

**MICHIGAN STATE  
UNIVERSITY**

**Occasional Paper No. 40**  
*Latino Studies Series*

**Mexican-origin Migration In the U.S.  
and Mental Health Consequences**

*by Israel Cuellar  
Michigan State University*

**Occasional Paper No. 40**

*May 2002*



**Julian Samora Research Institute**

Michigan State University • 1407 S. Harrison Rd., Suite 301

East Lansing, MI 48823-5286

Phone (517) 432-1317 • Fax (517) 432-2221

Home Page: [www.jsri.msu.edu](http://www.jsri.msu.edu)



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*This paper was presented at the cross-cultural research exchange between the U.S. and Spain conference entitled “Beyond Our Borders: Language, Culture, Education, and Marginality in an Era of Globalization,” May 21-23, 2002 in Valladolid, Spain.*

## **About the Author:**

**Dr. Israel Cuéllar**, a professor in the MSU Department of Psychology, became the Julian Samora Research Institute’s Director in August 2001. He holds a Bachelor’s Degree in psychology, a Master’s Degree in Clinical Psychology and a Ph.D. in Community Psychology from the University of Texas-Austin. Before joining Michigan State University, he worked as a clinical psychologist for state and community mental health agencies in Texas and was a professor in the Department of Psychology & Anthropology at the University of Texas-Pan American in Edinburg. His areas of expertise include mental health, multicultural psychology, acculturation, and community health. Dr. Cuéllar developed the Acculturation Rating Scale for Mexican Americans-II (ARSMA-II), a paradigmatic measure for assigning degree of multicultural integration in persons living in multicultural contexts. Prior to his current position, Dr. Cuéllar provided continuous rural mental health services for 16 years to residents of Starr County, arguably the poorest county and the county with the highest percentage of Hispanics (97.5%) in the United States. He has been a member of the American Psychological Association for 16 years and received the “Distinguished Contribution to Science Award: Year 2000” from the Texas Psychological Association. He served as Director of the Bilingual/Bicultural Adult Psychiatric Inpatient Unit of the San Antonio State Hospital (SASH) from 1977-1984.

Michigan State University  
East Lansing, Michigan

Julian Samora Research Institute  
Dr. Israel Cuéllar, Director  
Danny Layne, Layout Editor

### SUGGESTED CITATION

Cuellar, Israel (Ph.D.) "Mexican-origin Migration in the U.S. and Mental Health Consequences," *JSRI Occasional Paper #40*, The Julian Samora Research Institute, Michigan State University, East Lansing, Michigan, 2002.

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# Mexican-origin Migration In the U.S. and Mental Health Consequences

Although there is a clear understanding that migration is stressful, the mental health consequences of internal migration within the boundaries of the United States and, specifically, labor related migration has very limitedly been studied.

According to the World Health Organization (Brundtland, 2001), the two major contributing factors to the increasing importance of mental ill health in the global burden of disease is (1) the rapid change occurring in the world and (2) the large number of persons living in poverty. Rapid acculturative stress is most dramatic in bordering nations with extreme economic differentials, such as that between Mexico and the United States. Poverty is a great obstacle to achieving a sense of well-being that comes from enjoying good health, prosperity, hope for the future, a sense of community, personal safety, and peace of mind that comes from predictability of life events. The cyclical and transnational migrants from Mexico and Central American - and from within the U.S. - constitute, arguably, the largest and longest recurring migration in the world. It is motivated by employment, historically and primarily in the agricultural industry, and is characterized by poor, rural, Latinos, mostly of Mexican-origin who have limited education. They make this annual cyclical migration under great sacrifice, stress, and suffering for the opportunity to work and earn American dollars.

