# NIH Public Access

## Author Manuscript

*Health Psychol*. Author manuscript; available in PMC 2006 August 30.

Published in final edited form as:
*Health Psychol*. 1995 December ; 14(7): 632–640.

# Panel V: Adaptive Health Behaviors Among Ethnic Minorities

**Shirley P. Bagley**,
*Chair*

**Ronald Angel**, **Peggye Dilworth-Anderson**, **William Liu**, and **Steven Schinke**
*Members*

## Abstract

Race, ethnicity, and cultural attitudes and practices are among the variables that influence health behaviors, including adaptive health behaviors. The following discussions highlight the important role of social conditions in shaping health behaviors and the central role of family in promoting health across the Asian, Hispanic, Native American, and African American ethnic groups. Factors that may lead to health-damaging behaviors are also discussed. The need for additional research that identifies correlations among physiological, social, and behavioral factors and health behaviors, as well as underlying mechanisms, is called for.

### Keywords

aging; behavior; coping; ethnicity; health

---

Although little is known about the adaptive health behaviors of minority groups, in this article, we nevertheless summarize what is currently known, using both empirical research and theoretical treatises. We address the adaptive health behaviors of four minority groups: Asian Americans, Native Americans, African Americans, and Hispanic Americans. Although there are many similarities, each group presents unique issues related to the study of adaptive health behaviors.

Adaptive health behaviors among Asian Americans are discussed with regard to the usefulness of race and ethnicity as variables in the study of behavior. We suggest that Asian cultural diversity needs to be understood by researchers before they can meaningfully engage in health research with this population. This is especially true because cultural expectations and norms shape the adaptive structures within a culture. We use the cultural characteristics of mainland China and their association with health behaviors as an example.

The discussion on Native Americans emphasizes the influence of social conditions on their health behaviors. We also focus on the health habits and practices of young Native Americans and their potential effects on future health status. We suggest how to intervene in the lives of Native American adolescents to help alter their responses to health-changing conditions.

---

Correspondence concerning this article should be addressed to Shirley P. Bagley, National Institute on Aging, National Institutes of Health, Building 31C, Room 5C35, 9000 Rockville Pike, Bethesda, Maryland 20892..

Panel members are listed alphabetically.

Shirley P. Bagley, National Institute on Aging, National Institutes of Health, Bethesda, Maryland; Ronald Angel, Department of Sociology, University of Texas, Austin; Peggye Dilworth-Anderson, Department of Human Development and Family Studies, University of North Carolina, Greensboro; William Liu, Department of Sociology, University of Illinois, Chicago; Steven Schinke, School of Social Work, Columbia University.

William Liu is now at the Division of Social Science, Hong Kong University of Science and Technology, Clear Water Bay, Hong Kong.

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

The last two discussions in this article on African Americans and Hispanics focus on cultural indicators that may help to better understand health behaviors among these two groups. In both discussions, it is clear that the family serves as a major force that helps develop and maintain health-promoting and health-damaging behaviors.

Indeed a common thread among all four discussions is that familial influences must be considered to better understand adaptive health behaviors among minority groups. Thus, future research may benefit from approaches that allow for an examination of individual health behaviors situated in a familial context.

## Asian Americans

### Ethnicity as a Research Variable

There is a conspicuous absence of systematic research on Asian Americans' health status and a corresponding lack of data on adaptive health strategies in this population. There are a number of reasons for this, and they are given elsewhere by Yu and Liu (1992). Briefly, two major reasons for the lack of Asian American health research should be mentioned. First and foremost is the diversity of Asian Americans as cultural groups with respect to major language origins, racial heritage, and religious beliefs and levels of economic development. The sampling of Asian American subgroups poses an enormous problem of sample design accompanied by prohibitive costs associated with sample acquisition. A second and related reason is that there is insufficient political reason to obtain health data from Asian Americans given the myth that Asians are the "model minority" who can take care of their own problems.

Given the lack of information on adaptive health strategies in Asian Americans, our descriptions of the culturally shaped and health-relevant adaptive strategies in this group must be restricted to some carefully collected data on Chinese populations in Shanghai and Hong Kong as examples. Although there are certainly vast differences between Chinese in Shanghai and Hong Kong and those in the United States, these data may nevertheless be used to highlight some of the cultural issues that may be relevant to many Chinese Americans. The Shanghai data come from an on-going and much published database that began in 1987 and deals with the study of the lives of older persons. The sample was selected from one health district consisting of 5,055 households obtained using stratified cluster sampling. The Hong Kong data come from a similar study that took place in 1991 and was based on a random sample of all households that consisted of at least one person 65 years of age and older. Both studies focused on senile dementia and Alzheimer's disease. We selected a number of relevant topics that may shed some light on the adaptive strategies of Chinese families in dealing with old age care.

### Social Support

Following current practices, we measured social support using items that accessed social ties; social network; community participation; contacts with friends, relatives, and coworkers; and the presence of confidants. In general, measures of social support were positively related to the degree of life satisfaction and feelings of loneliness and were negatively associated with depressive symptoms as measured by the Center for Epidemiologic Studies—Depression scale. These older respondents expressed preference for sharing a residence with their adult children and grandchildren, and these parental and grandparental relationships seemed to be more important than other social ties. With respect to confidants, men most often named their wives as their confidants, whereas women most often named their adult sons. However, widowed husbands, in the absence of a spouse, turned to their children as their confidants. Finally, an overwhelmingly large proportion of older persons and their children still held on to the traditional values of filial piety and, the obligation of adult children to take care of their aging parents. In addition, having confidants was significantly associated with one's general well-

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

being, life satisfaction, and the absence of loneliness. Other forms of social support, formal or informal, that were not related to familial social ties were generally inconsequential with respect to life satisfaction.

