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Cultural Expressions, Meanings, Beliefs, and Practices of Mexican American Women During the Postpartum Period: An Ethnonursing Study

Valera Hascup

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CULTURAL EXPRESSIONS, MEANINGS, BELIEFS, AND PRACTICES OF
MEXICAN AMERICAN WOMEN DURING THE POSTPARTUM PERIOD: AN
ETHNONURSING STUDY

A Dissertation

Submitted to the School of Nursing

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By

Valera A. Hascup

March 2011

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Valera A. Hascup

2011

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MEXICAN AMERICAN WOMEN DURING THE POSTPARTUM PERIOD: AN
ETHNONURSING STUDY

By

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ABSTRACT

CULTURAL EXPRESSIONS, MEANINGS, BELIEFS, AND PRACTICES OF MEXICAN AMERICAN WOMEN DURING THE POSTPARTUM PERIOD: AN ETHNONURSING STUDY

By

Valera A. Hascup

May 2011

Dissertation supervised by Rick Zoucha, PhD, APRN-BC, CTN

The purpose of this ethnonursing study was to discover, understand, describe, and explicate the emic expressions, meanings, beliefs, practices, and experiences of postpartum Mexican American women living in a Passaic, New Jersey, community and to gain an understanding of any phenomena in the postpartum period. Leininger's culture care diversity and universality theory was utilized as the undergirding framework for this study. Eight key and 15 general informants participated in this study. The ethnodemographic interview guide, a qualitative enabler, was used to assist with the collection and analysis of data. NVivo 8.0, a qualitative software program, was used to assist with data management and organization. The data were analyzed and interpreted into categories, patterns, and themes that were confirmed through multiple interviews. Through face-to-face interviews and field notes, the researcher discovered, understood,

described, explicated, and analyzed the cultural expressions, meanings, beliefs, practices, and experiences of Mexican American women during the postpartum period. The findings from this study focus first on nursing knowledge development, pointing the direction for future research to determine effective nursing care actions. Early interventions assist in providing culturally congruent care to postpartum Mexican American women. Implications for nursing research, theory, education, and practice are offered.

DEDICATION

This dissertation is dedicated to my late husband William, who died just as I entered the dissertation phase. I did not know when I entered the PhD program at Duquesne University 2 short years before that his death would occur. Of course, we can never know those things, and God had other plans for me. William sacrificed as much, if not more, than I did in encouraging me to pursue my dreams, giving up vacations, weekends, and holidays so that I could devote time to my studies. My happiness was the most important thing to him. He said he would never stand in the way of my desire to pursue my dreams, and he never did. He believed that we have one life to live, and we must live it to the absolute fullest in every way, every day, including pursuing our dreams, so I did. That was the way he lived his life as well.

My typical weekend morning would be to give him a kiss before he got up and tell him, “I am going to work on the dissertation all day until 5:00 pm, and then I’m all yours!” William so hoped he would see me finish the PhD before he died, but it was not meant to be. As with human life, I believe the dissertation also had a life of its own, and when it was meant to be finished, it was finished. My love, my confidante, my closest friend, my everything—this is for you. You earned it as much as I did. Without you, it all seems so meaningless now. Ironically, though, you knew it would be the dissertation that would save my life. Your last words to me were that you would not worry about me, for I had Jerri, my schoolwork, my career, and my horse to keep me focused and busy. As always, you were right because the dissertation caused me to focus on something other than the profound grief, loss, and abandonment that I felt, the depths of which cannot be

fully articulated to this day.

This dissertation is also dedicated to my beautiful daughters Jacqueline and Jerri Lynne. Jerri Lynne has been my constant support and encouragement, not only as a daughter but also as a friend, companion, and confidante. Jerri, you are truly a gift from God. I love you more than life itself. Thank you for being you. Jacqueline, I hope I have inspired you to pursue your dreams; you are very special to me.

This dissertation is also dedicated in loving memory of my mother, Alexandra (Alice) Gedrich Reed, and my father, Alfred Guy Reed, for they both recognized the value and importance of an education simply because they did not have one. Mother was a true visionary. She believed education was empowerment for women, and with education comes independence. She was a constant inspiration, encouraging me every step of the way to pursue education and my dreams and to never allow challenges to deter me from my goals. I have become the woman she hoped I would be.

I also would like to dedicate this work to Senor Xavier Armando Lopez Carvajal. Senor came into my life at a very dark time, and his friendship made me realize that I could rise from the depths of the abyss of despair and grief into the light of life and live, laugh, and love again. Thank you, Senor, for helping me believe that I could find happiness and meaning in life, even if for a brief moment in time. I know that God sent you to me. I will be forever indebted to you for your friendship, and I will never forget you. Muchas gracias, Senor, for your love and care, for your concern for my time, for motivating me, believing in me, inspiring me, and, most importantly, for understanding me and accepting me as I am. You are truly an awesome man. Te amo.

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Chapter 1: Introduction

Background of the Study

Since its beginning, nursing has accepted a holistic, social justice approach to client care as an essential part of its practice framework. According to Barnes (2005), “Social justice is a broad term that is primarily concerned with how we related to each other as persons, communities, and nations” (p.14). From its inception, nursing has always been concerned with the basic right of people to live with dignity, regardless of their socioeconomic status or ethnicity. Therefore, the concepts of social justice and nursing have been inextricably linked. Social justice is how nurses break down barriers, work to end inequity, and provide the restoration and maintenance of health to all people, regardless of race, ethnicity, or social status (Barnes, 2005).

Nightingale (1969) in her *Notes on Nursing* discussed this holistic perspective, the dimension of the environment, and the impact of the environment on the patients for whom she cared. However, it was not until the 1950s that Madeleine Leininger (2006) realized that something was missing in nursing care, and that missing link was culture. Leininger determined that it was imperative for nurses to gain cultural knowledge to deliver culturally appropriate and congruent care that fosters the concept of social justice. It is essential that nurses discover people’s professional and generic care expressions, meanings, beliefs, practices, and experiences within their cultural context in order to provide culturally congruent care (Leininger, 2006). Interestingly, Leininger (1994) estimated that, by 2010, U.S. nurses and other healthcare professionals would care for patients from all cultures around the world (Leininger, 1994). Mead (1935) stated,

If we are to have a richer culture, rich in contrasting values, we must recognize the whole gamut of human potentialities, and so weave a less arbitrary social

fabric, one in which each diverse human gift will find a fitting place. (p. 322)

Eliminating health disparities in vulnerable populations is a goal of Healthy People 2010 (U.S. Department of Health and Human Services, 2007), which promotes the concept of global social justice. Access to healthcare services for Hispanic women is essential to achieving this goal. Studies indicate that Hispanic women do not effectively utilize healthcare services as compared to Caucasian or African American women due to cultural and linguistic barriers (Budetti, Shikles, Duchon, & Schoen, 1999). Projections estimate that by 2050 the Hispanic population of the United States will be over 102 million, constituting 24% of the nation's population (U.S. Department of Commerce, 2004). According to the U.S. Federal Government (1999), *Hispanic or Latino* is a person of (a) Cuban, (b) Mexican, (c) Puerto Rican, (d) South or Central American, or (d) other Spanish culture or origin, regardless of race. The term *Spanish origin* can be used in addition to *Hispanic* or *Latino* (U.S. Federal Government, 1999). Of the Hispanic subgroups, Mexican Americans number more than 20 million and represent more than half of the Hispanic population in the United States (Ramirez & Suarez, 2007).

Leininger explicated the cultural context of clients through the concept of culture care. Cultural expressions, meanings, beliefs, practices, and experiences unique to any culture influence health, wellness, and illness (Berry, 2002; Leininger, 2006). Leininger and others have identified universal Mexican cultural values that can assist nurses in understanding the lifeways of this population. Interestingly, these studies have focused on Mexican immigrant women but have excluded the postpartum period. In fact, there is no current extant research regarding the postpartum period or sequelae in Mexican American women (Berry, 1996, 1999, 2002; Callister & Birkhead, 2002; Johnson, 2005; Leininger, 2006; Marin & Marin, 1991; Martinez-Schallmoser, 1992; Martinez-Schallmoser,

Telleen, & MacMullen, 2003).

Purpose and Specific Aims of the Study

The purpose of this ethnonursing study was to discover, understand, describe, explicate, and analyze the emic (i.e., insider) expressions, meanings, beliefs, practices, and experiences of Mexican American women during the postpartum period to identify and gain an understanding of any phenomena in the postpartum period. The interviews occurred within the environmental context of the participants' homes and community. This study posits that (a) care meanings, (b) beliefs, (c) practices, and (d) somatic expressions experienced by Mexican American women are influenced by their cultural worldview.

The specific aims of this study were as follows:

1. To discover, understand, explicate, and describe the emic perspective of Mexican American women in the postpartum period.
2. To understand the culture care expressions, meanings, practices, beliefs, and experiences and identify any phenomena during the postpartum period that would assist healthcare providers in early identification of physical and mental health issues and, therefore, a need for early intervention and treatment.
3. To identify and explicate implications for care with nurses and healthcare providers in delivering culturally congruent and appropriate care to this vulnerable population based on knowledge gained from studying the lifeways of Mexican American women during the postpartum period.

Domain of Inquiry

The domain of inquiry for this ethnonursing study was to discover, understand, describe, explicate, and analyze the cultural expressions, meanings, beliefs, practices, and experiences of postpartum Mexican American women living in Passaic County, New Jersey. This domain of inquiry is of major interest to nurses because of the limited knowledge nurses have of this group's naturalistic, generic, and folk expressions,

meanings, experiences, and practices during the postpartum period. In addition, this study contributes to nursing practice by discovering new knowledge to guide development of culturally congruent nursing decisions and actions. This study also provides a basis for future research about whether planning professional care that incorporates generic practices will lead to meaningful, beneficial healthcare that will meet the unique cultural needs and expectations of Mexican American women. It is hoped that cultural pain and cultural conflicts will be lessened, and professional cultural imposition practices will be prevented. Importantly, it is also hoped that patient safety and patient satisfaction will be improved by the delivery of culturally congruent care.

Research Questions

The open discovery process with focused research questions elicited in-depth data regarding the cultural expressions, meanings, practices, beliefs, and experiences of Mexican American women during the postpartum period. The findings were inductively derived from the data.

The research questions that guided this study were as follows:

1. How do Mexican American women describe the postpartum experience?
2. What are the generic cultural expressions, meanings, beliefs, health and self-care practices, and experiences of Mexican American women during the postpartum period?
3. In what ways do worldview, cultural and social structure, and ethnohistory influence the care expressions, meanings, beliefs, practices, and experiences in the home and community context for Mexican American postpartum women?

Theoretical Supports for the Study

This study was based upon Leininger's theory of culture care diversity and universality in combination with her Sunrise Enabler. This theory provides an ideal

framework to discover the culture care expressions, meanings, beliefs, practices, and experiences of ethnically diverse people. Understanding the full meaning of the social and cultural contexts is critical and involves using Leininger's Sunrise Enabler to Discover Culture Care (see Appendix A). The Sunrise Enabler displays the theoretical underpinnings and influences on culture care that guide this study (Berry, 2002; Leininger, 2006).

The major areas represented in the model are (a) worldview, (b) culture and social structure dimensions, (c) environmental context, (d) language, and (e) ethnohistory. Leininger & McFarland (2002) defined *worldview* as "the way an individual or group looks out on and understands their world about them" (p. 83). *Culture and social structure dimensions* include (a) technological, (b) religious, (c) philosophical, (d) kinship, (e) social, (f) political, (g) legal, (h) economic, and (i) educational factors as well as (j) cultural values and (k) lifeways (Leininger & McFarland, 2002). All of these factors are dynamic patterns and features of a specific culture. These factors provided a framework that guided the literature review, the design of the ethnodemographic interview guide, and the data collection.

Environmental context "refers to the totality of an environment . . . that give[s] interpretive meanings to guide human expressions and decisions" (Leininger & McFarland, 2002, p. 83). Language and ethnohistory are two other important factors. According to the Sapir-Whorf hypothesis (Berthoff, 1988), all people have a need to make sense of the world around them, and the main tool for doing so is language. Language evolves from worldview, e.g. how people view and experience their world and how they express that experience (i.e., linguistic determination). It is a dyadic

relationship. Language predisposes people to look at the world in a certain way.

Leininger realized that language was an important dimension and that cultural expressions and meanings differ from culture to culture and differ over time.

Ethnohistory “refers to the sequence of facts, events, or developments over time, as known, witness or documented about a designated people of a culture” (Leininger & McFarland, 2002, p. 83).

Significance for Nursing

It is estimated that 24% of the female population of the United States will be comprised of Hispanic women by 2050 (Misra, 2001), with more than 10 million Mexican American women living in the United States (Ramirez & Suarez, 2007). The Mexican American population has a birth rate of approximately 50% higher than non-Hispanics (Bernstein, 2004). Mexican American women face multiple barriers in accessing healthcare, including socioeconomic, cultural, and linguistic ones. It is hypothesized that these sociocultural and linguistic factors may pose critical challenges that influence pregnancy and postpartum outcomes (Misra, 2001).

According to Callister and Birkhead (2002), increasing cultural diversity in the United States requires that maternal child healthcare providers become culturally competent. Callister and Birkhead stated that cultural competence includes both culture-specific and culture-generic knowledge, attitudes, and skills. Callister and Birkhead recognized evidence in the literature that providing culturally competent care leads to positive patient outcomes, and providing culturally competent care can lead to significant improvements in the welfare of women and children. Therefore, it is imperative that nurses develop an understanding of the postpartum experience of Mexican American

women in order to promote culturally congruent and competent care for this rapidly growing Hispanic subgroup. Doing so will assist in meeting the mission and vision of Healthy People 2010 (U.S. Department of Health and Human Services, 2007).

Knowledge is needed regarding culture-specific and culture-generic expressions, meanings, practices, beliefs, practices, and experiences of postpartum Mexican American women. This study will generate new nursing knowledge leading to the provision of culturally competent care by nurses, other healthcare providers, and organizations that can make significant improvements in the health and well-being of woman and infants. Understanding the phenomenon under study in this cultural group may improve outcomes not only for Mexican American mothers but for other cultures as well. Zoucha (2001) stated that nurses must put aside ethnocentrism and accept that every health worldview is equally valid. Nursing has been moving toward cultural competency by implementing the practice of cultural sensitivity. Barnes (2005) stated,

Nurses aspire to cultural competence not because the concept is trendy or politically correct . . . but because nurses are pragmatists who understand that recognizing cultural differences enables them to act with patients and their families in ways that enable them to heal. (p. 31)

Culturally competent nurses are not just content to learn about other cultures but view the vulnerable within a wider social context and intervene from within that context. With the increasingly rapid growth of the Mexican American population, it is vital that nurses develop a cultural awareness that will lead them on a lifelong journey of acquiring cultural knowledge and competence in order to fully develop and integrate culturally appropriate nursing care services for Mexican American women. Marginalized populations, such as Mexican American women, experience discrimination and poor access to healthcare that make them vulnerable to numerous health problems (Barnes,

2005). In other words, nurses have a moral and ethical responsibility to understand the uniqueness of the culturally diverse patient population(s) whom they serve. Camphina-Bacote (2002) stated that developing cultural competence is a process, not an event, and consists of five constructs: (a) cultural desire, (b) cultural awareness, (c) cultural knowledge, (d) cultural skill, and (e) cultural encounters. According to Camphina-Bacote, “Cultural competence is an essential component in rendering effective and culturally responsive services to culturally and ethnically diverse clients” (2002, p. 181). There is no greater need for this knowledge than in the Mexican American postpartum period.

With the exception of Leininger’s extensive work (Berry, 2002; Leininger, 1985, 1990, 1994, 2006), few published nursing theories incorporate the concept of cultural competence because they were published well before its emergence as a concept for nursing (Barnes, 2005). Therefore, utilizing Leininger’s ethnonursing methodology led to understanding of the lifeways of postpartum Mexican American women. Data obtained from this research study contribute vital information regarding the postpartum period in Mexican American women and significantly add to nursing knowledge by assisting in theory development that will guide culturally competent, sensitive, and congruent nursing actions and interventions specific to postpartum Mexican American women. Latino(a)s have been called the silent or invisible minority because minimal research has been conducted in this population (Caudle, 1993).

Nurses play a vital role in helping culturally diverse women achieve their expectations regarding their traditional practices during the postpartum period, creating positive health outcomes. An understanding of and appreciation for their culture will facilitate recognition of and respect for these practices. Culturally competent care is

dependent on nurses' ability to understand, accept, and integrate culture care expressions, meanings, beliefs, practices, and experiences into their professional practice. As a result of added knowledge, nurses can incorporate into the plan of care the three action modes detailed by Leininger: (a) preservation and maintenance, (b) accommodation and negotiation, and (c) restructuring and re-patterning healthcare practices, when necessary, to provide for optimal postpartum outcomes. Callister (1995; Callister & Birkhead, 2002) maintained that nurses who are willing to learn about a patient's culture through education can contribute to promoting positive psychosocial and physiological outcomes.

This study identified unique cultural expressions, meanings, beliefs, practices, and experiences that determine behavior in the postpartum period of Mexican American women, leading to the provision of culturally sensitive, congruent, competent, and ethical care. Little extant, current nursing research exists regarding the unique aspects of the postpartum experience for Mexican American women. Future research, both quantitative and qualitative, is needed in this domain of inquiry to fill the current gap in nursing literature.

Definitions

The following definitions were used in this study:

Culture. Learned and shared beliefs, values, and lifeways of Mexican American women that are generally transmitted intergenerationally and influence their thinking and action modes (Berry, 2002).

Care. Assistive, supportive, enabling, and facilitative culturally based ways to help Mexican American women in a compassionate, respectful, and appropriate way to improve a human condition or lifeway (Berry, 2002).

Culture-specific care (culturally congruent care). Care that is tailor-made and fits specific cultures in appropriate ways (Berry, 2002).

Mexican American woman (women). Woman (women) living in the United States who self-identifies as a Mexican American.

Postpartum, postpartum period, puerperium, 4th trimester. A 6-week interval between the birth of the newborn and the return of the reproductive organs to their normal, non-pregnant state. The physiologic changes that occur during this time, while distinctive, are normal (Lowdermilk, Perry, & Bobak, 2000).

Generic postpartum care. Culturally learned and transmitted lay, traditional, or folk caring behaviors or concerns by family, friends, or healthcare professionals who assist, support, or enable Mexican American women during the postpartum period.

Assumptions

The major assumptions underlying this study emanated from Leininger's (Leininger & McFarland, 2002) assumptions in her culture care theory.

1. Experiences and meanings of human care can be understood when viewed within a cultural context.
2. Care meanings and experiences within the cultural context of care contribute to understanding of health, illness, and well-being and add to the body of nursing knowledge.
3. Care meanings and experiences are embedded in the Mexican American worldview and social structure and can be identified within a naturalistic environmental context.
4. Culture care concepts, expressions, meanings, practices, beliefs, practices, experiences, possess diversities and universalities among all cultures, including that of Mexican Americans.
5. The Mexican American culture has specific attitudes toward the postpartum experience.
6. The Mexican American culture has generic (e.g., lay, folk, and indigenous)

care knowledge and practices, as well as professional care knowledge and practices, that may differ from the Anglo American culture. These may change over time in women distanced from their homeland and culture.

Summary

Research-based knowledge is vital in the area of transcultural nursing and postpartum Mexican American women. This study sought to understand and discover the meanings, beliefs, practices, patterns, experiences, and expressions of postpartum Mexican American women within the cultural context of the community setting. Little is known about the health variables and practices in Mexican American women, a culturally, ethnically, and linguistically distinct group. To date, no research exists regarding cultural expressions, meanings, beliefs, practices, and experiences of the Mexican American postpartum period. This study provides knowledge about the factors that may be useful in developing theories that will lead to future studies focusing on Mexican American women's healthcare issues.

Chapter 2: Literature Review

Understanding the cultural expressions, meanings, practices, beliefs, and experiences of Mexican American women during the postpartum period requires an understanding of the ethnohistory of (a) Mexicans, (b) Mexican Americans, and (c) Mexican American women. A lack of awareness of social, political, and cultural factors prevents nursing from achieving a comprehensive, holistic perspective of human health and, therefore, impacts appropriate healthcare, particularly for vulnerable populations (Barnes, 2005).

The synthesis of the literature begins using the components of Leininger's Sunrise Model to illustrate a comprehensive cultural perspective of Mexican American heritage. One component of Leininger's model is worldview, which includes environmental context, language, ethnohistory, and the cultural and social dimensions of (a) religious and philosophical factors; (b) educational and technological factors; (c) economic, political, and legal factors; (d) kinship and social factors; and (e) cultural values, beliefs, and lifeways (Berry, 2002). Using Leininger's model and methodology facilitated the understanding of the postpartum period in Mexican American women within the cultural context. The synthesis of the literature review also contains studies that relate to the health and well-being of pregnant Mexican American women, including the impact and influence of immigration and acculturation.

Worldview

Worldview refers to an encompassing perspective that guides one's thinking and decisions about all aspects of life, including (a) health, (b) well-being, (c) death, (d) dying, and (e) disability, including care actions (Leininger, 2006). Berry (2002) stated

that the Mexican American worldview is a “tightly woven concept with the concept of a divine will that has ultimate control over their lives” and that while prayer asks God to intercede, the view that “God’s will be done” persists (p. 364). In the Mexican American worldview, religion is an important part of the social structure. The concept of divine will, or God’s will, is embedded in daily life (Berry, 1996, 1999, 2002; Purnell & Paulanka, 2003; Zoucha & Zamarripa, 2003).

Ethnohistory

The land and environment of Mexico. Mexico (see Appendix B) is bordered on the north by the United States, on the east by the Gulf of Mexico and the Caribbean Sea, on the south by Belize and Guatemala, and on the west by the Pacific Ocean. Its area is approximately 758,425 square miles. More than half of Mexico is an elevated central plain flanked by two mountain ranges, the Sierra Madre Occidental to the west and the Sierra Madre Oriental to the east. The low, flat Yucatán Peninsula forms the southeastern tip of Mexico. The climate has both temperate and cold regions, with temperatures ranging from 59° to 70°F. The rainy season extends from May to October, with annual rainfall ranging from 10-25 inches (Microsoft, 2002).

Mexico’s growing population and heavy resource use have taken a toll on the environment. Soil erosion and pollution of waterways and aquifers by chemicals are common. The most serious pollution problems occur in Mexico City, the most heavily populated city in Mexico. Heavy traffic, high concentration of industry, and domestic energy use combined with severe meteorological and geographic conditions have led to the exacerbation of the pollution issue (Microsoft, 2002). The rate of deforestation is also high, as more and more land is being cleared for agriculture.

Mexico's heritage of environmental protection dates back in history to the Mayan culture when farming was guided by an ecological framework. Ancient land-management traditions were lost after the conquest of Mexico by Europeans, and further deterioration occurred until the late 1800s. At that time, the modern environmental legacy began. By the early 1990s, there were approximately 70 protected areas in Mexico. However, the extent of the areas and the degree of protection varies depending on how the law is interpreted. Protected sites are still threatened by (a) deforestation, (b) poaching, (c) dumping, (d) mining, (e) overgrazing, and (f) erosion (Microsoft, 2002).

The people and society of ancient Mexico. To understand Mexican Americans, one has to understand their Mexican heritage (Vigil & Beierle, 2002). The indigenous people of Mexico are part of a long, rich history of advanced Native American civilizations that equaled those of the Egyptians (Microsoft, 2002). Archeological evidence has documented that accurate calendars existed and that the indigenous people of the area were master artisans, understood astronomy, and built huge empire. The Olmecs were the first known inhabitants, dating back to 2000 BC, although archeological finds and artifacts have been reported dating back to 9000 BC (Berry, 2002; Wikipedia, 2001).

Mayans built astounding cities throughout North and Central America, but in the 12th century AD, their empire fell. The Aztecs formed the last great empire before Herman Cortes arrived in 1519 and conquered the area. The Spanish ruled for three centuries and exploited the area and its people. The Spanish also introduced Christianity, which virtually destroyed the Aztec culture, desecrating and eliminating temples and replacing them with churches (Berry, 2002; Vigil & Beierle, 2002; Wikipedia, 2001).

The Spanish interrupted the indigenous lifeways and created a colonial empire that refashioned the land, the people, and their culture (Vigil & Beierle, 2002; Wikipedia, 2001). Everything now came under Spanish domination—the land, the labor, and the wealth—crushing the people into perpetual bondage and servility. The significant cultural achievements of the Indians were destroyed forever. The cultural and social pairing that would define the future Mexican people and nation began, and a new Mexican culture evolved. The Spaniards imposed a sexual conquest on the vanquished that led to a new mixture of people. As a result, a “socio-physiological heritage” in which skin color and physical traits became associated with feelings of inferiority and superiority surfaced: the lighter skin tones of the Spanish were considered superior, and the darker skin tones of the Indians were considered inferior. These perceptions still exist today among Mexicans and Chicanos (Vigil & Beierle, 2002).

A rigid Spanish caste system replaced the former collective Mexican society. In this new culture, those born in Spain (the *peninsular*) received the highest social position. The *criolla* (those of Spanish ancestry born in Mexico) followed next in prestige, with the *mestiza* (those of mixed Spanish and Indian ancestry), just a notch above the Indians, who were on the lowest social level (Ramirez & Suarez, 2007). About 60% of the people of Mexico are *Mestizo*, 30% are descended from the Mayan and Aztec empires, and 9% are of European heritage (Microsoft, 2002; Wikipedia, 2001).

The Ethnohistory of Mexican Americans

Impact of Mexican/Mexican American revolutions on worldview. People of Mexican heritage settled on land that is now the Southwestern United States well before any White settlers came to the area (Berry, 2002; Vigil & Beierle, 2002; Zoucha &

Zamarripa, 2003). The Mexican-American War of 1846-1848 brought a wave of American settlers to the region, resulting in cultural conflict and intercultural hostility (Vigil & Beierle, 2002). The new order that was established resulted in land resources, labor structure, and wealth distribution that favored the Anglo Americans. “By 1900, Mexican immigrants numbered approximately 200,000” (Zoucha & Zamarripa, 2003, p. 264).

The “Great Migration” occurred between 1900 and 1930, with an additional 1 million immigrants entering the United States. This migration period was perhaps the greatest in the history of the world (Zoucha & Zamarripa, 2003). The Mexican Revolution that began in 1910 forced an exodus of Mexican émigrés trying to escape political turmoil and violence (Garcia, 1997). Historically, women’s participation in revolutionary struggles correlated with the development of a feminist consciousness; this was the case in the Mexican Revolution of 1910. In the 1920s, large numbers of middle class Mexicans emigrated to the United States (Berry, 2002; Zoucha & Zamarripa, 2003). At the same time, World War I caused an economic growth spurt in every sector of the country, causing a labor shortage. U.S. employers sought workers south of the border to fill this need. Immigration policy hindered Mexican immigration; however, Congress waived immigration restrictions for Mexicans, validating their importance in the U.S. labor market (Garcia, 1997).

After the 1910 Revolution, large-scale immigration from Mexico began and continues to the present day. This immigration has met with episodic anti-immigrant backlashes; the Repatriation of the 1930s and Operation Wetback in the 1950s are two examples. Between 1910 and 1930, approximately 1 million Mexicans entered the United

States. Not only did Anglo Americans give them a hostile reception, but they were also subjected to (a) police brutality, (b) violence in the workplace, (c) segregation, and (d) general rejection by the mainstream culture. As a result, immigrants from the Mexican urban middle class promoted immigrant nationalism, which was manifested by maintaining (a) the Spanish language, (b) a symbolic identification with Mexico's pre-Columbian civilizations, (c) adherence to Catholicism, (d) special reverence to Our Lady of Guadalupe, and (e) celebration of Mexico's patriotic holidays. These efforts reflected, in essence, a desire to return to their homeland of Mexico. To offset a negative stigma and to provide a sense of cohesiveness, Mexican Americans especially relied on maintaining cultural traditions in music, art, and drama, activities that were believed to be as important as religious, political, and economic endeavors (Vigil & Beierle, 2002).

The Great Depression revolutionized the Mexican American community in the United States. Unemployed Mexicans were seen as a problem, and the federal government deported thousands of undocumented Mexicans. By the end of the 1930s, thousands of young Mexican Americans exposed to Anglo society practiced Mexican Americanism, an ideology that embraced assimilating into the American value system and adhering less faithfully to traditional Mexican cultural values (Menchaca, 2002). These young people were committed to breaking down segregation and fighting discrimination.

The Mexican American population increased from approximately 3 million in the 1940s to approximately 20 million in 2000, with the total Latino population equaling over 30 million (Vigil & Beierle, 2002). World War II saw tremendous numbers of Mexican American men enrolled in all branches of the armed forces, and Mexican American

women worked in war industries alongside Anglo women. After the war, discrimination and rejection resumed, leading to the 1947 establishment of the American G.I. Forum, which was organized by Mexican American veterans to advocate for civil rights (Menchaca, 2002).

Since the 1960s, the tremendous influx of Hispanic immigrants has reinforced Hispanic culture. In spite of the persistence of Mexican American cultural values and the resurgence of Mexican immigration, the 1960s and 1970s saw many Mexican Americans who were not well assimilated into the mainstream culture make dramatic progress in breaking down obstacles. Caught up in the intellectual turmoil in the United States, young Mexican Americans sought to create a new identity while struggling for the same civil rights of previous generations, setting the mood for the creation of the Chicano movement (Vigil & Beierle, 2002). The Chicano movement was perceived to be a deliberate subordination of Mexican Americans by a racist American society. Members of the Chicano movement rejected assimilation into mainstream Anglo culture.

The 1980s saw the current anti-Mexican hysteria in the United States that was characterized by legislation to dismantle affirmative action and bilingual education (Vigil & Beierle, 2002). This history of oppression, tension, and hostility has deep roots. Additionally, in the 1980s, the term *Hispanic* took on a special generic meaning. Observers have argued that the term represents rejection by the Mexican American leadership of both cultural nationalism and radical positions supported by the Chicano movement (Garcia, 1997; Menchaca, 2002). During the 1980s, Mexicans constituted more legal emigrants bound for the United States than any other country in the world (Valdivieso, 1990).

The 2000s saw continued immigration from Mexico and continued expansion of Mexican communities throughout the United States. In 2000, the U.S. Census estimated a population of approximately 35 million Latinos, approximately 80% of whom were Mexican (Menchaca, 2002; U.S. Department of Commerce, 2004). Mexican American culture and identity will continue to change as a result of assimilation into Anglo society. It is also noteworthy that Mexicans are the source of the most undocumented immigrants from any country (U.S. Department of Justice, 1989).

Ethnonyms. An *ethnonym* is defined as a proper name by which a people or ethnic group is known, either one that is self-assigned or assigned by another group (Wikipedia, 2001). The term *Chicanos* (*Chicanas*, the feminine gender form in Spanish) is used for Mexican Americans born in the United States but is also a generic ethnic name for Mexicans in general. Other regional labels include (a) *Californios* (Mexican immigrants living in California), (b) *Hispanos* (Mexican immigrants living in New Mexico), (c) *Tejanos* (Mexican immigrants living in Texas), (d) *Tusconeses* (Mexican immigrants living in Arizona), (e) *Latinos*, and (f) *Hispanics* (Vigil & Beierle, 2002). Most Mexican Americans settled in the Southwestern part of the United States in what was formerly northern Mexico during the Mexican Revolution in 1910 and during the large-scale immigration of the 1920s (Berry, 2002; Vigil & Beierle, 2002; Zoucha & Zamarripa, 2003). Many of the settlers had Spanish backgrounds and, to date, self-identify as *Hispanos* even though much intermarriage has occurred with Indians (Vigil & Beierle, 2002).

Mexican Americans are a widely diverse group of people of Mexican heritage who were born in the United States. Mexican immigrants, particularly children educated

in the United States, identify with the term *Chicano*. However, many members of both populations refuse to identify as Chicano (Vigil & Beierle, 2002). According to Zouha (2003; Purnell & Paulanka, 2003), the 1989 Latino National Political Survey reported that the “most popular self-referent . . . was *Mexican*” (p. 264). The term *Chicano* is derived from *Mexica*, with the *x* pronounced like *sh* in English (Vigil & Beierle, 2002). Over the years, the term became synonymous with the impoverished Mexican people. During the large-scale immigration into California of the 1920s, the term *Chicano* became common among the new immigrants: “To activists, it signified a turn away from a hyphenated label that was selected by non-Mexicans, and laid out a non-assimilationist path to becoming American and a bilingual-bicultural ethnic identity” (Vigil & Beierle, 2002, p. 5).

The present Mexican American individual is the outgrowth of environments that include the historical-social background of Mexico. This background includes ideas, beliefs, and patterns of behavior that are more closely related to Mexican culture rather than to Anglo American culture (Vigil & Beierle, 2002). While most speak English, Spanish is considered the primary language.

Current Mexican American demographics. Mexican Americans today live in (a) California, (b) Texas, (c) Illinois, (d) Arizona, (e) Florida, (f) New Mexico, (g) New York, (h) Colorado, (i) Ohio, and (j) Arkansas, with the majority living in California (31%), Texas (18%), New York (8.1%) and Florida (7.6%; (Population Resource Center, 2005; Ramirez & Suarez, 2007). In 2002, Hispanics comprised 13.3% (37.4 million) of the U.S. population, with people of Mexican heritage constituting 66.9% of the U.S. Hispanic population. Of the Hispanic subgroups in the United States, Mexicans have the

largest population under the age of 18 (37%; (U.S. Census Bureau, 2002, 2006).

Furthermore, over one quarter of Hispanic children under the age of 18 live in poverty.

The U.S. Census Bureau projected that by the year 2050, 25% of the total U.S. population will be Hispanic.

Language. Leininger posited that social structure and worldview factors influence care and health through language and environment (Berry, 2002). Martin and Nakayama (2000) rhetorically questioned how much of a person's worldview is shaped by the language he or she speaks. The answer, they claimed, is found in two different positions: nominalist and relativist.

The nominalist position posits that perception is not shaped by the language a person speaks but, rather, is an arbitrary expression of thought. "A tree is an *arbre* in French and an *arbol* in Spanish, but we all perceive the tree in the same way" (Martin & Nakayama, 2000, p. 152). The relativist position claims that the language a person speaks, particularly the structural component, determines his/her thought processes, perception of reality, and cultural patterns. According to the Sapir-Whorf hypotheses (Berthoff, 1988; Sapir, 1949), language determines, enables, and constrains what is perceived and attended to in a culture, as well as the upper limits of knowledge and, most importantly, defines a person's experience. Sapir and Whorf stated that the variation in verb tenses may cause people to think differently in regard to action or movement (Martin & Nakayama, 2000; Sapir, 1949). Locke (1998) posed an interesting point: "Within the dominant culture is how much the culture should tolerate those who do not speak standard English" (p. 10). Hurtado and Rodriguez (1989) stated the following:

Language is perceived by some White Americans as the one mutable feature of culturally diverse groups and therefore the place to demand assimilation . . .

Language is the means by which culture is transmitted (p. 401)

Many variations exist in Spanish dialects among Mexican Americans. The Spanish spoken in colonial times differs from that of immigrants in contemporary times, and regional differences are present as well. Cultural implications such as conflict with the English-speaking American society also affect language patterns (Vigil & Beierle, 2002).

Language serves a vital role in preserving Mexican culture. Mexican Americans adhere to a bilingual style, preferring to speak Spanish at home and in social activities with Mexican American friends and family (Leininger, 2006; Vigil & Beierle, 2002). Leininger (Berry, 2002) maintained that, in order to deliver culturally competent and congruent care, nurses need to speak at least two languages. Zoucha (1998) stated that the Mexican American patient highly values the healthcare provider who attempts to speak his/her language and perceives the attempt as a caring behavior. Spanish is the *de facto* official language of Mexico and Mexican Americans. There is no *de jure* official language at the federal level. However, 97% of Mexicans speak Spanish. Approximately 100 indigenous languages are still spoken in parts of Mexico, such as (a) Zapotec, (b) Mixtec, and (c) Nahuatl (Aztec), to name a few (Wikipedia, 2001).

In today's healthcare arena, the emphasis is on culturally appropriate and linguistic services that support Leininger's work over the past 50 years. The Office of Minority Health (OMH) has developed Cultural Linguistic Appropriate Standards (CLAS) to oversee the delivery of linguistic services, and several of these standards are cross-walked with Joint Commission Accreditation of Healthcare Organizations (JCAHO) standards to enhance compliance and standardize the delivery of culturally competent care (OMH, 2002).

Cultural and Social Structural Dimensions

Religious and philosophical factors. The Roman Catholic Church has greatly influenced Mexican society (Purnell & Paulanka, 2003). However, the Church has not retained much political influence since 1917, when the Constitution severely limited its power by banning religious teaching in schools as well as banning public worship. The Roman Catholic Church was also denied legal status and prohibited from owning property. Government officials often ignored the restrictions; nevertheless, tensions arose between Church and State. The restrictions were lifted in 1992, but Mexico remains a secular state (Wikipedia, 2001).

Leininger (Leininger & McFarland, 2002) stated that, in order to understand the role of religion in the Mexican American culture, one must go back to the Spanish invasion of Mesoamerica and the imposition of the Roman Catholic religion on Aztec society. Catholicism's many saints and rituals can be compared to Aztec worship traditions. The Indians adopted the Catholic beliefs and practices that were meaningful to them into their own worship traditions. These many saints and artifacts are present today in the Mexican and Mexican American cultures. Our Lady of Guadalupe, representing a brown-skinned Virgin Mary, is highly revered in Mexican American society and is a symbol of hope (Leininger & McFarland, 2002; Wolf, 1958).

For Mexicans and Mexican Americans, religious faith supports everyday existence and helps them cope with the trials and tribulations of daily life. Religious artifacts such as candles and pictures of saints are typically found in the home. Reliance on God leads Mexican Americans to be more present-oriented (Berry, 2002).

Additionally, Mexicans and Mexican Americans possess a perspective of external locus of control, believing that whatever happens to them in life is God's will. The present orientation and worldview perspective influence timely care-seeking behaviors, which can have serious healthcare implications (Berry, 1996, 1999, 2002; Burk, Wieser, & Keegan, 1995; Zoucha & Zamarripa, 2003, 2008). Mexicans and Mexican Americans believe that God determines health and illness and that God determines when and if a person gets well.

Within the realm of religion is *curanderismo*, a Mexican folk tradition that involves the use of herbal remedies and prayer to provide healing on (a) emotional, (b) spiritual, and (c) physical levels (Ramirez & Suarez, 2007). Therefore, it is imperative that nurses caring for this population conduct a cultural assessment to formulate a care plan to deliver culturally congruent and appropriate care based on worldview beliefs and practices.

Educational and technological factors. According to Rothman, Gant, and Hnat (1985), the social structure factor of education is influenced in the Mexican American culture by language, which, in turn, influences both professional and generic healthcare” (as cited in Berry, 2002, p. 208). Many Mexican Americans come to the United States with limited education, while second and third generation Mexican Americans have significant education and job skills (Berry, 2002; Purnell & Paulanka, 2003; Zoucha & Zamarripa, 2003). Mexican American immigrants from rural areas with little educational background may not see education as a priority because it is not needed in order to obtain work in Mexico (Zoucha & Zamarripa, 2003). Since 1992, the Mexican Reform Act has required education through the ninth grade. However, the poor in rural areas believe in

teaching children only what is important for them to know. For many Mexicans, high school and college educations are not available, and immigration to the United States is their only hope for a better life (Zoucha & Zamarripa, 2003, 2008).

The United States, with its scientific biomedical worldview, places high value on technology in all aspects of life, including healthcare. However, for Mexican Americans, this is not the case. Sophisticated technology in daily life and/or healthcare is normally not available and, as a result, is not easily understood, requiring more patient and detailed explanations of its use to the Mexican American client by healthcare providers (Berry, 2002).

Economic, political, and legal factors. Ranches and farmlands are still owned by Mexican Americans who trace their roots to the early centuries. Upon immigration to the United States, many Mexican Americans gravitate to the same kind of work that they did at home, such as (a) migrant farm work, (b) landscaping, (c) construction, and, for women, (d) domestic work. However, Mexican Americans have increasingly moved into skilled and professional positions and into business enterprises, although they lag behind Anglo Americans in these positions of higher social status because of the education issue discussed in the previous section. Today, Mexican Americans constitute the largest segment of the United States' agricultural work force. Mexican Americans were also the major factor in union efforts to improve working conditions for farm workers nationwide in the twentieth century (Vigil & Beierle, 2002).

