The important role of culture in the rehabilitation process and the need to be sensitive to cultural differences are emphasized. Forty-seven studies and articles are reviewed, and five factors that influence the acceptance of disability in Mexican American culture are identified. Each of these factors is briefly discussed, and implications for rehabilitation practice are identified.

Of primary importance in the rehabilitation process is the individual's reaction and adaptation to disability. Individuals differ in their reactions to disabilities (Dembo, Leviton, & Wright, 1956; Dohrenwend & Dohrenwend, 1969, 1974; Linkowski, 1971, 1987; Linkowski & Dunn, 1974; Saflilos-Rothcchild, 1970; Woodrich, 1982; Wright, 1983), and the degree of acceptance of disability may influence decisions to apply for services and the success of the entire rehabilitation process. As stated by Linkowski (1987), "Acceptance of disability is assumed to be an important 'mediating' variable. It can assist researchers and practitioners in understanding the connection between the person's disability and self-perception and, further, in predicting independent living, educational, and vocational rehabilitation program-related outcomes" (p. 1).

Good health and the prevention of disability are major interests of peoples of all cultures (Clark, 1959), as is rehabilitation following or set of a disability. The manner in which different cultures view, react to, and treat disability, however, varies considerably. One may say that acceptance of disability is influenced by culture (Kleinman, 1978; Kunce & Cope, 1969; Peterson, 1967). Arnold (1987) concluded:

Cultural elements such as language, family roles, gender roles and beliefs and acculturative stress can play a significant role in the etiology, symptom manifestation, and rehabilitation treatment of disabilities. Culture can influence (a) the beliefs about causation, (b) the conditions that qualify as "sickness," (c) the expectations about what time affected person should do, and (d) the expected actions of others in response to that person's condition (Mumford, 1981). Essentially, it is believed that when sociocultural elements are included in the assessment and rehabilitation process, clients will be more accurately evaluated and effectively rehabilitated than when these elements are excluded. (p. 15)

The United States is a pluralistic society with many ethnic minorities. It seems essential that rehabilitation workers understand the meaning of disability and reaction to disability of each client. To do this, it is necessary to gain some understanding of culturally determined perceptions and definitions of disability.

The purpose of this article is to examine acceptance of disability among Mexican Americans, the largest Hispanic group in the United States. It should be noted that in rehabilitation literature there is some ambiguity and disagreement as to what term to use when referring to Hispanics of Mexican origin. In this article the term "Mexican American" is used; Garcia (1981) reported that this is the term most widely chosen by members of this group when referring to themselves, and Smart (1988) also found this to be the case. Other terms that have been used include "Chicanos," "Hispanos," "Latinos," and "Spanish Americans."

According to Padilla (1976) and Schreiber and Homiak (1981), knowledge about Mexican American culture is based on research of questionable value. Therefore, conclusions must be drawn with caution. These authors raise the following concerns about existing research on the topic: (a) an undue focus on rural, lower class Mexican Americans; (b) failure to separate the effects of culture from he effects of socioeconomic factors; (c) failure to keep abreast of rapid demographic changes; and (d) an over-reliance on survey methods of research.

FIVE CULTURAL FACTORS INFLUENCING ACCEPTANCE OF DISABILITY

Despite these limitations, the authors have reviewed the literature on the rehabilitation of Mexican Americans and have identified five factors that may be associated with the acceptance of disability among Mexican Americans. The identification of these factors was based upon a logical classification of characteristics that arose from reading and reviewing the literature. These particular five factors were chosen after having reviewed a number of articles. As more research is done in this area, it may become necessary to expand or delete this classification system, but at this time, it seems to offer a useful means of categorizing various characteristics of Mexican American culture. The five factors identified were the following: (a) a familial, cohesive, protective society; (b) a stoic attitude toward life in general; (c)
well-defined gender roles; (d) religious views; and (e) reliance on physical labor. There may well be a great deal of ambiguity and disagreement among researchers about the definition of each of these factors and the role they may play in the acceptance of disability, but their existence is, at least to some extent, evident in the literature.

