

University of Nebraska - Lincoln

DigitalCommons@University of Nebraska - Lincoln

Faculty Publications, Department of Child, Youth,
and Family Studies

Child, Youth, and Family Studies, Department of

3-2010

Conceptions Regarding Children's Health: An Examination of Ethnotheories in a Sending and Receiving Community

Maria Rosario de Guzman

University of Nebraska-Lincoln, mguzman2@unl.edu

Jennifer deLeon

University of Nebraska-Lincoln

Gloria Gonzalez-Kruger

University of Nebraska-Lincoln

Rodrigo Cantarero

University of Nebraska-Lincoln, rcantarero1@unl.edu

Follow this and additional works at: <http://digitalcommons.unl.edu/famconfacpub>



Part of the [Community Health Commons](#), [Health and Medical Administration Commons](#), [Health Communication Commons](#), [Health Policy Commons](#), [Health Services Administration Commons](#), [Inequality and Stratification Commons](#), [Latin American Studies Commons](#), [Personality and Social Contexts Commons](#), and the [Place and Environment Commons](#)

de Guzman, Maria Rosario; deLeon, Jennifer; Gonzalez-Kruger, Gloria; and Cantarero, Rodrigo, "Conceptions Regarding Children's Health: An Examination of Ethnotheories in a Sending and Receiving Community" (2010). *Faculty Publications, Department of Child, Youth, and Family Studies*. 104.

<http://digitalcommons.unl.edu/famconfacpub/104>

This Article is brought to you for free and open access by the Child, Youth, and Family Studies, Department of at DigitalCommons@University of Nebraska - Lincoln. It has been accepted for inclusion in Faculty Publications, Department of Child, Youth, and Family Studies by an authorized administrator of DigitalCommons@University of Nebraska - Lincoln.

Conceptions Regarding Children's Health: An Examination of Ethnotheories in a Sending and Receiving Community

Maria Rosario T. de Guzman, Jennifer deLeon,
Gloria Gonzalez-Kruger, and Rodrigo Cantarero
University of Nebraska-Lincoln

Corresponding author — Maria Rosario T. de Guzman, University of Nebraska,
135 Mabel Lee Hall, Lincoln, NE 68588-0236; email mguzman2@unl.edu

Abstract

Ethnotheories are beliefs that adults hold about children and the factors that impact upon their development. Scholars suggest that "ethnotheories" serve as cultural models that underlie motivations for parenting practices and the way adults organize children's early experiences. This study examines Mexican adults' ethnotheories about children's health in two communities that are linked by transnational migrants and serve as sending and receiving communities for workers. Forty-four Mexican adults in six focus groups discussed well-being issues affecting children in their communities. Qualitative analyses using grounded theory revealed a complex conception of children's health issues that included physical, psychological, and behavioral components and an interwoven system of causes with microlevel issues embedded in broader social, economic, and cultural contexts.

Keywords: ethnotheories, health, ethnicity and race issues, transnationals

The shifts in the ethnic composition of the United States, and particularly the rapid increase in the Latino population are now well known. Latinos now comprise the largest ethnic minority group in the country at 14.2% (41.3 million) of the population. With more than a 100% increase in the last two decades, Latinos accounted for 58% of the country's growth in that period, with another 188% increase projected between the Years 2003 and 2050 (U.S. Census Bureau, 2005).

Of concern among professionals working with Latino populations is their health status. National studies identify numerous health risks that affect Latinos, including elevated mortality risks from heart disease, tuberculosis, diabetes, and certain types of cancer (Centers for Disease Control & Prevention, 2004). Latinos also have increased rates of infectious diseases (e.g., measles, syphilis, and AIDS) and are at higher risk for obesity, depression, and anxiety (Centers for Disease Control & Prevention, 2004; Guendelman, 1998; Napolitano & Goldberg, 1998).

Findings are similar for immigrant children who lag behind their native peers on general physical well-being indicators, with this gap especially broader among low-income popula-

tions (Reardon-Anderson, Capps, & Fixx, 2002; Zambrana, Dorrington, & Hayes-Bautista, 1995). National data show that young Latino children's immunizations are less up-to-date than non-Latinos and that they have higher risks for parasites, asthma, lead poisoning, and iron-deficiency anemia (Guendelman, 1998). And while immigrant children have the same access to health care as nonimmigrants, they are less likely to utilize that resource (Reardon-Anderson et al., 2002), especially for children of undocumented parents (Berk, Schur, Chavez, & Frankel, 2000).

Young immigrant and nonimmigrant children show similar levels of school engagement and the same rates of behavioral issues. However, a disparity favoring nonimmigrant children emerges by late childhood into adolescence (12-17 years), with older Latino children and teens displaying higher tendencies toward risk-taking, obesity, and substance use compared to natives (Guendelman, 1998). And while this disparity is somewhat apparent even among younger children, this gap is isolated to those from low-income families.

Cultural Beliefs and Health

Cross-cultural research has long recognized the cultural dimensions of health, and the culture-related distribution of illnesses (Harkness & Keefer, 2000). However, the links between culture, health, and health disparities in ethnic populations have not been elaborated. Acculturation and related experiences impact the health of ethnic populations. For instance, negative mental health outcomes have been linked to racial discrimination (Dion, Dion, & Pak, 1992; Meyer, 1995), and favorable health outcomes appear to erode with acculturation (Clark & Hofsess, 1998; Franzini, Ribble, & Keddie, 2002). Cultural traits also serve as protective factors, such as family orientedness (i.e., "*familismo*") and family support, as well as expectations and conceptions of "success" (Escobar, Nervi, & Gara, 2000; James, 1993). Unfortunately, little is known about the interwoven nature of culture and health, and even basic information regarding cultural conceptions of health, and beliefs about children's well-being is greatly lacking.

