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The Relationship between Acculturation and Illness Referral Systems among Urban Mexican-Americans

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THE RELATIONSHIP BETWEEN ACCULTURATION AND ILLNESS REFERRAL SYSTEMS

AMONG URBAN MEXICAN-AMERICANS

by

Heidi Vyhmeister

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The researcher, Heidi A. Vyhmeister, is the daughter of Dr. Werner K. Vyhmeister and Dr. Nancy J. (Weber) Vyhmeister. She was born in Chillán, Chile, on July 18, 1960.

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CHAPTER I

INTRODUCTION

Persons of Hispanic origin compose the second largest ethnic minority in the United States, the first group being American Blacks. Because of rapid biological growth and immigration, it is predicted that within the next decade, Hispanics will become the country's largest subcultural group (O'Brien, 1982). Much has been written regarding health beliefs and practices of Hispanics. There is consensus in the literature that Hispanics display a great deal of divergence from Anglo-American beliefs and practices (Rubel, 1960).

Illness behaviors are based on socioculturally defined values and rationales which lead to specific perceptions of an illness and the steps to be taken in order to alleviate it. The choices a person makes regarding the source of treatment of disease are known as an illness referral system. This is a pattern common to a specific culture which, although varying slightly in individual situations, establishes the pathway taken when attempting to move from illness to health (Weaver, 1970).

Illness referral systems within the Hispanic-American culture have been described by several authors (Ailinger, 1977; Weaver, 1970). There has been some comment made regarding changes resulting from adaptation to the Anglo-American culture. There are no actual data available on the subject. In addition, what has been written regarding

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Hispanics most often does not make clear distinctions between the various subgroups within the Spanish-speaking population. For example, Puerto Rican-Americans, Cuban-Americans, Spanish Americans, and South Americans are often grouped together as "Hispanics." The largest subgroup in the United States, composed of Mexican-Americans (U.S. Bureau of the Census, 1980), will be the focus of this Thesis. All subgroups mentioned in the literature review will be identified by national origin unless this has not been done in the literature itself, or the group referred to is of mixed origins, in which case, these persons will be referred to as Hispanics.

As more and more health care facilities and personnel have to deal with Hispanics, it becomes vital that health care professionals understand the health behaviors of their clients. This cannot be realistically achieved by stereotyping all Hispanics as subscribing to the traditional health beliefs identified in nursing and anthropological research. It is necessary to be able to anticipate behaviors more accurately, based on a knowledge of the client's exposure to Anglo-American society and his particular cultural background.

Statement of the Problem

Although a relationship between acculturation and illness referral systems has been postulated, no research has been reported that either supports or rejects this supposition. A variety of studies have been conducted to measure acculturation (Cuellar, Harris, & Jasso, 1980; Padilla, 1980) or illness referral systems (Ailinger, 1977; Weaver, 1970). No studies have looked at both in relation to the Mexican-American population.

It was the purpose of this study to analyze the relationship between acculturation and illness referral systems in persons of Mexican descent within an urban setting. The resulting data will serve to expand the knowledge base necessary for the practice of crosscultural nursing.

CHAPTER II

REVIEW OF LITERATURE

Spanish is the fourth most common language spoken in the world, after Chinese, English, and Hindi (Tutherly, 1980). Interestingly enough, the United States has the sixth largest Hispanic population in the world, exceeded only by Mexico, Spain, Colombia, Argentina, and Perú. This is a heterogeneous group composed of individuals of many differing national origins and racial characteristics, who may or may not speak Spanish. They are all united, however, by a common neglect on the part of the health research sector. It is not known at present how many Hispanics are born or die each year in this country. Efforts are being made to improve data gathering but their effectiveness is often limited by the undisclosed presence—and therefore natality, morbidity, and mortality—of millions of Hispanics who have entered the United States illegally (Trevino, 1982).

Various anthropological and sociological studies have provided a basis for understanding Hispanic culture, generally doing so by comparing it to the Anglo-American culture. Culture has been defined by Fejos as "the sum total of socially inherited characteristics which one generation can tell, convey, or hand down to the next, in other words, the non-physically inherited traits we possess" (1959, p. 43). Of primary interest within the present study is that portion of culture

comprising the health beliefs and practices identified within the

Mexican-American community.

Health Beliefs and Practices

The great majority of the material concerning health beliefs

and practices among Hispanics and Mexican-Americans focuses on folk

illness and cure. Because of the predominance of Mexicans in the

United States, most of the literature concerns Mexican health behaviors

and beliefs. The five major illnesses consistently identified are:

caída de la mollera, mal de ojo, empacho, susto, and mal puesto. It

should be noted that these are more clearly connected to Mexican

culture but are also observed in other Hispanic cultures (Hautman,

1979; Rubel, 1960).

Caída de la mollera is seen only in infants and small children.

It is a depression or "falling in" of the anterior fontanelle. This is

believed to occur when a blow or shock dislodges the hard palate, thus

removing the support for the fontanelle. This depression of the palate

causes inability to suck, irritability, vomiting, and diarrhea. Cure

is achieved by returning the palate and fontanelle to their proper

position through a variety of maneuvers.

Mal de ojo, translatable as "evil of the eye," does not carry

the connotation of witchcraft but of too strong a glance. It

originates when an improper bond is created between two people (as when

a neighbor admires a handsome child) and then not severed by touching

the person's head or face. The person afflicted with mal de ojo is

drained of the will to act and becomes subject to the stronger power of

the other. Manifestations are sudden severe headaches, inconsolable

weeping, fretfulness, and high temperature. Cure is rapidly achieved

if the person who neglected to break this bond is found and touches the ill person on the head or forehead. If the source of the mal de ojo cannot be identified, a curandera (healer) uses rituals involving an egg to extract the evil from the person. If left untreated, mal de ojo can be fatal. Severe coughing and vomiting rupture the bile sac, after which there is no effective cure available.

Empacho is caused by a failure of the digestive system to pass a chunk of food into the intestinal tract. The cause may be the food itself, or eating when one is not hungry or is stressed. Symptoms include stomach pain, diarrhea, vomiting, and anorexia. At time an abdominal mass can be felt. Treatment is carried out by a family member, a sobador(a) (masseuse/healer), or a curandera, and consists of massaging the back and pulling at the skin over the spine until a snapping sound is heard. A purgative, such as epsom salts, milk of magnesia, or castor oil may also be given.

Susto (fright) can be caused by a shocking experience, such as seeing a ghost or being involved in an accident, or by the stress resulting from inability to fulfill one's social role responsibilities. Symptoms include restlessness during sleep, anorexia, depression, listlessness, and disinterest in personal appearance. This is due to the absence of the spirit of the person which is said to be wandering after being frightened away. The cure is effected by a curandero (male healer) or espiritualista (spiritualist), or by the family members, who engage in rituals calling the spirit back to the body. The ritual ends with the abrupt showering of the patient with water which should jolt him back into this world. If susto is not recognized soon enough, it can become very advanced, in which case a priest is called in to bless

(<u>ensalmar</u>) the person. If not arrested, susto can degenerate into <u>tis</u> (tuberculosis), and prove fatal.

<u>Mal puesto</u> is the only illness of maleficent nature, and is caused by a hex placed on the sufferer by another person. The symptoms vary considerably, and include behavior changes, labile emotions, and convulsions. The cure is magical and can be carried out by a <u>curandero</u> or <u>brujo</u> (male witch).

Beliefs regarding health and illness are based on a holistic conception of man, and the Hippocratic humoral theory of disease. Wet, dry, hot, and cold must be kept in the right balance within the person to maintain health. The most important of these is the hot-cold balance. Various foods, diseases, and remedies are assigned a hot/cold value which may or may not coincide with actual temperature. If a disease is considered to be "hot," then "cold" remedies and foods are given in the correct amount to balance the system again (Currier, 1978).

Emotional origins for disease are recognized. Disruptions within the social structure and the roles a person must fill are also seen as a source of illness. The person is not considered responsible for his illness—he is an innocent victim of forces in the environment. Whatever a physician may diagnose as the cause of the illness does not alter the patient's perception of the origin of his disease. Therefore, doctors who do not take these forces into account, or at least refrain from scoffing at them, are considered poor practitioners (Clark, 1970).

When a person feels ill, he presents the symptoms to his family and friends for validation, as illness involves expenditure of money

and time for them. If the kin group validates the illness, then referral to a health care system will occur (Clark, 1970; Spector, 1979). For the same reason, should a practitioner propose a course of treatment, the patient cannot agree or disagree independently. After discussion with the people who will meet the social and financial obligations the patient cannot meet due to his illness, he will convey the decision to the practitioner (Clark, 1970).

Health practitioners, either lay or professional, are chosen depending on availability, but are more importantly, by reason of perceived knowledge of, and ability to cure certain diseases (Fabrega & Zucker, 1979). Personality and culture also enter into the decision, as Hispanics will prefer a person who understands their sociocultural background and will work within it. An important aspect of this is the willingness to consider and include the family and community in the diagnostic and treatment process (Foster & Anderson, 1978; Toohey & Dezelsky, 1980). Treatment prescribed by a curandera (healer), for example, is open to criticism and discussion by the family and the patient, who then accept or reject it, with no hard feelings on the the part of the healer (Clark, 1970).

Marginal practitioners within the medical system—such as chiropractors and homeopaths—are more acceptable to Mexican-Americans, as they are similar to some folk practitioners. Physicians do not normally belong to the patient's authority structure, which is composed of kin, and powerful members of the social group. For this reason, they are not authority figures among Mexicans in the barrio as they are in Anglo-American society. Thus, a doctor's prescription may be ignored if so dictated by the patient's society (Clark, 1970).

Other problems that raise barriers between Hispanics and the professional health care system include minority sensitivity to so-called second class status citizenship, which even in case of serious illness may cause them to hesitate to utilize agencies or facilities perceived to be unfriendly or unsympathetic (Rosenblatt & Suchman, 1964). The language barrier is a significant problem for many, as is poverty. The perception of time, and the importance which a Hispanic places on punctuality may differ greatly from that of the professionals at the clinic, causing hostility on all sides and discouraging further visits (Spector, 1979). Another very Hispanic problem is the carefully structured relationship between males and females. Very often the client and health practitioner are of opposite sexes. This can be perceived as a threat to the modesty and decorum that is felt to be necessary in maintaining proper relationships outside of the family. This threat in turn will probably cause a patient to become upset, hostile, and possibly leave the system (Clark, 1970).

Zola (1964) states that delaying and nonparticipation in medical care, aside from being associated with culture, is linked with low socio-economic status. The person feels that if he has not been able to cure himself, then whatever disease he has must be very serious, and delays seeking medical help for fear of the diagnosis he will receive. Although this behavior is common to all socio-economic strata, Zola contends it is seen more frequently in low income groups.

In 1978 the median income of Mexican-Americans was $12,800 per year, and 18.6% of Mexican-Americans were below the poverty level. An additional 7.4% were in the group earning only 25% more than poverty

level income (U.S. Bureau of the Census, 1980). Thus a large number of Mexican-Americans will underuse the health system both because of cultural background and low socio-economic status.

In her study of illness behavior patterns among Hispanic migrant workers, O'Brien (1982) found that medical care is illness or injury oriented, and illness is only recognized when it interferes with effective day to day activity. Through use of grounded theory O'Brien identified the underlying attitudes and behaviors. The main concept was that of pragmatic survivalism. This is "a pattern of behaviors and attitudes that focus on achievement and maintenance of low-level wellness in the most practical manner possible for the continuance of productive life" (p.21). The subconcepts she identified were: (a) role-constrained illness perception--a person is not ill unless he cannot carry out usual role responsibilities; (b) parochial-restricted health behavior--a function of availability of health care choices and knowledge; and (c) reality-accomodated treatment response--if the patient feels better, treatment is discontinued; easily carried out treatments are accepted more readily.