A FAMILIAR, COHESIVE, PROTECTIVE SOCIETY

Rivera (1983) and Rivera and Cespedes (1982) pointed out that Mexican American family units play important roles in rehabilitation outcomes. Collier (1983), Cruz (1979), Guerra (1973), Rivera (1983), Schreiber and Homiak (1981), Turnball and Turnball (1987), and Zayas (1981) characterized the reaction to disability of the tightly knit, family- oriented Hispanic culture as providing support and comfort at home. According to Cruz (1979), "Hispanic families tend to overprotect and paternalize their disabled. Even if a disabled individual wants to learn to be independent and self- sufficient, he [or she] is seldom allowed to do so" (p. 33).

Arnold and Orozco (1987) studied various family interactions of 44 bilingual, bicultural Mexican American clients served by the Texas Division of Rehabilitation. They reported that families of clients were less encouraging of assertive behavior and of self-sufficiency. One factor, age, was found to be positively related to the amount of independence encouraged, and the relationship was even more evident when the variable of socioeconomic status was considered, suggesting that as client age and socioeconomic status increased, so did the family's encouragement of independence.

Rivera (1983) also regarded the treatment of some Hispanic children with disabilities as overprotective, particularly in cases of congenital disabilities. He noted a greater concern on the part of Hispanic families and reported that children with disabilities are kept at home to be taken care of and may not even be allowed to attend school.

Marion (1980) found evidence that feelings of protection and acceptance of children with disabilities were typical emotions, especially in Mexican American and Black families, both of whom had extended family networks. Marion added, however, that much of the research on minority children with disabilities "did not stress the strength of minority and culturally diverse families and tended to ascribe pathological conditions to atypical family structures" (p. 617).

Garza (1986) reported that it is quite common to hear a Spanish speaking person refer to an individual who is blind as "un pobre ciegito" (a poor blind man). In addition, he asserted that illnesses, faults, and disabilities may become extensions of the person and are often treated with nurturing, sympathetic ladness, and comfort, with family loyalties and other cultural factors (including religion) fostering dependency and isolation. He concluded that there is a tendency for family members to protect relatives who are blind and to keep them close by.

Finally, Zayas (1981) observed that the orientation of Hispanic rehabilitation counselors was to have a more paternalistic and sheltering notion of disability than do Anglo rehabilitation professionals.

STOIC ATTITUDES TOWARD LIFE IN GENERAL

"La vida es aura" (Life is hard) is a common expression among Mexican Americans. Living is hard because of unavoidable hardships and suffering. Problems should be endured with dignity and courage. Saunders (1954), Clark (1959), and Harward (1969) found an attitude of resignation and acceptance and a belief that "nothing can be done" toward health problems and disabilities. Indeed, it was reported that, in time of stress and misfortune, lower-class Mexican Americans tended to view difficulties as simply a part of life that fate had decreed. There was less inclination to question or berate than among Anglo Americans. This seems to have been based on the Mexican American's acceptance of his or her state of health, as it was, whether good or bad, with no thought of doing anything to change it. In the same study, Harward found that 47.7% of a sample of Mexican Americans, in comparison with 19.5% of Anglo Americans, indicated that a disability was an extreme hardship. This suggests a difference in emotional feeling about disablement.

Angel (1985) cited the importance of reference group factors in the experience of disability, suggesting that, if most of the people in one's immediate reference group have backaches from working in the fields, such a symptom may not seem worth mentioning. Speaking of mental illness, Rogler (1982) noted that there is some evidence that Mexican Americans tend to delay treatment until the illness becomes severe. Furthermore, illness is viewed as a manifestation of weakness of character, and the need for treatment is viewed as disgraceful, indicating a loss of pride.

