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I am submitting herewith a dissertation written by Emma Kathleen Wright entitled “How Mexican-American women define health: Cultural beliefs and practices in a non-native environment.” I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Communication and Information.

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How Mexican-American women define health: Cultural beliefs and practices
in a non-native environment

A Dissertation Presented for
the Doctor of Philosophy
Degree
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Emma Kathleen Wright
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Dedication

To my parents, Creg and Shirley Bishop, who have provided unfailing support, love, and guidance throughout all of my life and academic endeavors.

To my partner, George Wertz, whose love, support, patience, and pep talks are a constant.
Hey, you're right. I can do it!

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Abstract

Culture impacts the ways people evaluate and respond to health and illness. As a result, Mexican-American culture plays a part in how women take care of their health and react toward the threat of breast cancer. Using previously identified dominant cultural factors that may influence the health of Mexican-American women as a foundation, this qualitative study describes how Mexican-American women define and maintain health, particularly breast health.

Hispanics are the fastest growing minority group in the United States. As a result, it is important to better understand how Mexican-American women define health and take care of themselves. Doing so will not only provide richer insights into the health behaviors of women but provide insights into family health behaviors. This study is important because it adds to the current body of knowledge by investigating the cultural beliefs of Mexican-American women, a sub-group within the larger Hispanic ethnic category. While several researchers have studied the cultural beliefs of Hispanics, it is imperative that scholars begin to further investigate the cultural beliefs of the sub-groups within the larger Hispanic ethnic category. In addition, previous studies have primarily been conducted in states that border Mexico, thus providing an opportunity for this study to contribute to the current body of literature by giving a voice to Mexican-American women in the southeast.

Using a grounded theory approach, ten in-depth interviews were conducted with Mexican-American women in the southeast. The main theme that emerged from the data was: The Maintenance of Health through Traditional Practices in a Non-native

Environment. Two thematic constructs that participants engage in helped to describe how the women in the study maintain health in a traditional manner when they live in a non-native environment: (1) the belief that health is a combination of the body and mind and (2) the belief that health care is a Mexican woman's responsibility.

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Chapter I

INTRODUCTION

Culture, defined as the values, beliefs, and rules of behavior shared by a group, guides decisions and actions (Leininger, 2001). This means history and experiences of a cultural group is key to understanding the social and cultural factors of health (Wenger, 1993). For example, Mexican-American culture plays a part in how women react toward the threat of breast cancer, as culture impacts the ways people evaluate and respond to health and illness (Kavanagh & Kennedy, 1992).

Health is the state of wellbeing that is culturally defined or valued (Leininger, 2001), and includes the social and biological activities of individuals contributing to health or changing conditions that are deemed unacceptable (Bauwens & Anderson, 1988). As such, a person's health reflects his or her ability to participate in activities that are culturally meaningful and beneficial according to socially established patterns (Leininger, 2001). When discussing health, the cultural implications of illness must be investigated. The way an individual defines illness, which is often based on cultural assumptions that involve more than symptoms of pain (Sobralke, 1985), is important because it often forms the basis for the perceptions of what is needed and decisions about why, how, for what purpose, and when he or she will seek health care (Fabrega, 1973). The concept of illness includes considering problems with physical, emotional, spiritual, mental, and psychological matters (Sobralke, 1985). In turn, cultural beliefs, values, family traditions, social structure, and an individual's worldview have an impact on how individuals respond to stress, pain, and illnesses. This means that culture is an integral

part of an individual's overall health and health care seeking behavioral processes (Leininger, 2001).

Factors Contributing to Health Perceptions and Behavior

Each culture has unique attributes that set it apart from other cultures (Kavanagh & Kennedy, 1992). Previous research has identified several dominant cultural factors that may influence the health of Mexican-American women. First, family plays an important role in health care from decision making (Reinert, 1986) to social support (Napoles-Springer, Sanotya, Houston & Perez-Stable, 2005) to caregiving (McCarthy, Ruiz, Gale, Karam & Moore, 2004). In addition, women are usually responsible for maintaining the health of their family (John, Resendiz & Vargas, 1997), and they may use utilize a variety of methods including folk health practitioners (Gonzalez-Swafford & Gutierrez, 1983; Lopez, 2005). Finally, Mexican-American women may be modest or embarrassed about some physical exams or sexual topics (Napoles-Springer et al., 2005; Reinert, 1986) and prefer unhurried interactions with their medical providers, often expecting social interactions as part of the visit (Clark, 2002).

When working with migrant groups, acculturation is also an important factor. Acculturation, or the change that occurs as members of one cultural group enters another culture, impacts established ideas about health as individuals manage, maintain, and sustain their original cultural values within a culture that is different from their own (Keefe, 1992). As such, acculturation influences Mexican-American women's health perceptions and decisions. For example, research supports that a Mexican-American woman's health may be affected by length of time in the United States (McKenna, 1989),

familiarity with majority culture and English language (Melville, 1980), and amount of exposure to those outside the Mexican-American community (Clark & Hofsess, 1998; Melville, 1980; Negy & Woods, 1992).

Investigating Mexican-American Women's Health

There are several reasons this study will focus on how Mexican-American women define and take care of health, particularly their breast health. First, it is imperative that researchers begin to further investigate the cultural beliefs of the sub-groups within the larger Hispanic ethnic category. Currently, the federal government defines Hispanic or Latino (these terms are often used interchangeably) as a person of Mexican, Puerto Rican, Cuban, or South or Central American, or other Spanish culture or origin regardless of race. Thus, Hispanics may be of several races (U.S. Census Bureau, 2000). While the larger Hispanic group shares a common ancestral language, categorizing them together in one ethnic category in health care literature is problematic. This is especially evident in health agencies that often collect data using the broad identifier of Hispanic, which can be detrimental as each group has their own distinct culture. Generalizing about all Hispanics can overlook the diverse history and specific cultural identity, and health needs, of each subgroup (Torres, 1996).

This study will add to the current body of knowledge by filling a gap in the literature as it will investigate the meaning-making of Mexican-American women in relation to their health and breast health. Very few studies have focused on this specific group and topic. The few studies that do investigate the individual sub-ethnic groups within the larger Hispanic group find different responses in regard to health behaviors.

For example, Garbers, Jessop, Foti, UribeArrea, and Chiasson (2003) investigated the barriers to breast cancer screening for low-income Mexican and Dominican women. In their study, Mexican-American women most frequently cited shame and embarrassment or not having money as barriers to having mammograms while Dominican women cited fear or not having health insurance as barriers.

In addition, Mexican-American women are the primary health care providers in their family, with medical information passed from mother to daughter. As such, women are responsible, through a process of discussing symptoms with family and friends, for deciding when an illness is beyond their ability to treat. Women may also consult folk healers before utilizing scientific health care treatment or physicians. This process means that both traditional and scientific medicine is often used (Gonzalez-Swafford & Gutierrez, 1983). As the fastest growing minority group in the United States (U.S. Census Bureau, 2000), it is important to better understand how Mexican-American women define health and take care of themselves. Doing so will not only provide richer insights into the health behaviors of women but provide insights into family health behaviors.

Finally, previous studies have primarily been conducted in states that border Mexico, such as California, Texas, Arizona, and New Mexico, with a lack of research outside the southwest. This has drawn criticism from researchers (Schreiber & Homiak, 1981), thus providing an opportunity for this study to contribute to the current body of literature by giving a voice to Mexican-American women in the southeast.

Purpose and Research Question

The purpose of this study is to describe how Mexican-American women define and take care of health, particularly their breast health. Using the existing body of literature about Mexican-American women's health as a starting point, the researcher intends to describe this phenomenon in a way that will allow various health communication stakeholders, including those involved in public relations, community health, and public health, to better understand the thought processes that Mexican-American women go through as they make decisions about their health in a non-native culture. A qualitative approach was selected to allow women to discuss health in their own words, and grounded theory was used to allow the researcher built theory as data was gathered and analyzed. The following research question was stated: How do Mexican-American women define and take care of health, particularly their breast health.

Chapter II

LITERATURE REVIEW

This qualitative study investigates how Mexican-American women define and take care of health, particularly their breast health. Following a grounded theory approach, technical literature, which includes “reports of research studies and theoretical or philosophical papers, ...can serve as background materials against which one compares findings from actual data gathered” (Strauss & Corbin, 1990, p. 48). As a result, the following pages include a review of literature related to culture, communication, health, acculturation, and Mexican-American health. The following is examined: (1) communication and culture (2) the process of acculturation (3) the relationship between Mexican-American health and acculturation (4) the relationship between Mexican-American culture and health.

Communication and Culture

“Communication is the development, adoption, and transmission of messages between and among people to achieve some desired effect” (Hill & Dixon, 2006, p. 70). During the communication process, information is transferred among two or more social systems in a purposeful manner. The social systems within which the exchange takes place are embedded within a larger suprasystem or cultural environment that contextually binds the overall process (Barnett & Lee, 2002). Culture is the values, beliefs, norms, rules of behavior, and lifestyle practices of a particular group of people that are learned and shared, and then used to guide thinking, decisions, and actions in a pattered manner (Leininger, 2001). All societies have culture that helps to define and set them apart from

others (Kavanagh & Kennedy, 1992). Recognizing a group's culture or shared beliefs, values, and behaviors can be helpful as we attempt to better understand the meanings a group attributes to life experiences (Helman, 2007).

Communication and culture influence each other. The culture in which individuals are socialized influences the way they communicate, and the way that individuals communicate can change the culture they share over time (Gudykunst, 1997). Hall (1959) stated that communication is culture and culture is communication. Culture is a created system of explicit and implicit designs for living that are shared by all or specifically designated members of a group at a specific point in time. It can be exhibited in habits and tendencies to act in certain ways, language patterns, values, attitudes, beliefs, customs, and thought patterns. In other words, culture is considered the property of a group as the meanings that are attributed to verbal and nonverbal communication are determined by society as a whole. Without a general consensus, the meanings of symbols and group interactions would be impossible to determine.

Culture as Static or Dynamic—Varying Perspectives

When evaluating communication and culture literature, two different perspectives emerge, which can be described as static and dynamic based on how one views culture. The first assumes culture is represented by a group who collectively participates in specific activities and rituals. As a result, culture resides in the collective minds of people within a community, with people using culture as a guide or set of social rules that they may rely on in social situations (Murdock, 1945). Culture is viewed as external to the individual and as such it is static. People are simply used as vessels, carrying culture with

them from one generation to the next (Kessing, 1974). As a result, this more positivistic perspective of culture suggests it has specific qualities that can be measured and predicted.

On the other hand, culture can be perceived as a learned set of patterns or shared perceptions that reside in an individual's mind. This viewpoint is more compatible with the current study and assumes that culture is ever-changing as people constantly learn and participate in their culture. This perspective believes culture is comprised of various symbols such as language and art that make up an intricate system of meanings. In turn, individuals use these resources, which are often shared with family members or those that have close relationships, as they make decisions. Culture is considered flexible, as it involves a variety of experiences and interpretations that result in multiple beliefs, values, and behaviors (Geertz, 1973; Schneider, 1980). These presumptions result in a more interpretivistic approach to research, allowing researchers to observe participants within a given context.

Dutta (2007) discussed context in terms of the rich web of intertwined local environments within which health meanings are continually negotiated. As such, context is the setting where life is lived, making contexts static and dynamic. Dutta (2007) argued that contexts help to connect local cultural systems with broader social structures as meaning is constructed. In other words, "contexts are the conduits that connect the local and the global, and that provide the reference in the backdrop of which meanings are articulated and negotiated" (p. 321).

Communication Among Different Cultures

When discussing culture and communication, some use the terms intercultural and cross-cultural communication interchangeably. However, Gudykunst (2003) differentiated between the two as he stated that intercultural communication is generally defined as the face-to-face communication between people of different cultures, or the study thereof. He defined cross-cultural communication as an area of research within intercultural communication that compares the face-to-face communication across cultures. When studying intercultural and cross-cultural communication, he noted the process of communication between people from different cultures or subcultures is the same as the process of communication between people from the same culture or subculture.

When researching the link between the culture and communication, studies usually fall into one of two categories, etic or emic. While the two are certainly not exclusive, it seems that an etic approach to cultural communication may be more in line with cross-cultural communication while an emic approach may be more closely aligned with intercultural communication. Emic research, which is more applicable to this study, focuses on describing a culture from the perspective of the members of the culture being examined (e.g. Gao, 1998; Garcia, 1996; Hecht, Ribeau & Sedano, 1990). The goal is to understand the culture as a member of the culture understands it. On the other hand, etic researchers often seek to examine culture in terms of dimensions of cultural variability in order to explain differences or similarities in communication behavior across cultures (e.g. Carbaugh, 2000; Fitch, 1991; Hecht, Collier & Ribeau, 1993; Miyahira, 1999). This

means that certain aspects of the culture are selected and categorized and then compared to the same selections from another culture (Pike, 1966).

Postulates, Ends, and Means: Components of Culture

Three components of culture have an impact on communication: postulates, ends, and means. Postulates are the things we often take for granted, or the everyday “facts of life.” These facts may be unconscious assumptions we learn as we are socialized into a culture (Olsen, 1978). Each social group has these worldviews, which are comprised of belief and value systems that allow members to evaluate and attach meanings to the reality that surround them. However, people may have a difficult time articulating this worldview because they are often learned through an unconscious process and are simply accepted by many as “the way things are” (Kraft, 1978).

Postulates often include how one defines self, a person’s relationship to others, or his or her relationship to the environment or supernatural phenomena (Olsen, 1978). A person must understand cultural postulates in order to make predictions about behavior as he or she communicates with those from another culture. By attempting to understand the postulates guiding another’s communication behaviors, there is increased opportunity to predict behavior and decreased likelihood of misunderstandings (Gudykunst & Kim 1984).

Cultural values are shared understandings of the desired ends of social life, or where one hopes to finish in a given situation. They express a collective view of what is important or unimportant, good or bad (Olsen, 1978). Simply stated, values are the desired outcome, or end, of social life (Triandis, 1967). Values also inform the ends an

individual hopes to attain in his or her life. Because values are fuelled by both culture and group memberships, understanding the values of those with which one wishes to communicate increases the ability to make both cultural and socio-cultural predictions about a group (Gudykunst & Kim, 1984).

Being familiar with cultural norms and rules can also help one determine what is the acceptable and unacceptable means for reaching the ends of social life (Olsen, 1978). The norms and rules of communication vary across cultures, and behavioral expectations tend to be violated more often when one communicates with those who are from a culture that is different from his or her own (Gudykunst & Kim, 1984). These norms are important as they are the basis for rules that allow members of a culture to spontaneously engage in everyday life and social behaviors without having to constantly guess at how they should behave or wonder what other people are going to do. It is these rules and norms that help to establish expected behaviors for particular situations. In other words, cultural postulates, ends, and means all influence the way individuals and groups encode messages and decode incoming stimuli when communicating with those that are different from themselves (Olsen, 1978).

Socio-cultural Influences

Socio-cultural influences, or the social relationships within a culture that are involved in the social ordering processes, impact communication. These relationships develop as interactions with others become consistent behaviors or patterns. This means socialization within a culture and the social relationships that are formed influences the way one communicates. Three major socio-cultural influences that impact

communication with those that are different than ourselves include: membership in social groups, role expectations, and the definition of interpersonal relationships (Gudykunst & Kim, 1984).

Individuals are usually members of groups because he or she is born into them such as families, racial or ethnic groups, age groups, and gender groups; or people are members because they join them such as service, occupational, religious, and ideological groups. Group members tend to reinforce other members' established social behaviors or norms since members usually have a shared set of values. As a result, these memberships impact communication with those outside the group or those that are different (Gudykunst & Kim, 1984).

Communication with another person is based on predictions that are made about them. These predictions are often based on the groups that a person is a part of or the positions a person holds. For example, there are certain role expectations for a physician, teacher, student, mother, father, or priest. In turn, these expectations influence the interpretation of behaviors and the predictions made about individuals. It is important to note that while role expectations vary within any culture, there is a greater tendency for variance across cultures (Sarbin & Allen, 1968). Knowing the role expectation of someone from another culture can help avoid inaccurate interpretations and predictions about their behavior, or assist with effective communication (Gudykunst & Kim, 1984).

Interpersonal relationships differ from role relationships as they involve the use of psychocultural data, or that involving cognitive processes and attitudes. This means taking into account the different ways interpersonal relationships, such as causal friends,

close friends, or lovers, are defined and negotiated. Understanding these relationships influences communication with people involved in these relationships. For example, the way a given relationship is interpreted influences how incoming stimuli is interpreted and the predictions that are made about the behavior of others involved. Being unaware of how others define interpersonal relationships can lead to misinterpretations of their behavior and inaccurate predications about how they will behave (Gudykunst & Kim, 1984).

Finally, the environment in which communication occurs also influences how messages are encoded and decoded. As a result, the location, climate, and setting as well as the perception of the environment all influence how incoming messages are interpreted and the predictions that are made about other's behavior (Gudykunst & Kim, 1984). For example, a "physician asking a member of the opposite sex to remove his or her clothes means one thing in the physician's office, but an entirely different thing in a bedroom; the context tells the receiver how to interpret the message" (Deutsch, 1961, p. 398). Hall (1976) discussed environment as part of the context within which communication occurs. As a result, the influence of context or environment on behavior and communication can be expected to vary across cultures.

The Process of Acculturation

As members of one distinct cultural group enter an environment where another distinct culture exists, there is an opportunity to observe changes that occur. Keefe (1992) discussed acculturation as the process through which the members of one group enter a new environment while managing, maintaining, and sustaining their original cultural

values. During this process, change occurs as a result of the continuous contact between cultural groups. Generally defined in terms of one group of people assuming the cultural traits of another group (Negy & Woods, 1992), acculturation usually denotes the process by which an ethnic group adopts the culture of the dominant group it is joining (Mena, Padilla & Maldonado, 1987). As a result, acculturation has been measured accordingly, meaning the values and traits of the dominant culture are traditionally used as the standard with the assumption that movement toward that standard is preferable.

Teske and Nelson (1974) noted that acculturation is a bidirectional process that does not require changes in values within the acculturating group. This is different from the assimilation process or the acceptance of mainstream cultural elements of the host society by an individual (Kim, 2005). Assimilation involves the individual fully and freely integrating into and identifying with the societal, economic, and political life of the majority population (Clark & Hofsess, 1998). During the assimilation process, which is unidirectional, Teske and Nelson (1974) posited value changes are required within the assimilating group. Huff and Kline (1999) argued that for assimilation to occur there is generally some change in acculturation such as language, values, laws, or customs. However, because people may resist many of the dominant culture's values, there may be very little cultural assimilation.

Two dimensions of culture are important to the measurement of acculturation; one is psychosocial and includes identity, which is based on self-identity, and the other is socio-demographic, which includes variables such as the number of years in the United States, the ability to speak the dominant language, and educational level. These

dimensions intersect in the area of health as the strength of cultural beliefs and practices often influence health status, use of health care services, and health outcomes (Cuellar, Harris & Jasso, 1980).

