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UNDERSTANDING THE CULTURE CARE PRACTICES  
OF RURAL IMMIGRANT MEXICAN WOMEN

by

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Submitted to the Doctoral Program Faculty  
of the School of Nursing in partial fulfillment  
of the requirements for  
the degree of  
Doctor of Philosophy in Nursing

Duquesne University  
2005



**DUQUESNE  
UNIVERSITY**  
SCHOOL OF NURSING

PHD PROGRAM  
STUDENT FORMS

**FORM #4 – APPROVAL OF FINAL DEFENSE OF DISSERTATION**

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**DATE OF ADMISSION:** August, 2002  
**DISSERTATION TITLE:** Culture Care of Immigrant Mexican Women

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7/26/05  
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# UNDERSTANDING THE CULTURE CARE PRACTICES OF RURAL IMMIGRANT MEXICAN WOMEN

Catherine Archibald Johnson

Duquesne University, 2005

The purpose of this macro ethnonursing study was to understand the culture care meanings, expressions, patterns and practices of immigrant Mexican women who live in a rural community in Ohio. Leininger's Culture Care Diversity and Universality Theory was utilized as an organizing framework in studying the domain of inquiry. Interviews were conducted with twenty-four general informants and twelve key informants all of whom were immigrant Mexican women. Exhaustive analysis of audio-taped interviews revealed nine data categories and five patterns from which three main themes emerged. Respecting and supporting cultural identity, self-determination, self-reliance and the role of mothers were discovered as significant culture care values of informants. These findings also detailed what immigrant Mexican women value and expect from nurses in the professional caring relationship. A pictorial model was developed to illustrate the interrelationships of these findings and culturally congruent care. Implications and recommendations for nursing theory, practice, education, administration, and research are offered with directions for future nursing research.

Dissertation Advisor: Rick, Zoucha, DNSc, APRN-BC, CTN

## DEDICATION

This dissertation is dedicated to my husband, Robin, who has encouraged and supported me throughout the challenging years of doctoral education. He has been by my side, night and day as editor, research consultant and best friend.

I also dedicate this dissertation to my children, Becky, Lauren, Katie, Elizabeth, Ben and Emma and to my mother, Rebecca. They were always there to listen to my woes as well as my joys, constantly supporting and encouraging me to continue.

In loving memory of my father, Robert L. Archibald, and my grandmother, Sally Kate Archibald, who both served as my inspiration and who always encouraged me to succeed in all things that truly matter.

## ACKNOWLEDGEMENTS

Many people have helped me and contributed to the genesis and realization of this study. I am especially indebted to Dr. Rick Zoucha, chair of my dissertation committee, who tirelessly assisted me in finding the essence of the ethnonursing method, and hearing more clearly the voices of the immigrant Mexican women who shared with me their lives.

I also want to thank Dr. Carl Ross, Dr. Bobbe Gray and Dr. Margaret Clark Graham for their unfailing support and advice. Their collective wisdom has enriched this study and my knowledge.

Finally, I cannot ever sufficiently thank the wonderful immigrant Mexican women who participated in this study for their elegance, insight and incredible strength and determination. They are an inspiration to me for my future professional development and research.

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## I. INTRODUCTION

### A. Background of the Study

Immigration to the United States has significantly increased since the early 1980s. With the increase of cultural diversity in all regions of the country, caregivers and nurses in particular are challenged to gain relevant cultural knowledge in order to care for changing client populations. Of all immigrant groups in the United States, none has more pressing needs than Mexican immigrants. Barriers to needed health care have been identified for immigrant Mexicans, particularly women, including providers who do not speak Spanish and lack relevant knowledge of every aspect of the culture. While Mexican immigrants may present to both rural and urban health settings, it is nurses working in rural communities stressed by inadequate budgets, limited trained staff and severely curtailed services who are increasingly challenged to provide quality care across the lifespan to a population whose culture and health beliefs they may not adequately understand. Re-conceptualizing and redesigning services to meet the needs of rural Mexican immigrants poses a significant challenge to nursing for the foreseeable future. Mexican immigration and barriers to immigrant health must be briefly reviewed to make entry into this complex matter and to develop a deeper understanding of its significance.

During the 1990's, 11.3 million immigrants came to America from all over the globe. Many of them migrated individually and many brought their families. By the year 2000, there were over 30 million foreign nationals authorized to live and work permanently in the United States equaling 11.5% of the total population (Kaiser, 2001). Between 1995 and 2000, the number of immigrant families with children and young

adults grew by 15% (Urban Institute, 2001). Nearly 20% of the nation's children are children of immigrants and one out of every five school-age children is the child of an immigrant. Immigrants represent 5.7% of the high-school student population and 3.5% of the primary school population (Urban Institute). In twenty states, children of immigrants represent more than one-sixth of the children (Urban Institute).

Demographic patterns in the United States indicate that Hispanics are the most rapidly growing ethnic minority and will become the majority ethnic group of the U.S. population by 2050 (Flores, Abreau, Olivar, & Kastner, 1998). The census of 2000 reported that approximately 13% of the population of the United States is of Hispanic origin (Marotta & Garcia, 2003). The Hispanic population increased 10% from 1980 to 1990 but experienced a 58% increase during the period 1990-2000 (Marotta & Garcia). In fact, the dramatic growth in this population over the past decade is largely due to Mexican immigration (Marotta & Garcia). Mexican immigrants are the largest subgroup of Hispanics now accounting for 58 % of the total Hispanic immigrant population (Marotta & Garcia). National demographics also reflect changing relocation patterns with increasing numbers of Mexican immigrants moving to communities in the Midwest and South (Kaiser Foundation, 2001; Marotta & Garcia). While most settle in urban communities, rural Mexican immigrants comprise 9% of the total Hispanic population (Marotta & Garcia).

Immigrants may face a multitude of barriers to health care. Low-income immigrants are more than twice as likely to be uninsured as other low-income citizens. It is estimated that 59% of low-income immigrants do not have health insurance and only

15% receive Medicaid (Kaiser Foundation, 2001). In addition to lack of health coverage, immigrants experience poorer access to services than other citizens (Choi, 2001). Even when health care is accessed, immigrants continue to face many barriers to quality care. Lack of mutual understanding due to different cultural values and norms between provider and client impedes treatment plan development and compliance (Choi). Cultural barriers can make provision of care more difficult, especially if nurses do not appreciate the dilemmas confronting immigrants as they face a new culture. Neufeld, Harrison, Hughes, Spitzer and Steward (2001) assert that recent health care reform and restructuring has had adverse effects on the health of immigrant women due to changes in services that lack cultural sensitivity, differentially restricting immigrant women's access to resources, and failing to address their most pressing needs.

Immigrant Mexican women are at significant risk for health disparities due to language and cultural barriers (Lobell, Bay, Rhoads, & Keske, 1998). In the Midwest United States migrant women are largely Hispanic and experience serious health problems, such as skin infections due to pesticides, diabetes, hypertension, urinary tract infections, sexually transmitted diseases and HIV/AIDS (Gaston, 2001). They are also frequently victims of sexual assault and physical and emotional abuse (Gaston). Mosca, Jones, King, Ouyang, Redberg, Hill's (2000) study of women and heart disease found African American and Hispanic women are dying at a higher proportion than Caucasian women due to heart disease. Cardiovascular diseases are the leading cause of death in immigrant Mexican women (Graham-Garcia, Raines, Andrews, & Mensah, 2001). While Hispanic women have been identified as having a higher risk for obesity and Type 2 diabetes, immigrant Mexican women experience a rate three times higher than non-



Hispanic whites (Graham-Garcia et al.). Kattapong, Longstreth, Kakull, Howard, Bowes and Wilson (1998) found that immigrant Mexican women experienced increased mortality compared with non-Hispanic white women.

Disease incidence rates differ among immigrant Mexican women according to place of birth and level of acculturation. Acculturation refers to how a person takes on the characteristics of another culture other than their own (Leininger, 1995). U.S. born Mexican women are at higher risk for developing cancer than recently immigrated Mexican women (Gaston, 2001). Health promotion and screening activities also vary with level of acculturation. Less acculturated pregnant Mexican women have an increased likelihood to refuse AFP testing than those more acculturated (Urdaneta, Livingston, Aquilar, Enciso, and Kaye, 2002). Borrayo and Guarnaccia (2000) found significant differences between Mexican women born in Mexico as compared to U.S. born women of Mexican decent. Immigrant Mexican women born in Mexico had lower socio-economic status, were less likely to have health insurance, received fewer health professional interventions, performed breast self exams less frequently, and were less motivated to seek health care interventions (Borrayo & Guarnaccia).

The unique acculturation experience of immigrant Mexican families has been widely studied and recognized as an essential factor to consider when looking at health behavior and health outcomes of all family members (Juarbe, 1998; Marin, Tschann, Gomez, & Kegeles, 1993). Within the Mexican family, the mother is the primary care giver and influences the health of all family members (Berry, 2002; Urdaneta et al., 2002). Grandmothers and other women in the family serve as consultants to mothers when questions of the health or illness of family members are concerned (Berry). By

examining and understanding the culture care meanings, expressions, patterns and practices of Mexican women, the nurse can begin to understand how to more effectively impact the health and well-being of the entire Mexican family.

Lack of understanding and misconceptions of immigrant Mexican women's view of health and their understanding of risk factors have been associated with increased morbidity and mortality resulting from hypertension, stroke, and diabetes (Graham-Garcia et al. 2001; Kattapong et al. 1998). It is of particular note that recent studies indicate that immigrant Mexican women are under researched (Gaston, 2001). The exclusion of immigrant women from health science research has been identified as one of the factors contributing to these health disparities (Neufeld et al. 1999). Researcher's at the National Institutes of Health (NIH) have identified women's health as a research priority since 1985, including the special populations of African American, Hispanic/Mexican and poor women (Woods, 1994).

To better understand and provide ethical, culturally congruent care of all immigrants particularly those of Mexican origin, nursing research is needed to discover and describe the unique experience and perceptions of immigrant Mexican women. This exploration must include understanding the influences of immigrating from one culture to another and the impact of this change on health and well-being.

Immigrant Mexican women who have recently moved to the U.S. are caught in a transition between a predictable past and an uncertain future. Given that the majority of Hispanics in the United States are native born (64%) many immigrants experience massive cultural reorientation which has been found to have far reaching health consequences (DeSantis, 1997; Graham-Garcia et al., 2001). Physical and psycho-

emotional consequences of living in circumstances of prolonged discomfort and stress during the immigration process are well documented (DeSantis). These health impairments are especially difficult to manage when barriers exist to the provision of health care.

Mexican women who immigrate to rural areas in the Midwest find the added disadvantage of living in small communities that are facing increasing socioeconomic challenges. In 2001, 14.2 % of rural residents were classified as poor, as compared to 11.1 % of residents in urban areas (NACRHHS, 2002). Rural residents have higher rates of chronic disease and limitations affecting activities of daily living yet face higher rates of un-insurance. They also lack access to primary care, diagnostic facilities, acute care facilities, specialized health care services and services for the terminally ill (NACRHHS). Behavioral health services are also in short supply in rural communities, yet the incidence of emotional and mental illness is consistent or higher within rural communities as compared to urban. Even without the availability of appropriate behavior health services, the Substance Abuse and Mental Health Services Administration (SAMHSA) have reported that rural residents have similar or higher incidence and prevalence rates of mental illness and substance abuse as compared to urban populations (NACRHHS). Adding these challenges to those already faced by immigrant Mexican women increases their health risks and potential barriers to finding the health they need.

Beyond factors of immigration and barriers to health mentioned above, nurses working with immigrant Mexican women in rural communities must seek understanding of the unique cultural context of this population in order to provide culturally congruent care. By first understanding the cultural context of the rural immigrant Mexican women,

nurses can better preserve, accommodate and integrate the cultural values and lifeways of the population to whom they provide care. Fundamental to this purpose, the nurse must also be willing to learn the Spanish language, at least at a basic level, in order to communicate care and concern for the Mexican immigrant. By demonstrating this desire and willingness to learn, the nurse can reduce barriers and develop meaningful, effective and lasting relationships with his or her clients.

The cultural context of clients and their place in optimal provision of nursing care has been uniquely explicated by Leininger (1995) through the concept of culture care: the combined meanings, expressions, patterns and practices unique to any culture and presumed to influence health and illness and informs care. Leininger and others (Berry, 1999; Marin & Van Oss Marin, 1991; Villarruel & Leininger, 1995) have identified common Mexican cultural values that can assist nurses in understanding the thinking, decision and actions of this population. It is of note, however, that these studies have mainly involved urban Mexican immigrants with minimal description of the impact of immigration and the influence of acculturation on immigrant Mexican women. By exploring the culture care meanings, expressions, patterns and practices of immigrant Mexican women living in rural communities in the Midwest, relevant cultural knowledge can be expanded to improve care.

#### B. Purpose of the Study

The purpose of this study, or domain of inquiry, was to understand the culture care meanings, expressions, patterns and practices of immigrant Mexican women who live in a rural community in the Midwestern United States. Findings from this study will

assist nurses in promoting health and well-being of immigrant Mexican women through providing culturally congruent healthcare.

### C. Specific Aims

The specific aims for this study were:

1. To discover and describe the emic (local insider's) views and perceptions of health and well-being of immigrant Mexican women.
2. To discover and describe culture care meanings, expressions, patterns and practices of immigrant Mexican women
3. To discover and describe emic perceptions of culturally congruent professional care services.

### D. Research Questions

The research questions for this study were:

1. How do immigrant Mexican women in a rural setting describe health and well-being?
2. What are the practices used by immigrant Mexican women that promote health and well-being?
3. What do immigrant Mexican women identify as needs from nurses to assist them promote attaining and maintaining their health and well-being?

### E. Theoretical Support for the Study

The central domain of inquiry of this study was the culture care meanings, expressions, patterns and practices of immigrant Mexican women living in a rural community in order to promote health and well-being. The theoretical perspective for this study was based upon Leininger's Theory of Culture Care and the Sunrise Enabler of Transcultural Care Diversity and Universality (Leininger, 1995). This theory provided a framework from which to discover care meanings, expressions, patterns and practices of people from diverse cultures. Grasping the full meaning of cultural context was critical and involved examining the elements of Leininger's Sunrise Enabler to Discover Culture Care (Figure 1). This research tool displays the theoretical underpinnings and influences on culture care that guided this research study (Leininger, 2004).

Major areas of influence represented in this model are worldview, cultural and social structure dimensions, environmental context, language and ethnohistory. Worldview is defined as "the way people tend to look at the world or their universe to form a picture or a value stance about their life or the world around them" (Leininger, 1995, p.105). Cultural and social dimensions include technological factors, religious and philosophical factors, kinship and social factors, cultural values and lifeways, political and legal factors, economic factors, and educational factors. These influences are defined as "dynamic patterns and features of interrelated structural and organizational factors of a particular culture" (Leininger, 1995, p. 105). These patterns provided a framework that guided the literature review, design of the interview guide and structured data collection within the ethnonursing method.

Leininger's Sunrise Enabler to Discover Culture Care

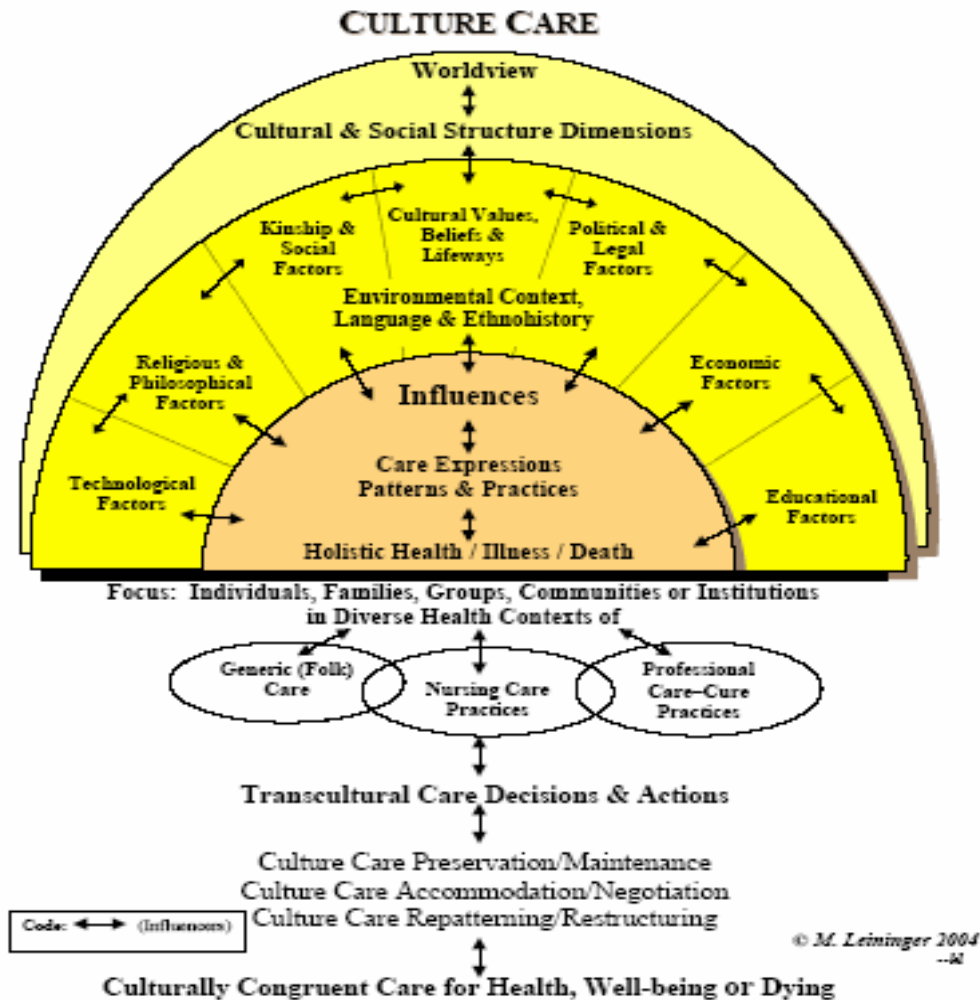


Figure 1: Leininger's Sunrise Enabler to Discover Culture Care

Note: From website <http://www.madeleine-leininger.com/>. Reprinted with permission.

Language is another important factor to consider in terms of its impact on the perceptions of the people and formulations of reality (Sapir, 1947). Environmental context is defined as the totality of an event, situation or particular experiences that give meaning to human expressions, interpretations and social interactions in particular physical, ecological, sociopolitical and/or cultural settings (Leininger, 1995).

Ethnohistory refers to the historical events and experiences of cultures, which assist in explaining human lifeways and influences culture care (Leininger, 1995).

#### F. Operational Definition of Terms

1. *Culture* refers to the learned, shared and transmitted values, beliefs, norms and lifeways of a particular group that guide their thinking, decisions and actions in patterned ways (Leininger, 1995).
2. *Care* refers to cultural phenomena related to assisting, supporting or enabling experiences or behaviors towards or for others with evident or anticipated needs (Leininger, 1995).
3. *Culture care* refers to the learned and transmitted values, beliefs and patterned lifeways that assist, support, facilitate or enable individuals or groups to maintain health and well-being or deal with illness, handicaps or death (Leininger, 1995).
4. *Culturally congruent (nursing) care* refers to those cognitive based assistive, supportive, facilitative or enabling acts or decisions that are tailor-made to fit with individuals, groups, or institutional cultural values, beliefs and lifeways in order to provide or support meaningful, beneficial and satisfying health care or well-being services (Leininger, 1995).
5. *Emic* refers to the local or insider's view and knowledge of a culture (Leininger, 1995).
6. *Etic* refers to outsider's view and knowledge of a culture (Leininger, 1995).
7. *Health* refers to a state of well-being that is culturally defined, valued and practiced, and reflects the ability of individuals (or groups) to perform their daily



role activities in culturally expressed, beneficial and patterned lifeways (Leininger, 1995).

8. *Nursing* refers to a learned humanistic and scientific profession and discipline focused on human care phenomena and activities in order to assist, support, facilitate or enable individuals in order to maintain or regain their well-being (or health) in culturally meaningful and beneficial ways, or to help people face handicaps (Leininger, 1995).
9. *Rural* refers to open country and settlements with fewer than 2,500 residents (U.S. Census Bureau, 2000).

#### G. Limitations of the Study

The findings of this study are limited to immigrant Mexican women who live in rural communities in the Midwest United States. The findings may be transferable, but would not be generalizable to any other individual or group. Transferability of findings to nursing practice, education, administration and research is further discussed in chapter five.

#### H. Assumptions

Assumptions concerning this study are:

1. Informants will be willing participants and will be truthful about their responses and comments.
2. There are differences and similarities in the meanings, expressions, patterns, and processes related to health between all cultural groups in the World.

3. Aspects of the unique environmental and social context of a particular culture influence individual and group values, beliefs and practices.
4. Immigrant Mexican women living in rural communities in the Midwest United States are influenced by unique factors and context that should be understood by nurses in order to provide culturally congruent care.
5. Culturally congruent nursing care occurs when health and well-being meanings, expressions, practices and patterns are known and used appropriately and in meaningful ways by the nurse.

#### I. Significance to Nursing

With increasing numbers of Mexican immigrant women living in rural communities, nurses practicing in these areas must seek to understand and integrate cultural knowledge into the nursing care they provide as well as assist in the identification and development of appropriate services needed by these individuals, groups and communities. The 2000 Census reflects the growing number of Hispanic immigrants moving into the Midwestern States (Marotta & Garcia, 2003). Mexicans are the largest group and often work as migrant workers or in other agricultural roles in rural areas. In these rural communities, they face a multitude of barriers to maintaining their own health and well-being. Environmental, political, technical, economic and legal factors serve as barriers particularly as these small communities are ill prepared to provide the needed social services and supports. Local health care service providers may also serve as barriers by not accommodating their language or understanding or respecting their religious beliefs, kinship relationships or cultural values and lifeways.

Immigrant Mexican women are the main caregivers of the Mexican family and are responsible for most of the parenting within their family. Reliance upon extended women family members for advice, regarding health and illness, is a common care pattern in the Mexican culture, but immigrant women are removed from these supports as they live in communities thousand of miles from their families. The emotional and social isolation this might lead to is an additional stressor and factor to be considered in determining health and well-being.

In many cases the immigrant Mexican woman arrives in rural communities without legal documentation. Many immigrant Mexican women travel to the United States with their husbands who are working as migrant workers and have legal visas. The women do not have the needed authorization and travel across the border in hiding with risk to their safety (Wilkinson, 2003). Access to health care as well as other social programs for women and children is severely limited by the lack of legal documentation, specifically the social security number.

The immigrant Mexican women of rural communities face many risks to their health and well-being. They are separated from family and friends that are central in their lives. If undocumented, they face the risk of deportation and the lack of health care and social services. They are isolated from traditional support systems and often, due to language barriers, cannot access health care providers, such as nurses, who assist in meeting their needs.

Culturally competent care is reliant on a nurse's ability to accept and integrate the culture care meanings, expressions, patterns and practices of clients into her or his professional practice. Nursing leaders, educators, organizations and accrediting bodies

have articulated the need for culturally competent nursing care for all clients. Health care departments and other health care providers in rural communities have set these same standards. However, the research base for culturally competent care for immigrant Mexican women living in rural communities is limited.

In this first chapter, the researcher has briefly identified barriers to optimal access and utilization of the US health system for immigrant Mexican women as a subset of all underprivileged immigrants. Further, it has documented the importance of an understanding of the cultural context of clients and their place in provision of nursing care, particularly as explicated through Leininger's concept of culture care. The domain of inquiry is to understand the culture care meanings, expressions, patterns and practices of immigrant Mexican women who live in a rural community in the Midwestern United States. Findings from this study will assist nurses in promoting health and well-being of immigrant Mexican women through providing culturally congruent healthcare.

## II. LITERATURE REVIEW

### A Introduction

Understanding the culture care meanings, expressions, patterns and practices of Mexican immigrant women in rural communities in the Midwest United States demands deepened familiarity and respect for the Mexican immigrant experience. In this review of literature the researcher focuses on information fundamental to this end, derived from research studies that examine elements of the Mexican immigrant community and culture in the U.S.

The review begins with the ethnohistory of Mexicans immigrants. Then, using components of Leininger's Sunrise Enabler illustrating the Theory of Culture Care Diversity and Universality (Leininger, 1995), the literature regarding cultural knowledge of Mexicans is described. The components of the Sunrise Enabler considered are worldview, including ethnohistory and language and the cultural and social structure dimensions of 1) cultural values and lifeways, 2) kinship and social, 3) religious and philosophical, 4) political and legal, 5) economic, and 6) technological and educational factors. The further dimension of Mexican views of health and well-being is also be explored. Environmental context will be considered and integrated in Chapter Three.

The review also includes a synthesis of literature particularly relating to immigrant Mexican women's health and illness, including exploration of the impact of immigration and acculturation on health and well-being. A summary of findings and directions for future research concludes this literature review.

## B. Worldview

In order to prepare for entrance into any culture, understanding factors that influence the lifeways, values and beliefs of the people of that culture is vital. According to Leininger's Sunrise Enabler (1995), a culture's worldview, in addition to dimensions of the culture and social structure, are foundational to that understanding. Dimensions include cultural values, beliefs and practices; religious, philosophical or spiritual beliefs; economic factors; educational beliefs; technology views; kinship and social ties; and political and legal factors. Leininger (1995) has also stressed the need for a thorough understanding of the environmental context and ethnohistory experienced by members of a culture in order to achieve true understanding of culture.

The Mexican worldview, as describe by Villarruel and Leininger (1995), is "focused on their extended family, belief in God's help, and that one must deal with present time reality"(Villarruel & Leininger, p.370). In order to understand the Mexican immigrant's worldview, one must consider the historical traditions of Spain and Mexico (Mesoamerica) as well as the history of Mexican immigration to the United States.

### *Ethnohistory*

The history of the Mesoamericans spans centuries. The first significant civilization is generally accepted to be the Olmec around 1500 B.C. Considered by some to be the mother culture of pre-Hispanic Mexico, the Olmec worshipped the jaguar as supernatural (Palfry, 1998). Artifacts from this time period display images of combined physical characteristics of humans and felines and have been found scattered throughout Mexico.

The Maya flourished between 600 AD and 900 AD and were the largest homogenous group of Indians north of Peru. The Maya are generally considered the most advanced of all the Mesoamerican groups. Mayan culture was based on farming which included the cultivation of maize, beans, squash, cotton, cacao and chili peppers (Palfrey, 1998). Outstanding intellects, the Maya developed hieroglyphic writing that has not yet been fully deciphered. They calculated the lunar cycle and, through their knowledge of astronomy and mathematics, predicted eclipses and created a unique calendar system, thought to be more exact than the one used today (Palfrey).

The nomadic tribe of the Mexica (pronounced may-SHEE-ka), more commonly known as the Aztecs, occupied the region during the 13th century (Palfrey, 1998). The Aztecs considered themselves the chosen people of the sun and war god Huitzilopochtli (Palfrey). The Aztec were a highly organized society, ruled by a king and dominated by a noble class of priests, a warrior class, and an active merchant class (Palfrey). According to Aztec belief, their world existed under the fifth sun, following four previously destroyed suns. In order to keep the sun rising, the main mission of the Aztec, abundant offerings of human hearts were made to appease Huitzilopochtli. The Aztec engaged in war with other societies for the primary purpose of capturing prisoners for sacrifice to the gods (Palfrey). Modern day religious practices have been influenced by Aztec ancient religious customs, such as All Souls Day observed on November 2<sup>nd</sup>. This religious holiday closely coincides with the Aztec's autumn rituals in honor of departed ancestors. This has given rise to the modern Day of the Dead observance which is annually observed in Mexico on November 1<sup>st</sup> (Urdaneta et al. 2002).

With the Spanish conquest of 1500's and the settlement of New Spain began the destruction of many elements of the native cultures and exploitation of Mexico's natural resources. Conversion to Christianity continued to destroy the cultural heritage and natural history of the people of Mexico. One exception was the continuance of native knowledge and use of medicinal plants. This knowledge was incorporated into the Spanish medicinal system (Villarruel & Leininger, 1995). There are, in fact, many similarities between the Aztec and Spanish cultures, including belief in personal sacrifice as a means for personal redemption and collective good (Villarruel & Leininger). There were also similarities between their health beliefs, including the hot-cold classification of illness, and the belief that disease can be caused by invisible forces (Villarruel & Leininger). The integration of the beliefs of these two cultures, as well as the unique beliefs, values and customs of ancient Mesoamerica and other ethnic influences, create the foundations of Mexican culture.

Nueva España's (New Spain) political, social and economic structure was based on a feudal system, dividing the conquered lands into huge estates, known as *encomiendas* (Palfry, 1998). Over 500 Spanish landlords or *ecomendero* owned estates, and the unpaid labor of the native inhabitants worked the fields and mines. The *ecomendero* was charged to provide for the physical well being of the native Indians, but most *ecomendero* exploited them. Hundreds of thousands of Indians died from abject working conditions, while others succumbed to new diseases introduced by the Spaniards: smallpox, measles, plague, tuberculosis, and the common cold (Crawford, Heidler & Heidler, 1999). At the time of the Spanish Conquest, about nine million



indigenous people inhabited Mexico's central plateau. These indigenous people numbered less than two and a half million by 1600 (Crawford et al.).

This devastation of the indigenous Indian population created a huge labor shortage. In order to provide the manpower needed for Nueva España's industries of farming, ranching and mining, thousands of African slaves were imported (Palfry, 1998). Many Africans were eventually able to purchase their freedom with remuneration they received for their tireless labor. By 1650 more than 150,000 Africans lived in Mexico, a figure that surpassed Spanish immigration (Palfry). The Afro-Mexican presence is not widely known. However, Mexican "corridos" or song-stories tell of slave uprisings. Other cultural influences from the period of slavery include contributions to music such as the marimbas of Mexico, which actually have their origins in Africa (Palfry).

This history of immigration to Mexico during the Colonial period has resulted today in a rich ethnic population in Mexico, including mulattos (Spanish-African), castizos (Spanish-Indian/European), and zambos (Indian-African) (Palfry, 1998). Additionally, large numbers of Filipinos, Chinese, Jews and Europeans of assorted nationalities immigrated to Mexico during this era adding richness to the cultural heritage of the Mexican people (Crawford et al. 1999).

In the 1830-40's new Americans moved to that part of the Southwest United States which is now Texas, and settled on land owned by Mexico. The Mexican government allowed this settlement as long as the inhabitants respected the Catholic religion, and abided by Mexican law. Increasing conflict ensued, however, as the settlers demanded more autonomy, resulting in the first imperialistic war in the history of the United States. Through the doctrine of "Manifest Destiny," Americans believed that the

land they “needed” could and would be theirs (Crawford et al., 1999). The Treaty of Guadalupe Hidalgo was signed in 1847 when Mexico relinquished one half of its territory to the United States for 15 million dollars (Crawford et al.)

The Mexican Revolution of 1910, a civil war in Mexico, killed over one million citizens, and forced over one million Mexicans to immigrate to the United States for safety and survival (Crawford et al., 1999). Many Mexican American families can trace their arrival in America to this period. These new Americans were limited to employment in agriculture, mining and the railroad. Due to the political unrest in Mexico leading to the Revolution, many immigrants resisted political organizations. This however resulted in minimal labor organizing and resultant reduced political influence. The Confederacion de Uniones Obreras Mexicanas (CUOM) was formed in 1928, giving Mexican workers the first organization to advocate for wage parity (Vigil, 1998).

At the beginning of U.S. involvement in WWII in 1942, Mexico and the United States signed the “Bracero Treaty” which was called “legalized slavery” by the U.S. Department of Labor officer in charge of the program, Lee G. Williams (Calavito, 1992). More than four million experienced farm workers from Mexico moved throughout the United States supporting American agriculture as farmers left to join the military. Despite the success of the “bracero”, they suffered harassment and oppression from racist extremist groups (Calavito). The bracero treaty ended on May 30, 1963, however the expert agricultural worker from Mexico, in the role of the migrant worker, continues to serve as one of the foundations of the American agricultural complex (Calavito).

The ethnohistory of Mexican immigrants to the United States includes the rich native history of the Olmec, Mayan and Aztec cultures, and brings with it valuing of

innovation, commitment to culture and sacrifice of self for the good of the whole. The Spanish conquest devastated the native culture and exported many of its cultural and natural resources. However, the Spanish infused the native culture with rich, centuries old European influence. Through Spain's overpowering attempts to convert the natives to Christianity, the social and religious context was changed, but many of the indigenous religious practices survived to be reflected in modern Mexican religious celebrations. Africans were brought to Mexico to provide much needed labor due to the drastic reduction of native Mexicans decimated by mistreatment and disease. Increased immigration to the United States began during the Mexican Revolution of 1910 and continued through active recruitment of Mexican agricultural workers during World War II. Patterns of harassment and oppression have been recognized throughout this history of labor immigration and serve as a backdrop to consider the experience of the Mexican immigrant laborer today.

### *Language*

Language is an important influence on the culture care values, expressions, patterns and practices. The primary function of language would appear to be communication. While this may be true, it is also much more. Language involves not only overt speech as part of a social exchange but, also, symbolic organization as a form of communication with oneself which can be described as thought (Mandelbaum, 1970). Language provides both inter and intra personal processes that impact, and perhaps shape, reality. Sapir (1949), theorized that language predetermines reality, what one sees in the world. He described language as primarily a vocal actualization of the tendency to see realities symbolically (Sapir). In addition to the formal constructs of language, Sapir

expanded on Boas's belief that language is heuristic in that its form predetermines one's observations and experiences (Mandelbaum, 1970). Boas (1938) was the first to describe the power of language and also its ability to limit. Boas and Sapir (1949) both warned that as science and experience grow, all must recognize the limitations of language and the need for its continued development (Mandelbaum). In other words, language acts as a filter, allowing one to see the "real world" only in the categories of one's own culture's language (Mandelbaum).

Only a few of the native languages such as Nahuatl and Maya have been documented through artifacts. The Maya language has been retained through discovered manuscripts including Maya hieroglyphic inscription, ceramics and painted murals (Barnett, 2005). Unfortunately few other artifacts have been discovered. The all-inclusiveness devastation of the Mexican culture and people by the Spanish conquest apparently included obscuring the native languages and dialects (Barnett). In only a few generations, native Mexicans were wiped out in the central valley of Mexico and with them the native language, *Meshtleeko*. Spanish friars attempted to translate this language via Latin characters, but unfortunately sounds did not exist in Castilian Spanish that were integral to understanding the native tongue (Barnett). The guttural "j" and the "x" with the "sh" sound are examples from these attempts (Barnett).

Language serves a vital role in maintaining the culture of Mexico for the immigrant Mexican. Mexicans, more than any other immigrant, continue to use Spanish within their homes and communities (Friedman, 2003). Within Mexican immigrant communities, attempts to speak the Spanish language are highly valued, and facilitate the

development of a trust relationship (Zoucha, 1998). Language is the most evident barrier experienced by Mexican immigrants seeking health care in the United States (Spector, 1996). These language barriers include not only the lack of Spanish-speaking care providers, but also the lack of the ability to describe and discuss health concerns within a cultural context. Within the Mexican culture the use of the Spanish language is an affirmation of ethnic identity as well as the primary means of communication within the family (Urdaneta et al., 2002). Health care providers use of knowledge they have of Spanish when communicating with Mexican immigrants has been found to facilitate a more trusting environment (Urdaneta et al.) Studies have shown that ethnicity and language concordance between client and physician results in better functioning and improved overall health status (Perez-Stable, Napoles-Springer, & Miramontes, 1997).