Using records from a TB sanitarium in Texas, Nall and Speilberg (1978) identified 53 Hispanic patients who had been discharged from the institution. Twenty-seven of these had complied with the in-patient treatment, and 26 had not. Both groups were socially homogeneous, and males and females were distributed evenly. These persons were interviewed to determine the factors influencing their attitude to medical treatment. The researchers found that few used folk cures (12%), and only 19% sought curatives from kinfolk or friends. If the patient was married, with the spouse present, lived near his relatives,

sought advice from his family, and had a high degree of knowledge of and contact with his neighborhood, then acceptance of treatment was low. Persons who sought advice from friends, who were socially alienated, and under 40 years of age, were more likely to comply with the treatment. Persons who were older than 40 years on age, and women who spoke little English were less likely to comply. The researchers contend that folkways are not the cause of rejection of medical treatment. The true problem is that the family and community will not give up its members.

Zola (1966) described the cultural influence on perception of symptoms as serious and worthy of medical attention. Values and beliefs held by different cultures caused the same symptomatology to be viewed in different ways, and varied the person's response to illness.

Illness Referral Systems

When illness is perceived, relief is sought in a variety of ways. An illness referral system is defined as "the process of selecting a health care alternative by an individual who perceives he is ill" (Ailinger, 1977, p. 53). There is general agreement to the effect that illness referral systems are socio-culturally determined. In many cultures illness referral systems have been studied by anthropologists or health care professionals, but a lack of consensus is seen in diverse conceptions of the system.

Hautman and Harrison (1982) studied health beliefs and practices in an Anglo-American neighborhood. A convenience sample of 100 individuals 18 years old or above which excluded doctors and nurses was used. Most respondents were of the middle class. Although 65% utilized a private physician for health care, and others went to Health

Maintenance Organizations, clinics, and chiropractors, a wide variety

of folk treatments and over the counter medications were used for

self-treatment. If self treatment failed, the next step usually was

orthodox practitioners, although 49% consulted pharmacists regarding

medications and treatment for problems perceived to be self limiting.

The author concludes that it is difficult to separate Anglo folk

beliefs from Anglo medicine, because much of the culture's perception

of illness is incorporated into orthodox medical practice.

O'Brien (1982) describes an indigenous health care system among

the Mexican-American community composed of the curandera/o (healer),

yerbalista (herbalist), and sobador/a (masseuse). She compares it to

the professional system composed of the physician, registered nurse,

and practical nurse, stating that both systems are parallel and little

communication between the two exists. Folk illnesses are taken to the

lay system, whereas "orthodox" ailments are referred to the

professionals. Leininger (1978) sees indigenous health care systems as

different from professional systems, although some overlapping and

interdigitation is often seen. The rationale behind the use of both

systems is given as the belief "that in the particularly crucial area

of life and death, reliance on only one therapist or therapy, or system

of care may be too precarious" (Scott, 1977, p. 347).

The most common view of illness referral systems is that both

lay and professional practitioners form part of one system. Various

authors have described the process. Polgar (1963) identifies three

phases: self-addressed, where the client and health actor are one and

the same; lay health phase, in which the person solicits and/or

receives help from the immediate social group; and the professional

phase, in which help is sought from a health actor recognized by the group. This may be a healer or a western practitioner.

Weaver (1970) described the illness referral system of Spanish-Americans living in New Mexico (descendants of Spanish settlers when the area belonged to Spain). According to him, "an illness referral system is a subsystem of the medical system which includes all health actors and their expected and actual behaviors in illness situations" (p. 141). Weaver's study took the form of interview, both with individuals and with groups, in predominantly Spanish-speaking towns and villages, over a period of three summers. Discussion was initiated with the presentation of an hypothetical situation describing a particular setting, and identifying which member of the social group was ill. Sometimes symptoms were given, and at other times not. Age and sex of the hypothetical patient were varied to increase the breadth of the information obtained. When the same questions and situations were put to non-Hispanic respondents, the answers were completely different.

On the basis of the data collected, Weaver identified five phases in the illness referral system. The first of these is the self-addressed phase, which in rural non-acculturated Hispanics is relatively short, as illness is almost immediately referred to the mother or wife for treatment. In urbanized Hispanics this is a somewhat longer phase. The kinship phase is the next step, and centers in the household. Among both urban and rural Hispanics illness is the primary concern of women. The mother's authority in this will override the father's. If she needs advice or help she will go to her female consanguineous relatives, beginning with the eldest and following on

down the age scale. If these are not available, her female in-laws are called upon in the same order. Elder sons and other males act as couriers or may be asked for advice on referral to other practitioners, but not on methods of curing. Consulting the relatives also serves the function of conveying news regarding the patient's illness. A person often included in the kinship phase but who is not kin is the comadre (ritual co-parent, or godmother of one's child) (1970).

The community phase is entered due to a possible disagreement within the family regarding the patient's complaint. Help is sought from a variety of persons, including fellow church members, neighbors, the priest, the postmaster, the storekeeper, and so forth. These persons are valued for past experience with a particular disease or skill in treating it. They may also provide transportation for appointments with an orthodox medical practitioner or for visitors to a hospitalized patient (Weaver, 1970).

Health actors included in the folk specialist phase are the curandera or medica (healer), medico (man with superior knowledge for treating a particular disease, such as maleficio—witchcraft, or broken bones), albolario (deal with witchcraft), sobador/a (masseuse), and partera (midwife). Not all of these roles are mutually exclusive as, for example, a partera may also be a curandera and sobadora. The folk health practitioner is usually visited at his or her home, diagnosis is preceded by a gossip session, treatment is given and/or herbs prescribed, and the patient pays what he can afford, all in the spirit of a gift, rather than fee for service. If the symptoms are not alleviated he is told to return when able. The choice of practitioner is determined by the perceived nature of the illness. Most

gynecological and venereal problems, for example, are seen as the province of the <u>medica-partera</u>. For urbanized Hispanics, both the community and folk specialist phases are often skipped as they go directly to the last, urban professional phase (Weaver, 1970).

All licensed medical and paramedical personnel are included in the fifth phase, as are health structures or subsystems such as private practice, group health plans, hospitals, clinics, and pharmacies. Villagers are often unaware of a professional referral system within the health care system. Referral to another professional causes loss of prestige in the eyes of the patient, as he then perceives the referring practitioner as not completely knowledgeable and skilled. Villagers will arrive at this phase only when all other recourses have failed. Should this fail also, both rural and urban Hispanics are likely to return to the folk specialist or community phases (Weaver, 1970).

Ailinger (1977) spent 14 months living in a cooperative in a fringe low-income suburb of an eastern metropolis. Over half the residents were Latin-American (from Colombia, Dominican Republic, El Salvador, Nicaragua, Paraguay, and Perú). Nineteen families (99 persons) participated in the study. Verbal permission was obtained from the participants and research was conducted in Spanish. Each family recorded in a family health calendar all illnesses occurring during the month. Data collected were: name of the ill person, symptoms, remedies used, and on whose suggestion. Half the mothers and fathers, one third of the children, and two thirds of the extended family and boarders reported symptoms of illness. Most frequently

reported were headaches and gastrointestinal complaints for fathers, and respiratory problems for children.

Self treatment was seen in 60% of cases for problems such as headaches, colds, and menstrual complaints, with treatment consisting of herbal remedies and both prescription and nonprescription drugs. Referral to the social network was seen in 10% of illnesses. This includes recommendations for treatment from family or friends. Friends were usually those from the same country of origin. Lastly, about 30% of the incidents were referred to the professional network. Almost all contacts were with Spanish-speaking physicians. There were no reports of contacts with folk practitioners or nurses. Persons referred to the professional network were usually clients with chronic problems such as rheumatism, allergies, skin problems, and gastrointestinal disturbances (Ailinger, 1977).

The three steps were not always taken consecutively. Some went directly to the social or professional network without self-treatment. Those not satisfied with treatment received at the professional stage shopped around or returned to self treatment. Ailinger postulates that folk practitioners, although not used directly, were influential in terms of the traditional remedies used by the clients in self treatment.

Although these two studies address illness referral systems in only a portion of the Hispanic population, similar behaviors have been observed by Spector (1979) among Puerto Ricans, and in South Americans by the researcher.

The difference between rural and urban Hispanic behavior patterns was pointed out by Weaver (1970). He felt this was a result

of greater exposure to the Anglo-American way of life. This change in behavior by contact with another culture is known as acculturation.

Acculturation

The traditional model of acculturation is unidimensional and linear: group X from Culture A comes into contact with Culture B (the dominant culture), and gradually its members relinquish Culture A's behaviors as they take up those of Culture B. The final result is total integration with Culture B (Szapocznik, Scopetta, Aranalde & Kurtines, 1978). However, behavioral scientists have since realized that there are more variables than time and exposure involved. Szapocznik and Kurtines conceptualize acculturation as:

> A multidimensional process involving an accommodation on the part of the migrant group to a total cultural context. According to this model of acculturation, the process may be unidimensional, two-dimensional, or multi-dimensional, depending upon the cultural context involved. (1980, p. 143)

Keesing and Keesing state that the speed of acculturation has to do with the similarity between the two cultures. However, a group may accept the material elements of another culture quite rapidly without becoming acculturated (1971, pp. 353-354). Berry (1980) postulates a three phase process of acculturation involving contact between two groups or an individual and a group, conflict between the two caused by differences, and adaptation. This adaptation can take three forms: (1) assimilation--complete identification with the new culture; (2) integration--acceptance of some of the new culture and its behaviors while not totally rejecting the old, thus arriving at a "blend" that enables the person or group to function within the new culture; or (3) rejection. Rejection is seen in withdrawal or

segregation, and may be chosen by the individual, imposed by the group, or by the host society.

In order to create a theoretical model that would identify the elements involved in acculturation, Padilla (1980) studied Mexican-Americans in southern California. Three hundred eighty-one subjects were interviewed (68 males and 313 females). The average age was 43 years, and the majority were married. The subjects were grouped into generational levels in order to correlate these to the findings.

The interview schedule used consisted of 584 questions covering awareness of cultural heritage, loyalty to the ethnic group, socio-economic information, and social spheres (interaction with neighbors, friends, relatives, and public agencies). Factor analysis of the questions resulted in the identification of 15 Cultural Awareness (CA) Homogeneous Item Dimensions (HID's): Respondent's language familiarity; respondent's cultural inheritance and contact; respondent's knowledge of Mexican cultural symbols, historical events and contemporary personalities; ethnicity of peers during childhood; respondent's legal first name; spouse's language familiarity and preference; spouse's cultural inheritance and contact; spouse's legal and preferred first name; parents' language familiarity and preference; parents' cultural inheritance and contact; parents' ethnic identification; father's legal and preferred first name; perceived group discrimination; and perceived personal discrimination (Padilla, 1980).

In addition, 11 Ethnic Loyalty (EL) HID's were identified: respondent's language choice in situations dealing with other people; respondent's language preference in personal situations; respondent's

preferred first name and children's first names; number of children who speak Spanish; preference for ethnicity of associates; perception of Mexican culture; perception of Mexico and U.S.; preference and maintenance of contact with Mexico; respondent's identification with a group name; ethnicity of associates at present; and preference and consumption of Mexican food.

Cultural awareness and ethnic loyalty were postulated as the central concepts in acculturation. Eight factors were extracted from the main concepts. The respondent's cultural heritage, spouse's cultural heritage, parents' cultural heritage, and perceived discrimination fell under CA. Language preference and use, cultural pride and affiliation, cultural identification and preference, and social behavior orientation were found to be components of EL.

A second-order factor analysis found that in actual fact, CA included all the factors except for perceived discrimination and cultural pride and affiliation. Social behavior orientation was found to be a component of both CA and EL.

The final model was hierarchical--the first level composed of the 26 HID's, the second level of the eight factors, and the third level of the two main concepts. Reliability of CA was 0.98 and of EL, 0.83. Intercorrelation between CA and EL was 0.37.

Using the CA and EL scores of the respondents, Padilla identified five clusters (or types). The highest combined scores formed the cluster of the least acculturated, and as acculturation increased, scores dropped. Positive correlations were established between acculturation and education, generational level, and income. An inverse relationship was found between acculturation and ethnic

density of the neighborhood. Padilla acknowledged also that personal factors do enter into acculturation and account for the small amount of nonconformity to type seen.

Using Padilla's model, Keefe (1980) studied acculturation in urban Mexican-American families. She found that kin are a factor in acculturation. Large extended families were positively correlated with low acculturation, but paradoxically, many acculturated Mexican-Americans were found to have close knit, large extended family networks. Keefe suggests the reason for this is provision of warmth, protection, and group strength for persons who belong to neither culture in reality.

