

University of Nebraska - Lincoln

DigitalCommons@University of Nebraska - Lincoln

Great Plains Research: A Journal of Natural and
Social Sciences

Great Plains Studies, Center for

Spring 2002

Latino Families in the Perinatal Period: Cultural Issues in Dealing with the Health-Care System

J. Martin Maldonado-Duran

Family Service and Guidance Center, Topeka, KS

Maria Manguia-Wellman

Family Service and Guidance Center, Topeka, KS

Sari Lubin

Shoam, Israel

Teresa Lartigue

National Institute for Perinatology, Mexico City, Mexico

Follow this and additional works at: <https://digitalcommons.unl.edu/greatplainsresearch>



Part of the [Other International and Area Studies Commons](#)

Maldonado-Duran, J. Martin; Manguia-Wellman, Maria; Lubin, Sari; and Lartigue, Teresa, "Latino Families in the Perinatal Period: Cultural Issues in Dealing with the Health-Care System" (2002). *Great Plains Research: A Journal of Natural and Social Sciences*. 596.
<https://digitalcommons.unl.edu/greatplainsresearch/596>

This Article is brought to you for free and open access by the Great Plains Studies, Center for at DigitalCommons@University of Nebraska - Lincoln. It has been accepted for inclusion in Great Plains Research: A Journal of Natural and Social Sciences by an authorized administrator of DigitalCommons@University of Nebraska - Lincoln.

**LATINO FAMILIES IN THE PERINATAL PERIOD:
CULTURAL ISSUES IN DEALING WITH THE
HEALTH-CARE SYSTEM**

J. Martín Maldonado-Durán, M.D.

*Family Service and Guidance Center
325 SW Frazier
Topeka, KS 66601-1963*

Maria Munguía-Wellman, M.S.W.

*Family Service and Guidance Center
Topeka, Kansas*

Sari Lubin, O.T.

*Shoam Clinic
Shoam, Israel*

and

Teresa Lartigue, Ph.D.

*National Institute for Perinatology
Mexico City, Mexico*

ABSTRACT—Migration of young Latinos and Latinas has increased in many towns in the Midwest. These young people will experience the perinatal period in a new cultural environment. We focus on the interface between families of Latino origin and the Midwest health-care system, particularly in the care of the pregnant woman or couple and in the care of the infant. Issues of culture are central in the perinatal period, and often the staff in health-care centers is not aware of the importance of several traditional and “folk” health-care beliefs in this period. These beliefs impact the care of the pregnant woman, the baby, and the couple’s conception of health and illness, as well as the remedies to solve problems. We review, from the mother and infant mental and physical health point of view, the main culturally based health beliefs and precautions and the culture-bound conditions in pregnancy and for the baby.

KEY WORDS: culture-bound syndromes, folk remedies, health-care system, Latinos, migration, perinatal period, transcultural

Latin American Migrants in the Midwest

The United States and many other industrialized nations face the phenomenon of continued migration from “third world” countries. In the US one-fifth of all children are the offspring of immigrants (Hernández 1999). Many migrants are from Latin America, predominantly Mexico and countries in Central America (mostly Guatemala, El Salvador, and Nicaragua). Economic hardships like unemployment and chronic instability drive this migration. Other reasons are prolonged military dictatorships and armed conflicts (as in Guatemala, El Salvador, Nicaragua, and more recently in Mexico). Due to these events, some immigrants have undergone considerable psychological trauma: sudden uprooting, fleeing from military repression, and multiple losses (of family members, friends, home, culture, and country). Many have been direct victims of political violence.

Migration is a solution and a problem. It is a solution to the immediate danger of death, incarceration, and torture in the most extreme cases. In the more frequent scenario, it provides persons with opportunities for work and a better economic outlook. Migrants come in response to the clear demand and need for their labor. Increasing migration to the Midwest makes for very rapid social change in areas that previously were very homogeneous, with mostly Caucasian families of European origin. The move to the new culture carries a cost: living where a foreign language is spoken, encountering very different cultural practices and more individualism (Marín and Marín 1991), and enduring separation from the mother culture and, at times, discrimination and racism.

The migrant population is often quite young, of reproductive age (Phinney et al. 2000). Therefore, their experiences of forming a family and having children often will occur in the new “host” culture. For most families, migrants or not, the perinatal period (pregnancy, childbirth, and the first three years of the baby’s life) represents particularly vulnerable conditions for the adults and the infant (Ammaniti et al. 1999; Maldonado-Durán et al. 2000). During this time, people normally resort to cultural practices and values, traditions and family support to deal with the challenges of coping with the pregnancy, having a baby, becoming a parent, and looking after the baby. Traditions and cultural prescriptions give a sense of orientation, of belonging, and help define “what to do.” Some of these patterns and care practices are impossible to maintain in the new culture, or they may lose their meaning in the new social context. In the extreme, they may be perceived as absurd, primitive, or superstitious. In the context of migration,

neighbors and community agencies may not be able to understand customs and rituals nor participate in them with the migrant family (Grizenko and Sayegh 1992).

As a result, culturally based practices and traditions may be abandoned abruptly as obsolete or impractical. In their absence, parents may feel “lost,” more uncertain, or even guilty because some important milestones or cultural markers are missing or taboos are transgressed. We mention here two examples: the institution of *compadres* and respecting the period of *cuarentena* in the care of a newly delivered woman. The *compadres* is a system of social bonding, mutual help, and support established around (Catholic) religious milestones like baptism or confirmation. Most frequently, it is initiated by having a friend (or a couple) become godparent(s) to one’s child, for instance, at baptism. The godfather or godmother have a lifelong supportive relationship to the child and could become substitute parents if need be, as this is their acquired duty (Falicov and Karrer 1980). They also become very close to the parents of the child, who are now their *compadres*. An immigrant to the Midwest may not be able to carry out this important transgenerational protective ritual. This would leave the baby more “unprotected” and may be a source of anxiety for the parents about the future of their child. Something has been unfulfilled; a tradition has been broken due to their relative isolation in the host culture.

The *cuarentena* is a period of approximately 40 days in which the newly delivered woman should receive special care from a mother figure, avoid eating certain “cold” foods, not work physically, nor be exposed to drafts of air. This may be impossible if she has no one to look after her or if she has to work or take care of young children at home. This contrasts with the traditional situation in which other women are able to support her at this time. Going back to work soon, having to go out, and engaging in work break a social taboo and contribute to the woman’s feeling unprotected, guilty, and more vulnerable.

The migrants themselves may feel that the “old beliefs” are obsolete and unnecessary (Moro and Barriguete 1998; Moro and Nathan 1999) but do not have anything to replace them and propitiate a positive outcome for the pregnancy, childbirth, and first years of the baby’s life. Quickly discarding old beliefs may signal difficulties in the process of migration: the person might make desperate efforts to be like “everyone else” without really fitting in.

