

CULTURAL HEALTH HYBRID:
AN EXPLORATION OF CHANGING HEALTH BELIEFS
AND ATTITUDES AMONG HISPANIC AND HISPANIC AMERICAN WOMEN

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Abstract

Using two focus groups with 8 Hispanic and 9 Hispanic American women, this study compared health beliefs and attitudes between Hispanic and American women. This study identified strategies that both groups of women use to negotiate health information from two distinct health cultures: traditional Hispanic culture and American clinical culture. Findings indicate that both Hispanic and Hispanic American women see health as having a physical and psychological component, see themselves as responsible for protecting their health, and practice preventive behaviors. However, Hispanic American women do not believe in culture-bound syndromes the way Hispanic women do, nor do Hispanic American women believe in a connection between culture-bound syndromes and chronic disease. Interestingly, both groups of women adapt to a clinical health culture in their own way. Hispanic women adopt clinical practices while maintaining their traditional practices. In contrast, Hispanic American women pick and choose practices from traditional and clinical health culture. This study proposes the theory of cultural health hybrid to examine changing health attitudes and beliefs in Hispanic and Hispanic American women.

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Preface

Dedicated to my grandmother, Nohemy Largacha, whose unwavering faith and supernatural strength were the inspiration for this research study, and to my mother, Stella Rubin, whose insatiable quest for health information is a model for engaged patients.

I would like to thank Jane Twomey, Ph.D. and Mary Miscally, Dr.P.H. for their guidance through the iterative process that culminated in this paper. I also thank Mariana Serrani for her Spanish-language assistance and translation certification. Finally, I thank Jason Decker for his advice, patience, and motivation; and Stella and Phil Rubin for their loving encouragement and support.

Table of Contents

Abstract	ii
Preface.....	iii
Introduction.....	1
Cultural Health Hybrid	4
Literature Review.....	6
Beliefs and Attitudes as Barriers to Health Self-Efficacy	6
Changing Health Beliefs and Attitudes.....	11
Research Questions	13
Method	14
Participant Recruitment	15
Procedures.....	17
Data Analysis	19
Results.....	20
Participant Description.....	20
Shared Health Beliefs and Attitudes	21
Differences in Health Beliefs and Attitudes	23
Strategies to Negotiate Health Cultures	27
Discussion	32
Implication of Findings.....	32
Emerging Attitudes	33
Cultural Health Hybrid	34
Limitations	36
Implications for Further Research	37
Appendices.....	39
References.....	63
Curriculum Vitae	69

Cultural Health Hybrid: An Exploration of Changing Health Beliefs and Attitudes
Among Hispanic and Hispanic American Women

In 2010, Hispanics made up 16.4% of the United States population, a marked increase compared to 12.5% in 2000. U.S.-born Hispanics contributed the most to this increase, from 7.5% in 2000 to 10.3% in 2010. By comparison, the number of foreign-born Hispanics increased slightly from 5% to 6.1% during the same time period. This translates into almost 32 million Hispanic Americans and 18 million Hispanics living in the United States in 2010 (Motel, 2012). Currently, U.S.-born Hispanics outnumber foreign-born Hispanics. In this paper, I will use the term *Hispanic* to refer to people who immigrated to the United States as adults and *Hispanic American* to describe people born in the United States to Hispanic parents or who immigrated as children. These two terms include synonymous classifications, such as Latino/a, Chicana, and Mexican American, which are often used to refer to Hispanic Americans.

Hispanic culture influences health care decisions and patient-doctor communication. Doctors are deemed worthy of respect by virtue of their authority, social position, and education (National Alliance for Hispanic Health, 2001). Respect for doctors manifests itself in patients assuming a passive role in health decisions. This is contrary to American health culture, which encourages patients to play an active role in their health care (Talavera, Elder, & Velasquez, 1997). Respect in Hispanic culture implies not asking questions, even if a patient does not understand a diagnosis or prescription, nor voicing disagreement about treatment recommendations (National Alliance for Hispanic Health, 2001). Therefore, Hispanic culture can create barriers in patient-doctor communication.

Some health beliefs and attitudes prevalent in Hispanic culture may create barriers to health self-efficacy (Ashing-Giwa, Padilla, Bohórquez, Tejero, & Garcia, 2006; Coronado, Thompson, Tejada, & Godina, 2004; Pérez-Stable, Sabogal, Otero-Sabogal, Hiatt, & McPhee, 1992; Poss & Jezewski, 2002). Self-efficacy is the belief a person has in his or her ability to perform a necessary activity (Bandura, 1977). Furthermore, belief in one's ability to successfully carry out a task also affects how a person will attempt to cope in a given situation. To explore the influence of beliefs and attitudes, I use the following definitions: *beliefs* are the “probability dimension of a concept” —is its existence probable or improbable? And *attitudes* are the “evaluative dimension of a concept”—is it good or bad? (Fishbein & Raven, 1962, p. 35).

The American Psychiatric Association defines culture-bound syndromes as “localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations (American Psychiatric Association/Guarnaccia & Rogler, 1999, p. 1322). Culture-bound syndromes often describe mental illnesses such as clinical depression and generalized anxiety disorder (Bayles & Katerndahl, 2009; Braun, 2008). Hispanics colloquially refer to these culture-bound syndromes as *ataque de nervios* (nervous attack), *nervios* (nerves), *susto* (fright), and *mal de ojo* (evil eye). Hispanics and Hispanic Americans are more likely to experience psychological distress than their non-Hispanic counterparts in the United States (Dey & Lucas, 2006). Hispanics believe culture-bound syndromes have supernatural or mystical causes rather than clinical explanations, thus preventing them from seeking medical attention. In addition, Hispanics avoid talking to their doctors about symptoms they associate with culture-bound syndromes because they believe

doctors will not know, understand, or accept such syndromes (Braun, 2008). This further creates a barrier in patient-doctor communication, and ultimately produces an obstacle to access treatment, especially in cases where a mental illness is the clinical explanation for a culture-bound syndrome.

Prevalent health attitudes in Hispanic culture can lower people's perception of health self-efficacy. Fatalism is a common health attitude among Hispanics. Fatalistic people accept the perception of having little or no control over their health outcomes and therefore do not engage in preventing or treating chronic disease because they see the effort as futile (Chavez, Hubbell, McMullin, Martinez, & Mishra, 1995; Hubbell, Chavez, Mishra, & Valdez, 1996). Similarly, external locus of control is a common health attitude, often manifested in God's will (punishment or reprieve) and doctors' healing ability (Ashing-Giwa et al., 2006; Roncancio, Ward, & Berenson, 2011). Lastly, moral attitudes about sexual behaviors pose a barrier to health care. The misconception that abortions cause cervical cancer, or that any cancer diagnosis is a punishment from God for bad behavior, also prevents Hispanic women from sharing health information with family and loved ones (Chavez, McMullin, Mishra, & Hubbell, 2001). Moral attitudes create barriers because they prevent younger generations from knowing their family health history and inhibit afflicted people, especially women, from seeking treatment or emotional support.

Newer studies, however, suggest that beliefs and attitudes are changing, especially among Hispanics who have lived in the United States for decades and Hispanic Americans who grew up immersed in American culture. These two groups demonstrate higher self-efficacy when it comes to their health (Flórez, Aguirre, Viladrich, Céspedes,

De La Cruz, & Abraído-Lanza, 2009). They are also more likely to attribute family history as a risk factor for breast cancer (Chavez et al. 1995), and use preventive services more frequently to detect breast and cervical cancer (Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005).

Cultural Health Hybrid

This study aims to propose cultural health hybridization as a theory to explore the changing beliefs and attitudes among acculturated Hispanics and U.S.-born Hispanic Americans. In the late 1980s, the theory of cultural hybridization emerged as a strategy that allowed Latin America to compete in the modern era, yet retain folk customs as a fingerprint of unique cultures (Canclini, 1989). Cultural hybridization was a possible mechanism to expand and renew cultures. It is not a planned process, but rather a by-product of the “migratory process” and “economic and communication exchange” (Canclini, 1997, p. 112).

Observational learning, a process in which people see how others’ behaviors are reinforced, contributes to cultural health hybridization by allowing people to learn from their social environments and adopt behaviors (Bandura, 2001). Observational learning is a natural process among families and “accounts for why people in the same family have common behavioral patterns” (Baranoski, Perry, & Parcel, 2002, p. 170). This may also explain how Hispanic Americans, despite growing up immersed in American culture, know of traditional Hispanic health beliefs and attitudes (Bayles & Katerndahl, 2009). Observational learning is a mechanism for cultural health hybrids to incorporate attitudes that can lead to higher internal locus of control, thus resulting in higher health self-efficacy (Zachariae et al., 2003).

This study is important because culture greatly influences Hispanics' and Hispanic Americans' experience of health care in the United States. The cultural difference poses communication challenges for patients, doctors, health educators, and health campaign planners (Centers for Disease Control and Prevention, n.d.). However, as the evidence suggests, traditional Hispanic health beliefs and attitudes are changing. Therefore, researchers, communicators, and clinicians need to be culturally sensitive and aware of the health and attitude continuum among Hispanics and Hispanic Americans (Talavera et al., 1997).

In this study, I compare Hispanic and Hispanic American women's health beliefs and attitudes. I also identify strategies they use to negotiate health practices from two different health cultures. Health communication professionals who design health education campaigns can use the results of this study to inform campaigns for Hispanic audiences. In addition, public health professionals can use these findings to further examine the role of culture as part of social determinants of health outcomes. Lastly, clinicians can use these findings to augment their cultural competence training.

Literature Review

This literature review summarizes studies that illustrate how health beliefs and attitudes affect health self-efficacy in Hispanics and Hispanic Americans. I also present evidence that traditional health beliefs and attitudes are changing among some groups of Hispanics. Although, I used the Fishbein and Raven (1962) definition of beliefs and attitudes, there is still disagreement about their definition in the literature. Some would argue that the attitudes I present here have a dimension of belief in addition to an attitude. Therefore, I present beliefs and attitudes together. However, their importance here is that beliefs and attitudes are barriers to health self-efficacy.