Mexican Americans living in the United States have become more educated and more independent from their families. Two-income households are now common. Traditional gender roles in the Mexican American culture are beginning to change as

more acculturated men and women accept these changes. Women are breaking away from the Mexican culture that defines women's role as housework. However, many Mexican Americans continue to work at low-paying jobs, requiring both husband and wife to work (Vigil & Beierle, 2002).

Most importantly, however, is that while Mexican Americans still rely on modern shopping malls, *barrio* shops and stores existing today cater to the cultural and social mores of the population. These barrios serve as cultural, social, and political meeting grounds. Small, family-operated stores called *tienditas* serve immediate needs in the neighborhood. The concept of the outdoor market, called *tianguis*, has moved products out into the streets of Mexican American neighborhoods. The establishment of the North American Free Trade Agreement (NAFTA) in 1994 between Mexico and the United States initiated an increasing number of Mexican American entrepreneurs (Vigil & Beierle, 2002).

Since the Roosevelt New Deal era, Mexican Americans have generally affiliated with the Democratic Party. However, with Mexican American social mobility has come more support for conservative causes, and many Mexican Americans have been won over by the Republican Party due to its focus on abortion and family values. However, many Mexican Americans avoid political activities, fearing consequences related to their documented or undocumented status in the United States. Mexican Americans are still noticeably underrepresented in local, state, and federal government offices, although a few Mexican American legislators and other political leaders were elected in the late twentieth century (Vigil & Beierle, 2002).

In terms of healthcare, Berry (2002) stated that economic, political, and legal

factors all affect the social structure but particularly impact its family and healthcare dimensions. Mexican Americans are typically employed in low-paying jobs with little or no healthcare benefits. Undocumented Mexican Americans fare even worse (Berry, 2002; Vigil & Beierle, 2002). Interestingly, in spite of their poverty level, few Mexican Americans participate in welfare programs or free healthcare clinics. Leininger (2002, 2006) and other researchers have posited that this may be due to (a) the concept of succorance (i.e., the act of care and social support), (b) family support, and (c) their strong work ethic (Berry, 2002; Callister & Birkhead, 2002; Warda, 2000).

Kinship and social factors. Kinship practices emphasize family and extended family networks, with the patriarchal family dominance pattern in traditional Mexican American households (Berry, 2002; Vigil & Beierle, 2002; Zoucha & Zamarripa, 2003). Despite the influence of generational change (Berry, 2002; Purnell & Paulanka, 2003; Zoucha & Zamarripa, 2003), traditional beliefs and customs have persisted. Collectivism and family concerns supersede individualism. *Compadrazgo*, the concept of co-parenthood, stems from Catholicism and is practiced in baptism, where the godmother and godfather roles are present. *Machismo*, or male dominance, is a role of protection and care for one's home and family but often has a negative impact on male-female relationships (Berry, 2002; Vigil & Beierle, 2002; Zoucha & Zamarripa, 2003, 2008). Males are perceived to have strength, wisdom, bravery, and knowledge about sexual matters (Zoucha & Zamarripa, 2003, 2008). Childbearing Mexican American women may be at risk for sexually transmitted infections, such as human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), because of (a) male dominance, (b) possible sexual promiscuity in Mexican American men, and (c) female

meekness (Callister & Birkhead, 2002). The social hierarchy of the eldest male and female is present, and the sense of obligation, or filial piety, that one owes to the elders remains (Vigil & Beierle, 2002). Often, the grandparents may take over the care of grandchildren to help the parents (Callister & Birkhead, 2002; Vigil & Beierle, 2002).

Marriage follows traditional customs. Romantic love is now more common with Mexican Americans, but choices still are carefully scrutinized by the elders. Patriarchy is the foundation of the family unit, combined with Marian Catholic ideology which places women in an exalted position. However, these beliefs are changing through acculturation to the American lifeway. The values stressed in the Mexican American culture are (a) personal honor, (b) respect for the elderly, and (c) proper courtship protocol (Vigil & Beierle, 2002).

In terms of healthcare, Mexican Americans adhere to the “family-care concept” (Callister & Birkhead, 2002; Zoucha & Zamarripa, 2003), which includes the entire family in healthcare decisions. The concept of *familism* is the foundation of this culture in which the family takes precedence over all aspects of life, including work. By including the family in healthcare decisions, rapport, trust, and confidence can be created to increase adherence to a healthcare plan (Zoucha, 1998; Zoucha & Husted, 2000).

Cultural values, beliefs, and lifeways. Leininger, through her ethn nursing research and that of others (Berry, 1996, 2002; Leininger, 2006; Martinez-Schallmoser, 1992; Martinez-Schallmoser et al., 2003; Zoucha, 1998), compiled a list of care constructs that Mexican Americans value and prioritize (see Table 1). Leininger (2002) stated that her main purpose in creating this list of constructs was to illuminate the great diversity of care meanings and values in various cultures in order to increase

understanding about human care and caring.

Table 1

Care Constructs

Dominant Culture Values	Culture Care Meanings and Action Modes
Extended family as support system	Involve family for support (other care); succorance
Religion-primarily Roman Catholic	Acceptance of God's will; spiritual healing
Reliance on folk traditions, especially food and remedies	Healing with foods; native foods for well-being
Belief in hot-cold theory	Maintaining balance and harmony
Patriarchy (male decision maker)	Filial love
High respect for authority and elderly	Mother makes home care decisions
Traditional folk-care healers for folk illnesses	Use of folk remedies, foods, and rituals
Exact time less valued	Present-oriented
Interdependence with kin and social activities	Involvement with extended family (other care)

Adapted from *Culture Care Diversity and Universality: A Worldwide Nursing Theory* (2nd ed.), by M. Leininger, 2006 (Boston, MA: Jones and Bartlett), p. 109.

Purnell (2003) and other researchers (Berry, 1996, 2002; Callister & Birkhead, 2002; Martinez-Schallmoser, 1992; Martinez-Schallmoser et al., 2003; Purnell & Paulanka, 2003; Zoucha & Zamarripa, 2008) supported the care constructs as described by Leininger (Berry, 2002). These authors confirmed that the family is seen as the most important source of health information and, at the same time, presents the most significant barrier to more positive health-seeking behaviors due to Mexican Americans' worldview and the fact that health behaviors are closely tied to their perspective of an external locus of control. Pain and suffering are perceived to be a necessary part of life to be endured: they are part of God's will (Berry, 1996, 1999, 2002; Burk et al., 1995;

Martinez-Schallmoser, 1992; Martinez-Schallmoser et al., 2003; Zoucha & Zamarripa, 2003, 2008). Health for Mexicans and Mexican Americans is the ability to work, take care of the family, and feel well (Zoucha, 1998). Therefore, health treatment is not sought until very late, often when a person can no longer work.

The value of *familismo* is expressed through loyalty, reciprocity, and solidarity among family members, and these factors emphasize community connectedness. Within the domain of community, interpersonal relationships are reconciled through the concept of *simpatia* (Marin & Marin, 1991; Zoucha, 1999; Zoucha & Zamarripa, 2003, 2008). *Simpatia* is exemplified by a spirit of cooperation and an emphasis on social harmony. Avoidance of conflict is most important. Related to *simpatia* is the concept of *respeto*, which governs interpersonal relationships and behaviors. Respectful behaviors are governed by (a) age, (b) sex, (c) social position, (d) economic status, and (e) degree of authority (U. S. Department of Health and Human Services, 1988).

It is important that nurses and healthcare providers not only understand the impact of worldview on health behaviors and plan care that is consistent with this belief but also understand other beliefs and values that impact healthcare delivery. Cultural beliefs incorporated into the plan of care have been found to enhance compliance among Mexican Americans (Caudle, 1993; Warda, 2000). It is important for healthcare practitioners to determine Mexican Americans' perception of an illness' cause and the home remedies and treatments that have been used (Kleinman, 1980). Caudle (1993) stated, and Kleinman (1980) concurred, that if the explanatory model of illness is not addressed, the Mexican American client will not be satisfied and will be less likely to comply with the medical regimen. Mexican Americans value personal conversation to

determine their explanatory model of illness and perceive this as *simpatia* and *personalismo*, reflecting the cultural need for smooth, positive interpersonal relations (Caudle, 1993; Warda, 2000; Zoucha, 1998; Zoucha & Zamarripa, 2003, 2008). Mexican Americans' role expectations of healthcare staff are based on (a) sex, (b) age, (c) educational preparation, and (d) ethnic and racial identity (Mardiros, 1984).

Mexican American Women: A Past Unveiled

Acculturation and adaptation to Anglo lifeways have had a profound influence on the beliefs, values, and attitudes of Mexican American women today (Ramirez & Suarez, 2007). Leininger (2002) stated that more diversity exists within a culture than across cultures, and so it is with the Mexican American culture. In spite of the diversity within the culture, there are common unifying themes of values and traditions. In order to understand the Mexican American woman, one must once again turn to history.

The history of Mexican American women began with the migration from Asia to the Americas around 40,000 BC (Ramirez & Suarez, 2007; Vigil & Beierle, 2002). "The Aztec, or *Mexica*, was an advanced civilization with egalitarian attitudes toward women" (Ramirez & Suarez, 2007, p.1). Women were held in high regard in the Aztec culture. They were educated, participated in religious ceremonies, contributed to economic production, and experienced the same legal status as males with regard to marriage, divorce, and property rights (Ramirez & Suarez, 2007). Historically and to the present, Mexican women's roles as wife and mother were considered important for the well-being of society. History reveals that pregnancy and childbirth were associated with social and religious ceremonies of great importance in which the priestess/midwife, or *partera*, conducted official rites (Cotera, 1976; Garcia, 1997). In summary, *Mexica* women's lives

were ones of high status, egalitarian laws, and participation across the social spectrum (Ramirez & Suarez, 2007).

The Spanish Colonial period from 1521 to 1821 brought the downfall of the *Mexica* civilization when Herman Cortes razed Tenochtitlan in 1521. It was at this time that *Mexica* women lost their high societal status. History reveals that the destruction of the *Mexica* society caused a disruption in the social structure, religion, and educational system that was characterized by abuse, humiliation, and slavery after Cortes' invasion (Cotera, 1976; Garcia, 1997). It was during this colonial period that women were excluded from participating in all social events. Their role was to serve in the home as housekeepers, wives, and mothers. The expectation for colonial women of all social classes was to marry and bear and raise children (Garcia, 1997; Mirande & Enriquez, 1979). This period of time did not contribute to the development of women, regardless of social position. Convent life, therefore, became a viable alternative for women who did not want to marry but wanted an education (Cotera, 1976; Garcia, 1997; Mirande & Enriquez, 1979). However, convent life was restricted to the aristocratic social class, and the exclusion of women from other social classes enforced the oppressive class structure now present (Garcia, 1997; Mirande & Enriquez, 1979).

In secular life, women no longer held important religious roles. However, the *Mexica* incorporated their Aztec beliefs and practices into Catholicism. The Mexican goddess *Teteo Innen*, or Earth Mother, was analogous to the Virgin Mary, and she became known as *La Virgen Guadalupe* (The Virgin of Guadalupe; (Ramirez & Suarez, 2007). As a result, by the 17th century, Mexican Indians had formed a new version of Catholicism that blended (a) pre-Hispanic religion, (b) European Catholicism, and (c)

symbolisms of colonial society (Ingham, 1986). This blending was the foundation of *curanderismo*, Mexican folk healing (Trotter & Chavira, 1981).

During the Spanish colonization of the Southwestern United States that began in the 1600s and extended to the 1800s, permanent settlements were located in Texas and California. Due to harsh frontier life, strict gender roles regarding the division of labor were not possible, and women gained higher status and more freedom (Blea, 1992; Cotera, 1976). Not only did women work at farming chores, herding livestock, and household duties, but many women also assumed the role of midwife and performed general medical care (Blea, 1992). However, intermarriage changed the racial background from Indian to *mestizo*, which brought permanent changes to the cultural aspects of religion, language, and society. The strict caste system remained intact, with the *mestizo* and Indian farming the land. These conditions were the impetus for the revolution to gain independence from Spain (Ramirez & Suarez, 2007).

The period of *Porfirismo*, when the liberal Porfirio Diaz was in office from 1877 to 1911, created a time of political stability and a time of great activity for women. Women had more social presence, became more aware of social and gender issues, and participated in social movements. This feminist period stressed respect for women and a recognition of their inherent qualities. This feminist society caused an awareness of women's issues, albeit at an extremely slow pace, and teachers were the protagonists for the changes in women's issues (Pablos, 1999).

Mexican American Women in Contemporary Times

As of 1990, Mexican American women reportedly had a high school graduation rate of approximately 50%, compared to a rate of 81% among non-Hispanic White

females. Mexican American females had a median of 10.6 years of completed schooling, compared to other groups with at least 12 years. Only 6% of Mexican American women have a bachelor's degree, compared with 22% of the total population. Educational levels affect income, and almost 50% of Mexican American females live below the poverty level. Among Mexican American women, 51% make up the labor force. Noteworthy, however, is that there are extremely low numbers of Mexican Americans in healthcare professions, suggesting that educational barriers prevent access to high-level professions (Ramirez & Suarez, 2007).

This disparity in education and income also exists in access to healthcare for Mexican American women. They underutilize healthcare services compared to non-Hispanic Whites, and more importantly, they are the least likely to have a regular healthcare provider or regular source of healthcare (Callister & Birkhead, 2002; Ramirez & Suarez, 2007). These facts reveal serious issues concerning healthcare access for Mexican American women. Cultural and social factors also contribute to this group's limited access to healthcare.

Mexican American Women's' Perceptions of Health and Well-Being

Well-being. Since its beginning, the nursing profession has attempted to define and understand *health* (Mendelson, 2002; Nightingale, 1969). Meleis (1990) conceptually defined *health* as (a) a state, (b) a process of development, (c) an actualization, (d) an outcome, and (e) a lifestyle. Leininger (2005) stated,

Health was discovered as an often restorative attribute and defined as . . . a state of well-being that is culturally defined and constituted. Health is a state of being to help individuals or groups to perform their daily role activities in a culturally expressed patterned lifeway. (pp. 10-11)

Health status is biomedically defined. It is more concrete than the concept of *health perception*, is shaped by personal experiences and expectations, and often is not consciously recognized (Mendelson, 2002). Mendelson stated that it is imperative that the operational definitions of *health* elicit cultural understandings and contextualize cultural dimensions of lifeways in order to fully define the concept. The most commonly quoted definition of *health* was formalized by the World Health Organization (WHO, 2007) and defined *health* not just as an absence of disease or illness but as a condition of total physical, mental, and social well-being.

Societal changes in the United States have greatly influenced women's roles, both within the home and in the workforce. However, for Mexican American women, their role in the household has remained the same. Mexican American women have been described as "keepers of the culture and carriers of collective healing experiences" (Bushy, 1991, p. 148; Mendelson, 2003). The focus for Mexican American women is (a) providing a healthy environment and good food, (b) monitoring hygiene practices, (c) diagnosing and treating minor illnesses, and (d) deciding when to seek lay and professional healthcare (Mendelson, 2003). "Within this web of domestic and care giving roles lie responsibilities and obligations of household health" (Mendelson, 2003, pp. 147-148). Their health beliefs and practices rely on cultural explanations of illness (e.g., hot-cold theory) and traditional healers to treat cultural illnesses (Mendelson, 2003).

The worldview of Mexican American women regarding health and well-being is an integrative one that includes (a) environment, (b) physical health, and (c) mental well-being. Health is perceived as non-corporeal and transcends the physical plane, while illness is perceived as a physical breakdown, resulting in the loss of the ability to fulfill

traditional roles (Mendelson, 2002). Mexican American women contextualize health into all aspects of their lives, with responsibility for not only facilitating and maintaining physical health but also creating an environment for their families that allows opportunities for social and mental development (Mendelson-Klauss, 2000). The family is a source of emotional support for Mexican American women and is thought to protect against mental illness (Callister & Birkhead, 2002; Niska, 1999).

Divine will and health. Religion and the acceptance of God's will, a perspective that is an intrinsic part of the Mexican American social structure, are embedded in daily life and sustain Mexican Americans during trials and tribulations. Mothers are concerned for the safety of their children and rely on God for protection (Berry, 2002; Mendelson-Klauss, 2000; Zoucha & Zamarripa, 2003, 2008). Incorporating this spiritual context into one's total health is congruent with the Mexican view of health. Mexican American women believe health is more than freedom from illness and includes the (a) physical, (b) social, (c) emotional, and (d) spiritual integration of their family (Callister & Birkhead, 2002; Lopez, 2005). Prayer is part of the daily routine for Mexican American women and offers a stabilizing source of emotional support. Prayer is also a manifestation of Mexican American women's faith and spirituality (Berry, 1996; Mendelson-Klauss, 2000; Mendelson, 2002; Rojas, 1991). Prayer serves as a conduit through which to give thanks, develop strength, and make decisions, without which emotional balance and harmony could not be maintained (Mendelson, 2002).

Curanderismo. Mexican American beliefs regarding disease and healing are a syncretism of Aztec and Spanish beliefs. Disease results from either supernatural or natural causes, as mind and body are one (Berry, 1996). These beliefs are expressed in

curanderismo, “a synergetic, eclectic, and holistic . . . mixture of beliefs derived from Aztec, Spanish, spiritualistic, homeopathic, and modern ‘scientific’ medicine” (Rojas, 1991, pp. 2-3). Focusing on the patient rather than the disease means helping patients resolve their problems; often, solutions are found on the spiritual level. It is impossible to fully know the person if one disregards his/her deepest reality: that of the spiritual being (Rojas, 1991). The spirit expresses itself through the mind and the body but “is neither the mind nor the body” (Rojas, 1991, pp. 2-3).

In the belief system of *curanderismo*, the mind, body, and spirit are inseparable. Therefore, a major perspective of the Mexican American worldview is that balance and harmony are essential to health and well-being, and any disruption in this balance and harmony may produce illness (Rojas, 1991). Mexican American families today perceive *curanderismo* as both biological and social events, either microbial or supernatural. The combination of the biomedical paradigm with the personal, spiritual paradigm serves to explain the unexplainable in illness (Lopez, 2005).

Folk systems and healers used today. Three central aspects of folk medicine include (a) the role of family and folk healers in diagnosing and treating illness; (b) the connection between religion, illness, and the use of ritual religious healing practices; and (c) the universality of health beliefs, symptoms, and rituals of healing practices among Latino communities (Mendelson, 2003). The folk systems used today by Mexican Americans and other Latino groups incorporate folk and religious modalities in an accessible and affordable secondary healthcare system (Lopez, 2005).

The *curandero(a)* is recognized as a folk healer with the ability to diagnose and treat illnesses in the physical, psychological, and spiritual realms. Faith healers or

espiritistas/espiritualistas have no medical expertise but attempt to heal the soul by conducting séances or reading cards. *Yerberos* or herbalists maintain *botanicas* where natural herbal remedies and religious amulets are available, as well as offer consultation and advice. The *sobadores/sobadoras* deal exclusively with physical problems and use therapeutic massage techniques. *Parteras*, lay midwives, are also part of the folk system (Lopez, 2005).

Mexican American women's worldview strongly influences health-seeking behaviors. The family, a source of information and advice, also presents the greatest obstacle to positive health-seeking behaviors (Zoucha & Zamarripa, 2003, 2008). Intergenerationally, Mexican American women have achieved harmony by participating in interrelated health practices that have been drawn from folk and/or professional healthcare sectors. These healthcare behaviors directed at maintaining wellness consist of (a) lay self-care, (b) good nutrition, (c) physical activity, (d) a positive outlook, (e) relaxation, (f) prayer, (g) balance of energy, and (h) adherence to cultural herbal and non-herbal traditions (Sanchez, 1997). These behaviors and beliefs align with Kleinman's (1980) descriptions of the cultural lay health arena that symbolizes the rich reserve of trusted self-care practices that are used to maintain or restore harmony (Sanchez, 1997).

Although the reliance on traditional healers in acculturated Hispanic women is decreasing, the use of self-care and home-based remedies persists. Data from the Hispanic Health and Nutrition Survey (HHANES) confirmed decreasing reliance on traditional healers (Mendelson, 2003). The persistence of traditional folk systems (see Table 2) points to the need for (a) low cost care, (b) cultural preservation/maintenance,

and (c) cultural empathy in care, which is often missing in the Western biomedical healthcare system (Berry, 2002; Lopez, 2005).

Table 2

Folk Healers

Cultural Affiliation	Hispanic Term	English Term	Associated Belief
Puerto Rican (PR) and Mexican American (MA)	<i>Curandera</i>	Folk Healer Spiritualist	Chosen by God and highly respected; cures or breaks hexes, illnesses, and ailments.
PR and MA	<i>Yerbero</i>	Herbalist	An expert in herbal medicine; intervenes to help cure ailments of natural or supernatural origin.
PR	<i>Santera</i>	Sainterist	Prescribes prayers, teas, and herbal mixtures.
PR and MA	<i>Espiritista</i>	Psychic	Has divine power to analyze dreams, foresee the future, and explain the present situation related to hidden experiences or in another life.
PR and MA	<i>Brujeria</i> <i>Bruja</i>	Witchcraft	Has supernatural power to place hexes and curses and cause bad luck or despair; believed to be capable of “healing” through potions, verses, and magic.
PR	Intermediator	Medium	Has supernatural power to serve as a spiritual receiver or channel communication from the dead, similar to someone who conducts a séance.
MA	Intermediator	Medium	Treats emotional problems and physical illness by transporting the spiritual self of the victim; treats the spirit, body, and mind; prescribes teas, medicinal baths, and prayers.

Adapted from “Cultural Beliefs and Healthcare Practices of Childbearing Puerto Rican Women and Mexican American women: A Review of the Literature,” by M. R. DePacheco & M. H. Hutti, 1998, *Mother Baby Journal*, 3(1), p. 16-17.

It is noteworthy that the literature revealed that many health practices and beliefs among Mexican American women align with mainstream non-ethnic groups, indicating that nurses must be careful of stereotypical preconceptions of Mexican American women.

Folk beliefs and illnesses. Mexican American folk beliefs associate specific folk illnesses with specific imbalances, either natural or supernatural, or social distress. For example, exposure of a pregnant woman to an eclipse will cause her baby to have cleft palate or lip. This folk belief originated with the Aztecs who believed that an eclipse meant a bite had been taken out of the moon. Therefore, if a pregnant woman views the eclipse, a bite would be taken out of the baby’s lip or mouth (Burk et al., 1995). Table 3 lists other examples of folk beliefs and illnesses found in Mexican American culture.

Table 3

Culture Bound Illnesses

Spanish Term	English Term	Illness
<i>Empacho</i>	Blocked Intestine	Occurs when a bolus of food sticks to the wall of the intestine and may result from eating improperly cooked foods or eating certain foods at inappropriate times.
<i>Susto</i>	Fright Sickness	Results from an emotionally traumatic event, such as an accident, a death, or any real or imaginary fright.
<i>Antojos</i>	Cravings	The belief that an infant may have characteristics of the item that the mother craves during the pregnancy if the craving is not satisfied.
<i>Cuarentena</i>	40 Days	The period following the birth of the child (postpartum) during which certain dietary and activity restrictions are observed to allow the mother time to recover from the pregnancy and birth and to bond with the baby. This is a protective ritual designed to prevent certain illnesses from occurring later in life, like uterine problems and arthritis.

Mexican American Women: A Synthesis of the Literature

Cultural prenatal health behaviors, beliefs, and practices. The review of the literature revealed current research that focused on several areas relating to Mexican American women: (a) cultural prenatal health behaviors, beliefs, and practices; (b) childbirth practices and *matresence*; (c) the Latina paradox; (d) the role of acculturation and social support; (e) cultural aspects of postpartum depression; and (f) cultural rituals and traditional practices as protective factors.

Birth rates. Birth rates in the Mexican American population are unusually high (Kay, 1980) due to sustained high fertility rates (Child Trends Data Bank, 2005). Three interpretations have been traditionally presented in the literature to account for the higher birth rates in this population: (a) religion, (b) socioeconomic class, and (d) culture. The first factor, religion, refers to the fact that the majority of Mexican Americans self-identify as Roman Catholics. The Roman Catholic Church has traditionally been opposed to contraceptive methods, other than the rhythm method, and has favored large families (Kay, 1980).

The second factor, socioeconomic status, suggests that the low income and educational levels of Mexican Americans make birth control difficult for them. However, this finding is not consistent in the literature. Kay (1980) stated that both Mexican American and Black families share similar economic issues, yet Mexican Americans consistently have larger families, negating the premise that socioeconomic status influences birth rates.

The third factor, culture, offers a predominant explanation in the literature. However, this finding is also inconsistent. Mexican American values and worldview are

significantly different from those of Anglos and Blacks. The concept of *familism* suggests that Mexican American women value the maternal role and large numbers of children and prefer to remain in the home, fulfilling their traditional roles. This perspective suggests that the best predictor of birth rate is whether Mexican American women work outside the home (Kay, 1980). Another overarching cultural theme in keeping with traditional Mexican worldview is that of *machismo*, indicating the larger the family, the more virile the male (Bushy, 1991; Mendelson, 2003).

Pregnancy. Pregnancy is a happy time for Mexican American women and is considered a time of wellness and health, not a time of illness or disease state, as it is viewed among other cultural groups in the United States. Often, prenatal care, while valued, is not sought until late in the pregnancy for this reason. Mexican American women often seek family advice before seeking medical care; thus, the concept of *familism* may delay prenatal checkups (Zoucha & Zamarripa, 2003, 2008).

Purnell and Paulanka (1998) stated that more acculturated Latino couples choose to attend prenatal classes, contrary to Gallo's (2003) phenomenological study ($N = 12$), which reported that the majority of Latina women did not attend prenatal classes. Lack of transportation, limited financial resources, and the belief they did not need additional information were the primary reasons for not seeking prenatal education. Berry's (1996) qualitative ethnonursing study ($N = 40$) confirmed the same barriers for not accessing prenatal care.

Historically and to the present, many folk beliefs and practices surround pregnancy in Mexican American culture (Berry, 1996; DePacheco & Hutti, 1998; Kay, 1980; Zoucha, 1998), and these beliefs are handed down intergenerationally through the

elder women in the family. Mexican American women, depending on degree of acculturation, may not adhere to these beliefs and practices. For example, cool air and night are to be avoided in adherence with the hot-cold theory. Foods eaten during pregnancy also must adhere to the hot-cold theory (Zoucha & Zamarripa, 2003, 2008). The mind and body are thought to be one and must be kept in balance, which is also evident in the adherence to the hot-cold theory (Berry, 2002; Zoucha, 1998). Cravings must be satisfied or the infant may have physical markings on his/her body, indicating what food was craved. Pica, eating ashes or dirt, is found in women of lower socioeconomic status but is not common. Milk is to be avoided as it is thought to make the baby too large and lead to a difficult delivery conditions in pregnancy, such as (a) nausea, (b) vomiting, (c) heartburn, and (d) constipation, which are treated with herbal drinks. Mexican American women believe in vitamin and iron preparations to strengthen the blood and prefer to take them as supplements rather than consume an herbal drink (Kay, 1980).

Mexican American women also believe in activity and work during pregnancy and continue with all but the heaviest activities. They believe in prenatal massage, performed by a midwife or elder female, to ensure the fetus is in a favorable position for delivery. Frequent sexual intercourse is encouraged to lubricate the vaginal canal to facilitate an easy delivery. Activities to be avoided are hanging laundry or reaching high, which are believed to cause a knot in the umbilical cord (Zoucha & Zamarripa, 2003, 2008). Baby showers are not planned until delivery is near. Celebrating early is thought to cause bad luck and the evil eye. Historically, the baby shower is a female solidarity event and is very festive.

The mind-body connection is very strong in Mexican American culture, and during pregnancy, serenity is encouraged through thinking pleasant thoughts. Moonlight is thought to be dangerous, night is to be avoided, and a moon in the eclipse phase is dangerous (Zoucha & Zamarripa, 2003, 2008). Slight anxiety is soothed by an herbal drink of *azahar*, or orange blossom tea, an old world remedy of Arab Spanish physicians. One of the beliefs in this culture is that pregnant women are prone to great anger, or *coraje*, which can cause serious complications such as abortion and premature labor (Kay, 1980). Mexican American women are very modest, and the pelvic exam is very disturbing for them. Most cultures prohibit men from viewing intimate female body parts. Gender-congruent care is conducted by the midwife, who may conduct pelvic exams without violating cultural taboos (Galanti, 2004; Zoucha, 1998).

The core values of religion, family, and the power of God are well documented in the literature (Berry, 2002; DePacheco & Hutti, 1998; Kay, 1980; Kruckman & Smith, 2002; Lopez, 2005; Martinez-Schallmoser, 1992; Martinez-Schallmoser et al., 2003; Purnell & Paulanka, 2003; Zoucha, 1998; Zoucha & Zamarripa, 2003, 2008). Mexican Americans view the mind and body as inseparable and view themselves as being in harmony with man and nature. Maintaining balance and harmony is deeply rooted in the hot-cold theory of health and illness (DePacheco & Hutti, 1998; Zoucha & Zamarripa, 2003, 2008). Folk remedies and other medical information are handed down intergenerationally. Herbal remedies and teas are commonly used for a variety of conditions. When these treatments fail, alternative healers are sought, such as a *curandera*. However, DePacheco and Hutti (1998) found in a review of the literature that *curanderismo* is not a core value and that the only prevailing traditional healthcare

practice was the use of as midwife or *partera*. In contrast, a study by Saunders (1954) conducted in Mexico revealed that *curanderismo* is a well-established medical tradition.

Sherraden and Barrera (1997) concluded that birth outcomes provide a powerful statement about social and economic well-being: “No cold statistic expresses more eloquently the difference between a society of sufficiency and a society of deprivation than the infant mortality rate” (p. 608). This study analyzed the birth experiences of 41 Mexican immigrants who had either delivered normal or low birth weight babies and revealed that the family played a critical mediating role in providing support and protection to these women (Sherraden & Barrera, 1997). Socioeconomic factors were determinants in families’ abilities to provide support.

Burk et al. (1995) confirmed in their qualitative study of pregnant Mexican American women living in the Rio Grande area of southern Texas the importance of *familism* in Mexican American culture by using Giger and Davidhizer’s transcultural nursing model to explore this culture (no sample size was given). These authors discovered that no other ethnic group has been as persistent in maintaining its beliefs, practices, language, and lifeways as Mexican Americans. Core values such as *respeto* (respect) and *personalismo* (personal relationship) are features of Mexican American communication patterns. Zoucha (Zoucha, 1998, 1999) confirmed the presence of these core values in his studies. Johnson’s (2005) qualitative ethnonursing dissertation ($N = 36$) included a discussion of birth outcomes, family planning, conception, and abortion but did not discuss pregnancy, childbirth, and the postpartum period in this population.

Berry’s (1996) dissertation used Leininger’s ethnonursing method to explore the culture care expressions, meanings, and experiences of pregnant Mexican American

women ($N = 33$). This was the only study to specifically examine pregnant Mexican American women's culture care expressions, meanings, and experiences, the caveat being that the postpartum period was not included in the study. Instead, it focused solely on the antenatal period. Berry postulated that due to the strong Mexican cultural orientation, improved prenatal outcomes are present, supporting the Latina epidemiological paradox (McGlade, Somnath, & Dahlstrom, 2004). This paradox is due, in part, to strong extended family support and the preservation of traditional beliefs that influence pregnancy outcomes (Berry, 1996).

Childbirth practices and matresence. Until the 1950s, most Mexican American women preferred to deliver at home, attended by the lay midwife or *partera* (Kay, 1980). The midwife directed the birth process, including the preparation of the home and supplies. From the eighth month of pregnancy and during early labor, the mother was encouraged to drink chamomile tea to assure effective contractions. To attend a woman during delivery is a woman's role, specifically and ideally the role of the midwife and the woman's mother (Galanti, 2004). Cultural tradition dictates that a husband not see his wife or child until delivery is over and both have been cleaned and dressed (Galanti, 2004; Kay, 1980; Zoucha & Zamarripa, 2003, 2008). "For many, the presence of men during delivery is considered an uninvited intrusion into the Mexican culture" (Zoucha & Zamarripa, 2003, p. 272; 2008). During labor and delivery, expressions of pain range from stoic to free verbalization (Zoucha & Zamarripa, 2003, 2008).

Childbearing practices changed abruptly when Mexican American women began to deliver in hospitals during World War II, when wives of servicemen were eligible for hospital birth (Kay, 1980). There was an acute alienation from the traditional protective

practices that were part of young Mexican American women's history of cultural tradition. There was no need for her mother's knowledge and support in this biomedical environment dominated by a male physician and technology. The alienation from traditional knowledge and support persons led young Mexican American women to panic, to be verbally expressive (Zoucha & Zamarripa, 2003, 2008), and to be labeled as difficult (Kay, 1980).

Mexican American women delivering in hospital settings today are concerned with competency in healthcare professionals, regardless of gender and cultural orientation (DePacheco & Hutti, 1998). Kay (1980) determined that childbirth practices and beliefs are directly correlated with degree of acculturation. New immigrants opt for hospital births because of the care they believe they will obtain. Depending on the degree of acculturation of the husband, he may or may not be present during labor and delivery (Zoucha & Zamarripa, 2003, 2008). "Health-care providers must respect Mexicans decision to not have men in the delivery room" (Zoucha & Zamarripa, 2003, p. 272). With a focus now on family-centered care, gender-congruent supportive care by mothers, sisters, other female relatives, or friends continues today in the labor and delivery setting. Gender-congruent support from female relatives during the childbirth period is still important for Mexican American women (Galanti, 2004).

Gallo's (2003) dissertation focused on understanding the lived birth experience from a cultural context. In this phenomenological study, Mexican born participants ($N = 12$) were asked to describe their birth experiences, the meaning of the experiences to them, and the meaning of giving birth in the United States. The findings from Gallo's study revealed that Mexican American women were strongly influenced by generic

beliefs that were embedded in their culture, and they made decisions according to these beliefs. However, these women would set aside those beliefs if they believed the choice would result in better outcomes for their babies. “The primary focus was placed on the actual event of childbirth, which was defined as the woman’s labor and birth process” (Gallo, 2003, p. 42). The postpartum period was not discussed, except for a brief mention of *La Cuarentena*.

Motherhood in Mexican American culture is considered the fulfillment of the ultimate role of womanhood. Motherhood establishes a degree of status and respect that is unrivaled in any other role, male or female. However, the power of motherhood extends only to her children; it is not a source of power outside of her household. Mexican American culture reflects the same value regarding motherhood, but it has been altered by Anglo American culture and societal values, including economic productivity. While Mexican American mothers are expected to be mothers first, they are also expected to contribute to the economic well-being of their family. In addition, in assuming the mother role, the Mexican American woman is expected to forge new relationships congruent with this rite of passage (Kay, 1980). “Education level and degree of acculturation are key issues when developing health education and interventions for risk reduction” (Zoucha & Zamarripa, 2003, p. 272).

The role of acculturation and social support. Acculturation and loss of protective factors were thought to influence Mexican American prenatal health-seeking behaviors, as well as Mexican American women’s worldview regarding pregnancy, prenatal care, and the postpartum period (Kruckman & Smith, 2002; Posmontier & Horowitz, 2004; Stern & Kruckman, 1983). Balcazar, Peterson, and Krull (1997) described in a

quantitative study ($N = 500$) a classification system based on acculturation status and family cohesiveness and examined the degree to which these variables determined the degree of exposure to acculturation stress, social isolation, and health-related high risk behaviors in pregnant Mexican American women. Epidemiologists addressed the concept of cultural protective mechanisms in pregnant Mexican American women, indicating that these protective factors shelter pregnant women from adverse health issues. Balcazar et al. (1997) examined this cultural orientation hypothesis using indicators of acculturation segmenting Mexican American women into a more meaningful subgroup

Typically, women are classified as either high acculturated or low acculturated. Results revealed that the low acculturated Mexican American female represents a more traditional cultural orientation: high family cohesiveness and strong ties to the extended family network. However, recent immigration status may indicate that social support networks are not present because friends and relatives are often left behind and the women have not reestablished social networks in the United States. More importantly, these women may not have information about how to access and navigate the healthcare system in the United States. The implication would be that acculturation stress develops. Lack of coping strategies for dealing with this stress have not been fully developed and are compounded by (a) economic factors, (b) lower English proficiency, (c) lower literacy rates, and (d) residency issues. According to the researchers, these issues are thought to lead to postpartum depressive symptomology (Balcazar et al., 1997).

On the other hand, the high-acculturated Mexican American woman has developed family-oriented strategies and social networks that provide support. These women are less traditional and share many of the values of the dominant U.S. culture.

Most importantly, these women have developed a sufficient acculturation experience that has enabled them to develop effective coping strategies. Financial and residential stability are more evident, as well as a higher educational status and English proficiency. Stress in this group takes on a different role and is not from acculturating to a new culture but from problems within the dominant culture, such as discrimination and other obstacles to success. Considerably important is the fact that in this group of highly acculturated women, high risk behaviors, such as smoking, alcohol use, and drug use, may be more prevalent, all of which are associated with American cultural values and place this vulnerable population at higher risk for health problems (Balcazar et al., 1997). However, this study focused primarily on acculturation stress and did not specifically examine the cultural context of the postpartum period in Mexican American women.

In an integrative review of acculturation, perinatal outcomes, and immigrant Mexican American women, Callister and Birkhead (2002) addressed sociocultural factors posited to influence perinatal outcomes in this population. Noted again was the Latina paradox that has been well documented over the past two decades. Results revealed that as Mexican American women become more acculturated, traditional cultural practices are reduced, and high risk behaviors are adopted that decrease the positive perinatal advantage of the Latina paradox (Johnson, 2005; McGlade et al., 2004). Poor perinatal outcomes include low birth rate with an associated higher mortality and morbidity rate.

The postpartum period for Mexican American women. Historically, the postpartum period has been considered a time of vulnerability for mother and baby. Cultural patterning offers protection and support in the adherence to specific rituals during the postpartum period (Stern & Kruckman, 1983). *La cuarenta/La cuarentena*, a

postpartum rest period with specific rituals, has been observed among Mexican women. Typically, new Mexican mothers experience a 40-day rest period that includes (a) protective seclusion, (b) restriction from bathing or washing hair, (c) adherence to the hot-cold theory, (d) social support from family and friends, (e) proscription from household chores, and (f) education and assistance from female relatives. Expectant mothers often return to the family home to be cared for, and prescriptive foods are prepared for the new mother (DePacheco & Hutti, 1998; Posmontier & Horowitz, 2004; Stern & Kruckman, 1983; Zoucha & Zamarripa, 2003). Bathing is restricted as a protection for the new mother against cold air or *mal aire*. The new mother wears (a) a traditional abdominal binder, *faja*; (b) warm and loose fitting clothing; (c) socks; and (d) a head covering in adherence to the hot-cold theory. These measures are perceived to prevent future uterine problems, breastfeeding difficulties, or arthritis (DePacheco & Hutti, 1998; Zoucha & Zamarripa, 2003).

Gradually, more acculturated Mexican American women learned that following traditional rituals in the immediate postpartum was not necessary. Eating a regular diet did not cause a catastrophe, and bathing actually felt good. However, the protected and privileged status of the postpartum convalescence, surrounded by supportive females, was hers no longer (Kay, 1980). Traditional herbal remedies used in the past were no longer of value for mother or baby. “My mother’s weeds” were not needed (Kay, 1980, p. 2). Formula was given, ending the art of breastfeeding (Kay, 1980). There is no current nursing research regarding understanding the cultural expressions, meanings, beliefs, practices, and experiences of the Mexican American postpartum period.

The Latina paradox. Johnson's (2005) dissertation focused on understanding culture care practices of immigrant Mexican women ($N = 36$) using Leininger's qualitative ethnonursing methodology but did not focus on pregnancy and childbirth per se. Johnson discussed the epidemiologic paradox regarding birth outcomes of Hispanic women, revealing that Mexican immigrant women have better pregnancy outcomes than Mexican American women born in the United States.