Leininger (1978) sees language and communication as variables in how illness and nursing care are viewed and received by ethnic groups. By first being aware of one's own cultural perspective, nurses can move forward and learn meanings and expressions that shape the reality of the "other" culture. Even in learning the mechanics of another language, the nurse can gain awareness of the cultural referents integral to true understanding of the language and the people (Leininger, 1995; Seelye, 1994). Effective communication is essential in all aspects of provision of nursing care.

Multiple strategies to communicate with clients with limited English proficiency have been developed. The use of bilingual staff interpreters, as well as ad hoc interpreters such as family members, staff or community volunteers and telephone language lines are services that have been developed to assist in this process (Urdaneta et al., 2002). In the

Mexican immigrant community is not uncommon for children to translate for their mothers. This creates uncomfortable and ineffective communication between provider and immigrant Mexican women (Berry, 1999).

For nurses interacting within cultures other than their own, understanding the relative nature of language and its impact on the reality of speakers of that language is vital. Nurses who are visitors to another culture bring their own cultural language categories and interpret everything in those terms. Being aware of this formation of reality through language will prepare the nurse for the intercultural challenges ahead.

### C. Cultural and Social Structure Dimensions

#### *Cultural Values and Lifeways.*

Leininger (1995) described cultural values as common cultural bonds that influence and give meaning to peoples thinking and actions. Within the Mexican culture personhood (*personalismo*) and respect (*respeto*) are important values to consider in all interactions and relationships (Villarruel & Leininger 1995). *Personalismo* refers to the preference of personal contacts over institutional ones (Villarruel & Leininger). Its influence in health care relationships has been well documented (Zoucha & Reeves, 1999; Zoucha, 1998). Appearing unhurried, knowing and asking about personal aspects of life, and acknowledging skills and strengths are highly valued by Mexican clients.

*Respeto* is an element in positive interpersonal relationships and is demonstrated by deferential behavior towards others as deemed appropriate for their age, gender, and

social position (Villarruel & Leininger, 1995). Addressing clients by their title (i.e. Senor, Senora) is a sign of respect and indicates a reciprocal relationship. These values and reflective patterns of relationships with Mexican immigrants must be acknowledged in order to develop the trust relationship desired by advanced practice nurses.

*Kinship and Social Factors.*

Family is the single most important institution for the Mexican immigrant population (Berry, 2002; Chavez, 1997; Purnell & Paulanka, 2003; Warda, 2000; Zoucha & Reeves, 1999). The traditional nuclear family is the foundation of society and takes precedence over other aspects of life (Kemp, 2001; Purnell, 1998). The concept of familism (*familismo*) is a major value in the Mexican culture. *Familismo* emphasizes interdependence over dependence, affiliation over individualism, and cooperation over confrontation (Urdaneta et al., 2002). *Familismo* is the valuing of family considerations over individual or community needs characterized by a sense of loyalty and solidarity among family members (Kemp, 2001; Purnell & Paulanka, 2003; Zoucha & Reeves, 1999). The Mexican family provides a primary source of emotional support and members are expected to help each other in times of need (Chavez, 1997).

The typical family pattern is patriarchal in nature with the father or oldest male holding the greatest power. Men are expected to provide for and be in charge of their families. The concept of *machismo*, characteristic of the Mexican-American culture, depicts men as having wisdom, strength, valor and self-confidence. According to Warda (2000), "The role refers to men functioning as providers, protectors, and representatives of their families to the outer world." (p. 206). In traditional Mexican families, the father

is the ultimate authority and sons have the responsibility for the protective care of their sisters (Berry, 2002).

Although an increasing number of women are working outside of the home, homemaking remains the primary role. Women are the main caregivers and are responsible for most of the parenting. Concern for a woman's health values, beliefs and practices, therefore, goes beyond the individual and includes the children and spouse. Higgins and Learn's (1999) ethnographic study of adult Hispanic women found that women reported taking better care of their families than of themselves. Examples given were described as taking time off work if family members are ill but not for themselves and not wearing seatbelts but insisting their children wear them. Better understanding of the culture care values and practices of Mexican immigrant women and providing culturally relevant information and support will impact on the health and well being of the entire Mexican immigrant family (Higgins & Learn).

Extended families are evident as part of the Mexican social structure. Hispanic families are child-centered and children are highly valued because they ensure continuation of the family and cultural values (Purnell & Paulanka, 2003). Children are taught at an early age to respect their parents and older family members. Elder family members are held in high respect and valued for their knowledge and experiences. The strong sense of personal obligation to the family is demonstrated by the care provided for elderly family members. When elderly parents or grandparents are unable to live on their own, they usually move in with children. Research has shown that non-Hispanic white elders were twice as likely as Hispanics to reside in nursing homes (Baxter, Bryant, Scarbro, & Shetterly, 2001). Baxter et al. also reported that Hispanic elders were more



than twice as likely to receive home care services. Research has shown that a family centered model of health care decision-making is more highly valued than individual autonomy (Kemp, 2001). Family members commonly provide care for relatives who are ill and must be included in all planning processes.

The concept of family extends beyond bloodlines to include *compadres*. The *compadrazgo* system is comprised of adopted families whose kinship with the family is based on a selection process where the *compadres* function as godparents or as a second set of parents. These *compadres* often provide a safety net and substantial aid in times of crisis. Decision making about health matters is a family matter and not usually left to the individual in the Mexican culture (Urdaneta et al., 2002). The *compadrazgo* system is included in this family network and must be accommodated by health care providers. Providers should be familiar with these cultural practices and not violate *familismo*

Among newer Mexican immigrants, gender roles and the cultural norms related to family structure are likely to be followed (Warda, 2000). Family centered values, including father's role as ultimate authority, mother's role as caretaker, and high values of children and elders must be acknowledged when working with Mexican immigrants. *Machismo* or male qualities of dominance has been described as "false machismo" and "true machismo" (Urdaneta et al., 2002). True machismo is defined as a father's love of family and his role as protector and supporter (Urdaneta et al.). False machismo is created by a loss of dignity and respect leading a man to put down women and brutalize them (Urdaneta et al.). *Marianismo* is a term that conveys admiration for motherhood and emphasizes the covert power and centrality of the mother. Families that practice *marianismo* and the positive form of *machismo* are mutually supportive and reinforcing.

*Succorance*, or the value of assisting those in need or accepting assistance is also part of the cultural heritage of Mexican families.

*Religious and Philosophical Factors.*

Mexican Americans are deeply religious people. Within the Mexican culture religion has a great influence on daily life and their belief in God is prominent in their political and social ideologies as well as their health and illness beliefs. It is estimated that 85-90% of Mexican immigrants are Roman Catholic (Zoucha & Reeves, 1999). As a group, Mexican American Catholics have remained religiously devout throughout their history and are strongly guided by their vision of cultural pluralism versus assimilation. In the United States Hispanics, the majority of whom are Mexican Americans, account for over 25% of the total Roman Catholic population (Gallup & Castelli, 1989). The growth of the Mexican American laity has not been reflected in the growth of Mexican American clergy. Not until 1970 was the first Mexican American bishop appointed to the American Catholic Church hierarchy and since then only 20 Mexican American bishops have been added (Abalos, 1986).

Mexican American religious traditions include many feasts and celebrations throughout the liturgical calendar. Christmas celebrations usually include midnight mass on Christmas day, known as La Misa de Gallo (Abalos, 1986). Another important tradition is a performance of La Pastorela, a passion play of Spanish origin dating back to the Middle Ages. This drama provides a popular interpretation of the prophecies preceding the coming of Christ. The last day of the year is a special time for Mexican Americans. It is a time to give thanks for God for all of God's grace during the past year. This is an important family event and all members actively participate.

The most important feast for Mexican Americans is El Miercoles de Ceniza celebrated on Ash Wednesday (Abalos, 1986). This feast is a time for the people to reflect on their lives on earth and publicly profess their Christian faith. The image of the suffering Christ and sorrowful mother are two important elements of this season and serve as a focus for ceremonial activities. The observance of Holy Saturday and Easter Sunday are days of joy and celebration with the highlight of the sacred encounter of the risen Christ and his mother.

In addition to religious ceremony and celebration, three other practices are important in the religious lives of Mexican Americans: sacraments, devotional acts and practices, and prayers to evoke divine protection. Sacraments such as baptism, first communion and matrimony are an important part of the Mexican American family and serve to strengthen kinship and ties to the extended family (Abalos, 1986). Another important sacrament in the life of young children is quinceañera, honoring a young woman's fifteenth birthday. A mass is celebrated to give thanks to God for her passage from youth to adulthood.

Devotional acts are those religious acts carried out with some regularity using some image such as a book or rosary. The Sacred Heart is a devotional expression to Christ that represents his eternal love for all mankind. This image is frequently found on a badge, known as a *détente*, which is displayed on home alters or carried in the wallet (Abalos, 1986). There are many devotions to specific saints such as San Martin de Porres and San Martin Caballero (St. Martin of Tours). Mexican merchants display San Martin de Caballero image as a reminder to treat the poor with dignity and respect as he did (Urdaneta et al., 2002).

Practices such as blessings are expressions of one's faith and thanksgiving and are integral to the Mexican American culture. They have been defined as having either ascending or descending direction and often are combinations. Ascending blessings include prayers of praise and thanksgiving and are found in statements like "Bendito sea Dios" (Blest be God), which is a common Mexican saying. Religious candles and metals are also an important part of the religious blessing. They are brought to the priest as part of the blessing. Milagros (miracles) are small silver objects that symbolize special needs for which people are asking for healing (Urdaneta et al., 2002). It is a petition to the saint to concede a miracle for which the person makes a promise in return. People may pin a milagros to a sick persons clothing or at the bedside of the patient.

Mexican immigrants have a deep religious faith and a commitment to God first, family second and the individual last. Their celebration of religious holidays and related family traditions are integral to their culture and should be understood and respected by nurses interacting with this culture.

#### *Political and Legal Factors.*

The political history of the Mexican immigrant over the past 170 years is one of oppression and discrimination. Political issues, such as working conditions and wage disparity are important items on the political agenda of Mexican immigrants. Recent changes in immigrant laws affect most Mexican immigrants and continue to be a topic of concern for many. The Mexican immigrant community has increasing political presence and increasing influence in establishment of fair and equitable laws for the regulation of wage, living and working conditions for this increasing population, but harassment and discrimination persist.

With the recent downturn in the economy and an increase in unemployment, naturalized American workers have become more vocal about the increase in immigrant labor. Organizations such as the Federation of American Immigration Reform (FAIR) claim that illegal immigrants, willing to work at substandard wages and poor working conditions, decrease wages and working conditions for the American worker (Wilkinson, 2003). Others argue, however, that American companies have saved money through the use of the immigrant worker allowing them to stay in this country contributing tax dollars and economic stimulus to local communities. This is particularly critical to rural communities that are more reliant on smaller numbers of businesses.

Over one million Mexicans have received immigrant visas to reside and work legally in the United States (MacIel & Herra-Sobek, 1998). More immigrant visas are issued to Mexicans than to any other nationality (MacIel & Herrera-Sobek). Another 265,000 Mexicans have received temporary or non-immigrant visas (MacIel & Herrera-Sobek). The U.S. Immigration and Naturalization Service (INS) estimates that there are as many as 3.5 million Mexicans currently residing in the U.S. without proper legal authorization (MacIel & Herrera-Sobek). Many of these “undocumented” immigrants are family members of immigrants with authorized immigration status. It is estimated that it takes a Mexican immigrant nearly 12 years to complete the process for a legal visa due to the process of allocating visas utilized by the INS (MacIel & Herrera-Sobek). Family members of migrant workers often chose to be with their husband or wife and bring their children with them, even if it means all may be undocumented and subject to deportation.

In December, 2000 the Legal Immigration and Family Equity Act (LIFE Act) was enacted to provide Mexican family members temporary, non-immigrant visas, with work

authorization to come to the U.S. while waiting for processing of their immigrant visas (Immigration and Naturalization Services Statistics, 2002). This act will assist in reducing the number of undocumented women and children and allow them to apply for federal health care assistance.

However, the spirit of cooperation has not been consistent in the treatment of undocumented immigrants from Mexico. Since 1996 and the adoption of the most comprehensive immigration and law reform ever enacted, more than 800,000 Mexicans have been deported (MacIel & Herrera-Sobek, 1998). Additionally, there have been over 1, 200, 000 detentions and more than 2,000 deaths at the border (MacIel & Herrera-Sobek). This ongoing struggle for workers to enter the U.S. in order to increase their work opportunities and improved lifestyle for their families will continue.

In Ohio, the total Latino population is 200,563 (1.8%) as of March 2002 (Kaiser Foundation, 2002). The Immigration and Naturalization Service (INS) estimates that in 2000, approximately 40,000 undocumented Mexicans lived in Ohio. This number is up from 29,000 in 1990 (Wilkinson, 2003). Several non-profit organizations attempt to monitor and support this population with special emphasis on migrant workers. Both documented and undocumented workers come to Ohio primarily for agricultural jobs, for which they are actively recruited. Examples of jobs that immigrant workers are recruited to include nurseries, greenhouses, fruit and vegetable processing, meat processing plants, construction, as well as farm workers (Wilkinson). Most workers enter the country legally but some stay after their visas expire (Wilkinson). Mexican immigrants in Ohio experience harassment and discrimination, such as lower hourly wages, and lack of benefits (Wilkinson). Frequently, these workers are designated as a temporary worker,

which allows employers to avoid the issues of documentation. This also allows employers to avoid paying health care benefits or retirement afforded other workers.

Recently, accounts of injury and death of Mexicans attempting to enter the country using “coyotes” have been reported in the local and national news. “Coyotes” are people who specialize in trafficking people across borders. Tyson Foods was recently charged with conspiring to recruit and smuggle undocumented workers to jobs in poultry processing plants (Wilkinson, 2003). Many of the charges were dropped but the case brought into national focus the increasing plight of undocumented workers within corporate America.

Mexican immigrant workers must have documentation for sustained employment. The “Black Market” is readily available, where social security cards and permanent resident cards, known as “Green Cards”, can be obtained for a hefty fee (Wilkinson, 2003). In 1996, the IRS introduced the Individual Tax Identification Number (ITIN), which can be obtained by anyone regardless of immigration status. It “allows” any individual to pay taxes and file and receive a tax return, but they cannot collect social security benefits. Advocates for undocumented immigrants encourage the use of the ITIN versus illegal documents. According to leaders of a non-profit advocacy group in rural Ohio, the ITIN number allows workers to show their true name in order to work and pay taxes, both prerequisites for future applications for amnesty (Wilkinson). This number also enables the procurement of bank accounts, which allow workers to protect their earning, as many are forced to carry all of their money with them at all times, putting them at risk for theft and injury.

Despite recent changes, it is clear that the Mexican immigrant is faced with a stressful and possibly threatening environment when entering the United States to work. Many immigrants travel with families who must face the additional stress of school enrollment and possible restriction due to lack of immunization records. Health care services for themselves and their children are difficult to identify and due to lack of cash or insurance out of reach. Understanding the complex processes of immigration and its inherent stress will enable the nurse to provide support to Mexican immigrant families throughout this process.

#### *Economic Factors*

As noted above, Mexican immigrants comprise the largest percentage (56%) of the Hispanic population in the United States (Keller, 1996). According to the Council of Economic Advisors (1998) the Hispanic population has more than doubled between 1980 and 1997, in large part because of immigration. For many, the economic and educational opportunities available in the United States are major factors contributing to the decision to immigrate. The report *Changing America* (1998) describes the socioeconomic status of the Hispanic population in the U.S. These findings show that Hispanic lifestyles have generally declined over the past 25 years. Hispanics have been described as having less education, are more likely to live in poverty, and have lower paying jobs and jobs that do not provide health insurance (Baxter et al., 2001; Purnell & Paulanka, 2003). However, Chavez (1997) points out that the Hispanic poor represent only about one-fourth of the Hispanic population yet appear more visibly in the media. Furthermore, the increasing Hispanic population, including those of Mexican origin, is comprised of many new immigrants who tend to start at the bottom of the economic ladder (Chavez).



The primary source of income is through earnings from the labor market. According to the Council of Economic Advisors (1998), examining the combined resources of family members better reflects the economic status of individuals. Male earnings are the largest source of household income, although women's earnings are becoming an increasing portion of the household income. The median wages of Hispanic men and women are significantly lower than other ethnic groups. This gap in wages is due, in part, to the difference in educational attainment (Changing America, 1998). Disparity in wages can also be attributed to differences in occupations available. Hispanic employees are more likely to hold lower paying and lower skilled occupations such as working as laborers or in service occupations (Berry, 2002; Changing America, 1998).

Since the early 1990s, Hispanic income has fallen while other racial and ethnic groups have experienced an increase. It was not until the late 1990s that an increase in income for the Hispanic population was noted. However, the Hispanic poverty rate is still very high. More recent Mexican immigrants are also more likely to live in poverty (Purnell & Paulanka, 2003). Poverty among children is associated with risks to health and child development as well as the potential for long-term economic disadvantage (Changing America, 1998). Age differences may also contribute to differences in economic, health or social status among racial and ethnic groups. More than 30 percent of Hispanics are below the age of 17, which reflects increased number of children, born to new immigrants (Changing America). Approximately 5% of the Hispanic population is 65 years and over and the poverty rates among the elderly are considerably higher than other groups.

Mexican immigrants face significant obstacles to obtaining needed health care. These include insufficient family income, inadequate or lack of private health insurance, restrictions to Medicare funding, language barriers, lack of health care facilities in Hispanic communities, and legal status (Baxter et al., 2001; Berry, 2002; Warda, 2000). According to the U. S. Census Bureau (2004), 66% of Hispanics were less likely than white non-Hispanics to be covered by health insurance. In addition, young adults (18 to 24 years old) were less likely than other age groups to have health insurance coverage (U.S. Census Bureau, 2004). In a recent study of older Mexicans, Angel, Angel and Kryriakos (2002) reported that the uninsured were more apt to be younger, female, poor and foreign born. These individuals reported fewer health care visits, were less likely to have a usual source of care and more often received health care in Mexico (Angel et al.). Data revealed that complete lack of insurance among older Mexican immigrants was relatively rare. However, an interesting finding of that report was that respondents reporting no insurance were the most economically disadvantaged, had the least medical care contact and yet were in relatively good health (Angel et al.).

Medicaid, the nation's major health coverage for low-income people, plays a significant role for immigrants because of their high poverty level and lack of workplace coverage. Policy changes restricting Medicaid coverage, and the resulting confusion surrounding eligibility, is largely responsible for lack of coverage of Mexican immigrant families.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) changed cash assistance and treatment of all legal immigrants with regard to Medicaid coverage. Previously, all legal immigrants had access to the same public

benefits as any U.S. citizens. PRWORA eliminated individuals who are not U.S. citizens from public benefit programs. This shift in basic federal policy has had numerous detrimental effects. Affirmative proof of legal status through complicated documentation and verification processes are now required to determine Medicaid and CHIP eligibility determination processes (Kaiser, 2001). Additionally the “sponsor deeming” requirement of the new law deters enrollment by individuals whose income and resources are too high (Kaiser).

Additionally, many Mexican immigrants perceive Medicaid enrollment, or any public assistance as a threat, leading to potential problems with their legal status in the future (Kaiser, 2001). Without health insurance, Hispanics are less likely to have a regular health care provider or to have seen a physician in the past year (Baxter et al.,2001). The implications on the quality and quantity of health care for the Mexican immigrant are significant. Addressing the health care needs of Mexican immigrant will require special attention by communities and health care providers. Mechanisms for improving coverage and reducing the financial burden on low-income older persons would be particularly important for the Hispanic elderly.

#### *Technological and Educational Factors*

Immigrants from Mexico have taken part in an education system with different standards than those in the U.S. The Mexican School Reform Act of 1992 requires that a child in Mexico attend school through the ninth grade (Purnell, 1998), however there is no monitoring or enforcement of this requirement. Some families live a two hours walk from any bus service and simply keep their children at home to help with herding the cattle and working to maintain the family. Mexican children attending school in Mexico

must often pay for their own busing, tuition, books, uniforms, and learning materials. Many families cannot afford these expenses in spite of the placing a high value on education. Seeking a better education for their children is a major reason many Mexicans immigrate to the United States (Purnell, 1998).

Once immigrating to rural communities, Mexican immigrant families face stressed education systems that often cannot meet their needs. The effect of increased immigration on rural communities throughout the United States has stretched limited education resources, resulting in the reduction of quality and quantity of appropriate education provided to immigrants.

Title VI of the federal Civil Rights Act of 1964 has, in some ways, made it easier for immigrants and migrants to obtain benefits by requiring federally funded service providers (Medicare and Medicaid) and schools to offer translating services to persons with limited English skills (Ruiz-Beltran & Kamau, 2001). In rural communities this stretches budgets but, also, reveals the lack of available bi-lingual teachers.

Schools face a growing need to serve children of immigrants with limited English skills. Forty percent of foreign-born children have limited English proficiency (LEP) (Urban Institute, 2001). Half of LEP children attend schools in which a third or more of their classmates have LEP. (Urban Institute, 2001) Mexican children soon learn the English language, but the adult parents go to work in factories or agriculture, learning only enough English to get by (Urban Institute). This often places the child in the role of translator for their parents.

#### D. Health and Well-Being

Mexican health care beliefs and practices are based on notions of maintenance and equilibrium (Urdaneta et al., 2002). Preventive rituals are conducted to promote this balance and include prayers, relics, faith, herbs, and spices, all used to ward off disease and increase well-being (Leininger, 1995). Traditional definitions of health among Mexican immigrants may include having a sturdy body, the ability to maintain a high level of normal physical activity and the absence of persistent pain (Fishman, Bobo, Kosub, & Womeodu, 1993). Illness may be considered a state of discomfort and incapacitating disability (Urdaneta et al., 2002). Many Mexicans may classify illness as either “natural” or “unnatural”. Natural illness is caused by God’s will or fate; whereas unnatural illness originates from evil done to the ill person by another (Urdaneta et al.).

Health care beliefs and practices of Mexican immigrants are quite varied. Common practices in Mexico include the frequent use of self-prescribed over-the-counter prescription medications, which are at low costs, as well as the use of healers and folk remedies. In Mexico, Mexicans have much more control over their own treatment and make decisions accordingly. Mexican immigrants who come to the U.S. bring with them the expectation of control over their own treatment plans, including the availability of medications. Many immigrants will bring medications with them or have their relatives send them in the mail (Kuipers, 1995). Research has shown that even though Mexican immigrants practice different procedures while in Mexico, they are open to some health care practices of the U.S. and quite readily adjust to changes (Kuipers).

Research indicates that Mexican immigrants highly value outward demonstration of respect in interpersonal relations (Zoucha & Reeves, 1999). It is, therefore, vital that

nurses are aware and respectful of the traditional health care practices of Mexican immigrants including Hot and Cold Theory, particular folk practices, and deep belief in the overarching acknowledgement of God's will. Some Mexicans believe that good health is God's will and is maintained by dietary practices related to Hot and Cold Theory to keep the body in balance (Purnell, 1998). Eating a balance of hot and cold foods is believed to prevent disease. This classification is not based upon food temperature, but rather upon the quality of particular foods. If foods are not balanced, the body is thought to develop a hot or cold disease. Hot diseases include liver problems, diarrhea or constipation and rashes and fever. Hot diseases are corrected by eating a balance of hot foods such as chocolate, cheese, and cereals. Cold diseases include cancer, pneumonia and rheumatism. Cold foods such as fresh vegetables, tropical fruits, and dairy products are thought to cure these diseases.

Other common folk health practices revealed in the literature include herbolarios, yerbero, curanderismo and parteras. The herbolarios and yerberos are herbalists that use all parts of plants and trees for healing. It is common for many families in rural areas to grow small plots of herbs for healing. For those without the ability to grow their own herbs, there are botanicas, yerberias and candle shops that sell herbs both fresh and dried (Urdaneta et al., 2002).

Curanderismo is a common folk practice based on the knowledge of herbal remedies, Spanish prayers, altered states of consciousness, and healing rituals (Villarruel & Leininger, 1995). It operates at three levels: material, spiritual and mental, and is utilized when serious emotional or physical diseases are experienced.. The curandero combines the elements of empirical and ritualistic remedies with the ultimate healing

power from God. Major tenets of curanderismo that must be understood in order to understand Mexican healing practices include (Villarruel & Leininger, p. 374):

- The body and mind are inseparable
- Religious, interpersonal or sociological, supernaturalistic and naturalistic, balance and harmony are important.
- The body and soul are separable.
- Interaction and communication exists between the natural and supernatural worlds.
- The patient is an innocent victim.
- The healer (curandero) is expected to interact openly with the patient.
- The curandero is expected to use the healing powers for good only, as God can take them away if they are abused.
- The devotion of the curandero to God, their piety and dedication are critical facets in their abilities to heal.

A further traditional belief in Mexican culture is that pain is God's will. Delay in seeking treatment for pain may result accordingly. Ability to endure pain and to suffer stoically is another health related value. Mexicans may also believe that pain and suffering are consequences of immoral behavior (Purnell, 2003)

While Mexican's have common folk practices, they also have illness folk beliefs, such as *Caida de la mollera*, *Mal ojo*, *Susto* and *Empacho*. *Caida de la mollera* is fallen fontanel in infants as a result of forcefully removing the nipple from the baby's mouth, bouncing the baby too roughly or from a fall. *Mal ojo* is a disease in a child who is admired and not touched. *Susto* and *Empacho* may occur in adults or children. *Susto* is

caused by a frightening experience resulting in the person to temporarily losing their spirit. *Empacho* is abdominal pain that is thought to be caused by a chunk of food that is unable to pass through the intestinal track (Kuipers, 1999). These illness beliefs must be fully understood and respected by nurses working with Mexican immigrant clients.

Most of the births in Mexico still occur in the home (Urdaneta et al., 2002). *Parteras*, or midwives, are women who are over 30 and themselves mothers or grandmothers (Urdaneta et al.). They usually learn the skill from their mothers, and are committed to protecting the modesty of the patient. Protection of patient modesty is an important cultural value. Understanding and supporting modesty has been established as an important cultural value when caring for Mexican immigrant women (Urdaneta et al.).

Nurses attempting to discover factors that influence cultural similarities and differences in values, beliefs and lifeways of their clients are asked to collect and synthesize large amount of cultural information. This requires developing skills in cultural assessment and building knowledge about the culture, also known as “holding and reflective knowledge” (Leininger, 1995, p.109). Holding knowledge is critical to understanding the meanings of behaviors and useful in reflecting what is seen and heard. By understanding the folk and illness beliefs of the Mexican immigrant, the nurse can conceptualize a more complete plan of care that is inclusive of all the clients needs.

## E Mexican Women’s Health and Illness: A Synthesis of the Literature

Transcultural nursing theory recognizes that culture care meanings, expressions, patterns and practices are passed from generation to generation (Leininger, 1978). Folk and illness beliefs of mothers have a huge impact on the health and well-being of the entire family and are passed down mother to child. As nurses recognize this impact and



works with the Mexican immigrant woman in promoting her health, the health of the entire family will also be positively affected.

This synthesis of the literature presents an overview of the health of Mexican women. Second, the health of the subgroup migrant farmworker women is described. It is of note that migrant farmworker women in some studies are singled out as a sub-population, and at times included in the general categories of Hispanic or Mexican American, depending on the location of the sampling. Third, disease specific studies that include Hispanic or Mexican women are discussed, including studies of heart disease, diabetes, hypertension, stroke, breast cancer, AIDS/HIV, and drug addiction. Fourth, studies regarding birth outcomes, family planning, contraception use and abortion are described. Fifth, literature regarding the impact of acculturation on the health of Mexican women are reviewed in light of its prevalence. A discussion of studies looking at culture care beliefs, values and practices of Mexican immigrants follows.

Many research studies focusing on the Hispanic population have been conducted over the past twenty years, predominately involving Mexican immigrants. Hispanics have been called the “silent minority” due to lack of research regarding their health beliefs and behaviors (Graham-Garcia et al., 2001). In particular, there is a deficit in health research of Mexican immigrant women from a cultural perspective (Higgins & Learn, 1999). Neufeld et al.(2001) identified the need for increased participation of immigrant women in health research studies due to lack of understanding of their key determinants of health and illness.

Researchers have found that the immigration process itself compromises income and social support of immigrants and increases their health risks (Neufeld et al. 2001).

Often within families that immigrate, gender roles reconfigure and women are faced with multiple new roles that differ in symbolic meaning from their cultural values and patterns (Neufeld et al.) Immigrant women are faced with potentially conflicting cultural values, resultant stress, and the disappointment that their life course fails to fulfill their cultural expectations (Neufeld et al.). These concerns are significant for the Mexican immigrant women living in small rural communities. Migrant women often travel from community to community with their husbands as they work on migrant farms, increasingly cut off from social supports and threatening their cultural values. This social isolation and loss of cultural supports increase the risk for health problems with few opportunities to seek professional help.

Flaskerud and Uman (1996) described the causes of stress for Mexican immigrant women as cultural conflict, isolation from familiar social networks, problems with language, employment and discrimination and a consequent decline in self-concept. Their study looked at the impact of immigration and acculturation on immigrant Mexican and Cuban women. What is unclear from this and other studies that have looked at immigrant women is which specific cultural values and patterns are disrupted and how these impact on health and well-being. Ongoing research is needed to explicate these cultural meanings and increase understanding of the Mexican immigrant woman's experience as they immigrate to a new country. Only then can nurses fully understand how they might compliment the immigrant woman's strengths and work to decrease stress.

Diseases prevalent among Mexican immigrants are communicable diseases and diseases from lifestyle changes. Communicable diseases common among the Mexican migrant population include tuberculosis, gastrointestinal infections, hepatitis A, measles

and mumps and are associated with substandard housing, lack of clean running water, and low immunization rates (McCarthy, 2000).

Increased incidence of diseases associated with lifestyle of the Mexican immigrant has been linked with changes in lifestyle since moving to the United States. These lifestyle changes include physical inactivity and dietary practices. Crespo, Smit, Carter-Pokras and Anderson (2001) found that physical inactivity among Mexican immigrant women was greater than for Mexican immigrant men; however, inactivity was lower among those who spoke mostly English than among non-English speaking men or women. Physical inactivity and diets high in calories have been found to lead to hypertension, heart disease, cancer and diabetes among Mexican immigrants (Kuipers, 1999).

Cardiovascular disease and diabetes mellitus are two of the top ten causes of death in Mexican immigrant women and are diet related (Garcia-Maas, 1999). Obesity and gallbladder disease also have a high incidence among Mexican immigrant women and are related to nutritional practices (Garcia-Maas). Focusing on the Mexican immigrant woman's perception of health and healthy lifestyles will provide needed insight into factors that influence these patterns and how these patterns can be changed to improve health and achieve a higher quality of life as well as decrease morbidity and mortality among Mexican immigrant women.

Psychological stress has been correlated with increased risk for hypertension and cardiovascular morbidity and mortality (Scott, Jorgensen, & Suarez, 1998). Immigrant Mexicans have been found to experience increased psychological stress due to

intergenerational conflicts, inadequate medical insurance, and compromised health service due to language barriers (Sundquist & Winkleby, 1999).

### *Migrant and Seasonal Farmworker Women*

Few nursing research studies have been found that look specifically at the health and well being of Mexican immigrant women living outside of urban areas and those who are first generation immigrant who have recently left Mexico. Gaston (2001) states that one fifth of the 2.5 million migrant and seasonal workers in the United States are women and have unique and serious health problems and barriers that have been under researched and under treated. Farmworker women experience increased incidence of serious skin infections from pesticides, diabetes, hypertension, urinary tract infections, STD's, and AIDS-HIV (Gaston). Chronic diseases, such as multiple sclerosis and lung disease, have also been identified among farmworker women (McCarty, 2000).

The lifestyle of the farmworker woman is one of multiple responsibilities and changing gender roles. As the Mexican immigrant woman becomes more independent, in contrast to the cultural norms of *marianismo*, increased cultural conflict with their spouses is possible. Concerns have been raised, by several authors, regarding the increased incidence of physical and emotional abuse of migrant farmworker women. This has been related to low self-esteem and alcohol and drug abuse of partners (Gaston, 2001; Champion, 1999). The battered farmworker woman has been described as a woman of childbearing years, age 15-40 years, generally Mexican, afraid of their partner and living with or married to a partner who uses drugs or alcohol (Gaston). Specific research has not been found regarding the changing cultural context of battered immigrant Mexican women. Champion did find that stress related to seasonal and migrant work placed

adolescents at a higher risk for physical and emotional abuse. The role of the nurse in abuse identification, as well as providing family support services is critical. Recognizing factors that increase the possibility of abuse is part of the knowledge needed to provide comprehensive culturally competent care. By understanding the multiple stressors encountered by the rural, recently immigrated Mexican women, nurses can work with to reduce stressors inherent in the immigration process and its impact on health and well being.

#### *Disease Specific Studies*

Cardiovascular disease is the leading cause of death in Hispanic women of all Spanish origins (Graham-Garcia et al., 2001). Mosca et al. (2001) found that African and Hispanic women die at a higher rate than Caucasian women from heart disease. Major risk factors for cardiovascular disease include hypertension, obesity and smoking. Some research studies have found a higher prevalence of high blood pressure among Mexicans and Cubans than non-Hispanic white women. Increased incidence of obesity has been found among Mexican women (Graham-Garcia et al.). According to the American Heart Association (Mosca), eighteen percent of Hispanic females smoke cigarettes increasing their risks for heart disease, cancer and a variety of other diseases. Smoking cessation programs, as well as lifestyle risk assessment and intervention programs, must be developed with the specific needs of the Mexican immigrant women in mind. By implementing interventions that are culturally relevant, nurses can play a vital role in health promotion for each woman as well as the families they influence for generations to come.

Another health problem associated with hypertension and stress is stroke. Kattapong et al. (1998) found that the Mexican women experienced increased mortality due to cerebrovascular disease as compared to non-Hispanic white women and were least likely to report hypertension as a stroke risk factor. Further research regarding risk factors and associated cultural beliefs and health behaviors of Mexican immigrant women is necessary in order to develop intervention programs that communicates facts and lifestyle changes that are culturally appropriate, significant and valued by the Mexican immigrant women who are at risk. Only programs that address the specific culture care beliefs, patterns or practices that place the Mexican immigrant woman at risk will be effective in the reduction of cardiovascular and cerebrovascular disease.

Diabetes has a three times higher prevalence among Mexican Americans than non-Hispanic whites (Diabetes Statistics for Latinos, 2002). One in ten Mexican Americans older than 19 has diabetes (Diabetes Statistics). One ethnographic study found that Mexican immigrants attempt to connect diabetes directly to their present history. Jezewski and Poss (2002) found that the majority of Mexican American men and women in their study identified *susto* as the cause of their diabetes. Andrews and Boyle (1999) describe *susto* as a sickness that originates with a frightening experience resulting in anxiety, loss of appetite, social withdrawal, listlessness and insomnia. Strong anger was also found to be a perceived contributing cause of diabetes (Jezweski & Poss). This study also found that most participants knew of herbal home remedies that could be used in treatment of diabetes but their use varied person to person. The herb most often used was *nopal* (*Opuntia*), which is the young leaf of the prickly pear cactus and is used to lower blood sugar (Jezewski & Poss). Nurses working with Mexican immigrant woman with

diabetes must assess their culture care beliefs regarding diabetes. By understanding the underlying cultural beliefs, the nurse can integrate them with other elements of the treatment plan. Lifestyle modifications may be necessary and as previously mentioned consideration of the cultural impact of these modifications must be made.