Acculturation in Mexican-American Women

Mexican Americans have been more persistent than most ethnic minorities in the United States when it comes to maintaining their language, cultural beliefs, and traditions (Moore & Cuellar, 1970). This might be attributed to the close proximity of the United States to Mexico, which has helped Mexican Americans retain many of their oral traditions and folk practices which can be seen in domestic life, including the maintenance of health (Magana & Clark, 1995). Melville (1980) described four elements that promote acculturation within the group: attitudinal facilitators, cogitative facilitators, behavioral facilitators, and cultural brokers. Attitudinal factors are those attitudes and values that cause an individual to be ready to adapt and accept to those elements of a culture that are different than his or her own. For example, the act of migrating usually indicates a readiness to adapt a new life, but maybe not to give up previous values and social relationships. Mexican-American women were more willing to adapt to changes when they saw benefits such as better pay or that it led to improved living situations. In fact, Melville (1980) posited that class aspiration was the primary factor in attitudinal acculturation with either the values provided by class membership or the aspiration toward membership promoting acculturation as Mexican-American women took steps to learn about and adapt to the majority culture.

Cognitive factors include information and familiarity with the majority culture, or methods by which Mexican-American women gain this information. Knowledge of the English language was the most important of these as it allowed the women to more easily navigate their communities and its various activities and services. Second in importance was education as it was closely related to class status and class aspiration. Melville (1980) found that those who had received secondary education found it easier to learn English, date non-Hispanic White men, enjoy majority media, and adapt to the majority culture.

In addition, Melville discussed that Mexican-American men often acculturate more quickly than Mexican-American women because of certain behavioral facilitators, or activities, such as employment and shopping, that promote positive contact with the majority culture. In other words, women who work in jobs that put them into contact with the majority population, such as sales or restaurants, seem to acculturate more quickly than those who are work in a more closed job, such as a factory. This meant that women who worked in the home were isolated and had a limited opportunity to acculturate. Similarly, those who were dependant on others, usually men, to complete errands such as shopping were often unsure of themselves and failed to acculturate (Melville, 1980).

Melville (1980) identified three types of cultural brokers, or people or organizations that provide aid to individuals as they become familiarized with the majority culture. First, Mexican-American children were identified as brokers because their mothers were introduced to many facets of the majority population such as holidays, national heroes, and social concerns. Relatives who precede new migrants were also

brokers for acculturation as they were sources of support and information as they introduced Mexican-American women to a variety of medical facilities, schools, and other services. Lastly, service institutions were brokers as they may provide Mexican-American women with guidance and classes in anything from English to driving.

The Relationship Between Mexican-American Health and Acculturation

Traditional Measures of Acculturation's Impact on Health

Acculturation and socioeconomic status are often closely linked. For example, as individuals become more acculturated they are more likely to have higher incomes and levels of education. Specifically, as there are increased levels of acculturation and income, studies have shown people are more likely to use health care services (Deyo, Deihl, Hazuda & Stern, 1985). As a result, low socioeconomic status has been shown to have a significant negative outcome on health. This is important because ethnic minority women have lower socioeconomic status than do their non-Hispanic White counterparts (Schulz, Krieger & Galea, 2002).

Socioeconomic status also impacts a person's ability to pay for health insurance. While it is often difficult to estimate health insurance numbers for Mexican Americans because of the significant number of undocumented immigrant Mexican-American workers (Franks, Clancy, Gold & Nutting, 1993), research suggests that approximately 33% of Mexican Americans are uninsured (Trevino, Moyer, Valdez & Stroup-Benham, 1991). While a lack of insurance limits access to health care and can have a negative impact on health, Garbers et al. (2003) posited that simply increasing access to health care services, such as mammography screenings, may not increase participation among

the Hispanic population. She argued that while health initiatives often address poverty barriers, such as providing free mammography and cancer screenings, women still fail to participate.

Isolating the language spoken by individuals as primary variable to measure acculturation is also common. For example, Stein, Fox, and Murata (1991) investigated if the level of understanding and knowledge about the risks and symptoms associated with breast cancer could be related to acculturation as they focused on women who speak English as a second language. As they examined the link between language spoken and the use of preventative health screenings, they found a correlation between mammography use among Hispanic women and their level of English language use and proficiency. Among Hispanic women that participated in the study, they found that those who requested interviews in Spanish were significantly underscreened, with 86% never having had a mammogram. Participants who elected to conduct their interviews in English had a mammography rate of more than 47%, which was only slightly lower than the non-Hispanic White and Black women that participated in the study. Stein et al. (1991) claimed this shows that acculturation plays a role in Hispanic women's preventative screening behaviors. Marks et al. (1987) had similar findings as they examined several acculturation variables, including language, country of origin, contact with homeland, and parental expectation of children. The researchers found that only language was predicative of breast cancer screening behavior among elderly Hispanic women, with those who used English having participated in screenings more frequently.

In addition, studies that relied on language as the primary variable to identify acculturation also found use of English correlated with fewer perceived barriers to medical care (Chesney, Chavira, Hall & Gary, 1982). However, researchers focusing on language spoken also found that as Mexican-American women become more acculturated they are more likely to participate in risky behaviors such as sex with multiple partners (Nyamathi, Bennett, Leake, Lewis & Flaskerud, 1993), using tobacco (Palinkas, Pierce, Rosbrook, Pickwell & Bal, 1993), and drinking alcohol (Black & Markides, 1993).

Broadening Acculturation Variables in Relation to Health

While many researchers use language as a primary acculturation variable, Molina and Aguirre-Molina (1994) posited language alone fails to measure core beliefs and practices within the Hispanic population in relation to specific health and medical conditions. As a result they called for research that further defines and measures the role these beliefs and practices have in relation to health, a dynamic process that is constantly changing. Specific to the Hispanic population, the researchers suggested exploring how cultural beliefs influence the use of health care services, definitions of health and illness, family roles and values, the perceived role of the health provider, the importance of folk beliefs, and the role of traditional health practices and healers. For example, many Hispanic immigrants experience levels of cultural shock as they relocate to a foreign environment, which is often overlooked by health care providers, even though it can have a significant impact on their health. In addition, some Hispanics reported they fear computerized medical records used by physicians would be used to deport them. Some felt they received inhumane treatment by physicians because of their immigration status;

they stated that physicians often assume because they were undocumented they were not a human being and therefore treated them as third-class citizens. This resulted in Hispanics reporting they felt they had no patient rights, i.e. the ability to file complaints against physicians for failing to offer services (Napoles-Springer et al., 2005).

Other indicators of acculturation among Mexican Americans might include: age, area of residence, immigration status, length of time in the United States, and amount of contact with Mexican-American community. When age is considered, those Mexican Americans who moved to the United States when they were older, such as seniors, usually maintain traditional Mexican cultural values and beliefs more readily than do children (McKenna, 1989). For example, elderly Mexican-American women generally maintain pre-established beliefs about health and illness, which results in behaviors consistent with more traditional values and beliefs such as the use of folk medicine.

Where one lives may affect the acculturation process. For example, researchers found that Mexican Americans living in urban areas are often more acculturated as they usually have higher levels of education and more exposure to the majority population's values (de Paula, Laguna & Gonzalez-Ramirez, 1996). However, Adams, Briones, and Rentfro (1992) argued that while those living in rural areas are less acculturated, it is really membership in a segregated community, which can happen in either rural or urban areas, that predicts slow acculturation rates.

Immigration status has also been found to affect the acculturation of Mexican Americans. Researchers de Paula et al. (1996) found that Mexican Americans who were living in the United States illegally experienced an increased sense of isolation or may

have less social interaction with the majority population, in an attempt to reduce their chances of being discovered and possibly deported by immigration services. Those Mexican Americans who are living in the United States legally do not have the same fears about deportation and are often less apprehensive about interacting with the majority population. Therefore, they have more interaction with the majority population and often increased rates of acculturation.

Studies also support that the rate and amount of acculturation Mexican Americans experience is related to the length of time they have been in the United States. Arcia, Skinner, Bailey, and Correa (2001) found length of residence was associated with the cultural orientation of current and desired environments and with ethnic identity among Mexican Americans. In other words, first-generation Mexican Americans held more cultural values that were considered traditionally Mexican while future generations became significantly more bicultural. Castillo (1996) posited this may be because as individuals live in a foreign country for an extended time they reduce allegiances to their own cultural customs and traditions as they have fewer people with which to share them.

Similarly, Clark, and Hofsess (1998) argued that individuals who are heavily involved in the Mexican-American community are less acculturated as the segregated community assists with the retention of traditional Mexican cultural values. This was supported as Negy and Woods (1992) investigated how the contact Mexican Americans have with the Mexican-American community affects acculturation and the acculturation process. The researchers found that Mexican Americans who have extensive contact with people outside their community have increased rates of acculturation.

The Relationship Between Mexican Culture and Health

Studies have shown that Mexican-American patients perceive illness as a state of physical discomfort. Having good health is typically seen as having a sturdy body with the ability to maintain a high level of physical activity with the absence of pain (Abril, 1977). As a result, illnesses that initially have few symptoms, such as cancer, diabetes, or high blood pressure, are often difficult for Mexican-American patients to perceive.

Research has also found that while Mexican Americans often solicit advice from family members about health decisions (Reinert, 1986), they use a variety of methods to diagnose and treat problems ranging from folk practitioners, or *curanderos*, to visiting medical professionals in health clinics or hospitals (Abril, 1977; Engebretson, 1994; Kay, 1977; Keegan, 1996; Lopez, 2005; Magana & Clark, 1995). However, when a Mexican American is using both folk and scientific medicine, they may not share this information with medical professionals (Keegan, 1996). While it appears that few Mexican Americans rely solely on traditional folk medicine (Abril, 1977; Rodriguez, 1983), it is apparent that a variety of holistic alternative health and illness beliefs and remedies is an important part of their overall culture (Lopez, 2005).

Family, Social Support, and Caregivers

Mexican Americans have very tight-knit families, including both nuclear and extended members. Males are traditionally the head of the family and are consulted before decisions are made as they do not like to lose authority, even within their immediate family. This affects health care as men believe they should be included in counseling sessions. In addition, the entire family may want to be included in the health

care decision-making process. This may create a difficult situation for the health care provider when the families' wishes differ from that of the provider. However, it can benefit patients by providing a strong support system that can assist them in coping with illnesses and treatment (Reinert, 1986).

Hispanics reported that the inclusion of family members in making health care decision was viewed as necessary but something that was often overlooked by physicians. It was noted as especially important to Hispanics that physicians seek family input prior to making decisions about surgery or treatment of serious illnesses. Hispanic women often reported that the family also influenced their likelihood of obtaining health care services because the husband and family's health came first, or were more important than their own health needs (Napoles-Springer et al., 2005).

A strong sense of obligation to the family, or familism, is an important Mexican-American value. To understand this value, one must investigate how it is incorporated into the family unit. Familism is especially evident in the way Mexican Americans provide care for their elderly family members. This plays a role in perceptions of health and health care as elderly Hispanic women view health not as the absence of illness but as the natural decline of health. As such, health and illness are related to interdependence within the family (McCarthy et al., 2004). This connection and dependence on family is indicative of a more collectivist culture (Hofstede, 1980, 1991, 2001). As a result, aging Mexican Americans anticipate that as they age they will be taken care of by their family (McCarthy et al., 2004). This is in contrast to the non-Hispanic White perspective that is usually considered more individualistic (Hofstede, 1980, 1991, 2001). An individualistic

perspective involves a person feeling the loss of his or her independence during the aging process and that he or she has become a burden for their family. This is in stark contrast to the anticipated strong social support and acceptance that Mexican Americans expect (McCarthy et al., 2004).

Women are usually the caregivers in Mexican-American families, especially when it comes to health (John, Resendiz & Vargas, 1997). Several studies have investigated health care seeking among Mexican-American women and girls (e.g., Burk, Wieser & Keegan, 1995; Duffy, 1997; Duffy, Rossow & Hernandez, 1996; Rew, Resnick & Blum, 1997), many of which give us insights in to how Mexican-American women attempt to provide a healthy environment for their families. For example, in what is considered one of the first studies of a Mexican-American barrio, Kay (1977) described a holistic understanding of health among Mexican-American women that included the environment, physical health, and mental wellbeing. Nearly twenty years later, Clark (1995) described the complexity of maternal responsibilities in health work and the burdens of care giving among Mexican-American mothers. Mexican-American women maintain health within their family by attempting to provide good nutrition, exercise outlets for family members, and preventative health care. This care may include culturally traditional teas or rubs or more progressive over-the-counter medications and consultations with medical professionals (Mendelson, 2003).

Cultural can have a real affect on health practice, and as a result, outcomes. For example, the quality of social support from family, a practice highly driven by culture, has been shown to have significant consequences for health. Among Mexican-American

immigrant women, social support is a major factor predicting their positive birth weight outcomes despite low socioeconomic status and poor use of prenatal care (Guendelman, 2000). Social support has also been found to be important to the health of the elderly (Pillemer, Moen, Wethington & Glasgow, 2000) and a significant factor in the recovery process of people with illnesses ranging from depression (Skarsater, Languis, Agren, Haggstrom & Dencker, 2005) to heart disease (Shen, Myers & McCreary, 2006). Research suggests that social support helps those who are ill in a variety of ways from disease management, participating in required treatment, and obtaining necessary health resources. When Hispanic women do not receive the family support they need, they often experience feelings of emotional imbalance as well as physical ailments (Mendelson, 2002). However, while understanding the social support groups that are manifested in a culture is important to understanding how individuals view and assume caretaking responsibilities – both for themselves and others – is just a start. There are also many family and social practices that are negotiated based on health, each affecting health,

Modesty, Respect, and Congeniality Affect Health Interactions

Mexican Americans tend to be modest when it comes to discussing sex. As a result, researchers have found that Mexican Americans may be embarrassed about consulting medical practitioners, especially those of the opposite sex, about sexual matters. Treatments or physical exams may be refused if one is required to expose their body (Reinert, 1986). Researchers have found that modesty is common among older Hispanic women as they often fail to provide more private health information to physicians unless specifically asked. The women reported they may avoid visiting a

medical facility for feminine reasons such as for vaginal itching because of taboos related to discussing their reproductive organs. In addition, they reported that in the Hispanic culture, male physicians should not see women without clothing and that in order to remain modest it was better to have a female doctor. However, some older Hispanic women have reported extreme embarrassment with gynecological examinations, even when the physicians are women. Hispanic women reported additional discomfort with these topics when the physicians did not speak Spanish (Napoles-Springer et al., 2005).

The concepts of *respeto* and *simpatía* (respect and congeniality) also influence interactions that Mexican-American women expect to have with medial professionals as they prefer unhurried interactions with providers that include social greetings and gentle techniques, which are considered signs of respect (Clark, 2002). In addition, Hispanics have a high degree of respect for authority figures. For example, studies have shown that physician recommendation was key to Hispanic women choosing to participate in cervical and breast cancer screenings (Austin, Ahmad, McNally & Stewart, 2002).

The Role of Spirituality

Many young Hispanics report they were raised to solicit help from God for minor health problems and solicit care from physicians only when illnesses were serious (Napoles-Springer et al., 2005). This supports the culturally traditional Mexican belief that some illnesses are considered to be the will of God, or sea por Dios. As such, it is believed that individuals suffering from these illnesses are being punished. In addition, illnesses with symptoms that are not fully understood, such as cancers, diabetes, or autoimmune disorders, may fall into this category, causing them to receive delayed or

inadequate medical attention. Similarly, long-term illnesses may be believed to be a part of one's destiny and may be endured by an individual without seeking treatment (Scheper-Hughes, 1983).

Folk Practices

Grounded in 16th century Hippocratic theories of humoral pathology, many Mexican-American folk medicine practices are based on the belief that the body is made of four "humors": the hot fluids of the blood and yellow bile and the cold fluids of phlegm and black bile. As a result, illness was viewed as an imbalance in the humors, and treating illness was believed to be a process of restoring balance by eating certain foods or herbs (Chesney et al., 1980; Clark, 1970; LeVine, 1993; Madsen, 1973). These beliefs are a result of the Spanish-Catholic tradition melded with Native-Indian traditions that resulted in a mixture of humoral and herbal medicine (Chesney et al., 1980).

As mentioned, few Mexican-Americans rely solely on traditional medicine. However, the practice does remain intact in their culture. For example, researchers found a correlation among low socioeconomic status, low levels of acculturation, old age, and a belief in folk medicine (Abril, 1977; Rodriguez, 1983). Today, because their culture is rich with alternative health and illness beliefs and remedies, Mexican Americans have access to many nontraditional health care resources (Lopez, 2005). Seeking to treat illnesses caused by an imbalance in the body, women or healers often attempt to identify the degree of imbalance. Imbalances exist in food, water, air, between man and God, or between hot and cold (Gonzalez-Swafford & Gutierrez, 1983). *Curanderos* (male) or *curanderas* (female), or religious healers, are recognized as folk healers with the ability

to diagnose illness and provide interventions both from the natural and supernatural realm (Chesney, et al., 1980; Clark, 1970; Madsen, 1973; Manduo, 1983; Trotter & Chavira, 1997). The *curandero* attempts to correct the imbalances with prayers, pledges, or *mandas* that are made to supernatural forces. These rituals may involve candles and other traditional artifacts (Gonzalez-Swafford & Gutierrez, 1983).

The *curanderismo* is an important part of Mexican-American culture as it encompasses spiritual and emotional elements beyond the physiological components of health (Lopez, 2005). Generally a member of the nuclear family, which may include godparents and close family friends (Manduo, 1983), one of the primary functions of the *curandero* is to listen or observe as family members discuss treatment options for an ill family member, and then to offer support. This differs from the traditional role of physicians who ask many invasive questions and then dictate what treatment a patient will follow. In addition, *curandero* treatment takes place in the community, does not have specific business hours, and is usually supported by donations.

Other folk health practitioners include herbalists, or *yerberos*, who may use natural herbs, homeopathic medicines, religious amulets, and special diets to help cure illnesses (Applewhite, 1995; Gonzalez-Swafford & Gutierrez, 1983; LeVine, 1993). On the other hand, masseuses, or *sobadoras*, deal exclusively with physical imbalances as they massage joints and bones to correct imbalance while alleviating pain and tension (Gonzalez-Lee & Simon, 1990; Gonzalez-Swafford & Gutierrez, 1983).

While folk medicine is used by Mexican Americans, researchers have questioned the prevalence of traditional healers and health beliefs among this population

(Higginbotham, Trevino & Ray, 1990). For example, studies show that Mexican-born women who had been in the United States for five years or less were three times more likely to use the services of a *curandero* than those women who had been in the United States longer than five years (Skaer, Robison, Sclar & Harding, 1996). In addition, only 4% of Mexican Americans reported visiting a *curandero* in the past 12 months, with visits often coinciding with dissatisfaction with medical practitioners (Higginbotham, Trevino & Ray, 1990). On the other hand, Mexican-American women continue to use home remedies, such as herbal cures, to treat minor illnesses (Clark, 1995). However, Applewhite (1995) found that even when elderly Mexican Americans were raised with a tradition of *curaderismo*, they would seek assistance from medical professionals for more severe illnesses.

Summary

Past studies with Mexican-American women have grouped them in the larger Hispanic cultural category (Torres, 1996), which leads to a poor understanding of how Mexican women construct meaning. In addition, while the deficit in research among this population outside the states that border Mexico has been criticized (Schreiber & Homiak, 1981), little has been done to fill this knowledge gap. Guided by the research question, how do Mexican-American women define and take care of health, particularly their breast health, this qualitative study adds to the current body of literature by investigating the meaning-making of Mexican-American women in relation to their health.

