whenever possible, her husband would attempt to organize a yearly routine.

"We picked carrots in Texas, frijol bean and cotton farther north, and all the way to Idaho to pick potatoes when the crops were good. Not that I did any picking, I always stayed with the other women in the camp and cooked - that was enough work, believe me! I was always looking after the children that were too young to work, sometimes even breastfeeding two or three at a time, and I also carried my invalid daughter with me. All my children worked hard. Because my husband was a troquero he was always busy organizing things, so the kids had to be very responsible and pick hard to make money. In other families sometimes the woman works and then both parents can supervise their children in the field but with us,

mostly because my youngest daughter Maricela can't walk or take care of herself, my kids grew up fast."

"We lived in Mission for a long time, and went north every year. I wasn't legal but we never had any problems until the year they told me I had to sign a piece of paper to say I was a legal U.S. citizen. That was about 1940. I refused because I said then that I would never sign a piece of paper, so we moved back to El Mirador and I had two more kids. Then we became legal, *arreglamos el pasaporte* ['we fixed our passports', although Doña Catalina only holds permanent residency and not U.S. citizenship] - and I had the last of my kids in the U.S. Felipe, my husband, did the circuit without me those years that I was on the ranch, but he always wanted me there. Men always want their wives there so they can cook for them, but it also keeps them out of trouble, away from drinking too much."

"Felipe was a *troquero* until 1964. The only reason we stopped was because he got sick with diabetes, but my sons took over the *troquero* position and could help relatives to find work, just like my husband did. He was a good *troquero*, never made the women work. Now the women have to work and do all the cooking as well, but they say the men help more."

"My mother had to carry around Maricela," Irma adds. "By the time Maricela was 12 she was pretty big and my mother never complained. She would never say so but it was getting hard for her to cook and take care of the whole family and also take care of Maricela. Even though my father would never admit it, his diabetes was bad and he couldn't work very

hard anymore. Plus people started buying their own cars in the 1960's and started to organize themselves a little more. When my parents finally stopped working it became even more important for me and my brothers and sisters to keep on going north. Even though we missed our mother and father, we wanted to make money to help keep the family going. It was during the 1960's that we started going to Washington and Oregon regularly. If we went farther we could work longer. Normally, a woman doesn't work the crops without a husband but I was with my brothers and they took good care of me. We all stayed together in the cabin and took care of each other. "

Doña Catalina does not describe the choices she made in terms of immigration policy and access to U.S. farm fields, and for her politics and policy are not important. Nonetheless U.S. immigration policy played a part in directing the patterns her family's work took over their 50 years in the migrant stream. Doña Catalina always travelled with her family. She would never travel by herself, and only reluctantly allowed her children to make the trip without her. Historically, workers' primary value was in numbers (Pfeffer 1980). Whether it was a family loading up into a 10-ton truck or a group of single men, workers' identity didn't matter to the farmer as long as there were enough workers for the short time he needed them. As a troquero, Doña Catalina's husband recognized the value of family-based farmworkers. Families worked better together, caused less trouble, and took up less space than single men. Families still prefer to cram into one housing unit rather than share public space with others. Families also cause less trouble. They are less likely to protest work wages and conditions because

frequently the entire family depends upon income from harvesting crops as there are no home-based economic activities to supplement harvest earnings.

This family-based pattern of social organization differs substantially from patterns of migrant streams in other parts of the U.S. In the eastern stream in the 1940's to 1960's, mainly single black men travelled within an organized convoy system to camps in the north, then returned to other labour camps in the south in the winter (Nelkin 1966, Goldschmidt 1966). Single men still today rely heavily on organized transportation to find work (Chi 1985). In California today, mostly single men of predominantly Hispanic origin make their permanent home in Mexico and live in barrack style dormitories (Day 1970, Cockcroft 1986). In New York and Florida, a similar pattern of single men sharing accommodation prevails, with an increasing Puerto Rican population (Bleiweis et al 1977, Chi 1985). Both families and single men work together in Colorado and Wisconsin, although single men form the majority of workers (Slesinger 1987, Littlefield & Stout 1987). Even though the family unit is well-established in Whatcom county and some migrants have had the same boss for over twenty years, in today's patterns of migration the travelling family unit stands out as somewhat of an anomaly.

Doña Catalina does not tell an unusual tale when she describes the casual nature of her family's border crossings. Doña Catalina's first trip across the Rio Grande occurred in 1920 or 1921, towards the end of the first unofficial Bracero program ["bracero" literally translates as "strong man"]. The program allowed Mexicans to work temporarily in the U.S. to counter labour shortages because American men were fighting a war (Briggs 1984), yet Doña Catalina and her husband crossed the border illegally. The second year they went a

formal route, and subsequently had their pictures taken. Yet they did not return to Mexico at the end of the harvest season. When Doña Catalina refused to sign a document in 1940 and returned to Mexico, she may have been responding to anti-Mexican attitudes prevalent during the war years that led to regular riots and attacks on Mexicans. She and her family, as illegals, were prime targets (Cockcroft 1986). Doña Catalina never learned about policies or the intricacies of legislation limiting the kind of work she did. As both she and her husband could neither read nor write, interpreting local anti-Mexican hysteria may have led them to return to El Mirador.

Their final return took place during the height of the official Bracero program (1942-1964), which reenacted the First World War's labour shortages and solutions by offering temporary work to Mexicans according to U.S. agricultural employers' needs for the duration of the war. The program was extended 20 years beyond the end of the war, characterized throughout by low farm labour wages, and virtually no attempts to honour non-discriminatory housing and work conditions (Cockcroft 1986). However, during this period, Doña Catalina and family acquired legal status, although braceros officially held temporary employment status only. The family's status when crossing the border was not a factor invoked by Doña Catalina to explain her decisions to cross, or her ability to get work. The conditions of work once across, however, highlight the fundamental powerlessness of the migrant to affect change in the work process.

COMMENTARY

Mexicans and Mexican Americans respond to economic conditions and labour needs of the U.S by acting as a renewable, flexible and ultimately dispensable labour supply. Bustamente (1978) terms them "commodity migrants". The term can be applied to similar movement patterns existing in Europe and other countries where an economically powerful country takes advantage of lower wages in less-developed countries alongside them, and ultimately comes to depend on migrant labour for continued economic growth (Castles 1989, Sassen 1987). In the early 1990's, the general features of U.S.-Mexico immigration are shaped in part by export-zone development in Northern Mexico. Since the 1960's, the Mexican government has promoted an industrial development policy which encourages Mexicans to move to the border region. Men find it difficult to find work in border factories because the *maquiladora* [sewing] industry is dominated by women workers, and as a result men frequently take advantage of the burgeoning illegal document market to try their luck in the U.S. (Fernandez-Kelly 1983). U.S./Mexico immigration also promotes circular wage labour migration such as agricultural work that is sustained through ongoing U.S. immigration policy loopholes (Keely 1989, Bean et al 1989). Immigration into the U.S. also results in work-based enclaves of legal and illegal Hispanics who settle primarily in the southern states or in harvest regions such as eastern Washington, or Wisconsin (Portes & Bach 1985).

The specifics of 20th century U.S. immigration policy towards Mexico reflects U.S. agricultural labour requirements, leading more than one critic to argue that "immigration policy towards Mexicans has not been a settlement policy,

but, rather, a labor policy" (Wells 1984). The two Bracero Programs (the second ended in 1964) and the "green card" program which followed it provided a bridge allowing Mexicans to work in the U.S. until such time as a different Mexico-directed policy could be enacted. The post 1988 Amnesty deadline extensions also provide a striking example of how programs disguised as temporary measures to alleviate labour shortages extend until such time as new policy comes along to replace it. The most recent provisions geared to farmworkers extend from the close of the Amnesty program in 1988: "The intent is to admit [farm]workers....If the secretaries of agriculture and labor certify that shortages exist, workers will be admitted under the replenishment program to replace those who were legalized.. The [programs] are compromises made with the agricultural sector to make sure labor supply is not interrupted while adjustments are made regarding the presumed unavailability of illegal migrant workers" (Keely 1989:168-169). In short, except for short periods of repatriation in the 1920's and 1930's, 20th century immigration policy has consistently allowed a loophole which makes it possible for Mexicans to work legally in U.S. agriculture.

"Commodity migrants" help keep American food costs down because the burden of keeping workers healthy and productive falls on Mexican, and south Texas families, not on the employer (Bustamente 1978). The farmer, the principal beneficiary, only assumes responsibility for the worker while on the job. "By caring for the very young and very old, the sick, the migrant labourer in periods of rest, by educating the young,... [migrants] relieve the capitalist sector and its state from the need to expend resources on these necessary functions" (Wolpe in Marx 1987:152).

Work conditions reflect the government's and employers' lack of concern over sustaining this renewable population. Patterns of exploitation range from *coyotes* [border runners who recruit Mexicans and use their illegal status while working in the states to frequently rob them or pay them less than they are earning] who treat illegals as virtual slaves; to *troqueros* [supervisors similar to *coyotes* except they recruit people with documentation] who often cheat workers through withholding pay; to farmers who underpay workers for piece-work crops. Farmers negotiate with the *coyote* or the *troquero* only, leaving the worker essentially powerless, frequently lost, and invariably unable to return home as debts to the leader and lack of knowledge of the U.S. make quitting more difficult. Living conditions such as quality of shelter and access to water supply little concern the farmer, for frequently workers stay only a couple of weeks and never come back, reinforcing the perception that the farmer is dealing with an endlessly renewable work force.

Bustamente argues that "commodity migrants" fill not only an economic, but also a symbolic vacuum in the U.S., a country "that emphasizes working with brains rather than with backs" (Briggs 1984:108). Mexicans are a dispensable population, he argues, who not only accept minimum wage or less but also accept their social definition as deviants. Migrants play the role of scapegoat for unsuccessful employment policies ; "in times of crisis, the powerlessness of the commodity migrant... makes them a favorite target to be blamed for the crisis" (Bustamente 1978:185). Cockcroft (1986) documents a long history of conflict erupting between U.S. workers and Mexicans over access to jobs during times of economic hardship . Unions and worker organizations, instead of working with migrants to improve worker conditions, frequently

charged them with undercutting efforts to establish satisfactory work conditions by accepting piece-work wages and poor housing conditions. Illegal immigrants who accept work at below minimum wage, keep wages low and take away jobs from American citizens.

Perhaps as a result of this long-standing acrimony between the two groups, it was the Chicano population in the U.S., and not labour leaders, who spearheaded activist movements to try to rectify perceived injustices in migrant work conditions (Montiel 1978). In part, the 1964 War on Poverty Act "set a dramatic precedent in the United States for the preferential direction of resources towards persons identified in the particularistic terms of race and culture rather than in the universalistic terms of class" (Wells 1984:264). However, agricultural worker concerns are perhaps also more basic than labour's: minimum wage legislation, child labour laws, and worksite health standards still remain to be enforced. Nonetheless, in general discriminatory practices within the U.S. are accepted, not challenged and reinforce and legitimize the prevailing relations of production, leading to policy which time and again makes it easy for Mexicans to enter the American work stream, but powerless to change work and living conditions once they get there (Cockroft 1986).

One of Ruben's cousins, Sandra, has been working as a migrant all her life, frequently alongside Ruben and his family. Sandra's family grows smaller every year as her children marry and either find other work or make the journey with their new families. As her husband is sick and unable to work, Sandra worries that farmers will turn her family away one of these years when only the two of them travel north. Much as she hopes her relatives

will show clemency and help her find work, she finds herself after 50 years of migrant labour with no guarantees, no stability, and no reciprocal loyalty between herself and the farmers she has worked for. *"Los migrantes, no comtamos por nada"* [We migrants don't count for anything]. Limited by gender and *tradicion* from seeking work by herself, and bound to the Washington work stream by her connections and her kin, she finds that farmers there only want families because families don't cause trouble, don't try to unionize, and stay for the whole season. Families stabilize and create a more dependable work force, a complement to industrialization: "the nuclear family, because of its mobility, can conform to the vagaries of changing jobs" (Nash 1979:86). As a single worker with an ill husband, at 52 Sandra's options are almost all used up.

The economic structure that underlies worker demand provides a powerful framework which many workers are powerless to change. Nonetheless, if a family is large, healthy and hardworking they are a valuable commodity, and are consequently in a position to negotiate, to establish a presence through collaborating with others which allows them some measure of control over their work and personal lives.

## B: SOCIAL NETWORKS IN LABOUR MIGRATION

The network of kin that thrives underneath formal policy crosses national boundaries. Despite changes in immigration policy, people consistently communicate and help one another, whether they live in Texas or Mexico and whatever their legal status. International migration is a social, as well as an economic process. (Massey & Garcia 1987). Research on the role of social factors in immigration processes suggest networks play a crucial role in shaping the different patterns of labour-based movements. Mexicans, like other immigrant populations, often go to areas in the host country where they know others from home (Portes & Bach 1985). The economic "pull" of labour harvest requirements doesn't account for the social structure of Mexican American migrant workers. Kin processes are affected by the economic needs of the employers in the north, but in turn kin processes play a role in defining the shape of family based Mexican American migration. To assume that the leap from crossing the border into the U.S. to picking fruit in Whatcom county Washington can be explained solely by international market demands and labour mobility underestimates the role social networks play in directing people to certain work streams in the U.S.. Migration transforms social processes.

