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Health and illness conceptualization of Mexican American children, ages 8-12



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Health and Illness Conceptualizations of Mexican American Children, Ages 8 - 12:

An Ecological Perspective

by

Diana Esperanza Amaya Rodriguez

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

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in the

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of the

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Dedication

This dissertation is dedicated to:

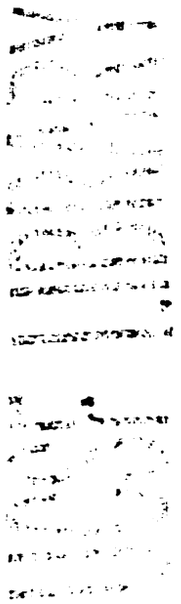
To Joaquin, my husband, you are my hero, and the wind beneath my wings. To Gabriel, my son, my biggest distracter and biggest reason for finishing, you are the light of my life. On to this new phase of our lives. I love you both so much!

And, to the memory of my mom and dad,Esther and Ismael Amaya. You showed me that all things are possible, and provided an environment that allowed me to grow and thrive.

...la vida de tu hijo es como una semilla que has sembrado y ha brotado en el jardín de tu hogar. Y tú, como padre, eres el jardinero que ha de darle la atención necesaria para que crezca y se desarolle normalmente hasta que llegue a la madurez.

[Translated]

...the life of your child is like a seed that has been sown and has sprouted in the garden of your home. And you, as the parent, are the gardener who needs to give the necessary attention so that your child can grow and develop normally until they reach maturity.
(Amaya, 1970, p. 7)



Acknowledgments

Although this journey in this phase of my life was often a lonely one, I was not alone at all. For, God has blessed me with so many special people who helped to support and guide me all along the way.

I wish to thank Dr. Christine Kennedy for mentoring and guiding me along the process as I embarked on this journey. You helped me to realize that I am capable of scholarly contributions. You also helped me to cultivate a love for research with, about, and for children, and, that it is alright to have fun in the process. To Dr. Janice Humphries, thank you for teaching me about qualitative research and for sticking with me. I will forever remember you reminding me to go back to my original research questions when I got stuck or went off on a tangent. And to Dr. Susan Kools, thank you so much for coming in with fresh eyes and cheering me on.

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To Mary Lynch, you were my first impression of UCSF, you gave me encouragement to return to and stay in school. To Dr. Jeanne DeJoseph for your care and nuturing as I prepared to give birth to my son and the qualifiying examination papers.

Anita Ali, Edward Amaya and Louis Amaya for your love, support, and caring. To Rebeca Ross, for all the different ways you helped support me, like, taking Gabriel on Fridays and SG.

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To my Informants, both children and parents. I am honored and touched that you shared your experiences, drawings, and homes with me. Your stories inspired and motivated me in so many. Without you, this research would never have happened. You have my most

humble and deeply felt gratitude.

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Abstract

HEALTH AND ILLNESS CONCEPTS OF MEXICAN-AMERICAN CHILDREN, AGES 8 - 12: AN ECOLOGICAL PERSPECTIVE

by Diana Esperanza Amaya Rodriguez

Much research and theorizing on the development of children have been done without reference to the cultural and social context in which it occurs, resulting in a dearth of research linking cultural and ethnic factors to child development theories utilized with Mexican American children. Factors such immigration, acculturation, and the Mexican family context, all which shape psychosocial adaptation, make direct applications of child development theories to Mexican children limited in their usefulness without further study. Discovering how Mexican American children conceptualize health and illness will help in developing culturally competent nursing interventions, an objective set forth by Health People 2010.

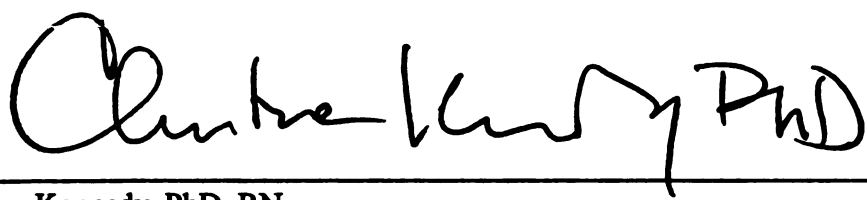
The purpose of this study was to explore and describe the Mexican American child's conceptualization of health and illness; and to explore and describe factors that contribute to how a Mexican American child conceptualizes health and illness.

A contextualized approach was utilized in this ethnographic investigation with Bronfenbrenner's Theory of Ecology. The data analysis followed the Developmental Research Sequence as described by Spradley (1979). Data collection consisted of participant observation in school and family environments, and interviews with 23 children and their parents in English and Spanish and drawings from the children.

The way that these children conceptualized health was in a very positive way. Being healthy meant that they felt good physically, and about themselves, and they had a sense of hope

for the future. They participated in achieving health by making choices about nutrition, exercise, life style choices, and in taking care of themselves. The children conceptualized illness in terms of how they felt physically and emotionally. A significant influential factor in their conceptualizations were there parents. Factors found in the parents that seemed to be reflected in the children included their outlook on life that one has to *Seguir Adelante* so that one can move on in spite of difficult circumstances; and that even though they had a belief in God, they still had to do everything they could to keep their children safe and healthy.

The children and parents did not leave health and illness issues up to chance. Regardless of the education, language ability, and income the parents sought medical health care. Although, the children and the families identified with the Mexican culture in positive ways and with a sense of pride, the decisions and choices that these families made about their health and healthcare were not grounded in cultural preferences. Rather the parents seemed to make their choices about health care on what was the best way to take care of their children.



Christine Kennedy, PhD, RN

Dissertation Committee, Chair

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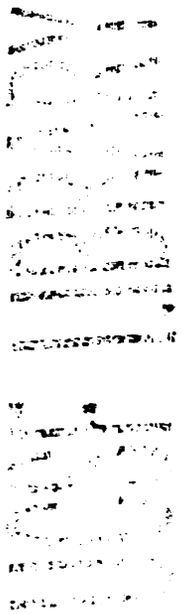

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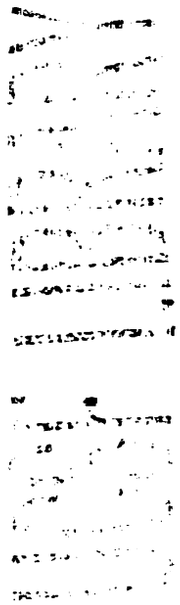

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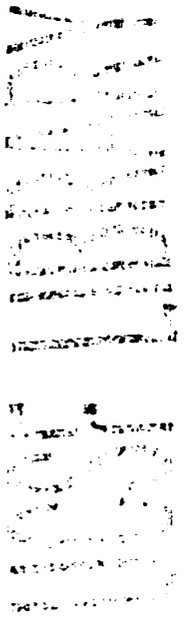

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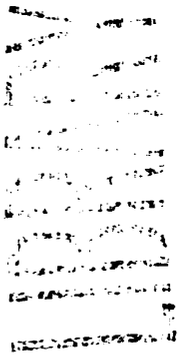
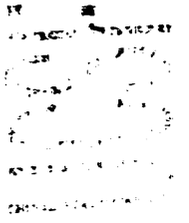
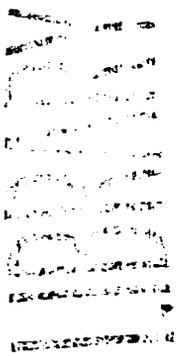


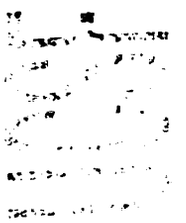


# CHAPTER ONE

# LATINO CHILDREN AND THE SIGNIFICANCE OF THEIR ENVIRONMENTS TO THEIR HEALTH STATUS

In this chapter the purpose of the study and its significance will be introduced. The factors that will be discussed have the potential to influence the conceptualizations of health and illness of Latino school-aged children: their health status, and the family as a significant context of the environment and acculturation.





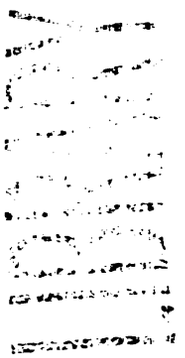
## Introduction To The Problem

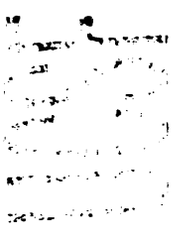
### *Latino Children*

In the United States (U.S.), Latinos comprise the largest, fastest growing, and youngest ethnic minority group. In 2000, approximately 12% of the total U.S. population was Latino (U.S. Census Bureau, 2000b). The majority of Latinos live in the West comprising up to 44.7% of the population, as compared to 32.8% of non-Hispanic whites (U.S. Census Bureau, 2000b). The number of Latino children has grown faster than any other racial and ethnic group, growing from 9% of the child population in 1980 to 16% in 1999 (Federal Interagency Forum on Child and Family Statistics, 2000). In some California cities, Latino children, under the age of eighteen years of age make up approximately 55% of the total population of children (A. E. Casey, 1997). Projections indicate that by 2020, more than one in five children in the U.S. will be of Latino origin (Federal Interagency Forum on Child and Family Statistics, 2000).

Latino school age children are often at increased risk for disease and disability as a result of poverty, as well as limited access to and utilization of health care services

(Mendoza, 1994). Latino children represent 16.2% of all children in the U.S., yet comprise 29% of all children in poverty (U.S. Census Bureau, 2000b), in spite of the efforts of their parents to pull their families out of poverty (Miranda, 1991). Although child poverty rates have decreased by more than 25% since 1993, poverty rates for Latino children remain high at 28%, while poverty rates for White children are at 9% (National Center For Children in Poverty, 2002). Key factors that contribute to their poverty status include Latino parents' low hourly earnings, and their parents' greater likelihood of not having a high school diploma. The lack of education and their minority status makes them more vulnerable to changes in the economy, and to persistent and widespread employment discrimination (Miranda, 1991).



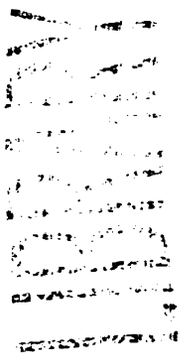


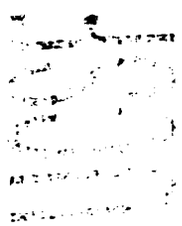
*Who Is A Latino?*

There is such a diversity within the Latino population that no one has found an identifier acceptable to all members of this complex group (Goldsmith, 1993). The category Latino does not really exist except as a classification created by federal statisticians to provide data on people of Mexican, Cuban, Puerto Rican, Dominican, Colombian, Salvadoran, and other Latin American nationalities (Massey, Zambrana & Bell, 1995). In theory, "Hispanic" refers to those who can trace their origins to an area colonized by Spain, but in reality this definition portrays few common traits, instead reflecting tremendous national diversity (Massey et al., 1995).

The heterogeneity of Latinos in national origins in part reflects the great variation in the timing of each group's arrival, and Massey and associates (1995) have summarized the history of the arrival of Latinos in the following categories. In 1836, Mexicans and

Spaniards who settled in the Southwest long before the Anglos arrived became U.S. citizens following the 1848 Treaty of Guadalupe Hidalgo between Mexico and the U.S. The migration of people coming to the U.S. from Mexico began around 1890 and this movement continues. Puerto Ricans acquired their citizenship through colonial conquest in 1898. Cubans arrived primarily between 1960 and 1990. Most recently Dominicans, Salvadorians, and Guatemalans have started to migrate to the U.S. Additional factors limiting generalizeability of research conducted with Latinos to the entire Latino population include issues of acculturation, education, language skills, socio-economic status, regional differences, and number of generations in the U.S. (Council of Scientific Affairs, 1991).

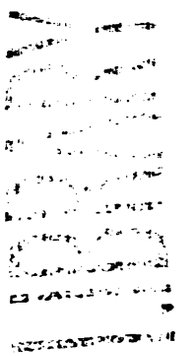


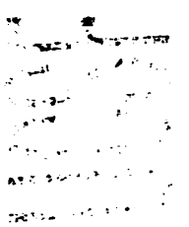


As noted above, many researchers have focused on Latinos who are poor, leading to the assumption that all Latinos are poor. However, there is an understudied Latino middle and upper class that is rarely addressed in the literature (Brischetto, 2001; Zate, 1994). For the 9.52 million people (43.6% of Latinos) in the U.S. who make up the Hispanic middle class, assimilation and cultural conflict remain vital issues. Yet, despite being well-educated, well-informed, and well-paid, these Latinos remain largely unknown. For now, the media, the political system, corporations and health care research seem to project all Latinos as poor, working-class, and newly immigrant. There is no documentation of the health status and health and illness beliefs among the Latino middle or upper class.

As racial and ethnic minorities continue to become a larger portion of U.S. society, their lives, family diversities and family values will need to be better understood

(Baca Zinn, 1995). Outside of the Hispanic research community, Latino families have persisted in remaining an afterthought in most theoretical developments, continuing to be studied with methods and models that were developed among African Americans (Massey et al., 1995). Although the status of Latino families is affected by some of the same dynamics that other families of color face, there are aspects of Latinos that make their experiences unique (Ortiz, 1995). For example, Latino families are generally younger with more children. Many Latino families are immigrant families, so they are struggling to adjust to a foreign language and a new culture. These experiences are occurring at a time in the U. S. of unstable economic conditions with declining opportunities for less-skilled workers.

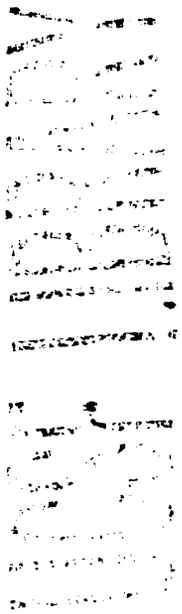




*The Latino Family*

There are about 7.6 million households with a householder of Latino origin, constituting approximately 11% of all U.S. households (U.S. Census Bureau, 2000a). The majority (63%) of the Latino households are Mexican, about 15% are Central and South American, 10% are Puerto Rican, 5% are Cuban, and 7% are classified as Other Hispanic (U.S. Census Bureau, 2000a). Hispanic households are more likely to be family households (81%), as are the majority of all households in the U.S. (67%) (U.S. Census Bureau, 2000b). But the family composition of Latino families is different from non-Hispanic households (U.S. Census Bureau, 2000a). About 68% of Latino family households are married-couple families, contrasted with 78% of the non-Hispanic family households (U.S. Census Bureau, 2000a). Families headed by females are 23% of all Hispanic families, and families headed by a males are 5% (U.S. Census Bureau, 2000a).

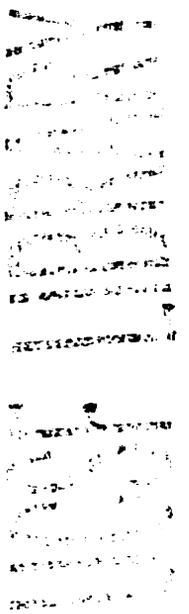
Non-Hispanic households headed by females and males are 17% and 5% respectively (U.S. Census Bureau, 2000a). In 1999, 23.3% of Latinos were employed full-time earning $35,000 or more, as compared to 49.3% of non-Hispanic workers (U.S. Census Bureau, 2000b). The proportion of Hispanic workers making $50,000 or more was 9.6%, while 27.4% of the non-Hispanic workers were at that level (U.S. Census Bureau, 2000b). Latinos are more likely than non-Latino whites to work in service occupations (19% and 11.8% respectively) (U.S. Census Bureau, 2000b). Furthermore, Latinos were almost twice as likely to be employed as operators and laborers than non-Latino whites, and only 14% of Latinos are in managerial or professional occupations as compared to 33.2% of non-Latino whites (U.S. Census Bureau, 2000b). In 1999, 22.8% of Latino families fell below the poverty level, compared with 7.7% of non-Hispanic families (U.S. Census Bureau, 2000b). Many of the jobs that Latinos have are disproportionately low paying, nonunionized, with limited fringe-benefits, resulting in dependency on subsidized social and health services (de la Torre & Rochin, 1992).



Research on the Latino family has been quite extensive over the past decades and has been characterized as negative and pejorative, as well as lacking in empirical support (Staples & Mirandé, 1980). More recently, a shift has occurred in the research conducted among Latino families, in that what was once considered primarily exploratory and without comprehensive theoretical grounding (Vega, 1990), has evolved to current family theory and research that is increasingly concerned with understanding the accommodations, vulnerability, and resilience of the Latino family in its endeavor to survive daily living while maintaining cultural roots (Vega, 1995). More specifically, a

major theme that has emerged in Latino family research is about the role and internal dynamics of families and social networks for communication, socialization, distribution of resources, preservation of cultural patterns, family reformation, and immigrant resettlement (Vega, 1995).

The Latino child needs to be studied within the context of the family because a child's psychosocial adaptation occurs and is shaped by the family and its social support networks (Rumbaut, 1994; Solis, 1995). Within the Latino culture, inasmuch as the child's personal identity is attached to the family identity, the family adjustments and crises associated with the process of immigration and adaptation will have strong effects on the behaviors and attitudes of the members of the family (Gil & Vega, 1996). Strong empirical evidence suggests that the quality of social support maintained by the Latino family provides powerful protective effects on health and emotional well-being (Vega, 1995). However, there is no research that adequately examines the health and illness conceptualizations of the Latino school age child within this context.



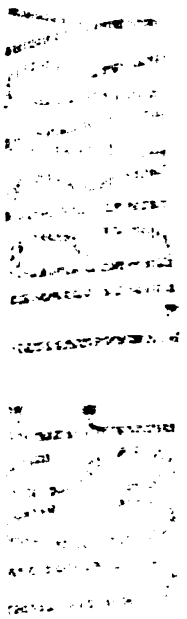
## Immigration and Acculturation

### *Immigration*

Latinos are an immigrant population, making immigration the heart of Latino population dynamics (Massey et al., 1995). International migration as a social process potentially confounds other processes that are related to poverty and family composition in the U.S. and must be considered when conducting research with Latinos. Migration is a selective process and the more barriers there are to entry, the more selective the immigration process (Massey et al., 1995). The more physical, legal, and economic

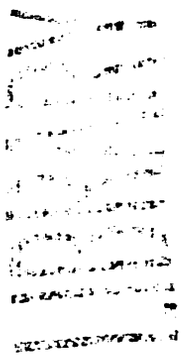
obstacles that are in place, the greater the impact on traits such as motivation, education, and wealth.

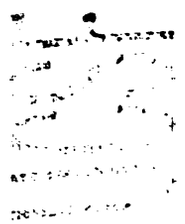
Most discussions about migration seem to be based on the assumption that migration is unidirectional, "they" are coming here to the U.S. to stay. However, a closer examination of the patterns of movement between the sending community and the host community demonstrates that this assumption is erroneous and simplistic. The tale of two cities, Redwood City, CA, U.S. and Aguililla, Michoacán, Mexico, is an example of how the fluid relationship between rural Mexico and the urban North has evolved as people work to build a better life (Garcia, 1995). Immigrants to Redwood City from Aguililla all have family in Mexico and many return on a regular basis with U.S. dollars and influences. Aguililla is often called the "the other Redwood City" (Garcia, 1995, A 1). The impact of its American counterpart is evident from the clothes that the children wear, to a bumper sticker on a car about a child making the honor roll at a school in Redwood City. Likewise in Redwood City, there are many signs of home; in fact, a stretch of Middlefield Road is known as "Little Aguililla" (Garcia, 1995, A 1). As a result of the relationship between the two cities, Aguililla has prospered uncharactistically by Michoacán standards. Having lived with the influence of Redwood City in their Mexican hometown, new arrivals to Redwood City come to a city that has parts of it named after their Mexican hometown.



Américo Paredes has described the border as "not simply a line on a map but, more fundamentally, ... a sensitized area where two cultures or two political systems come face to face" (Rouse, 1991, p. 15). Aguilillans now live in a transnational space and

survive by combining different forms of cultural experiences; in many respects, they have come to inhabit a border zone (Rouse, 1991). The relationship between the two cities is intertwined in so many ways, but the line between them never really disappears. Rouse (1991) determined that the border between Mexico and the U.S. used to be a narrow strip separating the two countries, but now relationships such as those between Aguililla and Redwood City (hundreds of miles apart in distance) prompt one to question how wide this border has become and how peculiar its characteristics are. So rather than migration being a unidirectional phenomenon, it is oftentimes a revolving loop of movement. The circular movement raises the questions: who influences whom; when does acculturation start; and who is acculturating to what?



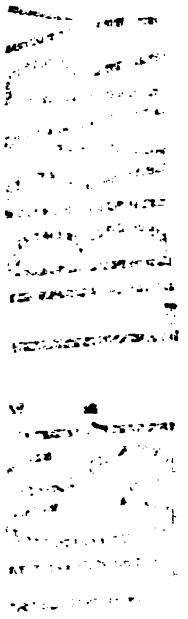


*Acculturation*

Gordon (1964) defines culture as a way of life of a society, consisting of a prescribed way of behaving or norms of conduct, beliefs, values, and skills, along with the behavioral patterns and uniformities based on these categories. However, it is the norms and values of the society which generally determine the nature of the social groupings and social relationships; change and modification come about through the action of persons in social groups. Three functional characteristics of the ethnic group or subsociety are that (1) it serves psychologically as a source of group self-identification, (2) it provides a patterned network of groups and institutions so that an individual is able to confine their primary group relationships to their own ethnic group, and (3) it reflects the national cultural patterns of behavior and values through the prism of its own cultural heritage. Processes that are included in discussions of culture are assimilation and

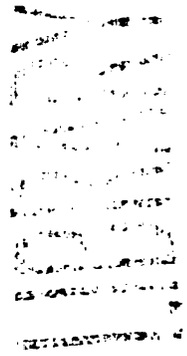
acculturation when one culture encounters another culture.

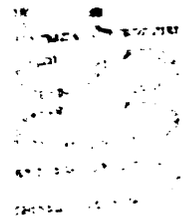
Acculturation has been described as a change in cultural behavior in two cultures that interface, (Berry, 1980; Gordon, 1964). The acculturation literature published by the Social Science Research Seminar on Acculturation in 1954 defines acculturation as "culture change that is initiated by the conjunction of two or more autonomous cultural systems ..." (Favazza, 1980, p. 104). The implications are that acculturation is a process that is mutual and agreeable to both cultures involved, and that there is equal power in the process. However, usually the flow of culture is not balanced; the direction of change is usually predominantly unidirectional, appearing as if one culture is dominating the other (Berry, 1980). Although it would appear that culture change is in one direction, there are changes in the dominant society as a result of the presence of immigrants. Minor modifications such as cuisine, recreational patterns, names of places, and residential architecture have added flavor and variety into the dominant lifestyles, but have hardly changed its Eurocentric nature (Gordon, 1964). Changes in the dominant society occur at regional levels. For example, at a deeper, more subtle level, Rodriguez (1992) described California as "Latin - [where] there is a different sense of leisure here and a freedom from busy-ness" (p. 142) in comparison to the East coast. However, whatever changes that do occur in the dominant society as a result of the acculturative process are not usually acknowledged in research about cultural change.



Research about culture change seems to be based on the assumption that acculturation will be towards the dominant society. Yet, in the U.S. what exactly does that mean? Schlesinger (1992) reported that a dominant "American" society exists, with

Eurocentric roots, but it is being pulled apart by various ethnic/cultural (non-Eurocentric) groups that insist on being recognized. However, West (1993) pointed out that African Americans have never really had equality with the dominant society, even though they have been present in the U.S. since the colonization by Europeans, including Spaniards. Rodriguez (1992) wrote about the "American" society that he watched from the outside looking in as he was growing up, and then as an adult, from within, looking out. Either way, he wrote about the "American" society and his Mexican background as if they were two different worlds. Immigrants and their successive generations would either increasingly ascribe to the values and behavior patterns of the dominant society, or they would acculturate to the norms of the barrio where some characteristics of the traditional culture are maintained (Negy & Woods, 1992).





But what about the 2nd and 3rd generation children who are brought up assimilated or acculturated? Is the return to cultural roots what is meant by Hansen's Law, "what the son [or daughter] wishes to forget the grandson [or granddaughter] wishes to remember" (Schlesinger, 1992, p. 41). Is that de-acculturation or de-assimilation? The process of returning to one's roots has not been observed by researchers, nor has it been considered in research, public policy, or interventions that address acculturation.

*Acculturative Stress*

Berry (1980) has termed a class of behaviors as acculturative stress which occurs as a result of the acculturation process. These behaviors can include such problems as language problems, perceived discrimination, perceived cultural incompatibilities, and commitment or lack of commitment to culturally prescribed protective values/behaviors,

like familism or cultural pride (Gil, Vega, & Dimas, 1994). There are mediating factors that may affect an individual's ability to adapt successfully to one's environment and when the stressors exceed an individual's ability to cope, the negative outcomes occur (Gil, Vega, & Dimas, 1994). Differences in acculturation levels between parents and their children may contribute to all children experiencing acculturative stress as previously discussed.

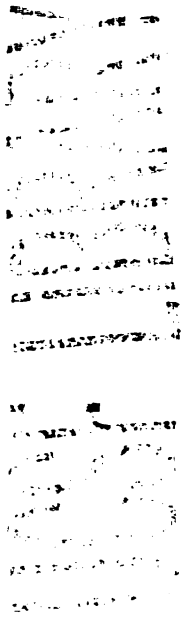
*Measurement of Acculturation*

Generally, acculturation is measured by language usage (Cuellar, Harris, & Jasso, 1980; Deyo, Diehl, Hazuda, & Stern, 1985; Marín et al, 1987). Language is considered one of the more easily measured changes produced by acculturation, therefore, it is considered a reliable shorthand measure for evaluating acculturation. Essentially, language acquisition is being measured.

How is acculturation measured in children? One acculturation scale (Franco, 1983) assessed the level of acculturation by the responses given by adults, usually their teachers, in relation to the children. The questions asked were about such things as the student's language proficiency, parents' occupation, knowledge of language spoken at home, which language and ethnic identifier was thought to be preferred by the student, the educational level of the head of household, what was thought to be the child's musical preference, and the child's citizenship or how many generations the child's family had been in the U.S. The responses reported were the thoughts and perceptions of the teacher about the children. There is no information as to how accurate the responses were. And, as in the adult scales, this tool cannot possibly reflect the whole experience that the child

has in learning to be American.

Measuring acculturation with the current tools has its limitations. First, language usage as a measurement of acculturation is inadequate. How can one indicator such as language reflect as complex a process as acculturation when one has the potential to cope with acculturation in a variety of ways? Language usage does not reflect the circumstances with which an immigrant came to the U.S., or the willingness to learn about living here or the willingness to learn the language or other dominant cultural mores. Secondly, researchers cannot agree on the appropriate definition of the construct and on a measure that satisfactorily assesses it (Negy & Woods, 1992). Third, acculturation has been associated with social status, which is not necessarily reflected in language preference (Negy & Woods, 1992). The multidimensional nature of acculturation may preclude ever having one scale that adequately and sufficiently captures it, possibly requiring multiple measures and methods of assessment (Negy & Woods, 1992).



Measurement of acculturation seems like a snapshot of the level of acculturation attained. But, is acculturation a one-time only event that never changes? At what point is it considered acculturation - when someone first arrives to the U.S., after one year, after two years? Is acculturation ever remeasured (or is the increase in English usage ever reassessed?)

### *Acculturation and Public Health Policy*

Levels of acculturation have been indicators of socioeconomic position, in that those who are more acculturated tend to have higher levels of education and income,

leading to a greater use of health care services, and to potentially better levels of health (Molina, Zambrana, & Aguirre-Molina 1994). Finally, the literature is not clear on exactly how acculturation will be used in public health policy, interventions, or analysis. Will it be used to assess individuals or groups, and then determine a plan of action? Will research be based on the assessments, or will assessments be done prior to individual interventions? Also, acculturation as defined above involves a bidirectional relationship. Will the "American" culture ever be scientifically assessed to determine the influence of other cultures, and how this affects individual acculturation?

Although research seems to support the predictive ability of acculturation and certain health behaviors, measuring acculturation with the current methods is inadequate. Additional knowledge can be gained by considering other factors of the immigrant/minority experience.

## Latino Family and Acculturation

Despite these issues, acculturation is important to consider because it can be a significant predictor of a number of other variables. The level of acculturation has been associated with level of perceived social support (Griffith & Villavicencio, 1985), self-concept (Mainous, 1989), noncompliance with medical therapy in asthmatic children (Pachter & Weller, 1993), low birth weight infants (Scribner & Dwyer, 1989), stronger familism attitudes[1] (Sabogal, Marín, & Otero-Sabogal, 1987), and higher vulnerability to

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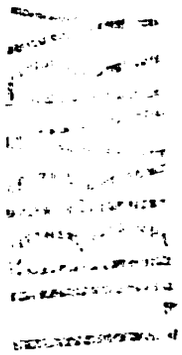
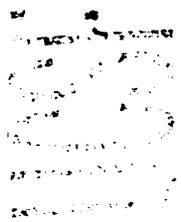
[1] Familism has been defined by Triandis, Marín, Betancourt, Lisansky and Chang as the strong identification and attachment of individuals with their families (nuclear and extended) and strong feelings of loyalty, reciprocity, and solidarity of family members (Sabogal, Marín, and Otero-Sabogal, 1987).

illicit drug use (Vega, Alderete, Kolody, & Aguilar-Gaxiola, 1998). The family environment and acculturation process involves how the values and communication in the families change during the intergenerational process, which are profoundly rooted in cultural changes of both immigrants and their children (Vega, 1995). Studies indicate that acculturation is associated with family dysfunction and higher rates of adolescent pregnancy (Ventura & Tappel, 1985) and difficulties with self esteem (Gil, Vega & Dimas, 1994). And, by or through evaluating the effects of acculturation at the community level, the social nature and the group dynamics within communities, negative effects on the health of immigrant populations have been observed (Vega & Amaro, 1994).





Clinical studies with Cuban families demonstrate that the acculturation process often disrupts the traditionally close-knit family (Szapocznik & Kurtines, 1980; Szapocznik, Santisteban, Kurtines, Perez-Vidal, Hervis, 1984). Szapocznik and colleagues (1984) concluded that current family maladaptive functioning, intergenerational conflict, and intracultural conflict place families at risk for future adolescent drug abuse. Children generally acculturate faster than parents, and boys acculturate faster than girls. Children of immigrant parents end up with the dilemma of learning to deal with cultural practices in the home that often conflict with the American culture that they learn in the school environment. As Rodriguez (1992) wrote,"Immigrant parents send their children to school (simply, they think) to acquire the skills to 'survive' in America. But the children return home as American" (p. 173). Children emerge from their experiences at home and school with different experiences from their parents, which

has the potential to impact their health and future health care practices.

Gil and Vega (1996) discovered that although familism remained high among Cuban and Nicaraguan families, family cohesion deteriorated significantly as a function of acculturation and time lived in the U.S. among these families. Furthermore, high levels of acculturation stress experienced by parents and adolescents had negative effects on parent/child relations by increasing the level of cultural conflicts in the family resulting in detrimental effects on adolescent self-esteem and teacher derogation for Nicaraguan adolescents.

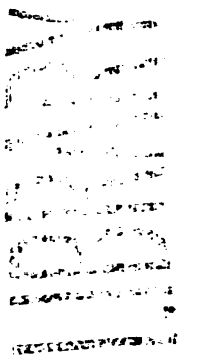
## Influences on Health and Illness

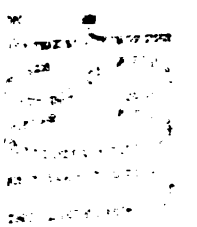
In spite of the quickly growing numbers of Latino children, little culturally relevant literature exists about the health status of school age children (6-12 years old). Much of the information about the health status of Latino children focuses on chronic illnesses and disabilities, low birth rate and mortality, and border health issues (Gutierrez & Maese, 1993; Mendoza et al., 1992; Mendoza & Fuentes-Afflick, 1999). However, while Latino children as a group are depicted as children at risk, specific information about subgroups of Latino children suggests otherwise. For example, when subgroups of Latino children are divided by ethnicity, the health status of Mexican-American children does not appear to be drastically different from those of the general population, while Puerto Rican children have substantially poorer health (Angel & Worobey, 1991; Arcia, Keyes, & Gallagher, 1994, Mendoza & Fuentes-Afflick, 1999). Data about Cuban American children show that their health is consistent with their generally advantaged economic position and success as an immigrant group (Angel & Worobey, 1991; Flores,

Bauchner, Feinstein, & Nguyen, 1999).

*Barriers*

Significant factors exist that affect the health and health care of Latino children. Cornelius (1993) determined that Latino children are disproportionately represented on factors that are considered barriers, which he categorized into three types. The first type of barrier relates to the affordability of health care, such as the availability or lack thereof of insurance and income, and its correlation to homes headed by single mothers (Aday, 1992; Cornelius, 1993; Worobey, Angel & Worobey, 1988). Having health insurance is associated with increased access to care and greater use of services (Flores et al., 1999), and has been determined to be the strongest predictor of access to health care (Hubbell, Waitzkin, Mishra, Dombrink, & Chavez, 1991).



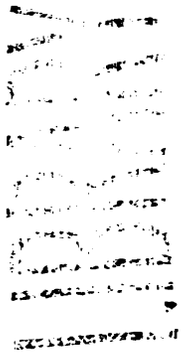


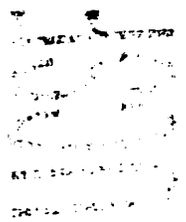
Secondly, barriers exist as a result of geographic or regional location, usually resulting in a smaller range of choices of health providers for residents of inner-city and rural areas (Cornelius, 1993). However, in border areas such as the San Diego area, Mexican immigrants, documented or otherwise, preferred to return to Mexico for health care rather than seek health care in the U.S. side (Chavez, Cornelius & Jones, 1985; Mena, 2002). Those who prefer to seek primary health care in Mexico, find that, although they may find similar treatment and medications closer to home, they can also find the same care south of the border along with cultural empathy, speed and low cost (Mena, 2002).

*Neighborhood Environments*

The neighborhood environments in which Latino children live contribute to their

health, morbidity and mortality. Pedestrian injuries, poisonings, burns, aspirations, and assault injuries were more common among Latino children, partially explained by poverty and overcrowded living conditions, and neighborhood conditions (Winn, Agran, & Anderson, 1994). Kennedy and Rodriguez (1999) discovered that 75% of the children recruited for a study to determine risk-taking behavior in Hispanic children lived in the 2nd, 3rd, and 4th highest crime areas of San Francisco, and that the children played significantly more inside than outside. Less outside play can lead to a decrease in physical activity and exercise which can impede optimal health for a child now and in the future.





*Child's Own Health Status*

And, third, the health status of the child may be viewed as a barrier in that, the poorer the health status of the child, the greater the need for health care, and therefore the more the need was not met, the greater the barrier (Cornelius, 1993). The perceived health status of the child by the mother determines the severity of the illness which determines whether or not they seek health care for the child, and this is related to the cultural definitions of health and illness (Angel & Worobey, 1988; Irigoyne, & Zambrana, 1982).

Additional factors exist that affect the health and health care of Latino children. Access to health care has not been reported to be affected by the residency status of the children, whether as legal or illegal residents (Hubbell et al, 1991). Preventative health care is not a priority to recent Mexican immigrants (Chavez et al, 1985). Medical care is more likely to be obtained Mena, J. (2002, July 29). U.S. insurers tapping a market for cross-border health coverage; Trend: Many southland Latinos seek care in Tijuana, with its ease of language, faster service, and cheaper medicines. *L.A. Times*, pp. B-1. d when

medical problems are acute and readily apparent resulting in care that is delayed, fragmented and episodic (Redlener, 1993). However, it is not clear if this is a reflection of cultural values or the realities of their survival.

*Immigration Status*

Immigrant Latino children are at risk of ill health because the immigration process itself is an intense and stressful process in which children are torn by conflicting social and cultural demands while trying to adapt to an unfamiliar and, at times hostile environment (Board on Children & Families, 1995). Furthermore, studies show that as the length of stay for adult immigrants increased in the U.S., their health declined: those who had lived in the U.S. five years or less were healthier than those had lived in the U.S. ten years or more (Board on Children & Families, 1995). However, in general, very little research has been done about children and the effects of immigration. The research that has been done has focused on risk factors, rather than on protective factors (Prilleltensky, 1993).

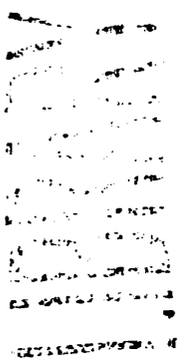
*Parental Background*

Education, income, and ethnic/racial backgrounds of the child's parents are determinants of socioeconomic class that affect the health status of the Latino child (Irigoyen & Zambrana, 1982). More significantly, the mother's educational level appears to be a critical variable, much more than the father's education, family income, and family size. As stated previously, it is the mothers who determine whether or not a child is sick, and whether or not to seek treatment. Choice of health related services is determined by educational level, knowledge of, and ability to obtain these services, (which will be

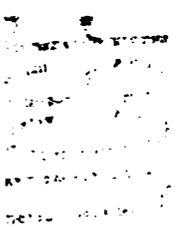
illustrated below). It has also been reported that the less educated a mother is, the more fatalistic her view of health is (Mechanic, 1964); however, more recently the opposite was reported (Mikhail, 1994).

*Ethnic Identity*

Latino children form their ethnic identity through the influence of their own ethnic background along with the experiences that they encounter when in contact with the dominant society (Bernal, Knight, Garza, Ocampo, & Cota, 1990). In the context of everyday observations and interactions in family, peer group, and school and recreational settings, children learn about the actions, thoughts, ways of feeling, values, and repertoires of behavior that are required to fit into their ethnic groups and into the larger dominant society (Martin, 1982).



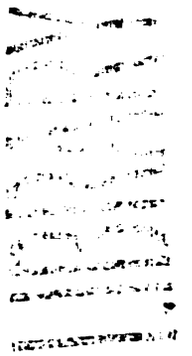
Children also learn about their ethnic identity within the context of the family from their mothers (Cota & Knight, 1991). The more that the mothers identified with and taught about their heritage the more the children identified with and were engaged in ethnic behaviors, and were more likely to speak Spanish (Bernal et al., 1990). Children bilingual in both Spanish and English construct universal and semantic representations for nonverbal concepts that parallel both languages, which are influenced by culture and language (Gonzalez, 1994). Although the role of the mother has been written about, the role of the father is rarely mentioned.

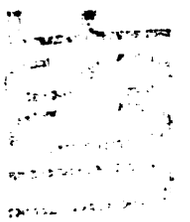


*Downward or Upward Movement?*

The choices that parents make in terms of the social environment plays a crucial role in the course that their children's lives will take, which may explain second-

generation outcomes and their "segmented" character (Portes, 1996). The social contexts that the children encounter make them either vulnerable to downward assimilations or better able to withstand the challenges of acculturation (Portes, 1996). It appears that the children of immigrants no longer adapt to the "mainstream American culture" (Portes, 1996). Portes (1996) has observed three distinct forms of adaptation, which he called "segmented assimilation" (p. 72). The first, is the description of acculturation into the white middle class. The second and third forms of adaptation are linked to the societal environment and the positive or negative effects on children. They either acculturate to permanent poverty and assimilation to the underclass, or they make rapid economic advancement with intentional efforts to preserve the immigrant's community values and tight solidarity. There are several factors that contribute to the outcome, including skin color, language, and immigrant communities.