It could be argued that urban China, especially Shanghai, has been isolated from outside, non-Socialist societies for so long that the social structure with respect to neighborhoods and *danwai* (one's work unit) might have had an extraordinarily strong impact on the lives of people. Urban China remains very much *agemeinschaft,* in Tonnies' sense, and social support is determined by the individual's ties to work and social groups. However, we found that much is the same in Hong Kong, which is quite different with respect to social and work roles. Both Hong Kong and Shanghai have a high population density and are generally short of adequate housing. It thus is not surprising to see that household size is small and a household is only available to nuclear family members. Yet, the use of household composition as a measure of the family may mistakenly lead people to believe that nuclear families are the mode in this region. In Shanghai, for example, the necessity of having nuclear units (because of the urban housing shortage) is compensated by what Pan (1991) called the "network of nuclear units" dominated by the parental household. Myron Cohen (1991) cogently pointed out that the change of the Chinese family structure and functions are related to a pragmatic adaptation to preserve the traditional values. It should be remembered that the Chinese strangely value lineal obligations that keep the parents' and children's generations mutually supportive at different times of the family cycle. Children are cared for by their parents when the need for parental care is obvious. Conversely, parents preferred and obtained the care from their children when the former became aged. Here, the need for care requires the nuclear family of the children's generation to make whatever adjustment necessary to ensure the well-being of the older family members. This is an important point often neglected by family sociologists when they discuss the global trends of nuclearization of the family.

## Family Structure

The above discussion leads to further explication of the interaction between family and race and care of aged parents. During the past decade, a number of independent studies, including the reports of two successive general censuses of China, have shown that there is a growing trend of what is usually called the "stem family." The first such report came from Fei (1991) on the basis of his successive visits to a village he studied for 40 years. This singular report of such a change challenged many studies of Chinese urban families, which reported that the dominance of the nuclear family was the result of the declining number of multigenerational families under the socialist regime.

In spite of the dominance of the nuclear family, which in many cases is as much the result of the urban housing shortage between 1949 and 1980 as it is the deliberate attempt to discontinue the traditional extended family, there remains a large proportion of nuclear families that includes one or two older grandparents. Whether this is considered a stem family or a nuclear family depends on whether one has the perspective of the older or the younger generation. Instead of saying that there is an increasing number of nuclear families with one or two parents residing in the household of the young couple, Fei (1991) concluded that there is really an increasing number of stem families. This type of residence has made it easier for the middle generation to care for both their parents and their young children. Fei's observations were confirmed by Cohen (1991).

In the context of these recent reports on the changing Chinese family, the Shanghai data demonstrated that there exist both stability and transitions. Family living provides familial support to its members at different stages of the family cycle. When third-generation children need parental care and first-generation grandparents can assist in child rearing, the nuclear unit becomes more flexible and better adapted to the demands of career development and child

NIH-PA Author Manuscript

rearing. This seems to be a collective solution to problems of the young and the old. Unlike the episodic social support given at times of need in the West, the spousal and filial support in Shanghai is much more stable, permanent, and culturally sanctioned. It is an adaptive, though not unique, solution to both the demands of urban living and the need among older persons to have close familial ties during the latter portion of their life cycle.

### Family Adaptation to Older Persons' Social Support Functions

When older immigrants from Asia arrive in the United States to live with their adult children, they view social support as deriving primarily from family members. According to a Western value system that values individual freedom and independence, this could induce stress. However, the result could be pathological, neutral, or even positive, depending on the cultural values of the family. In American society, the family adapts to the needs of children by moving to a better school district, making financial sacrifices or even changing jobs, adjusting the time of the family supper, or even postponing holidays. In China, adjusting one's lifestyle for older parents is no different from providing care and support to one's children. The only difference is that the person being cared for is at a different end of the age spectrum.

Child development experts have argued that children should be cared for by natural parents. Unless parents are unfit for the job, this idea has been considered to be a guiding principle in the U.S. court system, buttressed by the cannons of social welfare practice. In contrast, the ethos, at least in the West, is that when the roles of care giving and care-needing are reversed, it is natural for aged parents to be cared for in institutions, rather than by their natural children at home. This prevailing view in America is also gradually influencing health practitioners in many Asian countries. The Shanghai data remind us that the mere presence of adult children is still considered to be the most desirable form of social support by their older parents. It is therefore not surprising that many older Asians in America prefer to be cared for by their natural children. Anecdotal observations suggest that three-generation families are emerging as important institutional adaptive strategies for Vietnamese, Cambodia, and Laotian families. Unfortunately, reports of such strategies have not appeared in professional journals. Such adaptive strategies should be considered to be an important element in understanding health and health care in Asian Americans.