Measurement of acculturation must be carried out cautiously as there are problems whenever cross-cultural equivalence is attempted. Furthermore, causal ordering of acculturation cannot always be construed as the antecedent of behavior (Olmedo, 1980). For example, in studying coping mechanisms in a Mexican-American barrio (neighborhood), Hoppe and Leon (1977) found that the families that were having problems adapting were not all Mexican as had been anticipated, but were predominantly--all but one--from the United States.

Using Padilla's model of acculturation, Cuellar, Harris and Jasso (1980) developed an Acculturation Rating Scale for Mexican-Americans (ARSMA). This consists of 20 Likert-type questions addressing language familiarity and usage, ethnic interaction, ethnic pride and identity, cultural heritage and generational proximity. Item analysis resulted in exclusion of questions that attempted to tap ethnic distance and perceived discrimination. The answers are scored

on a scale of 1 to 5, with 1 being Mexican/Spanish, and 5
Anglo/English.

The questionnaire was tested using a sample of 88 hospitalized
(psychiatric) Mexican-American patients, and 134 students or staff from
the San Antonio State Hospital and the Bilingual/Bicultural Training
Programs in Michigan, Arizona, New Mexico, Texas, and Mexico City. Of
the latter, 17 were from Mexico City, 13 were Anglo-American, and 104
were Mexican American. Ninety-two of the subjects were males and 129
were females.

Based on the data obtained from the subjects, Cuellar, Harris
and Jasso (1980) identified five types of Mexican-Americans by
acculturation level. These are: Type 1, ARSMA scores of 1.0-1.99,
very Mexican; Type 2, ARSMA scores of 2.0-2.79, Mexican-oriented
bicultural; Type 3, ARSMA scores of 2.8-3.2, truly bicultural; Type 4,
ARSMA scores of 3.21-4.0, Anglo-oriented bicultural; and Type 5, ARSMA
scores of 4.01-5.0, very anglicized.

Methodologic Approach

In order to study acculturation and illness referral systems, a
variety of approaches can be used. The best by far, and most commonly
employed in cross-cultural research, is ethnography. Ethnography is
research involving prolonged contact with a culture or group in order
to learn as much as possible by participant observation. Once the
major social structure features and values have been identified, the
researcher can determine the health-illness caring system. Leininger,
who has pioneered research in trans-cultural nursing, suggests that
based on such knowledge of a culture, a classification of constructs

can be developed. These constructs can then be analyzed and findings applied to nursing (1978).

However, since it is not always feasible to carry out such indepth research, an appropriate methodology which is specifically oriented toward qualitative data and its analysis is that of phenomenology (also known as grounded theory or constant comparative analysis). This methodology is considered to be particularly appropriate for use in areas where no theory regarding a situation exists, or where there is insufficient previous knowledge to permit the use of a quantitative methodology. Constant comparative analysis is also useful when a fresh perspective on a familiar topic is desired (Stern, 1980).

Glaser and Strauss (1968, 1978) have described the process of and uses for grounded theory. A general area of interest is identified, a relevant population is selected, and data collection is commenced. This may be through interviews, observation, or participant/observation. All pieces of data collected are coded by substantive content. These groups of data are then analyzed by the researcher and assigned to categories according to obvious fit. Data collection continues until it is apparent that no new categories will emerge. The researcher then attempts to organize these categories into core categories, from which he or she will be able to identify main variables or concepts. Further data collection in the areas of the main concepts identified will serve to validate, expand, alter, or even possibly eliminate the concepts identified. Credibility of the concepts and the framework they are part of, is determined by their ability to fit the cases studied and to explain the researcher's or

reader's own experience of the phenomena (Oiler, 1982; Stern, 1980).

Glaser (1978) proposed the use of multiple comparison groups to enhance the credibility of the resultant theory. Detailing the differences or similarities of the groups provides for a better delimitation of the theory. Also, a more comprehensive set of data is likely to be obtained, since there is an increased likelihood of the emergence of negative cases. Speed of analysis of the data is also increased with comparison groups, as points of difference or similarity help identify concepts and their relationships.

Analysis of the data--through coding and category formation--often occurs simultaneously with data collection. Because of this, the researcher can change approach or seek additional or different data in order to fill gaps or explain emerging concepts. This results in a theory which is firmly rooted in the data--and in reality. Another source of input for the analysis is the review of literature. Findings in the literature are treated as other data collected, coded and categorized, and fit into the final framework. If they do not, in the end, fit into an otherwise cohesive and functional theory, they are discarded (Oiler, 1982).

Based on the literature available, it was the researcher's position that Padilla's model of acculturation, as operationalized by Cuellar et al, best reflects reality and suits the purposes of the proposed study. Weaver's model of illness referral systems accounts for the options available as seen in the literature and in personal experience. Application of the model to the proposed population might, however, have been a source of artificiality and bias, as his research involved Spanish-Americans in New Mexico, and might not be

representative of the behavior of Mexican-Americans in Chicago.

The phenomenologic approach was considered to be most appropriate for collection and analysis of data on illness referral systems among urban Mexican-Americans. Because of the paucity of previous knowledge on the subject, another major consideration that prompted the selection of this methodology was the fact that a qualitative approach would create a broader and deeper data base than would a quantitative approach.

Definition of Terms

Acculturation was defined as "those phenomena which result when groups of individuals having different cultures come into continuous firsthand contact, with subsequent changes in the original culture patterns of either or both groups" (Redfield, Linton & Herskovits, 1936, p. 149). For the purposes of this study acculturation was represented by the score obtained from the Acculturation Rating Scale for Mexican-Americans (ARSMA).

Illness referral systems were defined as the pattern of choices habitually made by a person regarding health care options, as described through interviews using the Illness Referral Systems Interview Schedule developed by the researcher.

A Mexican-American was defined as a person born in Mexico and/or having a Mexican parent or grandparent and who presently lives in the United States.

Research Questions

It was the purpose of this research to answer the following questions:

1. Is there an identifiable illness referral system among Mexican-Americans in Chicago?

2. Do different levels of acculturation exist among Mexican-Americans in Chicago?

3. Is there a relationship between identified illness referral systems and acculturation level among Mexican-Americans in Chicago?

Assumptions

It was assumed that:

Answers given by the subjects would reflect their true beliefs and practices.

The subjects would be able to accurately recall instances of illness within their immediate social group, and report them.

Persons in both groups of subjects had access to both lay and professional health care systems.

CHAPTER III

METHODOLOGY

Research Design

This reseach design was descriptive and used an interview

methodology. A convenience sample was obtained, and both qualitative

and quantitative data analyses were used.

Sample

A convenience sample of 50 Mexican-American women was obtained.

Criteria for inclusion were: age between 19 and 46 years, and being

the mother of dependent children. Marital status was not an inclusion

criterion. The rationale for the above criteria was that the decisions

regarding treatment of an ill person are most often made by the mother

or wife, thus resulting in an illness referral system more

characteristic of the family than of the individual himself. Because

of this only one individual from each nuclear family was interviewed,

i.e., the mother or wife. The ages of 19 to 46 were chosen as it was

expected that this would enhance homogeneity of the sample in terms of

developmental stage. The majority of the subjects would be concerned

with rearing and supporting a growing family. Because of early

childbearing, women past the age of 46 are more likely to be

grandmothers and act as consultants rather than as primary

decisionmakers.

Two different neighborhoods were used in order to increase the

likelihood that sufficient cases would be found for different

acculturation levels. Neighborhood A was highly Mexican, and drew many

of the new arrivals from Mexico. The subjects interviewed there were a

self-selected sample, who utilized the services of the settlement

house. Therefore, the sample might not be representative of new

arrivals. Half of the subjects (25) were selected from neighborhood A.

A settlement house was used as the location for the interviews.

Subjects were drawn from mothers bringing children to classes or coming

to classes or activities themselves.

The other half (25) of the sample was obtained from

neighborhood B. Neighborhood B included persons of varied ethnic

origins. Many of these were Mexican. Access to this group was

achieved through church members at the Spanish-speaking church attended

by the researcher in the neighborhood. Church members were asked to

introduce the researcher to people in the community who met the

inclusion criteria. Persons interviewed were, in turn, asked to

introduce the researcher to others who could participate in the study.

Church members were used for access but not as subjects. This method

of sample selection in neighborhood B decreased the likelihood of

unwillingness to participate in the study.

Procedure

Potential respondents were approached by the researcher and

asked if they would be willing to participate in the study.

Information about the purpose of the study and the implications for the

respondent of participation in the study was given to each one prior to

obtaining verbal consent (See Oral Consent Summary, Appendix A).

Subjects were asked to report their illness referral patterns

in a specific situation. Administration of the acculturation scale followed the interview. This was done in order to prevent researcher bias during the illness referral portion of the interview.

Consent

Neither the research methodology nor the type of data to be collected were considered to place the subjects at risk. The subjects were in no way experimented upon, and other than the time involved, there was no cost to them.

It was expected that not all the subjects would be able to read and/or write, thus making it impossible to obtain written consent from all. A further consideration was the fact that many Mexicans and Mexican-Americans are reluctant to sign documents, even if consent is actually given—particularly if the person requesting the signature is a stranger. In addition to a culturally engendered distrust of signing papers, there was the possibility that some of the subjects might be undocumented residents. Any action on the part of the researcher that could be interpreted as official fact-finding for the Immigration and Naturalization Service might have immediately caused these people to falsify information, withdraw, or even terminate contact. Precedent for the use of oral consent had been well established by other researchers studying Hispanics (Ailinger, 1977, 1982; O'Brien, 1982; Weaver, 1970). Because of all the potential hazards to the reliability and validity of the research that could result from the use of written consent, oral consent only was used with all the subjects.

Confidentiality was preserved by numerically coding the data obtained and not using the subjects' names or addresses in any way in the study. Consideration to privacy was given during the interview.

Instrument

Two instruments were used. The first (Illness Referral Systems Interview Guide) recorded the illness referral systems of the respondent. The instrument provided the researcher with space to record briefly the case reported and who was involved, and to list sequentially all referral options selected in that situation. Spaces were also available to record the rationales for each referral. Additional space was allowed for comments and discussion of any alternate illness referral patterns (See Appendix B).

All the subjects were interviewed using the Illness Referral Systems Interview Guide developed by the researcher (See Appendix B). The respondents were asked to recall a case in which a family member or close friend was ill, and describe: the nature of the illness, when it occurred, the steps taken to obtain the care deemed appropriate, what this care was, and who provided it. She was also asked whether she considered this to be a typical case and if not, what types of cases would elicit a different behavior pattern. It was expected that this approach would produce the most positive response from the subjects, would rapidly build rapport between the subject and the researcher, and would provide richer data in that it was based on reality. All persons were interviewed by the researcher.

This interview guide was pilot tested using five women meeting the inclusion criteria. No difficulty in administration of the interview was found.

The second part of the interview consisted of the administration of the ARSMA (See Appendix C). The instrument could be administered either in English or in Spanish. The reliability and

validity of the instrument, established by Cuellar, Harris, and Jasso (1980) was tested in several ways. Alpha coefficients of 0.88 for normal subjects, and of 0.81 for hospitalized subjects were obtained. Test-retest reliability was assessed in a sample of 16 Mexican-American psychotic patients, by the same rater, and with a five week interval. A correlation of .72 was obtained. Test-retest was also used with a sample of 26 staff members, with a one month time lapse. A correlation coefficient of .80 was obtained. Interrater reliability on 26 patients was found to have a correlation coefficient of .89.

Validity of the ARSMA was determined in several ways. Twelve staff members were asked to evaluate 26 patients on a scale of 1 to 5 such as is used by the instrument. The mean score for each patient resulting from these ratings was correlated to his or her ARSMA score using Spearman Rank Order. A correlation coefficient of .75 was obtained. In addition, correlation with the Wechsler Adult Intelligence (vocabulary subtest), Biculturalism Inventory, and the Behavioral Acculturation Scale was found to be positive.

In order to control for problems arising from poor reading skills, the ARSMA was administered orally to all subjects. The questions were asked as they are stated in the instrument.