This study explores adults' naturalistic beliefs about health issues of transnational children. The study was conducted in one Mexican sending community and its corresponding United States receiving community. The goal was to explore beliefs about what constitutes health, the factors that impact upon well-being, and the roles of migration and transnationalism in children's health. By focusing on ethnotheories, the study explores the cultural underpinnings of health issues and attempts to uncover basic beliefs about the role of transnationalism in well-being.

Transnational Communities

A large segment of the Latino population is "transnational"; that is, they maintain close ties with at least two communities (community of origin and current residence), through continued communication, maintenance of social ties, and sometimes repeated travel between countries (Portes, Guarnizo, & Landolt, 2006). In some cases, communities themselves become transnational as neighborhoods, towns, or villages evolve into "sending communities" through frequent and continuous migration to a particular "receiving community." For instance, workers who successfully find work in the United States can help pave the way for family members or neighbors to migrate to and work in their new community (Boyd, 1989).

The links between transnationalism and well-being are complex. On the one hand, it provides individuals with invaluable sources of social and instrumental support, thus facilitating adjustment into the new country. However, transnationalism can also hinder adjustment by lowering the need to establish social ties with one's new community. Indeed, maintaining social links with one's country of origin has been linked to positive as well as negative health outcomes such as depression (Murphy, 2006; Van Oudenhoven, Ward, & Masgoret, 2006). What is less known is the role of transnationalism in the physical, emotional, and behavioral health of children.

Contexts, Culture, and Parental Beliefs: Theoretical Approach

To better understand the interplay between culture, environment, and children's early experiences and development, Harkness, Super, and colleagues (Harkness, Super, & van Tijen, 2000; Super & Harkness, 1986) propose a theoretical framework they termed the "developmental niche." Its components include the physical and social setting, cultural customs and practices of child care, and the psychology of the caregivers, otherwise known as "ethnotheories." These three components operate in a coordinated manner in ways responsive to the features of the larger ecology, thus making the individual and the niche mutually adapted (Super & Harkness, 1986).

Culturally structured beliefs play a significant function in socialization and child rearing, including serving as the underlying motivation for parenting practices and the way by which adults organize children's early experiences. Ethnotheories are "cultural models" that are shared among members of a cultural group and reflect the broader belief systems that people in a given society hold. These beliefs, therefore, serve as a venue through which broad cultural values are instantiated in the everyday experiences of children. As Harkness and Super (2006) suggest ethnotheories are the "nexus through which elements of the larger culture are filtered" and as such are "an important source of parenting practices and the organization of daily life for children and families" (p. 62).

Indeed, empirical research shows that beliefs differ significantly across culture groups (e.g., Bornstein, Tamis-LeMonda, Haynes, Painter, Galperin, et al. 1996), and that parenting practices in turn covary with those conceptions (e.g., Parmar, Harkness, & Super, 2004). And while there are very few studies examining ethnotheories among transnationals, migrant or ethnic groups, research indicates differences in beliefs between migrants and nonmigrants in their host community; as well as between migrants and those from their country of origin (for review, Bornstein & Cheah, 2006).

Exploring naturalistic beliefs about migrant children's health might help explain at least part of the disparities discussed earlier, and help fill the gap in knowledge about perceptions of health among immigrant and transnational families (Napolitano & Goldberg, 1998). Because basic health forms the foundation for normative functioning, including healthy family relations and well-being, it is imperative that issues related to health should be better understood in order to have a fuller understanding of the functioning of the Latino population.

In line with this aim, the study utilizes focus group discussions conducted in both a sending and receiving community, with both community leaders and residents, allowing for the

exploration of the issue at hand through multiple perspectives. Moreover, because of the exploratory nature of this study, the use of qualitative focus group discussions will be particularly useful in allowing for the issues and perceptions to emerge naturally, in ways that presupposed categories through surveys or other structured methods would not capture.

Methods

Participants

This study was conducted in two sites identified by local collaborators and contacts as being sending and receiving communities for immigrants. The U.S. community is a mid-sized rural Midwestern town with a population of about 44,000. Recent estimates put the Latino population in this community at 16% (U.S. Census Bureau, 2000), which is an increase of over 100% in one decade. This rapid increase is attributable to the recent opening of a meat-packing plant in the vicinity. The Mexican city is in a northern state near the U.S. border, with a population of approximately 2,300. It is a town surrounded by agriculture production, and the main industry is comprised of raising apples that are exported to the United States. Many of the recent immigrants to the U.S. site maintain close ties with their sending community, and in some cases travel back-and-forth between towns. The strong and sustained links between these two communities and the continued contact between the immigrants and their Mexican home city was the primary reason for choosing the two sites.

Three focus groups were conducted in each community. One group was comprised of key informants, and the other two focus groups were of community members conducted separately by gender. In the United States, participants were recruited through a field coordinator with the assistance of a key community contact. The field coordinator was familiar with the Latino community in the U.S. site, and the key community contact had numerous contacts in both the United States and Mexico sites. Recruitment of participants was done primarily through word of mouth. In Mexico, the *Presidente* (similar to a mayor) of the community and his staff coordinated recruitment, also primarily using word of mouth to find individuals who were willing to discuss health issues affecting Mexicans in the two communities. Due to each site's legal age of consent, participants had to be 19 years of age or older and willing to be audiotaped.

With the exception of key informants, participants had to be Mexican and resident immigrants (U.S. site) or residents (Mexico site). Key informants were familiar with local issues and were recruited from among health care professionals, health program coordinators and educators, community organizers, and local politicians. Key personnel and community contacts suggested foregoing the collection of demographic data from key informants due to limited time availability, but also to follow-local norms regarding working with community leaders.