In many cities and towns in the Midwest, the health-care system is quite sophisticated and technologically advanced. It places a high value on

technology, efficiency, and providing services at as low a cost as possible. Despite this, many immigrants will have very limited or no access to the health-care system, particularly because of their lack of health-care insurance (Pérez- Stable 1987; Ginzberg 1991; Mendoza 1994; Flores et al. 1998). As a result, they will often access public health care, which is overwhelmed with multiple demands on its limited resources. It is important for those who work in the field of health care to have an understanding of the health beliefs, practices, rituals, and traditions of families, including those of immigrants. This is clearly a priority in the perinatal period, in which almost by necessity the involvement of health-care professionals is expected.

Here we illustrate some of the difficulties immigrants have in dealing with the modern health-care system. Health-care providers' lack of familiarity with some of these themes may leave the client feeling misunderstood (Ijima-Hall 1997). Immigrants may then avoid health care as much as possible. Health care providers may experience frustration and find the immigrants difficult to understand, anchored in old beliefs and superstitions.

First, we describe several common values and themes important to many Latino families, which inform who they are and how they interact with health-care professionals. The degree to which families hold these traditions and beliefs depends on many factors, one of which is the length of time they have spent in the new country and how much they have adopted the host culture. Our current description of practices might be more applicable to the newer immigrants and to those coming from more rural areas. Second, we illustrate some of the most common traditional practices in the care of the pregnant woman and the baby. Finally, we address culture-bound conditions that affect pregnancy and the infant and that need to be understood when medical care is provided to them. These conditions are thought to be ways in which distress is manifested in a culturally permissible way (Littlewood 1990).

Latino Ways of Relating and Interacting

Some important themes are fairly recurrent in most Latino families. They represent constructions that are likely to be encountered in other immigrants, particularly those of traditional cultures, and may be important to take into account in dealing with these families. We illustrate the main beliefs and attitudes that may appear puzzling or actually strange to an observer from a different cultural context. Knowing the practice and its

meaning may help to convey to the family that they are understood. Due to limitations of space, we address each item very briefly, only to highlight the most salient points.

Being Latino. It is important not to assume that every person called Latino has the same cultural practices, values, or origin. In the Midwest it is often thought that every person with a Hispanic surname must be “Mexican,” as Mexicans comprise the majority of immigrants. People from Cuba and Puerto Rico have a different background than those from Guatemala, for example. The former are heavily influenced by Afro-Caribbean beliefs and rituals, for instance, the belief in spiritism or the influence of spirits in causing diseases or anxiety (Bird 1981). Many of those beliefs are rooted in the practices of African slaves brought to the Americas centuries ago. As a result of this diversity, a person from Central America or Puerto Rico might feel offended or misunderstood if “lumped” with all other Mexicans. The generalizations we make here may not apply at all to a given family or social group.

“Familism” and the role of the extended family. This term is often used to refer to the traditional family orientation of Latinos. Families tend to be extended rather than nuclear, to the extent possible (if relatives are also able to migrate). There is less emphasis on individuation, individual achievement, and self-differentiation (Falicov and Karrer 1980; Phinney et al. 2000). People traditionally rely on extended family members to accomplish tasks, and conversely, other relatives will expect help to be reciprocated. Dependency is accepted as normative and is rewarded.

What one family member does really has repercussions, not only for him or her but also for the whole family. Loyalty to the family is expected. Shame can be brought on the whole family by the behavior of one of its members. There are more “blurred boundaries,” as members are less “autonomous” and more interdependent. Relatives traditionally can count on each other at any time (Garcia Coll and Vazquez Garcia 1995). This also makes relatives feel free to intervene in the activities of other family members.

Traditionally, children do not have to leave home at age 18 but stay with the family until they marry. Young children are not encouraged to speak their mind but rather to be respectful, obedient and considerate. Older people are highly respected and may have the last word on disputes or differences of opinion between relatives or on matters of health care.

Mother-child relationship. The strongest relationship it is possible to have in life is between the child and his or her mother. Even adults may say that the most important attachment is to their mother. Many Caucasian

American adults would state that the most important relationship in the family is between the spouses (Falicov and Karrer 1980). Among most Latinos, the primary loyalty is to that "blood relationship" rather than to any other acquired liaison (e.g., through marriage).

Latino mothers, as in other traditional societies, relate to the baby in a different way than is typical in industrialized Western societies. They relate more with touch and holding and rely less on speech (i.e., they tend to talk less to the baby) (Moro 1998; Stork 1986). They also may play less with them, as a recent study documented by comparing the practices of parent-child interaction in a city in the United States with those in a town in Guatemala (Rogoff et al. 1993). In the Latin American country, other children, rather than the parent, are expected to play with their young sibling. Parents usually provide longstanding body contact and the child is often carried for extended periods of time. Verbalization and dialogue are not central to the culture, as love is conveyed more through gestures and actions rather than through words. Mothers would rarely say to their child, "I love you," as might be common in other groups.

Traditionally, the baby is not separated from the mother practically at any time during the first few years. Therefore, any separation may be experienced by the baby as very stressful. Babysitters are not known, and if necessary, family members, like aunts and grandmothers, are the (expected) substitute caregivers.

Recently in a medical clinic, the nursing staff consulted with a Latino mental health professional in order to get help for a two-year-old girl who would "freak out" when a separation from her mother was attempted. Repeatedly, she would scream inconsolably and loudly when expected to separate from her mother, a woman from Puerto Rico. The staff assumed that since the little girl was two years old, she would agree to stay with other (unknown) caretakers while her mother underwent a minor diagnostic procedure. The mother was rather intimidated and agreed to that separation. The consultant asked the mother why she thought her daughter was so scared. When she revealed that her daughter had never separated from her it became easy to understand her fear. The staff had thought originally that there was a disorder in the girl or her mother, leading to an abnormal closeness. Eventually, a family member was asked to remain with the girl while the mother underwent the procedure. (Maldonado-Durán et al. personal observations)

Syncretism in health beliefs and religion. After the conquest by Spain, there was an amalgamation between the beliefs of the European conquistadors and the aboriginal peoples (e.g., Aztecs, Tlaxcaltecs, Mayas). As a result of this fusion of belief systems, a new syncretic set of religious and health beliefs arose (Villaseñor-Bayardo 1994). For example, in central Mexico an important religious symbol like the Virgin Mary became “Guadalupe Tonantzin.” The virgin of Guadalupe is an autoctonomous avocation of the Virgin Mary (a virgin with “Indian” features). However, she also received attributes and expectations similar to those of the old Aztec goddess Tonanzin, who was a maternal deity (Villaseñor-Bayardo 1994). The cult of the saints and virgins in Guatemala and Mexico is imbued with many of the practices of adoration of the old idols and natural gods (of rain, fertility, etc.). A similar phenomenon occurs among traditional people of Mayan origin, attributing to Christ many features of the sun god, making them equivalent (Holland 1978).

Similarly, many “folk” health beliefs are the product of the fusion of aboriginal and Spanish cultures. Beliefs in *aire* (the pathogenic influence of air coming into the body) was an old Aztec belief (Kearney 1984; Viesca-Treviño 1992) that is very common among Mexicans and Central Americans. They may fear the entrance of air in the body, as it could damage a woman who recently delivered or the newborn baby. Having the baby exposed to air is considered undesirable. With symptoms of an upper respiratory infection, people might think they “got air” inside the chest and practice moxibustion (see below) (Risser et al. 1995) while also taking an antibiotic prescribed by a physician, thus addressing the problem from both angles, traditional and modern. Only when this syncretic belief system is understood can traditional and medical strategies coexist in order to adequately deal with health and illness.

Language and cultural barriers in dealing with the health care system. Despite migration, many health-care centers in the Midwest (including public health, medical private practices, and mental health services) have few (or no) staff members who are bilingual (English and Spanish) or who are familiar with cultural practices. A consequence may be that the immigrants themselves do not feel welcome in those centers, where communication may be enormously difficult in the first place. The clients may feel uneasy when the staff experience discomfort with the communication, as though they are “creating problems.” In Latino cultures, facial expression and nonverbal forms of communication play a central role in social interactions. On seeing a distressed (or tense) face, the Latino person may decide

to never go back there, if possible. This means that there is a great deal of sensitivity to feelings of uneasiness, of being unwelcome, of creating discomfort in another. The client may be very fearful of being a nuisance and creating a problem, preferring to stay away from the service providers. Such discomfort may be perceived merely by not being welcomed or received not warmly but in a businesslike manner.

Even when the Latino person or family can speak English, another possible barrier is the style of communication. People are expected to have an introductory period before revealing certain details, allowing *confianza* (trust) to develop. Latino people tend to explore the unspoken interpersonal atmosphere to ascertain whether it is prudent to ask for a service or reveal a problem. In interpersonal exchanges they often wait for the right time to discuss something, usually based on nonverbal cues. So the communication traditionally is not direct and to the point but more oblique and hyperbolic. It may be considered rude to ask for something after a very brief introduction. Rushed staff and services with very limited time cannot foster this type of communication nor allow *confianza* to develop. This may frustrate the staff and leave the clients feeling unable to reveal their problems.

Latinos may feel that discussing difficult things about the family is a betrayal and might bring embarrassment or shame to the whole family. For example, themes such as incest or sexual abuse are disavowed or flatly denied for this reason. The same is true for domestic violence. Also, for many Latinos it is wrong—a kind of betrayal—to express negative thoughts about a family member. Only after a relationship of trust is established can these topics be discussed.

Concept of time. Time and the clock do not rule many Latino families, like many others coming from traditional societies. Traditionally, people were more guided by the appearance of the sky and natural phenomena than by the machine-clock. Time is more an approximation or an insinuation rather than a statement of a physical reality. In a health-care setting, a person with an appointment at 9:00 may come at 9:15, or much earlier than 9:00, misunderstanding the expectation of punctuality. The person or family may be quite surprised if they cannot be served if they were somewhat late. From the point of view of the family, they have fulfilled their commitment to come at approximately a certain time. In Latin America in general, people make engagements around a certain time rather than really meaning a specified hour or minutes on the clock. Indeed, when invited to a function at a home or to a social occasion, Latinos may consider it rude to appear exactly on time.

Individual attention, personal distance, touch, and proximity. In US health-care settings, Latino families or individuals may be quite surprised about the little time they spend with the doctor or nursing staff. The practice in which the physician keeps several patients waiting in different consulting rooms, going quickly from one to the other, is surprising and bewildering. It may seem impersonal and rushed. Most families would expect the physician to see each patient one at a time in his or her only consulting room.

The professional manner of greeting and asking questions, and even the physical distance between the staff and patient, are important messages that are determined by culture. In the US, the usual distance between doctor and patient may be perceived by the Latino client as lack of interest, as cold and uninvolved. Most commonly, Latinos greet each other with a smile (to diminish social tension) and a handshake. Handshakes are also used on departure to signify a continued relationship and to imply that the person is welcomed back. Touch is used freely between adults and children, and between people of the same gender, as a way to convey empathy and acceptance, and when dealing with health issues, to infuse hope. Even unconsciously, immigrants may experience the absence of these physical manifestations of acceptance as emotional distance and coldness. People tend to expect a certain degree of personal treatment, first, rather than going directly into the problem at hand. Also, the use of humor and diminutives in questioning may assist the clinician in eliciting a description of the problems, obtaining more information in this way (Falicov and Karrer 1980).

Expressions of emotions and distress. In Latinos, the expression of emotions is expected and accepted, particularly happiness, excitement, fear, and sadness. Crying openly or in public is accepted, particularly for women. Men are also expressive emotionally. The expression of emotions is ritualized. It is more acceptable when it refers to phenomena or events that are happy, scary, or sad.

By contrast, internal distress and suffering that are not related to external events are more difficult to acknowledge. For instance, depression, or a lack of happiness or interest in pleasurable things, is more difficult to express. Distress of this kind is also expressed through somatic symptoms.

There is information from transcultural studies in mental health that distress, suffering, and fears in traditional societies are often somatized (Escobar 1987; Fabrega 1990; Guzder 1992). For instance, if a clinician were to ask the pregnant or newly delivered Latino woman if she is depressed, she will likely say no. Culturally, she would have social pressure to

say that she is mostly happy about her condition or the new baby. Saying something different might bring bad luck or be considered ominous. Postpartum depression as such may be denied, despite feeling quite depressed (Kumar 1994).

However, the patient may readily endorse symptoms like backaches, headaches, pervasive tiredness, and difficulties sleeping. These expressions of distress are acceptable, as they are "outside of her control." Also, there is a social stigma associated with words like depression and mental health problems (Katon et al. 1984). In contrast, symptoms like exhaustion, and little energy are more socially acceptable because they do not hint of personal failure or difficulty coping with change in one's life (Gureje et al. 1997). This tendency to express tension or emotion through bodily symptoms has been noted in several traditional cultures. The physician or health worker dealing with this situation may need to take this into account when evaluating the presence of those emotional conditions.

Traditional care during the pregnancy. In most cultures, the mother-to-be will experience uncertainty and a need for psychosocial support, particularly from a maternal figure. The cultural belief system and the woman's actual mother may be protective factors in dealing with these stressors. Migration may put this system at risk, perhaps due to the absence of the woman's mother (who may have stayed in the country of origin). Preventive strategies may be unavailable to the pregnant Latino woman or couple. A central theme of the perinatal period in poor countries is high infant mortality (Sheper-Hughes 1992). Poverty, nutritional issues, and infrastructural conditions in many third-world countries lead to a high rate of infant mortality, which is a real and constant danger for Latino families during pregnancy and the early years of the child's life.

There are a number of traditional prescriptions to ensure that the pregnancy will progress normally. One of them is vapor baths or *temazcal* baths. In the rural or more traditional areas of Mexico and Central America, a pregnant woman may periodically be exposed to one of these baths (Pury-Toumi 1997). They are similar to those used in Scandinavia (sauna) in order to eliminate "toxic products" through sweating and to be cleansed properly. The person goes into a small bathhouse similar to an igloo but made of adobe. Water is poured over hot stones and the vapor and heat lead to the cleansing of the body. This hot bath agrees with the "hot state" of pregnancy and cleanses the woman of negative influences (Cosminsky 1992).

Another important precaution may be *ser sobada* (to have a massage). This is practiced typically by a *curandero* or traditional healer. The woman

has a massage, but her abdomen is also manipulated. This is thought to help the baby prepare for the delivery and assume an appropriate position. Not having this reassuring practice may lead to problems during the delivery.

The pregnant woman is thought to have a “hot state.” The classification of states between hot and cold is based in the aboriginal beliefs about the balance of states and humors (Lopez Austin 1984). Her diet has to consist of “hot foods” (Cosminsky 1992; Moro and Barriguete 1998). This does not have as much to do with the actual temperature of the food as with their inherent properties, based on an old traditional classification. Chicken is considered “hot,” but many fruits are deemed “cold.” A careful observance of the diet is important to ensure that the pregnancy will progress well.

In many traditional cultures, such as in the aboriginal cultures in Mexico and Central America, a woman would have to deliver her baby with the assistance of other women, like female relatives. The placenta is buried near the house. Also, the stump of umbilical cord (when it falls off the baby) is buried nearby. It is thought that the place where the umbilical cord was buried is the root of the person; they say that “where you left the *ombliigo* (umbilical cord) is the place where you belong forever.”

After birth, the umbilical stump on the newborn is carefully covered with a band of clothing so that the baby won’t develop an umbilical hernia. In some areas, for the same reason a small coin is applied over the umbilical area when the stump falls off. When there is reddening of the umbilical area, the mother or grandmother might apply a composition of some herbs with a piece of cloth, perhaps with some medicinal infusion. Only if it did not improve, would they consult a doctor. As noted, the delivery is mostly an affair of women; many would prefer to go to a midwife or even a female doctor rather than a male physician.

In contrast, in the US it is likely that the delivery will take place in a hospital. The Latino partner or husband may not expect to witness the delivery and he could be somewhat traumatized by the event if not prepared for it.

Care of the baby. We will focus only on some of the most salient practices, as well as those that are likely to be misunderstood or puzzling for health-care professionals with a more European American view of infant care. In general, the Latino family views the baby as quite vulnerable and dependent. The infant is traditionally considered as a “gift” and it is thought that having a baby may bring good luck to the family. Some practices

described below are central to the idea of the baby's dependency and need for intimacy between parents and infant.

Co-sleeping. In most Latino families, the baby will sleep at least with the mother, or with both parents in their bed (co-sleeping). A relatively high proportion of other minorities in the US like African Americans, also practice co-sleeping (Lozoff et al. 1996), as do a fair proportion of Caucasian families. It would be surprising for an immigrant Latino mother to realize that in many families the baby, even the newborn, might sleep in his or her own bed and room, away from the mother. Given the perceived fragility of the baby, the mother feels she has to be very close to her infant. Also, being alone and not needing the constant presence of the mother are not deemed important traits that must be fostered gradually. Being alone may be almost impossible if typically houses are quite small and people do not have individual rooms to sleep in. Many individuals in traditional Latino families will rarely be alone in their lives. Sharing the room and the bed (as well as many other material things that are scarce) are normative aspects of growing up. Of course, those sleeping arrangements and practices are common in most countries in the world (Lipson et al. 1996)

Breastfeeding. As in many other cultures, the method of feeding is changing rapidly in Latin America, where increasingly mothers are resorting to bottle-feeding (Scheper-Hughes and Sargent 1998), which is perceived as more modern, hygienic, and "scientific." However, the traditional expectation and belief is that the baby naturally should be breastfed on demand. A prescription given by well-meaning health-care staff to feed the infant every three hours would go against the belief that the baby should dictate when to eat depending on many factors. The mother values herself as being available to the baby and allowing him or her to depend on her. A traditional view of motherhood is the ideal that mother should put her needs aside to meet those of the baby. Certainly, most mothers do not customarily consult the clock when it comes to infant-care practices. They would value their intuition to "know what to do" and would depend on the advice of an elder woman regarding how to respond to the baby's needs.

Where to breastfeed? Breasts are considered predominantly as nurturing organs and not as sexual ones. Therefore, a woman may find it very natural to breastfeed the baby in any public place. Also, others around her are not likely to see this as an indiscretion or a sexual provocation, but as natural maternal care. The mother may expose her breast to feed the infant in a number of public places like a bus, street, or marketplace. It would be surprising to her if someone thought this was "inappropriate" or offensive.

But the prevailing attitude in the Midwest is that breastfeeding is a private activity, particularly when it involves exposure of breasts. Therefore, according to the majority, women should do this while concealing their breast and preferably not feed the baby in public. In certain public spaces, like malls, mothers may be advised to breastfeed in the bathrooms instead of on benches where other people can see what is happening. Feeling uptight about breastfeeding would be hard to understand for a traditional Latino.

A resident in psychiatry admonished a Latino mother for breastfeeding her newborn baby in front of her five-year-old child. This child was in therapy with the resident, who realized the mother was breast-feeding the baby with the five-year-old around. The mother felt very surprised and shocked by this comment, which after all came from a respected health professional. He had indicated it might be “overstimulating” or seductive for the five-year-old to see the feeding. She thought her son should be able to realize what she was doing, that is, breastfeeding the baby as she had seen her mother and aunts so when she was a child. The doctor mentioned that he might feel compelled to call the child protective services unit for exposure of the child to the breasts of the mother. Eventually, she felt so misunderstood and uncomfortable with the therapist that she did not return to see him anymore. (Maldonado-Durán et al. personal observations)

Besides the issue of breastfeeding, Latino babies are bottlefed for extended periods of time, often until age two or three. This is in direct contrast with the recommended practice in the US not to bottlefeed beyond one year or so.

Infant crying. During the first few years of life, mothers try to keep the baby calm, as it is important to maintain a state of contentment as much as possible. Infant crying is quickly soothed by touching, carrying, feeding, and rocking. Brazelton (1972) has described in his studies in Yucatan that the baby is not left to cry but is quickly picked up or carried around, so there is not much crying. The notion of letting the baby cry, cry himself to sleep, or soothe himself is dissonant with the cultural value of maintaining a state of harmony in the child and with the value of maternal care and self-abnegation. The baby is often carried around for extended periods of time, often most of the day. When older, the baby may be taken to work supported by a shawl the mother uses for that purpose. In this way, she may be able to work and take the child to her work.

Swaddling (for the newborn and very young infant) is a technique to help the baby get a sense of security and control, which resembles in this way the condition he had in utero. It consists of tightly wrapping the infant in a blanket or piece of cloth, thereby constricting the movements of the body, particularly the limbs. It is thought that letting the baby flail around while crying might be detrimental. Other soothing techniques are used to destimulate and calm the baby. For instance, baths during the night in "water lettuce," or in water in which lettuce leaves have been left for a while, are thought to soothe and calm the baby and help the baby sleep.

An immigrant woman from Mexico brought her infant son to consultation because the baby was crying a lot at eight weeks of postnatal life, particularly during the night. Her family's theory was that perhaps the baby was frightening himself with his hands when he flailed them around without being contained. She had not wanted him to feel scared and hopeless, so she decided to try swaddling, among other maneuvers, to soothe him, which eventually led to complete recovery. (Maldonado-Durán et al. personal observation)

Culture-Bound Conditions in Pregnancy and Infancy

Culture-bound syndromes are entities, in this case, groups of behaviors and emotions, that appear mostly within a certain cultural group and have a personal meaning to the individual. Within that cultural group, the symptoms tend to be similar.

Traditionally, becoming pregnant and having a child are considered the result of the will of God rather than something over which people may have control or could "plan." This belief is changing rapidly in Latin America, particularly in urban centers. Also, pregnancy and having babies are still an identity-defining developmental task and a highly valued female function (Poma 1983). A woman is not fulfilled if she cannot be a mother. Not being able to have a child may represent a failure as a woman or spouse. The same is true of miscarriage, which may be felt as a "punishment" from God. The woman might experience shunning or rejection by others (e.g., the family of the spouse) because of that "failure."

In most countries in Latin America there is high infant mortality, plus poverty associated with precarious material conditions, a high rate of extreme poverty, and widespread malnutrition (Resnikoff et al. 1971). Until very recently, many families had experienced the death of one or even

several infants or young children, commonly due to preventable diseases like infections, dehydration, and malnutrition. Similarly, pregnancy and childbirth could be quite dangerous in the absence of medical care, surveillance, and prenatal observation. Infection is also quite possible. Several culturally valid constructions evolved to explain and cope with these problems. A common theme is the perception of external dangers to the pregnancy and to the baby. These culture-bound conceptions of disease are described in this section. A common theme to many of them is the externalization of causality. The world is perceived as full of perils surrounding vulnerable people. Due to unfortunate circumstances, these omnipresent evils can cause a disease or actually kill the baby of a pregnant woman. The most common dangers are spirits, ghosts, witchcraft, evil wishes from others, envy, and damage from ingested foods or beverages. Due to space limitations, we describe simultaneously the conditions that affect pregnancy and the baby.

The specific ways in which each cultural group understands distress, tension, illness, and health lead to conditions that can be called culture-bound; such conditions tend to be understood only in a certain cultural context. For instance, anorexia nervosa (Prince 1983; Lee 1996) and attention deficit disorder (Anderson 1996; Klasen 2000) have been thought to be bound to cultures of rich and highly industrialized countries like the US. In traditional societies, there are "illness states" that can be understood as the manifestation of traditional conceptions of distress and illness. These "folk" conditions are unique to each culture, but in this case, some of the states described here are fairly similar to those in other groups in Asia, Northern Africa, and the Middle East. They are an explanation or conception of "disorder," distress, or disease that is fairly unique to a belief system or a cultural group, although they have commonalities with those of other cultures.

Even a few decades ago, it was not uncommon for a Latin American mother to give birth to eight to twelve children, of which perhaps three or four died very young. Anthropological studies suggest that in these conditions of threat, mothers have to embrace certain beliefs about the causes of disease in order to cope with them (Grizenko and Sayegh 1992). One of the features of those causes is that it is external to the child and to the family. Something that happens to the child is introduced to, taken away from, or done to him or her, but from a source external to the family. This element of externalization appears to be crucial in order to alleviate a possible sense of guilt or personal responsibility for the disorder or even the death of the

child. Another important factor is that it is a shared belief and that these conditions can happen to anyone.

In the context of these beliefs, many signs of distress in the baby, which in other cultures could be described as excessive crying, sleep disturbance, feeding difficulties, or self-regulation problems, are interpreted as manifestations of those "folk" conditions. Such symptoms in the US are considered within the domain of infant mental health. In the traditional Latino culture, they are in the domain of magic or the supernatural. This issue should be kept in mind when there is an encounter between a "scientific" (Western) health professional and a family anchored in the ancient belief system.

These folk ailments are not described rigorously in any medical textbook, and specific beliefs and practices really vary from region to region or between different Latin American countries. Here we refer only to the most usual elements and beliefs and in each section mention the remedies for these problems. Conditions like *ataque de nervios* ("nerves") and *saladera* (bad outlook and fortune, disgrace brought about by salt as a result of evil intention or envy from another person) are culturally relevant in Latino groups (Dobkin de Rios 1981) but are not as common in the perinatal period, so they will not be reviewed here.

Damage from eclipses. Exposure of a pregnant woman to an eclipse may lead to negative effects on the pregnancy itself, that is, to miscarriage or stillbirth. Eclipses are also thought to cause a number of malformations in the baby, such as cleft lip or palate (Olavarrieta 1978), but also neural tube defects and anencephaly (a condition in which a baby is born without the brain forming completely, and which leads to the death of the baby shortly after birth). The origin of the fear of eclipses stems from the aboriginal cultures of Mesoamerica. Eclipses were intensely feared, particularly solar ones, as they were associated with the constant worry that the sun could be finished any time. In the Aztec religion, the sun needed to have its energy renewed constantly (e.g., with blood from sacrifices). Practically any malformation in the baby or negative event in the pregnancy may be attributed to an eclipse.

During the pregnancy, the woman may need to ward off this danger by constantly wearing a metallic object around her waist, tied up with a red cord. This is a preventive device, as traditionally an eclipse is not foreseeable or preventable. When she comes to the perinatal clinic to be examined, she may feel embarrassed to discuss this important precaution or explain why she has a metallic key hanging by a cord from her waist. Nevertheless, the metallic object is reassuring and helps her feel protected.

“Mal de ojo” (evil eye) and other effects of envy (witchcraft or “mal puesto”). Becoming pregnant and having a baby (particularly a baby boy) can be perceived as the height of femininity and becoming realized as a woman. They are a blessing from a patriarchal society’s point of view. These fortunes may elicit feelings of envy in others, as in other women not so blessed. Envy is a common theme and a problem in many traditional cultures (Thomas 1984). Given the closeness of family members and the general scarcity of goods and commodities, there is a great deal of emphasis on fairness and sharing. People have to follow a number of maneuvers and socially sanctioned rituals to try not to elicit envious feelings in others. These precautions may include techniques like making devaluing comments about one’s condition (for example, not to exhibit too much happiness about being pregnant but to complain that it is uncomfortable), one’s achievements, or one’s plans for the future. Causing others to feel envy could have pathogenic effects. These might include the desire in the envious person that one’s good fortune go away or change. The envy felt by someone may lead them to engage in maneuvers or rituals that would spoil the happiness in the envied person. This could include a range of actions, from talking badly about the envied person, to the practice of a witchcraft ritual to ruin that good fortune, for example, by making the baby ill or the pregnancy go badly.

Along the same lines, to reduce envy, once the baby is born, a woman or her family could minimize the beauty of the infant or the happiness they experience. Both of these things might trigger bad feelings in others. Therefore, when referring to the baby, the mother may not say “He is the most beautiful baby in the world” or “He is beautiful,” but more toned-down versions like “He is OK,” “He looks funny,” “He looks curious,” or even “He is a little ugly . . . poor thing.”

The maneuvers to avoid envy by minimizing one’s happiness and good fortune may be surprising to the observer from another culture. The mother and father, for instance, may appear rather subdued regarding the birth of their child; instead of bubbling with happiness; they often do not “brag” about the baby.

Witchcraft is done through the offices of a woman who is a “witch,” who prays and knows rituals that will induce a disease on the desired target (sometimes referred to not as a natural disease but as a *mal puesto* or imposed malady). These beliefs are quite widespread, as a recent study in Mexico dealing with people who attended the public health system suggested (Campos Navarro 1992). Around 65% of those persons interviewed

said that people can readily become sick because of these influences, and a similar proportion believed in the power of *curanderos* (folk healers) or had actually consulted with one. A specific form of damage to the pregnant woman or baby is the "evil eye" (*mal de ojo*). The infant is thought to be quite vulnerable to the effects of the evil eye (Burleigh et al. 1990). This consists of damage through "heavy eyesight" fueled by feelings of envy toward the fortunate person (Hernández Murillo 1984) or through excessive admiration of the baby by the person with heavy eyesight (Burleigh et al. 1990). The infant who is a victim of the evil eye may appear anxious and scared, have sleep difficulties, cry excessively, and fail to eat normally. Actually, many negative events or symptoms in the baby may be "explained" by evil eye. The pregnant woman who is a victim of evil eye may experience anxiety, sadness, or difficulties with the progression of the pregnancy, like not gaining weight or developing a hemorrhage.

According to evil eye custom, a person may unwittingly damage the baby by admiring him or her too long, or by making too many positive comments. The mother would worry if a person looked directly and insistently, with admiration, at her baby. The admiring person might experience a subtle envy that would be pathogenic. The evil eye is a widely held belief, in countries of Northern Africa, for instance, and in several Mediterranean countries of Europe (Leach and Fried 1972).

The threat of evil eye is warded off in the baby through several means. One may be to avoid looking too insistently at the child or admiring him or her "excessively." Another is patting the infant's head slightly after making a positive comment. This is thought to alleviate the effects of the eyesight. The mother may place a red object, like a choral bracelet or a red string around the baby's wrist as something to protect him or her from the evil eye. A seed called *ojo de venado* (deer's eye) is sold in many markets in Mexico to be placed around the child's neck or wrist, also thought to be protective.

Once the person (baby or mother) is already the victim of those influences, the remedy may be to be "cleansed" through a *limpia* (cleansing). This may be achieved by a family member or by a *curandero*. Often, an egg is passed over the body of the person to absorb the negative energy or influence. Also, a special combination of herbs is used to perform this cleansing. The bundles of herbs can be bought already made in the markets in Mexico.

"Susto" (fright) and "Muinas" (anger). It is commonly believed that a state of anger and tension during pregnancy might negatively influence the "nerves" of the pregnant woman or even the baby in utero. Therefore,

muinas (episodes of rage or intense anger) are to be avoided. The family commonly tries as much as possible to prevent their pregnant relative from receiving bad news or from getting them suddenly. Negative impressions are to be screened out; the family has a duty to “buffer” or “shield” the expecting person from negative emotions. In the arena of health care, the family may not want negative news (e.g., hypertension or a malformation in the baby) to be given to the mother-to-be, particularly if it is very bad news or affects her seriously. For instance, a diagnosis of a malignancy is commonly not revealed to the affected person in most of Latin America (and in most other traditional cultures in the world). The fear is that the person might lose hope if she were to know the diagnosis, and in a pregnant woman, this might affect the pregnancy or the baby. A health-care worker may wish to check with the spouse or family about whether certain information should be given to the pregnant woman. To “tell the truth” is not as central a value as it might be in the “typical” European American family. Regardless of culture, in many interpersonal exchanges the “truth” may be embellished, changed somewhat, or deferred in order to preserve a state of harmony, dignity, or hope in a difficult situation.

Susto refers to a state of sudden fright. Other names for this condition are *espanto* (being frightened), *pasmo* (sluggishness), or *pérdida de sombra* (loss of one’s shadow). The condition has been described in several countries in Latin America and in Asia (Rubel et al. 1992). In the mother-to-be, it can happen upon receiving bad news, seeing something frightful or scary, or encountering a threatening or scary animal. In the infant, it may occur after a fall, a sudden unforeseen experience, or witnessing something scary (e.g., violence) (Villaseñor-Bayardo 1994). When this happens the future mother’s or the baby’s “good fortune” (soul) is believed to abandon their body. The pregnant woman might show *susto* by becoming anxious, restless, unable to sleep, or very emotionally vulnerable and irritable (Logan 1993). The baby with *susto* may not sleep well, be anxious or too sober, be very easily startled or scared, cry excessively, or not eat properly. In other words, the baby might show symptoms that in the Westernized nosology might be diagnosed as disorders of sleeping, eating, or excessive crying, or as post-traumatic stress disorder.

To remedy the *susto*, the “soul” (state of well-being or good luck) needs special help to return to the person’s body. To achieve this, a *curandero* (healer) or shaman may conjure the soul to return, or administer special potions prepared with medicinal herbs, to the baby or the pregnant woman to drink in order to cure their *susto* or state of fright (Maduro 1983). The

shaman or *curandero* may pray and use special herbs to “bring the soul back” to the baby. The family may first attempt to cure the *susto* by themselves, and if the person does not improve, call the *curandero*.

Aire. *Aire* literally means “air,” but its true meaning is a symptom or disease that develops as a result of penetration of air into the body where it should not be. In the Aztec belief system, air was thought to enter the joints and other parts of the body if one was not careful or watchful. Sudden exposure to drafts or cold air was widely feared, and precautions were taken against that possibility. The belief in the danger of air is widespread in Latin America, but also in Asia (LaDu 1985). A woman in the postpartum period should not be exposed to cold drafts as they might interrupt the production of milk. Also, they may lead to an illness like pneumonia or fever because of the contrast between the cold air and the “hot” states of pregnancy and the postpartum period. A woman may come out of hospital completely wrapped; with even her head covered, and the family may experience great anxiety about her body being exposed to air, even when the weather is hot outside. Similarly, the newborn baby is considered “hot,” and therefore cold temperatures or foods could damage him. Thus, the family experiences anxiety if the baby is not sufficiently covered, even in the summertime, to prevent entrance of air in the eyes, the head, or the stomach. On examining a baby, a physician might ask the parents if it is acceptable to undress the baby. Undressing the baby without permission may make the parents fear that the baby will become ill as a result of the cold air. *Aire* is cured with herbal medicines or potions, or with “moxibustion” (creating an empty space by burning alcohol inside a glass cup and applying it to the skin on the affected area), or by pulling of the skin of the baby or woman. All of these may be dangerous to the child, particularly the moxibustion.

Caida de mollera (sunken fontanelle). Sunken fontanelle is a poorly defined condition that affects only infants and very young children. In Guatemala it is referred to as *caida de varillas* (fall of “spokes” that are thought to keep the head attached to the torso). Its most obvious sign is the perception that the central fontanelle (on top of the baby’s head) assumes a concave position (which is most often due to dehydration) as opposed to being a soft, flat surface. The baby will become listless, less responsive, and more irritable. In diagnosing sunken fontanelle it is not necessary that the actual fontanelle become concave, but the signs of irritability, sleeplessness, and discomfort in the baby may lead to the diagnosis. It is thought that the problem is a mechanical one—the fontanelle sinks due to some lack of support or to suction action from inside the head by a negative influence.

The manifestations of sunken fontanelle are irritability, intense crying, digestive difficulties, lack of appetite, and apathy in the baby.

People often think that this condition results from a sudden withdrawal of the nipple from the mouth or from a frightful experience or a fall (Kirhofer Hansen 1997). As it is conceived as a mechanical defect, parents may attempt to remedy it by turning the baby upside down and gently hitting the soles of the feet (a danger here is shaken baby syndrome when done abruptly).

There are other possible remedies. A common intervention is preventive: when the baby has a negative experience or a fall, the parent might hold the infant upside down, by its feet, to avoid the "sinking." Another is to try to restore structures to their original position by attempting to apply pressure upward on the roof of the mouth (Kay 1993).

Conclusions

We have presented an overview of the most salient cultural issues that may arise for those who work in providing health care during the perinatal period. The encounter between cultures, one modern and highly technological and "efficient," the other rooted in traditions and magical beliefs, and then transplanted, may lead to misunderstandings, clashes, and mutual criticism and mistrust. The encounter of cultures is also an opportunity for an exchange of ideas and practices and for mutual understanding and respect. We have attempted to highlight some of the common themes and concerns of Latinos in order to aid the understanding of immigrants and their way of thinking, feeling, and relating.

One of the most important needs is to provide culturally sensitive health care. Rather than misperceive some of the traditional beliefs and health practices as antiquated or alien, health-care staff can take advantage of some of the strengths of traditional immigrant Latino families (Mendoza and Fuentes-Afflick 1999), such as the emphasis on family support (Berry 1999), culturally prescribed care practices for the pregnant mother and for the baby, and the importance assigned to the role of being a mother, among others.

References

- Ammaniti, M.C., M. Candelori, R. Pola, and R. Tambelli. 1999. *Maternité et Grossesse* [Maternity and pregnancy]. Paris: Presses Universitaires de France.

- Anderson, J.C. 1996. Is childhood hyperactivity a product of Western culture? *Lancet*, 348:73-4.
- Berry, A.B. 1999. Mexican American women's expressions of the meaning of culturally congruent prenatal care. *Journal of Transcultural Nursing* 10:203-12.
- Bird, H.R. 1981. The sociopsychiatry of spiritism. *Journal of the American Academy of Child Psychiatry* 20:725-40.
- Brazelton, T.B. 1972. Implications of infant development among the Mayan Indians of Mexico. *Human Development* 15:90-111.
- Burleigh, E., C. Dardano, and J.R. Cruz. 1990. Colors, humors and evil eye; indigenous classification and treatment of childhood diarrhea in highland Guatemala. *Medical Anthropology* 12:419-41
- Campos Navarro, R. 1992. Prácticas médicas populares: Algunas experiencias sobre el proceso de autoatención curativa [Popular medical practices: Some experiences on the process of self-prescription and cure]. In *La Antropología Médica en México* [Medical anthropology in Mexico], ed. R. Campos, 186-208. México City: Universidad Autónoma Metropolitana.
- Cosminsky, S. 1992. La atención del parto y la antropología médica [Care during delivery and medical anthropology]. In *La Antropología Médica en México* [Medical anthropology in Mexico], ed. R. Campos, 139-68. México City: Universidad Autónoma Metropolitana.
- Dobkin de Rios, M. 1981. Socioeconomic characteristics of an Amazon urban healer's clientele. *Social Science and Medicine* 15B:51-63.
- Escobar, J.I. 1987. Cross-cultural aspects of the somatization trait. *Hospital Community Psychiatry* 38:174-80.
- Fabrega, H. 1990. Hispanic mental health research: A case for cultural psychiatry. *Hispanic Journal of Behavioral Sciences* 12:339-65.
- Falicov, C., and B. Karrer. 1980. Cultural variations in the family life cycle: The Mexican American family. In *The Family Life Cycle and Family Therapy*, ed. E. Carter and M. McGoldrick, 134-63. New York: Gardner Press.
- Flores, G., M. Abreu, M.A. Olivar, and B. Kastner. 1998. Across barriers to healthcare for Latino children. *Archives of Pediatric and Adolescent Medicine* 152:1119-25.
- García Coll, C.T., and H.A. Vazquez García. 1995. Hispanic children and their families: On a different track from the very beginning. In *Children of Poverty: Research, Healthcare and Policy Issues*, ed. H.E. Fitzgerald, B.M. Lester, and B. Zuckerman, 857-63. New York: Garland.

- Ginzberg, E. 1991. Access to healthcare for Hispanics. *Journal of the American Medical Association* 265:248-52.
- Grizenko, N., and L. Sayegh. 1992. The role of transcultural child psychiatry: Clinical applications and recommendations. In *Transcultural Issues in Child Psychiatry*, ed. N. Grizenko, L. Sayegh, and P. Migneault, 179-218. Montreal: Éditions Douglas.
- Gureje, O. G.E. Simon, T.B. Ustun, and D.P. Goldberg. 1997. Somatization in cross-cultural perspective: A World Health Organization study in primary care. *American Journal of Psychiatry* 154(7):989-95.
- Guzder, J. 1992. Transcultural themes for families of Indian origin: Relevant issues for child psychiatric interventions. In *Transcultural Issues in Child Psychiatry*, ed. N. Grizenko, L. Sayegh, and P. Migneault, 131-47. Montreal, Canada: Éditions Douglas.
- Hernández, D.J. 1999. Children of immigrants. One-fifth of America's children and growing: their circumstances, prospects and welfare reform. Master lecture at biennial meeting of the Society for Research in Child Development, 15-18 April, at Albuquerque, New Mexico.
- Hernández Murillo, R. 1984. El mal de ojo: Un estudio en comunidades indígenas [The evil eye: A study in indigenous communities] In *La Medicina Invisible: Introducción al Estudio de la Medicina Tradicional en México* [Invisible medicine: Introduction to the study of traditional medicine in Mexico], ed. X. Lozoya and C. Zolla, 2d ed., 150-62. 150-62. México City: Folios Ediciones.
- Holland, W.R. 1978. *Medicina Maya en Los Altos de Chiapas* [Mayan medicine in the highlands of Chiapas], 76-77. México City: Instituto Nacional Indigenista.
- Ijima-Hall, C.C. 1997. Cultural malpractice: The growing obsolescence of psychology with the changing US population. *American Psychologist* 52 (6): 642-51.
- Katon, W., R.K. Ries, and A. Kleinman. 1984. The prevalence of somatization in primary care. *Comprehensive Psychiatry* 25:208-15.
- Kay, M.A. 1993. Fallen fontanelle: culture-bound or cross-cultural? *Medical Anthropology* 15:137-56.
- Kearney, M. 1984. Los conceptos de aire y susto: Representaciones simbólicas del ambiente social y geográfico percibido [The concepts or "air" and "fright": Representations of the perceived social and geographical environment]. In *La Medicina Invisible. Introducción al Estudio de la Medicina Tradicional en México* [Invisible Medicine: Introduction to the Study of Traditional Medicine in Mexico], ed. X. Lozoya and C. Zolla, 2d ed. 130-49. México City: Folios Ediciones.

- Kirhofer-Hansen, K. 1997. Folk remedies and child abuse: A review with emphasis on *caida de mollera* and its relationship to shaken baby syndrome. *Child Abuse and Neglect* 22 (2):117-27.
- Klasen, H. 2000. A name: What's in a name? The medicalization of hyperactivity, revisited. *Harvard Review of Psychiatry* 7:334-44.
- Kumar, R. 1994. Postnatal mental illness: A transcultural perspective. *Social Psychiatry and Psychiatric Epidemiology* 29:250-64.
- LaDu, E.B. 1985. Childbirth care for Hmong families. *Maternal Child Nursing* 10:382-88.
- Leach, M., and J. Fried, eds. 1972. *Funk & Wagnalls Standard Dictionary of Folklore, Mythology and Legend*, 359, 837. San Francisco: Harper San Francisco.
- Lee, S. 1996. Reconsidering the status of anorexia nervosa as a Western culture-bound syndrome. *Social Science in Medicine* 42:21-34.
- Lipson, J.G., S.L. Dibble, and P.A. Minarik. 1996. *Culture and Nursing Care*. Los Angeles: USCF Nursing Press.
- Littlewood, R. 1990. From categories to contexts: A decade of the "new transcultural psychiatry." *British Journal of Psychiatry* 156:308-23.
- Logan, M.H. 1993. New lines of inquiry on the illness of *susto*. *Medical Anthropology* 15:189-200.
- López-Austin, A. 1984. La polémica sobre la dicotomía frío-calor [The polemics around the hot-cold dichotomy]. In *La Medicina Invisible: Introducción al Estudio de la Medicina Tradicional en México* [Invisible medicine: Introduction to the study of traditional medicine in Mexico], ed. X. Lozoya and C. Zolla, 2d ed., 73-90. México City: Folios Ediciones.
- Lozoff, B., G.L. Askew, and A.W. Wolf. 1996. Cosleeping and early childhood sleep problems: Effects of ethnicity and socioeconomic status. *Developmental and Behavioral Pediatrics* 17:9-15.
- Maduro, R. 1983. Curanderismo and Latino views of disease and curing. *Western Journal of Medicine* 139:868-74.
- Maldonado-Durán, J.M, T. Lartigue, and M. Feintuch. 2000. Perinatal psychiatry: Infant mental health interventions during pregnancy. *Bulletin of the Menninger Clinic* 64:317-43.
- Marín, G., and B. Marín. 1991. *Research with Hispanic populations*. Newbury Park, CA: Sage Publications.
- Mendoza, F.S. 1994. The health of Latino children in the United States. *Future Child* 4:43-72.

- Mendoza F.S., and E. Fuentes-Afflick. 1999. Latino children's health and the family-community health promotion model. *Western Journal of Medicine* 170:85-92.
- Moro, M.R. 1998. *Psychothérapie Transculturelle des Enfants Migrants* [Transcultural psychotherapy of migrant children]. Paris: Dunod.
- Moro, M.R., and J.A. Barriguete. 1998. Aspectos transculturales de la alimentación del lactante [Transcultural issues in infant feeding]. In *La Alimentación y Sus Efectos en el Desarrollo* [Feeding and its effects on development], ed. T. Lartigue, J.M. Maldonado, and H. Ávila, 337-62. México City: Editorial Plaza y Valdez & Asociación Psicoanalítica Mexicana.
- Moro, M.R., and T. Nathan. 1999. Ethnopsychiatrie de l'enfant [Child ethnopsychiatry]. In *Nouveau Traité de la Psychiatrie de l'Enfant et de l'Adolescent* [New textbook of child and adolescent psychiatry], ed. S. Lebovici, R. Diatkine, and M. Soule, vol. 3., 423-43. Paris: Presses Universitaires de France.
- Olavarrieta, M. 1978. *Magia en los Tuxtlas, Veracruz* [Magic in the area of the Tuxtlas, Veracruz], 59-146. México City: Instituto Nacional Indigenista.
- Pérez-Stable, E.J. 1987. Issues in Latino health care. *Western Journal of Medicine* 146:213-18.
- Phinney, J.S., A. Ong, and T. Madden. 2000. Cultural values and intergenerational value discrepancies in immigrant and non-immigrant families. *Child Development* 71:528-39.
- Poma, P.A. 1983. Hispanic cultural influences on medical practice. *Journal of the National Medical Association* 75:941-46.
- Prince, R. 1983. Is anorexia nervosa a culture-bound syndrome? *Transcultural Psychiatry Research Review* 20:299-300.
- Pury-Toumi, S. 1997. *De Palabras y Maravillas* [Of words and marvels]. México City: Ed. Regiones.
- Resnikoff, R., S. Pustilnik, and D. Resnikoff. 1971. Mexico: Struggling for a better future. In *Psychiatry around the globe*, ed. J. Leff, 184-202. London: Dekker (Royal College of Psychiatrists).
- Riser, A.L., and L.J. Mazur. 1995. Use of folk remedies in a Hispanic population. *Archives of Pediatric and Adolescent Medicine* 149:978-88.
- Rogoff, B., J. Mistry, A. Goncu, and C. Mosier. 1993. Guided participation in cultural activities by toddlers and caregivers. *Monographs of the Society for Research in Child Development* 58:1-174.

- Rubel, A.J., C.W. O'Neill, and R. Collado Ardán. 1992. Introducción al susto [Introduction to fright]. In *La Antropología Médica en México* (Medical anthropology in Mexico), ed. R. Campos, 105-20. México City: Universidad Autónoma Metropolitana.
- Scheper-Hughes, N. 1992. *Death without Weeping: The Violence of Everyday Life in Brazil*. Berkeley: University of California Press.
- Scheper-Hughes, N., and C. Sargent. 1998. The cultural politics of childhood. In *Small Wars: The Cultural Politics of Childhood*, ed. N. Scheper-Hughes, and C. Sargent. 1-33. Berkeley: University of California Press.
- Stork, H. 1986. *Enfances Indiennes: Étude de Psychologie Transculturelle et Comparée du Jeune Enfant* [Indian childhood: Study of the compared transcultural psychology of the young child]. Paris: Paidós-Le Centurion.
- Thomas, N. 1984. La brujería como una concomitante de la envidia [Witchcraft as a concomitant of envy]. In *La Medicina Invisible: Introducción al Estudio de la Medicina Tradicional en México* [Invisible medicine: Introduction to the study of traditional medicine in Mexico], ed. X. Lozoya and C. Zolla, 2d ed., 186-200. México City: Folios Ediciones.
- Viesca-Treviño, C. 1992. *Medicina Preshispánica de México* [Pre-Hispanic medicine in Mexico] Mexico City: Ed. Panorama.
- Villaseñor-Bayardo, S.J. 1994. Ébauche d'Ethnopsychiatrie Nahuatl [Outline of Nahuatl ethnopsychiatry]. *Annales Médicales-Psychologiques* 152 (9):589-99.