Several studies have found that Mexican immigrant women demonstrate lower participation in breast cancer screening than all other U.S. or Hispanic subgroups (Borrayo & Guarnaccia, 2000). Mexican immigrant women do not have a higher rate of breast cancer, but they do have a higher rate of late stage diagnosis (Richardson et al., 1992). Zambrana, Breen, Fox and Gutierrez-Mohamed (1999) found that Hispanic women have higher mortality rates from breast cancer due to this late stage detection and are underutilizing screening procedures regularly. Multiple research studies have attempted to identify factors that contribute to this lower rate of BSE and mammography including lower socioeconomic status (Richardson et al.); decreased access to medical care and lack of education (Flaskerud & Uman, 1996); lack of recommendation and education by health professional (Richardson et al.).

Acculturation and legal status has also been identified as contributing factors. Peragallo et al. (2000) found that limited knowledge of breast care, unemployment and short period of residence in the United States were factors associated to inadequate breast care. They found that acculturation to be a salient factor influencing the health practices of Hispanic women and should be incorporated in future health research. Nursing interventions are needed to assist Mexican immigrant women to see the value of regular breast care, with special sensitivity to their modesty concerns. Procedures must be evaluated and restructured to increase their privacy and communicate respect, care and

concern for their cultural values.

Kuba and Harris (2001) found that eating disorders among Mexican immigrant women involve complex interactions of ethnocultural identity, eating practices and cultural expectations. Anorexia is associated with patterns of family rigidity and cultural pressures, such as *mariamismo*, which includes the belief in virginity at marriage. This Findings from this study stressed the need for clinicians to move away from stereotypes and towards an integration of complex understandings of cultural influences on health and well-being (Kuba & Harris). Through transcultural nursing theory nurses can identify cultural influences using a variety of tools and integrate this understanding through culturally congruent nursing care plans and approaches.

*Birth Outcomes, Family Planning, Contraception and Abortion Studies*

Numerous research studies have been found that support the notion of an “epidemiological paradox” regarding birth outcomes of Hispanic women (Guendelman, English, & Chavez, 1995; Jones, Bercier, Hayes, Wentreck, & Bond, 2002; Zambrana et al., 1999). Hispanic women have been found to have a low rate of Low Birth Weight (LBW) infants and lower infant mortality as compared with all other groups, despite lower SES, lower education level and lower utilization of prenatal care (Balcazar, Castro, & Krull, 1995; Zambrana et al., 1999). First generation Mexican immigrant women have better pregnancy outcomes than those Mexican immigrant women born in the United States (Zambrana et al.). Loss of “protective factors”, though not fully described, is thought to explain the increase risk of poor pregnancy outcomes associated with increased acculturation (Zambrana et al.). Researchers who studied Mexican immigrant women’s perception and utilization of prenatal care found that prenatal care is valued but



often initiated later, contradicting the myth that Hispanic women do not value prenatal care (Scribner, 1996). Scribner also identified that Mexican immigrant women are at higher risk for gestational diabetes and an even higher rate is seen in first generation Mexican immigrant women. Due to these detrimental health outcomes and risk to the fetus, nursing must find innovative culturally appropriate ways to provide prenatal care to Mexican immigrant women. Community health programs using *promotoras*, lay or peer health educators, have been successful in a variety of areas, including prenatal care for Mexican immigrant women (B. Scott, 2003). This type of program is culturally congruent with the role of the *parteras*, or midwife, that is common in Mexico and consistent with Mexican cultural beliefs

Researchers have found family planning practices among Mexican immigrant women have been found to be inconsistent until their third or fourth pregnancy, contributing to them having the highest birth rate of all other ethnic groups in the United States (Unger & Molina, 1997, 2000). Several research studies looked at this low use of contraception and found that contributing factors include the male dominated Mexican culture that make it difficult for women to use contraception if the partner does not wish them to do so (Ortiz & Casas, 1990), strong emphasis on family and motherhood (Peragallo et al., 2000) and Mexican men's view that multiparity is an expression of virility (Weist, Finney, Barnard, Davis, & Ollendick, 1993). Unger and Molina (1997) found that factors that influence Mexican women's contraceptive use include preference for reversible methods, desire for no more sons, level of self-efficacy and degree of social support. Jones et al. (2002) found that a history of the use of contraceptive foam and

suppositories, condoms and oral contraceptives were the most often used by Mexican immigrant women in their study

In addition to their use in family planning, condoms as a prevention for STD's and AIDS/HIV has never been more important to Hispanic men and women. There was a three-fold increase in the incidence of new AIDS cases among Hispanics as compared to non-Hispanic whites in 2000 (CDC, 2003). Hispanics are also disproportionately affected by other STD's, compared to non-Hispanic whites (CDC). Several studies have looked at Mexican immigrants use of condoms and reported lack of condom use (McQuiston, Doerfer, Parra, & Gordon, 1998; Sabogal & Catania, 1996; Van Oss Marin, Gomez, & Hearst, 1993). McQuiston's et al. study utilized a qualitative research method and identified values and beliefs that influence the use of condoms by Hispanic men and women. They found that communication and building of trust preceded the use of condoms, which increased over time in a relationship. The cultural value of familismo was found to be an influence on the use of condoms, focusing on staying healthy to fulfill one's family responsibilities. This culture specific information is vital for nurses when building appropriate educational and intervention programs for Mexican immigrants.

Hispanic women have a higher incidence of having abortions than non-Hispanic white women, but less than African Americans (Kaplan, Erickson, Stewart, and Crane, 2001). Kaplan's et al. study is one of the few that looks at abortion use among Hispanic women and found that Hispanic women use abortion under the same circumstance as do women in the United States, to resolve and unintended or unwanted pregnancy. The cultural influence that was found to be significant in abortion use among Mexican immigrant women was their beliefs about the decision making power of the woman

within the Mexican family. This understanding can assist the nurse in supporting women making this decision.

### *Impact of Acculturation*

As a result of worldwide immigration, research in the mid to late 20<sup>th</sup> century has focused on acculturation and cultural patterning. Beginning with studies of Native American tribes, ethnographical research focused on culture from a more holistic perspective. These early studies emphasized the use of the ethnographic approach to understand the interrelationships of culture, power and place. This understanding explains how cultures are imposed, invented, networked and transformed through the process of diffusion and acculturation (Gupta & Ferguson, 1997). Through the study of different immigrant groups and identification of their particular processes, the uniqueness of each ethnic group can be recognized and incorporated when working with different cultures.

Research studies have cited several cultural factors that are influential in shaping health behavior and have explored the impact of acculturation on the health outcomes of immigrants. In conducting these research studies there has been tremendous debate about the definition of acculturation. Winthrop (1991) defined acculturation as the process of systematic cultural change of a particular society carried out by an alien dominant culture and through direct contact. The minority culture, or foreign culture, learns language, habits values and standards from the dominant culture through the process of acculturation (Winthrop). Assimilation is a process by which minority or foreign cultures enter societal positions and attain political, economic and educational standards of the dominant culture. Winthrop has developed cross-cultural generalizations about acculturation and assimilation. These generalizations are:

- Dominant cultures coerce minorities and foreigners to acculturate and assimilate. This process is slower when minorities are territorial or occupation concentrated and isolated.
- Acculturation must precede assimilation.
- Even though a minority is acculturated, they are not necessarily assimilated.
- Acculturation and assimilation serve to homogenize minorities into the dominant group. Factors that facilitate or prevent this process include age, ethnic background, religion, politics and economic factors.

Leininger (1995) defined acculturation within a context of socialization and cultural encounters and her definitions of acculturation and assimilation are conceptually consistent with other anthropologists. These concepts assist the nurse working with immigrant populations in defining additional influences and factors to consider. As a result of immigration and increasing participation in the American way of life, Mexican women are influenced simultaneously by their own culture and by the cultural, social, political, educational, technological, legal and economic realities of the majority society in which they now live. Multiple research studies have shown that Hispanics women become more acculturated over time as indicated by multiple measures, including increased English language use (Kaplan et al., 2001). The impact of acculturation has overall both a positive and negative effect on the health of Mexican immigrant women. Increased smoking, increased drinking alcohol and multiple sexual partners have been associated with increased acculturation (B. V. Marin et al., 1993). The negative impact of acculturation upon pregnancy outcomes has also been well documented. Juarbe et al.

(2002) found that physical activity of older Hispanic women increases with elevated socioeconomic status and high levels of acculturation. Other positive health outcomes of increased acculturation among Mexican women include declining obesity and increased self-esteem (Flaskerud & Uman, 1996).

Despite the significance of acculturation on the health of cultural groups, measurement has not been consistently defined and carried out. Early tools measuring acculturation, such as the Acculturation Rating Scale for Mexican Americans (ARSMA) (Cuellar, Harris, & Jasso, 1980) were linear in design, correlating increasing acculturation with increased time spent in the new culture. This design has evolved, as has the understanding of acculturation, to recognize the multivariate nature of the acculturation process. Yet, even in light of these additional dimensions, acculturation continues to be measured by a relatively narrow range of factors, despite increased understanding of the impact of acculturation on all aspects of daily life.

In reviewing over 170 abstracts of research articles related to measurement of acculturation of Mexican Americans, the majority of studies used two tools: the ARSMA/ARSMA II and the Short Acculturation Scale for Hispanics (B. V. Marin, Perez-Stable, Marin, Sabogal, & Otero-Sabogal, 1990).

These tools were constructed for quantitative research studies and not clinical practice. Leininger (1995) constructed the Acculturation Enabler in the early 1960's as a tool to assist nurses in assessing clients as they take on the lifeways of another culture. It was designed for use as part of the ethnonursing research method as a research guide, but other disciplines have used it to obtain credible, reliable and meaningful data about informants (Leininger, 1995). Leininger (1995) later developed the Alternative Short

Assessment Guide in 1985 that was designed to be used by practicing nurses in short term, emergency and acute care centers to obtain brief and general assessments of their clients.

### *Culture Care Values, Beliefs and Practices*

In a study of 87 cultures, including Mexican, Leininger (1998) has developed twelve dominant culture care constructs that describe the values, beliefs and patterned lifeways that support health and well-being. These constructs include *respect; concern; attention to/with anticipation of; helping, assisting and facilitating; active listening; giving presence; understanding cultural beliefs, values, lifeways; being connected to/or relatedness; protection of/for; touching; providing comfort measures; and showing filial love*. These universal culture care constructs described those elements of culture that are consistent from culture to culture. In combination with specific cultural knowledge these universal care constructs can be thought of as necessary cultural knowledge for culturally congruent care.

The development of cultural specific knowledge involves both studies regarding specific conditions or diseases of Mexican immigrant women as well as their specific health beliefs and traditional cultural practices (Duffy, 1997). The breadth of medical science research studies has been surveyed in this literature review. The addition of specific information on diverse cultural patterns and practices of health as well as illness has been achieved through transcultural nursing studies.

Each culture has cultural care meanings, expressions, patterns and practices that are unique to that culture and must be understood in order to provide culturally competent care (Leininger, 1991). During the past three decades a number of ethnonursing studies

have utilized the Theory of Cultural Care Diversity and Universality to discover cultural care meanings, expressions, patterns and practices of diverse cultures. Villarruel and Leininger (1995) described the culture care values, beliefs and research findings of Mexican immigrants: this is consistent with the findings of Leininger (1995), Stasiak (1991), (Dugan, 1988), Wenger (1986) and Zoucha (1998). Dominant care themes that were recognized in these studies include:

- Care means succorance or the means to provide direct aid to the family in different ways.
- Caring was expressed as filial love or love of family.
- Caring for others was the predominant mode of caring, including being attentive to family and kin, being assistive to others and being supportive of family needs and concerns.
- Caring means respect for gender differences and family roles, including mother as care taker and father as protector.
- Caring means the use of folk rituals and practices to promote healing, health and well being (beinestar) and to consider professional care practices.

These care themes reflect a beginning understanding of the values and beliefs of what it means “to care” to an immigrant Mexican.

Zoucha’s (1998) ethnonursing study sought to discover the experiences of Mexican Americans who received professional nursing care. The study’s purpose was to explore the care experiences, views, patterns and meanings of Mexican Americans in order to increase nursing’s knowledge of their cultural values. Three universal themes were abstracted by the researcher and include; Mexican Americans values care

expressions and practices that were personal, friendly and respectful; Mexican Americans viewed nurses as non-caring if they did not combine generic care values with professional nursing care practices; Mexican Americans desired confidence in all aspects of care that was provided by family, friends or nurses. Zoucha and Reeves (1999) described the significance of the value of human caring as personal for Mexican Americans and the type of nurse-client relationship that is, therefore, most effective. Mexican Americans's expectations for nursing care were found to be attention, respect, concern, time, helping, communicating in Spanish and love (Zoucha & Reeves).

Warda (2000) identified practices that would support the cultural care needs of Mexican clients and assure culturally congruent care. These include:

- seeking and understanding client's perspectives, knowledge and beliefs and incorporating those into care;
- personalismo which includes building confidence, giving respect and in a caring kind way spending time with clients;
- demonstrating cultural comprehension;
- providing system supports including providing Spanish speaking care givers.

Berry (1999) explored culture care needs of pregnant Mexican women using the ethnonursing method and synthesized six major themes. These include:

- generic culture care included protection of the mother and fetus by older Mexican women and was greatly influenced by religion and family beliefs and practices;



- generic culture care was family obligation for provision of filial succorance, sharing of oneself and being with the childbearing mother;
- culture care was respect for familial caring roles;
- culture care was concern for professional knowledge, protection, being attentive to, and explaining;
- culture care was use of the Spanish language;
- professional prenatal care was valued and influenced by legal, economic and technological factors.

Higgins and Learn (1999) conducted a focused ethnography with Mexican women in New Mexico and found the following themes related to their culture care beliefs and practices:

- health is a balance among the body, mind and spirit and is related to lifestyle;
- practices of a healthy diet, adequate exercise, avoiding tobacco and tobacco smoke, stress reduction and moderate use of alcohol are valued and will lead to a healthy life;
- subjects believed they had control over most aspects of their health;
- subjects were influenced by modern trends in health care;
- subjects reported taking better care of their family than themselves.

#### F. Summary of Literature

With the dramatic increase of Mexican immigration to the United States in the past two decades, nurses are frequently working with people caught between two

cultures, who may be highly stressed as they negotiate complex and threatening immigration processes. Nurses are challenged to understand the complexities faced by Mexican immigrants and integrate this knowledge into their plan of care. Transcultural nursing theory has given nursing a multidimensional approach from which to identify cultural similarities and differences between cultures. This approach demands a discovery process, from which nurses can learn as much about their own cultural beliefs as they learn about those of other cultures. The outcome of this transcultural nursing process is the development of a common ground on which both the nurse and the client can build a relationship, grounded in trust and hope.

Understanding the worldview, ethnohistory, language, cultural and social context of a culture is the beginning of this discovery process. The Mexican worldview focused on family and belief in God serves as a foundation of understanding the culture. The cultural history of the Mexican people is one of magnificent diversity, blending rich native cultural traditions with those of Europe and Africa. Throughout their history, Mexicans have consistently demonstrated self-respect and self-sacrifice in their work and family life. Within the Mexican culture, family is the most important institution and family gender roles include strong roles for men and family caretakers for women. Children are highly valued and elders are respected. Decision-making is a family process and input from godparents and friends are welcome. This important cultural value of familismo is one of many that must be acknowledged and respected by nurses and all health care providers in order to provide effective, culturally congruent health care to this important population.

Understanding the cultural values, beliefs and experiences of the culture is the next step of discovery. Synthesis of relevant literature has revealed a variety of historical, cultural, economic, political and environmental factors that impact on the health of Mexican immigrant women, putting them at significant risk for health disparities. Examination of the stress and negative health outcomes associated with immigration has been well described in the literature. Studies have identified specific stressors, such as conflicting cultural values and gender role changes that result from the social isolation, language differences, discrimination and cultural conflict experienced throughout the immigration process. Mexican immigrant women face health risks associated with communicable disease and lifestyle changes. Migrant farmworker women face illness and disease from poor sanitation and living conditions. Heart disease, diabetes and obesity have been identified as outcomes of lifestyle changes in smoking frequency, fatty diets and reduced physical activity. Gender role changes have also been identified as increasing the risks of Mexican immigrant women for domestic violence.

Barriers to health care services, such as lack of insurance, language and cultural barriers have been identified as having a significant impact on Mexican immigrant women. Researchers have found that Mexican immigrant women's participation in women's health promotion activities, including pap smears and mammography, as well as participation in prenatal care, is significantly lower than all other ethnic groups. Family planning services are used only after several pregnancies and condom use is low among Mexican immigrant men and women alike. Understanding the cultural influences on these behaviors is vital for nurses hoping to implement culturally congruent care and promote health and well-being. As primary caretakers of their families, Mexican women

impact upon the health of family members in a variety of ways. Cultural beliefs and practices regarding health and illness are communicated generation to generation. By giving attention to the health of Mexican immigrant women, the health of the family and community will be impacted.

Mexican immigrant women face discrimination, harassment, health disparities and impressive barriers to health care services. Mexican cultural values, beliefs and lifeways have been identified through research studies in recent years, yet these studies have focused primarily on those Mexican women living in urban communities. Consequences of immigration and the lived experience of Mexican immigrants, particularly those living in rural communities have yet to be fully explored. Further ethnonursing research is needed to expand the availability of relevant cultural knowledge expressed by rural Mexican immigrant women. The intent of this study is to make entry into the shape and nature of the lived experience of rural Mexican immigrants through a ethnonursing study of Mexican immigrant women living in a rural community in the Midwest United States.

### III. METHODOLOGY

#### A. Design

Expansion of cultural knowledge through the use of the ethnonursing research method can provide relevant information regarding the culture care meanings, expressions, patterns and practices of clients from a diverse range of cultures. Nursing educators and leaders can use this information in their on-going effort to assure cultural competence of their staff. Leininger's Theory of Culture Care Diversity and Universality (1995) provides nurses working with Mexican immigrant women a framework from which to focus on these multiple factors. The researcher used Leininger's (1978, 1985, 1990, 1995, 2001) ethnonursing research method to explore the culture care meaning, expressions, patterns and practices of a group of Mexican immigrant women in a rural community in order to provide in-depth understanding of this population from an emic perspective.

Ethnonursing method was chosen for this study because it is well suited to discovering and understanding diverse and similar culture care practices of immigrant Mexican women and because it critically considers emic and etic perspectives and points of view. Ethnonursing is a qualitative research approach that utilizes naturalistic, inductively derived, largely emic, open inquiry discovery methods to describe, understand and interpret people's meanings, experiences, and symbols that relate to nursing phenomena (Leininger, 1995, 2001).

Leininger's ethnonursing method draws from the fields of ethnography, ethnoscience and ethnology. Leininger gave a new "language" to nursing research

providing a means to study nursing phenomena within the scope of human caring (Agar, 1986; Leininger, 1995). Interrelated with the theory of Culture Care Diversity and Universality, ethnonursing method provides nurse researchers a means to systematically observe and document people's daily life experiences related to human care, health and well being (Leininger 1978, 1985). The theoretical assumptions and orientational concepts and models provided by this theory were described in chapter one and gave shape to the researcher's observations and perspectives.

As is the case with ethnography, ethnonursing is neither subjective nor objective; rather it is interpretative providing a means to mediate two cultural points of view through a third (Agar, 1986). Figure two illustrates this research process.



Figure 2: Illustration of Ethnonursing Process

Ethnonursing is first a function of the nurse researcher who brings to the experience the first cultural viewpoint, the traditions of nursing and a professional framework from which to view events and make sense of them. The cultural group of interest brings the second, unique viewpoint and holds important cultural information needed by nurses. The nurse researcher attempts to describe the traditions and lifeways of the cultural group through conceptual frameworks valued by the profession, thus creating the third viewpoint. A research mentor supports the researcher by providing input and support throughout data collection and data analysis and thus adds to the establishment of credibility. The outcome of this process is the discovery of cultural information that when used by nurses aides in the establishment of culturally congruent nursing care.

The goal of ethnonursing research is to “know as fully as possible actual or potential nursing phenomena such as the meanings and expressions of human caring in different or similar contexts” (Leininger, 1995, p.89). Through the theoretical perspective of Leininger’s Theory of Culture Care Diversity and Universality and the ethnonursing method discovery and understanding of universal and diverse human care meanings, patterns and values were revealed.

### B. Context of the Study

This research study was conducted in southwestern Clark County, a rural county in Ohio. This community was chosen because the researcher has lived and worked within it for more than five years and is familiar with people within the community. Issues of access were minimized by this choice. The immigrant Mexican community has evolved

over many years. Large farms and nurseries have employed Mexican farmworkers for many years to maintain the nurseries and package the products. Migrant farmworkers were the primary source of labor for the nurseries, but as the nurseries' growing and harvesting time is now much longer, lasting eight to nine months, many migrants decided to stay and live in local communities. Currently, some of the Mexican immigrants work for the nurseries year round but many are unemployed from December to March each year.

Three small communities, New Carlisle, Medway and Park Lane were home to all of the key and general informants in this study. Census data indicate median resident age is 35.4 years with the median household income of \$39,081 and median house value of \$84,500 (U.S. Census, 2000). Race distribution in New Carlisle is White Non-Hispanic 95.4%, Hispanic 2.7%, American Indian 1.0% and Other 2.9% (U.S. Census). These figures far understate the large and growing Mexican population in New Carlisle and the adjoining communities. It is of note that several key informants stated to the researcher that the Mexican population is "not seen" in New Carlisle, but is growing every year. Del Pueblo (2004), a local nonprofit Hispanic advocacy agency, estimated the documented Mexican immigrant population living in the area to be 3000 migrant workers who live in the area for six to nine months out of the year. Del Pueblo estimates the number of undocumented immigrant workers to equal that amount.

A large Roman Catholic Church in a nearby village and a local hospital coordinate one of the few interfaces between health care professionals and this immigrant community, the Migrant Health Fair, which is held every summer. This event gathers over thirty volunteer health care providers, including doctors, nurse practitioners, nurses



and social workers, and provides physical exams, acute care services, medication review and referrals. A medication assistance program is also on site to assist those who cannot afford medication for chronic illnesses such as diabetes and hypertension. According to many of the immigrants, this is the only time throughout the year they see a health care provider.

The major provider of health care for children is a publicly funded clinic in a city 17 miles away. Transportation to health care facilities is a major concern for many immigrant families as well as their inability to get away from the fields during the growing season in order to take their children for needed doctor visits.

Del Pueblo is the non-profit agency that serves as an advocacy group and translator service for this immigrant Mexican community, and serves as its hub. Del Pueblo provides English as a Second Language classes for many of the immigrants, and serves as a clearinghouse of information and resources for the community. Del Pueblo was founded by a nearby liberal arts college and receives outside funding from a variety of private foundations. In the past, funds were generated through Del Pueblo to provide interpreter services to local agencies and health care providers working with Mexican immigrants. Due to funding cut backs and a shortage of qualified interpreters, these services are now no longer available.

Some Mexican families who are migrants, or have recently immigrated to Ohio, live on the grounds of the nurseries in dormitory style concrete buildings. Others, in Medway, are primarily non-English speaking, undocumented immigrants who are uninsured and often unemployed. Many of these families have recently moved from Mexico, typically through California or Texas, and have many difficult issues facing

them including interpretation and transportation. Often they seek assistance from Del Pueblo which provides community social service and medical referrals, immigration advice and interpreter services. Until recently, Del Pueblo provided English as a Second Language (ESL) classes. Due to staffing and budget shortages, the agency can no longer do so.

Families in New Carlisle and Park Lane live in modest residential homes. These are primarily working families of documented immigrants who speak English as a second language. Many of the women came to the area as migrant workers, often with their families. They married local residents, immigrants or fellow migrant workers, and stayed to reside permanently in the area. The Texas Migrant Council (TMC) Head Start Program employs several key and general informants of this study. TMC is one of the primary Hispanic organizations in the area. TMC has provided Head Start programs for migrant families since 1971. Initially, the TMC program opened Head Start programs in Texas for six months out of the year and then moved with the migrants north as they traveled for agricultural employment. There are now TMC programs in Indiana, New Mexico, Texas, Wisconsin and Ohio. There are eight sites in Ohio. This concentration of programs is an indicator of the numbers of migrant workers traveling through Ohio.

### C. Informants

Through years of research experience, Leininger (2001) has identified the optimal numbers of key and general informants for different sizes of ethnonursing studies. For a macro ethnonursing study 12-15 key informants are needed with twice the number of general informants, or 24-30 general informants. Key and general informants are

essential in ethnonursing studies as the major source of cultural information, particularly relating to health, well-being and general lifeways. Key informants are described as persons who are thoughtfully selected and perceived to be knowledgeable about the topic and the domain of inquiry, which in this study is the culture care of immigrant Mexican women (Leininger, 2001). General informants also have broad, general ideas about the domain of inquiry, but may not, for a variety of reasons, possess complete knowledge of it or be able to articulate it clearly or in the needed depth and breadth. In this study, twenty-four general informants were selected who met the inclusion criteria, but were not able to communicate their experiences as fully as necessary.

Determination of whether the informant was a general or key informant occurred after the researcher made initial contact and conducted an initial interview. The researcher evaluated the depth of information obtained and the informant's ability and willingness to describe their experiences, beliefs and values. If they were not able to articulate their experiences as fully, or showed a reservation or inability to share information, the Mexican immigrant woman was designated a general informant. If the information was of the quality needed to answer the research questions, and describe the domain of inquiry, the informant was designated a key informant and additional interviews were scheduled.

For this study, informants were chosen based upon the following criteria: referred by members of the community, immigrant Mexican female, over the age of age 18, living in a rural community in the Midwest United States. During the five years working within the local Mexican immigrant community, the researcher interacted with all known community agencies and developed contacts with many members of the immigrant

Mexican community. The initial informants were identified through personal contacts made by the researcher and were asked to participate in the study. After the initial interview, the informants were asked to identify other Mexican immigrant women who could be interviewed. Through this snowball sampling process, further informants were identified.

Snowball sampling is described as a special non-probability method used when the desired sample characteristic is rare (Polit & Hungler, 2003). This technique begins with a few eligible informants and continues by asking them to identify and refer other people who meet the inclusion criteria (Polit & Hungler). Snowball sampling was chosen due to the inclusion criteria for a specific trait, Mexican immigrant women living in a rural community, and the difficulty in identifying this population. One limitation of this method is that all subsequent subjects will relate in some way to the initial contacts made. Therefore, it was critical to make entry into the community through reliable channels, free from special interests and unknown bias.

Twelve key informants were selected who met the criteria for the study and were able to describe their experience, make comparisons and explain discrepancies. Twenty-four general informants participated in initial interviews and provided useful cultural information. Data collection focused on interviews with general and key informants. Cultural information was gathered from two to three in-depth interviews with each key informant lasting one to two hours each and one interview with each general informant, lasting from thirty minutes to an hour. These interview data were audiotape recorded and analyzed by the researcher. A continuous process of data collection, data analysis and confirmation with key and general informants was conducted until consistencies were

revealed and information became repetitive. At this point it was determined that saturation of the data was obtained.

#### D. Instruments

Ethnonursing is a qualitative research method that avoids a priori judgments and hypotheses to be tested through scientific means. Instead ethnonursing is a method that is designed to learn from “the people through their eyes, ears and experiences” (Leininger, 2001, p.79). This is achieved through naturalistic observations, participant interviews and reflections through the eyes, ears and experiences of the nurse researcher. The researcher is the major “instrument” of the ethnonursing method and as such must be skilled in suspending judgment and predetermined truths in order to let the people’s voice be heard. Through intense self-examination through journaling and reflection upon their own cultural values, beliefs and experiences the researcher can hold in check their own cultural views in order to be responsive to the people’s ideas and interpretations of life.

In this study, data collection strategies included the use of a semi-structured, open-ended inquiry interview guide for use with key and general informants and Leininger’s (1978, 1985) Observation-Participation-Reflection Guide (Appendix A). Mexican immigrant women key and general informants were asked a series of open-ended questions congruent with the domain of inquiry and developed by the researcher in the form of an interview guide (Appendix B). Questions were developed to be open ended in order to learn as much as possible from the informant and reduce possible bias or etic points of view. The questions served as prompts for the researcher, with the interviews being conducted as a conversation rather than in a questionnaire format. Each

question addressed only one aspect of the topic. All questions were pre-tested with a Mexican woman colleague prior to their use in order to identify areas of confusion or misinterpretations.

The questions were organized into ten sections that reflect the cultural and social structure dimensions described in Leininger's Sunrise Enabler. These sections include questions addressing the emic view of environment, kinship, religion, economics, education, and political factors affecting health and well-being. Taken together, these areas provided the cultural context from which to understand the domain of inquiry. Health and well-being, including culture care practices and beliefs and caring, are primary areas of the domain of interest and were the focus of the interviews. The section *Health and Well-Being* included questions regarding informants' definitions of health and well-being as well as health practices they remembered from their childhood or are currently using. The section *Caring* included questions about the informants experience with, and perceptions of, nurses addressing the third research question. Data from all questions explored the domain of inquiry and provided answers to all three research questions.

The last section invited the informant to share anything else about herself, her health and well-being, or any questions for the researcher. This allowed the informant to question the researcher as needed. This often introduced new areas of concern. At all times throughout the interviews, the researcher followed the informant's lead in terms of areas the informant was interested in discussing.

Pitfalls in interviewing were avoided by the researcher not taking a cell phone into the interview and avoiding other distractions. All but five of the interviews were held

in the informants' home. The five interviews held outside informants' homes were held in the local library in a study room that limited environmental noise and interruptions. Two tape recorders were taken to all interviews as well as several tapes. No problems were encountered with tape recordings. Pitfalls such as shallowness of information were avoided by moving the interview at the rate comfortable for the informant, following chronological order in questions or responses, and being sensitive with certain areas such as salary, resources and relationships.

Systematic, contemporaneously written field notes of what was observed and learned while making observations, interviewing and participating in the activities and events of informants' lives were maintained. Notes were made immediately after interviews, often in the car following the interview as well as other times of contact with the cultural group. These notes provided etic sources of data, such as observations and perceptions, and provided a means of checking interpretations and strengthening validity.

#### E. Procedures for Data Collection

Leininger's Observation-Participation-Reflection (OPR ) Guide (Appendix A) was used to allow the researcher to "get close to the people, study the total context and obtain accurate data from the people" (Leininger 2001, p.94). This guide ensured accurate observations and interpretations of findings by guiding the researcher from one level of data collection to another. The initial phase of the OPR, primary observation and active listening, had begun three years prior as the researcher entered the community as a doctoral student and a nurse practitioner. Through observation of patterns and activities within the community, such as work and shopping patterns, entertainment activities,

church participation and community festivals, the researcher became increasingly aware of the rich ebb and flow of the immigrant Mexican community. Field note taking continued throughout all phases of data collection allowing the researcher to record salient observations and reflections regarding the people, their interactions and other contextual information.

The second phase, primary observation with limited participation, involved the researcher's participation in a selected local events with limited exposure. Special care was taken to acknowledge the difficulty nurses typically have moving from the role of "doer" to that of observer (Leininger, 2001). The researcher consciously planned a change in role from community health provider to researcher through shifting from roles previously engaged in, such as a nurse practitioner in the annual Migrant Health Fair, to observer and community member. The researcher began to volunteer at the TMC Head Start as a classroom helper and as volunteer office staff with Del Pueblo. Within this context, the researcher listened to immigrant men, women and children in the community, and began to see interconnections and relationships that influenced the lives of these informants. Only through this generally unobtrusive presence in the community could the researcher begin to build the trust necessary to engage in the next level of data collection.

The third phase of the OPR, primary participation with continued observations, began after Institutional Review Board approval for the study early in December 2004. Interviews with key and general informants began in mid December 2004 and continued through late April 2005. As previously mentioned, the snowball method of informant recruitment was utilized. The researcher arranged for an interpreter to assist with the



interviews if the informant requested. The use of interpreters by local agencies and health care providers is a common feature of this community and the professionalism of this study's interpreter was established through references. Confidentiality was assured regarding information communicated through the interpreter by preparing the interpreter prior to interviews and the interpreter signing a Confidentiality Statement (Appendix C).

A consent form (Appendix D), which included a description of the study and which were written in Spanish or English, was given to each informant at the first encounter. Informants were asked if there were any questions or concerns about the research process or the interviews. They were then asked to sign the consent before continuing the interview. With the informant's permission, audiotapes were made during the interview. All informants agreed to the audio-taping of interviews and the pace and flow of the interview appeared comfortable to the informant. Informants were thanked for their participation at the end of each interview and follow-up interviews were arranged with key informants as needed.

Interviews continued with all informants until saturation of data was achieved. Saturation is an indication of the comprehensive, exhaustive exploration of cultural information and informs the researcher when data collection can stop. Observations of redundancies and duplication of ideas, meanings and experiences revealed through on-going analysis of fieldnotes and key informant interviews gave the researcher assurance that the findings were complete.

From the interviews it became clear that the immigration status of the informants varied, and was of high importance to all informants. Questions relating to the informant's personal immigration history and the impact of the informant's status on their

lives were included. Accordingly none of the informants responded to questions regarding the political system of the US and Mexico and they were deleted.

Similarly, the majority of the informants were unable to differentiate the concept of “health” from that of “well-being.” The researcher attempted in several ways to probe these concepts through interview questions, but ultimately dropped the well-being questions as the majority of informants defined health and well-being in the same terms. The informants also had difficulty with the wording of the “care” questions, and the researcher restructured these questions using scenarios in order to elicit accurate responses.

The fourth phase of the OPR, primary reflection and reconfirmation goes hand in hand with Leininger’s third and fourth phases of data analysis, Pattern and Contextual Analysis and Major Themes, Research Findings, Theoretical Formulations and Recommendations (Leininger, 1995). In ethnonursing studies data collection, with concurrent data analysis, proceeds until the data is found to be complete through discovery of saturation of ideas and recurrent patterns. Increasing credibility and confirmation of accuracy of the research findings were gained through the identification of recurrent patterns of ideas identified in general and key informant interviews, researcher reflections on these informant reports, and subsequent verification and reconfirmation with key informants.

#### F. Procedures for Protection of Human Subjects

This study was approved by the Institutional Review Board (IRB) of Duquesne University in December, 2004. Ethnical considerations including informant’s privacy,

respect, dignity and comfort were a consideration throughout the development of this study's design. Informed consent was obtained from each informant before interviewing began, using the English or Spanish Consent Forms (Appendix D). Consent forms and their explanation were provided in two versions, Spanish and English to each informant and they selected the version of the consent they felt most comfortable reading. It was explained that no risks were anticipated from participation in this study and possible benefits of the study included improved health service provision to Mexican immigrants. Informants were informed that they were free to withdraw from the study at any time.

Confidentiality of all data, specifically audio taped interviews and field notes, is maintained in a locked lateral file in the researcher's home. The study's interpreter signed a confidentiality statement (Appendix C) ensuring confidentiality of information provided by the informants. The field notes, audiotapes and other transcribed materials will be destroyed after completion of the study in order to protect informant's privacy and assure confidentiality.