In the United States, the male focus group was comprised of seven participants ranging in age from 33 to 70 ($M = 43.14$; $SD = 14.59$), and who had lived in the United States from 1.5 to 23 years ($M = 11.50$, $SD = 6.70$). One participant had completed college, one completed high school, and four had either completed ($n = 2$) or had some ($n = 2$) grade school educa-

tion. All males were married, with one having a spouse who was not in the United States at the time of data collection. Six retained Mexican citizenship and one had dual Mexico-U.S. citizenship. Three had permanent residency status.

The female focus group in the United States had eight participants ranging in age from 30 to 54 ($M = 37.75$; $SD = 7.87$), and who had lived in the United States from 10 to 20 years ($M = 14.32$, $SD = 3.09$). One participant had completed high school, one completed grade school, and four had some grade school education. Five females were married with spouses residing in the United States. One female was separated and two were divorced. Seven retained their Mexican citizenship and one had dual Mexico-U.S. citizenship. Four had permanent residency status. For both male and female groups in the United States, all self-identified as being either Mexican (53%), Mexican American (7%), Hispanic (27%), or Latino (13%). All were born in Mexico and reported speaking either mostly (33%) or only (53%) in Spanish; 13% reported speaking both English and Spanish equally.

In Mexico, the male focus group had seven participants ranging in age from 19 to 61 ($M = 42.29$; $SD = 14.89$). Three participants had college degrees, one had some college education, one had completed grade school, and two had some grade school education. Six were married. All had at least one relative working in the United States, and reported communicating with them from 0 to 10 times a month ($M = 3.86$, $SD = 5.52$).

The female focus group had nine participants ranging in age from 24 to 55 years ($M = 39.56$; $SD = 10.92$). One participant had a college degree, three had some college education, four had completed grade school, and one had some grade school education. Six were married and one was widowed. All had at least one relative working in the United States, and reported communicating with them from 0 to 16 times a month ($M = 3.50$, $SD = 2.83$).

Procedures

Community members actively collaborated with the researchers in constructing the study, choosing the sites, and in developing the questions. As such, many components of the study were coconstructed with the participants themselves. This participatory model of research was utilized in order to have a more in-depth and culturally appropriate approach, as well as to ensure that the experience was mutually beneficial for researchers and participants.

Discussions were facilitated by bilingual Latino researchers who were highly involved in the Latino community and in Latino research. They used a guide with a range of open-ended questions focusing on the physical, mental, and environmental health issues faced by Latino immigrants in their sending and host communities and other issues relevant to their health outcomes. Questions specifically asked about children's health problems and their causes, as well as a comparison of those issues in both communities. All focus groups were conducted in Spanish except for the key informants group in the United States. Discussions were audiotaped, and then transcribed. The Spanish transcriptions were checked for accuracy and then translated into English. All English translations and the one English transcript were checked for accuracy before analyses. This process was carried out by two professional translators, the project field coordinator, three graduate students, and three undergraduate students.

Data Analysis and Coding

A grounded theory approach was used to identify themes emerging in the discussions (Strauss & Corbin, 1998). Grounded theory is a particularly useful method in exploring new areas of inquiry and in describing subjective experience as is the case in the current study (Creswell, Hanson, Plano Clark, & Morales, 2007; Strauss & Corbin, 1998). Here, grounded theory is used to explore respondents' theories and conceptions about child health and the beliefs they have about the causes of issues.

Coding was performed using qualitative text analyses software, MaxQDA (MAX QDA, Verbi Software, Marburg, Germany). Coders were two graduate students and one undergraduate student with extensive experience in working with qualitative data. Coders initially read the transcripts in their entirety in order to familiarize themselves with the questions and the overall flow and content of the discussions. Two of the coders then identified units of the text that were pertinent to the issues discussed above. Coders met to discuss and resolve discrepancies in their identification of pertinent textual units.

As part of this first step, coders worked independently to label the textual units identified above and collapsed synonymous codes. For instance, "lots of trash in the neighborhood" and "lots of garbage scattered around the neighborhood" were given the same label. Coders then discussed their codes and resolved discrepancies. This step was done repeatedly until codes could no longer be collapsed. This iterative process resulted in refinement of codes.

The second step involved axial coding, or the linking of coded units into broader categories that better capture the phenomenon of interest. In this step, codes identified in the first step were examined together with the intent of looking for underlying themes or broader categories into which the codes might be subsumed. A total of three themes were identified for types of health issues and ten broad categories were extracted for causes of those issues.

In the final step, relations among themes were discussed and positioned within a theoretical model (selective coding). A larger story was developed from the interconnections among themes and compared across groups based on respondents' discussions regarding the relations among those issues. Coders continued discussion and comparison of their procedures through these final steps. Throughout the analyses, procedures were repeated until themes and codes could no longer be collapsed into broader ideas, and until all coders were in agreement.

Results

A total of three axial codes were identified for the health issues children faced and 10 codes for their causes. Interconnections and broader themes were extracted from these codes and are described and summarized below. Examples are also drawn from the focus group discussions.

- (i) *Physical health issues.* Many responses pertained to physical health issues that respondents believed children in their community commonly experienced. These health issues included respiratory illnesses (asthma and flu), viruses/bacteria-related diseases, diabetes, allergies, vision, cancer/leukemia, obesity, and dental prob-

lems. In the case of diabetes and obesity, focus groups indicated a higher incidence upon coming to the United States. They did not indicate differences in prevalence rates for the other diseases.

- (ii) *Mental health issues.* A second category of health issues discussed were those that were psychological issues that hampered children's (and families') normative functioning. These included hyperactivity/attention-deficit hyperactivity disorder, stress, depression, general psychological issues, self-mutilation, neurological problems, and learning/school problems.
- (iii) *Behavioral health issues and risky behaviors.* The last group of health issues that focus groups mentioned had to do with health-compromising behaviors. These behaviors are considered "risky" in as much as they endanger a child's well-being or preclude them from normative experiences (e.g., graduating from school). These behaviors include substance use/abuse, suicide and suicide attempts, teen pregnancy, and dropping out of school.