The review of literature begs the following questions: What do Mexican-American women consider to be healthy? How do Mexican-American women define or recognize illness? How and with whom do Mexican-American women communicate about health and health decisions? What role does family play in a Mexican-American woman's health? If a Mexican-American woman is the primary health care provider in her family, how is her health affected by this role? Does modesty or a feeling of embarrassment about certain health topics affect Mexican-American women's health care decisions? What role does folk medicine play in Mexican-American women's health care? Do the spiritual beliefs of Mexican-American women cause them to feel that some illnesses are a punishment or beyond their control? Have Mexican-American women's ideas, beliefs, or behaviors about health changed since they have been in the United States? Where does breast health fit into a Mexican-American woman's overall idea of health?

Chapter III

THEORETICAL FRAMEWORK AND METHODOLOGY:

The Qualitative Paradigm

A qualitative paradigm was chosen for this study because it best allowed the researcher to answer the research question: How do Mexican-American women define and take care of health, particularly their breast health? Qualitative research is a “systematic investigation that attempts to understand the meanings that things have for individuals from their own perspectives” (Taylor, 1994, p. 266). Strauss and Corbin (1998) stated it included:

any type of research that produces findings not arrived at by statistical procedures or other means of quantification. It can refer to research about persons’ lives, lived experiences, behaviors, emotions, and feelings as well as about organizational functioning, social movements, cultural phenomena, and interactions between nations. (p. 10-11)

Believing in a world of multiple realities, qualitative researchers operate under the assumption that not everyone interprets and experiences the world in the same way. Qualitative researchers attempt to gain a better understanding of participants’ realities by examining their experiences and associated meanings (Strauss & Corbin, 1998). These meanings, created through interactions with others, include anything they come in contact with from simple objects to every-day events (Taylor, 1994). As a result, it is suggested that qualitative methods are used when the purpose of research is to explore attitudes and perspectives of a certain cultural group and to gain a more comprehensive understanding.

In the current study, a qualitative method allowed Mexican-American women to voice their thoughts, opinions, and beliefs, in their own words. Focused on understanding the lived experiences of individuals in a specific context, qualitative researchers are unconcerned with statistical generalizations. However, after identifying patterns among participants, some conceptual generalizations about cultural groups might be made. For example, it may be assumed that key concepts could generally apply to similar participants within similar contexts (Taylor, 1994).

Qualitative research moves from specific ideas about a subject or topic to more general ones, which allows for the discovery of shared meanings. Participant responses are seen as fluid, with the constant ability to change. Through the analysis process, those meanings and patterns yield valuable field data that is then applied to a grounded theory approach in which theory often emerges from data (Strauss & Corbin, 1998). Data interpretation, which is heavily reliant upon the researcher's interpretation of the findings, is key to the qualitative research process. As a result, the researcher is considered the research instrument.

Grounded theorists may use a variety of methods, such as interviews, ethnographies, group interviews, or textual analysis as they search for themes and patterns within the data (Strauss & Corbin, 1998). Grounded theory was used for this study because, unlike quantitative research that generally relies on testing theory, this study assists in the building of theory. Strauss and Corbin (1998) posited that as grounded theorists gather and analyze data they "identify, develop, and relate the concepts that are the building blocks of theory" (p. 13).

The Long Interview

The long interview is considered one of the most effective ways to capture the way participants see the world in their own words. This allows us to see the world of an individual as he or she sees it. As a result, McCracken (1988) discussed the interview as “one of the most powerful methods in the qualitative armory. For certain descriptive and analytic purposes, no instrument of inquiry is more revealing” (p. 9). As such, interviews allow researchers to draw meaning and understanding from interactions with participants as they seek to better understand human behavior and how individuals create meaning.

Interviews are structured to assist researchers in allowing individuals with specific relationships to issues or subjects to express these relationships in their own terms. McCracken (1998) stated:

The selection of respondents must be made accordingly. The first principle is that “less is more.” It is important to work longer and with great care with a few people than more superficially with many of them...it is important to remember that this group is an opportunity to glimpse the complicated character, organization, and logic of culture. (p 17)

Because of the flexibility this method allows, with the ability to be conducted in various locations, the researcher can collect data in a setting that is natural to the participants. Studying participants in their natural setting allows researchers to engage and/or observe individuals and record their behavior in a setting where they generally participate in everyday activities. This means that “where” the data is gathered is an

important part of qualitative research because location or context may change the meanings that researchers attempted to identify. Simply stated, locations and times may change meanings. As a result, researchers collecting data in a natural setting often develop a deeper and more thorough understanding of a communication phenomenon than they would in an artificial setting (Taylor, 1994). Since discussing health care and breast health topics may be sensitive in nature, in this study, conducting interviews in a surrounding that is familiar to the women assisted in creating a comfortable research environment.

Pilot Study

A pilot study that focused on Mexican-American women and their decisions about breast screenings was conducted prior to the current study. The purpose of the study was to examine how Mexican-American women make breast health decisions. Two women, both born in Mexico, were chosen for in-depth interviews. The women were both over the age of 40 (aged 46 and 70 respectively), had lived in the United States for more than 20 years, and were current residents of Knoxville, TN. The participants selected the locations, with one interview taking place at a dining room table in the participant's home and one interview conducted over lunch at a café. Interviews took a little more than one hour to complete.

The researcher conducted interviews, transcribed the interviews, and analyzed data. Interviews began with participants describing recent health decisions to help build their involvement with health decisions. Questions then moved to what information informed these decisions. For example, participants were asked about where information

was sought and obtained and what prompted the need for information. Participants were then asked how others influenced health decisions. Finally, questions were asked about influencing factors or barriers that affected their participation or non-participation in breast screenings.

Participants were encouraged to talk freely about their health decisions and about decisions specifically related to breast health and breast screenings. Both interviews were recorded on audiotape so the researcher could transcribe details and quotes from the interview. Hand motions and non-verbal communication were noted, as deemed necessary by the researcher, during the transcription process.

The researcher found that while women made certain efforts to take care of their health, they avoided or failed to participate in regular health screening such as mammograms and pap smears. The women believed health was an important part of their life, but failed to make time or see the importance of preventative medical tests. In addition, while most public health research reports are related to system barriers, such as health insurance or language barriers, the women in this study seemed to view these barriers as annoyances, working around them when trying to participate in healthy behaviors that relied on professional medical services. During the interviews, it was the personal barriers, such as placing their family first and limited time that stopped the women from participating in regular preventative screenings. These findings suggested that the current study should focus on how women define health and the behaviors they participated in to maintain their health and breast health.

The pilot study also revealed that interviews could be used as the primary method for gathering data in the current study. In addition, the study helped the researcher develop additional questions. For example, the current study broadened the focus from focusing only on breast health to women's overall health as a way to gain additional knowledge about how Mexican-American women define and take care of their health, particularly breast health.

Participants

Criteria for selection were that women were born in Mexico and moved to the United States and were between the ages of 35 and 50. This age group was selected because the suggested age to begin mammograms is age 40, with many health campaigns targeting this age group (American Cancer Society, 2006). This sampling strategy allowed the researcher to examine the phenomenon – how Mexican-American women take care of their health, particularly their breast health.

Purposeful sampling was used for this study. In other words, participants were selected according to the aims of the research:

The logic and power of purposeful sampling lies in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research. (p. 169)

Decisions about what area to sample are generally determined according to dimensions, such as age, gender, or status and are established in advance for a study (Glaser, 1978).

Original participants were identified through community and informal contacts from organizations such as Alianza del Pueblo, a Knoxville-based Hispanic service organization, as well as through local restaurants with large numbers of Mexican-American employees. However, the researcher encountered some difficulty gaining access to participants. In general, women were apprehensive about the interview procedure, often admitting after the interview that they had originally feared it would involve “right or wrong” answers. When interviews were scheduled with women who were not referred by their close friends, the potential participants often failed to keep their scheduled appointments. During the data gathering period four women failed to show up for scheduled interviews. As a result, the researcher relied heavily on the snowball technique (Lindlof & Taylor, 2002), as the preliminary participants were asked for the names of women they thought would be willing to participate in interviews. After women completed the interview, they often appeared to enjoy the process, showing interest in how the data would be used. At this point the women were more likely to assist the researcher in finding additional participants. Several participants were recruited for the study when participants called friends and scheduled appointments for the researcher during the causal conversations that took place after data collection.

The sample consisted of ten participants. There is no required number of participants when conducting a qualitative study, as qualitative research should be conducted to the point of saturation, or when each interview no longer adds unique information to the collection of data (Glaser & Strauss, 1967; Morgan, 1988; Strauss & Corbin, 1998). Researchers have suggested saturation can occur with as few as five

participants or as many as 20, depending on the qualitative inquiry (Lincoln & Guba, 1985; Marshall, 1996). Ten interviews were conducted, even though theoretical saturation was reached at the seventh interview.

The women who participated in the study were dispersed within the targeted age-range; the youngest woman was 35 and the oldest was 50. All of the participants were married and had children living at home. The women had lived in the United States for varying lengths of times, the shortest six months and the longest 35 years. All of the participants, except one, worked outside the home.

Interview Protocol

In order to help the participants feel more comfortable, each interview was conducted in a location familiar to the participant. Similar to the pilot study, a majority of interviews took place in the women's homes, usually at their kitchen tables over a cup of coffee or tea. A few interviews, at the request of the participants, took place at the Alianza del Pueblo in their informal sitting room or at a local café close to the participant's home.

The interviews lasted between 45 minutes and one and a half hours and were recorded on audiotape. Five interviews were conducted in Spanish and five interviews were conducted in English. An interpreter and translator were used for those interviews that were conducted in Spanish. An interpreter translates back and forth between individuals, and a translator works with written material, translating from one language to another (Baker, 1981). Freed (1988) suggested interpreters should be similar to the participants, i.e., they should share similar ethnicity, gender, age, and other characteristics

that might otherwise interfere with the focus of the interview. Murray and Wynne (2001) stated the “matching” of an interpreter with participants should be guided by the purpose of the interview and by the interviewees’ wishes. Keeping in mind modesty and personal issues, the researcher found interpreters who were female and from Latin America. Transcriptionists (see Appendix A) and interpreters (see Appendix B) signed IRB-approved confidentiality forms, expressing they would keep all data gathered for the study confidential.

Each interview began with the participant also signing an IRB-approved consent form, expressing she understood the purpose of the study and that all data collected would remain anonymous. Participant could receive consent forms in English (see Appendix C) or Spanish (see Appendix D). Then, the researcher explained the interview process to participants, emphasizing the participants’ answers should be their opinion and that there were no wrong answers. The researcher used a discussion guide during interviews (see Appendix E), beginning with broad questions about how the participants defined health, then moving to more specific questions about how they take care of their health and breast health. As with the pilot study, participants were allowed to talk freely about their health beliefs and decisions. At the close of each interview, participants were provided with a \$30 gift certificate to Kroger to compensate for their time.

Data Analysis

Following the tradition of grounded theory, this researcher sought to develop theory. Corbin and Strauss (2008) stated:

Developing theory is a complex activity...theory denotes a set of well-developed categories (themes, concepts) that are systematically interrelated through statements of relationship to form a theoretical framework that explains some phenomenon. The cohesiveness of the theory occurs through the use of an over-arching explanatory concept, one that stands above the rest. And that, taken together with the other concepts explains the what, how, when, where, and why of something. (p. 55)

The researcher in this study described how Mexican-American women maintain their health and breast health in a non-native environment.

As grounded theory dictates, data collection and analysis were conducted simultaneously. All interviews were transcribed and coded within two days of each interview, allowing the researcher to investigate new questions in subsequent interviews that might not have been considered before. The researcher transcribed all interviews that were conducted in English. A transcriptionist transcribed the interviews that were conducted in Spanish. Following interview transcription, three stages of coding: open, axial, and selective (Corbin & Strauss, 2008) were completed; more than 240 hours were spent collecting and analyzing data.

Open Coding

All transcripts were coded by the researcher, line-by-line, using an open coding procedure. Strauss and Corbin (1998) described this open coding procedure as the “analytic process through which concepts are identified and their properties and dimensions are discovered in data” (p. 101). In other words, this fluid process allows one

to uncover thoughts and ideas, during the process naming concepts that are essentially the building blocks of theory.

During the open coding procedure, codes/concepts were marked in the left column of transcripts, using Microsoft Word. Following each interview, a separate summary list was created for each interview that contained all the concepts for that individual interview. As interviews were conducted, a master list of concepts was also created (see Appendix F), with each concept labeled by participant (i.e. P1, P2, P3, etc.). The researcher used consistent codes when possible to mark similar thoughts, ideas, and behaviors. As a result, when the lists were electronically alphabetized, patterns were more easily uncovered.

As the data were broken down, examined piece by piece, and compared for similarities and differences, 295 individual concepts were recorded in the master list. An example of the open-coding process is seen in the interview with P8. She discussed the effect of having a positive attitude on a person's overall health as she stated "I think if you are not well mentally, you can fall sick." This concept was coded as "believing having positive attitude can overcome physical ailments."

As the researcher created the list of concepts, preliminary categories/themes were marked in a note pad. For example, it was noted that the concept about maintaining a positive attitude might be grouped into a sub-category of "believing positive attitude will promote good health," and a larger category of "the mind and health." These preliminary categories were helpful as the researcher conducted the second stage of the coding process, axial coding.

Axial Coding

Following open coding, the researcher conducted the axial coding process as concepts were collapsed and related to broad categories or themes (Corbin & Strauss, 2008). Categories are the “cornerstones” of developing theory as they represent concepts in a broad or abstract manner. Generated through a process of making comparisons that note similarities and differences, categories provide the means by which theory can be integrated (Corbin & Strauss, 1990). The researcher conducted axial coding by printing out the master list of individual codes. These pages were then cut in to individual pieces of paper, each containing one code, that were then placed into piles. Each pile represented behaviors, events, etc. that were related and were then grouped into larger categories. As a result, an outline, or categories and subcategories, emerged. The data were reassembled as the relationships among the categories and subcategories were further uncovered (Strauss & Corbin, 1988). For example, concept such as “defining healthy as being able to take care of her children” and “defining healthy as being able to take care of her home” caused the researcher to note a sub-category of “defining healthy by her ability to take care of her family.” Sub-categories were used to create larger categories. For example, “defining health as taking care of the physical body” and “defining health as taking care of the mental self” caused the researcher to note a possible category of “believing health is a combination of the body and mind.” Similarly, the sub-categories “feeling health care is her responsibility” and “diagnosing and treating illness” lead the researcher to note a preliminary category of “seeing herself as the first line of defense.”

At the completion of axial coding, four categories had emerged: (1) the body and health, (2) the mind and health, (3) the choice to avoid professional medical care, and (4) the belief that the cause of illness should be explained. As noted by Strauss and Corbin (1998), each of the categories, derived from the data, represented the phenomenon, or helped to answer “What’s going on here?” (p. 113).

Each of the categories had sub-categories. During the axial coding process, the researcher followed Strauss and Corbin’s (1998) suggestion to ask “why?” or “how come?” (p. 127). As a result, subcategories helped the researcher to create and further clarify each category by answering questions such as “when, why, where, how, and with what consequence?” (Strauss & Corbin, 1998, p. 124). These questions also assisted as the researcher identified contextual factors and linked them with process, or what is called the paradigm. For example, while:

context doesn’t determine experience or set the course of action, it does identify the sets of conditions in which problems and/or situations arise to which persons respond through some form of action/interaction and emotion (process), and in doing so it brings about consequences that in turn might go back to impact upon conditions. (Corbin & Strauss, 2008, p. 88)

As the researcher analyzed data for context, she continued to ask questions and make comparisons. These comparisons uncovered conditions, actions, interactions, emotions, and consequences (Corbin & Strauss, 2008). Conditions “allow a conceptual way of grouping answers to the questions about why, where, how, and what happens”

(Corbin & Strauss, 2008, p. 89). In other words, the researcher attempted to identify circumstances or conditions that lead participants to have a particular response.

Responses made by participants to situations, problems, or events were described as actions, interactions, and emotions. Finally, consequences, or the outcomes of actions, interactions, or emotional responses to events were recorded to document what happened as a result of actions, interactions, or emotions. For example, P2 stated:

My husband, last year it happened for him to passed out. Two times in one day, one morning. So, they went to the emergency room. And they did all the tests. They did at [local hospital name] hospital. All the tests that they thought it might be, and they didn't discover anything. They didn't know why. They did brain, they did heart, they did diabetic tests, cholesterol tests. And all the things you can imagine. And, it was nothing. ...So, I believe, I believe in doctors, yes, I do believe, but I just don't believe in the machines.So, I got my book that I read, for example, when he passed out, we go that book.

In this example, the condition was P2's husband becoming ill, being taken to the emergency room, and failing to receive a diagnosis. The action, interaction, or emotions, or response by the participant, was a failure to trust medical equipment. The resulting consequence was that when they returned home, P2 used personal health texts and treated her husband as she determined was appropriate. Along this line, P2 also noted she often

chose to treat herself and her family when they were ill because going to the doctor was often pointless.

Identifying conditions, actions, interactions, emotions, and consequences allowed the researcher to identify processes or “the flow of action/interaction/emotions that occur in response to events, situation, or problems” (Corbin & Strauss, 2008, p. 87), often with the purpose of reaching a goal or dealing with a problem. Using the example above, along with other similar participant data, the researcher determined that when a participant or her family was not feeling well, she preferred to handle the situation on her own as opposed to visiting a doctor who she believed usually failed to provide the reasons for illnesses.

It should be noted that following suggestions by Corbin and Strauss (2008), the researcher did not code for conditions or consequences. This meant that while conceptual names were placed on categories, these names did not point to whether a category denoted a condition, action, interaction, emotional response, or consequence – the researcher made these distinctions. The paradigm was used as a tool to assist the researcher in an attempt to better “understand the circumstances that surround events and therefore enrich the analysis” (p. 90), not as a set of directives. Corbin and Strauss (2008) noted that beginning analysts fixate on the specifics of the paradigm, and as a result, overlook the logic behind its use and what the use of paradigm is designed to do.

Being overly concerned about identifying “conditions” or “strategies” or “consequences” in data rigidifies the analytic process. The final result may be technically correct but there is something missing, and that something

is the creativity and feeling that give qualitative research its soul. (Corbin & Strauss, p. 90)

As the outline was further developed, two major themes, grounded in the data, emerged that reflected the dynamics of Mexican-American women and how they maintain their health. These overarching categories included “the belief that health is a combination of the body and mind” and “the belief that health care is a Mexican woman’s responsibility.” (See Appendix G for the complete outline.) This integration process allowed the researcher to begin the next stage of the coding process, selective coding, when categories were linked around a central or core category and the resulting theoretical formulation was refined (Corbin & Strauss, 2008).

Selective Coding

With the goal of building theory, the researcher continued to the next coding stage, selective coding. During this stage, categories were linked around a core category resulting in a “refining and trimming [of] the resulting theoretical construction (Corbin & Strauss, 2008, p. 263). Corbin and Strauss (2008) stated the “core category represents the main theme or phenomenon of the study, while the basic social process or whatever the process is can be found embedded in that main theme” (p. 266). In other words, concepts alone do not yield theory. Concepts and categories that emerged from the data during open and axial coding must be linked and filled in with detail to construct theory from the data. This resulted in a theoretical or explanatory framework that helped explain the phenomenon investigated in this study. Consistent with grounded theory approach, the process uses a set of carefully defined categories that are interrelated through statements

of relationship or patterns to form a framework that explains some relevant phenomenon. As a result, themes are not simply listed but are interrelated into a larger theoretical scheme (Strauss & Corbin, 1988).