#### G. Procedures for Data Analysis

Leininger's Phases of Ethnonursing Data Analysis Guide (Appendix E) was used to assure rigorous, systematic and comprehensive data analysis (Leininger, 2001). This taxonomy provided the researcher a framework from which to systematically collect and analyze the data at increasingly complex levels of synthesis and abstraction. Each level of the guide describes a mechanism of data conceptualization and analysis, moving from simple to complex. From *collecting* and *describing* data in phase one to *identification* and *categorization* of data in phase two, these two phases break down the complex interview

data to fundamental units of descriptors and *categories* that can be further scrutinized in phase three. Phase three looks at the overall pattern of data for recurrent statements and similar and/or different meanings and explanations. It is during this third phase that additional information, gained from on-going interviews with key informants, allows the researcher to explore possible generalizations that can be made about the informants' view of the domain of inquiry. It is through this back and forth analysis that the researcher begins to "see" the recurrent *patterns* of meaning. These patterns represent the informants' consistent ways of thinking about the domain of inquiry. The researcher must continue to maintain focus on the *emic* perspective found in the transcripts of audio taped interviews. For this reason the patterns are described and explained through verbatim quotations from these transcripts in order to assure the credibility of the patterns as truly "from the people". The last phase of the guide requires synthesis of thinking, which means putting the patterns together into themes to make a new meaning or structure related to the domain of inquiry. These themes describe fundamental understanding of the domain of inquiry from the perspective of the culture represented by the informants. Through this process, and this synthesis of data resulting in discovery of new meaning, the researcher adds to the existing knowledge of that culture. The first phase, *Collecting, Describing and Documenting Raw Data*, involved the use of a field journal, the interview guide and the OPR enabler. Data collection focused on the domain of inquiry and research questions as previously described. The second phase, *Identification and Categorization of Descriptors and Components* involved coding and classification of data based upon the domain of inquiry, culture care values, beliefs, patterns and practices. Responses to questions, as well as other emic and etic descriptors, were studied for

similarities and differences and identification of recurrent responses. Descriptors and categories were identified, and are developed in Chapter Four. From phase two, these data flowed into phase three, *Pattern and Contextual Analysis*, with further identification of similar or different meanings, expressions, interpretations or explanations of data related to the domain of inquiry. Patterns were abstracted from the data, and are also presented in Chapter Four.

Finally the last phase of analysis, *Major Themes, Research Findings and Theoretical Formulations and Recommendations*, was achieved through synthesis of research findings and creative formulations by the researcher. Major *themes* were identified, supported by observable categories and interpreted patterns with confirmation by informants. These are also presented in Chapter Four.

In sum, this analytical process builds reliable research findings through its systematic approach, guiding and focusing the process on emic data. Understanding and further discovery is achieved through increasingly detailed analysis of data. The concurrent process of data collection with this analysis supports the accuracy and credibility of the findings.

#### H. Substantiation of Research

Qualitative research, as with all scientific research methods, must employ appropriate criteria to guide and evaluate the quality of its findings. Lincoln and Guba (1985) developed useful criteria, supported by Leininger, for use in ethnonursing studies. These include credibility, confirmability, meaning-in-context, recurrent patterning,

saturation and transferability. The researcher utilized these criteria throughout this research process to assure quality.

Credibility refers to the “truth” or believability of the findings established between the researcher and informants. Efforts to substantiate these truths included committing time to understand the interpretations and explanations of observed behaviors and experiences. The process of gaining entry into the community and identifying reliable initial informants is critical to credibility of the ethnonursing process. The researcher had been “in the field” with this population over five years and through contact and trust building between researcher and subjects, successful entry into the community was made. Carefully selected key and general informants provided rich, cultural information that was needed to answer the research questions and gain credibility.

Confirmability demands commitment to seeking accurate evidence that has been directly observed through repeated contacts. Establishing a feedback loop with key informants regarding what the researcher sees and believes is vital. In order to “see” correctly, the researcher first built relationships with key informants that demonstrated genuine interest in the Mexican immigrant community and assurance that its beliefs were heard and respected. The researcher sought confirmation of identified culture care meanings, expressions and patterns through interviews with general informants and re-interviews with key informants. Research findings can be confirmed and deemed authentic through this on-going process of data analysis and data collection. The “meaning-in-context” criterion must be met in order to achieve an accurate and “true” interpretation and understanding of the culture.

Observations of repeated experiences or repeated patterns or sequence of events, known as recurrent patterning, are important indications of the quality of the research findings. These recurrent patterns were observed through analysis of interview data with key and general informants. The use of Leininger's Phases of Ethnonursing Analysis, as outlined above, provided a means to build reliable interpretations of data through a sequence of pattern identification, verification and re-verification with key informants and confirmation activities.

The transferability criterion does not attempt to produce generalizations from a quantitative perspective. Rather it relates particular findings in one context to a similar context or situation. For the researcher this is done in the hope that the meanings, interpretations and inferences found in this study can be helpful to others nurses, as they look at similar cultures and immigrant communities. The transferability of data from this study is discussed in Chapter Five.

### I. Summary

The ethnonursing research method is a naturalistic, inductive, qualitative research process that is primarily designed for, and used in, the discovery of culture care meanings, expressions, patterns and practices of cultures. For this study, the researcher employed ethnonursing research method to build cultural data and interpretations through observation, participant observation, reflection and reconfirmation. Twelve key informants provided the major portion of this cultural information, with twenty-four general informants providing breadth of cultural meanings and expressions. Using the building process of Leininger's four phases of ethnonursing analysis, research findings

were explicated, refined and made increasingly credible and confirmable through the concurrent process of data collection and data analysis until saturation was achieved. Through this well developed, refined nursing research method accurate, insightful and meaningful cultural knowledge of Mexican immigrant women was discovered, and is discussed in the following two chapters.



## IV. FINDINGS

### A. Introduction

In this chapter the researcher presents findings from the study *Understanding The Culture Care Practices Of Rural Immigrant Mexican Women* that sought to discover the emic perspectives of immigrant Mexican women living in rural communities in western Clark County, Ohio. Research questions were developed to guide the study in exploring the definitions of health and well-being of immigrant Mexican women, their specific practices of health promotion and illness care, and their descriptions of how nurses could assist in promoting, attaining and maintaining their health and well-being. The context of the study has been carefully defined and considered in order that the emic and etic viewpoints aid in understanding cultural meanings.

In the following sections, demographic information of the key and general informants is presented with a discussion of characteristics of informants that influenced the data collection process. Research findings are then presented. Each phase of Leininger's Phases of Qualitative Data Analysis is presented with the findings from each phase explicated. This data analysis process begins with *collection and description of raw data* involving the identification of key phrases or descriptors that serve as the basic unit of coding and analysis. From there, data relating to culture care and health and well-being were *categorized* and identified through quotations from informant interviews. The next step of the process is *analysis of data* with discovery of recurrent *patterns* of similar and different meanings, expressions and explanation of culture care practices. These *patterns*

are supported by the *categories*, and lead to the third phase of data analysis, *synthesis of data*, resulting in the creation of *themes* that describe the culture care meanings, expressions, patterns and practices of immigrant Mexican women.

### B. Key and General Informants

Twenty-four general informants and twelve key informants were selected and interviewed for this study. Demographic descriptions of key informants (Table 1) and general informants (Table 2) are summarized below. All of the informants were women, born in Mexico, who immigrated to the United States, and currently living in the same rural area in southwestern Ohio. The number of years since immigrating varied between 25 years and 3 months. Spanish was the first language of all informants, eight of whom were able to speak English to some degree. Four of the key informants and eight of the general informants were undocumented immigrants. Undocumented immigrants are those who are foreign-born and who enter the U.S illegally. Alternately, they have entered the United States with visas for restricted purposes or entry times and have overstayed the limits of their visas. They, therefore, are also illegal immigrants.

Key informants are the primary source of emic data and were identified using the snowball method of informant identification. The researcher continued to interview new informants until twelve informants were found that provided a meaningful depth of information regarding the culture care practices of immigrant Mexican women.

One challenge encountered was the desire to include undocumented women as key informants. The researcher attempted to interview women who were undocumented and living in employer-provided housing. The researcher chose an interpreter who was a

member of the immigrant community and well known through her work at the TMC. The undocumented women appeared to trust the authenticity of the purposes of the research, and many accepted the researcher and interpreter into their homes. While they answered all questions, they did so with a minimum of response. Specific questions about their experiences coming from Mexico were often answered with “yes” or “no” with no further description of the experience. The researcher was able to include four undocumented women as key informants, and conducted multiple short interviews with them, in order to slowly build trust. Increasing depth of information was obtained as the interviews continued.

*Table 1. Demographic Characteristics of Key Informants*

Informant Number	Age	Language(s)	Years in Ohio	Religion	Immigrant Status
001	25	English/Spanish	3	Catholic	Documented
002	27	Spanish	2	Catholic	Documented
003	27	English/Spanish	6	Christian	Documented
004	29	English/Spanish	7	Christian	Documented
005	22	Spanish	4	Catholic	Undocumented
006	37	Spanish	8	Christian	Undocumented
007	28	English/Spanish	12	Catholic	Documented
008	27	English/Spanish	5	Catholic	Documented
009	27	English/Spanish	3 mos	Catholic	Undocumented
010	42	English/Spanish	25	Catholic	Documented
011	37	English/Spanish	7	Catholic	Documented
012	33	Spanish	2	Catholic	Undocumented

General informants provided broad general information about their experiences, beliefs and values. Demographics of this group are summarized in Table 2 and are similar

to key informants in age, language, religion, and years in Ohio. Eight of the general informants were undocumented.

*Table 2: Demographic Characteristics of General Informants*

Informant Number	Age	Language(s)	Years in Ohio	Religion	Immigration Status
#13	40	Spanish	2	Catholic	Undocumented
#14	31	English/Spanish	2	Catholic	Documented
#15	50	Spanish	3	Catholic	Undocumented
#16	35	Spanish	6 mo	Catholic	Undocumented
#17	36	Spanish	7	Catholic	Documented
#18	33	Spanish	12	Catholic	Documented
#19	34	Spanish	7	Catholic	Documented
#20	38	English/Spanish	13	Catholic	Undocumented
#21	42	English/Spanish	28	Protestant	Documented
#22	44	English/Spanish	27	Protestant	Documented
#23	46	Spanish	28	Protestant	Documented
#24	39	Spanish	2	Protestant	Undocumented
#25	23	Spanish	7	Protestant	Undocumented
#26	25	Spanish	5	Catholic	Undocumented
#27	31	Spanish	22	Catholic	Documented
#28	44	Spanish	7	Catholic	Documented
#29	55	Spanish	13	Catholic	Documented
#30	32	Spanish	2	Catholic	Documented
#31	28	Spanish	1	Catholic	Documented
#32	25	Spanish	2	Protestant	Undocumented
#33	24	Spanish	5	Protestant	Documented
#34	22	Spanish	2	Protestant	Documented
#35	29	English/Spanish	5	Catholic	Documented
#36	20	English/Spanish	3	Catholic	Documented

In summary, this study was conducted in a rural region of Ohio, a state that has demonstrated increased numbers of both documented and undocumented Mexican immigrants. Despite census data that describe low numbers of Hispanic residents in Clark County, it is widely believed that the actual number of immigrant Mexicans is much larger. A common perception of the immigrants is that they are “not seen”: their absence

from the 2000 Census data would seem to support this contention. Many informants hesitated to reveal themselves to “outsiders”. This fact made data collection a challenge. Nonetheless, the researcher was able to recruit for the study four key informants and eight general informants who are undocumented immigrants. Discovery of undocumented status and its implications proved to be an important component of understanding social and cultural influences on the health and well-being of immigrant Mexican women.

### C. Presentation of Findings

#### *Description of Raw Data*

This study utilized Leininger’s (2001) Phases of Ethnonursing Analysis for Qualitative Data (Appendix E) to guide the analysis of data. Data, including audio taped interviews, observations and field notes were analyzed concurrently throughout data collection in order to continue the verification and confirmation process. The first phase involved the collection and transcription of informant interviews. From these transcripts key phrases were identified as significant due to their strong relationship with the domain of inquiry and/or the importance given by the interviewee, and represented an aspect of culture care. Over 300 descriptors were generated from the raw data.

#### *Categorization of Data*

Recurrent descriptors were studied for their meaning in relationship to the domain of culture care. Analysis of descriptors generated from the raw data began with the researcher’s entry into the community and continued throughout the interview process. Categories of responses emerged from the researcher’s repetitive reading of verbatim transcripts and patterns of responses to questions identified through questions, and data

managed with computer software. Analysis then proceeded to the identification and development of categories generated from these descriptors.

As the researcher interacted with the immigrant community in more direct ways over time, increased understanding of the community, and the multiple influences on the immigrant women was gained. By hearing their stories and sitting in their homes filled with the sights, sounds, scents and family dynamics of their lives, the researcher better understood their information from a fresh and new perspective. By watching the flow of the lives of the immigrant women the researcher could analyze the data within the context of their lives, not her own.

Through the concurrent processes of data gathering and data analysis, the researcher identified factors that were potentially significant as they related to the domain of inquiry. The researcher would then return to the key informants to gather additional information that would assist in determination of relevance. Through this process the researcher gained increased depth of understanding and increased confidence in the credibility of the research findings.

HyperRESEARCH 2.6, ethnographic software compatible with an Apple G5 computer, was chosen to manage the large amount of interview data obtained. This software provided a means of coding the interview data using the descriptors assigned to key phrases as determined by the researcher. From this emerging database the researcher analyzed the frequency, similarities and differences in responses, and the relationships among descriptors. Concept maps were then developed that provided visual representations of the categories and subsequent patterns of data.

From this analysis nine *categories* of responses that related to the culture care of immigrant Mexican women were identified which could be tracked from the raw data gathered in Phase I, and the descriptors generated through that data gathering process. These categories reflect a beginning understanding of the culture care of immigrant Mexican women by revealing significant aspects of their values, beliefs and health practices. The nine categories are: 1) *cultural and religious traditions*; 2) *folk care practices*; 3) *good thoughts*; 4) *hard work*; 5) *communication*; 6) *mother's role in the family*; 7) *health and well-being*; 8) *caring nurses* and 9) *non-caring nurses*.

Comments from informants that support the category of *cultural and religious traditions* reveal their connection with spiritual, religious and cultural traditions passed down from mother to daughter. *Cultural and religious traditions* involve the lifeways and religious customs that were common and valued by the informants. One key informant (011) referred to “Mexicans are very spiritual people. I want my daughter to learn that from me.” Religious practices such as prayers for the sick or family members in Mexico were mentioned often as the majority of the key and general informants were Catholic. Key informant #004 said “we always go to mass every Saturday and we always light candles and ask for prayers for our family in Mexico.”

Key and general informants provided rich descriptions of *folk care practices* that they remembered from their childhood as well as those they continue with their families. Folk care practices are traditional remedies or practices related to health and illness. All informants reported the use of folk practices that had been passed down from grandmothers and mothers. Key informant #011 described “my grandmother believed in cleansings that were necessary to keep you well. She would use them to stay healthy and

only gave them to us when we were sick”. Key informant #006 referred to her mother’s use of teas and herbal remedies: “She always knew what to do, either giving me peppermint tea for a stomach ache or special creams from the aloe plant if I had dry skin.”

Comments extrapolated from the raw data supported the view of life of the immigrant women as demonstrating incredible personal strength and optimism, referred to as *good thoughts*. These *good thoughts* include not only optimism and positive outlooks, but also the intentional effort to think positive thoughts in order to stay well. Key informant #007 described her *good thoughts* that “We, Mexicans, live a whole life. We love being happy, healthy and with our family.” Key informant #009 described, “Being Mexican means being positive and optimistic.” General informant #018 described the impact of good thoughts as “being sick is in your head so you have to stay happy to stay healthy.”

*Hard work* was a common phrase used by informants. Comments regarding the informants’ values and beliefs about *hard work* displayed inner strength and determination of the informants. Comments such as “we work to survive” (key informant #001) and “its God’s plan that we work for our family here” (general informant #017) reflect this category of response.

Key and general informants all discussed the difficulty they have had with *communication* and language barriers with nurses and other health care providers. Comments that were repeatedly heard were “nurses need to learn Spanish” (key informant #002) and “I can’t speak English and they can’t speak Spanish but they should learn at least a little.” (key informant #006). Availability of interpreters was identified as



a major problem as well. Key informant #009 said, “I try and help those who can’t speak English. There is no one else to help them at the hospital.” Even those informants who could speak English found barriers. General informants #014 stated “When I am in pain I can’t think in English, but there was no one there who I could talk to.”

The importance of the *mother’s role in the family* in Mexican culture was revealed in informant interviews. All key and general informants talked about how central their mothers and in some cases grandmothers were in their family and described their practices of maintaining health and providing illness care. All informants related their current health practices and those with their own children as being passed down from their mothers or grandmothers. Key informant #011 stated, “My grandmother always said the home is who you are and the mother is the center of the home.” Mothers were described as the major health care decision maker for all family members. General informant #014 stated, “My mom will call and tell me what to do if my son is sick. She will even send the teas or medicines from Mexico. She knows what to do.”

Definitions of the category of *health* focused on the informants’ efforts to be active as well as think *good thoughts*. Key informants #009 stated: “Health means being happy and being active. You have to stay up and active or you will get sick.” Besides the physical and emotional elements cited as central in the definition of health, nutritional practices were also noted, such as key informant #006 stated “To stay healthy my mom would cook for us. She always thought we should eat fruit and fresh vegetables.”

Many of the key and general informants vividly described their interactions with nurses in Ohio. Eight of the key informants had babies in the United States since immigrating. They described the positive experiences they had with *caring nurses*. Key

informant #001 stated, “The nurses took good care of me and my son. They made you think they really care about you.” General informant #014 stated, “They were all very nice. They would check on me and ask me what I needed.”

Spanish speaking informants described the difference in care they experienced from *non-caring nurses*. Key informant # 002 said, “Nurses treat you different if you can’t speak English. They act like you aren’t there.” This non-caring behavior was described by key informant #012 as “the nurse walked away from me when I was talking like I wasn’t even there.”

Such rich details, willingly provided by the informants through the interview process, served as the primary data for *pattern* and *theme* recognition. The researcher continued to collect data in order to test and challenge the *categories*. Through scrutiny of this interview data recurrence of ideas relating to the categories emerged, and patterns were identified.

#### *Analysis of Patterns*

Multiple interviews were conducted with key and general informants, and from these the researcher identified five patterns of culture care and expressions of health and well-being: 1) *doing what it takes to support self and family of immigrant Mexican women*; 2) *expected care from nurses by showing interest, respect and support for immigrant Mexican women*; 3) *avoiding non-caring, disrespect and lack of interest from nurses to Spanish-speaking immigrant Mexican women*; 4) *expected care from nurses who communicate in Spanish*; and 5) *expected care from nurses who help mothers as they care for their family*.

These patterns were revealed from a deepened understanding of the informant's recurrent responses to questions and are supported by verbatim interview data. The researcher identified these patterns of culture care through analysis of the nine categories derived from verbatim transcriptions of key and general informant interviews. The researcher raised exploratory and clarifying questions about the categories and possible relationships and patterns among them with key informants during follow-up interviews. Further detailed information was gathered thereby. As increased clarity of the categories was gained through repeated interviews, the researcher began to recognize recurrent patterns of similar meanings and expressions in the interview transcripts. The five patterns were identified through analysis of this data and reflect culture care values, beliefs and patterned lifeways of the immigrant Mexican women involved in this study. The categories that reveal and support each of the five patterns are explored below. Each pattern is described using verbatim excerpts from both key and general informant interviews. The patterns are revealed through the words of the informants: this is vital to assure focus on the emic perspective.

Pattern One: *Doing what it takes to support self and family of immigrant Mexican women.*

*Doing what it takes* means surviving and thriving while maintaining their Mexican identity. Being proud of Mexican heritage is demonstrated by displays of Mexican artifact throughout the community. As noted in fieldnotes, in all of the homes visited during the interviews, Mexican decorations, including pictures of locations in Mexico, colorful vases and flowers were present and informants described these possessions with great pride and vivid description of where they bought the items in

Mexico or what the pictures represent. Inside and outside of several informants' homes, Mexican flags were displayed. Having pride in their cultural identity is evident in this community and appears to provide strength and support to the people.

Determination to survive and thrive was found to be the driving force for many of the informants' move to Ohio from Mexico and their work as migrant workers. As the informants described their worldviews, values and beliefs this pattern of strength and determination with regards to themselves and their family became clear. The categories of *good thoughts*, *communications*, *hard work*, and *cultural and religious traditions* informed the researcher about this pattern of culture care and will be described using verbatim quotations to explicate their meaning. A strong sense of cultural identity emerged as a connection between these categories. In particular, the optimism expressed in good thoughts was often connected with the informant's pride in their Mexican heritage as well as their Mexican family. As described in the category *good thoughts* informants referred to this strength as part of being Mexican. One key informant (011) described the Mexican people in this way.

The Mexican people are always optimistic. We will always find a way. No matter what, we find a way to survive. It is extreme though. We will also get depressed and drink and listen to the Mariachi, but then wake up and get dressed and get back to work.

One key informant (011) described her connection with homeland, family and nature as living a whole life:

I think Mexico is very spiritual, very natural. It is about many things more than routines like it seems here. It is about family, flowers, the mountains and the

sunsets. You don't get to see that here so much and you need that. There you go on long walks and see things you may have never seen before. There is a difference in terms of the spiritual, religion, nature; a whole life.

This excerpt expresses the pride and deep satisfaction gained from being Mexican. The natural elements of "family, flowers, mountains and sunsets" were expressed as elements that were "needed" for a "whole life". It is from this "whole life" that *doing what it takes* is made possible.

Another key informant (009) described the strong family connections that were characteristic of her life in Mexico and the strength derived from family, "We had our church because it was in our village and we had our land and nature. We had everything we needed." The immigrant Mexican women informants were closely linked with their cultural identity, which was evident in a variety of ways. It was revealed in their love of their homeland and their family, their dress, and their homes. It was also revealed in their use of the Spanish language and their descriptions of themselves as Mexican or Chicano. All of the informants stated they primarily used Spanish in their home. Four of the key informants and 18 of the general informants spoke only Spanish. Despite valuing English as a means to increase opportunities in the U.S., the informants also highly value use of Spanish as their primary means of *communication* in their community. One key informant (001) stated: "I don't speak English and it is hard. No one in my family speaks English. I hope my daughter learns in school though. It will help her. But it is too late for me."

General informant #014 stated: "I don't speak English. I am trying and I do understand some English words. My husband speaks English and he helps me." General

informant (016) stated: “ I haven’t been able to learn English. It is hard when you are older. I am trying to learn though. I can understand some words. But at home it doesn’t matter, we speak Spanish. Everyone does.”

Relating their strength and ability to survive through *hard work* was also consistently identified as part of “doing what it takes”. Describing *hard work* as a cultural value as well as a family value reinforces its importance. Key informant #010 described her family’s history of hard work in this way:

My mommy and father always worked hard, they had to. They would leave us with our grandma and go north to work in the field as migrants. It was the only work they could find and it took care of all of us. When I was old enough I traveled with them. It was all I could do. I come from a family of hard workers.

Eight of the key informants had at some time worked for the local nurseries as migrant workers. Many of the women first traveled to Ohio with their families who were migrant workers. Indeed, many of their families were multi-generations of migrant workers. Key informant #007 described her family’s commitment to increased opportunities through hard work as:

I was born in Mexico and lived there until I was 4 yrs old. My family was migrants and we moved to Brownsville, Texas. They traveled and I stayed with relatives. It was scary because it was so big. My family still lives there. I have 3 brothers and 4 sisters in my family. I had friends that were migrant workers so I went with them to Ohio. Then I met my husband. We got married and I stayed in Ohio. When I worked as a migrant I was planting and cutting. It was hard but it as worth it. Look where we are now. We are buying a house.

Another informant (006) described her family's heritage of hard work as:

I was born in the country in Mexico. We came to Texas almost 12 years ago.

Then my mother and father came to Ohio, and worked as migrants. I worked as a migrant along with my parents. I met my husband in Texas, and then we got married. I worked at the nursery trimming and planting. His brother came to Ohio to work at the nursery, and he liked it so he stayed. We are all doing well here. My parents are moving here soon.

Many of the informants described the lack of jobs in Mexico as the primary reason they left their homeland. Key informant# 001 described how she coped with meeting the needs of her family as:

We moved here to work because there was no jobs in our home town. I worked in the nurseries until I became pregnant. Now I can't work because of the baby so I baby-sit for other families. You have to find a way to help. You can't just sit and wait for someone else to do it. You have to do it yourself.

*Doing what it takes* also includes demonstrating the importance of *cultural and religious traditions*. For many of the informants their belief in "God's will" was central in their religious beliefs. General informant #019 stated she moved to Ohio because it was God' will: "We are lucky to work. We came because we knew there were jobs here. Even if we can't see our family we know it is God's will for us to work here. We are blessed. "

General informant #022 described her optimism related to her belief in "God's will" as:

When we came here we didn't have jobs and we lived with my brother, but I knew it was God's will for us to be here. We got jobs at the gas nozzle plant and we have our own house. I knew we would be okay.

The immigrant Mexican women in this study have supported themselves and their families by *doing what it takes*. For the immigrant Mexican women this has meant traveling from their home in Mexico to work in the field of Ohio thousands of miles away. It has meant leaving parents, grandparents and other relatives who provide them stability and support. It has meant leaving a country in which they have great pride and moving to new communities with few family members and friends. It meant hard work, good thoughts and observing cultural and religious traditions in order to survive and meet the demands of health and well-being of their family.

In some cases, the undocumented immigrant is unable to *do what it takes* due to barriers such as unemployment, low wages, no insurance and no support systems, due to the lack of needed documentation. Public assistance is, therefore, not available and other forms of community support is not always available or reliable. One general informant (015) described her family's needs and how one agency, Del Pueblo, helped:

I came just 1 year ago. I came to live with my son and daughter. I had a job but then I lost my visa. I don't have any job now or any help. I need help getting my papers. Maria at Del Pueblo is helping me. I don't know where to go. I don't have a car and my son works at the palate company so I can't go during the day. It is really hard. I need help. I came because my daughter was working for the nurseries and said I could work as well. But now I don't work and I can't get my papers so I can't work. I don't know what to do. I don't know where to go here,



but Maria is helping me. We need help with many things. We don't have a doctor and my grandson gets sick (asthma) and I can't find a doctor. Maria said they could help us with that too. We couldn't find jobs in Mexico. That is why we came to California. We found jobs there first. There were a lot of jobs when we first came but then there were more people than jobs. Then I came to Ohio. My children have tried to help but they don't have enough money or time. Thank God Maria will help me.

This extreme lack of opportunities, services and supports for the undocumented immigrant is not isolated. Informants tell of many families, particularly of undocumented immigrants, who struggle to survive due to employment and language barriers. Even in the face of these huge barriers, immigrant Mexican women continue to try to improve the situation for their families. For many of these undocumented Mexican immigrant women *doing what it takes* means accepting the help of others. This is of particular importance to those immigrant women who do not speak English.

Several of the key informants who speak English regularly transport friends and family members to the doctor, clinic or hospital and translate for them. One key informant (006) stated that it was the way of the Mexican people to give of their time and energy to help others.

I try to help here. At least it is good to have one person to try and help. Most families work so you have to look for someone to take you if you can't speak English or can't drive. I don't know what they do. At least people need to try and help. Find out if they need help and what is wrong. That's what I think people should do so I try and help.

This aspect of “doing what it takes” emphasized the important cultural values of good thoughts, communication, hard work, cultural and religious traditions. This pattern recognizes the personal strength that is built on self-determination and self-reliance. These acts of kindness support the Mexican cultural value of succorance, but due to the contextual issue of living thousands of miles from their extended families informants have had to adapt some of the traditional patterns of decision making and family life. The informants strongly reflect filial love and valuing of family, as they describe their lives in Mexico, but as the informants describe their community in Ohio they describe a community of few family members and friends and new acquaintances. Due to this contextual difference the researcher has observed patterns of caring that reflect the immigrant Mexican women’s adaptation to building her own self-reliance and self-determination. They also focus on building supportive connections within their community, not through the family or *compadrazgo* network as they would in Mexico. These changed care constructs again reflect the immigrant Mexican commitment to *doing what it takes* to survive for themselves and their families. Nurses must become part of this community network, providing the support and connection the women seek

Pattern Two: *Expected care from nurses by showing interest, respect and support for immigrant Mexican women.*

This pattern describes the informants’ expectations for care provided by nurses. Through scrutiny of the categories of *caring nurse, cultural and religious traditions, folk practices* and *communications* the pattern was revealed. Both key and general informants described activities that *caring nurses* should demonstrate to support immigrant Mexican women’s health. A common description made by informants of a *caring nurse* was

showing “interest in my life”. This was described in a variety of ways such as asking questions, taking time, speaking Spanish, listening, smiling and providing privacy for immigrant Mexican women.

In the category of *caring nurse* several descriptors were identified that describe what *caring* looks like. Informants described smiling as a way nurses can show interest and respect. Showing the “face of nice” makes a difference according to one of key informant (002) “They should be nice. Because they are nurses they should always have the face of nice. They should also explain every procedure they do. Especially if it involves touching” Key informant #007 described her value of nurses who show interest and respect for her children as:

We were all very healthy. I now have 2 children and they have yearly check-ups. My daughter had many ear infections. I think nurses should try and find out what people need and not assume. They should smile when they come into the room and introduce themselves. Even if we don’t speak English. They should treat us like they treat anyone else.

Nurses also demonstrate caring and respect by listening. Key informant #005 described her experience with nurses who listened:

Nurses and doctors are nice here. Like for an example, a week ago my husband’s nephew was in the hospital and I asked a question and the nurses answered them. She acted like she really cared and listened to what I said. Even though I don’t speak very good English she really tried to understand me. That was nice. They were nice.

Asking questions and taking time with immigrant women, particularly those who don't speak English were also described as ways caring nurses could show respect and support to immigrant Mexican women. Key informant (009) described how a nurse showed respect by taking time and listening:

Nurses who come to you and ask what you need and will listen to you really makes a difference. They take their time and talk to you. It makes you think that they really care about you. That is caring. Being with a person when they are in pain and listening.

*Communication* was viewed as a very important demonstration of caring and respect. A key informant (008) who often helps non-English speaking migrant families as an interpreter mentioned how families can be supported through understanding and communication:

Many of the families I know that are migrant are only here for a short time. We hardly get to know them. They are very shy and you can't find things out right away. Most of the migrants live in camps provided by the nurseries. They are warm and safe and that is what matters most. Being safe. When they go to the hospital or doctor and can't speak English no one asks questions about their lives. Most nurses would never believe where they live. Nurse should try and find out about the lives of their patients. How can they really help them unless they know this?

Speaking the language and taking time to communicate was clearly voiced as an important demonstration of caring by immigrant women. Privacy is also an important issue for immigrant Mexican women. Respecting privacy and being discrete are

described as important actions taken by *caring nurses*. Key informant #007 described her thoughts on caring nurses respecting privacy as:

They (nurses) can be more interested in the life of the patient. They need to do everything they can to help them get better..... Explain every procedure you do.... Be gentle. Especially when they touch you, and they touch a lot. And they should always close the curtain and make sure to keep you covered. That is only right. They need to take time to provide better care.

Respectful actions and attitudes are equally important in demonstrating caring and respect. Valuing what the immigrant woman has to say and respecting her enough to listen and provide adequate time and privacy are important values to the immigrant woman. When nurses demonstrate interest and respect immigrant Mexican will feel valued.

This pattern also identifies the expectation that nurses will provide support to immigrant Mexican women. An important way of supporting immigrant Mexican women is to acknowledge and support the integration of their *cultural and religious traditions* and *folk practices*. These traditions and practices are highly valued by the informants and are passed down generation to generation, typically from mother to daughter. Cultural traditions and practices related to aspects of life such as religion and spiritual activities are important to be understood and supported by nurses. Informants consistently mentioned practices involving healings including prayers and lighting candles. One key informant (011) stated:

We are Catholic and we use candles in our home in a variety of ways. Mainly for prayers and healings. You would only use white candles. If you need harmony

and sweetness in your home you would take a white candle and sprinkle it with sugar and walk around your home and pray for happiness and sweetness to return.

I do this in my home.

Another key informant (012) described her religious healing prayers during mass as:

We are Catholic and celebrate mass every week. We always celebrate the religious holidays at home as well. We light candles for the sick too, at home and at mass. We have a corner of the kitchen that has a Madonna and candles that we light if someone is sick. Only white candles. Sometimes I light a candle even if I just feel down.

A general informant (013) described the practice in her Catholic church.

We are Catholic and in Mexico if someone was sick we would light a candle for them and the priest would say a prayer for them during mass. This was really nice to hear their name in Mass. Here we still light candles but I never heard of them saying prayer during Mass. Its not the same but it is nice.

In the homes of the Catholic informants (9 key informants and 16 general informants), the researcher observed religious icons and candles that were displayed in the living areas. In the Christian homes (3 key informants and 8 general informants) crosses were displayed but not candles or other ritualistic materials. Other forms of spiritual healing activities described by informants include sweepings with herbal packets of pine and mint, and the egg remedy described by key informant (011) below. Other informants were asked about these practices and several of the informants stated they

remember their family in Mexico doing these rituals, but none reported doing them in their own homes. According to the key informant (O11):

Another herb my grandmother used was pine herbs, like leaves, from pine trees.

The pine trees here are not like those in Mexico. But she would take the pine leaves and mint and make a pack and hit her legs and back with them, all over her body really. And if we were sick she would sweep them all over our body.

Flowers are also very important in Mexico. White flowers mean purity and red means love. If you need love to come your way you would use white or red flowers with the cleansing pine and pine packet. You would sweep it over you.

Have you ever heard about the egg remedy? I don't know a Mexican who doesn't do this. They all do around here. First you take an egg and touch it all over the person's body, the one who is sick. With it you are taking all the bad and the pain the evil spirits. Then take a glass with water half way up and then crack the egg into the glass. The belief is that if the white is covering the entire yolk when you drop it into the water you have taken all the bad away. Then you get rid of the egg far away from the person, like flushing it down the toilet. They say to do this on Tuesdays. Tuesdays are very strong spiritual days in Mexico. I don't know exactly why, but they think Tuesday is the day closest to God.

In summary, the pattern of *expected care from nurses by showing interest, respect and supports for the immigrant Mexican woman* includes descriptions of behaviors that caring nurses must demonstrate. Actions to demonstrate showing interest and respect include asking questions, taking time, listening, smiling and providing privacy. Providing support to immigrant Mexican women can be seen in nurses who attempts to understand

cultural, religious and family traditions and with immigrant women integrate them in plans of care. The religious healing rituals including lighting candles and prayers were widely practiced by the Catholic informants. The sweeping rituals and the egg remedy were known to many of the informants but not widely practiced. All of these practices are grounded in the cultural values of Mexican immigrant women, which the caring nurses must acknowledge and support in order to provide effective and culturally congruent nursing care.

Pattern Three: *Avoiding non-caring behaviors, disrespect and lack of interest towards Spanish-speaking immigrant Mexican women.*

This pattern reflects the informants' view of nurses' negative behaviors when they are interacting with Spanish speaking immigrant Mexican women. These non-caring behaviors are described as disrespectful and lack of interest. This pattern is also revealed in the categories of *non-caring nurse, cultural and religious traditions* and *communication*.

Recognition and support for cultural identity emerged as significant influence on informants' relationships with nurses. As one key informant discussed care she received from nurses, she began to cry. As she described how she felt when treated with disrespect by nurses, the researcher began to better understand that the issues being discussed were of deep cultural valence. Key informant #010 describing her basic values of cultural identity and respect and how nurses display lack of respect when she said:

When I had my baby I couldn't speak English. The nurses at the hospital were really mean. They had given me an epidural but it didn't work and I could feel everything. I tried to tell them but they walked away. My friend tried to tell them I



was having so much pain. The nurse said she had just checked and that I was fine. She hadn't checked. She didn't even act like I was there. She acted like she thought I was lying. She acted like I was nobody. But I am somebody. It was her job to help me. I felt like she didn't even care about me. She wouldn't even look at me when she came in the room.