The United States, in addition to having the world's largest immigrant population estimated at over 20 million in 1990 (Rumbaut, 1996), has arguably the largest and longest reoccurring cyclical migrant population in the world. Mexican-origin migrants, both from within the U.S. and throughout Latin American - although

primarily Mexico - travel thousands of miles on an annual basis. The trip from South Texas to the state of Michigan and back is at least 3,200 roundtrip. An estimated 45,000 migrants travel annually to Michigan, an important "fruit belt" state. As many as 1.2 million migrants make the annual trip from the southern regions of the United States and Mexico to regions throughout the U.S. in search of agricultural work. These migrants are burdened both with poverty and the challenges of surviving and making a living, sometimes in inhospitable labor camps and farms. Of the 1.2 million migrant farmworkers in the U.S., a conservative estimate of 600,000 to 750,000 are illegal. Most illegal Latinos are from Mexico and El Salvador. Migrants are often referred to as the "working poor."

Migrant labor bolsters the American economy, while migrant remittances fuel the Mexican economy. The migrant labor force in the U.S. that comes from Mexico (transnational migrants) is equivalent in size to one-eighth of the entire Mexican workforce. Many migrants "settle-out," the process referring to remaining in the U.S. and residing in vicinities near the agricultural businesses that initially drew them to that area. If migrants are fortunate to find regular, year-round employment, many choose to remain and "settle-out." The "settling-out" process has, over many years, transformed the ethnic and class composition of communities in many regions of the United States (Garcia, Gouveia, & Rochin, 2002, in press).

As large and significant as the migrant workforce is in the U.S., there is surprisingly little known about the mental health consequences of the migrant experience.

Migrants often live in fear of deportation, or reside in less than favorable housing, work under less than favorable work conditions, and endure discrimination, prejudice, and abuse in a foreign environment. Additionally, migrants have limited resources, limited English communication skills, and are generally separated from family and social supports. All of these factors, and others, place them at increased risk for developing mental health related problems. Paradoxically, the few mental health studies that have been conducted suggest the opposite, that this population is psychologically healthy and relative to Latinos who reside in the “settled-out” communities, may be better-off from a mental health perspective.

This paper focuses on the need for understanding mental health consequences associated with migration and the agricultural migrant experience.

### **Immigration to the United States**

Immigration refers to the movement of people from one country into another. The number of immigrants and the country of origin of immigrants coming into the U.S. changed dramatically during the past century. There have been three distinct waves: the 1901-1930 wave totaled 18.6 million immigrants; the 1931-1960 wave was much smaller in size and totaled only 4 million immigrants; and the third wave, between 1966 and 1997, totaled 23 million immigrants.