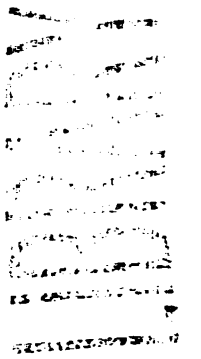
*Skin Color*

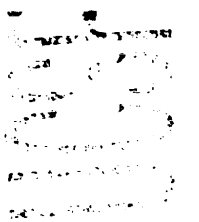
The color of their skin is an extrinsic characteristic that may cause children to experience discrimination in a way they never did before immigrating. By virtue of moving into a new social environment that is shaped by different values and prejudices, physical features can potentially become handicaps. Latinos are a racially heterogenous population because of the variety of origins, including European, African, Asian, American Indian, and various other "mixtures" (Massey et al., 1995). As a result, race is a divisive influence among Latinos. Color prejudice exists in Latin America, but it is more subtle and more intertwined with social class. Race is not viewed as a dichotomy, but rather as a continuum. The racial diversity that exists when Latinos encounter the White

culture, forces them to deal with racial tension that is different from their own cultural system of racial classification (Massey et al., 1995; Portes, 1996). U.S. markets reward Hispanics differently on the basis of skin color, in that dark-skinned Hispanics earn lower wages than lighter skin Hispanics (Massey et al., 1995).

*Language*

Language is a significant determinant as to whether or not a child will assimilate upward or downward. Data indicates that a majority of Latinos are either bilingual or monolingual Spanish speakers (Massey et al., 1995). There does not appear to be a penalty when one is bilingual in the labor market, in fact, it may even be rewarded. However, Latinos who are not English speaking have lower wage earnings, and reduced opportunities for advancement. Latinos who do learn English well and graduate from high school tend to achieve the same socioeconomic level of the dominant group. Language must be recognized as a principle mediating factor that affects how Latinos adapt and react to changing social and economic conditions in U.S. society. Therefore, measuring language usage in acculturation scales still is important as limited as it is.





Often, when parents are Spanish speaking only, their bilingual children are used as translators, possibly placing them in awkward positions (Prilleltensky, 1993). This issue has significant implications for the health care setting. It is not appropriate for children to be relaying confidential, potentially private, difficult, and complicated information back and forth. Furthermore, there is no way of assuring that their language skills are adequate. Using the children as a translators also raises issues regarding the role they have in the family and the possible conflicting power that is given them for this role.

*Immigrant Communities*

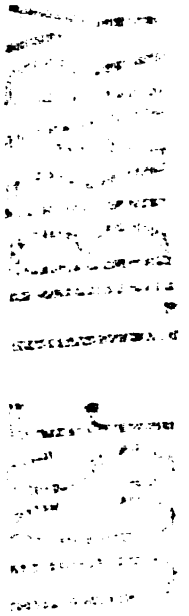
The concentration of immigrant households in cities puts new arrivals in contact with native-born minorities, leading to an identification of the conditions of immigrants and the native poor. The second-generation youth become socialized to the marginalized native youths and their ways of coping in their difficult situations. Because, they don't know of other ways of coping to counteract the native youth influence, they adopt a marginalized perspective, possibility limiting future possibilities for upward mobility.

The communities that Latinos live in can be viewed as communities of limited opportunities or as a resource made up of available well-established networks (Portes, 1996). Children of immigrants either assimilate to the adversarial existence at the bottom of the mobility ladder (a network of resources within a community by which a person can attain upward mobility) or create a niche in which members of the second generation can exist can bypass outside discrimination and the threat of vanishing mobility ladders. Massey and her colleagues (1995) indicated that Latinos are less vulnerable to downturns in the economy and therefore, less likely to form underclass communities, implying that there is a lesser degree of segregation for Latinos. However, Moore (1989) points out that all minority groups are impacted by economic shifts, and that for Latinos, the effects differ based on geographic regions. There are enclaves of stable economies which have become niches in which immigrants find themselves. And, while they do not get people out of poverty, they do provide the communities with a wage-based economy. These niches can be viewed as either a barrier to upward mobility, they can be viewed as an environment with intentional efforts to preserve the immigrant's community values and

tight solidarity, thereby enabling children to grow up without encountering discrimination, nor with a desire to seek the upward mobility ladder.

### *Cultural Influence*

And finally, there are cultural scripts in the Latino culture that may lead to socially desirable responses (Marín & Marín, 1991). For example, when approached to be invited to participate in a study, they may verbally agree to participate, but in actuality may not want to participate and have little or no actual follow-through for appointments. Triandis, Lisansky, Marín, and Betancourt (1984) determined the presence of *simpatía* as a cultural script for Hispanics. A cultural script is a pattern of social interaction that is representative of a particular group. *Simpatía* is a characteristic that implies a tendency toward avoiding interpersonal conflict, emphasizing positive behaviors in agreeable situations, and de-emphasizing negative behaviors in conflictive circumstances. Simpatía has been explained as a result of cultural values that include *respeto* (respect) and *dignidad* (worthiness).



### *Public and Social Policies*

Likewise, public health policy that has been developed without considering the unique qualities of Latino children and their families can potentially result in policies that are of little value to them, their families, and their communities. Gaps in scientific knowledge about the environmental contexts in which they live or the processes through which these environments affect the course of child development exist resulting in inappropriate public polices (Bronfenbrenner, 1979b). Public policies, regulations, court decisions and other institutions that affect the Latino child and his family are based on

various assumptions about how the American family "ought" to be (Garbarino, Gaboury & Plantz, 1992). If these assumptions are applied to all families, implying that families "should" be this way, rather than families "may" be this way, then the effects of these policies will not help diverse families, but may in fact punish them.

Public policies impact the availability of health care, or the perceived availability of health care on the part of parents. Proposition 187 was passed in the state of California in November 1994. The proposition was designed to limit the availability of health care and education to individuals (basically, the children) suspected of being in California without legal documentation. Although the proposition passed, eventually it was successfully challenged in 1998, rendering it unenforceable (Garcia y Griego 2002). However, the passage of the proposition had a fatal effect in the life of at least 1 child in Southern California. The parents, not knowing that they would not be denied treatment and would not be reported for lack of legal documentation, delayed seeking treatment for their child, and sadly, as a result of the delay, the child died. And, lest one think that young children are not aware of such faraway abstract things like public policies, oftentimes they are. For example, in my pilot study, a six-year-old boy spontaneously began talking about Proposition 187 during an interview, that took place before the incident just described (Rodriguez, 1995a, lines 384-429):

> (Child): 187, that's a bad. That's a bad, people can't go to school and they have to go to another place... That's why the baby's going to Mexico [referring to a family friend and her baby sharing the house with this family]...
>
> (Interviewer): Does it scare you?

(C): Yeah.

(I): Do you think about it?

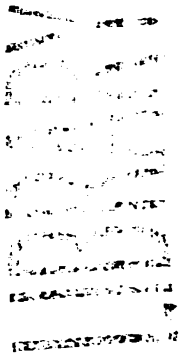
(C): Yeah....It's not really for kids.

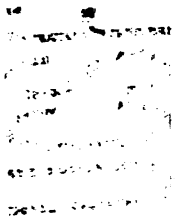
(I): Well, it affects kids...Do you think 187 will make people not go to the doctor?

(C): Nope, and when you sick you have to die.

(I): Cause of 187?

(C): Yeah...When I get bigger 187...I'm going to say no.





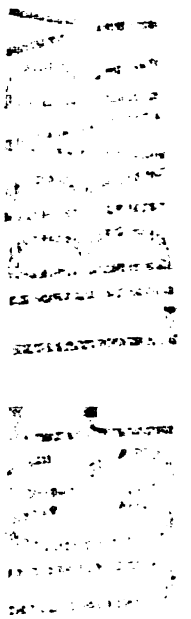
*Summary*

Although the home environment sets the stage for how and what children learn about the world, children individualize and adapt what is communicated to them. Children either vary the information to some degree or create new beliefs (Aamodt, 1972; Porter & Villarruel, 1991). Factors found in the Latino culture need to be considered when studying the health and illness beliefs of Latino children.

Children's ethnic identity has the potential to impact their health status. Ethnic identity is a multidimensional notion that consists of a set of one's own ideas about membership in one's own ethnic group (Bernal et al, 1990). Identity formation is knowing who one is, and where one is situated in the systems of one's life (Garbarino & Kostelny, 1992). School-aged children begin to see themselves in the context of families and other people, such as friends and teachers. The development of ethnic identity is influenced by the ethnic and racial groups with which one identifies, which groups are preferred, and the attitudes toward one's own group and the majority group (Garbarino & Kostelny,

1992).

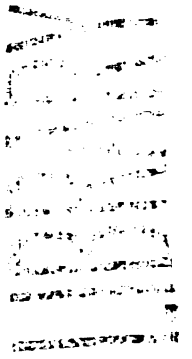
Establishing one's identity is a difficult and complex process in and of itself; however, ethnic and minority children who differ in color, language, and appearance from the dominant group are presented with even more challenges since they must also deal with prejudice and discrimination by individuals and institutions (Garbarino & Kostelny, 1992; Rumbaut, 1994). Experiences or perceptions of exclusion and rejection on racial or ethnic grounds undermine acculturation into the dominant society, resulting in acculturative stress which is associated with higher levels of depressive symptoms and greater parent-child conflict (Rumbaut, 1994). Acculturative stress can also result from acculturation gaps between children and their parents (Gil, Vega & Dimas, 1994). Additional effects of acculturative stress, discrimination, and prejudice may be manifested as poor performance in school or as health complaints in the health care system (Luna, 1992). Acculturation and the family will be discussed further in the next section.

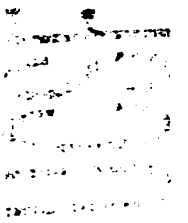


In conclusion, evidence suggests that there are many factors in the social-cultural environment of the Latino children that affects their health status and in turn might affect how they conceptualize health and illness. Some of these factors are poverty, access to health care, their personal health status, their environments, immigration, the level of education of their parents, more specifically of the mother, family income, ethnic/racial backgrounds of the child's parents, ethnic identity and public policies. As is evident, none of the factors discussed occurs without including the family environments of the children's lives.

## Statement of the Problem

Much of the research done to date has many limitations and its relevancy for Latino children has not been demonstrated. Research and theorizing on the development of children has been done without reference to the cultural and social context in which it occurs (Harkness, 1980). By ignoring the cultural context to describe children's development, the differences between the structure of development and the structure of the child's environment are not made clear, leading to the assumption that all children have the same structure of development regardless of environmental influence (Harkness, 1980). What has been deemed as "normative" developmental stages or processes have been based on Western or Eurocentric middle-class behavior. Direct applications of child development theories to Latinos for cross-cultural research cannot be done because those theories do not take into consideration factors such as the family context and issues of acculturation. A cultural view of the developing child must be taken that will show that the family is the key mediating structure of that culture, the crucible in which is forged the child's developing competence (Edgar, 1995).





How Latino school-age children, ages 8-12, conceptualize health and illness is an area that needs to be studied within an environmental context, because how they conceptualize health and illness may impact their health status. Their health problems may have cultural underpinnings affected by the family's cultural perspective of health (Mendoza 1994). Latino children are at higher risk for disease and illness due to factors in their environment such as poverty, limited access to health care, educational level of their parents, and the neighborhoods in which they live. School-aged children have significant

health concerns as demonstrated in self-ratings of health, especially in Spanish speaking Mexican-American and Puerto Rican youth (Mendoza et al., 1992). Although these manifestations may be similar in other cultural groups, they may also be expressed differently by Latino children. Furthermore, exactly what these cultural underpinnings are that are affected by the family's perspective of health have yet to be articulated. As a result there is a dearth of research linking cultural and ethnic factors to concepts of health and illness in childhood (McCubbin, Thompson, Thompson, McCubbin, Kaston, 1993).

Research and theorizing on the development of Latino children without including the family environment has limited generalizeability for them. A cultural view of developing children within the family context must be taken because the family is the mediating structure of culture in a child's development. Health and illness conceptualizations in school-aged children need to be examined within the context of the family because a child's psychosocial adaptation occurs and is shaped by the family and its social networks. Acculturative stress is a potential effect of the acculturative process, and has resulted in family disruptions, low self-esteem and teacher derogation, and may have significance in health concerns.

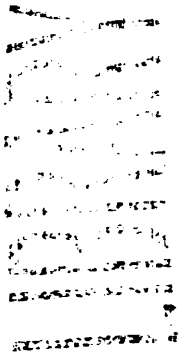
## Purpose of the Study

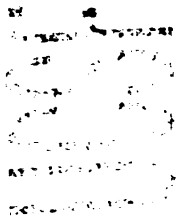
The purpose of the study was to investigate the following questions: first, how do Mexican-American children, ages 8-12 years old, within the context of their families, conceptualize health and illness? And, second, how are their conceptualizations of health and illness influenced by their family, and cultural and social environments?

## Significance Of The Study

### *Relevancy for Latino Children*

The perspectives of Latino children on health and illness need to be considered because factors exist in their socio-cultural environments that significantly impact the health and health status of Latino children. These factors include affordability of health care (Cornelius, 1993), geographic or regional location (Corneluis, 1993), the perceived (Angel & Worobey, 1988; Irigoyne & Zambrana, 1982) or actual (Cornelius, 1993) health status of the child, the immigration process (Board on Children & Families, 1995; Prilleltensky, 1993), ethnic identity and perceived racial discrimination (Gil, Vega & Dimas, 1994; Rumbaut, 1994; Luna, 1992), and public policy. All of these factors are determined and mediated by their families. By seeking the voices of Latino children about their concerns, feelings, and experiences in their words and language, the knowledge generated will indeed reflect their perspective and lived experience. As health care providers, we can provide better culturally relevant care and interventions based on these children's and their families' perspectives. Learning how Mexican-American children conceptualize health and illness will help to develop nursing interventions and public policy that are culturally relevant, an objective set forth by Health People 2010 (Jackson, 2001).



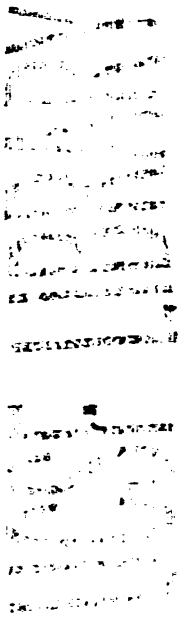


### *Implications for Nursing Practice and Public Policy*

One of the fundamental goals of pediatric nursing practice is to provide family-centered nursing care with children because the family is largely responsible for the child (Foster, 1989). The family most significantly enhances or hinders the child's

development, and it is the family to which that child must be ultimately be accountable. The family also is where the child learns about the thoughts, feelings, values, and repertoires of behavior that are required to fit into their groups and into the larger dominant society (LeVine, 1977; Martin, 1982; Zayas, 1994). Currently, there is a great challenge to deliver appropriate health care and social services to children and their families in a population that represents a growing ethnic diversity (Lewit & Baker, 1994).

Yet, as much as the child is viewed within the context of the family in clinical practice, prevalent research on conceptualizations of health and illness does not reflect this perspective. Most of the previous research done on how children conceptualize health and illness has taken the child out of the context of the family. The perspective of investigating school-aged children's concepts of health and illness only within a unidimensional perspective, for example, only in the individual cognitive framework, does not fully advance research-based family-centered nursing practice.

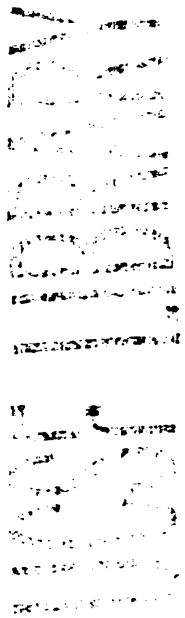


Nursing theorists have included the concept of the environment as a principal element in the nursing paradigm, along with persons, health and nursing (Chinn & Kramer, 1991). Yet, Chopoorian (1986) argues that currently the environment is thought to be a rigid, static concept that does not inform the nursing paradigm in a meaningful way, nor does it foster inclusive images and relationships. The environment needs to be more fully integrated into nursing theory and research because it includes social, political, and economic structures that also produce human, social relations where domination, power, and authority are reproduced in everyday human interactions. Furthermore, the social world and its structures make up the framework of everyday life of people,

characterized by their habitual, mundane, routine activities, which has not been of much interest to most disciplines. It is in the mundane routine habits in which people live and exist until something interrupts the regular. This mundaneness is the least understood or addressed by researchers. Yet, it is from this mundaneness that people react and respond, making interpretations out of everyday life (Chopoorian, 1986).

## Summary and Conclusion

In conclusion, research and theorizing on the development of Latino children without including the family environment has little relevancy for them. A cultural view of the developing child within the family context must be taken because the family is the mediating structure of that culture in children's development. Health and illness conceptualizations in school-aged children need to be examined within the context of the family because a child's psychosocial adaptation occurs and is shaped by the family and its social networks. Acculturative stress is a potential affect of the acculturative process, and has resulted in family disruptions, low self-esteem and teacher derogation, and may have signficance in health concerns.



# CHAPTER TWO

# CHILDREN'S CONCEPTUALIZATIONS OF HEALTH AND ILLNESS: A CRITICAL ANALYSIS OF CURRENT RESEARCH AND INTRODUCTION OF BRONFRENBRENNER'S ECOLOGY OF HUMAN DEVELOPMENT

The importance of considering the perspective and environment of Mexican-American children, ages eight to twelve, in understanding how they conceptualize health and illness has been demonstrated, yet, such a study has not been done. In this chapter the previous research that has been conducted to determine how school-age children in general conceptualize health and illness will be discussed. However, direct applications of the research findings have limited applicability to Mexican-American children, necessitating a new and fresh approach to this area of research. The *Ecology of Human Development* will be introduced as a theoretical framework to be utilized in this study to determine how Mexican-American children, ages eight to twelve, within the context of their families, conceptualize health and illness. Its historical background, propositions, definitions, assumptions and application to the study will be presented.

## Current Status of Conceptualizations of Health and Illness

How children conceptualize health and illness has been the focus of research for several decades. A concept is a mental idea that encompasses the attributes of a variety of events (such as health and illness), generally serving an adaptive function (Pidgeon, 1985). A child usually has a set of concepts that is used for interacting with the environment. Environmental stimuli are distinguished and absorbed into one's conceptual repertoire. Children react to environmental stimuli primarily through a process of

assimilation and interpretation. Therefore, their health and illness concepts are their beliefs about health and illness.

Authors have speculated that knowledge of how a child conceptualizes health and illness could allow health care providers to appropriately approach children and their families when educating, supporting, and intervening about issues of health maintenance, illness prevention, and illness treatments (Bibace & Walsh, 1980; Kalnins & Love, 1982; Perrin & Gerrity, 1981; Wood, 1983). It may be that when children receive explanations that are understandable and appropriate, they will have a greater sense of control and decreased fear over events that occur during an illness (Bibace & Walsh, 1980; Perrin & Gerrity, 1981); however, this has not been substantiated. Although much research has been done to determine how school-age children think about health and illness under the assumption that education can influence health behavior or health related decisions in the future, or that future health care practices may be predicted and possibly changed through education, little research has been done to confirm this (Lewis & Lewis, 1982).

The research selected for review focuses primarily on healthy, school age children, and how they conceptualize health and illness. The review will demonstrate that research about how a child conceptualizes health and illness has evolved in three overlapping phases. The early studies, or the first phase, focused on the child within the context of the family and environment in which the child lived. Around the mid-70's the second phase began with the application of Piaget's theory of stages of cognitive development about how children conceptualize health and illness. Different experiences were thought to influence health and illness conceptualizations, including previous

illnesses, hospitalizations, and chronically ill siblings. All of the research that was based on Piagetian theory supported the notion that how children conceptualize health and illness was dependent on their level of cognition, paralleling Piaget's theory of cognitive development. In the late 1980's and 1990's, the third phase began by returning to investigating whether the family and culture were influential in how children conceptualized health and illness, and broadened the scope of possible influences to include domains and structure of knowledge rather than stages of cognitive development such as the Novice/Expert model. The findings of these later studies call into question the validity of stage development as the sole explanation of conceptions of health and illness. Other aspects that have been studied throughout the history of health and illness conceptualizations are the belief that illness is a punishment and how children define health.

Langford (1948, 1961) was one of the first authors to describe how a child who experiences illness and hospitalizations could become emotionally disturbed. He concludes that children view illness as a punishment, and that the trauma of it could lead to dependency patterns, rebellion, or chronic invalid reactions. Those taking care of sick children needed to be aware that attention to the psychological needs of the child when convalescing is important in the over-all care of the sick child.

*Significance of Family and Culture*

One of the earliest studies attempted to study the conceptualizations of health and illness of school age children within the family (Mechanic, 1964; Rashkis, 1965; Campbell, 1975) and socio-culture contexts (Rashkis, 1965; Aamodt, 1972). Mechanic

(1964) sought to determine to what extent the varied patterns of health and illness behavior could be accounted for by exploring the development of health attitudes and behavior, and also how mothers might influence their children's attitudes.

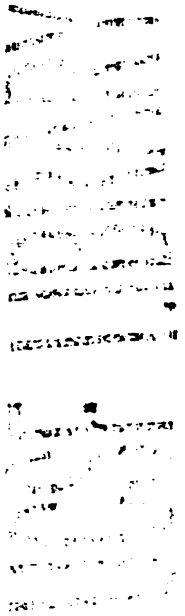
> A wide variety of items and scales were utilized to obtain information about the characteristics of mothers and their children . . . . We have examined hundreds of tables which bear on the hypotheses . . . . However it would be . . . improper to consider these results without taking into careful consideration . . . the cases where the results were not consistent or were even contrary to the hypotheses posed . . . . Our procedure, therefore shall to be to convey the sense of the findings . . . (p. 446).

He concluded that the statistical significance of the findings was "too small and... inconsistency too great" (p. 451) to determine significant maternal influences, except in one area: the attitude of the mother toward health and illness differed with the level of education she had attained, in that the less education she had, the more fatalistic were her attitudes.

Rashkis (1965) speculated that how a child conceptualizes health is dependent on the organization and interpretation the child gives to the perceptions of one's body, to the responses of others to their body, and to the effects of the environment upon their well-being. Furthermore, the mother contributes to the child's conceptualizations of health, which includes her health values, that are adopted from her culture. The child is then oriented to practices, beliefs, and values regarding health initially through the parents (the mother), and then by society. The findings of this qualitative study, during which Rashkis

conducted interviews with children, she demonstrated that health is conceptualized as a positive-toned feeling, that children recognize their limitations at keeping themselves well, that they are vulnerable to illness, and that eating is the most important self-care activity they can do. Although Rashkis indicated that the environment is significant in developing concepts of health, she did not incorporate this into her data collection, analysis and reporting.

Aamodt (1972) based her study of children's health and illness beliefs on the anthropological assumption that inculturation into beliefs, values, and attitudes toward health and healing is a lifetime process. In the children from the Papago reservation in Arizona, the process included transmission and rearrangement of cognitive orientations in the individual within the culturally constituted environment. The younger children did not perceive illness as a result of their actions and thoughts, but the older children did, which was consistent with the adult belief in the Papago belief system that illness can be a result of one's thoughts or that of a relative.



Campbell (1975) worked on the assumption that the growing child's acquisition of social roles depends on learning the concepts that are relevant to those roles. As children grow, they adopt adult perspectives that lead to appropriate role function. Illness is a situation that may serve as a strategic arena where attitude formation, role formation, role learning, and other aspects of acquiring general social orientations occurs. Although the mothers and children had consensus on the salient components on the meaning of illness, knowledge of how a mother defined illness was not predictive of her child's definition. Furthermore, the children's own health history and age seemed to influence their concepts

of illness. As children matured, their knowledge base becomes enlarged, organized, and repeatedly transformed. General intellectual development and unique experiences add to changing conceptualizations, but the extent to which they do may be determined by their level of development.

Natapoff (1978) maintained that the definition of health is difficult to determine because it is culturally determined and this varies. Health is a value or concept that is also derived from one's cognition and ideas. She reported that children view health in a positive way, enabling them to do what they really want to do, like playing. The philosophical nature and content varied with the age of the child. Although Natapoff determined that health was difficult to define because of cultural determinations, she did not make the connection between cultural influences and the findings of the ways children defined health.

*Cultural Explanatory Model For Conceptualizations of Illness*

Kleinman, Eisenberg, and Good (1978) have theorized that conceptualization of illness is shaped by culture in that how we perceive, experience, and cope with disease is based on our explanations of sickness, and the meanings given to it. The model is socioculturally constructed and includes five elements: etiology of disease, onset of symptoms, pathophysiology, course of illness, and the treatment of the child's illness experience. Explanations and meanings have been shown to influence expectations and perceptions of symptoms, the particular labels attached to symptoms, significance placed on them, and responses that come from those labels (Kleinman et al 1978).

Robinson (1987) conducted a qualitative study based on the conceptual

framework of Kleinman, Eisenberg, and Good, who maintained that illness is socially constructed and that the child's perspective needs to be understood. Health was conceptualized as a desired state, independent of sickness. Health was defined as "feeling fine," was viewed as a positive feeling, and identified with "feeling like playing." The context for the construction of meaning is in the family. The focus of the conceptualizations of illness focused on the experiential, and grounded in the implications illness had for daily life. The children's conceptualizations were sophisticated in that they knew that one could be sick and healthy at the same time. Although the model was designed to explain illness, concepts of health were derived from it as well as concepts of illness.

Munet-Vilaró and Vessey (1990) sought to elicit children's explanations of their leukemia from a Hispanic perspective. Although this study was about chronically ill children, it was included in this review because it is one of the few studies on conceptualizations of illness with Latino children, and it utilizes a qualitative method. Their sample consisted of Puerto Rican children (in Puerto Rico) limiting its generalizeability to other Latino children in the U.S. The children selected were between the ages of six to twelve, because this group was consistent with the Piagetian level of concrete operations. Although twenty-three out of twenty-seven were assessed to be of a sufficient cognitive maturity, they did not discuss how the assessments were conducted. Framing their interview questions within the Kleinman and associates' model of explanations for illness, they determined that cultural factors do indeed influence a child's concept of illness. However, the interview guide did not have questions that elicited

explanations based on culture. Any attributions to culture were speculative because the interpretation of the data was not consistent with the data they presented.

*Influence of Piaget's Stages of Cognition*

A significant shift occurred in the late 70' and 80's when research on the school-aged child's concept of health and illness began to be developed primarily within Piaget's cognitive development framework. Neuhauser, Amsterdam, Hines and Steward (1978), investigated the locus of control and the level of cognition along with other factors that were thought to influence health and illness conceptualizations. They reported that, indeed, the child does conceptualize healing differently than the adult. Preschool-age children were more likely to determine they were sick by external cues from others and external body cues. Children ages eight and nine-years-old were likely to base their judgements about being sick on internal cues, like when their "stomachs were hurting."

Bibace and Walsh (1980) described children's concepts about the causes of illness within the framework of Piaget's three stages of development. Healthy children between the ages of 2 and 6, in the prelogicial thinking stage, attributed the illness to an external concrete phenomenon, or "magic." Children in the concrete-logical stage, ages 7 to 10, believed that illness was caused by becoming contaminated either by actual contact with something outside the body, or by physically engaging in harmful actions. Children in the formal-logical stage, 11 years or older, began to understand that other factors may be involved with illness and may involve a pyschosocial component.

The construct of illness causality was further studied in relation to Piaget's theory of cognition. Causal explanations for illness (Perrin & Gerrity, 1981; Sayer, Willett, &

Perrin, 1993; Simeonsson, Buckley, & Monson, 1979) appear to be predictable and consistent with cognitive development. Children progress from global, undifferentiated and egocentric concepts to increasingly abstract principles. The "germ theory" and "illness as punishment" are leading "causes of illness" in the thoughts of the school aged child, and they are often inaccurately applied (Wood, 1983).

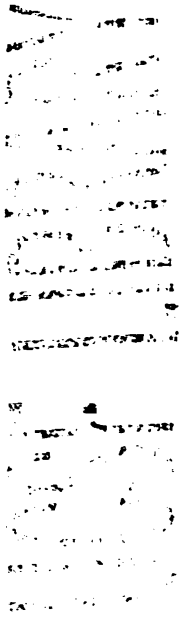
Experiences with illness and level of cognition have also been investigated. Carandang, Folkins, Hines, and Steward (1979) studied a sample of healthy children, half of whom had siblings with chronic illnesses and half whom did not. They reported that the impact of living with a sibling with a chronic illness affected how children conceptualize illness. This was demonstrated by the participants who had chronically ill siblings; they did not perform at the expected cognitive level of conceptualizing illness. The authors speculated that the stress of illness not only impacts the chronically ill child, but also other family members, possibly causing a form of cognitive regression. In a study investigating how age, sex, and previous hospitalizations affected children's understanding of hospital concepts, Redpath and Rogers (1984) determined that there was a relationship between the children's medical concepts and their level of cognitive development. Although previous hospital experiences were not found to significantly improve the pre-schoolers hospital concept scores, it did in the 2nd graders.

### *Illness As A Result Of One's Actions*

#### *Illness As A Punishment*

One of the determinants that Brodie (1974) and Kister and Patterson (1980) studied was the notion that children perceive illness as a punishment. Brodie (1974)

hypothesized that parental warnings against foolish behavior, self-indulgence, and disobedience served as a rationale for the child's belief that his illness was in some way caused by his behavior. She reported that the children with higher anxiety levels perceived illness as a possible punishment for their misbehavior and saw it as a disruptive force in their lives. Kister and Patterson (1980) utilized Piaget's work on moral development in trying to understand the use of immanent justice[2] and contagion on how children conceptualize health and illness. They concluded that children's understanding of illness increased as their ages did. Many of the children did accept immanent justice as an explanation for illness and accidents. They also concluded that young children overextended the attribution of immanent justice to explain illnesses and accidents. However, although the authors' research pertained to how the children utilized this concept as part of their explanations of illness, they did not define what the concept meant.



*Controlling Their World*

The perception that children have about how they can control their world may be influenced by a perceived vulnerability to health problems and resultant anxiety (Gochman, 1971). He concluded that higher anxiety scores had negative correlations, and lower anxiety scores had positive correlations with perceived vulnerability scores and potential health behavior. However, he derived his conceptual framework from adult literature, with no efforts to rationalize its use among children. Green and Bird (1986)

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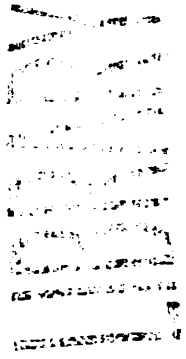
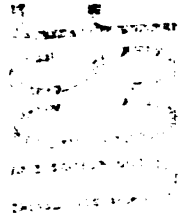
2 Immanent justice is the belief that bad behavior could lead to illness (Grabmeier, 1999).

sought to determine if children could associate the concepts that keep people healthy, such as exercise, and taking medicine with how people become ill, such as getting germs, bad weather, or infection. More specifically, when the causes of health and illness are compared, will the child view activities such as eating and exercising more frequently, and therefore, rank self-care higher than other causes of illness? They reported that the most frequently mentioned cause of staying well was self-care in all the grades. Differences across grade levels were observed. In the younger children, the causes of illness were well differentiated. For the older children, the pairs luck vs. born that way and germs vs. poor self-care, were ranked similarly. Family was ranked as the cause of health by boys more than girls. The conclusions supported the notion that even the young children are aware of the connection between their own actions and their level of health.





Hester (1987) conducted a descriptive study to determine how school-age children perceived healthy and unhealthy children, based on Watson's perspective that health is a subjective state of mind and body. She concluded that school-age children perceived health from a multidimensional perspective. School-age children considered health holistically, recognizing the importance of nutritional, dental, physical, social, emotional and other aspects as components of healthiness. Illness was viewed as an aspect of unhealthiness.

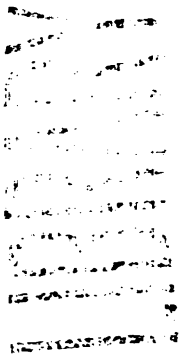
*Novice vs. Expert Model*

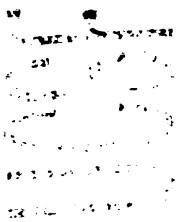
An emerging model is the Novice vs. Expert model, which provides an alternative to the Piagetian cognitive framework (Yoos, 1994). The Piagetian approach of studying the domain-general cognitive structures and operations is critiqued because it

disembodies a child's knowledge about the problem at hand. The novice vs. expert model supports the importance of domain specific experiences with health and illness in perceiving and solving problems (Yoos, 1994). Bird and Podmore (1990) studied how children understood the concepts of health and illness from a social constructionist perspective. This view focused on the child's access to knowledge about important issues, which is mediated by many cultural constraints, such as cultural ideas about what is appropriate for children of certain ages to know about. The findings of the study question the usefulness of a Piagetian framework for interpreting data. Although the researcher made attempts to code the data using Piagetian levels of coding, that attempt had to be abandoned because the responses from the children were not detailed enough to allow reliable coding of Piagetian stages, or to determine the causes of illness as internal or external. The findings also revealed that adults have an important role in interpreting health concepts to children, for assuring that they have adequate access to knowledge about health and behavior that can affect one's health. It is possible that children's awareness of health concepts may reflect their access to relevant information as much as their cognition. However, although cultural relevance related to how and what children learn about health issues is cited as significant, it is not discussed in the findings or in the significance of the findings.

Olvera-Ezzell, Power, Cousins, Guerra, and Trujillo (1994) also questioned the relevancy of Piagetian stages of cognition when studying the health and illness concepts of Latino children, because it may be that different behaviors related to health, such as hygiene, nutrition and safety, require different kinds of knowledge. It appears that

experience is more influential than cognition. The findings support significant effects of age and gender on their understanding of the relationship between behavior and the areas of health, nutrition and safety. Mexican-American children were very knowledgeable about practices that influence health in the areas of hygiene and safety, and as the children increased in age, so did the complexity of the rationales for their responses. In the only study to determine a gender difference in knowledge of nutrition, the authors speculated that girls are more knowledgeable than boys because they are expected to assume the role of the mother as caregiver.

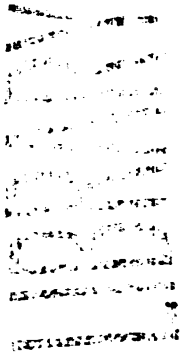


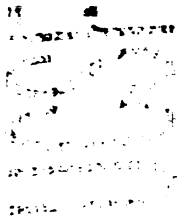


Gratz and Piliavin (1984) hypothesized that children are more knowledgeable today about the disease processes such as the germ theory and contagion although this was not supported by empirical data. Half of their sample of 48 were children whose fathers were physicians. They assumed that these children would have access to health related information and therefore would be more knowledgeable in these areas. Their findings revealed that children from medical families were not more knowledgeable about germ theories and environmental factors. The older group (fourth and fifth graders) had a greater belief in external causation, which could be attributed to a greater awareness and increase in knowledge of environmental hazards. Had the health professionals been nurses, would the findings have been different?

Hergenrather and Rabinowitz (1991) asserted that Piagetian theoretical frameworks have their limitations in the study of how children conceptualize health and illness. Rather, they proposed it may be the quality of the children's thoughts that accounts for what they know and understand about various domains of knowledge at

different ages. They also proposed that it may be the structure of knowledge in a specific domain that may be important. Finally, they concluded that as one increases in age and acquires more knowledge in specific areas a shift in the concepts that frame and organize the domain occurs which results in the facilitation of reasoning, problem-solving, and learning skills within a particular domain. Their findings indicated that young children (ages six to seven) used non-illness-related concepts when interpreting illness-related phenomena, while older children (ages 13-14 years) evoked illness-related concepts almost exclusively. All of the children relied on behavioral cues, such as their mothers taking their temperatures or telling them they were sick, to determine when they were sick. The older children relied more on internal cues. The belief that misbehavior causes illness was rare.





## *Limitations of Current Research*

The area of school-aged children's health and illness conceptualizations has been deemed an important one as evidenced by the number of published studies over the decades. However, there are many limitations with the current research done to date, in general, and its relevancy for Latino children has not been adequately demonstrated. The issues that will be addressed relate to theories, concepts, and research perspectives, and methodological issues; e.g., procedures for obtaining empirical data and for increasing external validity or generalizeability.

### *Theoretical Limitations.*

Several theoretical perspectives were utilized in the body of research examined. Much of the research investigating the conceptualizations of health and illness in children

has been primarily conducted within Piaget's theory of cognitive development, and was done so without a critical analysis of the theoretical assumption (Eiser, 1989). Learning and development are too complex and heterogeneous to be accurately characterized by a stage theory such as Piaget's (Flavell, 1982). More specifically, researchers have relied on Piaget's work for general conceptualization of intellectual organization and development, without acknowledging the role of other domains of development at the individual, social and cultural level (Eiser, 1989; LeVine, 1982). The tasks that were developed by Piaget to assess cognitive development are ethnocentric, requiring a Eurocentric cultural context to conceptualize the purposes of the individual tasks, and the relevant standards of competence (LeVine, 1982). Children of a culture other than Eurocentric culture (assuming a degree of commonality that may not exist) may not have had the opportunity or need to learn some of the tasks called for in a Piagetian scheme. Flavell (1982) cautioned that children are born with different aptitudes, and that tasks can vary in difficulty because children may have had various educational and life experiences that could be useful to performing the tasks. As the child's fantasy world develops, Piaget's theory would attribute the evolving phenomenological world to a mere representation, rather than as a construction of reality (Bronfenbrenner, 1979a). Research with the novice vs. expert model contradicts the notion that cognition and age are the primary determinants of conceptualizations of health and illness (Yoos, 1994). And, finally, the Piagetian theory focuses on what the child is *unable* to do or to understand rather than on what the child is a*ble* to do, and on what the child *can* acheive. The focus was on the cognitive immaturity, and therefore, the limitations of the child's ability, or lack thereof,

to understand health and illness concepts (Rushforth, 1999).

Application of the explanatory model of illness by Kleinman and associates (1978) broadened the range of possible influences of culture into the development of illness conceptualizations, because one of its assumptions is that the concept of illness is socioculturally constructed. However, its five elements of explanations sound very much like the biomedical model for explanations of illness. Its use imposes onto the children the biomedical framework of illness explanations, rather than letting the explanatory framework come up from the words and thoughts of the children. Specific questions about "causes," "symptoms," "pathophysiology," "treatments," and "course of illness" will yield answers that fit those categories. Children may be able to articulate responses to fit these categories because that is how they are educated about their illness. However, this does not inform us of what they think or feel about their illness, or how they experience it. Furthermore, its explanatory power for illness concepts has been extended to explanations of health. How does one derive an explanation of "health" from questions about symptoms, pathophysiology, course of illness?

*Methodological Limitations*

Additional limitations with the current research are related to methodological issues. There is a lack of clarity about what concepts of health and illness are, that leads to a lack of systemic and coherent data collection (Gochman, 1985). Studies that attempted to determine health concepts reported findings in terms of illness concepts and vice versa (Biback & Walsh, 1980; Robinson, 1987). Definitions of contributing factors such as the environment were not clear (Rashkis, 1965).

Much of the research reviewed has its limitations for generalizeability even for Eurocentric children. With the exception of the two studies conducted with Latino children, all of the children were recruited from middle-class, university affiliated communities. These children may have had opportunities afforded them just by virtue of being in such academic environments that children in rural, lower-middle class, or inner-city children may not have had, such as improved access and availability of health care, and environments more conducive to promoting cognitive development. Furthermore, investigators did not describe sufficiently how cognitive-developmental levels were determined (Burbach & Peterson, 1986).

The measurements utilized imposed onto the children *a priori* assumptions about how they conceptualize health and illness. While the knowledge gained has provided some insight into this phenomenon, there is still much to learn. By seeking the voices of Latino children about ***their*** concerns, feelings, and experiences in their words and language, the knowledge generated will indeed reflect their perspective. As health care providers we can provide better culturally relevant care and interventions based on their perspective.

### *Summary and Conclusion*

Current research on how school-aged children conceptualize health and illness has been studied with several theoretical frameworks, which include maternal and cultural influences (Aamodt, 1972; Campbell, 1975; Mechanic, 1964; Natapoff, 1978; Rashkis, 1965), Piaget's theory of cognition (Bibace & Walsh, 1980; Carandang, Folkins, Hines, & Steward, 1979; Neuhauser, Amsterdam, Hines, & Steward, 1978; Perrin & Gerrity, 1981;

Redpath & Rogers, 1984; Sayer, Willett, & Perrin, 1993; Simeonsson, Buckley, & Monson, 1979; Wood, 1983), a cultural explanatory model of illness (Munet-Vilaró & Vessey, 1990; Robinson, 1987), that illness is a punishment (Brodie, 1974; Kister & Patterson, 1980), internal and external locus of control (Gochman, 1971; Hester, 1987) and novice vs. expert model (Bird & Podmore, 1990; Gratz & Piliavin, 1984; Hergenrather & Rabinowitz, 1991; Olvera-Ezzell, Power, Cousins, Guerra, & Trujillo, 1994).

Research on how school age children conceptualize health and illness has little relevancy for Latino children because it has been done without reference to the cultural and social context in which it occurs. What has been deemed as "normative" developmental stages or processes in how school age children conceptualize health and illness has been based on Western or White middle-class behavior. Latino children need to be studied within the context of their families because their pyschosocial adaptation occurs and is shaped by the Latino family context (Rumbaut, 1994; Solis, 1995). Because the Latino child's personal identity is attached to the family identity, the way the family adapts to circumstances such as immigration and crisis will have strong effects on the behaviors and attitudes of the children (Gil & Vega, 1996).

Despite the quickly growing numbers of Latino children, little culturally relevant literature exists about the health status of school age children (8-12 years old). Much of the information about the health status of Latino children focuses on chronic illnesses and disabilities, low birth rate and mortality, and border health issues (Gutierrez & Maese, 1993; Mendoza et al., 1992; Mendoza & Fuentes-Afflick, 1999). Furthermore, current

literature focuses on Latinos who are poor, when in fact, 9.52 million (43.6% of Latinos) are considered middle class (Brischetto, 2001; Zate, 1994). There is no documentation of the health status and health and illness beliefs among the Latino middle and upper class.

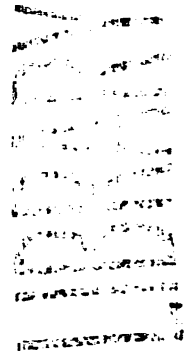
Although evidence indicates that conceptualizations of health and illness are shaped by culture, the influence of the mother, previous experiences, and cognition, no one has studied the Latino child's conceptualization of health and illness within the context of the Latino family; nor is the cultural influence apparent in previous research findings. Thus, there is a dearth of research linking cultural and ethnic factors to concepts of health and illness in childhood for this group (McCubbin, Thompson, Thompson, McCubbin & Kaston, 1993). Without information about how Latino children conceptualize health and illness, health care providers are limited in their ability to provide developmentally ***and*** culturally competent care (Porter & Villarruel, 1991), which has implications for public policy. The previously discussed theoretical approaches utilized to determine how children conceptualize health and illness have contributed knowledge in this area, however, are at best, limited in their scope for studying the child within the context of the Latino family; therefore, a new approach needs to be considered.

## Theoretical Framework:

### Brenfrenbrenner's Ecology Of Human Development

Bronfenbrenner (1979a) conceived of the ecological environment as extending far beyond the immediate situation directly affecting the developing person, such as the objects to which that person responds or the people with whom that person interacts on a face to face basis. Equally as important are the ***connections*** between other persons in the

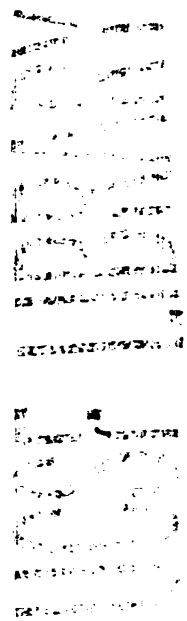
present setting, the nature of these links and their indirect influence on the developing person as they affect those who deal with that person first hand. The emphasis in this theory is not on the traditional psychological processes of perception, motivation, thinking and learning, but on their ***content - what*** is perceived, desired, feared, thought about, or considered as knowledge, and ***how*** does this knowledge change as a function of a person's exposure to and interaction with the environment. What is important for behavior and development is the environment as it is perceived, rather than how it exists in "objective" reality; which, of course, begets the question of whose "objective" reality.



The ecology of human development differs from social psychology, sociology, and anthropology in several ways (Bronfenbrenner, 1979a). First, none of the disciplines mentioned has the phenomenon of development as its primary concern. The focus of the ecological orientation is on the phenomenon of *development-in-context*. Second, ecology of human development allows for the interaction of biological and social forces to be specified acknowledging their influence on human development. And, finally, what is at the very core of the ecological orientation and its most distinguishing feature is the progressive accommodation between a growing human organism and its immediate environment, *and* the way in which this relation is mediated by the remote systems that affect the totality of the child's existence. In other words, the use of ecological orientation means that we cannot account for or understand the relationships between the children and their parents without understanding how the conditions surrounding them affect their interaction, because each family's particular experience is linked with culture and ethnicity (Garbarino & Abramowitz, 1992). "The ecology of human development lies at a

point of convergence among the disciplines of the biological, psychological, and social sciences as they bear on the evolution of the individual in society" (Bronfenbrenner, 1979a, p. 13).

In this section, the historical origins of the Ecology of Human Development (EHD) will be outlined, as well as the assumptions, propositions, and definitions, and how EHD frames the research question: How do Latino children ages eight to twelve conceptualize health and illness within the environment of their families?



*Historical Origins*

Bronfenbrenner and Crouter (1983) described the evolution of the research of the development-in-context in three stages. The first stage begins in 1879 and lasts to 1930. During this period new paradigms emerged with the first model by Galton comparing children living at different social addresses or contexts. The second model introduced the family structure as a key environmental context affecting the course of human development. The research conducted during this time was primarily descriptive, involving the comparison of developmental outcomes between persons, mainly children, brought up in different settings, defined either by geography or social background. During this era considerations of occupational and socioeconomic status originated, that to this day continue to be major variables considered in studies of human development.

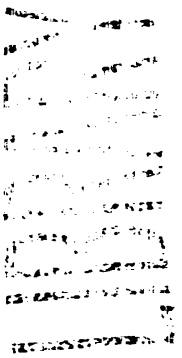
The second stage, which began in the 1930s and lasted until the early 1960s, brought on many rapid and revolutionary changes in the evolution of research on development-in-context, influenced by Freud, Piaget, Lewin, Hull, Vygotsky, and others, and setting the stage for three different trajectories (Bronfenbrenner & Crouter, 1983).

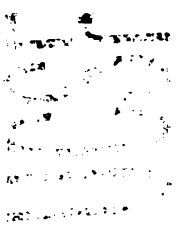
Three paradigms that emerged during this stage provide evidence of a transition from structural to process models. The first, initiated and developed by Levy, focused on parent-child relationships and their effect on the child's behavior and development. The second paradigm expanded the comparison of children living at different addresses to include the parents. And finally, children's groups were identified as a context for human development and focused on the relationships children had with adults and others in their social world outside the family. Research methodologies included ethnographic, longitudinal, and experimental interventions.

The developments of the first two stages were significantly influenced by historical events (Bronfenbrenner & Crouter, 1983). Historical and cultural changes created new features in the environment that could affect developmental processes, capturing investigators' attention, and resulting in new directions for theory development and research. For example, Lewin's theoretical ideas were based on his experience in World War I. In his analysis of *Kriegslandschatt* (war landscape), he described his perception of the landscape as he neared the front line, from one of pastoral peace to threatening terrain. The unemployment of fathers during the Great Depression resulted in studies focusing on the impact of fathers on the family as a childrearing system, looking more specially for *detrimental* effects. Subsequent to the Great Depression, studies focused on whether or not mothers entering the work force brought on *undesirable effects* in children's development. World War II brought on the second flurry of studies focusing on fathers and the effects of their absence in children's development.

The end of the second stage results in an evolution of the *person-process-context*

*model* (Bronfenbrenner & Crouter, 1983). More complex operational definitions of environmental domains and the relationship to the developing person and to each other were more clearly explicated, setting the stage for redefining the environment as context for human development that consists of a series of interdependent systems. Some of the systems more directly involve the child than others. This emerging paradigm had the following features. First, differences in social class may result in differences in childrearing and outcomes, but also in the process that connects them. Second, the developmental processes are assumed to vary as a result of biological and environmental factors. Third, childrearing and belief systems are treated as important considerations of childrearing behavior. Fourth, there is a possibility of reciprocal influences, i.e., the environment influences the child, and the child influences the environment. And, finally, developmental effects can be cumulative. However, gaps in the model include no allowances for analysis of the processes that were affected by external contexts such as culture and class; and in spite of longitudinal studies that were conducted, environmental changes over large time were not explored.



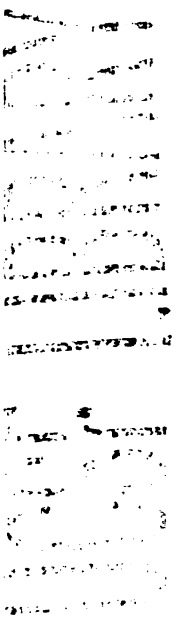


Two major occurrences provided the foundation for the evolution of settings as a microsystems model (Bronfenbrenner & Crouter, 1983). Lewin (as cited in Bronfenbrenner & Crouter, 1983) provided an alternative to the psychoanalytically derived parent-child model. He emphasized the power of the immediate environment in steering the child's behavior, and the importance of the activities taking place in that environment as a context for evoking behavior. Spitz (as cited in Bronfenbrenner & Crouter, 1983) operationalized the delineation of developmentally relevant features of the

immediate setting resulting in a differentiation between social and physical aspects of the environment. As a result, a new conceptualization was formed. Parents can encourage and shape the child's psychological growth by adapting and changing the child's environment to the child's changing capacities. When the second stage ended and the third stage began is not clear.

### *Ecology of Human Development*

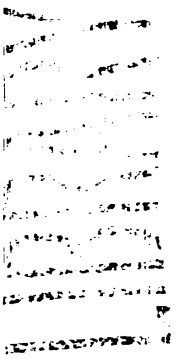
Bronfenbrenner (1979a) drew from Lewin's conceptualization of the environment as a set of regions each contained within the next and how they interact with each other. He then incorporated the organization of the concepts to describe the structure of the ecological environment where human development occurs as proposed by Brim (Bronfenbrenner & Crouter, 1983), see Figure 1: The Ecology of Human Development. He defined the structures of the ecological environment in the following way (Bronfenbrenner, 1979a, pp. 22-6): *Microsystems* are a pattern of activities, roles, and interpersonal relations experienced by the developing child in a given setting with particular physical and material characteristics. Not only are the objective properties included, but also how these properties are perceived; *Mesosystems* are the interrelations among two or more settings in which the developing child actively participates, such as school, home and neighborhood; *Exosystems* are those systems that the child never enters, but in which events occur that affect what happens in the child's immediate environment; and finally, *Macrosystems* are the nested, interconnections that comprise the overarching patterns of ideology and organization of the social environment, common to a particular culture or subculture, with particular attention to additional factors

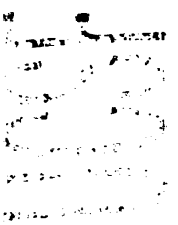


including developmentally instigative belief systems, resources, hazards, and life styles.

*Propositions, Definitions, & Assumptions*

In this section the general phenomenon of movement through ecological space, which is both a product and a producer of developmental change, will be presented in the form of conceptual definitions as outlined by Bronfenbrenner (1979a). A general principle that pervades all of the basic concepts in the ecological perspective states that "In ecological research, the properties of the person and of the environment, the structure of environmental settings, and the processes taking place within and between them must be viewed as interdependent and analyzed in systems ways" (Bronfenbrenner, 1979a, p. 41). The propositions will be stated first, and then the definition of the concept as identified in the italics will be given.

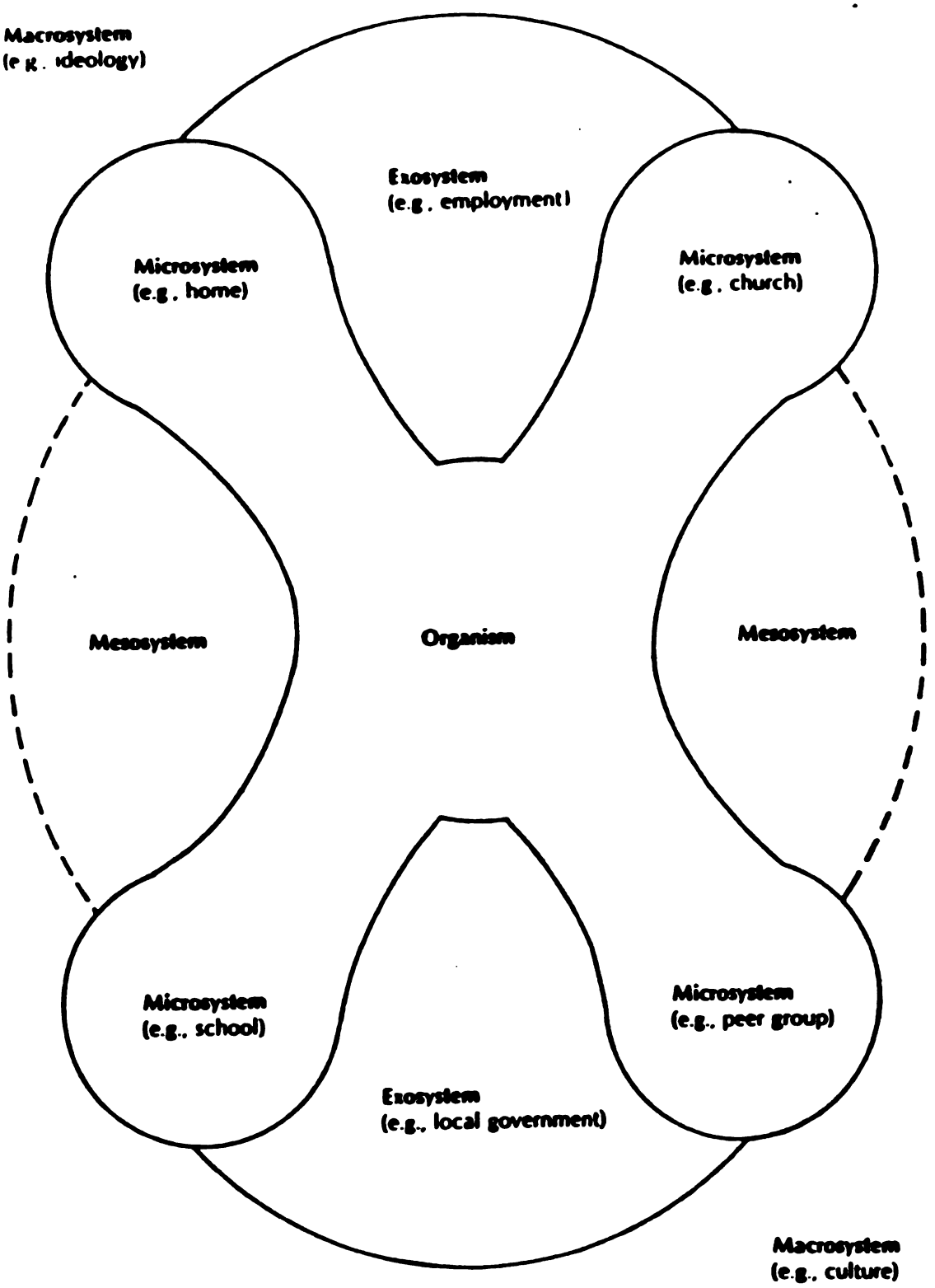




Proposition 1 - *Ecological Transition.* Development does not take place in a vacuum, it is always embedded and expressed through behavior in a particular environmental context. An *ecological transition* happens whenever a child's position in the ecological environment is altered as the result of a change in role, setting, or both.

Proposition 2 - *Human Development.* Development involves a change in the characteristics of the person that has continuity over time and space. It is not temporary or situation-bound; it takes place at the same time in two domains, those of perception and action; and each of these domains has a structure that is the same in the four levels of ecological environment. In other words, does the developing child's view of the world extend beyond the immediate situation to a notion of other settings in which he has actively participated, to external contexts with which he has had no direct contact, and

Figure 1: The Ecology of Human Development (Garbarino & Abramowitz, 1992, p. 29)



then to his consistent patterns of social organization, belief systems, and lifestyle? *Human development* is defined as the process through which the growing child acquires a more extended differentiated and valid conception of the ecological environment, and then becomes motivated and able to engage in activities that reveal the properties of, sustain, or restructure that environment at levels of similar or greater complexity in form and content.

Proposition 3 - *Ecological Validity.* The generalizeability and interpretation of the findings of a study in progress can be affected by the properties of the environmental contexts in which the study was done, or from which the sample was drawn. *Ecological validity* refers to the extent to which the environment experienced by the subjects in a study has the properties it is intended or assumed to have by the investigator.[3]

Proposition 4 - *Ecological Experiment.* The primary purpose of an ecological experiment[4] is not one of hypotheses testing, but of discovery - the identification of the system's properties and processes that affect and are affected by the behavior and development of the child. An *ecological experiment* is an effort to investigate the progressive accommodation between the child and its environment through a systemic

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3

Given the nature of the methodology selected, ethnography, the significance of this proposition brings up the notion of the *etic* and *emic* perspective, which will be discussed in the following chapter.

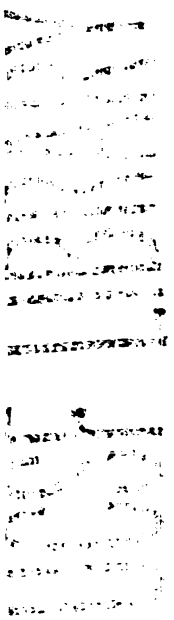
4

The use of the word "experiment" is not to be misinterpreted as an argument against the use of other methods such as ethnography, since this method can provide invaluable scientific information and insights by detecting and analyzing systems properties within the immediate setting and beyond (Bronfenbrenner, 1979a).

contrast between two or more environmental systems or their structural components.

*Person-Process-Context Model*

The selected model will be the *Person-process-context model* which is within the *Mesosystem model* (Bronfenbrenner, 1986). This process paradigm provides for assessing the impact of the external environment at the mesosystem level, on a particular family process and its impact on the developing child, and how they influence the health and illness conceptualizations of a school-aged Latino child.



*Assumptions*

The implied assumptions are:

* The child lives in a world of environments. All of the environments, including those affecting the child directly, such as the family, school, church, and community, to those that indirectly affect him, such as parent's employment, and to a broader level, public or social policies, culture, or subculture.

* All of the environments interact with each other. What needs to be studied are not only the **outcomes** of the interactions, but **how** they interact.

* Children can cause changes in their own environments, and the environments can cause changes in children.

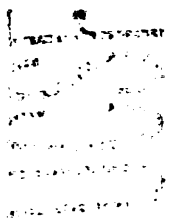
*Strengths of EHD*

There were many strengths in the use of EHD in this study. The major contribution of the ecological approach was the way it focused attention on the relationship of the development of the child to both the immediate family context and the more distant cultural environment (Garbarino & Abramowitz, 1992). The ecological

perspective revealed connections that might have otherwise gone undetected about how Latino children conceptualize health and illness thus enabling me to look beyond the obvious to see where the most significant influences potentially were (Garbarino, Gaboury & Plantz, 1992). Its use kept Latino children in the context of the family for a more holistic look at how they conceptualize health and illness. It provoked a fresh alternative from the conventional development theories (Garbarino & Abramowitz, 1992). Knowledge gained within this perspective was contextualized within the child's environment, potentially making the development of interventions and public policy based on this knowledge more relevant. And finally, EHD was a natural fit with the methodological assumptions of ethnographic method.

*Limitations of EHD*

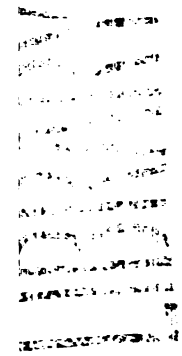
A limitation of the framework is that EHD is very broad and all encompassing. While all the systems defined are important to consider in the development of the child, initially it is very overwhelming and intimidating to broach. However, selection of the *person-process-context* model provided boundaries and parameters that helped to focus the specific question asked, which will be discussed further in the next section. Although the selected model provided parameters of study that limited the systems to be included initially, it did not exclude any that came to light as being significant.

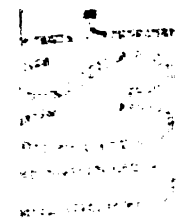


Another limitation is that the theory places culture, in the macrosystem (Personal Communication, V. Armstrong, September 1995). The way families function is largely determined by cultural values. It does not make sense to place the role of culture into an outer sphere as if it were this overarching entity. It may be that culture exists in the

macrosystem as a cultural phenomenon, such as community events during a holiday or the community milieu, but manifests in the mesosytem as the family lives its cultural heritage, such as food eaten, clothes worn, and family values that are considered important and passed on to the next generation.

EHD does not propose directionality of relationships. However, given that the relationship between the child and environment is reciprocal, it does not appear that the theory is meant to determine directionality. Rather, it provides for examination of the process itself, whether it be linear or circular.





*Summary*

Bronfenbrenner's theory of the Ecology of Human Development conceives of the ecological environment as extending far beyond the immediate situation directly affecting the developing person (Bronfenbrenner, 1979a). Equally as important are the ***connections*** between other persons in the present setting, the nature of these links and their indirect influence on the developing person as they affect those who deal with him first hand. The emphasis of the theory is not on the traditional psychological processes of perception, motivation, thinking, and learning, but on their ***content***, in that what is perceived, desired, feared, thought about, or considered as knowledge, and ***how*** this knowledge changes as a function of a person's exposure to and interaction with the environment. What is important for behavior and development is the environment as it is perceived, rather than how it exists.

## Research Questions

The research questions were, first, how do Mexican American children, ages 8-12 years old, within the context of their families, conceptualize health and illness? And, second, how are their conceptualizations of health and illness influenced by their family, cultural and social environments?

## Summary and Conclusions

The theory of ecology was an appropriate theory for studying the Latino child within the context of the family using the ethnographic method. It presumes that the reality of the child consists of several systems, including home, school, community, and culture, that impact the development of the child, whether or not the child has direct contact with them. The ecology theory allowed for the notion of culture to be expanded to a multicultural environment, to investigate its impact on family functioning (Szapocznik & Kurtines, 1993). Literature has provided evidence that many factors are involved when a child conceptualizes health and illness, and this is the only theory that allowed all of those factors to be examined at the same time. Information gleaned within this conceptual framework about how the child conceptualizes health and illness was within the context of the child's world.

Utilization of the theory of Ecology of Human Development in order to learn about how Latino school-aged children conceptualize health and illness broadened the scope of inquiry to include their environments and how it relates to them.

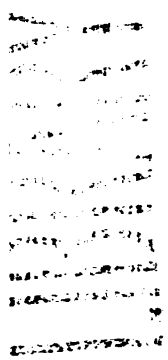
In conclusion, current studies on the conceptualizations of health and illness are important contributions, but they are not inclusive of factors such as culture and the role

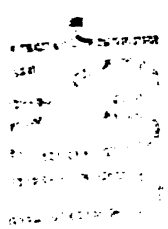
of the family. Latino children need to be studied because they are at higher risk for disease and illness, and how they conceptualize health and illness may impact their health status. The Ecology of Human Development was a new approach to use with this topic because it presumes that a Latino child lives in the context of a family and a culture and is in keeping with the methodological assumptions of the ethnographic method. The selected model within EHD was the *Person-process-context model* which is within the *Mesosystem level.*

# CHAPTER THREE

## RESEARCH DESIGN: ETHNOGRAPHY

In the quest for the "truth," what we believe to be truth and how we look for it is determined by the paradigms we select. One of the methods within the naturalistic paradigm is ethnography. It is essential to recognize the reflexive nature of social research because we are part of the social world that we study. The purpose of this chapter is to demonstrate the utility of this ethnographic approach to study Latino children and their conceptualizations of health and illness. The ethnographic perspective will be introduced along with how it contributed to this research conducted within the child-development-in-context and knowledge of conceptualizations of health and illness in Latino school-age children. Furthermore, I will explore the lenses with which I approached my question. And finally, the research design utilized will be described.





### Ethnography

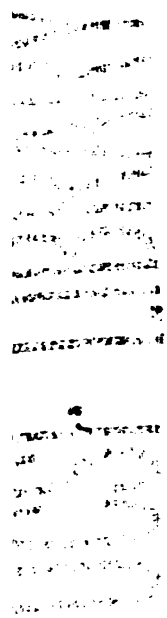
*Ethnos* come from the Greek, referring to a people, a race or cultural group (Vidich & Lyman, 1994). Ethnographic refers to a subdiscipline in anthropology, a science devoted to describing ways of life of humankind. Geertz (1973) maintained that one of the aims of anthropology is to expand human discourse, along with instruction, amusement, practical counsel, moral advance, and the discovery of natural order in human behavior. Behavior patterns, customs, and the way people live, or *culture*, can all be defined, interpreted, and described from more than one perspective. However, the central question remains: whose perspective is privileged and published (Spradley, 1979)? Culture is defined by Spradley as "the acquired knowledge that people use to

interpret experience and generate social behavior" (1979, p. 5). Anthropological writings are fictions, not as in false stories, but rather, in the sense that they are "something made," constructed. The line between the representation of culture and the substantive content is difficult to determine, threatening the epistemology of anthropology and, suggesting that its source is not social reality but rather scholarly artifice (Geertz, 1973).

Classic anthropology defined cultures as having patterns with shared meanings that are unique and self contained to the specific groups (Rosaldo, 1993). Its methods dictated a specific way of studying cultures, interpreting data, and writing up the findings. Investigators who were outsiders to the cultural community were the only ones who that determine what the "objective" truth was, and then would go home and write about the "true account of the culture" (Rosaldo, 1993, p. 30). A culture was studied without regard to the political, economic, or historical events that were occurring. Cultural groups were described as static and were studied as cultural wholes. The ways in which groups met and intersected was not discussed. The ideal of the classic ethnographer echoed the ideal for positivist inquiry, i.e., that the knower and the known are independent and constitute a discrete dualism (Lincoln & Guba, 1985). The classic works of Malinowski, Radcliffe-Brown, and Mead were used as examples of classic ethnographies and were studied for how they can inform the novice about fieldwork, taking field notes, and writing theory (Mascia-Lees, Sharpe, & Cohen, 1989; Rosaldo, 1993). However, these same works are now viewed by many as relics of the colonial past, because, Rosaldo (1993) stated that according to Geertz, the social sciences have changed in their conceptions of the object of analysis, the language of analysis, and the position of the analyst. Such works of the past

have yielded skewed ways in which analyses and interpretations were constructed, written as if the researchers were simply vehicles for transmission with no voice of their own (Fine, 1992). Although culture, politics, and history have always existed and influenced ethnographies, in the background, **now**, they are being acknowledged and brought to the foreground as never before. For in this new context, ethnographies no longer are thought to produce timeless truths.

New ethnography proposes that the ethnographer comes with his or her own life experiences, age, race, economic situation and gender, all which contribute to being more able to grasp certain human phenomena better than others, and that understanding is not constructed in a detached, neutral, or impartial way (Rosaldo, 1993). The position as the outsider also influences the ethnographer's observations. Rosaldo illustrates this point poignantly by acknowledging how his attempts to understand and explain headhunters' grief and rage were very inadequate until he experienced the death of his wife. It was then that he was able to understand what they had been trying to tell him, **and** to reflect on the observations that they had made about him.



Rosaldo (1993) further critiqued classical anthropology and its emphasis on cultural patterning. Classical anthropology depicts cultural patterning as unique and self-contained as each design in a kaleidoscope. But, because the range of human possibilities is so great, the only prediction that can be made with certainty is that they will not match. Cultural patterning cannot be predicted from one case to the next. Factors such as processes of change, internal inconsistencies, conflicts and contradictions make the assumptions of the classic vision of unique cultural patterns erroneous. Studies based on

classic depictions of cultural patterning with classic norms of analysis are not able to study borderlands, the zones of difference within and between cultures. In classical anthropology, cultural borderlands are annoying exceptions. Borderlands emerge not only at the boundaries of officially recognized cultural units, but also at less formal intersections, where aspects of life such as gender, age, economic status, and life experiences converge. With new ethnography, cultural borderlands have moved from being marginal to being a central location. One of the fundamental goals of new ethnography is to give voice to other points of views across the boundaries (Mascia-Lees, Sharpe, & Cohen, 1989)

## *Ethnography and the Child in Context*

### *Child Development and Anthropology*

Although linking child development with ethnography may seem initially curious, it is a natural combination because the very nature of ethnography allows children to be studied within the context of their development (Harkness, 1980). Mead (1928) initiated the first study of child development within a culture. Although subsequent research was grounded in the anthropological perspective, a shift occurred in the 1960s, to psychological studies of developing children (LeVine, 1980), decontextualizing resultant developmental theories. The prevailing attitude was that although ethnography was essential for cross-cultural research, it was regarded as mere description or background information instead of scientific data, and therefore, was excluded or reduced to a paragraph in published reports (LeVine, 1980).

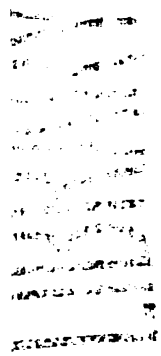
LeVine (1980) reminded us that much of the psychology on which child

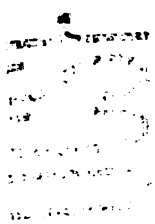
development research is based is not so much a body of universal principles like biochemistry but more a reflection of western conceptions of the individual. All empirical psychology is folk psychology to some degree, profoundly influenced by cultural assumptions that scientists share with their subjects of the same culture, and all folk psychology is empirical to some degree, embodying a folk wisdom effective in a specific milieu. Regardless of the paradigms used to frame the research, assumptions are made about child psychology in the U.S. Our beliefs, values, and ideologies concerning development affect every phase of research, including the research question, the organization and collection of the data, and the interpretation of the findings (LeVine, 1980).

Kessen suggested that future research should focus once again on the child in context (in Harkness, 1980). However, Harkness (1980) discussed psychology's primary focus on monocultural studies and the resulting problems that hamper research of the child in context. Monocultural studies are usually carried out by researchers who are members of the same culture as the subjects, e.g., white, middle-class America. Because there are usually shared cultural values and beliefs about how people should be or are between the researchers and their subjects, the cultural influence is not recognized. This would not be problematic if the theories derived from children of White, middle-class America were not applied to children of different cultures and ethnicities. Monocultural emphasis raises two problems. The first is that, the differences between the developmental processes and the environmental processes are not clear, and any influences from the cultural context is ignored. This supports the assumption that all

children have the same structure of development regardless of their environment. Second, the amount of variation that can be observed in individuals tends to be much greater than the amount of variation in the context. Therefore, along with the close cultural affinity between the researcher and the subject, the culture becomes invisible. When the culture is held constant, individual variation will be the major element in the outcome variable. But the effects of different contexts may be assessed over and above the individual variations.

Perspectives offered by cross-cultural research include allowing investigators to look closely at the impact of their belief systems on scientific theories and research paradigms (Rogoff & Morelli, 1989). Cross-cultural research can significantly reshape the current thinking about the development of children because existence of culture-specific patterns of thought and behavior can be demonstrated; and cross-cultural research can refine our understanding of environmental variables and their influence on child development (LeVine, 1980). Viewing the differences in life's arrangements in different cultures has allowed psychologists to examine very basic assumptions regarding developmental goals, the skills that are learned and the contexts of development. Conversely, comparative research across cultures has also provided evidence of the similarities in development, e.g., achievement of sensorimotor skills and language acquisition. Developmental researchers who have worked in other cultures are convinced that human functioning cannot be separated from the cultural and more immediate context in which children develop (Rogoff & Morelli, 1989).



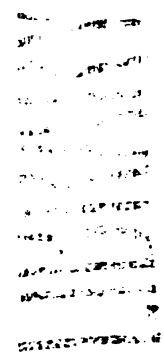


*Appropriateness of the Use of Ethnography*

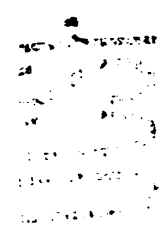
In a pilot study conducted among six Latino children, ages six to twelve, children were interviewed in an attempt to discover how they conceptualize health and illness (Rodriguez, 1995a). The children were recruited from a nurse-run clinic in the Mission District in San Francisco, CA. Data collection procedures consisted of obtaining permission from the parents during a clinic visit to include their children in the study. The content the children were asked about included questions regarding what happened when they got sick, how did they know they were sick, and how were they cared for. Interviews were conducted once, on a one-to-one basis in the children's homes. The parents were not interviewed. Two themes were derived, among others, that bore further investigation. First is the significance that peers and socialization have for children in this age group. Consistently, the children who had been sick and had to stay home said that they missed their friends, or the places that they meet their friends-school, the Boys club, their friends' houses, and basketball practice. Second, mothers played a significant role when children were sick. None of the children mentioned their fathers, whether or not the fathers resided in the home. The mothers were the ones who took care of them, determined when the child was sick, when the child was getting better, and cued the child into how anxiety producing the illness experience was for the child. Although content analysis was conducted on the interviews obtained, most of the children were not forthcoming with their responses, leading to the conclusion that just one time interviewing, was not sufficient to get the quality and depth of information that I thought could be obtained (my *a priori* assumption). The experience of conducting this pilot study demonstrated that

other methods of data collection were going to be necessary in order to study the informant, therefore the ethnographic method was selected.

Hammersley and Atkinson (1983) described the ethnographic method as a social research method, drawing from a wide range or sources of information, such as participant observation and interviews. The researcher participates in the lives of the subjects for an extended period of time collecting whatever data is available to illuminate the issues. In this case, to study how Mexican-American school-age children conceptualize health and illness. The essential core of this activity is to understand another way of life from the native point of view (Spradley, 1979). "Rather than *studying people,* ethnography means *learning from people"* (Spradley, 1979, p. 3, emphasis in italics in original version).

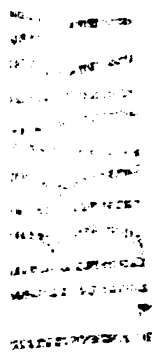


Rizzo, Corsaro, and Bates (1992) demonstrated how ethnographic and interpretive analysis are well suited for research with children because of their ability to locate processes in their historical and socio-cultural contexts. Features of these two methods such as field entry, prolonged engagement in the setting, and triangulation of information sources have allowed them to generate detailed, historical, and ecologically sensitive chronologies that are necessary for an improved understanding of human action and development. Analysis of routines that surround activities about health and illness capture how children interpret information from the adult world into their world, simultaneously contributing to the reproduction of some elements of the adult culture while bringing about changes in other ways (Corsaro, 1992).



## Reflexivity

Wertsch and Youniss (1987) favored the assumption that knowers exist in a sociohistorical context and that this context influences the way that they understand the phenomena they study. Furthermore, the situatedness of the researcher is integral to, rather than distinct from, the knowledge process. We need to acknowledge the personal more than we do now, because our statements about ourselves need to be linked with those that we study, for in reality neither stands alone (Krieger, 1985). Failure to do so results in continuing in the classical ethnographic tradition (Villenas 1996). In keeping with the new ethnography perspective I examined my situatedness and the perspectives that I brought to the research. I came to this research project with many perspectives that influence who I am and how the research was conducted.



### *My Historical Perspective*

I am the daughter of a minister and a college professor who immigrated to the U.S. from Argentina to go to college. My mother was born in Los Angeles, CA, to parents who were both from Mexico. She was a registered nurse. Both of my parents have parents and grandparents who originally were from Spain. Both of my parents, here in the U.S. and in Argentina, were brought up in families who were active in the Church of the Nazarene, a protestant denomination. Both of my parents achieved accomplishments that were firsts for Latinos. My father was the first Argentine citizen to earn a Ph.D. in philosophy and religion in the U.S. [personal communication, E. Vega, 1975]. My mother was the first Mexican American accepted into a certain associate degree nursing program in the Los Angeles area in the 1940s, even though she initially was told to go to a two-

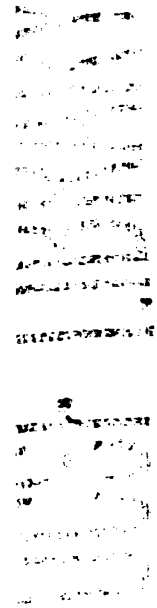
year county school [personal communication, E. Vega Amaya, 1975]. I was born in Kansas City, MO, while my father was attending seminary. My father graduated from Pasadena College/Point Loma Nazarene University, and then returned to teach, earning a tenured, full professor position. I too, graduated from Pasadena College/Point Loma Nazarene University, and have returned to teach.

I initially thought that the quest to find gaps in knowledge about children's health and illness concepts began with graduate studies. However, it was probably the quest that began long before returning to school that brought me here in the end. Graduate studies demonstrated to me in a very big and real way that the published literature about Latino children and families was not fully representative, because I could not find publications that represented my family and me. So, one of my objectives was to try to develop and conduct research that was more representative of the varieties of Latina/o experiences, that might include me - brought up greatly influenced by my family environment, middle income, and bilingual, with educated parents. In other words, to broaden the scope of how Latino families are represented in the literature.

I am a mother, which added another dimension to my approach to the study. As I think about the impact on how my child is parented when he is sick, I reflect on how I was parented when I was sick as a child. However, this represents another gap in information. My parents have both passed away, long before I had my son, therefore, I have no one to ask. The memories that I have are special memories, because they represent feelings of safety, protection, being cared for, and that it was OK to be sick. What were the factors in my environment, about my parents and family that contributed

to those memories? How can I pass those kinds of memories on to my son? As I reflected on the memories of my past, I decided to study the Latino children, to try to answer my own questions about how I was parented as a child, and to share the voices of the children with other health care providers to help improve their care.

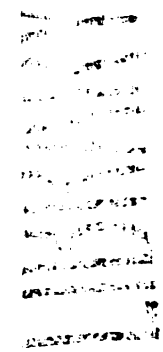
I am also a pediatric nurse. As a nurse, I have worked in various health care settings taking care of many families of Latino origin. I have seen how they have been unfairly treated by members of the health care team as a result of erroneous assumptions. For example, some providers assume that Spanish-speaking families only need the simplest basic information because, they won't be able to understand more complicated concepts. As a Latina nurse, I have also seen how these families have looked at me as someone who might have a different understanding. Often I have advocated for them by trying to share their voice when no one else would. In my previous positions, I could only advocate for one or two at a time. However, at an academic level, by conducting research with a Latino sample, I can share the voices of many more Latino children and families, and that became my foremost objective.

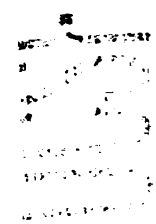


*Insider or Outsider?*

One of the fundamental issues concerning ethnographic research among minorities is who is more qualified to conduct it, the outsider or the insider (Zinn, 1979). Claims have emerged to which truth is better - Insider truths that rebut Outsider truths and Outsider truths that rebut Insider truths (Merton, 1972). The insider position claims that insiders have a monopolistic or privileged access to knowledge of a group, and the outsider position maintains that unprejudiced knowledge about groups is uncovered by

nonmembers of those groups (Merton, 1972). There are advantages and disadvantages to both positions. Collins (1986) outlines potential advantages to the outsider position, 1) objectivity, 2) the tendency for people to confide in strangers in a way they wouldn't with one of their own, and 3) the ability of the stranger to see things that would be more difficult for an insider to see. Zinn (1979) suggested that potential advantages of the insider position are that 1) the lenses that minority researchers approach a question with may prompt them to ask questions in a different way, capturing a different response, 2) there may be aspects of a minority group that one from the dominant group may not be able to comprehend, and 3) possibly most importantly, is that it is less apt to encourage distrust and hostility, and the experience of feeling excluded from the community at large. One of the disadvantages of insider field research is the "subjectivity" of the researcher that could lead to "bias" in data gathering and interpretation (Zinn, 1979).

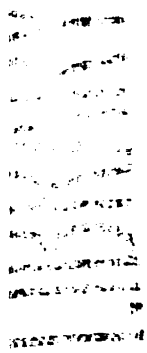




So who am I, an insider or outsider? And, who determined that in this study? Did I? Did the families that I recruited? I was an insider in many ways. On a personal level, I am Latina, a mother, and bilingual. Although I grew up assimilated to the dominant white culture, there are aspects of the Latino culture with which I identify, and am comfortable with. Especially now, as a mother, some memories come to me about my childhood that I had forgotten, like the Spanish words that were used in our home instead of English. On a professional level, I am an insider because of how I gained entrée into my field. My husband is a bilingual teacher in the one of the schools where I recruited children from. Entrée was rather simple, and I had much support from him, and his principal.

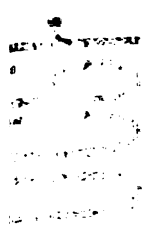
In other ways, I considered myself an outsider. The very fact that I was completing

a Ph.D. program made me a minority of a minority group. I had graduate education which provided me with a perspective that few assimilated Latinos have. I grew up in an academic setting because my father was a college professor. I did not grow up with folk-type medicine, because my mother was a nurse. I was from UCSF. Was my Spanish good enough for the families? Because I did grow up assimilated, there are things about the Latino culture that I don't know, and I may not have realized what they are. What I find rather ironic, is that I have never felt like I quite fit into the dominant culture completely, nor do I feel that I fit into the Latino culture (whatever that means) completely either. So I have seen myself as someone who is both in the margin and in the center. Regardless of my insider/outsider position, in my efforts to share the voices of "others," at what point do I become the "other"?



*Etic/Emic*

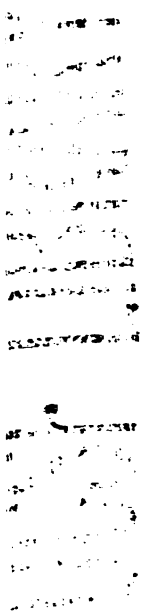
An unresolved issue from the beginning of ethnography that remains today is that of values. Whose values should guide the observations, the observer - the *etic,* or the observed - the *emic* (Vidich & Lyman 1994)? More fundamentally, how is it possible to understand the other when the other's values are not one's own. Furthermore, how are we to determine truth when we are in a time when Western Christian values are no longer the reference point from which to determine truth, and hence no longer the benchmark from which self-confidently valid observations can be made? Are ethnographic statements one or the other, or are they a blending of the two (Agar 1980)?



*A Developing Perspective - Los Ojos De Los Niños*

In determining what perspectives I would take, I considered the family

perspective, the feminist position, and the cultural perspective. I decided that while all are important, and to some degree have influenced me, they did not reflect the perspective I wanted to take. I took the perspective of the child. I wanted to take on the eyes of the children, *los ojos de los niños,* in order to see through the eyes of children at the age and in the circumstances that they were in. Although, initially this appeared simple, in essence this was very difficult, because regardless of their culture of origin, all children have a "culture of childhood" (Fine & Sandstrom, 1988, p. 34). This perspective has methodological implications, because I had to acknowledge what I thought I knew about childhood from my own experiences, and set them aside (Fine & Sandstrom, 1988). In essence, I had to try to become their peer, in order to begin to take on their perspective. By taking on their perspective through their eyes, I hoped to gain an understanding in the freshness and inventiveness of their thoughts (Matthews, 1994). My goals were that they would teach me more about how they viewed the relationships that existed in their environments and what it meant for them to be healthy and/or sick, and to share their voices.



*Summary and Conclusions*

In conclusion, reflexivity needs to be acknowledged in social science research because we are also part of the social world we study. New ethnography acknowledges the perspective of the researcher, such as age, race, gender, and life experiences that are brought to the research study. One of the fundamental goals of new ethnography is to give voice to points of views of others. Ethnography allows children to be studied within the context of their development, therefore, it was an appropriate method for research with

children. The ethnographic methods of participant observation and interviews allowed me to understand the ways that Latino children ages eight to twelve conceptualize health and illness. The perspective I chose was that of the children's, *de los ojos de los niños*. I sought to see through the eyes of the children in their world as they saw and experienced it.

## Research Design

The ethnographic approach described by Lincoln and Guba (1985) and data analysis as outlined by Spradley (1979) were utilized. Consistent with the perspective of the ecology of human development, this approach facilitated the study of how Latino children conceptualize health and illness within their socio-cultural and historical context. The nature of qualitative research required that the investigator continuously develop questions and analyze data until themes and patterns emerged. Qualitative research required that attention be given to credibility, transferability, dependability and confirmability as discussed by Lincoln and Guba (1985).

### *Setting - Description of Selected Field*

Two schools in a town in San Joaquin County, CA were selected for data collection because of the high percentage of Latinos in the schools. Although the town was comprised of 24% Latinos (Tracy Chamber of Commerce, 1995), the student bodies of the schools serving as sites for data collection were 42-50% Latino (H.A. Clover Middle School, 1994-95). Children of Mexican origin were to be selected because they comprised the majority of the Latino population (D. Laven, personal communication, June 1996). The median income for the selected city is given for the whole city, which in

1990, was $40,256 (City of Tracy, 1995). However, the Mexican population is considered to be a stable population, representing all levels of socio-economic status (D. Laven, personal communication, June 1996). Because the influence of immigration and acculturation impacts Mexican children regardless of their place of birth, and is considered to be a factor in their health status, all children of Mexican origin meeting the inclusion criteria were considered for the study regardless of place of birth.

### *Description of Sample*

The sample size was difficult to determine *a priori* because data was to be collected until themes emerged and were saturated; however, at least three children in each grade, (3rd, 4th, 5th, and 6th) were initially sought out for inclusion for a minimum of 12 children.

### *Inclusion/Exclusion Criteria*

*Inclusion Criteria.* Healthy children between the ages of 8-12 years old, with at least one parent who self identified as Mexican, regardless of country of origin, currently enrolled 3rd, 4th, 5th, and 6th grade bilingual classes in a selected elementary and middle school in a town within the San Joaquin County in CA were eligible for inclusion. The children who participated provided verbal assent and agreed to be audiotape recorded. The parents all provided written consent in either English or Spanish.

*Exclusion Criteria.* Children who were monolingual or had chronic illnesses or disabilities that were in acute exacerbation, which included, but were not limited to, asthma, cystic fibrosis, or cancer, were excluded from the study. Another exclusion criteria included parents who had an impaired or limited cognitive, visual, or verbal

ability (e.g., developmentally delayed). And finally, families currently undergoing stresses or crises, not related to health or illness, resulting in dysfunctional family dynamics (e.g., abuse of any kind, physical or sexual), resulted in those children not being included as well.

*Human Subjects Approval*

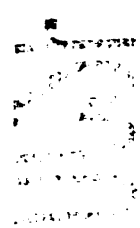
Approval from the Committee on Human Subjects Review (CHR) was obtained November 1996. A letter of approval was obtained to conduct the research project in the selected school district. Support and approval was also sought from the two principals of the schools utilized. Since there was such a high percentage of primarily Spanish-speaking parents, all correspondence, consents, and all other communications with the parents was in English and Spanish. All of the parents of children in the selected grades, including the non-bilingual classes, were notified of my presence in the schools and why, via a letter sent home from school (Appendix A). Although, opportunity was provided for the parents to question, or express concern, to either to me or one of the principals, none was voiced. Once observations began, and children were identified as having met the inclusion criteria, individual letters went home to the parents explaining the study, and asking permission for their child to participate (Appendix B).

*Use of Special Subjects*. Minority children were selected for the study because they often are at increased risk for disease. The focus of the study was on Latino children because they comprise 65.2% of the minority children in the U.S. Children in bilingual Spanish classes were identified through consultation with the principles of the schools. Children at this age have the cognitive ability to mentally represent their perception and

to view themselves and their behavior objectively (Deatrick & Faux, 1991). Generally, at this age they are able to communicate effectively about objects that are not visible to the person receiving the message and culture has played an integral part of the development of the child.

*Risks and Benefits to Subjects*. There was no apparent direct benefit to the participants. Since there is very little information about how Mexican American children respond to illness, the knowledge gained from interviewing the children and their families will contribute to the body of knowledge about the community of Mexican American children and their families in a town from San Joaquin County, CA. Data from this study will provide to nurses caring for these children beginning information about how Latino children conceptualize health and illness so that more appropriate interventions and services can be planned. Data from this study will provide additional knowledge about Mexican American children and their families that could potentially guide culturally appropriate public policy. A thank you gift of a $10.00 gift certificate to Target stores was given to the children that participated at the beginning of the first interview. As previously stated, there was no apparent benefit for participation in the study. However, at the end of the interviews, many of the parents expressed appreciation for having the opportunity to participate in such a study, to have their perspective brought to light, and having had the opportunity to have had their voices listened to and expressed during a time of much political hostility (recent passage of Prop. 187). For me the investigator, I had worried about the possibility of many not wanting to participate in such a study, but found that was not the case.

Respondents could possibly have found the experience disquieting or painful to discuss unpleasant experiences with illness from their past or that could have been potentially occurring. An unobtrusive interview style and privacy was utilized to help overcome this. Counseling services would have been available in the event that a child or parent requested it, but no such request was made. Additionally, children may have become bored during the interview process. Efforts were made to keep the children engaged by assuring the age appropriateness of the questions asked (hence the additional activities of storytelling and art). The families were assured of confidentiality, anonymity, and privacy with erasure of tapes at the end of the study. However, although the parents and children were assured of confidentiality and anonymity, they were also informed that if evidence of abuse of any kind became apparent, that I was morally and legally obligated to report it to the proper authorities. The data was stored in a secured location. The name of the participants and their subject number was kept in a separate secured location from the data. Small transcribed segments will be used for educational or publication purposes, without any identification of respondents.



*Consent and Assent.* At the time of the first interview, a signed consent from the parent (Appendix C), and verbal assent (Appendix D) from the child was obtained and documented, and kept together. Each parent and child received his/her copy of the consent and assent forms, respectively. Demographic forms recorded addresses from the participants only if they wished to receive a study report at the completion of the study.

*Recruitment Strategies*

Participant observation in the 3rd, 4th, 5th, and 6th grades in the two schools was the

first activity that occurred. The elementary school had 3rd, 4th, and 5th graders, and the middle school had 6th, 7th, and 8th grade levels. In the elementary school, I volunteered in the physical education and the music classes, and in the middle school, in a 6th grade bilingual class. Volunteering in the classes allowed me to observe children in their school environments, identify children for inclusion into the study, and to develop a relationship with the children in order to enhance data collection. I had obtained a list of all of the identified bilingual children in the elementary school (n=200[5]), and from this list I selected children (n=12) during the observation times I had in the two classes. Once I had selected children, I then observed a bilingual class in all of the grade levels from which most of the children came. In the 6th grade level, I volunteered in a bilingual class, and then selected children from a compiled list of all of the bilingual 6th graders (n=39). Additional observations were made in the schools at various functions, field trips with two of the grades, and in additional classes that were not bilingual. The two observations made in the non-bilingual class were made because, one of the classes was a Gifted and Talented class, from which one of the students came from, and the other class was the health education class that all 6th graders had to take.

The parents of the eligible children received a written explanation of the study, and an invitation for their child and family to participate (Appendix B). A self-addressed, stamped postcard was included in the letter that allowed the parents to return the card to

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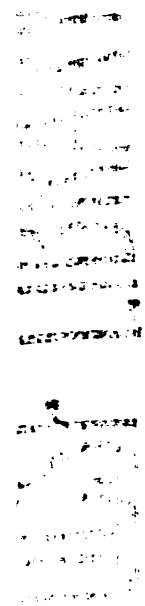
The lists of bilingual children from the two schools included all of the bilingual children, with language abilities in English ranging from no English knowledge to fluent in English.

the teachers or me indicating whether or not they were interested. Because children may not always have followed through with giving information to parents sent home from the schools, a follow-up phone call was made to ascertain that the parents received the letter.

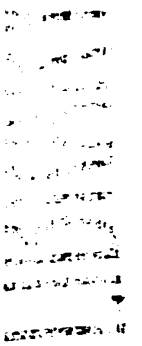
Once I had made contact with families, interviews took place. Initially, I interviewed children in their homes and one-to-one, with the exception of one. I attempted to schedule the second child interview at the same time of the family interview, but that was not always possible, resulting in a third visit to the home in many instances. The only time that I was not able to interview the child in her home was because her mother was a teacher, and usually worked late at the school, preferring that I interview her daughter in her classroom after school. However, I did interview all of the parents in their own homes. Several of the children (n=7) had siblings who met the inclusion criteria as well, and they were invited to participate. Of the seven siblings invited to participate, ultimately two did not get interviewed because of time constraints on my part. With the twenty-three children interviewed, there was a total of thirteen sets of parents interviewed and five children whose parents were not interviewed.



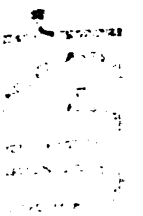
*Sample Selected*

The children approached for recruitment were selected based on their language assessment scores when they were tested for language ability. Through the schools, the children were tested on English and Spanish ability and were given two scores, A through F (a score of A indicated no ability in the language tested and a score of F indicated fluency in the language tested), each reflecting their abilities in the respective languages. Most of the children I selected had scored a level of E on their English test. These

children were generally thought to be very fluent in English, although, they generally spoke primarily Spanish at home; no child was selected with a lower score than E. Children were selected with the higher English language scores, so that the interviews could be conducted primarily in English. However, the assumption was made that if the children maintained Spanish language fluency in their homes, that there was also some kind of cultural influence. Three of the children were selected because their parents were bilingual teachers in the schools. Even though these children were primarily English speaking, and were not in bilingual education classes, they were able to speak some Spanish. These children were selected in an effort to recruit children representative of the range of socioeconomic levels represented among the families of Mexican-American origin.



The number of children approached for the study was 34. Among those 34, five refused. Of the five that refused only one returned the refusal card, with no explanation of why. Three of the refusals occurred during the follow-up phone call to determine if they had indeed received the recruitment letter. Reasons for refusal were because they were "too busy," and not interested in participating. The final refusal came from the child himself. He was a sibling of one of the subjects who had initially agreed to participate, but when I arrived at the home, the mother said he didn't want to do it anymore, and she didn't know why. I had difficulty reaching four of the children who had initially been sent a recruitment letter. Of these children, no one returned a refusal letter. One child had been removed from school in November, two did not have a phone which made follow-up very difficult, and one's mother was never home when I attempted to set up an appointment,



so after five attempts I considered him lost to follow-up.

A purposive sample of twenty-five children agreed to participate in the study see Table 1, but two were not interviewed due to lack of time on my part before I relocated to

Table 1: Summary of Interviews That Occurred

| Subject | 1st Interview | 2nd Interview | Fam Interview | Sibling |
|---|---|---|---|---|
| 1 | yes | yes | yes | yes to 10 |
| 2 | yes | yes | yes | yes to 25 |
| 3 | yes | yes | yes | no |
| 4 | yes | yes | yes | yes to 24 |
| 5 | yes | yes | yes | no |
| 6 | yes | no | no | no |
| 7 | yes | no | yes | no |
| 8 | yes | yes | yes | no |
| 9 | yes | yes | yes | no |
| 10 | yes | yes | yes | yes to 1 |
| 11 | yes | yes | yes | no |
| 12 | yes | yes | yes | yes to 23 |
| 13 | yes | yes | no | no |
| 14 | yes | yes | no | yes to 17 |
| 15 | yes | yes | yes | no |
| 16 | yes | yes | yes | no |
| 17 | yes | no | no | yes to 14 |
| 18 | yes | yes | yes | no |
| 19 | yes | yes | yes | yes to 21 |
| 20 | yes | no | no | yes to 22 |
| 21 | yes | yes | yes | yes to 19 |
| 22 | no | no | no | yes to 20 |
| 23 | yes | yes | yes | yes |
| 24 | yes | yes | yes | yes to 4 |
| 25 | no | no | no | yes to 2 |

San Diego, CA. Of these children interviewed, nineteen completed the two-part interviews. Eighteen of the children interviewed had parents who were interviewed as well. One child completed a first interview, but did not complete the 2nd interview, although her parents did. Two children completed the two interviews, but I was not able to complete the parent interviews because of schedule conflicts. Three children completed one interview, but due to difficulties with scheduling were not able to complete the second and parent interviews. Two children were identified siblings who agreed to participate in the study, but were not able to be scheduled. Of the children who have participated, five were sixth graders, six were fifth graders, five were fourth graders, six were third graders. There were 13 girls and 10 boys, see Table 2.

Table 2: Summary of Grade Levels of the Children.

| GRADE | ♂ | ♀ | TOTAL |
|---|---|---|---|
| 3RD | 3 | 3 | 6 |
| 4TH | 1 | 5 | 6 |
| 5TH | 3 | 3 | 6 |
| 6TH | 3 | 2 | 5 |
| TOTAL | 10 | 13 | 23 |

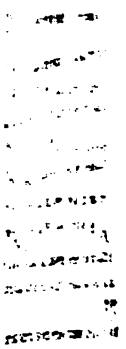
All of the sets of parents who preferred to have the interviews conducted in Spanish, immigrated to the U.S. from Mexico (n=11) , see Table 3. The primary region of origin was Michoacan, Mexico. Most of the children interviewed were born in the U.S. (n=17) of the children were born in the United States, and the rest were born in Mexico (n=6), and immigrated here as young children. Only one immigrated here within the last 3-4 years. One family was comprised of 3rd generation U.S. born Mexican-Americans.

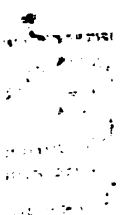
Table 3: Summary of Sample Descriptions

<table>
<tr><td colspan="8">Description of Sample, n = 23</td></tr>
<tr><td colspan="4">♂ n=10(43%)</td><td colspan="4">♀ n=13(57%)</td></tr>
<tr><td colspan="8">Grade Level in School</td></tr>
<tr><td colspan="2">3rd n=6(26%)</td><td colspan="2">4th n=6(26%)</td><td colspan="2">5th n=6(26%)</td><td colspan="2">6th n =5(22%)</td></tr>
<tr><td>♂ = 3<br>(13%)</td><td>♀ = 3<br>(13%)</td><td>♂ = 1<br>(4%)</td><td>♀ = 5<br>(22%)</td><td>♂ = 3<br>(13%)</td><td>♀ = 3<br>(13%)</td><td>♂ = 3<br>(13%)</td><td>♀ = 2<br>(9%)</td></tr>
<tr><td colspan="8">Sets of Parents Interviewed - n = 13</td></tr>
<tr><td colspan="4">Children with siblings - n =7 (30%)</td><td colspan="4">Single children - n=12 (52%)</td></tr>
<tr><td colspan="8">Place of Birth of Children</td></tr>
<tr><td colspan="4">Born in U.S. = 17 (74% of children)<br>* All but 2 children were in bilingual classes<br>* Both Parents born in U.S. =1<br>* One parent born in U.S. & One parent born in Mexico = 1<br>* Parents born in Mexico = 13<br>* Mother born in U.S., child in care of Grandmother who is legal guardian and she was born in Mexico<br>* Don't know = 1</td><td colspan="4">Born in Mexico = 6 (26% of children)<br>* All were in bilingual classes<br>* All of the parents were born in Mexico</td></tr>
<tr><td colspan="8">Religion as Reported by Children - Catholic - 22</td></tr>
<tr><td colspan="8">Income/Year/Parents Interviewed</td></tr>
<tr><td colspan="2">$7 ,000-19,000<br>n=6</td><td colspan="2">$23,000 33,000<br>n=4</td><td colspan="2">$50,000-86,000<br>n=3</td><td colspan="2">Parents not interviewed, income unknown<br>n=5</td></tr>
</table>

In the families (n=3) who comprised the upper income level, both of the parents worked. The parents had their own insurance through work. Most of the parents had a college education. The families were small, 2 children in each family, and intact. Two of the families were purchasing homes that were more in the "suburbs," which were outside of the downtown area. The children who were not in the bilingual classes were in this sociodemographic section.

The families (n=4) who comprised the middle level of income were comprised of intact families, with 2-4 children. Both parents worked, and they had their own insurance through work. The level of education was through high school and community colleges. The housing of these families was more varied and they lived in different parts of town or on the outskirts of town. One family lived on a farm, and another in a mobile home. They did not share housing with other people.





The families (n=6) with the lower income level all resided within a small section of town that had public housing, and a higher percentage of apartments. The highest level of education for these families was approximately up to the third grade in Mexico. Many of the families in the study lived within a about 4 block radius of each other. These families were comprised of a variety of family constellations. There were many more children of many different ages within a family. If there was a father in the home, he had a job. The mother may or may not have had a job. All of them received some type of public assistance. Some of the jobs that the parents had were seasonal. Many of the parents had jobs in the cannery in town. Towards the end of the data collection, there was word that the cannery was going to close, leading to expressions of concern about what

they were going to do.

All of the children were reported to be healthy by the parents. Some of the children had allergies and one had anemia. None of the children had apparent exacerbations of illness that interfered with their daily activities. Also during the time of the interview, several of the children reported either having some kind of minor illness, or just getting over one. (Note: many of the interviews took place during the rainy and cold season). None had any recent experience with hospitalizations, and two had been hospitalized when they were infants & toddlers.

There were additional characteristics of the sample that are important to consider. First, the younger children were more engaged during the interview process than were most of the older children. Secondly, although all of the children were assessed to have achieved a level of fluency in English, several of them seemed to have had difficulty with the English language.

*Age Differences.* One of the expectations that I had about interviewing children was that I had thought that the fifth and sixth graders, the older children, would be easier to interview and to obtain spontaneous information from, and that the third and fourth graders, the younger children, would be more quiet or reserved. However, my experience was that the younger children were more engaged, less inhibited, and at times, just talked about what they wanted to, with few prompts or questions.

WHAT I'M WONDERING IS IF YOU HAVE ANYTHING THAT YOU THINK WE OUGHT TO KNOW THAT WE DON'T KNOW YET ABOUT YOU.

R: Sometimes I get nervous.

YOU DO?

R: Because you like know my mom's having a baby and my dad's asleep and I think he goes somewhere .... I know I could call my sister but if my sister's not there .... Because you know sometimes they say that if the baby doesn't come or the mom dies and the baby comes .... Because I call my sister and my sister not there and a car is not here, then my uncle's somewhere and someone I don't know, you can't tell them cause they don't know. ....

DO YOU KNOW ABOUT CALLING 911?

R: Uh-huh .... It's because the mom's the best, they're the best family there is, because my dad, sometimes they drink but my dad doesn't do that. Or they smoke and the baby's coming and you know, I was like thinking of my dad, I'm happy because my dad's not drinking and smoking because if he drinks and he doesn't, you know how people are when they drink, they go any place with another, with another girl, and other stuff. That's why I'm happy that my dad doesn't drink .... Because, the best family I have .... It's because like mothers and dads the most the most thing they have, your friends not more. Cause it's your dad and your mom. Cause my mom has me and I have my mom and I need to take care of my mom and it's like something, because, you know my brother's not here, he's in the Marine Corps and my sister she has a husband, she's married. I'm the only kid and my little sister.

IT SOUNDS LIKE YOU HAVE A LOT OF RESPONSIBILITY.

R: It's like I'm taking care of my mom a lot. It's the best thing that you have in the

world .... It's better, like kids take care of their family and family takes care of the kids.

(Subj. 11, 3rd Grade, Female, Lines 397-463)

Many of the sixth grade children that participated in the interviews were cooperative, polite, and answered my questions with responses that were about those questions, no more, no less. There are no examples of interviews with the older children that are spontaneous and engaging as the previous example. Furthermore, they were more likely to not provide me with a drawing.

*Children's Language Abilities.* All of the children were English speakers, with all but two of them recruited from bilingual education classes. As previously discussed, all of the children who were assessed to have a high level of English fluency. And, with the exception of two of the children, Spanish was the primary language used at home. In one family, both languages were spoken. About half of the children reported they preferred speaking Spanish, and the other half reported they preferred speaking English.

WHAT'S EASIER FOR YOU TO SPEAK OR READ OR THINK IN, ENGLISH OR SPANISH?

R: They're both good for me to. Sometimes I mix up the Spanish with the English and then the English with the Spanish cause I like when I'm here, here in California, ... I like to talk more in English but when I go to Mexico, I like to talk more in Spanish cause they show me there more, more words, like good words. But I like both.

(Subj. 12, 6th Grade, Male, Int. 1, Lines 333-340)

However, it appeared that at times, several of the children seemed uncomfortable speaking in English, as evidenced by their flow of speech that was often slow and halting. Many times a child would try to explain something in English with difficulty, and switch to Spanish, "WHAT DOES IT FEEL LIKE FOR YOU WHEN YOU'RE SICK? DOES IT FEEL LIKE ANYTHING? R: It feels like you're, oh what's that word (pause) IS IT EASIER IN SPANISH? R: Yeah. YEAH? SAY IT IN SPANISH. R: Triste. [Translated - Sad] (Subj. 13, 5th Grade, Female, Int. 1, Lines 102-106). When I gave them the option of saying something in Spanish, immediately, their flow of conversation was smoother and quicker.

WHAT IF HE WAS A LITTLE BIT SICK?

R: Try to keep him in bed and then, uhm, like, I don't know how to say it.

SAY IT IN SPANISH.

R: In Spanish, como tratarlo de mantanerlo, como, como en esa, como no quiero que se me quida mas, mas, more sick.

[Translated]

R: In Spanish, like take care to cover him up, like, like , like, I don't want him to get more sick.

(Subj. 5, 5th Grade, Male, Int. 1, Lines 319-323)

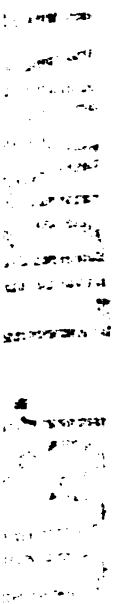
*Sources of Data and Data Collection*

Participant observation was the beginning of data collection and was primarily utilized as a way to gain entrée into the schools, and to assist in identifying children as potential informants. Once potential informants were identified, interviews were

conducted. The interviews with the children and their parents were the primary source of data collected for this study. However, additional sources of data included drawings from the children, and other supplemental documents and observations.

*Participant Observation*

Participant observation (Spradley, 1980) provided a way to gain entrée into the schools, so that potential informants could be identified and approached. As previously stated, observations in the elementary school occurred initially in the physical education and music classes, because those were the classes that all of the children passed through. As I began to establish myself in the school, I was able to make observations in other areas, such as in bilingual classes, so that I could continue to identify children for inclusion into the study. In the middle school, I began observing in the sixth grade bilingual class for the purpose of identifying children for inclusion into the study. I was able to observe a gifted and talented, and health a education class. I also was able to make observations in the homes of the families I visited.



Being a participant observer was very useful in being able to determine how to select the bilingual children. Through the participant observation I was able to learn about the assessment process for bilingual children. The whole process of the assessment and scoring of the children in their fluency in English and Spanish was explained. Upon understanding the whole process, I was able to make a decision of how to select the children, and have a rationale for that decision (see earlier discussion on how the children were selected based on their English language fluency).

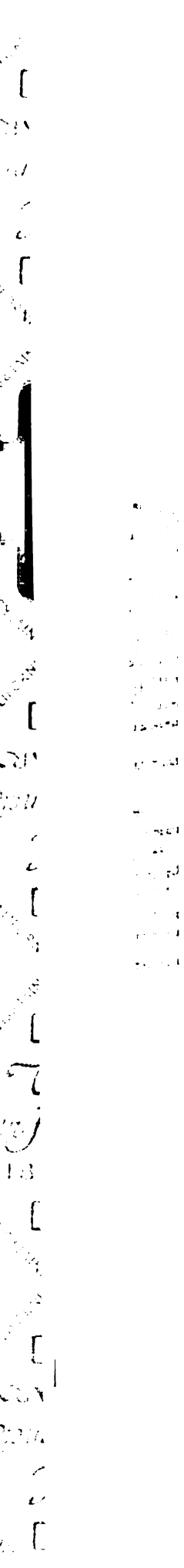
*Ethnographic Record*

An ethnographic record (Spradley, 1980) was kept to record the observations made. I initially made condensed notes during my observations. Condensed notes are notes taken during the actual time in the field of what actually occurred. Upon completion of my observations, I would take my condensed notes, and then write expanded accounts of my observations. Expanded notes are notes that are taken from the condensed notes, and then the details of the condensed notes are filled in and described in greater detail. A fieldwork journal was used to record more of the personal side of the research process, such as my experiences, ideas, fears, mistakes, and so on; as well as the day to day activities. Additional recorded information included reactions from the informants and the feelings I observed in myself. Upon the completion of my interviews with the children and/or their parents, I recorded the following information for each family, the events prior to the interview, my observations of the environment and atmosphere, and the demographics of the family, which was kept separate from the fieldwork journal.

Additional documentation was kept that included memos to further develop emerging themes. Examples of the themes that were developed into memos as they emerged included how cultural values are passed down, environment and space, the role of the church and God in their lives, and *Seguir adelante (translated - keep moving forward).*

*Interviews*

The interview guide was investigator-developed for this study, see Appendix D. The content of the questions were designed to illicit from the children their thoughts and



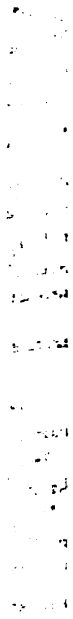
insights about their experiences with health, illness, and Mexican cultural experiences. The initial interview guide was tested in the pilot study with children recruited via a nurse- run clinic as previously mentioned. Although the objective of the pilot study was to understand the health and illness conceptualizations of children, the interview guide focused on the experience of being sick, rather than on health and illness. The interview guide for this study included questions about illness such as, what does being sick feel like, how does one get sick, and who takes care of them when they are sick? The content of the interview guide was also expanded to include questions about health and the Mexican culture. The content about health included questions such as, how does one become and stay healthy, and what does healthy feel like? The questions about the Mexican culture included questions such as, what does being Mexican feel like, what are special foods that you like, and what are some of the differences between living here in the U.S. and in Mexico? The interviews usually lasted between 35-45 minutes. In most cases a second interview was arranged with the child and then with the family.

I began the interview process with some basic questions pertaining to health, illness, and cultural topics. In the beginning of the data collection, the interviews seemed stiff and awkward. Many times the child would respond to a question with an awkward and painful (for me) silence.

WHEN YOU HAVE YOUR ASTHMA, IS HAVING ASTHMA THE SAME AS BEING SICK?

R: A little.

A LITTLE? IN WHAT WAY IS IT LIKE BEING SICK?



R: (pause, no response)

ARE THERE WAYS THAT IT'S THE SAME? IS THERE ANYTHING ABOUT IT THAT MAKES IT THE SAME AS BEING SICK?

R: (pause, no response)

HOW IS IT DIFFERENT FROM BEING SICK?

R: (pause, no response)

ARE THERE WAYS IT'S DIFFERENT FROM BEING SICK?

(pause, shakes head no)

NO? OK. SO UMM, WOULD YOU SAY THAT ASTHMA IS THE SAME AS BEING SICK?

R: Yeah.

(Subj 2, Female, 4th Grade, Lines 126 - 140)

UMM, LET'S CHANGE THE SUBJECT A LITTLE BIT. DO YOU KNOW WHAT HEALTHY MEANS ...?

R: Like, I don't know.

OKAY, SO IF YOU WERE TO THINK OF WHAT IT MEANS TO NOT BE SICK, WHAT WOULD THAT MEAN TO YOU?

(Silence)

... WHEN YOU'RE NOT SICK, WHAT'S DIFFERENT?

R: Like my nose doesn't hurt a lot and I can breathe well.

DO YOU FEEL DIFFERENT?

R: Yeah.

HOW?

R: I don't know.

(Subj. 6, Female, 5th Grade, Lines 92-103)

However, as the interviewing process continued, there were fewer instances as described above. The interviews felt less awkward to me, and the children were much more animated. I began starting the interviews off with questions about school, hobbies, and other topics.

WHY DON'T YOU TELL ME A LITTLE BIT ABOUT YOU, HOW OLD YOU ARE, WHAT YOU LIKE.

R: Umm, I'm nine years old and my hobby is birds cause I really enjoy them and we have lots of animals at our home. I like hamsters too, even though they are kind of stinky sometimes. Umm, I hate spinach and cooked vegetables. I like strawberries and carrots and

RAW CARROTS OR COOKED CARROTS?

R: Raw. And Umm, I like to explore and I like to get lost a lot so I can explore.

WHERE?

R: Oh, like forests, plains, that kind of stuff. The good thing about it is that I always find my way home.

(Subj. 7, 4th Grade, Female, Lines 6-18)

*Relationships With the Families*

The content of the interview guide for the parents was loosely based on the interview guide for the children, however, the questions were of a broader and deeper

nature to include the experiences of the parents as they were growing up about their experiences with health care and with being sick. Eliciting responses from the parents was not at all problematic, and they seemed to welcome the opportunity to share the information they did share. Often the interview ended with the parents thanking me for the opportunity to tell their stories, and that the questions made them think about things that they had either not thought of in a long time, or had never thought about.

Most of the contact with the families ended with the final interview. However, there were a few families that maintained extended contact with me. Several times I was invited back to their homes or to family social events. One example of this was when I was invited to a first communion of a sibling of one of the informants and then to a party after the service. Later the sibling became an informant herself. Because of the nature of the method and the intimacy of the community, occasionally the relationship between me as an investigator and the families became blurred and in the end I felt like I had made friends with several of the families.

*Drawings*

Drawings were collected because as was learned in the previous pilot study (Rodriguez, 1995a), that while interviews yielded important information, additional approaches would be necessary to further uncover the children's thoughts and to enhance the credibility of the research (Pelto & Pelto, 1978). Drawings were collected because they are a natural way for children to express themselves, children between the ages of five and twelve will usually produce drawings fairly readily, and they have great potential for generating nursing research data (Malkiewicz & Stember, 1994). Drawings help

children to express themselves when they may not be able to do so verbally, and requesting a drawing may be a way to reduce tension (Scavnicky-Mylant, 1986; Stafstrom, Rostasy, & Minster, 2002). Therefore, drawings are an important vehicle for preadolescent children to tell their stories and express their feelings (Malkiewicz & Stember, 1994). Although obtaining drawings for data collection can yield important findings, caution must be used in their interpretation (Kotzer, 1990); therefore, the drawings were utilized as an adjunct with the intensive interviews, and explanations for the drawings were sought from the children.

At the beginning of data collecting the children were instructed to draw pictures about what we had talked about after I left, and I would collect during the next interview. However, I found that, initially, I was not able to collect the drawing either because the child forgot to draw it, or had drawn it and left it at school. Also, the ones I did collect were drawn on notebook paper, in pencil. Within the first few interviews I realized that how I was going about collecting the drawings was not very successful. I began to change how I was going to collect the drawings. I started to bring with me drawing paper and the biggest box of crayons I could find. I also, started to draw along with the children, so that the focus was not totally on the child drawing and interviewing. The types of the drawings and the consistency with which I was able to collect them, immediately improved! It occurred to me that a sub-conscience assumption I had made was that these children had crayons and paper at home with which to draw. I began to realize that many of these children did not have them. In some instances, the children commented on how many colors there were in the box I had brought. Furthermore, several asked if I could

leave the crayons and paper with them. The interviews became more free-flowing, more playful, the children, seemed to not fidget as much, siblings and friends of the child informants wanted to participate by drawing themselves.[6] A potential limitation to allowing the sibling or friend to participate could have been that the consented and assented child may have been inhibited from speaking freely. Initially, this had been the case, however, within a few minutes, the informants were engaged and participative in the interview process, as well as drawing pictures. The drawings were used as a supplement to the interviews with the children.

Being a novice at collecting data from children was a process that evolved during the data collection process. As I found my own way, so to speak, I found that the children seemed more at ease, more engaged in the interview, and more spontaneous in their rapport with me.

*Supplemental Sources of Data*

Other observations were conducted to support and triangulate the findings of the interviews. As themes emerged from the interviews, I sought to observe similar themes in the supplemental observations. An example of how I used the supplemental sources of data was in the area of immigration and illegal status. In an interview with a child, and then with a mother of another child, the topic of immigration and legal status was one of

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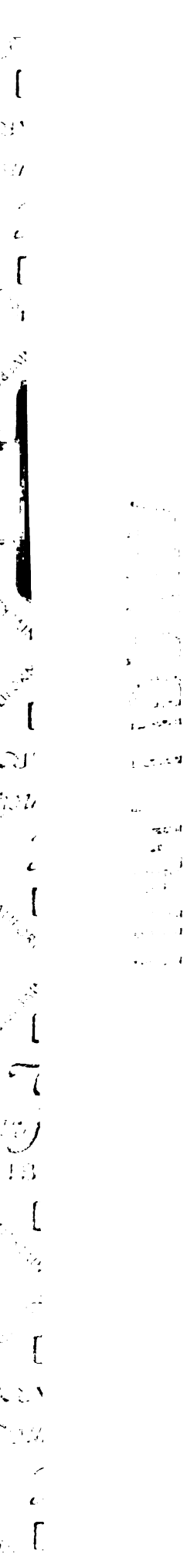
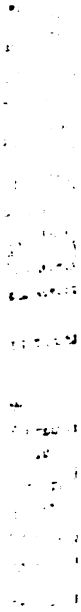
Although the siblings and a friend of some of the child informants drew drawings to give me, and I collected them, they were not allowed to talk during the interview with the child informant, nor did I use their drawings as part of the data analysis. The siblings and friend were allowed to stay during the interview with the child informant, only with the approval of the child being interviewed.



the topics discussed in relation to the Mexican culture and how they felt about it. With the topic of immigration in my mind as a result of the interview, I was able to observe in one of the parent meetings (discussed in the following section), as the topic of immigration and illegal status was discussed. The same feelings and issues were discussed in this setting as were discussed with the child and mother during the interview. The supplemental observations I was able to make confirmed to me that my findings were consistent in more than one way.

As a result of entrée into the school system, I gained access to additional areas for data collection. The primary one was through a Family Center that provides services to the families. The services of the Center are made available to the parents of children who were enrolled in the town's school system. When parents apply for services they must identify who their children are, what school they go to, and what grade they are in. The services that are provided by the Center range from homework assistance programs, literacy classes, classes on nutrition for children, developing employability skills for high school students, drug abuse prevention, conflict resolution for students, and parenting support groups. Additional programs are provided based on the identified needs of the community. At the time of my first encounter with the director of the Center, they were providing classes and services pertaining to immigration. Many of the programs and services are provided in English and Spanish. My contact with the program was primarily through their Spanish-speaking parent support group. No tape recording, interviews, or recruiting occurred during these times of observations. I explained that I was conducting interviews with some of the families of the community. I was not conducting interviews



with them, but that I wanted to learn more of the concerns that Spanish-speaking parents of the community had. Verbal permission was obtained from all of the parents, allowing me to remain, which, initially was done at the beginning of every meeting. Over time I developed a relationship with the group, such that needing to get permission every time was not necessary. Eventually I provided a teaching session on immunizations, which was well received.

Observations were made of the community at large. Time was spent in public places just observing open air markets, the mall, and various neighborhood communities in which the families lived.

I had the opportunity to attend regional meetings about the changes of the Medi-Cal system that were currently being made, how the changes were being implemented, and how they impacted the recipients. Information was collected through the newspapers and written information received from the meetings. Through this I was able to learn about the services that Medi-Cal providers were expected to provide, and then to realize that this was not always happening with the families I interviewed.

*Data Analysis*

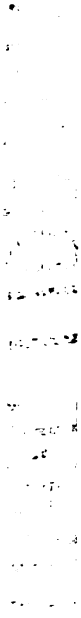
Data was analyzed following the Developmental Research Sequence as described by Spradley (1979). The recorded interviews were transcribed verbatim in English or Spanish. The transcriptions (English and Spanish) and field notes were entered into a computer with the QSR Nud•ist software for management of the data. Data analysis began with the first interview. The Spanish transcripts were read and analyzed in Spanish. The findings of the analysis were translated to English. The translations were done by

myself, and then checked for accuracy by a secondary person who was a bilingual Spanish educator.

Ethnographic analysis is the exploration for parts of a culture and their relationships as conceptualized by the children. Culture as defined by Spradley refers to the "acquired knowledge that people use to interpret experience and generate social knowledge" (1979, p. 5). Usually this insider information as it is known to the children is hidden, and it is the ethnographer's responsibility to discover this hidden knowledge.

Domain analysis, focused on the larger units of cultural knowledge, including cultural symbols, and identified the inherent semantic relationships that were embedded in the data (Spradley 1979). For example, ways to be healthy included not taking drugs, needing good mental health, and being active. Another example of a semantic relationship was that not taking care of yourself is a way of getting sick. The data was categorized for various domains, which included the following broad domains, health, what makes someone healthy, illness, what makes someone sick, how is one cared for when sick, what being sick feels like in the children's interviews, and cultural likes. In the parent interviews, the same previous domains found in the children's interviews were identified, as well as other domains, such as health care received when children, beliefs in God, ways to make sure the children are healthy and how they take care of the children when sick.

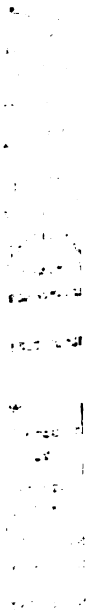
Taxonomic analysis, was the search for the internal structure of domains which lead to contrast sets and structural questions (Spradley, 1979). An example of a structural question for the children was "How would you use the word health?" Responses to this



question yielded answers such as discussing food as healthy, or whether or not a peer had healthy behavior. An example of a structural question for the parents was "Do you think that changing the way you cook is a way of changing your culture?" To this question, one mother responded that since she was changing her cooking to using oil rather than lard, that, yes she was changing her culture.

Componential analysis sought for the attributes that indicated differences among symbols within a domain (Spradley, 1979). An example of this level of analysis, would be a further explanation for changing one's culture, is that the good things of one's culture such as, language and family values, one keeps; but the bad parts of it, one leaves behind, such as cooking with lard, rather than oil.

Theme analysis examines the relationships among the domains and how they are linked to the culture as a whole (Spradley, 1979). An example of a thematic analysis with the children that the various aspects and activities that one engages in to be healthy involve choice making of some kind. Therefore, for these children, being healthy has to do with choices such as, eating well, exercising, keeping good mental and social health and avoiding things that make one sick. A thematic analysis that was embedded in the interviews of the parents was an in vivo theme - *"Seguir adelante,"* [translated] *"one has to move forward."* This phrase meant that one had to move forward in life, often for the sake of the children. Moving forward meant that one had to do things like come to the U.S. for a better life, change one's cooking habits (or cultural practices) to provide healthy food for the family, or go back to school to be an example to the children. These actions that these families took to move forward were choices that the parents made.



All of these strategies lead to the discovery of cultural meaning. Cultural meaning was created with the use of symbols, which are the objects or events that refer to something within the culture, and language is the primary symbol. The meaning of the symbols are its relationships with other symbols in a particular culture. The goal of ethnography was to understanding cultural meanings by tracing all the relationships among the symbols within a culture.

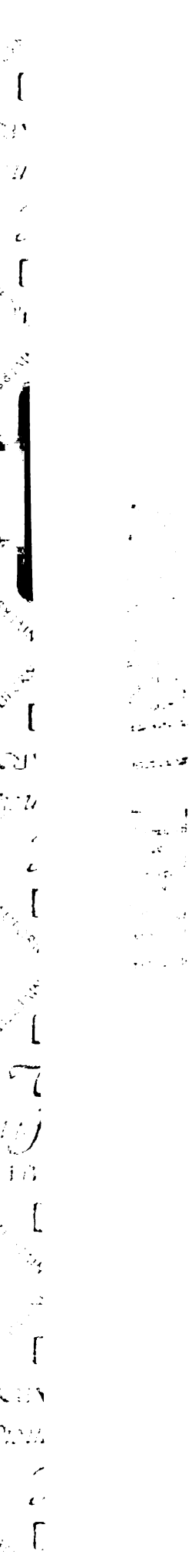
Initially, analysis began with domain analysis only, and then as the data collection progressed, and intensified, the analysis also progressed and intensified. Often times several of the levels of analysis occurred at the same time during the interviews. The second interviews with the children were opportunities to test ideas and themes. The interviews with the parents occurred once, therefore, member checks and confirming findings of the first interviews occurred in subsequent interviews with other parents. The drawings from the children, and supplemental data were all used to support and confirm the findings of the analysis of the interviews.

*Trustworthiness*

Following in the naturalistic perspective, credibility, transferability, dependability, and confirmability, and the techniques for assuring truthfulness are necessary for assuring trustworthiness of qualitative inquiry as outlined by Lincoln and Guba (1985).

*Credibility (Truth Value)*

The techniques involved in assuring credibility results in the greater likelihood that the findings will be found credible, and that the informants (the constructors of the reality) will agree with the findings of the study. The techniques utilized to increase the

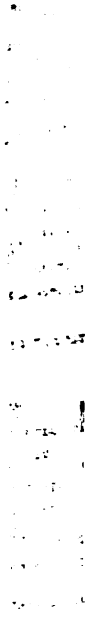


likelihood of producing credible findings and interpretations included prolonged engagement, persistent observations, and triangulation. An activity done to provide an external check on the inquiry process was peer debriefing. And finally, member checking was done to assure that the informants agreed with the findings of this study.

*Producing Credible Findings and Interpretations.* Prolonged Engagement is spending sufficient time in the field to learn the culture, building trust amongst the informants and learning the multiple influences, the scope of what is to be observed. I spent approximately ten months in the field that I collected data in. I functioned as a volunteer in the schools during the entire duration of the school year. I was in the field during school times, holidays, and special family events to which I was invited. I had the opportunity to spend time in the homes of the families, often on more than one occasion. I was collecting data and interviewing children and their parents right up to the day the moving truck came to move me and my family. I had the opportunity to move from being an outsider, to not quite, but almost, an insider. I do not believe that spending more time in the field, while I would have enjoyed it, would have given me more data or information for the purposes of the study.

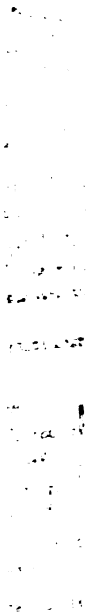
Persistent Observations are to identify those characteristics and elements that are most relevant, providing depth to the observations. Persistent observations in the schools allowed me to focus on factors that contributed to how children conceptualized health and illness, the health education that they received in school.

Triangulation is the process whereby multiple methods are utilized for assuring credibility including multiple sources and methods. Interviewing and participant



observation were two different sources of data collection. Multiple sources also included multiple copies of the same information (repeated interviews of the children and their families) and different sources of the same information (verifying an informant's account of an incident with another person, e.g. parent or teacher). For example, one child relayed in an interview that she thought that she got sick more last year because of the carpet in her class room. When the mother was interviewed, she relayed the same information. I did not specifically ask her about her thoughts of the carpet from the last year, but it was given unsolicited. When I had a chance to observe in the different class rooms in the elementary school, I was in the class that the little girl was in the year before, and was able to ask the teacher about the carpet without divulging confidences. The teacher also felt that the carpet was the cause for many of the illnesses that her students had.

*External Check - Peer Debriefing.* Peer debriefing provided me with an opportunity to meet with a neutral party for the purpose of helping to keep me "honest," to assure that the investigative process pertains to substantive, methodological, legal, and ethical matters; and to provide an opportunity to test working hypotheses. Conceptualization and analytic processes were reviewed since the inception of the research with my two faculty mentors, Dr. Christine Kennedy and Dr. Janice Humphries, and they participated all along the way until the end. Towards the end of the analysis period, I utilized two colleagues of mine as peer reviewers, one was a child development psychologist, and the other was a student counselor with her doctoral background grounded in Bronfrenbrenner's theory of ecology.



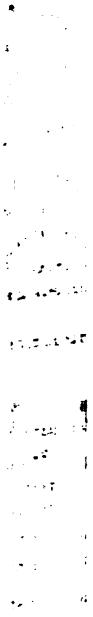
*Member Checks*. Member checks is the process where the informants have an opportunity to review the results of the analysis and to agree or disagree. Member checks occurred at various points of the research process. First, the findings of the initial interviews were reviewed with the children to check for accuracies. As the research continued, insights gleaned from the first interviews and thereafter, were incorporated into the interviews for confirmation or refutation by the informants. For example, as children described what being sick felt like, I took the descriptions from the previous children, and incorporated their descriptions into questions for the next children, especially when they were reluctant or slow to respond. An example of such a question was "Some children have told me that feeling sick feels like you are bored, or sad. What do you think?"

*Transferability (Applicability)*

The establishment of transferability is necessary so that one can determine if the findings of this study can hold up in another time and/or context. A thick description is required so that this can be determined. A thick description requires that a data base is provided, or detailed information about the selected sample, so that transferability decisions can be made. A thick description of the sample is provided in the discussion of sample, and selection of the sample.

*Dependability (Consistency)*

Dependability determines the consistency of the findings, and one must have dependability in order to have credibility. One cannot have credibility without dependability. Dependability can be achieved through triangulation, peer reviews, and



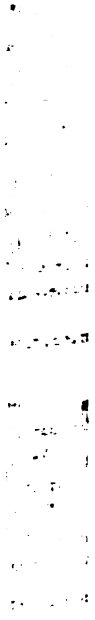
repeated observations of the same event with the same findings all of which have been previously discussed.

*Confirmability (Neutrality)*

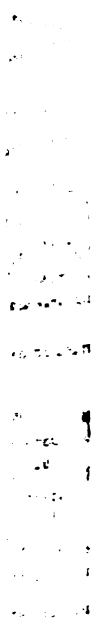
Confirmability is the ability to demonstrate neutrality, not in researcher objectivity, but in the data and interpersonal confirmability. Along with the techniques utilized in dependability, the primary technique for confirmability is an audit trail. An audit trail is the documentation of the stages of analysis so that an external auditor can follow the natural history or progression of events and to understand how and why decisions were made. Furthermore, the trail should lead the auditor to similar conclusions as the investigator. Documentation included in the audit trail include a reflexive journal, a journal to record the information about myself (reflexivity) and method in the form of three logs. A daily schedule log was used to record the daily schedule and the logistics as they pertain to the study. A personal diary for the recording of reflections, thoughts, feelings, insights as they related to the project. And, a methodological log in which methodological decisions and accompanying rationales were maintained

## Summary

The selected field for study was a town in San Joaquin County, CA. Consent and assent were obtained prior to any interviewing of the children or parents. First interviews were arranged with the children, and then the second child interviews were arranged at the time of the parent interview. Drawings from the children were collected as another source of data to support their interviews. As I improved my data collection abilities, I adapted my interview and collection of drawings so that I was able to improve the data



collection process. Twenty-three children in the grades of third to sixth were interviewed, along with their parents in most of the cases. Data analysis was conducted with the Spradley method of ethnographic analysis. Trustworthiness was maintained by achieving credibility, transferability, dependability, and confirmability.



# CHAPTER FOUR

# RESEARCH FINDINGS

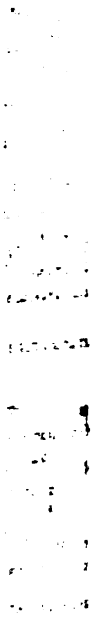
In this chapter the findings of the research will be discussed. The following sections will address the research questions. First, how do Mexican American children, ages 8-12 years old, within the context of their families, conceptualize health and illness? And, second, how are their conceptualizations of health and illness influenced by their family, cultural, and social environments?

## Children's Conceptualizations of Health and Illness

The first research question was, how do Mexican American children, ages 8-12 years old, within the context of their families, conceptualize health and illness? Although there was variability in the complexity of how the children discussed their understanding of health and how to be healthy, they were very knowledgeable about choices one had to make to be healthy. Their explanations of illness were interesting in that they described what it felt like to be sick in terms of emotions, while their awareness that they were getting better was described in terms of physical feelings and abilities. An unexpected finding was that the complexity of the children's understanding or explanation of health and illness did not necessarily increase with the age of the child. In other words, some of the more complex explanations of health and/or illness came from fourth graders, while some of the least complex responses came from sixth graders.

### *Conceptualizations of Health*

The way that the children spoke about health seemed to have more to do with positive feelings and emotions, a sense of hope, rather than physical feelings or



sensations. The children believed that they were active participants in their health by taking care of themselves. The two main ways to take care of themselves were nutrition and exercise. They had to make life-style types of choices that affected their health. Some of these life-style choices also had to do with whether or not they gave in to peer pressure. They viewed health in a holistic way, that health had to do not just with the physical part, but also with the social and mental part of their beings. The children learned what they knew primarily from their parents. Other places they learned their information from included school and the doctor's office.

*Attributes of Health*

The children described being healthy in many ways, mostly pertaining to how their current daily lives were affected. Occasionally health was described as an absence of problems, like their nose not hurting or not being able to breathe well. However, many described emotional feelings, "It feels good, cause you don't have nothing to worry about" (Subj. 17, 5th Grade, Female, Int. 1, Line 136). Additional descriptions included feelings of happiness, and feeling like they could do anything. Another common response was that they did not have any problems, "Uhm, like right now I'm healthy. ... Like I don't have any problems" (Subj 5, 5th Grade, Male, Int. 1, Lines 58-60). For one child this means that "you don't problems of any trouble with other people .... Problems with ... like asthma, ... that you don't have to worry about if you run real fast you could get asthma .... I don't have problems with anything that I could get sick like allergies (Subj. 17, 5th Grade, Female, Int. 1, Lines 140-152).

Frequently the children described health or healthy as being able to participate in

activities of life, which included being able to hang out with friends, playing, going to school, going to the store with your mom, being active in sports (Illustration 1), and being able to get lost in a field. One sixth grader seemed to be saying that one is able to live life with gusto, "when you're healthy, it's when you're real healthy ... you play with something a sport or something, you really play it with joy" (Subj. 1, 6th Grade, Male, Int. 2, lines 199-202)!

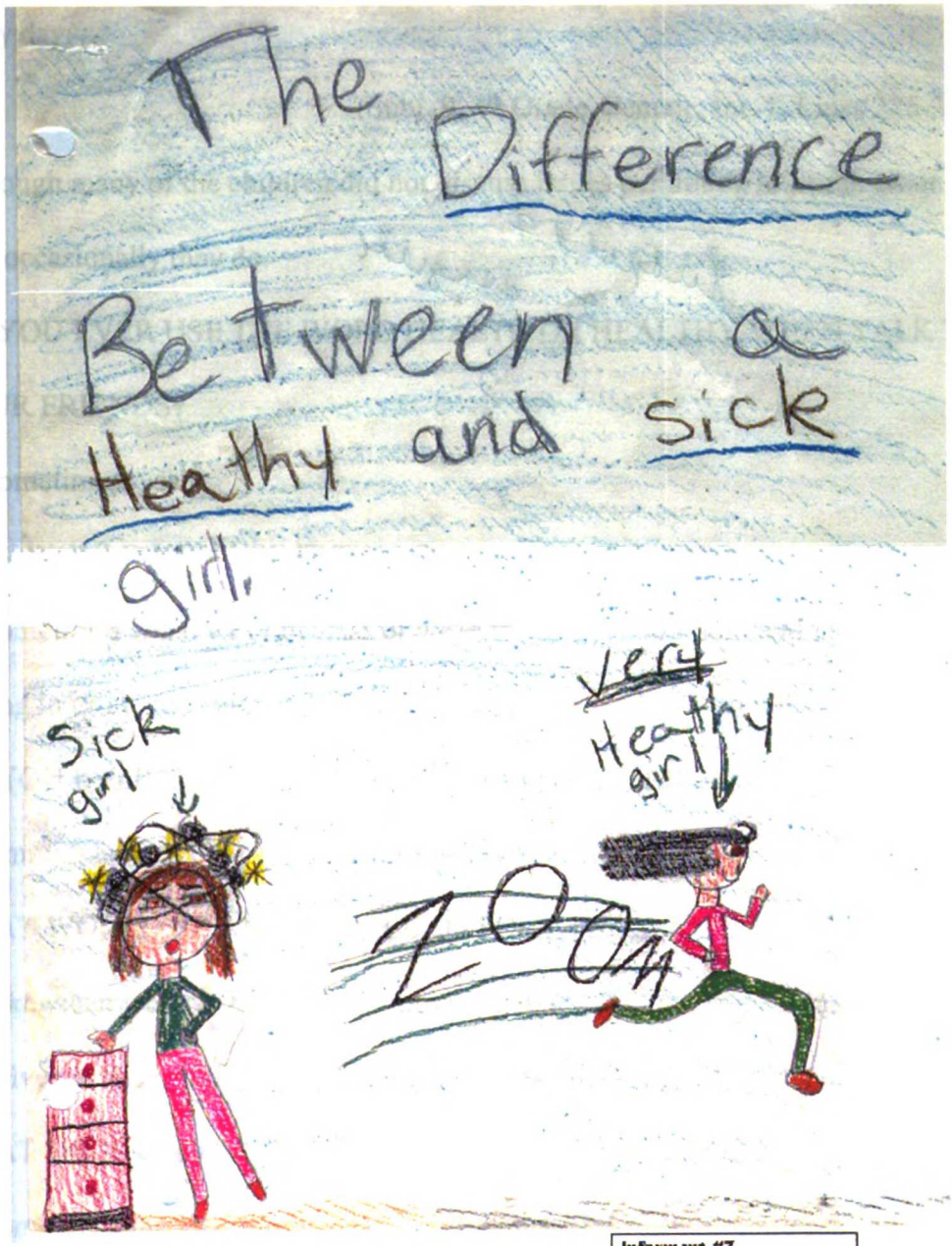
While most of the responses about health were about the present, one fifth grade boy, who also was the younger brother of Subject 1thought about health and about how it related to the future. For him, things that he may do now, such as taking drugs can affect his health, which can directly affect the future and his options, "To me it means like the future. Like being healthy, and you can do a lot of things. If you liking drugs, you just sit there, you don't have a future, you don't do nothing" (Subj. 10, 5th Grade, Male, Int. 1, Lines 134-136). Being healthy was important because it "give you more energy to learn, do lots of things" (Subj. 12, 6th Grade, Male, Int. 1, Lines 67-68).

Although a few of the children thought that one could not be sick and healthy at same time, most of the children believed that one could be sick and healthy at the same time. For example, one could be healthy, but have a cough, headache or a disability, "[referring to one with a disability] They're not sick, but I think they might be healthy unless they get sick, like a virus or something. Cause they're not really sick" (Subj 4, 6th Grade, Male, Int.1. Lines 258-260).

Finally, one child thought that she was healthier now than when she was younger was because she was bigger, and that possibly her tonsils were better, therefore she was

Illustration 1 - Subj. 7, 4th Grade, Female

Drew what her idea was of the difference between a healty and a sick girl. As a sick girl, she drew herself leaning on a dresser. As a healthy girl, she drew herself running very fast and smiling.



not getting sick as often

WHY DO YOU THINK YOU'VE BEEN HEALTHIER SINCE YOU'VE BEEN NINE? R: Maybe I'm growing up and my body has begun to change and maybe I have been growing and my tonsils, maybe they have been getting better and better every day.

(Subj. 9, 4th Grade, Female, Int. 1, Lines 325-329)

Although many of the children did not discuss issues pertaining to health amongst themselves, occasionally they do.

DO YOU EVER USE THE WORD HEALTH OR HEALTHY WHEN TALK TO YOUR FRIENDS?

R: Sometimes, yeah.

HOW WOULD YOU USE IT THEN?

R: Sometimes when we're in class or we're inside the classroom and the teacher is talking to us about health and what do we do, sometimes we do talk.

DO YOU EVER TALK ABOUT IT WITH YOUR FRIENDS?

R: Ummm, not really often, but sometimes we do.

WHAT WOULD BE AN EXAMPLE OF SOMETHING YOU WOULD SAY?

R: Like when we're at lunch sometimes we talk on, they do, sometimes we ask ourselves is this healthy food or is it gonna make us feel good?

WHAT DO YOU GUYS SAY IF IT'S NOT HEALTHY FOOD?

R: Sometimes the girls throw away, we taste it first.

OH YOU DO?

R: And if it isn't good, well...

(Su 9, 4th Grade, Female, Int 1, Lines 76-93)

DO YOU EVER WHEN YOU ARE TALKING WITH YOUR FRIENDS DO YOU USE THE WORD HEALTHY?

R: Yes, sometimes like my friend's sister I'll say "your sister's pretty health, tell me what does she do?" she exercises, she goes in the gym and all those things. Sometimes I think that she is doing a pretty good job in doing her health good. Sometimes he is in good health too sometimes he's not, but I still tell him he that he is in good shape he's always doing a good job with his health, and everything. Everything he does like when he eats, he's not trying to eat that much fat, he's trying to eat low fat low cholesterol.

(Subj. 12, 6th Grade, Male, Int. 2, Lines 69-79)

*Making Choices That Contribute to Good Health*

The children were very aware of what one had to do to be healthy, or how one stayed healthy, but, good health does not just happen, "... they need to take good care of them their selves," (Subj. 5, 5th Grade, Male, Int. 1 Line 72). The children overwhelmingly viewed being healthy as a result of their behavior. The types of responses given were not the types of things left to chance. There was no indication that they believed that they did not have control over their abilities to achieve and maintain health or that it was left to chance. In fact they clearly understood that one had to take care of themselves in order to be healthy. All of the things they did or did not do were intentional decisions to do them or not, therefore I categorized them as choices (Illustration 2). The

Illustration 2 - Subj. 15, 5th Grade, Male

This child drew himself as if he were thinking. On one side of his thought, he had written bad, and on the other side god (good), as if he were making a decision.

children talked about children talked about nutrition, exercising, taking care of yourself, obeying their parents, taking care of their mental, emotional, and social parts of their lives, and staying away from sick people as ways to be or stay healthy. The children were not especially articulate or wordy in their responses, however, the responses that they gave were strongly supported by their drawings (Illustrations 3, 4, and 5).

*Nutrition*. Every child in the study talked about good nutrition as a very important thing to do to achieve and maintain good health. Good nutrition included eating vegetables, fruit, fluids, milk, juices, vitamins and not too much candy, "Oh, when you're healthy you eat good. You eat lots of vegetables, lots of fruits and you have to eat lots of those cause if you don't, your body needs those foods to umm, to be healthy" and furthermore, "to cook not putting too much oil and like that" (Subj. 16, 6th Grade, Female, Int. 1, Lines 160-163, 173).

Even if one was sick or had a disability, eating good food was a way of still being healthy, "[referring to someone with a disability] If they eat the right things they can be healthy" (Subj. 1, 6th Grade, Male, Int. 1, Line 456).

One child felt that some people in Mexico are not as healthy because they don't always have enough to eat or they have to eat food from the garbage,

> Being Mexican is kind of sad because people are poor and the house is dirty and they don't have nothing to eat and I never being like that and I do know in Mexico we did have a house and something to eat and some of the people who did they did not and I feel like I don't know, sad people .... They eat too much junk, they

Illustration 3 - Subj. 23, 3rd Grade, Male

This child drew a tree of good banans.

Illustration 4 - Subj. 9, 4th Grade, Female

This girl drew about the many ways to take care of herself. In corner she wrote that she likes to eat strawberries, and also drew a bowl of them. In another, she drew herself in bed, in the corner, and very small. She wrote that when she is sick, she is sad. And, finally she drew the things that she likes to do, read, listen to music, and write.

Illustration - 5 - Subj. 16, 6th Grade, Female

This picture is about taking care of herself by playing soccar. One girl in the picture is drawn saying that she feels good, and the other one that she likes to play. Next to the field, is a table with healthy food, fruits and vegtables.

eat food from the garbage that's not that health cause it has too much germs in it.

(Subj. 3, 6th Grade, Female, Int. 1, Lines 175-188)

*Exercise.* Another way to be and stay healthy was to exercise, which was discussed by all of the children. Some of the activities the children talked about included running, soccer, walking, tennis, basketball and riding a bike (Illustrations 6, 7, and 8). Exercise is important to feel good, be healthy, and to do other activities. Exercise "gives you more muscles" and makes "all the bad things get out of you .... Like even if you're skinny, you get like in normal shape sometimes" (Subj. 12, 6th Grade, Male, Int. 1, Lines 80-84).

*Taking Good Care of Yourself.* In addition to good nutrition and exercise, taking good care of yourself was important to achieving and maintaining good health, which included wearing warm clothes, taking baths, brushing teeth and going to the dentist "... brushing your teeth. Cleanness. Hygiene I think it's called and I can't remember some other words that I just learned" (Subj 7, 4th Grade, Female, Int.1, Lines 265-267), wearing a helmet when riding your bike (Illustration 7) and getting enough sleep.

DOES THE WORD HEALTH MEAN ANYTHING TO YOU?

R: Healthy? That means like umm, not go in the street when you're just, you're gonna go get your ball, you just wait when the car pass, then you could go. And health means that when a car's coming you [look] both ways first and then you cross. Healthy means that to take care of you, and mom.

(Subj. 11, 3rd Grade, Female, Int. 1, Lines 45-50)

Illustration 6 - Subj. 14, 4th Grade, Male

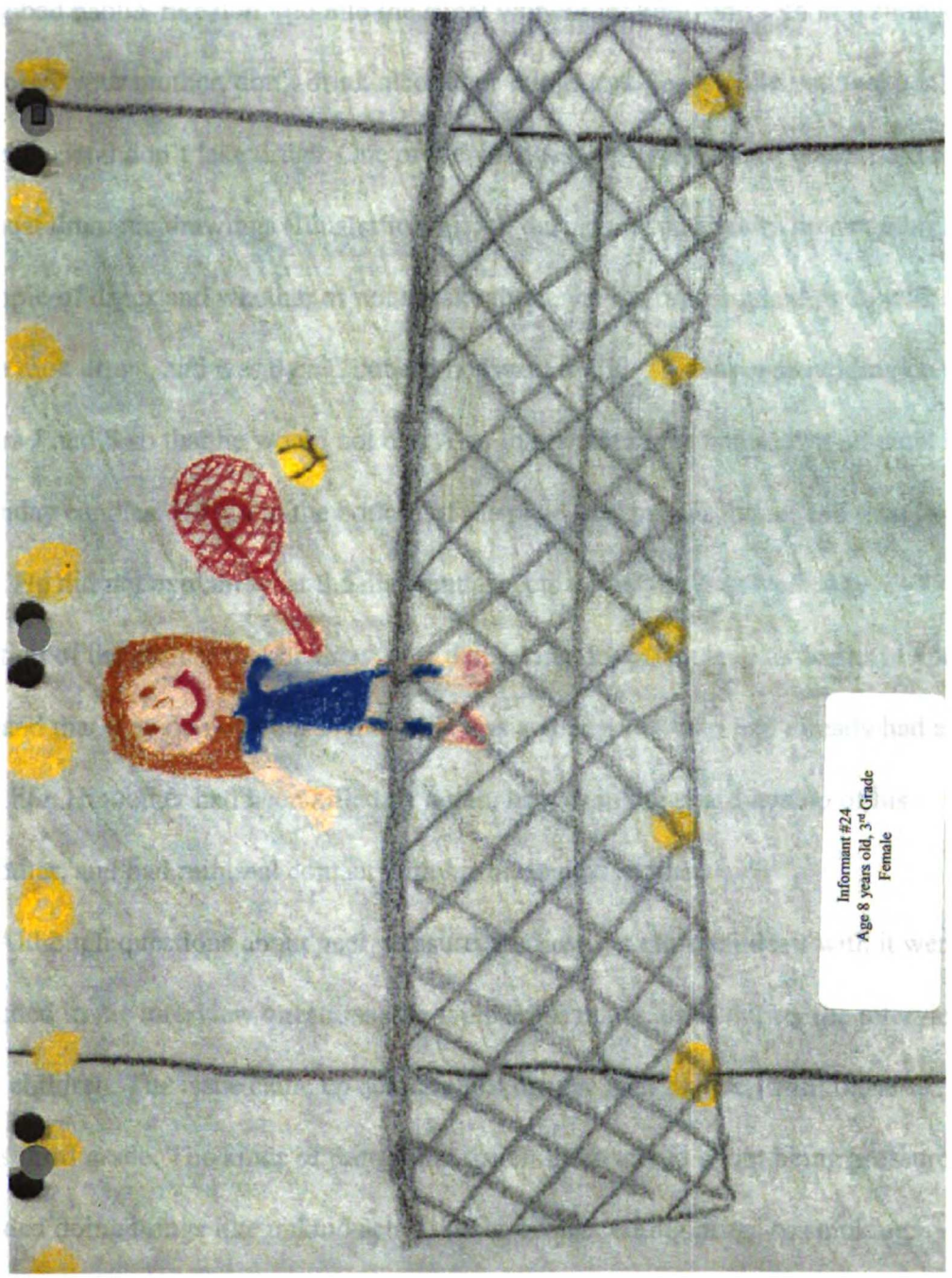
This picture is about two boys playing a game of basket ball.

Illustration 7 - Subj. 20, 3rd Grade, Female

This young girl drew herself with a bike and wearing a helmet.

Illustration 8 - Subj. 24, 3rd Grade, Female

This picture is about a girl playing tennis, a favorite sport for this young girl.



*Life-Style Choices*. There were MANY things that they talked about that people need to do to achieve and maintain good health that were not included in the previous sections. These choices were life-style kinds of choices such as issues of safety and avoiding bad habits, like don't go into the street without looking, don't go into stranger's houses, obey your mother, don't drink alcohol or things that don't make you feel bad, don't smoke, and don't take drugs. One of the youngest children, a third grader, drew one of the most dramatic drawings (Illustration 9). All during our interviews he never brought up the topic of drugs and whether or not to take them, yet his drawing had to do with a boy who took drugs, and was dying, but did not want to die. The boy was holding on to the letters J and S so that he would not die. Also in his picture he had drawn an eight ball, and birthday candles. He got to the bottom of the page, and put his name, and then just stopped. He did not explain what the different aspects of his drawing were. My explanation of the picture that he drew, was that taking drugs can lead to deaths in young people, and that they do not want to die. This was a young boy who had already had a difficult life. His father had been killed by a gun, he was in the guardianship of his grandmother, and had minimal contact with his biological mother.

Although questions about peer pressure and how the children dealt with it were not included in the interview questions, the topic arose many times during the interviews with the children. The issue came up across all of the age groups, even with those as young as third grade. The kinds of things that the children talked about being pressured to do included doing things like unkind acts to other people, taking drugs or smoking.

HOW DO YOU GET HEALTHY OR HOW DO YOU STAY HEALTHY?

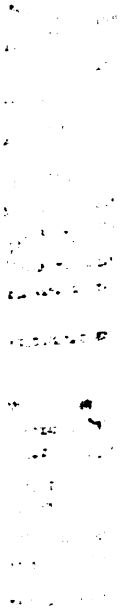
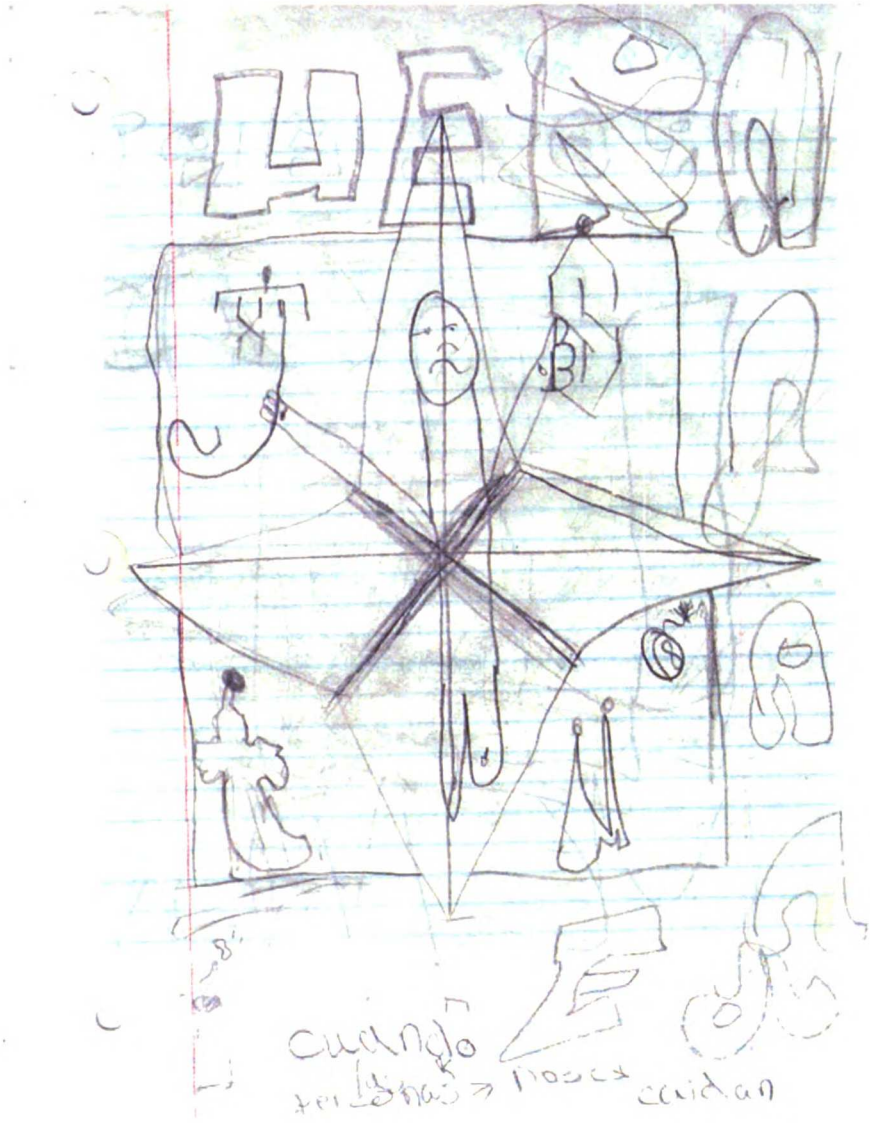


Illustration 9 - Subj. 8, 3rd Grade, Male

This is a picture of someone who took too many drugs, and is dying, but does not want to die. He is hanging on to the letters J and B, so that he does not die. Down in the bottom the child wrote, when one does not take care of themself.



Informant #8
Age 8 years old, 3rd grade
Male

R: .... Like some of the kids that are in my school, some of them, sometimes they ask me if I want to smoke or something. I don't want to.

KIDS AT YOUR SCHOOL ARE SMOKING ALREADY?

R: Yeah.

AND HOW COME YOU DON'T WANT TO?

R: ... I want to be healthy.

WHAT DO YOU TELL YOUR FRIENDS? HOW DO THEY ASK YOU TO SMOKE? HOW DO THEY ASK YOU OR TALK ABOUT IT TO YOU?

R: They ask me, they say, like "After school, do you want to go with us over there at the park and smoke with us?" And I say no.

THESE ARE FIFTH GRADERS OR YOUNGER?

R: Yeah, fifth graders.

FIFTH GRADERS. SO WHAT DO THEY SAY WHEN YOU SAY NO?

R: They said like if I'm scared or something. Like I'm a chicken, like I'm a baby.

WHAT DO YOU THINK ABOUT THAT?

R: They're uh, I ask myself why do they do that? They don't get nothing from it.

THAT'S A GOOD QUESTION. UMM, WHAT DO YOU MEAN BY IF THEY DON'T GET NOTHING. WHAT ARE YOU THINKING ABOUT WHEN YOU SAY THAT?

R: They umm, they don't get more healthy

(Subj. 13, 5th Grade, Female, Int. 1, Lines 194-217)

One boy talked about how his cousins and friends talked about some American children, and the way that they were talking made him comfortable to the point that he asked his friends to leave when they talked that way.

> Jesus has a bad attitude. Jose, Jesus, OK, he say "Oh, I hate that gringo or I hate him." Just cause from the car. I got lots of friends that are American here. I got Mexican friends at school. And when Armando and Jorge come over here, cause they're Mexicans, they talk about them. And I just say "leave" cause the friend that right here Americans is they don't talk about Mexican people. They have friends that are Mexicans too.
>
> (Subj. 1, 6th Grade, Male, Int. 2, Lines 247-254)

*Emotional/Social/Mental Health.* Emotional, social, and mental health were important to all of the children, along with how they dealt with it, from the youngest to the oldest. The children included things like don't be mean to your mom, reading and listening to music for pleasure, to taking care of your emotional health such as, anger, and relationships.

> R: ... your mind? It's a type of health and like there's strings, everything's attached to like social health and physical health and if you don't have very good mental health, that you're not going to get very good physical or social health.
>
> WHAT'S SOCIAL HEALTH? I'VE NEVER HEARD OF THAT BEFORE?
>
> R: Umm, relating to others.... Cause you can't really live with like only two like really good parts of the health. Like you can't just have physical and social health and not be very good mentally, healthy. So, like if you're not mentally healthy then

you're not gonna be very, it's gonna affect your physical and social health.

(Subj. 4, 6th Grade, Male, Int. 2, Lines 113-130)

*Avoiding Other Sick People.* Many of the children talked about staying away from someone who is sick, staying home from school if they are sick, or staying way from other people so they don't get other people sick "When I'm sick, I cannot do anything but stay in the house, not go outside. Go nowhere. If I go to school, like not go around [other people] so I won't get them contagious .... HOW COME? R: I don't want them to get germs from me when I cough" (Subj. 12, 6th Grade, Male, Int. 1, Lines 171-173 and 302-303).

*Summary of Conceptualizations of Health*

The children were very knowledgeable about achieving and maintaining health. Their outlook on health was very positive. They had a holistic perspective in that health is about their physical, emotional and social well-being. Health was not something that just happened, but rather that they had to participate in their good health, to take care of themselves. Nutrition, exercise, life-style choices were all choices that they participated in to achieve and maintain good health.

## *Conceptualizations of Illness*

*Health Status of the Children*

All of the children were healthy children from healthy families, none of them had experienced serious or chronic debilitating illnesses. Their experiences with hospitals were minimal. The two who had stated they had been hospitalized, were hospitalized as an infant for croup, and a toddler for appendicitis respectively. The rest of the experiences

with hospitals were through the emergency department for non-life threatening accidents or illnesses, and they were not admitted. However, all of them had access to primary care physicians, and seeing the doctor during illnesses was articulated by all of the children. Asthma and allergies were the only conditions that were mentioned several times by the children as something they experienced or that one of their siblings had. Anemia was the only other chronic condition that was reported. None of the children were reported by their parents to be in acute exacerbations of their allergies, asthma, or anemia. Many of the children did not live close to their grandparents, since most of the grandparents still lived in Mexico, so the children could not really talk about having a sick grandparent. Most of them knew about a sick grandparent, but did not really know about what they were sick with, or what the experience was like for them.

*What Being Sick Feels Like*

An interesting finding was that when the children described what it was like for them to be sick, they described it in terms of emotional feelings as well as actual physical feelings. However, when they described getting better, it was in primarily in terms of their physical abilities.

*Emotional Feelings.* Many of the children expressed emotional feelings when describing what it was like for them to be sick. The feelings they described included feeling bored or sad. "WHY ARE YOU SAD? R: Because I don't feel well, and my friends probably like, like, my friends, they want to play with me or something and I can't play with them because I'm sick" (Subj. 5, 5th Grade, Male, Int. 1, Lines, 172-174). Another emotion that one child talked about was getting mad when she got sick, "Well I

feel sad since, like mad, .... And my brothers are very happy and then me, I'm mad because I can't do some of the things that they do. I'm sick" (Subj. 17, 5th Grade, Female, Int. 1, Lines 277-279). They talked about wanting to be well, missing friends and school, and that they didn't feel like doing anything.

There is a sense of a loss of control. "... cause I'm why can't I take this away?" (Subj. 17, 5th Grade, Female, Int. 1, Lines 277-278). "WHAT ABOUT WHEN YOU'RE SICK? WHAT'S THAT LIKE FOR YOU? R: Umm, it's, you didn't want it to happen [vomiting] (Subj. 11, 3rd Grade, Female, Int. 1, Lines 72-74). Along with the loss of control when vomiting, there was embarrassment. One child was describing her visit to the emergency room when she was very sick with vomiting. Although she had been vomiting at home with her parents prior to going to the emergency department, she did not refer to that experience as embarrassing as she did while at the emergency department. This young lady was a very composed and articulate fourth grader, and it appears that part of her embarrassment came from being around strangers during a vulnerable time. Although her dad had taken her to the emergency department, she was primarily in the care of strangers. Even though she said that the nurse did not do anything to embarrass her, rather she had comforted her, she still found the experience difficult. Another reason she found the experience embarrassing is that the patients in the bed next to her could hear her as well.

> Well, a lady came, she took me to one of those rooms that has a bed and a curtain and she took the blood pressure and it really squeezes your arm. It kind of hurts. She had to take it two times. And the second time it was embarrassing because

when she did it, I had to throw up and it was on me and she was holding me like right here and then so I threw up in a bucket kind of thing. And you know, I had to wipe my mouth and I had to do it all over again. [Tone in her voice - seemed like it was hard for her to talk about - embarrassment]

OH, I BET THAT FELT AWFUL. I'M CURIOUS, WHAT WAS EMBARRASSING ABOUT THAT?

R: Throwing up in her arms and right in front of her.... It was embarrassing for me in front of the nurse because umm, because I don't know, it's hard to explain. It was just really embarrassing, to do it in front of her and I could hear the neighbors saying, "Wow, she's really sick" and stuff.

.... DID SHE [THE NURSE] DO ANYTHING TO MAKE YOU FEEL THAT WAY?

R: Not embarrassed, she just kind of comforted me.

(Subj. 9, 4th Grade, Female, Int. 1, Lines 170-209)

Another way of not having control over a situation when sick was the feeling of not wanting to go to school because they can't pay attention, "When I'm sick I wish I didn't go to school .... You don't put a lot of attention" (Subj. 6, 5th Grade, Female, Int. 1, Lines 251-253).

Contrary to their positive outlook on life when talking about health and being healthy, when talking about being sick, there was a sense of hopelessness. One child felt that it was like quitting, "To me, like, when I'm sick, to me it feels like I'm just quitting" (Subj. 10, 5rd Grade, Male, Int. 1, Line169-170). During the second interview, I asked him

to explain what he meant a little more, and he explained "Like kind of giving up, you can't do nothing anymore. Like you're going to stay sick forever, you're not going to be able to do things anymore, like that" (Int. 2, Lines 158-160). One child simply stated that if one is not healthy, it means that one was sick and you had problems.

Their drawings were particularly interesting in that when the children drew about topics other than illness, their drawings usually took up the whole page, and were very colorful. However, some of the children chose to draw a picture of something having to do with illness. In some of the drawings about being sick, the drawings were less colorful, took up less space on the page, and often the children drew themselves small and in the corner (Illustrations 4 and 10) as if they felt small, insignificant, and vulnerable.

*Physical Feelings*. Physical feelings were the physical feelings described by the children about being sick. Explanations of the physical feelings were less descriptive and more straight to the point, "IF YOU WERE NOT HEALTHY, WHAT WOULD YOU BE? R: I would be in the doctor's. And I would be sick" (Subj. 8, 3rd Grade, Male, Int, Lines 58-60). The physical attributes that the children described included a headache, feeling like going to throw up, stomach ache, symptoms of a cold - runny nose, nasal mucus & cough, a change in their voice - hoarse, a feeling of something in throat, feel weak, hurts, can't participate in activities like basketball, feeling hot and feeling strange, "WHAT DOES BEING SICK MEAN ... TO YOU? R: When you feel bad, when you're, when you feel dolores. Umm, cuando te duele la cabeza y cuando te sientes mal o algo que pasa [Translated: When you feel pains. Uhm, when your head hurts and when you feel bad or something happens]" (Subj. 9, 4th Grade, Female, Int. 1, Lines 291-295). "And

Illustration 10 - Subj. 18, 3rd Grade, Female

This young lade drew herself sick in bed, being cared for by her sister. Although she had a full page to draw in, she drew herself small and in the corner, with nothing else in the picture.

Informant #18
Age 8 years, 3rd Grade
Female

sometimes like, I get sick and throw up and like something, my stomach gets hurt or something" (Subj. 11, 3rd Grade, Female, Int. 1, Lines 72-77). There was a sense that something was out of the ordinary or feeling strange, "Something being wrong with your body or like out of order or something" (Subj. 4, 6th Grade, Male, Int. 1. Lines 93-94).

The children talked occasionally about taking medicine. The children did not really talk about the things they did not like about being sick, except for when it came to taking medicine, because they did not like it. "The thing I don't like when I get sick that I have to drink a lot of medicine .... Well, medicine, they tastes like I don't know, I don't like them" (Subj. 2, 4th Grade, Female, Int. 1, Lines 100-104)! Although the children did not talk about taking antibiotics, several did know about medicines like Tylenol or Contact. The only child that appeared to take medicine on a regular basis for his anemia stated that the reason he was taking the medicine was for his heart, "Because it helps me to take the anemia" (Subj. 8, 3rd Grade, Male, Int. 1, Line 31). One girl explained why her little sister got a cough and that the medicine from the inhaler helps her to not cough, "SO IS THERE ANYTHING SHE CAN DO TO PREVENT GETTING IT [THE COUGH]? R: Yeah, not when she's running or something, she gets the little, what to you call it, the pumpie [inhaler]?, and she gets the medicine to not cough" (Subj. 3, 6th Grade, Female, Int. 1, Lines 272-275).

Often the children felt they had to tell their parents that they were sick, rather than their parents knowing on their own that they were sick. When children told their parents they were sick, usually it was in terms of what they were feeling physically.

*Getting Better.* As previously stated, the children knew they were getting better

when their physical symptoms started to go away, "... I'm not that hot and I don't cough too much and I throw up" (Subj. 3, 6th Grade, Female, Int. 1, Lines 376-377). Being able to return to their regular activities like playing, or getting up and walking around was another indication that they were getting better. "HOW DO YOU KNOW WHEN YOU'RE GETTING BETTER? R: Well, sometimes, sometimes I go out and see things. I'll play a little with my sister. And I go do stuff that kids do" (Subj. 10, 5th Grade, Male, Int. 1, Lines 258-261). One young lady described the feeling of getting better as more power for her body, "When I'm getting, I know because I feel better and I just feel more energy to get up and play and to do different kinds of stuff. Like I have more power in my body (Subj. 17, 5th Grade, Female, Int. 1, Lines 385-387).

*A Little Bit Sick and A Lot Sick*

The term "a little bit sick and a lot sick" is an in vivo term that came up early in the data collection. The children described being sick in degrees of sickness, a little bit sick and a lot sick. "HOW ARE YOU TODAY? R: A little bit sick .... WHAT ARE YOU A LITTLE SICK WITH? R: Like a cough .... DID YOU GO TO SCHOOL TODAY? R: Yeah" (Subj. 2, 4th Grade, Female, Int. 1, Lines 2-12). For most of the children the difference between being a little bit sick and a lot sick had to do with the impact that it had on one's life and whether or not they could still participate in their normal activities, such as going to school.

> WHAT WOULD THE DIFFERENCE BE [BETWEEN A LITTLE BIT SICK AND A LOT SICK]?
>
> R.1: Cause if you were so sick you would have to drink a lot of medicine and if

you were just sick, you wouldn't have to drink a lot of medicines.

WOULD YOU GO TO SCHOOL IF YOU WERE A LOT SICK?

R.1: No.

IF YOU WERE A LITTLE BIT SICK?

R.1: Yeah.

(Subj. 2, 4th Grade, Female, Int. 2, Lines 94-101)

The severity of the illness was considered when describing the difference between a lot sick and a little bit sick, such as having cancer and a cold. A cold was a little impact, therefore, was a little bit sick, and having cancer was a big impact, therefore, a lot sick. Another way of making the distinction of being a little bit sick or a lot sick, was that one didn't feel like doing anything if a little bit sick, but if a lot sick, one was weak. Often as the children described the difference they became very specific as to what was a little bit sick and a lot sick.

COULD [YOU] TELL ME THE DIFFERENCE BETWEEN [A LITTLE BIT SICK AND A LOT SICK?].

R: A little bit sick is? Well, when I'm a little bit sick I still play around. But I don't feel so good. And then I cough too much maybe or I got allergies too much. Sometimes I'm feeling weak cause too much playing around ....

CAN YOU TELL ME WHAT A LOT SICK IS?

R: A lot sick is when, a lot sick is I sleep when I'm real sick. Or I can't do nothing, I just lay on the couch. And I just stay there seeing TV.

CAN YOU GO TO SCHOOL WHEN YOU'RE A LOT SICK?

R: A lot? Only when your stomach is real hurting, I don't think you can go. But, if you sneeze, it's OK, you can go still.

(Subj. 1, 6th Grade, Male, Int. 2, Lines 194-209)

One boy described the difference between being a little bit sick and a lot sick as to whether or not he went to the doctor. As he was talking in this part of the interview, it was if his imagination got going and he went on to develop an analogy with an example of the difference between a bee sting and a wasp sting to explain the difference between the two degrees of illness.

DO YOU EVER GO TO THE DOCTOR WHEN YOU'RE SICK?

R: No. Sometimes when I'm very, very sick I do.

WELL, WHAT'S IT LIKE TO BE VERY, VERY SICK? WHEN YOU HAVE TO GO TO THE DOCTOR, WHAT'S THAT LIKE?

R: You feel very, you feel pain a lot, I think.

SO IS THAT LIKE BEING A LOT SICK?

R: Yeah.

WHAT'S A LITTLE BIT SICK?

R: Like you feel a little bit of pain. Like, when you, when you pick, like when you get a needle stick, it feels like that.

A LITTLE BIT SICK? OH. WELL, WHAT WOULD BEING A LOT SICK FEEL LIKE?

R: Like a bee sting you.

AND THAT'S WORSE THAN THE NEEDLE? YEAH?

R: Cause it has poison .... I mean a wasp. A wasp is when you're very, very sick. So the bee is when you're half sick. It has a big needle and it has more poison.

(Subj. 23, 3rd Grade, Male, Int. 1, Lines 116-134

*Kinds of Illness*

The types of illnesses that the children experienced were mainly colds, the flu, and the chicken pox. When trying to illicit stories about when they were last really sick, often the parents or the children could not remember a recent event. "CAN YOU REMEMBER THE LAST TIME YOU WERE SICK? R: I was uhm, not really, cause, I haven't gotten sick" Subj 24, 3rd Grade, Female, Int. 1, Lines 96-97). The children did not miss much school because of illness. In one instance, one girl stated that she never missed school; even when she was sick, her mother sent her any way. "Well, I never miss school. YOU NEVER MISS SCHOOL? R: If I get a cold or something, I can't miss school so I just have to go (Subj. 17, 5th Grade, Female, Int. 1, Lines 281-284).

Many of the children talked about allergies and asthma, but could not really explain what they were.

ARE ALLERGIES THE SAME THING AS BEING SICK?

R: Well, not really, that's what I think.

OKAY, WHAT'S THE DIFFERENCE?

R: Well, maybe because when you get close to something, it depends how, what allergies do you have. When you get close to something, maybe you get sick and when you're normally sick, you don't get sick from touching something.

SO ALLERGIES ARE NOT THE SAME AS BEING SICK?

R: No.

(Subj. 16, 6th Grade, Female, Int. 1, Lines 134-142)

Although some of the child subjects had asthma or allergies themselves, the ones who did not, knew several, either siblings or friends who did have them. One girl related a story about when she went to her cousin's house (Subj. 3), and that her younger cousin had asthma as well. She believed that her contact with the younger cousin caused her to have asthma, but did not understand how.

It was when I went to go when I spend the night at my cousin's house and her little sister has asthma and me, too .... but she has more than me and she got close to me a lot, and uhm, like I got a little bit more. And I had to stay at home .... I don't have to do it [take medicine] everyday but, uhm I do it sometimes.

WHAT DO YOU THINK CAUSES YOU TO HAVE YOUR ASTHMA?

R: I think when I was little I had asthma when I was born. I had asthma.

WHEN YOU GET YOU'RE YOUR ASTHMA ATTACKS NOW, WHAT DO YOU THINK CAUSES THEM NOW?

R: I don't know.

WHAT DO YOU THINK ASTHMA IS?

R: It's something that you have like in your chest and umm, if you were to cough or something, or have to cough hard for the asthma like to come out.

(Subj. 2, 4th Grade, Female, Int. 1, Lines 94-119)

*What Makes Someone Sick?*

All of the children believed that getting sick often had to do with not taking very

good care of themselves, "When you get sick - it's about how you take care of yourselves" (Subj 10, 5th Grade, Male, Int. 1, Lines 371-72). The explanations for how one gets sick were varied in the level of complexity and abstractness, however, increased complexity and abstractness did not increase with the ages of the children. For example, most of the children of all of the grades, including the older children believed that going without shoes on cold floor, playing too much in the cold, or going outside with wet hair made one sick. "HOW DO YOU GET SICK? R: I don't know. Well, when it's very cold" (Subj. 1, 6th Grade, Male, Int. 1, Lines 403-404). "Like in winter you can't go outside and play and if I do I'll get sick" (Subj. 2, 4th Grade, Female, Int. 1, Lines 89-90).

> R: ... like last year, before I went to Mexico, I was taking a shower, and automatically, my dad told me "Let's go, let's go cause your mom was waiting for you at the mall," and when I went out, I got sick. I got like a, you know what is calentura [Translated: fever]? Yeah, I got that. And then on the way to Mexico and after that day we went to Mexico, and then like over there I had a flu and I had to go to the doctor and I got sick, I had to throw up.
>
> SO WHAT DO YOU THINK CAUSED YOU TO GET SICK LIKE THAT?
>
> R: Probably when I got out of the bath .... Yeah. Cause I was in warm water and it was already cold outside. It was already like end of the the raining season when it got flooded that day.
>
> (Subj. 12, 6th Grade, Male, Int. 1, Lines 176-189)

One child explained that being in the cold and then going into a warm place makes one sick, but did not understand how that happened.

WHAT DO YOU THINK CAUSED YOU TO BE SICK?

R: Being like cold, cause usually I play like at six or seven o'clock, when it's kind of cold and when I'm coming home it's too hot and it mixes and gets you sick.

UMM, I DON'T UNDERSTAND THAT PART ABOUT WHEN THE HOT AND COLD MIXES. CAN YOU EXPLAIN THAT TO ME? ...

When you're cold and like you get in a hot place, it could make you sick.

(Subj 10, 5th Grade, Male, Int. 1, Lines 183-190)

Some also believed that going near someone with asthma or eating too much candy or junk food could make them sick.

All of the children had an understanding about germs, and that they could make one sick. Most of the children knew that it was contact with germs that could make themselves or other people sick.

YOU SAID ... WHEN YOU'RE SICK WHEN YOU GO TO SCHOOL ... YOU STAY AWAY FROM PEOPLE SO THEY DON'T GET SICK? HOW COME?

R: I don't want them to get germs from me when I cough.

HOW CAN THEY GET YOUR GERMS?

R: When I cough right at them or something, they'll get it like, they'll get, I'll spray the germs out and get into... They'll get sick.

(Subj. 12, 6th Grade, Male, Int. 1, Lines 300-307)

My brother's sick, too. It started out with him, me, my dad and my mom. So the whole family had a virus but half of it's better.

HOW IS IT THAT THE WHOLE FAMILY ENDED UP WITH THE VIRUS?

R: Well, my brother first had it. I don't know how but he first had the virus. He gave it to me. I gave it to my dad and my dad gave it to my mom.

HOW DO YOU THINK THAT HAPPENED, GIVING IT TO EACH OTHER?

R: Sharing foods and you know, kissing and that, like on the cheek and stuff. ...I think I even gave it to my friends, two friends.

(Subj. 7, 4th Grade, Female, Int. 1, Lines 70-86)

Furthermore, she had a holistic perspective of getting sick and believed that being sick sometimes had a purpose. Sometimes people have to get sick in order to get the germs out that were causing the sickness, by sneezing, vomiting, and coughing. Sometimes getting a headache was a sign to go and rest and to sort out your mind.

R: How sickness can help you? Well, when you have a sneeze kind of cold, the sneeze helps get dust out. And umm, sometimes even germs. When you throw up, it helps you get poisons, bad foods, things you really don't need, it helps you get it out. And, when you cough, it gets germs out. And umm, when you have a headache, it lets you know you got to rest and it helps you sort out your mind. Those kinds of things.

(Subj. 7, 4th Grade, Female, Int. 1, Lines 368-374)

*Getting sick as a result of one's actions.* All of the children thought that their behavior could result in placing them in situations that could cause them to get sick, such as, if they did not obey their mother, going out into the cold or rain, eating things one is not supposed to, and going out without a jacket in the cold or rain. "You get sick a lot ... cause you don't put your jacket or sweater on and you get like cold or asthma or

something like that" (Sub. 3, 6th Grade, Int. 1, Lines 29-31). "Like if another person is very sick and you get near them, you'll get sick, too. And uhm, if you eat stuff that you're not supposed to, that will make you sick, too" (Subj. 2, 4th Grade, Female, Int. 2, Lines 121-123).

> When I play a lot and my mom tells me to come, it's too cold, and I say "no, I want to play more", and I go outside, I'm being like naughty. Then when I get sick and say, "Why did I go outside and stay there when my mom told me?"
>
> (Subj. 10, 5th Grade, Male, Int. 1, Lines 364-367)

Or, if one did not do things they were supposed to do, such as exercise, eat right, or maintain cleanliness. "When you get sick is about how you take care of yourself when you get sick" (Subj. 10, 5th Grade, Male, Int 1. Lines 371-372). Another way a naughty behavior could result in illness was if it put the child in contact with germs, "BUT, WOULD THAT MAKE SOMEONE SICK? A NAUGHTY THING LIKE THAT [STEALING]? R: If it had germs on it, probably" (Subj. 7, 4th Grade, Female, Int, Lines 395-397). None of the children thought that thinking bad thoughts resulted in illness.

*Role of God.* While all, but one of the families reported that they were practicing Catholics, none of the children reported that they attended church on a regular basis. "DO YOU GUYS GO EVERY SUNDAY OR LIKE ONCE A MONTH? ... R: Sometimes we go" (Subj. 6, 5th Grade, Female, Int. 1, Lines 223-225).

> DO YOU HAVE A CHURCH THAT YOU BELONG TO?
>
> R: Yeah.
>
> ARE YOU ACTIVE IN YOUR CHURCH?

R: I pay attention. The only problem is that we're hecka busy on Sundays so we can't go so if I can I try and I pray to God and I tell him that I'm very sorry for missing church, things like, "Please forgive me, I'm sorry."

(Subj. 7, 4th Grade, Female, Int. 1, Lines 353-359)

It did not appear that God had a major place in their everyday lives. "DOES THAT BELIEF IN GOD AFFECT HOW YOU ARE OR THE THINGS THAT YOU DO ...? R: It doesn't affect me. I don't really think about that except for like mass or something" (Subj. 4, 6th Grade, Male, Int. 2, Lines 201-201). However, significant events such as first communions and confirmations were important, "HOW IMPORTANT IS FIRST COMMUNION TO YOU? ... R: Uhm, a lot. WHY? R: Because when you eat the thing at church, you have the the body of Jesus is the little bread, the vino [wine] is the blood Jesus" (Subj. 11, 3rd Grade, Female, Int. 2, Lines 319-324). Some of the children thought that is was pretty important for their parents as well. "WHAT WOULD HAPPEN IF YOU HADN'T TAKEN COMMUNION ...? R: Uhm, you can't take the bread or wine, and, uhm, (silence) .... BUT FOR YOU IT'S AN IMPORTANT THING? R: For my mom it is" (Subj. 24, 3rd Grade, Female, Int. 1 Lines 232-239).

However, there were times that the children prayed. "I pray for, in the night, I pray for my family, and for Jesus" (Subj. 11, 3rd Grade, Female, Int. 2, Lines 336-337).

Umm, I like to go, I like to hear what it's, and sometimes I like to go [to church] to hear what are they saying to, sometimes to pray, or to say thank you to the things that happen to me....

DO YOU EVER PRAY WHEN YOU ARE SICK?

R: Yeah.

AND WHAT DO YOU PRAY ABOUT?

R: Umm, when I was in third grade I was really awfully sick of my tonsils. Very, very often I was sick on my tonsils. And I didn't know what to do, and I went to the doctor and the doctor said I had to operate. I was afraid, so I prayed and the doctor said "you don't need to operate." He gave me medicine. And now I don't really [have] awful tonsils.

DO YOU THINK THE PRAYING HELPED?

R: Yeah.

WHAT OTHER KINDS OF THINGS DO YOU PRAY ABOUT?

R: Sometimes I pray for my grades, for my brother or sister or for my parents.

(Subj. 9, 4th Grade, Female, Int.2, Lines 116-132)

None of the children believed that God made people sick, and for the most part, really did not have much to say about the role of God in illness. "DO YOU EVER THINK GOD MAKES PEOPLE SICK? R: No, if they take care of theirselves" (Subj. 10, Int. Lines 359-360).

DO YOU THINK GOD HAS ANYTHING TO DO WITH PEOPLE GETTING SICK OR HEALTHY?

R: If He could and if He really wanted to, He'd try to keep every single person in this world well, but He knows that everybody has to get sick every once in awhile because, He knows, even I know, that sometimes sickness can make you, can help you."

(Subj. 7, 4th Grade, Female, Int 1, Lines 360-365).

*Care Received When Sick*

The children reported ordinary things that the parents did to care for them when they were sick. They were often sent to bed, given medicine, and told to rest. "When I'm sick I need to stay in the bed and have medicine and everything"(Subj. 5, 5th Grade, Male, Int. 1, Line 207). The children are monitored, "She's always asking if I'm feeling better and taking my temperature (Subj 4, 6th Grade, Male, Int. 1, Lines 113-114). Special foods that the children received included juice, Jell-O, avena [Translated: oatmeal], and caldo [Translated: soups].

WHAT DOES YOUR MOM DO WHEN YOU'RE SICK?

R: She gives me medicine, she gives me food that is not too cold and it's not too hot. And my mom takes very good care of me.

DOES SHE MAKE ANY SPECIAL FOODS FOR YOU

R: Yeah.

LIKE WHAT?

R: Soup, caldo .... That's like soup with chicken. And she gives me things that have ingredients that make me feel good and better every day.

DO YOU KNOW WHAT THAT INGREDIENT IS?

R: I don't know what she puts in it.

(Sub 9, 4th Grade, Female, Int. 1, Lines 337-350)

WHEN YOU'RE SICK, WHO TAKES CARE OF YOU?

R: My mom.

AND WHAT DOES SHE DO TO HELP YOU FEEL BETTER?

R: She, sometimes she told me to not get up ,she brings me the food on my bed and when my sister comes, my little sister, she told me to come and get my stuff.

WHAT KIND OF FOOD DOES YOUR MOM BRING?

R: Umm, like things like to drink and .... [a fruit] chayote .... It's a green like ball. It has umm espinas [Translated: thorns] .... but she takes the espinas out.

(Subj. 11, 3rd Grade, Female, Int. 1, Lines 86-103)

Most of the children said they received teas of various kinds. The different kinds of teas included canela [Translated: cinnamon],"If I have a bad throat, she'll do some canela so it'll feel better" (Subj. 12, 6th Grade, Male, Int. 1, Lines 226-227), yerba buena [Translated: a kind of mint] "A Mexican, what do you call it? Yerba buena .... it's warm and I like it cause it's good" (Subj. 3, 6th Grade, Female, Int. 1, Lines 68-73). And manzanilla [Translated: camomile] "She makes umm, lo voy a decir en espanol. Este, te de manzanilla .... Es para cuando se estas mal del estomago [Translated: I am going to say it in Spanish. Manzanilla tea .... It is when you are sick in the stomach] (Subj. 11, 5th Grade, Female, Int. 1, Lines141-144).

Treatments for fevers included taking Tylenol and an ice bag for the head. "Like if I got a calentura [Translated: fever], she comes and brings me like a bag with ice and puts it right here" (Subj. 5, 5th Grade, Male, Int. 1, Line 114).

*Going to the Doctor.* All of the children reported that they went to the doctor when they were really sick. "Le llama al doctor [Translated: She calls the doctor] and ... she takes me to the doctor, then she brings me back" (Subj. 11, 3rd Grade, Female, Int. 1,

Lines 130-131). Or, if they did not get better after a few days. " Like if the parents say that and you get uhm, like you will be sick like in two days and you're still sick they take you to the doctor" (Subj. 10, 5th Grade, Male, Int. 2, Lines 172-174). If the children went to the doctor when they were really sick, they usually got medicine. "When I get really hot, have a fever, or have a runny nose that's really bad and my throat's really bad ... then she just decides to take me to the doctor to get medicines" (Subj. 17, 5th Grade, Female, Int. 1, Lines 365-368). The children generally liked going to the doctor, and felt confident in the care that they received. On occasion, the children needed to go the E.D. for minor accidents like dog bites, broken ankles, or for illnesses.

> One day I felt so sick that my stomach started to hurt and she told me to sleep a little while and then when I waked up and it was still [hurting] and she took me to the hospital .... They put me like in a bed and then the doctor came and touched me like right here and then she then talked to my mom and everything ....
>
> THEN DID YOU STAY IN THE HOSPITAL?
>
> R: Yeah. A little while .... to the night but it was like estaba oscuraciendo [Translated: it was getting dark] [when went home].
>
> (Subj. 5, 5th Grade, Male, Int. 1 Lines 128-140)

*Other Kinds of Caring*. In addition to soups, teas, and medicine that the children receive when they are sick, other activities that helped the children to feel better included spending time with their family.

> DOES SHE DO ANYTHING ELSE TO HELP YOU FEEL BETTER? BESIDES FOODS? R: Umm, she spends the whole time with me.

DO YOU LIKE THAT?

R: Yeah.

... DO YOU GET TO SPEND THAT MUCH TIME WITH HER WHEN YOU'RE NOT SICK?

R: Usually no, cause they work a lot. When both of us, when all of us are together, it's usually Saturday. We go out places.

DO YOU LIKE THAT?

R: I like, I don't like just being one day all together ... Saturday. My mom gots to go work on Sunday.

(Subj. 10, 5th Grade, Male, Int. 1, Lines 217-228)

WHAT ARE THE THINGS THAT YOU LIKE TO HAVE PEOPLE DO FOR YOU THAT MAKE YOU FEEL BETTER? R: Umm, I don't know, like maybe like, sometimes when I'm not really sick we play... Or like my little sister, she goes to my bed and plays with me. That makes me feel better. And sometimes they read me a book or something.

(Subj. 11, 5th Grade, Female, Int. 1, Lines 150-155)

Although the children don't understand why, the two children with asthma seemed to believe that having a pet dog had helped them not have asthma as much.

Child: Yeah, cause like almost, cause, cuando fue, cuando me enferme? [Translated: when, when I got sick?]

Mom: Hace como un ano y medio. [Translated: It was about one and a half years ago].

Child: Oh yeah, like one year ago, I had to got to the doctor like almost I think,

Mom: Fue la ultima vez que se me puso mal y no mas y ya. Por eso digo que es como medicina. [Translated: It was the last time that she got very sick, and no more. That is why it is like a medicine.]

Child: I had like, I think it was three times a month, I had to go to the doctor. And then when we got our dog, I just didn't have to go to the doctor.

DO YOU HAVE ANY IDEAS OF HOW COME?

Child: Umm, nope.

HOW DOES THE DOG MAKE YOU FEEL? WHEN YOU'RE PETTING YOUR DOG?

Child: Good.

(Subj. 2, 4th Grade, Female, Int. 2, Lines 142- 153)

*Caring for Another.* The children stated how they would care for someone who was sick. The ways that they would take care of someone else were very tender, caring, and thoughtful, reflecting the ways that they relayed about how they were cared for when sick.

SO LET'S SAY YOU HAVE A FRIEND WHO'S SICK AND YOU'RE GONNA TAKE CARE OF HER. WHAT ARE THE KINDS OF THINGS YOU WOULD DO TO HELP HER FEEL BETTER? ...

R: I would give her the medicines when she has to take them. I'll give her some vegetables, help her to eat right. Umm, tell her to stay in bed for awhile, take a nap.

(Subj. 3, 6th Grade, Int.1 Lines 288-295)

WHAT WOULD YOU THINK ABOUT DOING TO HELP HIM TRY TO FEEL BETTER?

R: Ask him he needs something like constantly, well, not constantly, but like every twenty minutes or something. And if he needs it, you can do it for him. And, like always staying, like if he's ever in need of something.

(Subj. 4, 6th Grade, Male, Int. 1, Lines 273-278)

One young man described how he would care for his sister if she was sick,

Actually, if we go out and play and she can't play she'll cry. I'd stay with her and I'd give her medicine. When my mom like goes somewhere, she'll tell me what time to give her and I won't forget and I'll give her medicine. If she wants to see TV I'll pick her up and I'll move her. And I'll lay her down so she rests.

(Subj. 10, 5th Grade, Male, Int. 1, Lines 307-312)

*Mom & Dad Caring When Sick.* All of the children stated that their mothers took care of them when they were sick. However, upon further questioning, of the children who had a father present in the home, all of the children, except one, stated their fathers also took care of them. The reason this one father did not take care of the child was because he had to work. Although the fathers did the same kinds of things that the mothers did, there seemed to be a difference in the way they took care of the kids.

IS THE WAY YOUR MOM TAKES CARE OF YOU WHEN YOU'RE SICK DIFFERENT FROM THE WAY YOUR DAD TAKES CARE OF YOU?

R: Yeah .... My mom, she like feeds me, she feeds me, and my dad, he just like

asks me if I'm ok and if I want anything.

SO YOUR MOM JUST DOESN'T REALLY ASK YOU THAT, SHE JUST DOES IT?

R: Yeah.

AND YOUR DAD WILL ASK YOU AND THEN WILL HE DO IT?

R: Yeah.

UMM, HOW OFTEN DOES YOUR DAD TAKE CARE OF YOU WHEN YOU'RE SICK?

R: Most of the time. About half and half.

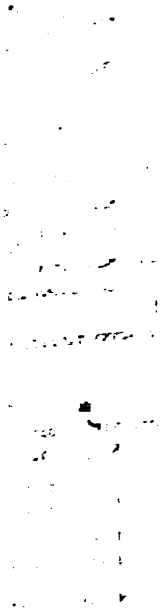
(Subj. 4, 6th Grade, Male, Int. 2, Lines 139-153)

But sometimes the children admitted that it was their mothers that made them feel better. "DOES ONE MAKE YOU FEEL BETTER THAN THE OTHER ONE? ... R: Yeah .... My mom (Subj. 11, 3rd Grade, Female, Int. 1, Lines 213-217).

Most of the time, the children mentioned that it was their mothers who took them to the doctor, however; there were several times that the children were taken to the doctor by the fathers.

*Children's Worries*

I did not initially plan to ask children about their worries; however, as the data collection continued, it became apparent that there were things that the children wanted to talk about, as demonstrated in the interview excerpt from Subject 11 about her mother having her baby. The children expressed many significant kinds of worries. The children talked about some of the things that they worried about, which included school, potential



floodings, their pets. The children worried about their families - Subj. 23: "When my Mom is sick, my Dad doesn't come, if he comes very late or my brother takes a long time coming from school," Subj. 12: "Oh yeah, and sometimes he gets worried when I'm with my friend and I come late, he gets worried about that" (Subjs. 12 and 23, 6th and 3rd Grades, Males, Int. 2, Lines 178-181).

> Oh yeah, I worry about her [his sister] 'cause umm, like sometimes I stay here then she goes and says "I'm gonna go to the bathroom", then she goes inside the room, she gets out through the window and when I can't find her no more, like I get worried .... Always, when she goes out I always find her at the park playing with her friends, something like that.
>
> (Subj. 10, 5th Grade, Male, Int. 2, Lines 202-208)

One girl voiced concern about her immigration status, which was something that she thought about a lot. She and her family were here in the U.S. without documentation, and she worried about that and that caused her to be sad.

> When I just first came? I don't know, because, it was kind of scary, cause I thought that, you know, we are immigrants, and I don't know, I thought they were gonna, uhm, take us to jail or something, 'cause (silence) .... I feel sad, cause we don't like have like permission to be here.
>
> (Subj. 13, 5th Grade, Female, Int. 1, Lines 277-280 and 365-364)

Her drawing (Illustration 11) is revealing in that she draws herself not connected to anything, like floating in the air; her sky and grass is very thin, as if she does not feel grounded, or connected.

Illustration 11 - Subj. 13, 5th Grade, Female

This is a self portrait of the child. She drew her self not touching the ground.

The worries that the children talked about resulted in them feeling sad, as mentioned earlier. They feel nervous - "I get nervous and sometimes I don't know what to do. I'm too nervous" (Subj. 10, 5th Grade, Male, Int. 2. Lines 224-225). And sometimes they get headaches, or other kinds of aches. "I feel scared that something's gonna happen. I feel headaches. Sometimes I get cramps or sometimes my back starts hurting a lot. I get nervous. [But] It goes away like in five minutes when they tell me what they've gone. Once they told me. " (Subj. 12, 6th Grade, Male, Int. 1, Lines 480-482 and 488-489).

Occasionally the children were able to describe what they did to manage their worry. "WHAT MAKES YOU FEEL BETTER WHEN SOMETHING LIKE THAT COMES INTO YOUR HEAD [LIKE YOUR WORRY]? ... R: I tell somebody. AND WHAT DO THEY SAY? R: They help me" (Subj. 24, 3rd Grade, Female, Int. 2, Lines 91-96).

> IS THERE ANYTHING YOU TRY TO DO SO YOU DON'T WORRY AS MUCH?
>
> R: Yeah. I tried at least to play, at least I won't worry that fast, at least a little. Sometimes I get worried and I react suddenly and I'm not worried any more and it goes away. Especially if I'm playing, I don't remember that my aunt was going to call me I won't be worried and all those other things.
>
> (Subj. 12, 6th Grade, Male, Int. 2, Lines 170-176)

However, sometimes when the children expressed their concerns, they were told not to worry. One boy expressed to his mom his worry, and was told, "Don't worry, because it's

okay, and nothing will happen" (Subj. 23, 3rd Grade, Male, Int. 1, Line 370). But this response was not always reassuring, and resulted in some children not sharing their concerns. One girl thought that if she expressed her concern, that she would be told to not worry, which is something she did not want to hear. "DO YOU EVER TELL YOUR MOM AND DAD ABOUT IT? R: No .... 'Cause they, uhm, maybe they'll say don't worry about it" (Subj. 13, 5th Grade, Female, Int. 1, Lines 336-339).

*Summary of Conceptualizations of Illness*

The overall health status of the children was healthy. Although they described many physical sensations when they are sick, they also talked about many emotional feelings as well, which included feelings of sadness, being mad, embarrassment, loss of control, and feeling a sense of a loss of hope. The children distinguished between being "a little bit sick" and "a lot sick," by how much of an impact their illness had on their daily activities. Many of the children talked about the things that worry them, which led to feelings of anxiety, headaches, and cramps. The children expressed worries that they had, which affected how they felt physically. The care that they received was not out of the ordinary, in that they were cared for at home with rest, good nutrition, acts of caring, and occasional home remedies of herbal teas.

*Summary of Conceptualizations of Health and Illness*

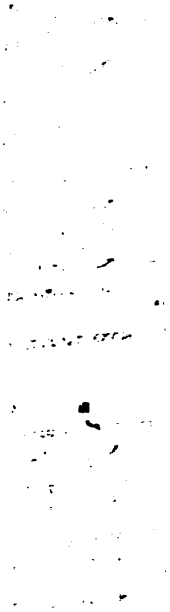
Overall, the children overwhelmingly viewed being healthy with a positive outlook on life, that one participates in daily living with gusto, and their future is impacted by the choices that they make now. Good health was not something that just happened, that one had a role in being healthy by making choices about nutrition,

exercise, taking care of themselves, and life-style types of choices. Their view of health was a holistic one, that included their physical, emotional, and social parts of their lives.

Generally, the children were very healthy, with two of them reporting having asthma and allergies, and one with anemia. Being sick was an experience that produced physical feelings and symptoms, along with a sense of hopelessness and emotional feelings of sadness, being mad, a sense of loss of control and embarrassment. They believed that they got sick because they did not take care of themselves. There were several ways that constituted not taking care of themselves that could result in getting sick, which included being out in the cold or rain, going from a cold temperature to a warm one, and coming into contact with someone who was sick and getting their germs. Being a "little bit sick" meant that one was sick, but still carried on with their activities. "A lot sick" meant that they had to stay home, felt really bad, and went to the doctor. The kind of care they received when they were sick included home remedies of herbal teas, such as tea of cinnamon, mint, or camomile. They were also sent to bed to rest, and stay warm. Often they were given soups, Jell-O, and other nutritious food. Other kinds of things that made them feel better was attention from their family members. All of the children went to the doctor when they needed to. Although mothers were reported as the ones who took care of them, in reality, it was both the mothers and fathers that participated in their care. But, they felt better with mother's care.

## How Conceptualizations Are Influenced

The second research question was how are the children's conceptualizations of health and illness influenced by their family, cultural, and social environments? The



influence of the family was evident in how the children conceptualized health and illness. Furthermore, there were other factors in the lives of the children which had the potential to impact their health, and therefore, had the potential to influence their health and illness conceptualizations, which include the language ability of their parents and the environments in which the children lived. And finally, there were differences in how and what the children reported about their thoughts that differed with their developmental stages.