The informants described encounters from their life experiences in the U.S. which were frequently in the emergency departments and obstetrical services of local community hospitals. A general informant (018) described the behavior of disrespect demonstrated by a *non-caring nurse* as:

When I got married I got pregnant and had my son at a big hospital in Dayton. It was really hard because I didn't speak such good English then and some of the nurses were mean. I would try and tell them something and they would just walk away, like they didn't hear me. But I think it is better now. Now I speak more English. They treat you better and I can tell them what I think.

A key informant (006) described her experiences with uncaring nurses as:

When I had my baby I had a really good experience. But that is because I could speak English. But I had one time when the nurses were really mean when I was helping a friend who couldn't speak English. They had given her a shot but it wasn't working. She was in pain. She told them and told them but they walked away. And I went back and told them she was having so much pain. The nurse said she had just checked and there wasn't anything she could do. She didn't even act like I was there. I felt like she didn't even care about us. I have been with other women who have had babies. I help them because I speak English. Some

nurses are nice but others don't know how to act. It doesn't take much to be nice.

Just a smile.

The perception that they weren't valued or respected is clearly demonstrated in the words of the informants as well as in their faces and the tone of their voices. Pain and sadness were seen in the faces of the informants. Lack of attention, interest and concern and disrespect were seen as barriers to the establishment of meaningful, successful relationships between nurses and the informants.

Several informants who attempted to assist non-English speaking immigrants have also described disrespect observed towards Spanish speaking immigrant women. One key informant (007) stated:

I think it is easier for me because I speak English but it is really hard for those who don't. Sometimes it seems people who don't speak English are ignored...

Some of the people who can't speak English are trying to learn but it is hard.

When you go with them it just seems no one talks with them.

Key informant #008 described her thoughts on the impact of nurses being too busy and its impact on communications:

In Ohio I have seen too many things. I try and help other people so I translate for them. Much time the nurse just comes to you in a hurry. You don't have time to ask questions. I speak the language but lots of people don't but even I need time to ask the questions and you feel uncomfortable. Because when you have a chance to communicate it is better to at least ask one question. These nurses need to take more time with us. When I see this I think they don't care.

Another key informant (006) described her experience as an interpreter for her friend having a baby as:

Like last year at Community Hospital I was going there to translate for my friend but there at the Hospital they needed me to translate in another room. So there I was running from one room to another. But it was nice and I wanted to help. I am glad to help. The nurses didn't know what was going on. They don't know the language but they should try.

Disrespect is also demonstrated by nurses through there lack of concern for informant's privacy and lack of attention. One key informant (#007) stated:

They don't bother to introduce themselves or even look at me. They are not always considerate of a woman's privacy. I have also seen where they also ignore people who can't speak English. They don't think I can understand because I don't always speak English but I can understand. The things the people think about us and say about us are sometimes bad things but they don't know I can understand. It makes me mad and sad.

A key informant further described her experience with being in pain and uncaring nurses as:

The nurses are very nice but some act frustrated when you don't speak English. They had some forms in Spanish that the nurses will give you, but not much else. I knew the language when I had a baby but when you are in pain you can't think so you can't speak in English and then they can't understand you. It is frightening when someone doesn't know what you are saying.

This pattern points to the disparity between the care provided to English speaking women as compared to non-English speaking women. The risk for emotional harm as well as physical harm is high for these women and they seemed to realize it.

Pattern Four: *Expected care from nurses who communicate in Spanish.*

This pattern supports the need for adequate *communications* with Spanish speaking immigrant Mexican women. In order for the immigrant Mexican women to demonstrate their self- determination and self-reliance they need to be able to communicate with health care providers as well as other community members. The importance of self-determination and self-reliance for Mexican women was found to be an important cultural value for all the informants. Self-determination means *doing what it takes* and “working to survive”. Being self-reliant involves being able to communicate thoughts, ideas, needs and desires. But for the immigrant woman who cannot speak English, self-reliance is threatened. This pattern was further revealed in the categories of *communication, cultural and religious traditions, hard work and caring nurses.*

This pattern of nurses supporting immigrant women by speaking Spanish was of great importance to the informants. As mentioned previously four of the key informants do not speak English. Five of the key informants who spoke English regularly assisted other women with interpretation if they went to the doctor or hospital. One of the informants had assisted in the local school district. All of the informants identified language as a barrier to obtaining quality health care.

All of the key informants stated that the majority of local health care providers in the region did not speak Spanish. They described the frustration they observed when these providers saw women who could not speak English. They all reported observing

some degree of discrimination and disrespect to non-English speaking Mexican immigrants by some providers, including nurses. Key informant #12 described her expectations of a nurse with regards to communication:

They should explain everything to me.....Sometimes my English is not very good and I want to hear things twice not just once. I need to make sure about my medicines. I need to be sure about what they want to do to me. Explain everything twice.

Another key informant (012) found speaking Spanish, if even just a word or two, showed immigrant Mexican woman respect and attention:

The first phrase someone says to you even if you can't speak the language means a lot. Just a little phrase like "are you okay" would really be nice. Just a smile or looking at you in the eye can help. A little thing can help a lot.

General informant #030 stated that "I also think nurses need to try and speak Spanish at least a few words. It will make a difference."

Pain can be a language barrier. An informant who could speak English found that not taking time to communicate to someone in pain is devastating. General informant #014 described her experiences in an emergency room as:

Once I had a terrible sore throat and I went to the emergency room. I could speak English but because of the pain I could not think when they asked me questions. I really couldn't think in English to answer. I could only describe my pain in Spanish and they couldn't understand. If they would have slowed down and talked to me I think I could have answered. It was all going too fast.

Clearly, nurses must make every effort to assist the immigrant Mexican woman to communicate in creative and beneficial ways. The caring nurse must make every attempt to speak the language of her client. If the nurse cannot speak Spanish, informants stressed the need for nurses to provide interpreters to help them communicate their needs. Key informant (006) found that nurses in the U.S. are willing but not always able to provide interpreters to communicate with people that don't speak English:

I think health care here can be nice but it depends on the language. Here people do not know how to communicate with people who speak Spanish. There is a nurse at the pediatrician's office that speaks some Spanish. A lot of people go there. But there really aren't many other people who speak Spanish. Sometimes you can get interpreters but many people don't know how to find an interpreter. Nurses don't even try to get them and they should.

A general informant (014) described her beliefs about the use of interpreters by Mexican women:

This area doesn't have many translators. They should try and make a call and get more for hospitals and doctors offices. Most Mexicans don't even know they can get a translator. In Mexico we don't have that many people from other countries so it is not a requirement. I don't think Mexican know to ask. And nurses don't really try and get them for you. You usually have to bring your own and if your family doesn't speak English, you have trouble.

In talking with local providers, the researcher found the perceptions of the informants to be correct. Only one pediatric office and a free clinic in the county provided bilingual staff members. The two local hospitals had no staff routinely

scheduled to interpret for Spanish speaking patients. They did have a telephone referral system that could be called using three-way call to provide interpreter services. This practice was rarely used and when asked where a three-way phone was that could be used, the staff at one hospital could not locate one. The informants viewed this absence of reliable interpreter services as a barrier to safe and appropriate care. Despite the mandate of the Title VI of Civil Rights Act of 1964 requiring the provision of interpreter services for all non-English speaking patients of providers who are providers for the Medicare or Medicaid systems, local health care providers plans for interpreter services are in name only and unusable by the non-English speaking immigrant women involved in this study.

By supporting the ability of the immigrant Mexican women to care for herself by providing translated material in practice areas, such as the emergency room or the obstetrical units will begin to fill the communication gap present in this community. General informant #014 made suggestions for translated materials in the emergency room including pain-rating scales with pictures, body part pictures and symptom pictures.

I think it would be useful to have a booklet that would have common words with pictures, like for stomach ache or headache that people could point to and the nurses would know what they needed help with. They would ask me certain thing I wouldn't even know what they were talking about. Something I could have read in Spanish and answered would have helped. Even if it something that is really general it would help, especially when someone is in pain.

Another general informant (030) said of an emergency department experience as:

If they had a picture, like happy faces or sad faced that would be nice. I want them to ask, but they have to understand if I can't answer because of the pain.

Like if you were there and having pain you would be able to tell them where the pain was. It could help tell how much pain you are having. I have seen those in some places. Many times in the emergency room you end up having to wait for an interpreter to arrive even to tell them what is wrong. This would make it nicer. No one has anything like this around here. Also maybe having a chart with parts of the body would be nice. And charts with pictures of headaches and stomachaches and sore throats. That would be nice.

In summary, this pattern of nurses communicating in Spanish to immigrant Mexican women revealed strong support for nurses speaking even a few phrases of Spanish as an important component of this pattern. Informants also described the need for interpreters when bilingual nurses are not available and translated written materials. These important strategies to communicate will assist nurses and immigrant women joining in providing care to the client and their family.

Pattern Five: *Expected care from nurses who help mothers as they care for their family.*

An important aspect of the informants' cultural and personal identity is that of mother. It also involves taking care of her family. Other patterns have reflected the importance of mother in the Mexican culture, as well as the importance of the role of mother to the informants but this pattern focuses on the importance of nurses acknowledging the *mother's role in the Mexican family* and helping her care for her family. Categories that assisted better understanding of this pattern were: *mother's role in the family; health; cultural and religious traditions; folk practices and caring nurses.*



All key and general informants emphasized the importance of the *role of mother* in providing care to families. All informants described their mothers as positive influences and central in their lives. The role of decision maker for health care of the family was also identified. One key informant #007 stated:

My Mom always made the decisions in our family because my father was always working out of the city. She was always there for us. She took care of us and always made us healthy and happy. I am the one to decide in my family. I am like my Mom. I used to complain about my mom ...”Mommy why are you doing this”...but now I understand.

In keeping with the previously defined pattern of *doing what it takes* key informant #010 described her mother and what she would do for her family:

Mothers in Mexico are very proud and will do whatever they need to do for their children. They will move away, like we have to be sure their children have what they need. One thing is learning English. They think I will come to America and send my child to a school so they can learn English and have more opportunities, even though they can't speak English themselves. Even though they have very little themselves

The mother's dedication and commitment in supporting her family is a universal pattern found in this study.

“Making sure everyone was healthy” was defined as primarily the mother's role. General informant #015 described her mother as the primary source for health care for her children but not herself:

My mother would take us to a clinic in our city. We would see a doctor from the city and get immunizations. She would always know what we needed. Even if she didn't have the money she would get it somehow. She always said she would make sure we were healthy. She always said she would get it what we needed and she always has. I don't ever remember her going to the doctor though. She is healthy but I don't ever remember her seeing a doctor.

This tradition of mother's providing care to keep family members healthy has been passed down mother to daughter for generations. General informant #020 stated:

I take care of my family in the best way I can. I want them to have everything nice. I want them to learn English so they can have good jobs. I make sure they see the doctor for checkups. I will go to the doctor only if I am really sick, but I never am. I can't afford to be sick.

Another key informant (009) described how she makes decisions regarding her child's care:

Whenever my son needs to be seen, if he needs it I will take him, no matter what people say. Some people say I take him too much. But I don't care. If he needs it I will take him. I would rather know there is nothing wrong than worry all the time. It is worth it to know he is okay. I save money ahead just for this. We don't have insurance but I will not neglect my son.

Central in the pattern of helping mothers care for their family is the immigrant Mexican women's definitions of health. The category of *health* was found to be a major influence on how nurses can "help". It must be understood that health for the immigrant Mexican women is more than physical; it has important spiritual and emotional

dimensions. Through the interviews, it was revealed that many cultural and social dimensions influence the informants' definition of health. Health was described as being happy, being active, being whole and being without pain or illness. A key informant (004) described health as:

I just try to take it easy. Before I worry about everything. I have a heart problem. I was worrying about everybody and then I decided to take care of myself. To me healthy means to be happy. That is the most important thing. Sometimes you worry and it gives you headache, then you are sick.

Another key informant (003) describe being healthy in this way:

Healthy is positive thinking. Never be in a bad mood. Never stay in bed. My mother always said that. Get up. Don't think about it. It worked. I was never sick growing up. Happiness is being healthy. It's the way you think. If you think you are sick you will be sick.

Concepts of health also included descriptions of when happiness was absent, or sadness. The spiritual dimension of health also seemed intertwined with patterns of happiness. One key informant (011) stated:

Healthy means being whole. Happy. If anything keeps you from being whole, physically or spiritually you become ill. I think being sad can make you sick as fast as anything can.

One key informant (004) stated:

Growing up everything we did was healthy. We ate healthy food, all fresh, and we were always outside. If ever we were sick my Grandma would say get up go outside. That would help us get better. You have to stay busy. I try and stay busy.

Since my baby was born I have tried to eat fresh foods and go for walks. But it is too cold now.

An active lifestyle was valued and practiced by all key informants. A key informant (001) described it this way:

I stay healthy by eating a lot of vegetables. Before in Mexico I played sports, but now I can't. I played baseball, basketball. I was good at it. Now I stay home with my baby. But I want to do more when she is older. It is more free in Mexico. You can walk or ride the bus everywhere. I was more active. But here you need a car. You need to find a ride from someone. And it is different, I don't know many people here.

One key informant (012) pointed out that increasing obesity among Mexican women is due to changing activity levels since moving to the U.S.:

In Mexico everyone walks everywhere but here we don't so much. That is why I think there are so many fat Mexican women here. You don't see that at home so much. So I take my daughter to the park every day that I can. I'm not going to get fat. My mother isn't fat.

A general informant (013) stated that:

I think healthy means being able to be active and have lots of energy. I also think its when nothing hurts and you have a healthy appetite. Nutrition is very important. Everything must be fresh. In Mexico we lived in the country with our family nearby. We would all cook meals together and all live in each other's houses.

Another general informant (019) stated:

I think that healthy means being able to be active and have the things you need to stay healthy, like vitamins and having other medicines available when you need them.

Several informants described the importance of maintaining health in order to prevent illness. These prevention strategies included not only physical illness prevention, but also spiritual and emotional health maintenance. One key informant (010) stated:

I think being healthy is not being sick. I was sick when I first came to Ohio. My grandson was sick first and then my daughter and then me. We didn't have money and we didn't have a doctor. It took a long time before we all were not sick. I think it was because everything was upset. It's settling down now.

Another key informant (001) described how difficult it is to be a mother and be sick. The pressure of keeping all of the family healthy is increased when mothers get sick.

To me being healthy is like not getting sick. Or like not eating well. I think that is what it means to me. When you are sick you can't keep yourself well or your family. Everything falls apart. You just can't be sick.

The interrelationship of illness and emotional health was also discussed. The emotional and psychological impact of "thinking you are sick" results in being physically sick. A key informant (009) stated:

I don't worry about me. Take a glass of water and drink a lot. That will help. I started feeling sick but its just nervousness. It's all in your head. You've just got to let it go. If you think you are sick it will be really bad but you've got to get up

and not think about it. Healthy also means not being sick. Not thinking bad thoughts.

The spiritual nature of the informants was evident in their descriptions of their valuing harmony and balance. Wholeness was described as maintaining harmony with the overall environment, which also influences health as described by another general informants (014):

Besides being physically healthy and active, it is also about the mind and other aspects of your life. If you are well balanced maybe you will feel good. Even in your environment. Like to me things have to be organized around you. Things must be clean and you must eat the right things and then you have less things to worry about and you feel comfortable about it and you feel comfortable where you are.

A key informant (010) described this as:

I know when I am getting sick. It's when things are crazy. Out of control. Out of balance. I know I just have to stop worrying. I have to let it go. And then I spend time with my daughter and my husband and I think of more important things. Not the worry. And I feel better.

One key informant (012) described how she maintained balance with stresses outside the family and underscored the importance of the role of her mother in this process.

I have a lot of support at home. My mother comes when I am working. She comes from Mexico so I don't have to have a babysitter for my daughter. I think family it the most important thing. I also don't let things get to me. If I feel stressed I just

come home play with my daughter and forget about it. It isn't as important as my family. Nothing is. My mom always taught me to be busy. If you are doing something you don't have time to worry. So that is what I do. I stay busy and think about my daughter.

Informants discussed strategies to maintain health and manage illness that were as diverse and holistic as their concepts of health. While maintaining health through positive thoughts, happiness, activity and wholeness has been discussed in the informant's descriptions of health, nutrition was also identified as important in the mother's role in maintaining health. All key informants and many general informants identified nutrition as a primary means to maintain health and emphasized the importance of the role of mother in maintaining adequate nutrition. One key informant (005) stated:

We like to eat a lot of fruit and fresh vegetables. My son needs to eat more vegetables. It is really something he doesn't like. He doesn't even like beans. To me being healthy is like not getting sick. Or like not eating well. I think that is what it means to me.

Nutritional strategies such as eating natural, fresh vegetables and fruits were noted by many informants. One key informant (012) stated:

My mother and father were very involved in preparing the food. The food was always very fresh and we ate at home. It's healthier that way. You never know what you are getting when you get it off the street. We had a garden and we would all help. It was the best thing.

General informants concurred with the importance of nutrition as fundamental to wholeness with statements such as "I believe that nutrition is most important. You must

have fresh foods, fruits and vegetables and not too much fat” (#024) and, “My family always eats fresh foods, vegetables and fruits. We always have milk, beans, fruits and vegetables with chili sauce. We eat about the same things now as when we were in Mexico but now we have more things available here” (#033).

Another aspect of the mother’s role in the family is *cultural and religious traditions* in the maintenance of the home environment. A key informant (011) described the traditional values associated with the centrality of the home in Mexican life and the mother’s role in maintaining that home, as:

My grandmother would always say keep your home fresh. Keep your windows open and let you home be refreshed. Your home is who you are and always have a clean home and healthy meals and this will bring harmony in your home. I do all of these things in my home. I can’t help it. It is in my blood. It is very important to me that my daughter learns these traditions and carries them on. I really want her to be spiritual like we are.

Key and general informants described multiple options for maintaining the health of their family as well as treating illness. All key and general informants reported the use of some generic (folk) care practices as well as professional care systems. They generally reported that in Mexico their families also utilized both systems, trusting in each. A key informant (004) put it this way.

If we got sick, Grandma would get us ready and take us into the city. Sometimes we would have to walk. There were no buses and sometimes they didn’t have a car. There was a clinic where you didn’t have to pay. But you had to wait too long. If she had the money she would take us to a doctor. Then you had to pay but



you didn't have to wait. But mostly she would take care of us at home. She had many remedies for us like teas and special foods that would make us better. It all helped us.

*Folk care practices* commonly utilized by the key and general informants included medicinal teas, massage, "sweating", physical cleansing rituals, and spiritual cleansing rituals. All informants discussed using these practices for not only themselves but also other family members, including their children. A key informant (011) described her grandmother's folk practices as including "cleansing" not only for illness but also health maintenance:

My grandmother always believed in cleansing. She believed that if you were ill you must first cleanse. She believed that you should never eat meats that are hard to digest when you are sick and she would make this potion of some kind of oils, I don't know the recipe. It would make you go to the bathroom all the time because you were cleansing. Doctors in Mexico say they don't recommend this but it isn't bad for you. But in the U.S. they say no way don't do this, but I do it anyway. What I think it does is keep your digestive system healthy. It doesn't allow food to stay in your system too long. That is bad for you.

Managing fevers often involved the practice of "sweating it out". A key informant (010) described this as:

My mother would wrap us up like there was a snowstorm. Then she would give us really good hot food, like chicken and vegetables. Then she would let us sweat it out. All those viruses and bacteria, whatever, they must come out. You would be

sweating a lot. She would give us fluids the entire time. I can see the logic because it works.

Herbal teas were most frequently mentioned as remedies employed by mothers and grandmothers and continued by the informants with their families. One general informant (014) described the type of teas used in her family traditions as well as other remedies provided by her mother in Mexico.

I always use teas that my mother sends me. I have one that is good for a really bad cough. It has eucalyptus and I add a lot of lemon juice and honey. I also have an extract of aloe vera that is used a lot for cuts and burns. I also have a cream made of honey and an ingredient from the bees wax and it really helps with my sons skin problems from his allergies. My son has never been really sick. The worse he has is dry skins and sniffles.

Another key informant (025) described her mother's use of teas:

My mother would use different types of teas if we were sick. My mother would even give teas to tiny babies if they were sick. She would use chamomile for many things, like constipation or a cough, or just to help us relax. Mint tea was also used to help with stomachaches.

Informants recalled remedies their mothers had used when they were young.

These traditions were often followed through to the next generation. General informant #017 stated described her mother's use of teas and how she continues it with her children:

She would also make some home remedies like teas that would make us feel better. She would make chamomile tea if we had a stomachache. She would also make a garlic lemon tea that would help if we had a cough. It tasted awful. I do

think it is good not to use too much medicine so I go to the store and get special teas they have there for my children. It helps.

One key informant (011) who recalled one of her grandmother's traditions described the use of herbs in ways other than ingestion:

My grandmother had rheumatism and she would grow herbs that she would use. She grew marijuana and would make tea with the herbs. My grandfather would also make compresses with the marijuana and lay them on her legs. Marijuana is not legal in Mexico but I am sure that of the police knew my grandparents grew it for her pain, they would not bother them.

Other remedies that informants continued as adults include the stomach remedy described by general informant (014):

Even for a stomach ache when I was a kid there was something like lard, something that would get really hot, like grease from an animal, and they would rub it on your stomach and I think it would stimulate the intestines. So if you had a stomachache and haven't been able to go to the bathroom you can do this without taking medicine and it would help.

Curanderos were mentioned as being utilized in Mexico, but not in Ohio. It has been reported, however, that there is a curandero in the southwestern Ohio community, but no mention was made of any of the informants utilizing her services. A key informant (001) described her experiences with curanderos in this way:

It is the custom in Mexico to have a curandero, but I am not used to that here. My mother was a curandero and a midwife. Everyone would ask my momma if she was a doctor. I do use herbs that my Momma tells me to if we are sick. I don't

know which ones; my momma just sends them to me. But I would never go to one here. It just wouldn't be the same.

A key informant (003) described her perspective on the use of curanderos as:

We would never go to see a curandero. You know why? I grew up as a Christian and that makes a big difference between being a Catholic and a Christian. It is totally different. It is not the church. It is the people. I think it is the people that behave with saints and it makes it all different. I don't have a word to describe it. But it is just wrong, sometimes. People visit curanderos. Catholic people would be more likely to see the curandero. At least the people I know. We kept away from that culture.

A general informant (013) described the blend of folk remedies and professional systems of care in Mexico, and the role of mother as decision maker in the use of over-the-counter medications, such as antibiotics.

When we had a fever my momma would get penicillin pills from the store. She knew what to do and what we needed. For stomachaches she would make home remedies like cornstarch and lemon. It would help. We would never take pills unless we needed them. She just knew what to do.

Understanding the immigrant woman's expectations of nurses and their utilization of professional systems of care was increased by informants' description of care in Mexico. In several cases, the informants discussed the difference between health care in the U.S. and in Mexico. One general informant (013) described her experience in having a baby in the U.S. compared to Mexico:

There are many differences in having a baby here compared to Mexico. Like in Mexico, I would have to share a room with 4 or 5 other people and there is no security. But here it is like going to a hotel. I have my own room and nobody can kidnap my baby. That was a big worry.

Providing mothers with a safe environment for their children would be one way of helping. Another would be assisting immigrant women, particularly the undocumented immigrant woman with access to needed health care for herself and her children. Several of the informants described their denial of services by several providers, including a rural hospital and a private physician. A general informant (017) described denied access for care of her son:

My little boy was sick and we went to a doctor but the nurses wouldn't let me see the doctor because I didn't have a social security number. So I went to another doctor at a big clinic and had to pay \$85. I always thought in America a doctor was suppose to see you if you were sick. I do not have papers to be here and I don't have a social security number. But my children should not suffer.

Another general informant (014) described her experiences having labor pains and not finding a hospital that would accept her as a patient:

I came here when I was pregnant and I went to the hospital because I thought I was in labor. They would not take care of me because I didn't have a social security number. I went to the first doctor who didn't want to take care of me either. So then I went to the clinic and they would see me but it was far away. When I finally did go into labor, my friend went back to the first hospital and

demanded that they take care of me and they did. It took all of my money though to pay the doctor and the hospital.

Disparity in terms of access to care for undocumented immigrant women is of major concern and nurses are looked to help in these situations. Specific self-care health practices, such as regular pap smears, STD testing, breast self-exam (BSE) and mammography were inconsistently practiced among the informants. Both key and general informants who had insurance and legal documentation were more likely to participate in yearly exams, and had seen a gynecologist. The women without insurance and/or needed documentation had not seen a gynecologist or had regular visits since coming to Ohio. One general informant (028) stated she only sought professional care in Mexico when she visited there. Another key informant (010) stated that women's health services were generally not found to be available or "friendly". A barrier to health care for Spanish speaking women that has been identified in the literature is when they must utilize their own children as interpreters. This is of particular concern when the women seek care for gynecological problems or prenatal care. The Spanish-speaking informants of this study did not identify this as a concern and the English-speaking informants stated they often provide interpreter services for the women who could not speak English. It appears that this community has reduced this barrier through cooperation and community support.

Supporting the multi-dimensional life of the Mexican woman, including the spiritual and emotional dimensions is also identified as part of the helping. The *caring nurse* can demonstrate her support by listening to her as she talks about her thoughts, fears and concerns about herself and her family. A key informant (007) who recently had

a baby also reflected on materials and communications a caring nurse could provide that would be helpful to her and her baby:

I would like to know more about my baby. I want to be sure he is okay. I worry. I want to know about things that would help him. But I ask my sisters and my friends and my neighbors. They don't know a lot. I would like it if the nurse could come to my house and give me ideas on how to take care of my baby. She could have papers that were in Spanish that would help me understand.

Through demonstrations of respect as previously defined, the caring nurse can help by listening and responding to care concerns of the Mexican mother.

In summary, five patterns were discovered through comprehensive analysis of categories of descriptors: components of data derived from transcripts of key and general informant interviews. As listed above, the five identified patterns are: 1) *doing what it takes to support self and family of immigrant Mexican women*; 2) *expected care from nurses by showing interest, respect and support for immigrant Mexican women*; 3) *Avoiding non-caring behavior of disrespect and lack of interest towards Spanish-speaking immigrant Mexican women*; 4) *expected care from nurses who communicate in Spanish*; and 5) *expected care from nurses who help mothers as they care for their family*.

Descriptors and categories in support of these patterns affirm the confirmability and credibility of the study and the meaning-in-context of the findings. As informant responses that reflected the categories were discovered and rediscovered in repeated interviews, saturation was determined. Patterns of culture care were thus identified.

### *Synthesis of Themes*

Utilizing the four phases of ethnonursing research analysis as described by Leininger (1987, 1990, 2002), the researcher identified three major culture care themes derived from the emic and etic data that have been described, categorized, analyzed and synthesized. These include: 1) *immigrant Mexican women value and expect nurses to demonstrate respect for their cultural identity*; 2) *immigrant Mexican women value and expect nurses to support their self-determination and self-reliance as a foundation to care*; and 3) *immigrant Mexican women value and expect nurses to support their role as mother and provider of holistic care to their family*.

*Theme One: Immigrant Mexican women value and expect nurses to demonstrate respect for their cultural identity.*

Theme One was formulated through synthesis of four patterns: 1) *doing what it takes*; 2) *expected care from nurses by showing interest, respect and support*; and 3) *avoiding non-caring behaviors of disrespect and lack of interest towards Spanish speaking immigrant Mexican women*; 4) *expected care from nurses who communicate in Spanish*. From these four patterns, the overarching theme of recognition of cultural identity of immigrant Mexican women was revealed.

Throughout data collection and data analysis, the researcher consistently identified indicators of the importance of cultural identity to the informants. Observations made in the early stages of observation and limited participation had included flags, decals on cars, local festivals, and language patterns all pointing to the importance of “being Mexican”. Understanding the importance of being Mexican continued through interviews with informants recalling their childhood in Mexico and describing the love,



strength and beauty of their country. Identification with their families' commitment to survival through *hard work* was associated with the strength of Mexicans and their cultural heritage of *doing what it takes* for their families. Emphasizing the importance of *cultural and religious traditions* and *folk care practices*, informants stressed the need for nurses to acknowledge and support them. It is through the remarkable strength of their cultural identity that the informants are able to further develop the self-reliance necessary to live in their new world. The pattern of *expected care from nurses who communicate in Spanish* reflect the importance of respect for language as a component of cultural identity and the importance of support for language, especially nurses attempting to speak Spanish.

When describing their interactions with nurses, the informants who were more fluent in English recounted positive relationships when nurses demonstrated respect. In describing the kind of nursing care they desired they revealed the care giving actions of nurses who acknowledged and respected their culture. These actions also demonstrated the nurses' respect and acknowledgement of informant and family. Informants went on to describe their experiences with nurses who were not caring and whose actions demonstrated a lack of interest in them. These actions signified lack of respect for the immigrant Mexican woman. Understanding this important value of respect for cultural identity is foundational for culturally congruent nursing care and will be further examined and applied in Chapter Five.

*Theme Two: Immigrant Mexican women value and expect nurses to support their self-determination and self-reliance as a foundation to care.*

Theme Two was formulated through synthesis of three patterns of: 1) *doing what it takes*; 2) *expected care from nurses who communicate in Spanish*; 3) *expected care from nurses who help mothers as they care for their family*. The strength, self-determination and self-reliance of the informants were clearly revealed in the pattern *doing what it takes* for their family and engaging in the brave enterprise of leaving family and social supports in Mexico to work in the fields of Ohio to provide for their children. As the researcher analyzed and synthesized the categories derived from the data, the influence of language on the informants' ability to provide was revealed. From the pattern of *expected care from nurses who communicate in Spanish*, the researcher came to better understand that language represented many different things to the informants. Continued use of the Spanish language in the home underscored the importance of "being Mexican" to the informants, yet they also acknowledged the importance of English as a means to secure increased security and opportunity.

The researcher also identified the pattern of the *expected care from nurses who help mothers as they care for their family* to be very important to the informants. Due to the central position being a mother holds for the immigrant Mexican woman and their commitment to that role, the immigrant Mexican woman dedicated herself to maintaining the health of the family. In their interactions with nurses, the informants found that it is of extreme importance to be able to "speak" to nurses, because they believed nurses have important and needed information to help and care. This information provides support for their self-determination and self-reliance, important cultural values. Informants also described the negative impact of language barriers on interactions with nurses and their desire for nurses to speak their language. This expectation also reflected the informants'

value of their cultural identity and the importance of acknowledgement of this identity by nurses.

*Theme Three: Immigrant Mexican women value and expect nurses to support their role as mother and provider of holistic care to their family.*

Theme Three was formulated through synthesis of three patterns: 1) *expected care from nurses who help mothers as they care for their family*; 2) *expected care from nurses by showing interest, respect and support for immigrant Mexican women*; 3) *avoiding non-caring behaviors of disrespect and lack of interest towards Spanish-speaking immigrant Mexican women*. In keeping with this study's domain of interest, culture care, the researcher sought to discover informant beliefs and values regarding health and well-being, including what they actually did to care for themselves. As data were collected through the interviews, it was consistently found that the informants, all mothers, would describe how they cared for their children or how their mothers cared for them. They were unwilling to talk about how they took care of themselves. The influence of the role of mother is so great, that it provides the focus for all care activities of the immigrant Mexican women. Every aspect of the world of these women is influenced by their role as mother, including their decisions to move to Ohio and work as migrants and their operational definitions of health and well-being.

As they discussed their expectations of nurses with regards to health care, informants stressed the importance of nurses understanding their focus as mothers and supporting them in that role. It was found that the informants value and need nursing support, particularly in areas of infant and childcare. As noted above, these values and needs are intensified due to the informant's separation from family and other social

supports in Mexico. As informants developed increased reliance on themselves and local resources, their need for health information and services provided by nurses became even more important. Several of the informants were new mothers, living thousands of miles from their own mothers, their primary source of traditional and folk care information and help. Informants voiced their hope that nurses could support them as they build their confidence in their own abilities as mothers.

In summary, the three identified themes are: 1) *immigrant Mexican women value and expect nurses to demonstrate respect for their cultural identity*; 2) *immigrant Mexican women value and expect nurses to support their self-determination and self-reliance as a foundation to care*; and 3) *immigrant Mexican women value and expect nurses to support their role as mother and provider of holistic care to their family*. These themes reflect the culture care values, patterns and practices of immigrant Mexican women and serve as a foundation for culturally congruent nursing practice.

The three research questions posed by this study were answered through the informants interviews. The data was collected using the Interview Guide that focused on obtaining information regarding the informants description of health and well-being, practices used to maintain their health and what the informants needed from nurses in doing so. The information gathered through both key and general informant interviews was rich and detailed in the areas of health, folk practices and caring and non-caring actions of nurses. The details of these “answers” has been described in the identification of the categories health and well-being; folk practices; caring and non-caring nurses. The following is a summary of the data collected that address each research question.

Research Questions 1: How do immigrant Mexican women in a rural setting describe health and well-being?

The informants of this study included well-being as part of health. They described health as being happy, active, living a whole, spiritual life.

Research Question 2: What are the practices used by immigrant Mexican women that promote health and well-being?

The informants described a variety of both folk and professional care practices that they have learned from their mothers and grandmothers that promote their health. All informants were mothers and all addressed health in terms of their family. The description of the varied practices are included in Chapter Four in the section *Pattern Five: Expected care from nurses who help mothers as they care for their families.*

Research Question 3: What do immigrant Mexican women identify as needs from nurses to assist them promote attaining and maintaining their health and well-being?

The informants articulated a variety of expectations of nurses to assist them promote their health and their families. The three themes of this study are conceptualizations of how nurses can assist and support the immigrant Mexican woman in maintaining their health. These themes will be further discussed in Chapter Five.

The immigrant Mexican women of this study consistently identified their cultural identity, strength, self-determination and self-reliance as important supports for themselves and their families. They sought support from nurses in the care of their families and offered recommendations of how nurses could assist them in these efforts. In

Chapter Five further explication of the themes and their application to the nursing practice, education, administration, research and theory will be discussed.

## V. DISCUSSION AND RECOMMENDATIONS

### A. Introduction

The purpose of this ethnonursing study was to understand the culture care meanings, expressions, patterns and practices of immigrant Mexican women living in a rural community in Ohio. Through the process of data collection and analysis described in Chapter Four, nine categories, five patterns and three themes emerged from analysis of the data. The nine categories of 1) *cultural and religious traditions*; 2) *folk care practices*; 3) *good thoughts*; 4) *hard work*; 5) *communications*; 6) *role of the mother in the family*; 7) *health and well-being*; 8) *caring nurses*; and 9) *non-caring nurses* were identified from data derived from multi-level analysis of the informant interviews. Further analysis and interpretation led to discovery of the five patterns: 1) *doing what it takes to support self and family*; 2) *expected care from nurses by showing interest, respect and support*; 3) *avoiding non-caring behaviors of disrespect and lack of interest towards Spanish speaking immigrant Mexican women*; 4) *expected care from nurses who communicate in Spanish*; and 5) *expected care from nurses who help mothers as they care for their family*.

These patterns were then synthesized and expanded to provide three overarching themes that answer the questions posed by this study: 1) *immigrant Mexican women value and expect nurses to demonstrate respect for their cultural identity*; 2) *immigrant Mexican women value and expect nurses to support their self-determination and self-reliance as a foundation to care*; and 3) *immigrant Mexican women value and expect nurses to support their role as mother and provider of holistic care to their family*. These

themes are grounded in the emic data collected and carry with them the voices of the immigrant Mexican women interviewed.