Causes of Health Problems

It should be noted that the flow of the discussion was such that responses were often phrased to cover causes of health issues for the community, rather than just children. It is likely that causes of health issues are true for both adults and children and as such, it is neither possible nor appropriate to extricate children's issues from those of adults.

Ten broad themes were extracted from the discussions. The discussions indicate that while causes co-occurred, some served as more immediate causes of health issues and others were more distal that fed into or exacerbated the more immediate ones. Summarized below are the main categories of causes of health issues discussed, as well as discussion excerpts.

(i). *Economic conditions in the sending communities led to migration* One theme that emerged was that economic conditions and lack of jobs in Mexico led to migration to the United States. While not directly causing health issues, this was seen as being a distal cause of many health issues children and adults faced. The men's focus groups particularly emphasized this, though it also emerged in other groups.

The financial situation is one of the reasons. It forces people to leave—it is one of the problems. Poverty is the base for everything. [Male focus group, Mexico]

Focus groups also indicated that the goal of many youth today is to migrate to the United States rather than finish their schooling.

During vacation, teens go to the United States to work and it's like they no longer want to return to school because they now see the little extra money as better. [Key informant group, Mexico]

(ii). *Migration as a result and a cause of social issues* While migration was seen as a result of poor economic conditions in Mexico, it was also seen as an indirect cause of health issues. Migration was discussed, primarily among the Mexico focus groups, as causing fam-

ilies to break up when only one or some of the family migrated and left the rest in Mexico. Focus groups suggest that children in Mexico sometimes become preoccupied with the prospect of migrating and working rather than studying, thus inevitably dropping out from school.

Participant 1: For many children, the problem is that they have is that they stay alone (referring to being a migrant). Just as children, because they have a number of sisters, and they have to act like the man of the house. The responsibilities that they have are so many that sometimes they cannot handle it. And so what is the easiest solution? Well, alcohol, drugs, or even suicide. [Key informants group, Mexico]

(iii). *Cultural attitudes and beliefs in the United States and Mexico* Surrounding all these issues, all focus groups indicated that cultural and societal beliefs contributed to health issues. This included beliefs originating from Mexico that were carried over to the United States such as attitudes about drinking (including among children), and the concept of machismo.

The male can go and do whatever he pleases, and then they are bringing those diseases home and they are affecting the women and they are affecting the children and putting everybody at risk and it's just the way it's always been done. [Key informant group, US]

Respondents also suggested that beliefs and cultural views in the United States contributed to health outcomes, for instance, more liberal views leading to breakdown of families.

Now the youth are very liberal. Before, the parents would make the children respect them and now they don't. The youth are too liberal now ... and in that area we are also very influenced by the United States. [Male focus group, Mexico]

Furthermore, many noted that pressures and stress are more prevalent in the United States despite better economic conditions and that outlooks among people in the United States are more negative, believing that these concerns brought about negative health issues.

In Mexico, it's a happy country. It has its crises and more lows than highs, but the Mexicans are of a happy blood. To arrive in a country with certain rules and certain limits, it depresses migrants. You start to enter into a different world and rules. And from the time a person starts walking, he starts to feel a sad country. [Female focus group, US]

(iv). *Unhealthy lifestyles* Focus groups suggested that for those living in the United States, lifestyle practices led to many health issues. In many ways, those lifestyle choices were brought about by being in the United States. For instance, migrants develop poor eating habits and get little exercise.

One thing that I have noticed, that many gain a lot of weight because of the poor eating habits they practice. Since they prepare one or two meals a day, but a lot of soda, fries, pizza, hamburgers. That fast food, for not, because they won't prepare it themselves. [Key informant group, Mexico]

(v). *Family issues* Like migration, family issues were seen as a result and a cause of negative health outcomes, and was an issue brought up in all focus groups. As mentioned earlier, family issues were said to result from migration and separation of family members. Nonetheless, family issues were also mentioned as being a cause of health issues. For instance, parent absenteeism, bad modeling of behaviors, single motherhood, and family cycles of alcoholism were mentioned as leading to behavioral as well as physical health issues.

The children, they don't learn anymore. They have problems at home because they feel abandoned by the father who is working on the other side. There are psychologists at the school and they go to them to look in that area and look at what the problem is, but that's what it is. I mean, there are many children with depression, or they feel abandoned by their father, leaving them for so long alone in the care of just the mother. [Key informant group, Mexico]

Another example, from the male focus group in Mexico:

Participant 1: Oh yes, single mothers

Participant 2: A lot of that. It affects mental health and that is one thing that is seen more.

Participant 3: More separations

(vi). *Social conditions for immigrants in the United States* All focus groups indicated that social conditions surrounding immigrant life contributed to health issues. This included isolation from the rest of the family and weaker social support upon moving to the United States, leading to depression and health-compromising practices.

I think it is like a vicious cycle. Let's say, they come to America, they don't know very much English, they have their families here, sometimes they are abused or underpaid or overworked and they come home and bring stresses home to the family and kids. You know, and the wife starts feeling depressed and then maybe ends up with depression and doesn't realize it and it just keeps on going round and round. [Key informant group, US]

Focus groups also indicated that conditions were harder for undocumented immigrants who experienced sadness over extended times away from Mexico, have no access to health care, have worse job prospects, experience deterioration of health due to difficult job conditions, and have concerns over legal status. However, one positive aspect was that their children are still able to participate in some government health programs, especially those born in the United States.

Participant 1: If they live as illegals, in addition to the depression, there's preoccupation. Not just if they're eating and sleeping. They also hope they don't get caught.

Participant 2: Or they come home only when someone dies. After so much time.

Participant 3: Many wait to come during Christmas or like. Sometimes they cannot come or they don't come so that those festive dates turn into sadness. [Mexico key informants]

Health deteriorates a lot differently between a citizen and a resident and between an undocumented person because they don't go to work at the same places. An undocumented person arrives, he is going to work as a laborer. A resident possibly already has been working for a company for years and is no longer a laborer. He is a "something," and his health isn't deteriorating so much. [Male focus group, Mexico]

(vii). *Economic issues in the United States* Both lack of and increased money in the receiving community was considered as a cause of health issues by all focus groups except for the Mexico key informants. Lack of work, pressure to pay bills, and general lack of resources were mentioned as leading to health difficulties.

When you're trying to make ends meet and you are trying just to hold on to life right here, you are not thinking about the vitamins that are apparently in all of the food. You are just trying to get what is comfort food, what could put the baby to sleep without having a tummy that it is crying for food [another participant: beans, lard, and rice]. So, that's right (laughter). That's right, that's all it takes. [Key informant group, US]

However, focus groups also mentioned that having money allowed migrants to engage in some unhealthy practices that led to health issues. In particular, having money allowed immigrants to engage in substance use and exacerbated unsafe sexual relations. While it was not clear whether this was seen as affecting the health of children/youth and/or adults, those unsafe practices nonetheless were either the immediate or distal causes of well-being issues.

Participant 1: Where I live, there isn't as much alcoholism because there isn't any money, there isn't anything and the alcoholism costs a lot of money over there.

Participant 2: Over there, the lack of work—it makes a person go to the cantina to drink. To pass the time there, to chew on peanuts there, with beer, with a strong drink that I know. And there goes the time. [Male focus group, US]

(viii). *Environmental issues* All focus groups discussed the environment as a cause of health issues. This ranged from the U.S. climate (immigrants not used to the cold weather) to man-made environmental factors in both U.S. and Mexico communities such as unhygienic surroundings, toxins in food including chemicals in vegetables and hormones in meat, as well as environmental contamination in farming communities (e.g., pesticides and dirt from animals/cattle).

Participant 1: I believe that, it's happening that people are sicker here because of the climate, right? The illnesses are different.

Participant 2: It is different in the United States, just the climate that exists here.

Participant 3: Well I think that right now it is even in the feeding, because it is given in the form of chemical products because previously there weren't so many illnesses. I even was able to talk with a diagnostic engineer. I asked why in those greenhouses, the tomatoes grow mature so quickly. On what base or what formula do they utilize? What is it that we are eating? What is it that is producing so much cancer? All of those sorts of things because I believe that if I eat a tomato I am eating a piece of poison, yes, that is true. I think that this is one of the primary reasons. In order to make a buck and more quickly I am going to poison humanity. And that, that is true because I see that situation—contamination. [Male focus group, Mexico]

Focus groups indicated inequity in environmental conditions—with more affluent neighborhoods having cleaner surroundings than poorer neighborhoods.

The clean neighborhoods are where the people with money live. In some places, there are very ugly markets and the people are dirty. There are some shipping containers, some carts,

some ramps where the trucks enter to unload fruits. And it smells. The pretty old district where you smell every thing, the very strong aroma of rotten fruit, it's bad. But there is a difference, well, yes, one hundred percent—an enormous difference. [Male focus group, US]

(ix). *Health care* All focus groups indicated that health care either alleviated or exacerbated health issues. While they indicated that there are better programs in the United States, there are barriers to accessing these services. For instance, medical care is often expensive or other issues such as transportation and paperwork can hinder its use. Two examples illustrate this below:

If one goes to a doctor here and they diagnose you with some major illness you need an operation—first they first search to see if you have the money. Over there the operation is completed and then one pays and in installments. And here if you don't have the money we are not going to treat you, we don't provide the service. Yes, very different, I think it is better over there in that area. [Female focus group, Mexico]

Not visiting the physician over there (US) is another thing. First because of the English, because they can't speak it, and it's rare for a physician over there in (U.S. site) to speak (Spanish). Second, because it's going to be very expensive. Third, if they are illegal, they can run the risk of being deported. So then, well, they medicate themselves, or if not they talk over here and they say I have a cough, I have a fever, I have this, what should I drink? Ah, so then, buy yourself something like this at the pharmacy, and they go and buy it at the pharmacy. Or what the teacher says, also. When you return, bring me penicillin, acetamol, all that in case I get sick. [Key informant group, Mexico]

Cultural beliefs such as self-medication and waiting until health issues are serious before seeing professionals was also discussed. Below are two illustrations.

And the other thing I see is that people bring medicine in from other countries, when they go home. It is dangerous and especially this antibiotic merry-go-round for children. We'll give you 2 or 3 until they feel better. Or sometimes, don't take the whole bottle, just 2 or 3 until you start feeling better. They'll the rest for next time because it's expensive. [Key informant group, US]

I was over there (US) and one of my nephews became sick, a little nephew. And then he was sent home from school because he was sick and we went to the clinic and they didn't tend to him quickly because my sister could not communicate with the person who was there because they spoke English, and she only speaks in Spanish. So the little boy was very sick when they admitted him, and they had to put him for 2 days in the hospital. But that was the way they serviced him. (Female focus group, Mexico)

Focus groups indicated that there are specific programs, particularly vaccination, that are just as good or better in Mexico, and that migrants often return to Mexico for their dental and eye care.

The level of vaccination here (Mexico) is fine, almost 100%.

It's something that in Mexico has received a lot of focus. The schools and all ask for their complete (vaccination) card. The mother who does not get her child vaccinated has consequences. Let's say, the DIF will take their child away. It's considered child abuse. If they don't have their vaccine and it is insisted and insisted to the mother, and the mother does not care, the child is taken away. But it is, yes, a good program.