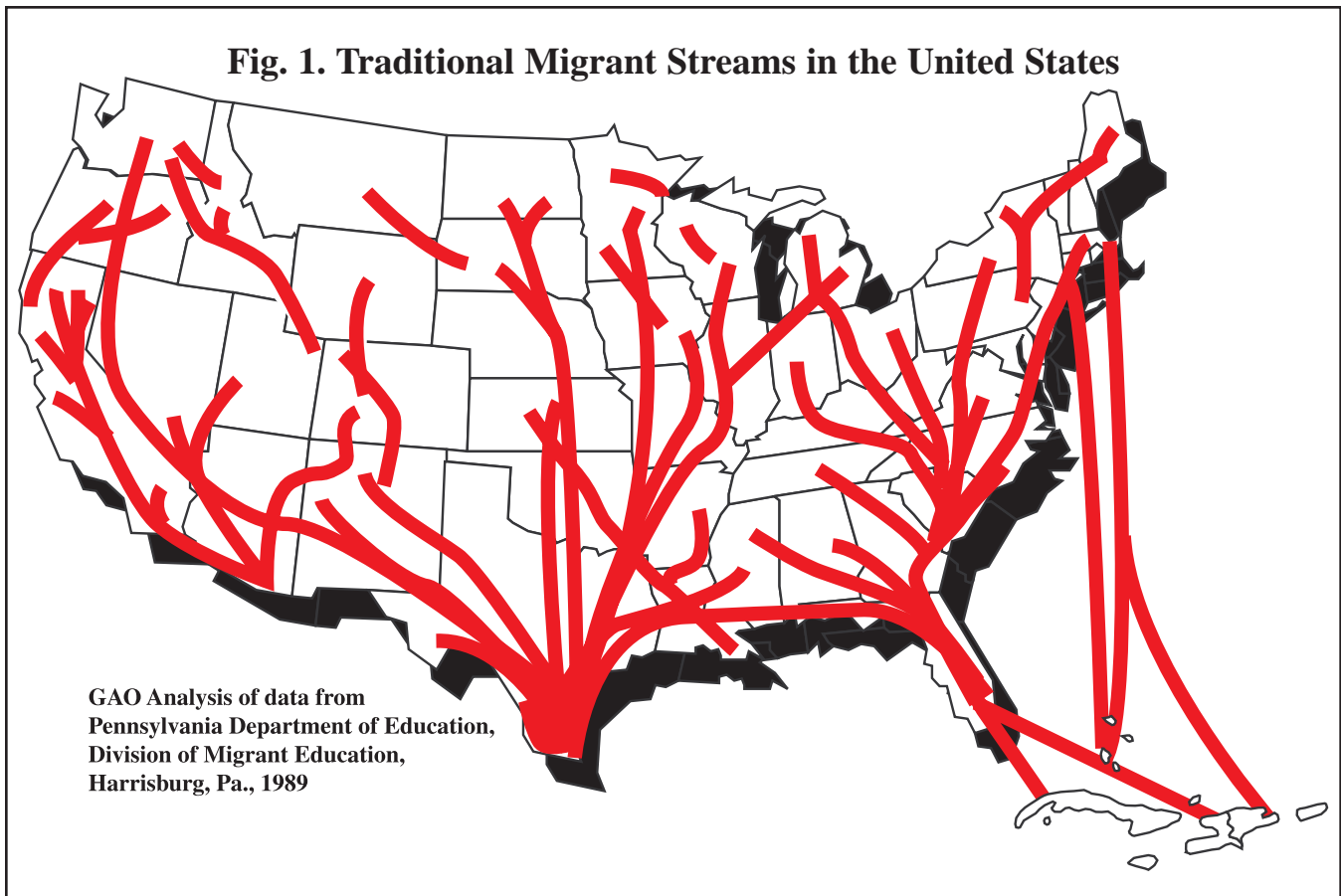
The origin of immigrants during the 1901-1930 wave were mostly (70%) from Southern and Eastern Europe. The origin of immigrants between 1931 and 1960 were from Northern and Western Europe (41%), 40% from Southern and Eastern Europe, and 15% from Latin America. In the third wave between 1966 and 1997, the percentage from all of Europe dropped to about 17%, Vietnam and Cambodia increased to 37%, and Latin America increased to 40% (Fernandez, 2001). In 1910, 14.7% of the U.S. population was foreign-born. In 1996, 9.3% was foreign-born (Fernandez, 2001).

In addition to the legal immigration from Mexico into the U.S., there is a substantial illegal immigrant population. In 1997 it was estimated that there were 600,000- 750,000 illegal migrant or seasonal agricultural workers in the United States during any given growing season. The estimated total number of undocumented, or illegal, Mexican-origin persons in the U.S. is as high as 5 million at any given time.

The Mexican-origin migrant population can be divided into (1) legal residents of the United States (e.g., green card holders and Mexican Americans) who travel, generally from the southern states to other regions of the U. S. to perform hired agricultural labor, and (2) citizens of Mexico (transnationals) who come to the United States to perform hired agricultural labor — a large percentage entering the U.S. illegally and a small percentage coming legally from Mexico on work visas — and approved labor contracts.

There are three migrant streams identified from Mexico and the Southern U.S. to regions within the U.S. (see Fig. 1): A California Stream in which Mexican-origin groups travel from Mexico and Southern California into the central valley of California and into the state of Oregon among other states. California is the nation’s leading agricultural state and employs the largest migrant workforce. The second migrant stream is known as the “Texas Stream.” It flows seasonally to the northern states as far as Michigan and Wisconsin and numerous states in between as farmworkers harvest vegetables, berries, apples, cherries, asparagus, etc. The third stream, referred to as the “Florida Stream,” travels up through Georgia, the Carolinas, and into the northeastern states of New York, New Jersey, and as far as Vermont, where vegetables, tobacco, apples, berries, etc., are harvested. The combined population of all three migrant streams during any given year is conservatively estimated at 1.2 million.