## Native Americans

Much evidence suggests that the health of Native Americans is worse than the health of America's general population (Mahoney, Michalek, Cummings, Nasca, & Emrich, 1989; Mao, Morrison, Semencin, & Wigle, 1986; National Cancer Institute, 1986). Health problems of Native Americans are often cited in relation to poverty and substance use. According to the Indian Health Service (IHS) 1990 data, over 28% of the Native American population falls below the poverty line, compared with less than 13% of the general population (Schinke, Botvin, & Orlandi, 1991). The percentage of high school and college graduates among Native Americans is lower than among the general population (55% vs. 66%, and 7% vs. 16%, respectively; Schinke et al., 1990). Native Americans have a rate of alcoholism six times greater than that of all other ethnic groups (Schinke et al., 1988).

Native American people suffer inordinately from cancers linked to behavioral and lifestyle patterns (Beauvais, Getting, Wolf, & Edwards, 1989; Brown, 1994; Mao et al., 1986; National Cancer Institute, 1986). Cancer is the second leading cause of death among Native American women and the third leading cause of death among Native American men (U.S. Congress, Office of Technology Assessment, 1986). Whereas cancer was a relatively rare problem for Native Americans in the earlier part of this century, deaths from cancer among Alaska Natives and American Indians in the northern United States now exceed average U.S. rates (Stillman, 1992). What is more, the 5-year survival rate for Native American people with cancer is the

NIH-PA Author Manuscript

lowest of any ethnic group in the United States (Stillman, 1992). Lung cancer is the leading cause of mortality due to cancer among Native Americans (U.S. Department of Health and Human Services [USDHHS], 1991). The most dramatic increase in lung cancer mortality has been among Native American women (USDHHS, 1991).

The unhealthy lifestyle patterns of some Native Americans account for the higher rates of some cancers and other health problems among them. According to the Centers for Disease Control and Prevention (1982), almost half of all factors that influence a person's chance of surviving to age 65 are related to lifestyle behaviors. Relative to cancer, about 30% of cancer incidence is related to tobacco use, and about 50% of all cancer deaths are related to diet (Cunningham-Sabo & Davis, 1993).

Because young Native Americans are at particularly high risk for later health problems and because these youth have great potential for learning and adopting adaptive health behaviors, we focus our discussion on the health priorities of Native American youth. Data presented here on adolescent adaptive health behaviors and practices are derived from the Adolescent Health Survey, which was conducted between 1988 and 1990 by the University of Minnesota and the IHS (Blum, 1992). Respondents were 14,000 adolescents from 15 states, 50 tribes, and 200 schools. Enrolled in grades 6 through 12, the adolescents surveyed were equally distributed by gender (49% were boys and 51% were girls) and lived in rural areas and on reservations. Almost 50% of the surveyed adolescents lived in a household with two parents, more than 33% lived with a single parent, and the remaining 17% lived in a household with a nonparent relative or with a nonrelative guardian. The adolescents completed a questionnaire concerning their physical and emotional health, substance use, social support, sexual behaviors, antisocial behaviors, and risk-taking behaviors.

NIH-PA Author Manuscript

## Death Rates

The death rate of Native American adolescents is twice as high as that of youths from other ethnic-racial groups, as revealed by comparison data reported in the study. The death rate of Native American boys 10–19 years old is nearly three times higher than that of all other racial and ethnic groups. For older teens, the ethnic disparity only increases. Native American adolescents 15–24 years old have a death rate three times the frequency from unintentional injuries compared with all other ethnic-racial groups. A large percentage of these deaths are associated with substance use. Unintentional injuries and suicide account for nearly three fourths of the total death rate.

## Physical Health

One fifth of the adolescents described their health as only fair or poor. Two fifths of the girls and one fifth of the boys believe they are overweight. Some youth may be at risk for health problems due to insufficient exercise, use of tobacco, and diets high in fats and cholesterol and low in vegetables, fruits, and fibers. Poor physical health was found to be related to problems at school, at home, with drug abuse, and from suicide attempts. Possibly, the link between health and these problems suggests maladaptive coping patterns for Native American youths.

NIH-PA Author Manuscript

About one half of the youths had not had a physical exam in the past 2 years. More than four fifths of the youths had not seen a medicine man in the past 2 years. Half of the boys and three fifths of the girls did not exercise regularly. When assessing their body image, more than one third of the girls said they were not proud of their bodies, whereas less than one fifth of the boys stated the same thing.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript



### Emotional Health

Adolescents rated their emotional well-being during the past month. Poor emotional health was found to be associated with family troubles, lack of supportive adults, various risk-taking behaviors, and suicide attempts. One in five adolescents reported having been a victim of sexual or physical abuse, or both. Adolescents who had attempted suicide, compared with those who had not, invariably reported less favorable emotional well-being, such as feeling bad after sleep, burned out, tense, unhappy, worried, upset, sad, depressed, and lacking in emotional control. Still most of the adolescents surveyed reported high levels of emotional well-being. Nearly 8 of 10 teenagers reported that their family cares about them a great deal; youth who reported that their parents had high expectations of them tended to report doing better in school.

### Social Support

When asked about their relations, male and female adolescents rated their families about equally in regards to caring, understanding, fun, and attentiveness. However, female adolescents expressed a greater urge to leave home than male adolescents and got upset at home more often than males. About one fourth of adolescents who were identified as potential problem drinkers stated a lack of caring on behalf of their parents, family, tribal leaders, school, and church. In light of such correlations, some Native American youth may use alcohol as a means of maladaptive coping when they lack positive social supports. Although the use of alcohol may be a maladaptive means of coping with stress, it may permit individuals to live in settings that lack social support.