The first step in the process involved deciding on a core category. When isolating the overarching theoretical scheme, the researcher followed the suggestions of Corbin and Strauss (2008) and reviewed the scheme for internal consistency and for gaps in logic while filling in poorly developed categories, trimming excess, and validating the scheme. During this process the core category was revised multiple times. For example, the researcher noted “Mexican-American women choose to maintain their own health.” However, the category was revised because it failed take into account how the women operate in a non-native environment. “Mexican-American women choose traditional health care practices” was also revised because it failed to encompass the maintenance of health and environment. Following several revisions, the core category, or the phenomenon, for this study was The Maintenance of Health through Traditional Practices in a Non-native Environment. The Mexican-American women in this study chose to maintain their health in a culturally traditional manner despite the fact that they now live in a non-native environment. This encompassed the main themes of the research and had the most explanative relevance and the highest potentials for linking the study’s categories together, or the ability to theoretically explain what the research is about. In addition, it helped to explain that under these conditions this set of events usually happen. In other words, when Mexican-American women attempt to maintain their health in a non-native environment they choose culturally traditional health practices.

Two main categories were unified around the core category, helping to further explain the phenomenon that was investigated in this study. These categories include: (1) the belief that health is a combination of the body and mind and (2) the belief that health care is a Mexican woman's responsibility. The aim of each participant in this study was to "maintain her health in a traditional manner." The following chapter will present and discuss these interrelated activities.

Quality and Trustworthiness of Research

Qualitative research is evaluated based on trustworthiness, or the truth-value of the inquiry. Four widely accepted criteria for judging trustworthiness include: credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). Credibility asks if the study "rings true" for the people being studied. For example, if the study participants read the results they would say, "yes, that's it, I just never thought of it that way." Dependability is the ability of an external check to be conducted. This means that someone other than the primary researcher could follow the researcher's process from point A to point B to point C. During the study's dissertation review process, the dissertation committee assisted with dependability as they reviewed this researcher's processes. Confirmability addresses whether the data is traceable to the sources, and not to the biases of the researcher. Both presenting the data to participants and working with the dissertation committee review process assisted in increasing confirmability. Finally, transferability, investigates whether those who read the study can make decisions about applying the findings of the study to other contexts or groups.

For the current study, the researcher met with two participants and presented them with the summary list of codes that contained the codes for their individual interview. As the researcher solicited feedback from participants, both of the women had a few questions about several of the codes from their interview. However, after the researcher defined and described what each of the codes meant, the participants felt the codes were an accurate representation of their interview and health beliefs. The researcher attempted to meet with additional participants, but because of the way participants were identified, primarily using a snowball technique, the researcher did not have access to several of the women's home phone numbers or was unable to schedule an additional meeting through the original contact.

Chapter IV

FINDINGS AND DISCUSSION

After ten in-depth interviews, the researcher found recurring themes in the data. The core category, or phenomenon, was The Maintenance of Health through Traditional Practices in a Non-native Environment. In other words, the women chose to maintain their health in a culturally traditional manner, or similar to the way they would have in Mexico, despite their new environment. Using a grounded theory approach, two thematic constructs emerged from the data that helped to describe how the women maintain health in a traditional manner in a non-native environment. The following theoretical framework helps explain how Mexican-American women define and maintain health, particularly breast health: (1) the belief that health is a combination of the body and mind and (2) the belief that health care is a Mexican woman's responsibility. The remainder of this chapter includes a presentation of the data used to establish these themes.

The Belief that Health is a Combination of the Body and Mind

Participants in this study defined health in terms of both the body and mind, believing that in order to be healthy a person should take care of both. This culturally traditional definition of health was evident as the women often talked about a holistic understanding and maintenance of health. Participants often described taking care of both the body and mind as they talked about attempts to maintain their health, discussing how this resulted in a positive health status.

P2: I have a body to take care of. I have one body. Then also, that one body is accompanied by a mind, emotions....You have to be cautious

about how they work. ...There is a connection that affects your health. If you are not mentally healthy, then that will be reflected in your emotions. And, then your emotions are going to be reflected in your body, your physical body.

P10: (Health is) the wellbeing of one's body...a healthy body, a healthy mind, or being happy.

P8: When I think about a healthy person, I think of a person that has a good demeanor about them. They are active. I also think mentally they are very positive, since health is also mental.

However, it should be noted that while the women in this study defined health as including the body and mind, there was no pattern among women who discussed the environment, such as air and water quality, as a part of their health definition. The few participants that discussed the environment talked about the impact their physical surroundings, such as the air, may have on health and the need to preserve the environment for the health of future generations. For example, P10 defined health as “*a healthy body, a healthy mind, or being happy. ...The environment is also an important part of health, to me. All of these make up your health.*” She discussed concern that the environment might have a negative impact on health as she said:

Yeah, I think...we moved from L.A. ...I used to think that there was (not) a more unhealthy city than this one, but now I think that this one is more unhealthy than that one. I like the outdoors, and I do think that has the impact on one's health. ...And, um, its just as time goes by, a lot affects us.

So, I try to get involved with projects that promote the environment's health so that the future doesn't look so bad. The environment impacts my kids health, well, everybody's health, not just mine.

The Body and Health

The women in this study usually discussed a healthy body in a culturally traditional manner as they described as a person's ability to participate in various activities. In addition, as Mexican culture dictates, participants expressed that a healthy person should experience little or no physical pain.

Defining health as an absence of pain.

When women referred to the absence of pain in their health definitions, being in good health and feeling no physical pain or painful conditions was often discussed in terms of no suffering from painful conditions such as arthritis or problems with the kidneys or liver. In addition, the women usually discussed having no pain as the ideal situation when they spoke about their own health.

P7: Let's say I want to be with no pain.... When I think of me being healthy it is because I don't have pain.

P9: I wouldn't have anything wrong with my body that would give me pain.

Defining healthy as being active.

Being active was also an important part of the participants' definition of health. This was evident as the ability to participate in desired activities was often interwoven into their health definitions. Participants usually discussed these activities as the ability to

work and take care of their family. In addition, the women commented that being unhealthy was a negative consequence of the choice to be inactive, or lazy.

P3: If I am not healthy, I cannot take care of myself. If I am healthy, I can take care of my family, work, take care of my home. I can't be an active person when I am not healthy. ...If you are lazy and always choose to lay around it is not good for your health. Your body needs to be active to be well.

While these findings are in line with the traditional beliefs of Mexican women, this study added to the current literature as it allowed the women, in their own words, to define the physical activities that made them feel healthy. In other words, what were the women able to do because they were in good health? What activities did they hope to have the ability to complete by keeping themselves in good health? For example, work had several health associations. The interviewees viewed work as an activity they were able to participate in because they were healthy. P3 said *“If you are healthy, then you can go to work with no problem, and you can function daily.”* While work was rarely the only activity mentioned by the women, it was almost always present in the participants' definitions of health. For example, P4 said she thought being healthy allowed one to *“work, travel, take care of our children, (and) spend time with our families.”*

Participants also saw work as something that helped them maintain a healthy lifestyle. For example, P8 described things she does to stay healthy as *“try[ing] to eat in a healthy way, and working, or doing some sort of exercise.”* Along this vein, the women in the study tracked the amount of physical activity they participated in during their

workday and factored this activity into their overall daily exercise. This helped the participants as they attempted to maintain a certain level of physical fitness or activity they deemed appropriate for a healthy lifestyle. P1, P3, and P5 discussed trying to make sure they maintained a healthy level of activity each day. Each of the women discussed monitoring the amount of physical activity they participated in at work each day and then supplementing their physical activity at home, if needed.

P5: Mainly, for me it is walking, not spending as much time sitting on the couch watching TV or being lazy all day. If you work, or if you walk all the time at work, then that is good for you because you have your workout for the day. Then, you do not have to worry about it as much. If you do not, then you have to make time for some physical activity.

P3: If I do not get exercise at work, then I will try to walk.

P1: I walk, you know. If I didn't walk (at work) then I'll come home and walk here.

In addition, participants described those who did not keep busy with work or other activities as lazy and thought these individuals had negative health because of their inactivity. It was apparent that the women in this study placed a high importance not only on working, but also on the ability to be able to work. For the women in the study, being healthy was closely associated with working, and vice versa. This may be attributed to the fact that the women interviewed were immigrants to a new country, and may have a certain mind-set and attitude about setting goals and working toward them. For example, the act of migrating may have indicated a readiness to adapt a new life, class aspirations,

or goals such as seeking jobs with better pay and improved living situations. Participants discussed people who do not work as failing to have goals. This may have impacted the women's affinity for grouping those who choose to be active and to work toward goals as positive and healthy while those who are inactive were seen as negative and unhealthy.

When discussing activities they could participate in because they were healthy, participants also talked about the ability to take care of their families. In other words, it appeared the women in this study were taking care of their health so they could work to help support their family and take care of the health of their family. When asked to define health, participants said

P6: Well for me it means, it is very important. It means being able to be a good mother to my children, being able to take care of them.

P8: When I am healthy, I can do the things I want to do. I can take care of my home and my family. ...I am happy. I feel well.

The Mind and Health

The fact that the women in this study attempted to maintain positive mental health or a sense of wellbeing as a part of their overall health care was also a traditional practice. Believing in the importance of mental health, which was deemed necessary for good health, the women discussed mental health as something that could negatively impact a person's physical health, if not cared for. This was exemplified as participants defined health as a healthy mind or as P6 said, making sure the "*mind was right*." However, this study adds to the current body of literature as participants described how the mind is important to their health: helping them to avoid physical pain and providing them with

the ability to overcome, control, or avoid physical illnesses. More specifically, participants believed a healthy mind helped them maintain good health as it allowed them to better fight illness.

Believing poor mental health leads to negative physical health.

When participants discussed the health of their mind, they usually did so in reference to how their mind affected their physical health. However, they rarely discussed the effect their physical health had on the mind. For example, P2 said “*If you are not mentally healthy, then that will be reflected in your emotions, and then your emotions are going to be reflected in your body, your physical body.*” In other words, the women in the study saw the mind as something that supported the health of the body. This concept was most often discussed in terms of stress and the various ways stress can present itself as a physical ailment. As a result, the women made attempts to take care of their mental health, with some women choosing relaxation techniques such as resting or reading and others choosing more physical activities such as exercising or working. P10 discussed how she relieved stress as she recounted:

Sometimes I have to find my own space and say...don't nobody talk to me, don't nobody see me. And that helps me with stress. Stress can be very hard on you. Stress can be very hard on your mind and your health.... So, that's how I kind of think that I can keep that part healthy.

When the women in this study described the effects of stress on their health, they usually talked about physical pain or associated it with painful conditions such as chest

pains or stomach pains. Participants discussed these conditions as being serious enough to seek professional medical treatment.

P7: The pain was real...and he (the doctor) said, 'How do you feel about living here? How do you feel about moving here? And, how do you feel about your lifestyle?' And, I said, I don't feel very happy about it....And, he said, 'That is the problem. You are under stress.'

P9: When I lived in California. I went to the doctor because I had chest pains...and (the doctors) told me it was probably due to stress.

Choosing a positive attitude to avoid illness.

Participants also discussed their mental health in terms of having a positive outlook or a positive attitude. Women believed having a positive outlook meant they would have good health. They discussed illness as something that could be avoided by maintaining a positive attitude or as something they had used, in the past, to overcome illness. For example, P8 stated it is important to have “*a good attitude and that [it] helps your physical health. I think that influences your health.*”

The interviewees also discussed the belief that they had overcome illness by not allowing themselves to dwell on feeling bad. When asked what she does if she is not feeling well, P2 described using her mind to assist her body as she overcame illness. P2 said “*I keep a good attitude...It's a matter of you having the will to overcome it...I know the sickness, and (think) you're not going to be bigger than me.*”

On the other hand, participants felt those who failed to be mentally positive were more likely to become ill. As a result, the women attempted to keep a positive attitude in

order to maintain good mental health and therefore, good overall health. P8 discussed this as she stated:

When I came from Mexico, I came with a positive attitude. I knew my life was going to be much different here....I always had that attitude that everything was going to be all right, I prepared myself mentally to be able to be stable. I think if you are not well mentally, you can fall sick.

For example, the women discussed the ability to feel better when they were ill, if they maintained a positive attitude. In addition, they believed that others, who were sick, often failed to try to overcome their illnesses with a positive attitude. Simply put, the women felt that those who were sick had chosen to allow themselves to be sick. P2 clearly discussed this and then differentiated between illnesses that can be affected by a positive mental status, and accidents, which cannot:

The way we think. And, basically, the way you think is how you feel. And, how you feel is how you are gonna show (on your physical body). And, your body, believe it or not, is gonna show because you believe it. What you think...and you see the consequence in your health...physical. And, then you will see it, I guess, if you have cancer, or if you (have) not very good cholesterol. But now, you cannot control when you have an accident. There is no choice.

The women also discussed chronically-ill friends or family members as if the family member chose to be sick, almost placing blame on the person for not choosing to be well. It appeared that most of these cases involved women who suffered from

headaches, backaches, or other non-life threatening ailments. The participants in this study often appeared frustrated when they discussed others that failed to have a positive attitude when confronting their illnesses. For example, P5 discussed how her sister failed to maintain a positive attitude when she feels ill. P5 said her sister, who lives in Mexico, frequently complains of headaches and other illnesses.

P5: Yes, there is control, yes (of illness with the mind)... We try to encourage her, and cheer her up, telling her things will be all right, but she lets herself be defeated. Her sickness is all she thinks about, so she ends up really being sick.... If it's not her back, it's a headache. She always says she's sick and that she is always trying to find a refuge in being sick. We try to tell her the motivation to go on comes from oneself, and that problems go away, but she feels that's the only way to be.

In other words, participants discussed that it was up to the individual to want to feel better. The women in this study expressed belief that a sick person must decide whether he or she wants to feel better before an illness can be overcome. This means that overcoming illness is often a mental process. P9 discussed this as she described how she would help take care of an ill family member:

It's up to the person to want to be healthy, or stay the way they are. Sometimes, when a person is feeling a little depressed, and there is someone to encourage them to move on; they get better. ... I would try to encourage them by telling them they can make themselves feel better.

The Belief that Health Care is a Mexican Woman's Responsibility

During the interview process, participants discussed their role as the person in charge of making health decisions about maintaining the health of their families.

Considered a dominant cultural factor in Mexican health care, this often involved the women diagnosing and treating illnesses and determining when to seek professional medical treatment. As a result, participants attempted to treat illnesses themselves, often using the assistance of another woman, and chose to rely on professional medical services only for serious conditions. When the women did see physicians, they felt the drugs they were prescribed had more negative side effects than benefits.

In addition, participants discussed that while they had made health care changes since moving to the United States, these changes were usually in relation to the differences in the health care systems in Mexico and the United States. The women discussed learning to maintain their health in a culture that was different than their native culture.

As the women in this study attempted to maintain health in the traditional role of primarily caregiver, they used culturally-traditional methods such as providing good nutrition, exercise, and preventative health care. The women discussed these activities as they described maintaining the health of their families in a holistic way that included providing a clean home, playing games that stimulated memory, encouraging children to read books, providing healthy meals, showing their children they loved them, and setting a good example for work ethic. When P2 discussed how she maintained the health of her children as she said:

I like to have everything organized and clean, you know, keep my children clean, teaching them to be responsible with themselves both inside and outside the body. I try to feed them with the right foods. ...Perhaps a nice bed they can rest (in). You know, and also show them that I love them and care about them by doing all the things, you know, my work. ... Affection, I guess, is another example of the emotional. Humans, the lives go by examples. You show them the way to live. You make an impact with the life. ...Because, there are good choices we can choose, and they can't be just lazy.

However, women in this study failed to report they participated in the culturally-traditional practice of consulting men, the traditional head of the family, before they made health decisions. When the participants were asked about a man's participation in health decisions, their responses indicated men would rather not be bothered with health decisions, often leaving the decisions to the women. As P6 said, "*Especiallly in Mexico, the men always say...this is woman's things...we are not to do that.*" Other women laughed when asked if their husbands helped with health decisions, as if the idea was silly. In fact, only one woman said her husband helped her with the health of the family and with health care decisions. It appeared, in this study, that men consulted the women about health decisions and for health advice as opposed to the women consulting the men. In addition, on the occasions that the women in the study discussed professional medical visits, they did not discuss men going with them. When P10 was asked if her

husband helps take care the family's health, she recounted how her husband expects her or his mother to take care of him when he is ill.

P10: Ugh...(laughs)...hardly ever...it is hard enough to get them to take a pill. Let alone go to the doctor. You know my husband, he has been here for a long time too, and he won't go to the doctor, and he will say, 'Ahhhh, I'll call my mother, she will tell me what to do; how to deal with it' [using a natural remedy].

The Choice to Avoid Professional Medical Services

Participants mentioned insurance and language barriers as health care related annoyances. However, the women did not believe the barriers stopped them from using professional medical services when they felt they were necessary, usually for serious medical conditions. Participants in this study discussed their preference to self-diagnose and treat illness while avoiding professional medical care when they decided an illness was something they were unable to handle.

P10: If I see that it isn't working (home remedy) or that they are really ill, I will go ahead and take them to the doctor. I just won't go running to the doctor.

P5: If I know that they are sick, and I know what's wrong then I will give them some medication to help. But, if they are very, very sick then I will take them to a doctor.

P3: ...a home remedy and I would do that. But if is something more serious then we would go to the doctor.

The women avoided professional medical services because they felt they knew what was best for their body and preferred to use traditional means of maintaining health such as treating themselves and their family members for illness. As a result, the participants chose to seek professional medical services only when illnesses or medical conditions were very painful or did not go away after they had tried to treat them for an extended period. This was mirrored during the discussions about how the participants felt about their breast health and how they took care of their breast health. Participants chose to avoid mammograms because they were seen as a medical test or procedure that was unnecessary if they could maintain their own breast health through the use of self-breast checks, which they reported conducting. This was the case even when the women had opportunities to participate in free mammograms, through services such as mobile mammograms. In addition, this study found no patterns related to a change in breast care depending on whether the women lived in Mexico or the United States. In other words, it appeared the women maintained their traditional breast health practices or those practices they had established in their native country, preferring to maintain health through self-breast exams.

While feeling embarrassment when discussing sex and their bodies, especially with those of the opposite sex, is considered culturally-dominant among Mexican-American women, the participants in this study did not feel this stopped them from participating in mammograms. However, the women did state that other women, usually older women, might avoid mammograms because of embarrassment, shame, or modesty. While there was not a pattern formed among participants, P1 exemplified this concept as

she discussed accompanying her mother to the doctor. The male doctor asked P1's widowed mother about her sex life, which caused her mother great discomfort. P1 recounted:

We went to see one doctor...and he asked her how often she (mother) was having sex. She asked me to tell him that she doesn't have sex. He told her that you have to have to have sex to be healthy and wanted to know why she wasn't having sex. He asked her if she wanted me to leave. She said 'no,' and that she 'wasn't having sex because that part of her life was over.' You just don't ask older women about their sex life. I asked my Mom if she would go back there and she said, 'No. No. Not for any reason.'

The women in the study reported they failed to participate in mammograms because of time constraints, fear of procedure, and wanting to conduct self-exams. For the women, consistent with the belief that they should be active, working, and taking care of their family, taking time to go to the doctor for a mammogram seemed like a burden.

Preferring to self-diagnose and treat illness.

It was obvious to the researcher that the women in the study took ownership of their own health and the health of their family, as Mexican culture dictates. As a result, participants preferred to diagnose and treat illness themselves, only turning to professional medical services for conditions they deemed serious.