**Fig. 1. Traditional Migrant Streams in the United States**



These migratory agricultural streams have been operating over many years, and are not exclusionary. Many migrants from South Texas, for example, travel to California and to Florida as well. A clear migratory pattern to the state of Michigan in the northern U.S. has occurred annually for at least 93 years when Mexicans were recruited to work in the sugar beet industry (*betabeleros*) in 1910 due to a shortage of workers created by WWI (Valdes, 1992).

### **Characteristics of Mexican-origin Migrants**

Many Mexican immigrants come primarily from subsistence-farming areas, such as the ones found in the municipalities of Allende, Moroleon, Salvatierra, and San Francisco del Rincon (Almanza, Angel, Circe & Lopez, 1997). Most are employed in one of four occupations: (1) services, (2) farms, (3) production, and (4) laborer. As many as 90% reside in Metropolitan Statistical Areas (MSAs), 14% are unemployed,

and 38% live in poverty (Saenz, 1996). Educational levels are low. Many migrants travel with their entire families, who historically worked as family units on farms. There is an increasing number of unaccompanied, male migrants, referred to as “stag workers.”

Mexico, because of its history and proximity to the United States, is the most significant contributor of foreign-born Latinos in the U.S. California receives about half of the immigrants from Latin America and the Caribbean, followed by Texas, New York, Florida, and Illinois. These are also the states with the nation’s largest concentrations of Hispanics.

In 1990, California had 7.7 million Hispanics (26% of the state’s population), Texas had 4.3 million Hispanics (26%), New York had 2.2 million (12%), Florida 1.6 million (12%), and Illinois almost 1 million (8%). Altogether, these five states held nearly 75% of the nation’s total

Latino population (Rumbaut, 1996). The 2000 U.S. Census shows that the Hispanic population is the fastest growing ethnic group and now constitutes the largest ethnic minority group in the United States, representing an estimated 12.7 % of the U.S. population, exceeding that of the Black population estimated at 12.6%.