### Nutrition

Nutritional adequacy varies from tribe to tribe because of differing sociocultural and economic factors, food availability, and food preferences. Nutritional factors contribute to at least 4 of the 10 leading causes of death in this population (i.e., heart disease, cancer, cirrhosis, and diabetes). Use of traditional foods has declined, and a dependency on purchased staples has increased. A certain degree of dietary monotony is evident. Intake of high-fat foods is widespread, whereas consumption of grains, fresh vegetables, and fruits is infrequent.

This report on the health of Native American adolescents raises concerns about the use of adaptive and maladaptive coping means by these high-risk youth. In particular, the summarized results suggest potential points of intervention in the following areas: youth involvement in programs to improve their own health, family support, health services, drug and alcohol use, and nutrition education. Other reviews on the health of Native Americans are also available. Especially illuminating are data from the National Institutes of Health on comparative rates of adaptive health behavior for Native American people and for members of other ethnic-racial minority groups and with members of the majority culture (Office of Minority Health, 1989; USDHHS, 1985). Rich data are also accessible on such related health-behavior topics as substance use and preventive health practices, as addressed by other panels presented at conferences and published elsewhere (Beauvais et al., 1989; LaFromboise & Rowe, 1983; Mahoney et al., 1989; Schinke et al., 1986,1987).

## African Americans

The literature on adaptive health behaviors among African Americans has been guided, in many respects, by three assumptions: (a) adaptive behaviors among African Americans are cultural in nature; (b) adaptive health behaviors are influenced by macrosocial conditions of the society; and (c) adaptive health behaviors are dynamic to the extent that they are changed and altered by situational factors. These assumptions are not mutually exclusive but instead represent variables that may influence and interact with one another. The idea that adaptive health behaviors are cultural in nature and are influenced by the broader society suggests that they

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

may exist within culturally accepted and appropriate norms and beliefs that are transactionally negotiated within the broader society. The literature also suggests that most adaptive behaviors are linked to shifting priorities and resources among African Americans that are determined by larger systems outside the African American community, such as economic and political institutions (Farley & Allen, 1987). It would follow then that shifting priorities and resources change the nature of adaptive health behaviors and influence appropriate behaviors given available resources. Thus, health behaviors can be dynamic to the extent that resources made available by the broader society and cultural group can change them. Therefore, culturally accepted adaptive behaviors are developed and maintained, for example, by learning to access, translate, and use a health care delivery system in the face of changing health status, income, employment status, and racial climate of the society. The following discussion focuses on the roles African American families play in developing and maintaining adaptive health behaviors that are shaped by culture, society, and changing conditions.

## Culture, Family, and Adaptive Health Behaviors

Culture is defined as a total way of life of a group of people and is spiritual, ideological, behavioral, emotional, material, and physical in nature (Keith, 1990). African American families are defined by both blood and relational linkages. Although most kin are related by blood, this is not a requisite. Family membership is not determined by blood only but by the nature of the relationship between individuals who share values, norms, and beliefs. Relational or fictive kin can have the same place, significance, and meaning as blood relatives in the family system. This definition of African American families is exemplified by White-Means and Thornton's (1990) and Lawton, Rajagopal, Brody, and Kleban's (1992) research on care giving to older persons in Black families. White-Means and Thornton found that taking care of others in the family is not necessarily determined by blood relationships. Their findings showed no difference in incentives to provide care to close relatives and fictive kin in African American families. This was not found among other ethnic groups in their study, with the exception of Whites. Lawton et al. (1992) found that Black caregivers of older persons could just as likely be a close or distant relative, and quality of care did not vary by closeness of blood relationship to the older person.

Given the definition of African American families and the cultural context of family functioning among African Americans, the family serves as a translator, negotiator, gatekeeper, stress absorber, and stress buffer for family members. Furthermore, the family serves as the primary group that gives meaning to, provides interpretation for, and helps create a response repertoire for developing and maintaining certain behaviors. The family also prepares its members to meet and respond to societal conditions that influence their survival and that of the group (Billingsley, 1992). Given the many roles African American families play in assisting and preparing their members for life skills and survival, developing and maintaining adaptive health behaviors are viewed here as a major role of the family. However, not all African American families can provide assistance that fosters adaptive health behaviors. Although the African American community has become more middle class in the past 20 years, a growing underclass, increasing teen and single parent households with poor mothers and children, also appeared in the past 20 years (Horton & Smith, 1990). As a result, for many African American families, such changes in the family may inhibit them from providing as sistance to family members to promote adaptive health behaviors.

Although it is beyond the scope of this discussion to address all the specific cultural aspects of the family that influence adaptive behaviors, family expectations and normative behaviors are emphasized here. Family expectations regarding sharing of burdens and problems have served the African American community very well. These expectations have influenced the size and composition of family support networks, proximity to kin, and the kind of support

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

that family members provide one another (Billingsley, 1992; Chatters, Taylor, & Jackson, 1985). For example, research showed that over 50% of low-income African American women who had low birth weight babies had lower perceived family functioning scores than did mothers who had normal weight babies (Reeb et al., 1986). These authors also found that both perceived size and composition of family network correlated highly with family functioning. Women from larger perceived support networks had fewer symptoms of psychological distress such as anxiety, obsession, hostility, and somatization. This research suggests that African Americans often use their families as stress buffers and stress absorbers and that this represents the development of adaptive health behaviors. It is possible that large, viable kin networks in the African American community provide individuals with the resources to develop and maintain certain health behaviors. For example, large kin networks can share goods and services that help promote and maintain health in the form of providing food and self-care information, networking in the health care community on behalf of the family, and helping translate the health care community to the family. Research shows that African Americans are not as likely to share money as a means of support but are much more likely than Whites to share their time with family members (Dilworth-Anderson & Marshall, in press). Sharing or giving time to a sick family member in the African American community can be viewed as a form of health support when one is ill.