No previous use of the ARSMA among Mexican-Americans in the urban center studied has been reported. Validity of the ARSMA for the target population of this research study was not known, since it was developed using a different population of Mexican-Americans.

Data Analysis

Each respondent was assigned a number which was used to identify both the interview guide and the ARSMA. No names were retained.

When 50 women had been interviewed, ARSMA scores were calculated for the whole group to determine if sufficient cases for all acculturation levels had been obtained. The ARSMA scores obtained were not compared to the illness referral information on any of the subjects until analysis of the interview guides had been completed.

Each respondent's Illness Referral Systems Interview Guide was color coded for sources of treatment and/or referral. The categories identified were: care or referral by respondent, the family (including husband as well as other relatives), the community, and the medical system. This coding facilitated category recognition and enabled the researcher to identify patterns of illness referral. Patterns were identified by sources of care and/or referral, since there was no significant repetition of sequence of care and/or referral. Within each pattern identified, sequence of care was addressed.

Glaser (1978) advocates determination of both interrater and intrarater reliability. Since the researcher was the only rater in this study neither one was done.

The distribution of demographic characteristics for the whole sample was calculated and t-test and chi-square statistics were used to determine if there were differences between neighborhoods. Tabulation of the types of illness reported and identity of the ill person were made.

Each illness referral system identified was described

demographically.   Sources of care and/or referral for each pattern were also described.

ARSMA scores were divided into three acculturation level groups.   Each group was described demographically.

A comparison between the two largest illness referral systems by mean ARSMA scores was made using a t-test.   In addition, a comparison between acculturation levels was made to determine frequencies of illness referral systems.

CHAPTER IV

RESULTS

This chapter will consist of four parts. The first will describe the demographic composition of the sample, and the remaining three will answer the research questions.

Demographic Characteristics of the Subjects

The subjects' ages ranged from 19 to 46, with a mean age of 30.5 years. Most were married, Roman Catholic, and born in Mexico. None had completed college, and most had gone no further than grade 6 (see Table 1).

The mean ages of each neighborhood subgroup (see Table 2) were compared by means of an independent t-test. There was no significant difference. Educational level, generation and marital status were also compared using the chi-square statistic (See Table 3). No significant difference was found in any of these. Therefore the respondents did not differ between neighborhoods in age, marital status, education, or generational level.

Illness Referral Systems

The respondents identified a great variety of illness situations. The most frequent of these were fevers, coughs, throat infections, vomiting, flu, colds, stomach problems, and diarrhea (See Table 4).

Table 1:   Demographic Characteristics

Age	Range	Mean	S.D.	Median	Mode
	19-46	30.52	7.2372	30	28

Marital	Married	Single	Widowed	Separated	Divorced
Status	39	6	1	1	3

Education	None	1-6	7-9	10-12	13-16
	1	18	10	15	6

Generation	1st	2nd	3rd	4th	5th
	42	5	1	1	1

Religion	R. C.	Pent.	None	Christian	Evangel.
	43	2	2	1	2

NOTE. In order to facilitate presentation of demographic data, Tables 1, 6, 7, 9, 10, 13, 14, and 15 are condensations of variable frequencies.

Table 2:   Comparison of Age by Neighborhood

	Age			
Neighborhood	Mean	S.D.	Range	t value
A	30.76	5.7683	21-42	.2275
B	30.28	8.5757	19-46	Not Signif.

The family members which were reported as having been ill were most often the respondent's children (See Table 5), although there were a few instances each of illness among the respondents themselves, their mothers, or husbands. Two cases reported illness among more than one child.

There were five illness referral systems identified. These

Table 3: <u>Chi-square Comparison of Marital Status, Education and Generation Between Neighborhoods</u>

| | Neighborhood | | | |
	A	B	χ^2	Significance
Married	20	19	.1166	None
Not married	5	6		
Grades 1-6	10	9	.0849	None
Above grade 6	15	16		
1st generation	20	22	.5952	None
Born in U.S.	5	3		

have been labelled as the: One-step pattern, Two-step pattern, Three-step (family) pattern, Three-step (community) pattern, and Four-step pattern.

One-step pattern

The one-step pattern involves care solely given by the wife/mother. Only one respondent fell into this group. She stated that her family's health needs were all dealt with by herself. She was 34 years old, married, had no religion, and a primary level of education. She was born in Mexico.

Two-step pattern

This pattern involves the use of the professional health care system if and when provision of care by the respondent is considered to be insufficient. As with all patterns which involved professional care, the decision to see a physician was based on a perception of inappropriateness or failure of home care.

Table 4: Types of Illness Reported by the Respondents

Illness	Frequency	Percent
Fever	19	38%
Cough	10	20
Throat infection	8	16
Vomiting	7	14
Flu	6	12
Cold	4	8
Stomach problems	3	6
Diarrhea	3	6
Broken leg	2	4
Headache	2	4
Ear infection	2	4
Chills	2	4
Broken ankle	2	4
Convulsions	2	4
Uterine tumor	1	2
Arthritis	1	2
Ovarian troubles	1	2
Pain	1	2
Bell's Palsy	1	2
Rheumatism	1	2
Hematemsis	1	2
Swollen eye	1	2
Fall	1	2
Lump	1	2
Tonsilitis	1	2
Dizziness	1	2
Muscular dystrophy	1	2
Hyperkinesis	1	2
Pneumonia	1	2
Chicken Pox	1	2

NOTE. Individual subjects reported more than one illness.

This group consisted of six respondents (See Table 6) whose ages ranged from 25 to 40. Three were presently married, and three were divorced or widowed. All were Roman Catholic, and had some education (half had an education of high school or above). Four of the respondents were born in Mexico, and the other two were born in the U.S. and had one or both parents born in the U.S.

Table 5:   <u>Distribution of Illness Reported Among Family Members</u>

Family Member	Frequency	Percent
Son	19	38%
Daughter	18	36
Self	4	8
Mother	4	8
Husband	3	6
Grandmother	1	2
Mother-in-law	1	2
Sister	1	2
Brother	1	2

<u>NOTE</u>.   Individual respondents reported illness in one or more family member.

Table 6:   <u>Demographic Characteristics of Two-step Pattern Respondents</u>

<u>n=6</u>

Age	Range	Mean	S.D.	Median	Mode
	25-40	31.33	6.3541	30	30

Marital	Married	Single	Widowed	Separated	Divorced
Status	3	0	1	0	2

Education	None	1-6	7-9	10-12	13-16
	0	2	1	2	1

Generation	1st	2nd	3rd	4th	5th
	4	1	1	0	0

Religion	R. C.	Pent.	None	Christian	Evangel.
	6	0	0	0	0

All reported illnesses in their children (4 sons, 2 daughters), the most common of which were throat infections (50%), fevers (33%) and ear infections (17%).   A cough, cold, flu, or chills were also reported.

Two of the respondents stated that there were no family members other than themselves available in the U.S. for advice or referral. Two respondents also observed that they would take a child to the professional health care system much sooner (within 24 hours) than they would go themselves. The reasons given for this were the inability of the child to convey what he or she was feeling, and the unpredictability of illness in children.

Five of the six respondents sought attention at a clinic, although two of these stated that they use the Emergency Room (ER) just as frequently. Only one respondent referred her child to a private physician, and even then reverted to self care shortly after. All used over the counter medications, and five employed home remedies as well.

Three-step (family) pattern

Twenty-six women reported an illness referral system involving care or referral given by themselves, their family, and the professional system. This was identified as the three-step (family) pattern. These respondents (See Table 7) had the same age range as the total sample. Most were married, although six had not been, or were not presently married. Educational backgrounds were equally distributed between primary and secondary/junior college levels. Most were Catholic born in Mexico, although six respondents were born in the U.S.

The family members that became involved in this referral system were: the husband (27%), the respondents's mother (19%), her sister (15%), the family as a whole (12%), a sister-in-law or daughter (8% each), and a mother-in-law, aunt, cousin, brother, eldest son, or

Table 7:   Demographic Characteristics of Three-step (Family) Pattern
Respondents

n=26

Age	Range	Mean	S.D.	Median	Mode
	19-46	30.9	7.7404	31	

Marital Status	Married	Single	Widowed	Separated	Divorced
	20	4	0	1	1

Education	None	1-6	7-9	10-12	13-16
	0	8	5	8	5

Generation	1st	2nd	3rd	4th	5th
	20	4	0	1	1

Religion	R. C.	Pent.	None	Christian	Evangel.
	25	1	0	0	0

grandmother (4% each). More than one family member was involved in some cases. It should be noted that for this and all other instances in which the husband was involved, his role was solely that of decisionmaker when entering into the professional health care system.

The role of the family in this pattern was two-fold: advice and referral. Male family members only referred, female relatives advised as well. The usual point of entry by the family into the illness referral system was after the respondent had initiated care herself. Sometimes, however, family members brought the ill member to the attention of the respondent so she could deal with the problem. When the ill member had grown children, these often took on the task of persuading the parent to seek medical attention.

More respondents reported use of the ER (solely, or in conjunction with other sources of care) than any other professional

health care agency (see Table 8). The average wait before entry into the professional health care system was three to five days. Ten (38%)

Table 8: Use of the Professional Health Care System
Three-step (Family) Pattern

	Source of Care				
	ER Only	Private MD	ER+ Private MD	Clinic Only	Multiple Professional Practitioners
Number	9	8	3	2	4
% of total	34.62%	30.77%	11.54%	7.69%	15.38%

of the cases reported were withdrawn from the professional system by the family, seven (70%) of these being later referred back to the ER, clinic, or physician.

Seven (27%) of the respondents reported use of over the counter medications, two (8%), that of home remedies, and nine (35%) reported the use of both.

Three-step (community) pattern

Two respondents stated that they treated health problems themselves, with input from the community (friend, teacher), and went to the professional system if this was insufficient. Both persons reported illness in their children: chicken pox, and a stomach upset. Both were married, Mexican-born, and with a low level of education (See Table 9). One went to a private physician, and the other to the clinic and ER. One respondent (Evangelical) stated that she prayed for healing first before entering the professional network.

Both women stated that their visits to a physician only served

Table 9:   Demographic Characteristics of Three-step (Community) Pattern Respondents

n=2

Age	Range	Mean	S.D.	Median	Mode
	28-33	30.5	3.53		

Marital	Married	Single	Widowed	Separated	Divorced
Status	2	0	0	0	0

Education	None	1-6	7-9	10-12	13-16
	0	2	0	0	0

Generation	1st	2nd	3rd	4th	5th
	2	0	0	0	0

Religion	R. C.	Pent.	None	Christian	Evangel.
	1	0	0	0	1

to confirm a diagnosis or treatment given them by the community members.

Four-step pattern

Fifteen women reported an illness referral system involving themselves, their families, friends and neighbors, and the professional health care system. Their ages ranged from 19 to 44 years, with a mean of 29. Most were married and Catholic, none had post-secondary education, and all were Mexican-born (see Table 10).

Family members involved in this pattern were: the husband (80%), the whole family (20%), the mother-in-law (20%), and a sister, brother, daughter, aunt, uncle, cousin, father or sister (7% each). Frequently more than one person was involved.

The persons from the community who played a part in this

Table 10: Demographic Characteristics of Four-step Pattern Respondents

n=15

Age	Range	Mean	S.D.	Median	Mode
	19-44	29.26	7.8782	27	27
Marital Status	Married	Single	Widowed	Separated	Divorced
	13	2	0	0	0
Education	None	1-6	7-9	10-12	13-16
	1	5	4	5	0
Generation	1st	2nd	3rd	4th	5th
	15	0	0	0	0
Religion	R. C.	Pent.	None	Christian	Evangel.
	11	1	1	1	1

pattern were most frequently female friends of the respondent (67%), neighbors (13%), the godfather of the child, or ritual co-parent (13%), and the child's teacher (7%). Neighbors were valued for possession of a car, telephone, or for experience with illness in children. The Pentecostal respondent emphasized a dependence on God for healing along with use of other resources.