However, social processes also transform migration, in particular, the processes of circular wage labour migration. The repetitious act of circular labour migration generates a relationship between the home and the place of work that transforms both locations ( Marx 1987, Watson 1977, Graves 1980, Massey & Garcia 1987). Kin relations and informal networks tie the

geographical spaces together. It is not space, but the social relations that occur in spaces, that anthropologists examine as the migrant social system: "the labour migrant's life at home and at work can be understood within the framework of one social system" (Marx 1987:150).

The following account connects the Leals' work status in Washington with a closely-related family in Nuevo Leon, Mexico, and seeks to show how national borders and legal status are perceived as impediments to ideals of family unity, and not as effective legal barriers to seeking work in the U.S. The Leal's kin network extends over 2,000 miles; this wide resource pool allows them to shape their social world, and alter in turn the social world of the migrant farmworker community in Washington they live in for seven months of the year.

Ruben and Silvia Leal have been married for 26 years. Ruben was a 'catch' in Silvia's eyes because he owns land, makes good money as a migrant, and holds American citizenship. Most importantly, however, his parents were born on the *rancho* and he grew up there. He knows about the highly religious, kin-based, land-centred life at El Mirador, believes in its *tradicion* of gender roles -- *el hombre manda aqui* [man rules in El Mirador] --; of carefully monitored child-rearing practices; of chaperoned dances where only girls over 15 can dance with boys preferably over 25; of love for the family dominating all else. Silvia correspondingly provides Ruben with traditional desirable qualities in a wife: she is a devout Catholic; a firm but loving mother; and supports him in all his decisions. Both hold positions of high respect in all the communities they live in, and are loving and caring. As their eldest

daughter Alejandra says; "They always go everywhere together and hug each other all the time. How many parents do you know who still do that?"

While Ruben has worked crops all his life, first with his parents Doña Catalina and Don Felipe and later with his brothers, he only brought Silvia and their six children north to Washington with him in 1982. Before that, Silvia alternated living in El Mirador and Mission, Texas, where all her children were born. Silvia's brother Oscar, his wife Imelda and their four children were all born and grew up in El Mirador as well. "His family and my family, we are close like this", says Silvia, and she lifts her hand and scrunches all her fingers together to show their love for each other. The Leals moved permanently to Mission, Texas in 1982, leaving Oscar and Imelda behind on the ranch. Imelda and Oscar had never left Mexico until 1988, when they heard about the agricultural worker policy in the Amnesty program.

Imelda describes how Ruben and Silvia concocted a way for her and her family to get across the border:

> "When Oscar and I were on the *rancho* [village] we had no land, he and the kids would have to work for others for $10,000 pesos a day [$4 U.S.] a day. That's nothing! We did whatever agricultural work was available, I sewed and sometimes Oscar would play music, but there was no life for the kids, my sons would never be able to *mantener* [support, sustain] a wife and kids on the ranch. So we decided to go north when Ruben told us we could get legal status."

"They say that before, every time a *migra* [border police] would turn his back, a Mexican would dive into the river and swim across, but now with the Amnesty program it's a lot harder. They have been patrolling hard since 1986. Ruben has a friend who lives on the border and knows when the police eat their lunch: they all like to eat their main meal together, so for half an hour a day nobody patrols the river. One day when they were eating all six of us jumped into a giant inner tube and paddled across the river. I was scared, I can't swim, but I wasn't scared enough not to try."

"As soon as we made it across we were bundled into Ruben and Silvia's truck and he took us to the little shack at the back of his sister's house where we hid for seven weeks, long enough for the paperwork to go through. Ruben had got us papers that said we worked 90 harvest days in 1985. We memorized everything we were supposed to have done; I even pretended I knew how much it hurt to pick onions! We stayed in that hut for seven weeks because Ruben said we had to wait six to eight weeks after applying for amnesty before we could get a temporary work permit. Ruben had already found us jobs up north even before we made the river crossing, but we wanted to make sure we had legal permits before we headed north because the *migra* [border police] patrols all the way to Houston and beyond. So we hid, and Silvia fed us because we had no money, and when it was time to go north we went in Ruben's truck because we didn't have a car. 15 of us fit into one truck, like sardines. Then we had to stay with Silvia and Ruben for another 10 days in Del Monte's labour camps until we got our own place. Ruben got us 7 months of work that year, that's a lot, way more than most migrants get even if they have been working 20 years."

> "We did it, took the risk, to get ahead, to make a life for our children [*para progresar*]. If it hadn't been for Ruben we wouldn't have been able to do it. We have even started to build our own house in Mission and that is because we get lots of work through Ruben. Sometimes when I am picking very hard my back aches and we don't ever seem to make any money, and we live in ugly labour camps, it doesn't seem like progress to me. But yes our life is better, much better. One has to suffer to get ahead [*Hay que sufrir para ganar*]."

*Hay que sufrir para ganar*- "Suffering" includes more than poor work conditions and the perception that there will be many more years of hard work before Imelda can rest. It distresses Imelda to leave her mother in El Mirador, so far away that they cannot afford to take time off to drive down and visit her during the harvest season. Nobody likes to leave Doña Catalina in Texas without the full complement of family support. Imelda knows a lot about herbal remedies, but is too far away to give advice to her sick father who would normally rely upon her for help. Suffering therefore also means putting up with work that is far away from family. Ties that bind Imelda and Silvia's family to Texas and Mexico do not dissipate over time or over distance, rather they become stronger (Keefe 1979, 1984, Keefe & Padilla 1985), sustaining emotional needs, but also sustaining the kin networks necessary to productive migrant work.

Imelda's move from El Mirador to Mission entailed calling in more social favours from family and friends than merely following Ruben's initiative and organization. In Mission, Ruben's three sisters live next door to their

mother, and all assisted in helping Imelda make the move, even though they owe her no formal kin support. Neighbours tacitly agreed not to report the family to the *migra*. Up north, where Ruben enjoys a long standing friendly relationship with Jock Smithers, the farmer he works with for 5 of the 7 months they spend in Washington, they ensure together that documents are legitimate, avoiding the issue of whether the worker herself is legal. As Mr. Smithers says: "All I want to see are the papers, I don't care where they come from." Ruben negotiated with the farmer to have Imelda and her family in the cabin alongside his, and convinced him that, even though they have never picked fruit for a living before, they have the strength and stamina necessary to do the first rate work Mr. Smithers demands from his employees.

Ruben negotiates with ease and charm. He uses a combination of convention and innovation in his network strategies to overcome the large geographical distances between kin. The norms of *tradicion*, interpreted from those of the ranch to provide behavioural scripts that work in the American context, provide Ruben with even more social responsibilities than he would hold if he stayed on the ranch. He is the eldest son in his generation and therefore assumes responsibility for his wife, his children, his mother and all his brothers and sisters. They call on him for rides to the doctor, to school, to work, for advice, for financial assistance and reassurance in times of need. As head of the family, he oversees his children's education, upbringing, protects his daughters, teaches his sons. Thus, *tradicion* requires him to always act first and foremost as provider for all relatives to whom he is responsible.

Within the norms of *tradicion*, however, he does not have to take care of Imelda and her family, yet he does so with enthusiasm. When time came to

take Imelda north, he called in favors he spent many years and much effort accumulating, favors that cross national boundaries. In El Mirador, Ruben is an important figure; he owns land, tractors and a house, and gives large parties every time he visits the ranch. Many owe him favors there. In Texas, his tireless patience with needy relatives places him in an authority position where few would question his requests for help. In Washington, Ruben presides over his large family; all are hardworking, non-drinking, and obedient. He speaks English, drives a tractor, is responsible and since he owns and farms land himself, he enjoys discussing agriculture with Mr. Smithers who in turn respects his opinion, values his family, and profits from his ability to informally recruit other large and hardworking families to fill the camp. When Ruben calls in a favor, people try to comply. Consequently, subtle negotiations about kin in one place can, and frequently do, extend to other locations. Ruben knows this, and seeks to establish reciprocal relationships in all his places of work.

COMMENTARY

Social ties are a migrant's most valuable resource (Eades 1987). Lamphere (1980) argues, following the Bott hypothesis, that strong nuclear family ties prevail when couples work together, and that the basic unit of responsibility remains the nuclear family even when families move. In the case of Washington migrants, economic gain revolves around successful family production. Since work conditions depend upon family units of production, it follows that the family would therefore be the most important unit. There is little organized room for what Lomnitz (1977) calls "the extended single roof household", where more than one family live under the same roof. Frequently, migrants do protect their family territory, and concern appears to

focus on their family only: "In the car going north to work, just me and my family go, no exceptions", one migrant asserts. Nonetheless, extended kin networks provide a wide protective net, and the Leals' story suggests that a great deal of time and energy goes towards sustaining reciprocal relationships with friends and relatives. The formal nuclear family unit, exemplified by divisions in labour camp housing by family units, regularly holds more than the family it is supposed to, and informal kin networks create a social system in which the house is merely a shell covering complex and enduring social ties. For example, 87% of Whatcom county families that travel in convoys going north do so with other relatives. Imelda shared living space, a convoy ride north, and was on the receiving end of her sister and brother-in-law's generosity for several months, in a culture in which "a married woman does not share her kitchen". Their close relationship suggests this family accepts responsibility for siblings as much as for parents and children (Gonzalez 1969), and not, as might be expected following Lamphere's argument, a dominant focus on caring only for the nuclear family.

Comaroff argues that an effective way to maintain control over social groups is through manipulating the structure of family relations (Comaroff 1985, also Nash 1979). An effective opposition to this tactic is to sustain and nurture wider networks in order to allow negotiation at the workplace. The isolated nuclear family is the ideal work unit for farmers: it is passive, mobile and unlikely to actively attempt to unionize. Families, however, do not exist in isolation, and recruiting suitable families also requires the employer to negotiate. If Mr. Smithers wants to keep the Leals happy and working for him, he needs to compromise his basic needs, hands for harvest, to accommodate Ruben's social negotiations. While Mr. Smithers modifies his

work practices to meet the Leal's needs to a certain extent, he argues he will make an effort only to the extent that it benefits his business. "I'd winterize those cabins and put in heaters if I could get the Leals to stay all winter, I've got lots of work for them to do, but they won't stay. I work around schooling and housing regulations because he and his family are hard workers. If he says someone is a good worker I trust him. He can recruit enough good people that I'm thinking about building more family-sized cabins".

Cordell & Beckerman argue that, when the focus shifts to people as manipulators of norms and relationships for their own social and psychological benefits, "rather than as passively obedient to social and institutional norms" (Cordell & Beckerman 1980:2), kin studies can profitably examine relationships between environments and kin processes. Established reciprocal relationships in a migrant population then, no matter where they are located, can contribute to changing the processes of migration. The Leals call in favours to have Imelda's family up north not only because Ruben benefits by recruiting yet another large and hardworking family for a preferred boss, but also because his relatives provide his family with social support in many ways, not least of which is for medical matters.

Social networks give power, both in getting work and in sustaining the south Texas migrants' social world at their work camps in the north. The following chapter builds upon the importance of wider family networks to argue that health, and keeping healthy, are important considerations invoked in decisions about which people one supports most. Not only are social networks a migrant's greatest resource in finding work, but social networks remain a crucial resource in issues of caring for oneself, and seeking health

care when someone gets sick. The tradition of caring for others, and looking after others, crosses over into issues of sickness and health, particularly when the financial well-being of migrants depends upon their ability to accomplish physically demanding tasks on a daily basis.

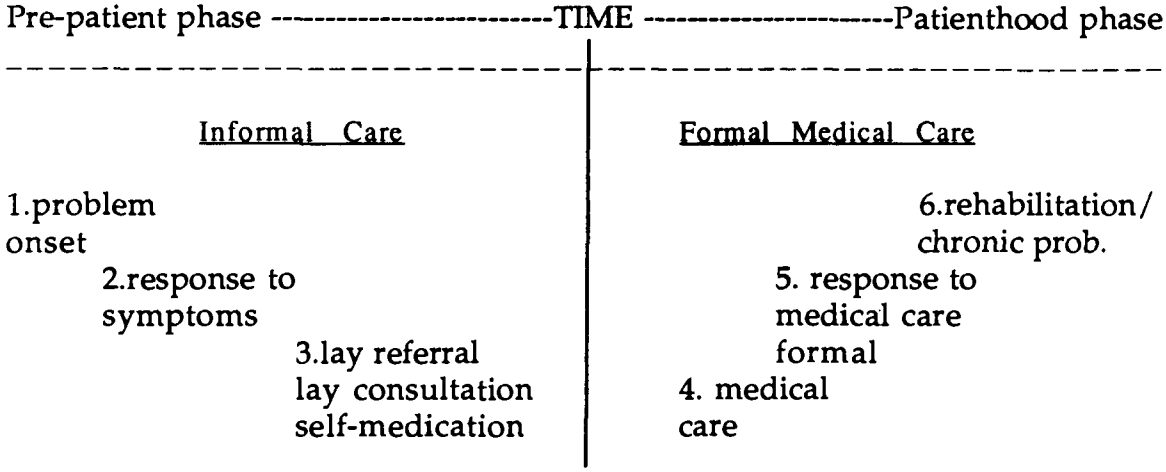
# CHAPTER TWO

## " KEEP IT IN THE FAMILY": CONFLICTS IN BIOMEDICAL TREATMENT AND SOCIAL HEALING

Tucked away in the back of the Leal's truck along with the tools and buckets of soap and lard lies a small plastic bag of medicine. Stocking up on medicines from Mexico, "good, strong and cheap", is part of Silvia and Ruben's yearly preparations to go north. They buy with prevention in mind, relying on knowledge about past illnesses in the north to be ready for any potential sicknesses. By preparing in advance, they try to avoid seeking medical help. Silvia states firmly: "I buy these medicines because I don't want to have to go to the doctor up north. It's expensive, not very helpful and they hardly ever cure your problems". The Leal's are not alone in their preoccupation with avoiding medical visits. Most migrants carry a bag of preventive medicines from Mexico, ranging from medicine for headaches to one woman's old turquoise hatbox stuffed full of syringes, needles and tranquilizers which she sells and administers to camp residents. Having medication on hand keeps treatment processes, whenever possible, within the domain of family and friends. "Illness is a family affair" (Bullough & Bullough 1982:80).