In fact, the women often discussed using a physician as a way to confirm their self-diagnosis. The researcher was most aware of this "second opinion" mentality as

participants discussed their method for deciding when to see a doctor. This was discussed as participants described the practice of determining a health condition was serious, such as with kidney infections. The women in this study would go to the doctor to confirm an illness and then usually receive medications. However, the women would usually not fill the prescriptions and chose treatment options with which they were more familiar such as home remedies. In addition, the women used professional medical services with apprehension and preferred to rely on themselves when treating illness. When they used medical services, they were often dissatisfied with the diagnoses they received and still chose to treat themselves.

When diagnosing themselves, the women in this study often relied on an understanding of how their own bodies functioned and what their bodies needed to be healthy. P9 stated “*We try to know when things are wrong with our bodies instead of having a doctor tell us.*” P10 also exemplified this as she stated:

So, I think that as we grow, we begin to learn what our bodies are trying to tell us and...we will say...this is not just menstrual cramps anymore. You know, this is something else. Something I cannot handle on my own. So, you have to listen to yourself, listen to your body.

This belief was also discussed as women described choosing not to participate in annual mammograms. Instead, they preferred to conduct manual self-checks for lumps in their breast. This was in line with other traditional health care beliefs that pointed to the women preferring to diagnose their own illnesses as participants could conduct self-checks and diagnoses about their breasts without relying on professional medical

services. As a result of these breast health care practices, the women believed they were in charge of their individual health care as they reported they were taking care of their breasts by eating properly and manually checking for abnormalities. If they felt there was no problem with their breasts, then the women in this study usually decided to maintain breast health with self-checks that they could administer. However, participants did report that if they found something wrong with their body, then they would visit a professional medical doctor for help.

P7: I think this is something, if we don't go to have the mammograms, we can check on ourselves and then we can go as soon as we can to check.

P4: I can check myself. And everything feels okay.

Participants' belief that maintaining health by doing what they felt was right for their body also applied to taking care of the breasts. As the women in this study discussed their breasts, they talked about maintaining breast health as a part of their overall health, which was part of a traditional, holistic process. Participants felt that if something were wrong with their breast they would know about it because they were in touch with their bodies. In other words, they would know if something were wrong with their breasts.

P2: So, when you think you are not healthy, that's when you know that you might pay attention. But nobody is going to come and solve the problem. It is up to me. ...When I had my children, they did it (mammogram). But after that, I just feel like my body, it functions right. You know when your body is telling you. And, you have the red light. Yeah, I think it's the red light. When you are suffering and something is

abnormal. Whether it is your heart, whether it is you blood, whatever, I don't know. It's just that you know. There is the wisdom that is inside of you saying you should. I just have that, believe that... you will know. You will find the answers about what you need to do. But in general, for checkups, I probably gonna start one day, but I don't feel like I got plans.

The women also believed that other healthy choices they made protected their breasts from cancer. This follows from the belief that women viewed their breast health as a part of their overall health. If their body was healthy, then their breasts were healthy. In other words, a healthy diet, healthy body, and a healthy mind kept the rest of their body healthy, so, the women in this study felt that their breasts were healthy as well. P7 stated *“For me, I try to take care of my whole body and I think that helps me be healthy everywhere. That is why I think I am healthy everywhere, my whole body, including my breast.”*

In addition, the women mentioned, they had read about natural ways to protect the breasts from cancer. P6 said she investigated natural ways to take care of her breasts, and *“since I tell you I read a lot. I read of ways to protect.”* This supported other traditional self-maintenance health beliefs and practices discussed in this study.

Using home remedies to maintain health and treat illness.

Participants reported they frequently participated in the culturally dominant use of home remedies, including herbal cures, to treat illnesses. However, none of the women discussed using an official *curandera* as part of their health care routine in the United States. Participants' use of home remedies made sense given they had expressed they felt

a sense of responsibility for their health care and the health care of their family. As a result, it seemed the natural choice that participants would prefer to use home remedies as a way to manage health, since this allowed the women to control what was prescribed for illnesses and allowed them to use remedies with which they were familiar, which gave them to a sense of control over side effects.

Participants usually chose remedies based on the illness they diagnosed and their success rates in the past with certain selections, using anything from herbal teas to natural rubs.

P2: I know what is the problem. I am not going to the doctor. Because, it is just that. ...So, the idea just came to my mind that 'you need to take this.' Because, I'm not going to the doctor just for this...I used a lot of gargles...You do this every two hours. So, it makes you tired, but it really works for me. So, I did basically three kinds of gargles and drank my teas and had honey.

P7: There is this kind of virus at school. A 24-hour virus, and, they have (it) in the stomach...Okay, my kids, never (get it), they always go to school. As soon as they say, 'mommy, I don't feel good, I feel like my stomach hurts and I feel like I want to throw up'...I just have the cup of tea (home remedy referenced earlier in interview) and I give to them at night when they feel not too good. Then in the morning before they go to school, I don't have problems with them.

P6: *I usually go and make some tea, some teas with herbs...and then rest.*

There is another tea that I make with vinegar. I mix it with herbs. I take it every few hours. I make another with lemon and vinegar. They work. I will try these.

While a majority of the home remedies were used for illnesses such as the common cold or stomachache, some women described using them to treat more painful infections such as kidney infections or diseases like diabetes and arthritis. For example, P8 discussed treating a kidney infection that made her very sick for several days:

There is a leaf...I do not know what the name is in English...(it) is the only herb that is good for (using) to drain the kidney, and it will help you a lot and you will have to pee like you are drinking any other water. So, you just need to boil the leaf and then drink water every day. And, you will be okay. ... I have maybe like four cups each day. And, the next day I was like with energy, because I was out of energy (before). I was with energy. I was very good.

The women also used over-the-counter medications, but these were usually used after participants had tried home remedies or in conjunction with home remedies. P3 described this as she said *“If I get sick, I will maybe try to treat myself with some things that I make at the house or some medicine that I have at home.”* P5 takes care of her family in a similar manner. She stated, *“If they are sick, and I know what they are sick from, I will probably make something to help them feel better or (use) some medication I have in the house.”*

The women in this study felt they face an increased challenge as they attempt to care for their health in the United States. Women mentioned the difficulty they had finding natural health supplies. When supplies were located, they were often very expensive, which was an added burden for the women. When participants had difficulty finding the supplies or ingredients they needed for their home remedies, they were unable to make certain remedies as they attempted to provide health care for themselves and their family. P9 stated that sometimes when she could not find the natural supplies she needed she would have to just “*give them whatever the doctor prescribes.*” P4 stated:

It is harder to find the natural herbs here. In Mexico, you can just go out in the countryside, and you can find them there, herbals, that people know and are familiar with. Here, I have a hard time going to the store and looking and you probably won't find it, even when you do.

However, with this challenge the women also appeared to have a renewed interest in taking care of their health through traditional methods. In fact, the women often discussed the use of natural remedies as if it were an art for which they had a new appreciation. P2 stated:

But, it took me a while to be aware and you know be resourceful. You know, do the things because I am convinced. Not because people tell me to. And (understand) why I'm doing it. My mom used to tell me thing and 'Why?' 'Why do I have to do (that)?' And, then 'Because you have to.' I didn't in my mind accept.

It seemed that health became a priority for the women as they struggled to maintain their health through traditional practices. Instead of health being something that just occurred, they now had to make it a priority. For example, when the women in this study moved to the United States, many of them moved away from their families and away from other women who had previously assisted them with the health care of their family. P8 described this as she said:

...if something went wrong, my mom was there, or maybe also my sisters and my dad. So, I think that makes you worry a little less. And, about the home remedies, when you have a hard time finding things and when you are doing them yourself, you learn to appreciate them.

Avoiding prescription medications.

While participants reported they used culturally traditional home remedies to treat illness, they also expressed concern about and avoidance of prescription medicine. The women often reported consciously avoiding medications, even after receiving prescriptions or buying them and having directions for taking the medications. For example, P7 described going to the doctor so that she could confirm she had a kidney infection. She received a prescription for a medication but chose to treat herself with a home remedy.

The women in this study felt that because they have used and are familiar with home remedies, they know the side effects. This appeared to allow the women to continue to provide defense against illness while maintaining their responsibility as

health care provider, a concept that emerged from the data as deeply engrained in their culture.

P6: You know when I started having my doubts with the medicine? One time I had a pain...in my side...on this side...and I went to see the doctor. And he said, 'You have a kidney infection.' And, he gave me medicine, the medicine, like a sample, and he said, 'When you finish, go to the drug store.' And he gave me the prescription. Well, I take the pill, and I take the one in the night, and I started feeling (she makes a bad face)...and he told me 'if you start feeling something is wrong, stop taking (the pill), go to the pharmacy and call me...and I will prescribe something by phone.' And in the morning, I start feeling worse. So, I take 6 or 8 pills and take them out of the box and start reading the paper and I can have leukemia, different kinds of cancer, I can get sick of my heart...I can get more than one infection (all were listed as side effects of the medication)...so I stop it.

P2: It just keeps getting worse because it is a consequence of the medicines you are taking. So, a cough, it (medication) might fix this one thing now, and then it affects something else (negatively).

In addition, the women did not fear addiction to home remedies, which was another concern of the women in this study with regard to prescription medications. When P10 discussed why she preferred to use home remedies as opposed to prescription medications, she stated “*it stemmed from all of this fear, I guess, of becoming addicted to*

pills.” P7 also addressed medications and addiction as she described a natural remedy that helps relieve stress:

It’s supposed to help with the stress (home remedy), and it doesn’t supposed to be addictive. And, you know some pills for stress are so good, but some of them are addictive. And, doctors say so many are not addictive anymore, but I don’t know.

Relying on other women for health advice.

The women in this study reported they learned how to maintain health through the traditional processes of watching other women take care of health and discussing health with other women. Participants reported they primarily learned to make and administer home remedies from female family members. This was not a surprise since the participants described women as the health care providers in the family. Women in this study usually learned home remedies from the women who took care of them. Participants often described the process of learning home remedies as beginning when they were children. They discussed how women learned to maintain health in a traditional manner from older women, such as their mothers, grandmothers, and aunts as they provided health care services to other family members.

P1 ...for example, my grandmother, in her little town, would cure people. She was not an official curandera, because she did not charge, but she was an elderly woman that everyone knew had information and knew things. So, people would go to her for certain ailments. And, I think that my mama has just learned that. She knows that through watching her,

and because they lived in a very small town and there was no permanent doctor, it was very difficult to seek professional medical attention, so they learned to take care of themselves...they (women) definitely learn from each other.

P6: When I was a little girl, my mother used to cure us. And, she always used to call me to help. Like one time, my brother had a (points to neck), something in here...a pain...and she said, 'Okay, now I'm going to cure you.' And she, we have a little basin especially for the curing, and, she put alcohol in it and a flame to sterilize, and water, boiling water. She put that in there. Then she cut next to the ear and there was puss that drained. And she washed. And, I watched and saw everything. And, I know what she put on it (an herbal rub) and how she cleaned, and I learned a lot.

P7: I have a teenage daughter, she's 15, and there's times when she might have menstrual cramps, and she might ask me what kind of tea she might take to make it better. And sometimes, she even does it on her own.

While not a pattern among the participants, several of the women who had sons said they had tried to share some home remedies and natural health care practices with their male children. However, the responsibility for taking care of their son's health seemed to fall to the son's wife after the men were married. P2 discussed this as she described her son's wife and her knowledge of natural medicine:

But she (son's wife) came here when she was two years old. But, she still learned all the ways (home remedies)...He (son) is used to me (taking care of his health), and he don't change when he married that wife. We are the same (she and wife).

In addition, two of the women mentioned their children, who were born in the United States, were less accepting of home remedies than were they. For example, P6 stated:

I used to do that with them (use home remedies often), but now, I have a son...see he love to have a massage when he comes home from school, 'oh, give me a massage...I'm really tired.' So, I massage him. Because, we learn all those things in Mexico. So, he feels very good. Then, he started going to the university, and he started physical therapy. Then, one time he said 'I am so tired,' and I asked if he wanted a massage. And, he said 'No, you can't, you haven't studied, you didn't go to school, you can't do that.' (laughs). And he now, he don't accept anything I tell him. And, he was always healthy. I always cured him; he never get sick.

P2 also discussed her U.S.-born children not wanting to take home remedies when they were sick. The researcher posits the children's choice to turn away from their cultural customs and traditions is probably a result of acculturation. The children, who were born in the United States, were more bicultural than their Mexican-born parents. This may have resulted from the children having fewer people to share cultural customs

with and, since they attended public schools, spending more time with those from the majority culture.

The women in this study also reported the traditional practice of relying on other women, primarily family members, for health advice and support during illness. This seemed logical since the women would call the person who took care of their health as a child to ask for advice about current health problems. As the women detailed their use of these social groups, the researcher noticed that many of the women in the study were separated from large portions of their family who still lived in Mexico. As a result, many of the women's conversations about health took place over the phone. For example, P8 discussed that health care was easier for her when her mother was physically there for her, and it was harder without her family's knowledge on which to rely.

When P5 discussed whom she would talk to for advice about health, she stated *"My mother. Well, my mother and my grandmother, and friends. If we know something that works we talk about it."* However, when asked whom they usually discussed health concerns with or called when they were not feeling well, their mother was the most common answer among participants. The women relied on these female sources for guidance about possible causes of ailments and the best course of treatment, usually seeking suggestions for home remedies.

P1: *Mom cured me of a sinus condition, with her home remedies.*

(Through suggestions made over the phone.)

P2: *My mom, she is the one. Well, the way (of) the culture, was taught by her; it is to go by the natural way.*

P3: *If it is a cold or an infection or something like that she (mother)*

might suggest a home remedy, and I would do that.

Referencing printed sources for health information.

The participants also reported they often relied on literature about natural or home remedies and professional medicine as they diagnosed and treated themselves and family members for ailments and illnesses. The women may have turned to these sources because of their migrant status. As noted, many of the women in the study were physically separated from their traditional social networks that were used as health resources in Mexico. During interviews, participants referenced printed material from texts containing both home remedies and scientific medical information. These texts were originally from Mexico and often described illnesses and several culturally traditional treatment options, including home remedies, which might be attempted before visiting a medical professional. P2 discussed these texts as she stated “*I have my books....They have things in them like the way that my mom used to treat us.*” She described how she used the books to treat her husband after he fainted several times.

P2: *So, I got my book that I read, for example, when he passed out, we go*

(to) that book. But you know, those sources are from doctors. But there are ways that it says to you, if you follow this list of symptoms you can do this. And, if you are not this way, you might to go to see the physician.

...So, it is just something that is so useful that I can go on my own, that I know I (can) depend.

P6 also discussed this when she treated a kidney infection:

I don't call the doctor. And so, I call a friend...and she give me a little book and said, 'you can read this.' I found in that book some things and right away, I was right. And since that time I read a lot...I love medicine. I have the opportunity....It had some natural ways in it, but it was a medical book. It tells you when you can try to handle something yourself. Using medical services for serious conditions.

The women usually determined how serious an illness was based on how much pain a person experienced. The researcher felt this method was in line with the cultural belief that good health was an absence of pain. In addition, if the participants had tried to treat an ailment and it was persistent, this would usually cause them to classify it as a more serious illness.

P6: But, if it is still bad I will go to the doctor. If it is something I can't handle...if there is a lot of pain, if something really hurts for a long time. Or, if I maybe have a high fever for a long time that I can't get rid of.

P9: If they are seriously ill, and they have been feeling bad for a couple of days, I will have to resort to a doctor...If they aren't getting any better after I try things at home, we go to the doctor, since it might be an infection.

Making changes to health care practices since moving to the United States.

When one takes into account the complexity of the U.S. health system and the language barrier many Mexican-Americans face, it might be expected the women in this study would discuss a decrease in the professional medical services they have used since

they moved to the United States. This was not the case with participants in this study. If anything, women discussed an increase in the use of professional medical services when they first moved to the United States. For example, while all of the interviewees said they were reared in homes that used natural medicine, many of them spoke of an increased use in professional medical services as they began making their own health care decisions in the United States. This increase in professional medical services was discussed as a brief period that was followed by a return to a health care regiment that was more similar to the one with which they were reared, which was more reliant upon natural remedies. P10 stated:

Well, there was a time when I began to feel it was a faster route to go to the doctor. Or, I thought it would be a faster route to go to the doctor. I'll just go, they'll give me a pill, I'll be fine. You know, instead of this prolonged treatment that I have to follow 3, 6, 10 days, or weeks, or whatever...(describes fear of medication side effects)...That has kind of made me re-think and go back to the more natural ways that are more customary. I think, maybe I should try that first...You know... I think that is kind of where that came of...to go back to the home remedies. We didn't die from what she (mother) gave me and from what we were taught. And, again, it comes from that fear of the medicines, a fear of becoming an addict. I though, ugh, maybe there is another way. So, that's how I came back (to natural medicines).

The temporary increased use of professional medical services when they first moved to the United States might be attributed to the fact that the women were attempting to fit in with their perception of U.S. culture. The women felt U.S. health care practices were culturally different than practices in Mexico. They perceived the U.S. system was reliant on professional medical services and placed little emphasis on natural medicines. The researcher associated the women's temporary increased use of professional medical services with the acculturation process. The women in the study were operating in an environment with cultural traits that were different, or that they perceived as different, from theirs. As a result, they decided which elements of their more natural health care behaviors they would manage, maintain, and sustain. The women felt that the main difference in the U.S. health practices and those in Mexico was the acceptance of natural medicine. In addition, they recognized that while they attempted to maintain traditional practices, they had made some changes to their health practices. This was a result of their operating in a majority culture that they perceived was more accepting of professional medical services that they often found useless, and less accepting of natural medicines. Changes usually included acknowledging they may have visited a medical professional more often than they did when they lived in Mexico. P6 stated:

Well, when you live somewhere...you take on little by little the ways. In Mexico they believe more in the natural ways. So, I still do some of the natural ways. But, I also see it is good to go to the doctor sometimes too. The ways of the doctors can be good too.

The temporary increase in the use of professional medical services was evident in women who moved to the United States as adults, but it was also seen in participants who had moved from Mexico as children. Acculturation was most evident as women discussed times when they started making their own health decisions. For example, they discussed making decisions about which part of the U.S. health culture they would adopt, and which part of their traditional health practices they would maintain as they navigated through a non-native environment. Overall, the women said they had an increased avoidance of professional medical services since moving, because they believed the U.S. system was more difficult to use. Difficulties were often attributed to being confused by insurance, being frustrated by language barriers, and believing physicians did not understand them. P3 stated:

It is very different because, for example, in Mexico it is very easy to go to the doctor to get help. Here, in the United States it is very difficult to go and get help. Insurance, other issues, like the language barrier, the trust is not there. ...In Mexico, because I would understand them more, and they would understand me...I think I would feel more comfortable if they spoke my language. It is more than just the language though. I just don't feel comfortable with the differences.

Women also noted the difference in expenses associated with health care in Mexico and the United States. Participants felt they provided their families with more preventative health care services in Mexico where health care services were more affordable. P10 stated:

Well, there are a lot of costs involved here that I couldn't afford here that I could have afforded there. And, the access to pre-or low-cost health care is more prevalent in my country than it is here. So, maybe more physicals, or more visits to the dentist, because I would have been able to afford it....instead of being here.

The Belief that the Cause of Illnesses Should be Explained

When diagnosing general illnesses, with the exception of accidents, the participants almost always attempted to find an underlying reason for the illnesses they diagnosed, believing ailments or sicknesses rarely happen without cause. Simply stated, when the women discussed an illness, they did so in terms that suggested it was contracted because a person had done something incorrectly. For example, the sick person did not have the correct state of mind or did not eat the right foods, and as a result he or she became ill. Women also discussed avoiding professional medical treatment because of a lack of confidence in professional medical services. They felt physicians conduct tests that failed to provide reasons for illnesses.