A pictorial model was developed to clarify these findings. Figure Three depicts the two dimensional relationships described in these findings between the immigrant Mexican woman and the nurse.

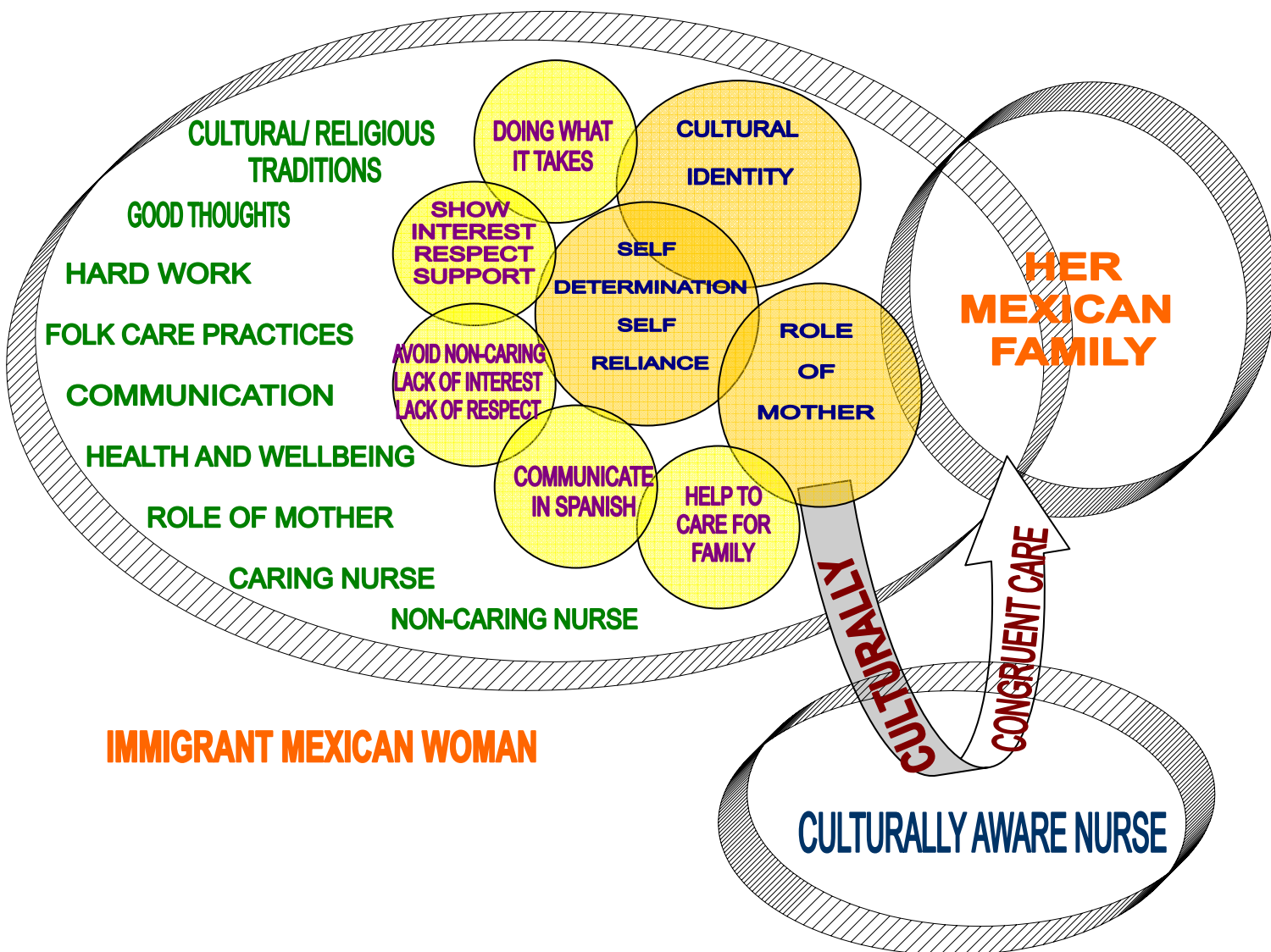


Figure 3: Culture Care Practices of Rural Immigrant Mexican Women



The central oval titled *Immigrant Mexican Woman* contains within it the categories, patterns and themes of culture care meanings and practices explicated from the emic data ascertained from the interviews. The categories are fundamental, repetitive reflections expressed by the immigrant Mexican women in response to interview questions and discussions with the researcher. These nine categories of 1) *cultural and religious traditions*; 2) *good thoughts*; 3) *hard work*; 4) *folk care practices*; 5) *communications*; 6) *health and well-being*; 7) *role of the mother*; 8) *caring nurses* and 9) *non-caring nurse* are the beginning emic representations of culture care constructs.

Patterns emerged from on-going interviews and interactions and represent a further understanding of the relationships between these care constructs. These include the five patterns of 1) *doing what it takes to support self and family of immigrant Mexican women*; 2) *expected care from nurses by showing interest, respect and support for immigrant Mexican women*; 3) *avoiding non-caring, disrespect and lack of interest from nurses to Spanish-speaking immigrant Mexican women*; 4) *expected care from nurses who communicate in Spanish*; and 5) *expected care from nurses who help mothers as they care for their family*. Though overlapping in their components each pattern represents a distinct pattern of culture care. The interactions of the patterns and the resulting synthesis created three themes. These interactions are displayed in overlapping circles of patterns with each other and with themes.

The third theme, *immigrant Mexican women value and expect nurses to support their role as mother and provider of holistic care to their family*, is represented with interlinking ovals with Her Mexican Family. This represents the prominence of the family in the life of the immigrant Mexican and includes not only the women's children

and husband, but also the family they left in Mexico, including their parents, grandparents, compadres, and other family and friends.

The depiction of the linkage between the Immigrant Mexican Woman and the nurse is presented with a semi-circular arrow labeled *culturally congruent care*. This represents the linkage between the culture constructs and desires of the immigrant Mexican women with the culturally aware nurse. The nurse prepares herself through a deliberate process of cultural awareness and expansion of appropriate cultural knowledge to become the culturally aware nurse. Through exchange of cultural perspectives and experiences the nurse can, in return, provide culturally congruent care in support of the immigrant Mexican woman and her family.

In this chapter each theme will be discussed and explicated using quotations from informants' interviews. Each theme's value and application to nursing practice, education, administration and research will be discussed. Recommendations are made regarding each theme as well as a discussion of future research in the areas of migrant and immigrant health, immigrant family health and transcultural nursing.

#### B. Theme One

*Immigrant Mexican women value and expect nurses to demonstrate respect for their cultural identity.*

As noted in Chapter Four, cultural identity emerged as the dominant value that influenced informants' culture care practices and definitions of health. Acknowledgement of cultural identity was consistently articulated as important in nursing care provision through the demeanor and presentation of professional self of nurses. All key and general

informants described the importance of being acknowledged as Mexican through recognition of the particular values and qualities of their cultural identity.

Data were gathered initially using the OPR processes of researcher observation and gradual participation within the community of immigrant Mexicans described in this study. Through such observations, the researcher identified salient examples of cultural identity within the community. Mexican flags and other displays of Mexican culture are visible in the homes and automobiles of many of the residents. Once interviews began, the researcher was able to observe further examples of Mexican cultural identity within the homes of all informants. Pictures of locations in Mexico, colorful blankets adorning furniture, and vases and other pottery from Mexico were displayed in living rooms and kitchens of the informants where interviews typically took place. Emic data were gathered through key and general informant interviews during Phase I. Informants' practice of speaking Spanish in the home and calling themselves Mexicans or Chicanos, informed the researcher of the continued deep importance of connection with Mexico. Coming to begin to understand this connection significantly informed the researcher's interpretation of details of the lives of the informants.

Identity drives the power of culture and is the source of meaning and experience. The "power of identity" is a cultural construct maintained by people of a culture (Castell, 1985). Morley (2000) found that Mexican migrant laborers adapted to their changing environments by further developing a strong sense of cultural identity. This focus on cultural identity provides a sense of "being" that allows migrant Mexicans to shape their world in ways that are meaningful to them, despite external realities incongruent with their values. Garza (1998) found that, in connection with culture and homeland, the

Mexican experience was more focused on their cultural identity than any other migrant group. The informants of this ethnonursing study revealed this same strong sense of connection to Mexico. They demonstrated the strength of this connection in their homes, language and positive and optimistic outlook on life.

Language, as an aspect of cultural identity, was described as important by informants and must not be underestimated by nurses caring for Mexican women. Their choice to continue the use of Spanish in their home and community is not one of defiance, as often thought, but one of cultural connection. Informants consistently identified cultural identity as very important in their life and their ability to maintain their health and well-being. Research has shown that Mexican immigrants persist longer than other immigrants in the use of their native language (Friedman, 1998). Garza (1998) also found that Mexicans see language as both symbolic and practical in providing a cultural link to Mexico. Both key and general informants of this study demonstrated a pattern of continued use of Spanish in the home. Despite expressing the value of speaking English as a means to increased opportunity, the majority of the general informants and one third of the key informants spoke only Spanish. This connection to their native language supports Garza's premise that language is more than a practical issue. It is fundamental to cultural identity. Understanding this important point is essential for nurses and other care providers who seek to offer quality care.

The four patterns supporting this theme focus on: *ways immigrant Mexican women do what it takes to take care of themselves and their family; ways nurses can demonstrate their interest, respect and support of immigrant Mexican women; avoiding*

*non-caring behaviors of disrespect and lack of interest towards Spanish speaking immigrant Mexican women; and expected care from nurses to communicate in Spanish.*

The first pattern, *doing what it takes to support self and family of immigrant Mexican women*, was revealed from the descriptors and categories of interview data that reflected the underlying strength, determination and hard work of immigrant Mexican women. Most of the informants had at one time or another been migrant workers and, as such, had left loved ones behind in Mexico in order to work in the fields of a foreign land. They did so in order to provide opportunity and economic stability for their families. For undocumented women, this meant extremely dangerous border crossings and other physical hardships. The undocumented women were reticent to talk about their experiences. The researcher hypothesizes that this is due to their reasonable fears of deportation if discovered by the Immigration and Naturalization Service (INS). Research findings in this study regarding the experiences of informants making illegal entry into the U.S. are, therefore, incomplete.

Considering these hardships, the informants that were undocumented displayed astonishing strength and resolve in coming to the U.S. and working in the fields or factories to care for their families. Immigrant Mexican women consistently described the importance of determination and self-reliance in words that reflected their inner resolve. Phrases such as “be smart about life”; “work to survive”; and “do what it takes” are reflective of the courage and strength displayed in their stories. Informants consistently detailed aspects of their lives in Mexico as happy and family oriented, but devoid of financial opportunities. Categories that identified this strength and determination are: *cultural and religious traditions; folk care practices; hard work*. These categories

described a family heritage of hard work: many informants were from families with generations of migrant workers. This dedication to providing for families despite personal hardships was extremely clear to the researcher. It continues in the lives of the informants in this study.

Descriptors of these categories surfaced in all key informant interviews. Without exception, all informants left Mexico for increased economic opportunity, but in so doing, all left behind a major part of their support system, their family. Many of the key informants reported returning frequently to Mexico to visit family. They did so to better cope with the day-to-day loss. For the undocumented informants this was an insurmountable hardship. Because of fear of deportation or the inability to return, undocumented informants reported not seeing their mothers or fathers for many years. Again, the strength to continue to live outside their homeland, and suffer the loss of their family, supports the importance of self-determination and self-reliance for the informants.

The informants' strong connection with other Mexicans in their community was also revealed as culturally importance. Despite being separated from traditional systems of support (their Mexican family), the informants supported those in need in a variety of ways. By assisting with childcare or translating the informants demonstrated their concern and support for others. This is demonstrated by comments regarding members of the Mexican community as "would do anything; give money, give time, give rides without question" if someone was in need.

Regarding the importance of spiritual, physical and emotional dimensions of life, one informant described living in Mexico: "There is a difference in terms of the spiritual, religion, nature; a whole life." The informants views of Mexico as a place that met all

their needs as children reflects on the difficulty they experience being so far away. The way the informants “deal” with this loss of homeland is by focusing on their cultural identity and traditions. This valuing of cultural and religious was found in many informant comments regarding the care provided by their mothers and spiritual and religious celebrations that are important and must be passed on to their children. Culturally and religious traditions as a category was identity in each of the five patterns reflecting this importance.

All informants described the practice of continuing use of Spanish in the home. The prevalence of this practice has been well established in the research literature, and confirmed by practices in this community. Comments such as “I learned English because my mother said it was important for me to learn English. But she didn’t learn English” reflect the practical as well as the symbolic importance of language experienced by the informants, and the cultural identity language provides.

The second pattern, *expected care from nurses by showing interest, respect and support for immigrant Mexican women*, follows from informant observations of how important it was for nurses to support the traditions of their culture, particularly during times of celebration such as the birth of a child. The categories of religious and cultural traditions, hard work, and caring nurse were foundational in understanding this pattern of care.

All of the informants were mothers and several had recently given birth in Ohio. Their experiences with nurses in both emergency departments and obstetrical services were prominent in their discussions of nursing care that was supportive. Informants stressed that nurses must understand the importance of following the traditions of the

client's culture during these important times. The category of religious and cultural traditions was derived from informants' descriptions of both the importance of women passing these traditions on to their children as well as nurses supporting the women in doing so. Understanding and acknowledging the importance of traditions in the lives of immigrant Mexican women, such as the first earrings and having family present during times of need, is critical if nurses hope to provide culturally competent care.

Within the category of caring nurse, informants described their desire for nurses to support their cultural identity by making eye contact and speaking on first meeting; smiles; showing an interest in their lives; and listening and taking time with them. In many cases the informants described supportive, caring nurses. Informants who spoke English, as well as those that did not, identified disparities between the care English speaking informants received compared with the care received by informants who did not speak English. All English-speaking informants described receiving attention from nurses that was compassionate in provision of care to them or their family. Specific verbatim responses that reflect these perceptions have been cited above. Non-English speaking informants described very different experiences with nurses, including nursing behaviors of non-caring, such as showing disrespect and disinterest. The researcher was struck by the intensity of feelings of the informants who had had such experiences, and pursued questioning key informants about these feeling. Their responses led to identification of the third pattern.

The third pattern, *avoiding non-caring behaviors of disrespect and lack of interest towards Spanish speaking immigrant Mexican women* reflects the categories of *hard work, non-caring nurses* and *communications* which were integral to understanding this



pattern. Non-caring actions include: treating non-English speaking women differently to English speaking women; acting with frustration when speaking with a non-English speaking woman; and ignoring and walking away while a non-English speaking woman is speaking. Either from first hand experience as a non-English speaking woman or as an interpreter for non-English speaking women, both key and general informant cited experiences with nurses where disrespect and disinterest were the norm. The verbatim accounts noted in chapter four consistently reflected the pain and harm to informants caused by such behaviors.

The fourth pattern, *expected care from nurses to communicate in Spanish*, again underscores the multidimensional importance of their own language to immigrant Mexican women. Not only is Spanish the primary language of their families in Mexico with whom they want to be linked, but also, as Sapir (1949) points out, language forms thought and reality, fundamental dimensions of culture. Nurses must at least attempt to communicate in Spanish in order to demonstrate their respect for the importance of this aspect of culture, and thereby support immigrant Mexican women's cultural identity. Even a stumbling attempt to communicate in Spanish will better connect the nurse with a Mexican immigrant woman.

By understanding underlying cultural values and beliefs, and their importance in providing stability in the life of the immigrant woman, nurses can increase their appreciation of every dimension of the culture of immigrant Mexican women, including the social supports, family structure, health and illness practices, language and traditions. Through such knowledge the nurses can avoid non-caring behaviors and implement

improved communication and more informed care giving strategies when working with immigrant Mexican women.

Theme one focuses on the importance of cultural identity and patterns of care that support this identity. It provides nurses with a foundational understanding of culture care meanings of immigrant Mexican women that include values of cultural identity, determination, self-reliance, and effective communication with nurses that result in care patterns that unite the nurse and the immigrant woman in a culturally congruent relationship. Through this relationship, the nurse can integrate the traditional cultural, religious and folk practices within the professional system of care and, through mutual respect and trust, work with immigrant Mexican women to meet their health goals and those of their family. Applications of this theme to nursing practice, education, administration and research are addressed below.

### C. Theme Two

*Immigrant Mexican women value and expect nurses to support their determination and self-reliance as a foundation to care.*

As mentioned above, the strength, determination and self-reliance of immigrant women is grounded in their cultural identity, language, traditions, folk practices and connections with others. The three patterns that reflect these characteristics are : 1) *doing what it takes*; 2) *expected care from nurses to communicate in Spanish*; 3) *expected care from nurses includes helping mothers as they care for their family*. For many the migrant experience has required immigrant Mexican women to adapt their support systems in order to maintain their health and well-being and that of their family. These adaptations

reflect the pattern of *doing what it takes* and have shifted their reliance on family and compadres to reliance on themselves and their own hard work. This pattern of care appears to differ from experiences of other Mexicans in the U.S. Previous cultural research studies involving Mexican Americans have described *succorance*, the cultural value of providing direct care to family and to support others as one of the prominent cultural values of by Mexican Americans (Leininger, 1991; Villarruel & Leininger, 1995). While informants clearly experienced support from family when living in Mexico, separation from these supports has necessitated adaptation in different ways. While succorance continues to be a cultural value, it does not appear to be as prominent.

The researcher hypothesizes that such a pattern is different due to the contextual difference between living as a migrant and living as a Mexican American in communities in the U.S. The majority of this study's informants have strong family backgrounds of migrant work. Migrant worker informants had grown up within families that separated parents from children and, in many cases, from extended family members. This living and working arrangement no doubt changed the social and family structure within these families as compared to Mexicans who lived in communities in which extended family members and compadrazgo were present. Informants described their lives in Mexico within communities that provided the important cultural values of the compadrazgo system and familismo that together provide a safety net and substantial aid in times of crisis (Kemp, 2001; Purnell & Paulanka, 2003; Zoucha & Reeves, 1999). Yet, their lives in Ohio were more focused on their own ability to support their families through the use of networks, language and support from others, including nurses. These contextual differences perhaps explain the unique pattern of increased reliance on self.

Increased reliance on communications and networks within their community becomes even more critical for non-English speaking immigrant Mexican women. Being able to communicate within their community, particularly regarding their family's health, is a critical factor in meeting their needs. The patterns of *expected care from nurses who communicate in Spanish* describe this interdependence of communication and self-reliance. The category of communications stresses the need for nurses to speak the language of their clients, including making every attempt to demonstrate respect and interest in their clients. Specific descriptors that were instrumental in defining this category and pattern include; learn Spanish; use interpreters; develop translated information. Verbatim accounts of informant interviews presented in previous discussions support the importance of communications particularly with clients who do not speak English.

Lack of language supports for the non-English speaking immigrant within U.S. health care systems puts a strain on their network of support and can result in increased risk for the family system. Nurses must understand the implications of the lack of language supports within health care systems and act responsibly by building these supports in themselves by learning the language; utilizing interpreters or interpreter systems; and supporting the development of translated materials that clients may need to provide care to their family.

Informant's described their ability to "make it" in Ohio as grounded in their ability to communicate with others. Never was this more important to informants than in their role as mothers accessing professional health care systems for their families. Informants described nurses who speak Spanish as central in caring, reflecting the

importance of communication in supporting self-reliance. Several nurse researchers found this pattern of response from people of Mexican heritage. Zoucha (1998) found that Mexican Americans believe communicating in Spanish with nurses is essential for care to be personal and friendly. This study supports that finding, and, additionally, finds that by doing so nurses can reinforce client values of determination and self-reliance.

Several key informants mentioned the absence of interpreters in local hospitals and other provider practices. It is much more common for the informants to use other family members, including their children and friends, for interpreter services. Generally informants did not think this was adequate, particularly in the case of using their children as interpreters. Two general informants mentioned their discomfort in using their children to interpret when the informant needed to see a health provider, particularly for women's health concerns. For this reason, two general informants mentioned they did not access health care in the U.S. and saw physicians in Mexico when they returned for visits.

Key and general informants gave useful recommendations regarding the development of tools that can be used to communicate with non-English speaking people, both in emergency departments and in other hospital units. A general informant (014) described the use of pain rating scales with pictures and charts with common phrases and pictures of symptoms as helpful to immigrant Mexican women. This same general informant questioned the reliability of translated materials and recommended that hospitals and other providers re-look at their consents and other important translated forms that were unintelligible due to the misinterpretation of Spanish words.

This second theme focuses on the importance of determination and self-reliance of immigrant Mexican women. These important qualities have sustained the informants

through the difficult immigration process, settling down to live in a culture outside their own, and managing separation from family support systems. Nurses must support these adaptations through actions that help informants meet their family's health care needs. These actions would include nurses speaking Spanish and nurses providing interpreters, accurately translated materials and other tools to facilitate communication between non-Spanish speaking nurses and non-English speaking Mexican women. The consequences of not supporting the immigrant woman's determination and self-reliance are negative health outcomes for themselves and their children.

#### D. Theme Three

*Immigrant Mexican women value and expect nurses to support their role as mother and provider of holistic care to their family.*

This theme was synthesized through the patterns: 1) expected care from nurses include helping mothers as they care for their family; 2) expected care from nurses by showing interest, respect and support for immigrant women; 3) avoid non-caring behaviors of disrespect and lack of interest toward Spanish speaking immigrant Mexican women.

The research questions of this study explored: 1) how immigrant Mexican women in a rural setting described health and well-being; 2) what practices are used by immigrant Mexican women that promote health and well-being; 3) what immigrant Mexican women identify they need from nurses to assist them promote, attain and maintain health and well-being. The informants described health as having physical, psychological, emotional and spiritual dimensions. They described a variety of both folk

and professional practices that assist them to maintain their health, but more emphatically how they maintain their family's health.

Informants from this study largely point to mothers as the primary source of a family's health traditions, including integration of folk and professional care systems. All informants described their mothers as the primary provider of health care in their family and their primary source of health information. Additionally, the informants were all mothers and identified provision of care to their children as their personal responsibility. For the informants, this often meant acting without their culture's traditional system of support, the extended family. Due to their immigration to Ohio, informants were cut off from the supports with which they grew up. The loss they now grieve.

This reflects the research findings of this study described in the pattern, *expected care from nurses includes helping mothers as they care for their family*. Inherent are the components of mother as the primary care provider in the Mexican family, and nurses who can provide help to mothers in providing this care. Mothers were described as very significant in both health promotion and illness care of family members. Both key and general informants described interactions with nurses that were supportive of their role as mother. Unfortunately, they also described interactions with nurses that were unsupportive. Identified categories that support the importance of the role of mother include: *mother's role in the family; health; and folk practices*.

Instrumental in defining the category of *mother's role in the family* is an understanding of the importance of living a family focused life in which the mother is the center of the home. A mother's role has been described as teacher of cultural traditions provider of health maintenance and illness care using folk practices, and health care

decision maker for family members. Nurse researchers have previously identified the importance of women and specifically mothers in the health of the family (Higgins & Learn, 1999; Warda, 2000). This study supports those findings and emphasizes the need for culturally congruent nursing care, which recognizes the separation of immigrant Mexican women from traditional support systems created by the process of immigration.

The second category in support of this pattern is *health*. As interview data were compiled, descriptors of components of health were developed. Key phrases such as “healthy means being happy” and “healthy means being active” were often heard. Dimensions of health also extended beyond physical health to encompass spiritual and emotional elements. Not only were these important descriptors of health, but also important elements of health promotions. Phrases such as “if you think you are sick you will be sick” were heard as well as “healthy means being whole.” A general informant (014) said “besides being physically healthy and active, it is also about the mind and other aspects of your life. If you are well balanced maybe you will feel good.” Being happy, reflecting emotional health; being active, reflecting physical health; being whole, reflecting spiritual health summarizes the key informants’ definition of health. This definition of health was discovered to be the foundation of health promotion and illness care activities described by informants. The immigrant women’s fundamental health value is the maintenance of a stable world, grounded in happiness, peace, activity, natural food and spiritual wholeness. For many of the informants, particularly the undocumented women, this stability was hard to achieve.

The third category in support of this pattern is *folk practices* that describe the importance of nurses supporting the culture care practices of immigrant Mexican women



by integrating their traditional folk practices with professional systems of care. Many folk practices were described as significant in the life experiences of the informants. Many of the informants continued some of the folk practices they recalled from their childhood. All informants voiced respect for their mother's effort to support their health as children, and the advice they gave. In many cases the informants continue to get advice from their mothers via the telephone. Many of the informants voiced loss of having their mother and other family members as supports. This loss is an important factor influencing the urgent need for culturally congruent nursing care provision when working with immigrant populations. The effect of loss of one's country on new immigrants has yet to be fully explored. Many of the informants were young mothers, thousand of miles away from their family, especially their mothers who they described as their primary support.

Informants also described nurses as important sources of information, particularly regarding care of babies and children. In the pattern, *expected care from nurses by showing interest, respect and support for immigrant Mexican women*, the informants described the type of care they required from nurses in order to meet their needs. They described how the nurse could show interest in a variety of ways, including smiling, making eye contact, listening and responding in Spanish if possible. They also described in the pattern of *non-caring* how nurses show lack of interest with Spanish speaking women in ways that cause harm and pain. Often informants sought information from nurses, only to be disappointed due to nurses' inability to communicate with them. This basic ability to communicate is foundational to the provision of nursing care. In order to provide the needed support for the important role of mother in the immigrant Mexican community, nurses must actively address the gap in communications between Spanish

speaking clients and health care providers. Nurses must demonstrate respect for the cultural identity, determination and self-reliance of immigrant Mexican women through their development of systems of communications that support the role of mother and provider of care to the family. Only then will nurses be able to support the immigrant Mexican woman and her family in ways that are culturally congruent and maximally therapeutic.

These three themes reflect the synthesis of research findings through research process developed by Leininger (1991). These themes describe the culture care of immigrant Mexican women in a small rural community. They reflect the strength and self-reliance developed by these remarkable women as they move through different geographic and cultural landscapes, seeking safety, security and relative prosperity for themselves and their children. Often learning from their parents who similarly traveled before them, they have negotiated huge cultural barriers in order to live and work in America; a land they associate with opportunity for their children. While they look to those around them, including nurses, to provide support in this transition to a new world, they may often find barred doors, unintelligible words and unhearing ears. Yet, immigrant Mexican women remain hopeful and positive, ready to engage in the process of cultural exchange with nurses necessary to meet their expectations of their role as mother. Making safe passage in this new world, particularly as it relates to health promotion and illness care for their families, is vital to the immigrant Mexican woman. Nurses who understand this, achieved through the process of increasing their own cultural awareness and knowledge, can be competent partners and competent nurses. In the following sections, specific recommendations are made that can improve nursing

practice in relationship to the provision of culturally sensitive and congruent care. Through shifts and re-patterning of nursing practice, education, administration and research these goals can be achieved. Optimal care may then be better assured not only for immigrant Mexican women but also for all immigrants entering a world of new opportunity.

#### E. Application to Nursing Theory

The philosophical and methodological underpinning of this qualitative nursing research study is Leininger's Culture Care Diversity and Universality Theory and the ethnonursing method (Leininger, 1991). Leininger states that culture is a universal phenomenon which encompasses the learned values, beliefs, patterns of behavior and life ways of any particular group of people (Leininger, 1991). This theory was developed through research studies conducted over 40 years involving over 87 cultures (Zoucha, 1998). Care constructs have been developed through Leininger's work and enhanced by the work of many other nurse researchers. In particular, several nurse researchers have focused their ethnonursing studies on Mexican culture and have revealed emic culture care values for Mexican Americans (Leininger, 1978; Stasiak, 1991; Zoucha, 1998). None have focused on immigrant Mexican women living in rural communities.

In this study, conceptualization of culture care of immigrant Mexican women was achieved through the rigorous implementation of the ethnonursing design previously described. In order for this study to impact on nursing practice, education, administration or research, confidence in the findings must be established. This was achieved by meeting the criteria of credibility, dependability, confirmability and transferability of the

findings (Lincoln & Guba, 1985). Credibility of the findings was determined by the researcher's prolonged engagement of over three years in the community, and the attention given to on-going observation and interviewing throughout the periods of data collection and analysis. This prolonged process allowed the researcher sufficient time to develop an in-depth understanding of the components of culture and of language. It also provided the opportunity for researcher and informants, particularly key informants, to build trust and establish rapport.

The process of on-going interviewing with key informants throughout the analysis also provided the researcher a mechanism to test for misinformation and distortions. Lincoln and Guba identified this process as the most important technique to establish credibility. Patton (1990) stated that researcher credibility in qualitative studies is of the utmost importance as the researcher is the primary data collecting instrument and the creator of research findings through their analytical process. Well-defined and tested data collection and data analysis processes were utilized to increase the credibility of the findings. The credibility of the researcher is well established in that she has worked as a family nurse practitioner and nursing educator for more than five years in the three communities of record. Through these two roles the researcher worked closely with clients and providers and had knowledge of the local community.

The dependability and confirmability of the research findings were established through an interactive process of scrutiny of the data and relevant supporting documents between the researcher and the researcher's doctoral faculty advisor. Through this process, agreement around the categories, patterns and conceptualization of themes was achieved, and the data found to be relevant and confirmable.

In qualitative research, external validity cannot be specified by the researcher. The applicability of the study's findings can only be established by the consumer of the research. Through the description of research findings using direct quotations from informant interviews and rich description of the research setting and context, those interested in the domain of the study can determine its applicability and transferability of findings. In this study the use of direct quotation from informants explicating the identification of categories, discovery of patterns and creation of themes supports the application and transfer of this study's findings to other settings and contexts.

In this study, the culture care constructs of respect for cultural identity, self-determination and self-reliance, and support for the role of mother, as described by immigrant Mexican women, are important to Leininger's theory because they have the potential to provide a means to explain and predict health outcomes for immigrant Mexican women as they receive culturally congruent care from nurses. The informants of this study clearly stated that, if respect for cultural identity and support for self-determination and self-reliance is present in the nurse-client relationship then effective health promotion and illness care for immigrant Mexican women and their families can take place. They also said that, if there is a lack of attention and disrespect within the nurse-client relationship, then no health promotion and illness care can occur. The predictive value of these findings and the specific recommendations for nursing practice, education, administration and research are outlined in the following sections.

## F. Recommendations for Nursing Practice

As the researcher found, care provided to immigrant Mexican women by nurses is not perceived as fair or equal, particularly to those women who do not speak English. Nurse researchers have reported disparities in health and unequal distribution of health care based on cultural difference (Duffy, 2001). Lack of cultural knowledge and sensitivity displayed by nurses providing care to clients from cultures with which they are unfamiliar has been identified as one reason for this disparity (Duffy, 2001). With increased globalization, nurses are faced with increasing numbers of clients from cultures other than their own. In this study informants described behaviors of nurses that reflect their lack of knowledge and sensitivity to difference. Only through increasing their own level of cultural awareness and knowledge of culturally competent care will nurses be able to impact on these health disparities, and improve the quality of care they provide.

The three themes of culture care identified in this ethnonursing research study reveal cultural knowledge that must be examined by nurses and incorporated into their practice. Leininger (1991) described three predictive modes of care that define nursing care decisions and actions, and can guide the provision of culturally congruent nursing care. These three modes are culture care preservation and maintenance; culture care accommodation and negotiation; and culture care re-patterning and restructuring. *Culture care preservation or maintenance* is defined as those professional actions or decisions that help people of a particular culture retain or preserve the relevant care values to they can maintain their health, recover from illness or face death (Leininger, 1995). *Culture care accommodation or negotiation* refers to supportive professional actions or decisions that help people of a particular culture adapt to or negotiate with others for beneficial

health outcomes (Leininger, 1995). Culture care re-patterning or restructuring are those assistive professional actions and decision that help people of a particular culture modify their lifeways for beneficial health outcomes (Leininger, 1995). For the researcher, cultural re-patterning was also defined as actions taken by nurses to modify their own perceptions, knowledge and skills for beneficial caring relationships with people of a particular culture.

Nurses caring for immigrant Mexican women must acquaint themselves with these modes in order to strengthen their skills and abilities in providing quality care to culturally diverse clients. Examples of how nurses can utilize these predictive modes in provision of nursing care to immigrant Mexican women are given in the following discussion of the themes.

#### *Theme One*

*Immigrant Mexican women value and expect nurses to demonstrate respect for their cultural identity.*

Theme One demonstrates the importance of cultural identity to the informants, and their high valuation of nurses who demonstrate respect for that identity. Both key and general informants described caring nurses as those who acknowledge the importance of cultural traditions, native language and behavioral demonstrations of respect to immigrant Mexican women. Immigrant Mexican women face many challenges as they seek financial security and stability for themselves and their families. Separated from the family members who serve as major support systems, these women are many times forced to rely solely on their own strength and self-determination. Cultural identity provides immigrants with a personal power base from which to build a secure life for

themselves and their family. Nurses must understand this dynamic and do all they can to communicate to immigrant Mexican women their respect and support for their cultural identity.

Culture care preservation and maintenance refers to assistive, supportive, facilitative and enabling nursing actions that help preserve or maintain culture care values. These care values must be preserved or maintained in order to support the health and well-being of the client and/or assist them in recovering from illness or facing death. In Theme One of this study immigrant Mexican women identified cultural identity as an important cultural value that influenced their ability to maintain their own health and that of their children. Nurses caring for immigrant Mexican women must work to acknowledge this cultural value, and demonstrate respect for it in ways that the client understands.

Informants defined specific behaviors that demonstrate support for their cultural identity, and specific behaviors that serve as barriers to that support. Specific supportive behaviors that were identified are: showing respect by making eye contact and speak on first meeting; smiling; showing an interest in the life of immigrant Mexican women; and listening and taking time. Informants described non-caring nurses as those who treat non-English speaking women differently from English speaking women; who act with frustration when speaking with a non-English speaking woman; who ignore a non-English speaking woman; and who walk away while a non-English speaking woman is talking. Each nurse who cares for immigrant Mexican women must consider these behaviors, and review the care they provide in light of these expectations. Nurses caring for immigrant Mexican women must recognize the importance of cultural identity, and



make every effort to preserve it by demonstrating respect. Through interactions that are direct (eye contact), inviting (speaking first), personal (smiling, listening and showing interest), and patient (listening and taking time) nurses can provide support for the cultural values of the immigrant Mexican woman. Nurses build a foundation from which to begin a meaningful, fruitful and caring relationship by translating into actions their inherent respect for the life and cultural identity of their Mexican women clients,.

Awareness of cultural diversity has often been slow to grow in small communities and rural areas in the United States with the result that nurses living and working in these communities and areas may have had little experience providing care to people outside their own culture. Nurses who have not been exposed to transcultural nursing theories and practices must take it upon themselves to learn the important skills of cultural self-assessment, cultural health assessments and utilization of cultural knowledge. They can no longer rely on what may be instinctive and unconsidered cultural biases to guide the care they provide to or for those from cultural backgrounds that differ from their own. Nurses must assess their own prejudices and examine the cultural myths and misinformation that can appear when immigrants join isolated communities. Nurses must see themselves as advocates for new immigrants and demonstrate that commitment through respect, bridging communication and information gaps, and welcoming immigrants to their new home. Through the mode of culture care preservation nurses can build meaningful relationships with clients that effectively provide culturally congruent care and nurses can serve as a model to other professionals and community members.