## *Family*

The role that the family had in how the children thought about health and illness seemed to be a very influential factor. There were many areas of consistencies between what the groups of children said and what the parent groups said. There were also many similarities in the stories and thoughts that were relayed among the individual family groups. However, the following discussion will focus on the key areas that seemed to be important to health and illness concepts among the parents, that were clearly evident in the child responses.

### *"Tienes Que Seguir Adelante"*

*Tienes Que Seguir Adelante* is an *in vivo* theme that was articulated by the mothers, and seemed to characterize their approach to life. The literal translation is that one has to move forward. The parents believed that having a positive attitude, or an optimistic outlook to life, was considered very important. "A positive attitude. ...having an optimistic look on life and having goals. .... Something..., that you look forward to. Being physically, physically well, as, as well as mental and spiritual health, too. I think

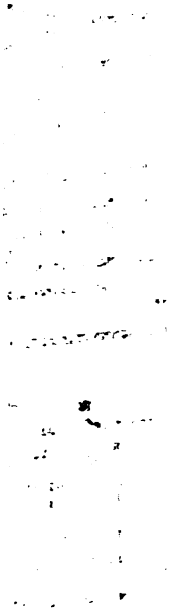
it's, it's all tied together" (Subj. 7, Mom, Int, Lines 599-604). Part of this outlook on life meant that one had to have hope, and that one needed to keep moving forward, rather than leave things to chance, such as health or life circumstances. In other words, one was an active participant in their life circumstances. *"Para Seguir adelante"* was the reason that the parents gave for many of the choices that they made, which included coming to the United States, trying to learn English, learning to cook in a healthier way, sending the children to school, participating in the interviews with me, or for finding a way to survive life's difficult circumstances. The tone in which this phrase was used was not one of sadness or labor, but one of pragmatism, and that is how life is.

For many mothers, finding a way to move forward was for the sake of the children. One single mother told of how she came to the town she currently lived in. She arrived with three children, one suitcase, and did not know anyone. She decided that she needed to move forward, because she needed to move her kids forward.

> Cuando yo vine ..., llegue con mis tres ninos, pues tenía mis tres niños, no mas y un veliz. Fue todo. No conocí a nadie. So empece, dijo "yo voy a salir adelante porque tengo que sacar a mis hijos adelante." So empece a trabajar .... Si, la vida no es facil. Trata uno de salir adelante no mas.
>
> [Translated: When I came ..., I came with my three kids. Well I had my three kids, and only one suitcase. That's all. I didn't know anyone. So I began, I said, "I am going to move forward because I need to move my kids forward." So I began to work .... Yes the life is not easy. One tries to just come out ahead.
>
> (Subj. 2, Mom, Int. Lines 352-355, 505)

The set of parents, although not divorced, separated several years ago. At the time of the interview, they seemed to have a very amicable relationship, but lived in different cities. The father was a very active participant in the lives of the children and during the interview. However, after they first separated, the mother reported that she was very depressed and sad, feeling very much alone and desperate. She began to realize that she was still the same person. She also began to realize what kind of an example she was being for her two sons, and decided that she needed to change and to move forward for the sake of her two sons. She began to go to school and to work. She finally came to a time when she could say

> Entonces ya se siente uno tranquilo sin la angustia de decir que va a pasar que va a pasar conmigo. Podre mantener mí trabajo para mantener a mis hijos. Uno podre seguir estudiando, podre hacer todo eso, y si se dice, se puede uno, puede uno lograr todo lo que uno quiere, si uno quiere sobre salir adelante y demostrarle uno a sus hijos que uno puede y es como ellos también tienen el empeño de seguire estudiando, y llegar,
>
> [Translated: Then one feels a peacefulness to say without anguish what will happen, will happen with me. I can maintain a job so that I can take care of my kids. One can move forward studying, can do all of that, and one can say, if one can, one can succeed and acheive all that one wants, if one wants to rise above to move forward and demonstrate to your kids that one can and it is like they also have the determination to keep studying, and arrive.
>
> (Subjs. 12 and 23, Mom, Int. Lines 358-365)



*Seguir Adelante* meant that sometimes one has to leave behind some of the old ways for newer better ways. One mother told of how she changed her way of cooking to use less fats and grease, so that the food could be healthier. In essence, she felt she was changing a part of her culture, so that she and her family could move forward.

Pues si, si hay diferencia de la comida de aquí y de la de alla [México], porque alla usa uno así mucho picante y este cocina uno así con manteca de cerdo y este aquí no, aquí yo me acostumbre a que cocino, se me quito eso de alla y aquí este cocino con aceite de ese que no tiene mucho colesterol, y esa es la diferencia y los niños estan acostumbrados a la comida pues lo que yo les hago aquí, y cuando vamos para México este pues no les gusta la comida de alla, no les gusta y esa es la diferencia ....

PIENSA QUE CUANDO CAMBIA LA MANERA DE COCINAR COMO ASI ESTAN CAMBIANDO UN POCO DE LA CULTURA DE MÉXICO?

R: Y pues yo creo que si.

Y QUE PIENSA DE ESO?

R: Pues este en una parte, pues esta bien porque deja uno algunas cosas que le hacen mal a uno pues y otras pues si me gusta la cultura de alla en otras formas pues si me gusta, y en otras no, como en eso de las comidas y todo eso...

ENTOCES LA PARTE DE COCINANDO, ¿QUÉ ESTAN CAMBIANDO, USANDO MENOS ... ACEITE O GRASA, ES PARTE DE SIGUIENDO ADELANTE PARA MEJORARSE?, ES PARTE DE ESO?

R: Pues si, si es.

[Translated: Well, yes there are differences in the food between here and there [Mexico]. Because there one uses a lot of spicy flavor, and one cooks with bacon lard and here no. Here I have become accustomed to how one cooks. I have lost the way of cooking in Mexico, and here I cook with oil that does not have much cholesterol, and it is different. And the children have become accustomed to the food that I make here, and when we go to Mexico, they don't like the food there, and that is the difference.

DO YOU THINK THAT WHEN YOU CHANGE THE WAY OF COOKING LIKE THAT, THAT YOU ARE CHANGING A LITTLE BIT OF THE CULTURE OF MEXICO?

R: Well, yes I think so.

AND WHAT DO YOU THINK OF THAT?

R: Well, on one hand, it is good because one leaves things behind, the things that are not good for them and and there are other things about the culture that I like, and some things that I don't, such as the foods.

THEN THE COOKING PART THAT YOU ARE CHANGING, USING LESS .... OIL AND FAT, IS THAT PART OF MOVING FORWARD TO IMPROVE YOURSELF? IS THAT PART OF THAT?

R: Well, yes it is.

(Subj. 16, Mom, Int., Lines 467-534)

And finally, another way to *Seguir Adelante* was to move to the U.S. from Mexico. Many of the families came to improve their lives, leaving lives in Mexico where

there was very little work, and conditions difficult. "¿PORQUÉ VINIERON DE MÉXICO? Mama: Por una vida mas mejor. Por un por venirnos, un futuro mas para adelante, mas, mas mejor [Translated: WHY DID YOU LEAVE MEXICO? R: for a life that was better. We came for a future that is, to move forward much more better" (Subj. 9, Mom, Int. Lines 426-428).

*Si Dios Quiere*

The translation of "si Dios quiere" is "If God wills it," or "God willing." Along with the decisions that the families made in order to *Seguier Adelante*, they also believed that while God had a role in their lives, they had responsibility to take care of themselves as well. As previously mentioned, all of the families, except one, were Catholic. None of the families attended mass on a weekly basis. Church seemed to be important for certain times in their lives and for the holidays. During data collection, I was invited to attend the first communion of one of the 3rd grade informants. This seemed to be a special time for the whole family as was evidenced by the celebration held after the mass. A few of the other third graders also had their first communion during this time. The parents all believed that although God had a role in their lives, that they, as well, had some control or influence over what happened to them or their children. It is important that as parents they do all that they can do to take care of their kids or themselves. After that, they can place the child in God's hands.

> R: Pues como le explico, trata uno de hacer lo mas que puede uno, como llevando los niños al doctor, pues lo que sea, sí uno esta enfermo, sí no lo voy a llevar al doctor, tengo que hacer lo posible que este en mis manos, de ayudarle y sí ya no se

puede ayudar, ni con un doctor, ni llevandolo yo, ni haciendo lo que mas pueda, entonces ya lo dejo en las manos de Dios, y sí El quiere ayudarme para que se cure, está bien, sí no, eso es lo que yo pienso.

[Translated: Like I say, one tries to do the most that one can do, like taking the children to the doctor, well, whatever, if one is sick. If not, I am not going to take them to the doctor. I have to do the most possible that is in my hands, to help them, and if I cannot help, nor the doctor, nor by taking them, nor by doing all that I that I can do, then I leave them in the hands of God. And if He wants to cure, that is good; if not, that is what I think.

(Subj. 9, Mom, Int, Lines 184-191)

"... even though I'm a practicing Catholic. I will try everything to not say "Si Dios quiere [Translated: If God wills it]." (Subj. 4, Mom, Int, Lines 260-261).

One father was very clear that the phrase is more of a phrase that one repeats. However, clearly, God allows us to live, but that we need to help creation. He goes on to say, however, that if you were to ask his mother, from a different generation, that her response would be a different one.

Ah, Creo que para nosotros sería mas una frase que se repite pero o sea en nuestras creencias, o sea, en nuestras creencias claro, si Dios nos permite vivír. Sí Dios quiere es algo que involuntariamente, con nuestra creencia hacemos pero sabemos bien que tenemos que ayudar en esa creencia .... De la filosofía de nuestra familia, pero fíjese que en cierta manera como dice usted con nosotros como somos una generación diferente de nuestros padres en el caso de mi madre

> sí usted le pregunta que parte toma la religión en su creencia medica sería muy diferente a mi respuesta.
>
> [Translated: Ah, I think, that for us, it is a phrase that one repeats, but in our beliefs, but in our beliefs, clearly, though if God allows us to live. If God wills it is something that we subconscienciously believe, but, we well know that we need to help that belief. The philosophy of our family, but think about it, in certain ways, like you say with us, we are a generation different from our parents, in the case of my mother. If you asked her what role does religion have in her medical beliefs, she would give you a different answer.
>
> (Subjs. 12 and 23, Dad, Int. Lines 978-982 and 997-1001)

*How Cultural Values are Passed Down*

What cultural values were considered important, and how they were passed on to the children differed when the families were divided into socioeconomic levels (Table 3). In the families who comprised the upper income level articulated that the cultural values that were important to them and ones they wanted to pass on to their children were more about appreciation for the Mexican arts, folk dancing, Mexican history, family and family history, and food. Language was not of significant cultural value because of the acknowledgment that if the children were truly to brought up bilingually, then they must have some level of immersion in the language to learn, utilize, and retain it. And, currently they did not have that level of Spanish language available to them. One father made the observation that because of their level of income and the availability of their leisure time, they were able to pursue those kinds of cultural aspects that they viewed as

important, as well as, leisure activities.

The families in the middle level reported that the values that were important to them included maintaining the language, family, respect, learning about the Mexican culture, working hard, and education.

The values that the families in the lower income identified as important to them were maintaining the language, and the family. Although the parents of this group did not articulate this sentiment, I got the sense that surviving was what was important, but a struggle; and that there just was not much to say about cultural values and passing them on to their children. The expressions of the eyes of the mothers were haunting ones. They rarely smiled, they talked like they were weary. It was like there was no hope in their eyes. The fathers expressed that sometimes they felt frustrated because the children did not always seem to appreciate the same values as the parents.

*Language*

The majority of the parent interviews took place in Spanish because the primary language of the parents in all of the families, except two, was Spanish, in spite of having lived in the U.S. for many years. Learning the English language was difficult for the parents. One mother described that although she had lived in the U.S. for many years, she still did not know English. She realized the importance of learning the English language, and she had made several attempts to take classes without success. One of the reasons had to do with difficulty obtaining childcare, which was also articulated by other mothers. She also discussed how she never really learned Spanish very well while growing up in Mexico, and that did not serve her well in her attempts to learn English. She eventually

gave up.

> Pero sera porque también como yo no fui a la escuela en México es muy dificil para mi agarrar el idioma que se habla aquí, es lo que casi nunca he podido, como me dicen solamente que empezaba a aprender el español y de alli empezar el inglés.
>
> [Translated: But, it could be because, I never went to school in Mexico, that it is very difficult for me to learn the language that one speaks here. It is something that I have not been able to do, like they tell me, just begin to learn Spanish, and from there, the English.]
>
> (Subj. 11, Mom, Int. Lines 676-680)

For most of the parents, the Spanish language was an important cultural tradition that they wanted to have their children retain. The only parents that were truly bilingual (however the interview was conducted in Spanish) were adamant that the children were going to learn their languages well. Papá: "entonces en su idioma que sepan hablar su idioma muy bien como les digo siempre, no quiero spanenglish, nunca," y Mamá: "Me van a hablar en espanol", [Translated: Dad: "Then in their language that they know how to speak their language very well, like I always tell them, 'I don't want Spanglish', never." and Mom: "They are going to speak to me in Spanish" (Subj. 12 and 23, Parent Int, Lines 1151-1154). However, for two of the families that were English-speaking, this was not an important consideration, and these were the two interviews that were conducted in English. Rather than insist that their children learn Spanish, which they did not, they felt it was more important that they have an appreciation and respect for other

languages. "And I think the most important thing that they have picked up is a respect for the culture and a respect for people who speak other languages and a knowledge that it's there if they want it" (Subj. 7, Mom, Int., Lines 787-790).

The community environment the families lived in did not require that the parents learn English. Everywhere I went, there was someone who spoke Spanish, items for purchase were usually labeled in Spanish, especially in the section of town where a majority of the families lived. The children were in bilingual education classes, where if they needed it, the teacher was able to communicate in Spanish. Many of the parents worked where their there was someone they could communicate with in Spanish. Although English was viewed as something to have, in reality, for the most part, the families were able to exist without the need to know English, except for one area.

The irony of the above observation is that although the town where the data collection occurred had a large percentage of Spanish-speaking families, a section of town had primarily Spanish-speaking shop owners, and the children were able to attend bilingual classes, the only pediatrician in the town that accepted Medi-Cal did not speak Spanish, nor did his office staff. The result was that for most of the families who participated in the study and who relied on Medi-Cal were receiving care from a provider who was not providing linguistically competent care, a requirement for Medi-Cal providers. As a result, oftentimes children were translating for their parents and the physician when they were the patient being seen. In one instance a 3rd grade child was translating for her pregnant mother during her obstetrician visits. "HAVE YOU EVER HAD TO TRANSLATE FOR HER WHEN SHE GOES TO HER VISITS PREGNANT?

R: Sometimes, yeah .... R: Sometimes, I don't know. And then I remember, and then I say, sometimes it's hard. A little bit" (Subj. 11, 3rd Grade, Female, Int. 2, Lines 64-69). Her mother discussed how she was nervous about the baby coming, because she did not know if there would be someone there to translate for her, and this seemed to cause her some anxiety. Therefore, she had made arrangements for her older daughter to be able to go with her to the hospital when the baby was born. "Y le dije, ahora ... yo quiero que tu vayas con migo y me ayudes. Porque, yo quieren me operan, ... no queiro que me operan hasta al ultimo tiempo", [Translated: I told her, now ... I want you to go to the hospital with me. Because, I want them to operate .... and I don't want them to wait to operate until the very last minute" (Subj. 11, Mom, Int. 2, Lines 345-351).

Another mother told a very detailed account about the problems she had with the same pediatrician, and about the struggles she had in communication. In one event, she took her child who had difficulty sleeping. She tried to communicate to the doctor what the problem was, and he had given her a prescription for medicine to help him sleep, and then the child slept too much. She finally took the medicine to someone who could read English, and found that the medicine was not appropriate for the child. As a result of this incident, she no longer takes that child there for his care. She sometimes would have to take her sixth grade daughter to translate when the younger children are sick, but had to wait for her to get out of school. If a child was running a fever, she would indicate on a list or written symptoms as to why she brought the child. The doctor would examine the child and write out a prescription. She would take it to the pharmacy and because they would write it in Spanish, she at least knew how to give it, but she never really knew why

the child was getting the medicine. Just from past experience, she would figure out that it was because of either an infection in the tonsils or ears.

## *Environment*

The environments that the children exist in are important to consider because, although they do not directly influence conceptualizations of health and illness, they impact their health status, which could potentially impact their conceptualizations. The environment includes many aspects of their lives, from the practical aspects, that includes the actual physical environments they occupied, to their socio-political environments which influenced access and availability of health care and influenced their practical choices for health living.

### *Physical Environments*

The observation and realization of the importance of space that the children lived in occurred more accidently, rather than intentionally. As a result of having been a participant observer in the homes, schools, and communities, my observation was that the space, in which the children and their families lived in impacted them, their health status, and their access to health care in a significant way.

Most of the children lived in small cramped housing that left them very little personal space if any. Initially, one of my requests during the interview was for a grand tour of their room (Spradley, 1980). Except for two of the children, none of them had their own rooms. Of these two, I was allowed to see the room of one child, but not the other. Oftentimes the children shared with another person, their sibling (perhaps with a sibling of the opposite sex), or their mother. Of these rooms that I was able to see, they

were very small, barely enough for 2 twin beds and maybe a piece of furniture. Just about as frequently, the children interviewed did not have a bedroom or their own bed to sleep in. Several of the families lived in homes where more than one family was living in two-bedroom apartments. One family of three children lived in a double mobile home unit, and the children slept in the living room, on the couch or on the floor. One boy did not have a bedroom, and when he was sick had to lay down on the couch in the living room, which he did not like. One family of five lived in a garage converted into a one-room living space, where the entire family slept. Their kitchen consisted of a corner with some small portable appliances for cooking. In another family, I never saw the inside of the home. The child informant met me on the dirt driveway. During one of our interviews, her mother had gone walking to the store for water, indicating that they did not have running water in their home. The interviews of these last two child informants, as did several other interviews, took place outside, under a tree.

Often the living environments, or the homes were clean and picked up, but in poor physical condition. One home, a mobile home, had a portion of the ceiling coming down in the room that we interviewed in, and part of the linoleum coming up in the kitchen, and the child in this home reported a history of allergies and asthma. Another home had the window patched with a piece of cardboard. Several of the families lived in the public housing area, in between the railroad tracks and the main street. Several of the children had pets that were allowed in the house. One family had bird in a big cage, near the eating area.

I observed in some of the classrooms that the carpet was old and had a musty

smell. Concern was expressed by the teacher of this classroom as to whether or not the carpet contributed to illnesses of the children. One 4th grade female thought that one of the reasons she had been so sick the year before was because of the carpet in her 3rd grade classroom and her mother echoed the same concern in the separate parent interview.

The above observations are important because, for many of the children interviewed, their living conditions were crowded, and some of the children lived in homes without proper cooking facilities, or running water. Also, many of the children lived in homes where they were exposed to mold and mildew, most likely contributing to asthma and allergies in the child informants and/or their siblings.

*Geographic Location and Health care Environment*

All of the families, regardless of whether they were born in the U.S. or Mexico, preferred to utilize medical physicians for their health care while growing up. Although this was the preference, this was not always possible because they either lived very far away from a doctor, or they did not have the money to go see one. However, if someone was really sick, then they were taken to the doctor. Although all of the families described usage of occasional home remedies in the form of teas or herbs for various ailments, none of the families included the use of curanderos, folk healers, or herbalists, in their health care practices and preferences. Inquiries about curanderos was often met with reluctance to discuss them and, at times, the families appeared offended, so I stopped asking about them. Although the families were treated with home remedies while they were growing up, except for the teas that were mentioned, the home remedies of the past were not utilized with today's children because going to the doctor was better and they all had

access to one. Although, only one mother said that she would consider going to a healer if the care from the doctor did not work first. Furthermore, the knowledge of how to use them was disappearing and the ingredients were harder to find.

> Porque eso los mantenía a ellos bien, eso en sus tiempos ellos, porque sabian cuales eran, nosotros ya no sabemos. Sí, así que ya no podemos seguir usando de ellos. Incluso ellos ahora que sí viven en el pueblo, ya no es tan fácil para ellos irlos a buscarlos donde vivían antes en el cerro. Ya no es tan fácil tampoco para ellos ir a conseguir aquellas plantas que ellos solitos podían ir a recogerlas y hacerlas. Ahora ya tambíen se basan en los doctores, ya estan en el pueblo. Ya mejor se basan en los doctores.
>
> [Translated: Because in their time, they used them well, because they knew which ones to use, we do not know, so we can not continue to use them. Including those who now live in town, it is no longer easy for them to go and look for them where they used to live in the hills. Now it is not so easy either for them to get the plants that only they could go gather and make. Now there, they basically use the doctors, now they are in the town. It is better that they basically use the doctors.]
>
> (Subjs 12 and 23, Dad, Int., Lines 936-942)

### *Growth and Development*

One factor that bears consideration in how the children conceptualized health and illness is growth and development. Given the amount of research that has been conducted utilizing growth and developmental frameworks, such as Piaget's theory of cognitive development (see Chapter 2) in attempting to understand how children conceptualize

health and illness, I had expected to find that the complexity of the explanations that the children provided for this study would have been more consistent with developmental levels. The youngest group, the third graders, provided responses that were consistent with Piaget's cognitive theory of development, in that they tended to believe that health and illness were impacted by concrete things or actions.

> [Healthy] means like umm, not go in the street when you're just, you're gonna go get your ball. You just wait when the car pass, then you could go. And health means that when a car's coming you [look] both ways first and then you cross. Healthy means that to take care of you, and mom.
>
> (Subj. 11, 3rd Grade, Female, Int. 1, Lines 45-50)

And, although, one of the children did not talk about the danger of taking drugs, it was the topic of his drawing (Illustration 9).

However, as the children got older, I did not find that the ability for a child to conceptualize health and illness with increasing complexity and abstractness was consistent with increasing age and development. For example, out of the five fourth graders, two were especially insightful about health and illness. One of them believed that maybe there was a reason for someone to get sick and that it was not always a bad thing to have happen.

> R: How sickness can help you? Well, when you have a sneeze kind of cold, the sneeze helps get dust out. And umm, sometimes even germs. When you throw up, it helps you get poisons, bad foods, things you really don't need, it helps you get it out. And, when you cough, it gets germs out. And umm, when you have a

headache, it lets you know you got to rest and it helps you sort out your mind. Those kinds of things.

(Subj. 7, 4th Grade, Female, Int. 1, Lines 368-374)

Another fourth grader thought that she maybe did not get sick as often because she was growing. She had an understanding that her body was maturing and therefore, that possibly contributed to her ability to be healthier.

WHY DO YOU THINK YOU'VE BEEN HEALTHIER SINCE YOU'VE BEEN NINE?

R: Maybe I'm growing up and my body has begun to change and maybe I have been growing and my tonsils, maybe they have been getting better and better every day.

(Subj. 9, 4th Grade, Female, Int. 1, Lines 325-329)

One of the fifth grade boys viewed health as having to do with the future, that decisions that one made now could impact the options that one had in the future. "To me it means like the future. Like being healthy, and you can do a lot of things. If you liking drugs, you just sit there, you don't have a future, you don't do nothing" (Subj. 10, 5th Grade, Male, Int. 1, Lines 134-136). And another fifth grader thought that a sign of good health was an absence of worry. "You don't problems of any trouble with other people .... Problems with ... like asthma, ... that you don't have to worry about if you run real fast you could get asthma (Subj. 17, 5th Grade, Female, Int. 1, Lines 140-150).

The sixth grade children all were required to take a health course as a part of the sixth grade curriculum. Additionally, at approximately eleven years or older, I had

expected that they would begin to understand that other factors may be involved with illness and may involve a psycho-social component. Given that they were all required to take such a course, and that they were of an age in which they should have been able to begin to think more abstractly, I had expected that they would have more complex explanations than the younger children would have had. Only one of the sixth graders talked about health from a holistic perspective, a perspective that included a physical, emotional, and mental component.

> Your mind? It's a type of health and like there's strings, everything's attached to like social health and physical health and if you don't have very good mental health, that you're not going to get very good physical or social health .... [Social health is] relating to others.... 'Cause you can't really live with like only two like really good parts of the health. Like you can't just have physical and social health and not be very good mentally, healthy. So, like if you're not mentally healthy then you're not gonna be very, it's gonna affect your physical and social health.
>
> (Subj. 4, 6th Grade, Male, Int. 2, Lines 113-130)

Most of the other sixth graders talked about health and illness in a more simplistic way. "You get sick a lot ... 'cause you don't put cold your jacket or sweater on and you get like cold or asthma or something like that" (Subj. 3, 6th Grade, Female, Int. 1, Lines 29-31).

While developmental levels are expected to impact how these children conceptualized health and illness, clearly there were other factors involved within their environments that influenced their conceptualizations of health and illness.

## Discussion and Summary

Overall, the children had very positive outlooks on what it meant to be healthy. Being healthy for them meant that they felt good, and they felt good about themselves. There was a sense of hope and for some, a consideration about the future. The children believed that they were active participants in their health by taking care of themselves. The two main ways to take care of themselves were nutrition and exercise. Other ways to be healthy included taking care good care of themselves. They had to make life-style types of choices that affected their health. Some of these life-style choices also had to do with whether or not they gave in to peer pressure. They viewed health in a holistic way, that health had to do not just with the physical part, but also with the social and mental part of their beings. The children learned what they knew primarily from their parents. Other places they learned their information from included school and the doctor's office.

Overall, these children were a healthy group, and therefore, did not have much experience with illnesses from which to draw upon for their explanations of illness. Their conceptualizations of illness described many physical sensations when they are sick, as well as emotional feelings, which included feelings of sadness, being mad, embarrassment, loss of control, and feeling a sense of a loss of hope. The children distinguished between being "a little bit sick" and "a lot sick" by how much of an impact their illness had on their daily activities. Many of the children talked about the things that worry them, which led to feelings of anxiety, headaches, and cramps. The care that they received when they were sick was not out of the ordinary, in that they were cared for at home with rest, good nutrition, acts of caring, and occasional home remedies of herbal

teas. They all had doctors that they went to see if they were really sick or did not get better after a few days. The children were able to explain why they received medicines like Tylenol and Contact. They were able to explain why some of the kids with asthma needed to use the "pumpie" to take away the cough, and they were able to explain why they received some of the different teas they were given. They were able to talk about going to the doctor and their mom getting a prescription or medicine, but they never talked about what that medicine was, which I found intriguing.

One of the unexpected findings was that the way children talked about health and illness was not consistent with their developmental levels. Often, the younger children were able to talk about why we need to get the germs out. Or that decisions that we make now can affect our future. However, most of the older children described getting sick as a result of being in the cold, or going from cold to hot. These responses were in spite of their developing cognitive level, and being in a required health course for sixth graders.

The children strongly reflected the parents' outlook on life in terms of health and illness and in how one takes care of someone when sick. There were several aspects of the family that seemed to be important. The mothers had an outlook on life that was about hope, and moving on toward the future. *Tienes Que Seguir Adelante* was an in vivo term that provided the impetus for what the mothers did and why. Many of the mothers recounted events in their lives that were difficult and unfair, but that one has to go and keep moving forward. This outlook took shape in several ways. First, one had to keep moving forward so that the children can keep moving forward. Also, the mothers thought that they needed to provide an example for the children about how to deal with life's

difficulties. That one could get a job and an education. And, the children needed to see that one needs to have self confidence. Another way to move forward is to leave things behind if they are not good for you, even if it means changing cultural practices. One of the cultural practices that several mothers talked about changing was how they cooked for their families. They were cooking with less oils and fats, making sure that the children had fresh vegetables and fruit, and that they ate at home most of the time because that was healthier. And, finally, moving forward was the reason many of the families left Mexico for the U.S., to have a better life, to keep moving forward.

Another outlook on life for both of the parents was not to accept the phrase, *Si Dios Quiere*, if God wills it. Rather, they believed that they needed to do everything they possibly could to keep their kids safe and healthy, with the acknowledgment that God does have a role in their lives, but they need to do their parts. Some of the parents believed that medical health care was available, therefore, it was their responsibility to use it, as a part of God's help. However, if we were to ask the grandparents, they guessed that their response would be different.

How and what cultural values are passed down differed within certain categories. It appeared that some of the differences that were significant in the different categories had to do with the level of education and income. Most likely education was more influential than income because it was the education of the parents that determined the kind of income they received. However, regardless of income, language abilities and education, ALL of the parents preferred and utilized the medical health care system. Overwhelmingly this was preferred over curanderos, folk healers, or herbalists. Whether

growing up in Mexico or U.S., the parents said that they went to doctors when sick, but could not always afford, or they were not near by. And there were parents who were brought up in Mexico and the U.S., who utilized only medical doctors, because their families could afford it. Home remedies were used, but often that was what was available, not necessarily preferred.

Language was a significant problem that the Spanish-speaking families encountered. The parents did not let the language barrier hinder their access to health care. But, once they got there, communication was a problem. This was more of a problem with the families who were dependent on Medi-Cal. The only pediatrician in the area to accept Medi-Cal payment, did not speak English. Language barriers created anxiety in the parents and children, and resulted in poor health care. Another result of the language barrier was that often when the parents gave medicine to the kids they did not know why they were giving it.

It appears that there are two reasons why the children may not have known about medicines they receive from the doctor. First, they were a healthy group and did not have many serious health problems. Therefore, they may not have gone to the doctor very often when they were sick. Second, if the parents did not know what and why they were giving medications, how could they teach the children about what they are giving? This could explain why the children did not talk about the medicine that they received from the doctor. There may also be a developmental influence, that is concrete thinking - medicine is medicine and makes you feel better.

The last area that appears to have influence on how children think about health

and illness is the environment. There were many factors in their environment that contributed to the health status, which could influence their conceptualizations. Examples of factors in their environment that may have contributed to their health status included the cold rainy weather that was occurring at the time of data collection, and the probable exposure to molds and mildew in their homes and classrooms.

What was overwhelmingly absent in the responses of the children and the parents were explanations and choices that reflected their cultural preference when selecting health care. Although there were some uses of a variety of simple home remedies, the majority of the families and children utilized different teas, made up of camomile, mint, and cinnamon. The parents were very clear that they did not prefer home remedies, or alternative healers. They even explained that in Mexico, the herbs and other things that used to be utilized were not as available as they used to be.

In conclusion, the children and the parents did not leave health and illness issues to chance. Regardless of the education, language ability, and income level, the parents sought medical health care. Although, the children and the families identified with the Mexican culture in positive ways and with a sense of pride, the decisions and choices that these families made about their health and health care were not grounded in cultural preferences. Rather the parents seemed to make their choices about health care on what they perceived to be the best way to take care of their children, and if that meant that they had to leave behind or change cultural practices, then so be it.

# CHAPTER FIVE

# DISCUSSION OF FINDINGS

In this final chapter a short summary and discussion of the main findings will be provided. Implications for nursing practice will be presented. And, to conclude the chapter, the limitations of the study and areas for future research will be highlighted.

## Summary and Discussion of Research Findings

Mexican American children are the youngest, fastest growing ethnic group in the U.S., (U.S. Census Bureau, 2002). There are factors in the lives of Mexican American children that influence their health and health status, which include disproportionate disease burdens, cultural and linguistic considerations which affect health and health seeking behaviors, and barriers to health care (Flores et al, 2002). Yet, much more needs to be learned in order to improve the care of Mexican American children because there has not been adequate research on the medical and nonmedical factors that affect their health (Zambrana & Logie, 2000). The aforementioned factors that influence their health and health status have the potential to influence their conceptualizations, yet there has been no research investigating how they conceptualize health and illness. Furthermore, research about how children conceptualize health and illness has been done with various theoretical approaches, but none has done so from an ecological perspective. This study sought to explore and describe how Mexican American children conceptualize health and illness within the context of their daily lives, and then to understand the factors that influence those concepts.

## *Significance of Findings About the Children*

### *Health and Illness Concepts*

The children in this study had very positive outlooks on what it meant to be healthy, which for them meant that they felt good, they felt good about themselves, had a sense of hope and, for some, a thoughtful consideration for the future. The children believed that they were active participants in their health by taking care of themselves, which included good nutrition and exercise. Good health had to do with not only the physical aspects of their lives, but also the social and mental parts of their beings. These children were a healthy group, leaving them with little experiences with which to draw upon for their explanations of illness.

The way that the children conceptualized health as primarily positive feelings of well being and being able to participate in their daily lives was not a unique finding to these children. Earlier research reported that children in general viewed health in a positive way, and that they are able to do the things that they really want to do, such as play (Nattapoff, 1978; Robinson, 1987). The finding that nutrition is important to maintaining good health is not a unique finding as well. Rashkis (1965) found that along with the positive feelings that children expressed, that they also viewed eating as the most important self-care activity. While these findings are not unique or new, they remain significant from a cross-cultural perspective, because they contribute to the current knowledge about how children have conceptualized health. Findings that were obtained from a Mexican American group of children, with a contextual framework, utilizing qualitative methods yielded findings that demonstrate commonalities in how children

think about health within different cultural groups of children. Furthermore, these findings have been consistent over time, from the 1960s to the 1987 to the present, a period of almost fifty years.

The way that these Mexican American children conceptualized illness had much to do with the physical sensations that they experienced. Their conceptualizations of illness included descriptions of physical sensations when they were sick, as well as emotional feelings. The children described being "a little bit sick" and "a lot sick" by how much of an impact their illness had on their daily lives. However, they also expressed feelings of sadness, being mad, feeling like they were losing control, and embarrassment. While it is not surprising that these feelings would be a part of how children would explain being sick, there is no prior research that examines conceptualizations of illness from a perspective of emotions and how emotions may also be a part of how children explain illness. Exploring the emotions that children experience during illness and if or how they contribute to explanations of illness, is an area for future research.

The belief that the children have choices that they can make which can result in being healthy, or sick is a unique and important finding. The choices they made were made from a good knowledge base of what health and health promoting behaviors were. Although, previous research demonstrates that children know that eating healthy food is important (Olvera-Ezzell, Power, Cousins et al, 1994), it does not include other kinds of choices that the children make in their everyday lives. For example, choices to exercise, wear helmets, obey their parents, look both ways before crossing the street, and so on. Conversely, they also understood that the choices they made could result in illness.

Earlier research has also explored this line of questioning, but has reported that children perceived illness or behavior that resulted in illness, as a punishment (Brodie, 1974; Kister & Patterson, 1980). The findings in this study are unique because the children viewed getting sick not as a *punishment*, but more as a *consequence* of the choice that they perhaps made, such as not coming in from the cold when told, or coming into contact with someone else who was sick. *Punishment* is a penalty imposed for a wrong doing, while a *consequence* is something brought on by a cause. This finding lends strong support to future health intervention work based on behavioral principles of choices, actions and consequences. It demonstrates that knowledge deficits alone do not account for health behaviors.

*Children's Worries*

Although this study was not designed to investigate the worries of Mexican American children, the children talked about things that concerned them spontaneously during their interviews. These expressed concerns reflect psychological or mental health aspects of the child's and family life. Most of the concerns that the children expressed were about their families, and potential harm that may come to them. One girl discussed her undocumented status, and how she was afraid that they would put her in jail. However, research indicates that the most common areas of worry for children are health, school, and personal harm (Henker, Whalen, & O'Neil, 1995; Silverman, Greca, & Wasserstein, 1995). The sample in these studies were predominantly African American and white children. The children were not immigrant children, and they lived in large metropolitan areas. The worries of the children in this study are different, they reflect the

experiences of the children which include immigration, undocumented status, racial tension in their community, and a strong emphasis on the importance of the family. There is no research examining the worries or concerns that Mexican-American children have, the effect they could potentially have on their health status or their conceptualizations of health and illness. These findings support needed work in this area.

*Bronfrenbrenner's Theory of Ecology*

Prior to this study, the research done to understand how children conceptualize health and illness utilized various theoretical frameworks, which primarily utilized the Piagetian framework, or a form of it (see Chapter 2). However, the previous approaches do not take into consideration the many different aspects of a child's environment, such as the family, school, community and culture, that could potentially influence health and illness conceptualizations; furthermore, Mexican American children were not included in the sampling. As previously stated, there are many factors in the Mexican American child's life that have the potential to affect their health, and therefore, their health and illness concepts.

The findings of this study are consistent with Bronfrenbrenner's theory of ecology (1979a, pp. 22-6) for exploring how Mexican American children conceptualize health and illness. The focus of the ecological perspective is on the person and environment (Grzywacz & Fuqua, 2000). The theory draws the health provider's attention to dispositions, resources, and characteristics of the children that influence their health and their conceptualizations (Grzywacz & Fuqua, 2000).

Moving away from a framework and methodology that disembodies a child's

many dimensions, such as cognition from the rest of the child, broadens and deepens our understanding of how and what children think, which is the strength of the theory. A contextual approach allows health care providers a more realistic view of Mexican American children within the circumstances that they are in. Furthermore, use of Eurocentric theoretical frameworks that have been developed utilizing children from the U.S. and Europe do not capture unique elements that children of color or who are immigrant children may experience, such as immigration and racial tension. We are reminded that child development theories that help to stimulate and guide our research in attempts to understanding children can be very useful, but we need to guard against limiting the possibilities in how we see them as human beings (Matthews, 1994).

### *Significance of Findings About the Families*

#### *Seeking Health care*

One of the most significant findings is that all of the parents routinely sought health care for their children when they were sick, and all of the parents had access to primary care for their children. This is an important finding for many reasons. First, most of the parents in the study had less than a high school education and, fell in the lower income category; and yet medical health care was available to, and utilized by all of the children. However, previous research seems to indicate that education, income, and ethnic/racial backgrounds of the child's parents are determinants of socioeconomic class which affects the health care utilization patterns of the Latino child, with the mother's educational level the most influential (Irigoyen & Zambrana, 1982; Lees & Tinsley, 1998). But for the families in this study, that variable did not have any bearing on the

access and availability that the children had, for regardless of the educational level of the mother and the fathers, they all utilized medical health care. Furthermore, this was the preferred care for the children by the parents.

*Language Barriers*

The language barriers and their resulting problems that the families encountered in the health care system are not a unique problem. Problems with communication can lead to an experiential barrier that can result in negative attitudes toward health care workers, lack of confidence in providers, and low levels of satisfaction with care (Clark, 2002; Flores et al; 2002). The mothers in this study indicated such by refusing to take their children to certain providers after negative experiences, or feeling the need to provide her own interpreter, even when going to the hospital for the delivery of her baby. Language barriers can also lead to dangerous situations in the home that have the potential to impact the health of the children. An ethnographic study done to understand pediatric injury from the mother's point of view demonstrated that the inability of the mother to speak English, along with other factors such as poverty and crowding, has the potential to result in unintentional poisonings (Mull, Agran, Winn, & Anderson, 1999). The mothers were not able to read instructions about safe storage of medicines, or other toxic substances written in English. The investigators observed that the children were exposed to unsafe storage of medicines and household chemicals in more than 80% of the homes visited.