The government is very careful. Occasionally, they also put vaccination brigades on the streets for someone who might have forgotten, and now the [vaccination] cards have come out of the promotion, from birth to 19 years of age. It's national priority, I mean ... they demand it a lot. We, each child that is born they have to—we are registered, in the health system. Then, they send us a paper each month, you know that this month we need to vaccinate this child, this child, this child; such and such child needs such and such vaccine. [Key informant group, Mexico]

The children (in Mexico) have their pediatrician, their doctor that is for them. They have their psychologist who comes and checks on them for, for their age right? And there exist groups who defend them, who protect them. [Female focus group, Mexico]

(x). *Transnationalism* Finally, as evidenced in previous excerpts, focus groups indicated that transnationalism had both positive and negative impacts on health. It provides migrants with a means of obtaining medicine or other treatments they might not otherwise be able to afford in the United States. Moreover, because transnationals often arrive after another relative or friend has already arrived in the first place, their adjustment into the U.S. system is often facilitated by others.

When migration has occurred, the older brother leaves, the older sister, and then later the other one goes—whichever has the possibility to work. They arrive and are able to have a home. The long-term ones go and in some way help them to register for programs. The point is that he is not completely marginalized from the government programs over there and they are able to get in. And then another arrives and they also look for a way. They aren't completely about "no you are undocumented not you!" They are able in some way to be in those support programs from the point of support for children when they're born over there to undocumented parents. [Male focus group, Mexico]

At the same time, continued access to health care from country of origin, such as ability to buy medicine, was seen as causing migrants to self-medicate or delay getting medical help until they were able to go home or went to the U.S. emergency room (see Example 2, Section i).

Finally, focus groups indicated that conditions were harder for undocumented immigrants for reasons related to their inability to continue ties with people in their country of origin, including extended times before returning to or visiting Mexico (see Section vi). Regardless of time between exchanged visits or moves between the United States and Mexico for these immigrants, cultural influences and effects on health perceptions seem to be apparent.

Interrelations Among Themes

Interrelations among themes were extracted in the final steps of the coding procedure. These interrelations were based fully on focus group discussions about causality and links among the various causes and conditions leading to health issues, as well as the health issues themselves. These interrelations are illustrated in Figure 1. It should be noted that this figure was constructed based on all the focus group discussions and does not represent any one ethnotheory. Instead, it represents the pattern that emerged with the groups taken together.

Focus groups identified distal causes of health issues, namely, economic conditions in Mexico (e.g., poverty) leading to migration to the United States. In turn, migration, along with cultural beliefs in the United States and Mexico were seen as leading to the more immediate causes of health issues, such as unhealthy lifestyles, family issues (e.g., family separation), and poor social conditions of Mexicans in the United States. In the United States, poor economic conditions and environmental issues were also considered as additional immediate factors leading to health issues. These proximal causes were themselves interrelated. For instance, poor social conditions led to unhealthy lifestyle choices, and poor economic conditions in the United States led to poor environmental conditions.

Finally, barriers to health care use and transnationalism were described as exacerbating and alleviating the effects of the immediate causes. Barriers to health care as a factor itself was impacted by cultural beliefs and social conditions in the United States.

Comparison of Responses Across Groups

In general, themes that emerged were consistent across focus groups. Differences emerged mostly in the degree to which respondents emphasized particular issues. In particular, all three Mexico focus groups emphasized the topic of immigration as a contributor to negative health outcomes. Moreover, it was mostly the female groups (in Mexico and the United States) that heavily emphasized the influence of cultural attitudes and beliefs on health issues. All, or nearly all groups mentioned unhealthy lifestyles, family issues, environmental issues (except U.S. key informants), and health care as causes of negative health outcomes.

Discussion

The goal of this study was to explore adults' beliefs about children's health in one United States and one Mexico community linked by transnational migrations. Results illustrate a complexity in perceptions regarding children's health issues which was seen as spanning physical, mental, and behavioral aspects of well-being. The causes of health issues were also depicted as a system of influences that included a broad array of factors that included the immediate environment, broad social conditions, and even broader systems of cultural beliefs. And while some of the factors identified were microlevel issues (e.g., lifestyle choices), all were seen as being embedded in the larger social, economic, and cultural contexts.

Consistent with the current literature, the focus group discussions highlight the role of sociocultural factors in children's health (e.g., Franzini et al., 2002), such as, the perception that cultural beliefs and attitudes in the United States and Mexico contribute to negative health outcomes. For instance, people in the United States were seen as being more stressed, worried, and having higher expectations, consequently affecting immigrants. In contrast, people in Mexico are seen as easy-going despite their added economic hardships. This is consistent with Escobar et al. (2000) review of large-scale studies that suggest some positive mental health outcomes of Mexican immigrants due to lower expectations of educational and financial attainment.

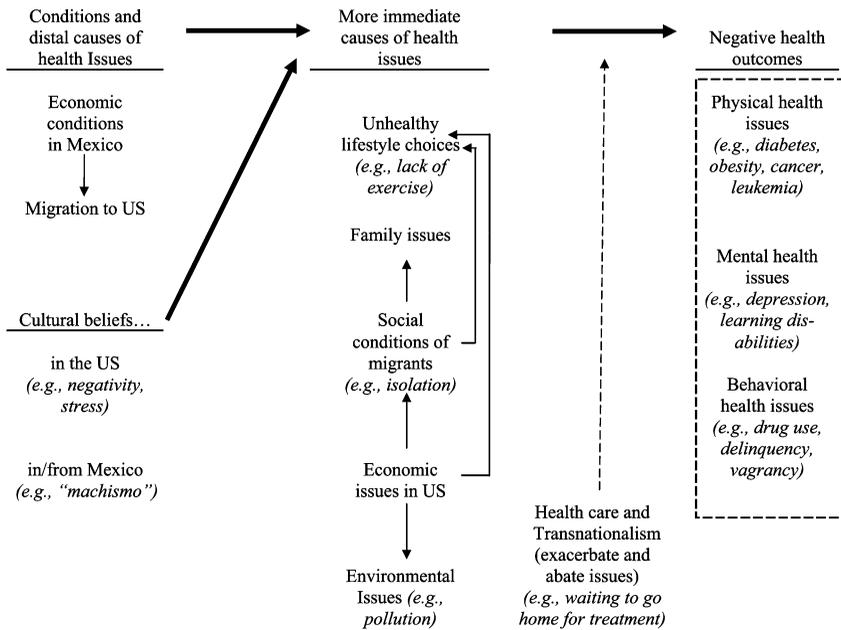


Figure 1. Illustration of interconnections among themes extracted for health issues of children and their causes.