"Informal" negotiations -- consultation and treatment occuring outside "formal" systems of medical care -- frequently operate alongside biomedical diagnosis and healing processes (McKinlay 1981, Jacobson 1987) [see diagram 4]. Indeed, it is a truism to say that all sickness events involve interpretation using informal knowledge such as family opinions, home remedies, and "old wives tales" (Kleinman 1986, Hunt 1989, Helman 1978).

**Diagram 4**
**Typical Sequence of Stages in Help-Seeking**




from: McKinlay, J. "Social Network Influences on Morbid Episodes" in Eisenberg & Kleinman *The Relevance of Social Science for Medicine* 1981 Dordrecht: Reidel.

In the five social stages of a sickness episode that McKinlay outlines, only one involves a formal medical visit. The other four occur outside the realm of formal medical care. The clinical encounter, brief, antiseptic and fundamentally distasteful to most, often leaves no lasting impression on people's understanding about sickness. Ideas from other people often help form ideas about sickness. Like many, the Leals and their extended kin hold to ideas about sickness that arise from family discussions and as a result the processes of healing also often stay within the family.

Keeping treatment within the family goes against current Western medical knowledge and practice. Ill people are supposed to consult a medical "expert" because this increases the chances that they will get better. "When in doubt, consult your doctor" is a common refrain heard in the U.S. and in pamphlets written up for migrants. This chapter discusses the conflicts that arise from

the fact that migrants don't use the clinics which have been set up specifically for them. The migrants I talked to refer to their family and friends first, leaving the doctor's definitions and advice as a last resort. As a result, I argue that getting migrants into clinics can be seen as a friendly form of coercion, because getting people to see themselves as "patients" is a necessary prerequisite to promoting well-being. Yet medicine, like other "games" played at work, also gives migrants the means to refuse to play into a process which doesn't benefit them.

After a brief overview of the institutional framework of migrant medical care, this chapter looks at a SeaMar clinic, a Whatcom county farmworker clinic and the strategies it uses to get people through its doors. The second section describes some of the medical alternatives the Leals call upon to reduce their chances of ever having to rely on biomedical help offered in a form which they don't consider legitimate. Migrant clinics, even though they are staffed by caring Hispanics and try to cater to migrant needs, simply do not fit the healing model the Leals and other migrants look for when they need help.

## A: BIOMEDICAL PERSPECTIVES: A MIGRANT CLINIC'S COMMUNITY

The growth of migrant clinics in the last 20 years follows 1960's opposition to poor work and living conditions. Health conditions before medical services became more readily available through the 1962 Migrant Health Act were "abysmal" (Rudd 1975). Doña Catalina describes how the only medical personnel she saw for twenty years were the Red Cross nurses dressed in white who came into camps to inoculate workers. Merely setting up a clinic, however, won't change statistics. It took the efforts of the United Farm Workers (UFW) in California during the late 1960's to make the Federal Government realize that it needed to establish a separate set of resources for farmworkers' use. The UFW set up the first farmworker clinic of its kind with flexible hours, Hispanic staff and doctors who recognized and looked for cases of pesticide poisoning (Day 1970, Davis & Johnson 1975). Farmworkers flooded to the clinic. The political implications of a clinic successfully run by the UFW, along with continued lobbying by Chicanos and other ethnic groups, may have led to a modification of the Migrant Health Act in 1970 to provide low cost care to both seasonal [within-state workers] and migratory [out of state] workers and their dependents.

SeaMar clinics, based in Seattle since 1975, is a non-profit organization that runs three clinics in Northwest Seattle. It lobbies for funds at the county and state levels and tries to increase its allocations by providing a variety of health-related services. The most northerly clinic opened in Bellingham in 1988, offering consultation with a rotating nurse-practitioner, doctor or psychiatrist. Low cost, flexible hours and a bilingual staff -- except the doctors

themselves -- are the clinic's main selling points. However, SeaMar's medical director Dr. Castro laments; "We can never provide enough services. We got money to provide pre-natal support for 25 mothers for the first time this year, and we still had 25 more that came in that we couldn't help."

Migrant clinics need to maintain a certain number of patients in order to maintain levels of funding. They also need to justify their existence by showing how they improve the migrants' general health conditions. SeaMar uses two main bodies of research as leverage to demand increases in funding. These two research areas are the health status of migrants and their patterns of utilization. While this type of data depends upon the patient actually visiting the clinic, it provides enough evidence to support activists' claims that migrant health ranks alongside "third-world countries".

The first general area of research is health status. Farm work is the United States' second most dangerous occupation. Not only accidents but illnesses arising from poor work and housing standards contribute to health patterns among farmworker populations that rank among the poorest in the nation (Sakala 1987). They die younger than other Americans: the average life expectancy in 1980 was only 49 years, compared to the national average of 62 years (Geranios 1988). This puts migrants in the same life expectancy range as people in Indonesia, India, Burma and Sudan. The infant mortality rate [29/1000 live births] is 25% higher than the U.S. average (Slesinger et al 1986), as are deaths from tuberculosis (Hibbs 1989), influenza and pneumonia (Neibel 1985). The incidence of diabetes, in particular, is three times higher in Mexican-American populations than in whites, and five times higher in migrant populations (Rosenwaike & Bradshaw 1989, Scheder 1987). Diabetes,

high incidences of diarrhea, nausea and vomiting, and miscarriage rates seven times the national average lead more than one researcher to blame sickness patterns on the pesticides, poor housing, sanitary conditions, and uncertain water supplies that prevail in the work conditions of the migrant (Sakala 1987, Arbab & Weidner 1986, Moses 1988). Schreiber & Homiak (1981) and Bullough & Bullough (1982) argue that the high disease and death rates of migrant workers are only tangentially tied to the farm work itself, and that poverty and ethnic discrimination override accidents and work-related sickness to create barriers to adequate health care. Lack of services, as well as work conditions, are seen as factors which contribute to poor health.

The second main research area, utilization patterns, receives considerable attention in contemporary health research as part of a wider movement to rectify health inequalities (Castro n.d.). Provision of low-cost, "culturally sensitive" services geared specifically to migrants over the past 20 years has not changed a basic pattern: migrants use health care facilities less than either the American norm or the Mexican-American norm (Slesigner 1981, Chi 1985, Littlefield & Stout 1985). Migrants are said to express a "general ignorance of the preventive health concept; they usually called upon the medical profession only when their symptoms of illness reached crisis proportions" (Chi 1985:484). Time, economic factors, and a general fear of the medical profession explain the "crisis" approach to using medical services (Newquist 1985, Tongue n.d.).

SeaMar adopts the biomedical model in its understanding of the physical body, where the patient has a mechanistic, individualistic body that is divorced from its social environment (Lock 1988). Such an ego-centred basis

for treatment can conflict with patients whose social and human world shapes a different set of ideas about sickness and treatment. Doctor and patient may leave the clinical encounter mutually frustrated with each other, reaching no consensus about healing processes. "The doctor didn't cure me all at once" complains a farmworker. The doctor later confides that "15 minutes of someone's life is nothing. I know they won't come back for a checkup and they probably won't even fill the prescription I wrote out for them" (Shane n.d.). SeaMar and other migrant clinics respond to the migrants lack of interest by arguing for the need to improve and increase services across the country since migrants clearly are not receiving adequate care. Migrants in turn react to the type of services offered in various ways, the most common of which is developing a set of preventive measures: preparations which reflect the social world they live in and not the doctors' diagnoses.

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Because most migrants live in camps without telephones and SeaMar has limited advertising funds, the clinic provides an outreach service to inform migrants of their existence. Alicia Dario's job takes her to labour camps where she puts up posters, chats with migrants, and spreads the word that SeaMar clinic will look after migrants when they need help. As a former migrant herself, Alicia's empathy and concerned assistance are probably SeaMar's best marketing device.

Alicia describes her work routine:

> "We get a lot of people in here who just don't have any money whatsoever. If they can scrape enough together to visit the clinic but

don't have enough to pay for the prescription or take the bus, or get clean, or eat, then the staff sends the client to me. I call all the agencies in town that can help with donations and the agencies are pretty good about helping out when they can. We had a woman come here last month whose husband had abandoned her at the bus station a couple of weeks before. She had been to lots of agencies in town and some had helped her but a local mission turned her away. Her son had hepatitis so I called around to the Food Bank for food and furniture donations and to the Salvation Army to see if they would pay for her son's prescription. I also got a crisis center to put her up in a motel. We gave her some canned food and clothes. I'm only supposed to do outreach services, that is, go to camps and make sure people know about the clinic, but I spend a lot of time just helping people get what they need so they can survive and maybe get a job. Of course, the kind of help we give makes the clinic look good in the migrants' eyes, and they think well of us on the whole, but we are limited as to what we can do. We can only help someone once, we can only give free medicine once, and we can only assist real migrants -- that is, out of state workers -- because our funds won't let us help local seasonal workers very much. I can't help someone on a long-term basis. Nobody in town provides long-term assistance; we do what we can during the crisis and hope things get better."

Another link SeaMar sets up is providing medical services to La Aguila daycare, a migrant child care centre funded by the Washington State Migrant Council (WSMC) that looks after migrant children aged 3 months to 5 years. Before being admitted into the daycare, each child must have a physical

examination, proof of inoculation, and various other health-related documents. These policies are common to U.S. daycares and La Aguila staff believe their policies are much more liberal than most daycares: they will accept children who are quite sick, they have long hours, and they do health "maintenance" as part of the daily routine. The latter involves daily health assessments, weekly staff reports where an unwell child is given more extensive health assessments and then described over a speaker phone to administrative staff in a distant town.

SeaMar staff visit the daycare twice over the summer to do a complete physical on all children. SeaMar supports this type of health intervention because they believe that access to daycare children "is often the only chance we get to assess the state of migrant children's health" (Ramirez n.d.). However, assessing health often leads to a diagnosis which entails placing the child on a medical regimen. "We will give your child prescribed medication at the Center according to WSMC policy. The necessary forms for that purpose must be signed at the Center's office before medication can be given. Medicine must be prescribed by a doctor. Non-prescribed medicine will not be accepted at the Center", states the daycare's pamphlet (WSMC 1989). There is no option. If a family wants to use the daycare they must conform to its health standards, which frequently leads them to SeaMar clinic.

Conforming to medical standards often conflicts with a family's ideas on health and healing. For example, the daycare is on the alert for young children who might develop physical or mental handicaps. Isaac, who is 8 months old, is developmentally delayed according to one of the staff. The parents, however, do not perceive any development problems. Daycare staff

feel that the parents are "blind, ill-educated". Upon the staff's insistence they took Isaac to the clinic -- which the parents paid for -- where the parents said he was cursorily examined and provided with information on nutrition and exercises. The parents do not wish to alter their customary feeding patterns and do not wish him to be removed from daycare because they do not consider him 'sick'. While the parents bring in the requisite medication and paperwork they don't give the child medication at home; they provide Pablum for daycare hours but feed Isaac tortillas and other acceptable foods in the morning and at night. Meanwhile staff continues to encourage them to seek a full physical checkup, and the family continues to insist there is nothing wrong. SeaMar, when they do their annual "free" checkup, may diagnose and prescribe medication which the family cannot afford and does not want.

COMMENTARY

SeaMar, the UFW and community Chicano groups have strong ties and publicly state their political goals to improve standards of living and fight discrimination against Hispanics at the state and local level. By working together they have successfully lobbied for funds to open a psychiatric unit in the county, to increase Hispanic participation on city councils and to maintain existing levels of funding for SeaMar. Nonetheless, their funds depend on producing patients, and to that end SeaMar recruits migrants to the clinic as aggressively as it defends its legitimacy at City council.