Research also suggests that involving the family in the treatment process is congruent with cultural expectations in the African American community. This is especially significant in therapeutic interventions and in encouraging the use of services (Bass, Acosta, & Evans, 1982). Some findings on African American families' social support to children with sickle cell disease showed that support significantly impacted the children's psychological adjustment to the disease (Hurtig, Koepke, & Park, 1989), compliance with treatment and psychosocial functioning (Dilworth-Anderson, 1994). These findings indicated that individual adaptive health behaviors may not exist to the same extent without the support of family among African Americans. For example, if compliance with a particular medical regimen is needed, presenting the expected health behaviors within a sociocultural framework that the family understands may lead sick individuals to practice adaptive health behaviors.

Research also showed that the family serves as a translator of disease and definer of illness behavior according to cultural beliefs. Cultural norms and beliefs about pain and suffering, therefore, influence the type of care that sick family members seek and accept both within and outside the culture. In addition, family cultural norms govern rules regarding appropriate expressions or acceptance of illness (Hernandez, 1991; Kleinman & Kleinman, 1991).

In many African American communities, cultural beliefs about illness are evidenced by the array of self-care regimens older African Americans often use for certain health problems such as diabetes, hypertension, and arthritis (Davis, McGadney, & Perri, 1990). Cultural beliefs are also evident in the meaning, interpretation, and help-seeking behaviors among some African American families as evidenced by responses to relatives who have Alzheimer's disease and other dementias. For a number of African Americans, particularly in the rural south, Alzheimer's disease and other dementias are viewed from the perspective of "folk medicine" (Snow, 1974; Watson, 1984). In many rural African American communities, a greater value is placed on emotional or affective patterns between individuals and role expectations than on intellectual or cognitive abilities (Gaines, 1989). As a result, individuals with dementia can perform roles within the kin system, even when they are disoriented outside this system. Therefore, a person with Alzheimer's disease may be able to function in the family for a long period of time without causing alarm. This person most likely will not receive any clinical intervention for this disease until advanced mental and physical symptoms are apparent (Gaines, 1989).

Given the manner in which many African American families culturally interpret illness and disease, it is possible, for example, that family caregivers of demented patients may not see a need to comply with the medical community's definitions and expected health behaviors. In these situations, the family's beliefs about the illness, which reflect cultural beliefs, serve to govern individual and family health behaviors (Davis & McGadney, 1993). These family and cultural beliefs are viewed as adaptive in that family members continue to play roles and are maintained within the family. In the case of older Alzheimer's disease victims, these beliefs may serve to lessen the possibility of them being institutionalized, which supports other cultural beliefs in the African American community that foster elder care within the family. Such cultural beliefs and attitudes, whether about Alzheimer's patients or about a child with a chronic health problem, can be used by health care providers in helping establish a framework in which to dialogue with families, design interventions for them, and create culturally relevant mechanisms through which families can interpret, translate, and use the health care delivery system within their cultural frame.

### FutureOutlook

The adaptive health behaviors of African Americans can be developed and maintained within family contexts. These contexts are, in part, shaped by cultural expectations and norms and are influenced by the changing conditions in society. We, therefore, suggest that socially, politically, and economically vulnerable groups, such as many African Americans, will experience difficulty maintaining adaptive health behaviors that have been fostered and developed within the family. Therefore, the strength of the social support system in American families that has addressed health issues may be challenged by changing social and economic conditions that have influenced the health status of the group as a whole. Future research on adaptive health behaviors among African Americans, therefore, needs to focus on contextual and societal factors that challenge families' abilities to develop and maintain behaviors that address health needs and concerns.

## Hispanics

A growing body of research clearly demonstrates that the Hispanic population of the United States is not homogeneous. Each of the three major nationality groups—Mexican Americans, Puerto Ricans, and Cubans—differ in terms of educational levels, income, migration history, and health (Angel & Angel, 1993; Bean & Tienda, 1987). These translate into significant differences in aggregate health levels and risk of disease and death (Angel & Angel, 1993; Heckler, 1986). So far we have very little information on the major health risks faced by each Hispanic subgroup, but the data suggest that adaptive health behaviors associated with a traditional cultural orientation have positive effects. Our task as researchers and as developers of public policyisto identify those adaptive aspects of traditional culture and begin to understand how health care reform and public policy more generally might preserve them.

Perhaps the most intriguing finding revealed by research on Hispanics is the potential protective health effect of a traditional cultural orientation among Mexican Americans. Rosenwaike (1987), for example, documented low heart disease and cancer mortality rates among recent Mexican American, Puerto Rican, and Cuban adult immigrants in comparison with native Whites and Blacks. Rosenwaike, as have many others, speculated that recent migrants have retained protective aspects of their culture of origin.