One of the strategies for overcoming the language barrier was to utilize the children as interpreters in many types of settings, including doctor office appointments, for the children themselves, or for the parents. Utilizing children as interpreters has the

potential to create acculturative stress for the children (Weisskirch & Alva, 2002). Weisskirch and Alva (2002) discovered that the boys and girls, ages 9 to 11 years old, in 5th grade, were least comfortable in translating for their parents and other relatives and that the closer the child was to the person s/he was translating for, the more distressed the child was with language brokering. Interpretation of the results of the study revealed that the children devalued their language brokering activities and that the children believed that it hindered their development, their parents' development, and the acculturation process as well (Weisskirch & Alva, 2002). The boys demonstrated higher degrees of acculturative stress, and were more likely to be less acculturated than the girls. The girls were more Spanish language dominant, and preferred interacting with those of Mexican American descent. It may be that because brokering requires high levels of cognitive and linguistic skills, which are not fully developed, they end up feeling insecure. More importantly, the role between child and parent is reversed, making the parents dependent on the child, a role that the child did not choose, but rather is in out of obligation. Because there is no such research to date, additional research needs to be done to explore the role that language brokering has with acculturative stress, which in turn has the potential to affect their health status, and therefore, their health and illness conceptualizations.

*Seguir Adelante*

A significant finding, which seems to be the underpinning of the mothers' outlook on life was the outlook of needing to *Seguir Adelante.* For these mothers, the outlook of *Seguir Adelante* means that one has hope and is optimistic, and this was the reason for

many of the actions they took when taking care of their family. This is a significant and important finding because it challenges reports that non-financial factors in Latinos, such as *fatalismo*, or the belief that one can do little to alter fate, may account for disparities in health and in the use of health care services (Flores, Bauchner, Feinstein, & Nguyen, 1999). Instead, this outlook on life motivated and empowered them to make choices, sometimes very difficult choices in their lives, rather than to sit passively by and let life-events happen. In a study investigating the survival, continuity and growth in Mexican American families from the parent's perspective, Niska (2001) uncovered this same sentiment when a father was describing the factors that contributed to family growth. He referred to this sentiment when he was describing how his daughter provided the inspiration for him to *seguir adelante*. It may be that it is in the home that the children observe choice making and that this results in the view that good health is a result of choices about one's health. However, further research needs to be conducted to further understand this perspective and the role it plays in contemporary health care issues.

*Si Dios Quiere*

The role church has in the lives of the families interviewed is an important finding. Parents felt strongly that they had a role in the events that take place in their lives in term of health and illness. While the church was an important part of their lives, they were not active, regular church goers. They reported that it was their responsibility to do what they could to keep their children safe and healthy, through taking them to the doctor, giving them healthy meals, keeping them warm, etc. This finding is consistent with the findings in a study exploring Mexican American families who had children with chronic

illnesses. Rehm (1996) also found that the families in her study developed a deeper faith in God, which was a major source of comfort and support for the parents after their children were diagnosed with serious illnesses. However, prior to the diagnosis of the children with their serious illnesses, the families in her study, as the families in my study, were not devout Catholics. For both of the families in these two studies, even though their child was in "God's hands," and "His will be done," they still had a responsibility to take care of their children, and to do whatever they could to participate in their care. These findings are important because Latinos have typically been described as fatalistic, passively accepting and adopting the phrase "*que sea lo que Dios quiera*" [Translated: let it be God's will] (Adam, Briones, Rentfro, 1992). Realizing that Mexican Americans may not be fatalistic, as previous research would have one believe, has implications for health promotion and preventative health care.

*Cultural Practices*

In this group of Mexican origin parents, there was a wide range of what was considered culturally valuable for them. For example, the value placed on maintaining the Spanish language was not the same for all of the families. Also, parents, intentionally have chosen to seek out medical health care when needed, regardless of their education level, whether or not they speak English, and regardless of income. They had access to and utilized medical health care options. In spite of where the parents grew up, in Mexico or the U.S., there were some of the parents who were not able to utilize medical health care because they could not afford it, or because it was too far away. In place of medical care, home remedies were utilized, however, not preferred. Also, there were some parents

who only utilized medical health care, because they could afford it, whether or not they were brought up in Mexico or the U.S. For these families, it appears that when they were growing up, that they utilized home remedies because that was what was available, not preferred. In an ethnographic study investigating the experiences of Mexican-origin mothers' when using health care services, Clark (2002) discovered that the use of home remedies and curanderos did not substitute for medical health care services regardless of their level of acculturation.

Attempts to explore the use of curanderos were eliminated from the interview process with the families. Questions about this practice often went unanswered, or were met with a reluctance to answer them. One father explained that curanderismo was a form of witchcraft, and that they did not prefer that to medical health care. One mother admitted that she might take her child to a curandero during an illness, only if the medical health care was not successful first. Of the families that were asked, none of them were aware of a curandero in the community. One can only speculate as to why the responses were what they were. Perhaps the use of curanderos indicated that one was ignorant of the use of medical health care. Or perhaps the use of curanderos indicated that one was of a lower social class, uneducated, or ignorant.

The differences in their responses to their rejection of *Si Dios Quire,* and to their preferences for medical care when a child is sick, and in their descriptions of the health care they received as children are unique to this group of people. Several times, the parents gave examples of how things in Mexico are changing such as the availability of plants and herbs for home remedies that are no longer as available. Or when talking about

their view of the role of God in their lives, one father suggested that his mother would respond differently than him. Could it be that these responses are a reflection of changes that have occurred in Mexico over the past several years? Life here in the U.S. has gone through many changes in the last three decades, does it not stand to reason that significant changes would also have occurred in Mexico as well? Some of the changes that may have happened include an increasing knowledge base of medical care. Furthermore, that as movement between the U.S. and Mexico border has become more fluid, there has been an increasing exchange of medical and technical information.

## Limitations to The Study

As with any study there were limitations to this study, which primarily have to do with the sample selection and methodology selected.

Examining the process of sample selection and identifying its limitations is important so that transferability of the findings of this study to other groups of Mexican American children can be determined. The selection of the children in the study resulted in limitations of the study. The children were primarily healthy children and did not have much exposure to other family members who were seriously ill. As a result of the healthy status of the children and their limited exposure to other sick people, it may be that they were able to articulate their thoughts and understandings of health more easily than their thoughts and understandings of illness.

Another aspect of the selection of the children was that several of the children seemed to have difficulty in articulating their thoughts and understandings. At first thought that maybe conducting interviews with them was not a good way to collect data

from them because they were too young, they might feel awkward, or might have refused to talk. But as data collection continued, I discovered that it was not necessarily the younger children who were having difficulties, since many of the ones that were having difficulties were the older children. It appeared that the ones who were having difficulties articulating were the ones who had difficulty with their English language abilities. However, obtaining data from their drawings as well, was an excellent way to support the content from their interviews. I also discovered that towards the end of the data collection phase, the younger children who were not subjects, but sat in on the interviews had quite a lot to say, and were eager to participate (although they were not included in the data analysis and they were discouraged from talking). It could be that in a group setting, the observing children were less inhibited and had a sense of fun in the process, that the subject children, at the beginning of the data collection phase when they were being interviewed alone, and with my inexperience, did not feel. Another possibility for the reluctance of the older children to participate is that they may have started to develop the tendency of withholding personal information from adults (Dixon & Stein, 2000). Perhaps in the future, conducting interviews with children in focus groups and in Spanish, would result in children having more fun and thereby, feeling more comfortable in responding, resulting in a better understanding of their conceptualizations of health and illness. Focus groups are an innovative way to understanding children's perspectives from a developmental approach (Kennedy, Kools, & Krueger, 2001). Participating in focus groups will elicit children's responses because children are more comfortable within the social context of their peers, and self-disclosure and decreasing self-consciousness will be

facilitated with a peer audience.

The cognitive developmental level of the children in this study was not consistent with their ability to explain their thoughts about health and illness. Given the amount of research that has been conducted utilizing growth and developmental frameworks, such as Piaget's theory of cognitive development (see Chapter 2) in attempting to understand how children conceptualize health and illness, I had expected to find that the complexity of the explanations that the children provided for this study would have been more consistent with developmental levels. The observations made with these children may be examples of attempting to apply Eurocentric child development theories to children of Mexican origin, without cultural or language considerations. The youngest group, the third graders provided responses that were consistent with Piaget's cognitive theory of development (Bibace & Walsh, 1980), in that they tended to believe that health and illness were impacted by concrete things or actions. However, the fourth graders had the most abstract thoughts and explanations of the sample. Although one of the sixth graders was able to articulate health in a holistic way, which included the mental, emotional, as well as the physical components, he was the only one. The other sixth graders responded with very simple responses. Weisskirch and Alva (2002) discovered that children who interpret for the families experience acculturative stress and that they showed lowered self-worth. It may be that this sense of lowered self-worth in 5$^{th}$ grade children resulted in feelings of self-consciousness and reluctance to be more engaged during the interview. The study only included 5$^{th}$ grade children, therefore, the findings of Weisskirch and Alva (2002), can only be applied to the older children of this study. The younger children,

while they may not have the linguistic or cognitive abilities that the older children have, perhaps they also didn't experience the self-consciousness and therefore the reluctance to speak in either English or Spanish, although there is no evidence to support this, leaving this an area to be explored in future research.

While there was some variability of the types of families sample, the sample selected does not represent Mexican American children and their families as a whole, nor was it intended to do so. The community selected was from a somewhat homogenous rural/farming community in Central California. Many of the immigrant families originally came from Michoacan, Mexico, which may have resulted in commonalities with these families that may not be present in families from other parts of Mexico or with different migration histories. Furthermore, in a community that had a high percentage of Mexican American families, and in spite of efforts to recruit children and families that were representive of all socioeconomic levels, years of education, and primary language usage, the majority of the families were from lower socioeconomic levels, spoke primarily Spanish in the home, and had mostly parents that had approximately six years of education. It appears that limiting the sample selection of the children to children from bilingual classes limited the availability of children and families in higher socioeconomic levels as well. Perhaps broadening the scope of where to recruit the children from would have increased the available pool of families in higher socioecnomic levels. The number of families that were in the higher socioeconomic levels with higher levels of education, and whose primary language was English, were too few to be representative of other families with the same demographics. While the findings of these families provides new

and intriguing findings, we still know very little about families in this category, which was one of the unmet goals of this study.

Much of what is understood about Mexican American people and their behavior, health status, and outcome measurement is related to their levels of acculturation. However, attributing or linking the findings of this study to levels of acculturation cannot be done, because acculturation was not measured or assessed for. Although, since many levels of acculturation are based on measurements of language usage, one could speculate that the levels of acculturation for these families and their children would result in low levels of acculturation for most of these families.

The use of the ethnographic methodology for understanding how Mexican American children conceptualize health and illness from an ecological perspective was an appropriate choice. This method allowed for the voice of the children to be heard in how they think about health and illness, and to examine the factors that influence their thoughts and understandings. However, the purpose of the study was to explore and describe, and not to predict, manipulate variables, or to measure the outcomes of interventions or manipulation of variables. Furthermore, while the findings of this study provide a beginning in our understanding of how Mexican American children think about health and illness, the findings cannot be applied to all Mexican American children because of the small sample size from a homogenous region. As is the nature of qualitative studies, the sample size was small because the determination of the sample size is based on upon theoretical saturation. Therefore, it is not intended for generalization beyond the participants. Applications to other groups are only possible to

the extent that they also have the same characteristics as these participants. Therefore, for greater transferability of the findings, much more research such as this study is needed with other groups of Mexican American children, to build upon the body of knowledge that this study provides before research about predictability, and interventions can be conducted.

In establishing credibility for trustworthiness, member checks, the process of achieving confirmation from the informants about the interpretation of the data, is vital (Lincoln & Guba, 1985). Attempts were made to incorporate member checks with the children when the second interview was conducted, and this occurred for the children who were interviewed twice. However, not all of the children completed the two interviews (see Chapter 3). Additional attempts were made to achieve member checks with the children as the findings of the beginning and subsequent interviews were incorporated in the interview guide. However, the parents were interviewed only one time, and therefore the parents did not have the opportunity to review the findings of their interviews. There were occasional instances when the opportunity arose to verify and clarify content of the interviews with some of the parents, but this did not happen with all of them. However, as with the children, content from the beginning and subsequent interviews was incorporated into the interview guide for the parents as the interview process progressed so that emerging findings and themes could be confirmed or refuted. As the time for the data collection drew to a close, there were increasing difficulties in completing second interviews with the children, and in arranging interviews with two of the parents, therefore, these interviews did not occur.

As part of the qualitative tradition, examination of me, the researcher, is imperative. I am aware that my role as the data collector influenced the data and their findings from the children. I was able to identify areas for improving the data collection, adapt the data collection process, thereby, improving the results of my efforts with the kinds of interviews and the drawings that I was able to collect. I was able to be less structured in my interviews, thereby letting the children tell more of their explanations and understandings. While interviewing the parents, I believe that my language skills in Spanish did not impede the process and that I was able to communicate very well with the families.

I spent approximately eight months in the field collecting data. Gaining entrée to the schools was smooth and not problematic. Gaining entrée to the homes and the children took time, and started out slowly. Clearly in the beginning, I was working from the *etic* (outsider) perspective. However, by the time I left the field, the rate at which children and their families were agreeing to participate was significantly higher, and faster, and almost more than I could keep up with. In the end when I encountered new children and families, many of them had heard about me and were eager to participate. This level of participation and enthusiasm from the parents was different than from the beginning of data collection, and may have possibly resulted in a sampling bias. Although I did not sense that parents felt inhibited when talking with me at any point, it may be that the parents towards the end of data collection responded differently than the ones in the beginning. By the time I left the field, I was immersed in the community at several levels. Although it appeared to me that the themes I identified were saturated, I wonder if I had

been able to stay in the field longer, what would have been different. At the point that I left, while I was not quite operating from the *emic* (insider) perspective, I was no longer a complete outsider either, once again leaving me somewhere in between.

Although I was able to communicate in English and/or Spanish with the children and their parents, and was a Latina, I was also a nurse and doctoral student. The simultaneous realities forced me to confront, my occasional contradictory identities (Villenas, 1996). Although I made every effort to learn from the informants with new and fresh eyes and ears, to disengage myself from what I knew as a mother, nurse, doctoral student, and having grown up bilingually and bilculturally, how does one really do that? How much of my nurse part and my doctoral part influenced what I saw and heard and how much of that was I even aware of? Would the interpretations that developed have been different if I had been from a different discipline, ethnicity, or primary language? Would I have been able to engage the children and their parents had I had different perspectives? I acknowledge that who I was and am influenced my area of interest and how I went about it. I also am aware that I felt very comfortable in the settings I found myself in, with the children, and with their parents. There was something familiar and comforting about being with them, which I enjoyed. However, although I believe that my perspectives influenced my understanding of their remarks, it is difficult to really identify how and in what way they did. What is important is for me to make every attempts to identify them and to include them for consideration.

A final consideration for limitations of the study has to do with the seemingly very trusting families and how they allowed me to enter their homes, interview their children,

interview them, and for a time, be a part of their lives. Data collection occurred during a very difficult political environment for immigrants, following the passage of Proposition 187 (Hovey, Kain, & Magaña 2000). This proposition required anyone encountering a person without the proper documentation to be in the U.S. be reported to immigration officials, regardless of who the reporting person may be, including health care providers or teachers. The presence of this proposition had the potential to make the parents very distrustful of a stranger coming to collect data as I did. I had anticipated that in light of this environmental hostility, that families would be reluctant to participate, and that I would have trouble recruiting children and the families. I found that of the few families who did refuse or did not participate, did so for reasons not having to do with this. Instead I found the children and families that did participate to be very willing to participate, to let me into their homes, and to share with me many aspects of their lives including very difficult stories about themselves. Often I felt that although I made every effort to provide them with informed consent in English or Spanish, and that they signed the consents in English or Spanish, whichever they preferred, that they still really did not understand the implications of participating in the study, which made me uneasy. This is a methodological issue identified with immigrants and research (Lipson & Meleis, 1989). Sometimes I was concerned that they thought that I was someone who could help them in their dealings with health care providers. Although I am not aware of anything different I could have done, I did continuously make efforts to keep them informed, and to assure that they understood my role as a researcher. In spite of my efforts to assure complete informed consent, I still felt that there was an imbalance of power, which may have

contributed to perceived, socially desired responses (Marín & Marín, 1991). All of which made me all the more protective of my informants. Future research into how Mexican Americans view the role of the researcher would help in providing insight into assuring that appropriate ways are considered in approaching them for research purposes, because, currently, little information is documented about these questions (Marín & Marín, 1991).

In summary, while there were many advantages to the ethnographic approach to the study, there were unavoidable limitations as well. The limitations were primarily related to the selection of the sample, and the qualitative method. Efforts were made to minimize these limitations. However, in spite of these limitations, utilizing the ethnographic method in understanding how these Mexican American children conceptualize health and illness was a useful approach. Despite these limitations, this study was the first to explore how Mexican American children conceptualize health and illness within a contextual framework.

## Implications for Nursing

How these Mexican American children conceptualized health and illness has important implications for health promotion. The children placed a significant value on good nutrition, exercise, making choices, and a consideration for the future. These positive aspects can form the foundation for interventions that are culturally appropriate for Mexican American children. Educating the children on ways to prevent serious illnesses such as diabetes and heart disease through diet and exercise is an example of how these findings could be utilized.

Healthy People 2010 has identified leading health indicators that have significant

relevancy for pediatric nurses (Jackson, 2001). Special areas that will be monitored for the next decade have specific significance for pediatric nurses because they pertain to health behaviors that begin in childhood and adolescence. Furthermore, nurses need to be concerned about the health behaviors of parents because they model health behaviors for their children. Two of the leading health indicators that have been identified pertain to physical activity and obesity. A decrease in physical activity and obesity in children has lead to a increase in the incidence of Type II diabetes in children (Dean, 2002; Ludwig & Ebbeling, 2001). Type II diabetes is more common in children of color, including Mexican American children.

Interventions can be developed that reinforce the importance of making good healthy choices in areas of nutrition and exercise. Because Latino youth have a higher rate of obesity (Lacar, Soto, Riley, 2000), educational programs can be developed to reinforce and support healthy choice-making about exercise and nutrition. Families need to be encouraged to continue to be positive role models, and then to be advocates for children in terms of promoting programs that encourage healthy lifestyles like physical education in schools.

The findings of this research provide additional evidence that children, and their parents of Mexican American origin, are a very diverse group of people. Their differences range in areas of cultural values, language preferences, education levels, and in many other ways. The best way to try to understand someone from a different group than one's own, is to talk to them and ask them. Approaches to groups of people with assumptions of how they ought to be is not providing the best care possible. Furthermore, although

there are some groups who do utilize folk remedies, one cannot assume that everyone from the same cultural group does. Encouraging health practitioners to think that way seems to lead to a level of mistrust on the part of the practitioner if someone denies the use of such remedies. Furthermore, assumptions such as these may be insulting to Mexican Americans who perceive medical health care to be superior.

Nurses need to be advocates to assure that our patients and their families receive culturally and linguistically appropriate care, regardless of the type of health care coverage they have. Whenever possible we need to make sure that public policies are being adhered to; policies such as the stipulation in the Medi-Cal Managed Care program that requires 24-hour access to an interpreter at all provider sites, and other stipulations for linguistic services (Aranda, 1997). It is imperative that appropriately trained interpreters and bilingual and bilcultural health care providers are utilized to assure good communication for all. Children being utilized as translators is not acceptable, and therefore should not be done. Clark (2002) also suggested that parents receive interventions in the form of noninterventionistic "interventions" such as, anticipatory guidance, patient teaching, and comfort measures. Parents should receive explanations explicitly, without jargon. Rationales for treatments should be made clear about standards of care here into the U.S., as they may differ from standards of care in Mexico. And, finally, to take the time to be personable, with smooth interactions. Pediatric nursing care is grounded in family-centered care (James, Ashwill, & Droske, 2002). Providing care for Mexican American families and their children embraces the value of the family in this cultural group.

## Areas for Future Research

This study was an exploratory study using a small unique sample of Mexican American children. While the findings of this research provide insight into how these children think about health and illness, much more research needs to be done in order to gain an understanding of a larger group of Mexican American children, thereby, leaving many possible future questions for research. Replication of this study in a different geographic area would broaden our knowledge of how Mexican-American children conceptualize health and illness. An area for consideration for the replication of this study would be the San Diego, CA, area, a city that borders the U.S./Mexico Border. The population of Mexicans and Mexican Americans differs greatly from the town where these subjects were recruited. The patterns of migration and the nearness of the border results in a Mexican population that is more fluid and dynamic. Access to and availability of health care in the U.S. and in Mexico are different, which results in a pattern of usage that differs from the families in this current study. Those who live closer to the U.S./Mexico Border are able to seek medical and dental care in Mexico if they so desire. The low cost of medical and dental care in Mexico is the most common reason for crossing the border for services (Macias & Morales, 2001). Furthermore, medications such as antibiotics, pain medication and contraceptives are less expensive and easier to obtain (Macias & Morales, 2001). Close proximity to the U.S./Mexico border provides an alternative to affordable health care for those without insurance. Of the people that crossed the border for medical and dental services in Mexico, 90% did not have insurance (Macias & Morales, 2001). The families who participated in this study, in the San

Joaquin County, CA, all had insurance or Medi-Cal for the children, but, did not always have insurance for some of the members of the families, usually the fathers. Some of the parents reported that usually the fathers put off seeking out health care because of the lack of coverage for them, or that it often was more difficult to purchase medications than it was in Mexico.

There is still very little understanding of Mexican American families who are in the middle to higher socioeconomic level. The findings of this study suggest that while they also approached life with an attitude to *Seguir Adelante*, how they went about doing that was different than the families in the lower socioeconomic levels. Future research needs to be done that specifically seeks and recruits Mexican American families in higher levels of socioeconomic status to investigate this finding.

As previously addressed, this current study did not include measuring the level of acculturation in the data collection. However, even though issues of acculturation are not fully understood and measuring acculturation has its limitations (Rodriguez, 1995b), there is still value in considering it in research with Mexican Americans children, especially when attempting to understand acculturative stress and how it may impact their health status. Including measurement of acculturation in future research about how Mexican American children conceptualize health and illness would be helpful in placing the findings of that research within the current body of work that also has included it.

Additional areas that could be researched further include a deeper investigation in the worries of immigrant children and how it may affect their health. And a study designed to explore what may have changed in Mexico that may have resulted in a change

in preferences for health care from folk to contemporary practices.

While interviewing children individually yielded important information, perhaps conducting focus groups with children would yield richer data. Possibly selecting children who demonstrated a better command of the English language, or conducting the data collection in Spanish would be helpful. And given that the younger children seemed more engaged in the interview process, it may be useful to consider limiting the ages to eight and nine year olds. Seeking the responses of the older children is important, therefore, alternative ways to gain into their insight would have to be investigated and considered.

The question of cultural influence remains an important and unanswered question: What is being considered, measured, or otherwise determined, and by whose determination is it being considered? Could it be that when we consider cultural preferences, are we attributing to cultural preference, which in actuality is an issue of access and availability? The use of folk medicine has been assumed to be culturally preferred. But if a group of people use something because it is more available, does that make it more culturally preferred?

Nursing science is still considered a "young" science, with research that continues to be primarily exploratory and descriptive. Nurse researchers are encouraged to develop programs of nursing research that progress towards developing interventions. However, this research has resulted in more questions about how the Mexican American children conceptualize health and illness and the factors that influence those conceptualizations. More still needs to be learned about these children so that in the future empirically derived interventions may be proposed. Several considerations for future research have

been provided.

## Summary and Conclusions

Utilizing an ethnographic approach, within the theoretical framework of the theory of ecology has provided a new way to examine how Mexican American children, ages eight to twelve conceptualize health and illness and to explore what are the factors that influence those concepts. Studying the child within the context of the child's social environment or social world allows us to examine the child as a whole entity, and not just a part of a whole. These children and their parents have a positive outlook on life which is reflected in their concepts of health and illness. However, these families, while they take pride in their Mexican culture, seek health care from a perspective that is grounded in what is best for the child, rather than from cultural preferences.

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University of California, San Francisco . . . A Health Sciences Campus

December 1996

Dear Parents,

I am interested in how Mexican-American children, ages 8-12 think about health and illness. I am conducting a nursing research project about this and would like to ask you and your child to participate. If you and your child are willing to participate with me, what we would talk about is what it means for your child to be sick or healthy.

What would happen is this: We would set up a time for your child and myself to talk that would be convenient for both of you. I would like to conduct the interviews in your home. Your child and I would talk for about 30-45 minutes, and the interview will be tape-recorded. Although the interview will be mostly in English, I will be asking your child some questions in Spanish. The tape recorder is important because, after the interview, I will be reviewing it to be sure I understand everything your child would like me to know. At some time after the first interview, I would like to talk with your child again, because, after reviewing the first interview, I may have some more questions to ask. The topics to be covered in the interview will be about what your child thinks about being healthy and being sick, and Mexican cultural influences. An example of the questions I will ask is "what does being healthy feel like?", "when you are sick, how do you know when you are getting better?", and "what does being Mexican mean for you?"

After I have completed interviewing your child, I would like to interview both of the parents if possible, because, much of what children learn about health and illness beliefs comes from their parents. Understanding how a child's parents think about health and illness will help me to understand how the child thinks about it.

At any time, you or your child may refuse to answer a question, or stop the interview. Whatever you decide to do, will not affect his status in school. You and your child will not be identified in any way. Your child's teacher knows about the study.

Oftentimes, people enjoy having the chance to talk about experiences that are important to them, such as when they are sick. Or, sometimes it is hard to remember things that may have not been very pleasant such as an illness and this may be the case for you and your child. When the study is done, I will write up a "combined picture" of my findings to share with other nurses, doctors, and health care providers. You may receive a copy of the final report if you want one. I think it is important to study what Mexican-American children think about health and illness and what it means, so that nurses and others can be better able to help them when they are sick.

If you are refusing to have your child and your family participate in this study, please return the enclosed self-addressed and stamped postcard by mail to me. I will follow-up with a telephone call no sooner than two weeks after I have sent out the letter if I have not received a card from you.

Thank you for thinking about letting your family participate in this study. I would be happy to answer any questions you or your child may have. You may reach me at ***1-800-484-2548, and then enter 1801.*** If I am not able to answer the phone, please leave a message, and I will return your call as soon as I can. Thank you for considering my request.

Sincerely,

Diana Amaya Rodriguez, RN, PhD(c)

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Diciembre 1996

Estimados Padres,

Estoy interesada en como niños Mexicanos edades 8 a 12, piensan de salud y enfermedad. Estoy conduciendo un estudio de esto, y me gustaría pedirles a ustedes y su hijo que participen. Si ustedes y su hijo están dispuestos a participar, hablaremos de lo que significa a ustedes y su hijo estar enfermos o saludables.

Lo que pasaría es: Hacemos una cita que es conveniente para que su hijo y yo hablemos. Me gustaría hacer las entrevistas en su hogar. Su hijo y yo hablaremos por 30 a 45 minutos, y la entrevista será grabada. Aunque la entrevista sera de mayor parte en ingles, voy a preguntarle algunas preguntas a su hijo en español. La grabadora es importante porque, después de la entrevista, yo estaré revisándola para estar segura que entiendo todo do lo que su hijo quisiera hacerme saber. Algun tiempo después de la primera entrevista, me gustaría hablar con su hijo otra ves, porque después de revisar la primera entrevista, quisas tendré algunas preguntas. Los temas que hablaremos sobre en la entrevista sera de lo que piensa su hijo de estar saludable o enfermo, y las influencias culturales Mexicanas. Un ejemplo de las preguntas que preguntare es "¿Cómo se siente estar saludable?", "¿Cuándo estas enfermo, como sabes cuando estas mejorando?", "¿Que significa ser Mexicano para ti ?"

Después de completar entrevistando a su hijo, me gustaria entrevistar a los padres, si es posible, porque mucho de lo que los padres piensan de salud y enfermedad me ayudara a entender como el niño piensa de esto.

A cualquier tiempo, ustedes o su hijo pueden rehusar contestar las preguntas. Lo que usted decida hacer, no le afectara a su hijo en la escuela. Usted y su hijo no serán identificados en cualquier manera. La maestra de su hijo esta informada de este estudio.

Muchas veces le da gusto a personas de hablar de las experiencias que son importantes para ellos, como cuando estuvieron enfermos. Algunas veces es difícil recordar cosas que no fueran muy agradables como una enfermedad, y esto puede ser el caso para ustedes y su hijo. Cuando el estudio se complete, escribiré un reporte de la información para compartir con otras enfermeras, doctores y otros que proveen servicios de salud. Usted podrá recibir una copia de este reporte final si desea. Yo pienso que es importante estudiar lo que niños Mexicanos piensan de la salud y enfermedad, para que enfermeras y otros puedan ayudarles mejor mente cuando los niños estén enfermos.

Si ustedes no permitiran a su hijo o familia participar en este estudio, por favor devuelva la tarjeta por el coreo. Yo confirmare por teléfono que usted a recibido la carta que le envie.

Gracias por considerar si permitirá que su familia participe en este estudio. Por favor llame si usted tiene preguntas. Marque ***1-800-484-2548, entonces marque 1801***. Si no estoy disponible. por favor deje un mensaje. Le respondare lo mas pronto posible. Gracias por considerar mi proyecto.

Sinceramente,

Diana Amaya Rodriguez, RN, Ph.D(c)


APPENDIX B: **University of California, San Francisco**
**Consent to Participate in a Research Study**

**Project Title:** Conceptualizations of Health and Illness in Mexican-American Children, Ages 8-12, An Ecological Perspective.

**Purpose:** Diana Amaya Rodriguez RN, MS, and Christine Kennedy, RN, PhD, PNP of the School of Nursing are conducting a study about how Latino children think about health and illness within the context of the family. The researchers are asking for your permission to interview you, your child and family for this research project.

**Procedures:** If you agree to allow the researchers to interview your family, Diana will talk with your child for about 35-45 minutes in your home. The conversation will be tape-recorded. The interview will be mostly in English, but there will be a few questions in Spanish. The topics to be covered in the interview will be about what your child thinks about being healthy and being sick, and Mexican cultural influences. An example of the questions I will ask are "what does being healthy feel like?", "when you are sick, how do you know when you are getting better?", and "what does being Mexican mean for you?" After the first interview has been reviewed I will follow-up with your child to make sure I understood everything correctly and to ask any further questions I may have after reviewing the first interview. A second interview will be set up, which will include the family members who wish to participate.

**Risks/Discomforts:** The family members who wish to participate may feel uncomfortable or sad talking about having been sick in the past. But all will have a chance to talk about anything that has to do with what it means to be sick or healthy. Participation in the study may involve a loss of privacy, but several things will be done to avoid this. For example, when the tapes are typed up, both tapes and transcriptions will be locked in a cabinet at all times. Your names will not be on the information; only code numbers will be used. Only Diana Rodriguez and her supervisor, Dr. Kennedy will have access to the information. Any identifying information on the tapes will be erased immediately. Any stories or quotations in any talks or publications will not be identified. Although the information about you and your family is strictly confidential, should evidence of abuse of any kind to the children in the household become apparent, I will report it to the proper authorities because I am bound morally and legally to do so.

**Benefits:** There are no direct personal benefits to you or your child. However, the information that your child provides may help health care providers understand better what a Latino child thinks about being sick or healthy. Sometimes people find that the attention they get from the researcher makes them feel special, and they like having the chance to talk about something that happened to them.

**Costs/Reimbursements:** As a thank you gift for your child participating in the study, your child will receive a $10.00 gift certificate.

**Questions:** You have talked with Diana Amaya Rodriguez about this study and have had your questions answered. If you have any further questions about the study, you may contact either of us at:

**Researcher:** Diana Amaya Rodriguez, RN, Ph.D(c)
Department of Family Health Care Nursing
School of Nursing
UCSF, San Francisco, CA 94143-0606
510-889-9983

**Supervisor/Researcher:** Christine Kennedy, RN, PhD, PNP
Department of Family Health Care Nursing
N411Y, Box 0606
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UCSF, San Francisco, CA 94143-0606
Office Telephone: 415-476-4697

If you have any comments or concerns about your child participating in this study, you should first talk with one of the researchers. If for some reason you do not wish to do this, you may contact the Committee on Human Research, which is concerned with the protection of volunteers in research projects. You may reach the committee office between 8:00 A.M. and 5:00 P.M., Monday through Friday, by calling (415)476-1814, or by writing: Committee on Human Research, Box 0962, University of California, San Francisco, San Francisco, Ca 94143. The approval number for this project is H7511-13256-01.

**Consent:** You will be given a copy of this consent form to keep.

Participation in research is voluntary. You are free to decline permission for your child to participate in this study, and your child is free to withdraw his/her assent to participate at any time. Participants may stop the interview at any time without affecting your child's status at school in any way. The signatures indicate that approval has been given for you and your child to participate in this study.

Date:_____ Signature of Parent/s:_____

Date:_____ Child's assent:_____

Date:_____ Signature of Researcher Obtaining Consent:_____

Address (only if you would like to receive a copy of the final report of the research):

_____

Thank you to you and your child for your time and effort.

Appendix e:

**University of California, San Francisco**
**Assent To Be A Research Subject**


**Project Title:** Conceptualizations of Health and Illness in Mexican-American Children, Ages 8-12, An Ecological Perspective.

**A. What is this study about?**

Diana A. Rodriguez, RN, MS and Christine Kennedy, RN, Ph.D are nurses from the University of California, San Francisco, and are doing a study to learn what Mexican-American children think about health and illness.

You are a Mexican-American child between the ages of 8 and 12, and are bilingual, so, the nurses are asking you to be in this study.

**B. What will happen to me if I am in the study?**

1. First, I will come to your house. When I am at your house for the first time, I will ask you some questions about health and illness which will be tape recorded. For example, some of the questions I will ask you are what do you think being healthy is? And, how do you think you stay healthy? Tell me about the last time you were sick. I will also ask you some questions in Spanish.

2. When we are finished with the first interview, I will listen to the tape and type up the interview. After I type up the interview, I will study it to try to understand what you have told me.

3. After I have studied the first interview, I would like to talk to you again to make sure that I have understood correctly what you have told me. During that interview, I may have some more questions.

4. When you and I have finished with the first interview, I will talk to your mom and dad, and the rest of your family about how they think about health and illness.

**C. What will it feel like?**

Usually kids like to have the chance to talk about things that have happened to them, like when they were sick. But, sometimes, talking about being sick may make you feel sad. If there is something you don't want to talk about or understand, just let Mrs. Rodriguez, know. Also, there may be some things that you may tell me that are very private. I will not tell your parents or teachers anything that you have told me, unless it is about something dangerous or abusive.

**D. Do I get anything?**

Yes, at our first interview I will give you a $10.00 gift certificate for you to spend any way you wish at the store.

**E. What if I have questions?**

You can ask Mrs. Rodriguez or call Dr. Kennedy with any of the questions you have.

**F. What are my choices?**

You have three choices:

- You can be in the study if you want to.
- You can choose to not be in the study. If you decide to not be in the study, that's OK. Nobody will get mad at you if don't want to do this.
- If you decide to be in the study and you change your mind later, that is OK too. You just have to tell Mrs. Rodriguez.

Appendix D: Interview Guide for Child

**Project Title:** **Conceptualizations of Health and Illness in Mexican-American Children, Ages 8-12: An Ecological Perspective**

Researcher/Doctoral Candidate: Diana Amaya Rodriguez, RN, MS
Department of Family Health Care Nursing

Principal/Investigator/Supervisor: Christine Kennedy, RN, Ph.D, PNP
Department of Family Health Care Nursing

Suggested Interview Questions and Probes: This guide only addresses the general areas of exploration, and as dictated by the method, will be constantly evolving toward greater specificity.

Open with introductory conversational talk.

1. How are you today?
   Probes: Are you feeling well, or are you sick?

2. Tell me what you think health or being healthy means.

3. What does being sick, or not being healthy mean to you?

4. What does being healthy feel like? What does it mean for you?

5. Have you ever been sick before? What were you sick with?
   Probes: What was it like? What happened? Did you go to the hospital? Doctor? Clinic? Nurse Practitioner?

6. How long were you sick? How did you know that you were better?
   Probes: Did you feel better? Did someone tell you you were better? Did you feel anything different?

7. Who took care of you when you were sick?
   Probes: How did you mom or dad treat you when you were sick?

8. Can you do things to keep you healthy?
   Probes: What are they? Eating? Safety? Taking care of your body?

9. Tell me a story about someone who is not sick. Tell me a story about someone who is sick.

10. Draw me a picture about how you feel. Can you explain it to me? What does this mean to you?

11. Lets pretend that your doll (or pet, friend, etc.) is not feeling well, how you would you take care of her/him? What would you do to keep them healthy?

12. Are there things that you can't do when you are sick?
Probes: Can you go out and play, or eat, or go to school?

13. What do you think makes you sick? What do you think would make you feel better?
Probe: Can you do things to make yourself feel better faster?

14. Which language is easier for you English or Spanish?

15. When you are sick, do you talk in English or Spanish?

16. What does being Mexican mean for you?
Probes: Special foods? Holidays? Do you have friends who are not Mexican? How do they differ from you?

17. What kinds of medicine to take when you are sick?

18. What kinds of activities/hobbies do you do?
Probes: Sports? Arts? Reading? Sewing?

Appendix E: Interview Guide for Parents

**Project Title:** **Conceptualizations of Health and Illness in Mexican-American Children, Ages 8-12: An Ecological Perspective**

Researcher/Doctoral Candidate: Diana Amaya Rodriguez, RN, MS
Department of Family Health Care Nursing
Principal/Investigator/Supervisor: Christine Kennedy, RN, Ph.D, PNP
Department of Family Health Care Nursing

Suggested Interview Questions and Probes: This guide only addresses the general areas of exploration, and as dictated by the method, will be constantly evolving toward greater specificity. The interview will be conducted in the language of preference of the parents, English or Spanish.

Demographic Information:
Name of child Date of Birth
Male/Female Grade in School
Name of parents
Dates of births Mother Father
Marital Status
Who else lives at home? Age? Relation?

Do you have any other children living anywhere else? If so, how many, and where are they?

How many years of schooling have you had?

Religion

Where were you born? Mother Father

Where was the child born?
Where were grandparents born?
Occupation: Mother Father

Total Annual income:
Do you own or rent you house?

Primary language?

If you can speak both languages, which is used more? English/Spanish

Brief health history of child, illnesses, hospitalizations, accidents, chronic conditions?

Do you think your child is: [very healthy] [healthy] [sort of healthy] [not very healthy]

1. Tell me about the last time you child was sick.
   Probes: Who took care of your child? What did you do for your child? Who took care of him/her? If both parents are working, how do you arrange for child care?

2. How do you know when your child is sick?

3. Do you use any special remedies?
   Probes: Foods, teas, herbs, pills?

4. Do you take you child to anyone other than a doctor or nurse when s/he is sick?
   Probes: Herbalist, Curandero?

5. Do you do special prayers?

6. What happened to you when you were sick as a child?

7. Are there things that your mom/dad did when you were sick as a child that you do or do not do for your child? What are they? Why or why not?

8. How would you explain being healthy? How would you explain being sick?

9. What do you do to try to keep your child healthy?

10. Where did you learn how to take care of your child when s/he is sick?

11. How/Where did you learn how to take care of your child to keep her/him healthy?

12. What does being Mexican mean to you? What do you want it to mean to your child? How do you try to instill that in your child?

13. What do you think are Mexican family values?
    Probes: What is important to you? How can you tell if someone is Mexican or not?

14. What is it like for you to take your child to the doctor or clinic? How helpful is the health care team when you go in with your child?

15. What are the things that you do to keep yourself and your family healthy?

16. If you immigrated here, what was that like for you? How did you learn about things like were to go for health care?

17. Tell me what you think the difference is in your family's level of health between Mexico and here, better, worse, same? Why do you think so?