## *Theme Two*

*Immigrant Mexican women value and expect nurses to support their self-determination and self-reliance as the foundation of care.*

As immigrant Mexican women face the challenges of living in a new country without the traditional supports they value and trust, new support systems are developed. Many of the informants in this study are members of families that have for generations traveled to the U.S. as migrant workers. These informants articulated cultural and family values of self-determination and self-reliance, which spring from their country of origin, and are reinforced by years of living separated from family and community. Fundamental to the life of the immigrant Mexican woman is recognition of her own power, gained through a strong cultural identity and increasing self-determination and self-reliance. Nurses must view these characteristics as essential to the health and well-being of immigrant Mexican women, and make every attempt to maintain and preserve them if optimal care is to be provided. For this to happen, changes are needed at many levels of the health care system.

In Leininger's (1991) second predictive mode of culture care, accommodation and negotiation, nurses assist, facilitate and enable nursing actions and decisions that help people adapt to, or negotiate with, others to achieve satisfactory health outcomes. As nurses work to support immigrant Mexican women's care values of self-determination and self-reliance, barriers to communication must be identified and dismantled.

Immigrant Mexican women who do not speak English face many challenges including disparities in work opportunities, racial discrimination and decreased access to health care. Nurses must acknowledge these disparities, facilitate effective

communication, and negotiate with community and social agencies and local, state and federal programs on behalf of immigrant woman. By speaking their language, at any level of competence, and providing interpreters and translated written materials, nurses can accommodate the language needs and demonstrate respect for immigrant Mexican women.

Nurses, particularly those living in rural Midwestern United States, must understand that as immigration continues at its current pace Spanish-speaking people, many from Mexico, will be the predominant ethnic group in the United States by 2050 (Flores et al.,1998). Accommodating this change by taking steps to become bilingual is an appropriate action for the caring nurse. Beginning with a few phrases the nurse can build a vocabulary that will provide the immigrant Mexican woman a sense of how important they and their language are to the nurse.

Assessing the availability of communication resources such as bilingual staff members, interpreters, translated written materials and other communication tools within local health systems is a further means by which nurses can accommodate the language needs of the non-English speaking immigrant Mexican woman. Negotiation with health care administrators to support strengthening of these resources may be necessary. The nurse must work to build increased interpreter resources, particularly if working in rural areas where there may be few bilingual staff members. Negotiating with administrators to provide staff interpreters in place of telephone translator services is essential.

Nurses must also negotiate time to develop their own Spanish speaking skills and to make available communication tools of the kind recommended by the informants of this study. Developing communication supports such as these will demonstrate to

immigrant Mexican women that nurses do value and support their important cultural values and understand their significance for care.

### *Theme Three*

*Immigrant Mexican women value and expect nurses to support their role as mother and provider of holistic care to their family.*

Informants of this study identified nurses as professionals who have important and needed health information. The provision of health information, particularly related to care of infants and children, is fundamental to the practice of nursing. Nurses who are hindered in the provision of this care due to language and cultural barriers cannot provide the quality of care to which they aspire. Through the mode of culture care re-patterning and restructuring, nurses can re-pattern their own practice through the acquisition and application of cultural knowledge. Nurses must seek to integrate their professional nursing care goals and practices with the cultural values and practices of the immigrant Mexican woman. The nurse must commit to a process of self-assessment and discovery in order to achieve this important collaborative process.

In beginning such a process towards cultural awareness, nurses must first identify their own values and beliefs. By so doing, they may become aware of the biases inherent in any ethnocentric perspective and initiate re-patterning of their own cultural values. By increasing awareness of the importance of culture in their own lives, nurses can increase their sensitivity to the cultures of others thereby gaining increased knowledge about the unique cultural values and practices of immigrant Mexican women. As nurses expand their cultural perspective to include the experience of immigrant Mexican women, a blending of cultural beliefs and values can occur. Through this process nurses and

immigrant Mexican women can effectively join in a partnership to plan and implement culturally congruent care.

The informants of this study voiced their value and expectation of nurses to demonstrate this high degree of acceptance and integration of cultural beliefs and values. Nurses must now embrace the responsibility to incorporate these transcultural nursing concepts and processes into their practice. In the case of nurses working with immigrant Mexican mothers, the primary provider of generic care to their families, the impact is geometric in proportion. By reducing the barriers to access to care and gaps in communication, nurses can pave the way for improved outcomes for all immigrant Mexican family members.

In summary, all nurses in the twenty-first century, regardless of their geographic location, must be prepared to provide culturally congruent care to clients with diverse cultural backgrounds. Nurses must be prepared in transcultural nursing and actively participate in cultural self-assessment. Through recognition of their own cultural values and beliefs, nurses are made aware of the essential role culture plays in being human. This role cannot be overlooked or neglected. By increasing their knowledge about diverse cultures, nurses can develop competencies that lead to provision of culturally competent care. Nurses must be aware of the unique cultural values of immigrant Mexican women and work to preserve them in order to maintain the immigrant women's health and well-being. Through their actions of cultural preservation and maintenance, cultural accommodation and negotiation and cultural re-patterning and restructuring nurses can demonstrate support for the immigrant Mexican woman's cultural identity, self-determination and self-reliance and role of being a mother.

### G. Recommendations for Nurse Education

Leininger (1995) defined three Phases of Transcultural Nursing Knowledge and Uses. This framework is useful in considering how nurses use transcultural nursing information and how educators should approach educating nurses about these important nursing concepts. In Phase I of this model, nurses become aware of and sensitive to culture care differences and similarities (cultural awareness). This important first step moves nurses to increasingly seek knowledge to assist them to explain what they observe and experience.

Phase II of this model describes how nurses use theory to explain, interpret and predict the transcultural nursing phenomena they observe in clinical settings with diverse populations. Nurses can use one of several nursing theories that describe cultural knowledge in their study of nursing phenomena. Phase III describes how nurses use transcultural nursing knowledge in practice and discover new knowledge or reaffirm existing knowledge through nursing research. This process is cyclical in that as transcultural nursing knowledge is gained, valued, utilized and refined the process begins again with each new discovery.

Nurse educators must understand that transcultural knowledge is initially gained by personal awareness and by increasing sensitivity. Curricular approaches must focus on strategies that foster this essential personal development. Duffy (2001) examined current approaches to cultural education across the country and found them obsolete. She found that nursing education programs that include cultural content significantly use static descriptions of a few culture's characteristics such as their food preferences, healing

practices and social mores, as the foundation of their cultural education. She recommended a more transformational approach to nursing cultural education, focusing on personal growth and development of cultural sensitivity through cultural experiences. This is much in keeping with Leininger's description of the beginning level of transcultural knowledge utilization.

Marcinkew (2003) stressed the need to incorporate transcultural nursing theories in nursing education in order to address the needs of increasing numbers of culturally diverse clients. Shearer and Davidhizer (2003) recommended the use of role-play to develop cultural competence allowing personal exploration of cultural values and beliefs. Thomas, Olivares, Kim and Beike (2003) recommended intense clinical immersion experiences to increase cultural awareness and sensitivity of nursing students. Utilizing a variety of strategies, nurse educators can better focus their efforts assisting students to develop their cultural awareness as a first step in transcultural education.

Nurse educators must also acknowledge the second phase of utilization of transcultural nursing knowledge: use of transcultural theories to explain nursing phenomena. Upper division courses in baccalaureate nursing programs must begin this knowledge and skill development. Graduate education must continue to focus nurses on theory utilization process and, concurrently, employ nursing research to evaluate transcultural nursing theories and expand relevant cultural knowledge.

Another question that must be addressed in baccalaureate nursing programs is inclusion of a language requirement, specifically the Spanish language, as part of the curriculum. United States demographics reveal the increasing size of Hispanic populations, with Mexicans leading all groups. This fact indicates that the U.S. will be a

bilingual nation within the lifetime of most nursing students. Requiring at least one Spanish conversation course early in the curriculum will give nursing students a beginning appreciation for aspects of Hispanic cultures and the ability to speak a few essential words and phrases. As this study's findings demonstrate, immigrant Mexican women value these attempts to speak Spanish by nurses. This study supports other transcultural nursing studies (Zoucha, 1998; Zoucha & Reeves) that have identified this phenomenon with other Mexican and Hispanic groups. Nurse educators must move to bridge the gap by providing nursing students beginning language skill development.

Recruitment of more students from Hispanic cultures, especially Mexican American students, must also be on the national agenda of nursing education planners. As with the need for increased representation of African American students in universities and important roles in society, affirmative action strategies should be considered for students of Hispanic origin. By giving incentives to choose nursing as a profession and making admission of Hispanic students a priority, increased numbers of nurses from Hispanic cultures will enter the workforce and provide the level of support desired by immigrant Mexican women.

As globalization expands cultural diversity in all parts of the world, nurse educators must acknowledge its importance to the practice of nursing. Curricula of associate degree and baccalaureate nursing programs must include dedicated transcultural nursing courses that focus learning experiences on enhancement of cultural awareness and sensitivity. Upper division baccalaureate and graduate nursing curricula should focus nurses on utilization of transcultural nursing theories, and the refinement and development of transcultural knowledge through nursing research. Including Spanish



language requirements within nursing curricula and providing incentives and admission priority to nursing students of Hispanic origin will enhance the number of practicing nurses who share the culture and language of a growing majority of U.S. citizens.

The three themes of culture care of immigrant Mexican women discovered in this research study provide examples of cultural knowledge that must be incorporated into nursing education. Each of these themes will now be discussed with regards to strategies and approaches to their incorporation into transcultural nursing courses.

### *Theme One*

*Immigrant Mexican women value and expect nurses to demonstrate respect for their cultural identity.*

In order for nurses to understand the importance of cultural identity to immigrant Mexican women, they must examine their own cultural experience. Nursing education must provide the means for nursing students to develop this examination process by focusing coursework on activities that build cultural awareness and sensitivity. Exercises that provide nursing students the opportunity to examine their own sense of cultural identity will allow students to expand their awareness of the importance of this cultural value to people of diverse cultures. These exercises will also provide nurses with increased awareness of their own power as a result of valuing and respecting their own cultural identity.

Further, nursing students should be given the opportunity to look outside their own lifestyle, in order to “see” the lives of others from a cultural perspective. Through observational and clinical experiences outside traditional clinical settings nursing students can begin to see the “bigger world” in which they will practice. These

experiences can be expanded to full cultural immersion experiences in upper division and graduate studies. Service learning has a place in this regard. Such experiences allow the nursing student to develop an expanded cultural perspective. This expansion provides the necessary foundation for provision of culturally congruent care.

*Theme Two*

*Immigrant Mexican women value and expect nurses to support their self-determination and self-reliance as a foundation to care.*

For the immigrant Mexican woman, development of a strong sense of cultural identity, self-determination and self-reliance serve as a foundation for her life in a new culture away from family and friends. Nursing students must be given the opportunity to “see” the experiences of the immigrant woman in order to be sensitive to these cultural values. Foundational to practice as culturally sensitive and skilled nurses, nursing students must develop a fundamental understanding of how cultural and societal factors, such as immigration status and migrant work patterns, impact on the health and well-being of immigrant Mexican women.

These elements of culture can be better understood using the constructs of transcultural nursing theory. Nursing students must develop advanced knowledge of transcultural nursing beyond mere memorization of lists of cultural characteristics. They must be able to “see” the world of the immigrant by utilizing nursing theory to examine cultural phenomena. Nursing education must provide the means and motivations for nursing students to embrace this level of transcultural knowledge utilization and apply it to nursing practice. Nursing students must be exposed to at least one of the transcultural

nursing theories, and required to utilize this theory to examine cultural influences impacting an individual client or a community.

Integration of transcultural nursing theory to assess an individual's cultural influences should be built into all clinical courses. Cultural assessments are a vital part of nursing care. As with other skill development processes, skills increase with repetition and feedback. Cultural assessment skills must be developed over time and systematically integrated across the curriculum to ensure that nursing students achieve an appropriate level of competence. Nurse educators must identify or develop clinical tools to assist the student in this skills development and develop the means to support acquisition of these important skills. These tools should be grounded in nursing theory and tested for their appropriateness and effectiveness.

### *Theme Three*

*Immigrant Mexican women value, and expect nurses to support, their role as mother and provider of holistic care to their family.*

Nursing actions and behaviors that are supportive, as well as actions and behaviors that serve as barriers to culturally congruent care, have been identified in this study. Informants described the importance of mothers in the Mexican culture to maintain the health and well-being of the family. Nursing students must examine their own family structures and the role of the mother in their own cultural background in order to ready themselves to interact with immigrant Mexican women. The importance of this cultural value must be acknowledged and demonstrated in ways that are meaningful to immigrant Mexican women in order to ensure their optimal care. Nursing educators must use these findings in the construction of cultural information within curriculum that supports

deeper understanding of the student's own cultural values as well as its importance in determining health beliefs and care practices.

It is vital that nursing students prepare themselves with cultural information before interacting with people of diverse cultures. This preparation should be part of all pre-clinical experiences. It should be as fundamental as preparing for care of a client who has specific medical conditions, such as diabetes mellitus or those receiving medication that have important nursing consideration, such as insulin administration. Nursing students should prepare themselves with particular care when they know they will be working with a client who is a recent immigrant - from anywhere in the world. Acquisition and utilization of cultural knowledge has a major impact on the practice of nursing, and should be afforded appropriate time and attention within the clinical training of nursing students. Faculty must include this information and build these expectations in clinical preparedness in order to begin the needed cultural skill building process.

In summary, an insightful, innovative plan for transcultural nursing education must be defined in nursing curricula that is focused on transactional processes, in order for nursing practice to be prepared for the expansion of culturally diverse nursing care that is currently taking place. This plan and its realization must acknowledge the importance of culture as an integral dimension of human behavior. It must also recognize that culture is an important influence on all aspects of nursing care. Nurse educators must build programs that encourage cultural awareness in students, and thus increase their cultural sensitivity. Curricular connections must be developed that increase cultural knowledge through the use of nursing theories and refine that knowledge through the application of nursing research methods. Through these integrated and transactional

processes the nursing student will be prepared to face the challenges of an increasingly culturally diverse world.

#### H. Recommendations for Nursing Administration

Developing nursing systems that support culturally congruent care should be the focus of nurse administrators in the twenty first century. Cultural factors have been overlooked as health care delivery is besieged by increasing costs, increasing demands and reduced availability of resources. Foley and Wurmer (2004) describe the need for innovative approaches, new partnerships and creative nursing administration leadership in order to address these system needs.

In this study it was discovered that the three community hospitals and the large medical center in a metropolitan area twenty miles away, mentioned by the informants, provided only minimal support for non-English speaking clients. When asked about interpreter services and other supports, such as translated materials, the majority of these Medicare and Medicaid providers described only minimal provision of services. Only a dial-up translator services and a few translated materials were included in the community hospitals' plans for provision of services to non-English speaking patients. When asked, only one had a two receiver telephone available for use. One large pediatric practice in a near-by community had bi-lingual staff members and a large amount of translated patient education material. Obviously, cultural and language differences were not recognized as a major issue for most of these organizations, despite the difficulties described by the informants.

Nurse administrators are in prime positions to positively impact the inclusion of cultural and language influences on health care organizations. As nurses, they recognize the importance of recognizing the needs of patients in order to provide adequate care. Hopefully through their leadership preparation, they have been exposed to the importance of culture in developing one's value and health care beliefs. It is critical that nurse administrators utilize this knowledge in advocating for system changes that will support the nursing staff's ability to assess and support these cultural and language differences. Specific administrative challenges posed by the three themes identified in this study are now presented with recommendations for needed system changes.

#### *Theme One*

*Immigrant Mexican women value and expect nurses to demonstrate respect for their cultural identity.*

In this study informants described the importance of nurses' demonstrating respect for cultural identity as a foundation for culturally congruent care. Several informants described recent interactions with the nursing staff of a local hospital's obstetrical services during childbirth. Ottani (2002) described childbirth as one of life's most significant events, which is culturally shaped and socially constructed. Nurses interacting with immigrant Mexican women as they prepare for childbirth must acknowledge the importance of this cultural phenomenon and demonstrate respect for the cultural traditions surrounding childbirth.

Nurse administrators responsible for this practice area must first be aware of the importance of relevant cultural knowledge of diverse populations in order to provide needed resources to nurses for optimal quality care. This often involves educational

programs and commitment of time in order to prepare staff to understand the cultural traditions of their clients. Additionally, the nurse administrator must develop managers and clinical leaders who recognize the importance of cultural factors on health and well-being. These staff resources can support the nurse's continuing education and skill development in cultural assessment and integration of cultural traditions and folk practices into the professional plan of care.

The Joint Commission for Accreditation for Healthcare Organizations (JCAHO) has defined specific evaluation criteria addressing cultural knowledge and cultural assessment of clients. In JCAHO's Comprehensive Accreditation Manual for Hospitals (2005) four standards that serve as "elements of performance" are described that address the organization's responsibility in addressing cultural needs of patients. One standard states: "Each patient has the right to have his or her cultural, psychosocial, spiritual and personal values, beliefs and preferences respected"(Standard R12.10). Other standards address assessing cultural variables that influence end-of-life care (Standard PC.2.20); learning needs (Standard PC 6.10); and food preferences (Standard PC 7.10). In a statement describing a new standard that will be effective January 1, 2006 requiring hospitals to collect information on the language and communication needs of patients, a JCAHO representative stated "research shows that difference in language and culture can have a major impact on the quality and safety of care" (JCAHO On-line, 2005). These standards reflect the growing recognition and expectation that patient care must be developed with consideration for the cultural and language needs of the patient. Nurse administrators must assure systems that will be able to meet these standards.

### *Theme Two*

*Immigrant Mexican women value, and expect nurses to support, their self-determination and self-reliance as a foundation to care.*

Prominent in the research findings of this study is the need to provide bilingual nurses or interpreters in order to support the self-determination and self-reliance of immigrant Mexican women. Non-English speaking informants made clear their recommendations for nurses to attempt to speak their language, provide access to interpreters and provide accurately translated written materials and other tools to support communication. Nursing administrators are in a central position to provide these badly needed resources to non-English speaking immigrant Mexican women.

Nurses should be given incentives and time to develop their Spanish language skills. Given U.S. demographics, the provision of bilingual Spanish speaking nurses is a logical budget request. For too long hospitals and other health care providers have developed plans for translation services that were impractical and not used. Dial-up translation services are not appropriate: they take too much time and delay care. On-staff bilingual interpreters are the only feasible option. The health care provider's status as a Medicare or Medicaid provider is at risk, according to Title VI of the Civil Rights Amendments 1964, if useable translation services are not made available to clients who have language barriers (Title VI, 2005). Nurse administrators must advocate for these staff positions and services. These improvements will benefit the staff, patients and ultimately the financial stability of the institution.



### *Theme Three*

*Immigrant Mexican women value and expect nurses to support their role as mother and provider of holistic care to their family.*

As increased numbers of immigrant Mexican families move to rural communities, small hospitals must demonstrate competence in their care. This competence will be, in large part, due to the staff's increased awareness of the influence of culture on human behavior and specifically health promotion and illness care. With increasing numbers of Mexicans working as migrant workers or living permanently in the region, the cultural diversity in rural communities is changing. With this change comes the need for nurses to obtain cultural knowledge in support of the Mexican families they now serve.

This study demonstrated the importance of the mother's role in the health promotion and illness care of family members. Nursing administrators of both acute care systems and community and ambulatory care systems of care, must provide their communities with staff members who acknowledge this culture care pattern, and are willing to re-pattern systems in support of the Mexican mother and family. Nursing administrators must seek innovative and creative system designs that support the immigrant Mexican woman in her role as a mother, as she faces separation from the powerful family systems of support in Mexico. McQuiston and Flaskerud (2003) describe the use of Lay Home Advisors (LHA) as support to Mexican mothers and families. These systems utilize care providers who are of the same culture as the client, providing connections with the cultural traditions that are so valued by immigrant Mexican women.

This type of innovation recognizes the importance of cultural factors in health and well-being and places it as the focus of system development.

In summary, nursing administrators are key to the effort to re-pattern health care systems in order to support cultural care practices of culturally diverse populations. In this study, three culture care themes were identified that challenge the nursing administrator to reprioritize resources in order to meet the needs of people of different cultures. Increased development of bilingual staff members, increased availability of interpreters, increased development of accurately translated written materials and development of innovative programs that support immigrant Mexican women are only a few of the recommendations made to nursing administrators in support of culturally congruent nursing care. As the world becomes more diverse, nursing care systems must be ready with fully trained, bilingual, culturally sensitive nurses at the forefront.

#### I. Recommendations for Nursing Research

Papadopoulos and Lee (2002) warn that cultural knowledge will only be gained if researchers are culturally competent. They suggest that nursing researchers have traditionally taken on the cultural perspective of their dominant ethnic group at the expense of the perspective of the minority. These reviewers of current nursing research textbooks found that none of the texts address issues of cultural competence (Papadopoulos & Lee). As with other research methods, credibility of findings is grounded in the perspective of the researcher, the relevance of the methods and their power to reveal the population of interest. If, as Papadopoulos and Lee contend,

contemporary researchers too often reflect only the view of the dominant culture due to lack of appropriate training, it is reasonable to refute the validity of their findings.

Leininger's (1991) ethnonursing method seeks to reduce cultural bias by grounding the researcher first in observation-only experiences with the population under study. Through development of the data collection process of the OPR (Appendix A), Leininger created a process that increases the validity and reliability of research findings by building the skills, perceptions, cultural awareness and cultural sensitivity of the researcher. The time spent preparing the researcher for entry into the field often exceeds time spent in direct informant interviews. Such preparation has a direct impact on the quality of the research findings. Issues of researcher bias in cultural perspective are minimized through the rigor of ethnonursing method.

Other research methods must employ this same level of attention to researcher preparation and their cultural awareness, sensitivity and competence. Through this emphasis on skill building and cultural awareness the researcher, as the main tool of cultural research, can be expected to gain credibility. To this end the three themes of culture care are discussed in terms of present and future research initiatives.

### *Theme One*

*Immigrant Mexican women value and expect nurses to demonstrate respect for their cultural identity.*

Ethnography and ethnonursing examine aspects of a specific culture that influence the study's domain of inquiry. The use of theory to provide a framework for understanding nursing phenomena gives enhanced meaning to research studies and broadens theoretical knowledge (Polit & Hungler, 2003). Research questions regarding

cultural phenomena are often guided by a nursing theory that fits with this conceptualization. Through this fit theory can guide the design of the study, the approach to data collection and analysis, and interpretation of the findings (Polit & Hungler).

In this study the domain of inquiry was culture care values, patterns and practices of immigrant Mexican women. The framework used in this ethnonursing study was Leininger's Culture Care theory, including the Sunrise Enabler that graphically represents worldview, language and social and cultural influences on culture care. The use of this theory and model helped form the research questions and the Interview Guide. The research findings themselves reflect this framework and substantiate its premise.

The identification of cultural identity, self-determination and self reliance and the importance of the role of mother in the Mexican family as cultural values of the immigrant Mexican women grew from data that was collected, analyzed and interpreted using Leininger's theory. The findings of this study strengthen Leininger's theory, enhance its power for research utility, and add to its relevance and application to nursing practice.

Nurse researchers interested in studying cultural phenomena must utilize nursing theories that provide the means to conceptualize and predict aspects of cultural phenomena. Leininger provided the foundational theory for transcultural nursing, but others have followed. Nurse researchers must commit to grounding cultural research in nursing theory that will provide depth and breadth to nursing's understanding of cultural phenomena as related to nursing practice.

This study described immigrant Mexican women's perception of their interactions with nurses, who were largely from the dominant Euro-American culture. These

perceptions were fraught with pain and frustration, described as being experienced by both cultures, as nurse and client sought to achieve a common goal. Such interactions represent an intersection between these two cultures, which greatly impacts each. For this intersection to be fully understood and maximized towards quality care, it must be viewed in relationship to both cultures together, not separately.

Traditional ethnographic research looks at culture from the standpoint of separateness. Cultures are viewed from an emic perspective in contexts that usually focus on the separations of a culture's community from others. With increasing globalization, emigration and migration, understanding intersections of cultures is of particular importance to those working with immigrants. The points of intersection of cultures, the transactions between those cultures, and the impact of the experiences within and between cultures, demand new applications of cultural research methods. Nurse researchers must further evolve research methods such as Leininger's in order to describe and maximize interactions between nurses and clients of different cultures who engage in the provision of care practices that promote health and well-being. Future research is needed to examine the impact of immigration on the health and well-being of those moving from one culture to another. Nursing research must look at cultural intersections between immigrants and nurses to better understand how these intersections can be more satisfying and productive.

In this study, informants expressed feelings of loss of family love and support including loss of social supports due to the traditional reliance upon family within the Mexican culture. The informants also described reliance on nurses for health information and support. It is imperative that nurses manage these cultural intersections in order to

provide the needed care and support as expressed by the immigrant Mexican women of this study.

### *Theme Two*

*Immigrant Mexican women value and expect nurses to support their self-determination and self-reliance as a foundation to care.*

One of the important findings of this study is the cultural value placed on retaining the use of the Spanish language as a means to strengthen cultural identity. The immigrant Mexican women who did not speak English valued it for their children but chose to retain their exclusive use of Spanish. For many of these informants, aspects of their cultural identity were lost when they moved away from family, friend and their homeland. Ethnographers as far back as Boas (1938) and Sapir (1949) have stressed the importance of language as a dimension of cultural identity. Nursing researchers using ethn nursing methods must explore this dimension of culture for both the immigrant family moving to a new culture and the nurse attempting to communicate with people of diverse culture who do not speak English.

For many nurses, the issue of learning a new language is a sensitive one. Comments such as “why do we have to learn” and “why don’t they learn the language if they chose to live in this country” have been heard by the researcher from nurses reflecting on the increasing numbers of immigrant Mexican living in local rural communities and the language barriers that have been created. Nursing research is needed to assess the perceptions of the nurses and define approaches that will be successful in bridging the communication gaps that exist between nurses and non-English speaking

immigrants. The issues of cultural intersections again may be relevant when looking at the issues of culture and language.

### *Theme Three*

*Immigrant Mexican women value, and expect nurses to support, their role as mother and provider of holistic care to their family.*

Guided by Friedman (2001), family nursing research has long recognized the importance of cultural considerations in understanding family dynamics. This study emphasizes the central position mothers take in the structure of the Mexican family. It also demonstrates the immigration process and documentation status of the informants as important influences on their health and well-being. The impact on the health of their families is unclear. Nursing research is needed to focus on immigrant families using ethn nursing methods, with particular attention to the impact of immigration, acculturation, language barriers, and documentation status on the health of the family. The impact of separation from families and friends due to the immigration process and the lack of cultural support in rural communities should be vigorously explored. Assessment of family stability and possible domestic and family violence may be raised within this context.

Research exploring the experience of undocumented immigrants, including factors influencing their health and well-being is needed. Informants of this study, who were not legally residing in the U.S., described increased stress, anxiety and having fewer opportunities as a result of being undocumented. Given the large numbers of illegal immigrants currently living in the U.S., nursing research is needed to explore the experience of living as an undocumented woman and its impact on the health of the

Mexican family. As political processes are evaluating this situation in the United States and proposing legal solutions, nursing must lend its voice to those advocating for humane and ethical treatment of the immigrant. Through valid research studies that describe health outcomes of undocumented immigrants, nursing's voice can be stronger and more effective.

In summary, nursing research must expand to consider the increased cultural diversity in parts of the world that previously have been less affected by globalization. This includes small communities and rural areas of the United States. Research studies using appropriate methodology, such as the ethnonursing method must be designed to ask questions of informants regarding their culture care values, beliefs and practices. Qualitative studies must also look at the impact of immigration, language barriers, separation and loss, and documentation status on the health and well being of immigrants from all nations, and particularly those from Mexico. Research designs such as Participatory Action Research must be explored in the descriptions of the phenomena of cultural intersections, which are of particular interest to nurses working with immigrants. Research studies must be developed to look at the impact of immigration on family members and the overall health of the family. In addition, research studies must not overlook the fact that nurses themselves are engaged in the transition to a more culturally diverse world. Through this research development nurses will be given the tools of cultural knowledge and cultural skill development needed to provide high quality culturally congruent nursing care to all clients.

Based upon the research findings of this study, the researcher will continue to work with immigrant Mexican women in rural communities, focusing on the impact of



immigration and specifically undocumented status on their health and well-being. The researcher is committed to describing and increasing understanding of the dynamic between non-English speaking immigrant Mexican women and nurses providing care. By looking at nurses, immigrant Mexican women and the intersection between their two cultures better understanding of this interactional process can be achieved. This could provide a better understanding of changes necessary for nurses to build the cultural sensitivity and skills required for culturally congruent care.

Acknowledging the importance of cultural identity as the foundation of culturally congruent care for immigrant Mexican women is one step in the process of their empowerment. This study identified the desire of immigrant Mexican women to improve their health and well-being and that of their families in rural communities through partnerships with nurses. The researcher believes the next logical step is conducting a Participatory Action Research (PAR) study within this community. This type of study focuses on research with participants. Reason (1998) describes the use of PAR to address methods of developing and improving collaborations between professionals and their clients as well as among community members. This method would allow the researcher to look at both the intersection between nurses and immigrant Mexican clients and exploring the needs of immigrant Mexican women in society. Nurse researchers are beginning to utilize PAR and the researcher support and encourage this expansion of qualitative nursing research.

Future research is also needed to further the development of the pictorial model, specifically the relationship between immigrants Mexican men, women and children and families with nurses. Further understanding of the impact of the development of cultural

knowledge and cultural self-awareness on the culturally congruent relationship will be explored.

Further research is also needed on the ethnonursing method, beginning with a meta-analysis of nursing studies utilizing the ethnonursing method. This type of study has yet to be completed despite years of utilizing the method with many different cultures. From this meta-analysis, further development and evolution of this important nursing research method will be encouraged and supported.

## J. Conclusion

This ethnonursing study has identified nine categories, five patterns and three themes describing culture care of immigrant Mexican women. Cultural values that were identified as essential in understanding the culture care of immigrant Mexican woman: cultural identify; self-determination and self-reliance; and the central role of the mother in the Mexican family. As the researcher considered the life experiences of the informants, expressed in emic descriptions during interviews, the unique perspective of these women emerged. In this immigrant community, the words used by the informants to describe themselves focused on their strength and self-determination. The informants acknowledged the importance of family and, in particular their mothers. Due to the distance away from their homes in Mexico, these women no longer relied on the cultural traditions of *familismo* and *compadrazgo* and developed increased reliance on themselves.

In this self-reliance, the immigrant Mexican women voiced support for the role of nursing in their community and sought contact with nurses particularly for health

information regarding childbirth and the care of infants and young children. These informants identified behaviors of caring nurses that were supportive of their cultural values and nursing behaviors that were barriers to culturally congruent care. These findings reflect the informants' well-developed sense of cultural identity and self-determination and self-reliance and their pride and deep sense of responsibility as mothers and care providers for their family.

Understanding cultural values serves as a foundation for nurses who wish to provide culturally congruent care to immigrant Mexican women. Implications for nursing practice include the utilization of Leininger's prescriptive modes of care to guide nursing decisions and actions that support culturally congruent care.

Nurses demonstrate cultural care preservation and maintenance by demonstrating support for the cultural identity of immigrant Mexican women by speaking to them upon meeting, smiling, listening, showing interest in their lives, asking questions and taking time. Nurses demonstrate culture care accommodation and negotiation by supporting the self-determination and self-reliance of immigrant Mexican women by speaking Spanish and providing tools that reduce communication barriers implement negotiation. Nurses demonstrate culture care re-patterning and restructuring by implementing systems such as Lay Home Advisors that support immigrant Mexican women's role as mother implement strategies that support culture care re-patterning and restructuring. These practices represent culturally congruent care for immigrant Mexican women.

Implications for nursing education include utilization of Leininger's Phases of Transcultural Nursing Knowledge and Uses as an organizing theme for developing cultural nursing educational programs. Nursing education must first develop nursing

students' own cultural awareness and sensitivity. From this important beginning, upper division baccalaureate and graduate nursing courses must stress utilization of nursing theory to interpret transcultural nursing phenomena and build knowledge of nursing theory using nursing research methods.

Addressing obvious and dangerous communication barriers between nurses and Mexican immigrants, as immigration continues to increase, is vital. Nursing educators must consider requiring Spanish language requirements in baccalaureate nursing programs and building incentives to recruit nursing students of Hispanic heritage as an attempt to bridge this gap.

Implications for nursing administration focus on the reprioritization of the importance of cultural factors influencing health care system development. Improved systems of communication for clients who do not speak Spanish are long overdue. Restructuring community health systems to support immigrant women who are mothers without traditional systems of support available to them must also be a high priority. By facing changing demographics and the changing priorities for care, nursing administrators must be advocates for culturally congruent care.

Implications for nursing research define needed refinements in the preparation of nurse researchers and the continuing development and revision of nursing research methods that will provide reliable cultural knowledge particularly when two cultures intersect. By further developing specific nursing research methods that address issues of caring, health and well-being, and influencing factors within and between diverse cultures, nursing research can refine previously identified cultural knowledge as well as discover new knowledge relevant to specific cultural groups.

This ethnonursing study focused on understanding the culture care meanings, expressions, patterns and practices of immigrant Mexican women living in a rural community in Ohio. The researcher was privileged to make entry into that community, and was entrusted by the informants with detailed responses to questions. The high seriousness with which informants participated in this study is testament to their desire to play a full and active part in their health care. Research findings provided answers to the research questions and revealed new knowledge regarding the domain of inquiry. Through application of the findings to nursing practice, education, administration and research additional questions were raised. Advancing nursing knowledge through on-going transcultural nursing research ensures that further studies will continue to address these questions.

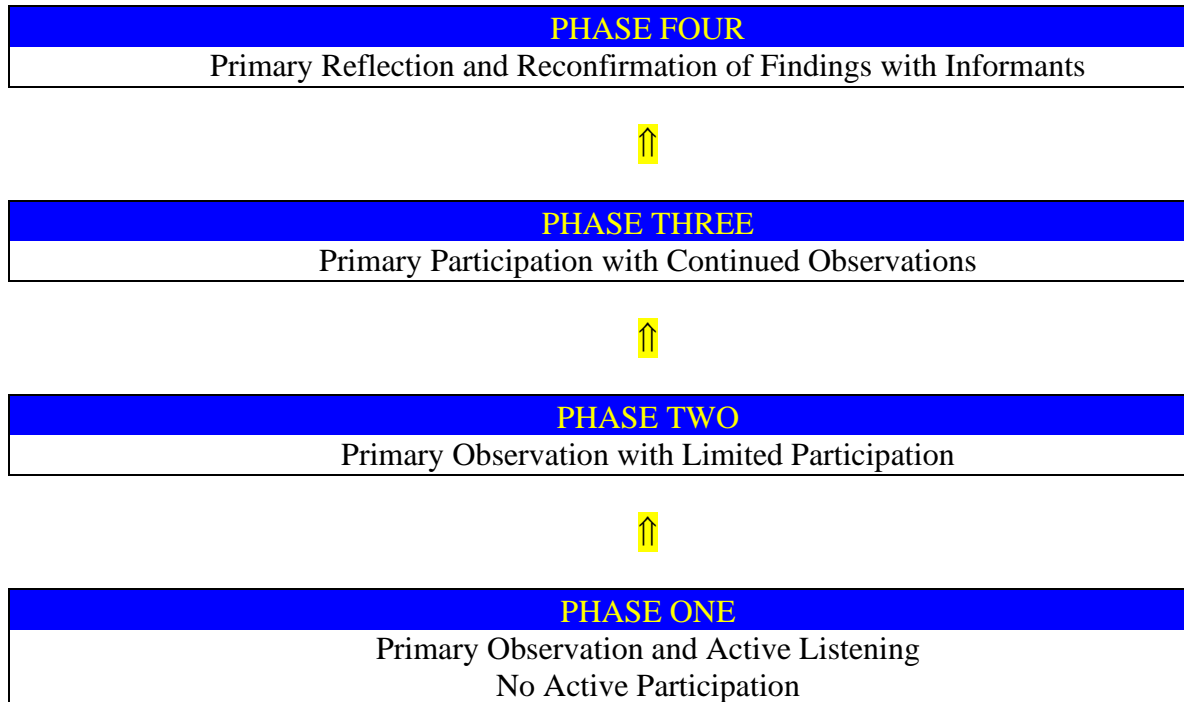
The care of immigrants is an increasingly important issue for health care in the United States. Nurses must take a lead role for, as with immigrant Mexican women, many people of the world outside the dominant Euro-American culture will look to nurses to assist them in making entrance to their new world. Nurses must accept this role, serving not as barriers but as advocates and cultural brokers, supporting immigrant families by understanding their culture care and their expectations of how nurses can assist them in maintaining it. Nurses can do this by better understanding their own cultural values and beliefs and recognizing the cultural intersection when entering in relationship with immigrants from diverse cultures. Through this understanding nurses can unite with new immigrants in building the opportunities they dreamed of when coming to their new land.

## APPENDICES

## APPENDIX A

The Observation-Participation-Reflection Model<sup>1</sup>

## The OPR Model



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<sup>1</sup> Leininger, M.(2001) Culture Care Diversity and Universality: A Theory of Nursing. Boston: Jones and Bartlett.

## Appendix B

## Key and General Informant Interview Guide

<b>Open Inquiry Interview Guide for Key and General Informants</b>	
ETHNODEMOGRAPHICS	
Informant #	Preferred Meeting Place:
Best method of contact:	Age:
Language spoken:	Request for translator:
Religion:	Place of Birth:
OPEN-ENDED QUESTIONS	
<p>Environment:            Can you tell me about where you were born?            Can you tell me about your childhood?            Tell me about your move to the United States.            Tell me about your life now. (housing, household members)            Describe how your life been different or the same since you came to the US.</p>	
<p>Kinship / Social Factors:            Tell me who you describe as family. (mother, father, compadres?)            If you were ill, could you describe who you would go to for help?            When you go to the clinic, could you describe who would go with you?            Tell me about the decision-maker in your family regarding health care</p>	
<p>Cultural/ Family Lifeways:            Describe some of your family's traditions and special events.            Tell me about your family's views of health and how to stay healthy.            Based upon your definition of family, tell me about the support available to you here in the United States</p>	
<p>Religious or Spiritual Factors:            You mentioned you were _____. Can you describe what being _____ means to you?            Can you describe how your religion affects your health and well-being?            Describe how religion plays a part when you are ill.            Tell me about any particular religious traditions you follow when you are sick.            Describe any particular religious traditions you follow to stay healthy.</p>	
<p>Economic Factors:            Tell me about working here in the U.S.            Sometimes I find it difficult to make ends meet. Can you describe how things are for you?            Describe healthcare in Mexico.            Describe healthcare in the U.S..</p>	



<p>Tell me about accessing healthcare here.  Tell me about paying for healthcare here.  Could you describe when you go to the clinic?</p>
<p>Political or Legal Factors:  Tell me about the political system in Mexico.  Tell me about the political system in the U.S.  Could you describe political factors here in the U.S. that affect your health and well-being?</p>
<p>Education:  Tell me about the educational system in Mexico.  Tell me about the educational system in the U.S.</p>
<p>Health and Well-Being  Describe to me what health means to you.  Describe what the phrase well-being means to you.  Tell me about what illness means to you.  Describe any foods, medicines or home remedies that you believe keep you healthy or improve your health when you are ill?  Tell me about any practices that you do to stay well.  Describe any practices that you do to treat your illnesses.  Tell me about any people in your community you use to assist you stay well or treat your illnesses.  Could you tell me about a curandero?  Describe things the curandero could do for you.  Tell me about any practices that you do now that differ from those you did in Mexico.</p>
<p>Care:  Describe what care means to you.  Describe signs of a caring person.  Describe a caring nurse.  Describe a non-caring nurse.</p>
<p>Nursing:  In your culture tell me about how nurses show caring?  Tell me about the care you have received from nurses.  Tell me about the care you receive from family compared to the care you receive from a nurse.  Tell me about ways nurses could assist you to stay healthy.  Tell me about ways nurses could assist you when you are ill.</p>
<p>General Views  Tell me how women show caring in your culture?  Is there anything you would like to share with me that we have not discussed?</p>

APPENDIX C  
Interpreter Confidentiality Statement

Confidentiality Statement

I, \_\_\_\_\_, understand that I may have access to personal information provided by persons involved as part of the study “ Culture Care Practices of Immigrant Mexican Women in Rural Ohio”. As an interpreter and transcriber participating in informant interviews, I recognize I have an obligation to protect the confidentiality of the information acquired in the conduct of the study. I also recognize that I may disclose information acquired only with the consent of the individual(s) who is (are) the sources of the information, and/or whom the information concerns, and of the nurse researcher.

My signature indicates my acknowledging and acceptance of the obligation and restrictions on disclosure, set forth above. I also realize that failure on my part to fulfill this obligation can lead to appropriate legal action.

\_\_\_\_\_  
Interpreter Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## APPENDIX D

Consent Form: English Version



DUQUESNE UNIVERSITY  
600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

## CONSENT TO PARTICIPATE IN A RESEARCH STUDY

**TITLE:** Culture Care Practices of Rural Mexican Immigrant Women

**INVESTIGATOR:** Catherine Johnson  
9008 Milton Carlisle Rd  
New Carlisle, Ohio 45344

**ADVISOR: (if applicable:)** Dr. Rick Zoucha  
Dissertation Committee Chair  
School of Nursing  
412-396-6545

**SOURCE OF SUPPORT:** This study is being conducted as partial fulfillment of the requirements for the Doctor of Philosophy in Nursing degree at Duquesne University.

**PURPOSE** You are being asked to participate in a research project that seeks to discover how immigrant Mexican women in a rural setting describe health and well being, define what they do to stay healthy and what they need to assist them in this process. In addition, you will be asked to allow me to interview you, for 30 to 90 minutes one to three times, with a bilingual interpreter if requested. The interviews will be audio taped and transcribed. These are the only requests that will be made of you.

**RISKS AND BENEFITS:** There are no known physical or psychological risks anticipated with this study. If you feel uncomfortable or wish to end the interview at any time you are free to say STOP. Breaks will be coordinated so as not to stop the free flow of information. There is no known direct benefit from

this study, although, there is the knowledge that you are sharing very important information about the health of Mexican American women.

**COMPENSATION:** Participation in the project will require no monetary cost to you. There will be no compensation for your participation.

**CONFIDENTIALITY:** Your name will never appear on any survey or research instruments. No identity will be made in the data analysis. All written materials and consent forms and audiotapes will be stored in a locked file in the researcher's home. Your response(s) will only appear in data summaries. All materials will be destroyed three years after completion of the research.

**RIGHT TO WITHDRAW:** You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time.

**SUMMARY OF RESULTS:** A summary of the results of this research will be supplied to you, at no cost, upon request.

**VOLUNTARY CONSENT:** I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board (412-396-6326).

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Participant's Signature

---

Date

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Researcher's Signature

---

Date

Consent Form: Spanish Version



DUQUESNE UNIVERSITY  
600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

CONSENTIMIENTO PARA TOMAR PARTE EN UN ESTUDIO DE  
INVESTIGACION

- TITULO:** Practicas culturales de cuida de mujeres Mexicanas inmigrantes en colocaciones rústicos.
- INVESTIGADORA:** Catherine Johnson  
9008 Milton Carlisle Rd.  
New Carlisle, Ohio 45344
- CONSEJERO:** Dr. Rick Zoucha  
Silla Del Comité De la Disertación  
Escuela del oficio de enfermera  
412-396-6545
- FUENTE DE APOYO:** Este Studio esta conductaza Como cumplimiento parcial de los requisitos para el Doctor de la Filosofía de la titula de Enfermería en la Universidad de Duquesne.
- PROPOSITO:** Usted es pedido tomar parte en un proyecto de investigación que procura descubrir:
1. Como mujeres Mexicanas inmigrantes en colocaciones rústicos describen la salud y bienestar.
  2. Definir lo que mujeres Mexicanas inmigrantes hacen para permanecer la salud y lo que necesitan ayudarlas en este proceso.
- Además, le pedirán permitir que se entreviste con le, por 30 a 90 minutos una a tres veces, con un intérprete bilingüe si está solicitado. Las entrevistas serán grabadas en audio y transcribieron. Estos son los únicos pedidos que estarán hecho de usted.
- RIESGOS Y BENEFICIOS:** No hay riesgos físicos o psicologicos sabidos anticipados con este estudio. Al cualquier tiempo, si usted se siente incomoda o siente deseo para terminar la entrevista, usted esta libre decir que gusta terminar la entrevista. Tiempo

libre se coordinara para que no yaga interrupción en el flujo libre de información.

No hay beneficios directos de este estudio. Aunque la información que usted comparte con nosotros es muy importante acerca de la salud de mujeres Mexicanas.

- COMPENSACION:** Participación en este Studio no se recrié costo monetario a usted. No habrá compensación para su participación
- CONFIDENCIALIDAD:** Su nombre nunca aparecerá en cualquier instrumento del examen o de la investigación. No se hará ninguna identidad en el análisis de datos. Todos los materiales y formas y cintas magnéticas para audio escritos del consentimiento serán almacenados en un archivo bloqueado en el hogar del investigador. Su response(s) aparecerá solamente en resúmenes de los datos. Todos los materiales serán destruidos tres años después de la terminación de la investigación.
- DERECHO DE RETIRAR:** Al cualquier tiempo, si usted se siente incomoda o siente deseo para terminar la entrevista, usted esta libre decir que crié parar y terminar la entrevista.
- RESUMEN DE RESULTADOS:** Si lo pide, un resumen de los resultados de este estudio será suministrado sin costo a usted
- VOLUNTARIO:** **CONSENTIMIENTO**  
He leído los antedichos de declaraciones y entiendo lo que se solicita de mi. Entiendo que al cualquier tiempo y por cualquier razón si me siento incomoda o siento deseo de terminar la entrevista, soy libre de retirar mi consentimiento.  
En estos terminas, yo certifico que estoy dispuesta a tomar parte en este proyecto de investigación.  
Entiendo que si tengo mas preguntas acerca de mi participación en este estudio, yo puedo llamar a Dr. Paul Richer, Chair of the Duquesne Universita Institucional Rebién Borrada (412-396-6326).

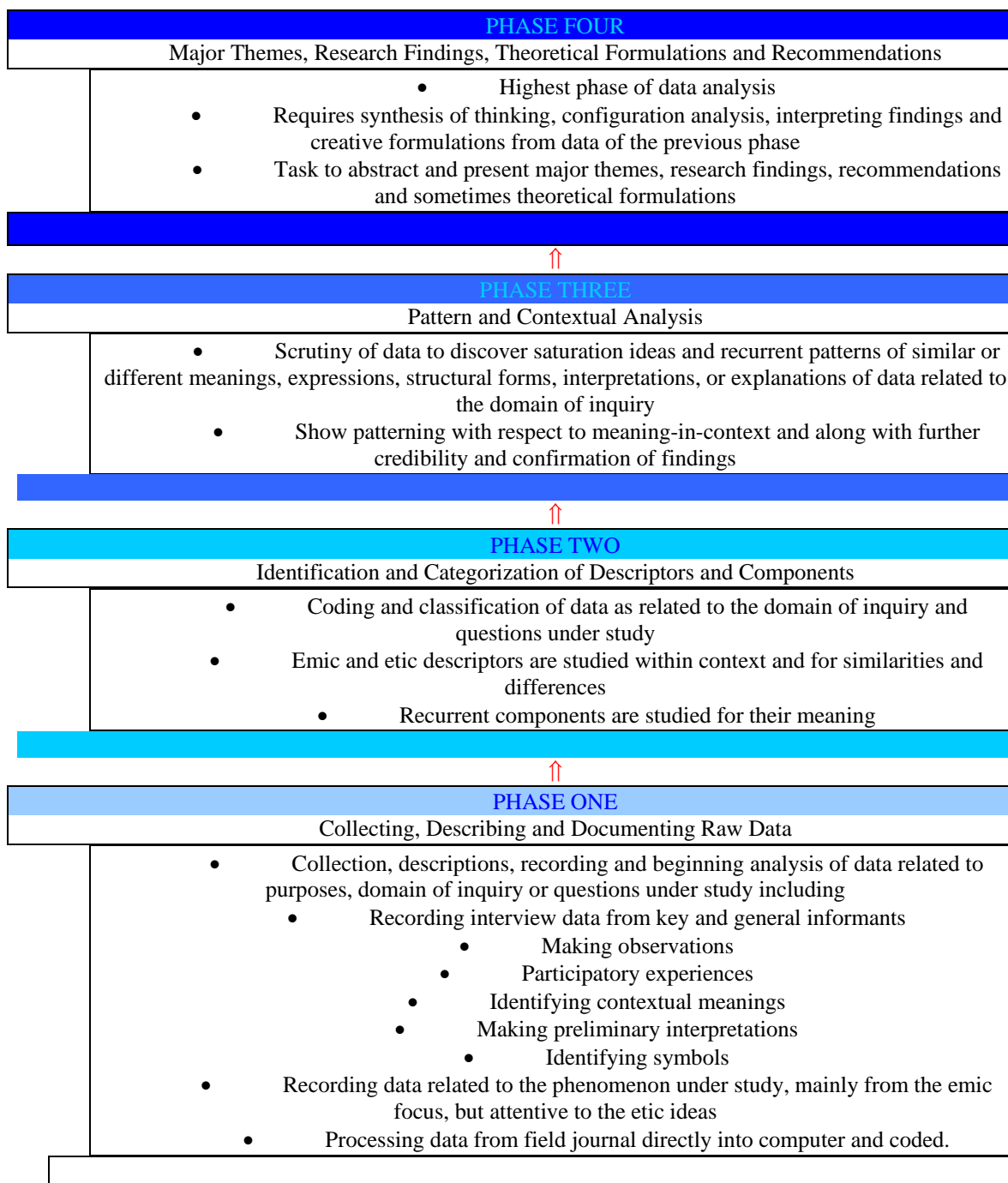
\_\_\_\_\_  
Firma de participante

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Firma de investigador

\_\_\_\_\_  
Fecha

## APPENDIX E

Phases Of Ethnonursing Analysis For Qualitative Data<sup>2</sup>

Leininger, M. (2001) Culture care diversity and universality: a theory of nursing. Boston: Jones and Bartlett Publishers. p95.

## REFERENCES

- Abalos, D. (1986). *Latinos in the United States: The political and the sacred*. South Bend, Indiana: University of Notre Dame Press.
- Agar, M. (1986). *Speaking of ethnography*. Beverly Hills, California: Sage Publishing.
- Andrews, M.M. & Boyle, J.S. (1999) *Transcultural concepts in nursing care*. (3<sup>rd</sup> ed.) Philadelphia: Lippencott.
- Angel, R., Angel, J., & Kryriakos, S. (2002). Stability and change in health insurance among older Mexican Americans: Longitudinal evidences from the Hispanic established populations for epidemiological studies. *American Journal of Public Health*, 92(8), 1264-1271.
- Balcazar, H., Castro, F. G., & Krull, J. L. (1995). Cancer risk reduction in Mexican American women: the role of acculturation, education, and health risk factors. *Health Educ Q*, 22(1), 61-84.
- Baxter, J., Bryant, L., Scarbro, S., & Shetterly, S. (2001). Patterns of rural Hispanic and non-Hispanic white health care usage. *Research on Aging*, 23(1), 37-60.
- Berry, A. B. (1999). Mexican American women's expressions of the meaning of culturally congruent prenatal care. *Journal of Transcultural Nursing*., 10(3), 203-212.
- Berry, A. B. (2002). Culture care of the Mexican American family. In M. Leininger & M. McFarland (Eds.), *Transcultural Nursing* (3rd ed., pp. 363-373). New York, NY: McGraw-Hill.
- Boas, F. (1938) *Race, language and culture*. Chicago: University of Chicago Press.



- Borrayo, E. A., & Guarnaccia, C. A. (2000). Differences in Mexican-born and U.S.-born women of Mexican descent regarding factors related to breast cancer screening behaviors. *Health Care Women Int*, 21(7), 599-613.
- Calavito, K. (1992). *Inside the state: The bracero program, immigration and the I.N.S.* Nashville, Tennessee: Rutledge Hill Press.
- Cassels, Manuel. (1985) *The information age*. Malden, Mass; Oxford Press.
- CDC. (2003). *Hispanic Health Facts*. Retrieved 04/01/04, from <http://www.cdc.gov/hiv/pubs/facts/hispanic.htm>
- Cervantes, A., Keith, L., Wyshak, G. (1999) Adverse birth outcomes among native-born and immigrant women: replicating national evidence regarding Mexicans at the local level. *Maternal and Child Health Journal*, 3(2), 99-109.
- Champion, J. (1999). Life histories of rural Mexican American adolescents experiencing abuse. *Western Journal of Nursing Research*, 21(5), 699-717.
- Changing America: Indicators of social and economic well-being by race and Hispanic origin. (1998). Retrieved 10/02/02, from <http://www.whitehouse.gov/WH/EOP/CEA/html/publications>
- Chavez, L. (1997). Hispanics and the American dream. *Education Digest*, 62(6), 57-60.
- Choi, H. (2001). Cultural marginality: A concept analysis with implications for immigrant adolescents. *Issues in Comprehensive Pediatric Nursing*., 24(3), 193-206.
- Council of Economic Advisers (1998) Retrieved March, 23, 2003 from <http://www.whitehouse.gov/infocus/healthcare.htm>

- Crawford, M., Heidler, D., & Heidler, J. (1999). Encyclopedia of the Mexican American war. Denver: ABC-CLIO.
- Cuellar, I., Harris, L. C., & Jasso, R. (1980). An acculturation scale for Mexican American normal and clinical populations. *Hispanic Journal of Behavioral Sciences*, 2(3), 199-217.
- Del Pueblo (2003) Del Pueblo [Brochure] Medway, Ohio.
- DeSantis, L. (1997). Building healthy communities for immigrants and refugees. *Journal of Transcultural Nursing*, 9(1), 20-31.
- Diabetes Statistics for Latinos. (2002). from [http://www.diabetes.org/utills/printthispage.jsp?PageID=STATISTICS\\_233187](http://www.diabetes.org/utills/printthispage.jsp?PageID=STATISTICS_233187)
- Duffy, M. E. (1997). Determinants of reported health promotion behaviors in employed Mexican American women. *Health Care for Women International*, 18(20), 149-163.
- Duffy, M.E. (2001). A critique of cultural education in nursing. *Journal of Advanced Nursing*. 36(4), 487-495.
- Dugan, A. (1988). Compadrazgo: A caring phenomenon among urban Latinos and its relationship to health. In M. Leininger (Ed.), *The essence of nursing and health* (pp. 183-194). Detroit: Wayne State University Press.
- Fishman, B. M., Bobo, L., Kosub, K., & Womeodu, R. J. (1993). Cultural issues in serving minority populations: Emphasis on Mexican Americans and African Americans. *Am J Med Sci*, 306(3), 160-166.
- Flaskerud, J., & Uman, G. (1996). Acculturation and its effect on self-esteem among immigrant Latino women. *Behavioral Medicine*, 22, 123-138.

- Flores, G., Abreau, M., Olivar, M., & Kastner, B. (1998). Access barriers to health care for Latino children. *Archives of Pediatrics and Adolescents*, 152, 119-125.
- Foley, R. & Wurmer, T.A. (2004) Cultural diversity. *Nursing Administration Quarterly*. 28(2), 122-128.
- Friedman, M. (1998) *Family nursing: research, theory and practice*. (4<sup>th</sup> ed.) Stamford, Connecticut: Appleton & Lange.
- Gallup, G., & Castelli, J. (1989). *The people's religion: American faith in the 90's*. New York: Macmillan.
- Garcia-Maas, L. D. (1999). Inter-generational analysis of dietary practices and health perceptions of Hispanic women and their adult daughters. *Journal of Transcultural Nursing*, 10(3), 213-219.
- Garza, R.O. (1998) *Interests not passions: Mexican American attitudes toward Mexico, immigration from Mexico, and other issues shaping U.S.-Mexico relations*. *International Migration Review*. 32(1), 401-423.
- Gaston, M. H. (2001). 100% Access and 0% Health Disparities: Changing the Health Paradigm for Rural Women in the 21st Century. *Women's Health Issues*, 11(1), 7-54.
- Graham-Garcia, J., Raines, T. L., Andrews, J. O., & Mensah, G. A. (2001). Clinical practice department. Race, ethnicity, and geography: Disparities in heart disease in women of color. *Journal of Transcultural Nursing*., 12(1), 56-67.
- Guendelman, S., English, P., & Chavez, G. (1995). The effects of maternal health behaviors and other risk factors on immunization status among Mexican-American infants. *Pediatrics*, 95(6), 823-828.

- Gupta, A., & Ferguson, J. (1997). Culture, power, place: Ethnography at the end of an era. In *Explorations in Critical Anthropology*. Durham: Duke University Press.
- Higgins, B., & Learn, C. (1999). Health practices of adult Hispanic women. *Journal of Advanced Nursing*, 29(5), 1105-1112.
- Immigration and Naturalization Services Statistics. (2002). Retrieved 10/19/02, from <http://www.ins.usdoj.gov/graphics/aboutins/statistics/index.htm>
- JCAHO On-line: [http://www.jcaho.org/about+us/news+letters/jcahonline/jo\\_05\\_05.htm](http://www.jcaho.org/about+us/news+letters/jcahonline/jo_05_05.htm)  
Retrieved April 28, 2005.
- Jezewski, M. A., & Poss, J. (2002). Mexican Americans' explanatory model of type 2 diabetes. *Western Journal of Nursing Research*, 24(8), 840-858.
- Jones, M. E., Bercier, O., Hayes, A., Wentrcek, P., & Bond, M. L. (2002). Family planning patterns and acculturation level of high-risk, pregnant Hispanic women. *Journal of Nursing Care Quality*, 16(4), 46-58.
- Juarbe, T. C. (1998). Risk factors for cardiovascular disease in Latina women. *Prog Cardiovasc Nurs*, 13(2), 17-27.
- Kaiser Foundation Health Insurance Coverage (2002). Retrieved 11/22/2003, from <http://www.census.gov/hhes/www/hlthins.html>
- Kaiser Foundation State Facts. (2001). Retrieved 10/10/03 from <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi>
- Kattapong, V. & Becker, T. (1993) Ethnic differences in mortality from cerebrovascular disease among New Mexico's Hispanics, Native Americans and non-Hispanic whites. *Ethnic Disease*, 3, 75-82.
- Keller, A. (1996). *Peopling of America* (4th ed.). New York: American All.

- Kemp, C. (2001). Culture and the end of life. *Journal of Hospice and Palliative Nursing*, 3(1), 29-33.
- Kuba, S. A., & Harris, D. J. (2001). Eating disturbances in women of color: an exploratory study of contextual factors in the development of disordered eating in Mexican American women. *Health Care Women Int*, 22(3), 281-298.
- Kuipers, J. (1995). Mexican Americans. In J. N. Giger (Ed.), *Transcultural nursing: assessment and intervention* (pp. St. Louis, MO): Mosby-Year Book, Inc.
- Leininger, M. (1978). *Transcultural nursing: Concepts, theories, research and practices*. New York: John Wiley & Sons. Reprinted in 1994 by Greyden press, Columbus, Ohio.
- Leininger, M. (1985) *Qualitative research methods in nursing*. Orlando, FL: Gruned & Stratton.
- Leininger, M. (1990) *Ethnomethods: The philosophic and epistemic bases to explicate transcultural nursing knowledge*. *Journal of Transcultural Nursing*, 1(2), 40-51.
- Leininger, M. (1991) *Culture care diversity & universality: A theory for nursing*. New York, NY: National League for Nursing Press.
- Leininger, M. (1995). *Transcultural Nursing: Concepts, Theories, research and Practices*. ( 2<sup>ND</sup> ED)New York: McGraw -Hill.
- Leininger, M. (2001). *Culture Care Diversity and Universality: A Theory of Nursing*. New York, NY: National League for Nursing Press.
- Leininger, M. (2004). The NTPR Project Discussion Board Posted November 18, 2004. Retrieved June 29, 2005 from <http://www.madeleine-leininger.com/>

- Lincoln, G. & Guba, Y. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications.
- Lobell, M., Bay, R. C., Rhoads, K. V., & Keske, B. (1998). Barriers to cancer screening in Mexican-American women. *Mayo Clin Proc*, 73(4), 301-308.
- MacIel, D., & Herra-Sobek, M. (1998). *Culture across borders: Mexican immigrants and popular culture*. Tuscon, Arizona: University of Arizona Press.
- Mandelbaum, D. (1970). *Selected writing of Edward Sapir*. Berkeley, California: University of California Press.
- Marcinkiw, K. (2003) A goal for nursing education. *Nurse Education Today*. 23(3) 174-182.
- Marin, B. V., Perez-Stable, E. J., Marin, G., Sabogal, F., & Otero-Sabogal, R. (1990). Attitudes and behaviors of Hispanic smokers: implications for cessation interventions. *Health Educ Q*, 17(3), 287-297.
- Marin, B. V., Tschann, J. M., Gomez, C. A., & Kegeles, S. M. (1993). Acculturation and gender differences in sexual attitudes and behaviors: Hispanic vs non-Hispanic white unmarried adults. *Am J Public Health*, 83(12), 1759-1761.
- Marin, G., & Van Oss Marin, B. (1991). *Research with Hispanic populations*. Newbury Park, California: Sage Publishing.
- Marotta, S., & Garcia, J. (2003). Latinos in the United States in 2000. *Hispanic Journal of Behavioral Sciences*, 25(1), 13-34.
- McCarty, M. (2000). Fighting for public health along the USA-Mexican border. *Lancet*, 35(6), 1020-1023.

- McQuiston, C., Doerfer, L. B., Parra, K. I., & Gordon, A. (1998). After-the-fact strategies Mexican Americans use to prevent HIV and STDs. *Clinical Nursing Research*, 7(4), 406-422.
- McQuiston, C. & Flaskerud, J. (2000) "If they don't ask condoms, I just tell them": a descriptive case study of Latino health advisers' helping activities. *Health Education and Behavior*, 30(1), 79-96.
- Moffit, P., Wuest, J. (2002) Spirit of the drum: the development of cultural nursing praxis. *Canadian Journal of Nursing Research*, 34(4), 107-116.
- Mosca, L., Jones, W., King, K., Ouyang, P., Redberg, R., Hill, M. (2000) Awareness, perception and knowledge of health disease risk and prevention among women in the United States. *Archives of Family Medicine*, 9(6), 516-517.
- Nachem, B. Community health programs for infants and children in Mexico. *Home Health Care Management and Practice*, 15(5), 416-423.
- NACRHHS (2002) Retrieved on March, 20, 2003 from <http://www.raconline.org/newsletter/web/fall04.html>.
- Neufeld, A., Harrison, M., Hughes, K., Spitzer, D., & Stewart, M. (2001). Participation of Immigrant Women Family Caregivers in Qualitative Research. *Western Journal of Nursing Research*, 23(6), 575-591.
- Ottani, P.A. (2002) Embracing global similarities : A framework for cross-cultural obstetric care. *Journal of Obstetric, Gynecology and Neonatal Nursing*. 31(1), 33-38.
- Ortiz, S., & Casas, J. M. (1990). Birth control and low-income Mexican-American women: the impact of three values. *Hisp J Behav Sci*, 12(1), 83-92.

- Palfrey, D. (1998). Mexico's colonial era: religion and society in New Spain. Retrieved 3/13/04, from [http://www.mexconnect.com/mex\\_/travel/dpalfrey/dpcolonial2.html](http://www.mexconnect.com/mex_/travel/dpalfrey/dpcolonial2.html)
- Papadopoulos, I., Lees, S. (2002) Developing culturally competent researchers. *Journal of Advanced Nursing*. 37(3), 258-264.
- Patton, M.Q. (1990) *Qualitative evaluation and research methods*. Newbury Park, CA: Sage Publishing.
- Peragallo, N. P., Fox, P. G., & Alba, M. L. (2000). Acculturation and breast self-examination among immigrant Latina women in the USA. *Int Nurs Rev*, 47(1), 38-45.
- Perez-Stable, E. J., Napoles-Springer, A., & Miramontes, J. M. (1997). The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. *Med Care*, 35(12), 1212-1219.
- Polit, D., & Hungler, B. (2003). *Nursing research: Principles and methods* (7th ed.). Philadelphia: Lippencott.
- Purnell, L. (1998). Mexican Americans. In L. Purnell & B. J. Paulanka (Eds.), *Transcultural health care* (pp. 397-421). Philadelphia: F.A. Davis.
- Purnell, L. & B. J. Paulanka (2003), *Transcultural health care*. Philadelphia: F.A. Davis.
- Reason, P. (1998) Political, epistemological, ecological and spiritual dimensions of participation. *Studies in Culture, Organizations and Society*, 4, 147-167.
- Richardson, J. L., Langholz, B., Bernstein, L., Burciaga, C., Danley, K., & Ross, R. K. (1992). Stage and delay in breast cancer diagnosis by race, socioeconomic status, age and year. *Br J Cancer*, 65(6), 922-926.



- Ross, H. (2001). Office of Minority Health Publishes Final Standards for Cultural and Linguistic Competence. *Closing the Gap*, February/March 2001, 1-3.
- Ruiz-Beltran, M., & Kamau, J. K. (2001). The socio-economic and cultural impediments to well-being along the US-Mexico border. *J Community Health*, 26(2), 123-132.
- Ryan, M., Twibel, R.S. (2002) Outcomes of a transcultural nursing immersion experience: confirmation of a dimensional matrix. *Journal of Transcultural Nursing*, 13(1), 30-39.
- Sabogal, F., & Catania, J. A. (1996). HIV risk factors, condom use, and HIV antibody testing among heterosexual Hispanics: the National AIDS Behavioral Surveys (NABS). *Hisp J Behav Sci*, 18(3), 367-391.
- Sapir, E. (1949). *Language* (2nd ed.). New York: Harcourt, Brace and World, Inc.
- Scott, B. (2003). Latina promotoras educate farmworkers. *Closing the Gap*.
- Scott, S. A., Jorgensen, C. M., & Suarez, L. (1998). Concerns and dilemmas of Hispanic AIDS information seekers: Spanish-speaking callers to the CDC National AIDS hotline. *Health Educ Behav*, 25(4), 501-516.
- Scribner, R. (1996). Paradox as paradigm--the health outcomes of Mexican Americans. *Am J Public Health*, 86(3), 303-305.
- Seelye, K. Q. (1994). Accord opens way for abortion pill in U.S. in 2 years. *NY Times* (Print), A1, A16.
- Shearer, R., Davidhiser, R. (2003) Education innovations. Using role play to develop cultural competence. *Jouranal of Nursing education*, 42(6) 273-276.

- Spector, R. (1996). *Cultural diversity in health and illness* (4th ed.). Stamford CT: Appleton and Lange.
- Stasiak, D.B. (1991) Culture care theory with Mexican Americans in an urban context. In M.M. Leininger's (9Ed.) *Culture care diversity and universality: A theory of nursing*. New York, NY: National League for Nursing Press.
- Sundquist, J., & Winkleby, M. A. (1999). Cardiovascular risk factors in Mexican American adults: a transcultural analysis of NHANES III, 1988-1994. *Am J Public Health*, 89(5), 723-730.
- Tate, D.M. (2003) Cultural awareness: bridging the gap between caregivers and Hispanic patients. *Journal of Continuing Education in Nursing*, 34(5), 213-217.
- Title VI of the 1964 Civil Rights Act. 2005. Retrieved May, 5, 2005 from <http://www.usdoj.gov/crt/cor/coord/titlevistat.htm>.
- Thomas, M.D., Olivares, S.A., Kim, H., Beilke, C. (2003) An intensive cultural experience in a rural area. *Journal of Professional Nursing*, 19(3), 126-133.
- Trotter, R. Ed. (1991). *Readings in ethnographic methods*. Phoenix, AZ: University Press.
- U.S. Census Bureau. 2004 sourcebook of census data. Retrieved December 8, 2004 from <http://www.census.gov/>.
- Unger, J. B., & Molina, G. B. (1997). Desired family size and son preference among Hispanic women of low socioeconomic status. *Fam Plann Perspect*, 29(6), 284-287.
- Unger, J. B., & Molina, G. B. (2000). Acculturation and attitudes about contraceptive use among Latina women. *Health Care Women Int*, 21(3), 235-249.

- Urban Institute (2001). Children of Immigrants. Retrieved February 28, 2003, from <http://www.urban.org/urlprint.cfm?ID=7670>
- Urban Institute (2004) Undocumented immigrants: facts and figures. Retrieved June, 2, 2005 from <http://www.urban.org/Template.cfm?NavMenuID=24&template=/TaggedContent/ViewPublication.cfm&PublicationID=8685>
- Urdaneta, M. L., Livingston, J., Aquilar, M., Enciso, V., & Kaye, C. (2002). Understanding Mexican American cultural beliefs and traditional healing practices. San Antonio: University of Texas, Department of Pediatrics.
- Van Oss Marin, B., Gomez, C. A., & Hearst, N. (1993). Multiple heterosexual partners and condom use among Hispanics and non-Hispanic whites. *Fam Plann Perspect*, 25(4), 170-174.
- Vigil, J. (1998). *From Indians to Chicanos: The dynamics of Mexican American culture*. Prospect Heights, Illinois: Waveland Press.
- Villarruel, A., & Leininger, M. (1995). Culture care of Mexican Americans. In M. Leininger (Ed.), *Transcultural Nursing: Concepts, theories, research and practices* (pp. 365-382). New York, NY: McGraw-Hill.
- Warda, M. (2000). Mexican American's perceptions of culturally competent care. *Western Journal of Nursing Research*, 22(2), 203-224.
- Weist, M. D., Finney, J. W., Barnard, M. U., Davis, C. D., & Ollendick, T. H. (1993). Empirical selection of psychosocial treatment targets for children and adolescents with diabetes. *J Pediatr Psychol*, 18(1), 11-28.

- Wenger, A.F. & Wenger, M. (1988). Community and family care patterns of the old order Amish. In M.M. Leininger' (Ed.), *Care discovery and use in clinical community nursing*. Detroit: Wayne State University.
- Wilkinson, N. (2003, July 3, 2003). Who's using whom? Undocumented workers in Southwest Ohio. *Dayton City Paper*, pp. 10-12.
- Winthrop, R. H. (1991). *Dictionary of concepts in cultural anthropology*. New York, NY: Greenwood Publishers.
- Woods, N. (1994). The United States Women's health research agenda analysis and critique. *Western Journal of Nursing Research*, 16(5), 467-479.
- Zambrana, R. E., Breen, N., Fox, S. A., & Gutierrez-Mohamed, M. L. (1999). Use of cancer screening practices by Hispanic women: analyses by subgroup. *Prev Med*, 29(6 Pt 1), 466-477.
- Zoucha, R. D. (1998). The experience of Mexican Americans receiving professional nursing care: an ethnonursing study. *Journal of Transcultural Nursing*., 9(2), 34-44.
- Zoucha, R., & Reeves, J. (1999). A view of professional caring as personal for Mexican Americans. *International Journal for Human Caring*., 3(3), 14-20.