Unfortunately, certain data suggest that this protectiveness is lost in the process of assimilation. For example, Savitz (1986) reported a convergence in rates of cancer for the Spanish surname population and the general population in Denver, Colorado, during the 1970s. It is highly likely that any protectiveness offered by a traditional cultural orientation is the result of specific behaviors that are lost as the result of incorporation into mainstream U.S. culture. Marcus and



NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Crane (1985), for example, hypothesized that the low incidence of lung cancer among Mexican Americans reported by Samet, Schraag, Howard, Key, and Pathak (1982), therefore, implies increasing male lung cancer rates into the next century. Because smoking and alcohol use among women increase with acculturation and because these behaviors increase the risk of adverse birth outcomes, future generations of Mexican Americans may also suffer poorer health (Amaro, Whitaker, Coffman, & Heeren, 1990; Guendelman, Gould, Hudes, & Eskenazi, 1990; Haynes, Harvey, Monies, Nickens, & Cohen, 1990; Markides, Ray, Stroup-Benham, & Trevino, 1990).

These data for adults are clearly intriguing and suggest that assimilation has complex, and not always positive, health benefits. Unfortunately, so far we do not know how assimilation influences the health of children. However, there are data to suggest that the protectiveness of traditional culture benefits infants as well as adults. For example, Mexican American infant mortality rates compare favorably with those of non-Hispanic Whites (Forbes & Frisbie, 1991). Dodge (1983) reported lower rates of asthma among Mexican American children than among non-Hispanic children.

Although it maybe true that assimilation has adverse health consequences for some Hispanics, it is more likely that acculturation (the process of adopting the culture of the host culture) and structural assimilation (through which one enters the economy of the host society) have somewhat independent effects on health. It is likely, in fact, that individuals and groups who are successful in gaining economic success will have health and functional capacity profiles similar to those of middle-class Americans regardless of their cultural orientation, whereas those who remain in poverty will suffer the greatest detriments in health status as a function of less successful structural assimilation. Net of economic success, in fact, it may be the case that the retention of aspects of one's culture of origin may have negative consequences on health in developed societies like that of the United States. The failure to seek timely medical care because of a suspicion of modern medicine, for example, could result in serious threats to health. So far we do not have a clear understanding of the health consequences of the complex association between acculturation and structural assimilation, and it is clear that such an understanding should occupy a prominent place on our future research agenda.

Family structure is clearly an important determinant of children's physical and mental health (Angel & Angel, 1993). Single mothers, including Hispanic mothers, report their children's health to be poorer than do mothers in two-parent families (Angel & Worobey, 1988a). One of the mechanisms of disadvantage associated with the loss of a traditional cultural orientation maybe the family disruption and strike accompanying poverty and the disorganized environments of many minority communities (Angel & Angel, 1993).

So far we do not have a good understanding of the specific health risks faced by Mexican Americans, Cuban Americans, and Puerto Ricans. Because each group consists of a different genetic pool, as well as a different cultural group, the identification of the major health risks faced by each requires much more focused research. Puerto Ricans, for example, move freely between Puerto Rico and the mainland where they are exposed to the health risks associated with urban decay and a declining economy. Mexican Americans are concentrated in the Southwest where the health risks they face are different. Cuban Americans have been a very successful immigrant group and face a very different health-risk profile than other Hispanic groups (Angel & Worobey, 1988b).

As is the case with other groups, the data strongly suggest that the family plays a major role in preserving the health of Hispanics. Single Hispanic mothers, like single mothers from other groups, report their children's health to be poorer than do mothers in two-parent families (Angel & Angel, 1993). Although single mothers who have adequate economic and social resources

NIH-PA Author Manuscript

can do an excellent job of raising healthy children, the serious disadvantage that single-parent families often experience clearly undermines the health of both adults and children (Angel & Angel, 1993; Granger, 1982; Hansell, 1991; Horwitz, Morgenstern, & Berkman, 1985; Menken, 1972; Starfield, 1990).

The family operates in many other ways to preserve health. The often documented health benefits of marriage most likely result from the social control that one spouse exerts on the other. It might be a nuisance to be nagged about being overweight or about smoking, but if the result is a loss of weight or cessation of smoking, the health benefits are obvious. As with other groups, then, the role of the Hispanic family and of local support systems in the maintenance of health should be investigated extensively. It is hardly necessary to further document the negative health effects of smoking or drug and alcohol abuse. What researchers need to understand better is how aspects of the community and the family control these behaviors.

At a more global level, researchers must also begin to understand how public policy and the social welfare system of the United States affect family life for Hispanics, as well as for other groups. The United States has no formal family policy and, as most everyone has come to appreciate, the U.S. welfare system is not well designed to enhance family life among those in need. We do not wish to imply that all marriages should be preserved, but a welfare policy that makes it almost impossible for a poor family to stay intact or for a single mother to escape welfare dependency is not adaptive.

As the other articles in this special issue make clear, researchers have a long wayto go before clearly understanding the protective aspects of specific cultures. For Hispanics, researchers are beginning to understand the complex process that leads from one's cultural orientation, to one's socioeconomic status and family situation, to specific health-risk behaviors. What researchers still lack is an understanding of how to preserve and encourage those aspects of culture and family that promote health. Understanding how to do so should occupy a high place on social and research agendas.