McGlade et al. (2004) further elaborated on the Latina paradox. Latinas in the United States have birth outcomes comparable to those of Caucasian women. What is striking in the Latina paradox is that favorable birth outcomes are not associated with socioeconomic status, and Latinos as a group are among the most vulnerable and socioeconomically disadvantaged ethnic population in the United States. Noteworthy is that Mexican American women have the strongest advantages in birth outcomes, perceived to be due to cultural protective factors and social support (McGlade et al., 2004). What remains unclear is exactly what those critical sociocultural protective factors are in the Mexican American postpartum period.

Postpartum depression: The role of cultural rituals and acculturation. Stern and Kruckman's (1983) classic work examined the incorporation of (a) symbolic behavior, (b) cultural rituals, and (c) cultural patterning of the postpartum period. In a review of the anthropological literature on childbirth, the authors discovered that little evidence was provided substantiating the existence of postpartum depression. Their conclusions resulted from the discovery of common elements in the social structuring of the postpartum period:

1. Protective measures designed to reflect the vulnerability of the new mother.
2. Social seclusion.

3. Mandated rest.
4. Assistance in tasks from the midwife or relatives.
5. Social recognition of the new social status of motherhood through rituals, gifts, or other means.

Stern and Kruckman (1983) stated that childbirth is a physiologically universal sociocultural event that is conceptualized, structured, organized, and experienced differently according to people's cultural lifeways and worldview. Stern and Kruckman hypothesized a relationship between postpartum social organization/mobilization and postpartum depression. Postpartum depression in the United States represents a culture-bound syndrome resulting from (a) lack of social structuring of the postpartum period, (b) lack of social recognition of the new role of mother, and (c) a lack of social support for the new mother. However, this study dates back to 1983, so its conclusions may not be valid in the 21st century.

Posmontier and Horowitz (2004) identified two emergent cultural classifications: technocentric and ethnokinship. *Technocentric* refers to those cultures that use technology to monitor the wellbeing of mother and infant and in which technology is the primary focus of the prenatal, intrapartal, and postpartum periods. They identified technocentric cultures as (a) the United States, (b) Canada, (c) England, (d) Western Europe, (e) New Zealand, and (f) Australia. The technology "ritual" consists of the use of electronic fetal and surveillance monitors of both mother and baby. Mother and baby are often separated within 1 hour after delivery to comply with Anglo American hospital rituals. Once the birth process is over, societal postpartum practices of monitoring are over within 24-48 hours, and mothers and babies are discharged to home at that time.

In contrast, ethnokinship cultures hold the social support rituals provided by family networks as the primary focus of the immediate and later postpartum periods. Posmontier and Horowitz (2004) stated that Stern and Kruckman's (1983) methodology used to form their conclusions may have been flawed due to recent evidence in the literature stating that postpartum depression is not a culture-bound illness (Alfonso, Horowitz & Mayberry, 2000). Interestingly, Posmontier and Horowitz cited Stern and Kruckman's classic work to support their definitions of *technocentric* and *ethnokinship* cultures and to confirm Stern and Kruckman's hypothesis that specific cultural rituals during the postpartum period act as protective forces that mitigate the development of postpartum depression. Postpartum rituals in ethnokinship cultures support the "nourishment, protection, rest, and healing of vulnerable new mothers and babies" (Stern & Kruckman, 1983, as cited in Posmontier & Horowitz, 2004, p. 38). Posmontier and Horowitz credited Stern and Kruckman with recognizing the limitations of biological and psychological theories as complete explanations for postpartum depression and proposed instead an interconnectedness of biological, psychological, and cultural factors with an emphasis on family structure, social support, and role expectations.

A qualitative cross cultural study by Oates et al. (2004) examined the presence of postpartum depression in 11 countries and 15 centers ($N = 90$). Morbid unhappiness was found in all cultures but did not necessarily warrant medical intervention. A concern expressed by many is the universality of the concept of depression. Many studies have used Western concepts and instruments to measure postnatal depression (Oates et al., 2004).

Kendall-Tackett (1994) confirmed a distinct postpartum period found in almost all societies that recognizes this time as distinct and separate from normal life. This is a time of apprenticeship in which women are mentored by other women in the art of mothering. The author confirmed this as a time of vulnerability that is governed by seclusion and mandated rest. Instrumental support is recognized as vital to this period, as well as social recognition of a new mother's new role and status. The rituals of (a) bathing, (b) washing of hair, and (c) binding of the abdomen were identified among rural Mayan, Guatemalan, and Mexican women (Kendall-Tackett, 1994).

Kendall-Tackett (1994) contrasted this extensive postpartum support system with that in contemporary American culture in which more attention and concern are given during the pregnancy than after the birth. After the discharge to home, usually 24-48 hours after a vaginal birth and 72 hours after a cesarean birth, the mother is left alone many times. Her husband returns to work within 1 week, and the social support of extended family may not be available. Kendall-Tackett stated that as a culture, "We have woefully neglected the needs of new mothers" (p. 3). She reflected that, historically, American women recognized the importance of providing practical and emotional assistance for postpartum women to recuperate and to transition into the major new role in their lives.

Kim-Godwin (2003) confirmed that Mexican American cultural beliefs and practices of the postpartum period include (a) rest, (b) seclusion, and (c) adherence to the hot-cold theory. Kim-Godwin recognized that in non-Western cultures, birth is holistic and involves moral and social values, environment, as well as the physical component. In contrast, Western births focus on the biomedical. In the Western framework, birth is

“managed” by an obstetrician. Gifts and celebrations are centered on the new baby, not the new mother. Interestingly, women in Western cultures have been given a higher status than in non-Western cultures, but paradoxically, less recognition is given to new mothers in the United States. The conclusion is that the postpartum rituals of enforced (a) rest, (b) seclusion, and (c) adherence to the hot-cold theory mitigate the development of postpartum depression.

Fitch’s (2002) conceptual-analytic dissertation reviewed various etiological perspectives on postpartum depression, as well as looked at the influence of culture and social support in relationship to postpartum depression in four distinct cultures: (a) Euro-American, (b) Asian, (c) Latino, and (d) African. The specific sub-group of Mexican or Mexican American women was not delineated. Fitch’s study, however, confirmed the significance of cultural rituals and social support serving as protective mechanisms mitigating the development of postpartum depression.

Acculturation and loss of protective factors are thought to play a role in the development of postpartum depression in Hispanic culture. Beck and Froman (2005) addressed acculturation in a quantitative study using the newly created Postpartum Depression Screening Scale-Spanish version and the Short Acculturation Scale in Hispanic mothers ($N = 527$). Three subgroups were included in the study: (a) Puerto Rican ($n = 129$), (b) Mexican ($n = 177$), and (c) other Hispanic subgroups ($n = 71$). The results revealed no consistent relationship between postpartum depression and acculturation; however, Beck and Froman stated that acculturation is a complex construct with problematic measurement. Findings of the study also revealed that significant predictors of elevated postpartum depression symptomology were (a) Puerto Rican

ethnicity, (b) cesarean delivery, and (c) single marital status. Clinical implications dictate that Hispanic mothers are a heterogeneous group and should not be treated as a homogenous group. Not all subgroups have the same level of acculturation or postpartum depression symptomology (Beck & Froman, 2005).

Martinez-Schallmoser (1992) explored in her quantitative study perinatal depressive symptoms, quality of life, social support and risk factors in a sample ($N = 66$) of Mexican American women using six instruments to measure acculturation: (a) social support, (b) quality of life, (c) risk factors, (d) clinical history data, (e) pregnancy, and (f) postpartum. It was found that the greater the degree of acculturation into the Anglo lifeway, the greater the risk of developing postpartum depression. As a part of the Latina worldview, religious views were not explored in this study. It was posited that antenatal or postpartum stressors might affect their belief in the external locus of control, lower their quality of life, and place them at greater risk for postpartum depression .

Guiding Framework

Leininger's theory of culture care diversity and universality was chosen as the guiding framework for this study because it provided the most holistic and comprehensive method to discover and understand common and diverse factors in the domain of inquiry. Using this theory directed this researcher to search for broad, holistic dimensions of humanistic culture care embedded in the areas of (a) worldview, (b) ethnohistory, (c) religion and spiritual orientation, (d) language, and (e) the other social structure dimensions present in Leininger's Sunrise Model, which Leininger developed to depict the different dimensions of the theory that would assist in explicating the largely hidden and embedded cultural influences (Leininger, 2006).

According to Leininger (2005), “Culture care would provide a distinctive feature by which to know, interpret, and explain nursing as a discipline and profession” (p. 35). More importantly, using the theory created an understanding of the cultural care diversities and commonalities to help nurses care for people of diverse cultures in a culturally appropriate way. In conceptualizing the theory, Leininger developed three major modalities to guide nursing decisions with the goal of providing culturally competent care: (a) cultural care preservation and/or maintenance, (b) cultural care accommodation and/or negotiation, and (c) cultural care repatterning or restructuring.

Philosophical Assumptions of the Theory

Leininger (2005) posited several beliefs and assumptions pertaining to her theory:

1. Human beings, created by God, are essentially good and caring.
2. Diverse cultures were created for a purpose.
3. It is nursing’s goal to help, understand, and care for diverse individuals.
4. The nursing profession, as a unique contribution to humanity, has a moral and ethical obligation to use culturally appropriate care modalities.
5. Nursing has a responsibility, through research, to discover cultural phenomena to develop and add to its scientific body of knowledge.

To achieve these philosophical ideals, nurses must expand their worldview from a unicultural to a multicultural perspective, which Leininger’s theory guides nurses in doing.

Summary

Chapter 2 presented a review of the literature regarding Mexican and Mexican American women. Ethnohistory; cultural and social dimensions; worldview; language; Mexican American women’s perceptions of health and wellness; cultural beliefs and practices in pregnancy, childbirth, the postpartum period; as well as the role of

acculturation, cultural rituals, and postpartum depression were presented. The literature also demonstrated the Latina paradox, the epidemiological paradox that women of Mexican descent have higher birth weight infants, less prematurity, and fewer complications than other ethnic groups (Bender & Castro, 2000; McGlade et al., 2004).

In addition, the literature explicated the role of acculturation: the more acculturated Mexican American women become to the Anglo lifeway, the greater their chance of foregoing traditional cultural practices that mitigate the development of postpartum depression (Beck & Froman, 2005; Kruckman & Smith, 2002; Posmontier & Horowitz, 2004; Stern & Kruckman, 1983). The importance of kinship and family in Mexican American culture was also substantiated (Bender & Castro, 2000; Berry, 1996; Martinez-Schallmoser, 1992; Martinez-Schallmoser et al., 2003; Zoucha, 1998; Zoucha & Zamarripa, 2003, 2008).

What has not been researched or demonstrated in the literature is the exact current cultural and social structure factors involved in a healthy postpartum period for Mexican American women and their babies. The literature review reveals a significant gap in nursing knowledge specific to the cultural expressions, meanings, beliefs, practices, and experiences of this cultural group in the postpartum period. Noteworthy is that these cultural factors take on new meaning as society transitions through time. This study provided a unique perspective on the phenomenon under study in women distanced by geography and time from their native culture. The intent of the study was to develop an understanding of the unique cultural context of the postpartum period in Mexican American women by discovering and understanding culture-specific and culture-generic knowledge, attitudes, beliefs, patterns of expression, and practices.

The end result of the provision of culturally competent care by culturally competent nurses, healthcare providers, and organizations can make significant improvements in the health and well-being of women and infants. This is particularly important given the Latina paradox. Reinforcing these cultural practices may improve outcomes, not only for Mexican American mothers but for other cultures as well. With changing Mexican American demographics, changes in cultural beliefs and behaviors occur. As these changes occur, a concurrent shift in healthcare needs will occur. As a result, it will become critical for nurses and the healthcare system to respond to the unique cultural needs of Mexican American women. Leininger's theory of culture care diversity and universality in combination with her ethnonursing methodology provides an ideal way to explore this domain of inquiry to obtain significant, meaningful, and current cultural data that will add to the body of nursing knowledge.

Chapter 3: Method

The Ethnonursing Research Method

A qualitative ethnonursing method was used for this study. The ethnonursing method was developed by nurse theorist/anthropologist Madeleine Leininger “as a naturalistic and largely *emic* focused open inquiry discovery mode to discover the informant’s world of knowing and experiencing life” (Berry, 2002 , p. 85). According to Leininger (2006), “The Ethnonursing Method is a very natural and humanistic method to use in nursing, and helps one to gain fresh new insights about care, health, and wellbeing” (Leininger, 2006, p. 39). Philosophically and epistemologically, the ethnonursing method is grounded in the *emic* perspective. It was the researcher’s task to learn phenomena and factors of health that influence health and care from the people’s perspective. Leininger (2005) defined the *ethnonursing method* as “a way of discovering, knowing, and confirming people’s knowledge about care, and ways to keep well, or how they can become ill or disabled” (p. 85). The ethnonursing research method was developed to enable researchers to study ideas related to the theory of culture care diversity and universality (Leininger, 2006). Phrased differently, the prefix *ethno* means *the people*, and the suffix *nursing* refers to a discipline focused on human care (McFarland, 1977), combining Leininger’s expertise in anthropology and nursing to create her theory and research methodology.

In keeping with the philosophical, epistemic, and ontological foundations of the ethnonursing research method, Leininger (2006; Leininger & McFarland, 2002) developed five guiding principles for using the methodology:

1. The first principle is to maintain open discovery, active listening, and a genuine learning attitude when working with informants in the setting in which the study is conducted.
2. The second principle is to maintain a curious posture about the “why” of what is seen, heard, or experienced, with appreciation for whatever is shared by the informants.
3. The third principle is to record whatever is shared by the informants in such a way as to maintain full meanings, explanations, or interpretations to preserve informant ideas.
4. The fourth principle is to seek a mentor who has experience with the ethn nursing method to act as a guide.
5. The fifth principle is to clarify the purpose of additional qualitative methods if they are used concomitantly with the ethn nursing method, such as life histories, ethnography, phenomenology, or ethnoscience.

If another method is added, it must fit the paradigm and domain of inquiry. The rationale for combining another theory with the ethn nursing method must be made clear at the beginning. Leininger (Leininger & McFarland, 2002) believed it is not necessary to add another method to the ethn nursing method.

The ethn nursing method was used to elicit data for this study. This method was chosen for its methodological congruency with the domain of inquiry, purpose, and goal of this study. Leininger (2001) posited that discovering the similarities and differences between generic care and professional care enables nurses to provide meaningful, beneficial, and culturally congruent care in alignment with her theory. Using Leininger’s action modes of culture care maintenance, preservation, accommodation, and repatterning to provide clients with culturally congruent, beneficial, and meaningful care is crucial for nurses’ understanding of Mexican American women’s naturalistic forms of cultural expressions, meanings, beliefs, and practices during the postpartum period. Leininger believes the ethn nursing method requires the nurse researcher to have the language

ability to communicate with the informants in order to gain that emic perspective. For this study, the researcher used a Mexican American RN as an interpreter since the researcher does not speak fluent Spanish (Leininger, 2001).

Leininger's ethnonursing method is a rigorous and systematic one that produces sound research. It focuses on naturalistic and inductive or emic modes of discovery to describe, explain, and interpret informants' worldviews and the meanings of their experiences regarding specific nursing care phenomena. Designed to be used with the cultural care theory, the ethnonursing method focuses specifically on transcultural nursing-related phenomena. Leininger perceived that quantitative research methods were not satisfactory to obtain the rich and often hidden cultural data that would add to the body of nursing knowledge. Through research using her theory and method, Leininger realized that both fit perfectly together to obtain rich, meaningful, and accurate cultural data (Berry, 2002) through the sharing of ideas by informants with the researcher in a naturalistic setting.

Using an inductive, emic approach helped to prevent the researcher from making preconceived judgments of *a priori* views or modifying informants' thoughts or words and enabled the researcher to use active listening skills and keep an open mind and a genuine learning attitude (Leininger, 2006). It was also important for the researcher to recognize her own biases and prejudices and bracket them. Leininger (2005) suggested using a mentor experienced in ethnonursing methodology to assist novice researchers in dealing with their own cultural biases. The motto "Know thyself" remains critical in transcultural nursing and research (Leininger, 2006, p. 122).

The ethnonursing method generates new nursing knowledge by discovering the full cultural context of the human experience by interviewing informants in a naturalistic setting to obtain a holistic view. Focusing on the theory and components in the Sunrise model, the researcher discovered, described, and analyzed the expressions, meanings, beliefs, practices, and experiences of Mexican American women during the postpartum period through face-to-face interviews and field notes. The data were analyzed and interpreted into categories, patterns, and themes that were confirmed through multiple interviews.

Setting: The community context. The ethnonursing method required that the researcher focus on the cultural context of the domain of inquiry. To fully discover and understand the in-depth cultural context, the researcher conducted this research in a naturalistic setting (Berry, 2002). This method is a naturalistic and open inquiry mode to discover the informants' world of knowing and experiencing life (Berry, 2002). This study took place within the informants' homes or a place of their choosing within the urban community of Passaic, New Jersey. In collaboration with the interpreter and researcher, the informants chose the time and place where they felt comfortable, thereby assuring privacy and keeping distractions to a minimum. Passaic, New Jersey, has a large Mexican American population (approximately 62%) that resides near the center of the town, which is the business section. Passaic saw a large number of immigrants from Central America, South America, and Mexico after World War II, and they settled in the lower east side, near the business section of the city and transportation. The home/community context refers to the informants' own homes or places of social or religious gatherings.

Informants. Leininger (2002) stated that the ethnonursing researcher does not have *subjects, samples, or populations* but, rather, works with key and general *informants*. These informants can be individuals, families, or groups of people in various contexts, such as organizations or communities. Key informants are those who are carefully and specifically selected by the researcher with the help of the gatekeeper. The key informants are described as the most knowledgeable about the topic and the domain of inquiry under study; they are also willing to openly share information with the researcher (Berry, 2002). Key informants “reflect the norms, values, beliefs, and general lifeways of the culture” (Berry, 2002, p. 93). General informants are not as knowledgeable about the domain of inquiry but have general knowledge and are willing to participate (Leininger, 2001, 2006). General informants were studied for reflection and for representations in the wider community (Berry, 2002). General informants have broad general knowledge about the domain of inquiry but, for any number of reasons, may not possess complete knowledge or be able to articulate fully on the topic.

Determination of whether the informants in this study would be key or general was made after the initial interview. The researcher evaluated the depth of the information obtained and the informants’ ability and willingness to share and describe their experiences. If the informant could not fully articulate his/her experiences and the information was not complete enough to fully answer the research questions or describe the domain of inquiry, he/she was designated as a general informant. If the informant was able and willing to fully articulate his/her experiences and the information answered the research questions and described the domain of inquiry, the informant was designated as a key informant.

Using the snowball method, informants were asked at the end of the interview if they knew of other potential informants; whether these informants would be key or general was determined by the researcher after the initial interview. Polit and Beck (2004) stated that snowball sampling has “distinct advantages” (p. 306). For one thing, the method assists researchers in gaining access to people who may be difficult to identify. Furthermore, the introduction from a referring informant can assist the researcher in establishing a trusting relationship with new informants (Polit & Beck, 2004). The snowball method was ideal for this study. Initial contact with possible further informants was initiated by the Mexican American RN gatekeeper.

The criteria for number of informants were established based on Leininger’s 30 years of personal research (Berry, 2002; Leininger, 2001, 2006). Leininger did not state her rationale or method for establishing these criteria. She did, however, state that large numbers alone are not the focus. The focus is obtaining the cultural knowledge to fully explore the domain of inquiry (Leininger, 2001).

Key informants were interviewed one to three times for about 1 to 2 hours, and general informants were interviewed once for about 1 hour (Leininger, 2001, 2006). Key informants were considered to be the main source for checking and confirming the reliability and credibility of the data. They were identified as those Mexican American women who experienced the postpartum period. After the initial interview, key informants were selected based on their knowledge of and experience in the domain of inquiry and their willingness to share information with the researcher. General informants were identified as those women who had knowledge of the postpartum period but may not have recently and/or personally experienced this phenomenon or were not able to

fully articulate their experiences. General informants were also those friends or family members who have supported and/or cared for women during the postpartum period. The general informants were those that had the same criteria as the key informants, with the exception that they had general ideas about the domain of inquiry and they may not necessarily have experienced the postpartum period. Inclusion criteria for selection of key and general informants included the following:

1. Self-identify as a Mexican American.
2. Age 18 years or older.
3. Be able to speak, read, and write English and/or Spanish.
4. Willing to share information about the domain of inquiry.
5. Key informants: willing to be interviewed by the researcher one to three times for 1-2 hours.
6. General informants: willing to be interviewed one time for about 1 hour to reflect on how similar or different their ideas are from key informants' ideas.
7. Key informants are those who personally experienced the postpartum period.
8. General informants may have personally experienced and/or have knowledge of the postpartum period.

Entry into the community. Because the researcher does not speak fluent Spanish, a Mexican American RN who was known to the researcher served as gatekeeper and facilitated the first few introductions of participants to the researcher. A gatekeeper is one who is known in the community and who is in a position of authority to grant or refuse entry (Luna, 1989). The community gatekeeper expressed verbal approval of the study and promised support in helping recruit informants. The gatekeeper also signed a confidentiality agreement. Additional informants were recruited using the snowball method. The researcher's status as a maternal child RN interested in helping Mexican American women with their future healthcare experiences by understanding their culture

also facilitated entry and established rapport. While the researcher is not Latina, she does speak limited Spanish and possesses knowledge about the culture. Combined with the gatekeeper's assistance, those skills alleviated feelings of apprehension, prevented cultural misunderstandings, and encouraged informants to participate in the study.

The gatekeeper acted as interpreter for those informants who wished to speak Spanish and accompanied the researcher to interviews with those informants. The researcher was careful not to present herself to the Mexican American women and community with preconceived ideas and biases that would lead to acquiring inaccurate data.

Research enablers. Leininger developed several research enablers to facilitate in-depth discoveries of specific data related to health, well-being, and overt or covert nursing phenomena. These enablers are interview/probe questions and are not mechanistic but, rather, invite open inquiry that encourages trust and collaboration. This researcher used the Sunrise, the Observation-Participation-Reflection, and the Stranger-to-Trusted Friend Enablers to gain in-depth knowledge about the informants' world of knowing. Leininger developed these enablers to draw out hidden data related to the theory (Berry, 2002; Leininger, 2006). The specific enablers used are discussed in the following sections.

Sunrise Model Enabler. Leininger (Leininger & McFarland, 2002) developed the Sunrise Model as a "conceptual holistic guide . . . to obtain multiple theoretical factors" (p. 79). It represents a cognitive visualization and roadmap of this domain of inquiry and related factors that need to be studied in-depth that may influence the care and health of people (see Appendix A). The model is not theory per se but identifies factors that must

be studied in relation to the theory and the domain of inquiry under study. The goal of the model is to open the researcher's mind to find not only the obvious but also covert knowledge in order to obtain the holistic perspective of healthcare influences and worldviews (Berry, 2002).

The Strange-to-Trusted Friend Enabler. To obtain credible information and to prevent unfavorable outcomes, Leininger's Stranger-to-Trusted Friend Enabler Guide was used (see Appendix C). This enabler assisted the researcher in moving from status of stranger to status of friend with informants (Leininger, 2006). According to Leininger (2006), when researchers are viewed as a stranger or outsider (e.g., the etic perspective), they may not be given accurate data. However, as the relationship moves from the etic perspective to one of friend or emic perspective, the data given are typically reliable and credible. The enabler is also designed to allow the researcher to assess his/her own behavior and to assess the progression of the data collection by assisting the researcher in being sensitive to verbal and physical cues from informants (Leininger, 2006). The enabler also encourages researchers to remain objective by constantly monitoring their behavior; encourages a trusting, collaborative participation between the researcher and informant; and validates and confirms the findings. According to Leininger (2006), this enabler has established "meaningful and credible data" (pp. 26-27) through research in approximately 30 cultures (Berry, 2002; Leininger, 1994, 2001, 2006). Leininger (2006) maintained that this enabler provides "high reliability and confirmability" (p. 27) when the researcher moves from stranger to trusted friend

The Observation-Participation-Reflection Enabler. This four-phase enabler (see Appendix D) assisted the researcher in gradually moving from an observer and listener

role to a participant and reflector role that included the informant and the domain of inquiry. This enabler was used to guide the researcher as she entered the informants' world in order to observe and remain with the informants in their natural cultural context while conducting the study. During the first phase, entitled "primary observation and active listening" (Leininger & McFarland, 2002, p. 90), the researcher observed and became aware of Mexican American women's environmental context by visiting informants' homes. During the second phase, "primary observation with limited participation" (Leininger & McFarland, 2002, p. 90), the researcher continued to observe but also began to participate in a limited way in the activities of the informants. During the third phase, "primary participation with continued observations" (Leininger & McFarland, 2002, p. 90), the researcher became an active participant with the goal of discovering findings directly due to involvement with the informants. The fourth stage, "primary reflection and reconfirmation of findings" (Leininger & McFarland, 2002, p. 90), occurred with informants through the trusted relationship that was present. When informants considered the researcher a trusted friend, the accuracy and credibility of the data increased.

Data Collection

The ethnodemographic data sheet (Appendix F) was completed by the informants and opened the interview. The ethnodemographic inquiry guide (Appendix G), a semi-structured interview guide, directed the interview with each informant. All interviews were conducted in English unless the informant requested to speak Spanish. The Mexican American RN gatekeeper, who served as interpreter, accompanied the researcher on each first interview and facilitated the introduction. The gatekeeper is a fluent, bilingual

Mexican American BSN RN known to the researcher through the academic setting. She has worked with this population in hospital, clinic, and outpatient settings. The gatekeeper accompanied the researcher on all interviews that were in Spanish and served as interpreter/translator. Whether the interview was in English or Spanish was solely determined by the informant. If an interview was in English, the researcher conducted it. If an interview was in Spanish, the interview guide questions were first stated in English by the interpreter and repeated in Spanish to the informant; the informant's responses were then translated into English by the interpreter. Data obtained through the Spanish interviews were immediately translated and transcribed by the interpreter from Spanish to English into MS Word.

All interviews were recorded using audiotape cassettes to ensure that informants' statements were captured verbatim. The interviews and transcription process were collaborative endeavors of both the researcher and the RN interpreter. Interviews in Spanish were back-translated by the interpreter to ensure semantic accuracy, correct interpretation, and translation. It is noteworthy that the interview guide changed over time based on the interviews conducted and data obtained. To promote credibility and accuracy of the data, a second outside Mexican American interpreter who signed a confidentiality statement also conducted a back-translation.

At the fifth and sixth interviews, the second interpreter conducted a verbal check for semantic accuracy and discovered incongruences in the interpretations by the first interpreter. To resolve the issue, the researcher believed the only way to assure absolutely correct translations was to use the services of GMR International, a certified translation/transcription agency. GMR provides certification of the accuracy of

translations upon request. All Spanish audiotapes were transferred to Mp3 files by Envision, a local video company in Hasbrouck Heights, New Jersey, in order to be uploaded to GMR International's website. The transcription and translation of the MP3 files of all 17 Spanish interview audiocassettes took about 2 weeks. The Spanish interviews were translated from Spanish into English, including the fifth and six interviews that were found to be incongruent in translation. The GMR translations of these two files were congruent with the second interpreter's translation. The researcher was assured that future translations by the second Mexican American interpreter would be accurate. The GMR transcriptions were used for the data analysis.

In the first interview, the ethnographic data sheet opened the interview. The ethnodemographic interview inquiry guide was used to obtain information and explored the cultural expressions, meanings, beliefs, practices, and care experiences with the informants. After the initial interview with all informants, the data guided the researcher to identify and select key and general informants. In the second or third interview with selected key informants, the researcher confirmed the information obtained from the first interview to assure the validity of the data and to offer another opportunity for the informant to add information. Information with general informants was confirmed at the end of the single interview.

As a result of the interpreter's interest and support, the informants expressed strong interest in participating in this study. Additional informants were recruited by the snowball method. The researcher's role as a maternal child RN who is interested in learning about Mexican American women and the childbearing period was a motivating factor encouraging the informants to participate in the study.

Protection of Human Subjects

To protect the rights and welfare of the individuals involved, informants were given verbal and written explanations of the purpose and plan of the research study for their later reference. The explanation had provisions for confidentiality and the right to withdraw from the study at any time, without penalty. Confidentiality of the informants was maintained by using codes rather than names in the process of recording and computerizing the field data. A separate notebook was used to document the names of the informants, and they were told that their names would not be used in the recording or reporting of the data. It was explained that no risks were anticipated with participation in this study. If any risks were actualized, the informants were told they would be referred by the researcher to their healthcare provider or clinic. Possible benefits were the knowledge obtained regarding the cultural context of the Mexican American postpartum period to promote understanding of the culture and deliver culturally sensitive, competent, and congruent care and improved health services to new Mexican American mothers.

A written informed consent was provided in English (Appendix H) and Spanish (Appendix I), whichever the informant preferred. Permission to tape record the interviews was sought, along with permission to take notes during the interview process. The purpose and use of the notes and recordings were explained to the informants. Interviews were conducted at a place and time selected by and convenient for the informants, assuring comfort and privacy. Both interpreters signed a confidentiality agreement as well.

Throughout the data collection, the researcher was sensitive to cultural data or potentially uncomfortable topics. The informants were informed that they could refuse to answer any question if they were uncomfortable, and they could withdraw at any time during the study without penalty. At no time did informants express any discomfort or refuse to answer questions. All written consent forms, semi-structured interview guides, audiotapes, and transcripts used in the study were stored in a locked file in the principal researcher's office and will be destroyed when all aspects of the study are completed. Consent forms, code sheets, and data were stored separately.

Data Analysis

Information gathered during data collection was reviewed and analyzed using (a) the previously mentioned enablers, (b) Leininger's Four Phases of Data Analysis (Appendix K), as well as (c) Leininger's six major qualitative criteria. In the 1960s, Leininger realized that qualitative criteria were needed to substantiate and accurately interpret qualitative data. Leininger identified six major criteria (see Appendix E) that are essential in substantiating rigorous qualitative findings. The criteria are studied prior to qualitative or ethnonursing data collection and used during data collection and analysis to ensure accurate and credible interpretations of the data (Berry, 2002; Leininger, 2006; Leininger & McFarland, 2002). These criteria were documented throughout the study and confirmed in the final analysis as the researcher used the phases of ethnonursing data analysis. Guidance was sought from Dr. Rick Zoucha, dissertation committee chair and methods expert, as well as from other dissertation committee members during this phase. Qualitative data were entered and managed on a personal computer using NVivo 8.0, a

qualitative software management program, after interviews were completed, a step which complemented Leininger's Four Phases of Data Analysis.

In Leininger's first phase of data analysis, Collecting, Describing, and Documenting Raw Data (Berry, 2002; Leininger & McFarland, 2002, 2006), the researcher collected, described, and recorded data related to the domain of inquiry and research questions. Raw data were documented using (a) a field notes journal, (b) a tape recorder, and (c) a computer. This phase included (a) recording interviews from key and general informants, (b) making observations, (c) having participatory experiences, (d) identifying contextual meanings and symbols, and (e) making preliminary interpretations. The researcher paid attention to emic and etic data. Interviews were transcribed into MS Word in text format. The entries included verbatim and observational data from the informants, as well as researcher dialogue, theoretical speculations, and feelings and detailed observations of the informants' environmental context. The interview data were dated, numbered, given an informant code, and given a code to identify where the data collection occurred, allowing the researcher the ability to recheck the data entry. Data analysis began at the start of the research process and continued until the end of the study. The researcher analyzed the fieldwork data from each day on an ongoing basis (Berry, 2002; Leininger, 2006).

In the second phase, Identification and Categorization of Descriptors and Components, data were coded and classified according to the domain of inquiry. The researcher identified recurrent elements. The researcher also studied emic descriptors (e.g., direct quotes from informants) for contextual similarities and differences (Berry, 2002; Leininger, 2006).

In the third phase, Pattern and Contextual Analysis, recurrent data patterns of similarities and differences were identified from the descriptors. Data were studied carefully to discover (a) saturation, (b) patterns of similar or different expressions, (c) meanings, (d) interpretations, (e) explanations, or (f) structural forms related to the phenomenon under study. Careful examination and analysis of the data took place and revealed patterns with respect to meanings in context as well as further credibility and confirmation of findings (Berry, 2002; Leininger, 2006). After 20 interviews were analyzed, data were repetitive, and no new categories were identified. Three more interviews were conducted to ensure saturation had been reached.

In the fourth and last phase, Major Themes, Research Findings, Theoretical Formulations, and Recommendations, the researcher abstracted and presented major themes, findings, and recommendations in relation to the culture care theory. This was the highest phase of data analysis, synthesis, and interpretation. Adhering to Leininger's method by using the previously mentioned enablers and Leininger's six qualitative criteria (Berry, 2002; Leininger, 2006) that were used throughout the data collection and analysis phase ensured credibility and accuracy of the findings.

Data Management with NVivo 8

Interviews were translated and transcribed into Microsoft Word immediately after each interview and uploaded into NVivo 8.0. The researcher initially immersed herself in the data by reading and re-reading all of the transcripts and listening to the audiotapes of each informant to get a feel for the data. NVivo 8 was used for preliminary coding. The researcher began by inductively coding each transcript line-by-line and classifying the interview data according to the domain of inquiry and the research questions identified

for the study. Accuracy of coding was enhanced by using an NVivo consultant to assist with and confirm data coding. Informants' key words and phrases were color coded using NVivo 8.0. Each code file was labeled with the informant's word(s) identified. Upon opening the file, the word and a number next to it appeared, as well as a label saying "internals," followed by the code number of the informant. Below each label was the informant's response. Using this technique simplified extrapolating informants' comments regarding specific concepts. Free nodes created in NVivo 8.0 served as containers for organizing the categories of data that correlated directly with the dimensions of Leininger's theory of culture care (Leininger & McFarland, 2002), enabling the researcher to easily review the data. Each code word and/or phrase was examined in context to substantiate the process of identifying the categories, patterns, and themes according to Leininger's method of data analysis.

Evaluation Criteria Establishing Rigor

The qualitative and quantitative research paradigms are philosophically different and, as such, need to be evaluated by different criteria. The goal of the qualitative-oriented researcher is not to produce measurable and objective outcomes but, rather, to inductively discover "the meanings, understandings, patterns, processes, characteristics, and attributes of the phenomenon under study" (Leininger, 2006, p. 60). According to Lincoln and Guba (1985), in order to discover truth, qualitative research methods are based on "multiple constructed realities that can be studied only holistically" (p. 37).

Rigor refers to the trustworthiness or credibility one can expect in study findings. Leininger (2002, 2006) established six qualitative criteria to ensure credibility of findings (Appendix E). These criteria parallel quantitative measures of internal and external

validity, reliability, objectivity that are used in quantitative research (Lincoln & Guba, 1985). Leininger noted that Lincoln and Guba (1985, pp. 301-327) established criteria of credibility, transferability, and confirmability but did not address meaning-in-context, saturation, and recurrent patterning. Therefore, Leininger incorporated these categories into her criteria. Lincoln and Guba added the category of dependability to their criteria, suggesting that this last criterion could be achieved by an independent auditor confirming an audit trail through the data. Leininger recommended the use of a skilled qualitative mentor to guide the data analysis with the researcher. In this study, Dr. Richard Zoucha served as the mentor.

Credibility, per Leininger's qualitative criteria (Appendix E), is achieved through prolonged engagement (Leininger & McFarland, 2002, 2006). Prolonged engagement occurred during the 12 months the researcher was in the field as participant-observer at the research sites. Involvement with the 23 informants during multiple interviews occurred in the home and community context during this time. The prolonged engagement allowed the researcher to move from stranger to friend (see Appendix C) and confirmed the credibility that true findings were heard. For example, the informants openly shared their thoughts on and experiences with domestic violence. The explanations of the meaning-in-context of domestic violence were then sought from other informants, leading to the category "circle of violence." Credibility of data was confirmed from other key and general informants to substantiate the information and interpretations.

Confirmability is achieved by informants reaffirming what the researcher has seen, heard, and experienced in regard to the phenomena under study (Leininger &

McFarland, 2002, 2006). The researcher had repeated contact with the informants, leading to confirmation of data. For example, at an interview, the researcher would introduce a topic by saying, “At the last visit, you told me _____. Can you tell me more about that?” When the informant introduced information that was different or not heard before, the researcher would query other informants regarding the commonality and meaning of the data. For example, one of the informants indicated that it was not necessary to have a husband to raise children. Her attitude was that if a husband was not going to be supportive and provide for the children, then he did not need to be in their lives. The researcher then queried other informants regarding this perspective, and they confirmed the accuracy of the data. To establish confirmability, the informants and researcher have to agree on the interpretation of the data (Leininger & McFarland, 2002, 2006).

Recurrent patterning occurs through prolonged engagement with the informants that allows the researcher to identify recurrent patterns in many of the social structure factors (Leininger & McFarland, 2002, 2006). For example, recurrent patterning was evident in the routines of informants’ family life that varied little day-to-day throughout the months of the study. The recurrent pattern of daily routine involved waking early, preparing breakfast for the children and husband/partner, preparing the children for school, and getting ready to go to work. The informants then returned home to prepare the evening meal and spend time with the children and husband/partner. Their lives were centered around children, family, and work. The phenomena of *La Cuarentena* was also a recurrent theme discussed and confirmed by all of the informants.

Meaning-in-context refers to data that are relevant and meaningful to people within life experiences (Leininger, 2006; Leininger & McFarland, 2002). During the study, the researcher went back to the informants to learn the significance of certain life situations to them. For example, one of the informants stated that she always pictured herself as a mother, saying, “Motherhood for me is my reason for living.” In the context of Mexican American culture, motherhood is seen as the ultimate achievement and the reason for a woman’s existence. The role of the woman in Mexican American culture is to have children, but in the context of economics, the informants were very concerned about providing for their children.

Saturation occurs when all that can be known about a phenomenon under study in the context occurs, information from multiple informants is repetitive, and no new data are discovered (Leininger, 2006; Leininger & McFarland, 2002). As an example of saturation criteria, informants repeatedly mentioned the importance of family, saying that family and God are the foundation of their lives. Family support was consistently discussed, as was prayer every day to give strength to the informants to get through each day.

Transferability is the final criteria for qualitative research. This criteria refers to whether the study will have meanings, relevance, or significance to another study in a similar context (Leininger, 2006; Leininger & McFarland, 2002). The goal in ethnography or any qualitative research is not to replicate research studies. Each research study is unique and cannot be replicated as it discovers in-depth cultural data within the meaning-in-context of the domain of inquiry. The theory of culture care

diversity and universality can assist researchers in examining data for commonalities and diversities in other culture care contexts.

Summary

The ethnonursing research method is a qualitative method with naturalistic and inductive qualities. This method is designed to be used with Leininger's cultural care theory in order to discover cultural care meanings, expressions, patterns, beliefs, practices, and experiences pertaining to specific cultures. For this study, the researcher used the ethnonursing method to gain cultural data through (a) observation, (b) participant observation, (c) reflection, (d) interpretation, and (e) reconfirmation of findings. Approximately eight key informants provided the majority of the cultural information for this domain of inquiry, and 15 general informants expanded the breadth and depth of the cultural data. The researcher used the four-phase process of Leininger's ethnonursing analysis, as well as Leininger's six qualitative criteria, to explicate, refine, and confirm the credibility of the data collection and analysis until saturation was reached. This systematic and rigorous research methodology provided accurate, meaningful, and credible knowledge of Mexican American women during the postpartum period that will add to the body of scientific nursing knowledge and lead to the provision of culturally appropriate and congruent care.

Chapter 4: Results and Findings

In this chapter, the researcher presents findings from this study, which sought to discover, understand, describe, explicate, and analyze the cultural expressions, meanings, practices, beliefs, and experiences of postpartum Mexican American women living in a suburban community in Passaic County, New Jersey. Research questions and the ethnodemographic inquiry guide were developed to guide the researcher in understanding the cultural context of the postpartum period. Noteworthy is that although the antepartum and intrapartum periods were not an initial focus of this study, the inquiry guide elicited rich data regarding these periods, including understanding the informants' descriptions of how healthcare providers show care and caring behavior. The context of the study has been defined and considered so that the emic and etic perspectives lead to understanding cultural meanings. The findings of this study are presented according to the analysis of the data into (a) categories, (b) patterns, and (c) themes.