If statistics support the expansion of services, then patients must be found to fill the time slots, whether the patient feels sick or not. Consequently, SeaMar supports research which documents poor health, and below-average

utilization rates for Washington migrants (Castro n.d.). SeaMar appears not to examine major studies such as Littlefield & Stout's (1985) Colorado study, and Slesinger's work in Wisconsin (1981) which all suggest that migrants make use of a wide range of services. A study conducted in the summer of 1989 suggests that Washington migrants delay seeking help for chronic illnesses until they can be treated by their preferred Texas or Mexican physician (Tongue n.d.). Thus, utilization is a year-round phenomenon, dictated perhaps as much by choice as by necessity. Many migrants, though by no means all, don't like clinics. Yet choice, the individual patient's needs and beliefs, don't fit into SeaMar's funding equation. A new doctor comments with wonderment: "I can't believe how few real [as opposed to local Hispanic-speaking] migrants we actually get here, and how hard it is to convince them that we are here for their good. At least 40% of the migrants who make appointments don't keep them, and follow-through rates are about 90% no-shows. I can't do a good job if they don't cooperate." Outreach programs and free yearly examinations for children are a necessary part of SeaMar's healing strategies, and they essentially replace voluntary cooperation on the part of the "patient".

SeaMar's efforts to expand its services can be seen as efforts to get patients to cooperate. This entails a subtle form of coercion. By falling into the network of services, migrants use agencies who often seek to define them and put boundaries around them. Migrants are strangers; "dirty, illegal, fatalistic" stereotypical farmworkers (Bustamente 1978, Zamiro n.d., Collero n.d.). Boundaries matter to the people who set them up (Barth 1978), and in this case the community through its charity networks sees work, language, and ethnicity as crucial boundary markers that separate the "us" from "them".

Charity keeps migrants off the main street of the town. Charity workers comment on migrants' untrustworthiness: "You have to be careful who you give donations to, half the time they don't really need the stuff; they throw out the food and furniture. I'm not convinced that because they are migrants they need the food bank." says one manager of a local food bank. Another food bank operator was less charitable. "All migrants lie, they abuse the system, it's just like a game with them, they come in to hassle us."[2] Food banks, like other charities, do not respond to individuals in need, but rather perceive "migrants" as a separate category, a needy group that has to be checked and supervised by getting lists of families from farmers and demanding ID cards before doling out free food.

When SeaMar associates with local agencies such as La Aguila daycare, the Salvation Army, Food Banks etc., they reinforce the very image they work to eliminate. Health care provides just as much opportunity to define and delimit groups as other types of organizations. When farmers refer workers to the clinic or to the food bank, it is as if they are making a present of the service. "Those who benefit from an asymmetrical distribution of power must work directly and personally to maintain the conditions of existence for their daily domination. The dominant cannot appropriate labour, services, goods, or the honour and respect of others without establishing and maintaining an interpersonal bond" (Miller et al 1989:15). Along with Mr. Smither's out-of-season strawberry gifts, his trip east to asparagus farms to

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[2] Migrants take advantage of their anonymity to gently harass food bank volunteers. Men will band together and go into the food bank in groups of 5 or more, claim to speak no English, and play dumb if they are told they have exceeded their bi-weekly allotments. They usually end up with more food than if they choose not to play this game.

visit his favorite families, the Christmas bonuses and winter telephone calls "just to see how things are going", migrant-centred health services fit into the package of paternalistic service provision which serves to maintain existing work conditions. As Nash, in her ethnography on Bolivian tin miners suggests, gains in basic life necessities often come in a package with paternalistic benevolence: "The gains...in health, education and welfare were real gains in the objective conditions of life, but...they often served to squelch the initiative of workers and to put them down and convince them of their inferiority at the very site where the service was offered" (Nash 1979:119). The farmer benefits by having a panoply of services from which migrants can choose as it keeps the migrants "happy" and at the same time reinforces their work role as temporary, unwanted outsiders. When migrants begin to use services and identify them as options, they are more and more likely to accept their position as migrants, as transient family workers without the benefits UFW and other advocates would like to implement, but with a separate set of benefits which are meant to make up for low wages and poor work conditions.

While SeaMar's aggressive recruitment of patients can be seen as the "medicalization of life" (Scheper-Hughes & Lock 1987) -- the ever-expanding role medicine plays in everyday activities. Medicalization also helps to control people in this particular case by making publicly available a service which maintains boundaries between workers and locals, and limits opportunities for change. SeaMar's goals are laudable and their achievements in getting money and services for an underserved minority is remarkable. Nonetheless they alienate their potential customers through the kind of services they provide, and through the methods they use to get

migrants into clinics. In the long run, SeaMar functions more as a political agency for which clients are valuable currency because they are migrant workers, rather than as an institution whose sole goal is to improve the health of workers as cheaply and universally as possible.

B: SOCIAL PERSPECTIVES ON HEALTH: KEEPING IT IN THE FAMILY

Imelda thinks American doctors are a big waste of time and money:

> "If you think I am going to wait for three hours so that the doctor can take my clothes off while my family sits outside in the waiting room, and so that he can make me buy expensive medication, well I'll have to be pretty sick indeed. Then he'll try and get me to come back a week later so I can wait for another three hours and get poked some more so he can tell me I'm all better. Well I know I'm all better, what do I need him to tell me that for! What does he tell me I don't already know? Nothing!".

Invectives of this type colour most of Imelda's comments about all American doctors, be they SeaMar staff or private physicians. Doctors in America, she maintains, don't listen to her, know her or trust the knowledge she brings with her to the clinical encounter.

While the migrants I interviewed have used medical services in most of the communities they work in, their choice generally is to make greater use of resources they know and trust, that is, their family and their friends. By taking precautionary measures to keep themselves out of the clinics, migrants maintain autonomy in healing practices that forces medical services like SeaMar into devising complex ways to get migrants to accept the biomedical way of treating sickness.

SeaMar presents a medical front to the public, and to Imelda it looks just like any one of a number of clinics she sees across the country. Clinical staff take

people away from their families, examine patients by touch, and prescribe cures which involve no one but the sick person. In contrast, in El Mirador, several people go at once to the doctor who often examines the patient from a perch 10 or 15 feet away and who prescribes medicine in such quantities that others can sample and discuss the effectiveness of the medication. For Imelda, accustomed to the El Mirador system of care, if the doctor follows American medical procedures such as the examining room, then "I'll just wait until I get so sick I can't work and then I'll go right to the hospital where they make you better right away." Not surprisingly, people like Imelda continue to depend on social resources and information they can obtain outside the doctor's office because the people she trusts reinforce, rather than challenge, her ideas about health and healing.

For Imelda and other interviewed farmworkers, SeaMar does not meet medical needs. When asked what factors prompted migrants to seek medical help, emergencies, specialists and an ability to speak Spanish were cited as three important reasons for seeing a doctor [see Appendix B]. This suggests that the interviewed migrants saw doctors as people with specific functions, to be called upon for specific ailments rather than as a resource for more common ailments. Non-emergencies such as chronic illnesses deserved less medical attention.

SeaMar's services fall short in many workers' eyes: they have no specialist on duty, they don't provide emergency services and many of their doctors don't speak Spanish. When asked what other resources migrants used for health care, most listed several relatives, including husbands, wives, mothers, mothers-in-law, whom they often contact by telephone sometimes two or

three times weekly, and Mexican pharmacists known as *farmaceuticos,* renowned for their over-the-counter diagnoses and strong, cheap drugs (Logan 1983). Not only does most healing happen outside the clinic, most migrants appear organized to keep things that way. The following two stories detail aspects of the Leal's healing strategies. The first is a tale of prevention, but prevention as defined by Silvia within the framework of her family's health. As such it little resembles the biomedical preventive ideal -- fruit after meals and regular exercise -- that SeaMar promotes, but arises from a different set of beliefs shaped by the dangers of migrant work and the consequent focus on the family. The second vignette describes how Ruben and Silvia negotiate gender and kinship roles to keep health as much as possible within the realm of their family and its peculiar brand of support.

Silvia's preventive measures

Every spring, Silvia goes on a pilgrimage. If she can motivate her children to rise at 5:30 A.M., they too make the trip, but otherwise she goes with Imelda or Gloria a couple of weeks before they travel north. This year, Silvia, Imelda and I prepare for the event by wearing washable sneakers. The road to the shrine is dusty, and we leave early so that we've finished the trip while the sun is still weak. Ruben drops us off in the center of Mission and from there we walk to the village of San Juan where two shrines stand in a church garden. Although the walk is no more than two hours long, winding through suburban residential areas, past their children's schools and through two small villages, Silvia and Imelda complain bitterly because they hate walking. Exercise when you harvest crops, they explain, is a good thing, but the rest of the year, forget it! Going on a walk is a major sacrifice. Along the way, Silvia and Imelda explain why they make this yearly expedition.

"What I am doing now is making a deal with God", says Sylvia. "I want a safe year, a safe trip there and back, a year where we are all well. The pilgrimage cannot change whether crops are good or whether work is good, but I can tell God that I want a safe year for my family. If God keeps me and my family safe and healthy, then I tell God I will return next year for another pilgrimage."

"If we have an accident, it is the will of God [*Si Dios quiere*]. But if I go on a pilgrimage, I am showing him he is all powerful, and that my family and I try to be good, I am reducing my chances that he will take anyone in my family. Most people who go north don't go on a pilgrimage, but I want God to know that he is responsible for our well-being and that I am trying to show him that I know that. So I make this trip every year for him. It is a sacrifice I make for my family".

This is Imelda's third year working as a migrant, and her third year on the pilgrimage. Although more pragmatic than Silvia in household matters -- "We are poorer" she explains -- she retains the devoutness of most ranch residents. Thus she explains her hard work and cheerful demeanour in the face of adversity to God's blessing, her *progreso* [progress] to God's will. Pilgrimages allow her to say thank you for keeping her and her family well and prosperous.

"Every year I make this sacrifice with Silvia, because the most important thing for me is to be blessed at every stage of the trip north. When we get to the shrines, I will light candles for a safe trip for our family, and another candle for everyone else who is going north. I make sure I fill up two bottles of holy water, one to sprinkle on the

doorstep of our house here, and the other to take north with me to spread around the house at the asparagus camp. This way we have holy water with us in the truck's glove compartment for the trip, which makes for a safe trip, and then we make our house safe by blessing it before we move in. Once the house is blessed we know we will all be strong and able to work hard and save money for our house here. We have done this every year since I moved to Texas."

Silvia interjects, "It is tradition in our family to go on a pilgrimage if someone is sick. When my first son was a baby he was very sick and was going to die, and Ruben and I made a deal with God that, if he spared Junior, when he was two we would go on a pilgrimage to San Isidro and cut off all his hair and leave it at the shrine there. Junior got better, and so we kept our promise even though it was a very very long walk".

"I often make deals with God which is okay as long as you keep your promises. You can't ask for too much, and you have to keep your promises. For example, when my children get sick I ask him to make them better and promise to burn holy candles in the kitchen for a week if they get better. When they do get better then I burn the candles and pray more. You have to keep your side of the bargain. That is why I go every year to the pilgrimage to give thanks because God has kept us healthy and safe all year."

The family as healing resource

Sitting over interminable cups of coffee and cigarettes, Silvia likes to sit back and talk, make jokes and explain how she takes responsibility for her children. While generally very loving , she claims -- and others support the notion -- that occasionally she is *cascaruda* [stubborn, bossy]. Does that make her the boss? Ruben laughs and says "Yes." Their eldest daughter Alejandra says "No, we behave well because we do not want to cause *mortificaciones* [physical manifestation of emotional distress] in my father. He's the real boss. If he had *mortificaciones* that would hurt us all very much".

When it comes to healing practices, the same hierarchy prevails: Silvia appears to hold the voice of authority on sickness but Ruben supervises and provides everyone with the incentive to stay healthy. Silvia explains their family's mutual dependence:

> "The first and most important thing is that I do everything with Ruben, including buying medicine and going to the doctor. I will ask Imelda or Gloria for advice often, especially Imelda for advice on herbs and medicines because she knows a lot. But it is Ruben's and my responsibility to take care of our family, and that is why Ruben is so helpful when we need to go to the doctor. If Ruben wasn't around and one of my kids got very sick then I know everyone in the camp would help but it is best when we can take care of all the problems ourselves. It is Ruben's responsibility as the head of household to make sure that his family is healthy. If we don't stay healthy then we can't work together as a team in the field, and this is very important to us. We make money if we work as a unit. The family is the most important thing."

"In order to keep our family healthy up north Ruben and I prepare before we leave, even though we don't get sick very much when we are up north. I have learned not to worry -- when I go to the clinics up there it is just to have my blood pressure checked. Ruben once had his checked and they told him it was high so now every year before we start work we get it checked but it is always normal so it seems like a waste of money to me. Clinics in the U.S. are expensive. When I was growing up on the ranch the only doctor I ever saw was in Monterrey, 150 miles to the south. Later they set up a clinic at the ranch for *practicantes* [interns] and they charge only what you can pay. So I only ever went to those two doctors until I moved to the U.S.. Even now I prefer Mexican doctors. There is a doctor in Las Flores, right across the border. He will treat you and cure you *de una vez* [all at once] which for me is an important sign that he is a good doctor, and he only charges $20 or $25 for the visit and medicine; that's Mexican medicine, it's stronger and better than what an American pharmacist will sell you, plus you don't have to get a prescription in Mexico. Once one of my daughters got really sick and we waited at the migrant clinic in Texas for four hours and I was so worried I told Ruben to take her to a doctor in Las Flores, Mexico, just any doctor, I didn't know anyone there at the time. Well the doctor in Las Flores saw us right away, we didn't have to wait and my daughter got better the next morning, we didn't have to go back at all. So now I always go to him when I have to go to a doctor, *yo le agarre fe* [I put my trust in him]. "

The stockpile of Mexican medicine Silvia carries with her serves her both in Texas and up north.

"When I carry medicine for common illnesses like coughs, colds, the allergies Imelda and I get from working inside with the potato crops, medicine for back pains, then I feel confident I can take care of just about anything my kids or I might get. I know Mexican medicine better than American, and the directions are written in Spanish. So for common sicknesses I hardly need ask for advice, but I'll still talk to Imelda about it anyways. For something that seems more serious, I check with Ruben right away but Imelda and Gloria will worry if someone is sick. They give me lots of support, more support than real expertise".

"Now if you think I bring a lot of medicine with me, you should see what Imelda stocks up on. She doesn't like to spend money on American doctors so she goes to the pharmacy on the way home from the ranch in Mexico and buys whatever medicine she guesses she'll need. If it's on sale she'll stock up. She also collects herbs from the ranch, and watches for this tiny, fiery hot red chili which only grows in northern Mexico that she buys by the kilo because she claims it is good for cholesterol. We don't run over and borrow each other's medicine and herbs every time we get sick, but she is a big help to me when I need advice, and like I said, support for when there are real problems. You can always trust Imelda to suggest a remedy which involves food or prayer. She'll go for medicines and herbs after that if they don't work, but I think Imelda would like to cure everything by eating."

DISCUSSION

Informal practices include more than mere negotiations among kin. Religious practices, different medicine options, different types of doctors, and confidantes all play into why migrants claim to use American doctors so little in a given year [see Appendix B]. Yet if the number of visits included Silvia's regular trips to the *farmaceutico* which frequently involve a free rapid diagnosis along with the medicine purchase, or if discussions with Imelda counted as a consultation, then Silvia probably seeks medical help at least as frequently as the average American. However because Silvia works as a migrant farm labourer her medical practices reflect the need to stockpile drugs with directions she can read, to avoid expensive doctor's visits by assessing their value to her rather than their correctness, and to invoke religious beliefs to come to terms with the dangers to physical well-being inherent in migrant work on the road and in the field.

Two consequences of migrant work on healing practices merit further commentary. The first suggests that when family role responsibilities change because of the demands involved in migration then the family also changes its healing practices. The second looks at *tradicion*, and how keeping a family healthy gives the Leals the chance to reaffirm their traditional beliefs in the face of daily exposure to the American way of life.

Family responsibilities for health care:

Firstly, the Leals appear to conform to patterns of help-seeking found in groups with strong network ties. "Protracted lay referral and delayed utilization is thought to be associated with strong tie networks which encourage individuals associated through the network to remain well, and

not claim the exemptions derived from the adoption of the sick role... Underutilizers appear to rely more on a variety of readily available relatives and friends as lay consultants" (McKinlay 1981: 88-89). In contrast, people with weak network ties get conflicting messages and information from a variety of different people and tend to seek medical help more readily. Silvia and Imelda fall into the first category of patterns of help-seeking: their lay consultations take place primarily with family members they see throughout the year and delays of four to five days before visiting a doctor is the norm. While network density appears to shape quantity and quality of lay consultation -- Imelda in particular depends on a small number of people for a large number of her social needs -- social interaction and health care consultation do not exist in isolation. Many other factors such as religious beliefs, distances, and ideas about family responsibility also contribute to shaping health-seeking patterns at the informal level within a migrant population.

Healing processes, like other social processes, change because of migration. As Eades argues, labour migration is accompanied by ideological shifts brought about by the exigencies of work and travel. Gender and kinship roles as ideological categories may take shape in response to the initial pressures to migrate, but change over time to give workers more autonomy and control over work and life (Eades 1987:10). Healing practices also arise from, and respond to, the yearly migration and concomitant changes in gender and kinship responsibilities. Who heals when, and what forms healing takes, are processes negotiated more from the constraints of work and family than from the quality and quantity of migrant-centred clinics. In short, the desire for

autonomy and control over healing measures prevails as much as attempts to establish control over work practices.

As the Leals and their kin move further from the Texas/Mexico border, each family member becomes a more valuable resource. Consequently the Leals scheme to have certain relatives with them because they will provide, amongst other things, a socially sanctioned opinion on matters of sickness and treatment. The Leals, because they are organized, have a similar pattern of family resources available to them in each of the places they live. Healing resources are generally used as follows:

1. Initial consultation with husband Ruben, with sister-in-law Imelda and sister Gloria, mother-in-law Doña Catalina and Silvia's daughter.
2. Non-prescription remedies; either herbal or folk remedies or over-the-counter medicine
3. Prescription remedies acquired over-the-counter in Mexico, acquired in advance of the trip north.
4. Visit to clinic, with the objective of not returning for a follow-through checkup. *Que curan de una vez* . [they should heal once and for all]
5. Follow-through visit if necessary.

The most unusual aspect of this hierarchy of resorts is the prominent place the male head of household, Ruben, holds in every decision made about sickness in the family.

The scarce literature on negotiation processes within migrant families points towards egalitarian decision-making processes within the nuclear family (Hawkes & Taylor 1975). Contrary to the "macho" myth of male dominance

in Mexican culture (Cromwell & Ruiz 1979), men do assume a voice of authority in decisions about illnesses that is traditionally described as the woman's domain. Anderson (1982) documents how equal consultation between partners also characterizes many health care decisions within Mexican American families: "Generally decisions relating to medical diagnosis and treatment are joint decisions by husband and wife...When the physician outlines a course of treatment...the parents go home, consider the situation, and invite the counsel of relatives" (Anderson et al 1982:334). The survey conducted in Whatcom county presents a similar set of patterns [Appendix A]. While women were considered to be the family health expert in 44% of families interviewed, and men in only 5%, joint expertise was cited by 42% of families, suggesting that both men and women play an important role in health processes in almost half of the surveyed families. In the Leal's case, Ruben's expertise and involvement is manifest in everyday concern with all aspects of his family's health. While women traditionally assume the role of primary care-giver for minor illnesses on the ranch, Ruben is involved there as well. In short, Ruben places more emphasis on his family's health than do most other migrant family heads.

Structural reasons for Ruben's unusual level of involvement in health care stems from his public role as male head of household, and from his wide knowledge base about migrant services. Up north, where Ruben has more or less hand-picked the families that share the labour camp, and where his responsibilities as supervisor leads him into overseeing the general health of his workers, he must secure knowledge about local doctors, clinics and medicines.

In taking on the responsibility for finding good, working families he also risks *mortificaciones* if he is unable to control the situation. "*Mortificaciones* are part of *La Raza*", explains one of Ruben's relatives, "part of the pain and responsibility of being a man and head of household. Men work hard to ensure they do not get mortificaciones because it is a sign of failure, of inability to maintain one's status as the male head of household. A man can get *muy corajudo, como un niño, muy terco, muy histérico* [very angry, like a child, very obstinate, hysterical]." It is this behaviour pattern which Ruben's children and wife fear most, and will work hard to avoid. Where *mortificaciones* on the ranch may occur when his family deviates from the ideal, during labour migration the ideal becomes harder to maintain, and Ruben must scramble to maintain the control he wishes to have. If someone for whom he is responsible becomes sick and does not get better soon, that person's sickness may be discussed firstly as God arbitrating and punishing personal weaknesses, and secondly as proof that Ruben doesn't work hard enough to sustain his family's well-being. Hence his frenetic work pace, his yearly mid-harvest trip south to ensure his mother's well-being, and his insistence upon consulting with his wife on health issues that he might relegate to the status of "women's problems" on the ranch. Since his family's income, and his high status as field supervisor at Smithers' farm also depends on his ability to control his family and those around him, Ruben is unlikely to loosen his grip on family health processes and all their implications as symbols of status.

Healing reaffirms tradicion:

Because migration makes it harder for the Leals to maintain *tradicion*, in turn the Leals use healing processes to aid them to maintain their traditional

value base. The ongoing effort to maintain these patterns suggests that, for the Leal's at least, being a migrant is second to being from El Mirador, "that most marvellous place," and they gladly enforce all the social customs that loyalty to the ranch way of life entails. *Tradicion,* ranch style, keeps the family together. *Las costumbres de aquí, es el apoyo en la familia, de ser unida* [our custom here at the ranch is family support, to be united]. *Tradicion* also includes a strong adherence to the Catholic religion, well-defined gender roles where the man takes a public role and the woman works within the home, public fiestas and dances where courtships can be well-chaperoned, and status defined by land ownership and Catholic piety.

These traditions get challenged in America. Migration restructures family life and makes it more difficult for family heads to control social life as they want. *Hemos cogido los malos costumbres de los Americanos en que las mujeres mandan* [We have picked up the American bad habit of letting women give the orders]. Careful watch over daughters becomes more difficult in the north and unless the camps and convoys are filled with known relatives and friends, daughters may find it very easy to acquire a boyfriend. Consequently, no non-relative, especially males, can travel in the cars going north -- "in my truck, just me and my family, nobody else" is a common refrain -- and family camps protect their space from single men sharing a family cabin. Women, because they work full-time in the field, do not have the time to care for the men as readily. In the regular packing and moving schedule, new divisions of labour arise which must be negotiated using non-applicable standards from the ranch. To sustain family tradition, women take on a more public role, and men a more private one. In short, maintaining family values means

making some adjustments in normal gender roles, and this is as apparent in healing practices as in work practices.

For the Leals and the Tijerinas, the family is a group over which they can exercise some form of control by invoking the idea of *tradicion*. Through religion as a form of health insurance, through involving the father in health care, or through emphasizing the family's ability to take care of sickness on its own the Leals attempt to impose ideals of health, productivity and ultimately control onto a potentially volatile social unit. In a highly uncertain work world, there exists a greater need to control the social environment than in more secure work situations. As Douglas (1970) hypothesizes, emphasis on control over the body -- as manifest in control over health practices -- reflects a restricted social world. "When the sense of social control is threatened...the symbols of self-control become intensified along with those of social control" (Lock & Scheper-Hughes 1988:24). Thus *mortificaciones*, while a commonly understood concept in Mexican culture, holds significant meaning in migrant families. They control their environment so that together they maximize their potential income. They also control access to ideas and people that might distort notions of *tradicion* and consequently jeopardize the family as a work unit. For example, Ruben sets boundaries around who gets to travel north with them, work with them, travel in the same truck as them. By doing so he maintains his "healthy" family, and conforms to the apparent norm in migrant families: "Cultures are disciplines that provide codes and social scripts for the domestication of the individual body in conformity to the needs of the social and political order" (Lock & Scheper-Hughes 1987:25).

Modern medicine and its systematic division between the patient and the other, caring relatives, might be seen as potentially threatening the desire to keep people within the family rein. In ignoring the clinics, or at least in refusing to take them seriously, the Leals reaffirm their faith in their ability to take care of themselves.

*Mortificaciones;* family: these are fundamental concepts in most Mexican Americans' way of thinking. They gain importance within migrant families because they are part and parcel of the processes of work. Yet work is not merely structural. Many other aspects of work also shape the way migrants view sickness at a level of symbol and meaning. The everyday framework of regular changes in scenery, climate, people, lead some people to view the world around them in a most unusual fashion.

# CHAPTER THREE

## SYMBOLS OF WORK AND POWER

> One farmworker complains: "All my health problems come from leaving Oaxaca, Mexico. In Mexico we worked hard and sweated off everything we ate. We had no money to buy food but we were surrounded by bountiful nature and could always find food. We would burn off energy milking a cow but we could replenish that energy right away by drinking the warm milk. In the United States there is too much food. Meat in America is always frozen and old, and frozen foods are bad for you, they stop you from sweating. Also the air here is so cold that people don't sweat, and that creates a permanent imbalance in a person that always makes them susceptible to getting sick. That is why people eat so much and are fat like me; you need to sweat to stay healthy and I can never sweat in America. In Texas in the winter it's too cold, and in the summer in the north it's most certainly too cold to ever sweat. This is why I get *mortificaciones*, because I live in the American environment. In Mexico I never got sick."

For this man, interviewed in Whatcom county in 1989, the 40 years he has spent working as a farm labourer gives a particular quality to his ideas about sickness. Aspects of work such as movement and climate mesh with more traditional ideas about hot/cold and balance/imbalance to shape a set of explanations which reflect his life's experiences.

The distinctions he makes between hot and cold properties of nature and food are typical for many Mexican Americans. "Cold air, rain, moist ground, the sun, fire and other features of the environment are commonly believed to be the sources of excess heat or cold that may enter the body, upset its normal balance, and cause illness" (Young 1981:58). Qualities of food are different because people can control them by mixing hot and cold, whereas the weather can't be controlled. For example, hot foods include pork, mangoes, honey and chiles whereas cold foods include apples, fish, bananas and potatoes. Many foods are *tibio*, neither hot nor cold. Overindulgence in foods of one

type leads to imbalances which in their turn can cause sicknesses (Kelly 1965, Schreiber & Homiak 1981).

The way this man explains his *mortificaciones*, tying them to external forces which he can't control such as the weather and certain foods, also reflects general trends in explanations amongst Hispanic populations with a cultural heritage in Central or South America. Emotional sickness comes from an imbalance between an individual and her physical, social, and spiritual worlds. Sources for imbalances can range from social factors through to germs and spirit possession (Willard & Arenas 1983), but in every case they rain in on the individual from the outside. The individual is not at fault.

With some farmworkers, *mortificaciones* arise from the weather; with others it is tied to how families behave. These different explanations do not fit in with the more universalistic explanations of Hispanic-speaking peoples' experiences that some researchers claim (Rubel 1984, Guarnaccia 1989, Low 1982). A culture-bound syndrome may be universally known as *susto* or *nervios*, but it is the variation across populations that may shed light on the particular contexts; the unique, political, social, environmental factors that give unique shape to a common idea. Singer argues against looking at symbols and rituals "as if symbols and rituals or perhaps values and beliefs constitute society independent of a political-economic context" (Singer 1990:179). Ideas about sickness: that is, how people make sense and explain disease; the issues of "why me?" and "why now?" (Helman 1978, 1985), arise in response to structural factors such as work, and in response to negotiated meanings such as cultural beliefs or group specific ways of looking at the body. (Pappas, Singer 1990, Lock & Scheper-Hughes 1987). Work conditions,

just as much as folk traditions or the quality of kinship relations, can contribute to shaping ideas about sickness and healing.

This chapter examines some of the ways work might shape the meaning people accord to a certain set of symptoms. The first section suggests that the social patterns involved in migration may affect the way the Leal clan understands sickness. Tight kin relations at work, and relatively constrained social contact for several months can promote different ideas. The second argues that the physical environment migrants encounter over the year helps to shape a unique perspective on health. Following extensive discussions with migrants who frequently and with deliberation employ the metaphors of sickness and health to describe the various regions of their working lives, this section suggests that sickness and health serve as metaphors to explain and to come to terms with the complexities of their work life.

## A: SICKNESS IS OUTSIDE THE FAMILY REALM

If context shapes the nature of illness explanations, then the highly social side of migrant work might be an important factor in defining and giving meaning to sickness within the migrant community. In a migrant labour camp, on any given evening, there are frequently 40 or 50 people wandering around public areas. Everyone goes to work together. Families and extended kin stick together and depend on each other. Because the family figures so prominently in the pragmatics of dealing with sickness, the Leal clan might also explain sickness etiology using a similar social framework, creating a "culture-bound syndrome" which is specific to the migrant population. Sickness as social, the idea of an "idiom of distress" within migrant groups -- illness which provides a means to express powerlessness in social situations -- would appear a logical outcome of a highly social, highly restricted lifestyle where sickness exists as one of the few legitimate forms of expressing social distress (Kleinman 1986). And yet as the following vignettes suggest, causes of and reasons for sickness are understood by the Leal clan as anything but social.

This section suggests that the meaning migrants give to sickness events are shaped by both the local family processes as well as the formal structures of work. However, given the importance of work, migrants can little afford to recognize the role families might play in causing distress, and instead focus on difficulties with work or more traditional causes of explanation as a means to understand sickness processes. This section therefore does not attempt to connect sickness etiologies with the social but rather to discuss how people

talk about sickness and to suggest that how people talk about it tells a great deal about how people view the world around them.

1. Cristal travels north with her parents Martina and Alfredo [see Figure 2]. She works alongside them in the field and has done so all her life. One year when she was twelve her oldest brother married and found work in Texas. Her parents decided for the sake of her schooling and her future that she would gain by staying in Texas, that they would do the circuit without her. Though she cried she obeyed her father and stayed behind, miserable and lonely. That summer she developed what she has come to call "hives", and made several trips to the Texas clinic to try and control the eruption of large red blotches that appeared all over her body, though located primarily on her face and chest. Her father called often from the north, worried she wouldn't get adequate medical help if he didn't supervise the visit to the doctor. After they returned in the fall, she made them promise not to leave her behind again. Now, at seventeen, bilingual, elegant and a strong believer in American ways -- taking sides with her father against her mother on the advantages of the American lifestyle --, Cristal travels north every summer and doesn't miss a single year. Her hives reappear regularly, and cause much concern and trips to the clinic.

"What causes hives?" I ask. "Allergies" she promptly replies. "And what causes allergies?" "I don't know, some say it's poison chemicals in the ground, others say it comes from eating too many "hot" foods but I don't believe them," Cristal says. "Bad blood" interrupts her mother, "from my side of the family". Father and daughter roll their eyes. "Some people get allergies and some people don't", they insist, "It just happens."

2. Other migrants comment on allergies, asthma and high blood pressure [sicknesses with a social etiology, according to biomedical research] :

"Allergies come from chemicals in the ground, from too much drinking, from the type of blood you inherit from your parents. Some people have weaker blood than others."

"Not everyone has the same humors in their bodies, that is why some people get allergies".

"High blood pressure, allergies, it's all from the blood. Blood can press on your nerves, give you high blood pressure, *se da borrachera* [makes you act drunk]".

"Asthma, that comes from the cold, and the change in weather. It gets worse if it's cold outside because inside your body the asthma is hot, and the cold air mixes with it and makes you sick. Everything should always be warm, air and food should be never too hot or cold."

3. Andres is diabetic. He also had a car accident in 1985 that paralyzed his right arm. His wife Sandra must look after his partially paralyzed body and cook special meals for him. His disabilities keep him inside the house, confined to the labour camps while the rest of his family picks crops. "Stuck inside with the women", he snorts. He can no longer drive his family up north, nor work once he gets there.

Andres gets *mortificaciones*. Over the past 10 years, Andres' spells of anger have increased, although since following a strict diabetic's diet over the winter, the spells have declined. Andres describes the feeling of *mortificaciones* as being out of control, in a rage, hysterical. These feelings give him great shame when they finally pass. "Any man can get them", he explains, "if their daughters behave incorrectly, or if they are failing to be a

good provider. My *mortificaciones* come because my children are not good, they want to be modern, and because I can't work."

"What is the cause of these feelings," I ask. "There is no cause," he replies, "they come about whenever they feel like it, and there is no reason for it, just that I am not a good man of *La Raza*". His wife Sandra suggests "they say at the hospital that it is the food he eats, and I think it is true but he would have *mortificaciones* anyway even if he didn't have diabetes because of the children." "Why doesn't Sandra get it too?" "Because it is a man's disease, it is what happens to a man when he cannot provide well. It is man's unhappiness, it comes from *La Raza* and there is nothing you can do about it."

COMMENTARY

Each of the above cases could fall under the rubric of an "idiom of distress", where perceived powerlessness at local levels translates into an "expression of physical complaints in the absence of defined organic pathology...and the amplification of symptoms resulting from established physical pathology" (Kleinman 1986:59). In other words, the process of "somatization", of becoming sick, is often influenced by socio-environmental factors.

Kleinman argues how important it is to tie social distress to wider political and economic factors. He suggests that "the social sources of human distress are local human contexts of power that distribute resources unequally, that transmit the effects of large-scale sociopolitical, economic, and ecological forces unjustly, and that place particular categories of persons under greatest social pressure" (Kleinman 1986:168). This argument parallels Rubel's epidemiological study of *susto* (1984) where the author sought to document

how *susto* occurs following people's inability to conform to a defined social role. Using a controlled experimental procedure he suggests that social roles are frequently determined from outside of the community but local social games reinforce inequalities, and lead to expressed social powerlessness through sickness.

*Mortificaciones* clearly meet the criteria of an idiom of distress: they are a legitimate means to express an inability to conform to local expectations of how a man should behave. Yet this is not how the Leal family explains *mortificaciones*. Their source, the real cause, they argue lies with La Raza which is outside individual control. According to Andres, his daughters merely set off an emotional state which lies latent in every man. To suggest that his daughters are the cause of his discomfort and not merely the trigger, that if they behaved well he might never have this behaviour pattern, is incorrect according to Andres' explanations. Andres' daughters cause him distress but he explains the source of his distress in the intangible, emotional sources that are part of being a man and not with the daughters themselves.

The usefulness of a socially-centred model of sickness explanations is of questionable validity when applied to a group which does not look at sickness in social terms. No one in the Leal clan, neither the patient nor caring family members, looks at sickness as a socially-related phenomenon. In each case, the explanations for their sickness centred upon events and processes far removed from individual/social relationships. So too with other migrants' explanations about allergies and asthma, and illnesses in general (Tongue n.d.). The only two instances where people are invoked to explain sickness occured when the Leals attempted to come to terms with two important kin

members' sudden deaths. Doña Catalina's eldest son Felipe died suddenly at the age of 22 on the ranch after wasting away to a shell of skin and bones. Because no one had seen anyone die in this manner before, Doña Catalina maintains her son was *mal puesto* [cast an evil spell] by jealous strangers in a nearby village. The other case involved Juan, Ruben's brother, who was killed in a hit-and-run accident while driving south for a mid-harvest visit to Texas. Because the accident took place under rather mysterious circumstances and because Juan was the most important and influential family member in his generation, his death has been much discussed as a possible *venganza* [vengeance] by someone who was jealous of him. Death, too, can tell people about the quality and morality of someone's life: a slow painful death means a life full of sins, whereas a person who dies suddenly was clearly a good Catholic. However, sickness causation -- explanations for here and now events --lie outside the individual and outside the boundaries of family life.

The notion of socially-induced distress, in a group where social resources are at a premium, contradicts the need for social support inherent in migrant work. The focus on individual sickness as an outlet for social distress may be a relevant focus in social systems where the concept of the individual, the self, is dominant (Helman 1985). However, in a social group where people may consider the nuclear family as the smallest social unit, where households shift and grow to accommodate relatives, and where extended family relations get stronger over time, notions of sickness as somehow part of the emotional life bound up in close relationships does not make sense. The need for family support to sustain working life decreases the likelihood that migrants will blame those same people for bringing about unhappiness and sickness. External forces -- *La Raza*, nature, blood, unexplainable sources

-- are legitimate explanations. Queries as to any understanding of sickness as an emotional response to social events met with blank stares.

Silvia scoffs at ideas that social relationships can make someone sick. However, the mere act of getting in a truck and driving two thousand miles to work can make a sick person healthy right away. Work in her eyes is clearly and frequently identified with health. The following excerpts suggest that sickness and health are powerful metaphors, but metaphors with a message about the wider world of work and its importance to migrants.

B: IF I DON'T WORK I GET SICK [*SI NO TRABAJO ME ENFERMO*]

1. "You get sick more if you don't work. Down in Texas I get sick a lot and I go to the clinic there to fix my cough, cold, and bone pains that I never get when I am working here." [Father of a family who has been working the crops for 20 years]

2. Imelda, Silvia, Alejandra and I are sitting in Imelda's half-finished house that her family hopes to pay off with the profits of this year's harvest. Although only the shell of the house is completed, and the little furniture they have barely fills the unfinished rooms, the kitchen is full and busy. Collected on top of the fridge are all the Mexican medicines that Imelda buys for her yearly trip north which she pulls down so that all three women can jointly explain the value of each drug. "*Mejoral*, now this medicine is like aspirin but it's stronger so it helps with the aches and pains you get bending over double to pick asparagus. *Naproxen*, mostly for colic and stomach pains, also helps for stomach pains from being bent over." Silvia and Alejandra laugh, "We don't get asparagus pains anymore" they say, "or at least we don't need medicine to treat a little stiffness. Imelda gets sore because she hasn't been doing the work as long as we have. It hurts but you get used to it. So we don't bring any of that stuff." Imelda continues listing the drugs she brings, "*Buscapina;* that's strong medicine that you buy by prescription only for colic; and I bring *Bronkaid* which is an anti-asthma drug for my daughter but I feel silly carrying this strong medicine up north because we never get sick there." "It's the heat here in Texas that makes people sick", says Alejandra, "up north we women all get skinny, the men all get fat with the good food and with the chance to work and sweat. To work is healthy, and so we don't get sick.

That's why my mother and I hardly bring medicine anymore, just stuff for little colds and stomach aches, not for serious illnesses."

Imelda reiterates the point, "You know, I've been doing this now for three years and I swear that people get sick more in the Rio Grande valley than anywhere else we travel to. Why last year we worked up north for seven months and my daughter didn't get sickness in her lungs once, and my boys didn't miss a single day of work. And the minute we crossed the Texas border to come home we felt that hot air and bang!, my daughter got sick from the air. I even caught a cold from the heat last year. People get sick here, not in the north".

"The air in the valley poisons you," says Silvia "but up north with the pine trees and the mountains the air cools you, it is fresh, and nobody gets sick. Some mornings picking asparagus I alternate from our warm cabin to the freezing cold pre-dawn air and I think for sure I'll get sick with all this change in temperature but nothing happens. Now here, if I even step into a cold shower after the hot sun, I get sick like that!" and she snaps her fingers, "You tell me, it has to be the good air and the hard work in the north that keeps us healthy."

Ruben strides into Imelda's house to drive them six blocks home. With his cowboy hat, boots, and big silver and gold cross hanging over his shirt Ruben looks and acts the part of family head. Silvia asks him to reiterate her belief that the north is a healthy place to be and his face lights up talking about the north, "I like the sun up there, and the air. I like pine trees and mountains. Around the asparagus crops it is the desert, hot and dry just like here. You

wonder how anything can grow in that sand and rock. But as soon as we leave eastern Washington for the coast we cross over this big hill and you suddenly feel the air get humid, and the pine trees start to grow, and we all get happy. I don't have to worry so much on the coast, the family is healthy and the air is fresh, nobody complains. The work is good, lots of chance to sweat, everyone gets strong and since we know we are making money in the north to finish up our house in Texas and to have good holidays on the ranch, to improve our position in life everybody works really hard. We've got no time for sickness up there. It's a good life in Whatcom county."

3. Sandra springs her ideas about the "healthy north, sick valley" on me before I had a chance to do much more than drop my backpack and accept a cup of coffee. Asking me to explain again why I had come all the way to this "sick and ugly place", Sandra responds to my mumbles about medicine and health with vehemence, "This valley is pure sickness", she spits out, "there isn't enough air here. Down here people used to get cancer and anemia, now you don't hear about that anymore; it's pure diabetes, it's always something." A couple of days later she explains why she thinks there is more sickness in Texas: "Why I'm healthy and strong [she gets onto the ground and demonstrates push-ups and other exercises to show her impressive muscles], and there's no reason for me to get sick but just as soon as I come into the valley in the fall I get sick. Every year. No exceptions. My nerves start to press on me, choke me. It's just too hot and too poor here."

"Up north I never get sick, and that is because sickness comes from the weather. When I come back from the north the sun is strong and no one is active anymore; one feels weak and lazy and hardly able to walk. People get

very lazy, like everybody else who lives in this valley all winter. Then when the cold comes in the fall it's even easier to catch cold because the temperatures change so much. The valley is dirty and poor. Lots of people don't have work here, it's just like Mexico. I'm really looking forward to leaving this spring to work, for me it's just like a vacation. As soon as I cross that Texas border I start to feel great! I sweat when I work and that keeps me in shape. Exercise is very agreeable, the food is better and the air is clean and crisp. Even though we sweat a lot and there are rapid changes in temperature, sometimes in the asparagus we end up wading through water or working in the frost and we still don't get sick. It just doesn't happen."

COMMENTARY

According to the Leals, Texas is "home", and El Mirador is "really home." The relatives they care for live in the south, they are respected as wealthy and influential people in the south and there they can relax. The north may startle with its beauty and wilderness, but affective relationships and confidence in the family get reinforced in the Rio Grande valley and even more so on the ranch. As housing at labour camps in the north compares poorly with the homes the Leals and the Tijerinas are building themselves in Texas, "home" also offers luxuries and comfort, concepts generally associated with positive images of well-being. Yet the south is the land of sickness and the north, surprisingly, is painted in positive colours.

This equation of the healthy north, and the sick south [particularly the Rio Grande valley], is striking when examined from the perspective of sickness as a metaphor for wider social and political relations. Anthropological literature frequently cites how health is used as a positive symbol and sickness as

symbolizing disorder and disease (Sontag 1978, Crandon 1986, Comaroff 1985), yet Texas-based migrants appear to reverse the equation. If we accept that sickness metaphors express negative perceptions, and metaphors of health reinforce the positive, then the Leals do choose to see their work world in positive terms, and "home", wealth and relaxation as negative. The frequently cited distinction between the north and south is a common, everyday way for migrants to talk about their lives, and overshadows other types of explanations such as those based on humoral theory or other "folk" illnesses.

The following sections present two possible explanations why most migrants interviewed commonly see their world in such dichotomous terms. The first suggests that people simply do get sick more often in Texas than in the north, and that the Leals merely emphasize what is already true. The second proposes and elaborates on the use of sickness as metaphor for the centrality of work in defining their lives and in playing a role in determining their happiness.

Epidemiological sickness:

The first approach suggests that locations are explained in terms of health and sickness because the Leals and their friends get sick more in Texas than they do in the north. This explanation, however, only partially reflects clinical reality. Many sick people do live in the Rio Grande valley, "We have a diabetes epidemic here" the local clinic official worries. The valley also claims higher rates of high blood pressure and miscarriages than other Texas counties (Becker 1976). Many former migrants who are too old or sick to travel stay in the valley, which may contribute to perceptions that the valley

is a place of sickness. While none of the Leals visited the doctor when I was in Texas, many relatives that surround the Leals during the winter months have chronic illnesses that shape their daily interaction; from Maricela's paralysis and Doña Catalina's arthritis to her daughter Irma's broken leg and ongoing hypochondria [much to Ruben's distress as chauffeur and family head!]. Thus the informal negotiation surrounding illnesses which occur at the family level may shape ideas about the valley as an area of disease and disorder.

Nonetheless, interviews and stories suggest that chronic episodes occur all through the year. Even though Sandra wants her family to move north and stay there because she claims she never needs doctors or medicine there, she regularly uses friends, relatives, clinics and over-the-counter medicine up north. Although Silvia and Imelda describe a sickness pattern which favors the north as a place where they "never get sick", their stories of sickness events suggest that indeed they continue to suffer minor, chronic illnesses when they work. Of the Texas-based families interviewed in Whatcom county, 54% remembered having used services in the north in the previous year, while the remaining claimed to have used services in Mexico or Texas, or no medical care whatsoever (see Appendix A). If perceived health status can in any way be inferred from utilization patterns, this study suggests that no real changes in perception about health status occur across locations, and that in fact, people may get sick more up north. Additionally, utilization studies by Littlefield & Stout (1987) and Slesinger (1982) suggest that other migrant populations show similar patterns. People use services more when out of the harvest states, but nonetheless a good proportion of visits to the doctor take place in the harvest communities.

Symbolic sickness:

The second explanation suggests that sickness functions as a metaphor for socio-political relations. Social groups use different aspects of the physical body as a metaphor for wider social relations, the "representational uses of the body as a natural symbol with which to think about nature, society and culture" (Scheper-Hughes & Lock 1987:x). The body and its physical ailments are a potent source of ideas for explaining the outside world, yet the shape these ideas take are molded in turn by factors from the outside world (Comaroff 1978). If the Leals and other migrants use positive and negative metaphors to distinguish between work and home, this suggests that work -- movement, distance, physical labour and the challenges of being a "commodity migrant" -- is important enough to merit these meaningful, oft-repeated distinctions.

Thus it becomes more appropriate, in the case of migrant workers, to look at the "political" body: the use of symbols of sickness and health to explain wider attempts to regulate and control people, and the attendant resistance to this process (Scheper-Hughes & Lock 1987, Pappas 1990). "What people say about their social world through the idiom of medicine are statements about political and economic realities" (Crandon 1986:464). Realities, however, are negotiable, and sickness metaphors provide yet another means for migrants to explain and make comfortable their world. The symbols, while "clearly part of the apparatus of power", are not expressions of powerlessness so much as symbols used by migrants to express and mediate the the realities of everyday life. (Comaroff 1985:119).

Some specific negative comments migrants make about everyday life in the "sick valley" suggest that the south exemplifies powerlessness. Families, no matter how they stick together, can do little to change their status or the quality of their lives. The valley is "sick" for many reasons, not least of which is feeling cornered into staying the same, *de no poder progresar* [unable to progress].

Doña Catalina: "I stay behind because I have arthritis, I can hardly move, I have to take care of my sick children, and I know I would be a burden to my son if he took me up north, they wouldn't have any time to get any work done so busy they would be looking after me."

Irma: "I can't get any work down here. I've been on welfare for a long time now, my husband left me and the only way I can feed my kids is to get welfare."

Silvia's nephew Sergio: "Unemployment is at 40%, I think, and now to get work in the valley you have to have Grade 12. Well that's crazy, I can't even read or write and what do you need reading for if all you do in your work is pack vegetables into crates? Before the oranges froze we could get winter work but now, nothing. I've been on welfare for years, but I don't go north because I have to leave my family and it's too easy to drink and spend everything you earn when you are up there."

Ruben Junior: "Down here it is nothing but poverty and sickness. People can't afford to buy land or houses and there's no chance to do anything to improve your life. I've finished high school and a mechanics course and I want to buy the *solar* [plot of land] next to my parents but I'll only make enough money to do that if I go north to work. It's really hard to find work here."

Imelda: "We want to build our own house here, some people have enough money to buy an already made house, but not many in the valley can afford to do that, at least not us migrants. You can live better here than in Mexico, but it isn't that nice. Nobody loves the valley but everybody always comes back."

Prevailing economic conditions justify the locals' views that the valley is poor and "going nowhere." Two of the five Texas counties that border on Mexico, including the Leals' home base, are among the poorest five counties in the U.S. (Weintraub1989). The border industrial program encourages industrial development a few miles away in Mexico rather than in the valley region, but few Mexican-Americans would look for work in Mexico, preferring welfare to the perceived indignity of daily Mexican wages. The valley swarms with police: border patrols; the anti-drug campaign has increased policing in Texas border towns; the immigration patrols continue to search for illegals trying to work their way north; and the local police and sheriffs oversee high rates of crime. With crowded clinics, unemployment offices and welfare bureaus, high drop-out rates, illiteracy and little perceived opportunity for advancement, the Leals and all their relatives universally sing the praises of the ranch in Mexico (clean and quiet with the chance to eke out a living in the fields) and work in the north (clean, underpopulated, and rich).

Yet the north, although more affluent, also limits opportunity. While the relative abundance of natural and material goods overwhelms most migrants at their first visit, the reality of labour camps and work expectations brings the migrants down to earth in terms of realizing their position in the social fabric

of the community. Because of the full range of migrant services provided such as daycare, clinics and food banks, the Leals only operate outside of the migrant community to shop and to visit the annual county fair. In the fall, services abruptly stop, and local farmers' promises that "we want them to stay all year" ring hollow when no attempts are made to winterize housing or guarantee work. Bureaucratic links to Texas such as school registration, unemployment programs and *troquero* contracts all have to be negotiated in the south. Migrants' eyes are equally open to the inequality at work, the scramble for a good position and the patronizing nature of the social services provided for them. The land of opportunity exists in the summer months only.

The positive and enthusiastic way the Leals see the north, particularly during the last couple of weeks in Texas preparing to move there, doesn't completely disguise the fact that they well know the limits of the north's bounty. Ruben implicitly understands this, and while he listens to his family's yearly plea to stay up north, and laments having to return to Texas in the fall, the reality is that no other option is feasible, or desirable. "In Texas and in Mexico, I do well for my family," says Ruben, "I can farm land in Mexico, yet still remain a U.S. citizen and collect old age pension when I turn 65. By working up north, we made enough money to build ourselves a house in Mission. Sure building goes slowly but now I have two houses (the other is in El Mirador) and if I lived up north I wouldn't have a single one. The kids make enough money to buy themselves school clothes and books, and my eldest daughter paid off her hairdressing school training by cutting people's hair in the camps all summer. You can do well for your family if you know how to play the game. But I have a responsibility to my family and to the traditions of the

ranch to stay in Texas and be close to the people who need me, and in the winter they need me. That doesn't mean I **want** to go home every fall, but we do."

Despite the limits on opportunity, the migrants interviewed appear to see how the northern world gives them power. When a migrant works, argues Sandra, she has control, she can influence her life to meet her needs. The north is a healthy place to be because through working there she and her family have some control, however limited, over the quality of their lives. Work is a meaningful resource which enhances status and daily life in the south; expressed in the symbols used to evoke the positive qualities of life in the north. And, adds Sandra, "What else is a migrant to do except pick crops? What other life is there?"

Family migrants making the long trip north may "choose" to emphasize the power that work brings them as positive, rather than seeing as positive the power that arises from kin and informal negotiations in the south. This selective focus can be seen as an attempt to establish control over the almost overwhelming structural limitations migrant work imposes on family life. In other words, migrants have no real choice but to choose to see the north as healthy, because the work they do does not provide them with any real choices. The ideal worker comes in a small social unit, does not stay long, and leaves when no longer needed (Pahl 1987, Castles 1989). In harvest work, the ideal employee also has a healthy body. The irony lies in the fact that the healthy body serves as a boundary which defines an acceptable worker as defined by the employers who profit by this weeding out process. And yet migrants use this same idea to reinforce their strength as a family unit, and

their ability to productively earn money by working as a group, which gives them the leverage to negotiate with the owner's demands. It turns the criteria for employment on its head, for a family with sufficient strength through networks, numbers and experience, can push for work patterns which favour the worker, even to the point of bringing along sick relatives, or in the case of Sandra, to pull out all the stops to get one last year of work even though no one gains financially by the deal.

Perceiving the north as positive gives the Leals' extended family power to take the limitations of migrant work in stride, to take advantage whenever possible of leaks in the system and to provide themselves with the best possible social and work situation. By stressing the positive in their work, the arenas they control, migrants are resisting being put down as the "commodity migrants" locals and policy-makers would like to create. If the north is a "healthy" place to be, it is because there the Leals create the opportunities to negotiate and manipulate resources which make possible an adequate life throughout the year.

# CONCLUSION

Participant observation is a powerful tool for placing people's lives into a broad context. It is necessary to take a close and detailed look at the processes of everyday life in order to come to some understanding of patterns that surface in ideas and actions about sickness. And yet, perhaps in the interest of saving time, or due to the more applied nature of much medical anthropology, a lot of current works on cultural issues in health take a narrow topic and then look at it from narrow, single-place perspectives. For example, many researchers choose the in-depth interview as a research technique to examine how people feel (e.g. Martin 1987, Pill & Stott 1988). They interview people in their homes. They schedule interviews around people's timetables. They take the subject's word on matters of how sickness is negotiated within the cultural framework of their lives. Research on migrants has tended to adopt the same narrow research perspective, but is limited to people who go to clinics. Moreover, events occuring in one three-week data collection period can only tell a partial story.

Condensed or narrowly focused anthropological data has severe methodological limitations. First, the fact that it can be based only on self-description allows no room for triangulation. Is the subject's word on its own good enough? Secondly, topic-centred research usually demands a hypothesis formulation that binds the kinds of questions a researcher can ask, leaving no room for ongoing insights to shape the research process (Cohen 1978). The end result may be fragmented. Thirdly, when researchers take the time to observe daily processes and surrounding events they are less likely to make faulty generalizations because they missed significant events. It is easy to

make a statement about universal processes when individual actions are taken from the context of their everyday lives. It is much more valuable, I argue, to attempt to describe the specific, to observe the context, because the ethnographic report can as a result reflect much more closely the realities of everyday life from the perspective of those who live it.

As a result of a wider research approach, diverse topics like religious activities and kinship ideologies take their place in medical anthropology research alongside doctor/patient interaction and rates of service utilization. Who Silvia seeks out as a friend in the north tells as much about reasons for non-utilization as do statistics on the need for Spanish-speaking doctors. It's simple to argue that poor migrant health in one area is a result of bad work and housing conditions and lack of access to medical care. It's equally simple to argue that cultural factors -- hot and cold explanations, *empacho, susto* -- result in defined patterns of healing. It is much more risky, although I argue much more rewarding, to enter the field with areas of research interest and with the goal of describing the context surrounding certain situations. "It is...grossly misleading to treat a piece of structure or some behavioural phenomenon as understandable in its own isolated terms without knowing the nature of the cultural influence by which it is dominated" (Cohen 1978:19). In a sense, I am advocating a return to the ethnographic precision found in anthropology that includes medicine with other categories such as kinship, politics and religion, and that studies the interrelationship between these categories and medicine, and not its isolation from everyday life (Turner1967, Nash 1980, Comaroff 1985, Okely 1983). If medical anthropology claims to contextualize sickness processes, it needs to maintain its holistic approach in order to do so convincingly. Medicine is an ethnographic

category. By taking medicine away from the context of healing, the researcher gives it an unnecessary importance which isn't reflected in the ways people live their lives.

However, research that is content with describing the subject's daily existence and the medical processes involved runs the risk of generating novel-like descriptions, of highlighting activities that undervalue the role of wider political and economic forces in the production of local events and local meaning. In the case of U.S. agricultural migrants, international economic processes affect daily life as much as local Chicano activism or family feuds because of the pivotal role the migrant plays in the fundamental enterprise of food production.

A look into the future may help to demonstrate why political and economic contexts are as important to medical practice as day-to-day interaction. Health practices may change drastically over the next decade because of international trade barriers. If free trade between the U.S. and Mexico takes place, Mexico's Border Industrial Program [BIP] will grow to accommodate the increased demand for low-wage Mexican labour. The flood of Mexicans north may result in more attempts to cross the U.S./Mexico border -- "the tortilla curtain" -- to try a hand at earning higher American wages. There will always be work for Mexicans in harvests; free trade does not mean that Americans will suddenly want to harvest their own crops at low wages. Farmers will still need pickers.

As fast as formal job markets develop, informal networks expand to reduce the uncertainty of work among strangers. Nonetheless the type of family that

migrates north to Whatcom county may change along with the flow of migration. Family organization will change if employment restrictions are lifted or lessened between the U.S. and Mexico, and smaller families may soon outweigh the larger cooperative units that now prevail. More single men may attempt the trip as the women in their families stay behind to work in the primarily woman-based *maquiladora* [sewing] industry in the BIP zone (Fernandez-Kelly 1984). If family structure changes, then so too do health practices. No longer able to rely on close kin for advice, families and men travelling alone may simply make even less use of health care than they already do. Health activists will find that their current word-of-mouth and outreach strategies to get people into their clinics no longer work. In order to keep "patients" coming through their doors, clinics may move away from working with individuals directly to providing services more bounded by bureaucracy and more overt in their systems of control. The more bureaucratized the clinics, the more organized, and the more they are able to function to limit the range of freedoms available to the new worker and to the old-timer alike.

The above example may exaggerate somewhat the potential impact of international trade policies, but it suggests that the statistics on utilization patterns or health standards do not reflect the reality that sickness is a social construct, an event that occurs within the framework of wider events and negotiated meanings. Family, free trade and transported cultural values and ideals all join in creating a set of medical patterns which are unique to Mexican American migrants and which change over time. The fact that migration is a fluctuating process has two major implications for future research in medical anthropology and on migrants.

Firstly, given the shifting family patterns found in Mexican-American migrants, there is a need to focus on family relations in medical anthropology research. Given also that sickness is socially constructed, and that much meaning is constructed at the family level, research can profitably look at the role that fluctuating access to family members plays in constructing meaningful ideas about sickness. The family gets remade at every move and must work constantly to maintain itself. The ways people work around forced separations and the choices they make about who they continue to use as healers when they are cut off from their normal social network can show how and why certain people become more important than others in negotiating ideas about sickness.

Secondly, future research needs to tie kin responses and sickness to the current political and economic situation. If labour relations change significantly in the next decade, and responsibility for sickness prevention shifts away from the family and onto health bureaucracies, then we can expect to encounter a resultant shift in meanings. The current emphasis on *mortificaciones* may give way to explanations about illness that reflect greater social isolation among farmworkers, rather than the cooperative nature of the family farmwork that currently prevails in Whatcom county.

The process of constructing ideas and actions about sickness is wider and more complicated than can possibly be explained in an interview, or through ethnographic research. Participant observation can only capture a minute proportion of the details that make up systems of medical care. Nonetheless, an anthropological description of the many levels of context involved in the

production of medical meaning paints a down-to-earth picture of the many facets of sickness. The real issues in providing care are such contexts as: who cares? why? what form does healing take? for what reason? why the family?. Farmworkers never tire of saying: "the family is the most important thing," and in their actions they confirm time and again that family shapes their healing life as much as it defines their work, their travels, and their goals. Only by thoroughly examining the everyday world of healing, of understanding why Imelda will wait five days with a fever before going to the doctor, or of tying in Ruben's concerns with the insecurity of his job and the tenacity of his social networks is it possible to develop an elementary understanding of appropriate support for healing activities.

# APPENDIX A

## MEDICAL SERVICE UTILIZATION AND LOCATION

1. Number of visits to formal medical services in 1988:

| NUMBER OF VISITS | NUMBER OF FAMILIES | NUMBER OF TEXAS-BASED FAMILIES |
|---|---|---|
| 0 | 10 | 8 |
| 1 | 10 | 5 |
| 2 | 5 | 3 |
| 3 | 6 | 4 |
| 4 | 1 | 1 |
| 5 | 1 | 1 |
| 6 | 0 | 0 |
| 7 | 0 | 0 |
| 8 | 1 | 1 |
| 9 | 0 | 0 |
| 10 and over | 3 | 1 |
| TOTAL | 37 families | 24 families |

Average number of visits to medical services in 1988 for all families: 2.2 visits

Average number of visits to medical services in 1988 for Texas-based families: 2 visits

2. Location of medical visits:

| LOCATION OF MEDICAL SERVICES | NUMBER OF FAMILIES | NUMBER OF TEXAS-BASED FAMILIES |
|---|---|---|
| Washington only | 18 | 10 |
| Texas or Mexico only | 4 | 3 |
| other [Oregon] | 1 | 0 |
| Washington and Texas/Mexico | 4 | 3 |
| No services used | 10 | 8 |
| TOTAL | 37 families | 24 families |

3. Health care expertise in the family:

"Who knows more about health care in the family?":

| PERSON | NUMBER WHO CITED AS EXPERT | % OF TOTAL RESPONDENTS |
|---|---|---|
| Wife | 16 | 44% |
| Husband | 5 | 14% |
| Both | 15 | 42% |

[One respondent said 'nobody' knew anything in his family about health.]

# APPENDIX B

## REASONS FOR SEEKING MEDICAL CARE

| FACTORS WHICH CAN INFLUENCE SEEKING FORMAL MEDICAL CARE | | | | |
|---|---|---|---|---|
| FACTOR | PREVENTS UTILIZATION | ENCOURAGES UTILIZATION | DOESN'T MATTER | TOTAL RESPONDENTS |
| Cost | 3 | 14 | 16 | 33 |
| Friend Suggests | 1 | 15 | 15 | 31 |
| Family Suggests | 0 | 13 | 16 | 29 |
| Speaks Spanish | 0 | 23 | 9 | 32 |
| Emergency | 0 | 29 | 1 | 30 |
| Already visited | 0 | 20 | 11 | 31 |
| Specialist | 0 | 22 | 10 | 32 |

## APPENDIX C

## TRANSCRIPT OF A CONVERSATION WITH SILVIA LEAL
**March 8, 1990**

Silvia: "If someone is sick, we wouldn't ask them to go to work. If Ruben gets sick here, or there, he just talks to Tony and tells him is sick, and it is no problem. If the family goes, even with one sick person, they will give the job anyways. Or if someone gets there and gets sick, they don't ask him to work, they give away his piece of land. This has never happened to us. Sometimes people get very sick, they can't work the rest of the term but they stay in the camp becasue the rest of the family is working. 3 years ago, a woman broke a leg, and it was okay. If a small family, it's still okay as long as the others keep on working, they just take some of the plot away."

Leslie: "Is it easy to find work if you are a small family?"

Silvia: "The *troquero* doesn't really ask, but sort of asks, wants the family to be big, and then it's okay. If are only two and one gets sick well it doesn't happen because they don't want families of just two. They want families with four or five. Maybe they will take two if the troquero is lacking people. He might put two pairs in one cabin, if the pair is willing. Have to figure it out here before going, if you don't mind living in the same cabin. They prefer that they come from the same *gente* [clan], sisters-in-law, or something like that, so there won't be any problems. Many people don't want to have one room in a 2-room cabin and share the kitchen. They want to be alone in their house. Couples are like solo men, troqueros don't want them. They don't want solo women either. These people cause problems. Couples can fight with other couples. They want men with a family. One woman who travelled with an aunt. The aunt was a big family -- eight. This other woman stayed with them and so they gave her work. They don't take women who are solo even if they are with other solo women. Up north they want families. In Lynden I have seen solo men but they are all from Michoacan. My niece got a house last year because she was lucky; they had an extra house in the camp because they had many big families and so they put her there with her husband. It was luck. They did a good job at the beginning so they

got more work. If they hadn't got the house they would have stayed with me. But they were lucky."

On going to the doctor...

Silvia: "They checked my anemia in Washington, Toppenish. They gave me a physical. I felt very *declinante* [declining] they told me I was very healthy, just anemic, they gave me pills, Every year when I get north, I get to Toppenish and before I go to work I get a checkup for my blood. Once a year, it always comes out normal. My husband needs to be checking his blood pressure because his came out a little high once. I'm fine except sometimes I feel a *molestia,* it is fatigue, I go to the doctor at Toppenish and they tell me I need to rest. You don't wait as long there because they have several doctors. Ruben went to the clinic in Belligham, and Felipe [her son]. My husband took Felipe to the clinic. Felipe got sick with chicken pox. I went too that time, we always go together. He had a lot of temperature. He had poxes in his mouth, and all over his face. I was scared. He couldn't eat anything, spicy or anything, he didn't want to open his mouth, he had sores all over his tongue, we went to a private doctor in Lynden, and he said not to worry, to give lots of liquids and that it would go away right away. The next morning he woke up the same, very sick. So my sisiter-in-law, Sardina's wife, said that "apparently in Bellingham there is a clinc' but she didn't know where it was, and so I said "we will go and look for it, asking around to find it." She said they take care of you well there. I wanted to get something for his temperature. "

"So we went to Bellingham and Ruben asked at the gasoline station and they told him where it was. A nurse came out and looked at Felipe outside because it was full inside. She said she would get the doctor to look at him. The doctor came out and looked at him too, and gave him 2 pills and a glass of water, he couldn't even open his lips. Then they brought him inside through the back door. They said to give him pure liquids, no solids, also take pills for the fever, they gave me pills. As soon as he took the pills the temperature went away, and he was full of *ranchas* [energy], he sat up, watched television, wanted to eat, but it hurt him still, gave him liquids only. This happened between the asparagus and the strawberry, so we weren't

working. The day we stopped working he woke up with it. It worked out well because I was able to stay home and look after him. Even after the work started the American wouldn't let him start, for three days. He had gross scabs on his hands and might damage the berries. He didn't want to stay in the house by himself, he stayed in the truck watching us, he sat there watching us, he wanted to work with us, he really wanted to go but the boss wouldn't let him because he could transmit infection."

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