## References


Amaro H, Whitaker R, Coffman G, Heeren T. Acculturation and marijuana and cocaine use: Bindings from HHANES *1982–84.* American Journal of Public Health 1990;80(Suppl):54–60. [PubMed: 9187583]

Angel, R., & Angel, J. L. (1993).*Painful inheritance: Health and the new generation of fatherless families.* Madison: University of Wisconsin Press.

Angel R, Worobey JL. Single motherhood and children's *health.* Journal of Health and Social Behavior 1988a;29:38–52. [PubMed: 3367028]

Angel R, Worobey JL. The health of Mexican-American children: Impact of acculturation on maternal reports of children's health. Social Science Quarterly 1988b;69:707–721.

Bass, B. A., Acosta, F. X., & Evans, A. (1982). The Black American patient. In F. X. Acosta, J. Yamamoto, & A. Evans (Eds.), *Effective psychotherapy for low income minority patients* (pp. 83–108). New York: Plenum Press.

Bean, F. D., & Tienda, M. (1987). *The Hispanic population of the United States.* New York: Russel Sage.

Beauvais F, Getting ER, Wolf W, Edwards RW. American Indian youth and drugs, 1976–87: A continuing problem. American Journal of Public Health 1989;79:634–636. [PubMed: 2705599]

Billingsley, A. (1992). *Climbing Jacob's ladder: Enduring legacies of African American families.* New York: Simon & Schuster.

Blum, R. (1992). *The state of Native American youth health.* Minneapolis: University of Minnesota Adolescent Health Program.

Brown AC. Dietary survey of Hopi Native American youth. Journal of the American Dietary Association 1994;94:517–522.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Centers for Disease Control and Prevention. *(1982). Riskfactor update: Final report under contract* (USPHS 200-80-0527). Atlanta, GA: Author.

Chatters L, Taylor R, Jackson J. Size and composition of the informal helper networks of elderly Blacks. Journal of Gerontology 1985;40:605–614. [PubMed: 3875644]

Cohen, M. L. (1991). Modernization of the Chinese family: A pragmatic adaptation to traditional values (in Chinese). In J. Chao (Ed.), *Chinese family and its transition* (pp. 15—22). Hong Kong: Institute of Asia/Pacific Research, the Chinese University of Hong Kong.

Cunningham-Sabo L, Davis S. Pathways to health: A health promotion and cancer prevention project for American Indian youth. Alaska Medicine 1993;35(4):275–279. [PubMed: 8160920]

Davis, L., & McGadney, B. (1993). Self-care practices of Black elders. In C. M. Barresi & D. E. Stull (Eds.), *Ethnic elderly and long term care* (pp. 73–86). New York: Springer.

Davis, L., McGadney, B., & Perri, P. (1990). *Learning to live with diabetes, hypertension and arthritis: Self care guides for Black elders* (Manuals I, II, & HI). Lisle, IL: Tucker.

Dilworth-Anderson P. The importance of grandparents in extended-kin care giving to Black children with sickle cell disease. Journal of Health and Social Policy 1994;5:185–202. [PubMed: 10138758]

Dilworth-Anderson, P., & Marshall, S. (in press). Social support in its cultural context. In G. R. Pierce, B. R. Sarason, & I. G. Sarason (Eds.), *The handbook of social support and the family.* New York: Plenum Press.

Dodge R. A comparison of the respiratory health of Mexican-American and non Mexican-American White children. Chest 1983;84:587–593. [PubMed: 6628011]

Farley, R., & Allen, W. R. (1987). *The color line and the quality of life in America.* New York: Oxford University Press.

Fei, H. (1991). The changing structure of the Chinese family: A rejoinder. In C. Jian (Ed.), *Chinese family and change* (pp. 3—8). Hong Kong: The Chinese University of Hong Kong Press.

Forbes D, Frisbie WP. Spanish surname and anglo infant mortality: Differentials over a half century. Demography 1991;28:639–660. [PubMed: 1769407]

Gaines A. Alzheimer's disease in the context of Black southern culture. Health Matrix 1989;6:33–38. [PubMed: 10318202]

Granger, C. (1982). Maternal and infant deficits related to early pregnancy and parenthood. In N. J. Anastasiow (Ed.), *The adolescentparent* (pp. 33–45). Baltimore: Brookes.

Guendelman S, Gould JB, Hudes M, Eskenazi B. Generational differences in perinatal health among the Mexican American population: Findings from HHANES, 1982–84. American Journal of Public Health 1990;80:61–65. [PubMed: 9187584]

Hansell MJ. Sociodemographic factors and the quality of *prenatal care.* American Journal of Public Health 1991;33:1135–1140.

Haynes SG, Harvey C, Monies H, Nickens H, Cohen BH. Patterns of cigarette smoking among Hispanics in the United States: Results from HHANES 1982–84. American Journal of Public Health 1990;80:47–53. [PubMed: 9187582]

Heckler, M. (1986). Secretary's foreword and charge to the task force. In *Report of the secretary's task force on Black and minority health* (Vol. 1, p. 9). Washington, DC: U.S. Department of Health and Human Services.

Hernandez GG. Not so benign neglect: Researchers ignore ethnicity in defining family caregiver burden and recommending services. The Gerontologist 1991;31:271–272. [PubMed: 2044999]

Horton, C. P., & Smith, J. C. (1990). *Statistical record of Black America.* Detroit, MI: Gale Press.