Similarly, focus groups emphasized the role of family issues in health outcomes. Research has pointed to the protective factor of family relations in the health of immigrants, particularly because of the traditional focus on family in Latino culture (Escobar et al., 2000; James, 1993). Emergent in the focus group discussions was the perception that family issues such as separation due to migration or the inability to return home to family were detrimental to health. These issues were seen as indirectly affecting health by promoting unhealthy or risky behaviors, but also directly affecting health by causing depression and other mental health problems. These findings reiterate the importance of family relations in the adjustment and overall health of Latino immigrants in the United States.

Finally, results are consistent with scholars' assertions about the positive and negative effects of transnationalism, especially with regard to health care (Murphy, 2006; Van Oudenhoven et al., 2006). An emergent theme from the discussions was the belief that continued links with the community of origin provides migrants with a means of obtaining medicine and treatments they might not otherwise be able to afford in the United States. However, these practices were also seen as impeding to accessing health care that might actually be needed. As such, consistent with earlier research, transnationalism is perceived as having benefits to well-being, but can also serve as an impediment to adjustment to the new host community and their practices.

Summary and Implications

Harkness and Super (2006) suggest that ethnotheories serve as a filter through which belief systems are instantiated into everyday behaviors and practices. Their developmen-

tal niche framework depicts the interplay between parental and adult beliefs about children and the environments in which children grow up. This framework emphasizes the interrelated nature of experiences, beliefs, culture and context, and how these, interacting together, have important implications for the overall functioning, socialization, and early experiences of children.

Several implications can be drawn from the current findings. First, findings reiterate the importance of taking a comprehensive approach to children's health. Focus groups revealed the view of "health" as comprised of physical, mental and behavioral components, all of which are equally important and inextricably linked. Similarly, causes of health issues are complex and intertwined – ranging from personal, to family, to community, and culture-level issues. A holistic approach to health, that focuses on the entire individual would be most productive when working with migrant populations in particular, who are experiencing challenges at multiple levels.

Second, results emphasize the role that cultural processes play in the health practices and health care utilization of migrants. As such, in addressing the health disparities facing migrant children, it is essential that these cultural issues be addressed. This includes building on the cultural assets that they might bring (e.g., positive outlook toward life and despite misfortunes), as well as addressing the beliefs that might deter healthy practices (e.g., self-medication). Practitioners should be aware of these cultural factors, and take them into account when building programs and in addressing clients' needs. Cultural beliefs are often deeply entrenched, and are not easily changed. However, practitioners who have a clear understanding of these beliefs and their implications for health are better equipped to work within or around those perceptions.

Finally, results also illustrate the unique challenges that transnational children face. While immigrants in general face specific, transnationals in addition have unique experiences that can abate or exacerbate health issues. As such, it is essential that programs delineate approaches that specifically address this population.

Limitations and Future Directions

This study illustrates the reality of transnationalism and the importance of understanding ethnotheories in elucidating the cultural underpinnings of health issues and practices. This study contributes to current research in various ways. Its focus on the cultural aspects of health is unique and sheds light on the roles of culture, beliefs, and transnationalism in the health and well-being of children. The focus on ethnotheories was useful in that a unique aspect of health and health issues was explored from the perspective of the participants, allowing cultural beliefs to emerge. Finally, the study also sought the perspective of multiple informants and collaborators in both countries who participated in the study and played significant roles, including study development and data collection. Having multiple perspectives allowed for a more thorough exploration of the issues at hand, and the model of participatory research gave respondents and the communities a more invested role in the study.

The current study is an exploratory investigation of children's health and transnationalism, and as such, several future areas of study are warranted. The developmental niche framework (Super & Harkness, 1986) used here to guide conceptualization, is comprised of three interrelated systems, only one of which was studied (ethnotheories). Future re-

search should directly examine the links between these folk beliefs and the corresponding behavioral practices across contexts or among various demographic groups, for instance, among migrants with and without transnational ties, migrants and natives, or migrants of different ethnic origins. These issues could also be studied over time to show how beliefs change as individuals and families adjust (or not) into their host communities. Those investigations could illustrate the interrelated and adaptive nature of the developmental niche among immigrants.

The themes drawn from the discussion were mostly consistent across focus groups. Responses did not differ significantly across countries and across males, females, and key informants. Given that these distinct groups each provide unique perspectives about the issue at hand, it is possible that further examination might better reveal those disparities if probed. For instance, males and females typically hold unique gender roles with regard to family life, particularly in Latino culture (Baldwin & DeSouza, 2001), and as such might provide differing perspectives regarding children's health. Similarly, other demographic characteristics might be linked to other differences in perspectives, namely documented versus undocumented migrants, parents of younger versus older children or teens, recent versus long-term migrants, and certainly high versus low socioeconomic status. Future research should be more purposeful in teasing out specific differences in perceptions in order to better depict the diversity in belief systems.

Finally, findings from this study are beginning to illustrate the positive and negative consequences of transnationalism with regard to health. Previous research indicates that transnationalism affords migrants particular benefits but also poses specific challenges with regard to health and adjustment. The current study looked specifically at health challenges. Further research should be conducted among transnational families and individuals to also examine the benefits of transnationalism to the well-being of immigrant children.