Approximately eight key informants and 15 general informants were sought using Leininger's (2001, 2006) 1:2 rule, and saturation of data was reached. Data were transcribed verbatim from audiotaped interviews. Only 5 of the 23 informants spoke fluent English; those interviews were conducted exclusively in English and transcribed verbatim by the researcher immediately after the interviews. Since the researcher is not fluent in Spanish, two bilingual Mexican American RNs recommended to the researcher assisted in collecting and substantiating the data. Both knew the names of the informants, and both signed a confidentiality agreement. The remaining 18 interviews were conducted in Spanish, translated from Spanish into English at the time of the interview by the interpreter, and then transcribed verbatim by the researcher immediately after the

interviews occurred. Therefore, data presented in this chapter take the form of direct quotations from the informants, with no alteration in grammar or syntax.

The Community

Less than 10 minutes from the researcher's home exists a setting that can only be described as Spanish. There is clearly a Mexican population, but the area lacks the colorful products, beauty, and connection to nature that one sees in Mexico. The neighborhood is more typical of a New York/New Jersey inner city neighborhood. As soon as one exits the state highway onto "D" Street, one is transported to another time and place. Early in the morning, Mexican male day laborers stand on the street corners, awaiting pick up by the various landscapers and construction crews that come by daily, looking for men to work on jobs for low wages and no benefits. Police patrol the area vigilantly due to complaints by female pedestrians of harassment by the Mexican men. Police cars are placed strategically in the middle of the main street, sending a powerful message to the men that law enforcement is present and harassment will not be tolerated.

Turning onto "M" Street, one is greeted with sights and sounds of heavy traffic and women walking on the sidewalks with toddlers in tow or pushing strollers. These women are accompanied by other Mexican women, either friends or family. All store signage is in Spanish, including (a) vegetable markets, (b) restaurants, (c) clothing stores, (d) laundromats, (e) dry cleaners, (f) dance clubs, (g) check cashing stores, and (h) coffee shops. The area is bustling with noisy activity early in the morning, which continues throughout the day. It was difficult for the researcher to believe that this was Passaic County, New Jersey, remembering the area from years ago as a wealthy, bustling, Mecca of expensive shops, magnificent homes, and an area labeled "doctor's row" where

physicians' private offices in magnificent older homes lined the street. However, check cashing stores and constant police patrol reinforced the inner-city neighborhood atmosphere of this once former beautiful city. This researcher experienced culture shock, having not visited the area in many years.

The researcher immersed herself in this environment by walking with the interpreter through the streets of the shopping district, window shopping, stopping to shop or to have coffee, attending mass at the nearby Catholic church, and spending time visiting with women at the Hispanic social services center. As the researcher interacted with the women and the Mexican American community over time, an increased understanding of the community and the many influences on the women was developed. Sitting in their homes, at the Hispanic social services center, or at the church annex; listening to their stories; and watching the family dynamics enabled the researcher to more fully understand these women's perspectives and to analyze the data within the context of their lives.

Mexican Americans have created a little piece of home for themselves in this area of Passaic County, giving them a sense of security and comfort and easing the sense of loneliness for their homeland that they experience so deeply. According to Purnell and Paulanka (2003), "Mexicans derive great pride and strength from their nationality, which embraces a long and rich history of traditions" (Purnell & Paulanka, 2003, p. 273). Mexican holidays are celebrated in this community, and in the summer, various church and street fairs celebrate Mexican culture. During the holidays, Mexican traditions are celebrated in the churches. Key Informant 3 relayed the story of family members carrying the Virgin of Guadalupe from home to home during the Christmas season. She stated, "I

won't do it, we won't do it, my sisters, the new generation won't do it, but my mother will do it, and we will get together and do it out of respect for her.”

Entry into the Community

The researcher's entry into the community to begin the study was a long and arduous process fraught with many obstacles. The first Mexican American interpreter/gatekeeper, an RN and former student of the researcher, initiated contact with 20 Mexican American women in Passaic who were interested in participating in the study. Data collection began in January 2007, and 10 interviews were completed by April 2007, at which time an impasse was reached. Informants who agreed to participate were no longer available or willing to participate, would not return phone calls, or would cancel appointments without notifying the researcher. Several informants had telephone numbers that were disconnected, and several had returned to Mexico to care for ill relatives. It is worth noting that many of the informants did not have telephones in their homes and relied mainly on the use of cell phones. If the informants did not have money to pay the home telephone bill or to purchase cell phone minutes, the researcher could not contact them to schedule or confirm an appointment time, a situation which became very problematic. Many times, the researcher and interpreter would be waiting for women who had confirmed an appointment, only to wait in vain. The interpreter, who confirmed the appointments, stated that the women's behavior was “cultural.”

The researcher then networked with a Cuban Latin American history professor colleague at the university where the researcher is a faculty member. The professor, who is very active in the Latino community, is a member of the Hispanic Directors Association of New Jersey (HSANJ) and presented the researcher with names of three

women who were active in the Latino community whom he thought would be helpful in obtaining a sample. One could not be reached, but the other two, a social activist and a Mexican American journalist, were most helpful. The social activist was secretary of the National Latino Peace Officers Association of New Jersey and outreach manager of the HDANJ. The National Latino Peace Officers Association's mission is one of advocacy and empowerment of the Latino law enforcement community and the community at large. The mission of the HDANJ is to further the progress of New Jersey's Hispanic community through cooperation and collaboration with other organizations by studying research, analyzing, and advocating for the welfare of the Hispanic community (Rivera, 2007). The researcher initiated phone contact with the social activist in May 2007, stating that a colleague had referred the researcher to her for assistance. The researcher explained the research study and the dilemma with obtaining a sample. The social activist referred the researcher to Senor H., director of the Hispanic social services agency, for further assistance.

Initial contact with Senor H. was initiated through telephone conversations. Connecting with Senor H. was difficult and not timely. The researcher initiated many phone calls in an attempt to speak with Senor. At the initial conversation in May, Senor inquired as to the researcher's background, credentials, and interest in the Mexican American female population. Senor H. requested a copy of the dissertation proposal and all documents to be used for data collection. After several in-depth phone conversations, Senor H. expressed interest and enthusiasm for this study, stating that, typically, no one was interested in exploring cultural care issues in Mexican American new mothers. He believed the study was important for the community and indicated his interest in and

support for it. The researcher forwarded to Senor H. the documentation required that he would present to the Hispanic social services agency committee members for further approval. Senor H. also stated he knew of the perfect interpreter for the project: an RN community health nurse from the local Catholic hospital's outreach program whom the Hispanic women of the community knew and respected. After about 4 months, Senor H. contacted the researcher with approval for this study and the interpreter's contact information. In August 2008, data collection and analysis began again after a long hiatus and continued until December 2009.

In addition, the Mexican American journalist provided the researcher with a contact number for the secretary of a Women, Infants, and Children's (WIC) program with a very large Mexican American population. The WIC program was held every Wednesday in a Roman Catholic Church in southern New Jersey and was a possible additional site for data collection, should one be needed. Both the northern and southern New Jersey sites would provide a Mexican American interpreter. However, logistically, the southern New Jersey site was less than ideal due to travel distance, and the researcher preferred to remain at the northern New Jersey area sites.

Setting

Interviews were conducted at a place determined by the Mexican American interpreter/gatekeeper and by informants and continued until saturation of data was reached. Selecting a time for the interviews was a collaborative endeavor between the interpreter/gatekeeper, informants, and researcher. Only the researcher, interpreter, and informants were present for the interviews. The first 10 interviews were conducted in the informants' private homes where preschool children were often present. Meeting in the

informants' homes allowed the researcher to understand and, for that brief period of time, experience the rhythm of their daily lives. Children were playing with toys, and relatives were often cooking in the kitchen. Husbands/Partners would arrive home after a day's work and be introduced to the researcher and interpreter. The informants were warm, gracious, and caring women and welcomed the researcher and interpreter by greeting with a hug and kiss and offering something to drink or eat.

The areas of Passaic County where the informants lived were perceived unsafe, according to the interpreter, who was from the community, and based on police reports of crime in the area. Therefore, all of the interviews were conducted during daytime hours. The majority of the informants lived in apartments, their names were not listed next to the doorbell, doorbells were often disconnected, and names on the mailboxes were often different from informants' names. The interpreter had to call the informants to announce that we had arrived because we did not know which doorbell to ring. The informants would then come down to let us in or, on some occasions, would be waiting outside to escort us up three flights of dark stairs to their apartments. Hearing their stories while sitting in their homes—embraced by the sights, sounds, and scents—and observing family dynamics allowed the researcher to understand the meaning-in-context of their daily lives.

The remaining 13 interviews took place at one of two locations, whichever was more convenient for the informants: the Church annex, a building that houses administrative and community health offices where the Hispanic members of the community and Church receive health screenings and information provided by the local hospital community outreach, or the Hispanic social services agency. The interviews in

each location were held in a private room. The researcher, informant, and interpreter were present, and if informants brought their preschool age children with them, the children were given toys, coloring books, and crayons for amusement while the interviews occurred. All of the children, including toddlers, were very well behaved.

The Roman Catholic Church in the Diocese of Passaic County was founded in 1924, and the Parish was founded in 1944. It has a predominantly Hispanic congregation, with some Filipino members and a total congregation numbering about 1,000. St. Anthony's also has a grammar school attended primarily by Hispanic children from the neighborhood. Because the neighborhood is in an area perceived as unsafe, all doors to the church annex were locked, and one was admitted to the building by pressing the buzzer and announcing one's name and purpose for the visit.

The Hispanic social services agency several blocks away is a community agency dedicated to providing social services to the Passaic County Hispanic community and is part of Catholic Charities. The Hispanic social service agency was established in 1972 to identify, study, and articulate the human service needs of the Hispanic community in Passaic County. The different programs offered by the agency reach the most vulnerable and at-risk populations. The agency also contributes to economic and social stability by means of job placement and support to families through crisis intervention. Assistance is offered to (a) families, (b) youth, (c) seniors, (d) the disabled, (e) people suffering from addictions, and (f) the homeless. Services are rendered without regard to race, color, or national origin. All doors to the center were locked, and admission to the center was obtained by pressing a buzzer and announcing one's name and purpose of the visit. Sitting in the waiting room, waiting for the interpreter and interacting with women who

were waiting for advice, provided the researcher an in-depth view of the sociocultural and economic context of these women's lives and created a greater understanding of the barriers and challenges these women faced in daily living.

Informants

Saturation of the data resulted in eight key and 15 general informants who were interviewed for the study, which is consistent with the 1:2 rule determined by Leininger's (2002) ethnonursing method. As shown in Appendix L, all of the informants were female, per the domain of inquiry. For this study, 20 informants self-identified as Catholic. All informants had children. Only four of the informants were single; the others were either married or partnered. The majority of the informants were between the ages of 26 and 45 and were homemakers with only the spouse or partner working. All of the informants except one were born in Mexico, the majority being from Pueblo Casa. The length of time informants had resided in the United States averaged between 11 and 20 years. Only seven of the informants had completed high school. Twenty informants spoke only Spanish at home. It is noteworthy that none of the informants admitted to reading, writing, and speaking English fluently. The majority of informants had three to four pregnancies. All of the informants had given birth. Six had experienced miscarriage, none had experienced stillbirths, and one had experienced an ectopic pregnancy. Ten informants did not plan their pregnancies, 12 delivered vaginally, seven had cesarean sections, and four had failed vaginal deliveries that resulted in cesarean sections. Nine informants experienced *melancholia de bebé* (baby blues), and nine experienced *la depresion* (depression) either during pregnancy or *postparto* (postpartum). Six informants had a history of general depression, and one received treatment for depression. The

majority of informants lived in an apartment, instead of a private home, and lived with their husband/partner and children. Five of the women admitted to experiencing verbal or physical domestic violence and/or witnessing it at home as children between their parents or in the lives of other family members.

Presentation of Categories

This section, the identification and categorization of descriptors and components, presents the second phase of Leininger's (2002) four phases of data analysis outlined in her ethnonursing analysis of qualitative data. In the first phase, data were collected, described, and documented. In the third phase, emerging patterns were analyzed, and in the fourth phase, major themes were abstracted from the data.

During the process of data collection and concurrent analysis, 17 categories that emerged from the data were identified: (a) *la familia* (family), (b) religion and God, (c) everyday life, (d) *valores* (values), (e) traditions, (f) caring and non-caring behavior, (g) folk beliefs, (h) prenatal beliefs, (i) intrapartum beliefs, (j) postpartum beliefs, (k) differences in living, (k) *machismo*, (l) motherhood, (m) circle of violence, (n) gender roles, (o) health, and (p) *melancolía de bebé* (baby blues) and *depresión postparto* (postpartum depression). These categories correlate with the cultural and social structure dimensions of Leininger's culture care theory as depicted in the Sunrise Enabler, which describes the worldview of a society by guiding the exploration of the cultural and social structure dimensions. A complete description of these categories supported by data from the researcher's observations and field journal are presented here and provide a contextual perspective to the culture care worldview of Mexican American women.

Culture Care Worldview According to the Culture Care Theory

Family. *Familism* is one of the most important values among Mexicans and Mexican Americans. The traditional family, *la familia*, is the core of this society and comes before all else, excluding God but including work. Individuals derive strength from family ties and relationships. Comments expressed by the informants supported this category. Informant 1 stated,

Um, one of the most important values is family, *la familia*. Family is God. I think that it's willing to support a lot of our decisions in our daily life. I would include our extended family, not only our nuclear like we used to . . . you know the most important is family; to always keep your family together. That the distance doesn't have to matter or the time, anything else doesn't matter, but if you have your family, that's the important thing.

Strong family ties that include both immediate and extended family characterize Mexican American life. All informants viewed the family as being of primary importance, and their comments supported this domain. For the informants, family consisted of not only husband and children but also (a) parents, (b) aunts, (c) uncles, (d) cousins, (e) grandparents, and (f) friends, confirming findings expressed in the literature. When asked to tell about their family and whom they considered part of it, informants offered the following comments. Informant 1 stated,

Well, my nuclear family is my husband and my two children, and my extended family is my, starting with my mother, my sister, my aunts, my uncles, my cousins, my grandparents, um . . . we're really in Mexico never, so I hear a lot like from my second cousin, my third cousin, my fourth cousin, for us everybody was my cousin whether the first one . . . so it really doesn't matter [laughing]. Even when people get married, once they get married, it's their family, there is no thing just as, oh no, she's just your wife. No, it's family.

Informant 2 stated,

Well, all . . . I'm talking about my family, my sons, my daughter's close friends . . . it's just friends as well, friends that you know would be there for you in any kind of emergency or anything . . . so when I think of family, it's a big group

you know, besides the brothers and sisters and sisters-in-laws and brothers-in-laws.

Informant 2 also commented on the importance of family, stating, “Family is willing to support a lot of our decisions in our daily life.” Informant 8 shared the importance of leaving work when there are family problems:

When I have to leave work because of the children, the boss is ok with that, Thank God. At my husband’s job, the boss loves him, so whenever there is a problem at home, it’s ok for him to leave. He works for a paint company.

Religion and God. The majority of the Mexican American informants were Roman Catholics. Mexican Americans are deeply spiritual, possess a strong faith, and have dependence on God as part of their spiritual worldview. It is noteworthy is that the women in this study did not necessarily attend church on a regular basis; however, they considered themselves to be devout Catholics. Many of the women had statues and religious symbols in their homes, and the informants prayed throughout their day. God and prayer were present in their thoughts, regardless of what they might be doing at the time. Their religion influenced every action in their daily lives, as reflected by their comments. Their religious views also affected their health-seeking behaviors. Informant 7 shared these comments with the researcher:

I have a lot of faith, faith moves mountains, and God will cure anything. God also has the medicine, which would be the doctors, so I know to take Tylenol for a headache or Advil for headache or pain.

Informant8 revealed how the importance of God is reflected in her and her children’s everyday lives:

My children understand the importance of having religion present in our lives. I have taught my youngest child about praying. Although we cannot make it to church every day, we all know the importance of it. My children are accustomed to praying before they do or go anywhere.

It is also noteworthy that, for many of the women, religion and God were one and the same, and several expressed not necessarily being “religious” but having a strong faith in and connection with God. Religion and faith help Mexican American women cope with everyday trials and tribulations. For these women, religion, God, and faith are all intertwined and often cannot be separated but are thought of as one entity, as reflected by comments from the informants. Informant 2 revealed,

I don’t go to church all of the time, but I was raised as a Catholic, and we all went to church together every Sunday when I was at home in Mexico. Now, I don’t go as often as I should, but I pray every day for my family and to stay healthy.

When asked about the influence of God in her daily life, Informant 9 shared that she writes down her feelings about God. She asked if she could share the following with the researcher:

May my home be a home of love. There are no disappointments here because you give us patience to be forgiving and realize our mistakes. There is no injustice here because you give us the ability to comprehend. You teach us to not abandon one another because you are always with us. You fill our lives. Every morning you give us an opportunity to sacrifice to you. Every night we find ourselves with more love toward our partners. May we find more confidence and love for you. Our happiness gives us a motive to love you more and we can show others what you have done for us.

Informant 9 also stated, “I don’t practice religion that much, but I am very tied to it. It’s very important being a daughter of Guadalupe in my religion, and I am a daughter of *La Virgen de Guadalupe*.” Informant 6 related,

I’m Catholic, I’m a believer. The only greater person that I confide everything to and put my all into is God. Every day I gives thanks to God for opening my eyes among the people I love the most—my family. My faith. If my faith is strong, and without my Catholic beliefs, I don’t know where I would be in her life right now, how empty it would be.

Everyday life. Everyday life for the informants in this study revolved around (a) God, (b) prayer, (c) children, (d) family, and (e) work, if they worked outside of the

home. Routines for the women were similar to each other, depending on whether they stayed home or worked outside of the home. The meaning of God and prayer were especially interwoven in their daily lives. Informant 1 stated that religion gives her a sense of security:

You see from the time I wake up in the morning, even from the time we get out of the house, I just say “God protect me and be with me,” and so it’s from the time you wake up until the time you go to sleep and you thank him with prayers.

Informant 7 stated, “God is the base of my life, everything I do because of him,” confirming the deep connection and reliance on God as a source of strength to cope with everyday life.

Informant 12 commented on work, home, and caring for children, stating the following:

I don’t work and the majority of people that I know work. My neighbor upstairs works every day, but I’m here all the time and take care of all the meals for my children. She’s not like that and comes home at 6:00 p.m. from work to cook.

Informant 4 stated, “After work, I would need to cook, and help my children with their homework. After this, I would make sure that they are in bed early.”

Valores (Values). *Respeto* (Respect), honesty, belief in God, hard work, family unity, and education are highly valued among Mexican Americans, which was reflected in the informants’ comments. Their comments were consistent with the structural dimension of cultural values, beliefs, and lifeways that revealed what values or *valores* are most common and important to the informants and guide their daily lives. Family, marriage, belief in God and prayer, respect, manners, work, honesty, and education were consistently mentioned by the informants. Informant 10 believed that *la familia* (family), *respeto* (respect), and honesty were important values and stated the following:

The most important thing that I have is *mi familia* [my family]. I would like to be able to help my family in the difficult moments. Also, it's important to respect those around me. It's important to be honest.

Informant 12 shared that *respeto* (respect) is most important:

Also, I want [the children] to respect and love their family. If you don't help your family and others then they will not want to help you later on. You need to be there for them so they can be there for you. Respect is first.

Informant 6 related her thoughts on the strength and hardworking character of Mexican

American women:

I have pulled my three children through without their father. I definitely don't need him, I don't need a man because I've done everything I can do for my children. I can do everything. The Mexican American woman is very strong and hard working.

Mexican American women expressed that providing an education for their children is one of the most important things they could do. Informant 20 shared her thoughts:

I want them to take advantage of the opportunities here. I want them to be educated so that they can defend themselves at work. They see their father and that he works in a kitchen and comes home with burned hands. So they understand the importance of education. My oldest child likes to play the drums and he is in a band. I see that he enjoys it a lot, but he needs to make sure that he does he still studies.

Informant 1 shared her thoughts on the importance of education for her son:

I think the most important thing for me is for him to value himself. I think it's for him to put himself first, meaning that, and of course his family, respect me, respect himself, definitely he has to . . . education, he has to learn the value of it. For me, it's very important for him to be a good man because I never had my father.

Traditions. Traditional beliefs and customs have persisted in spite of the influence of generational change due to acculturation into the lifeways of the United States. Mexican Americans have recreated a piece of Mexico for themselves in Passaic County that offers them a sense of home and security. Regardless of how many years

they have lived in the United States, Mexican Americans have a strong attachment to their homeland that is often reflected in the communities they create. Informant 10 spoke about cultural and religious traditional values that are important not only for her but also for her to teach her children:

In Christmas, I teach my children the nativity scene. We also put up the tree. We also put up the tree that is a tradition from here. We celebrate the 16th of September, which is important day for us. My youngest argues with me because she's an American, but I tell her that I respect her flag, so that she has to respect ours so we also celebrate the Fourth of July. Another traditional difference is Halloween and Day of Saints. They are celebrated the same day in two types of ways and we celebrate both.

Informant 11 shared similar thoughts:

From what I know, I think the majority [in my community] follow similar traditions. In Mexico, we believe a lot in the Virgin of Guadalupe and you can see when we all get together to pray to her during the day.

Informant 11 also believed that helping one another in the community is a tradition. For example, she stated, "If someone sees that your hands are full, and you are carrying a baby, they will help you." Finally, the majority of informants indicated that Spanish must be spoken in the home as a means to preserve their culture. Informant 15 confirmed this, saying, "I speak only Spanish at home and with friends."

Caring and non-caring behavior. Emerging from the data was the informants' perspective of caring and non-caring behavior. Informants shared with me several comments about the meaning of *care*. For example, Informant 1 stated, "Caring—care means support, people show care by calling you to see how you are, what can they do for you, do you need anything." For Informant 3, *caring* is "others being there for you, asking how you are, calling you—just being interested." *Non-caring* for this informant is not being interested; she provided an example of her sister not taking the time to pick up the phone to see if she needs anything, to see if she wants to talk, or to ask how she feels.

. . . I think with my sister, she is so busy with her job, she has so much on her mind with my grandfather, my mother being there, worrying about how my mother is doing . . . coming home to her family, she doesn't have enough time to . . . maybe . . . I know she thinks of me but it's not how I want it . . . I don't think it takes much time

Informant 6 described *non-caring* as follows:

Not to call me, don't receive any mail from Mexico and if something they know I like to eat . . . if none of those things are happening, then I know people don't care, I am not important to them.

Informants' perceptions of caring and non-caring behaviors in healthcare professionals paralleled their general perceptions about caring and non-caring behaviors exhibited by friends and family. One very important element was healthcare providers communicating with them, especially in Spanish. Informant 4 delivered her second child in South Carolina and perceived that her doctors treated her better because "they spoke to me in Spanish and explained everything to me, even why I had the cesarean section for the first baby." Her first delivery occurred in Passaic County, and she perceived her care to be non-caring due to not only the language barrier but also lack of information. Non-caring behaviors occur when "they just come in and check you and don't allow you to ask questions," she said. Caring behavior from doctors for Informant 5 also included speaking Spanish, a factor she believed was very important: ". . . it is our language and sometimes we have questions and we want the direct answers from them."

Other informants cited non-caring behaviors by nurses. Informant 3 shared the following regarding a nurse she perceived as inattentive to her needs:

. . . before they let the baby's father in, they started [the cesarean section], and I was scared, and one of the nurses came in and held my hand, and "Oh, don't do it too hard, you are going to break my hand." . . . It wasn't a caring remark and it wasn't professional . . . No, they were not interested in me, I was shaking, I was trembling, I remember perfectly well the shakes. When it was time that my daughter was coming, I didn't have the attention from the nurses or the doctor. I feel they just let me suffer. They gave me no pain medication, nothing.

Informant 9 shared similar comments regarding inattentive clinic nurses and doctors:

They don't look at me, they don't speak to me directly, they don't take the time, so to me they really don't care. Basically when I have my notepad and I'm actually reading, well, what they do is like, "Ok, yeah, yeah, yeah" . . . about 5 minutes, and they leave.

Folk beliefs. The informants in this study revealed that Mexican American women engage in folk medicine practices and use a variety of prayers and herbal remedies. Herbs used for treatment of headache or stomach ache and during the postpartum period, *La Cuarentena*, included (a) arnica Mexicana (camphor weed), (b) ruda (rue), (c) pirul (pepper tree), (d) manzanilla (chamomile), (e) mint, and (f) romero (rosemary; see Appendix M). Informant 6 stated gave this description of herbal usage during *La Cuarentena*:

Drink the teas for at least three days, arnica, romero, peru, ruba, boil the herbs in water—take a little bit of that drink that to clean yourself and you also have to bathe yourself with that. This takes out all of the air you had in your stomach. Then you bind yourself [with the *faja*] and you have to cover your head as well.

The informants in this study did acknowledge the use of folk healers (*curanderos*). These practices vary between families as well. Informant 6 stated, "In my family and my husband's family too . . . we go to the *curandero* first and then the doctor." However, this informant stated that she prefers to see the doctor first: "Personally, for me I always use the doctor first. Not the *curandero* first. I am not accustomed to seeing a *curandero*, but the majority of Mexicans are."

Regardless of individual family practices, the worldview perspective in this culture reflects harmony: one must be in balance with God, family, and spirit. This cultural belief is the basis for the reliance on folk medicine in this culture. Informant 22 stated,

Everything in life has to be in balance, spirit, mind, body. It all contributes to your health, if you stress too much, if you worry about work, you're gonna stress out, you're not gonna eat right, and you're not gonna feel right, you're not even gonna feel like going to church, you know, you're even gonna be, "Why do you do this to me now? What did I do?"

Informants also described specific folk beliefs and practices. Informant 22 spoke about *empacho* during the postpartum period: "Eating too many starchy foods contributes to empacho or constipation especially after delivery." Informant 2 discussed herbal remedies used in her family:

Mother would do the, uh, the mint, you know, we'd have the mint leaves outside she'd pick those for stomachaches, and fever—the mint tea. And like I said we never used the tea bags; it was always the mint leaves from out in the yard.

The informants also held several other folk beliefs, such as *mal de ojo*. Informant 1 stated, "Baby wears a bracelet with red bead on it to ward off evil eye." Informant 17 shared,

Mal de ojo. It's when the baby starts crying and their forehead gets warm, not a fever, just heat. Suppression in both eyes. Nothing has happened to my children, I have always dressed them in red.

Informant 16 related a folk belief pertaining to the hot-cold theory: "If the baby is born already and your husband comes home late they say he might bring in cold air into the house and it will affect the newborn."

Despite these practices, the informants believed that ultimately God (i.e., fate) controls life, health, divine will, and the environment, reflecting an external locus of control. Informant 3 shared this perspective when her grandfather was dying:

My grandfather had cancer . . . he didn't want to take the pills, "I have faith that my God is gonna save me," and you know . . . so did we . . . and then we did have to put the faith into the medical side of it.

At the same time, the informants also believed that they had a responsibility to take care of their health. Informant 6 stated, “I believe God will help you, but as a person, you also have to put your part in. I have to do something to help.”

Prenatal beliefs. All of the informants stated that children are highly valued and desired, and pregnancy is regarded as an important event in Mexican American culture. The informants stated they received support from immediate and extended family members and believed in obtaining prenatal care in the United States, although it was not always an option in Mexico. Informants revealed that pregnancy is viewed as natural in Mexican culture; therefore, in Mexico, women do not always seek prenatal care and may not be aware of the need for it. Additionally, informants related that prenatal care is not always available in Mexico, and/or women do not have the financial means to pay for it.

All of the informants in this study believed prenatal care was important and sought prenatal care at local obstetric clinics. Informant 5 stated, “Over here you see the doctor many times, in Mexico you don’t have that opportunity. Not everybody in Mexico can afford to go and see a doctor.” Informant 6 concurred, stating, “Here, I do go to the doctor, but back home, if you go to the doctor you would have to keep paying. So people go to the midwife.” Informant 1 added, “Being healthy during pregnancy means eating well, taking care of oneself, seeing the doctor for prenatal care is important.” Informant 10 held the same perspective: “You should have prenatal care and take care of yourself. I didn’t take care of myself during my first pregnancy [in Mexico].”

For Mexican American women, the prenatal period abounds with “old wives tales” and folk beliefs, confirming the magico-religious paradigm of this culture. Informant 16 spoke about prenatal old wives tales, saying, “Yes, when I was pregnant,

some women would tell me to not walk through an area because someone died there, and it could affect my pregnancy.” Informant 1 shared that her grandmother holds many folk beliefs:

She said cravings must be satisfied, if not it might “mark the baby.” No early baby shower, it brings bad luck. Baby wears a bracelet with red bead on it to ward off evil eye. Mother follows diet—stay away from spicy foods, hot foods. Mother is to “eat for two.” Herbal bath to be done following delivery.

Informant 23 shared another folk belief: “We do say that if you are craving something in particular you need to eat it because otherwise the baby is born with a birthmark.”

Informant 18 shared her belief that because her baby girl was born during a personal crisis, she was born with a gift of psychic ability: “Yes, she was born with a gift. I didn’t notice it, but my other daughter did, she was born with two teeth.” Informant 14 stated, “Walk a lot so the placenta isn’t stuck. Drink a lot of water and liquids. Talk to the baby while inside of you. Don’t scratch your tummy due to the stretch marks.”

During the prenatal period, all of the informants sought advice first from a respected family member, usually their mother or grandmother, and then the *curandero* or a physician. Informant 16 confirmed this perspective: “I think your mother is the best to provide advice. She has experience and knows about the good and bad things to do since she has been through [life].” Informant 17 stated, “My mother always gave me the best advice.” Informant 10 stated,

The first people to provide you with advice have to be within your family, so your mother. I came to the United States while I was pregnant, and since I didn’t have a lot of family support here, I went back and gave birth over there. I came back here after it was born.

Another issue informants commented on was the use of a midwife or *curandero* and traditional superstitions. Informant 5 talked about the use of a *curandero* for a baby that is mal-positioned in utero:

The *curandero* will send you to take a bath of flowers or herbs and to drink some of them as a tea. During my three pregnancies I never went to the *curandero*, I went to the doctor. Women use the *curandero* when they are pregnant if the baby is not in the right position, they do a maneuver on your stomach, after that they send you for a bath. After, you also wear a tight girdle.

Informants also spoke about their views on abortion, which is considered morally wrong in Mexican culture due to Roman Catholic doctrine. Informant 10 confirmed these beliefs regarding abortion: “I don’t believe in abortion. My grandmother believes it’s a sin. I didn’t even think of that as an option. My children came first for me.” Informant 19 also spoke about abortion as a moral issue:

No, I think they first . . . it’s when they found out I was pregnant, um . . . they kind of felt, well . . . you know he doesn’t want the baby, or he doesn’t want the responsibility right now then you should just get rid of it, you know, you still have your life ahead but going back to religion to me although I didn’t practice it, I felt like that’s a big role, that’s a sin, he’s already here, why does he have to pay. . . I couldn’t carry that with me

Intrapartum beliefs. Social support of family and friends was very important to the informants in this study. The informants preferred to have their mother, another close female relative, or a close female friend with them during labor. Informant 10 stated, “I would have liked my Mom at least. In Mexico, you are not allowed to have anyone.”

Many of the informants in this study preferred their husbands to be with them during labor. Informant 1 stated, “My husband was with me during labor, my family was not here, they were in Mexico.” Informant 5 stated it was very important to have her husband present during labor: “For us, it is very important that the husband has to be there while the baby is arriving, they have to see their baby born.” Informant 9 had a difficult choice to make as to who would support her in labor. When asked whom she would want to support and be with her in labor, she said,

My husband . . . I would have liked to have another person, but I wasn't allowed. My husband and my family did not get along, and it comes to a point where you have to decide if you go with your current family or not.

The presence of God in these women's lives was prominent during the intrapartum period and reflected the fatalistic worldview that there is an external locus of control, including during delivery. Informant 11 stated, "You would just entrust yourself to the Virgin to make sure all goes well." Informant 11 related this intrapartum advice given to her by the older women in the family:

They would tell me to put in a lot of effort. They say that during childbirth you have to put yourself into God's hands. Some say that you shouldn't scream because you waste a lot of energy.

Prayer also played a prominent role. Informant 11 stated that the doctor told her that her baby might be born with Down syndrome, and because she was very frightened, she turned to prayer, to God, and to the Virgin for support:

I was scared, but well, I got him, and then I asked the Virgin of Guadalupe for her health, and the baby was fine . . . I kept prayer all of the time during labor and delivery about that, for religion to give me support.

Informant 15 also expressed her belief in the power of prayer during childbirth: "I would pray to the Virgin and to God for them to be born healthy."

Postpartum beliefs. The major belief and practice surrounding the postpartum period in Mexican American women is *La Cuarentena*. *La Cuarentena* is a 40-day period of (a) rest, (b) restricted activities, and (c) a special diet after birth and offers a mother the time to bond with her newborn. Friends and older women in the family care for the new mother and baby by (a) providing meals, (b) caring for other children, and (c) helping with mundane household takes.

The custom of following some, if not all, of the practices of *La Cuarentena* was common among the study informants. Comments by Informant 1 reflected the magico-

religious paradigm found in *La Cuarentena* and the limitations of living in the United States, away from family:

We have, oh my God, you know we . . . we are not only religious but superstitious [laughing]. You know, it used to be years ago, I honestly don't follow it, but my Grandmother will tell me you are not supposed to wash your hair after you have a baby, because, God forbid, the coldness is gonna get into your body and then years from now you are gonna be in severe pain, from muscles because you are not supposed to do anything . . . actually just supposed to be on bed rest, not do anything. God forbid you touch a broom . . . But you see, in Mexico, that's possible. You cannot afford to do those things because your family is close to you. In Mexico, you tell family, they take care of you. But here, you know, if my mom is not here, then I am by myself, so I wasn't really able to do what my grandmother wanted me to do.

Informant 2 related the beliefs and practices followed by her mother and sisters:

My mom came out to visit and stayed with me a couple of days just before I had the baby and afterwards. My sisters would come and help as well—keep up the house and fix the meals.

Informant 13 further described care by the older women in the family for the new mother:

They couldn't get up for 42 days after birth. They took very good care of them. They would give them hot chicken soup. They would take them a shower with herbs. They would prepare a hot shower with the weeds that the midwife had prepared. They would cover them good. They were very careful.

The hot-cold theory is an important concept during *La Cuarentena*, which Informant 12 confirmed:

The water they give you in the hospital is ice water, and it should be warm water. I don't have anyone here to make sure that I follow that, but I do have some aunts who make sure that their daughters don't eat the food from here, and they prepare it for them. They shouldn't bathe with cold water either. It should be a warm herbal bath. The herbs they use are rue, rosemary and some other herbs that are not available here. They drink hot tea or a corn flour drink. Arnica is only used when you have had a cesarean. You drink a little of that to help you heal.

Differences in living. Informants painted a revealing contrast between life and healthcare in the United States and in Mexico. Informant 1 related,

Care here in the U.S. is very different than in Mexico. Women in Mexico usually do not work, their role is to take care of home, husband, children, so when you

have a baby, there are family and friends that will help you and you can follow the traditional practices. This is not possible here. Everyone works; many do not have their moms or grandmothers here, so it is difficult.

Informant 2 confirmed that women in Mexico often delivered in the home with a midwife or *partera* present: “My mother gave birth at home; she never went to the hospital. A midwife was with her at the time.” Informant 14 revealed that in Mexico, she delivered all three of her babies at home. The doctor was from a rural area.

Yes, he would go to my house, and just come for the delivery. I never got any other care. For my second delivery, he came to my in-laws home, he told me to go upstairs, and I had the baby right then. Where we live, only those with money and insurance go to the hospital.

When the researcher asked this informant about obtaining prenatal care, she replied,

It’s not common, and there’s no money. You just know that you will be fine. When you have the contractions, you call someone to come over. In my third pregnancy, my water broke at 5:00 a.m. at home, and the doctor came at 1:00 p.m. I couldn’t give birth and had to go to the hospital for emergency and get a cesarean because the placenta was bleeding. There have been people die with this doctor because a month before two people died at childbirth. It’s mostly an economic reason.

Informant 16 also compared the differences in lifestyle in Mexico versus the United States:

There is so much to do here. Not in Mexico, for example, the women mostly spend the day cooking, and here you are doing many things at a time. It’s different here because you have to work.

This informant also confirmed that lifestyle differences make it difficult to follow *La Cuarentena* in the United States, although it is followed strictly in Mexico:

Yes in Mexico, they stay in bed, are taken care of by the other women in the family, because the women don’t work, but here everybody works so it’s hard to follow the *Cuarentena*. We have an herbal bath after delivery, sometime during the first seven days. I don’t remember what herbs they put in, but it’s like a sauna and feels so good. Then they wrap you in a blanket. Your hair is also washed in the herbal water, and you are also given some of the same water to drink to cleanse you inside and out.

Informant 6 indicated that *La Cuarentena* is practiced here “a little bit, but not that much.” She further explained,

Here, they just go straight to work. But in Mexico, the majority most of the time, the mother or mother-in-law, they strictly take care of them for the 40 days. Cooking meals that won't harm the mother, not to lift anything heavy, bathe the baby the first few days, things the women would do for the new mom.

Informant 6 also pointed to other contrasts between life in Mexico and life in the United States, including employment and cost of living.

I feel that here and there is very different. Over here, my husband has a good job he can support the family, and I can get a different type of food for the kids . . . I can get meat, I can get, fruit, vegetables, milk, and other products that are important for the kids' health. In Mexico, the jobs are few; you won't be able to buy all the food they have here, and sometimes because of the short of money, they can't buy the different things they needed, and I thought that they would be affected in their life and health, that's why it's much better here.

This informant stated that diet is also different in the United States than in Mexico.

In Mexico, it's all fried, very greasy . . . when I first came here, it was a little hard [to adjust]. I try to cook not that greasy, I try to keep with the healthy foods, but every once in a while, I do my Mexican dishes. My family and friends want the traditional Mexican food, tacos . . . not all of them but some of them.

Several informants provided comments that revealed the differences in sociocultural gender roles between Mexico and the United States. For example,

Informant 6 stated that in Mexico the men prefer to have the women stay at home:

[The men] don't give [the women] much money to dress, to eat, and they don't like them to go out, and for the woman to obey the husband. The men always bring just enough to eat, but they love to drink in Mexico. Very few women actually go out to work in my country. Back in Mexico, the men want to keep the women at home.

In addition, Informant 8 stated that her role as mother would be very different in Mexico because she would have to spend more time with her children than she does in the United States because in Mexico she would not be able to work: “Here you have to work in order to be able to survive and keep them ‘above their heads.’” In Mexico, it would be totally

different. She would cook, spend more time with the children, and educate them.

Informants' comments did not indicate that they preferred the lifestyle in Mexico versus that in the United States, only that there were differences in lifeways.

Informants stated they preferred the healthcare system in the United States and were comforted by the technology, especially in labor and delivery and in newborn and pediatric care. Informant 21 stated she trusted the doctors more here in the United States because the doctors in Mexico stated she would need to have an abortion, but the doctors here in the United States stated her pregnancy was fine.

Machismo. *Machismo* is defined as overly assertive or exaggerated masculine behavior reflected by male (a) superiority, (b) dominance, (c) sexual infidelity, (d) aggression, and (e) drinking. *Machismo* is legitimized through a patriarchal social system common in Latino culture that promotes and condones this behavior (Gilmore & Gilmore, 1979; Mayo & Resnick, 1996; Stevens, 1973). While acculturation has changed some aspects of gender roles, comments from informants in this study confirmed the presence of *machismo* in Mexican American culture. Informant 1 discussed how her grandmother cared for her grandfather:

She did everything for him, everything. Even when my grandfather, by the end of his illness, he was still able to do a lot of things for himself . . . the women of the house took care of him completely. My grandmother, you know I wouldn't do it for my husband, but she would dress him, and you know, I'm talking about when you are 50 years old, and completely healthy. She would help him shower, she would dress him, don't ask me why . . . she never did mention it . . . that's the way she was.

Alcohol consumption seems to be a prominent element of *machismo* as well.

Informant 22 stated that it is the rare exception when Mexican and Mexican American men do not drink:

A lot of them do it. And there's no exception, at least for one or two. I think it's more one of those things that makes them more of a man. I think that if a guy doesn't drink, or "What's wrong with you? What are you, a girl? You don't drink?" It's like peer pressure.

Informant 7 confirmed another component of *machismo*: husbands doing nothing to help in the home or with the children: "I feel my husband just goes to work, and comes home whereas I do everything else." Informant 9 concurred that very few Mexican or Mexican American men help the women in the family with household tasks or the children: "The majority are very macho." Informant 12 suggested that men "don't want to appear less masculine by helping around the house."

Motherhood. All of the informants believed that pregnancy was a very happy time, regardless of their circumstances. To be a mother and care for their children was their sole purpose in life. Informant 5 said, "Children are my life." Informant 6 confirmed the importance of having children for Mexican American women: "Having children is something beautiful, something sacred."

For most, their children were more important to them than their husbands.

Informant 1 stated,

They are the reason that I live for. My children are the most important and valuable things that I have, I would do anything for them . . . I never imagined myself without children, like I wouldn't have children.

Informant 5 stated that if her husband could not be supportive to her and the children, he did not have to remain with them:

If he's not somebody who wants to be there for his child, then yes, I have to fight for my child, I don't need that man. I told my husband that if he didn't want to be there for me and my children, fine, he can just step out because I can provide for my children.

Informant 7 also believed that having children was a woman's main purpose in life and her husband was second: "I tell my husband that my children always come first."

Circle of violence. Domestic violence is rarely spoken about in the Mexican American culture, although it is common. Women are afraid to reveal that they are in an abusive relationship for fear of more abuse if the husband were to find out they were discussing the abuse with someone. The philosophy of Mexican American women is that problems in the home remain in the home and are not to be shared with anyone. However, due to the close trusting relationship between the informants, the interpreter, and the researcher, the informants began to tell a story of a pervasive cultural problem: domestic violence consisting of both physical and verbal abuse.

For some informants, domestic violence appeared following the birth of a baby. Informant 17 stated her husband was very “macho”: “*Machismo* is when your husband tells you what you can and cannot do. They control everything. They don’t let you do what you want to do.” This informant stated that when she came home from the hospital and was resting in bed after having their baby, her husband made her get up out of bed and cook for him. If she did not get up, he was going to hit her.

Other informants shared comments regarding domestic violence that they either personally experienced or witnessed in their families. Informant 10 stated that her stepfather was violent to her because of his drinking and that he was very jealous of her. In fact, he was violent toward everyone in the family:

He was violent to everybody. Sometimes we thought it was just with us, because we were not his kids, but he was violent even with his own kids. Violent to everybody in the home. When I had my baby, I saw it wasn’t good to raise my kid in that environment because he was violent, and I decided to come to the United States with the baby. They wanted me to leave the baby with them, but I said “no” because I had to leave that experience; I don’t want my child living the same type of life.

Informant 13 stated,

I have a brother who is bad with his wife and has a lot of *machismo*. It is a sense of power and control. I think it is cowardly behavior. When I lived with my parents, my brother treated me very badly, but when one becomes educated and independent, you feel that you are able to defend yourself. They become more violent when you are independent . . . when I was little, my father was violent towards my mother . . . we would tell him to stop.

This informant also stated that women do not talk about domestic violence in this culture; it is something they simply accept: “The majority don’t talk about it. The brother that I mentioned is violent with his wife. She doesn’t say anything about it and just keeps going on the same vicious cycle.”

Informant 14 experienced not only spousal abuse but also abuse from her spouse’s family. She related this story when asked by the researcher if her spouse’s parents had any influence over his behavior:

Yes, I sometimes think they want him to fight with me. My sister-in-law and I have problems. She tells my husband I have another man. When I was in Mexico, my mother-in-law would not let me leave the house, they thought I was going to see other men. I was practically locked in—I wasn’t even allowed to see my mother.

This informant stated the only way she can control her spouse is to threaten to call the police.

Here, it’s been verbally. When I was pregnant he pushed me once, but I told him if he ever did it again, I would call the police. People have told me I can call 911. That’s how I have controlled him. He only does it verbally, so I try not to listen to him. He listens to his sister; she tries to calm him because she knows that if someone hears us fighting, the neighbors can call the police.

Informant 20 confirmed the fear factor in reporting domestic violence:

I’ve seen a lot of women stay in bad marriages out of fear . . . my mom was one of those cases. She went through a lot of abuse through my dad. He came to the United States and then brought me here where he continued to be abusive until I told him I had enough. He used to hit her because of his drinking. My husband also hit me in the face and my children would see.

The informants in this study believed that the circle of violence is created and perpetuated by the mother. Informant 20 stated, “It comes from their parents and the way they were raised.” This concept is supported by psychologically oriented anthropologists, according to Gilmore and Gilmore (1979). Informant 20 added, “Mothers perpetuate it because they treat the boys differently. It is that way in Mexico. Men are treated differently, they are treated better.”

Gender roles. Gender roles for men, women, and children are clearly defined within the Mexican American culture. Children’s roles include (a) respect to elders, (b) honesty, (c) obedience, (d) politeness, and (e) no “talking back” to adults. The male role is that of decision maker and financial provider for the family. The female role is that of (a) wife, (b) mother, and (c) caretaker of the home, children, and family, epitomizing the strength of the Mexican American woman.

Regarding the role of children in the Mexican American family, Informant 1 stated, “When growing up, we sit quietly, we don’t have anything to say, and just listen. There is an expectation that children will just listen and obey.” Informant 3 stated that the expectation for children is to be very respectful toward adults: “Be very respectful. I think its respect our elders. In my family I learned that you always have your respect for your elders, that is very important . . . listen to your mother, that is number one.”

Informant 19 shared her thoughts on the importance of honesty that was taught to her by her parents:

My parents always said I had to be honest at work. My dad always told me to be honest, because since I didn’t study in school I wouldn’t work in an office but I would probably work in a house and I would have to show I can be trusted. He said that if I cleaned something I should always put it back and never take it.

The male's role in the family was patriarchal and one of dominance. Informant 1 stated, "He is supposed to be the decision maker . . . whatever he said, that's what it was . . . there was no argument." Informant 5 stated the role of the men is "just to work and support financially her and the children financially." The informant stated men do nothing in the house—"Nada!"

The importance of women's role was also revealed in the informant interviews. The sociocultural expectation was that even if they worked outside of the home, their main duties were (a) caring for the children; (b) assisting with homework; (c) disciplining the children; (d) attending to and caring for the husband and family, including cooking, cleaning, and shopping; and (e) offering support to other family members as needed. Informant 5 stated, "The woman's role in the family is to watch the children, and make sure they are very well taken care of, and have dinner ready for her husband and have the house cleaned." Informant 6 stated the woman's role "is to cook, clean, to iron, to be a homemaker, to stay at home and take care of the children and family." In other words, women are expected to do it all.

The mother's role as described by the informants was central to maintaining and caring for the family unit. Informant 3 shared her thoughts: "[The mother] is really the force of the family, she is like the glue of the family, she keeps everything together. She is the important person in the family." Informant 1 stated, "My grandmother had 10 children—her advice was not to complain—she birthed 10 babies, pain is a part of childbirth and life—its women's role, accept it."

Health. *General health* as defined by the informants focused on the ability to be active in daily activities, regardless of how they actually felt physically or emotionally,

and included (a) thinking positive thoughts, (b) relying on God, (c) eating healthy, and (d) exercising. Informant 2 stated, “Good health is just being able to do your everyday chores, being able to get out and take a walk if you’d like.” Informant 4 stated that she asks God for help in everything, including health: “I always ask God for help over everything. I think it’s up to God to whether I am healthy or not, and that if I get sick it’s in God’s hands.” Informant 6 believes exercise contributes to good health: “Keeping healthy, walking . . . I walk a lot. I try my best to eat healthy.” Eating healthy for the informants included avoiding the fried and fatty foods in the Mexican diet and eating more salad and vegetables, staples not found in Mexico, according to Informant 3: “We don’t usually eat salad and vegetables in Mexico, it’s not big for us, but it plays a big role in how you take care of yourself.” Informant 7 emphasized the importance of good health for women: “If you don’t maintain good health, what’s it going to be like for you the next day? You won’t be able to do what you need to do like work and take care of your family.”

General health beliefs and health in the antepartum were overlapping, as (a) diet, (b) exercise, and (c) positive emotions were cited as important in both areas. Maintaining good health in the postpartum period also included adhering to the hot-cold theory and following the traditional practices of *La Cuarentena*. The postpartum period is considered to be a vulnerable time, and traditional practices provide protection for the new mother by maintaining and restoring warmth, which is perceived to be lost during delivery. Rest and limited physical activities during this time are considered very important in order to promote recovery after delivery.

Melancolía de bebé (baby blues) and depresion postparto (postpartum depression). Almost half of the informants experienced *melancolía de bebé* (baby blues) after delivery and felt some depression (*depresion postparto*) in the postpartum period.

Informant 3 was asked to describe her feelings after delivery and shared the following:

I think that I felt, um . . . alone, I felt sad, um . . . not helpless, because I kind of at the same time thought that I had my son and he was the one that was giving me happiness, but um . . . I felt like in the sense I didn't have anyone to share it with.

Informant 6 was very unhappy after delivery and described herself as “very young, very confused, and very depressed.” Informant 8 admitted to feeling depressed after delivery and crying. When asked to share her thoughts after delivery, she stated, “I can't even tell you, because I don't even know because all I did was cry and cry and cry, and I don't know how to explain or express it.” Informant 9 related feeling sad after delivery but did not attribute her sadness entirely to the baby:

I did feel sad after my first child's birth because the father wasn't there with me. My mother was able to help me understand that the baby wasn't responsible for what happened. I didn't have any bad thoughts with my other two daughters. I would share a lot of my feelings with my mom.

Informant 13 admitted to having *depresion* (depression) and feelings of sadness after the birth of her son: “I wanted to sleep all day. I had a lack of energy.” Informant 23 also admitted to *melancolía de bebé* (baby blues) and “feeling sad for a few days after birth.” When asked if she shared her feelings with anyone when she felt sad, she stated, “No, we didn't have time for it. I went through it *completamente solo* [all alone].”

Summary

Descriptors of generic expressions, beliefs, and experiences from key and general informants were presented in the above section for each of the 17 categories that emerged from the data analysis. Patterns of care with the meaning-in-context were synthesized

from the descriptors discovered in the raw data, according to the second and third phases of Leininger's (2001) analysis and are discussed in the following sections.

Patterns

The following six patterns of generic care were discovered in this research:

1. The importance of *la familia* (family).
2. Belief in God as protector, provider, and source of comfort and strength in everyday life.
3. Seeking knowledge from elder women in the family to maintain maternal and infant health and well-being.
4. Maintaining traditional *valores* (values).
5. Caring as “doing” for new mothers.
6. Non-caring as “not showing interest.”

These six patterns were identified through analysis of the study data and reflect culture care values, beliefs, practices, and experiences of the informants during the postpartum period. The set of patterns are reflexive and support one another. The categories that support each of the six patterns are explored in the sections that follow. Each pattern is described using verbatim quotes from the informants, assuring presentation of the emic perspective.

Pattern 1: The importance of *la familia* (the family). The family, or *la familia*, is the central focus of Mexican American culture, as every aspect of life revolves around it. Categories supporting this pattern are (a) family, (b) religion and God, and (c) everyday life. Comments supporting this pattern were shared by informants: “I think in the Mexican culture and I see it in my family, family, it’s everything. The family provides for every and any support you need, emotionally and financially,” said

Informant 3. Informant 1 believed, “. . . we’ll be in the hospital with new mother, but you know, that person is never alone.” She further added,

When I was pregnant, I would go to church, and I would ask the priest to bless my belly. When my daughter was born, you know it’s another belief to take them to church and you present them to the Church, and *La Virgen de Guadalupe*. After delivery, the family takes care of you. But here, you know, if my mom is not here, then I am by myself, so I wasn’t able to do what my grandmother wanted me to do.

For many of the informants, *la familia* and God were inseparable. Statements such as “family is God” (Informant 1) indicated that family and God were a constant presence to offer support in all aspects of daily life. “The family taking care of the family no matter what” was a common, universal theme among all informants.

Pattern 2: Belief in God as protector, provider, and source of comfort and strength in everyday life. This pattern is supported by the categories of (a) family, (b) religion and God, (c) everyday life, (d) values, (e) traditions, (f) prenatal beliefs, (g) intrapartum beliefs, and (h) health. All of the informants believed that God is in full control of every aspect their lives, but they also stated that they have to do their part. Informant 11 stated, “The most important thing is to believe in God. If you believe in God, everything will go well.” Informant 10 presented her view:

It does mean a lot to me that God exists and that he is with me. I think that he has control in my life whether it’s good or bad. I do believe that he exists, but like it’s said, help yourself and God will help you.

Informant 6 also expressed that people have to do their part to take care of themselves: “I believe that God will help you, but as a person, you also have to put your part in.”

Informant 7 emphasized the omnipotence of God: “I think when you have faith, it can move mountains. God will cure anything At the same time, I know that God has created

medicine and I know that I can take it when I need it.” Finally, Informant 5 related her beliefs about religion and God during pregnancy and birth and after delivery:

During pregnancy religion is very important—constantly asking God to help me with the baby, and the pregnancy, and that everything will be ok, and hopefully go well during labor. Once the baby is born, after a month, I go to church and I feel that definitely take that baby to God, and thank him for allowing the child to be ok and for having him. That’s my custom, and my mother’s and sister’s as well.

Pattern 3: Seeking knowledge from the elder women in the family. This pattern is supported by the categories of (a) family, (b) religion and God, (c) traditions, (d) folk beliefs, (e) prenatal beliefs, (f) intrapartum beliefs, (g) postpartum beliefs, (h) gender roles, (i) values, (j) caring and non-caring behavior, and (k) differences in living. The informants revealed a strong respect for the elder women in the family and elder female friends and reliance on them for advice and support during the antepartum, intrapartum, and postpartum periods. These women’s support provided a cloak of protection for mother and baby. Informant 14 related her family’s beliefs regarding pregnancy and postpartum:

Mother would tell me to not get upset. There’s also a belief to not eat everything you crave because then the child is born with its mouth always open. We have a Mexican believe that after birth we take a bath in herbs.

Informant 1 stated, “If in Mexico, family would do everything for you after delivery – you are to rest and recover.” Informant 22 revealed, “And after pregnancy they gave us the 40-day treatment, and what we eat we have to watch a lot.” Informant shared information about wearing the *faja*, a tight abdominal binder:

Yes, I did wear it, it’s the one thing that helped me, helped my back, during the pregnancy what your back does it’s carrying all of that weight, plus the weight loosens up your bones, so after delivery it’s even more so, you know, you feel it, when you bend down, you feel it, how your back is all open, your pelvic cavity also you feel it, so I think that’s one thing that helped me. Um, they say not to wear jeans, wear dresses, which I wore jeans.

Pattern 4: Maintaining traditional values. This pattern was supported by the categories of (a) family, (b) religion and God, (c) *valores* (values), (d) folk beliefs, (e) traditions, (f) differences in living, (g) everyday life, (h) gender roles, (i) health, (j) motherhood, (k) prenatal beliefs, (l) intrapartum beliefs, (m) postpartum beliefs, and (n) *melancholia de bebé* (baby blues) and *despresion postparto* (postpartum depression). For the informants in this study, traditional values included not only the intrinsic personal, moral, and societal *valores* (values) such as *respeto* (respect), honesty, marriage, and family but also included those traditional values and practices related to the entire childbirth continuum (i.e., antepartum, intrapartum, and postpartum).

Informant 5 stated that in Mexican American culture, starting a family takes precedence, and educational opportunities are missed: “I want my daughter being better than me, I want her to become professional because sometimes we let pass by the opportunity that we had for starting a family. Starting a family has more importance than education.” This statement supports the worldview of the importance of children in the Mexican American culture.

La Cuarentena, the traditional 40-day period of rest and seclusion following birth, was the most significant postpartum practice discussed by the informants in this study. Informant 5 stated, “Being without my mom or grandmother after delivery made it impossible for me to follow grandmother’s traditions, primarily *La Cuarentena*.” The majority of the informants in the study indicated that they were not able to follow all of the traditional postpartum practices of *La Curantena* due to lack of gender-congruent support, but they attempted to incorporate some of the practices into their postpartum recovery period. The informants indicated it was disturbing for them not to be able to

adhere to *La Cuarentena* practices as prescribed by their mothers and grandmothers.

Informant 1 stated,

. . . when you have a baby, there are family and friends that will help you and you can follow the traditional practices. This is not possible here. Everyone works, many do not have their moms or grandmothers here, so it is difficult.

Informant 3 stated the importance of a woman being supported and cared for by her family after delivery:

. . . I think it's very hard, and you do need to have your family. I think during and after you need to have your family because you do have mixed feelings, and especially if it's the first time, something new, and you do need the support and kind of a guidance of the elder women in your family.

Pattern 5: Caring as “doing” for new mothers. The concept of care for the informants in this study was action-oriented: the act of “doing.” The act of doing included “showing interest,” which was perceived as caring. This pattern was supported by the categories of (a) family, (b) traditions, (c) caring and non-caring behaviors, (d) folk beliefs, (e) prenatal beliefs, (f) intrapartum beliefs, (g) postpartum beliefs, (h) *machismo*, (i) gender roles, and (j) health. Informant 3 stated that for a new mother, caring is “giving actions not material.” Informant 16 described what she believes caring to be:

When my husband sees that I'm sick during pregnancy or after delivery he takes care of me carefully, he would go to the pharmacy and get my medicine. My sisters through the phone or coming to visit me they take care of me. When I lost my baby, my sister came to cook. When my babies were born, my sisters come over to help with the children. They do things for me.

Informant 13 shared this experience with the *partera* (midwife in Mexico):

Yes, she was laying down like this. She pushed, and when the partera would tell her push, push, push, she would pull herself from the cord. Those people were very careful with them. They would take care of them a lot. They couldn't get up until 42 days after. They took very good care of them. They would give them hot chicken soup. They would take them a shower with herbs. They would prepare a

hot shower with the weeds that the midwife had prepared. They would cover them good. They were very careful.

Pattern 6: Non-caring as “a lack of interest.” This pattern was supported by the categories of (a) family and (b) caring and non-caring behaviors. Informant 20 provided her beliefs about non-caring: “It feels bad if a person doesn’t care for you then they don’t call you or doesn’t show any interest.” Informant 3 stated that for her as well, “Non-caring is not showing interest.” Non-caring for Informant 7 was “not calling you, not asking if you need anything, not showing interest in you—they wouldn’t be important to them, they wouldn’t be interested.”

The informants also indicated that healthcare providers who did not speak Spanish indicated a lack of respect and non-caring behavior by not showing an interest in attempting to communicate with them in their language. Informant 10 stated that not only did the doctors and nurses not speak Spanish to her, but she also did not speak one word of English. A translator was not provided to her, and as a result, she perceived the healthcare providers to be non-caring and had a very bad experience:

They have a different treatment for me, and I don't know because they maybe, the difference, because the nurses were mostly African American, they don't speak Spanish and then when I was ready to leave, they didn't give me a wheelchair, I gotta walk the whole way out of the hospital and everybody was getting a wheelchair, and I got a c-section, and I had to carry the baby out of the hospital, and then one of the nurses scratch me over my arm [showed arm] a big and deep scratch.

Introduction of Themes

From these patterns were derived three major themes, which are presented in the sections that follow:

Theme 1: God, prayer, and family are the base of everything in life and provide support, strength, and protection. This universal theme is supported by these

patterns: (a) the importance of *la familia*, (b) belief in God as protector and provider, (c) seeking knowledge from elder women in the family, and (d) maintaining traditional values. The informants in this study identified that God, prayer, and family were interwoven and provided support for dealing with the trials and tribulations of everyday life, which were intensified during the postpartum period. The deep faith and spirituality of the informants was revealed by constant prayer, especially during postpartum. Informant 21 shared, “Every day I would pray, but after the first [delivery], I had complications, and I would pray more because I became very sick.” Informant 22 stated that her mother and significant other were not supportive of her, and she prayed constantly after delivery to *La Virgen* and God, “Now is the time where I will go to church often, I would ask the *Virgen* and God to help me through this, I would pray her and God” Informant 11 confirmed the importance of *La Virgen de Guadalupe* and prayer: “In Mexico, we believe a lot in the *Virgin of Guadalupe* and you can see when we all get together to pray to her during her day.” Prayer was particularly important during pregnancy, childbirth, and postpartum, and this strong focus on prayer and God was illustrated by comments such as this one made by Informant 11:

From the minute that I found out I was pregnant, I put myself in the *Virgin’s* hands. During the pregnancy, they told me that there was a possibility that my child would be born with Down syndrome. I put my child and myself in the *Virgin of Guadalupe’s* [*La Virgen’s*] hands for everything to turn out right. I kept praying during labor and delivery, and after delivery for [*La Virgen’s*] help.

Informant 11 shared that she prayed more after delivery not simply for herself but because of her concerns for her baby.

Informant 20 revealed that she also would ask for God’s help during pregnancy, delivery, and postpartum. The informant stated that her prayers after delivery were more focused on her God’s protection of her new baby rather than herself:

I would ask for His help during the pregnancies. During the childbirth, I would ask him to help me deliver him faster. I would always pray that they were healthy and that I would have a fast recovery after the birth. I would pray more for God to protect my new baby.

It is noteworthy that, for the majority of the informants, religion and God were separate. The informants connected religion with attending formal church services. All informants except one were Roman Catholic, but none attended church services on a regular basis. Informants expressed that in Mexico, they were more likely to attend church on a regular basis: “In Mexico, I would go to church every day, but here I have gotten away a little a bit from it, I don’t know why, I still have faith,” said Informant 14.

Regardless of church attendance, God offered a sense of security in daily life for the informants. When asked about the importance of God and religion in everyday life, Informant 10 expressed that she gained,

. . . usually a sense of security because when I came to this country there was a church on my way home from work. There was a statute of baby Jesus, and I would cry in front of it and pray. I would ask him for help and make sure that he kept my son and I together all the time. So I think that the help was more spiritual than anything else. I would ask for faith and strength.

This belief was repeated throughout the interviews by all informants.

Theme 2: Protection of mother is transmitted intergenerationally by elder Mexican American women and is influenced by religion, folk and family beliefs and practices. This theme is supported by the following patterns: (a) *la familia*, (b) belief in God as protector and provider, (c) seeking knowledge from elder women in the family, (d) maintaining traditional values, and (e) caring as “doing.”

The informants relied completely on the wisdom and advice of the elder women in the family or female friends, both in Mexico and in the United States, during all phases of the childbirth continuum; however, this reliance was intensified during postpartum.

The informants shared their feelings of vulnerability as first-time mothers, and felt comforted and protected by the wisdom of the elder women in the family. Information would be sought first from the elder women, usually mother and/or grandmother first, then either elder sisters or aunts or friends, followed by the *curandera* and/or the physician. Traditional postpartum beliefs and rituals, such as *La Cuarentena*, were perceived by the informants to offer protection to both mother and baby. The informants attempted to adhere to the postpartum rituals and practices that were passed down by their mothers, grandmothers, and aunts, but acculturation into the lifeways of the United States often prevented them from adhering completely to *La Cuarentena*. Illustrating this, Informant 1 stated, “Without my mom or grandmother after delivery made it impossible for me to follow grandmother’s traditions.”

Many of the study informants did not have mothers, grandmothers, or aunts present in the United States and relied on either friends or sisters-in-law during the postpartum period, revealing a “family of women” who provided support. Informant 10 stated that she came to the United States while she was pregnant, “but since I did not have the support of my grandmother, mother, and aunts, I returned to Mexico to have the baby, and then I returned to the United States after *La Cuarentena*.” Informant 5 stated that she also had no grandmother or mother here, so she relied on her sister-in-law for help: “She helps me with my children a lot, and after I had the babies and any problems I may have with the family or if I need advice, I go to my sister-in-law.”

The influence of religion and folk practices is also present during the postpartum period. Folk practices during postpartum included (a) ritual herbal baths, (b) drinking of herbal teas, (c) maintaining warmth, (d) resting, and (e) limiting activity. Informant 13

confirmed both the influence of religion and folk practices and the influence of acculturation:

I prayed every day for a safe delivery and a quick recovery. [My mother and grandmother] took me to shower when I had my first daughter. My mom took me a shower with weeds, not with a lot of them, but I don't remember the name of them. I felt good when they took me a shower with water and that I was able to recuperate very quickly. It felt good that they took me a shower.

Informant 5 described her reliance on religion and family practices for protection:

. . . religion is very important. I am constantly asking God to help me with the pregnancy, the delivery . . . hopefully all will go well during labor, and the baby, and that everything will be ok. Once the baby is born, after a month, I go to church, and I feel that definitely take that baby to God and thank him for allowing the child to be ok and for having him. That's my custom and my mother's and my sister's as well.

Many informants confirmed the folk practice of herbal baths after delivery.

According to Informant 14,

You can do one or the other, either sauna with alcohol and sulphur, or herbal bath. The herbal bath is more effective, but some people prefer the other. You go to a steam bath; they bathe us there with the herbs. That helps get us clean. They say that when you are having a baby your bones are separated, so the steam bath helps the bones with the warm air. We also believe that woman that can't get pregnant should take those baths to help them have a baby. Those are beliefs we have; we don't know if they work or not, but we still do them.

Informant 19 described a *temescal* bath, which is a vapor bath using the earth: "It's a vapor bath and the woman goes in there and it's very hot." Informant 20 also described the ritual bath:

They give us an herbal bath. They add rosemary and a holy herb to boiling water. They cover us so that we sweat it in. It is believed that this helps with the cooking the milk for the baby. Otherwise, the baby will get sick and get diarrhea.

This Informant also stated that her mother and grandmother suggested that she eat a lot of chicken soup and that she not take a bath at the hospital "but rather we would take a hot

herbal bath with rosemary after three days.” Informant 21 described the bath she received:

It’s like a steam bath. They usually recommend to do it during the 40 days, I recently did it and you feel the difference. You sweat a lot cause it’s a steam bath with all of those herbs that’s melting, and it relaxes your body, and they wrap you around with blankets with a lot of heavy blankets after you get out of the bath. They tell you to step out of the tub and they wrap you as soon as you get out. You don’t even dry yourself; you only dry your face. And you’d be wrapped from head to toe.

Informant 15 stated she helped her daughters after their delivery. However, her daughters did not believe in the traditional practices:

I didn’t feel sad; they think differently and I have to respect that. I cannot force my beliefs on them. I did help them for 3 weeks. I would feed them, help them with the baby, and take care of them. I haven’t seen those herbs here either. My mom would say the bath was to help your body get strong. They didn’t believe in that, so maybe their body is not strong now.

Regarding superstitions, protection of the baby from “evil eye” or *mal de ojo* is very important, as Informant 5 illustrated:

Evil eye—*mal de ojo*—I believe in that, when the baby is born I use a red bracelet (hand or foot) or under the T-shirt, or use the T-shirt backward, break an egg in water to see if the baby had a problem. Then, you give the baby an egg bath.

Theme 3: Showing interest, being attentive, and speaking Spanish indicate respectful behavior and are central to the meaning of care. This theme is supported by (a) *la familia*, (b) maintaining traditional values, (c) caring as “doing,” and (d) non-caring as not showing interest. Theme 3 speaks to relational aspects of caring for postpartum Mexican American women. Mexican American informants described (a) showing respect, (b) being attentive to, (c) carrying out acts of “doing,” and (d) speaking Spanish as the best way to express care to an individual.

During the postpartum period, caring acts by family and friends included (a) helping with the new mother and baby, (b) helping with household tasks, (c) cooking, and

(d) caring for other children. Caring for these women was taking action, and the action of “doing” something for the new mother would assist her during the postpartum period as well as show interest in her. Informants also perceived calling, keeping in touch, and asking how they were as indications of caring and interest. Informant 4 defined caring acts like this: “to take care of me and be considerate. I would like for them to help me and cook and help me with the baby so that I can sleep.” Informant 20 stated, “Right now since I had the baby, my mom always shows she cares for me, and she always calls. She has seen me through all of my pregnancies when the babies were born.” Informant 6 added, “My family who would me call ask me how I am doing, and my friends, just one friend who is religious who always calls me, the nurse that takes care of my daughter.” She also described caring for a new mother as “cooking meals that won’t harm the mother, not to lift anything heavy, bathe the baby the first few days—things the women would do for the new mom.” According to this Informant, “It feels nice that someone cares for you.”

Non-caring behavior for all of the informants was “not doing”: (a) not calling, (b) not visiting, (c) not asking if the new mother needed anything at all, and (d) not showing interest in the new mother. Informant 6 described non-caring behavior as follows:

Not to call me, I don’t receive any mail [from Mexico], and if there is something they know I like to eat . . . if none of those things are happening, then I know that people don’t care, I am not important to them.

Healthcare providers who (a) spoke to the women while maintaining eye contact, (b) answered their questions, (c) showed an interest in their lives, and (d) spoke Spanish were perceived to be caring individuals. The informants believed respectful behavior to be (a) listening to them, (b) allowing them to ask questions, (c) explaining information to them, and (d) acknowledging and addressing their individual needs and concerns. In other

words, respectful behavior involved being attentive to them and taking an interest in and being concerned about their everyday lives. In the Spanish translations, the verb *attender*, which translates “to care for or look after,” was the verb most commonly used to describe caring behavior. Attention to and showing interest were directly associated with caring for these informants. For Informant 5, doctors who show care “ask you, ‘What do you have? How do you feel?’ Others just come in to check you and don’t allow you to ask questions.” Informant 19 described an act of caring by one of the nurses at the hospital who was caring for her after delivery: “A nurse that worked in St. Joseph’s, her name was Ana. She gave me a stamp of the Divine Child of Jesus; it’s very miraculous. Most children could die, but my daughter is healthy.”

Healthcare providers who spoke Spanish were very important to the informants. Informant 13 discussed what she perceived to be caring behavior from her healthcare providers:

Yes, the doctors will sit down next to me and start talking to me. They would ask me where did I work and what I do. They gave me trust, and I trusted them too. They would tell me everything was going to be okay, and they would tell me not to be scared. They would tell me since it was my first time not to be scared. I had good support, and that was important. By sitting next to me and talking to me not like a doctor but as a friend and speaking to me in Spanish.

Informant 5 stated,

The majority of the doctors, they treat me very well. They are not Hispanic, one is Filipino, the other is Dominican, both speak Spanish. If they don’t speak Spanish, the nurse will translate for me, but I am not sure she is saying everything the doctor is saying. It is much better if I can communicate directly with the doctor. Then, I can be sure of what he is saying.

When the researcher asked Informant 9 how she felt about the doctors and healthcare system in the United States overall, she offered this perspective:

I do believe that they help us. We may have a language barrier, but we find a way to communicate. A lot of times, when you don’t have the means to pay for your

medical care and you make an appointment, you don't actually get one until months later. If you were to go to a private practice you can get an appointment right away, but you would need to pay \$60.00 or \$80.00. They are good doctors, and they do help out. Initially, I went to the clinic, and then now I go to a private. The doctors are good once you're in there, but to get an appointment, it takes a few months. It may not even be them, but maybe the receptionists are the ones who decide.

Research Questions

The three research questions posed by this study were answered through the data from the informants' interviews. Data were collected using the Ethnonursing Inquiry Guide that focused on obtaining information regarding the domain of inquiry. Rich information was obtained from key and general informant interviews regarding (a) cultural beliefs and lifeways; (b) kinship and gender roles; (c) political factors; (d) religious and spiritual factors; (e) meanings and experiences of care; (f) prenatal, childbirth, and postpartum practices of care; and (g) meanings and care experiences after delivery. The answers to the research questions were obtained from the data analysis. The following is a summary of the collected data that provide answers to each of the research question.

Research question one: How do Mexican American women describe the postpartum experience? The informants of this study described the cultural practice of *La Cuarentena* in rich, descriptive detail. *La Cuarentena* is not only a rich cultural tradition but also provides a protective mechanism during the vulnerable state of postpartum for both mother and baby. Even if *La Cuarentena* is not always practiced in the traditional way, it has an effect on the postpartum experience. All informants, regardless of their degree of acculturation, the presence of the support of elder women, or their own personal beliefs, practiced *La Cuarentena* to some extent. If no other women were available for help, a few husbands would assume that supportive role.

Research question two: What are the generic cultural expressions, meanings, beliefs, health and self-care practices, and experiences of Mexican American women during the postpartum period? The informants described a variety of folk and traditional practices during the postpartum period for promoting recovery and maintaining health. *La Cuarentena*, the 40-day period of seclusion, was extensively detailed by the informants as the key generic practice during the postpartum period. This period consisted of (a) support by the elder females of the family or friends; (b) rest; (c) special foods, particularly chicken soup and herbal teas; and (d) the wearing of the *faja*, the tight abdominal binder believed to assist in achieving a “flat belly” and keeping the abdominal organs in place. The hot-cold theory was adhered to in the postpartum period. Informants drank only hot fluids and dressed warmly to avoid any chill they believed would cause long-term health issues, such as gynecological issues or arthritis. Certain foods and fluids were to be avoided such as pork (which was perceived to be heavy and “infectious”) and lemon or lemonade (which was thought to decrease breast milk production). Noteworthy is that while not all aspects of *La Cuarentena* may be followed, the informants always attempted to include those aspects that they were able to, given lack of female support.

The informants also discussed in detail their reliance on and the importance of God, prayer (especially to *La Virgen*), and family for support and strength. The informants shared that their baby girls were taken to church about a month after delivery to be presented to *La Virgen de Guadalupe* as thanks for a safe delivery and healthy baby. Being a true daughter of *La Virgen of Guadalupe* was very important to the informants, as *La Virgen* is a symbol of hope for Mexican Americans and Mexican

American women. Various expressions were used to connote terms in the postpartum period, such as *postparto* (postpartum), *la depresion postparto* (postpartum depression) *la Cuarentena* (the 40-day postpartum recovery period), *faja* (abdominal binder) *trieste*, (sad) and *triestza* (sadness).

Research question 3: In what ways do worldview, cultural and social structure, and ethnohistory influence the care expressions, meanings, beliefs, practices, and experiences in the home and community context for Mexican American postpartum women? Rich descriptors of the community, worldview, and cultural and social structure dimensions of Mexican American women were reflected in the key and general informant interviews. Morley (2000) revealed that Mexican laborers adapt to a changing environment by fostering a stronger cultural identity. A similar focus on cultural identity allows Mexican American postpartum women to shape their experience in ways that are meaningful to them, in spite of realities that are incongruent with their values, beliefs, and practices. Mexican Americans are more focused on their cultural identity than any other immigrant group (Garza, 1998). The informants in this study revealed this same strong sense of cultural identity and attachment to their native homeland, which was expressed by following the same postpartum generic traditions and practices, as much as possible, as adhered to in Mexico, as well as communicating in Spanish.

This strong sense of cultural identity was also demonstrated by the connectedness with each other in the community, forming a supportive social network. Despite being separated from traditional support systems (i.e., their Mexican family), the informants demonstrated their support for each other by offering to care for children, go shopping, or

assist the new mother in any way possible. This researcher hypothesized that, based on the data from this study, the postpartum experience in the United States during this transitional cultural situation is strongly influenced by the Mexican American worldview, and equilibrium is established during postpartum by following those traditional practices that are meaningful to these women. Stern and Kruckman (1983) hypothesized that a structured postpartum period, enforced by a period of rest, seclusion, special diet, social support, and recognition of the role of mother, contributes to the health and well-being of mother and baby, promotes recovery, and mitigates the incidence of postpartum depression.

Summary

This chapter presented the findings of the second and third phases of data analysis and closed with the presentation of three major themes. The second phase of data analysis identified 17 categories related to the domain of inquiry of understanding the cultural expressions, meanings, beliefs, practices, and experiences of Mexican American women during the postpartum period within the context of a northern New Jersey community. The third phase of data analysis revealed six patterns related to the domain of inquiry out of which evolved the three major themes. Chapter 5 fully explicates the three themes within the context of the literature.

Chapter 5: Discussion of Findings, Implications, and Recommendations

This chapter includes discussion of the thematic findings as they relate to extant knowledge regarding the cultural expressions, meanings, beliefs, practices, and experiences of Mexican American women during the postpartum period. The purpose and specific goals of this ethnonursing study were as follows: (a) to utilize participant observation and semi-structured interviews to gain an emic and in-depth understanding of the lifeways, beliefs, and practices of the postpartum period among Mexican American women living in a community setting in Passaic County, New Jersey; (b) to identify how the worldview, cultural, and social structure dimensions influence postpartum Mexican American women's generic, traditional, and professional healthcare beliefs and practices; (c) to discover and describe culture care knowledge, including folk and professional caring practices, that promote the health and well-being of Mexican American women during the postpartum period; and (d) to explore ways to integrate both folk and professional healthcare practices into culturally competent, appropriate, and sensitive care to postpartum Mexican American women. It is vital to achieve these goals in order to educate nurses in developing a culturally competent postpartum plan of care based on Leininger's three action modes.

Noteworthy is the fact that minimal extant research literature exists regarding the domain of inquiry for this study. An exhaustive search was conducted using multiple nursing and non-nursing databases, such as (a) CINAHL, (b) pre CINHALL, (c) ProQuest, (d) ProQuest Dissertations, (e) PubMed, (f) Medline, (g) PsychInfo, (h) EBSCOhost, and (i) eHRAF (Yale University's Collection of Ethnography, Department of Anthropology). Berry (1996, 1999, 2002) stated in her research that she found "few nursing studies . . .

that explicated generic cultural care during pregnancy in the Mexican American culture” (p. 204), while this study discovered *no* extant nursing studies explicating generic cultural postpartum care among Mexican Americans women. Any discussion of the cultural context of the postpartum period occurred primarily among anthropologists (Kruckman & Smith, 2002; Stern & Kruckman, 1983) and nurse anthropologists (Kay, 1980). This researcher focused this study on the postpartum period because of the paucity of literature regarding this crucial period and the significance for nurses to understand the beliefs and practices of the most rapidly growing Hispanic subgroup in order to deliver culturally sensitive and competent care.

Of importance is the fact the postpartum period is considered to be the most vulnerable period for Mexican American women, while in the Anglo culture in the United States, the prenatal period and only the first hour postpartum are considered to be vulnerable times. Once a woman successfully negotiates that 4th stage of labor, as this hour is called (Bobak et al., 1995), she is discharged from labor and delivery to the postpartum floor, and the physiological monitoring of blood pressure, pulse, temperature, heart rate, and lochia are no longer assessed as frequently. This is in direct contrast to every other culture in which the focus is on mother and baby during what is believed to be the most vulnerable time: the postpartum period, which lasts 30 to 40 days or longer, depending on culture (Burk et al., 1995; Callister, 1995; DePacheco & Hutti, 1998; Horn, 1990; Kay, 1980; Kendall-Tackett, 1994; Kim-Godwin, 2003; Kruckman & Smith, 2002; Olson, 1992; Posmontier & Horowitz, 2004).

Finally, this chapter presents (a) conclusions, strengths, and limitations of the study; (b) implications for nursing, education, practice, and research; and (c)

recommendations for future studies. This discussion interprets the findings within the context of the current literature. The domain of inquiry for this study was understanding the cultural expressions, meanings, beliefs, practices, and experiences of Mexican American women during the postpartum period within the context of their lives in a Passaic County, New Jersey, community setting.

The discussion of the findings in Chapter 5 focuses on the themes that were identified in relation to the domain of inquiry. The thematic findings were grounded in the data obtained through the interviews and the researcher's observations and reflected the perspectives of the Mexican American women informants. Each theme is presented and discussed. Leininger's (2002) three predicted modes of nursing care actions and decisions derived from culture care theory are presented to support the provision of culturally competent and congruent care for postpartum Mexican American women.

A schematic model was developed to visually clarify these findings and their relationships. Figure 1 depicts the worldview of Mexican American women and the relationship in these findings between the women and the nurse. The entire schematic represents the worldview of postpartum Mexican American women. Contained within the worldview are categories, patterns, and themes of culture care beliefs and practices explicated from the emic data obtained during the informant interviews. The postpartum experience is influenced by this worldview. The 17 categories, listed in the schematic and fully explicated in Chapter 4, are repetitive and, at times, overarching reflections of responses given by the informants in response to the guided interview questions and dialogue with the researcher. The categories represent a broad emic perspective of culture care constructs.

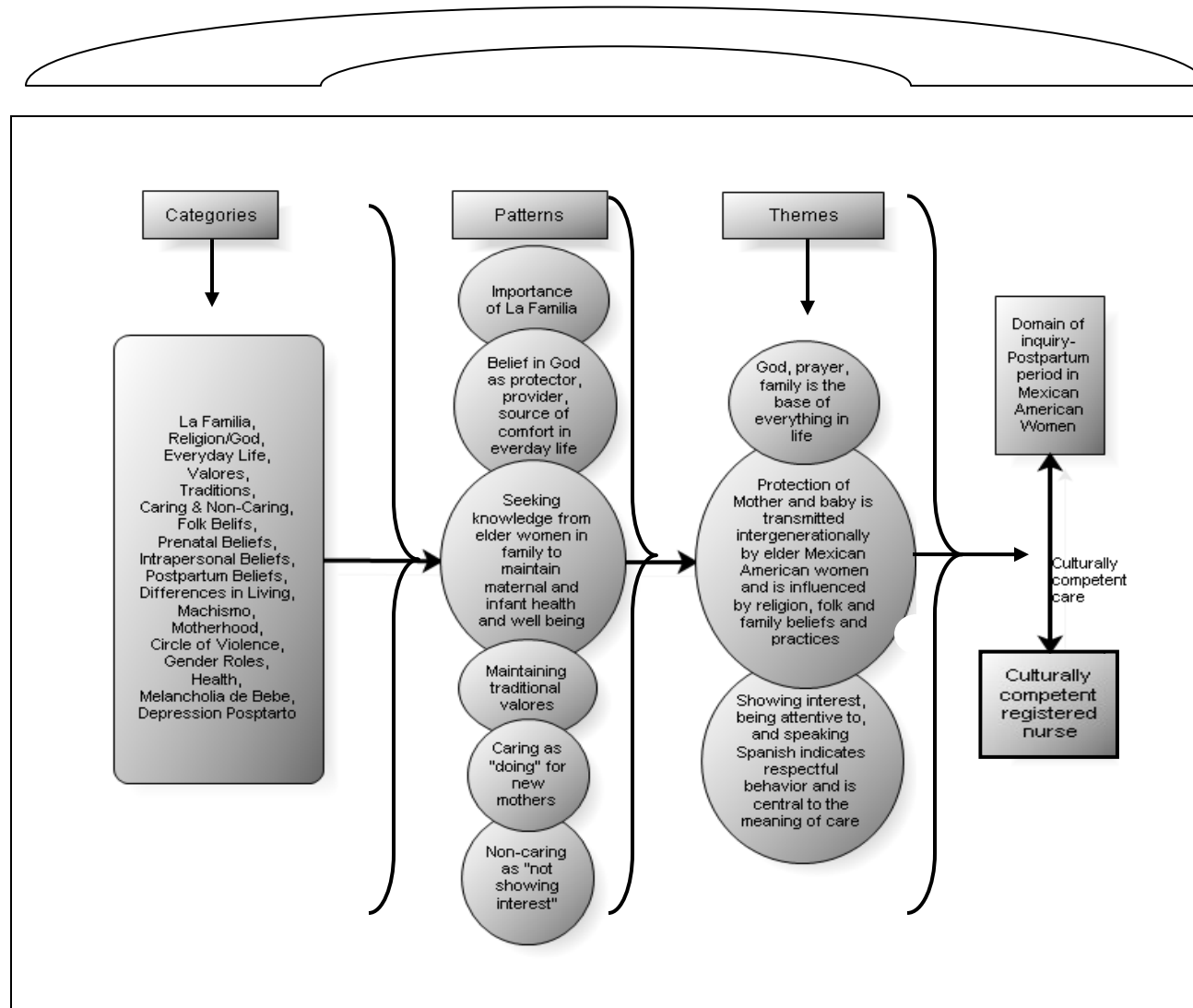


Figure 1. The cultural context of culture care practices of Mexican American women.

Six patterns, listed in the schematic and explicated fully in Chapter 4, emerged after re-immersion and re-reading of the data obtained within the categories and from ongoing informant interviews. The patterns are also overlapping at times in their components, but each represents a distinct construct of culture care. Further synthesis of the patterns resulted in the identification of three overarching themes, which are listed in Figure 1. The interconnectedness of categories, patterns, and themes is indicated by the arrows in Figure 1. The schematic reveals overarching components of the worldview that are present in the Mexican American culture that directly influence the postpartum experience.

The three themes represent the worldview of the domain of inquiry of Mexican American women. The nurse may improve cultural competency by understanding the interconnectedness of the themes because they represent the worldview that influences the postpartum experience. When nurse understands the domain of inquiry, she/he can provide culturally competent and congruent to postpartum Mexican American women, and gain knowledge of the antepartum and intrapartum periods as well. These three periods in the childbirth continuum are inextricably linked. Most importantly, by understanding that the worldview influences all three periods, the nurse can deliver culturally competent, congruent, and sensitive care that is holistic in its totality, which is crucial.

This researcher identified that nurses were culturally naïve regarding cultural beliefs and practices of Mexican American women based on her personal experience of working in labor and delivery for 29 years in four different hospital organizations. The first hour after delivery, the 4th stage (Bobak et al., 1995), is the beginning of

postpartum, and it was clearly evident to this researcher that culturally sensitive, appropriate, and congruent care was not being delivered and, regretfully, was not a priority among nursing peers. What was most disturbing to this researcher was the fact that all of the hospitals but one had a high number of Mexican American female patients, and nurses were no more culturally savvy in those organizations. After conducting a literature review, it was evident to this researcher that no extant research existed regarding the postpartum beliefs and practices of Mexican American women; however, research had been conducted regarding prenatal beliefs of Mexican American women (Berry, 1996, 1999, 2002) and intrapartum beliefs and practices of Latinas (Gallo, 2003).

It was due to this researcher's personal experience of observing culturally incompetent care to Mexican American women and the discovery of no extant research regarding the beliefs and practices of childbearing Mexican American women that prompted the focus of this study on the postpartum period. As stated previously, the intent of the study was not to investigate the antepartum or intrapartum periods, but serendipitous findings of this study revealed the overarching aspect of the worldview of Mexican American women influenced all three childbearing periods.

Holistic, culturally sensitive, and competent care is the care Leininger (2001, 2006; Leininger & McFarland, 2002, 2006) stressed that nurses must deliver and that, today, is so lacking in settings across healthcare. Nurses who understand the worldview of Mexican American women and the ways antepartum, intrapartum, and postpartum beliefs and practices are interrelated will be prepared to care for women in any one of the maternal child areas.

Theme 1: God, Prayer, and Family are the Base of Everything in Life and Provide Support, Strength, and Protection

For Mexican American women, the first theme identified was “God, prayer, and family are the base of everything in life.” This theme was supported by the patterns of (a) the importance of *la familia*, (b) God as protector and provider, (c) seeking knowledge from elder women in the family, and (d) maintaining traditional values.

God, religion, prayer, and family were all interwoven into daily life, and faith, church, and community life permeate the lives of Mexican Americans (Berry, 1996, 1999; Burk et al., 1995). All of the informants in the study admitted to having family, God, and prayer as the central focus in their daily lives, and this was intensified during postpartum. These three concepts formed the foundational base of the lives of the informants in this study and offered support during the vulnerable postpartum period.

The literature confirmed that the worldview of Mexican American women is “closely intertwined with their spiritual beliefs” (Berry, 1999, p. 205). This concept was confirmed by the religious articles and statues viewed within the contextual setting of the homes of the first 10 informants who were interviewed. The literature richly describes religious icons within the home context, saying that “many homes contain shrines with statues and pictures of saints” (Clemen-Stone, McGuire, & Eigsti, 1998, p. 181). Statements from informants such as, “I have faith,” “I leave it to God,” and “God will take care of me,” are examples of this reliance on God and reflect, to some degree, the belief in an external locus of control (Eggenberger, Grassley, & Restrepo, 2006).

Within the community context, interviews occurred in the Catholic Church administrative annex building, reflecting the Catholic Church’s important role of serving and assisting Mexican Americans in this community. The Catholic Church in this community supports and strongly collaborates with the local hospital’s outreach

programs, particularly those geared to Mexican American women's health issues with a focus on pregnancy and the postpartum period. Antepartum, intrapartum, and postpartum health assessment and education are provided in designated rooms on the second floor of the Church administrative offices annex.

Spiritual care beliefs and practices that offer a source of strength and promote health and well-being are woven into the daily lives of Mexican American women and their families (Kruckman & Smith, 2002; Leininger & McFarland, 2002; Stern & Kruckman, 1983), as was clearly reflected in the informants' lives. While Mexican American women have been stereotyped as devoutly Catholic, Amaro's (1988) study did not confirm that finding. The study revealed that, on a self-rating scale of religiosity from 1 (*not at all*) to 5 (*extremely religious*), only a small percentage of women considered themselves to be extremely or very religious (0.7% and 14.6%, respectively). The majority of the women rated themselves as somewhat (48.9%) or slightly (32.1%) religious. On average, women participated in some form of religious activity on a monthly basis. The most common activities cited were praying and attending church.

The majority of the informants in this study were Roman Catholic, and the most frequent religious activity cited was prayer throughout each day, which is congruent with Amaro's (1988) findings and those of other researchers (Burk et al., 1995; Martinez-Schallmoser et al., 2003; Page, 2004). Statements such as giving thanks to God for everything in their lives and praying throughout the day were common. Prayer and reliance on God and *La Virgen* provided a source of strength for these women in coping with everyday life. Informants revealed that their reliance on prayer to God and *La Virgen* during postpartum was intensified.

Of interest is that the informants in this study distinguished between religion and God. Religion was associated with church attendance. When the researcher asked how religion influenced and was important in their daily lives, particularly during postpartum, the frequent response was, “I don’t know about religion, but I believe in God, and I pray every day. My faith is very strong.” The majority of the informants indicated they did not attend church regularly in the United States, but God and prayer were ever-present in their daily lives. The informants indicated attending church in Mexico was much easier for them. Children could play outside in the park by the church, and the women did not have to worry about them or cope with restless children during mass. For a few moments out of their day, they could concentrate on mass without having to worry about the children. In the United States, the situation was different, and the informants indicated it was often a hassle to take three or four young children to church.

The reliance on family, God, and prayer was intensified postpartum. The informants expressed concern for a safe delivery, a healthy baby, and an uneventful recovery from birth and believed that while appealing to God and *La Virgen* in prayer would not necessarily assure a positive outcome, they still believed, “God and *La Virgen* will take care of me.” Magana and Clark (1995) examined the role of religion as a protective mechanism for Mexican American women and their babies. Their findings indicated that religiosity led to a positive attitude regarding pregnancy. It was noteworthy that the researchers discovered that religiosity declined with acculturation. However, in a study by Romero, Robinson, Haydel, Mendoza, and Killen (2004), it was hypothesized that “the maintenance of culture of origin values such as *familism* may decelerate the rate of acculturation within families, leading to less intergenerational strife and better health

outcomes” (p. 35). The findings also revealed that the Virgin of Guadalupe was a source of strength and comfort for Mexican American women, and this was confirmed by the informants in this study.

This researcher discovered that while many of the informants had lived in the United States for a very long time, they were not very acculturated into American lifeways. However, acculturation played a factor in terms of religiosity, as informants admitted to not attending church regularly, which is congruent with Mangana and Clark’s (1995) research.

Familism. *Familism* is a central and dominant construct that plays an important role in caring for postpartum Mexican American women. *Familism* reflects the group-centered or collectivistic nature of the Mexican American culture that centers on the welfare of the group rather than the individual (Romero, Robinson, Haydel, Mendoza, & Killen, 2004). Research has clearly demonstrated that “one of the most important social structure factors in the Mexican American culture is family and kinship ties” (Berry, 1999, p. 206; Villarruel & Leininger, 1995). During pregnancy, *familism* discourages heavy work and any activities that would negatively affect the woman and pregnancy, such as smoking, drinking, or use of drugs (Lipson, Dibble, & Minarik, 1997).

The link between familism and the postpartum is especially strong. Family support is more essential for Mexican American women during this vulnerable period than any other time during pregnancy, providing a solid foundation of trust and support for Mexican American women. This is evidenced by the informants’ comments that family is everything and that, no matter what, they can rely and trust in the family to offer the support and care they need. The influence of *familism* was a dominant theme

throughout the interviews. Findings illuminated the informants' reliance on their families not only to meet their needs but also to solve problems. According to informants, this reliance on family support intensified during postpartum, especially in terms of physical support and care and advice for themselves and for caring for the newborn.

The literature is replete with discussion of *familism* and the central role family plays in the life of all Hispanic groups, particularly Mexican Americans. It has been posited that Latino families that have a high degree of *familism* have (a) positive interpersonal family relationships, (b) greater family unity and social support, (c) collaborative family support in daily activities, and (d) close contact with extended family (Romero et al., 2004). For the informants in this study, extended family included (a) mother, (b) sisters, (c) aunts, (d) uncles, (e) cousins (first, second, or third removed), (f) grandparents, and (g) friends. All were considered members of a "family" that makes up the community to which one belongs.

Interestingly, in an ethnographic study of Mexican Americans, Kay (1977) found that while large extended families had declined, "close family ties were maintained through frequent visits and telephone contact" (p. 204). Informants in this study confirmed that frequent phone contact was the primary way of keeping in touch and feeling close to family members, regardless of where they lived. Frequent visits were only possible if close family lived nearby. For the majority of the informants in this study, this was not the case, so they relied on phone contact. Another finding in this study confirmed by the literature was that informants believed that telephone contact indicated interest and caring behavior.

For Mexican American women in this study, family and kinship were central to (a) providing hands-on assistance, (b) offering guidance when making decisions, and (c) offering emotional support, particularly during postpartum. The postpartum period was a time when female support was essential to recovery. Absence of female relatives, such as mother, aunt, or grandmother, was perceived as detrimental to participation in traditional practices and, more importantly, perhaps detrimental to achieving health and recovery, not only postpartum but also in the long term. If family were not present here in the United States, the informants stated that friends would help them after delivery; however, the informants indicated that help from friends was somewhat limited and not quite the same as help from a mother, aunt, or grandmother. Of interest is that while the informants did not necessarily ascribe to some of the generic beliefs and practices of the elder women, they complied because “they know best,” revealing the concept of *respeto* (respect), which was one of the most important cultural values informants cited. Comments such as, “I tell my children they have to respect their family,” “The most important thing I have is my family . . . you have to respect them,” and “What we’ve had instilled in us from the beginning . . . respect . . . you don’t see much of that anymore . . . I tell my children you have to respect family and others if you want respect,” were echoed throughout the interviews, validating the importance of the family. The researcher hypothesized that the informants may have complied with the traditions not only out of respect but also from a level of belief or acceptance that these practices were beneficial in some way and not harmful.

Romero et al. (2004) found that high levels of *familism* are associated with positive health outcomes, particularly during the postpartum period. Positive health

outcomes during postpartum are correlated with social support, which is an important aspect of *familism*. The informants relied heavily on social support from their respective families, another finding supported by the literature (Berry, 1996, 1999). Leininger (2002) stated that Mexican Americans have less mental illness due to their close relationships with extended family members who give direct support for their cultural beliefs and values. Religion and family ease daily stresses and conflicts, according to Leininger (2002), and the informants clearly articulated this belief in the study. Of interest is that the literature clearly points to social support as one of the strongest mitigating factors in the development of postpartum depression (Beck & Froman, 2005; Beck & Gable, 2003; Hascup, 2003; Kim-Godwin, 2003; Leininger & McFarland, 2002; Posmontier & Horowitz, 2004; Sherraden & Barrera, 1997; Stern & Kruckman, 1983).

Jones and Bond (1999) conducted a study on predictors of birth outcomes and observed the importance of *la familia* and having children: “Children are considered a gift; bearing and rearing children are the essence of womanhood; pregnancy and birth are considered sacred activities for women” (p. 60). The informants’ views on (a) motherhood, (b) pregnancy, (c) children, and (d) birth are congruent with the literature’s findings. The desire to bear children is consistent with the concept of *familism*, and *la familia* is considered to be a major source of identity, self-esteem, and social support among Mexican American women (Dilworth-Anderson & Marshall, 1996).

A study conducted by Amaro (1988) indicated that the roles of childbearing and motherhood have been cited as “extraordinary sources of fulfillment for Mexican-American women” (p. 6). Children are highly desired and valued in Mexican American culture (Burk et al., 1995). The assumption is that cultural and religious traditions of

Mexican American women promote attitudes that are favorable regarding childbearing. The informants in this study confirmed the literature and believed that motherhood was their “reason for being” and their role in life with statements such as, “My children are the reason I live for,” “Children are my life,” and “I would do anything for my children,” exemplifying the importance and central role of children in *la familia*. Pregnancy is viewed as a family event and a time of great happiness, even if the pregnancy is unplanned. The informants were devoted to having children and placed the welfare of their children above that of their husbands. One informant expressed her feelings about the importance of children:

. . . Yes, because being married it’s only about signing a paper with a person you barely know. You cannot guarantee your husband will be with you forever. Your children are yours forever until they are gone . . . they are from your body, they are your blood.

Fatalism. Closely tied with *familism* is the construct of *fatalism* in Mexican American culture, a concept clearly described and confirmed in the literature. Mexican beliefs have long regarded notices of divine or supernatural imposition, and in general, Mexican attitudes and beliefs have been described as fatalistic (Berry, 1999; Graf, Blankenship, Sanchez, & Carlson, 2007; Zoucha & Husted, 2000; Zoucha & Zamarripa, 2003, 2008). Leininger (2002) confirmed that, for Mexican Americans, fatalism and “the concept of divine will has ultimate control over their lives” (p. 365). Martinez-Schallmoser (1992; Martinez-Schallmoser et al., 2003), Burk et al. (1995), and Eggenberger et al. (2006) confirmed the presence of this external locus of control in Mexican American culture.

Prayer is used to intercede with God, but ultimately, one must accept God’s will. This theme is reflected particularly during the postpartum period, during which women

rely not only on God but also on *La Virgen de Guadalupe* to sustain them. The informants considered themselves to be daughters of *La Virgen* and gave thanks to her for their safe journey through this rite of passage. After delivery, many of the informants took the baby to church. If the baby was a girl, she was dedicated to *La Virgen*, indicating the baby was “now a daughter of *La Virgen*.” If the baby was a boy, he was dedicated to God, and thanks were given to God for a healthy baby. Prayers were dedicated to both *La Virgen* and God, asking for their help to be a good mother and “do the right thing” for the child.

Of interest to the researcher is the fact that the literature speaks extensively of *fatalism* in Mexican American culture. However, this researcher did not find the concept of fatalism present among the informants in this study or the informants in a previous study the researcher conducted (Hascup, 2003). In the 2003 study, which explored the cultural context of postpartum depression among low income Latinas in a clinic setting, informants relied on God, prayer, and *La Virgen* but did not express a fatalistic perspective. The informants also believed that they were given the ability by God to make the right choices for themselves. Their attitude was, “If you are sick, God is not going to come down from the sky and cure you.” They believed in prayer and relied on their deep faith, but the “bottom line is up to you to do the right thing for yourself, make the right choices.”

The informants in Hascup’s (2003) study also believed children were a gift from God, even if a child was born with a defect. One of the informants in the current study stated that her child was a special gift because of her autism, and she thanked God every day for the privilege of caring for the child. This informant shared that, initially, she was

devastated that she had a child who is severely autistic. Her husband abandoned her and the three children, leaving her destitute. In order to obtain medical care for her severely autistic daughter, she came to the United States with no money and no family. At the same time, she said that the birth of her daughter was actually the best thing that ever happened to her. Her children became closer to her and each other, and she obtained wonderful medical care for her daughter here in the United States. The informant stated she was very grateful and happy for her life now and believed there was a special reason why God sent her this child, a special purpose in life for her.

The informants' attitudes in both studies regarding the heartaches and tragedies in life were overwhelmingly positive. All of the informants believed that while God does have full control over a person's life, He also gives people the ability to make the appropriate decisions for themselves. Religious faith was a very important source of comfort and strength for the informants, particularly after delivery when concerns were centered on the baby. The researcher discovered that, rather than being passive and fatalistic about life and outcomes, the informants took a proactive spiritual approach by remaining positive and relying on prayer. This approach to life is supported by the findings in Page's (2004) study.

Theme 2: Protection of Mother and Baby is Transmitted Intergenerationally by Elder Mexican American Women and is Influenced by Religion, Folk, and Family Beliefs, and Practices

The role of mother for Mexican American women is highly valued and is seen as *the* most important sociocultural role women can attain. This worldview lends itself perfectly to adherence to the rich traditional beliefs and practices during the postpartum period. However, no discussion of the postpartum period would be complete or can be completely understood from a sociocultural, emic context without first discussing the

other two antecedent components of maternal care: the antepartum (prenatal) period and the intrapartum (childbirth and/or delivery) period. The folk beliefs and practices that are inherent in the antepartum and intrapartum periods set the foundation for the continuation of protective mechanisms for mother and baby in the postpartum period. All three are intricately intertwined to provide protective care for mother and baby via a rich history of cultural traditions.

Contrary to the extant literature that indicates Mexican American women seek late or no prenatal care, the informants in this study did seek and receive early prenatal care at the obstetrical clinic of the Catholic hospital located in the community. This practice was also exhibited by the informants in Hascup's (2003) previous study, which took place in an obstetrical clinic setting at a Bergen County medical center. However, *prenatal care* has a very broad meaning to Mexican American women that includes advice and folk belief practices from elder women in the family as well as professional prenatal care. In this study, the informants utilized a combination of folk beliefs and practices plus professional care.

Most interesting is that the informants perceived they received better care in the U.S. healthcare system than in the Mexican healthcare system. They believed technology was more widely used in labor and delivery in the United States than in Mexico, and this belief provided a sense of security and "caring" for the informants regarding their babies' well-being. This belief presents somewhat of a dichotomy since the informants held strictly to other non-technological and non-pharmaceutical modes of self-care steeped in ancient beliefs and practices and preferred non-invasive methods of professional care; these practices are also supported by the literature (Horn, 1990; Olson, 1992; Posmontier

& Horowitz, 2004; Sawyer, 2006). For example, in terms of speeding up labor, informant 23 stated that “in Mexico, we take a hot baths with herbs to make [labor] easier.” Informant 10 shared that drinking hot teas is believed to speed up labor: “Cinnamon tea, because it’s hot and they believe that helps to have a faster delivery.” The informants did not necessarily reveal to their healthcare practitioners the use of folk medicine. Similarly, they volunteered no information about these practices to the researcher or interpreter; however, when the researcher asked about folk beliefs and practices, they were very willing and almost excited to share that information. The researcher interpreted the willingness to share this emic information as a sign of trust and acceptance, as Leininger (2002) noted.

The literature indicates that pregnant and postpartum women are strongly influenced by their mothers and mothers-in-law (Bobak et al., 1995). According to Burk et al. (1995), “Older, more experienced women in the family serve as role models to teach and advise younger women . . .” (Burk et al., 1995, p. 42). The informants in this study spoke extensively about the role of the elder women in the family, and their heavy reliance on advice from their mothers was confirmed repeatedly in the literature (Berry, 1996, 1999, 2002; Bobak et al., 1995; Burk et al., 1995; Hascup, 2003; Kay, 1977, 1980; Kendall-Tackett, 1994; Kim-Godwin, 2003; Kurzon, 2000; Leininger & McFarland, 2002). The informants sought advice first from their mothers and grandmothers and, if mothers and grandmothers were not present, then aunts, sisters, and, lastly, close female friends. The reliance on care by the elder women was reflected by comments such as, “I would ask my mom or grandmother for advice,” and “The first people to provide you with advice have to be within your family, so your mother.” One Informant stated,

I think your mother is the best to provide advice—she has experience and knows the good and bad things to do [meaning she knows the good things to do and the bad things not to do] since she has been through it

The informants consistently spoke of a “family of women” if their own family were not present on whom they could rely for support and advice.

The magico-religious paradigm of Mexican American women is a worldview dominated by spirits, religion, and a belief that events are predetermined; therefore, little can be done to change their outcome (Berry, 1996, 1999, 2002; Burk et al., 1995; Callister, 1995; Cotera, 1976; Dennis et al., 2007; Florez et al., 2009; Kay, 1980; Mirande & Enriquez, 1979; Zoucha & Zamarripa, 2003). While the researcher did not find a rigid fatalistic attitude present among the informants in this study nor in her previous study (Hascup, 2003), the overarching belief was that God has full control over one’s life, but one must take responsibility and handle what one is given by making the best choices for oneself. According to Gonzalez-Swafford and Gutierrez (1983), this is a predominant attitude among Mexican Americans. Therefore, if disease or illness is the will of God or caused by “providence” or the unknown, the way to combat it exists not in the realm of the real world but in the supernatural or spirit realm. As a result of these spiritual beliefs, the informants relied heavily on prayer during pregnancy, childbirth, and postpartum for guidance, support, and strength in order to make the best decisions. Through prayer, an appeal to God and *La Virgen* was made for a healthy pregnancy, a safe delivery, recovery from birth, and a healthy baby.

Many family beliefs and folk practices are believed to offer protection to the woman during the antepartum, intrapartum, and postpartum periods as well as protection to the new baby (D'Avanzo, 2008; Gonzalez-Swafford & Gutierrez, 1983; Lipson et al., 1997). The literature speaks of the many folk practices to which Mexican American

women adhere during the antepartum and postpartum period. These folk practices have been passed down by mothers and grandmothers and are “used within the confines of the extended family” (Lipson et al., 1997, p. 211). The informants in this study spoke at length about the various family folk beliefs and practices related to (a) diet, (b) exercise, and (c) religious practices. Much discussion about the postpartum period centered on *La Cuarentena*.

Antepartum (Prenatal). Some of the prenatal folk beliefs informants expressed were that exposure to an eclipse or walking in the moonlight can cause a baby to be born with a cleft lip or palate. The Aztecs believed that an eclipse occurred because a bite had been taken out of the moon. As a result, if a pregnant woman was exposed to an eclipse or moonlight, her baby would have a bite taken out of his/her mouth. This belief remains today, hundreds of years later, among Mexican and Mexican American women (Kurzon, 2000; Zoucha & Zamarripa, 2003, 2008). Informants in this study detailed the wearing and placement of pins during pregnancy either on their clothing or next to their skin, preferably next to their “tummy,” when going out at night during an eclipse to protect them from this phenomenon. The informants also believed that *antojos*, or cravings, must be satisfied or the infant will be “marked” with that object that the mother craved during pregnancy; this belief was also supported by extant literature (Kurzon, 2000; Lipson et al., 1997). Early baby showers were also to be avoided “for fear of bringing bad luck.”

Additional prenatal beliefs revealed by the informants included (a) sleeping on one’s back to avoid harming the baby, (b) keeping active by walking to assure a fast delivery and to avoid loss of amniotic fluid which can cause the baby to “stick” (*se pega*) to the wall of the uterus, (c) engaging in frequent sexual intercourse to keep the vaginal

canal lubricated to ensure an easier birth, (d) avoiding drinking milk which is believed to cause a large baby, and (e) avoiding reaching over one's head to prevent the umbilical cord from wrapping around the baby's neck. All of these beliefs are well documented in the literature (Amaro, 1988; Berry, 2002; D'Avanzo, 2008; Hascup, 2003; Lipson et al., 1997; Zoucha & Zamarripa, 2003, 2008).

Informants also spoke about the role of the *curandera*, a traditional Mexican American health practitioner. The informants indicated that in the United States, one might seek the services of *la curandera* if the baby were malpositioned (i.e., in a breech position) in utero. One informant stated that *la curandera* would attempt to reposition the fetus by manually manipulating it in utero: "If the baby is not in the right position, they do a maneuver on her stomach. After that they send her for a bath and tell her to wear the *faja*." It has been this researcher's personal clinical experience that obstetricians in the United States perform the same maneuver, which is called a "version," and a tight abdominal binder is applied if the version has been successful.

Intrapartum (labor and delivery). Informants stated that grandmothers passed down to their daughters and granddaughters the concept of *sufriada*, perpetuating a stereotypical myth of the Mexican American woman as a passive participant who is "expected to suffer in silence and deliver a child to her husband" (Lipson et al., 1997, p. 211). "Childbirth is a painful part of life. Accept it; it's a woman's role" was the belief passed down to the informants intergenerationally and accepted by the informants as part of a woman's role. Congruent with the attitude of accepting the pain of childbirth as a part of life and contrary to the stereotypical myth of *sufriada* is the reality of the strength possessed by Mexican American women. Informants revealed that Mexican American

women are strong women, and they believed they do not necessarily need men to care for them, especially if the man is not going to be supportive and provide care for the children.

The informants preferred to have their mothers, aunts, grandmothers, or close friends with them during labor, confirming the desire for gender-congruent support (D'Avanzo, 2008; Hascup, 2003; Lipson et al., 1997; Zoucha & Zamarripa, 2003, 2008). More traditional or less acculturated husbands are typically not present during labor and delivery because they believe this is a woman's domain, reconfirming the concept of gender-congruent support. A belief also exists that the husband should not see his wife and baby until both have been washed and dressed. This is a protective folk practice to prevent harm to mother and/or baby (Zoucha & Zamarripa, 2003, 2008). *Machismo* also plays a part in the practice of keeping husbands out of the "woman's domain of childbirth." It is believed that men who participate in this rite of passage are less "macho" and are open to teasing by other males.

More acculturated Mexican American men are now taking prenatal classes with their wives and supporting them in labor and delivery (Zoucha & Zamarripa, 2003, 2008). However, it has been this researcher's personal clinical experience in labor and delivery that if the Mexican male is present during the birth, he takes a more "backseat" role. Typically, a female relative is also present to offer emotional and physical support and coaching, while the husband sits quietly at the head of the bed, allowing the elder female to serve as the primary support person. The informants revealed that many of their husbands were present in labor and delivery in addition another female such as mother, grandmother, aunt, or sister, confirming the desire for gender-congruent support as well

as the role of the more acculturated male as stated in the current literature. Comments such as, “I want my husband with me; he should see his child born,” were common among the informants, reflecting a more egalitarian and acculturated perspective regarding childbirth.

Meaning of *health* in the antepartum, intrapartum, and postpartum periods.

The informants in this study defined *health* and *well-being* in the childbirth period as positive emotional health. Staying healthy for Mexican American pregnant informants meant “eating well, taking care of oneself, and seeing the doctor for prenatal care,” as well as adhering to the traditional practices. In 2007, Hartweg and Isabelli-Garcia conducted a descriptive qualitative study using focus groups to explore the meaning of health among Mexican and Central American women immigrants. The authors posited that “the health outcomes and health practices of immigrant Latinas tend to decrease with acculturation to the U.S. culture” (Hartweg & Isabelli-Garcia, 2007, p. 53).

Thematic findings included “being happy” and “having good emotions” as crucial for maintaining health and well-being. Common among the informants in this researcher’s study was the belief that life must be balanced and stress kept to a minimum during the pregnancy because negative emotions affect the baby by causing either a premature birth or possibly a spontaneous abortion. Following folk practices during the antepartum and postpartum periods offered protection and prevention for women from *susto* (fright sickness) and *antojos* (cravings). Postpartum women are protected from *empacho* (intestinal obstruction) and cold temperatures, and the newborn is protected from *mal de ojo* (evil eye), *caida de mollera* (sunken fontanelle), and *empacho*.

The “hot-cold theory” as a folk protective mechanism. Informants’ antepartum, intrapartum, and postpartum dietary practices are related to the hot-cold theory, which is based on the ancient Greek humors of (a) blood, (b) black bile, (c) yellow bile, and (d) phlegm. The four humors must be balanced in the body in order to maintain health and wellness, and any imbalance is believed to cause illness and disease. Certain illnesses and conditions are considered either hot or cold states and are treated with foods that complement those states. Humoral therapy does not refer to the temperature of foods (Lipson et al., 1997).

Pregnancy is considered a hot state; therefore, all spicy foods are avoided. All of the informants believed that health involved a balance of (a) hot, (b) cold, (c) wet, and (d) dry. Informants were told to stay away from spicy foods or “hot” foods, and the pregnant woman was to “eat for two.” Gaining weight was not a concern since heavier meant healthier to the informants, not only in pregnancy but in general. The intrapartum and postpartum periods are considered to be cold states; therefore, “cold” foods are to be avoided. “Hot” fluids and foods are provided that are believed to provide warmth for the mother and baby, allowing the baby to be born in “a warm and loving environment” (Zoucha & Zamarripa, 2003, p. 317). Informants spoke extensively of “taking a tea” for various discomforts when close to delivery and in labor.

Use of herbal remedies and folk practices during antepartum, intrapartum, and postpartum. The use of herbal remedies is a part of the ancient art of *curanderismo* or folk healing (Sawyer, 2006). *Curanderismo* embraces three modalities: (a) candles, (b) oils, and (c) herbs. A *curandero(a)*, depending on gender of the practitioner, may use all three or just one modality in healing rituals. The egg is believed to possess mystical

properties and is often used in rituals associated with *mal de ojo*, as informants described. The egg is believed to absorb negative properties, hence the placement of the egg under the crib of a baby who is believed to be suffering from *mal de ojo*. The informants also believed that the placement of red bracelets on the baby's wrist or ankles also protects the baby from *mal de ojo*, practices well supported by the literature (Hartweg & Isabelli-Garcia, 2007; Ingham, 1986; Kurzon, 2000; Mendelson, 2002; Sawyer, 2006).

All informants relied heavily on herbal teas as part of folk beliefs and practices, remembering as children the use of herbal teas as remedies for every problem. Author Eliseo Torres revealed this about her fascination with *curanderismo* and herbalism as a child:

. . . it was natural to begin here, remembering as I did that for every illness and with every ritual there would always be a freshly brewed cup of tea perhaps chamomile (*manzilla*), mint (*yerba buena*) or aniseed (*anis*). (as cited in Sawyer, 2006, p. 5)

Informant 6 stated that her mother told her “to walk a lot and drink cumin tea to ease the discomfort of labor contractions.” Cumin or *comino* seeds are boiled to make a mild and soothing tea that is also used for teething babies (Sawyer, 2006). One uses *arago* for headaches, *anis* tea for menstrual cramps, mint teas for stomach upsets, and chamomile, *anise* (calming and aids sleep), and *arnica* teas (cramps and stomach discomforts) postpartum. One informant described the garden her mother had where she grew fresh herbs, including mint. Herbal steam baths in postpartum are done with various herbs such as rue, rosemary, and perut, an herb from the ginger family. Appendix M provides an extensive list of folk remedies. The use of herbal remedies is well supported by the literature, validating the informants' practices (Sawyer, 2006).

The use of herbal remedies was passed to the informants intergenerationally, validating the extant literature. Mexican American women still use herbs extensively, and many of these herbs have been known and used since ancient times. “Many of the remedies used today were introduced by Europeans at the conquest of Mexico in the sixteen century” (Gonzalez-Swafford & Gutierrez, 1983, p. 32). The literature reveals that most of the herbs are prepared as an infusion or a tea (Gonzalez-Swafford & Gutierrez, 1983). It is noteworthy that herbalism was more widely accepted than the use of a *curandera(o)*.

Postpartum beliefs and practices: *La cuarentena*. From a cultural perspective, many diverse postpartum practices exist both within and between cultures (Dennis et al., 2007), and Leininger posited that more diversity exists within a culture than between cultures (Leininger & McFarland, 2002). Many traditional postpartum practices are based on supernatural or religious beliefs. Medical anthropologists have described health and illness frameworks in culturally diverse groups that include religious, magical, or supernatural beliefs (Stern & Kruckman, 1983). All traditional practices are preventative and protective, focused on primarily providing protection of mother and baby physiologically, emotionally, spiritually, and socially. In order to facilitate the bonding experience, family members take over the normal household duties and care for the other children.

From the social perspective, *La Cuarentena* protects the new mother from *machismo*, where she would be expected to perform all household duties, and care for her husband as well. However, men who are very *macho* do not respect *La Cuarentena* and resent abstinence from sexual relations. Informant No. 10 shared,

Some women want to keep that at 40 days of abstinence [because of machismo]. Some men won't respect that and will just have sex or they will force them to have sex or they will start having problems as a couple because of this, because they don't believe in that, they don't want to wait. That's a big thing and sometimes couples have big problems [because of this].

The majority of the informants believed in adhering to the traditional practices and beliefs that were passed down to them generationally by the older and wiser women in the family. All of the informants in this study adhered to as many of the traditional practices as possible; however, their level of adherence depended on the presence of the mother, grandmother, or aunt to share in and assist with those traditional practices. The general belief was, "Maybe the practices don't work. We're not sure if they do, but you never know." Out of respect for the wisdom of the elder women, the informants followed family and cultural folk practices during the prenatal and postpartum periods. Even if the informants did not fully embrace belief in the protection of the folk practices, they expressed feelings of guilt if they could not comply with at least some of the practices during the postpartum period.

Traditional practices centered around the hot-cold theory of providing warmth to the new mother and baby immediately after delivery and following a special diet. The postpartum period is considered to be a cold state due to the loss of body fluid and warmth that occurs during the delivery. Informants stated they preferred warm fluids after delivery, instead of the ice chips, ice cold juices, and drinks that are typically provided by nurses in labor and delivery units. Informants stated chicken soup was frequently given after birth. Foods to avoid included anything containing lemon and all cold fluids, as the informants were told by the elder women that these inhibit the flow of breast milk. If the mother was breastfeeding, chocolate was also to be avoided since it

was believed to give the baby “stomach aches.” Herbal teas taken after delivery included a cinnamon tea, which informants stated helps produce more milk since cinnamon is considered to be a “hot” food and “hot” fluids and foods “help produce more milk and more water than anything.” Meat is to be avoided, especially pork because “pork has too many infections, so you can’t eat that.” Informants strictly adhered to this belief if they had a cesarean section because they believed that being “cut” made them especially vulnerable to any toxins found in pork.

Informants described the period after delivery as a “cold state . . . you get all of this cold going into your back.” Therefore, it is important to follow *La Cuarentena* “because your back is all open, your bones are all open.” Informants described wearing the *faja* “to help everything go back into place” after delivery. The elder women felt it was important to wear the *faja* “to keep the waist in shape.” It also helps the back because “your back is all open.” Informants were also told not to wear tight jeans because “it cuts off the circulation in your legs . . . wear dresses instead.” A traditional belief was that if “you want to get your body back . . . that’s one thing, you have to do bed rest, you can’t do a lot of movement.” Informants stated how they recovered and how well they felt after delivery depended on their diet. They did not believe in eating heavy foods, such as pizza, because they can make a person feel sluggish and heavy. On the other hand, chicken soup is filling and healthy, and informants believed it helped them tremendously during recovery from birth.

While the literature speaks extensively to postpartum rituals among many cultures during the postpartum period, the Mexican American culture has not been studied in depth. A qualitative, systematic review of the literature on traditional postpartum

practices and rituals conducted by Dennis et al. (2007) revealed that “many cultures around the world observe specific postpartum rituals to avoid ill health in later years” (p. 487). The systematic review examined the literature from 51 studies in over 20 different countries. Most interesting was that 28 studies involved Asian and Southeast Asian women, and only two studies involved Latin America: Guatemala and Mexico. The Dennis et al. study identified cross cultural commonalities, specifically (a) organized support for the mother, (b) periods of rest, (c) prescriptive diet regarding foods to be eaten or avoided, (d) hygiene practices, (e) infant care, and (f) breastfeeding. The study also revealed the importance of allowing the mother to be “mothered” for a period of time after the birth, reflecting the central role of *familism* not only in the Mexican American culture but in many cultures throughout the world as well. The authors posited that a structured postpartum period and the concept of *familism* may facilitate the social role transition to motherhood, consistent with the information obtained from the informants’ interviews for this study.