Horwitz SM, Morgenstern H, Berkman LF. The impact of social stressors and social networks on pediatric medical care use. Medical Care 1985;23:946–959. [PubMed: 4021580]

Hurtig A, Koepke D, Park K. Relation between severity of chronic illness and adjustment in children adolescents with sickle *cell disease.* Journal of Pediatric Psychology 1989;14:117–132. [PubMed: 2723954]

Keith, J. (1990). Aging in social and cultural context: Anthropological perspectives. In R. Binstock & L. George (Eds.), *Handbook of aging and the social sciences.* New York: Academic Press.

Kleinman A, Kleinman J. Suffering and its professional transformation: Toward an ethnography of interpersonal experience. Culture, Medicine, and Psychiatry 1991;15:275–301.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript


LaFromboise TD, Rowe W. Skills training for bicultural competence: Rationale and application. Journal of Counseling Psychology 1983;30:589–595.

Lawton P, Rajagopal D, Brody E, Kleban MH. The dynamics of care giving for a demented elder among Black and White families. Journal of Gerontology 1992;47:103–114.

Mahoney MC, Michalek AM, Cummings KM, Nasca PC, Emrich LJ. Mortality in a Northeastern Native American cohort, 1955–1984. American Journal of Epidemiology 1989;129:16–26.

Mao Y, Morrison H, Semencin R, Wigle D. Mortalityon a Canadian Indian reserve 1977–1982. Canadian Journal of Public Health 1986;77:263–268.

Marcus AC, Crane LA. Smoking behavior among U.S. Latinos: An emerging challenge for public health. American Journal of Public Health 1985;75:169–172. [PubMed: 3966624]

Markides KS, Ray LA, Stroup-Benham CA, Trevino F. American Journal of Public Health 1990;80 (Suppl):42–46. [PubMed: 9187581]

Menken J. The health and social consequences of teenage childbearing. Family Planning Perspectives 1972;4:54–63.

National Cancer Institute. (1986). Cancer in minorities: Report of the subcommittee on cancer, part I. *Report of the secretary's task force on Black and minority health.* Washington, DC: U.S. Department of Health and Human Services.

Office of Minority Health. (1989). *Cancer and minorities.* Washington, DC: Author.

Pan, Y. K. (1991). The hypothesis of the nuclearization of urban Chinese family. In C. Jian (Eds.), *Chinese family and its transition* (pp. 81–92). Hong Kong: Institute of Asia/Pacific Research, the Chinese University of Hong Kong.

Reeb KG, Graham AV, Kitson G, Zyzanski S, Weber MA, Engel A. Denning family in family medicine: Perceived family vs. household structure in an urban Black population. The Journal of Family Practice 1986;23:351–355. [PubMed: 3760797]

Rosenwaike I. Mortality differential among persons born in Cuba, Mexico, and Puerto Rico residing in the United States, 1979–81. American Journal of Public Health 1987;77:603–606. [PubMed: 3565656]

Samet JM, Schraag SD, Howard CA, Key CR, Pathak DR. Respiratory disease in a New Mexico population sample of Hispanic and non-Hispanic Whites. American Review of Respiratory Diseases 1982;125:152–157. [PubMed: 7065516]

Savitz DA. Changes in Spanish surname cancer rates relative to other Whites, Denver area, 1969–71 to 1979–81. American Journal of Public Health 1986;76:1210–1215. [PubMed: 3752322]

Schinke, S. P., Botvin, G. J., & Orlandi, M. A. (1991). *Substance abuse in children and adolescents.* Newbury Park, CA: Sage.

Schinke SP, Orlandi MA, Botvin GJ, Gilchrist LD, Trimble JE, Locklear VS. Preventing substance abuse among American Indian adolescents: A bicultural competence skills approach. Journal of Counseling Psychology 1988;35:87–90. [PubMed: 17392927]

Schinke SP, Orlandi MA, Schilling RF, Botvin GJ, Gilchrist LD, Landers C. Tobacco use by American Indian and Alaska Native people: Risks, psychosocial factors, and preventive intervention. Journal of Alcohol and Drug Education 1990;35(2):1–12.

Snow, L. F. (1974). Folk medicine and older Blacks in southern United States. In W. Watson (Ed.), *Black folk medicine* (pp. 53–66). New Brunswick, NJ: Transaction.

Starfield, B. (1990). Social factors in child health. In M. Green & R. J. Haggerty (Eds.), *Ambulatory pediatrics* (pp. 30–36). Philadelphia: W.B. Saunders.

Stillman, P. (1992, September 23). Racism, poverty contribute to high cancer death rates. *Lakota Times,* p. B4.

U.S. Congress, Office of Technology Assessment. (1986). *Indianhealth care* (Publication No. OTA-H-290). Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services. (1985). *Report of the secretary's taskforce on Black and minority health. Vol. II: Crosscutting issues in minority health.* Washington, DC: Author.

U.S. Department of Health and Human Services. (1991). *Cancer mortality among Native Americans in the United States.* Washington, DC: Author.

Watson, W. (1984). *Black folk medicine: The therapeutic significance of faith and trust.* New Brunswick, NJ: Transaction Books.

White-Means S, Thornton M. Ethnic differences in the production of informal home health care. The Gerontologist 1990;30:758–768. [PubMed: 2286334]

Yu ESH, Liu WT. U.S. national health data on Asian/Pacific islanders: A research agenda for the 1990s. American Journal of Public Health 1992 December;82:12.

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript