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The Relationship Between Acculturation Level of Mexican-American Parents and Coping with their Chronically Ill Children

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THE RELATIONSHIP
BETWEEN
ACCULTURATION LEVEL OF MEXICAN-AMERICAN PARENTS
AND
COPING WITH THEIR CHRONICALLY ILL CHILDREN

BY
Nancy Ellen Tena

A THESIS

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ABSTRACT

THE RELATIONSHIP BETWEEN ACCULTURATION LEVEL OF MEXICAN-AMERICAN PARENTS AND COPING WITH THEIR CHRONICALLY ILL CHILDREN

By

Nancy E. Tena

This investigation focused on 19 Mexican-American families with neurologically impaired children to determine to what extent they selected particular coping patterns in relationship to their level of acculturation to the Anglo-American culture. Using the Acculturation Rating Scale for Mexican-Americans (ARSMA), the families were categorized according to acculturation level (low, bicultural, and high). The families identified coping patterns (Family Support, Social Support, and Medical Support) which were helpful to them by completing the Coping Health Inventory for Parents (CHIP). Only one statistically significant relationship between acculturation level of these families and extent of their use of coping patterns was found: high acculturated fathers used social support to a greater extent.

DEDICATION

To my mother, Ellen Jane McMackin, RN, who dedicated much of her life to the nursing profession and was a role model and mentor to me.

ACKNOWLEDGMENTS

This thesis has been a synthesis of my academic and life experiences and I thank Doctors Donna Larson, Mary Horan and George Sturm for their assistance, guidance, and encouragement throughout this project. Also I thank Dr. Katherine Kim who supported and motivated me to formulate my ideas and begin the initial thesis proposal.

I am grateful to the professionals at the sites where I acquired my subjects. Without their willingness to assist me in the identification of subjects this research project could not have been done. Especially I want to thank Sara Lujan who took extra effort to talk with families in order to gain their consent.

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Chapter 1

Introduction

Raising a child with a chronic illness, disability, or handicap presents special problems and challenges for the family. The chronically ill child depends upon his/her family to provide long-term care and support. The family must provide this care and also manage day to day family life (McCubbin, 1987). For some families, the struggle may not be as difficult as for others; however, for all families, a chronic childhood illness is a major stress that can have a profound impact (Leventhal & Sabbath, 1986).

Professionals who work with families of chronically ill children need to assess parental coping behaviors in order to learn if the parents are adapting successfully or if intervention is needed to promote parental coping to improve family life (McCubbin, 1987).

One expects that the presence of a chronically ill child would lead to significant breakdown of family functioning. However, research reveals that a substantial number of families of chronically ill children make satisfactory adjustments (Hill, 1949; Holaday, 1984; Venters, 1981). The way in which these families make satisfactory adjustments and cope with their chronically ill children varies from one family to the next (Holaday, 1984). Many variables have an effect on the coping behaviors. One important variable to examine is the cultural background of the family.

Several nursing leaders have identified the importance of cultural awareness as an essential part of understanding unitary man (Brink, 1976; Rogers, 1985). This understanding can then lead to the provision of holistic patient care in our multicultural society (Fong, 1985; Leininger, 1978). According to Leininger (1978),

Cultures have their own naturalistic or familiar built-in modes of caring behavior which are generally known to the people, but are frequently unknown to nurses of other cultural backgrounds. The essence of nursing is caring; and the essence of transcultural nursing is caring for people of diverse cultural backgrounds. Transcultural nursing activities, functions, and processes will vary with social structure and cultural systems of a designated culture and in relation to acculturation, to culture contacts and culture history. (p. 36)

Furthermore, Louie (1985) found that higher morality rates and greater severity of illness of noncaucasian groups were linked to apathy of health care professionals toward these groups. Because of the health professional's apathy, there was neglect to appraise the cultural factors, thus leading to misdiagnosis and ineffective treatment (Louie, 1985).

Lazarus (1966) also considered cross-cultural implications in relation to stress and coping:

The rules concerning how threat will be coped with can be considered invariant and universal, and yet these mechanisms can be regarded as activated by certain specific classes of conditions that vary with the culture. Cross-cultural observations in the various areas of psychological stress provide us with clues about what is invariant and what is specific to the culture or subculture. (p. 23)

This study will focus on the Mexican-American culture. Mexican-Americans constitute the second largest minority group in the United States (Falicov, 1982). As this population and their health needs continue to grow, it is imperative that professional nurses gain a better understanding of Mexican-American cultural values. Within the Mexican-American population there is a wide range of variability in the extent to which different individuals have assimilated the sociocultural and psychological characteristics of the Anglo-American society (Falicov, 1982). Not only is it important for the nurse to understand Mexican-American values and norms in a broad sense, but it is also important to examine specifically the level of acculturation of each Mexican-American family and what impact acculturation has on coping behaviors. The process of acculturation occurs when there is movement in the behavior of members of one cultural group toward the standards of the other cultural group (Padilla, 1980).

The relevance of cultural variables is acknowledged in the field of psychology. For example, Olmedo and Padilla (1978) found that acculturation level must be considered as a moderator variable in cross-cultural studies that compare Mexican-Americans and Anglo-Americans. Further, Lazarus (1966) found that the coping methods used by individuals come from their cultural background as well as from the unique experiences of the social and physical environment in which they live.

Knowledge of the cultural values of the Mexican-American and awareness of the changes brought on by the processes of migration and acculturation will help the nurse assess the coping strategies of the individual Mexican-American. The purpose of this study is to examine the relationship between the acculturation level of Mexican-American parents and coping with their chronically ill children.

Chapter 2

Review of Literature

This chapter reviews research which examines coping behaviors used by Anglo-American families and Mexican-American families. Since the studies of acculturation have not dealt specifically with coping behaviors, the literature on acculturation research will be reviewed in the chapter on the conceptual framework. The literature will add strength and clarity to the theory of acculturation as it is presented within the context of the theoretical framework.

The child with a chronic illness has been identified as a considerable stressor on the family system (Tavormina, Boll, Dunn, Luscomb, & Taylor, 1981; VanOs, Clark, Turner, & Herbst, 1985; Venters, 1981). One of the early crises occurs for the child and the family when confirmation of the diagnosis precipitates a period of stress, denial, and depression (Correa, 1987; Oppenheimer, 1980). The family unit must begin to cope with the chronicity of the illness. Due to dysfunctional coping strategies, some families may not be able to cope with all of the hardships of the illness (Thomas, 1987). Yet, other families are able to maintain and/or develop functional behavioral patterns to meet the present and future illness-related hardships (Tavormina et al., 1981; Venters, 1981). The literature on family response to a child with a chronic illness is contradictory. This confusion may result in part from reliance on medical diagnosis for organization of data instead of identification

of common aspects of conditions such as deviations in child functioning, appearance, condition visibility, etc.

(Thomas, 1987).

Coping Behaviors Used by Anglo-American Families

Patterson (1985) examined critical variables such as demands, resources, family definition and coping to learn what effect each variable has on the family's ability to comply with prescribed home treatment. Patterson focused the investigation on 72 two-parent families who had one or more children with Cystic Fibrosis (CF) living at home. The family coping pattern of maintaining integration, cooperation, and an optimistic definition of the situation was found to be an important predictor of family compliance. The coping score reflected the efforts of mother and father together rather than either parent's individual coping behaviors.

Other research related to children with CF demonstrated that mothers tended to get over-involved with the children while fathers withdrew and pulled away; this difference in response led to marital strain (Travis, 1976). Brandt (1984) also reported that families with handicapped children were at risk for marital conflicts as well as problems with caregiving, finances, parent-child interactions, and child-sibling relationships.

Venters (1981) studied coping strategies of parents of 100 families managing childhood CF. Those families who functioned on a higher level maintained two coping

strategies. One strategy was the family's ability to "endow the illness with meaning" (p. 292), while the other strategy was "sharing the burdens of the illness" (p. 292). These strategies appeared to both minimize stress and strengthen family functioning. In an early study of families managing childhood cancer, Chordoff, Friedman and Hamburg (1964) found that the parental coping strategy of searching for and finding a philosophical or religious framework was frequently used to explain the "why" of the disease.

McCubbin (1983) studied 100 families with CF children to learn if there were coping patterns which parents of chronically ill children used to successfully manage family life and health. The following three coping patterns emerged as measured by the Coping Health Inventory for Parents (CHIP): (a) maintaining family integration, cooperation, and an optimistic definition of the situation; (b) maintaining social support, self-esteem and psychological stability; and (c) understanding the medical situation through communication with other parents and consultation with medical staff. McCubbin validated these patterns against criterion measures of adaptive family life dimensions of cohesiveness, expressiveness, conflict reduction, organization and control, and improvements in the child's health.

McCubbin's study focused on the chronic illness of CF, which has specific issues with which the parents must deal: (a) the genetic factor, (b) lack of a cure, (c) shortened

life span, (d) complex and time consuming regimen of daily treatments such as pulmonary and dietary management, and (e) frequent exacerbations of pulmonary infections. Since CF is found predominately in the Caucasian population, McCubbin's findings exemplify coping behaviors of mainly Caucasian parents (92% of McCubbin's sample).

Several issues were emphasized in McCubbin's study:

(a) parents can manage to raise a child with chronic illness in a positive way; (b) families are an integral part of the total treatment and rehabilitation program; (c) families with and older CF member, families with limited incomes, and single parent families are at a high risk; (d) parents need to balance the concentrated care with personal investments in themselves as individuals, in the family as a whole, and in their understanding of the medical situation; and (e) fathers are valued as their coping efforts impact the family organization, reduce family conflict, and promote optimum health of the child (McCubbin, et al., 1983).

A descriptive study conducted by Holroyd and Guthrie (1986) examined the severity of childhood chronic disease and its impact on the family. Holroyd and Guthrie studied three clinical groups (parents of children with neuromuscular disease, parents of children with CF, and parents of children with renal disease) and compared them with parents of control subjects matched by age to the clinical cases. The researchers investigated the quality and quantity of stress in these families by using the

Questionnaire on Resources and Stress (QRS). The three clinical groups in Holroyd and Guthrie's study (1986) exhibited different patterns of stressful response. Responses were found to be dependent on the nature of the illness and the requirements for care which were imposed on the families. Holroyd and Guthrie found that parents of children with neuromuscular disease experienced a wider spectrum of problems than those in the two other clinical samples. Many of the children with neuromuscular disease were wheelchair bound and almost totally dependent. Additionally, many were mentally retarded. Parents suffered cycles of loss, adaptation, and loss again as the child deteriorated. These factors severely strained the parents' coping abilities. The sample of parents of children with CF were in the mild to moderate range of functional disability. Holroyd and Guthrie (1986) found that these families were into a routine and at a stable point, reflecting less stress than the sample of children with neuromuscular disease. Moreover, the sample of parents of children with renal disease related less stress than the other two clinical groups but more stress than parents in the control group.

Coping Behaviors Used by Mexican-American Families

The literature notes significant differences between coping behaviors of Mexican-American and Anglo-American parents. Holroyd and Guthrie (1986) indicated that one variable which may have had an influence on the higher QRS score in the sample of parents of a child with a

neuromuscular disease was the heavier concentration of Hispanic parents (25% compared to 0% in the other two clinical groups). The researchers discussed a possible association between Hispanic background and lack of husband's support. However, they did not discuss the different type of support that was accessible to Mexican-American mothers. Spinetta (1984), in a study of Mexican-American families of children with cancer, discovered that Mexican-American mothers relied more upon one another for support, unlike Anglo-American mothers who relied upon their husbands for support. Copeland, Silberberg, and Pfefferbaum (1983) studied sixty-six parents (34 Anglo, 30 Hispanic and two others) of children with cancer and found differences between Anglos and Hispanics in their perceptions of the hospital treatment. The Hispanic parents perceived the physician as less confident in the treatment, were more reluctant to approach the physician, and had a lower sense of participation in treatment decisions. The investigators identified these differences as factors which may have contributed to higher stress in the Hispanic group.

Beaver's study (1986) of coping in families with retarded children cited several examples of dysfunctional families. One example cited was a traditional Hispanic family who chose not to utilize outside social contacts for fear that others might mistreat the handicapped 3 year old. Furthermore, the father imposed rigid discipline on the seven older siblings, even though no one was allowed to

restrict or punish the retarded son. Although Beaver used this family as an example of a dysfunctional family, it should be emphasized that care must be taken not to label the Hispanic family as dysfunctional until an assessment and understanding of the culture is made. The behavior of the father has cultural roots. In the Hispanic value system these coping behaviors are within the norm (Correa, 1987; Falicov, 1982). One needs to further examine the areas of conflict within the family before labeling it dysfunctional.

Arnold's review of selected needs of Hispanic handicapped individuals (1983) identified studies which examined the attitudes and coping behaviors of Mexican-American families with retarded children. In Vasquez's study (1974), Mexican-American mothers of retarded children were more accepting of their children than comparable Anglo-American mothers. Baca (1975) examined the coping strategies of Mexican-American vs. Anglo-American parents of institutionalized retarded children. In that study, parents underwent similar experiences in trying to understand and cope with their child's disability. However, Mexican-Americans differed significantly from Anglo-Americans in their adherence to religious explanations. The use of folk medicine was also prevalent among Mexican-Americans, and some parents reported superstitious causes of mental retardation. Furthermore, Mexican-American parents used the extended family in decision making to a greater degree than did the Anglo-American parents. Finally, Arnold (1983)

cited multiple mental health research studies supporting the idea that the extended family was a definite supportive resource to the handicapped member.

Shapiro and Tittle (1986) studied 50 Mexican-American mothers of disabled children and 22 Mexican-American mothers of nondisabled children. The mothers of disabled children were found to be much more aware of the emotional component in the coping process manifested in their reaching out to families in similar situations and in their seeking support from their own families. The investigators found that certain culture specific attitudes and cognitions such as acceptance, resignation, and God's will were concepts endorsed by the majority of subjects. These attitudes or coping behaviors were found to be helpful in minimizing the development of parental depression and psychosomatic symptoms.

Several authors identified factors which interfered with the successful implementation of intervention programs aimed at Mexican-American families of disabled children (Adkins & Young, 1976), Hispanic families of handicapped children (Arnold, 1983), and Mexican-American families of visually impaired children (Correa, 1987). Factors which Adkins and Young identified were (a) strong family pride which was resistant to the help of anyone outside the family unit, (b) the need for approval of any treatment plan by the priest, (c) family values which encourage the child to be passive thus reducing the affected child to a dependent

state, and (d) superstition and lack of knowledge about medical and rehabilitation technology. These factors reflect the values of the Mexican-American culture and can be viewed as coping behaviors.

Arnold noted the following cultural factors: (a) time orientation distinctions, (b) language differences, (c) distinct methods of dealing with misfortunes such as disability, and (d) different values regarding social and vocational changes including criteria used to determine career success. Arnold found that these factors interfered with the rehabilitation process unless the health provider incorporated them into the rehabilitation program.

In addition to the factors that Adkins and Young identified and Arnold noted, Correa (1987) reported that family tradition and support were gained through a loyal extended family network. Furthermore, the father maintained the dominant role in the family; since the father has the "final word," he must be consulted in any decision regarding the care of the child.

Summary

This chapter reviewed research studies which described coping behaviors used by Anglo-American and Mexican-American parents who have chronically ill children. The literature reveals that culture does have an impact on coping behaviors used by parents, and suggests that there are differences in coping behaviors used by Anglo-American and Mexican-American families. Since Mexican-Americans vary in the level to

which they are acculturated into the Anglo-American culture, a study of coping behaviors of Mexican-American families must consider the family's level of acculturation, the topic of this research.

Chapter 3

Conceptual Framework

The conceptual framework for this study is based on family stress theory, variation in cultural value orientations, and the theory of acculturation. The ABCX (Hill, 1949) and the Double ABCX (McCubbin & Patterson, 1983) models of family stress theory provide an understanding and explanation of why families of chronically ill children develop different coping strategies. Variations in value orientations (Kluckhohn, 1953) offer information about the differences between Mexican-American and Anglo-American cultural values. Finally, acculturation theory offers an explanation as to why Mexican-Americans develop different strategies even within their own culture.

Family Stress Theory

Family Stress Theory is an area of knowledge which social scientists use to describe and predict the effect of both moderate and major loss and change in the family. There is substantial research to document the nature and dynamics of adjustment to stressful life events. The theory of family stress proposes that the stress process includes: (a) a stressor event that produces a change in the family, (b) a recognition of that event as being stressful and, (c) the selection of a method of coping with the stressor. The coping strategies can lead either to health-enhancing or health-threatening behaviors (Hill, 1949; McCubbin, 1979; McCubbin, 1984; Venters, 1981).

McCubbin and Patterson (1983) proposed the Double ABCX model of family stress to explain how families over time adapt to multiple stressors by using various family resources, with the aid of certain perceptual factors. Such family resources and perceptual factors are the components of a coping process aimed at achieving family balance. The Double ABCX model uses the Hill ABCX model as a base but adds post crisis variables. These variables include the "aA Factor," the "pile-up" of demands for change within the family as it must deal with both normal and situational events.

The family with a chronically ill child is faced not only with the strains and hardships associated with the illness, such as increased financial burdens, increased caretaking tasks, and increased marital or sibling conflicts, but also with the expected changes in families. The needs and demands of a family are always changing. They do not remain static. Expected changes, such as birth and development of children, growth and development of the adult family members and changes in society, make demands upon the family which call for adjustment and adaptation. When a family experiences a chronic stressor such as caring for a chronically ill child, the family is said to experience a pile-up of demands (Beavers et al., 1986; McCubbin, 1984; Patterson, 1985; Venters, 1981).

The normal or expected changes and the chronic stressor contribute to the pile-up as well as the prior strains,

consequences of family efforts to cope, and intrafamily and social ambiguity (Patterson & McCubbin, 1983). A prior strain, which may be exacerbated when a new stressor is experienced, is the result of an unresolved hardship or is inherent in the ongoing role of being a parent (Pearlin & Schooler, 1978). The consequences of the family's coping efforts can lead to further stress and strain (e.g., the family that must move to be near a medical center and thus is distanced from other family members, or the parent who must work longer hours to alleviate the financial strain and is thereby isolated even more from the family). Intrafamily and social ambiguity is experienced when these families face the child's prognosis and have to decide whether or not to have more children or to pursue their career goals (Leventhal & Sabbath, 1986).

The other post crisis variables in the Double ABCX model include the "bB Factor" (the family resources) and the "cC Factor" (the family's perception of the situation). The "bB Factor" identifies those resources which are part of the family's capabilities for confronting the demands of the stressor event. These resources include: (a) the personal resources of each family member (economic well being, education, physical and mental health), (b) the internal resources of the family system (flexibility and organization), and (c) social support (medical services and extended family) (McCubbin, 1983). Resources for dealing with a childhood chronic condition vary from family to

family (Thomas, 1987). A family's available social support, financial status, problem solving skills, wellness, and repertoire of coping strategies contribute to its ability to cope with this type of stressor.

The "cC Factor" describes not only how the family initially defines the stressor (i.e., the diagnosis of the child's chronic illness) but also how it redefines the situation over time. A family may redefine the situation as a "challenge" or as an "opportunity for growth" or it may feel continually overwhelmed by the stressor and its hardships (McCubbin, 1984). Therefore, the definition the family places on its own situation becomes an important component of the family's coping ability.

The meaning the family attaches to the stressful event is a result of the value orientation which is learned within its culture. Culture is learned and transmitted from one generation to another and is a guide to a group's thoughts, actions and sentiments (Fong, 1985; Leininger, 1978). Through the socialization process, the individual learns cultural values, meanings, beliefs and patterns of behavior. The person learns to develop a specific way of solving vital problems (Fong, 1985). Therefore, in order to understand the individual's cultural orientation and resulting coping behavior, the theories of value orientation and acculturation are considered.

Variation in Cultural Value Orientation

Variation in cultural value orientation, proposed by Kluckhohn (1961), has been tested and modified in a variety of cultures (Brink, 1984; Kluckhohn & Strodbeck, 1961). According to Kluckhohn (1953),

a value orientation is a generalized and organized conception, influencing behavior of time, of nature, of man's place in it, of man's relation to man, and of the desirable and undesirable aspects of man-environment and inter-human transactions.
(p. 342)

Kluckhohn (1961) postulated that human beings are faced with a limited number of common human problems for which all people in all places must find solutions. It is the ordering of these solutions that creates the distinctive profile of a culture (Brink, 1984). All possible solutions are present in varying degrees in the total cultural structure of every society. There will not only be a dominant profile of first order value choices, but also substitute second and third order choices. Differences among the various cultures are based on the pattern of preferences for each of these solutions in a dominant substitute profile of values (Spiegel, 1982). However, one may see second order choices moved into the first order in the process of sociocultural change. This may explain how the first generation Mexican-American parent may demonstrate a different coping behavior than the second or third generation Mexican-American parent.

Kluckhohn (1961) has proposed that there are five common human problems and each problem has three possible solutions (see Table 1). The value orientations of the Anglo-American and Mexican cultures offer further insight into and an understanding of some of the fundamental differences between the two groups. Although a century of association has inevitably acculturated both groups to some extent, a number of cultural traits that neither group has totally relinquished still persists.

The Anglo-American and the Mexican cultures of today share similar views regarding the first orientation, the basic nature of man. Both cultures view the basic nature of man as neutral. However, in the past, Anglo-Americans believed that human nature was innately evil, but perfectible (Kluckhohn, 1953; Spiegel, 1982).

The second orientation, man's relation to nature, demonstrates how the Mexican culture is different from the Anglo-American. The mastery-over-nature position is a strong value of many Anglo-Americans. This position based on the assumption that there are few problems that cannot be solved. With the help of technology and money, humans can prolong life (Brink, 1984), go to the moon (Spiegel, 1982), and do a thousand other things to exploit nature and make it serve human needs (Kluckhohn, 1953). Although chronic illnesses, such as cancer and long-term mental illness, have not been mastered, there is hope. Problem solving is the key in this orientation (Spiegel, 1982). On the other hand,

Table 1

Five Common and Universal Human Problems and Their Attempted Solutions

Problem	Description	Solutions
Basic Nature of Man	attitudes held about the innate good or evil in human behavior	1. Neutral/Mixed 2. Good 3. Bad
Man-Nature	the way people relate to the natural or the supernatural environment	1. Harmony with 2. Mastery over 3. Subjugated to
Relational	the preferred way of relating to groups	1. Individual 2. Collateral 3. Lineal
Activity	the preferred pattern of action in interpersonal relations	1. Doing 2. Being 3. Being-in-Becoming
Time	the temporal focus of human life	1. Past 2. Present 3. Future

the subjugation-to-nature orientation assumes that little or nothing can be done by humans to prevent natural disasters, illness and death (Brink, 1984; Kluckhohn, 1953). One simply accepts the inevitable and goes on living. "If it is the Lord's will that I die I shall die" is an expression which illustrates this fatalistic attitude. Many Mexicans hold this value orientation (Brink, 1984; Kluckhohn, 1953).

Relational orientation, the third orientation, explains the concept of how humans relate to one another. According to Campa (1972), the Mexican holds a deeply ingrained individualism which is based on feeling; something that is the result not of rules and collective standards but of a person's momentary emotional reaction. Mexicans resist standardization in order to achieve individual freedom. In contrast, Anglo-Americans utilize the collateral orientation. They achieve success and security through institutional guidance and rules which are a reflection of the American value of democracy. They have a sense of individualism through action and self-determination unlike the feeling based individualism of the Mexican. The Mexican folk song "El Rey" (the king) depicts this concept in the following verse (Tena, 1980):

I told my friends the shepherds that you don't
have to be the first in making an entrance but
knowing how you make the entrance is what counts.
(p. 23)

Within the fourth orientation, activity, one finds the dichotomy between being and doing. The Anglo-American

achieves individualism by what he does whereas the Mexican experiences the individuality of being (Tena, 1980). The Mexican's value as a person lies in his being rather than, as in the case of the Anglo-American, in concrete accomplishments. Campa (1972) cites the psychological study done of college students from Mexico and Michigan; individualism and personalism were found to be central values for Mexican students. Efficiency and accomplishments are derived characteristics that do not affect the worthiness of the Mexican; whereas in the Anglo-American efficiency and accomplishments are equated with success, a value of highest priority in the Anglo-American culture (Campa, 1972).

The fifth orientation is that of time. To Mexicans the present time is most important. Nothing is more disquieting to Anglo-Americans, who believe that time is money, than the time perspective of Mexicans. This attitude is usually referred to as "mañana psychology." Actually, it is more of a today psychology because Mexicans cultivate the present, thus, excluding the future. They believe that the latter has not yet arrived, therefore, it is not a reality. They do not want to relinquish the present, so they hold on to it until it becomes the past. To Mexicans, ten o'clock is ten o'clock until it is eleven o'clock, so when they arrive at ten-thirty for a ten o'clock appointment, they believe they are right on time. Anglo-Americans are future oriented as manifested in their planning of life so far in advance that

the present loses its meaning (Brink, 1984; Campa, 1972; Tena, 1980). For instance, 1988 cars are for sale in October of 1987; January magazine issues are published in December; cemetery plots and even funeral arrangements are bought on the installment plan in advance.

Acculturation

The theory of acculturation offers further explanation for an individual's cultural orientation. One can identify certain cultural traits which are characteristic of the degree to which each individual is acculturated into the dominant culture. The spectrum of acculturation, if placed in a linear continuum, would range from an extremely culturally valued Mexican individual to an extremely culturally Anglocized individual (Tena, 1980) (see Figure 1).

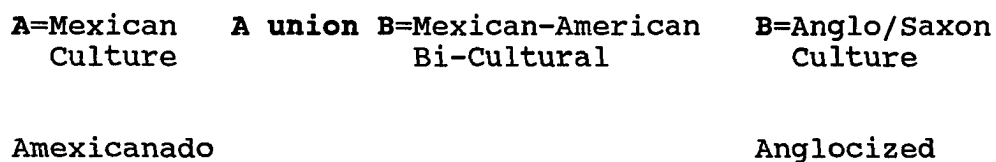


Figure 1. A Spectrum of Acculturation

As the acculturation spectrum moves from the extreme Mexican to the extreme Anglo, there are individuals in whom traits from both cultures are found. When this occurs, a third

subculture emerges, namely, the Mexican-American (Tena, 1980). If one were to take it a step further and examine the cultural values along the acculturation continuum, the following would be found (Tena, 1980):

<u>Mexican</u>	<u>Value</u>	<u>Anglo/Saxon</u>
a=Catholic	Religion	a1=Protestant
b=Spanish	Language	b1=English
c=Extended	Family	c1=Nuclear
d=Individualism	Self-Conduct	d1=Collectivist
e=Rigid	Sexual Roles	e1=Flexible
f=Machismo	Male Image	f1=Chauvinism
g=Marianismo	Female Image	g1=Women's Liberation
A=a,b,c,d,e,f,g	B=a1,b1,c1,d1,e1,f1,g1	

Figure 2. Values along the Spectrum of Acculturation.

<u>Value</u>	<u>Mexican-American</u>
Religion	a,a1=Catholic/Protestant
Language	b,b1=Spanish (Tex-Mex)
Family	c,c1=Extended
Self-Concept	d,d1=Individualistic/Collectivistic
Sexual Roles	e,e1=Flexible
Male Image	f,f1=Machismo
Female Image	g,g1=Marianismo

$$A \text{ union } B = a,a1,b,b1,c,c1,d,d1,e,e1,f,f1,g,g1$$

Figure 3. Synthetization of the two cultures to form the Mexican-American Culture

Change in the behavior of members of one cultural group toward the standard of the other cultural group is known as the phenomenon of acculturation (Padilla, 1980). The model of acculturation which Padilla (1980) proposes involves two essential elements: (a) cultural awareness, and (b) ethnic

loyalty. Cultural awareness is defined as the individual's knowledge of specific cultural material (e.g., language, values, food, history, art) of the cultural group of origin and/or the host culture. Ethnic loyalty means the individual's preference of one cultural orientation to the other. Preferences are indices of each behavior, cultural awareness and ethnic identification; these preferences convey information of the extent of an individual's level of acculturation. For example, the lesser acculturated individual prefers ethnic related activities and maintains a network of the same ethnic group (Padilla, 1980).

In addition to cultural awareness and ethnic identification, the model holds five dimensions as important in determining acculturative change. These dimensions include: (a) language, (b) cultural heritage, (c) ethnicity or maintenance of ethnic pride and identity, (d) generational level and the degree of ethnic interaction, and (e) inter-ethnic distance and perceived discrimination (Padilla, 1980). The process of acculturation is multidimensional in this model unlike other models which view acculturative change as a unitary process dependent on only generation level.

Understanding the acculturation process offers information about individual differences that assist in the interpretation of the social and psychological impact of the meeting of cultures at the level of the individual (Lazarus, 1966; Padilla, 1980). There are Mexican-Americans who: (a)

remain very Mexican in their cultural ways, (b) discard some cultural values in exchange for new ones (e.g., the children of Mexican immigrants who are bilingual instead of monolingual or who do not continue to hold to the rigid sexual roles), and (c) clearly assimilate into the mainstream of American society as noted by altering family names to pass as Anglos (e.g., a name such as Adame would become Adams, Martinez to Martin) (Tena, 1980).

Acculturation, Health Attitudes and Behaviors

Acculturation is a significant variable for the health professional to consider (Olmedo & Padilla, 1978; Padilla, 1980). The level of acculturation of Mexican-Americans, as noted by several researchers, is helpful in explaining attitudes and behavior in relation to this population's health practices (Scrimshaw, Engle, Arnold, & Haynes, 1987; Smith, 1986; Wells, Hough, Golding, Burnam, & Karno, 1987).

Smith (1986) identified acculturation as having an effect on Mexican-American teenagers' pregnancy decisions. She examined the degree to which teen mothers followed the prevalent health care practices of the general population in relation to how well they were "acculturated" or had accepted the local mores and customs. Less acculturated pregnant teen Hispanic women were found to be more compliant with parental traditional values. Parental values acted as a strong deterrent to culturally deviant sexual behavior. Conversely, Hispanic teen women who were more acculturated to the dominant Anglo-American society tended to reflect the

sexual behavior of the Anglo-American teen instead of their parents' behavioral code.

Scrimshaw (1987) studied 581 primiparous women of Mexican origin or descent in two Los Angeles hospitals, and found that there was a relationship between acculturation and the decision to breast-feed. This was examined as the authors compared prenatal intentions to breast-feed with postpartum behavior. The less acculturated women were more likely to breast-feed than those who were more acculturated.

Language, one aspect of acculturation of Mexican-Americans, has been found to have an impact on health behaviors and attitudes (Copeland et al., 1983; Deyo, Diehl, Hazuda, & Stern, 1985). A cross-cultural comparison study conducted by Copeland and associates (1983) assessed the differences between Hispanic and Anglo-American perceptions of the treatment given to their children with cancer. Copeland found that Hispanics did not feel as close to their physicians or as well informed as did Anglo-Americans. This was partly due to educational barriers as well as barriers in communication.

Deyo and associates (1985) used a simple language-based acculturation scale to examine the relationship between English language use, acculturation, and health behavior. The researcher found that language use, as one dimension of acculturation, had the greatest direct impact on physician-patient interaction. The data demonstrated the heterogeneity of Mexican-Americans with regard to birth

control behavior, attitudes toward folk healers, and "fatalism" about health. A higher percentage of Mexican-Americans who spoke Spanish did not use oral contraception, used folk healers, and had a more fatalistic attitude toward health than those who spoke English.

Wells and associates (1987) found that the level of acculturation had an effect on the utilization of health services by Mexican-Americans. The researchers compared the rates of health service utilization by Mexican-Americans of low and high acculturation to rates of use by non-Hispanic whites in Los Angeles. The sample included 1,209 non-Hispanic Whites and 1,194 Mexican-Americans. Mexican-Americans who were less acculturated had significantly lower rates of usage of outpatient services than non-Hispanic Whites. There was a greater underutilization of care for emotional problems as compared to physical problems. The researchers postulated that less acculturated Mexican-Americans tend not to be as familiar with available services; they also tend to experience language difficulties or other problems such as lack of transportation or child care. Moreover, less acculturated Mexican-Americans are more likely to use folk practitioners. Further, less acculturated Mexican-Americans often lack health insurance and/or have low incomes which prevent them from obtaining medical care.

Summary

A child with a chronic illness has been identified in the literature as a stressor to the family unit. How the family copes with this stressor is dependent on how the stressor is perceived and what resources are available. For the Mexican-American family, the way the stressor is perceived and the resources used are to some degree a function of the family's level of acculturation and value system.

As was identified in values orientation theory, each culture maintains its own value orientation profile. All three solutions to the five human problems are present in every society but are preferred to different degrees. Mexican-Americans rank their solutions differently than do Anglo-Americans.

How Mexican-American families experience life in the United States will affect the values each continues to maintain. The Mexican-American family who has lived in the United States for several generations will have a different outlook than the Mexican-American family who has just moved to the United States. The ordering of the value choices will change as the Mexican-American family becomes more acculturated into the Anglo-American society. Therefore, acculturation level is an important variable in this study of the coping behaviors of Mexican-American families with chronically ill children.

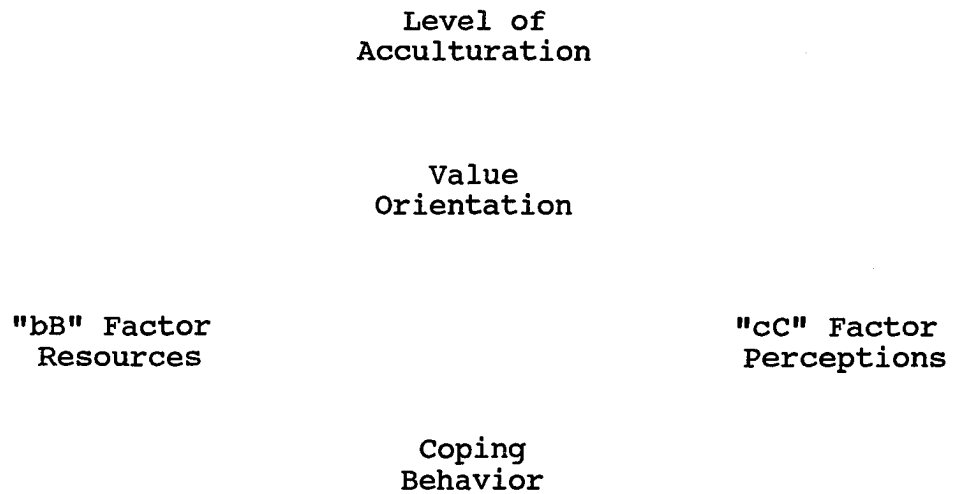


Figure 4. A Diagram of the Conceptual Framework

Research Question

To test the conceptualization that acculturation of the Mexican-American is an important variable in coping patterns used by families caring for their chronically ill children, the following research question was formulated:

Is there a relationship between the acculturation level of Mexican-American families and the extent to which they select particular coping patterns in caring for their chronically ill children?

Definition of Terms

Anglo-American refers to English speaking people living in the United States who are of Anglo/Saxon origin.

Mexican-American refers to people living in the United States who are of Mexican origin. Spanish is spoken or understood by them or by their parents or grandparents. They continue to practice or identify with specific customs of their ancestors. In this study further characteristics are noted in the Acculturation Rating Scale for Mexican-Americans (ARSMA).

Family is a social unit of people who live together and share life's day-to-day functions. In this study the family refers to the parent(s) of the chronically ill children who have participated in this study.

Acculturation is defined as a process of change or adaptation from one culture to another. This process of change may occur in one or both groups (Keefe, 1980). In this study acculturation will be determined using the ARSMA.

Coping behavior is defined as an active process encompassing both the utilization of existing family resources and the development of new behaviors and resources which aid in strengthening the family unit and alleviating or minimizing the impact of stressor events (McCubbin, 1979). In this study, coping behaviors will be measured within the three coping patterns as defined in the Coping Health Inventory for Parents.

Chronic illness is defined as any anatomical or physiological impairment that interferes with the child's ability to function fully in the environment. For this study the type of chronic illness was limited to cerebral palsy, spina bifida, post-meningitis, neurofibromatous, and congenital defects all of which resulted in neurological deficits. The neurological deficits such as impairment in mobility and/or loss of useful function of one or both upper extremities affect the child's functional abilities. Some children with these conditions also have mental retardation and/or seizures. In this study they were not excluded. However, children only with mental retardation or seizures were excluded from this study.

Chapter 4

Methodology

Design

This exploratory/descriptive study employed in-home interviews using the Acculturation Rating Scale for Mexican-American (ARSMA) and the Coping Health Inventory for Parents (CHIP) to determine the relationship between the acculturation levels of Mexican-American parents and the coping behaviors they used in the care of their chronically ill children.

Sites

Names of Mexican-American and Anglo-American families with neurologically impaired children were obtained from several sites in Western Michigan. Primary sites included churches and developmental centers. Because an adequate sample was not obtained at these sites, the following secondary sites were accessed: hospitals, rehabilitation centers, migrant clinics, local health departments, pediatricians, neurologists, and public school districts. All of the sites encompassed both rural and urban areas and offered a broad base for finding a representative sample.

Subjects

Subjects were parents of Mexican-American children with a neurological impairment. At least one of the parents was of Mexican heritage. If one parent was Anglo-American, this parent was also included in the testing since the Anglo-American parent very likely had adopted some of the Mexican-

American culture into his/her own value system. The parents did not have to be married or living together. However, in order to be part of this study, the parent who was not living with the child must have been involved in the child's life. This involvement meant a regular arrangement of visitation (e.g., weekly or bimonthly weekends) and financial support.

Language was part of the measurement of acculturation level. Therefore, it was a goal of the investigator to obtain a sample of parents who were monolingual Spanish, bilingual Spanish and English, and monolingual English. It was not necessary for the parents to be literate. The instruments were available in both Spanish and English, were administered by the investigator in the families' homes, and, if the parents were illiterate, the investigator read the instrument in the language of their preference and recorded the subjects' answers.

Criteria which pertained to the characteristics of the children included the following:

(1) The age range was four years through 12 years with the diagnosis made at least 6 months prior to the interview.

(2) The neurological impairment had affected his/her functional abilities (e.g., cerebral palsy, spina bifida, post-meningitis, post head injury).

(3) The child was not in an acute stage of illness at the time of the interview (e.g., an acute illness requiring hospitalization).

(4) The child lived at home with parent(s).

Snowball sampling technique was used to obtain the sample of 19 families. For example, the first families identified through the primary sites knew of other similar families and directed the researcher to them. In addition, the priests and directors at the primary sites directed the researcher to other sites, such as those identified as secondary sites.

Selection, Testing and Instrumentation

When interviewing ethnic minorities, some of the potential problems are: (a) high refusal rates owing to suspicion on the part of respondents, (b) language used by the interviewer may not be of equal status or ethnicity as language used by the interviewee, (e.g., a Tex-Mex version of Spanish versus an more pure form of Spanish), and (c) an often transient mobile population (Welch et al., 1973). Welch (1973) found that interview data can be obtained from Mexican-Americans with the same degree of reliability as from other groups. Although Welch's study found the potential problems of interviewing ethnic minorities to be exaggerated, this researcher considered the potential problems and took the following precautions:

(1) Minimized suspicion by offering an explanation for the study in the language of the subject. The consent form was available in Spanish and English.

(2) Provided the instruments in both languages and had available a Mexican-American interviewer who was bilingual.

(3) Used snowball sampling to help minimize suspicion. Often the families interviewed knew one another, and the investigator gained support and references from them. Demographic factors, such as socioeconomic status, education level, and religious preference could possibly affect the internal validity. However, when studying the Mexican-American, it should be noted that these traits tend to be related to the individual's level of acculturation. The less acculturated Mexican-American tends to be in the lower economic class, a laborer or farm worker, and Catholic. This varies with the level of acculturation to the dominant society. Therefore, it would be detrimental to the study to attempt to control demographic variables.

The experimenter effect and sample size were seen as possible threats to external validity. The experimenter effect was controlled by the use of a structured interview with directions given to the subjects to complete the two instruments as honestly as they could at the time of administration. The tools were explained and the researcher was available to answer questions. The sample was small due to the restrictive populations of Mexican-Americans with chronically ill children. It is not possible to generalize the findings to a wider population, but the study will offer insight into possible relationships which will add to the body of nursing knowledge.

Instruments

The Acculturation Rating Scale for Mexican-Americans (ARSMA), developed by Cuellar and Jasso in 1979, was used to measure the level of acculturation of the subjects (see Appendix A). The scale differentiates five types of Mexican-Americans based on level of acculturation: (a) very Mexican, (b) Mexican-oriented bicultural, (c) "true" bicultural, (d) Anglo-oriented bicultural, and (e) very Anglicized. Four factors are identified by the scale: (a) language familiarity, usage and preference, (b) ethnic identity and generation, (c) reading, writing and cultural exposure, and (d) ethnic interaction. The scale contains 20 items which are scored on a five point Likert scale with responses ranging from one point for Mexican/Spanish to five points for Anglo/English. The range of the total score falls between 20 and 100 points. The average score (total score divided by 20) designates the level of acculturation. The questions are designed to tap preference and behavioral tendencies or actual behavior. The instrument has been shown to discriminate between Mexicans, Mexican-Americans and Anglos and distinguishes between generations in Mexican-Americans from first generation (subject born in Mexico) to fifth generation (subject, parents and grandparents born in U.S.) (Cuellar, Harris, & Jasso, 1980; Olmedo & Padilla, 1978).

The scale was developed to be used with normal and clinical populations, monolingual Spanish populations as

well as bilinguals, and individuals of varying educational backgrounds. ARSMA can be given in English, Spanish or both languages, depending upon the preference of the subject. It can be administered individually or as a group test.

Internal consistency was reported to have a coefficient alpha of .88 for normal (unhospitalized) subjects (Cuellar and Jasso, 1980). Test-retest reliability was also assessed. The correlation coefficient of stability was .72, $p < .01$ for the hospitalized subjects and .80, $p < .01$ for the normal sample. The correlation coefficient for interrater reliability was obtained and found to be .89, $p < .01$.

The content validity of ARSMA was analyzed and tested in several separate analyses by Cuellar and Jasso (1980). Twelve staff members rated the acculturation level of 26 patients. Staff ratings were compiled and correlated with the actual ARSMA scores of the 26 patients to yield a Spearman rank-order correlation coefficient of .75, $p < .01$. Generation and level of acculturation were cross-tabulated and a significant relationship between generation and ARSMA scores was found when divided along lines of the five types (a Kendall's Tau of .55, $p < .01$).

Concurrent validity of the ARSMA instrument was demonstrated by administration of the ARSMA, the Biculturalism Inventory (BI), and the Behavioral Acculturation Scale (BAS) on separate days. The three scales were administered on a random basis, one each day on

three consecutive days. Correlation coefficients were sufficiently high (ARSMA with BAS yielded a rho of .76, $p < .001$; ARSMA with BI yielded a rho of .81, $p < .001$; BAS with BI yielded a rho of .77, $p < .001$), indicating that all three scales were measuring the same behaviors or characteristics in the sample population. Kendall's Tau correlation coefficient was used to assess the extent of agreement between scales in classifying subjects by type. The results indicated that the three scales agreed with each other significantly, as a Kendall's Tau of .72, $p < .001$ was obtained between ARSMA and BI, and a Kendall's Tau of .60, $p < .001$ between ARSMA and BAS.

The Coping Health Inventory for Parents (CHIP) was used to identify the coping behaviors each parent perceives he/she is using to manage family life. This inventory was developed to assist clinicians with assessing and evaluating how each parent is coping and whether coping behaviors are having a positive or deleterious effect on the child and the family as a unit (McCubbin et al., 1983). The instrument is in English (Appendix B) and has been translated to Spanish for this study with the permission of its author (Appendix C).

CHIP is a self report instrument which includes a checklist of 45 specific behaviors such as "talking with other parents in the same type of situation" or "encouraging child with medical condition to be more independent." Subjects were instructed to record how helpful (on a scale

from 0 to 3) each behavior is in their particular family situation.

As CHIP was developed, two general levels of coping were defined: (a) coping behaviors as defined by each item on the inventory, and (b) coping patterns which are combinations of specific coping behaviors. Coping Pattern I is called Family Integration, Co-operation and an Optimistic Definition of the Situation. This pattern reflects 19 individual behaviors that focus on strengthening life and relationships and the parents' outlook on life with their chronically ill child. Coping Pattern II, labeled Maintaining Social Support, Self-esteem and Psychological Stability reflects 18 behaviors. This pattern involves the parent's efforts to develop relationships with others to engage in activities which enhance individual identity and self worth, as well as to develop behaviors to manage psychological tension. Coping Pattern III is labeled Understanding the Health Care Situation through Communication with Other Parents and Consultation with the Health Care Team. Eight behaviors are indicative of this pattern and are directed at the parents' relationships with the health care team and other parents of chronically ill children.

The coping scale scores are computed for each of the three patterns by means of an unweighted summing of a parent's helpfulness ratings (0=not helpful; 1=minimally helpful; 2=moderately helpful; 3=extremely helpful) of the

behavior items in each pattern (McCubbin, 1987). A maximum score of 57 is possible for Coping Pattern I, a maximum score of 54 is possible for Coping Pattern II, and a maximum score of 24 is possible for Coping Pattern III, totaling 135.

The reliability of CHIP was determined in a study of 185 parents of children with CF (McCubbin et al., 1983). Using Cronbach alphas computed for the items on each coping pattern, the reliabilities of .79, .79, and .71 were reported for Coping Patterns I, II, and III, respectively.

The validity of the instrument has been tested and demonstrated in several studies. In one particular study of families of children with CF, validity assessments of CHIP were done using the Family Environment Scale and two indices of the health status of the chronically ill child (height/weight index and pulmonary functioning index) (McCubbin et al., 1983). The coping patterns were positively associated with the dimensions of the family environment as well as improvements in the child's health status (McCubbin, 1987). Another study assessed validity using the CHIP inventory to learn if usage of these coping patterns was significantly higher in high conflict families than in low conflict families. A significant relationship was found; both parents (in high conflict families) used all three coping patterns (McCubbin, 1987).

Procedure

Approval from the primary sites was gained in order to access the names of families included in this study.

Because the potential sample from the primary sites did not meet the sample size targeted for this study, the secondary sites were also contacted for approval. The appropriate individual (e.g., pastor, administrator, nursing director, or program director) was contacted by the researcher and the study was explained. This was done by phone or site visit. A follow-up letter was subsequently sent. Once approval was obtained, the researcher made an on site visit and/or phone calls to explain to the staff members of the institution the study and the criteria for identifying the sample. In this way, the researcher gained the cooperation of staff in recruiting families for the study.

Once a family had been identified and one of the parents had signed a consent form (see Appendix D) to release his/her name, address and phone number, the parent was contacted by phone or home visit by the researcher. Space was provided on the consent form for the parent to specify the mode of contact. The verbatim explanation (see Appendix E) describing the reason for the study was read to the parents during the initial interview. If the initial contact was by phone and the parents were interested, then an appointment for a home visit was made. The appointment with the parent was arranged at the convenience of the parents. At this home visit, the informed consent form (see Appendix F) was presented and explained by the researcher, and then signed by the subject. Each subject was assured that anonymity and confidentiality would be maintained and

that the results of the study would be available if he or she wished to see them. If the subjects were Spanish speaking only, the bilingual interviewer offered an explanation of the study and the consent form in Spanish.

Once consent was obtained, the interview was conducted and the instrument was administered in the family's home. Each parent was given each instrument to be completed independently, in separate rooms or at two separate visits, to insure that each parent report was his/her own answers. The interviewer explained the rationale for the independent testing and was available to explain or read any portion of the instruments.

The data were collected by the author and/or a bilingual/bicultural Mexican-American interviewer. The interviewer had obtained a Masters Degree in Clinical Psychology and had worked extensively in these West Michigan communities with Mexican-Americans and mental health issues. Upon completion of the instruments, the subjects were verbally thanked and reminded that the results of the study would be made available to them.

Chapter 5

Data Analysis

A total of 43 parents (or 25 families) were approached and requested to take part in the study. Thirty-one (or 19 families) agreed to participate and completed both instruments. Demographic data for subjects are shown in Tables 2-3. Demographic data for the children are shown in Table 4.

Subjects were grouped according to their acculturation level score which was tabulated from the questionnaire, Acculturation Rating Scale for Mexican-Americans (ARSMA). Parents who had a score between 1.00 - 2.79 were placed in the lower acculturation level; parents with a score between 2.80 - 3.20 were considered bicultural; and parents with scores between 3.21 - 5.00 were placed in the high acculturation level. The demographic data are organized by the parent's acculturation level to offer a further understanding of the spectrum of acculturation (see Tables 5 and 6).

Nineteen families participated in this study. For 12 of the families both parents completed the two instruments. For the other seven families, only the mothers participated. For each parent who participated, an acculturation score was obtained by dividing the sum of the scores by the number of questions (which was 20). The range of acculturation scores for this sample fell between 1.05 and 4.75 with a mean score of 2.80. As noted in Tables 5 and 6, 13 parents fell into

Table 2

Demographic Data for Entire Sample - Age Group, Marital Status, Religion, and Site Where Subjects Live

Demographic Characteristics	Number
Age Group	
25 - 30 years	11
31 - 35 years	9
36 - 40 years	7
41 - 45 years	4
Marital Status	
Married	24
Divorced	4
Separated	2
Never Married	1
Religion	
Catholic	23
Pentecostal	4
Baptist	2
No Affiliation	2
Site Where Subjects Live	
Large City	11
Small City/Town	15
Migrant Camp	5

N=31

Table 3

Demographic Data for Entire Sample - Occupation, Educational Level, and Language Spoken

Demographic Characteristics	Number
Occupation	
Homemaker	13
Unskilled laborer	7
Skilled laborer	6
Migrant farmer	4
Professional	1
Educational Level	
Did not graduate from high school	15
High school graduate	11
Some college	3
College graduate	2
Language Spoken	
Spanish only	5
Mostly Spanish, some English	6
Spanish and English equally	10
Mostly English, some Spanish	7
English only	3

N=31

Table 4

Demographic Data for Children - Gender, Age Group, and
Diagnosis

Demographic Characteristics	Number
Gender	
Male	7
Female	12
Age Group	
4 - 5 years	8
7 - 10 years	7
11 - 12 years	4
Diagnosis	
Cerebral Palsy	10
Meningitis (Post)	3
Spina Bifida	2
Congenital Defect, Hearing Impaired	2
Retts Syndrome	1
Neurofibromatosis	1

N=19

Table 5

Acculturation Levels by Religion, Education Level, and
Occupation

Demographic Characteristics	Acculturation Level Number of Subjects		
	Low	Bicultural	High
Religion			
Catholic	7	10	6
Pentecostal	4	-	-
Baptist	-	-	2
No Affiliation	2	-	-
Education Level			
Did not graduate from high school	11	4	-
High school graduate	2	4	5
Some college	-	1	2
College graduate	-	1	1
Occupation			
Homemaker	6	3	4
Migrant farmer	4	-	-
Unskilled laborer	-	4	3
Skilled laborer	3	2	1
Professional	-	1	-

N=13 Low Acculturation
N=10 Bicultural
N= 8 High Acculturation

Table 6

Acculturation Levels by Language Spoken and Site Where
Subjects Live

Demographic Characteristics	Acculturation Level Number of Subjects		
	Low	Bicultural	High
Language Spoken			
Spanish only	5	-	-
Mostly Spanish, some English	5	1	-
Spanish and English equally	3	5	2
Mostly English, some Spanish	-	4	3
English only	-	-	3
Sites Where Subjects Live			
Migrant Camp	5	-	-
Small City/Town	5	8	2
Large City	3	2	6

N=13 Low Acculturation
 N=10 Bicultural
 N= 8 High Acculturation

the low acculturation level, 10 parents in the bicultural level and 8 parents (4 of whom were Anglo-American) in the high acculturation level.

For purposes of further data analysis, the mean of the mothers' and fathers' acculturation level scores were used for families in which both parents participated. Mothers' scores were used for the remaining families. The average scores for the 12 couples with data from mother and father were similar to the individual parent scores. In nine families, the parents had acculturation level scores in the same acculturation level. In the remaining families, parents' scores were only one acculturation level apart (i.e., bicultural and high acculturation). Each of these three families had one Anglo-American parent. None of the Anglo-American parents scored at 5.00; it was assumed that they had taken on some of their spouses' Mexican-American cultural traits. Therefore, it is suggested that the acculturation levels of the seven families where only mothers participated were similar to what they would be if the fathers had participated. The 19 families were divided into the three levels of acculturation by their scores as identified earlier. The scores categorized the families into the following groups: nine families in the low acculturation level; four families in the bicultural level; and six families in the high acculturation level.

Internal consistency of the Coping Health Inventory for Parents was computed by means of Cronbach's Alpha. The

reliability coefficients for each of the three coping patterns were .71 for Coping Pattern I, Maintaining Family Integration, Cooperation, and Optimistic Definition of the Situation; .88 for Coping Pattern II, Maintaining Social Support, Self-esteem, and Psychological Stability; and .66 for Coping Pattern III, Understanding the Medical Situation Through Communication with Other Parents and Consultation with Medical Staff.

The research question investigated in this study was: Is there a relationship between the acculturation level of Mexican-American families and the extent to which they select particular coping patterns in caring for their chronically ill children?

Coping pattern scores for each parent were computed by dividing the sum of their answers in each pattern by the number of items in that pattern, resulting in a percentage. This computation was done to take into consideration the uneven number of behaviors within each coping pattern (Coping Patterns I, II, and III consisted of 19, 18, and 8 behaviors respectively). The coping pattern scores for families with two parent participation were averaged. The coping pattern scores for the seven mothers were considered the score for the family. For Coping Pattern I, average scores were similar to the individual scores. However, the other two coping patterns had several partners with dissimilar scores.

To identify the extent of use of particular patterns by acculturation level, the percentage of use was computed. This computation involved several steps. First, each family's individual coping pattern scores were divided by their total CHIP score as noted by the ratios in Figure 5.

Family #1 CHIP scores			
Patterns			
<u>Family</u>	<u>Social</u>	<u>Medical</u>	<u>Total</u>
50	40	20	110
Ratios			
<u>Family</u>	<u>Social</u>	<u>Medical</u>	
50/110	40/110	20/110	

Figure 5. An Example of the Ratio Computation.

Each ratio represented the percent of extent each family used a particular coping pattern. The results of each coping pattern ratio for each family were next grouped by acculturation level (low, bicultural, and high), and then summed. These sums were then divided by the number of families within each respective acculturation level. For instance, in the low acculturation level group the scores for each coping pattern of nine families were summed and then divided by nine to come up with the average percentage of use for each coping pattern by acculturation level.

As can be seen in Table 7, the following patterns of usage were noted. In Coping Pattern I, Maintaining Family

Table 7

Percentage Use of each Coping Pattern by Acculturation Level

	Acculturation Level		
	<u>Low</u>	<u>Bi-cultural</u>	<u>High</u>
	%	%	%
Family Integration Cooperation, Optimism	42	38	38
Medical Communication & Consultation	34	35	32
Social Support, Self- esteem, Stability	24	27	30
Total Coping Patterns	<u>100</u>	<u>100</u>	<u>100</u>

Integration, Cooperation and an Optimistic Definition of the Situation the low acculturated families used this pattern to the greatest extent. With regards to Coping Pattern II, Maintaining Social Support, Self-esteem, and Psychological Stability, the high acculturated families tended to use this pattern to the greatest extent. Finally, in Coping Pattern III, Understanding the Medical Situation Through Communication with Other Parents and Consultation with Medical Staff, the bicultural families used this pattern to the greatest extent.

To identify differences in the extent of use of each of the coping patterns by families in the three acculturation levels, three ANOVA's were computed. The three acculturation levels were used as the categorical variable and the percentage of use of the specific coping pattern was used as the dependent variable. This analysis was performed by computer using the SPSS-X program. As can be seen in Table 8, results of all three ANOVAS were nonsignificant. In other words, the family's acculturation level was not significantly related to the extent of use of particular coping patterns. However, ANOVA for mothers (N=19) and fathers (N=12) separately resulted in one significant relationship (see Table 9). The relationship between the father's acculturation level and Coping Pattern II, Maintaining Social Support, Self-esteem and Stability, demonstrated that as fathers became more highly acculturated they used social support systems more frequently.

Table 8

One Way ANOVA for Coping Scores of Mexican-American Families
by Acculturation Level

Analysis of Variance Summaries

Source	SS	df	MS	F	p
Family Integration Cooperation, Optimism					
Between groups	.0056	2	.0028	.9768	ns
Within groups	.0457	16	.0029		
Total	.0513	18			
Social Support, Self- esteem, Stability					
Between groups	.0114	2	.0057	2.1275	ns
Within groups	.0428	16	.0027		
Total	.0542	18			
Medical Communication & Consultation					
Between groups	.0031	2	.0016	.8368	ns
Within groups	.0300	16	.0019		
Total	.0332	18			

Table 9

One Way ANOVA of Coping Scores of Fathers by Acculturation Level

Analysis of Variance Summaries

Source	SS	df	MS	F	p
Family Integration, Cooperation, Optimism					
Between groups	.0049	2	.0024	.9412	ns
Within groups	.0234	9	.0026		
Total	.0283	11			
Social Support, Self-esteem, Stability					
Between groups	.0303	2	.0151	4.3755	<.05
Within groups	.0311	9	.0035		
Total	.0614	11			
Medical Communication & Consultation					
Between groups	.0125	2	.0062	2.6714	ns
Within groups	.0210	9	.0023		
Total	.0335	11			

Chapter 6

Discussion and Implications

This research examined the relationship between the acculturation level of Mexican-American parents and the coping patterns they used in caring for their neurologically impaired children. Literature has suggested that culture has an impact on the way in which a parent copes with caring for his/her chronically ill child. Furthermore, previous research has discussed implications of acculturation level in regard to the Mexican-American's health care practices. An understanding of the Mexican-American parent's acculturation level can assist the health care provider in developing a greater understanding of the individual and, as a result, in providing better health care.

The ANOVA analysis of the parents' scores as a family did not show a significant relationship between acculturation level and extent of use of coping patterns. Furthermore, the acculturation levels of parents in a family were found to be close, indicating that parental values were similar. This similarity between parents may itself be a result of the process of acculturation.

In nine families, the father and mother were in the same acculturation level; in only three families, one parent was bicultural and the other highly acculturated. Some of the traits on the ARSMA are fixed and others can change over time. Therefore bicultural parents married to high

acculturated parents adopted several Anglo-American traits, but because of ties to Mexico, have remained bicultural.

There was one significant finding that pointed toward a relationship and could offer direction for further research. As the fathers' acculturation level rose so did the use of Coping Pattern II, Maintaining Social Support, Self-esteem, and Psychological Stability. In other words, the lower acculturated fathers tended not to rely on coping behaviors which may have taken them outside the family unit as much as the higher acculturated fathers did. This finding is consistent with literature and is reflective of the values of the Mexican male (i.e., protector and provider of the family) (Correa, 1987; Rodriguez, 1983).

There were other interesting findings, although not significant, which warrant discussion. Regardless of acculturation level, all of the subjects used Coping Pattern I, Maintaining Family Integration, Cooperation, and an Optimistic Definition of the Situation more than the other two coping patterns. An explanation for the lack of a significant relationship between acculturation level and use of this pattern may be due not only to the small sample size but to the fact that the Mexican-American parent in general values "the family," regardless of the level of acculturation. This result is congruent with literature (Falicov, 1982; Rodriguez, 1983) and consistent with value orientation theory (Brink, 1983). As Rodriguez (1983) stated

although one cannot generalize about the Mexican-American family . . . , the existence of strong family support systems appears to persist despite differences in education, regional differences and varying degrees of assimilation into American life (p. 138).

The helpfulness of Coping Pattern I to these parents was apparent upon interview. Several factors which offered insight into the importance of family support were common among these families. Sixty-eight percent of mothers, a figure distributed fairly evenly across acculturation levels, stayed home with their children. When both parents worked, they either worked opposite shifts so one parent could be home with the chronically ill child, or they would hold an older sibling responsible for the care of the affected child. One divorced couple lived together in order to care for their affected child.

Respite care is a service which allows parents a reprieve from the constant care and demands of raising a chronically ill child. Although use of respite care as a coping behavior was not identified on the CHIP, the researcher asked the parents if they had used it or would use it in the future. The majority of parents (79%) said they would not use respite care. Those parents who reported using respite care (16%) were of varied acculturation levels. Their reason for using respite care was not to have an occasional rest from constant care but rather to rely on this resource, at times of additional stress when extended family members or older siblings were not available (i.e.,

one mother had a baby and the father was not able to take off from work; a divorced mother was hospitalized with breast cancer). Interestingly, the parents of one child who reported they would use respite care if necessary were both highly acculturated and had extended family nearby. They did not want to burden their family and had even thought about institutionalizing their child in the future.

Another aspect of Coping Pattern I is maintaining an optimistic definition of the situation. Several behaviors, which many parents found extremely helpful, relate to this aspect. These behaviors include "Belief in God," "Believing things will always work out" and "Telling myself that I have many things I should be thankful for." Ninety percent of the parents found the coping behavior, "Belief in God," extremely helpful. The 10% who found it minimally helpful or moderately helpful were in the higher acculturation levels. No parent found it "not helpful." The coping behavior, "Believing things will always work out" had 87% of the responses as "extremely helpful." The majority of the 68% of the parents who rated as extremely helpful the coping behavior, "Telling myself that I have many things to be thankful for," were in the lower and bicultural acculturation levels. These responses reflect the Mexican-American's second value orientation of subjugation-to-nature.

Although there was no statistically significant relationship found between acculturation level of the

families and Coping Pattern II, Maintaining Social Support, Self-esteem and Psychological Stability, there were six coping behaviors within Coping Pattern II which yielded some interesting results and are worthy of discussion. The six behaviors included "Becoming more self reliant and independent"; "Involvement in social activities with friends"; "Getting away by myself"; "Entertaining friends in our home"; "Allowing myself to get angry"; and "Being able to get away from the home care tasks and responsibilities for some relief." Greater than 50% of lower acculturated parents found these behaviors "not helpful" whereas the higher acculturated parents found these behaviors "moderately to extremely helpful" (none of the highly acculturated parents chose the response of "not helpful"). These particular behaviors are not in the behavioral repertoire of the low acculturated Mexican-American's cultural values (Falicov, 1982; Kluckhohn, 1961).

Although the ANOVA did not identify significant relationships, it appeared that Coping Pattern III, Understanding the Medical Situation through Communication with Other Parents and Consultation with Medical Staff, was perceived to be the second most helpful pattern to these parents. Further insight into the helpfulness of the medical support systems to these parents was gained during the interviews. In particular, the lower acculturated parents recounted frustrating experiences obtaining adequate medical care. They reported their desire for medical

intervention but often found their language and economic situation to be barriers. Several of these families spoke of using a curandero (folk healer) in the early days of diagnosis. Curanderos were sought and perceived of as more accessible because of similarity of language, other cultural values, understanding of concerns, and cost of services. Also, the parents held hope that the curandero would tell them that their child would be normal. As parents gained acceptance of their child's illness, they desired access to traditional medical treatment. Many of the bicultural parents who were once migrants made a conscious decision to settle into a community so their affected child could benefit from the medical services more consistently.

Applications to Practice

Understanding the impact of parental acculturation level on the use of specific coping patterns will require further investigation. However, the observations made by this researcher and the experiences recounted by the families can offer the nurse insight into the needs of chronically ill children and families of Mexican-American heritage.

The values of family and religion are strong in the Mexican-American culture. In this sample, these cultural values were reflected in the coping behaviors chosen. The nurse should view the family (siblings, grandparents, aunts, uncles, godparents) as a major source of support for the parents, especially during the initial periods of adjustment

and at other stressful times in the child's life (i.e., hospitalization, growth and development changes). For instance, when a child is required to be hospitalized for a lengthy period of time, a rooming-in arrangement would help alleviate the anxiety and stress that often results from the separation of the child from his family. Usually the mother will want to stay, but often an older sibling or other extended family member will stay when the mother cannot.

According to the demographic data, approximately 94% of the parents had a church affiliation (74% Catholic) and 90% stated that "Belief in God" was an extremely helpful coping behavior. Often the parents spoke of conferring with their priest before making decisions on treatment. These data support the literature (Correa, 1987; Guendelman, 1983; Rodriguez, 1983). The nurse must be aware of the significance of religion and must consider its impact on the child's plan of care in order for the plan to be effective.

Other findings may explain why some Mexican-American parents may not openly describe their feelings and identify their need to nonfamily members. For example, the finding that the higher acculturated fathers used social support systems more than the less acculturated fathers may offer some explanation. The initial encounter of the parents and the nurse tend to be formal, polite and reserved and, even after repeated interventions, the parents tend to keep their distance. This tendency to remain distant was evident during the data collection process in the majority of the

less acculturated parents and many of the bicultural parents. The referral source had to contact several parents two or three times to obtain their initial consent. Once the initial consent form was signed, the researcher then had to contact these parents two or three additional times to set up the interview. The reason for this apparent reluctance was that the mothers needed to gain permission from their husbands.

With regard to Coping Pattern III and the parent's desire to communicate with medical staff in order to understand their child's condition and treatment, demographic data such as language spoken, education level, occupation, and sites where the subjects live can provide information in assisting Mexican-Americans into the health care system. For instance, 39% of the less acculturated parents spoke only Spanish and another 39% spoke mostly Spanish. The more acculturated the parents became, the more fluent they became in English. When it came to communicating with medical staff, many of these parents did identify how extremely helpful this behavior was in coping with caring for their child. However, those parents who were monolingual in Spanish verbalized their frustrations with the language barrier and lack of understanding of the child's condition and prognosis. The nurse can help these parents in several ways. If the nurse is not bilingual, an interpreter should be provided who has an understanding of medical terminology in Spanish and is part of the medical

team. The nurse must be able to trust the interpreter as well as gain the respect of the parents. If the nurse is not bilingual but can learn key phrases in Spanish, the parents will feel more comfortable, and the intervention can go more smoothly. It would be ideal to have staff fluent in both languages and bicultural so the parents can speak directly with them and thus develop more trust and understanding.

In regard to education level, 85% of the lower acculturated parents did not graduate from high school. Upon administration of the ARSMA and the CHIP, the researcher learned that several of these parents were illiterate in their first language. Obviously, the two behaviors which identified reading as a way to cope were not helpful to these parents. The nurse must assess the literacy level of the parents in either language before using literature as an informational and/or teaching tool. One way in which this can be readily done is to administer the ARSMA. The researcher found the ARSMA to be a nonthreatening tool; all of the parents were receptive to learning more about themselves and enjoyed answering the questions.

Seventy-seven percent of the less acculturated parents were either migrant farmers or homemakers. This group does not have medical insurance. Thus, medical services were limited, especially those necessary for chronically ill children. Nurses within the migrant health programs are a

tremendous asset and are often the keys to opening up the doors for services for these families. By assisting them with making application for Medicaid and/or Crippled Children's Services, the nurse can eliminate another barrier for these less acculturated families to gain access to medical services for their children.

Another issue for the migrant family is the inability to take time off from work to visit the doctor or clinic. For the father, who maintains the protector and provider image (machismo) and is often the sole driver in the family, getting his child to medical service is difficult. Offering evening clinics as well as having transportation available during the day, so the mothers can take the child while the father works, can help.

When families live in migrant camps and small rural towns, they do not have convenient access to advanced or specialized medical care. Although there are two large cities in west Michigan which offer specialized medical services, the migrant camps and many of the small rural towns isolate these families from them. For many the distance and the lack of transportation is a problem. In rural communities, the nurse may need to access community agencies and the church for assistance with transportation.

The researcher noted a discrepancy in the reporting of the variable of mental retardation by the parents and the referral source. According to the referral sources, 13 (68%) of the children had mental retardation whereas only 9

(47%) of the families reported their child as having mental retardation. When the researcher further questioned the parents who denied their child was mentally retarded, the child's abilities were emphasized. Even those parents who identified their child as being mentally retarded emphasized their child's accomplishments. There may be several explanations for this discrepancy. It is possible that the parents never understood their child's mental status due to the communication barrier; the parents may be using the defense mechanism of denial as a form of coping; the parents may find it difficult to admit to the researcher (an outsider) that their child was mentally retarded, since family pride is very important (Correa, 1987); or, possibly, the child was misdiagnosed because of the language barrier and cultural background.

If the child has been diagnosed as mentally retarded, nurses should assess the parents' understanding of the child's mental status. If there is a discrepancy, as was noted in this research study, the nurse should then consider the possible explanations as she attempts to help the parent maintain appropriate expectations for the child in order to promote optimal health and safety needs.

Implications for nursing also arise from the contrast between the strongly male-dominated Mexican-American family and the democratic structure of the Anglo-American family. This contrast has not only been found in the literature (Correa, 1987; Falicov, 1982) but was also evident in the

families in this research project. This male-dominated family structure became obvious during the data collection period when the married mothers would not consent to participate in the study until their husbands had been consulted and had consented. As mentioned earlier, ten parents did not participate because the husbands did not want to "subject their child and family to research." The mothers voiced an interest and stated that they would have agreed to participate in the research, but their husbands overruled them.

Additionally, implications for nursing arise from the need of families to maintain family privacy, and thus, their pride or "amor propio" (self-integrity). In the literature (Adkins & Young, 1976; Correa, 1987), the family pride of the Mexican-American is emphasized. For instance, these researchers learned that, that in order for the Mexican-American family to maintain "amor propio," they would rather hide their affected child within the family than to acknowledge the fact that their child required special attention. In this study, family pride was not only apparent during the recruitment phase of data collection, but many of the families who did participate shared how they felt about others caring for their children (e.g., never using respite care or baby-sitters outside the extended family unit; the migrant parents choice to not send their children to the developmental centers).

It is helpful if the nurse understands the parental roles. The mothers tended to be the primary caregivers (68% of the mothers were homemakers and 51% of the mothers said that the coping behavior "Working, outside employment" was not helpful), while the fathers' primary role was to provide for the family by working (100% of the fathers were employed, and 92% of the fathers said that the coping behavior "Working, outside employment" was helpful). Because of cultural values, if the father is not included in the decision-making phase of the child's plan of care, then the plan may not be followed even if the mother agrees and is the primary caregiver. The nurse should try to include the father at the time of instruction or offer the mother time to confer with her husband and allow for his input.

In summary, culture and the acculturation process are complex variables which have an impact on coping behaviors chosen by parents as they care for their chronically ill child. To what extent these variables are related should be further investigated. However, nurses can gain insight from the data gathered on the instruments as well as from the experiences gained by interviewing the parents.

Limitations

The findings of this study are limited by several factors. First, the small sample size was a limiting factor in this study. If the sample size had been larger, the results might have achieved significance, thus offering a positive answer to the research question. Nevertheless, the

observations and data offer information which deserves to be investigated on a larger scale. Because of the small sample size and the use of the convenience sampling technique, the findings of this study should not be generalized beyond this study sample.

Second, the reliance upon many agencies and professionals to identify children and obtain consent from their parents may be considered an extraneous variable which was not controlled. For example, although the researcher instructed the professional to explain the study face to face (as the literature stresses the importance of "personalismo" or making an intervention as personable as possible with the Mexican-American), some of the professionals were not able to approach the parents in this manner. Rather, they contacted the family by mail or by telephone. This method not only took more time to gain the consent from the parents but, in some cases, may have precluded some parents from participating. There were parents who, when initially contacted by mail did not respond, but, when contacted in person with further explanation, consented.

Another limitation was the somewhat heterogenous nature of the children's chronic illness. Sixty-eight percent of the children had mental retardation, 53% had seizures, and 42% had multiple handicaps (>3 handicaps). Any one of these variables could have an impact upon the parent's choice of coping behaviors. However, each acculturation group had a

cross representation of the 42% of the children with the multiple handicaps.

Although the CHIP was considered reliable with parents of chronically ill children, the instrument had never been administered to parents of Mexican-American heritage. Therefore, the reliability of the tool was a potential limiting factor in this study. Early in the data collection process, the interviewer learned that some coping behaviors were difficult for the parents to understand. Some behaviors were not in their repertoire of coping at all, i.e., "sleeping" and "eating." Some terms held different meanings for the parents of different acculturation levels. For instance, the term "family" included the extended family for the less acculturated parents, whereas the higher acculturated parents considered the term to mean the nuclear family. Some parents did not understand the term "coping," particularly the less acculturated parents who were monolingual Spanish. For these parents, the interviewer, with the assistance of the interpreter and the Spanish translated instrument, offered further explanation and attempted to make it as understandable as possible. If the less acculturated and bicultural parents had been given the CHIP without some explanation, the reliability of the tool with this population might have been in question. But, because the same interviewer and the same interpreter offered consistent explanations, the reliability coefficients, upon completion of the study, were found to be

satisfactory and consistent with the reliability studies reported by the CHIP's authors.

Suggestions for Further Research

Suggestions for further research include investigation into the areas which were identified as limiting factors in this study. First, the sample size must be larger. This can be accomplished in one of two ways. Either more time should be allowed or this study should be replicated in an area which has a larger Mexican-American population such as Texas, New Mexico or California. Second, random sampling would allow for greater generalizability of results. This could be done if a larger population were available.

Third, this study should be replicated in an area where one site could be utilized to identify subjects. This would enable the researcher to have more control when making initial contacts with potential subjects. The researcher could make her own contacts or could recruit her colleagues if it were done at her own site of employment. This could save time as well as provide more consistency, control, and possibly a higher participation rate. In addition to utilizing one site to access subjects, the site should be a specialty clinic or institution in order to control the variable of the nature of the child's illness. For example, it would be easier to obtain a homogenous sample from ambulatory clinics specializing in the care of children with cerebral palsy, seizure disorders or spina bifida.

Fourth, a CHIP instrument which is more relevant for the Mexican-American subject might reflect a better image of their patterns of coping behaviors. Adding behaviors more common to this culture such as use of folk medicines or curanderos and rewording the statements would assist those subjects who are less acculturated to have a clearer understanding of what is being asked. Also, an adjustment would be necessary in usage of specific terms which have different meanings in different cultures i.e., terms such as "family."

Fifth, although the ARSMA instrument can be very helpful in further research, it could be more useful if the individual's value orientations could be measured by acculturation level. To measure values such as time orientation or man-nature orientation, would take the instrument one step further in understanding the Mexican-American parent as an individual within his/her basic cultural background.

Finally, a similar study could be done by including a group of Anglo-American parents. A comparison group would consist of Anglo-American parents who have chronically ill children with similar characteristics as the chronically ill children of Mexican-American descent. The research could investigate the Anglo-American parents' group to compare the choice of coping patterns with the high acculturation Mexican-American group.

Conclusion

Although this investigation did not reveal a statistically significant relationship between the acculturation level of the Mexican-American parents and the coping patterns they use in caring for their chronically ill children, the demographic data, the data gathered from the instruments, the information offered by the parents upon interview, and the experiences with this population during the data collection phase all contribute to the body of nursing knowledge. This increase in growth of knowledge can stimulate other nurses to engage in further research with the Mexican-American population.

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APPENDICES

Appendix A

Acculturation Rating Scale for Mexican-Americans

The following questionnaire is a measure of acculturation. Items are presented in either English or Spanish, depending on the preference of the patient. All items are scored in relation to the following continuum:

Mexican		Bi-Cultural		Anglo
1	2	3	4	5
Spanish		Bilingual		English

Note: Where La Raza is used, it is assumed to indicate Mexicanos and Mexican-Americans.

Instructions to patient, client or testee: "We would like to ask you some questions about background and your lifestyle. It will take about 15 minutes, and if you have any questions as we go along, please feel free to ask. I can give you the test in either English, Spanish, or both. Do you have a preference?" (Proceed with the subject's preference.)

Instrucciones al paciente, cliente, sujeto: "Deceamos hacerle algunas preguntas sobre sus costumbres y manera de vivir. Se tomara unos quince (15) minutos. Y si usted tiene algunas preguntas puede hacerlas con confianza. Le dare un examen en Ingles o en Español o en los dos idiomas. Cual prefiere usted?"

Acculturation Rating Scale for Mexican-Americans

Name or number of Parent

Nombre o numero del padre

Evaluator

Evaluador

Sex

Sexo

Date

Fecha

Demographic Information

Informacion Demografica

How old are you? _____

Que edad tiene usted? _____

What is your marital
status? _____

Cual es su estado
civil? _____

What is your religious
preference? _____

Cual es su religion
predilecta? _____

How much education do you
have? _____

Cuantos años de escuela
tiene Ud.? _____

What type of work do you
do? _____

Que clase de trabajo hace
Ud.? _____

Sex of your child with the
chronic illness. _____

Cual es el sexo de su hijo
o hija que tiene la
enfermedad cronica? _____

Age of your child with the
chronic illness. _____

Que edad tiene su hijo o
hija que tiene la
enfermedad cronica? _____

Does your child have
mental retardation? _____

Es su hijo o hija
retrasado mental? _____

Does your child have
seizures? _____

Su hijo o hija padece de
ataques? _____

How long has your child
suffered with his/her
illness? _____

Por cuanto tiempo su hijo
o hija ha sufrido su
enfermedad? _____

Circle the number next to the answer that best fits the question.

Indique la contestacion que mejor acomode a la pregunta con un circulo.

1. What language do you speak?

1. Spanish only
2. Mostly Spanish, some English
3. Spanish and English about equally (bilingual)
4. Mostly English, some Spanish
5. English only

2. What language do you prefer?

1. Spanish only
2. Mostly Spanish, some English
3. Spanish and English about equally (bilingual)
4. Mostly English, some Spanish
5. English only

3. How do you identify yourself?

1. Mexican
2. Chicano
3. Mexican American
4. Spanish American, Latin American, Hispanic American, American
5. Anglo American or other

4. Which ethnic identification does (did) your mother use?

1. Mexican
2. Chicano
3. Mexican American

1. Que lenguaje habla?

1. Solamente Español
2. Mas Español, poco Ingles
3. Igual en Español como Ingles
4. Mas Ingles, poco Español
5. Solamente Ingles

2. En que lenguaje prefiere hablar?

1. Solamente Español
2. Mas Español, poco Ingles
3. Igual en Español como Ingles
4. Mas Ingles, poco Español
5. Solamente Ingles

3. Como se identifica usted?

1. Mexicano
2. Chicano
3. Mexico Americano
4. Español Americano, Latino Americano, Hispanic Americano, Americano
5. Anglo Americano u otro

4. Cual identificacion etnica tiene (tenia) su madre?

1. Mexicana
2. Chicana
3. Mexico Americana

- | | |
|--|---|
| <p>4. Spanish, Hispanic, Latin American, American</p> <p>5. Anglo American or other</p> | <p>4. Española, Latina Americana, Hispana, Americana</p> <p>5. Anglo Americana u otra</p> |
| <p>5. Which ethnic identification does (did) your father use?</p> <p>1. Mexican</p> <p>2. Chicano</p> <p>3. Mexican American</p> <p>4. Spanish, Hispanic, Latin American</p> <p>5. Anglo American or other</p> | <p>5. Cual identificacion etnica tiene (tenia) su padre?</p> <p>1. Mexicano</p> <p>2. Chicano</p> <p>3. Mexico Americano</p> <p>4. Español, Hispano Latino Americano</p> <p>5. Anglo Americano u otro</p> |
| <p>6-7. What was the ethnic origin of the friends and peers you had, as a child up to age 6? _____ (use codes 1-5) below)</p> <p>from 6 to 18? _____ (use codes 1-5 below)</p> <p>1. Almost exclusively Mexicans, Chicanos, Mexican Americans (LA RAZA)</p> <p>2. Mostly Mexicans, Chicanos, Mexican Americans</p> <p>3. About equally Raza (Mexicans, Chicanos, or Mexican Americans) and Anglos or other ethnic groups</p> <p>4. Mostly Anglos, Blacks, or other ethnic groups</p> <p>5. Almost exclusively Anglos, Blacks, or other ethnic groups</p> | <p>6-7. Cual era el origen etnico de sus amigos y companeros hasta la edad de seis (6) años? _____ (use las preguntas del uno a cinco)</p> <p>de 6 a 18? _____ (use las preguntas del uno a cinco)</p> <p>1. Exclusivamente Mexicanos, Chicanos, Mexico Americanos (LA RAZA)</p> <p>2. En su mayoria Mexicanos, Chicanos, Mexico Americanos (LA RAZA)</p> <p>3. Casi igual (Mexicanos, Chicanos, Mexico Americanos o RAZA) y otros grupos etnicos</p> <p>4. En su mayoria Anglo Americanos, Negros u otros grupos etnicos</p> |

- | | |
|---|--|
| | 5. Exclusivamente
Anglo Americanos,
Negros u otros
grupos etnicos |
| 8. Whom do you now
associate with in the
outside community? | 8. Con quien se asocia
ahora en la
comunidad? |
| 1. Almost exclusively
Mexicans, Chicanos,
Mexican Americans
(LA RAZA) | 1. Exclusivamente
Mexicanos,
Chicanos, Mexico
Americanos (RAZA) |
| 2. Mostly Mexicans,
Chicanos, Mexican
Americans | 2. En su mayoria
Mexicanos,
Chicanos, Mexico
Americanos (RAZA) |
| 3. About equally Raza
(Mexicans,
Chicanos, or
Mexican Americans)
and Anglos or other
ethnic groups | 3. Casi igual
(Mexicanos,
Chicanos, Mexico
Americanos o Raza)
Y otros grupos
eticos |
| 4. Mostly Anglos,
Blacks, or other
ethnic groups | 4. En su mayoria
Anglo Americanos,
Negros u otros
grupos etnicos |
| 5. Almost exclusively
Anglos, Blacks, or
other ethnic groups | 5. Exclusivamente
Anglo Americanos,
Negros u otros
grupos etnicos |
| 9. What is your music
preference? | 9. Cual musica prefiere? |
| 1. Only Spanish | 1. Solamente musica en
Español |
| 2. Mostly Spanish | 2. Por la mayor parte
en Español |
| 3. Equally Spanish and
English | 3. Casi igual en
Español como
Ingles |
| 4. Mostly English | 4. Por la mayor parte
en Ingles |
| 5. English only | 5. Solamente Ingles |
| 10. What is your TV
viewing preference? | 10. Que tipo de programas
de television
prefiere? |
| 1. Only programs in
Spanish | 1. Solamente
programas en
Español |
| 2. Mostly programs in
Spanish | 2. Por la mayor parte |

- | | |
|--|--|
| 3. Equally Spanish and English programs | programas en Español |
| 4. Mostly programs in English | 3. Igual programas en Español como Inglés |
| 5. Only programs in English | 4. Por la mayor parte en Inglés |
| | 5. Solamente programas en Inglés |
| 11. What is your movie preference? | 11. Que tipo de películas prefiere? |
| 1. Spanish-language movies only | 1. Solamente películas en Español |
| 2. Spanish-language movies mostly | 2. Por la mayor parte películas en Español |
| 3. Equally English/Spanish | 3. Igual Inglés y Español |
| 4. English-language movies mostly | 4. Por la mayor parte en Inglés |
| 5. English-language movies only | 5. Solamente películas en Inglés |
| 12. a. Where were you born (subject)?
___ Mexico ___ U.S.
___ Other
(Parents) | 12. a. En donde nació usted? (sujeto)
___ Mexico ___ Estados Unidos ___ Otro País
(Padres) |
| b. Where was your father born?
___ Mexico ___ U.S.
___ Other | b. En donde nació su padre?
___ Mexico ___ Estados Unidos ___ Otro País |
| c. Where was your mother born?
___ Mexico ___ U.S.
___ Other
(Grandparents) | c. En donde nació su madre?
___ Mexico ___ Estados Unidos ___ Otro País
(Abuelos) |
| d. Where was your father's mother born?
___ Mexico ___ U.S.
___ Other | d. En donde nació la mamá de su padre?
___ Mexico ___ Estados Unidos ___ Otro País |
| e. Where was your father's father born?
___ Mexico ___ U.S.
___ Other | e. En donde nació el papá de su padre?
___ Mexico ___ Estados Unidos ___ Otro País |
| f. Where was your | f. En donde nació la mamá de su madre?
___ Mexico ___ Estados |

mother's mother
born?
___Mexico ___U.S.
___Other

- g. Where was your
mother's father
born?
___Mexico ___U.S.
___Other

On the basis of the
above answers, circle
the generation that
best applies.

1. 1st generation =
subject born in
Mexico or other
2. 2nd generation =
subject born in
U.S., either parent
born in Mexico or
other
3. 3rd generation =
subject born in
U.S., both parents
born in U.S., and
all grandparents
born in Mexico or
other
4. 4th generation =
subject and parents
born in U.S. and at
least one grand-
parent born in
Mexico or other
with remainder born
in the U.S.
5. 5th generation =
subject and parents
born in U.S. and
all grandparents
born in U.S.

13. Where were you
raised?

1. In Mexico only
2. Mostly in Mexico,
some in U.S.
3. Equally in U.S.

- Unidos ___Otro Pais
g. En donde nacio el
papa de su madre?
___Mexico ___Estados
Unidos ___Otro Pais

Sobre la informacion
Anterior indique el
numero de la
generacion que mejor
le corresponde.

1. la generacion =
sujeto nacio en
Mexico u otro pais
2. 2a generacion =
sujeto nacio en
los Estados Unidos
cualquiera de sus
padres nacidos en
Mexico u otro pais
3. 3a generacion =
sujeto nacio en
los Estados Unidos
sus dos padres
nacidos en los
Estados Unidos y
todos los abuelos
nacidos en Mexico
u otro pais
4. 4a generacion =
sujeto nacio en
los Estados Unidos
y por lo menos un
abuelo nacido en
Mexico u otro pais
5. 5a generacion =
sujeto y sus dos
padres nacidos en
los Estados Unidos
y todos sus
abuelos nacidos en
los Estados Unidos

13. En donde crecio
usted?

1. En Mexico
2. La mayor parte
del tiempo en
Mexico y la menor

- | | | | |
|-----|-----------------------|-----|------------------------|
| | and Mexico | | parte en los |
| 4. | Mostly in U.S., | | Estados Unidos |
| | some in Mexico | 3. | La misma cantidad |
| 5. | In U.S. only | | de tiempo en los |
| | | | Estados Unidos y |
| | | | en Mexico |
| | | 4. | La mayor parte del |
| | | | tiempo en los |
| | | | Estados Unidos y |
| | | | la menor parte en |
| | | | Mexico |
| | | 5. | En los Estados |
| | | | Unidos |
| 14. | What contact have you | 14. | Que contacto ha tenido |
| | had with Mexico? | | usted con Mexico? |
| 1. | Raised for one year | 1. | Criado un año o |
| | or more in Mexico | | mas en Mexico |
| 2. | Lived for less than | 2. | Criado menos de un |
| | 1 year in Mexico | | año en Mexico |
| 3. | Occasional visits | 3. | Visitas |
| | to Mexico | | ocasionales a |
| 4. | Occasional | | Mexico |
| | communication | 4. | Comunicaciones |
| 5. | No exposure or | | ocasionales |
| | communications with | | (cartas, llamadas |
| | people in Mexico | | telefonicas, etc.) |
| | | | con gente de |
| | | | Mexico |
| | | 5. | Ningun contacto o |
| | | | comunicacion con |
| | | | gente de Mexico |
| 15. | What is your food | 15. | Que tipo de comida |
| | preference? | | prefiere? |
| 1. | Exclusively Mexican | 1. | Solamente comida |
| | food | | Mexicana |
| 2. | Mostly Mexican food | 2. | Por la mayor |
| 3. | About equally Mexican | | parte comida |
| | and American | | Mexicana, parte |
| 4. | Mostly American food | | Americana |
| 5. | Exclusively American | 3. | Los mismo Mexicana |
| | food | | y Americana |
| | | 4. | Por la mayor parte |
| | | | comida Americana |
| | | 5. | Solamente comida |
| | | | Americana |

16. In what language do you think?

1. Only in Spanish
2. Mostly in Spanish
3. Equally in English and Spanish
4. Mostly in English
5. Only in English

17. Can you read Spanish?

_____Yes _____No

Can you read English?

_____Yes _____No

Which do you read better? Rate the subject on the following continuum:

1. Reads only Spanish
2. Reads Spanish better than English
3. Reads both Spanish and English equally well
4. Reads English better than Spanish
5. Reads only English

18. Can you write in English?

_____Yes _____No

Can you write in Spanish?

_____Yes _____No

Which do you write better? Rate the subject on the following continuum:

1. Writes only Spanish
2. Writes Spanish better than English
3. Writes both Spanish and English equally well
4. Writes English

16. En que idioma piensa usted?

1. Solamente en Español
2. La mayor parte en Español
3. Igual en Ingles y Español
4. La Mayor Parte en Ingles
5. Solamente en Ingles

17. Puede leer en Español?

_____Si _____No

Puede leer en Ingles?

_____Si _____No

En cual lenguaje lee mejor? Indique con un circulo el numero que mejor corresponde:

1. Lee solamente Español
2. Lee mejor Español que Ingles
3. Lee igual en Ingles que en Español
4. Lee mejor en Ingles que en Español
5. Lee solamente en Ingles

18. Puede escribir en Ingles?

_____Si _____No

Puede escribir en Español?

_____Si _____No

En cual lenguaje escribe mejor? Indique con un circulo el numero que mejor corresponde:

1. Escribe solamente en Español
2. Escribe mejor en Español
3. Escribe igual en Ingles que en

- | | |
|--|---|
| <p>5. better than Spanish
Writes only in
English</p> | <p>Español
4. Escribe mejor en
Ingles que en
Español
5. Escribe solamente
en Ingles</p> |
| <p>19. If you consider yourself
a Mexican, Chicano,
Mexican American,
member of La Raza, or
however you identify
this group, how much
pride do you have in
this group?</p> | <p>19. Si se considera usted
como Mexicano,
Chicano, Mexico
Americano, Miembro de
la Raza, o cualquiera
que sea su identidad
con este grupo, que
tan orgulloso se
siente de ser un
miembro de este
grupo?</p> |
| <p>1. Extremely proud
2. Moderately proud
3. Little pride
4. No pride but does
not feel negative
toward group
5. No pride and feels
negative toward La
Raza</p> | <p>1. Extremadamente
orgulloso
2. Moderadamente
orgulloso
3. Poco de orgullo
4. Nada de orgullo,
pero tampoco no se
siente negativo
respecto a este
grupo
5. Nada de orgullo y
tiene sentimientos
negativos hacia
miembros de La
Raza</p> |
| <p>20. How would you rate
yourself?</p> | <p>20. Que clasificacion se
daria a usted mismo?</p> |
| <p>1. Very Mexican
2. Mostly Mexican
3. Bicultural
4. Mostly Anglicized
5. Very Anglicized</p> | <p>1. Muy Mexicano
2. En gran parte
Mexicano
3. Bicultural en gran
parte
4. En gran parte
Americanizado
5. Muy Americanizado</p> |

Total Score _____

Average Score _____

Total score is the sum of all 20
multiple-choice item circled.
Average score is the total score
divided by 20.

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These consist of pages: 93-99

U·M·I

Appendix D

Informed Consent for Human Subjects Project I

I, _____ give
name of parent

_____ permission to release
name of agency

my name, address and phone number to Nancy Tena, graduate student in nursing at Grand Valley State University for purposes of participation in her research project concerning the coping behaviors used by Mexican-American parents as they care for their neurologically impaired children.

Please check one of these:

You may contact me by phone _____ or make a home visit if no phone is available _____.

Thank you.

Informed Consent for Human Subjects Project I
(Spanish Version)

Yo _____ le doy permiso a
(Nombre del padre o madre)

_____ para que le proporcione
(Nombre de la agencia)

mi nombre, domicilio y numero de telefono a Nancy Tena,
enfermera titulada haciendo estudios de graduado en Grand
Valley State University; el proposito sera para participar
en su proyecto de investigacion acerca de la manera de como
los padres de familia Mexico-Americanos se las manejan para
cuidar y atender a sus hijos/hijas que estan
neurologicamente incapacitados.

Por favor chequee uno de estos:

Ud. puede ponerse en contacto conmigo por telefono
_____ o puede visitarme en casa si no hay
telefono _____.

Muchas gracias.

Appendix E

Verbatim

I am Nancy Tena, a graduate student in Nursing at Grand Valley State University. _____ the _____ at _____ has given me permission to contact you to determine if you would be willing to participate in a research project concerning which coping behaviors Mexican-American parents use to manage their child with a chronic illness.

If you agree to participate, I will ask you to complete two questionnaires. One questionnaire will identify some traits of your culture, and the other will identify coping behaviors you find helpful in raising and caring for your child with a chronic illness. It should take about one hour.

All of your responses will be anonymous and held in confidence by me; moreover, your name, your spouse, and your child's name will be removed and not used on any material generated by this study. You may ask me questions and you may drop out of this project at any time. The results of this study will be available to you.

Verbatim
(Spanish Version)

Yo soy Nancy Tena, estudiante titulado haciendo estudios de graduado en enfermeria en Grand Valley State University. _____ el _____ en _____ me han permitido en ponerme en contacto con Ud. para ver si Ud. se interesaria y es tan amable de participar en un proyecto de investigacion para estudiar la manera de como los padres de familia Mexico-Americanos se las Manejan para cuidar a sus hijos con enfermedades cronicas.

Si Ud. esta de acuerdo en participar, le pedire que llene dos formularios de preguntas. Uno de los formularios identificara algunas características de su cultura, y el otro investigara las maneras que ha usado y le han aydado a Ud. para poder atender a su hijo/hija con la enfermedad cronica. Esto le tomara como una hora.

Todas sus respuestas seran anonimas y seran guardadas en estricta confidencia por mi. Ud. podra hacer cualquier pregunta, y tambien podra retirarse de este proyecto cuando quiera. Los resultados de esta investigacion podran ser compartidos con Ud.

Appendix F

Informed Consent for Human Subjects Project II

I, _____ agree to serve as a subject in the study of acculturation level of Mexican-Americans and coping behaviors identified by parents of children with chronic illness, under the supervision of Nancy Tena, a graduate student at Grand Valley State University. The study will attempt to look at relationships between each parent's cultural values and their effect on the ways in which each parent copes with their chronically ill child. The procedure in which I will participate is the completion of two questionnaires with the availability of the investigator. I understand the questionnaires will require no more than one hour to finish in my own home. There are no expected risks. The information which is gained from this study may help me and other parents in the future as it contributes to nursing.

I understand that my answers will not be told to anyone and that I may withdraw from participating in this study at anytime. I have had an opportunity to ask questions.

I have read and fully understand the foregoing information.

Date

Subject's Signature

Witness

Informed Consent for Human Subjects Project II
(Spanish Version)

Yo, _____ acepto en participar como sujeto en esta investigacion de niveles de aculturacion de la poblacion Mexico-Americana, y tambien de las maneras que usan para poder sobrellevar mejor el tener en cuidado hijos con enfermedades cronicas; esto se llevara a cabo bajo la supervicion de Nancy Tena estudiante graduada en enfermeria en la Universidad de Grand Valley State. El proposito de esta investigacion es para desarrollar un mejor entendimiento de las varias maneras de como los padres Mexico-Americanos sobrellevan las dificultades de atender a un hijo/hija con enfermedad cronica.

La manera como voy a participar sera llevando dos formularios de preguntas en la que el investigador estara al tanto de esto. Yo entiendo que los formularios de preguntas me tomaran no mas de una hora en llenarlos y esto se hara en mi domicilio. No me expondre a ningun riesgo. Los conocimientos que se logran de esta investigacion quizas me puedan ayundar a mi como a otros padres en el futuro puesto que contribuira al conocimiento de la profecion de enfermeria.

Yo entiendo que esta se mantendra en confidencia y que tengo la libertad de retirarme de este proyecto en cualquier momento. Yo he tenido la oportunidad de hacer preguntas.

Yo he leida y entendido completamente toda la
informacion siguiente.

Fecha

Firma de Sujeto

Firma de testigo