Most respondents reported going to a private physician and/or the ER (see Table 11). Nine respondents (67%) left the professional health care system. Examples given of interruption of professional care were: discontinuing antibiotics before completion of the course, not following prescribed regimes, discharge from hospital against medical advice, and not returning to the clinic for follow-up visits. Seven of these subsequently reentered the medical system. Three of these seven cases referred the ill member back to the mother, family,

Table 11: Use of the Professional Health Care System
Four-step Pattern

	Sources of Care			
	Private MD Only	MD+ER	Clinic+ER	Clinic Only
Number	5	5	4	1
% of Total	33.33%	33.33%	26.67%	6.67%

or community again. Of those who left the professional network, four

(44%) were referred to the respondent, four (44%) were referred to the

family, and six (67%) were referred to the community. Some cases were

referred to more than one person.

Two (13%) of the 15 respondents reported the use of home

remedies. Three (20%) reported the use of over the counter

medications. Six (40%) of the respondents reported the use of both

home remedies and over the counter medications.

Summary

The first research question was: Is there an identifiable

illness referral system among Mexican-Americans in the urban center

studied? This can be answered affirmatively. Two patterns of referral

were reported by sufficient numbers to be generalizable to the sample

group. The first of these was the three-step (family) pattern which

involves care and/or referral on the part of the wife/mother, the

family, and the professional health care system. The second referral

system identified was the four-step pattern, which includes

participation by the community as well.

Acculturation Level

Acculturation Rating Scale scores for all respondents ranged between 1.1 and 4.1. The mean was 2.1140, with a standard deviation of 0.8385. The scores were very evenly distributed within this range, and no modality emerged (See Table 12). The researcher grouped these into

Table 12: ARSMA Scores

	n	Range	Mean	S.D.	Median	Mode
Total	50	1.10-4.10	2.1140	0.8385	1.95	
Low	33	1.10-2.25	1.5727	0.3496	1.60	
Medium	11	2.45-3.20	2.7182	0.2732	2.60	2.55
High	6	3.60-4.10	3.8167	0.1693	3.75	3.75

three levels with arbitrarily selected cut-off points. Responses fell into three discrete groups: low acculturation (1.1-2.25), medium acculturation (2.45-3.2), and high acculturation (3.6-4.1). Although by strict mathematical division of the ARSMA scale into thirds, one of these respondents (ARSMA 3.6) should have been included with the medium acculturation group, the 0.4 point gap between the score in question and the next lowest one (3.2) was considered to warrant the present division between the groups.

Low acculturation

Thirty-three respondents were included in the low acculturation group. Their mean ARSMA score was 1.5727 with a standard deviation of 0.3496, and there was no modal distribution of the scores. The respondents' age range was that of the whole sample, most were married

and Roman Catholic. All had been born in Mexico, and most possessed a primary education only (See Table 13).

Table 13: Demographic Characteristics of Low Acculturation Respondents

n=33

Age	Range	Mean	S.D.	Median	Mode
	19-46	31.18	7.7840	31	27,28,34
Marital	Married	Single	Widowed	Separated	Divorced
Status	29	3	0	1	0
Education	None	1-6	7-9	10-12	13-16
	1	16	8	7	1
Generation	1st	2nd	3rd	4th	5th
	33	0	0	0	0
Religion	R. C.	Pent.	None	Christian	Evangel.
	28	1	2	1	1

Medium acculturation

Eleven respondents' ARSMA scores placed them in the medium acculturation level. The mean score was 2.7182, with a standard deviation of 0.2732, a median of 2.6, and a mode of 2.55. The age range was 19-36 years, with a mean of 28. Most were married, Catholic, and born in Mexico. All had completed at least six grades of education, and three had attended college (See Table 14).

High acculturation

Six respondents fell into the high acculturation category. The mean score for these respondents was 3.8167, with a standard deviation of 0.1693, and a median and mode of 3.75. The mean age was 31.5, with

Table 14: Demographic Characteristics of Medium Acculturation
Respondents

n=11

Age	Range	Mean	S.D.	Median	Mode
	19-36	28	6.0698	28	25

Marital	Married	Single	Widowed	Separated	Divorced
Status	8	1	1	0	1

Education	None	1-6	7-9	10-12	13-16
	0	0	2	6	3

Generation	1st	2nd	3rd	4th	5th
	9	2	0	0	0

Religion	R. C.	Pent.	None	Christian	Evangel.
	10	1	0	0	0

a range of 24 to 40 years. All were Catholic and born in the United
States (predominantly second generation). Two were married, two
divorced, and two single. A majority had high school education or
above (See Table 15).

The ARSMA mean score for respondents from neighborhood A was
2.1280 with a standard deviation of 0.9364. The mean for respondents
from neighborhood B was 2.0960 with a standard deviation of 0.7446.
There was no significant difference in ARSMA mean scores between
respondents from the two neighborhoods (independent t-test value was
.1310).

Summary

The second research question was: Do different levels of
acculturation exist among Mexican-Americans in the urban center

Table 15:   Demographic Characteristics of High Acculturation
Respondents

n=6

Age	Range	Mean	S.D.	Median	Mode
	24-40	31.5	0.8566	28	28

Marital	Married	Single	Widowed	Separated	Divorced
Status	2	2	0	0	2

Education	None	1-6	7-9	10-12	13-16
	0	2	0	3	1

Generation	1st	2nd	3rd	4th	5th
	0	3	1	1	1

Religion	R. C.	Pent.	None	Christian	Evangel.
	6	0	0	0	0

studied?   This was also answered affirmatively.   Three levels of
acculturation were identified in the sample group.   Most respondents
fell into the lower acculturation group.

Relationship Between Acculturation and Illness Referral

Mean ARSMA scores were computed for each illness referral
pattern identified (see Table 16).   The one-step pattern was excluded
because of small sample size (n=1).   Respondents in the two-step
pattern showed no clearly defined acculturation level.   The ARSMA mean
for the three-step (community) pattern is not meaningful because of
small sample size (n=2).   Therefore analysis was centered on the two
largest groups.

Although the mean ARSMA score for the three-step (family)
pattern was 2.2519, four respondents with high-level acculturation were

Table 16:   Comparison of ARSMA Scores Between Referral Systems

			ARSMA Scores			
	n	Range	Mean	S.D.	Median	Mode
Two-step	6	1.45–3.75	2.825	0.8566	2.55	
Three-step (family)	26	1.10–4.10	2.2519	0.9344	1.95	
Three-step (comm.)	2	1.55–1.70	1.625	0.1061		
Four-step	15	1.10–2.25	1.72	0.3463	1.7	1.3

included in this group. Three of these stated that finances affected their choices. When they did enter the medical system, two went to the ER, one to the clinic, and one to a physician or the ER depending on availability. Only one of the two married women in the subgroup stated that her husband participated in decision-making.

The four-step pattern ARSMA range was that of the low acculturation level, although the mean was slightly higher than that of the total low acculturation group.

A comparison of mean acculturation scores between the two largest subgroups (three-step [family] and four-step) was made by means of an independent t-test (two-tailed). A statistically significant difference was found between the two groups (see Table 17). Analysis of variance between all means was not carried out because of the small size of the other subgroups.

Illness referral systems represented within each acculturation subgroup were also identified (See Table 18).

The low level acculturation group included all the respondents

Table 17: <u>Comparison of Acculturation Between Three-step (Family) and Four-step Pattern Respondents</u>

I.R.S.	ARSMA Scores			
	Mean	t-test	Degrees of freedom	Significance
3-step (family)	2.2519			
		2.0698	39	.05
4-step	1.7200			

Table 18: <u>Distribution of Illness Referral Systems by Acculturation Level</u>

I.R.S.	Acculturation		
	Low	Medium	High
One-step	1	0	0
Two-step	1	3	2
Three-step (family)	14	8	4
Three-step (comm.)	2	0	0
Four-step	15	0	0

in the four-step, three-step (community) and one-step patterns. Also included were one of the two-step pattern and 14 of the three-step (family) pattern respondents.

Respondents in the medium acculturation group reported a three-step (family) illness referral system most frequently. Three of the two-step pattern responses also fell into this category. There was

little leaving of the professional system (18%), and only rarely was the community included.

Illness referral systems reported by the high acculturation group were the two-step and three-step (family) patterns. After entry into the professional health care system, 33% reported referral to self or family--usually for home care.

Summary

The final research question was: Is there a relationship between illness referral systems and acculturation level among Mexican-Americans in the urban center studied? The results indicate that low levels of acculturation are associated with a referral system that includes the respondent, the family, the community, and the medical system. Higher levels of acculturation are associated with exclusion of the community from the referral system.

CHAPTER V

DISCUSSION

As was stated in Chapter II, the theoretical base for the

Illness Referral portion of this study was to be Weaver's (1970) study.

He presented a five-step model in which the ill person progressed from

one step to the next, with some bypassing of steps, or returning to

previous steps. This model cannot adequately describe the data

obtained in the present study. Discrete and sequential steps were not

consistently observed. For this reason, the different patterns will be

diagrammed as a number of interlocking circles which are not closed

systems.

One-step pattern

Since there was only one representative of this illness

referral system, no conclusions can be drawn. A larger sample might

have found more women who shared her beliefs.

This pattern can be presented as a single circle, in which care

is provided entirely by the wife/mother (See Figure 1).

Two-step pattern

The respondents in this group had a slightly higher level of

acculturation than the total group, and were from the middle portion of

the total age range. Fifty percent were single parents, a much higher

percentage than that found in any other group. When one considers in
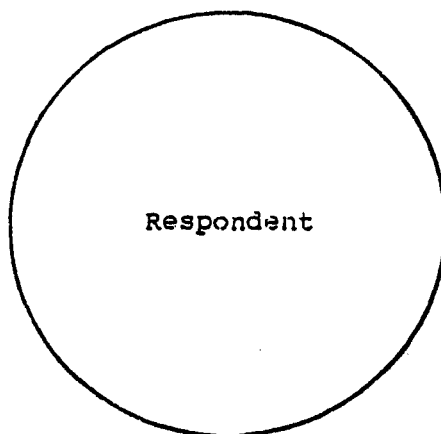
Figure 1: One-step pattern

addition that 33% stated they had no relatives in the area they could turn to for advice, it is understandable that they should choose this pattern of illness referral. These persons might, under other circumstances, report the use of a three-step (family) pattern. The absence of community involvement may be due to level of acculturation.

Again, the small sample size allows only tentative conclusions to be drawn. The two-step pattern would be diagrammed as two interlocking circles, in which there are both separate and common areas of care and referral (See Figure 2).

Three-step (family) pattern

The demographic characteristics of the respondents reporting the use of a three-step (family) pattern very closely parallel those of the whole group. The major difference is the high incidence of Catholicism among this subgroup.

The input from the family did not increase the use of home remedies, as could have been expected (See Appendix D for listing of
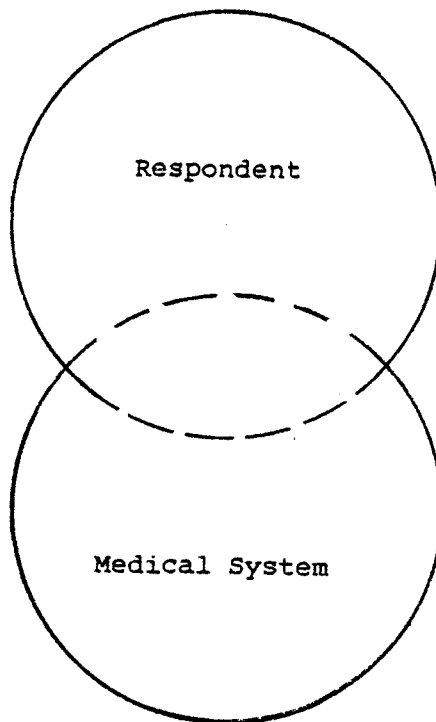
Figure 2: Two-step pattern

home remedies). There was, however, a greater variety of medical

facility use than in the two-step pattern.

The presence of the four most highly acculturated respondents

in this group is not surprising if Keefe's (1980) statement that

accultured persons rely heavily on their families for warmth and

support is taken into consideration. Interestingly, of the two that

were married, only one felt her husband had any say in health care. It

should be noted that this pattern is seen in Anlgo-American society as

well (Hautman & Harrison, 1982).

The three-step (family) pattern can be diagrammed as three

interlocking circles representing the three components of the system

(See Figure 3).
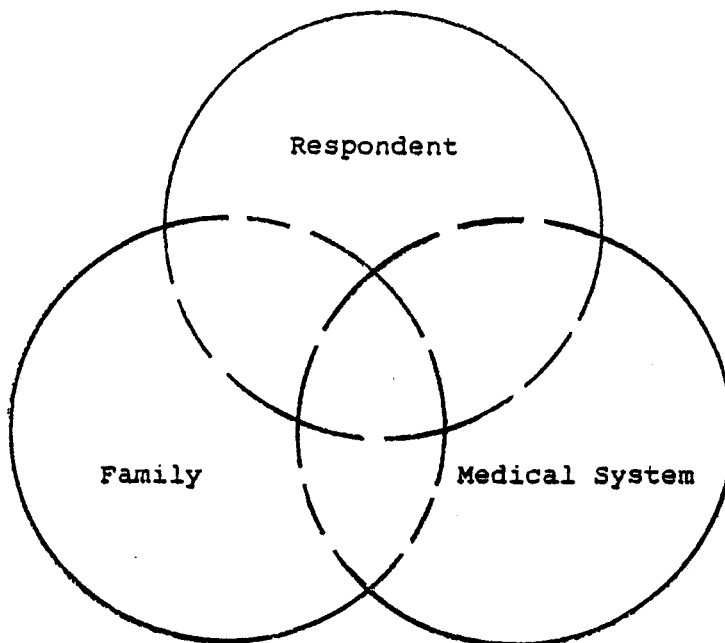
Figure 3: Three-step (family) pattern

Three-step (community) pattern

Very little can conclusively be said about this pattern, as it was reported by only two persons. Demographically, the distribution is most similar to the four-step pattern distribution. Since both were married, it is interesting that neither one considered her husband to be a part of the decision-making process.

The three-step (community) pattern is presented in the same way as the three-step (family) pattern, with the substitution of the community for the family (See Figure 4).

Four-step pattern

The demographic characteristics of this group most closely resemble those of the low acculturation subgroup, as they were all part of that group. There was a greater involvement on the part of the
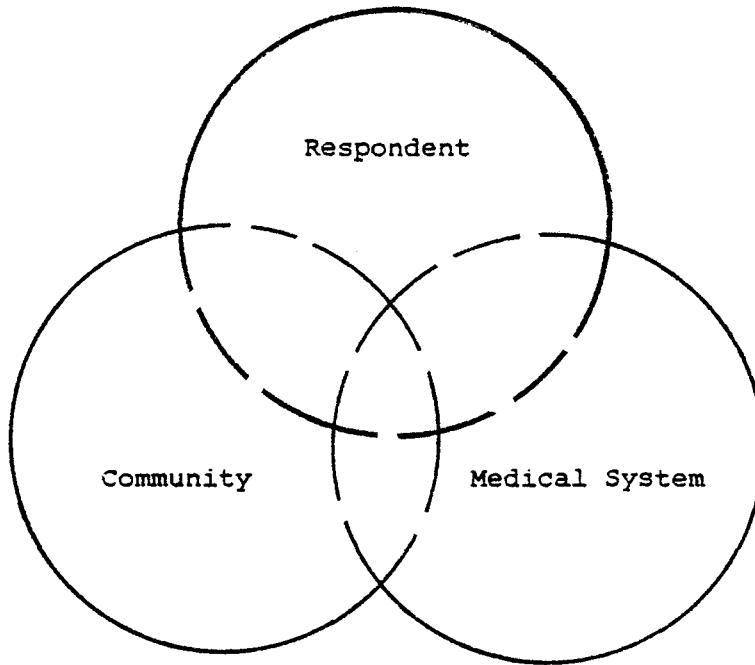
Figure 4:   Three-step (community) pattern

husband, and a high level of fluidity and movement from phase to phase.

If the amount of the time spent outside of the professional health care

system is taken into consideration, the low incidence of home remedy

use is surprising. It is possible that the cases recounted were not

representative, or that for some reason, the respondents chose not to

disclose the extent of their reliance on home treatment.

The behaviors recounted make this pattern the one most like

that described by Weaver (1970). The difference lies in the fact that

his family-addressed phase has been divided into two: respondent given

care, and family care. In addition, there is no self-addressed phase

(unless the respondent was the ill person) and no folk specialist

phase. The four-step pattern can be diagrammed, then, as four

interlocking circles (See Figure 5).

The absence of a folk specialist phase in all the patterns is

Respondent

Family

Medical System

Community
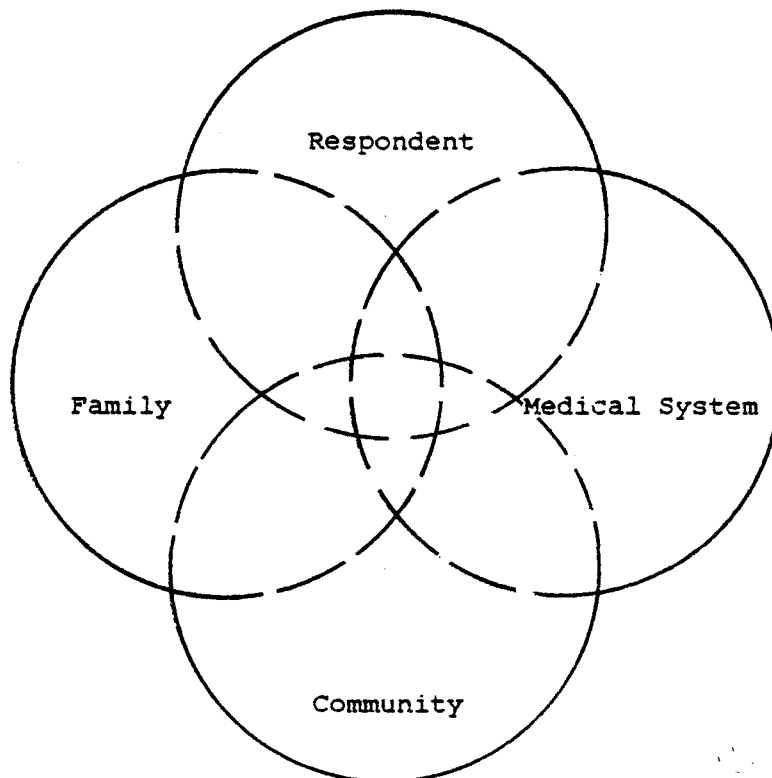
Figure 5: Four-step pattern

explained by several factors. Respondents, both singly and in groups,

stated that folk specialists were employed by older persons, and by

those coming from the south of Mexico where indigenous beliefs and

practices still obtain. They stated that these persons were to be

found in a different part of the city than that where the research was

being conducted. Those respondents who had grown up in Mexico also

pointed out that they had become used to using the medical system as

medical care is free.

It was expected that there would be some report of the folk

illnesses cited in the literature. No folk illnesses were mentioned by

the respondents. Some of the Mexican health beliefs reviewed in the

literature were reflected in comments made by respondents when

discussing the etiology of a particular illness, or describing home remedies employed.

The researcher interviewed a <u>curandera</u> (healer) to obtain information about the services she provided and the clientele that sought these services. The <u>curandera</u> stated that she gave only advice and readings, and the people came to her for help with emotional and relational problems. When questioned about folk practitioners involved in provision of care for the physically ill, she replied that there were <u>brujos</u> (witches) and <u>herbalistas</u> (herbalists) in the city, but their whereabouts are a closely guarded secret, as some of their practice is extra-legal. For this reason it is possible that respondents would have omitted the report of use of folk practitioners when speaking to the researcher, since she was a stranger.

A question which also arises is whether the relatively frequent and rapid use of the professional health care system was in fact so, or whether this was an attempt to provide the researcher with the information that the respondents thought was desired.

Differences between patterns by acculturation

The only patterns identified within the study sample which can be significantly associated with acculturation levels, are the three-step (family) and the four-step patterns. The mean ARSMA scores of the two are significantly different. Thus it can be said that persons in this sample with low acculturation levels are more likely to involve the family, community and medical system, whereas the higher the acculturation level becomes, the less likely it is that the community will be involved.

The one-step, two-step, and three-step (community) patterns

cannot be generalized because of small sample size.

Implications for Nursing

O'Brien's (1980) concept of pragmatic survivalism is borne out
by the present research. Frequent statements reflecting initiation (or
cessation) of treatment because of interference with daily life were
made. No information on preventive care was volunteered by the
respondents. Health promotion and disease prevention are areas of
legitimate nursing concern and action. It is not, however, to be
expected, that the Mexican-American population will voluntarily come to
the professional health care system for preventive health care. For
this reason, the major emphasis should be placed on outreach into the
Mexican-American community.

This outreach can take more than one form, depending on the
major concerns of the particular segment of the community which is to
be reached. One type of interaction with the community which could be
more readily acceptable than others is education in home health care.
This could include basic hygiene, disease prevention, first aid, and
common remedies for minor ailments. Effort should be made to
incorporate the clients' health beliefs and practices whenever
practicable and correct. A better knowledge of the home remedies used
in the community will help the nurse to select those which are
beneficial and incorporate them into her teachings.

For nurses working in a direct care agency (hospital, clinic,
Health Maintenance Organization, etc.), the implications of this study
lie in the awareness of the importance of the family and community in
the decision making process. Care should be taken to be accepting of
their participation in the referral and care-giving process (Clark,

1970) in order to prevent inappropriate termination of professional health care. Identification of the client's acculturation level can give the nurse an indication of which persons are likely to be important in this process.

In addition, a clear explanation of the goals of the professional system and means being used to achieve these goals should be given to the client and his family, as very often clients do not adhere to treatment because of lack of understanding. The nurse should plan to explain the treatment plans carefully, possibly more than once, and bring in an interpreter if necessary.

Recommendations for further research

Because of the nature of this study, its scope is limited, and the results are generalizable only to the sample group. Further research should include a larger sample and at least two interviews with each respondent to establish a greater degree of trust and disclosure. Other neighborhoods in the city should be used as well to include persons from different parts of Mexico, and increase the number of persons with higher levels of acculturation.

No information was obtained about the actual level of wellness in the families of the respondents. Administration of a wellness inventory to each family would help describe each illness referral system in terms of outcome.

The best way to obtain accurate and complete data on the subject would be to carry out an ethnography of the Mexican-American population in Chicago. The cost and time involved, however, render this approach impracticable for most researchers.

SUMMARY

Two different patterns of illness referral in the
Mexican-American population studied were identified. One of these
provides care and referral by the wife/mother, the family, and the
professional health care system (three-step [family] pattern), and the
other uses the community as well (four-step pattern). The ARSMA means
of these groups were significantly different. The three-step (family)
pattern is associated with high levels of acculturation, whereas the
four-step pattern is associated with lower levels of acculturation.
Three other less frequent patterns were identified.

The subjects were divided into three acculturation groups based
on ARSMA scores, with cut-off points determined by the researcher. The
majority of respondents in the sample had scores at the lower end of
the acculturation scale. Further research is needed to obtain more
definitive and generalizable data on which to base trans-cultural
nursing care for this population.

REFERENCES

Ailinger, R. L. A study of illness referral in a Spanish-speaking community. <u>Nursing Research</u>, 1977, <u>26</u>, 53-56.

Berry, J. W. Acculturation as varieties of adaptation. In A. M. Padilla (Ed.), <u>Acculturation: theory, models, and some new findings</u>. Boulder, Colo.: Westview Press, 1980.

Clark, M. <u>Health in the Mexican-American culture: a community study</u> (2nd ed.). Berkeley, Calif: University of California Press, 1970

Cuellar, I., Harris, L. C., & Jasso, R. An acculturation scale for Mexican-American normal and clinical populations. <u>Hispanic Journal of Behavioral Sciences</u>, 1980, <u>2</u>(3), 199-217.

Currier, R. L. The hot-cold syndrome and symbolic balance in Mexican and Spanish-American folk medicine. In R. A. Martínez (Ed.), <u>Hispanic culture and health care: fact, fiction, and folklore</u>. St. Louis: C. V. Mosby, 1978.

Fabrega, H., & Zucker, M. Components of illness and type of medical practitioner: a comparative study. <u>Social Science Medicine</u>, 1979, <u>13</u>(1), 13-23.

Fejos, P. Man, magic, and medicine. In I. Goldston (Ed.), <u>Medicine and anthropology</u>. New York: International University Press, 1959.

Foster, G. M., & Anderson, B. G. <u>Medical anthropology</u>. New York: John Wiley & Sons, 1978.

Glaser, B. G. <u>Theoretical sensitivity</u>. Mill Valley, Calif.: The Sociology Press, 1978.

Glaser, B. G., & Strauss, A. L. <u>Time for dying</u>. Chicago: Aldine Publishing Co., 1968.

Hautman, M. A. Folk health and illness beliefs. <u>Nurse Practitioner</u>, 1979, <u>4</u>(4), 23; 26-27; 31-32.

Hautman, M. A., & Harrison, J. K. Health beliefs and practices in a middle-income Anglo-American neighborhood. <u>Advances in Nursing Science</u>, 1982, <u>4</u>(3), 49-64.

Hoppe, S. K., & Leon, R. L. Coping in the Barrio: case studies of
     Mexican-American families. Child Psychiatry and Human
     Development, 1977, 7(4), 264-275.

Keefe, S. E. Acculturation and the extended family among urban
     Mexican-Americans. In A. M. Padilla (Ed.), Acculturation:
     theory, models, and some new findings. Boulder, Colo.:
     Westview Press, 1980.

Keesing, R. M. & Keesing, F. H. New perspectives in cultural
     anthropology. New York: Holt, Rinehart, and Winston, Inc.,
     1971.

Leininger, M. Transcultural nursing: concepts, theories, and
     practices. New York: John Wiley & Sons, 1978.

Nall II, F. C., & Speilberg, J. Social and cultural factors in the
     response of Mexican-Americans to medical treatment. In R. A.
     Martínez (Ed.), Hispanic culture and health care: fact,
     fiction, and folklore. St. Louis: C. V. Mosby, 1978.

O'Brien, M. E. Pragmatic survivalism: behavior patterns affecting
     low-level wellness among minority group members. Advances in
     Nursing Science, 1982, 4(3), 13-26.

Oiler, C. The phenomenological approach in nursing research. Nursing
     Research, 1982, 31, 178-181.

Olmedo, E. L. Quantitative models of acculturation: an overview. In
     A. M. Padilla (Ed.), Acculturation: theory, models, and some
     new findings. Boulder Colo.: Westview Press, 1980.

Polgar, S. Health action in cross-cultural perspective. In H. E.
     Freedman (Ed.), Handbook of medical sociology. Englewood
     Cliffs, N. J.: Prentice-Hall, 1963.

Redfield, R., Linton, R., & Herskovits, M. J. A memorandum on
     acculturation. American Anthropologist, 1936, 38, 149-152.

Rosenblatt, D., & Suchman, E. A. The underutilization of medical-care
     services by blue-collarites. In A. B. Shostak and W. Gomberg
     (Eds.), Blue-collar world: studies of the American worker.
     Englewood Cliffs, N. J.: Prentice-Hall, 1964.

Rubel, A. J. Concepts of disease in Mexican-American culture.
     American Anthropologist, 1960, 62, 795-814.

Scott, C. S. Competing health care systems in an inner-city area. In
     M. H. Logan and E. E. Hunt Jr. (Eds.), Health and the human
     condition: perspectives on medical anthropology. North
     Scituate, Mass.: Duxbury Press, 1978.

Spector, R. E. Cultural diversity in health and illness. New York:
     Appleton-Century-Crofts, 1979.

Stern, P. N. Grounded theory methodology: its uses and processes. Image, 1980, 12(1), 20-23.

Szapocznic, J., & Kurtines, W. Acculturation, biculturalism, and adjustment among Cuban-Americans. In A. M. Padilla (Ed.), Acculturation: theory, models, and some new findings. Boulder, Colo.: Westview Press, 1980.

Szapocznic, J., Scopetta, M. A., Aranalde, M. A., & Kurtines, W. Cuban value structure: treatment implications. Journal of Consulting and Clinical Psychology, 1978, 46, 961-870.

Toohey, J. V., & Dezelsky, T. L. Curanderas and brujas--herbal healing in Mexican-American communities. Health Education, 1980, 11(4), 2-4.

Trevino, F. M. Vital and health statistics for the U.S. Hispanic population. American Journal of Public Health, 1982, 72, 979-982.

Tutherly, L. R. Understanding your patient: Hispanic profile. Professional Medical Assistant, 1980, 13(2), 26-27.

United States Bureau of the Census. Statistical abstract of the U.S.: 1980 (101st ed.). Washington, D.C.: U.S. Government Printing Office, 1980.

Weaver, T. Use of hypothetical situations in a study of Spanish-American illness referral systems. Human Organization, 1970, 29(2), 140-154.

Zola, I. K. Culture and symptoms--an analysis of the patient's presenting complaints. American Sociological Review, 1966, 31, 615-630.

Zola, I. K. Illness behavior of the working class: implications and recommendations. In A. B. Shostak and W. Gomberg (Eds.), Blue-collar world: studies of the American worker. Englewood Cliffs, N. J.: Prentice-Hall, 1964.

BIBLIOGRAPHY

Ailinger, R. L. Hypertension knowledge in a Hispanic community. _Nursing Research_, 1982, _31_, 207-210.

Bullough, B., & Bullough, V. _Poverty, ethnic identity, and health care_. New York: Appleton-Century-Crofts, 1972.

Cohen, L. M., & Fernández, C. L. Ethnic identity and psychocultural adaptaion of Spanish-speaking families. _Child Welfare_, 1974, _53_, 413-419.

Folstead, W. J. (Ed.). _Qualitative methodology: firsthand involvement with the social world_. Chicago: Markham Publishing Co., 1970.

Glaser, B. G., & Strauss, A. L. _Awareness of dying_. Chicago: Aldine Publishing Co., 1965.

Griffith, S. Childbearing and the concept of culture. _JOGN Nursing_, 1982, _11_(3), 181-184.

Jackson, R. K. The effects of the organizational setting on ethnic nurses and patients. In _A strategy for change_. American Nurses' Association, 1979.

Johnson, A. W. _Quantification in cultural anthropology: an introduction to research design_. Stanford, Calif.: Stanford University Press, 1978.

Kleinman, A. _Patients and healers in the context of culture_. Berkeley, Calif.: University of California Press, 1980.

Landy, D. (Ed.). _Culture, disease, and healing: studies in medical antropology_. New York: McMillan Publishing Co., 1977.

Logan, M. H., & Hunt Jr., E. E. _Health and the human condition: perspectives on medical anthropology_. North Scituate, Mass.: Duxbury Press, 1978.

Markides, K. S., Costley, D. S., & Rodríguez, L. Perceptions of intergenerational relations and psychological well-being among elderly Mexican-Americans: a causal model. _International Journal of Ageing and Human Development_, 1981, _13_(1), 43-52.

Martínez, C., & Martin, H. W. Folk diseases among urban Mexican-Americans. In R. A. Martínez (Ed.), _Hispanic culture and health care: fact, fiction, and folklore_. St. Louis: C. V. Mosby, 1978.

Padilla, A. M. (Ed.). <u>Acculturation: theory, models, and some new findings</u>. Boulder, Colo.: Westview Press, 1980.

Ragucci, A. T. The ethnographic approach and nursing research. In M. H. Logan and E. E. Hunt (Eds.), <u>Health and the human condition: perspectives on medical anthropology</u>. North Scituate, Mass.: Duxbury Press, 1978.

Read, M. <u>Culture, health, and disease: social and cultural influences on health programmes in developing countries</u>. London: Tavistock, 1966.

Romanucci-Ross, L. The hierarchy of resort in curative practices: the Admiralty Islands. In D. Landy (Ed.), <u>Culture, disease, and healing: studies in medical anthropology</u>. New York: McMillan Publishing Co., 1977.

Rudov, M. H., & Santangelo, N. <u>Health status of minorities and low-income groups</u>. Pittsburgh, Penn.: Centers for Health Education and Social Systems Studies. DHEW Publ. No. (HRA) 79-627.

Ruffin, J. E. Changing perspective on ethnicity and health. In <u>A strategy for change</u>. American Nurses' Association, 1979.

Samora, J. Conceptions of health and disease among Spanish-Americans. In R. A. Martínez (Ed.), <u>Hispanic culture and health care: fact, fiction, and folklore</u>. St. Louis: C. V. Mosby, 1978.

Simms, L. M. The grounded theory approach in nursing research. <u>Nursing Research</u>, 1981, <u>30</u>, 356-359.

Smoyak, S. A. Nurse and client ethnicity and its effects upon interaction. In <u>A strategy for change</u>. American Nurses' Association, 1979.

Staton, R. D. A comparison of Mexican and Mexican-American families. <u>The Family Coordinator</u>, 1972, <u>7</u>, 325-329.

Timmreck, T. C., & Stratton, L. H. The health opinion survey translated into Spanish as a measure of stress for Hispanic cultures. <u>JPN and Mental Health Services</u>, 1981, <u>19</u>(1), 9-13.

Wood, C. S. <u>Human sickness and health: a biocultural view</u>. Palo Alto, Calif.: Mayfield Publishing Co., 1979.

Wray, D. A. Culture, ethnicity, and the health care system. <u>Imprint</u>, 1981, <u>23</u>(1), 20; 74.

APPENDIX A

I am carrying out a study involving people of Mexican descent to find out what kind of choices they make regarding treatment when they are ill, and why they make these choices. I would appreciate it very much if you would help with this study by talking with me and answering some questions I have for you.

I would first ask you to tell me about a recent illness in your family and what was done about it. You could choose which you wanted to talk about. After that I would need to ask you a few questions about yourself—where you were born, what languages you speak, what your family and friends are like. This information will help me to place you into one of the subgroups in this study.

This will cost you nothing other than about one hour of your time. There are no risks for you other than the possibility that a question may upset you. There will be no immediate benefit from this study for you, but the information will help us in the future to better meet the health needs of Mexican-Americans in Chicago. Please feel free to ask me any questions you may have, and I will do my best to answer them.

At any time during the interview or after, you are free to stop answering questions or to ask that your answers not be used in the study. If you choose to answer the questions, what you say will be used, but there will be no way in which anyone else will know which were your answers. Neither your name nor your address will be included in this study.

If you're interested in the results of the study, I'll be glad to send you a copy.

APPENDIX B

ILLNESS REFERRAL SYSTEM

Respondent _____

Person who was ill _____

Nature of illness _____

_____

_____

Date of illness _____

Referred to _____

      by _____

Reasons _____

_____

_____

Treatment given _____

_____

_____

Referred to _____

      by _____

Reasons _____

_____

_____

Treatment given _____

_____

_____

Referred to _____

      by _____

Reasons _____

_____

_____

Treatment given _____

_____

_____

Referred to _____

       by _____

Reasons   _____

_____

_____

Treatment given _____

_____

_____

Referred to _____

       by _____

Reasons   _____

_____

_____

Treatment given _____

_____

_____

Different referral system:

What cases:

Why:

APPENDIX C

Acculturation Rating Scale for Mexican Americans

Name	Nombre
Sex	Sexo
Age	Edad
Marital Status	Estado Civil
What is your religious preference?	¿Cuál es su religión predilecta?

Last grade competed in school:	¿Hasta que grado asistió usted en la escuela?
1. Elementary 0–5	1. Primaria–6
2. 6–8	2. Secundaria 7–9
3. 9–12	3. Preparatoria 10–12
4. 1–2 years of college	4. Universidad 1–2 años
5. 2 years of college or more	5. Universidad 2 años y más

This questionnaire is designed to yield a measure of acculturation in Mexican Americans. With normal adults, it may be self-administered or given in groups. However, with certain clinical populations, individual administration is required, often incorporating the use of an informant and additional observational data. In such cases, the rater is required to make a judgmental rating for the subject. (For a complete set of instructions, please refer to the instructional material that accompanies this scale.) Items are presented in English, Spanish, or in both languages depending on the subject's preference. All items are scored in relation to one or the other of the following continuums:

	Mexican		Bicultural		Anglo
(Culture)	1	2	3	4	5
	1	2	3	4	5
(Language)	Spanish		Bilingual		English
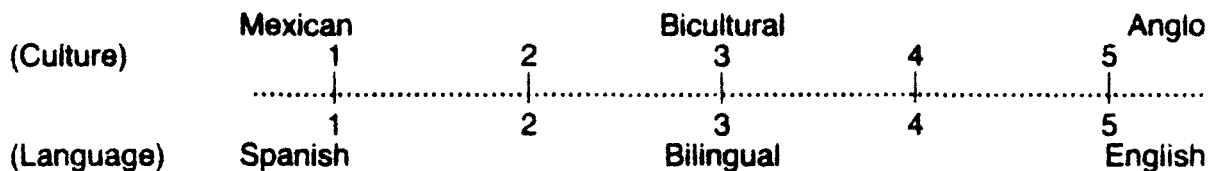
Where more than one answer seems appropriate, the subject or rater should base their choice, as best possible, on what would be most correct under normal circumstances or under most conditions.

Circle the number next to the answer that best fits the question.	Indique con un círculo la respuesta que considere mas adecuada.

1. What language do you speak?
  1. Spanish only
  2. Mostly Spanish, some English
  3. Spanish and English about equally (bilingual)
  4. Mostly English, some Spanish
  5. English only
	1. ¿Qué idioma habla usted?
	  1. Solamente Español
	  2. Mas Español, menos Inglés
	  3. Igual en Español y en Inglés (bilingüe)
	  4. Mas Inglés, menos Español
	  5. Solamente Inglés

2. What language do you prefer?
  1. Spanish only
  2. Mostly Spanish, some English
  3. Spanish and English about equally (bilingual)
  4. Mostly English, some Spanish
  5. English only
	2. ¿En qué idioma prefiere hablar?
	  1. Solamente Español
	  2. Mas Español, menos Inglés
	  3. Igual en Español que en Inglés (bilingüe)
	  4. Mas Inglés, menos Español
	  5. Solamente Inglés

3. How do you identify yourself?
  1. Mexican
  2. Chicano
	3. ¿Cómo se identifica usted?
	  1. Mexicano
	  2. Chicano

4. Mostly programs in English
5. Only programs in English

11. What is your movie preference?
1. Spanish-language movies only
2. Spanish-language movies mostly
3. Equally English/Spanish
4. English-language movies mostly
5. English-language movies only

12. a. Where were you born (subject)
☐ Mexico ☐ U.S. ☐ Other
(Parents)
b. Where was your father born?
☐ Mexico ☐ U.S. ☐ Other
c. Where was your mother born?
☐ Mexico ☐ U.S. ☐ Other
(Grandparents)
d. Where was your father's mother born?
☐ Mexico ☐ U.S. ☐ Other
e. Where was your father's father born?
☐ Mexico ☐ U.S. ☐ Other
f. Where was your mother's mother born?
☐ Mexico ☐ U.S. ☐ Other
g. Where was your mother's father born?
☐ Mexico ☐ U.S. ☐ Other

On the basis of the above answers, circle the generation that best applies.
1. 1st generation = subject born in Mexico or other
2. 2nd generation = subject born in U.S., either parent born in Mexico or other
3. 3rd generation = subject born in U.S., both parents born in U.S., and all grandparents born in Mexico or other
4. 4th generation = subject and parents born in U.S. and at least one grandparent born in Mexico or other with remainder born in the U.S.
5. 5th generation = subject and parents born in U.S. and all grandparents born in U.S.

3. Igual programas en Español como Inglés
4. Por la mayor parte en Inglés
5. Solamente programas en Inglés

11. ¿Qué tipo de peliculas prefiere?
1. Solamente peliculas en Español
2. Por la mayor parte películas en Español
3. Igual Inglés y Español
4. Por la mayor parte en Inglés
5. Solamente peliculas en Inglés

12. a. ¿En dónde nació usted? (sujeto)
☐ México ☐ Estados Unidos
☐ Otro País
(Padres)
b. ¿En dónde nació su padre?
☐ México ☐ Estados Unidos
☐ Otro País
c. ¿En dónde nació su madre?
☐ México ☐ Estados Unidos
☐ Otro País
(Abuelos)
d. ¿En dónde nació la mamá de su padre?
☐ México ☐ Estados Unidos
☐ Otro País
e. ¿En dónde nació el papá de su padre?
☐ México ☐ Estados Unidos
☐ Otro País
f. ¿En dónde nació la mamá de su madre?
☐ México ☐ Estados Unidos
☐ Otro País
g. ¿En dónde nació el papá de su madre?
☐ México ☐ Estados Unidos
☐ Otro País

Sobre la información anterior indique el numero de la generación que mejor le corresponde.
1. 1a generación = sujeto nacio en México u otro país
2. 2a generación = sujeto nacio en los Estados Unidos, cualquiera de sus padres nacidos en México u otro país
3. 3a generación = sujeto nacio en los Estados Unidos, sus dos padres nacidos en los Estados Unidos y todos los abuelos nacidos en México u otro país
4. 4a generación = sujeto nacio en los Estados Unidos, los dos padres nacidos en los Estados Unidos y por lo menos un abuelo nacido en México u otro país
5. 5a generación = sujeto y sus dos padres nacidos en los Estados Unidos y todos sus abuelos nacidos en los Estados Unidos

13. Where were you raised?
    1. In Mexico only
    2. Mostly in Mexico, some in U.S.
    3. Equally in U.S. and Mexico
    4. Mostly in U.S., some in Mexico
    5. In U.S. only

14. What contact have you had with Mexico?
    1. Raised for one year or more in Mexico
    2. Lived for less than 1 year in Mexico
    3. Occasional visits to Mexico
    4. Occasional communications (letters, phone calls, etc.) with people in Mexico
    5. No exposure or communications with people in Mexico

15. What is your food preference?
    1. Exclusively Mexican food
    2. Mostly Mexican food, some American
    3. About equally Mexican and American
    4. Mostly American food
    5. Exclusively American food

16. In what language do you think?
    1. Only in Spanish
    2. Mostly in Spanish
    3. Equally in English and Spanish
    4. Mostly in English
    5. Only in English

17. Can you read Spanish? ☐ Yes ☐ No
    Can you read English? ☐ Yes ☐ No
    Which do you read better? Rate the subject on the following continuum:
    1. Reads only Spanish
    2. Reads Spanish better than English
    3. Reads both Spanish and English equally well
    4. Reads English better than Spanish
    5. Reads only English

18. Can you write in English?
    Yes ☐   No ☐
    Can you write in Spanish?
    Yes ☐   No ☐
    Which do you write better? Rate the subject on the following continuum:
    1. Writes only Spanish
    2. Writes Spanish better than English
    3. Writes both Spanish and English equally well
    4. Writes English better than Spanish
    5. Writes only in English

19. If you consider yourself a Mexican, Chicano, Mexican American, member of La Raza, or however you identify

13. ¿En dónde creció usted?
    1. En México
    2. La mayor parte del tiempo en México y la menor parte en los Estados Unidos
    3. La misma cantidad de tiempo en los Estados Unidos y en México
    4. La mayor parte del tiempo en los Estados Unidos y la menor parte en México
    5. En Los Estados Unidos

14. ¿Qué contacto ha tenido usted con México?
    1. Criado un año o más en México
    2. Criado menos de un año en México
    3. Visitas ocasionales a México
    4. Comunicaciones ocasionales (cartas, llamadas telefónicas, etc.) con gente de México
    5. Ningún contacto o comunicación con gente de México

15. ¿Qué tipo de comida prefiere?
    1. Solamente comida Mexicana
    2. Por la mayor parte comida Mexicana, parte Americana
    3. Lo mismo Mexicana y Americana
    4. Por la mayor parte comida Americana
    5. Solamente comida Americana

16. ¿En qué idioma piensa usted?
    1. Solamente en Español
    2. La mayor parte en Español
    3. Igual en Inglés y Español
    4. La mayor parte en Inglés
    5. Solamente en Inglés

17. ¿Puede leer en Español? Sí ☐ No ☐
    ¿Puede leer en Inglés? Sí ☐ No ☐
    ¿En cuál lenguaje lee mejor? Indique con un círculo el número que mejor corresponde:
    1. Lee solamente Español
    2. Lee mejor Español que Inglés
    3. Lee igual en Inglés que en Español
    4. Lee mejor en Inglés que en Español
    5. Lee solamente en Inglés

18. ¿Puede escribir en Inglés?
    ☐ Sí   ☐ No
    ¿Puede escribir en Español?
    ☐ Sí   ☐ No
    ¿En cuál lenguaje escribe mejor? Indique con un círculo el número que mejor corresponde:
    1. Escribe solamente en Español
    2. Escribe mejor en Español
    3. Escribe igual en Inglés y Español
    4. Escribe mejor en Inglés que en Español
    5. Escribe solamente en Inglés

19. ¿Si se considera usted como Mexicano, Chicano, México Americano, Miembro de la Raza, o cualquiera que

this group, how much pride do you have in this group?
1. Extremely proud
2. Moderately proud
3. Little pride
4. No pride but does not feel negative toward group
5. No pride and feels negative toward La Raza

20. How would you rate yourself?
1. Very Mexican
2. Mostly Mexican
3. Bicultural
4. Mostly Anglicized
5. Very Anglicized

sea su identidad con éste grupo, qué tan orgulloso se siente de ser un miembro de este grupo?
1. Extremo orgullo
2. Orgulloso moderadamente
3. Poco de orgullo
4. Nada de orgullo, pero tampoco no se siente negativo respecto a este grupo
5. Nada de orgullo y tiene sentimientos negativos hacia miembros de La Raza

20. ¿Qué clasificación se daría a usted mismo?
1. Muy Mexicano
2. En gran parte Mexicano
3. Bicultural en gran parte
4. En gran parte Americanizado
5. Muy Americanizado

Total score _____ Total score is the sum of all 20 multiple-choice items circled.
Average score _____ Average score is the total score divided by 20.

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APPENDIX D

REMEDIES	USES
Chamomile tea	Stomach upset
Mint tea	" "
Ginseng tea	To give strength
Peppermint tea	Cold
Cinnamon tea	To calm a person
Oregano and honey tea	Cough
Potato peelings on forehead	Headache
Roast garlic or lit cigarettes in both ears	Earache/headache
Wrap feet in butter and brown paper	Fever
Rice water	Diarrhea
Pull skin over spine, castor oil by mouth	Indigestion
Tincture of marijuana	Rheumatism
Baked tomato poultices behind knees, on soles, on neck	Tonsilitis or fever
Green tomatoes baked with bicarbonate, applied to tonsils with pressure	Tonsilitis
Lemon tea	Sore throat/cold
Orange tea	" " "
Guava fruit	Diarrhea
Yerba buena	Stomach upset
Eucalyptus inhalations	Congestion
Garlic, cummin, cloves, and onion	Diarrhea

APPENDIX E
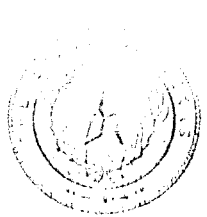
December 2, 1983

Heidy Vyhmeister
1040 West Granville 226
Chicago, Illinois   60660

Dear Heidy,

    Thank you for your interest in using the Acculturation Rating
Scale for Mexican Americans (ARSMA) published in the Hispanic Journal
of Behavioral Sciences, 1980, Vol. 2, No. 3, 199-217.

    You may make copies of the scale from the Journal article or
however you wish for your research purposes. It is my wish that the
scale be used and you have my permission to use it and make copies
as needed.

    Good luck with your study.

                                        Sincerely yours,

                                        Israel Cuellar, Ph.D.

The thesis submitted by Heidi Vyhmeister has been read and approved by the following committee:

    Dr. Dona Snyder, Director
    Associate Professor, Nursing, Loyola

    Dr. Ardelina Baldonado
    Assistant Professor, Nursing, Loyola

    Dr. Diana Hackbarth
    Assistant Professor, Nursing, Loyola

The final copies have examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Science in Nursing.

April 18, 1984
Date

Dona J Snyder, RN, Ph
Director's Signature