However, participants did not discuss a belief in spiritual or supernatural explanations or connections to health problems. In other words, the women did not report feeling illnesses were caused by an imbalance in the water, air, or between God and man, something that would require supernatural intervention. In general, participants failed to mention religion, spirituality, or the supernatural as causes for illness, even when prompted. The one participant that included this concept in her interview discussed praying to God when she had a very painful headache and thought it might be a brain

tumor. Her prayer was similar to the concept of *sea por Dios*, or the will of God, in which those with long-term illnesses such as cancer, or illnesses that are not fully understood, are believed to be part of a person's destiny (Scheper-Hughes, 1983). P2 stated:

So I prayed...And (said) it is your time to go and there is nothing to worry about. I know that I have to learn to go through today ill...At first I start thinking, maybe it is time for me to go...Maybe it is time for me to die, so I say, well, father, if it is the end of my life then I am complete in my mission. I'm okay, father, I wanted to do your will, and I'm okay. If that's what you want for me. I'm happy with what I have done in my life. I'm really satisfied because you have the power to keep me alive or take me. So, that's the way I meditated.

Believing health begins with diet.

When participants described the diagnosis and treatment of illnesses, they often discussed the food they eat. In fact, when the women talked about maintaining health, they all discussed the importance of a healthy diet and providing healthy foods for their family. P4 said “*Everything starts with the stomach. If you do not eat well your body will not be well.*” The researcher noticed women in this study explained the underlying causes of illness most often when they talked about their diet. Discussions that followed, about treatments, usually included the culturally dominant use of home remedies or natural remedies. To promote good health, participants attempted to maintain a diet that avoided fats and fatty meats and cheeses while it promoted vegetables, fruits, and lean proteins. The women discussed eating a balanced diet at several smaller meals throughout the day

as opposed to fewer, larger meals. The primary objective of a person's diet was to promote a healthy body and immune system, not to avoid weight gain or promote weight loss.

P10: I am eating things that has more nutrients and is better for my immune system. It keeps me healthy. I don't cook with salt. It helps keep my family healthy. And, I try to get the vitamins I need by eating a lot of fruits and salads... If you are giving your body what it needs to function then you are building a foundation to be healthy. I try to think about that when I prepare meals for my family.

P2: But I know the consequence that the way I take care of my body. I know if I ate junk food that is gonna affect my health. So in my life, I don't have health issues because I know, in my life, I know the right things, in my knowledge, that I need to go buy so that way I can avoid to have issues with my health.

P1: I eat a lot of fish, salads, fruit....I have a weight I like to be and I try to stay around that, but not for looks but because I feel better there.

Believing health begins with foods that are eaten may be a result of Mexican folk medicine that traditionally has its roots in the belief that illness is an imbalance of the "humors" (blood and bile). As a result, restoring balance is achieved by eating certain foods or herbs. The participants repeatedly discussed the concept of illness as a consequence of improper eating habits, or failing to take care of their stomach. Simply stated, the women in this study believed that when a person made poor food choices his

or her immune system was affected, causing him or her to become ill. In fact, the women noted that when someone became sick, it was usually because he or she had not been eating properly.

P6: I think that the headaches...everything comes from the stomach. The sickness. All the sickness comes from the stomach. And, if you don't take care of what you eat, like if, we are not perfect; we are humans.

Sometimes there is something I like a lot or we go to a party or something or we ate something that we aren't supposed to...there is a consequence.

You have headaches, you have stomachaches, and everything. You can feel bad, be sick, get sick with other sicknesses.

P3: Or, for a cold, it's because the person's immune system is weak...it can be because you are eating late or too much greasy stuff. I think it's the way they are eating, their eating habits.

Believing cancer is caused by injury or genetics.

When women discussed other people who had suffered from or died from cancer, they explained cancer as something that was a result of an injury. P2 discussed how she feared she would develop brain cancer because she hit her head when she dove into a pool as a child. When she has headaches, she stated she fears she has developed a tumor and is finally suffering the consequence of the childhood injury. She said:

But when I got that pain (recent, severe headache), I thought it was a consequence, a tumor or something. I start already praying. I thought I would have to face that consequence. I heard a lot of people say that you

know if you are in an accident, or, there was a lady in Mexico... I don't know how she got hurt on her head, but when she was little...but when she was a grown lady, maybe in her 40s or 50s, she got a tumor on her head. And, she said that she started feeling headaches, and after that she went to the doctor and there was a tumor. And, she had to have surgery, and sometimes my thinking tried to corrupt me and tried to get me into the worrying.

The women also discussed cancer and its link to injuries when they discussed women who suffered from breast cancer. P4 discussed her mother's friend that died from breast cancer as she stated:

She had a tumor, I think, on her breast. She died because she did not tell anyone and did not go to the doctor...I would think because she did not know it was serious. She had hit her breast...She did not know that the tumor was a consequence.

P5 told a similar story:

For example, there is a woman I know that hit her breast, here on the left side and she never said anything to anyone and she never talked about it because she was embarrassed. So, in time she got a tumor, and it just got bigger and bigger. And then she died.

The belief that cancer is caused by an injury was very interesting. Simply put, it seemed that if the women had not injured their breast, then they did not need to worry about breast cancer.

In addition, as the women attempted to explain the causes of cancer they discussed that a woman developed or had breast cancer because she had a history of the disease in her family. For example, when the participants discussed those who had suffered from breast cancer, they would often explain the cancer in terms of its genetic cause. P6 discussed her friend who was diagnosed with breast cancer as she stated *“And, two years before, her daughter had the cancer in the breast...and the family...it is in the family.”* As a result, women who did not have a history of cancer in their family felt breast cancer was a risk for other Mexican-American women, and it was something for which they personally were not at risk. P3 stated, *“And I don’t have anybody in my family with (breast) cancer, so I don’t really think about it.”* Similarly, P4 said, *“No one in my family has had it (breast cancer), so I don’t really worry about it.”*

On the other hand, P9’s daughter had a breast cancer scare, which caused her to feel she might be at risk for cancer. She stated, *“Yes, (she has worried) because I don’t know if I might get it. My daughter had cysts in her breasts, so that worried me.”* P8 also felt that women in her family were more open to discussing mammograms and participating in mammograms after someone in her family was diagnosed with cancer. This was similar to other women in the study who had a mammogram after a family member was diagnosed with breast cancer. P2 stated:

I feel like I don’t have to be worried...I guess this is a big concern, because a whole lot of women, from Mexico even, they have issues with it. But, I guess I feel that when I feel there is a problem I will go (seek professional medical attention)... In my family, now they talk more openly

about it because my cousins that are a little older than me, before they would doubt before going in for a mammogram, and now they do it regularly, especially because there is a history of cancer in my family.

However, participants usually did not follow up with annual mammograms after the tests showed they were cancer-free, which indicates that participants believed that breast cancer is hereditary or caused by an injury. In other words, when the women in this study discussed breast cancer, they recognized the disease as a health threat to women, if they had certain risk factors such as a family history of breast cancer or an injury to the breast.

Lacking confidence in U.S. professional medical services.

It was apparent that the women in this study expected to be told what was wrong with their health or the health of a family member when they visited a physician. When this did not happen, the women discussed a lack of confidence in U.S. professional medical services. This expectation is probably linked to the way the women in this study attempted to find a reason for an illness or ailment. This led to frustration when participants felt physicians had failed them when they could not tell them what caused illnesses, even after running multiple, expensive medical tests or sending them to different specialists. As a result, the women felt the U.S. health system was difficult to use. Participants reported they were usually seen by one physician in Mexico. P3 expressed frustration as she said, *“The doctors do not seem to understand what is wrong with you here, and they send you to many places and want to run so many tests.”*

Over the course of the interviews, this belief contributed to the women choosing to avoid professional medical services. In other words, “Why send a person to the doctor if I will just have to treat them anyway?” P2 recounted one such experience as she said:

My husband, last year it happened for him to passed out. Two times in one day, one morning. So, they went to the emergency room. And they did all the tests...All the tests that they thought it might be and they didn't discover anything. They didn't know why. They did brain, they did heart, they did diabetic tests, cholesterol tests. And all the things you can imagine. And, it was nothing... So, I believe, I believe in doctors, yes, I do believe, but I just don't believe in the machines....So, my husband, still he does not know.

P2 later discussed how she used her medical texts to diagnose her husband after he came home from the hospital. She took care of him since then, and she said he has not experienced additional problems.

The women discussed similar feelings about participating in mammograms as they described having a mammogram, usually when they first turned 40. However, when the exams returned no abnormal findings, the women often failed to go back for follow-up exams since their first exams did not find anything. The women then chose to do what they were comfortable with, self-manage their own breast health care. Women in this study were most comfortable performing manual breast screenings, and stated they would follow up with a physician if they thought anything was wrong with their breast health or

if they had pain or discomfort. If this occurred, they would visit a physician for help, or a “second opinion.”

Participants who were over the age of 40 and had participated in mammograms reported they did not have follow-up mammograms for a variety of reasons that included pain associated with the procedure, fear that mammograms may cause cancer because of radiation used during the exams, the mammograms did not find anything wrong with her breasts, or time constraints.

P6: When they start saying that we have to take x-rays (mammograms) and everything, I start doing it. But every time I went...it hurt me a lot. Because they put me in a machine and they press it a lot. And it hurt me. And, I decided I am not going to do it...They never find anything anyway.

P1: As far as a mammogram, I'm supposed to have another one. I've had two since I'm 40. I had one right when I turned 40 and then I'm 46. I've had another one some time in between...I just don't want to schedule that block of time.

P7: Like one thing makes me not too comfortable with the breast tests (mammograms)...because I was reading the other day about the women that are more often checking, having these tests, they are more, how do you say? They are more likely to get breast cancer because of the radiation...because of where they go in for the mammograms. I had mine when I was 40. Because the doctor says, you need to do it now. And, I went and it was okay, but I am afraid to go every year, because I read

this one doctor and she says, why you have to do this every year if you not have any problems? If you find out it is a problem, you must go and check on time, but if you don't have any problem, why you going?

Summary

This chapter described, using a qualitative approach, how the Mexican-American women interviewed for this study define health and take care of health, particularly their breast health. After ten in-depth interviews were conducted, the main theme that emerged from the data was: The Maintenance of Health through Traditional Practices in a Non-native Environment. Two thematic constructs participants engage in were discussed to describe how the women in the study maintain health in a traditional manner when they live in a non-native environment: (1) the belief that health is a combination of the body and mind and (2) the belief that health care is a Mexican woman's responsibility. The following chapter will include conclusions drawn from the research and recommendations for health communicators.

Chapter V

CONCLUSION

The main theme that emerged from the data was: The Maintenance of Health through Traditional Practices in a Non-native Environment. Two thematic constructs helped to describe how the women in the study maintain health in a traditional manner when they live in a non-native environment: (1) the belief that health is a combination of the body and mind and (2) the belief that health care is a Mexican woman's responsibility. This chapter will (1) draw conclusions from the main theme and theoretical framework that emerged from the data, (2) discuss importance of this study for health communicators, (3) make suggestions for future research, and (4) outline research limitations.

The Maintenance of Health through Traditional Practices in a Non-native Environment

Despite their non-native environment, women in the study defined health in terms of culturally-traditional definitions and attempted to maintain their health through methods that are culturally prevalent in Mexico, noting few changes in health care practices since moving to the United States. In addition, their general health beliefs and practices translated to the care of their breast health, as they viewed their breasts as a part of their overall health. These beliefs and actions were constant, in spite of the women feeling that the majority of people in their new environment held different health beliefs and maintained health in a way that was different from them. In other words, the women in this study attempted to maintain health through traditional practices, despite their non-native environment.

The Belief that Health is a Combination of the Body and Mind

It was not a surprise that women in this study defined health in a holistic manner, including both the body and the mind. This belief is consistent with previous research about Mexican-Americans that described a holistic understanding and maintenance of health among Mexican women, including the environment, physical health, and mental wellbeing (Kay, 1977). However, the interviewees' failure to include the environment, such as air and water quality, in their definitions and health care routines was interesting. The absence of discussions about environment may be attributed to the women living in a non-native environment where they felt they had less control over their physical surroundings. As a result, they focused on the elements of health care that were more easily maintained through traditional practices that integrate the body and mind.

In most instances when the women discussed health, they acknowledged its importance since they believed that having good health allowed them to live an active, pain-free life. This is also a culturally traditional belief and consistent with Abril's (1977) findings that Mexican-American patients perceived good health as having the ability to maintain a high level of physical activity with the absence of pain. Participants believed this was important because it meant they could work and take care of their families. In fact, it appeared that being able to take care of their loved ones was the primary reason women were interested in maintaining their health. This finding supported culturally dominant beliefs as the family and maintaining the family plays an important role in Mexican culture (Molina & Aguirre-Molina, 1994). In addition, the importance women place on the ability to work may be attributed to the fact that they were immigrants to a

new country, and may have a certain mind-set and attitude about setting goals and working toward them. For example, the women discussed people who do not work as failing to have goals. Melville (1980) stated that the act of migrating usually indicated a readiness to adapt a new life. He posited that as Mexican-American women acculturate they often had class aspiration or goals that included seeking jobs with better pay and improved living situations. This may have impacted the women's affinity for grouping those who choose to be active and to work toward goals as positive and healthy while those who are inactive were seen as negative and unhealthy.

The fact that the women in this study attempted to maintain positive mental health or a sense of wellbeing as a part of their overall health care was also supported by past research as a traditional practice (Kay, 1977). Most of the participants' conversations about the mind and health revolved around maintaining positive mental health in order to avoid physical ailments or illnesses. However, the women did not address the impact of physical health on mental health. For example, they did not discuss the concept of feeling mentally unwell or depressed as a result of a physical illness. In fact, it seemed that mental health was generally talked about as a preventative form of health care for the physical body.

The concept of using a positive attitude to overcome or avoid illness was interesting since it was not found in previous research related to this topic. The women felt strongly that maintaining a positive attitude had or could help them overcome and avoid illness. The belief that those who were ill chose to be ill emerged from the data. This belief might be expected in relation to illnesses that are caused by human action, for

example, smoking and lung cancer or obesity and heart disease. However, the women in this study expressed the belief that those who were ill, with anything from a cold to cancer, had usually brought this kind of illness on themselves or failed to overcome their illness because they did not have a positive attitude, believing they had “given in” to their situation.

The Belief that Health Care is a Mexican Woman's Responsibility

The data in this study supported previous findings that supported the belief that the responsibility for health care usually falls to women in Mexican and Mexican-American cultural settings (Gonzalez-Swafford & Gutierrez, 1983; John et al., 1997; Lopez, 2005). However, this study did not support past findings that men, the traditional head of the family, are closely consulted by women before health decisions are made. Previous studies found that Mexican-American men usually reported they should be included in health decisions, including counseling sessions with medical professionals, so they could maintain authority within the family (Reinert, 1986). The women in this study did not report discussing health decisions with men and believed their health and the health of their family was something for which they were responsible. As the women usually discussed health as something for which they were responsible, they used culturally-traditional methods such as providing good nutrition, exercise, and preventative health care (Mendelson, 2003).

Participants also reported they maintained health in a culturally traditional manner as they relied on self diagnoses and treatment of illnesses, relied on other woman for assistance with health concerns, and chose to reserve professional medical services

for serious conditions (Abril, 1977; Clark, 1995; Egebreton, 1994; Gonzalez-Swafford & Gutierrez, 1983; John et al., 1997, Kay, 1977; Keegan, 1996; Lopez, 2005). However, while past studies have found that Mexican-Americans often do not seek professional medical treatment because they lack insurance (Trevino, Moyer, Valdez & Stroup-Benham, 1991) or because of language barriers (Stein, Fox & Murata, 1991), this was not the case with participants in this study. While the women saw these barriers as annoying, they did not stop them from seeking professional medical services when they thought they were necessary. Participants reported they most often sought professional medical treatment as a “second opinion.” In other words, when the women did seek professional medical care they usually sought to simply confirm their own diagnoses. In addition, as the women avoided professional medical services they also failed to use the services of a *curaderismo*. However, this finding was in line with Higginbotham, Trivino, and Ray’s (1990) study that found a small portion, less than 5%, of Mexican-Americans use *curaderismo* services each year.

Breast health practices were also affected by the avoidance of professional medical services. The women in this study did not participate in mammograms, a professional medical service, because they preferred to maintain their breast health through the use of self-breast checks. The women failed to support past studies that have suggested Mexican-American women do not have mammograms because of language barriers (Chesney, et al., 1980; Stein et al., 1991), embarrassment, shame, (McKenna, 1989) modesty discussing sex and their bodies (Reinert, 1986), and expense of the procedure (Garbers, et al., 2003). However, Women who had mammograms usually did

so because a physician advised them to do so, thus supporting Austin, et al.'s (2002) findings that Mexican-American women see physicians as authority figures and will often follow their advice.

However, the women also discussed behaviors that were not noted as culturally traditional in the literature. For example, when the women saw physicians, they felt the drugs that were prescribed had more negative side effects than benefits. In addition, they often referred to printed sources for health information. While these were not considered traditional behaviors, they are in line with culturally dominant practices based on other health beliefs that surfaced during the current study. For example, avoiding prescription medications because they were unsure of the health effects may be related to the women feeling most comfortable with traditional home remedies. Women in this study often failed to take prescription medications, even after receiving prescriptions or buying them and having physician directions for taking the medications. This failed to support past studies, which have shown that Mexican-American women view doctors as authority figures, often participating in activities they recommend (Austin, et al., 2002). However, avoiding prescription medications not only allowed the women to remain the primary caregiver, but it also allowed them control over side effects as they were familiar with the effects of the home remedies they selected. Similarly, while the use of printed sources for health information is not documented in past literature as a culturally dominant practice, use of the medical reference texts allowed women to participate in the culturally dominant behaviors of diagnosing and treating illnesses without the use of professional medical services. In spite of perceiving their current environment to be one where the use

of professional medical services and medications was the dominant practice, the women continued to maintain health in a more culturally traditional manner.

The changes the women made to their health care behaviors after moving to the United States were often a result of not having access to the supplies they needed as they attempted to maintain their health through traditional methods. In other words, if they could not find the supplies necessary to make home remedies, they used professional medical care or prescriptions as a last resort. This was not a behavior the women intentionally pursued.

When coupled with participants' emphasis on the use of traditional practices, it was interesting that several of the women discussed an increase in their use of professional medical services when they first moved to the United States. However, these temporary changes were often dismissed by the women as something they tried because it was the "American way." In the end, they felt that a natural approach to health care was more beneficial for their health and began making efforts to maintain health in a more traditional manner, despite their new environment.

The choice to maintain health in a traditional manner often meant the women felt they had to work harder to maintain health in the United States as opposed to when they lived in Mexico. For example, the women had less access to other women, which was previously their primary source of health information, and reported they had difficulty obtaining natural health supplies. However, instead of allowing this to force them to use methods more readily accepted and available within the dominant culture, the women discussed a new appreciation for their culturally traditional methods of health care. As

they made additional attempts to maintain health in a traditional manner, they did so because they truly believed in the benefits and felt it was the best way to maintain health, even after trying the dominant culture's approach.

The way the women maintained their breast health was also impacted by their traditional health beliefs. While past studies have suggested Mexican-American women do not have mammograms because of language barriers (Stein et al., 1991), embarrassment, shame, and expense of the procedure (Garbers, et al., 2003), this did not appear to be the case with the women in this study. In addition, when Chesney, et al. (1980) investigated acculturation variables that predict breast cancer screening, they found language was the only variable predicative of screenings in elderly Hispanic women. This study found no patterns related to a change in breast care depending on whether the women lived in Mexico or the United States. However, because participants believed in a holistic approach to health care, taking care of the body and the mind, the women felt they were in touch with the things that were going on in their body. This meant they believed they would know if they had something wrong with their breasts and that their body would let them know. In addition, they chose to self-diagnose problems with their breasts and reported being comfortable with conducting self-breast exams. The women saw no need to have a professional medical test, or mammogram, to maintain their breast health; this was something they could maintain through the traditional practice of self-diagnosis.

These health beliefs were also evident as the women believed that when they diagnose an illness they must know the cause in order to best treat the illness. For

example, fighting an illness often meant diagnosing the root cause of the illness, with the women believing most illnesses have a connection to one's diet. This meant the women felt that an ill person had eaten an improper diet. Believing health begins with foods that are eaten may be a result of Mexican folk medicine that traditionally has its roots in the belief that illness is an imbalance of the "humors" (blood and bile). Restoring balance is achieved by eating certain foods or herbs (Clark, 1970; Chesney et al., 1980; LeVine, 1993; Madsen, 1973). As a result, the women in this study attributed everything from the common cold to kidney infections to a weakened immune system, caused by a poor diet.

Similarly, an unanticipated finding was that the women also attempted to find a reason for cancer. Most often, cancer was attributed to an injury. For example, if one had cancer of the brain it was attributed to a head injury. When injury was determined to be the cause of breast cancer, participants believed it was because a woman had hit her breast, causing a tumor. These injuries may have occurred in childhood and manifested themselves in adulthood. This impacted the women's beliefs about the causes of breast cancer as they usually thought breast cancer was a result of injury.

Women also attributed breast cancer to genetics, believing a woman had breast cancer because there was a history of cancer in her family. This is important as the women in this study discussed cancer as a problem for Mexican women. However, they did not feel personally at risk unless they had a breast injury or a family history of cancer. As a result, the women continued to maintain their breast health by using the traditional practice of self-diagnosis or manual self-checks as opposed to professional medical tests or mammograms, even when they did not feel they were not at risk for cancer.

Belief that diagnoses of illnesses should include determination of the cause of the illness often contributed to participants having little or no confidence in U.S. professional medical services. The women felt that when they used professional medical services, they usually failed to receive an adequate diagnosis when the cause of the illness was not determined. Simply stated, they felt that physicians often sent them to another physician or sent them home with a medication, failing to fully explain the illness or its cause. As a result, the women discussed that going to the doctor was often pointless. They felt they received no real answers about the cause of the illness and that they could better diagnose and treat ailments, usually using traditional home remedies while avoiding prescription medications.

The lack of confidence in U.S. professional medical services also affected the maintenance of their breast health. Women who had participated in mammograms usually failed to go for follow-up mammograms after the tests were negative. The women went for a mammogram and the physicians did not find anything wrong, resulting in the women believing that mammograms were simply another useless test. They believed professional medical tests often yielded the same “no problems” diagnosis that the women were able to achieve through their own traditional self-diagnoses using manual breast exams. In summary, the women felt they were best able to take care of their health using a holistic approach to health care and through traditional approaches to breast health maintenance.

Importance of the Findings for Health Communicators

The findings are important for health communicators in community and public health and health communication. The U.S. health care industry has gone through dramatic changes since 1990, shifting from a more traditional medical treatment model to one that sees the importance of and stresses prevention and wellness (Hetherington, Ekachai & Parkinson, 2001). One of the key objectives in promoting healthy behavior is to engage in regular screening for early disease detection (Champion & Springston, 2004). Unfortunately, screening is not occurring, with minorities most often failing to participate. Studies have shown that while breast cancer incidence (morbidity rate) is higher for non-Hispanic White females than for females in other racial and ethnic groups, it is minorities who carry higher mortality rates. The lower survival rate is due in part to delays in diagnosis and treatment. In fact, in 2003 the annual mammography screen rate for Mexican women was 64% as opposed to 71% in non-Hispanic White women (American Cancer Society, 2006).

The health status of Hispanics has become a national concern for health communicators as they are now the largest minority group in the United States (Smedley, Stith & Nelson, 2002), representing 44.3 million citizens or 14.8 percent of the total population (U.S. Census Bureau, 2007). It is expected that the Hispanic population will reach 53 million by 2020, 80 million by 2040, and nearly 97 million by 2050. To put this into perspective, that means that each year from now until 2050, the Hispanic population is projected to add more people to the United States than the majority, non-Hispanic White group (Day, 1996).

In order to address the higher rate of breast-cancer related mortality among Hispanic women, health communicators must look at the individual ethnic sub-groups that make up the larger Hispanic ethnic category, focusing on the possible differences between these groups. As intercultural communication models are formed, health communicators must remember that people pay attention to, ignore, or modify information based upon how it fits with their previously defined attitudes and beliefs (Hill & Dixon, 2006).

Community and public health communicators can use this study's findings as they seek to protect and improve the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention. The community and public health approach to health care differs from more traditional medical practices in the United States as it focuses on the health of entire communities, not just individuals. The goal of this type of health care is prevention, to try to prevent problems from happening or reoccurring through implementing educational programs, developing policies, administering services, and conducting research. Again, this differs from clinical professionals, such as doctors and nurses, who have traditionally focused on treating individuals after they become sick or injured (Scutchfield & Keck, 2003).

These findings are also important for public relations in health care settings. As the management of communication between an organization and its publics, public relations must seriously consider cultural identity, which is important as organizations seek to improve their communication with stakeholder publics (Davila, 2001). Strategic public relations management should involve not only segmenting stakeholders into

publics, but also creating appropriate messages for those publics once they are identified. Targeted preventative and educational health campaigns provide public relations practitioners and researchers with the opportunity to assist in saving lives and improving health as well-designed public relations messages are essential to effectively inform publics about healthy behaviors and to persuade them to adopt those behaviors. The segmentation of publics often results in intercultural communication as situations arise when an organizational public identifies with a cultural group different from the organization's cultural group. During these times, public relations practitioners can serve as "boundary spanners" (Dozier, Grunig & Grunig, 1995) who can help organizations better understand the perspective of their public, and vice versa. Strategic messages are needed that will both further an organization's goals, such as decreasing health disparities among minority publics, while taking into consideration how a targeted public may react to these messages – possibly based upon cultural beliefs. This means public relations practitioners should be especially interested in the meaning different groups ascribe to health within their larger cultural context.

Health communicators must consider that "to communicate effectively [one] must first recognize the distance between what is available and what [is] actually apprehend[ed], and then understand how the resulting differences impede success" (Hill & Dixon, 2006, p. 72). Keeping this in mind when communicating health messages would lead to health programs that would better reach the aforementioned targeted populations, such as the Mexican-American women in this study, as each requires information more closely targeted to their community's pre-defined health beliefs.

This study helps explain how Mexican-American women choose to maintain their health in a traditional manner, despite their non-native environment. As a result, the study helped to further define three cultural components – postulates, ends, and means – within the participants that may impact health communication (Olsen, 1978). First, the postulate of women seeing themselves as the primary person responsible for health was heavily socialized into the culture of the Mexican-American women in the study. The women believed their health and the health of their family was their responsibility and defined health in a holistic manner, which included both the body and the mind. These beliefs were often explained as “the way of her culture,” similar to Kraft’s (1978) statement that while postulates often include the way a person defines their relationship to their environment, it is usually an unconscious process that is simply accepted as the “way things are.” Health communicators must understand cultural postulates in order to make predictions about behavior as they communicate with those that may be from a different culture than themselves (Gudykunst & Kim, 1984). By defining and attempting to better understand this postulate, health communicators have an increased opportunity to predict the behavior of the Mexican-American women and a decreased likelihood of misunderstandings.

Second, this study identified the ends women hope to achieve through their health processes. Ends are expressed in a collective view of what is important or unimportant, good or bad (Olsen, 1978). As Triandis (1967) stated, ends, or values, are the desired outcomes individuals hope to attain in their lives. Fueled by a group’s culture, identifying ends allows communicators an increased ability to make predictions about how a group

will behave (Gudykunst & Kim, 1984). The women in this study expressed the following ends: experiencing an absence of pain and having the ability to maintain high levels of physical activity.

Lastly, means help to define what is generally accepted as the cultural norms and rules for reaching an end. These rules, or generally expected behaviors, allow members of a culture to know how to act in day-to-day situations without having to constantly guess at how they should behave (Olsen, 1978). This study provides a better understanding of what Mexican-American women define as their preferred methods of maintaining good health, the health of their family, and their breast health. Specific to this study, the women believed an acceptable means for reaching their desired ends were: self diagnosing and treating illness, using home remedies to maintain health and treat illness, avoiding prescription medications, relying on other women for health advice, referencing printed sources for health information, using medical services for serious conditions, and attempting to explain the cause of illness. Understanding these means assists health communicators as they communicate with those who may be from a culture that is different from their own (Gudykunst & Kim, 1984).

The following findings are especially useful to health communicators with an objective of increasing participation among Mexican-American women.

- Participants see other women, who are similar to them, as a source of health information.
- Participants maintain their health in order to be healthy so they can work (to provide for their family) and to be able to take care of their family.

- Participants avoid professional medical services because they believe they can achieve similar results using traditional, holistic methods.
- Participants believed cancer is the result of an injury and that they do not have a risk for breast cancer unless they have had a breast injury or have a family history of breast cancer.

As a result, the following suggestions are made for health communicators:

- Mexican-American women spokespersons should be selected for health campaigns.
- Female, Mexican-American community leaders should be involved in the development and implementation of local health campaigns.
- Hispanic churches and local service organization should be used promote health topics – while women mentioned hearing about breast health via mass media outlets, they discussed health and participated in breast health screenings at smaller venues such as when attending presentations at their churches or reading pamphlets or fliers from Hispanic service organizations.
- Health messages should convey that women need to participate in preventative health screenings so they will be healthy and can maintain the ability to work and take care of their family.
- Health messages should convey that preventative health screens with negative results are desired and do not mean one should fail to participate in additional or follow-up screenings. For example, “Medical tests that

find nothing aren't useless," and "Just because you have a good mammogram does not mean you do not need to go back."

- Educational materials about the importance of routine preventative screenings should be presented to women when they have a screening. Failure to do so is a missed communication opportunity.
- Messages should support women's efforts to promote health naturally by supporting campaigns with natural ways to maintain health (i.e. foods linked to positive health outcomes or the breast benefits associated with breast feeding).
- Breast health messages should support community (mobile) mammography efforts that Mexican-American women are already accessing.
- Breast health campaigns should use testimonials from Mexican-American women who were the first person in their family to have breast cancer.
- Breast health campaigns should convey that if a woman does not have an injury to her breast she is still at risk for breast cancer.
- Breast health campaigns should convey that breast cancer often has few or no symptoms, making it hard for individuals to detect the disease on their own.
- Breast health campaigns should support the women's self-check efforts with monthly reminder programs.

Suggestions for Future Research

This study provides a foundation for a number of research possibilities involving Mexican-American women and Hispanic-American women and health. Future studies might include:

- Replication studies with Mexican-American women in other states that do not border Mexico, to allow for comparison among groups.
- Replication studies, with each study focusing on a different sub-group within the larger Hispanic population, to allow for comparison among the sub-groups.
- Studies seeking to define behaviors and beliefs associated with other health disparities, or health inequalities, from which Mexican-American women suffer.
- Studies seeking to define the role of technology, such as the telephone and Internet, in the health communication of Mexican-American women.
- Studies seeking to define the health impact of Mexican-American women experiencing difficulty when locating supplies for home remedies.

Summary

This study helped to define two thematic constructs Mexican-American women engage in as they choose to maintain their health in a traditional manner, despite a non-native environment: (1) the belief that health is a combination of the body and mind and (2) the belief that health care is a Mexican woman's responsibility. Health communicators can use these findings as they seek to protect and improve the health of

those in their communities through preventative and educational messages and campaigns. As a result, health program and campaign messages will more closely target their communities' pre-defined health beliefs.

Limitations of the Study

As with any research that investigates the perspectives or beliefs of participants, this study's data are dependant on the truthfulness of the individuals participating in the study. However, if the participants chose to be less than truthful, there would have been inconsistencies in the data during the coding process. This was not the case.

Interviews were conducted in English or Spanish, based on the participant's preference. Those interviews conducted in Spanish required an interpreter. As such, selective interpreting occurred during interviews because it is impossible for an interpreter to provide an exact translation of a participant's entire dialogue during an interview (Murray & Wynne, 2001). This may have influenced questions that were asked during the interview or the conversational flow of the interviews. However, transcripts for the Spanish interviews included the women's exact responses.

The use of a snowball technique resulted in an inability to set up meetings with all the participants when documenting the study's credibility. As a result, only two of the ten participants were presented with the "summary list of codes" that contained the codes for their individual interview. However, both of the women expressed that the codes were an accurate representation of their interview and health beliefs.

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Appendices

APPENDIX A: Transcriber's Pledge of Confidentiality

As a transcribing typist of this research project, I understand that I will be hearing tapes of confidential interviews. The information on these tapes has been revealed by research participants who participated in this project on good faith that their interviews would remain strictly confidential. I understand that I have a responsibility to honor this confidentiality agreement. I hereby agree not to share any information on these tapes with anyone except the primary researcher of this project. I will delete all files on my computer after saving them to a CD (for the primary researcher). Any violation of this agreement would constitute a serious breach of ethical standards, and I pledge not to do so.

Transcribing Typist

Date

APPENDIX B: Interpreter's Pledge of Confidentiality

As an interpreter of this research project, I understand that I will be hearing confidential interviews. The information has been revealed by the research participants who participated in this project on good faith that their interviews would remain strictly confidential. I understand that I have a responsibility to honor this confidentially agreement. I hereby agree not to share any information from these interviews with anyone except the primary researcher of this project. Any violation of this agreement would constitute a serious breach of ethical standards, and I pledge not to do so.

Interpreter

Date

APPENDIX C: Consent Statement (English version)

CONSENT STATEMENT

The relationship between culture and Mexican American women's breast health.

INTRODUCTION

The purpose of this study is to examine, in your own words, your ideas about health and, as a result, your health behaviors. We are also exploring your perceptions about breast health and breast health behaviors. Your participation in this study is voluntary, you may refuse to answer questions that you don't want to answer, and you may stop the interview at any time.

INFORMATION ABOUT PARTICIPANTS' INVOLVEMENT IN THE STUDY

The interview will last approximately one hour. Interviews will be audio taped so that transcripts can be prepared for analysis. An interpreter will be used as necessary. Tapes of the interviews will be destroyed after a transcription is made. Nothing else will be required of you.

RISKS

There are no anticipated risks to participants in this study. However, if you feel uncomfortable as a result of the topics discussed during the interviews, information about local health facilities are available for you.

BENEFITS

This study will give us the opportunity to better understand the perceptions of Mexican-American women in relation to her health and breast health.

CONFIDENTIALITY

Audio tapes of interviews will be destroyed after the accuracy of the transcript is verified. Transcripts will be stored securely in a locked file cabinet and will be made available only to persons conducting the study. All information in the study records will be kept confidential. No references will be made in oral or written reports which could link you to the study.

COMPENSATION

Participants will receive a \$30 gift certificate to Kroger upon completion of the interview.

PARTICIPATION

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at anytime without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be destroyed.

CONTACT INFORMATION

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study,) you may contact the researcher, Emma Wright, at 476 Communication Building, University of Tennessee, Knoxville, TN 377996-0343, and (865)-974-8200. If you have questions about your rights as a participant, contact the Office of Research Compliance Officer at (865) 974-3466.

CONSENT

I have read the above information. I have received a copy of this form. I agree to participate in this study. I am 18 years or older.

Participant's signature _____ Date _____

Investigator's signature _____ Date _____

APPENDIX D: Consent Statement (Spanish version)

FORMULARIO DE CONSENTIMIENTO

Relación entre la salud de mama de mujeres mexicoamericanas y su cultura.

INTRODUCCION

El propósito de este estudio de investigación es examinar, en sus propias palabras, sus conocimientos acerca de su salud y consecuentemente sus comportamientos al respecto. También observaremos sus percepciones acerca de la salud de mama. Su participación en este estudio es totalmente voluntaria, y usted puede negarse a responder cualquier pregunta, y puede dar por terminada la entrevista en cualquier momento.

PARTICIPACION DE LOS SUJETOS EN EL ESTUDIO

La entrevista tendrá una duración de aproximadamente una hora. Las entrevistas serán grabadas para que posteriormente las transcripciones de estas puedan ser analizadas. Un traductor intervendrá a medida que sea necesario. Las grabaciones de las entrevistas serán destruidas después que hayan sido transcritas. No se requiere nada más de la participante.

RIESGOS

No hay riesgos anticipados para las participantes de este estudio. Sin embargo, si usted se siente incómoda como resultado de los temas discutidos durante la entrevista, se le proporcionará información acerca de los servicios de salud locales que están a su disponibilidad.

BENEFICIOS

Este estudio de investigación nos proporcionará la oportunidad de mejor entender las percepciones de las mujeres mexicoamericanas con respecto a su salud, específicamente la salud de mama.

CONFIDENCIALIDAD

Las grabaciones de las entrevistas serán destruidas después de que las transcripciones sean verificadas. Estas transcripciones serán guardadas bajo llave y solo tendrán acceso a ellas las personas encargadas de este estudio. Toda la información proporcionada en esta investigación se mantendrá en estricta confidencialidad. No se hará referencia alguna a su persona en los reportes escritos y orales de este estudio.

COMPENSACION

Las participantes recibirán un certificado de regalo para Kroger, valorado en \$30, al término de la entrevista.

PARTICIPACION

Su participación en este estudio es totalmente voluntaria. Usted puede negarse a seguir proporcionando información para este estudio en cualquier momento. Si decide participar, usted puede retirarse de este estudio en cualquier momento sin sanción y sin comprometer los beneficios que le corresponden. En caso de retirarse de este estudio antes de que toda su información sea recolectada, su información será destruida.

INFORMACION ADICIONAL

Si tiene dudas o preguntas relacionadas con el estudio y los procedimientos de este (o si ha

experimentado efectos adversos como resultado de su participación en esta investigación), puede ponerse en contacto con la investigadora, Emma Wright, al número telefónico (865) 974-8200 o a la dirección 476 Communication Building, University of Tennessee, Knoxville, TN 377996-0343. Si tiene dudas o preguntas acerca de sus derechos como participante en este estudio, comuníquese con la oficina encargada de el estudio, Office of Research Compliance Officer al número telefónico (865) 974-3466.

CONSENTIMIENTO DEL PARTICIPANTE

He leído la información detallada en este formulario de consentimiento y he recibido una copia de este formulario. Acepto participar en este estudio y soy mayor de edad.

Firma del participante _____ Fecha _____

Firma del investigador _____ Fecha _____

APPENDIX E: Discussion Guide

Grand Tour Question

Topic 1: Health

- Tell me what health means to you?
- What do you consider healthy?
- Is your health a part of your daily life?
- What does health include for you?
- What assumptions do you have about health?

Topic 2: Breast Health

- Tell me what breast health means to you?
- Is your breast health a part of your daily life?
- What does breast health include for you?
- What assumptions do you have about breast health?