Beliefs and Attitudes as Barriers to Health Self-Efficacy

Culture-bound syndromes are folk illnesses prevalent in Hispanic culture that can be barriers to health self-efficacy. Many times, they are terms for psychological illnesses or symptoms of a clinical disease, but with supernatural causes associated to the cause. *Mal de ojo* is a culture-bound syndrome, often used to describe a variety of maladies in infants. *Susto* is also a culture-bound syndrome described as a strong emotion caused by a frightening event, often attributed with precipitating the onset of type 2 diabetes.

Argote and Vasquez (2005) interviewed adolescent mothers (n=8) in Cali, Colombia, a large metropolitan city, about their beliefs in culture-bound syndromes. The researchers found that the young mothers have a strong belief in culture-bound syndromes, especially *mal de ojo*. Mothers expressed concern about protecting their newborns from *mal de ojo* to prevent mental retardation and malaise. They reported the strict practice of blocking newborns from strangers' line of sight to avoid malicious or unintentional *mal de ojo*. Participants listed the symptoms of *mal de ojo* as fever,

vomiting, diarrhea, sweating, insomnia, weight loss, and swelling. In severe cases, respondents said they believed *mal de ojo* could cause mental retardation. Mothers offered the following as treatments: prayer, seeking care from a folk healer, herbal cleansings, and avoiding milk and eggs.

Findings from Gil and López's (2007) interviews of women (n=20) in Turbo, Colombia, a small rural city, also support the previous study's findings. The researchers observed and interviewed mothers (mean age=28, age range: 17- 54) of young children about their beliefs and experiences with *mal de ojo* and its relation to malnutrition. They found that women listed diarrhea, vomiting, and fever as symptoms, and treatment as prayer, ritual baths, and herbal remedies. The researchers also found that mothers believed people could intentionally or unintentionally give a baby *mal de ojo*. If a community member envied the baby because he or she was cute or happy, they could intentionally give the baby *mal de ojo*. Women also believed that a doting father could unintentionally give their child *mal de ojo*, if the father carried the baby while still sweaty from being outdoors or was excessively attentive to the child. Women in this study noticed that their babies dramatically lost or gained weight after they contracted *mal de ojo*, indicative of a symptom associated to malnutrition or edema (swelling).

Poss and Jezewski (2002) explored the role of *susto* in perceived causes of diabetes using focus groups with Mexicans (n=18) and Mexican Americans (n=4) in a Texas border town. Eligible study participants had lived with diabetes for an average of 14 years and were enrolled in diabetes education classes. Despite participating in these classes, participants still believed that strong emotions (happy or sad) had triggered the onset of their diabetes. Almost all could remember a specific frightful event or *susto* to

which they attributed the onset of their disease. Common *susto* events include a car accident, witnessing a death by gunfire or drowning, being threatened with a gun, or the sudden death of a family member.

In a later study, Coronado et al. (2004) found similar results from focus group discussions with Mexican Americans (n=42) living in Washington state. Participants offered diabetes risk factors and symptoms consistent with clinical medicine. Risk factors included heredity, a diet high in fat and sugar, and obesity. Symptoms included increased thirst, urination, and tiredness. However, some participants concurrently believed that culture-bound syndromes such as *susto* or *coraje* made them susceptible to diabetes. Similarly, when asked about diabetes treatment, participants offered both clinical treatments (diet changes, more exercise, oral medication, insulin) and folk treatments (cactus juice, aloe vera, and violet water).

These studies show how deeply culture-bound syndromes such as *mal de ojo* and *susto* are entrenched in Hispanic culture, even among Hispanics living in the United States and Hispanic Americans. Culture-bound syndromes may mask underlying medical conditions, thus delaying medical care and disease management. Furthermore, their supernatural attributes prevent people from seeking medical attention, creating a barrier to perceived health self-efficacy.

In addition to health beliefs, Hispanics and Hispanic Americans have specific attitudes that create a barrier to their health self-efficacy. People with fatalistic attitudes believe there is little or nothing they can do to prevent disease and illness. Some have an external locus of control, meaning they believe others have the power to determine their health outcomes. Examples of powerful others are God and doctors (Borrayo, &

Guarnaccia, 2000). Lastly, moral attitudes create a barrier because people withhold information from family members and doctors to avoid shame and judgment when they believe others will perceive them as engaging in morally questionable behaviors.

In a seminal study, Pérez-Stable et al. (1992) randomly surveyed Hispanics (n=486) and Hispanic Americans (n=358) in San Francisco about their cancer attitudes and compared them to the attitudes of Anglo Americans (n=510). Among Hispanic and Hispanic American respondents, 46% saw cancer as a punishment from God, and 46% perceived cancer as a death sentence. Twenty-six percent believed that there was little they could do to prevent cancer. Hispanics' and Hispanic Americans' responses showed that they have higher fatalistic attitudes and a higher external locus of control as compared to Anglo Americans ($p < 0.001$).

Similarly, Ashing-Giwa et al. (2006) found that Hispanic breast cancer survivors (n=26) perceived God as a powerful locus of control. The researchers recruited a convenience sample of Hispanic women (mean age=56), to participate in focus groups in Los Angeles. Researchers found that culture affects Hispanic women's attitudes about their well-being. Women's coping mechanisms to survive breast cancer included accepting God's will and believing in the strength of prayer for healing. Women often saw prayer as a path to a cure; some even discontinued breast cancer treatment because they strongly believed that God would cure them. In addition, women tended to keep their diagnosis a secret because Hispanics often perceive cancer as a punishment from God.

In a larger quantitative study, Otero-Sabogal, Stewart, Sabogal, Brown, and Pérez-Stable (2003) surveyed Hispanic women (n=652) and Hispanic American women

(n=323) about their breast and cervical cancer attitudes. Researchers used random digit dialing to recruit participants (age range: 40-77) for a 20-minute telephone survey from four cities in California. The researchers found that 59% of women did not get regular mammographies, and 27% did not get regular Pap tests. Researchers also found that these women shared certain characteristics: higher fatalistic attitudes and more cancer-related fatalism. Lastly, researchers found that less acculturated Hispanic women who had immigrated to the United States within the past five years had higher fatalistic attitudes.

Chavez et al. (2001) explored Hispanics' (n=533) and Hispanic Americans' (n=270) attitudes about cervical cancer using random-digit telephone surveys. Trained interviewers asked women to rank six risk factors in order of greatest contribution to cervical cancer. The risk factors— abortions, lack of medical care, vaginal infections, many sexual partners, heredity, and sex at an early age—were developed by the researchers based on previous studies with Hispanic, Hispanic American, Anglo American women, and physicians. Abortions were the highest mean ranked risk factor among Hispanic women, followed by vaginal infections. Hispanic women in this study attributed cervical cancer to morally questionable behaviors in Hispanic culture.

These studies show that fatalistic attitudes, an external locus of control, and attitudes about morally questionable behaviors influence Hispanics' and Hispanic Americans' health attitudes, in particular breast and cervical cancers. In addition, these attitudes perpetuate a culture of secrecy because of the stigmas associated with cancer as God's punishment or a consequence of morally questionable behaviors.

Changing Health Beliefs and Attitudes

Despite entrenched beliefs and attitudes, newer research suggests that beliefs and attitudes are changing among Hispanics through the process of acculturation and among Hispanic Americans as a by-product of growing up in American clinical culture.

Acculturation is the cultural exchange of beliefs, attitudes and behaviors that people experience when they come into contact with a culture different from their culture of origin (Lara et al., 2005).

Santos, Hurtado-Ortiz, and Sneed (2009) surveyed Hispanic and Hispanic American college students (n=156, age range: 18-24) in Southern California about beliefs about type 2 diabetes. Researchers recruited participants using a convenience sample at a four-year university in Southern California and asked them to complete a 14-item “causes of illness” questionnaire by scoring the likelihood of each item from 1 (*definitely false*) to 5 (*definitely true*). All participants were at risk for type 2 diabetes; 21% were first generation and 80% were second generation or more. The questionnaire measured causes of diabetes on four dimensions: “emotional (anxiety, anger, stress, relationships), punitive (own fault, sin, sexual activity, punishment), natural (germs/infection, accidental, and cold/drafts), and mystical retribution (God’s will, punishment, bad blood, and genes/heredity)” (Santos et al., 2009, p.402). The researchers found that more assimilated students were less likely to attribute diabetes to dimensions commonly associated with culture-bound syndromes and external locus of control.

Similarly, Roncancio et al. (2011) found an inverse relationship between acculturation and fatalistic health attitudes. The researchers surveyed Hispanic women (n=1027) in Texas (mean age=21) to explore the influence of acculturation on fatalistic

attitudes and external locus of control (doctor). The authors selected survey questions from the Multidimensional Health Locus of Control measure and asked participants to respond on a scale from 1 (*strongly disagree*) to 5 (*strongly agree*). They found that more acculturated women had less fatalistic attitudes and were less likely to believe that their physicians controlled their health ($p < 0.001$).

Flórez et al. (2009) also explored breast cancer beliefs and their relationship to fatalism. The researchers interviewed Dominican-born women ($n=25$) over the age of 50 who had lived in East Harlem, New York, for an average of 25 years. The researchers found that the health locus of control among the women was complex. Participants in the study had both an internal locus (such as individual action) and an external locus (such as God's will). However, the researchers found a nuanced difference between women's perception of God's will. Participants did not perceive a cancer diagnosis as a punishment from God. Instead, they believed that God helps people who help themselves. Evidence for this belief was the women's proactive role in their health by getting regular screening, especially if they were at risk for breast cancer.

These studies suggest that health beliefs and attitudes are changing among younger Hispanic Americans and more acculturated Hispanics. These changes may contribute to higher health self-efficacy.

This literature review highlights health beliefs and attitudes characteristic of Hispanic health and newer studies that suggest subtle shifts among U.S.-born Hispanic Americans and acculturated Hispanics. However, the literature does not explore similarities and differences in health beliefs and attitudes between Hispanic and Hispanic Americans. Nor does the literature show how both groups of women negotiate

conflicting cultures: traditional Hispanic culture and American clinical culture. This study aims to explore what health beliefs and attitudes Hispanic and Hispanic American women share and which ones they do not. This study also identifies strategies that women use to negotiate health information from traditional health culture and American clinical health culture.