WELL-DEFINED GENDER ROLES
Rivera (1983) saw a relationship between the well-defined gender roles of men and women in the Mexican American culture and the acceptance of disability. Many Hispanic men have been taught that it is their responsibility to provide all of the resources for the family. Women are to be homemakers, and the Hispanic man with a disability may believe his life is devastated if he cannot fill his role when he cannot work because of a disability. Rather than admit that he needs help, which may be a sign of weakness, he may unsuccessfully try to continue working. Rivera concluded that the experience of a disabling condition may have a greater impact on an Hispanic male's self-image than it would on persons who perceive themselves and their roles less stringently. Related to this, Schreiber and Homiak (1981), in speaking of medical treatment, noted the difficulty on the part of men in tolerating loss of authority or self-esteem before family members who regard them as "patrones" (benevolent protectors). Therefore, it is not uncommon for men to discontinue treatment upon initial signs of symptom relief, because once a man is capable of resuming normal activities, treatment is no longer viewed as socially acceptable.

In contrast with the cultural factors facilitating return to work described earlier, Harward (1969) identified a negative factor in her study of Mexican American clients in the Arizona State Rehabilitation Agency. She observed that "the Mexican American male did not appear as threatened by being financially dependent as the Anglo American male" (p. 30).

**RELIGIOUS VIEWS**

Baca (1974), Cruz (1979), Lafitte (1983), Schreiber and Homiak (1981), and Zayas (1981) all pointed to the role that religion plays in the definition of disability, response to disability, and acceptance of disability. Many disabilities are viewed as having a supernatural etiology. As stated by Cruz (1979), "In many areas superstitions persist that disability is a punishment for some unnamed wrong" (p. 33).

Lafitte (1983) noted that the reaction to a physical or mental disability varies in different cultural environments. In the Hispanic milieu, a disability may be interpreted as divine punishment for sin, and the sin is usually thought to be that of the parents of the individual with the disability. Lafitte identified religion as an area in which the specific subcultural characteristics of Hispanic clients are of paramount importance to counselors to understand and identify the individual needs of clients and to help them reach higher levels of adjustment.

Related to the etiology of disability are the reactions to disability and treatment. Schreiber and Homiak (1981) observed the importance among Mexican Americans of the close association between religion and sickness, because illness often becomes the occasion for propitiatory rituals. Furthermore, the religious interpretation of disability and illness may be related to Samora's (1978) concept of acceptance of one's lot in life. According to Samora, this defeatist conception suggests that there is little, if anything, that one can do about the course of life events. Taken to its extreme, defeatist conception means that there can be few conscious attempts to change the course of those life events. Such attempts may be interpreted as thwarting God's will or, in the extreme, playing the role of God.

It should be noted that Ruiz and Padilla (1977) and Garza and Ames (1976) presented evidence that refutes the assumption that Hispanics are fatalistic and have an external locus of control. They have asserted that studies that have posited fatalism and external locus of control were methodologically inadequate because of such factors as the failure to control for socioeconomic status, the use of ethnographic methods, questionable cross-cultural techniques that use White, Anglo Americans as the standard of evaluation, and faulty generalizations.

Garza (1986) reported that most researchers have virtually no understanding of the cultural dynamics of the Chicano community and asserted that most psychological research involving Chicanos seems predominantly to view Chicano culture only in terms of the damage it causes to the individual's affective and cognitive processes. He was particularly critical of such research because, in his view, it seems that the notion that certain characteristics of Chicano culture may result in positive attributes is rarely considered.

**RELIANCE ON PHYSICAL LABOR**

It has been shown that Hispanics are overrepresented in physically demanding jobs and have lower levels of education. For any individual with a disability, the number of available resources and options will probably influence the acceptance of disability. Those individuals with fewer resources, such as employment opportunities and training options, might accept disability differently as compared with those who have a great number of opportunities and options open to them. For those Hispanic and Mexican American individuals who have earned their living by physical labor and have little proficiency in English, a physical disability may preclude many employment and training opportunities. The limited opportunities available may influence acceptance of disability; indeed, disability may represent more than a physical loss. Zayas (1981) stressed that many Hispanic men are laborers, and when disabled,
they lose the status that they previously had.