One of the most classic studies of postpartum rituals was conducted by Stern and Kruckman (1983). This anthropological study explored postpartum depression from a multidisciplinary and anthropological perspective. The authors identified that it was imperative to consider the impact of “the cultural patterning of the postpartum period” (Stern & Kruckman, 1983, p. 1027). They believed it was important to look at the structure and organization of the family and role expectations because review of the anthropological literature provided little evidence for postpartum depression. The authors hypothesized that a structured postpartum period mitigated the development of postpartum depression. In the study, the authors identified commonalities among cultures

in the social structure of the postpartum period that included (a) a structured postpartum period; (b) measures designed to protect mother and baby; (c) social seclusion and rest; (d) social support from females in the family, friends, or the midwife; and (e) recognition of the new social status through rituals or gifts. The researchers identified that while childbirth is universally similar physiologically, it is organized, conceptualized, structured, and experienced differentially due to culture:

. . . disease in the Western medical paradigm is malfunctioning or maladaptation of biologic and psychophysiologic processes . . . whereas illness represents personal, interpersonal, and cultural reactions to disease or discomfort . . . illness is shaped by cultural factors governing perceptions, labeling, explanation and valuation of the discomforting experience . . . illness is strongly influenced by culture . . . it is . . . culturally constructed. (Stern & Kruckman, 1983, p. 1027)

Stern and Kruckman did not parallel childbirth with illness per se but posited that postpartum depression is an illness and, as such, is culturally constructed. This important piece of classic research and others validate the importance of a culturally structured postpartum period providing protective and preventative mechanisms through established cultural practices and rituals for mother and newborn (Kendall-Tackett, 1994; Kim-Godwin, 2003; Stern & Kruckman, 1983).

Stern and Kruckman (1983) viewed postpartum depression as a “culture bound syndrome of Western culture” (Posmontier & Horowitz, 2004, p. 34), indicating that the rates of postpartum depression are high in the Western culture due to the lack of a specifically structured postpartum period. Beck, a noted nurse, researcher, and author, stated that the rates of postpartum depression in the United States are 10-20%, numbers which she believes are conservative (Beck & Gable, 2000). It is impossible to determine accurate numbers of postpartum depression cross culturally (varying from 0-30%) due to many factors, one of the most important being that the label of depression may be

unacceptable in some groups or not understood. It is important to note that if there is a strong support system in place for the mother and child, depression may not be an issue that needs to be diagnosed because the family is dealing with it.

In addition, Western measurements for depression screening are not appropriate for use in other cultures (Posmontier & Horowitz, 2004). Oftentimes, depression is expressed somatically, if at all. Another crucial factor is that it is not socioculturally acceptable to feel any negativity about motherhood. Motherhood is perceived to be the ideal state for all women to achieve; however, research has indicated that this is not necessarily the case (Beck, 2002). Postpartum depression or a feeling of sadness or unhappiness during this time is perceived to be taboo in many cultures due to the social stigma of negative feelings associated with motherhood. Depression is perceived as a sign of weakness or mental illness in many cultures (New York City Department of Health and Mental Hygiene, 2005).

Posmontier and Horowitz (2004) studied postpartum practices in relation to the prevalence of depression from *technocentric* and *ethnokinship* cultural perspectives. They defined *technocentric cultures* as those that focus on technology to monitor the well-being of mother and baby, particularly intrapartum and immediately postpartum, that crucial “1 hour” after delivery. Separation of mother and baby occur according to hospital rituals. Once the immediate danger associated with delivery is over, monitoring beyond 48 hours is not required, and mother and baby are discharged to home. This approach characterizes maternal care in Western cultures. In contrast, in *ethnokinship cultures*, “the social structure of the postpartum period is clearly recognized” (Posmontier & Horowitz, 2004, p. 36). Posmontier and Horowitz are among the few researchers to comment on the

Mexican culture and *La Cuarentena* as “. . . a 40-day rest period that includes protective seclusion, proscription from household chores, shopping and sexual intercourse, and assistance and education from female relatives” (p. 37). Ethnokinship cultures focus on family support and structured rituals in the postpartum period, which are common among Mexican American women.

The importance of traditional beliefs and practices during the postpartum period has clearly and succinctly been demonstrated by the informants’ interviews and is congruent with the literature. While it is evident that minimal research exists specifically about Mexican American women and the postpartum period, what literature that is available is congruent with postpartum practices cross culturally.

Theme 3: Showing Interest, Being Attentive to, and Speaking Spanish Indicates Respectful Behavior and is Central to the Meaning of Care

From the moment the researcher entered the community, it was apparent that Mexican Americans had recreated for themselves a part of their identity within the context of community. In other words, the community reflected Mexico—the language and the culture. One of the most striking observations and conclusions made by the researcher was the informants’ desire to maintain a strong ethnic identity, which was evidenced by speaking Spanish. This provided a sense of security and attachment to their homeland, and the majority of informants said they missed “their country.” This strong cultural identity included the use of the Spanish language when communicating with healthcare providers, which became most important during the postpartum period.

The informants placed a high cultural value on retaining and speaking the Spanish language not only within their homes and community but also with professional healthcare providers, reflecting the importance of language as a cultural value. The

informants indicated that even if they were bilingual, they preferred to speak Spanish in their homes because they did not want their children to forget their heritage, and they preferred healthcare providers who could speak Spanish. The informants believed this was most important during postpartum when they were receiving care instructions from the healthcare provider for themselves or their newborn, especially during this time when they felt most vulnerable. The informants expressed an increased comfort and trust level with the healthcare provider when Spanish was spoken. This was obvious to the researcher during the interviews with the informants. Informants who were bilingual and fluent in English preferred to have the interviews in Spanish and expressed feeling more comfortable and relaxed when speaking Spanish.

The extant literature on acculturation factors indicates that the maintenance of Spanish and learning of English is common among Latinos (Cuellar, Arnold, & Maldonado, 1995; Felix-Ortiz & Newcomb, 1995). Romero et al. (2004) discovered in their study that Mexican Americans *did not* tend to lose traditional cultural values as they embraced English and lost fluency in Spanish, which is contrary to the extant literature on acculturation. Of interest Acevedo (Acevedo, 2000) found that, among Mexican American mothers, Spanish speakers were at lower risk for cigarette smoking and mental health issues during pregnancy (i.e., prenatal depression) but were at higher risk for adverse parenting beliefs than were bilingual and English-only speakers. Heilemann, Lee, Stinson, Goshar, and Gross (2000) found that more acculturated Mexican American women experienced (a) more prenatal and postpartum complications, (b) excessive weight gain, more cesarean section births, (c) a higher incidence of sexually transmitted diseases, and (d) a higher incidence of substance abuse than less acculturated women.

However, it is important to note that these effects were most consistently predicted by place of birth, not language. Also noteworthy is that Hu and Covell (2000) found in a study of Latino adults in San Diego that the primary use of English was positively correlated with a higher frequency of health checkups, greater satisfaction with healthcare, and a self-perception of excellent health compared to two other groups: those who were bilingual and those who were primarily Spanish-speaking. Language acquisition is a positive aspect of acculturation, as it leads to a higher socioeconomic status through better paying jobs (Lara, Gamboa, Kahramanian, Morales, & Hayes Bautista, 2005).

Evidence of language differences between the informants and their healthcare providers diminished the ability for effective communication. Effective communication is key in providing quality care (Kemp, 2002; Zoucha, 1998, 1999). In communication with non-Spanish speaking healthcare providers, the informants perceived—and justifiably so—that important information could become lost or, worse, misinterpreted in translation, and their questions might not be answered accurately or completely. Healthcare providers communicating with the informants in Spanish indicated respectful and caring behavior that was personal and warm, which the literature supported (Zoucha, 1998).

The importance of the value of *respeto* or respect, a complex and multifaceted concept in Mexican American culture, was cited frequently in the literature and validated by the informants (Berry, 1996, 1999, 2002; Zoucha, 1998). From the analysis of informant interviews, respect indicated an action-oriented response—“doing” for an individual—and with this frame of reference, one’s needs, wishes, and feelings were

taken into consideration or *respected*. To the informants, *respeto* meant that healthcare providers were attentive to their needs and expressed interest in them not only from a professional healthcare viewpoint but also from a personal viewpoint and made an effort to speak Spanish to them. The informants in this study repeatedly used the Spanish verb *attender* to describe caring behavior. The English translation of the verb *attender* literally means *to look after or to care for* (Fortin, Galvez, Carvajal, & Agea, 2006). In analysis of translations of the informant interviews, *attender* meant *attention to* and related to the concept of care. The informants perceived the healthcare provider showed interest and cared enough for them to speak Spanish. This finding was also detailed in Schumacher's (2006) study. The informants cited numerous stories in which the healthcare provider did not speak Spanish, did not provide an interpreter, and did not provide explanations for any procedures that were done. Not only did these actions reveal a lack of respect for the individual informant, but they also indicated what informants perceived to be "non-caring" behavior.

Zoucha's (1999) study, which explored Mexican Americans' views of professional caring, identified that Mexican Americans valued warm and friendly communication and perceived it as caring behavior. Communicating in Spanish with nurses was viewed as an essential component of care, and Mexican Americans expected respect when receiving care from professional healthcare providers. Of interest in Zoucha's study was that Mexican Americans perceived nurses as non-caring if the generic care values were not combined with professional care. Informants in this study also shared this perspective.

Due to the technocentric aspect of maternal care in the United States' biomedical society, nurses may not be focused on learning or understanding the beliefs, lifeways, or language of postpartum Mexican American women. The length of stay after delivery is short (e.g., 48 hours for vaginal deliveries and 72 hours for cesarean sections), barring complications. In today's hospital setting, care on the postpartum unit is focused on the immediate physical healthcare needs of mothers and their newborn babies and on teaching mothers what the healthcare system, based on structured guidelines and strict algorithmic care plans, has deemed important, rather than focusing on culturally congruent care.

At the same time, speaking Spanish to provide postpartum discharge instructions that the Mexican American woman can understand indicates caring and respectful behavior, according to this study's informants. If the healthcare provider's behavior is perceived as non-caring and not respectful, Mexican American postpartum women will not follow instructions and may not return for appropriate follow up care, leading to possible negative outcomes for both the new mother and baby. Another negative outcome would be relaying negative hospital experiences by "word of mouth." The informants in this study indicated that if they had negative experiences with nurses or healthcare providers during labor, delivery, or postpartum that reflected non-caring behavior, they would share those experiences with their female friends and family members to discourage them from utilizing services provided by that hospital or healthcare provider.

When the researcher was seeking to obtain community approval from Senor H. for the study, one of Senor's first questions was, "Why are you interested in studying our women? What is this study going to do for our women? No one is interested in Mexican

American women!” This researcher was astounded to hear this belief from a community leader and found it to be tragic commentary of how Mexican Americans believe they are perceived in the United States and in this one small area of New Jersey.

Culturally Congruent Nursing Care

The remainder of this chapter discusses the interconnectedness of the three themes and the impact these themes have on delivering culturally competent, congruent, and sensitive nursing care, as well as implications for nursing theory, education, practice, and research. Today’s demographics reveal rising numbers of Latinos in the United States, with the Mexican American subgroup being the largest and having the highest birth rates. Therefore, the data from this study provided information regarding the culture care values, beliefs, and practices of Mexican American postpartum women to assist in delivering culturally congruent care. According to Leininger, all nurses must be prepared to provide culturally congruent care to the diverse clients they serve (Leininger & McFarland, 2002, 2006).

Interconnectedness of the three themes. As discussed previously, the three themes identified in this study are as follows:

1. God, prayer, and family are the base of everything in life.
2. Protection of mother and baby is transmitted inter-generationally by elder Mexican American women and is influenced by religion, folk, and family beliefs and practices.
3. Showing interest, being attentive, and speaking Spanish indicates respectful behavior and is central to the meaning of care.

While each of these themes is separate, all three are interconnected. They reflect the worldview of postpartum Mexican American women and speak to the strength,

determination, and cohesiveness that provide the foundation of their cultural identity. God, prayer, and family, Theme 1, form the foundation of and represent the lived context of their daily lives, specifically postpartum. Theme 2, gender-congruent support and care by the elder women in the family, is grounded in the traditions of family and focused on a strong belief in God, prayer, and folk practices that offer protection during postpartum and are based on the magico-religious paradigm. Theme 3, speaking Spanish, reflects the centrality of the meaning of *care* for Mexican American women. Speaking Spanish has a multidimensional aspect: not only do Mexican American women want to maintain the connection to their cultural identity, but they also want their cultural identity recognized and respected. Therefore, healthcare providers who attempt to speak Spanish indicate caring and respectful behavior. Nurses speaking Spanish acknowledge that, for that moment in time, however brief, they have made an attempt to enter the world of the Mexican American woman. Sapir (1949) stated that reality is embedded in language, and through language, culture is transmitted.

No rite of passage other than childbirth reflects so dramatically the interconnectedness of care and care practices of the three identified themes of this study. The importance of every aspect of each theme, as discussed previously, is revealed in the postpartum period and describes the worldview that influences the expressions, meanings, beliefs, practices, and experiences of postpartum Mexican American women. The study revealed that important factors present in the postpartum period are (a) God, (b) family, (c) religion, (d) folk beliefs and practices, (e) gender-congruent support and advice by the elder women in the family, and (f) the Spanish language—the totality of which reflects not only the cultural identity of the women but also their worldview.

Culturally competent nursing care. Leininger and McFarland (2006) defined *culturally congruent nursing care* as “culturally based care, knowledge, acts, and decisions used in sensitive and knowledgeable ways to appropriately and meaningfully fit the cultural values, beliefs, and lifeways of clients for their health and wellbeing, or to prevent illness, disabilities, or death” (p. 15). In order to aid nurses in delivering culturally congruent care, Leininger (2006) developed three nursing modes of action and/or decision making to deliver care that is congruent, safe, appropriate, beneficial, and meaningful to the people being served. Leininger also stated that researchers should focus on these three theoretical action care modes when conducting ethnonursing research (Leininger & McFarland, 2002). The three action modes are (a) culture care preservation and/or maintenance, (b) culture care accommodation and/or negotiation, and (c) culture care repatterning and/or restructuring (Leininger & McFarland, 2006).

Culture care preservation and/or maintenance. According to Leininger (2006), *culture care preservation and/or maintenance* refers “to those assistive, supportive, facilitative, or enabling professional acts or decisions that help cultures to retain, preserve, or maintain beneficial care beliefs and values or to face handicaps and death” (p. 8). Transcultural nursing theorists, such as Leininger (Leininger & McFarland, 2002; Purnell & Paulanka, 2003), believe it is important for nurses to examine and understand their own cultural values, beliefs, assumptions, and biases that affect how they make decisions and provide patient care. The nurse’s own cultural beliefs and values naturally impact the way he or she views the world and interprets what is seen, and they provide the mechanism for decision-making. Zoucha (2001) “urged that [nurses] put aside deep-

seated feelings of ethnocentrism and accept the value that every health worldview is equally valid” (p. 1).

Additionally, nurses must desire to view the world from another’s perspective, i.e., that of Mexican American women. In order to do this, nurses must also be willing to seek education that will allow them to become culturally competent so that they can deliver culturally congruent care. In other words, cultural competence is the mechanism for providing culturally congruent care: “Cultural competence is a way of practicing one’s profession by being sensitive to the differences of one’s constituents and acting in a way that is respectful of the client’s well-being” (De Chesney, Peil, & Pamp, 2008, p. 25). Without cultural competence, nurses will not be able to apply the three action modes in delivering culturally congruent care.

Of great interest is that, except for Leininger’s seminal work, the majority of nursing theories do not include cultural competence because they were published before the concept of cultural competence emerged in nursing (De Chesney et al., 2008). Culture is not static and is ever changing in the United States due to the tremendous impact of immigration and factors of acculturation. Nurses must be willing to embrace cultural diversity and to accept or at least respect other worldviews. This is the first step in providing culturally congruent care to all diverse populations, including Mexican American women in the postpartum period.

In order to preserve and/or maintain the culture care values, beliefs, and practices of postpartum Mexican American women, nurses and other healthcare providers must recognize the key values that are important in this culture. *Familism*, or family, is one of the most important cultural values in Mexican American culture. Family provides the

support—physical, emotional, and, at times, financial—that is crucial to maintaining health and wellbeing during postpartum. Family is intrinsically involved in care and decision making, a very strong finding in this study. Informants provided rich, in-depth descriptions of family involvement not only in life in general but particularly during the postpartum period. The family provides direct physical care for postpartum women, and as previously stated, family for Mexican Americans includes not just immediate family but extended family and friends as well. Nurses caring for postpartum Mexican American women must recognize and accept the importance of the family in health and wellbeing, including the reliance on the elder women in the family to provide support and offer advice.

Nurses must also recognize the importance of religion, faith, and God in this culture and must distinguish between them. To the informants, *religion* is attending church, and while the majority of the informants espoused the Roman Catholic faith, the majority did not attend church for various reasons. Of interest is that the Catholic faith does not condone fatalism. While this researcher did not find the informants to be fatalistic, the literature strongly supports fatalism in Mexican American culture. Nurses need to be aware of the possibility of fatalism because it impacts the pursuit of healthcare and the acceptance of healthcare practices. However, the informants' deep faith, spirituality, and reliance on prayer and God during postpartum as well as their daily lives was a pervasive finding in this study. Faith, prayer, and God offered sources of strength, hope, and safety. The very strong adherence to folk beliefs and practices is also noteworthy and particularly evident during the postpartum phase. This is reflected by the

various rituals, “superstitions,” and practices that have been discussed previously, reflecting the magico-religious and paradigm of this culture.

Nurses who understand the key values of Mexican American culture—God, prayer, faith, and family—will be able to delivery culturally competent, congruent, sensitive, and safe postpartum care in the hospital or community setting and provide patient satisfaction and positive outcomes.

Culture care accommodation and/or negotiation. Leininger (2006) defined *culture care accommodation and/or negotiation* as “those assistive, accommodating, facilitative, or enabling creative provider actions or decisions that help cultures adapt to or negotiate with others for culturally congruent, safe, and effective care for their health, wellbeing, or to deal with illness or dying” (p. 8). Because family is an overlapping construct in Mexican American culture, it is absolutely vital in providing support and care for postpartum Mexican American women. Within the maternal child setting in hospitals today, nurses are still adhering to many “sacred cows,” such as rigid visiting hours. Nurses and healthcare providers need to find a way to accommodate family members so they can remain with the laboring, delivering, or postpartum woman. Informants told stories of having to labor and deliver alone, without significant others or female relatives present. The informants stated it was frightening for them to be alone and to not have anyone explaining procedures in Spanish. Nurses need to take risks and become proactive in seeking ways to negotiate and accommodate family into the plan of care because family support equals caring and security to Mexican American women. Mexican American women rely on gender-congruent support of the elder women in the

family (i.e., mothers and grandmothers), in addition to aunts, sisters, or close friends, especially during postpartum.

Many less acculturated Mexican American husbands do not want to be present in labor or at the delivery, and maternal child nurses must respect this cultural expectation. Mexican American men believe that childbirth is women's domain and, therefore, best left to women (Zoucha & Zamarripa, 2003). Nurses need to recognize and accept this belief, avoid passing judgment, and maintain open communication with the expectant fathers while they are waiting for their wives to deliver. Doing so shows respect by acknowledging the father as the head of the family and providing information to him.

Nurses and healthcare providers need to be aware of the emphasis on adhering to the "hot-cold" theory in this culture as crucial to maintaining health, particularly in the postpartum period. Nurses need to understand the basics of providing warm fluids, such as hot tea and even warm water, immediately after delivery rather than offering ice cold juices and ice chips, as is the current practice in labor and delivery units in U.S. hospitals. Not recognizing the significance of the hot-cold theory violates a key value of maintaining balance and harmony in health to promote recovery. If a Mexican American postpartum woman refuses to shower or wash her hair, the nurse must recognize that this is the influence of the hot-cold theory beliefs, maintains health and well-being, and provides preventative protection to the mother by preventing becoming cold. Postpartum Mexican American women believe the influence of cold has detrimental long-term effects, including creating future gynecological and arthritis problems. Using Leininger's action mode of accommodation and negotiation for sponge bathing versus a shower is acceptable for Mexican American women, and it is acceptable to delay washing the hair.

Nurses can avoid cultural imposition and ethnocentrism when understanding the cultural beliefs and practices of the patients for whom they care.

Informants related many experiences of not receiving the time and attention they needed from nurses and healthcare providers. The informants perceived this to be a lack of respect and caring. For Mexican American postpartum women, caring is “doing” and being “attentive to,” whether it be through listening, communicating, or providing physical assistance. This was validated numerous times in the interviews with the informants. Providing uniquely individualized, culturally competent and congruent care shows the concept of caring to Mexican American women. Speaking directly to the woman and not down at her, maintaining eye contact, and offering explanations that are simple and void of complex medical jargon are all vitally important to establishing trust and confidence. Nurses can deal with the language barrier in several ways: (a) using the ATT&T translation line, (b) using Cyrophone, (c) utilizing Spanish translators provided by the hospital, (d) assigning nurses with Spanish-speaking skills to the patient, and (e) providing patients with educational materials written in Spanish.

Culture care repatterning and/or restructuring. *Culture care repatterning and/or restructuring* refers to “those assistive, supportive, facilitative, or enabling professional actions and mutual decisions that would help reorder, change, modify, or restructure the patient’s lifeway or the healthcare institution for better healthcare patterns, practices, or outcomes” (Leininger & McFarland, 2006, p. 8). Repatterning and/or restructuring of care for Mexican American postpartum women depends on the trusting relationship between patient and nurse. Ideally, one would prefer to apply the concepts of culture care preservation and/or maintenance and then culture care accommodation and/or

negotiation. The preferred action would be to preserve and maintain the culture care beliefs and practices of postpartum Mexican American women or, if that is not possible, to accommodate and negotiate for a mutually satisfactory plan of care. Communication in Spanish, respect, and trust are essential in promoting confidence in Mexican American women and developing positive relationships. Once a trusting relationship is developed and the nurse has gained an emic perspective, collaborative care can begin because the patient is open to receiving that care based on a trusting relationship.

Postpartum Mexican American women have many unique traditional beliefs that vary from woman-to-woman as well as family-to-family. Learning about these traditional beliefs from an emic perspective is vital for promoting positive outcomes for mother and baby. Mexican American women are initially reluctant to share these generic beliefs and practices, but once a trusting relationship is developed, they willingly share information. This researcher has discovered through personal experience that speaking a few words in Spanish opens the door for more open communication. Nurses must take the time to be centered and present with the Mexican American woman to show interest in and gain knowledge of her perspective of postpartum beliefs and practices. This is of particular importance with herbal remedies, as some may be innocuous and others may be harmful, especially if combined with medications that are dispensed postpartum. Nurses need to gain knowledge of herbs and herbal remedies as a first step in perhaps repatterning or restructuring the use of these remedies to prevent a negative outcome.

A positive finding in this study was the informants' acceptance of and trust in the U.S. healthcare system, nurses, and doctors, especially when healthcare providers demonstrated caring behaviors such as (a) showing interest, (b) being attentive, (c)

offering explanations, and (d) speaking in Spanish. Nurses caring for Mexican American postpartum women must have transcultural nursing knowledge in order to deliver culturally competent, congruent, and sensitive care for this population and to promote nurse-client experiences that lead to patient satisfaction based on the delivery of culturally congruent care.

Theoretical Implications of this Study

Leininger's culture care diversity and universality theory and the ethnonursing research method served as the philosophical and theoretical foundation for this study. The rigorous application of Leininger's theory and ethnonursing research method provided this researcher a way to discovering the rich, detailed, covert, emic data that were vitally important to gaining an understanding of the folk beliefs and practices of Mexican American women in the postpartum period. Serendipitous findings included rich cultural data about the beliefs and practices in the antepartum and intrapartum periods as well, although they were not the intended focus of this study.

This study emphasized the importance of understanding the worldview of Mexican American women and its impact on the postpartum generic beliefs and practices that are intrinsic to this culture. The goal of this study was to elicit emic data regarding key postpartum beliefs and practices of postpartum Mexican American women to provide nurses with the cultural knowledge they need to deliver culturally sensitive, appropriate, and congruent care whether in the hospital, clinic, outpatient, or community settings. The study supports the importance of combining generic care with professional care to

promote health in postpartum Mexican American women, which is an aspect of Leininger's theory (Leininger & McFarland, 2002). Kleinman (1980) believed that it was important for healthcare professionals to understand the patient's perspective regarding health issues because the healthcare professional's perspective is often very different from the patient's. This speaks to Leininger's (2006; Leininger & McFarland, 2002) belief that in order to deliver culturally congruent and competent care, one must combine professional healthcare practices with the patient's traditional practices. This study supports the importance of generic care and professional care in the promotion of postpartum health among Mexican American women. It is only through the detailed cultural assessment of Leininger's seven domains that this researcher was able to obtain the hidden emic data that are so important for understanding the depth and breadth of the postpartum culture care values, practices, and beliefs of Mexican American women.

This researcher was initially concerned about the possibility of the Sunrise Enabler being too prescriptive, but that was not the case. Using the theory, method, and Sunrise Enabler facilitated the discovery of that rich, hidden data about the phenomenon of study that otherwise might not have been obtained, while also providing additional emic data regarding the antepartum and intrapartum periods and the topic of domestic violence. The researcher thought that perhaps too much data were obtained that did not directly bear on the domain of inquiry. However, the open-ended semi-structured interview guide was just that—a guide—and if an informant offered a comment of interest, the researcher had the freedom to pursue that avenue, leading to unexpected rich data being obtained that otherwise might not have been identified. These additional findings add to the exciting possibilities of future research.

Implications for Nursing Research

Despite the existing body of transcultural nursing research, there is an urgent need for more knowledge. Transcultural nursing theories, multicultural research, and educational programs and practices can greatly assist nurses in moving into a global transcultural world. Unquestionably, transcultural nursing scholars have consistently led the way for more than four decades in transcultural nursing research related to cultural care as the essence of nursing and as the phenomena to explain and predict the health or well-being of people.

This study confirms the importance of using a theory and research method specifically designed to obtain postpartum culture care data of Mexican American women to add to the body of transcultural nursing knowledge. Research among vulnerable populations is desperately needed, particularly in the area of women's health. No extant studies investigated this study's domain of inquiry, supporting the need for research among Mexican American childbearing women. Several phenomena, such as (a) domestic violence, (b) *machismo*, (c) *marianismo*, (d) gender roles, (e) antepartum and intrapartum rituals, and (f) depression, both antepartum and postpartum, surfaced during these interviews, providing a basis for many exciting avenues of future research studies to fill the extant gap of nursing knowledge regarding lifeways of Mexican American women. The informants' willing discussion of domestic violence and their perspective regarding how it begins and is perpetuated in this culture have given this researcher many ideas for future research on this topic and the development of a model depicting "the circle of violence."

This study involved a small sample in northern New Jersey, and it would be interesting to explore the same domain of inquiry in another location in New Jersey or possibly in Mexico. Conducting research in Mexico would highlight Leininger's comparative aspect of cultural research. The rationale behind Leininger's (2006) comparative method "was to discover human care diversities and universalities in relation to worldview, social structure, and other dimensions cited, and then to discover ways to provided culturally congruent care to people of different or similar cultures . . ." (p. 39). Conducting international research using Leininger's comparative method would identify the emic and etic perspectives of postpartum care, leading to new insights about similarities and differences in professional postpartum care and postpartum generic or folk care knowledge, attitudes, and practices.

The comparative method was conceptualized to be a longitudinal research program in order to establish comparative cultural knowledge about what was similar and what was different about care phenomena in Western and non-Western cultures. The ultimate goal of this type of research, and this research study, was to take the findings and develop appropriate nursing decisions and actions using Leininger's three action modes to deliver culturally competent care (Leininger, 2006). The results of this research study are hypothesized to improve existing postpartum care practices while providing other phenomena for future research.

The following topics could also be considered for future research:

1. The use of herbalism in Mexican American culture to maintain and/or promote health and well-being.
2. The degree of acculturation regarding care meanings, beliefs, and practices for Mexican American women in the childbearing period.

3. The influence of language (i.e., speaking Spanish) on health outcomes among Mexican American childbearing women.
4. Gender role differences, specifically *machismo* and *marianismo*, and the ways these gender roles impact the lives of women living in the United States.
5. The concept of *fatalism*, specifically whether it is more prominent in other Mexican American populations in New Jersey and/or Mexico and in other Hispanic subcultures.
6. The concept of *machismo* and its relationship to domestic violence.
7. Commonalities or diversities in the domain of inquiry in other Hispanic subcultures, specifically how they compare with the domain of inquiry in Mexican American women, again reflecting the comparative analysis component of Leininger's method.
8. The role of *machismo* in domestic violence and during the postpartum period, as well as its mitigation by the presence of gender-congruent support and adhering to the practices of *La Cuarentena*.
9. A link between *machismo* and homosexual tendencies.
10. "The circle of violence" as possibly created by the gender roles assigned to males and perpetuated by the mother.
11. Antepartum depression risk factors and postpartum depression among Mexican American women and the use of appropriate screening tools possessing validated psychometric properties (e.g., Beck's Postpartum Depression Predictors Inventory Screening Scale and Beck's Postpartum Depression Screening Scale, Spanish Version).

Besides the comparative approach, this researcher believes a phenomenological approach might provide another perspective on several phenomena in the lives of Mexican American women. For example, this researcher would be most interested in exploring the lived experience of giving birth in the United States and the lived experience of domestic violence.

Implications for Nursing Practice and Education

This research study highlighted the fact that there is no extant nursing research in the domain of inquiry. One can assume that if there is no extant cultural knowledge about

the postpartum period in Mexican American women, then nurses cannot effectively, if at all, delivery culturally appropriate congruent and competent care to postpartum Mexican American women. This has tremendous implications for nursing practice and education.

Nurse researchers have identified disparities in healthcare (De Chesney et al., 2008) and barriers to obtaining healthcare for Mexican American women (Berry, 1996). Nurses' lack of cultural knowledge and sensitivity in caring for culturally diverse clients with whom they are unfamiliar has been identified as one reason for this disparity (Duffy, 1997). This study's findings support Duffy's research. Increased globalization has created an influx of culturally diverse clients. As stated previously, U.S. demographics reveal the Mexican American population to be the fastest growing and youngest of all Hispanic subgroups. The younger population equates with more women of childbearing age who will need prenatal, intrapartal and postpartal care, in addition to care for the newborn, increasing demand for maternal/child healthcare services for these women.

In this study, Mexican American informants identified nursing and healthcare provider behaviors that indicated a lack of knowledge and sensitivity to their postpartum beliefs and practices. Informants indicated that few Spanish-speaking healthcare providers were available to them, describing situations in which no interpreter was offered/available and, therefore, no information was communicated to them. Informants perceived this as non-caring behavior: the healthcare provider did not care enough for them to provide an interpreter. Based on the findings of this study, it is imperative that the language issue be addressed to deliver culturally congruent and safe care. JCAHO and OMH mandated that interpreter services must be provided to non-English speaking patients. Nurses need to advocate for their patients and not focus on the time-consuming

aspect of using interpreter services and phone translation lines. Education needs to be focused on these aspects of providing culturally sensitive, congruent, and appropriate care.

Informants described cavalier attitudes by nurses and healthcare providers, indicating informants' perceptions of non-caring behavior. Nurses caring for Mexican American postpartum women were totally unaware of the concept of the "hot-cold" theory and its importance, according to the informants of this study. Typically, nurses offer ice chips, ice cold drinks, and ice packs for the perineum after delivery, not understanding that postpartum is considered a "cold" period, a very vulnerable time for the woman, and must be treated with warmth.

Adhering to the hot-cold theory provides a method of protection for Mexican American postpartum women against future health problems, such as arthritis, back pain, and gynecological issues. Deferring an ice pack and offering hot blankets, hot tea, or even hot water is more acceptable, is a simple gesture, and is greatly appreciated by Mexican American women. In addition, this type of behavior demonstrates culturally sensitive, congruent, and competent care. Nurses can only impact health disparities and care appropriately for postpartum Mexican American women through their own development of cultural awareness, knowledge, and sensitivity and by making an attempt to communicate in Spanish.

It is noteworthy that conducting nursing research to add to the body of nursing knowledge in this domain of inquiry is not sufficient. This nurse researcher has an ethical and moral responsibility to disseminate the research findings, to present the findings in a clear and understandable way, and to show the relevance of the findings to nurses who

care for postpartum Mexican American women. However, disseminating the findings alone is not enough. Nurses must also be educated about (a) transcultural nursing, (b) the conduct of transcultural nursing research, (c) the use of Leininger's cultural model and its applicability to clinical practice, and (d) ways to apply the research findings from this study to clinical practice. Nurses need to understand the entire gestalt of the transcultural nursing and research process, including the impetus for the development of transcultural nursing.

In the mid-1950s when Leininger first introduced the idea of transcultural nursing as an important and formal area of study for the immediate and future of nursing, transcultural nursing was viewed as unnecessary and irrelevant (Leininger & McFarland, 2006). This attitude is present today, as demonstrated by informants' direct quotes regarding the nursing care attitudes and behaviors that reflected a lack of cultural awareness, knowledge, and sensitivity on the part of healthcare professionals. There has been a very slow response to and limited recognition of the critical need for transculturally prepared nurses, but transcultural nursing is slowly becoming a reality, due in part to increased globalization and the demand by patients to receive culturally appropriate and congruent care. At Dr. Yvonne Wesley's 2007 keynote address at the New Jersey State Nurses Convention in Atlantic City, she stated that the Transcultural Nursing Society needs to be more proactive in addressing healthcare disparities and providing solutions.

This researcher believes that understanding healthcare disparities stems from one's understanding of culture, and each individual nurse must be responsible and held accountable for learning about cultural diversity. The desire to become culturally

knowledgeable and aware has to be present. Nurses need to be encouraged to seek transcultural nursing education so that they can develop skills in working effectively with culturally diverse clients and then seek cultural encounters to hone those communication and care skills.

It is noteworthy, however, that nursing has not been the impetus in promoting cultural competency awareness. The impetus is coming from outside of nursing, namely JCAHO and the OMH (2002) that developed the CLAS standards in 2000. JCAHO has cross-walked some of its standards with the CLAS standards to promote culturally competent and linguistic care within the healthcare organizational setting. Once again, nursing has missed the opportunity to be a leader in this paradigm shift.

As a result, there has been a serious lack of qualified faculty and programs in transcultural nursing to meet the needs of students who are expected to serve clients from virtually every corner of the earth. A survey conducted by Leininger in 2002 revealed that “currently fewer than approximately 20% of faculty have been formally educated in transcultural nursing in the United States, and even fewer in other countries” (p. 50) Of concern, however, is that only approximately 48% of undergraduate, 9% of graduate, and 2% of doctoral students receive preparation in transcultural nursing, yet all nurses are expected to deliver culturally competent and congruent care (Leininger & McFarland, 2002, p. 50). This problem will intensify as consumers with multicultural value expectations and needs enter healthcare systems. In the 21st century and beyond, the trend will be to shift to a transcultural nursing paradigm. As nurses become educated in transcultural nursing, they will understand the multiple holistic, social structure, and

environmental factors that influence care, health, wellness, death, and dying from within a cultural context.

Nursing curricula need to incorporate comparative culture care knowledge, not only in the clinical practice context but also in academic administration and public policy. Undergraduate curriculum must focus on transcultural nursing courses and practicums that provide learning experiences for developing cultural awareness and sensitivity. Graduate curriculum must include transcultural nursing theories, clinical application of those theories, and the introduction to transcultural nursing research through a formal research project using Leininger's theory or that of another theorist.

A consideration that must be addressed in nursing curricula is the addition of Spanish language courses. As stated previously, U.S. Census Bureau (2006, 2008) statistics indicate the Hispanic population is the fastest growing minority group in the United States, with the Mexican American population as the largest Hispanic subgroup. As indicated by the informants in this study, Mexican American women value and perceive nurses and healthcare providers who speak the Spanish language as caring. Requiring at least one Spanish language conversation course will give the students an appreciation of the Spanish culture and the ability to have a basic conversation in Spanish. This study confirmed the findings of other studies regarding this phenomenon with other Mexican groups (Zoucha, 1998, 1999; Zoucha & Zamarripa, 2008). Leininger also confirmed that speaking more than one language is necessary today in order to effectively provide culturally congruent care for the population for whom one cares (Leininger & McFarland, 2002).

Nursing recruitment of more Hispanic nursing students must also be at the forefront of nursing recruitment agendas. Currently, Hispanics represent approximately 2% of the nursing workforce (Marquand, 2007). Providing incentives for Hispanic students to choose nursing as a profession is needed to increase numbers of Hispanic nurses in the workforce. Doing so will provide the level of support desired by Mexican American women.

This study and the three themes of culture care for postpartum Mexican American women discovered in this research provide an example of application of Leininger's theory and use of the ethnonursing research method, as well as provide examples of cultural knowledge that can be incorporated in transcultural nursing education.

Implications for Transcultural Nursing Administration and Leadership

Transcultural nursing administration refers to the process of assessing, planning, and making decisions and policies that will facilitate the provision of educational and clinical services that take into account cultural lifeways to promote beneficial outcomes (Leininger & McFarland, 2002). A transcultural nursing administration must reflect the goal of accommodating different cultural values and lifeways of people when perceiving care services and caring as the essence of nursing practice. Nurse administrators are in the prime position of promoting the inclusion of cultural diversity training and education in their organizations.

In this study, informants revealed various levels of support for non-English-speaking patients in doctors' offices and local hospitals. An unexpected finding was that even though a doctor's office or hospital may provide care to primarily Mexican American patients, interpreter services and written materials in Spanish were not always

provided, regardless of the office's or hospital's status as Medicare and Medicaid providers. AT&T and Cyrophone translation lines were available in hospital settings but not always used since nurses perceived them to be "inconvenient" and time-consuming. In addition, informants were not consistently provided with an interpreter in the hospital or doctor's office setting. Informants also reported feeling uncomfortable with a nurse who was not Spanish but who spoke Spanish acting as interpreter. Informants reported feeling fearful that what was being said by the physician or nurse was not being accurately or comprehensively related to them. It was obvious that cultural and language differences were not always recognized as a major concern by healthcare providers and healthcare organizations, in spite of difficulties encountered by the informants. The findings of this study indicated few organizations were culturally competent organizations, reflecting culturally sensitive and congruent care for the patients they served, namely postpartum Mexican American women.

The postpartum period among Mexican American women is culturally shaped and socially constructed (Stern & Kruckman, 1983). Nurses who care for postpartum Mexican American women must recognize and acknowledge the importance of traditional beliefs and practices and respect those traditions. Nurse administrators who have the responsibility for this practice area are in a key position to provide nurses with the resources they need to deliver culturally sensitive and congruent care. This includes offering cultural diversity educational programs presented by experts in the field, targeted to provide specific cultural information for the population being served. This training includes education on cultural assessment, integration of cultural beliefs and practices into the plan of care, and the use of translation lines such as AT&T and Cyrophone.

As the discipline of transcultural nursing moves into the third millennium, strong leadership will be essential to meet the needs of Mexican American postpartum women. Nurses educated in transcultural nursing concepts, principles, and research will be equipped to provide greater quality of care to Mexican American postpartum women. Most importantly, nurses have a moral imperative to educate themselves in transcultural nursing practice, which is essential to preventing cultural imposition, cultural conflicts, and other negative client outcomes. Transcultural nursing leadership will be imperative to respond to the increasing globalization of healthcare to prevent racial prejudices, cultural biases, and other serious problems that negatively impact well-being. Nursing administrators need to face the changing demographics and advocate for promoting and providing resources for delivering culturally sensitive, congruent, and competent care for Mexican American postpartum women. Leininger (1994, 2001, 2006; Leininger & McFarland, 2002, 2006) identified four major transcultural nursing leadership attributes.

1. *Persistence*. To achieve highly desired goals that will have beneficial outcomes, one must maintain a tenacious position even when his/her ideals are attacked or resisted.
2. *Predictive insights*. Predictive insights reflect intellectual astuteness and a willingness to go to the unknown with predictive hunches. With predictive insights, leaders draw and reflect upon existing transcultural nursing knowledge.
3. *Patience*. Patience is essential when introducing others to transcultural nursing concepts, principles, research methodology, and desired competencies. It requires being open to others and waiting for the right time and place to help others or implement system changes. Patience reflects thoughtful assessments using calculated risks and creative steps to move forward at the same time.
4. *Proactive stance*. Taking a position to influence others in achieving desired goals or outcomes, proactive leaders are visionary and know how to use strategies in creative ways to guide and influence others. They must take steps forward into the unknown and take risks. Being proactive means being an active listener and reflector, while simultaneously maintaining a proactive

stance. It means using transcultural nursing knowledge and skills in thoughtful, purposeful, and appropriate ways.