Second-level Grand Tour Questions [if not addressed previously]

Topic 3: Mexican-American Women Health

- Tell me what health means to a Mexican-American woman?
- What is considered healthy by Mexican-American women?
- Is your health a part of the daily life of Mexican-American women?
- What does health include for Mexican-American women?
- What assumptions do Mexican-American women have about health?

Prompts

- How do you make decisions about your health?
- Who do you talk to about your health decisions?
- Who do you go to for advice about health decisions?
- What do you do to try to stay healthy?
- What is the difference in being healthy in Mexico as opposed to the United States?
- What kind of things do other people do to try to stay healthy?
- I know this might be a difficult subject, but can you tell me what you think or feel about your breasts?
- Tell me about the last time you thought about your breast health.
- Do you think breast health is different than [reference other health topic discussed]? Why?
- Tell me about a time you sought assistance with your breast health.
- How do your friends take care of their breasts?
- How does your breast care differ now that you live in the United States?

APPENDIX F: Master List of Codes

Acknowledging familiarity with breast cancer screenings (P2) (P3) (P7)
 Acknowledging importance of mammograms (P1) (P9) (P10)
 Acknowledging they are not perfect in their healthcare (P1) (P3) (P4) (P7) (P10)
 Appreciating doctors (P6) (P7)
 Asking mother for health advice (P1)
 Attempting to diagnose reason for illnesses (P2) (P5)
 Avoiding professional medical treatment (P2) (P1)
 Becoming interested in natural medicine—in their own right (P2)
 Being afraid mammograms may cause cancer (P7)
 Being embarrassed by doctor's questions (P1)
 Being surprised at cost of natural Mexican supplies in US (P1)
 Believes doctors will not treat you if you do not have insurance (P9)
 Believing accidents are not controlled by mental attitude (P2)
 Believing Being healthy allows you to travel (P4)
 Believing being healthy allows you to work (P3) (P4) (P8)
 Believing being healthy means a good quality of life (P3) (P4) (P5)
 Believing being lazy is bad for your health (P3)
 Believing breast cancer can be avoided through healthy lifestyle (P2) (P3) (P6)
 Believing breast cancer is a consequence of not taking care of oneself (P2)
 Believing breast cancer is a problem for other women (P2)
 Believing breast cancer is a result of an injury (P4) (P5) (P6)
 Believing breast cancer is inherited (P9)
 Believing breast cancer may be a result of sexually promiscuity (P2)
 Believing cancer is a consequence of an injury (P2)
 Believing children accept home remedies (P10)
 Believing doctors do not have answers to health problems (P3) (P6) (P9)
 Believing doctors in Mexico understand her better (P3)
 Believing foods in Mexico are healthier (less chemicals) (P6)
 Believing for working too much can lead to stress (P10)
 Believing going to the doctor is part of US culture (P6)
 Believing having positive attitude can overcome physical ailments (P2) (P5) (P7) (P8) (P9)
 Believing home remedies are better because they are not addictive (P7) (P10)
 Believing in natural remedies (P6)
 Believing insurance makes health care difficult in US (P3)
 Believing it is difficult to access care in US (P3)
 Believing language barriers make health care difficult in US (P3)
 Believing mammograms are better than manual screenings (P1)
 Believing medical tests often fail to tell you what is wrong (P2) (P7) (P9)
 Believing medicine has too many negative side effects (P2) (P6) (P9)
 Believing mental attitude affects physical health (P8) (P2)
 Believing mental health affects physical health (P2)

Believing Mexican women are becoming more familiar with mammograms because of campaigns (P5) (P10)
 Believing Mexican women living in US are more likely to get mammograms (P9)
 Believing Mexican women think they do not need to worry about breast cancer (P7)
 Believing more natural remedies are used in Mexico (P4)
 Believing no family history of breast cancer means she is safe from cancer (P2) (P3) (P4) (P6)
 Believing older generations will wait longer to go to doctor than younger generation (P1)
 Believing others harm health by not eating on a regular basis (P8)
 Believing others harm health by worrying (P8)
 Believing passing out is a sign of another serious illness (P2) (P1)
 Believing people are more concerned with appearances than health (P2)
 Believing people depend too much on scientific studies to guide health decisions (P2)
 Believing people in Mexico are more healthy because of less stress (P9)
 Believing people try alternative before going to the doctor more in Mexico (P4)
 Believing positive personal relationship impact health (P8)
 Believing she is an independent person (P2)
 Believing she is healthy if she doesn't have pain (P3)
 Believing she took care of health issues differently in Mexico (P3) (P4)
 Believing she will know if there is a problem with her breasts (P2) (P4) (P6) (P9)
 Believing she would rather self-check her breasts (P4) (P7)
 Believing sickness comes from the stomach (P4) (P6)
 Believing some are sick because they are lazy (P2)
 Believing spiritual assistance will help with illness (P2)
 Believing stress can make you sick (P7) (P9) (P10)
 Believing taking care of breast health is a part of overall health (P7) (P8) (P9)
 Believing that access to care is not a problem (P2)
 Believing that just because a doctor says something does not mean it will happen (P6)
 Believing that many are turning away from home remedies (P2) (P6)
 Believing the medical system is confusing (P6) (P1)
 Believing there are consequences for being inactive (P5) (P7)
 Believing there are consequences for not eating the right foods (P3) (P4) (P5) (P7) (P6)
 Believing there are consequences for not resting (P7)
 Believing there are consequences for not taking care of oneself (P2)
 Believing there are consequences for not working (P5)
 Believing there are consequences for using professional medical care (P2)
 Believing there are consequences for working too much (P7)
 Believing they have an active part in their health outcomes (P2)
 Believing women die from breast cancer because they delay treatment (P4)
 Believing women in Mexico are familiar with mammograms because of campaigns (P1)
 Believing women in Mexico are talking more about breast health because of campaigns (P8)
 Believing women in Mexico have less information about cancer (P7)
 Believing you should not depend on pills (P7)

Believing you will get breast cancer if it is in your family (P6)
 Checking for breast cancer through self exams (P4) (P6) (P10)
 Choosing alternative methods when natural remedies don't work (P10)
 Choosing not to participate in mammograms (P2) (P4) (P6) (P7) (P1)
 Choosing to adapt to some health practices in the US (P2) (P6)
 Choosing to go for a mammogram if she feels there is a problem (P2)
 Choosing to keep some Mexican health practices (P2) (P6)
 Choosing to not complain about ailments (P3)
 Choosing to not go for regular mammograms (P1)
 Choosing to not tell others when she feels bad (P3)
 Choosing to participate in mammograms because of a family breast scare. (P9)
 Choosing to participate in regular paps because of irregular results in past (P1)
 Choosing to treat herself for external pain (P10)
 Choosing to treat with illness herself when she thinks she can cure (P9)
 Considering impact of environment on health (P2) (P10)
 Convincing family members to use home remedies (P2)
 Deciding to go to doctor when they cannot handle an illness (P1) (P5) (P9) (P10)
 Defining health as a healthy body (P10)
 Defining health as a lifestyle choice (P2)
 Defining health as an absence of diabetes (P7)
 Defining health as an absence of headaches (P7) (P1)
 Defining health as an absence of high blood pressure (P7)
 Defining health as an absence of high cholesterol (P7)
 Defining health as an absence of illness (P8) (P9)
 Defining health as an absence of pain (P7) (P1) (P9)
 Defining health as being able to take care of children (P6)
 Defining health as body functioning properly (P7)
 Defining health as genetic predisposition to illness (P1)
 Defining health as more than just the physical body (P2)
 Defining health as not being overweight (P7)
 Defining health as not having allergies (P7)
 Defining health as not taking medications (P7)
 Defining health as personal hygiene (P8)
 Defining health as taking care of the mental self (P2) (P6)
 Defining health as taking care of the physical body (P2) (P1) (P9)
 Defining health as taking care of the spiritual self (P2)
 Defining healthy as being able to spend time with family (P4)
 Defining healthy as being able to take care of her children (P4)
 Defining healthy as being able to take care of her family (P3) (P5) (P8)
 Defining healthy as being able to take care of herself (P3)
 Defining healthy as being able to take care of the home (P3)
 Defining healthy as physically active (P3) (P4) (P8)
 Defining healthy as strong bones (P7)
 Diagnosing self when sick (P2) (P7)

Discontinuing mammograms because they hurt (P6)
 Discussing fewer social resources for health advice (P8)
 Discussing health with close women friends (P1) (P5) (P6) (P9)
 Discussing health with her father (P7)
 Discussing health with sisters (P1)
 Discussing health with women that are close to them (P10)
 Discussing illness with her husband (P9)
 Discussing mammograms with her friends (P8) (P10)
 Discussing pap smears with family members (P1)
 Expressing a lack of trust in doctors (P3) (P9)
 Failing to discuss breast health with family members (P1)
 Failing to know what looking for in self-check (P1) (P9)
 Failing to make time for breast self-checks (P1)
 Failing to make time for mammograms (P1)
 Feeling afraid of being told they have breast cancer (P10)
 Feeling afraid she may overmedicate herself (P4)
 Feeling appreciative for medical technology (P2)
 Feeling apprehension before first mammogram (P10)
 Feeling breast cancer is a threat to health (P5)
 Feeling doctors run too many tests (P3)
 Feeling doctors send you to other doctors (P3) (P9)
 Feeling health affects others around them (P2)
 Feeling heavier people are healthier (P10)
 Feeling home remedies are used more in Mexico (P9)
 Feeling in Mexico if you are skinny you are poor (P10)
 Feeling it is taboo to be seen nude (mammogram) (P10)
 Feeling mammograms are embarrassing (P10)
 Feeling mammograms are uncomfortable (P10)
 Feeling medication works (P9)
 Feeling Mexican women may not want doctors to see their breast (P5)
 Feeling not getting mammograms can cause you to get breast cancer (P9)
 Feeling people with tans are unhealthy (P10)
 Feeling she could afford more health care in Mexico (P10)
 Feeling that health is often forgotten with daily distractions (P2)
 Feeling that older Mexican women are especially private about their breasts (P5)
 Feeling that you may make someone more sick if you try to treat them yourself (P4)
 Feeling that younger Mexican women are not as embarrassed about letting doctors see their breasts (P5)
 Feeling there is a lack of relationship with doctors (P1)
 Feeling thinner is better in US (P10)
 Feeling unconcerned about breast cancer (own) (P1) (P2) (P4)
 Feeling women don't get checked for breast cancer because they are embarrassed (P4) (P5) (P9)
 Feeling women don't participate in mammograms because they are shy (P10)

Feeling you receive treatment more quickly for breast cancer in US (P9)
 Feeling younger women will be more likely to participate in mammograms (P5)
 Gaining appreciation for home remedies (P2) (P6) (P8) (P10)
 Gaining appreciation for taking care of own health (P8) (P2)
 Going to the doctor for internal pain (P10)
 Going to the doctor for serious conditions (P5) (P9) (P10)
 Going to the doctor if something is wrong with her breasts (P4)
 Having a hard time affording natural Mexican supplies (P2) (P5)
 Having difficulty finding natural things in the US that were used in Mexico (P2) (P4)
 (P5) (P6) (P7) (P8) (P9)
 Having mammograms at church (P9)
 Having more difficulty obtaining medications in US than Mexico (P8)
 Hearing about more women having breast cancer in the US (P3)
 Hearing more about breast cancer in the US (P3)
 Including mental state in health (P8)
 Keeping mind active to keep it healthy (P10)
 Learning health practices from parents (P7)
 Learning healthy ways from new environment (P7)
 Learning home remedies from her father (P7)
 Learning home remedies from their mothers (P2) (P5) (P6) (P7) (P8) (P1)
 Learning home remedies from women (P4) (P5) (P10)
 Learning how the body functions (P2) (P10)
 Listening to body (P2) (P9) (P10)
 Listening to body when sick (P2)
 Maintaining connection with children to keep mind healthy (P10)
 Making time for herself to be mentally healthy (P10)
 Participating in breast checks (manual) at doctor (P1)
 Participating in breast manual screenings at doctor because of family history (P1)
 Participating in free mammograms at church (P8)
 Participating in mammogram because friend had breast cancer (P8)
 Participating in mammograms (P6) (P7) (P1)
 Participating in projects to help the environment (P10)
 Preferring natural remedies to pills (P10)
 Providing a clean home for family (P4) (P5)
 Providing mental challenges to care for family (P4)
 Realizing breast cancer is something she cannot detect or see (P10)
 Recognizing danger of mixing home remedies with natural remedies (P9)
 Relying on family when ill (P8)
 Remembering a phase when home remedies were not the first defense (P10)
 Saying she doesn't talk to her friends about breast cancer (P3) (P4)
 Saying she feels well most of the time (P3)
 Saying she is responsible for the health of her family (P4) (P5) (P10)
 Saying she talks to family and friends (women) about breast cancer (P9)
 Saying she would take care of her family differently in Mexico than US (P8) (P9) (P10)

Saying she would take care of her family the same in Mexico (P5)
 Saying women don't talk about breast cancer as much in Mexico (P3) (P9)
 Seeing breast health as separate issue because you schedule appointments (P10)
 Seeing doctors for painful conditions (P1) (P6) (P7) (P9) (P10)
 Seeing doctors for persistent conditions (P1) (P3) (P4) (P6) (P9)
 Seeing doctors if you can not treat yourself (P1) (P5) (P9) (P10)
 Seeing doctors should be reserved for surgeries (P2) (P10)
 Seeing headaches as a possible indicator of other illnesses (P2) (P6)
 Seeing herself as a first line of defense against illness (P1)
 Seeing medical care as expensive (P2) (P5) (P10)
 Seeing visits to doctor as sometimes unnecessary (P5)
 Serving as a source of health advice (P6)
 Stating breast health is not a part of her daily life (P1)
 Stating Mexican women are more private about breast health (P8)
 Stating older Mexican women are more private about feminine health (P8)
 Stating she doesn't make herself stressed about her health (P1)
 Stating that being overweight in Mexico is a sign of health (P8) (P10)
 Stopping smoking to promote health (P10)
 Supporting immune system with vitamins (P2) (P10)
 Taking care of family's health with husband (P9)
 Taking care of health by eating on a regular basis (P3) (P5) (P8)
 Taking care of health by relieving stress (P7) (P8) (P10)
 Taking care of health by understanding how mind and body work together (P2)
 Taking care of health so she can take care of family (P10)
 Taking care of health through exercise (P1) (P3) (P5) (P6) (P7) (P8) (P9)
 Taking care of health with food (P1) (P2) (P3) (P4) (P5) (P6) (P7) (P8) (P9) (P10)
 Taking care of her health is her responsibility (P7)
 Taking care of the family health is seen as a woman's job (P6) (P10)
 Taking care of the health of the family (P2) (P4) (P5) (P6) (P8) (P10)
 Taking care of the inside body (P2)
 Taking care of the outside body (P2)
 Taking care of their health by knowing their own body (P2) (P1) (P9)
 Taking care of their health by working (P2) (P3) (P5) (P8) (P10)
 Taking care of their health through balanced diet (P2)
 Taking care of their health through personal hygiene (P2)
 Taking care of their health with rest (P2) (P3) (P4) (P5) (P6) (P7) (P8) (P9)
 Taking care or health is an individual choice (P2) (P3) (P7) (P9)
 Taking charge of health after moving to US (P8)
 Taking herself to the doctor more as an adult (P10)
 Taking prescriptions and home remedies (P7)
 Talking to their mothers about health (P1) (P2) (P4) (P5) (P9) (P10)
 Teaching children healthy habits (P7)
 Teaching daughters home remedies (P2) (P6) (P8)
 Teaching sons home remedies to a lesser extent (P6)

Thinking breast cancer is discussed similarly in Mexico and the US (P10)
 Thinking breast cancer technology is more advanced in the US (P5)
 Thinking breast health is perceived the same in Mexico and the US (P5)
 Thinking doctors are good for serious conditions (P2) (P4) (P6) (P8)
 Thinking health practices are similar in Mexico and the US (P2)
 Thinking it would cost more to cure breast cancer in Mexico (P5)
 Thinking Mexican relatives go for mammograms because of a family history of breast cancer (P8)
 Thinking the idea of healthy is different in Mexico and the US (P8) (P10)
 Thinking the idea of healthy is similar in Mexico and the US (P3) (P4) (P7)
 Thinking the younger generation is quick to go to the doctor (P2)
 Thinking they don't believe in taking care of breasts in Mexico (P6)
 Thinking women don't participate in mammograms because they are expensive (P5)
 Thinking women don't participate in mammograms because they are lazy (P5)
 Thinking women don't participate in mammograms because they don't know where to go (P5)
 Thinking you have to see too many doctors for a diagnosis (P6)
 Treating illness by drinking plenty of fluids (P8)
 Treating illness by not dwelling on it mentally (P8)
 Treating illness with exercise (P9)
 Treating illness with food (P9)
 Treating illness with home remedies (P1) (P2) (P3) (P4) (P5) (P6) (P7) (P8) (P9) (P10)
 Treating illness with rest (P2) (P3) (P4)
 Treating self with OTC medications (P1) (P2) (P3) (P5) (P8) (P10)
 Treating self with prescription medications (P2) (P5)
 Trying to make healthy lifestyle choices (P7)
 Using books as sources for health information (P2) (P4) (P6) (P7)
 Using family support for encouragement when ill (P9)
 Using home remedies to avoid illnesses (P6)
 Using online as a source of health information (P10)
 Using vitamins to improve health (P2) (P6) (P7)
 Wanting to interact with her new environment (P7)
 Watching weight to feel better not look smaller (P10) (P1)

APPENDIX G: Outline of Categories and Subcategories

- I. The Belief that Health is a Combination of the Body and Mind
 - A. The Body and Health
 - 1. Defining health as an absence of pain
 - 2. Defining health as being active
 - B. The Mind and Health
 - 1. Believing poor mental health leads to negative physical health
 - 2. Choosing a positive attitude to avoid illness
- II. The Belief that Health Care is a Mexican Woman's Responsibility
 - A. The Choice to Avoid Professional Medical Services
 - 1. Preferring to self-diagnose and treat illness
 - 2. Using home remedies to maintain health and treat illness
 - 3. Avoiding prescription medications
 - 4. Relying on other women for health advice
 - 5. Referencing printed sources for health information
 - 6. Using medical services for serious conditions
 - 7. Making changes to health care since moving to the United States
 - B. The Belief that the Cause of Illness Should be Explained
 - 1. Believing good health begins with diet
 - 2. Believing cancer is caused by injury or genetics
 - 3. Lacking confidence in U.S. professional medical services

Vita

Emma Kathleen Wright was born in Bristol, VA, on June 14, 1975. She was raised in Blountville, TN, where she attended Indian Springs Elementary School, Holston Middle School, and Sullivan Central High School. After Emma graduated from high school in 1993, she went to The University of Tennessee (UT) where she earned a bachelor's degree in communication with an emphasis in public relations in 1997. Following several years of professional work, Emma returned to UT and began work toward a master's degree in the College of Communication and Information while she continued to work as a public relations practitioner, mainly in the health care industry. After she completed her master's degree in 2005, Emma continued her academic career as a graduate teaching associate in the School of Advertising and Public Relations at UT while she pursued her doctoral degree in communication and information. Emma's primary concentration was public relations with a secondary concentration in public health. Her research interests include health, risk, cultural, and crisis communication. Currently, Emma is an instructor at East Carolina University in Greenville, NC, and expects to complete her doctoral requirements in the fall of 2008.