Research Questions

RQ1: What health beliefs and attitudes do Hispanic and Hispanic American women share?

RQ2: What health beliefs and attitudes do Hispanic and Hispanic American women not share?

RQ3: What strategies do Hispanic and Hispanic American women use to negotiate between traditional Hispanic health culture and American clinical health culture?

Method

This study aimed to explore similarities and differences in health beliefs and attitudes between Hispanic and Hispanic American women. In addition, this study aimed to identify strategies that Hispanic and Hispanic American women use to negotiate health information from two distinct health cultures. To achieve this exploratory process, I conducted two focus groups with women who self-identify as Hispanic or Hispanic American and live in Washington, D.C.

Segmenting Hispanic and Hispanic American women was imperative to this study. To segment women systematically, I used two measures: their cultural self-identification and dominant language. Language dominance verified that potential participants' cultural self-identification matched my operational definitions (See Appendix A). I adapted questions from acculturation scales previously used with Hispanic audiences to implicitly gauge potential participants' preferred language (Marín & Gamba, 1996; Marín, Sabogal, Marín, Otero-Sabogal, & Pérez-Stable, 1987). I determined potential participants' language dominance based on the language they most prefer to use in social situations, such as with their family, friends, or at work (Unger et al., 2002). Language dominance was necessary to segment women into one of two focus groups: Hispanic (Spanish-dominant) and Hispanic American (English-dominant). Language dominance served as a proxy for participants' high or low belief in culture-bound syndromes (Deyo, Diehl, Hazuda, & Stern, 1985).

To elicit Hispanic and Hispanic American women's health beliefs and attitudes, this study drew from focus group discussions. Focus groups allow the researcher to observe and participate in the discussion simultaneously, thus allowing for an emic

perspective, an approach in which the researcher adopts the insider perspective or the perspective of the people in the study. To start a discussion among the participants, I posed the same open-ended questions to both groups and allowed participants to partake in the conversation at their own comfort level. At specific points in the conversations, I probed for deeper detail without showing any bias about the mentioned health beliefs, attitudes, or behaviors (Rubin & Rubin, 2005). The nature of focus groups allowed for spontaneous and natural interaction among participants and provided an environment where women could share their private experiences and attitudes while minimizing the researcher-participant power difference (Mack, Woodsong, MacQueen, Guest, & Namey, 2005; Rubin & Rubin, 2005). Each focus group had a minimum of eight women and a maximum of ten to ensure that all women had an opportunity to share their perceptions and allow for spontaneous conversation in each group (Greenbaum, 1993). Because this study asks research questions about implicit beliefs and attitudes, it relied on the dynamic interaction of focus group discussions where participants lead the conversation and in the process delve deep into a topic through the process of sharing their thoughts and experiences (Rubin & Rubin, 2005).

Participant Recruitment

To answer the research questions, this study compared qualitative data from two focus groups: Hispanic and Hispanic American women. Each group included women living in the Washington, D.C. metropolitan area in August 2012. For the purpose of this study, Hispanic and Hispanic American women included women of all races, born in or descended from parents from all Spanish-speaking countries, including Spain, and

countries in the Caribbean, Central America, South America, and the United States.

Women had to be age 18 or over to participate.

I excluded anyone who did not self-identify as Hispanic or Hispanic American. I excluded men to ensure that women would feel comfortable sharing potentially private health details, some of which would normally not be topics of conversation in the presence of men in traditional Hispanic culture.

After the Johns Hopkins University's Homewood Institutional Review Board (HIRB) reviewed the research design to ensure it met the ethical treatment of participants and approved the design, I recruited Hispanic and Hispanic American women for two weeks in July 2012. To recruit women, I posted English- and Spanish-language flyers in Washington, D.C., neighborhoods with a large number of Hispanic residents (Mount Pleasant, Columbia Heights and Adams Morgan) and distributed Spanish-language flyers at a school for English as a Second Language in Dupont Circle (See Appendix B). To ensure fully recruited focus groups, I also used snowball sampling. To recruit Hispanic American women, I sent recruitment notices via the Johns Hopkins University graduate communication listserv, and via email to friends and family members. The recruitment emails asked readers to participate (if they met the criteria) or to inform women who might qualify (See Appendix C). I posted short messages and a link to a web version of the English-language recruitment flyer on Facebook and Twitter (See Appendix D). Interested participants contacted me either by phone or email.

I corresponded with women who expressed interest via email to set up a conveniently mutual time to speak on the phone and go through the screening questions (See Appendix A). To accommodate last-minute cancellations, I enrolled 10 women in

each group and accepted up to five women on a waitlist. Two days before each focus group I contacted each woman to confirm her attendance. If a woman cancelled, I invited another woman from the waitlist. Otherwise, I contacted the women from the waitlist, thanked them for their interest and informed them that the group was at full capacity. There was an overwhelming interest from Hispanic women; over 40 called to express their interest in participating.

Procedures

I segmented women into two groups based on their self-identification as Hispanic or Hispanic American and their responses to questions from a screening questionnaire administered over the phone. I moderated both focus groups in August 2012 on a weekday evening in a Johns Hopkins University classroom at the Dupont Circle campus. Each participant received a confirmation letter or email with details about the time, location, and directions to the Johns Hopkins University Dupont Circle campus (See Appendix E).

Participants arrived at 7 p.m. to have dinner and get acquainted with the researcher and one another before the focus group. This mingling time was important because the group dynamic depended on participants' comfort level, especially since they were meeting for the first time to discuss sensitive topics.

At the beginning of both focus groups, I gave each participant a copy of the informed consent form, summarized the document to the group, and gave participants time to read the consent form and ask questions (See Appendix F). All the women signed the consent form in my presence and I collected them before starting the audio recording. The Hispanic group received a Spanish-language informed consent form translated by the

student researcher and certified by a language expert, who was not involved in the study. HIRB approved the translated informed consent (See Appendix G). The Hispanic American group received an English-language informed consent form approved by HIRB. At the end of each group, all participants received a copy of the informed consent form for their records. The consent form had my contact information and the principal investigator's contact information in case participants had any questions after the focus group. To protect the participants' privacy, I kept the signed consent forms at my residence in a locked drawer.

To capture the discussion for analysis after the focus groups, I audio recorded the discussions with consent from participants. To maintain confidentiality, I kept the digital audio files on a password-protected computer. I led both focus groups using a moderator's guide, which I developed in English and Spanish (See Appendix H). I moderated the group with Hispanic women in Spanish, in which I am fluent, and in English with the Hispanic American group. To open the discussions, I asked broad questions to explore women's definitions of health. Then I explored women's beliefs in culture-bound syndromes and their thoughts on chronic disease prevention. Lastly, I asked women if they saw any connection between culture-bound syndromes and chronic disease. After the focus group, I administered a short questionnaire to collect anonymous demographic information, family medical history, and reactions to the discussions (See Appendix I).

As a thank-you gift for participating, I gave each woman a copy of the U.S. Office of Women's Health *A Lifetime of Good Health: Your Guide to Staying Healthy* in English or Spanish and a \$30 WMATA SmartTrip metro card.

Data Analysis

I transcribed each focus group session from the audio files and analyzed the transcript data, noting similarities and differences in the responses from participants. In addition, I noted any themes that emerged from the data, defined as concepts or statements arising in the conversations from more than three people in one or both groups (Krueger, 1998). One main emerging theme was women's implicit and constant negotiation of health information from Hispanic and American health cultures.

I present the results organized by research questions and include anonymous verbatim quotes from the research participants to illustrate key points from the discussions.

Results

This chapter presents the findings from two focus groups conducted in August 2012. One group consisted of Hispanic women, the second of Hispanic American women. I present the findings as answers to the study's research questions using narrative descriptions and direct quotes from the focus group transcripts. I translated quotes originally collected in Spanish into English and present only the English translation in this paper.

I opened both focus groups with general questions about health, asking women to define health and share preventive behaviors. I then asked participants about their thoughts and beliefs in culture-bound syndromes. Next, I asked participants about chronic disease prevention, specifically diabetes, high cholesterol, high blood pressure, breast cancer, and cervical cancer, all of which are prevalent among Hispanics living in the United States. Finally, I asked participants whether they believed culture-bound syndromes could cause or trigger chronic disease.

Participant Description

A total of 17 women participated in this research study, segmented into Hispanic or Hispanic American groups. Eight women participated in the Hispanic group and nine women participated in the Hispanic American group. All participants lived in the Washington metro area and their ages ranged from 23 to 68.

Hispanic women were born in the following countries: Bolivia (n=2), Dominican Republic (n=1), El Salvador (n=1), Mexico (n=1), and Peru (n=3). Time spent living in the United States ranged from two months to 37 years; the median was 15.5 years. Six women had lived in the United States more than eight years; two women immigrated

within 12 months of the study. Six women arrived as adults (age 18 or over) in the United States; one woman arrived at 16 years of age. I moderated this group in Spanish because this group preferred Spanish as their primary language. Participants' ages ranged from 24 to 68; the median age was 54.5. Some women were college-educated; one had an elementary education and two had a high school diploma or vocational degree.

Hispanic American women self-identified as American and with the following countries: Dominican Republic (n=1), El Salvador (n=1), Guatemala (n=1), Honduras (n=1), and Mexico (n=2). Two women primarily identified with their place of birth (El Salvador and Mexico), despite immigrating to the U.S as children (at age 10) and preferring English. One woman, who was born in El Salvador and immigrated at the age of five, succinctly identified herself as Latina, often a term preferred to Hispanic American. Three women were born and raised in the United States to parents from the Dominican Republic, Honduras, and Guatemala. Two women were daughters of Mexican fathers and non-Hispanic mothers, and one was the daughter of a Mexican mother and a non-Hispanic father. I moderated this group in English because these women preferred English as their primary language. Participants' ages ranged from 23 to 48; the median age was 32. All women were college-educated, and some had graduate degrees.

Shared Health Beliefs and Attitudes

Hispanic and Hispanic American women in this study share some health beliefs and attitudes. Both groups of women share a holistic definition of health, attitudes about

self-responsibility for health outcomes, and agency in chronic disease prevention. I present their responses to answer this study's first research question:

RQ1: What health beliefs and attitudes do Hispanic and Hispanic American women share?

Health definition. Hispanic and Hispanic American women share the view of health as two distinct, but connected components: physical and psychological, sometimes referred to as emotional. A Hispanic woman in her mid-50s and a volunteer *promotora* (lay health educator) defined health as “physical health, emotional health and societal health.” A Hispanic woman in her mid-20s, originally from Bolivia, concurred: “We need to take care of the mind and the body.” Similarly, Hispanic Americans used language that reflected both components. A 32-year-old woman born to a Mexican mother shared “being well physically and mentally.” A Hispanic American woman in her mid-20s born and raised in New York to Dominican parents defined health as “being able to function in different capacities.”

Health responsibility. Both Hispanics and Hispanic Americans shared a strong sense of responsibility for protecting their health. When I asked both groups of women, who they thought was the person most responsible for their health, the answer in both groups was unanimous: “ourselves.” When I probed and asked who they thought was responsible for staying informed about their health, the majority of women in both groups replied that it was up to them.

Chronic disease prevention. When I asked both groups which chronic diseases they thought were preventable and treatable, women from both groups shared opinions on a continuum of disease control, citing lifestyle habits, regular cancer screenings for early

detection, and treatment “if a disease is caught in time.” Several Hispanic women agreed that chronic diseases are treatable if found early “with exams and when they are tended to in time.” A 60-year-old woman from Peru shared her opinion on prevention: “I think that you can prevent [chronic conditions] if there are checkups and good nutrition.”

Similarly, some Hispanic American women believed chronic diseases were preventable “with diet and exercise, except breast cancer.” A 31-year-old woman born to a Mexican father illustrated the point: diabetes, high blood pressure, and high cholesterol “are diet and exercise, and the cancers are through checkups. Not necessarily preventable if it’s genetic, but you can catch it early.” A 23-year-old woman born to Guatemalan parents concurred: “diabetes or high blood pressure—if your family members have those diseases, then as you grow up you can do things to go against it; that way it doesn’t form.” A third woman elaborated on controllable risk factors: “with diabetes ... you can back track if you lose the weight, eat healthy, and live an active lifestyle.”

Hispanic and Hispanic American women in this study share a holistic definition of health that includes a mind-body connection. In addition, both groups of women see themselves as the sole protectors of their health in whom lies the responsibility to stay informed about health matters. Furthermore, both groups believe that healthy lifestyle habits and regular screenings can prevent chronic diseases.

Differences in Health Beliefs and Attitudes

Responses from Hispanic and Hispanic American women about culture-bound syndromes and their connection to chronic diseases varied greatly between and within the groups. I present their responses to answer this study’s second research question:

RQ2: What health beliefs and attitudes do Hispanic and Hispanic American women not share?

Disagreement about belief in culture-bound syndromes. Within the group of Hispanic women, not all expressed their belief in culture-bound syndromes such as *mal de ojo* and *susto*. Some Hispanic women explicitly rejected the existence of the culture-bound syndromes: “It’s only a belief and has not been proven.” Some others expressed some degree of belief. A woman in her early 70s who was originally from El Salvador explicitly stated that she believed in them: “Yes, it has been proven because I have cured many children of *mal de ojo*.” Some of the Hispanic women who said they do not believe in *mal de ojo* mentioned that in the past they had agreed to folk remedies to cure their children when others suggested that their children had *mal de ojo*. This contradiction prompted the woman in her 70s who claimed to cure *mal de ojo* to proclaim, “Either way, they believe.”

A few women described *mal de ojo* as negative energy, characterized by negative emotions such as envy or jealousy. One woman shared a definition common in her country: “In Peru, *mal de ojo* is used as something sending bad energy, especially to a child.” However, a few Hispanic women said *mal de ojo* often describes medical conditions. A woman in her mid-20s offered an example of the dual use: “Colloquially, *mal de ojo* is used to describe an ocular infection. But also its meaning is commonly distorted a bit [to describe] things like envy.”

Most Hispanic women defined *susto* as fear. However, a couple of women, originally from Peru and Bolivia, shared a definition of *susto* from their countries: “When they take away the *ajayu*—*ajayu* is a word in Aymara that means soul—when they take

away your soul, they snatch your spirit, your tranquility. It's used more in rural areas, not as much in the cities.”

Fewer Hispanic American women were familiar with all of the culture-bound syndromes. Of the nine participants, three women (each with one non-Hispanic parent) were entirely unfamiliar with *mal de ojo*, *coraje*, and *susto*. One woman of Caribbean descent who grew up in New York was unfamiliar with *susto*. Contrary to the Hispanic group, the majority of Hispanic Americans did not believe in culture-bound syndromes, but knew of them from hearing their families talk about them. Hispanic Americans collectively described *susto* as being scared or fearing something without mention of the folk belief of losing one's soul. However, similar to the Hispanic group, Hispanic Americans described *mal de ojo* as a superstitious belief commonly associated with negative emotions: “*brujería* (witchcraft), negative vibes, envy.” In addition, they described *mal de ojo* as something that warranted vigil: “precaution against it, something you have to protect yourself from.” Despite their knowledge of culture-bound syndromes, Hispanic American women dismissed their existence and instead recognized that their parents believed in them as “a way [to] explain everyday life stuff.”

Disagreement about culture-bound syndromes as causes of chronic disease.

When I asked Hispanic women if they thought culture-bound syndromes could be responsible for chronic diseases, only a few women believed in a direct cause-and-effect connection. Some others thought health beliefs could indirectly cause health issues, for example, when believers seek treatment from traditional healers instead of clinical medicine. A woman in her mid-40s, originally from the Dominican Republic, illustrated this point:

When they say a child has *mal de ojo*—“Doctors won’t do anything about it because they don’t know about those things”—that’s what the old folks say. So instead, [parents] start putting all sorts of things on the child’s eye and he ends up really sick. He could end up blind because they didn’t take him to the doctor.

In contrast, Hispanic American women do not believe in a connection between culture-bound syndromes and chronic disease. One woman in her late 40s offered her observation:

Over the years, I’ve realized it’s a coping mechanism to understand the world around them when things don’t make sense. My mom’s friend hit her breast, [got a] bruise [and thought] she got cancer from the bruise. It don’t [*sic*] come from that.

Another woman concurred: “You hear stories and you know in your head it’s a lie, but the story is told so truthfully: When your uncle got furious he got diabetes, from the *coraje* he got diabetes.” A third woman added an observation about potential underlying risk factors: “There’s always some crazy explanation of why someone fell ill ... some battle between a friend or family member. It’s illogical. It doesn’t make sense at all because there are so many other factors why that person had xyz.”

Hispanic and Hispanic American women in this study differ in their belief of culture-bound syndromes. Furthermore, Hispanic women disagreed about the type of connection between culture-bound syndromes and chronic disease. However, Hispanic American women indicated that they did not believe in culture-bound syndromes and therefore, did not believe in a connection between culture-bound syndromes and chronic

disease. Instead, these women accepted that their parents used culture-bound syndromes to explain chronic diseases.

Strategies to Negotiate Health Cultures

Hispanic and Hispanic American women use specific strategies to negotiate between two distinct and potentially conflicting health cultures. I present their responses to answer this study's third research question:

RQ3: What strategies do Hispanic and Hispanic American women use to negotiate between traditional Hispanic health culture and American clinical health culture?

Hispanic women found ways to adopt new health practices, while maintaining health practices native to their home countries. They adapt by staying informed, asking their doctors to recommend foods with healing properties in lieu of prescribing medications, and seeing medical and homeopathic doctors in tandem.

Staying informed. To protect their health, Hispanic women stay informed by reading about health and talking openly with their doctors. A woman in her late 60s, who has lived in the United States more than 30 years, offered, "I learned from the [health] clinic, on the Internet, from books and the library." Similarly, a 60-year-old woman, who has also lived in the United States more than 30 years, echoed:

I learned how to take care of myself via newspapers, magazines, and television.

I'm not a fan of going to the doctor, but I have an annual checkup. That's how I learned, via television and also from the doctors and nurses.

Preventive care. Some Hispanic women expressed their dislike of seeing medical doctors, yet they comply with annual checkups and recommended preventive

screenings. They also ask their doctors to help them find natural alternatives to medication. A Hispanic woman in her mid-50s shared her tactic:

I am allergic to doctors, completely allergic—I don't like doctors, I don't like medicine. When I go to the doctor every year for a physical, I tell him not to prescribe me anything because I won't take it. Tell me what fruit or vegetable has the same things so I can eat that.

Mixed-method health care. Hispanic women shared their mixed-method approach to health care. A woman in her late 60s who has lived in the United States more than 30 years shared her tandem approach:

I have my general medicine doctor for checkups and a homeopathic doctor. She has a medical degree and certifications in homeopathic medicine. She doesn't prescribe medications that are going to have side effects. The medicines are flower- and root-based and sold at Whole Foods.

In contrast, Hispanic American women used different strategies to reconcile health practices from traditional Hispanic health culture and American clinical health culture.

Traditional remedies for comfort. Hispanic American women described home remedies, such as tea, as “comforting” and something that makes them feel closer to their mothers, particularly if they live far away. Although these women did not consider their mothers' home remedies a treatment for their ailments, they found comfort in them regardless of their efficacy. One woman in her late 40s, who was born in El Salvador and whose family when she was a child, said, “I need that comfort. My mom lives in another state. It just makes me feel closer to her when I do those things.” A different woman in

her early 30s, born in the United States to Honduran parents, shared, “Even if I don’t really know if I think it works, I’ll do it. Why not? It’s not going to kill me. It’s easy and comforting.”

Self-advocacy in health decisions. Hispanic Americans risk family conflict for the sake of advocating for their health. A woman who wanted a second opinion about a tumor shared the following anecdote:

I told my mom: “I’m going to go for a second opinion.” She was so angry at me, she said, “You’re disrespecting the doctor. How could you go behind his back and ask somebody else?” [I said,] “This is my life, I’m sorry that you disagree but I have to do this for me.” It was a big deal! Huge fight! I knew what was right for me ... I got the second opinion and it made a difference.

Choosing health practices. Unlike their parents, Hispanic American women have a choice of health attitudes and behaviors from two cultures. Women noted that their parents did not have the same choice because when they immigrated they brought over their traditional health attitudes. One woman in her late 40s, who immigrated at age 5, shared her experience:

Growing up bicultural, you pick what you want from whatever culture you like. Eventually you get to a certain age [and say] I like this, I don’t like that—this is who I am. They didn’t have those choices. They grew up in a certain template and when they come here, the template doesn’t work.

Inner conflict about health practices. However, the privilege of choice sometimes creates internal struggles for Hispanic American women. Some women perceived American health culture as logical and evidence-based and Hispanic health

culture as intuitive and natural. A woman in her late 20s, born to Dominican parents and raised in New York, offered the following perspective:

These Americans and all these rules; we have a rule for everything; everything hurts the baby, hurts the pregnant women. My Dominican side is saying we have too much going on. Let's keep it simple and weird. And my American side is saying no, we need to follow protocol. We've done research about this and we know because the FDA told us ... NIH told us why. My mind is very split: half of me thinks we're in America, we're logical and intelligent. Then a piece of me thinks this stuff is intuitive and if I have to tip the baby sideways, hit them with my knee because it cures flatulence, then I might do it because my grandma said it was okay.

Hispanic women protect their health by staying informed on current health issues in the media. In addition, they compromise when it comes to regular medical care by complying with regular checkups and screenings, but being honest with their doctors about their intent to not take prescription medicine. Other women compromise by using a mixed-method approach: seeing a medical doctor and going to a homeopathic doctor for herbal-based treatments.

Similarly, Hispanic American women preserve a link to their mother's home remedies by turning to them when they seek comfort. They will, however, follow their own instincts to seek second medical opinions and risk familial peace. Finally, these women are aware of their ability to choose what health practices they want to carry on from their Hispanic parents, though choosing what health culture to follow can sometimes create inner conflict.

In summary, the results of these focus groups demonstrate Hispanic and Hispanic American women's beliefs about health, culture-bound syndromes, perceived ability to prevent chronic disease and the connection between culture-bound syndromes and chronic diseases. Hispanic and Hispanic American women defined health as a composite of physical and emotional (psychological) well-being. In addition, both groups of women saw themselves as the responsible party for protecting their health. Finally, both groups of women share a similar prevention attitude, which includes agency. They listed lifestyle habits, such as physical activity, balanced diet, and health screenings, as important aspects of preventing chronic disease. The majority of women in both groups knew of culture-bound syndromes, but the majority of Hispanic American women did not believe in them or their connection to chronic disease. Instead, they recognized lifestyle behaviors and genetic risk factors as the primary causes of chronic disease.

Hispanic women struggle to hold on to their health beliefs and attitudes and protect their health in a clinical-based society. To adapt, they add new habits to their arsenal of traditional health practices. On the other hand, Hispanic American women have the privilege and burden of picking and choosing from their parents' traditional health culture and from the American clinical culture in which they grew up. At times, these women make hard choices to protect their health and risk going against traditional Hispanic health culture.

Discussion

Findings from this research study align with findings from previous research, in particular literature suggesting subtle shifts in health beliefs and attitudes among Hispanics and Hispanic Americans. I discuss the implications of my findings and further discuss the theory of cultural health hybrid. Then, I discuss the limitations of the method I used and limitations unique to this research design. Finally, I discuss implications for future research.

Implication of Findings

Interestingly, these findings echo traditional beliefs and attitudes cited in literature as historical barriers for higher self-efficacy among Hispanics and Hispanic Americans (Coronado et al., 2004; Poss & Jezewski, 2002). However, the strategies that both groups of women use to reconcile traditional Hispanic culture and American clinical culture support the argument that beliefs and attitudes are changing among some groups of women. Similar to Santos et al. (2009), younger, U.S.-born Hispanic Americans in this study were less likely to attribute the onset of diabetes to a culture-bound syndrome such as *susto*. Furthermore, Hispanic American women in this study did not see diabetes or cancer as a punishment from God. On the contrary, these findings suggest that Hispanic American women do not have an external locus of control, and are likely to have high self-efficacy, meaning they are more likely to engage with their health.

Although Hispanic Americans did not believe in culture-bound syndromes (*mal de ojo*, *susto*, and *coraje*), they were familiar with the concepts from hearing their parents talk about them. Interestingly, their descriptions of *mal de ojo* and *susto* were similar to descriptions offered by Hispanic women in this study and from previous literature

(Argote & Vasquez, 2005; Gil & López, 2007). In addition, these women relied on clinical medicine for treatment, but found comfort in home remedies that they recognized were not cures. Furthermore, these findings confirm Poss and Jezewski's (2002) observation: "The more 'Mexican' a person is, the more likely he or she is to use home remedies, and the more 'Americanized' the person is, the more likely he or she will use Western medicines" (p. 368).

Emerging Attitudes

Neither group of women explicitly expressed fatalistic attitudes, external locus of control, nor moral attitudes, contrary to the findings from Ashing-Giwa et al. (2006), Otero-Sabogal et al. (2003), and Pérez-Stable et al. (1992). However, a substantial amount of time has passed since those researchers published their findings. And given the rate of growth among Hispanic Americans between 2000 and 2010 (Motel, 2012), it is not surprising that new research suggests a shift in beliefs and attitudes (Flórez et al., 2009; Roncancio et al., 2011; Santos et al., 2009). Both groups in this study were well informed of preventive care, lifestyle changes to prevent or control diabetes, and risk factors for hypertension and high cholesterol. Women most often cited heredity as a diabetes risk factor. For this reason, some Hispanic women made sure to get regular checkups.

Hispanic American women had dual belief systems, but many were not aware of them until something in the focus group discussion sparked an insight into their own choices and attitudes about health practices. This finding suggests that they implicitly negotiate health practices from two distinct health cultures. Furthermore, we see the role of observational learning as the mechanism that links women to their mother's home

remedies and their knowledge of culture-bound syndromes. However, Hispanic Americans' emerging attitudes of individualism and self-advocacy lends credence to the theory that these women have higher self-efficacy as a result of adopting American clinical attitudes and behaviors.

Cultural Health Hybrid

In this paper, I propose the theory of cultural health hybridization to examine the evidence for intercultural exchange found in this study. Women in both groups fit the description of a cultural health hybrid: blending beliefs, attitudes, and practices from two distinct health cultures, and simultaneously maintaining a link to tradition as they adapt to a clinical-based health culture. We can imagine the process of hybridization along a continuum, starting from strictly adhering to the health practices of one culture, to a gradual shift of blending and adopting health practices from a culture of origin with a new culture. However, based on evidence from this study, it seems that hybridization is an implicit, and at times, intuitive process. We see evidence of this process in most of the women in this study. Interestingly, a common theme was the strategies that Hispanic and Hispanic American women use in their cultural health hybridization process. Finally, it seems that cultural health hybrids are as unique as the women in this study; therefore, the evidence does not support the concept of an ideal cultural health hybrid.

Hispanic women add clinical-based health practices to an established arsenal of traditional health practices brought over from their country of origin. Adding a health practice minimizes the need to discontinue or replace traditional health practices. Based on the findings, it seems easier for these women to add new clinical-based health practices than to replace favored traditional health practices.

In contrast, Hispanic American women pick and choose between clinical and traditional health practices. They implicitly select health practices that work best for them, even though this self-discovery process can create conflict with family members or within themselves. We see support for this conclusion in a woman's description of a family dispute over her seeking a second opinion for a tumor. Her mother explicitly echoes traditional health attitudes of respecting doctors by following their advice and abstaining from a second opinion for fear of appearing to question the doctor's authority and education. However, this woman demonstrated her high level of self-efficacy when she expressed her need to do what was best for her. Lastly, we see inner conflict in the woman who pits the U.S. Food and Drug Administration against her grandmother's intuitive remedies. She explicitly refers to her Dominican side and her American side, attributing intuition and simplicity to Dominican practices, and clinical, evidence-based approaches to American practices.

Something else to consider is the possibility of inter-family conflict as a result of differences in acculturation between generations. In a family comprised of Hispanic parents and adult Hispanic American children, we can conceive of at least two scenarios where inter-family conflict could arise. The first conflict scenario might occur when Hispanic parents refuse to seek clinical treatment for an illness, preferring to rely on traditional health remedies, and their adult Hispanic American children, who favor American clinical practices, disagree. The second scenario to consider is when Hispanic American children reject traditional health remedies, thus rejecting their Hispanic parents' customs and beliefs. Although this study did not find evidence for either of

these hypothetical scenarios, it is important to consider them as possible points of contention in family dynamics.

Interestingly, Hispanic Americans shared the experience of living as cultural health hybrids, though only one woman explicitly expressed this concept when she referred to herself as growing up bicultural. Based on these findings, it seems that most Hispanic American women related to the concept of living between two health cultures, but are not conscious of making these choices when confronted with traditional and clinical health practices.

There are practical implications for using the theory of cultural health hybridization. First, health campaign planners can use the continuum of hybridization to segment audiences to tailor health messages. Clinicians can also use these results to increase their cultural sensitivity and improve patient-doctor communication with Hispanics and Hispanic Americans patients. Clinicians may relate better to their patients if they understand Hispanics' possible rejection of clinical medicine, and Hispanic Americans' use of comforting traditional remedies.

Limitations

The small sample size of this study precludes other researchers from generalizing these findings to larger sample sizes or different populations. Although this study proposes a theory to explore changes in health beliefs and attitudes, further research is necessary to explore the topic more deeply.

Another limitation was the broad definition of Hispanics and Hispanic Americans. Some would argue that there are cultural differences within Hispanic culture based on geography, ethnic affinity, and historical events in Spanish-speaking countries and within

the United States. A more homogenous focus group may have elicited deeper health cultural insights segmented by country of origin or by regions in the United States. Another limitation was the variance in factors that contributed to acculturation, such as number of years living in the United States, age at immigration, and generation status (first or second generation). Others would also argue that cultural health hybridization is a by-product of globalization and therefore not exclusive to immigration. In addition, the advent of online health information may also contribute to a global clinical-based view of health and medicine outside of the United States.

This research design would have benefited from segmenting participants by age cohort (under and over 40 years of age). This is important because researchers may be able to identify subtle shifts in attitudes between generations. Recruiting Hispanic women who have lived in the United States more than 20 years may have resulted in deeper insights about how acculturation contributes to cultural health hybridization. Lastly, recruiting Hispanic American women who were first or second generation and born to two parents of Hispanic descent would have resulted in richer data and clearer evidence for the argument of cultural health hybrids.

Implications for Further Research

This study argues that cultural health hybridization is a useful construct to examine and study changes in health beliefs and attitudes among Hispanic and Hispanic American women. However, given the small sample size of this study, at this time the construct is not generalizable. Future studies should consider replicating this study with narrower inclusion criteria to add to the breadth of culture competence literature. In addition, researchers should consider examining, if and how, Hispanic and Hispanic

American men experience cultural health hybridization. Finally, large, random quantitative studies could examine what factors (e.g., education, socioeconomic status, race, time in the United States) contribute most to the theory that this study puts forth: cultural health hybridization.

Appendix A

FOCUS GROUP SCREENER

Introductory text

[If first contact was via EMAIL]

Thank you for being available to talk on the phone. As I mentioned in the email, my research is specific and I need to ask you some questions to make sure I find the best fit. Is this still a good time to talk?

[If yes, CONTINUE]

[If no, SCHEDULE DATE & TIME TO TALK]

[If first contact is via PHONE]

Thank you for calling me. I appreciate your interest. My research is specific and I need to ask you some questions to make sure I find the best fit. Is this a good time to talk?

[If yes, CONTINUE]

[If no, SCHEDULE DATE & TIME TO TALK]

[FOR ALL PHONE CALLS]

I am master's student at Johns Hopkins and I'm doing research for my thesis. Anything that we talk about is confidential and private. I will not share the details of our conversations or your name with anyone. I am not associated to any part of the government of law enforcement organization.

Demographics

Are you 18 or over? (Yes/ No) [IF NO, THANK AND END]

Birthplace _____ [If not US, or Spanish-speaking country, THANK AND END]

[If foreign born]

How old were you when you moved to the US? _____

How long have you lived in the US? _____

Acculturation

What language do you mostly speak with your family? (English/ Spanish)
... friends? (English/ Spanish)
... work? (English/ Spanish)

When people ask where are you originally from, what do you answer? _____

Health Beliefs

Are you familiar with *mal de ojo*? (Yes/No)

What does it mean to you? _____

Are you familiar with *ataque de nervios*? (Yes/No)

What does it mean to you? _____

Are you familiar with *susto*? (Yes/No)

What does it mean to you? _____

Availability

Great! You meet the criteria for my research study. Are you available on [Date, time & location TBD] for a 90-minute focus group? Food and refreshments will be provided for your convenience.

[If YES, collect contact information to send reminder.]

[If not available, THANK AND WAITLIST]

DATE: _____

NAME: _____

PHONE: _____

EMAIL: _____

ADDRESS: _____

PREFERRED: email post mail

Thank you – I will send you a reminder email/letter with the date, location, time and directions to the focus group meeting. If you have any questions, feel free to call or email me at 202.683.8092, slp22@jhu.edu.

CLASIFICACIÓN PARA GRUPO FOCAL

Introducción

[Si primer contacto es por EMAIL]

Gracias por haberme hablado por teléfono. Como le mencioné en mi correo electrónico, mi tesis es sobre un tema específico y necesito hacerle algunas preguntas. ¿Tiene unos minutos ahora para las preguntas?

[Si sí, CONTINUAR]

[Si no, HACER CITA & HORA PARA HABLAR]

[Si primer contacto es por TELEFONO]

Gracias por llamar. Aprecio su interés. Mi tesis es sobre un tema específico y necesito hacerle algunas preguntas. ¿Tiene unos minutos ahora para las preguntas?

[Si sí, CONTINUAR]

[Si no, HACER CITA & HORA PARA HABLAR]

[PARA TODAS LLAMADAS]

Yo soy una estudiante en Johns Hopkins y estoy haciendo investigaciones para la tesis de mi maestría. Cualquier cosa de que hablemos es confidencial y privada. Yo no voy a compartir los detalles de nuestra conversación ni su nombre con nadie. No tengo ninguna asociación con el gobierno u organismo de la ley.

Demográficas

¿Es usted mayor de 18 años? (Sí/ No) [Si no, GRACIAS Y TERMINE]

¿Dónde nació? _____ [Si no EEUU, o hispanohablante, GRACIAS Y TERMINE] [Si nació en el extranjero]

¿Cuántos años tenía cuando se mudó a los EEUU? _____

¿Cuántos años ha vivido en los EEUU? _____

Aculturación

¿Qué idioma usa usted cuando habla con su familia? (inglés/ español)

... amistades? (inglés/ español)

... trabajo? (inglés/ español)

¿Cuándo las personas le preguntan de dónde es originalmente, como contesta?

Creencias de la salud

¿Ha escuchado hablar del *mal de ojo*? (Si/No)

¿Qué significa eso para usted? _____

¿Ha escuchado hablar del *ataque de nervios*? (Si /No)

¿Qué significa eso para usted? _____

¿Ha escuchado hablar del *susto*? (Si /No)

¿Qué significa eso para usted? _____

Disponibilidad

¡Qué bueno! Usted califica para mi estudio. ¿Está disponible [fecha, hora & lugar TBD] para un grupo focal de 90 minutos? Se servirá comida y refresco.

[Si SÍ, pida información para mandar noticia.]
[Si NO, GRACIAS Y LISTA DE ESPERA]

FECHA: _____

NOMBRE: _____

TEL: _____

EMAIL: _____

DIRECCION: _____

PREFERIDO: ___ email ___ correo

Gracias – le mandare una carta/email para recordarle la fecha, lugar y hora para el grupo focal. Si tiene alguna pregunta me puede llamar o mandar un correo electrónico:

202.683.8092, slp22@jhu.edu.

Appendix B

Recruitment Flyers



\$30 Metro card

for your opinion on
health topics

Who?

Hispanic women who live in Washington, Maryland or Virginia. Must be 18 years old or older to participate.

What?

Participate in a research focus group about health topics. The meeting will last 90 minutes. Dinner and refreshments are served.

Sign up!

Contact Sandra Paredes, **202.683.8092**, slp22@jhu.edu

Free metro card!



\$30 tarjeta de metro

por su opinión sobre
temas de la salud

Buscamos

Mujeres hispanas que viven en Washington, Maryland o Virginia. Participantes deben ser mayores de 18 años.

Para

Participar en un grupo focal sobre la salud para un estudio de investigación. La reunión durará 90 minutos. Se servirá cena y refrescos.

Inscribase

Comuníquese con Sandra Paredes, **202.683.8092**, slp22@jhu.edu

¡Tarjeta de metro gratis!



Appendix C

Email Recruitment



Dear Classmates,

For my thesis study, I am seeking **Hispanic-American** women to participate in a research focus group about health issues. Must be 18 years or older to participate.

Women can speak **English** and can live in the District of Columbia, Maryland or Virginia.

If you or someone you know is interested in participating in this research please email or call.

For more information, please visit the online recruiting flyer: <http://tiny.cc/HispanicHealth>

Best,
Sandra L. Paredes

Master's Candidate in Communication
Johns Hopkins University
☎ [202.683.8092](tel:202.683.8092)
✉ slp22@jhu.edu

Appendix D

Social Media Recruitment



Sandra L. Paredes shared a link.

July 31, 2012



Calling Hispanic-American women 18+ in DC, MD & VA: We want your opinion about health in a research study. More info: <http://tiny.cc/HispanicHealth>



Sandra L. Paredes shared a link.

July 30, 2012 near Washington



For Hispanic Women 18+ in DC, MD & VA: Voice your opinion about health in a research focus group. More info: <http://tiny.cc/HispanicHealth>



Sandra L. Paredes @slp22

31 Jul

Calling Hispanic-American women 18+ in DC, MD & VA: We want your opinion about health in a research study. More info: tiny.cc/HispanicHealth

Expand



Sandra L. Paredes @slp22

30 Jul

For Hispanic Women 18+ in DC, MD & VA: Voice your opinion about health in a research focus group. More info: tiny.cc/HispanicHealth

Expand

Appendix E

Confirmation Email & Letter



Dear Participant,

Thank you for agreeing to participate in my **focus group about health**.

Here are details to **remind you where and when** to meet me for our discussion. The session should last about 90 minutes. Dinner and refreshments will be served.

As a thank you for your time and participation, you will receive a a \$30 metro card and a book about health prevention.

Thursday, August 16, 2012
7:00 pm - 8:30 pm

Johns Hopkins University
1717 Massachusetts Ave NW
Washington, DC 20036



Transportation:

Metro Red Line - Dupont Circle Station
Bus #42 - Connecticut Ave. & Q St. NW
Bus #L2 - Connecticut Ave. & N St. NW
Buses #S1, S2, S3, S4, S9 - 16th St. & P St. NW

If you need further information, please call or email me at [202.683.8092](tel:202.683.8092), slp22@jhu.edu.

I look forward to meeting you and thank you in advance for your assistance.

Sincerely,

Sandra L. Paredes

Master's Candidate in Communication
Johns Hopkins University
[☎ 202.683.8092](tel:202.683.8092)
[✉ slp22@jhu.edu](mailto:slp22@jhu.edu)



Sandra L. Paredes
Candidata a Maestría
Johns Hopkins University
slp22@jhu.edu
202.683.8092

Estimada Participante,

Gracias por aceptar ser participante de mi **grupo focal sobre la salud** para mi tesis.

Aquí le mando los detalles para **recordarle donde y cuando** nos vamos a reunir para el grupo. La reunión durará 90 minutos. Se servirá cena y refrescos.

Como agradecimiento por su tiempo y participación, usted recibirá una tarjeta del metro con un valor de 30 dólares y un libro sobre la prevención de la salud.

Lunes, 13 agosto de 2012
7:00 pm - 8:30 pm

Johns Hopkins University
1717 Massachusetts Ave NW
Washington, DC 20036



Transporte:

Línea roja del metro - Parada Dupont Circle

Bus #42 - Parada Connecticut Ave. & Q St. NW

Bus #L2 - Parada Connecticut Ave. & N St. NW

Buses #S1, S2, S3, S4, S9 - Parada 16th St. & P St. NW

Si necesita más información, por favor comuníquese conmigo a mi celular o por correo electrónico: **202.683.8092** o slp22@jhu.edu.

Espero conocerla pronto y gracias de nuevo por su participación.

Atentamente,

Sandra L. Paredes

Appendix F

Johns Hopkins University
Homewood Institutional Review Board (HIRB)

	Informed Consent Form
Title:	Hispanic Women's Perceptions and Attitudes of Health
Principal Investigator:	Mary Miscally DrPH, MPH, Johns Hopkins University Faculty
Date:	March 12, 2012

PURPOSE OF RESEARCH STUDY:

- The purpose of this research study is to understand Hispanic women's attitudes and perceptions about health to better communicate with Hispanic audiences.
- We anticipate that approximately 20 people will participate in this study.

PROCEDURES:

- You will be asked to share and discuss your thoughts and experiences with health issues in a focus group with women who may share similar experiences as yourself.
- The focus group will be at a location in Washington, D.C. and will be audio recorded.
- You will be asked to attend one focus group for approximately 90 minutes.

RISKS/DISCOMFORTS:

- The risks associated with participation in this study are no greater than those encountered in daily life or in an educational setting.

BENEFITS:

- Benefits to you: You will have the opportunity to discuss your health and how you protect it.
- Benefits to health professionals and to society: This study may benefit health professionals by contributing to the knowledge about communicating and relating to Hispanic women about health issues and providing health information and. From this study, results could be used to inform future research about the difference between health attitudes in United States and Latin American countries.

VOLUNTARY PARTICIPATION AND RIGHT TO WITHDRAW:

- Your participation in this study is entirely voluntary: You choose whether to participate. If you decide not to participate, there are no penalties, and you will not lose any benefits to which you would otherwise be entitled.
- If you choose to participate in the study, you can stop your participation at any time, without any penalty or loss of benefits. If you want to withdraw from the study, please contact the student researcher Sandra Paredes (bilingual), at (202) 683-8092.

CONFIDENTIALITY:

- Any study records that identify you will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Johns Hopkins University Homewood Institutional Review Board and officials from government agencies such as the National Institutes of Health and the Office for Human Research Protections. (All of these people are required to keep your identity confidential.) Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.
- All audio files and study documents will be kept on a password-secure computer and locked file cabinet to protect confidential information.

COMPENSATION:

- You will receive a \$30.00 WMATA metro card, valid on the Washington, D.C. metro and buses and a copy of the United States Office of Women's Health *A Lifetime of Good Health: Your Guide to Staying Healthy* as a gift for your participation in the focus group. You will receive the metro card and book at the end of the focus group.

IF YOU HAVE QUESTIONS OR CONCERNS:

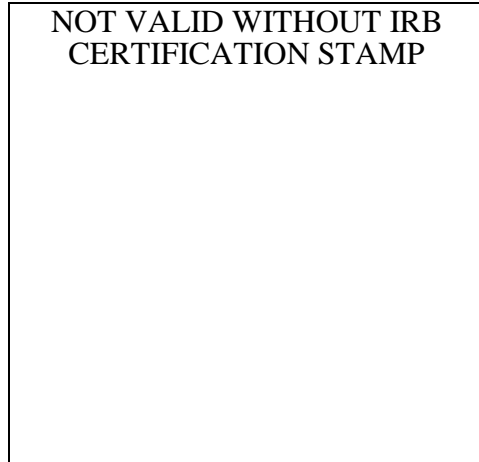
- You can ask questions about this research at any time during the study, by contacting the student researcher, Sandra Paredes (bilingual), at (202) 683-8092; or the principal investigator, Mary Miscally (only speaks English), at (202) 663-5776.
- If you have questions about your rights as a research participant or feel that you have not been treated fairly, please call the Homewood Institutional Review Board at Johns Hopkins University at (410) 516-6580.

SIGNATURES

WHAT YOUR SIGNATURE MEANS:

Your signature below means that you understand the information in this consent form. Your signature also means that you agree to participate in the study.

By signing this consent form, you have not waived any legal rights you otherwise would have as a participant in a research study.



Do not sign after the expiration date of: _____

FOR PARTICIPANTS CAPABLE OF GIVING CONSENT:

Participant's Signature **Date**

Signature of Person Obtaining Consent **Date**
(Investigator or HIRB Approved Designee)

Universidad de Johns Hopkins
Junta Institucional de Revisión de Homewood
(HIRB, por su sigla en inglés)

Consentimiento para Participar en un Estudio de Investigación

Título:	Las percepciones y las actitudes de las mujeres hispanas sobre la salud
Investigadora principal:	Mary Miscally DrPH, MPH, Profesora de la Universidad de Johns Hopkins
Fecha:	12 de marzo del 2012

PROPOSITO DEL ESTUDIO INVESTIGATORIO:

- El propósito de este estudio de investigación es entender las actitudes y las percepciones de las mujeres hispanas sobre la salud con el objetivo para mejorar la comunicación con el público hispano.
- Anticipamos que aproximadamente 20 mujeres hispanas participarán en este estudio.

PROCEDMIENTOS:

Le pediremos que participe en un grupo focal de mujeres, que comparten experiencias parecidas a las suyas, y le haremos preguntas para que comparta sus ideas y experiencias en cuestiones de salud.

El grupo focal tendrá lugar en Washington, D.C. y el audio será grabado.

Le pedimos que participe en un grupo focal que durará aproximadamente 90 minutos.

RIESGOS/INCOMODIDAD:

Los riesgos de participar en este estudio no exceden los riesgos de la vida cotidiana o en un entorno educativa.

BENEFICIOS:

Beneficios para usted: Usted tendrá la oportunidad de hablar sobre su salud, y como se cuida.

Beneficios para los profesionales de la salud y la sociedad: Este estudio puede beneficiar a los profesionales de la salud contribuyendo al conocimiento de cómo comunicarse y relacionarse con mujeres hispanas sobre cuestiones de la salud y como proveerles información sobre la salud. Los resultados de este estudio se usarán para informar futuros estudios de investigación sobre las diferencias en las actitudes en relación con la salud entre los Estados Unidos y países Latino Americanos.

PARTICIPACIÓN VOLUNTARIA Y DERECHO DE RETIRAR DEL ESTUDIO:

Su participación en este estudio es enteramente voluntaria: Usted decide si quiere participar. Sí usted decide no participar, no hay sanciones y usted no perderá ninguno de los beneficios que le corresponden.

Sí usted decide participar en este estudio, usted puede retirarse en cualquier momento sin ninguna sanción y sin perder ningún beneficio. Sí usted quiere retirarse del estudio, por favor comuníquese con la investigadora estudiantil Sandra Paredes, al (202) 683-8092.

CONFIDENCIALIDAD:

Cualquier documentación del estudio que la identifique será mantenida en forma confidencial en la medida de lo posible y permitido por la ley. La documentación de su participación puede que sea leída por las personas que garantizan que las investigaciones se desarrollan de acuerdo con las reglas establecidas. Entre otros la documentación puede ser leída por los integrantes de la Junta Institucional de Revisión de Homewood de la Universidad de Johns Hopkins, oficiales de gobierno de organismos como los Institutos Nacionales de la Salud y la Oficina para la Protección de las Personas en Investigaciones. (Todas estas personas están obligadas a mantener su identidad en forma confidencial). Por lo demás, la documentación que la identifique sólo estará disponible para las personas que estén trabajando en este estudio, a al menos que usted autorice a otras personas para que vean los documentos de este estudio.

Todos los archivos de la grabaciones y los documentos de este estudio serán mantenidos en una computadora protegida a con clave y en un gabinete con llave para proteger la información confidencial.

COMPENSACIÓN:

Usted recibirá una tarjeta de metro de WMATA de 30 dólares para usar en el metro o en los buses de Washington, D.C. y una copia del libro titulado *Buena salud de por vida: Su guía para mantenerse sana*, publicado por la Oficina para la Salud de la Mujer del Departamento de Salud y Servicios Humanos de los Estados Unidos, como obsequio por participar en el grupo focal. Usted recibirá la tarjeta del metro y el libro al izar el grupo focal.

SÍ TIENE PREGUNTAS O PREOCUPACIONES:

Usted puede hacer preguntas sobre este estudio mientras el estudio se esté llevando a cabo, comunicándose con la investigadora estudiantil, Sandra Paredes (bilingüe), al (202) 683-8092; o con la investigadora principal Mary Miscally (sólo habla inglés), al (202) 663-5776.

Sí usted tiene preguntas sobre sus derechos como participante de un estudio de investigaciones o siente que ha sido tratada injustamente, por favor llame a la Junta Institucional de Revisión de Homewood de la Universidad de Johns Hopkins (sólo hablan inglés) al (410) 516-6580.

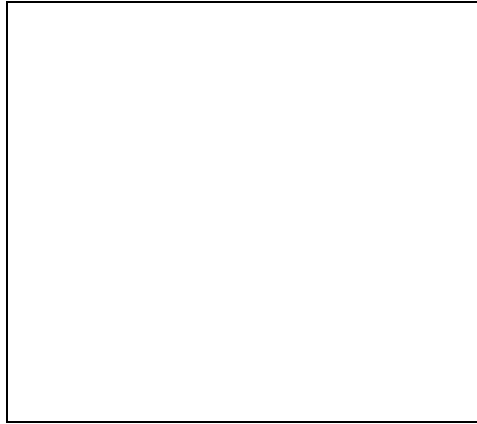
FIRMAS

LO QUE SU FIRMA SIGNIFICA:

Si firma significa que usted entiende la información en este consentimiento. Su firma también significa que usted ha decidido participar en este estudio.

Al firmar usted está dando su consentimiento, usted no ha renunciado a ningún derecho legal que de otro modo tendría como participante en un estudio de investigaciones.

NO ES VÁLIDO SIN EL SELLO DE CERTIFICACIÓN DEL HIRB



No firme después de la fecha de vencimiento: _____

PARA LAS PARTICIPANTES CAPACES DE DAR SU CONSENTIMIENTO:

Firma de la participante Fecha

Firma de la persona obteniendo su consentimiento Fecha
(Investigadora o persona designada por HIRB)

Appendix G

Johns Hopkins University
Homewood Institutional Review Board (HIRB)


Certificate of Translation

Study Title: Hispanic Women's Perceptions and Attitudes of Health

Principal Investigator: Memi Miscally, DrPH, MPH

HIRB Application #: HIRB00000417

I, Mariana Serrani, certify that, to the best of my knowledge, the translation of the informed consent document(s) from English to the language of Spanish for the research study listed above is accurate.



Signature of Individual Certifying

5/1/2012

Date

Health Communication Project Manager

Certifier's Title/Position

Westat

Certifier's Institution/Organization



Signature of Principal Investigator

6-14-12

Date

Note: None of the study's investigators may certify the translation. However, the PI is required to affirm the certification by signing this form.

Appendix H

FOCUS GROUP MODERATOR'S GUIDE

I. INTRODUCTION

Hello, my name is Sandra Paredes. I am the moderator for today's focus group discussion. I am a graduate student at Johns Hopkins University.

Give each participant a consent form to read and sign. I have just handed you a consent form for participation in this focus group. I will read the form aloud as you read it along with me. When I finish, I will ask you to sign the form before we begin our discussion.

Read the consent form.

I want to thank each of you for agreeing to participate today. Your views are important for this research study. Before I begin, I want to be clear about what will happen with the results of this discussion. I will take the notes and recording from this focus group and summarize what I learn across all of the focus group discussions. I will write a report about what I learned from the focus groups, but without identifying any individuals who participated. If I use a quote from a focus group in our report, I will not name the person who made the statement. In other words, as explained in the consent form, your responses will remain confidential.

GUIDELINES

To make this session run smoothly, here are a few discussion guidelines.

- There are no right or wrong answers.
- Say what you believe, whether or not anyone else agrees with you.
- I need to hear from everyone, but you don't have to answer every question.
- Please talk one at a time. Please speak in a voice at least as loud as mine.
- We have a lot to cover and to make sure we cover everything; I might interrupt the group discussion and introduce the next topic.
- Feel free to leave to use the restroom at any time. I just ask that only one person leave the room at a time, so we can keep the discussion going.
- Please turn off your cell phones or set them to vibrate.

To get started, please introduce yourself. Please tell us your first name only.

I. HEALTH

Q1. How do you define health?

What does being healthy mean to you?

When I say “protect your health,” what does that mean to you?

Q2. What does each of you do to protect your health?

(health check-ups, balanced diet, physical activity, sleep, relax)

Do you do some of these things with your family?

How did you learn what to do to stay healthy?

(learned from mother, family, friends, doctors)

Q3. When you don't feel well, who is the first person you go to for advice?

(family, doctor, homeopath)

Q4. What other sources do you turn to for health advice?

(doctor, television, internet, library)

Q5. Who do you feel is the most responsible for your health?

Who do you feel is responsible for you being educated and informed about your health?

II. HEALTH BELIEFS

Q1. Free association:

Susto, Mal de ojo, Coraje, Ataque de nervios

Q2. What do these things mean to you?

Q3. How did you hear of these things?

(family, friends, neighborhood, home country)

III. DISEASE BELIEFS

Q1. Free association:

Diabetes, high blood pressure, high cholesterol, breast cancer, cervical cancer

Q2. In your opinion, are any of these diseases preventable?

Yes? Which ones? How?

No? Which ones? Why?

Q3. For the diseases that you think are not preventable, do you think they have treatment?

(medical treatment, homeopathic or alternative treatments, home remedies)

Do you think people can live normal lives with these diseases?

Q4. Do things like *susto*, *coraje*, *mal de ojo* play a role in these diseases?

If yes, how?

What about other strong emotions, can they trigger disease?

Q5. Do you think the environment affects your health?

(work, home, neighborhood, friends, family)

Q6. How do you balance your emotional and physical wellbeing to stay healthy?

(family, friends, spirituality)

Before we move on to the last section of today, are there any comments that you didn't get a chance to say?

VI. POST-GROUP QUESTIONNAIRE

Please answer these short questions. You don't have to put your name on them. Your answers are confidential.

After you are done, you may hand them back to me and I will give you a thank you gift for volunteering your time to take part of this focus group.

GUÍA DE GRUPO FOCAL

I. INTRODUCCIÓN

Hola, mi nombre es Sandra Paredes. Soy la moderadora para la charla del grupo focal. Yo soy estudiante en la Universidad de Johns Hopkins.

Dar a cada participante una forma de consentimiento para leer y firmar. Les acabo de dar una forma de consentimiento para participar en este grupo focal. Les voy a leer en voz alta el documento y por favor sigan conmigo. Cuando acabe, les voy a pedir que firmen el documento antes de empezar nuestra charla. *Leer el consentimiento.*

Quiero agradecerles por participar. Sus opiniones son importantes para mi estudio. Antes de empezar quiero explicarles que voy hacer con los resultados de esta charla. Voy a tomar notas y a grabar esta conversación y las voy a resumir. Voy a escribir un informe con lo que aprendí en este grupo, pero sin identificar a nadie que ha participado. Si uso una parte de la conversación exacta, no voy a nombrar la persona que dijo las palabras. Quiero asegurarles, como les explico en el documento de consentimiento, que sus respuestas son confidenciales.

REGLAS

Para asegurar que la charla marche bien, les pido que observen los siguientes puntos:

- No hay respuestas correctas y equivocadas.
- Diga lo que cree, aunque no todas estén de acuerdo.
- Necesito escuchar la opinión de todas las presentes, pero no tienen que contestar todas las preguntas.
- Por favor hablen una a la vez. Por favor hablen en voz alta y clara.
- Tenemos mucho que cubrir en nuestra charla, para asegurarnos de que repasemos todos los temas, pueda que tenga que interrumpir la charla para introducir el próximo tema.
- Si necesitan salir a usar el baño, por favor salgan una a la vez para que podas continuar la conversación.
- Por favor apaguen sus celulares o póngalos en silencio.

Para empezar, por favor preséntese al grupo usando solo su primer nombre.

I. SALUD

Q1. ¿Cómo define la salud?

¿Qué significa para ustedes ser saludable?

¿Cuándo decimos “proteger la salud” que significa eso para ustedes?

Q2. ¿Qué hacen cada una de ustedes para proteger su salud?

(chequeo, alimentación balanceada, actividad física, dormir, relajar)

¿Hacen algunas de estas actividades con su familia?

¿Cómo aprendió que tenía que hacer para ser saludable?

(aprendió de la madre, familia, amistades, doctores)

Q3. ¿Cuándo no se siente bien, a quien es la primera persona que le piden un consejo?

(familia, doctor, homeópata)

Q4. ¿Qué otros recursos usa para obtener consejos de la salud?

(doctor, televisión, internet, biblioteca)

Q5. ¿Quién cree usted que es la persona más responsable por su salud?

¿Quién cree que es el responsable de que usted este bien informada sobre su salud?

II. CREENCIAS DE SALUD

Q1. Asociación libre:

susto, Mal de ojo, coraje, ataque de nervios

Q2. ¿Qué significan estas cosas para ustedes?

Q3. ¿Cómo aprendieron sobre estas cosas?

(familia, amistades, vecinos, país natal)

III. CREENCIAS DE ENFERMEDADES

Q1. Asociación libre:

Diabetes, presión alta, colesterol alto, cáncer del seno, cáncer de la cervix

Q2. En su opinión, ¿son algunas de estas enfermedades prevenibles?

¿Sí? ¿Cuáles? ¿Cómo?

¿No? ¿Cuáles? ¿Cómo?

Q3. De las enfermedades ¿qué no creen que son prevenibles, creen que tiene tratamiento?

(tratamiento médico, tratamientos homeópatas o alternativos, remedios caseros)

¿Creen que las personas con estas enfermedades pueden vivir una vida normal?

Q4. ¿Creen que las cosas como el *susto*, *coraje*, *mal de ojo* tienen algo que ver en estas enfermedades?

¿Sí, ¿cómo?

¿Qué otras emociones fuertes pueden provocar una enfermedad?

Q5. ¿Creen que el ambiente le afecta la salud?

(trabajo, casa, vecindad, amistades, familia)

Q6. ¿Cómo mantienen el equilibrio emocional y físico para mantenerse saludable?

(familia, amistades, espiritualidad)

Antes de que pasemos a la última sección de la charla, ¿hay algún comentario que alguien no tuvo la oportunidad de decir?

VI. CUESTIONARIO POST-GRUPO

Por favor contesten las siguientes preguntas cortas. No tienen que poner su nombre en la hoja. Sus respuestas son confidenciales.

Cuando terminen, me las pueden entregar y les daré un obsequio como agradecimiento por su ofrecer su tiempo para participar en esta charla.

Appendix I

Post Group Questionnaire



Thank you for participating in today's discussion.

Before we end the session, please answer these questions.

Birth year: _____

Birthplace: _____

Height: _____

Weight: _____

Do you have a history of any of these conditions?

diabetes

cancer: _____

high blood pressure

other: _____

high cholesterol

Did anything surprise you about today's discussion?

Occupation: _____

Highest level of education:

high school

college (associate, bachelor's)

graduate school (master's, doctorate)

professional school (accountant, dentist, law, medicine)



Gracias por participar en la charla de hoy.
Antes de terminar, por favor de contestar estas preguntas.

Año de nacimiento: _____

Lugar de nacimiento: _____

Altura: _____ Peso: _____

¿Tiene usted historia médica de las siguientes condiciones?

diabetes

cáncer: _____

presión alta

alguna otra condición:

colesterol alto

¿La sorprendió algo de nuestra charla de hoy?

Ocupación: _____

Nivel más alta de educación:

bachillerato

universidad (asociado, bachelor)

estudios posgrado (maestría, doctorado)

estudio profesionales (contaduría, dentistería, derecho, medicina)

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Curriculum Vitae

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