**CONCLUSION**

There is a serious unmet need among Mexican Americans for rehabilitation services that give adequate consideration to cultural factors. The large number of Mexican Americans coupled with their overrepresentation in physically demanding and dangerous occupations (Angel, 1984; Kapur, 1986; McLemore & Romo, 1985; Rivera, 1973) support this observation. Despite the high need for services, however, it is clear that Mexican Americans experience not only low referral rates to rehabilitation programs but also high drop-out rates after they have been declared eligible for services (Linsky, Arnold, & Hancock, 1983; Rivera, 1983; Suazo, 1986a, 1986b).

Although there are no studies reported in the rehabilitation literature that investigate the relationship between provision of culturally relevant services and application rates, such studies have been reported in the mental health literature. Burruel and Chavez (1974), Miranda (1976), Morales (1978), and Ponterotto (1987) viewed the underuse of mental health counseling services by Mexican Americans as the consequence of the culturally irrelevant services offered by monocultural Anglo American counselors. Ponterotto concluded: "It follows, then, if counseling services were more culturally sensitive and relevant, rates of use would increase" (p. 308). Indeed, three attempts to provide more culturally relevant services to Mexican American did produce increased rates of use (Laosa, Burstein, & Martin, 1975; Martinez, 1977; Morales, 1978). It is reasonable to assume that the same relationship between provision of culturally relevant services and application rates would be found in rehabilitation, where cultural factors considered would also include an understanding of the individual's perception and acceptance of his or her disability.

**IMPLICATIONS**

The five factors identified in this article that seem to influence the Mexican American's acceptance of disability carry with them implications for the entire field of rehabilitation—for the educator, researcher, and counselor. As America (the United States) becomes more culturally diverse, more and more thought needs to be given to the development of curricula that will ensure sensitivity to cultural diversity. Such curricula might include both theory and practica in multicultural counseling and might draw upon content in sociology anthropology, and other courses that would broaden human understanding beyond the mainstream Anglo culture.

Likewise, researchers might draw on techniques long used in the fields of sociology and anthropology, including methods such as participant observation, ethnographics, sociometry, network analysis, and analysis of social indicators. There is a particular need for the development of an acculturation scale that is short, practical, and empirically validated. Measurement of level of acculturation, which might include the five factors identified in this article, could thus become a routine part of the evaluation process with Mexican American rehabilitation clients.

Various implications for rehabilitation counseling practice seem evident. Perhaps most important is the care and attention that should be directed toward understanding the role of the family in the rehabilitation process. The importance of the family strongly suggests the inclusion of all family members in rehabilitation case management. Although inclusion may be cumbersome, it means involving family members in discussions about the meaning of the disability and possible altered roles of all the family members, as well as appropriate support that may be provided to the family member with the disability. It may mean increased home visits to become more acquainted with families in their home settings. Understanding of well-defined gender roles may also be best accomplished by working with the entire family because these roles are most clearly expressed in the family setting. When disability forces a modification of such traditional gender roles, a healthy adaptation may be best accomplished when the family understands and is supportive of such changes.

Likewise, a clearer diagnosis and treatment of a disability can be made when the religious beliefs and worldviews of clients can be understood and used in counseling. This may mean the ancillary use of others such as priests, ministers or curanderos(as) in support of rehabilitation goals.

In general, recognition of the five cultural factors identified in this article means broadening the concept of rehabilitation beyond a simple focus on the person with the disability. It means recognition and active incorporation of the social and cultural forces surrounding clients. Such recognition may force rehabilitation workers to move beyond the four walls of the clinic and into a more active participation in the broader cultural milieu of clients. Furthermore, it suggests more frequent use of the language and customs of clients if this milieu is to be incorporated into the treatment or service plan.
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