### A Transactional Mental Health Stress Model For Migrants

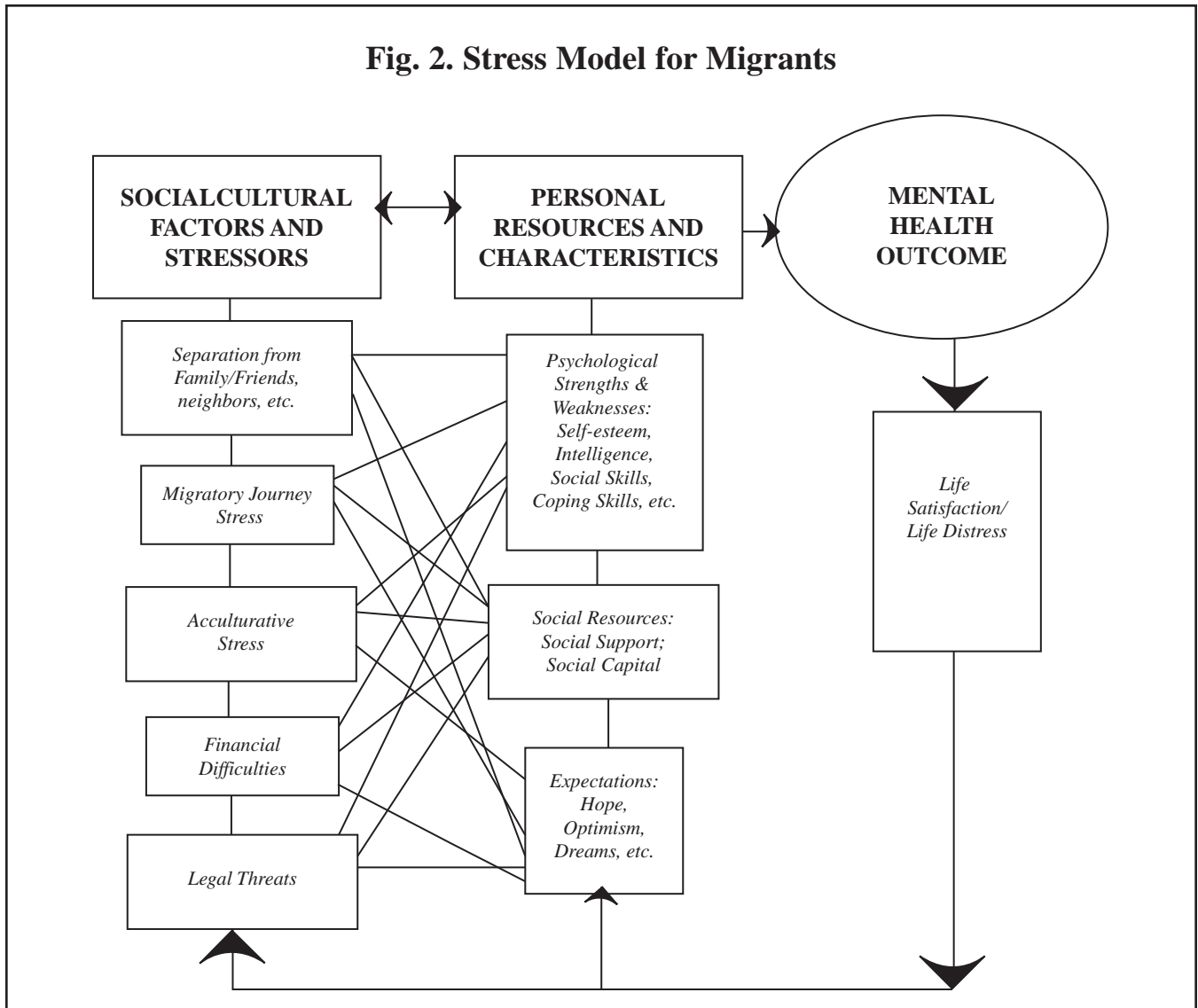
The stress model depicted in Fig. 2 is based on the idea that stress produces harmful effects on the mental well-being of individuals (Ensel & Lin, 1991). This model is transactional in that individual characteristics play an important role in terms of perception, coping, and buffering

external stress effects. Individual migrant experiences may vary substantially from one migrant to another and individual responses to similar experiences may vary as well based on psychosocial histories, resources, and individual characteristics.

### Mental Health Issues of Migrants.

Acculturative stress, stress associated with having to learn about a new and different culture including its language, customs, laws, and values, is a significant part of the migration experience. Hovey (2001) identifies over 20 culture specific stressors associated with the migrant experience that increase risk for mental health related problems (See Table 1). Table 1

**Fig. 2. Stress Model for Migrants**



groups migrant stressors into five primary areas: (1) Language and communication stressors (2) Social support and isolation stressors, (3) Work environment/conditions stressors, (4) Migrant journey and physical environment stressors, and (5) Social and cultural environment stressors.

graduate from college than third-generation, U.S.-born Chicanos.

Suarez-Orozco (1997) is not the only investigator to note that new immigrants sometimes have better mental health than more

**Table 1. Specific Sources of Stress Associated with Migrant Experience in the U.S.**

| STRESS FACTORS  | STRESS EXAMPLES   |
|---|---|
| <b>1. Language barriers</b>                               | Limited English communication skills; cultural misunderstandings; Poor or non-existent reading skills in English; limited Spanish language radio stations   |
| <b>2. Separation from supports</b>                        | Being away from family, friends, loved ones; inability to confide in others; Geographic and social isolation  |
| <b>3. Work Related Stress</b>                             | Difficult physical labor; Unpredictability of finding work; Unreliable work conditions; Difficult work conditions e. g., no days off, long hours; not being paid; miscommunications with employer; occupational hazards including pesticide poisoning; exploitation by employers; high risk of injury, etc. |
| <b>4. Migratory journey stress (physical environment)</b> | Swimming across polluted waters, traveling through deserts; crowded living quarters (e.g., back of truck); lack of water/food; unreliable transportation; poor housing; unfamiliarity with geography, terrain, etc.   |
| <b>5. Social/Cultural Environmental Stress</b>            | Restricted access to healthcare; fear of violence; experiences of discrimination; poverty; unfamiliarity with cultural customs, legal laws, geography, etc.; worries about the socialization of children; lack of daycare; concerns about the education of children, etc.                                   |