References

- Baldwin, J., & DeSouza, E. (2001). Marianismo and machismo: The social construction of gender in Brazil. *Interamerican Journal of Psychology, 35*, 9-29.
- Berk, M. L., Schur, C. L., Chavez, L. R., & Frankel, M. (2000). Health care use among undocumented Latino immigrants. *Health Affairs, 19*, 51-64.
- Bornstein, M. H., Tamis-LeMonda, C. S., Pascual, L., Haynes, O. M., Painter, K. M., Galperin, C. Z., & Pêcheux, M. (1996). Ideas about parenting in Argentina, France, and the United States. *International Journal of Behavioral Development, 19*, 347-367.
- Bornstein, M. H., & Cheah, C. S. L. (2006). The place of "culture and parenting" in an ecological contextual perspective on developmental science. In K. H. Rubin & O. B. Chung (eds.), *Parenting beliefs, behaviors, and parent-child relations: A cross-cultural perspective* (pp. 3-33). New York: Psychology Press.
- Boyd, M. (1989). Family and personal networks in international migration: Recent developments and new agendas. *International Migration Review, 23*, 638-670.
- Centers for Disease Control & Prevention. (2004). Data 2010: The Healthy People 2010 Database. Accessed July 17, 2004; <http://wonder.cdc.gov/DATA2010/focus.htm>
- Clark, L., & Hofess, L. (1998). Acculturation. In S. Loue (ed.), *Handbook of immigrant health* (pp. 37-59). New York: Plenum Press.
- Creswell, J. W., Hanson, W. H., Plano Clark, V., & Morales, A. (2007). Qualitative research designs: Selection and implementation. *Counseling Psychologist, 35*, 236-264.

- Dion, K. L., Dion, K. K., Pak, A. (1992). Personality-based hardiness as a buffer for discrimination-related stress in members of Toronto's Chinese community. *Canadian Journal of Behavioral Science*, 24, 517-536.
- Escobar, J. I., Nervi, C. H., & Gara, M. A. (2000). Immigration and mental health: Mexican Americans in the United States. *Harvard Review of Psychiatry*, 8, 64-72.
- Franzini, L., Ribble, J. C., & Keddie, A. M. (2002). Understanding the Hispanic paradox. In T. A. LaVeist (Ed.), *Race, ethnicity and health* (pp. 280-310). San Francisco: Jossey-Bass.
- Guendelman, S. (1998). Health and disease among Hispanics. In S. Loue (ed.), *Handbook of immigrant health* (pp. 277-301). New York: Plenum Press.
- Harkness, S., & Keefer, C. H. (2000). Contributions of cross-cultural psychology to research and interventions in education and health. *Journal of Cross-Cultural Psychology*, 31, 92-109.
- Harkness, S., & Super, C. M. (2006). Themes and variations: Parental ethnotheories in Western cultures. In K. H. Rubin & O. B. Chung (eds.), *Parenting beliefs, behaviors, and parent-child relations: A cross-cultural perspective* (pp. 61-80). New York: Psychology Press.
- Harkness, S., Super, C. M., & van Tijen, N. (2000). Individualism and the "Western mind" reconsidered: American and Dutch parents' ethnotheories of the child. *New Directions for Child and Adolescent Development*, 87, 23-39.
- James, S. A. (1993). Racial and ethnic differences in infant mortality and low birth weight: A psychosocial critique. *Annals of Epidemiology*, 3, 130-136.
- Levenson, R. W., Soto, J., & Pole, N. (2007). Emotion, biology, and culture. In S. Kitayama & D. Cohen (Eds.), *Handbook of cultural psychology* (pp. 780-796). New York: Guilford.
- Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior*, 36, 38-56.
- Murphy, E. J. (2006). Transnational ties and mental health. In R. Mahalingam (ed.), *Cultural psychology of immigrants* (pp. 79-94). Mahwah, NJ: Lawrence Erlbaum.
- Napolitano, M., & Goldberg, B. W. (1998). Migrant health. In S. Loue (ed.), *Handbook of immigrant health* (pp. 261-276). New York: Plenum.
- Parmar, P., Harkness, S., & Super, C. M. (2004). Asian and Euro-American parents' ethnotheories of play and learning: Effects on preschool children's home routines and behaviour. *International Journal of Behavioral Development*, 28, 97-104.
- Portes, A., Guarnizo, L. E., & Landolt, P. (2006). The study of transnationalism: Pitfalls and promise of an emergent research field. *Ethnic and Racial Studies*, 22, 217-237.
- Reardon-Anderson, J., Capps, R., & Fixx, M. (2002, November). The health and well-being of children in immigrant families. *The Urban Institute, Series B, No. B-52*.
- Strauss, A., & Corbin, J. M. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Newbury Park, CA: Sage Publications.
- Super, C. M., & Harkness, S. (1986). The developmental niche: A conceptualization at the interface of child and culture. *International Journal of Behavioral Development*, 9, 545-569.
- U.S. Census Bureau (2000). Quick facts about the US census. Retrieved December 31, 2007, from <http://www.infoplease.com/us/census/data/nebraska/#areas>
- U.S. Census Bureau (2005). Facts for features, Hispanic Heritage Month 2005: September 15-October 15. Retrieved June 29, 2007, from http://www.census.gov/Press-Release/www/releases/archives/facts_for_features_special_editions/005338.html
- Van Oudenhoven, J. P., Ward, C., & Masgoret, A. M. (2006). Patterns of relations between immigrants and host societies. *International Journal of Intercultural Relations*, 30, 637-652.
- Zambrana, R. E., Dorrington, C., & Hayes-Bautista, D. (1995). Family and child health: A neglected vision. In R. E. Zambrana (ed.), *Understanding Latino families: Scholarship, policy, and practice* (pp. 157-176). Thousand Oaks, CA: Sage.