One might rhetorically ask, why has there been a slow development in transcultural nursing administration, particularly in developing culturally appropriate courses, programs, and practices for nurses? The answer is multifactorial. The first major factor is the lack of nurse leaders prepared in transcultural nursing. Second, only a few schools of nursing offer courses in transcultural nursing administration practice; Kean University in New Jersey is among them. Third, there are no doctoral programs offering sequenced courses in transcultural nursing administration. Fourth, the strong ethnocentric beliefs and values of nurses of the dominant culture present a monocultural perspective in nursing schools. Fifth, an unspoken fear is that nurse administrators may not be able to handle the outcomes of using different cultural approaches, practices, and policies and that medical and hospital administrators and staff will never accept such changes. In other words, it is easier to maintain the status quo. Sixth, current services are conservative in philosophy, and to change to a multicultural perspective would lead to major difficulties. The idea of shifting an institution to a transcultural nursing philosophy and practice is often viewed as too overwhelming, especially for a university or healthcare setting (Leininger, 1994, 2006; Leininger & McFarland, 2002; Office of Minority Health, 2002; Zoucha, 1998).

Despite these issues, there is a societal imperative for the recognition of cultural diversity in the healthcare setting, and the OMH and JCAHO are now mandating culturally competent care initiatives, forcing the change to a transcultural nursing perspective within the healthcare arena. As Leininger envisioned over 50 years ago, transcultural nursing provides an overarching paradigm to lead nursing into the 21st

century and into the third millennium in order to provide culturally competent care to all people, including the large and quickly growing Mexican American population.

Developing cultural competence is a process that begins with cultural desire. The process has been slow, and much work remains to be done.

Conclusion

This study provides tremendous insight into the lives of postpartum Mexican American women and the type of care, care practices, and caring behaviors they feel are important to their health and well-being. Data were also obtained regarding the antepartum and intrapartum phases as well. The study clearly demonstrates the interconnectedness between the following culture care constructs: (a) God, prayer, and family are the base of everything in life and provide strength, protection, and support; (b) protection of mother and baby is transmitted intergenerationally by elder Mexican American women and is influenced by religion, folk, and family beliefs and practices; and (c) showing interest, being attentive, and speaking Spanish indicate respectful behavior and are central to the meaning of care. All of these constructs represent an in-depth look into the worldview of postpartum Mexican American women.

This study highlighted the significance of Mexican American women's worldview and its indisputable influence during postpartum, as well as discovering other phenomena for further study. One of the phenomena, *machismo*, negatively impacted postpartum Mexican American women and highlighted the importance of protective factors of *La Cuarentena* against *machismo*.

Nurses must be educated to understand the impact of worldview when delivering care to postpartum Mexican American women. Without this educated understanding,

meaningful culturally competent, congruent, sensitive, and appropriate care cannot be delivered to Mexican American women. Leininger stated that if care is not meaningful to the patient, then it is not beneficial (Leininger & McFarland, 2002). One important finding of this study revealed that healthcare providers speaking Spanish is considered meaningful and caring behavior by Mexican American women. One can presume that culturally incompetent care is not meaningful care to postpartum Mexican American women and is, therefore, not beneficial. In reality, one can hypothesize that culturally incompetent care is actually detrimental, causing cultural pain, patient dissatisfaction, and negative patient outcomes. Culturally appropriate and sensitive care leads to patient satisfaction and, most importantly, positive patient outcomes (Leininger, 1994, 2006; Leininger & McFarland, 2002; Office of Minority Health, 2002; Zoucha, 1998).

In today's healthcare arena, there can be no better rationale for developing an understanding of ethnically diverse clients, as patient satisfaction and positive patient outcomes significantly impact the financial aspect of delivery quality care—the bottom line for all healthcare institutions. The delivery experience and postpartum care Mexican American women receive is crucial to a healthy recovery period, both physically and psychologically. Therefore, it is imperative that nurses understand the worldview of postpartum Mexican American women to deliver culturally sensitive, appropriate, congruent, and competent care. Negative intrapartum and postpartum experiences for Mexican American women based on a lack of cultural understanding can lead to a negative experience that can lead to birth trauma, setting the stage for the development of post traumatic stress syndrome and/or postpartum depression (Beck, 2004; Beck & Froman, 2005; Beck & Gable, 2003). These negative sequelae not only impact the mother

but also the baby, family, and society (Beck, 1996, 1999; Cogill, Caplan, Alexandra, Robson, & Kuman, 1986). It is noteworthy that, with today's emphasis on evidence-based practice, Melnyk (Melnyk & Fineout-Overholt, 2005, 2010) stated that without including culture, one cannot have evidence-based practice.

Cheryl Beck (2004) conducted a phenomenological study to describe the meaning of women's traumatic birth experiences. The women in the study were identified as suffering from posttraumatic stress syndrome and postpartum depression. Birth trauma was any experience perceived by the woman to be negative to her or her baby and was aptly reflected in the title of the study that birth trauma is truly in the eye of the beholder. Four themes emerged from the study that described the essence of the women's experiences of birth trauma: (a) To care for me, was that too much to ask? (b) To communicate with me: Why was this neglected? (c) You betrayed my trust, and I felt powerless, and (d) The end justifies the means: At whose expense? While this study did not include Mexican American women, what it did point out was the similarities between Anglo women and the Mexican American informants in this researcher's study regarding birthing care and care practices: women want to be cared for (in the physical sense) and, most importantly, want to *feel* cared for (in the emotional sense). Women also want communication; they want to be told what is happening and what to expect in a language they understand. During this rite of passage, all women, regardless of culture, want to be respected. Not feeling cared for and not receiving communication caused the women in Beck's study to feel betrayed and powerless, which they equated with a lack of respect. The informants in this study also perceived nurses and healthcare providers not

communicating with them about what was happening and not speaking the Spanish to be non-caring and non-respectful behavior.

According to the Patient Bill of Rights (State of New Jersey, 2010), all patients are entitled to care that is congruent with cultural values, beliefs and practices—care that Mexican American women desire and deserve. Nurses must prepare themselves through an educational and experiential process that begins with cultural desire and awareness, moves toward an acquisition of cultural knowledge, and finally involves cultural encounters with Mexican American women to become culturally competent nurses who can deliver culturally congruent care to postpartum Mexican American women.

Limitations of the Study

The major limitation of the study was the inability of the researcher to speak, write, and respond fluently in Spanish since the majority of the informants spoke no English. Those who did preferred to have the interviews conducted in Spanish and preferred to sign the Spanish consent. In anticipation of this limitation, the researcher worked with two Mexican American interpreters who were fluent in both verbal and written Spanish and were familiar with the community where the data collection occurred. This researcher was studying Spanish at the time of data collection to develop linguistic skills, a fact that enhanced communication and strengthened rapport with the informants. The fact that the researcher was learning the informants' language is congruent with Leininger's (2006) theory (Berry, 2002). The use of (a) field journals, (b) notes, (c) assistance of experienced mentors, and (d) Leininger's qualitative criterion evaluation assisted the researcher in staying focused on the domain of inquiry, leading to a systematic and rigorous research process. On reflection, trust did not seem to be an

issue, as the informants were very comfortable with the researcher due to her association with the interpreter. However, had the researcher spoken fluent Spanish, the findings might have been more revealing. In addition, the researcher was not Mexican American and not part of the community; this was a limitation in that it took a very long time to gain approval, acceptance, and entrance into the community.

A possible limitation was that preschool age children were often present with the mothers as the interviews were taking place. The researcher provided paper, coloring books, and crayons for the children, who were extremely well behaved, but their presence could have affected the data. The informants appeared comfortable, but there is a possibility that information was withheld.

A further limitation would be a methodological issue involving translation as a translation service was used. It is possible that data would have been translated differently had the researcher been fluent in Spanish.

The potential for biased responses was addressed by rigorous adherence to Leininger's Observation-Participation-Reflection Enabler and the Stranger-to-Trusted Friend Enabler. As the researcher moved through the phases of the Observation-Participation-Reflection Enabler—from an observer/listener role to a participant/reflector role—the researcher reconfirmed the findings with informants. In the Stranger-to-Trusted Friend Enabler, the goal was to become a trusted friend. It was essential for the researcher to be trusted so that honest, credible, and in-depth information could be obtained from the informants (Berry, 2002). Leininger (Leininger & McFarland, 2002) determined through her many years of research that when informants trust the researcher,

the credibility and accuracy of the findings markedly increase. If the researcher is trusted, the informants are more likely to be open and reveal insights.

Acculturation level was not assessed by a formal acculturation scale. Therefore, results of this study cannot be assumed to be true of all Mexican American regarding postpartum beliefs and practices since culture care, the environmental context, and level of acculturation may vary.

A possible limitation was the informants' focus on care and non-caring behaviors linked to speaking Spanish. Informants perceived speaking Spanish by the healthcare provider as being caring. Informants also preferred to be cared for by Spanish healthcare providers, trusting the communication to be more accurate. On reflection, this researcher wonders if the findings would have been different if all healthcare providers spoke Spanish and were of Spanish ethnicity. Perhaps a comparative study in Mexico would provide further findings to support or refute this concern.

Summary

In Mexican American culture, meanings and expressions of postpartum culture care are embedded in the (a) worldview, (b) language, (c) social structure, and (d) environmental context. In order to provide holistic care that is culturally competent, congruent, and sensitive to this population, it is important for nurses to understand the perspectives of Mexican American women regarding care and caring behaviors during postpartum.

This chapter discussed the findings analyzed from interviews with 15 key informants and eight general informants as well as the researcher's observations and participation within the community. This study investigated the cultural expressions,

meanings, beliefs, practices, and experiences of Mexican American women during the postpartum period that were conceptualized within Leininger's theory of culture care. The ethnonursing research method was used to discover emic data of the phenomenon under study. Culture care meanings, beliefs, and practices were discovered using the informants' verbatim quotes. It was posited that postpartum care meanings, beliefs, practices, and experiences are embedded in the social structure and worldview and, as such, need to be studied within the naturalistic environmental context.

Seventeen categories, six patterns, and three themes emerged from the data analysis. Categories, patterns, and themes of culture care meanings, beliefs, and practices were identified and presented as they related to the theory of culture care. The three themes identified in this study reflect the synthesis of the research findings according to the process developed by Leininger (2002, 2006). The themes describe the influence of worldview on culture care of Mexican American women in the postpartum period. The themes also reflect the incredible strength of these women, and the devotion to their (a) culture, (b) traditions, (c) children, and (d) family. Mexican American women, despite facing many barriers, remain optimistic and hopeful.

The research questions were answered, and categories, patterns, and themes resulted from the data analysis explicating the cultural context of the postpartum period of Mexican American women and the context of culturally congruent care. Implications for nursing research, education, and practice and for transcultural nursing administration were presented, leading the way for the provision of culturally competent and congruent care for Mexican American women in the childbearing period. Limitations of the study were discussed, and recommendations for future research were highlighted.

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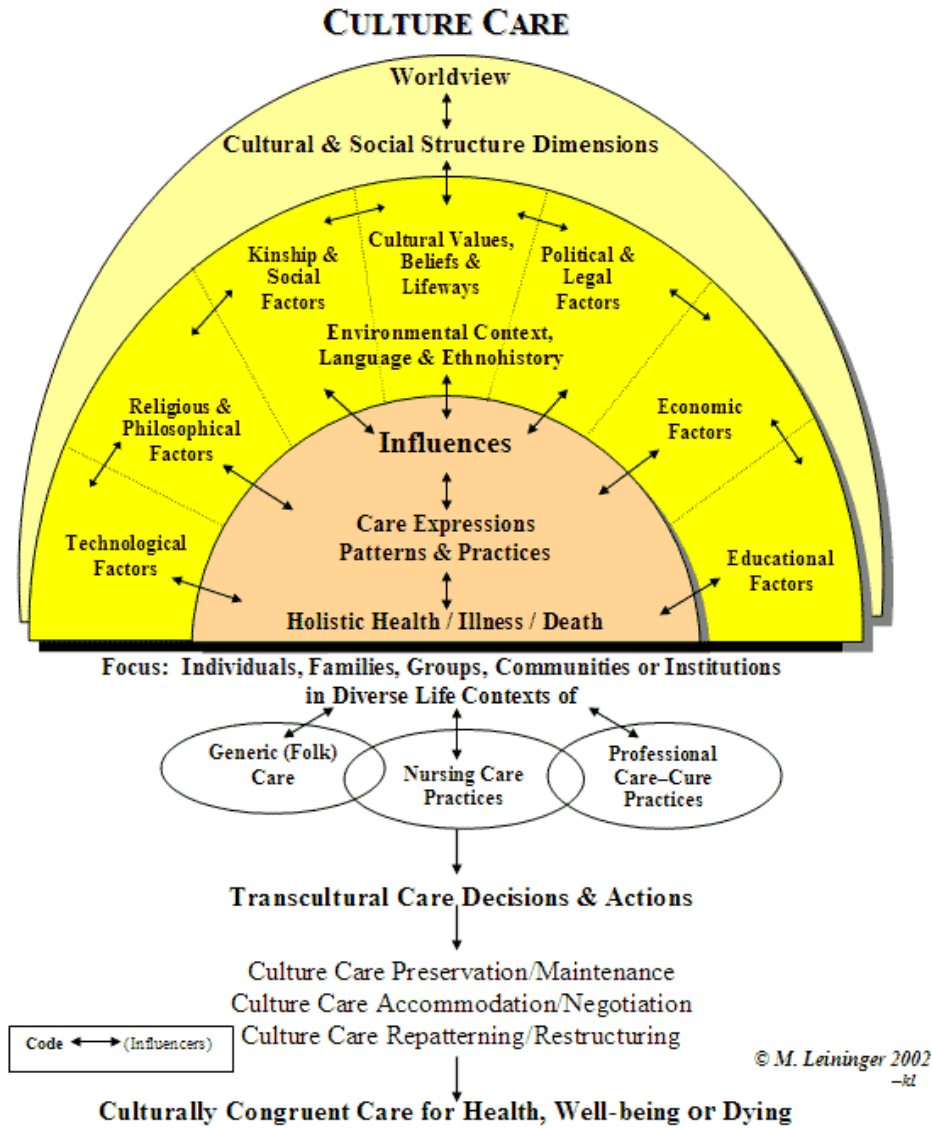
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Appendix A: Leininger's Sunrise Model

Leininger's Sunrise Enabler for the Theory of Culture Care Diversity and Universality



Used with permission from the Transcultural Nursing Website: <http://www.tcns.org>

Appendix B: Map of Mexico



Appendix C: Stranger-to-Trusted Friend Enabler

Indicators of Stranger (Largely etic or outsider's views)	Dates Noted	Indicators of a Trusted Friend (Largely emic or insider's views)	Dates Noted
Active to protect self and others; suspicious and questioning. They are the <i>gate-keepers</i> and guard against outside intrusions.		Less active to protect self; more trusting of researchers; less suspicious and less questioning of researcher.	
Actively watch and are attentive to what researcher does and says; limited signs of trusting researcher.		Less watching the researcher's words and actions; more signs of trusting and accepting a new friend.	
Skeptical about the researcher's motives and work; may question how findings will be used by the researcher or stranger.		Less questioning of the researcher's motives, work, and behavior; signs of working with and helping the researcher as a friend.	
Reluctant to share cultural secrets and views as private knowledge; protective of local lifeways, values, and beliefs; dislike probing by the researcher or strangers.		Willing to share cultural secrets and private world information and experiences; offer mostly local views, values, and interpretations spontaneously or without probes.	
Uncomfortable becoming a friend of or confiding in stranger; may arrive late, be absent, and withdraw at times from researcher.		Signs of being comfortable and enjoying friendship-sharing relationship; give presence, are on time, and give evidence of being a genuine, "true" friend.	
Tend to offer inaccurate data; modify truths to protect self, family, community, and cultural lifeways; emic values and beliefs are not shared spontaneously.		Want research truths to be accurate regarding beliefs, people, values, and lifeways; explain and interpret emic ideas so researcher has accurate data regarding the culture and informant.	

From "Culture Care of the Mexican American Family" by A. Berry, 2002, in M. Leininger and M. McFarland (Eds.), *Transcultural Nursing: Concepts, Theories, Research and Practice* (3rd ed.), (New York, NY: McGraw Hill), pp. 363-374.

Appendix D: Observation-Participation-Reflection Enabler

Phases	1	2	3	4
Focus	Primarily Observation & Active Listening (no active participation)	Primarily Observation with Limited Participation	Primarily Participation with Continued Observations	Primarily Reflection and Reconfirmation of Findings with Informants

From "Culture Care of the Mexican American Family" by A. Berry, 2002, in M. Leininger and M. McFarland (Eds.), *Transcultural Nursing: Concepts, Theories, Research and Practice* (3rd ed.), (New York, NY: McGraw Hill), pp. 363-374.

Appendix E: Leininger's Six Qualitative Criteria for Evaluating Qualitative Research

1. “**Credibility** refers to direct sources of evidence or information from the people within their environmental contexts of their *‘truths’* held firmly as believable to them.”
2. “**Confirmability** refers to documented verbatim statements and direct observational evidence from informants, situations, and other people who firmly and knowingly confirm and substantiate the data or findings.”
3. “**Meaning-in-Context** refers to understandable and meaningful findings that are known and held relevant to the people within their natural living environmental contexts and the culture (Note: This was not an explicit term of Lincoln and Guba, but deemed important for all qualitative studies by Leininger).”
4. “**Recurrent Patterning** refers to documented evidence of repeated patterns, themes, and acts over time reflecting consistency in lifeways or patterned behaviors.”
5. “**Saturation** refers to in-depth information of all that is or can be known by the informants about phenomena related to a domain of inquiry under study.”
6. “**Transferability** refers to whether the findings from a completed study have similar (not necessarily identical) meanings and relevance to be transferred to another similar situation, context, or culture.” (Berry, 2002 , p. 88)

Appendix F: Ethnodemographic Data Sheet

Ethnodemographic Data Sheet	
Number: _____	
Name: _____	
Age: _____	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered	
Ethnicity: <input type="checkbox"/> Mexican American	
Occupation: You _____ Your _____	
Spouse/Partner _____	
Religion: _____	
Birthplace: _____	
How many years lived in U.S. (you) _____	
Highest Education: <input type="checkbox"/> Elementary <input type="checkbox"/> Middle School <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Graduate School	
Number of Pregnancies: _____	
Experience with:	
Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No	
Stillbirth <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ectopic Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pregnancy Planned <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of Living Children: _____	

Number: _____

Age of youngest child: _____ **Girl** **Boy**

Age of oldest child: _____ **Girl** **Boy**

Primary Language Spoken: _____

Fluency in other Languages (speaking, reading writing) _____

Household composition (who lives with you at home?) _____

Where do you live? (Private home, apartment?) _____

Appendix G: Ethnodemographic Inquiry Guide

ETHNONURSING INQUIRY GUIDE FOR DISCOVERING CARE MEANINGS AND EXPERIENCES WITHING THE CULTURAL CONTEXT	
NUMBER:	
NAME:	
I. Introduction	II. Cultural Values, Beliefs, Lifeways
<p>As a maternal child nurse, I am interested in learning about your culture and way of life in order to assist healthcare providers in providing culturally appropriate care for Mexican American women, particularly new mothers after the birth of a baby.</p>	<p>As a nurse, I am interested in your cultural values and beliefs in order to be able to plan appropriate care for you.</p> <ol style="list-style-type: none"> 1. What values or beliefs do you possess that are important to you?
III. Kinship and Gender Roles	IV. Political Factors
<p>I am interested in knowing more about your ideas on family.</p> <ol style="list-style-type: none"> 1. Tell me about your family. Who do you consider to be part of your family? 2. Who is important in your life? 3. Can you tell me what the women do in your family? What do the men in the family do? Can you tell me what the children do? 4. Tell me what it means for you to have children. 5. Can you describe for me some of the family beliefs and values that are important to you to pass on to your children? 	<p>I would like to know more about your community.</p> <ol style="list-style-type: none"> 1. Can you tell me who the important leaders are in your community? 2. Can you tell me if you feel they are helpful to you? 3. Is your routine similar or different from other Mexican Americans that you know in your community?
V. Religious and Spiritual Factors	VI. Meanings and Experiences of Care
<p>I am interested in knowing about church and religion in your life.</p> <ol style="list-style-type: none"> 1. Would you tell me what religion means in your everyday life? 2. During pregnancy and childbirth? After delivery? 3. Can you tell me your thoughts on religion and health? 	<p>I would like to know more about how you care for yourself and keep healthy.</p> <ol style="list-style-type: none"> 1. What does good health and being healthy mean to you? 2. Can you explain for me what care means to you? 3. How do people show care? 4. Can you describe for me what you would consider to be non-caring?

VII. Prenatal, Childbirth and Postpartum Practices and Beliefs	VIII. Meanings and Experiences of Care After Delivery
<p>I would like to learn about your practices and beliefs about pregnancy, childbirth and after delivery.</p> <ol style="list-style-type: none"> 1. Can you share with me your thoughts about pregnancy? Childbirth? After delivery? 2. Who is a good person to provide advice for either a pregnant woman or new mother? 3. What might some of the older women in your family or community tell you about pregnancy? Childbirth? After delivery? 4. Describe for me what a healthy pregnancy means to you? 5. Who would you like to be with you in labor? What would they do for you? 6. How does a person show care for a new mother? 7. Would you tell me how you recover and gain strength after delivery? 8. What does it mean for you to have a healthy baby? 	<p>I would like to talk with you about who gives you care after delivery when you come home.</p> <ol style="list-style-type: none"> 1. What happened after your baby was born? Your feelings? Thoughts? 2. After delivery, how do you express how you feel? What words do you use? Feelings? Who would you share your feelings with? 3. How would people react when you told them how you felt (after delivery)? 4. What would care be like for a Mexican American woman at home after delivery? 5. How would you like to be cared for after delivery? By family? By friends? 6. Is there something you would have liked them to do for you that they didn't do? 7. Is there anything else you would like to tell me about what it was like for you at home during the first few weeks and months after delivery? 8. How is care different or similar to what would happen in Mexico or with relatives/friends in Mexico? 9. Is there anything else you would like to share with me about what we talked about?

Appendix H: English Consent

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Understanding the Cultural Expressions, Meanings and Experiences of Mexican American Women during Postpartum

- INVESTIGATOR:** Valera A. Hascup, MSN, RNC
Ph.D. student, Duquesne University School of Nursing
Pittsburgh, Pa. (201) 797-0384
- PURPOSE:** The purpose of this research study is to understand and explore Mexican American women's cultural expressions, meanings, beliefs, practices, and experiences of the postpartum period. You will be asked questions. The interview may take place at your home or a place of your choosing at a time convenient for you and will take about 1 to 2 hours of your time. You may be asked to be interviewed one to three times.
- RISKS AND BENEFITS:** There are no known risks or direct benefits from participating in this study. You will not be paid for participating in this study, nor will you be required to pay to participate. There is no particular benefit to you except the knowledge that you will help in the understanding of health issues in the postpartum period that will create and add to existing nursing knowledge. Understanding the postpartum period in Mexican American women may benefit their healthcare.
- CONFIDENTIALITY:** Your name will never appear on any survey or research instrument used for this study. Your responses to questions may appear as de-identified quotes, after anything that could identify you or anyone you refer to has been removed, in the findings section, should I present the study results at professional conferences or in professional publications. Your de-identified responses may also be shared with the chair and members of my dissertation committee. The person who will assist in transcribing the tapes will sign a confidentiality agreement and will not have access to your name. All written materials and consent forms will be stored in a locked file in my home and will be destroyed upon completion of all activities related to the study.

RIGHT TO WITHDRAW: You are under no obligation to participate in this study, and you may withdraw at any time. There is no penalty for withdrawing.

VOLUNTARY CONSENT: I understand that my participation in this study will include questions about my beliefs, practices, and experiences during the postpartum period. I agree to participate in this interview. I understand that the interview may take 1 to 2 hours of my time, and we may meet possibly one to three times. The interview(s) can be at my home, the clinic, or a place of my choosing. I understand that the information obtained during the interview will be studied and used for the purposes of increasing the understanding of the health beliefs, experiences, practices, and expressions of Mexican American women during the postpartum period. I have been assured of the confidentiality of this study, and I understand that the results of this study may be published or presented at conferences. My name will not be associated with the interview, and no individual data will be reported. The researcher has offered to answer any questions I may have about the study and my participation. I understand there are no known risks involved in participating in this study. If I sign a written consent, I will be given a copy. My signature indicates that I have read and understood the information and that I have agreed to participate in the study based on the information I have received. I further understand that if I should have further questions about my participating in this study, I may call Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board, at (412) 396-5081 or Dr. Rick Zoucha, the researcher's PhD advisor, at (412) 396-6545, and I will be given the opportunity to discuss in confidence, via an interpreter provided by the Center for International Nursing at Duquesne University, any questions with any member of the Institutional Review Board.

Informant's Name Date

Informant's Signature Date

Researcher Date

Appendix I: Spanish Consent

Numero de Código

ACTA DE COMPROMISO PARA PARTICIPAR EN UNA INVESTIGACION

Conociendo la Expresión Cultural, el Significado y Experiencia del Posparto en las Mujeres México Americana: Un Breve Estudio Étnico en Enfermería

IVESTIGADORA: Valera A. Hascup, MSN, RNC, CTN, CCES
229 Schepis Avenue
Saddle Brook, NJ 07663
(201) 797-0384

CONSEJERO: Dr. Rick Zoucha
Universidad Duquesne Escuela de Enfermeras
521 Fisher May
Pittsburg, PA 15282
(412) 396-6545

PROPOSITO: El propósito de esta investigación es comprender y explorar las experiencias de las mujeres México Americanas en su expresión y significado del period de posparto. Se le haran algunas preguntas sobre sus experiencias. La entrevista y hora podria llevarse acabo en su casa o en otro lugar de su preferencia, solo se tomara de una a dos horas de su tiempo. Usted podra ser llamado nuevamente para ampliar informacion en una nueva entrevista dos o tres veces mas.

RIESGO Y BENEFICIOS: No hay ningún riesgo o beneficio directo en la participación en el estudio. No habrá ningún pago por participar en el estudio ni se le requiere pago alguno por la participación. No hay beneficio en particular para usted

COMPENSACION: No hay compensación o pago por tomar parte en este estudio. Sin, embargo, la participación en este estudio no requerirá de su dinero.

excepto el conocimiento en el que usted como paciente ayudara al entendimiento de los sucesos de la salud mental durante el periodo de posparto que crea y adicionara conocimiento al que ya existe sobre la enfermería. Comprendiendo como el periodo posparto en mujeres México Americana puede beneficiar a la salud de ellas.

CONFIDENCIALIDAD: Su nombre no será revelado, ni nadie podrá identificarla a usted como persona participante en el estudio. La conversación será gravada. Las grabaciones serán usadas solo para uso del estudio y será escuchado solo por el investigador, consejero e interprete. La entrevista será conducida en un cuarto privado. Citaciones pueden ser usadas para reportar y explicar (explique) los datos y ningún nombre será adjunto. Toda la información relacionada a este estudio una vez que se haya completado será destruida. El interprete contratado para asistir en la traducción firmara un acuerdo de confidencialidad y no tendrá acceso a los nombres.

DERECHO A RETIRARSE: No esta en obligación a participar en este estudio, y podrá retirarse en cualquier momento. No hay ninguna penalidad por hacerlo.

**COMPROMISO
VOLUNTARIO:**

Yo entiendo que mi participación en este estudio incluirá preguntas acerca de mis creencias, prácticas y experiencias durante mi posparto. Acepto a participar en esta entrevista. Comprendo que la entrevista tendrá lugar en la clínica, su casa o en algún lugar de su elección y se tomara de una a dos horas de su tiempo, y sere entrevistada de una a tres veces mas. Comprendo que la información obtenida durante esta entrevista será estudiada y usada para el propósito de obtener más conocimiento en creencias en la salud, experiencias, prácticas y expresiones de las mujeres México Americana durante el periodo de posparto. Le aseguro la confidencialidad en este estudio, y comprendo que el resultado de este estudio puede ser publicado o presentado en conferencias. Mi nombre no será asociado con las entrevistas y todas las conclusiones serán agrupados en categoría o puede ser presentados en archivos individual para análisis y consultas. El principal investigador se ha ofrecido a contestar algunas pregunta que tenga acerca en este estudio y mi participación. Yo comprendo que no hay ningún riesgo envuelto en la participación en este estudio. Si firmo recibiré una copia de este consentimiento escrito. Mi firma indica que he leído y comprendido la información y que he aceptado la participación en este estudio basado en la información que he recibido.

Comprendo que si tengo preguntas a cerca de mi participación en este estudio, al Doctor Paul Richer, Presidente de la Junta Analítica Institucional de la Universidad de Duquesne al (412) 396-5081 o puedo llamar al Doctor Rick Zoucha, y Consejero Ph.D. al (412) 396-6545 y se me permitirá la oportunidad de discutir en confianza, vía un interprete estipulado por el Centro Internacional de Enfermería en la Universidad de Duquesne, cualquier pregunta con cualquier miembro de la Junta Analítica Institucional.

Nombre del Informador	Fecha
-----------------------	-------

Firma del Informador	Fecha
----------------------	-------

Principal Investigadora	Fecha
-------------------------	-------

Appendix J: Confidentiality Agreement

CONFIDENTIALITY STATEMENT

I understand that as an interpreter/translator and transcriber for a research study being conducted by Valera A. Hascup, PhD student in the School of Nursing at Duquesne University under the supervision of Dr. Rick Zoucha, I have access to confidential information. I agree to keep all data collected, read, interpreted/translated, and transcribed during this study confidential, and I will not discuss or reveal the contents of the data collection to anyone outside of the research team.

Name: _____

Signature: _____

Date: _____

Witness Signature: _____

Appendix K: Leininger's Four Phases of Data Analysis

Phase	Title	Description
First Phase	Collecting, Describing and Documenting Raw Data (Journal and/or Computer)	Researcher begins data collection related to the purpose(s), domain of inquiry (DOI), or research questions under study. This phase includes recording interview data from key and general informants, participating/observing, identifying contextual meanings and first interpretations, identifying symbols, and recording data from both emic and etic perspectives. Data from field journal and personal notes are coded by hand and entered into the computer.
Second Phase	Identification and Categorization of Descriptors and Components	Data are coded and classified according to the DOI. Emic and etic descriptors are studied for contextual similarities and differences. Recurrent components are studied for meaning.
Third Phase	Pattern and Contextual Analysis	Data are carefully scrutinized for saturation and for recurrent patterns of similarity and differences of meanings, patterns expressions, structural forms, and interpretations and explanations related to the DOI. Data are examined to reveal contextual meanings as well as credibility and confirmability of findings
Fourth Phase	Major Themes, Research Findings, Theoretical Formulations, Recommendations	This highest phase of data analysis, interpretation, and synthesis requires critical thinking, analysis, interpretation of findings, and creativity from the emerging data. The researcher's task is to present major themes, research findings, recommendations, and perhaps theoretical formulations.

Adapted from *Transcultural Nursing: Concepts, Theories, Research, and Practice* (3rd ed.) by M. Leininger & M. McFarland, 2002 (New York, NY: McGraw Hill), p. 95.

Appendix L: Demographic Table of Informants

Age	Frequency	Percent
21-25 years	2	8.7
26-30	6	26.1
31-35	5	21.7
36-40	4	17.4
41-45	3	13.0
46-50	1	4.3
51-55	1	4.3
56-60	1	4.3
Marital Status		
Single	4	17.4
Married	11	47.8
Partnered	8	34.8
Ethnicity		
Mexican	23	100
Education		
Elementary	7	30.4
Middle School	1	4.3
High School	7	30.4
Some college or technical schooling	1	4.3
College	6	26.1
Employment		
None	1	4.3
Self	1	4.3
Spouse/partner	15	65.2
Both	6	26.1
Religion		
Catholic	20	87.0
Protestant	1	4.3
Christian	1	4.3
Other	1	4.3
Birthplace		
Pueblo Casa, Mexico	11	47.8
Vera Cruz, Mexico	3	13.0
Mexico, Other	8	34.8
United States	1	4.3

(continued)

Years in United States	Frequency	Percent
1-5	2	8.7
6-10	4	17.4
11-15	7	30.4
16-20	7	30.4
21-25	2	8.7
>25	1	4.3
Education		
Elementary	7	30.4
High School	7	30.4
College	6	26.1
Some college or technical school	1	4.3
Middle School	1	4.3
Primary Language		
Spanish	18	78.3
English only	0	0
Both Spanish/English	5	21.7
Language Spoken at Home		
Spanish	20	87
English	2	8.7
Spanish and English	1	4.3
Language Spoken Outside of Home		
Spanish	13	56.5
English	3	13.0
Spanish and English	7	30.4
Fluent in Other Languages		
No	0	100
Yes	0	100
Living Arrangements		
Live with husband/partner and children	15	65.2
Live with children only	1	4.3
Live with husband/partner, children, extended family	3	13.0
Live with children and extended family	2	8.7
Live with husband/partner and extended family	1	4.3
Live with husband/partner, children and friends	1	4.3

(continued)

Number of Pregnancies	Frequency	Percent
1-2	8	34.8
3-4	12	52.2
5-6	1	4.3
7-8	2	8.7
Miscarriage		
No	17	73.9
Yes	6	26.1
Stillbirth		
No	22	95.7
Missing	1	4.3
Ectopic Pregnancy		
No	22	95.7
Yes	1	4.3
Planned Pregnancy		
No	10	43.5
Yes	9	39.1
One planned/other not planned	3	13.0
Type of Delivery		
Vaginal	12	52.2
Cesarean	7	30.4
Vaginal and cesarean	4	17.4
Number of Living Children		
1-2	11	47.8
3-4	9	39.1
5-6	3	13.0
Age of Youngest Child		
Infant	4	17.4
Toddler	10	43.5
Preschool	2	8.7
School	4	17.4
Adult	3	13.0
Age of Oldest Child		
Preschool	4	17.4
School	7	30.4
Teenage	7	30.4
Adult	4	17.4
Missing	1	4.3

(continued)

History of Baby Blues	Frequency	Percent
No	15	73.9
Yes	9	26.1
History of Depression During Pregnancy and/or Postpartum		
No	15	78.3
Yes	9	21.7
Treatment for Depression		
No	22	95.7
Yes	1	4.3
History of General Depression		
No	17	73.9
Yes	6	26.1
Treated for General Depression		
No	21	91.3
Yes	2	8.7
History of Domestic Violence		
No	18	78.3
Yes	5	21.7
Living in Apartment or Home		
Apartment	14	60.9
Home	9	39.1

Note: $N = 23$

Appendix M: Folk Remedies Healthcare Providers Should Know

Spanish Name	English Name	Uses	Efficacy	Safety
<i>Ajo</i>	Garlic	Hypertension, antibiotic, cough syrup, <i>tripaida</i>	+	+++
<i>Arnica</i>	Arnica	Used in tincture form externally for arthritis and sprains	+	+++
<i>Arnica Mexicana</i>	Camphor Weed	Used in solution form for stomach discomforts, such as gas and cramps; also a skin wash for minor dermatological disorders	+	+
<i>Azarcón/ Greta</i>	Lead/mercury oxides	<i>Empacho</i> , teething	- -	- - -
<i>Damiana</i>	Damiana	Aphrodisiac, <i>frio en la matriz</i> , chickenpox	0	+
<i>Estafiate</i>	Wormwood	Worms, colic, diarrhea, cramps, <i>bilis</i> , <i>empacho</i>	+ purge	- -
<i>Eucalipto</i>	Eucalyptus (Vicks Vapor Rub)	Coryza, asthma, bronchitis, tuberculosis	+ respiratory Sx; 0 TB	+
<i>Gobernadora</i>	Chaparral	Arthritis (poultice); tea for cancer, venereal disease, tuberculosis, cramps, <i>pasmo</i> , analgesic	+ as a poultice 0 as a tea	- - - (internal)
<i>Gordolobo</i>	Mullein	Cough suppressant, asthma, coryza, tuberculosis	+ Cough; 0 asthma, TB, coryza	++ (if right species)
<i>Manzanilla</i>	Chamomile	Nausea, flatus, colic, anxiety; eyewash	+ except eyewash = 0	++ (if no allergy)

(continued)

Spanish Name	English Name	Uses	Efficacy	Safety
<i>Hierba Buena, Menta, Yerba Buena</i>	Mint	Antiemetic. A tea made with mint proves relief from stomachache and nausea; aids digestion. Also is a mild stimulant & provides energy, restores spirits.	+	+
<i>Orégano</i>	Oregano	Coryza, expectorant, menstrual difficulties, worms	0/ + except worms = 0	+
<i>Pasionara</i>	Passion flower	Anxiety, hypertension	+++ sedative	++ (if right species)
<i>Rodigiosa</i>	Bricklebush	Adult onset diabetes, gallbladder disease	???	???
<i>Ruda</i>	Rue	Antispasmodic, abortifacient, <i>empacho</i> , insect repellent	???	--- (internal, external)
<i>Saliva</i>	Sage	Prevent hair loss, coryza, diabetes	???	-- (chronic use)
<i>Tilia</i>	Linden flower	Sedative, hypertension, diaphoretic	+ sedative, other = ???	-- (chronic use)
<i>Tronadora</i>	Trumpet flower	Adult onset diabetes, gastric symptoms, chickenpox	???	???
<i>Yerba buena</i>	Spearmint	Dyspepsia, flatus, colic, <i>susto</i>	++	+
<i>Zábila</i>	Aloe vera	External - cuts, burns Internal - purgative, immune stimulant	External + ++ Internal +/? ??	External + + Internal - - -
<i>Zapote blanco</i>	Sapodilla	Insomnia, hypertension, malaria	???	???

Key: (+ indicates yes, with + being least and +++ being most; - indicates no, with - being least and --- most, i.e., --- in the safety column indicates the treatment is significantly dangerous. ??? indicates the information is not known (Kemp, 2002).

Appendix N: IRB Approval



DUQUESNE UNIVERSITY

INSTITUTIONAL REVIEW BOARD
424 RANGOS BUILDING ♦ PITTSBURGH PA 15282-0202

Dr. Paul Richer
Chair, Institutional Review Board
Human Protections Administrator
Phone (412) 396-6326 Fax (412) 396-5176
e-mail: richer@duq.edu

February 13, 2008

Ms. Valera Hascup
229 Schepis Avenue
Saddle Brook NJ 07663

Re: Understanding the cultural expressions, meanings, beliefs, practices and experiences of Mexican American women during the postpartum period: an ethnonursing study conceptualized with Leininger's culture care theory (Protocol # 08-13)

Dear Ms. Hascup:

Thank you for submitting your research proposal to the IRB.

Based upon the recommendation of IRB member, Dr. Linda Goodfellow, along with my own review, I have determined that your research proposal is consistent with the requirements of the appropriate sections of the 45-Code of Federal Regulations-46, known as the federal Common Rule. The intended research poses no greater than minimal risk to human subjects. Consequently, the research is approved under 45CFR46.101 and 46.111 on an expedited basis under 45CFR46.110.

Attached are the consent forms stamped with approval and expiration dates. You should use them as originals for copies that you distribute.

This approval must be renewed in one year as part of the IRB's continuing review. You will need to submit a progress report to the IRB in response to a questionnaire that we will send. In addition, if you are still utilizing your consent form in one year, you will need to have it renewed. In correspondence please refer to the protocol number shown after the title above.

If, prior to the annual review, you propose any changes in your procedure or consent process, you must inform the IRB of those changes and wait for approval before implementing them. In addition, if any unanticipated problems or adverse effects on subjects are discovered before the annual review, they must be reported to the IRB Chair before proceeding with the study.

When the study is complete, please provide us with a summary, approximately one page. Often the completed study's Abstract suffices. You should retain a copy of your research records, other than those you have agreed to destroy for confidentiality, over a period of five years after the study's completion.

Thank you for contributing to Duquesne's research endeavors.

If you have any questions, feel free to contact me at any time.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "Paul Richer".

Paul Richer, Ph.D.

C:
Dr. Linda Goodfellow
Dr. Rick Zoucha
IRB Records