**Mental Health Findings.**

A subject of growing interest in acculturation research is the effect the American/U.S. culture has on the immigrant and migrant who is undergoing acculturation based on the Immigrant Paradigm of Acculturation (Cuéllar, 2000; Cuéllar, Siles, & Bracamontes, 2002). Suarez-Orozco (1997) noted that an increasing number of studies show that the new immigrant from Mexico displays better mental health and a better (“healthier”) attitude toward wanting to do well in school, and to express aspirations to

acculturated Chicanos. Vega, et al. (1998), compared adjusted lifetime prevalence rates for various mental disorders using the Composite International Diagnostic Inventory (CIDI) in Mexican immigrants with native-born Mexican Americans and found the native-born lifetime prevalence rate for any disorder (48.7%) was twice that of the immigrants (24.9%). Vega, et al., also found that short-term stay immigrants (less than 13 years) had almost half the lifetime prevalence rates for any disorder than long-term immigrants, those having lived in the U.S. for more than 13 years. In comparing the lifetime



prevalence rates for Mexicans in Mexico City with short-term immigrants, long-term immigrants, and native-born Mexican-origin populations, they found that prevalence rates increased with increased acculturation toward the U.S. Culture (see Table 2). Additionally, Vega and colleagues found that Mexican-origin individuals who were born and raised in the United States, or who had lived the longest in the United States, had higher prevalence rates for depression, affective disorders of any type, and any psychiatric disorder than those who were born in Mexico or had lived the longest in Mexico.

### Conclusions

Mexican-origin immigration, and transnational and migratory movements into the U.S. and within the United States, has a long, cyclical history that is associated with employment opportunities, particularly in the agricultural industry. Although the immigrant

and migrant experience can be enormously stressful, the mental health consequences have very limitedly been studied. Although it might be expected to find higher rates of mental health problems and disorders in the migrant and immigrant populations, the opposite seems to be the case based on a large, well controlled study (Vega. et. al., 1998) using a highly respected, reliable, and valid cross-cultural measure of mental health — namely the Composite International Diagnostic Inventory (CIDI). What is of concern is that mental health problems in immigrants and settled-out migrants seem to increase along with increased residency in the U.S. As Suarez-Orosco (1997) suggests, the immigrant and migrant may be attracted to come to the U.S. to work and improve his/her educational status and standard of living in accordance with the “American Dream,” but the long-term effects of that decision may prove to have, at least for some, an enormously stressful and detrimental impact.

**Table. 2. Residency in U.S. and Prevalence of Mental Disorders in a Mexican-origin Sample using the CIDI\***

| Psychiatric Disorder     | < 13 years<br>in U.S. | 13+ years<br>in U.S. | Native-Born<br>Mexican |
|--------------------------|-----------------------|----------------------|------------------------|
|                          | <i>n</i> = 884        | <i>n</i> = 851       | <i>n</i> = 1,145       |
| Major Depressive Episode | 3.2                   | 7.9                  | 14.4                   |
| Any Affective Disorder   | 5.9                   | 10.8                 | 18.5                   |
| Any Anxiety Disorder     | 7.6                   | 17.1                 | 24.1                   |
| Alcohol Dependence       | 8.6                   | 10.4                 | 18.0                   |
| Any Substance Dependence | 9.7                   | 14.3                 | 29.3                   |
| Any Disorder             | 18.4                  | 32.3                 | 48.7                   |

\*CIDI = Composite International diagnostic Interview

Source: Vega, A. William, Kolody, B., Aguilar-Gaxiola, S., Alderete, E., Catalano, R., Caraveo-Anduaga, J. (1998). Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican Americans in California. *Archives of General Psychiatry*, 55, 771-778.

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