Health Perceptions of Mexican American Women

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This article describes the health perceptions of a sample of moderately to highly acculturated Mexican American women. Using an ethnographic design, the author interviewed 13 women to determine their health perceptions. The interviews were guided by the domains of health described in the World Health Organization (WHO) definition of health. Three broad categories of health perceptions were identified: the physical body, the emotional component, and finding balance. With the addition of a spiritual component, the WHO definition was a useful tool for uncovering health perceptions. The process of in-depth ethnographic interviewing provided a contextual view of health in which the complexity of intrafamilial relationships was revealed, as were the importance of spirituality as a coping mechanism and the perception of health as an integrated, holistic experience.

In the United States, the Latino population has increased by almost 60% since 1990. Of the Latino subgroups, those of Mexican descent have experienced the largest growth (U.S. Census Bureau, 2001). Although health status (Markides & Coreil, 1986; Roberts & Lee, 1980) and health promotion (Duffy, Rossow, & Hernandez, 1996; Kerr & Ritchey, 1990; Walker, Kerr, Pender, & Sechrist, 1990; Walker, Sechrist, & Pender, 1987) have been studied within Latino populations, these studies have not illuminated cultural understandings of health because they are informed by biomedical principles of health that do not encompass personal (Hunt, Jordan, & Irwin, 1989; Kleinman, 1988) or cultural ideals of health. This has led to discordance between the client's perception of health and the physician's assessment of the client's health (Angel & Guarnaccia, 1989; Shetterly, Baxter, Mason, & Hamman, 1996). A greater understanding of the cultural context of health perceptions among Mexican American women will help nurses and other health care providers meet the health care needs of this growing portion of the U.S. population. This article reports on the health perceptions of a sample of moderately to highly acculturated Mexican American women living in the Southwest. It is a part of a larger study on health creation among Mexican American women.

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HEALTH, HEALTH STATUS, AND HEALTH PERCEPTIONS

Attempts to define and understand health have been an important part of nursing practice and nursing research. "Health has been conceptualized as a state, a process of development, an actualization, an outcome, and a style of life" (Meleis, 1990, p. 108). Smith (1981) placed health definitions into four broad categories: clinical, which represents the biological model of disease; role, which addresses an individual's ability to meet societal expectations; adaptive, which focuses on ecological explanations; and eudaemonistic, which focuses on high-level wellness.

Health status and health perceptions are two concepts important to research into the construct of health. Health status, the more concrete of the two, is consistent with Smith's (1981) clinical, adaptive, and role performance definitions. Epidemiological and biomedical research often report health status findings in terms of risk factors likely to lead to increased morbidity and mortality. In contrast, health perceptions are more difficult to conceptualize. Perceptions often rest at the unconscious level and are shaped by personal experiences and expectations. *Webster's Third New International Dictionary* (1993) defines perception as

> the integration of sensory impressions of events in the external world by a conscious organism, especially as a function of nonconscious expectations derived from past experience and serving as a basis for or as verified by further meaningful motivated action. (p. 1675)

It is likely, therefore, that one's health perceptions rest below the surface, are molded by experiences, and are

reflected in actions. To develop an understanding of health perceptions, a useful definition of health is one that directs the researcher to the sets of activities and actions that affect health and are reflective of health perceptions. For these reasons, operational definitions of health that solicit cultural understandings of health and contextualize the cultural aspects of life into the definition are important. All health definitions are limited because none encompass the complete range of health experiences for all individuals; however, the World Health Organization's (WHO, 1978) definition of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity" (p. 2) is valuable because of its inclusiveness. This perspective weaves health through the fabric of everyday life in which activities that support and detract from mental and social well-being are considered alongside the physical elements of health.

This global understanding of health is present within the Mexican American community. In a study of a Mexican American barrio, Kay (1977) described an integrative understanding of health among Mexican American women that includes the environment, physical health, and mental well-being. Clark (1995) described the complexity of maternal responsibilities in health work and concomitant burdens of caregiving among Mexican American mothers. A review of the literature showed that Mexican American women contextualize health into many aspects of their lives, viewing their responsibility in health work as facilitating physical health and providing an environment in which their families and the individual members have opportunities to develop mentally and socially (Mendelson-Klauss, 2000).

Health Perceptions and Health Status of Mexican Americans

Markides and Coreil (1986) reviewed the literature related to the health of Hispanics in the Southwest. Using mortality and morbidity indicators, Hispanics were healthier than African Americans and less healthy than European Americans. However, Roberts and Lee (1980) found that Mexican Americans perceived their health as fair to poor more often than did European Americans and less often than did African Americans. Other studies have also revealed that Mexican Americans, especially Spanish speakers, frequently self-rate their health as fair to poor. Angel and Guarnaccia (1989), using data from the Hispanic Health and Nutrition Evaluation Survey (HHANES), found that physicians rated the health status of 80% (N = 3,371) of the Mexican Americans as excellent or very good. Only 15% of Spanish speakers (n = 1,463) and 48% of the English speakers (n = 1,908) rated their health as excellent or very good. More recently, Shetterly et al. (1996) examined the phenomenon of negative health perceptions in the presence of positive health status. They found that Hispanics (N = 429) were 3.4 times more likely to report fair to poor health than were non-Hispanic Whites (N = 583). These differences were only moderately explained by markers of psychological well-being.

Varieties of explanations for this paradox have been proposed. Angel and Guarnaccia (1989) suggested that the discrepancy between health perceptions and health status is a result of individuals self-assessing affective disorders as indicators of poor health. They noted, "Research techniques that cast individual responses in terms of a culturally specific set of diagnostic criteria make it difficult to determine how emic categories are employed within specific cultural contexts" (pp. 1231-1232). Interestingly, self-identifying mental health problems as indicators of poor general health were considered paradoxical because only physical indicators of health were measured.

The response options used in Likert-type scales have also been proposed as an explanation for the paradox. For instance, Angel and Guarnaccia (1989, p. 1234) used the response options *excellente, muy buena, regular, o mala* in their study. The majority of the respondents chose *muy buena* or *regular.* Among less acculturated individuals, these options are descriptive of normal health, equivalent to the phrase "just fine" in English. Jones and Kay (1992) noted that 4-item, Likert-type scales were culturally more relevant than 5-item scales among Mexican American participants. Marin and Marin (1991) found that Hispanics frequently picked the choices at the poles when presented with Likert-type scales. Shetterly et al. (1996) concluded that self-assessments, although frequently used as indicators of health status, "may be more prone to cultural variations and ethnic differences in the interpretation of what constitutes good health" (p. 1801).

METHOD

This research, a descriptive ethnographic study of health creation among Mexican American women, was guided by the following three questions: (a) What are the health perceptions of Mexican American women? (b) What are the health-producing and help-seeking behaviors (proximate determinants of health) used by Mexican American women to produce health? (c) What roles do Mexican American women play in the household production of health? Ethnography, a research method especially well suited to answering questions that seek to understand the nature of a phenomenon from an insider perspective (Atkinson & Hammersley, 1994; Field & Morse, 1985) was chosen because the aims of the research were to understand the nature of health creation from the perspective of Mexican American women. This article addresses the findings specific to the first research question.

After securing approval from the institutional review board of a major southwestern university, data were collected from a purposive sample of 13 Mexican American women who were at least 18 years of age, mothers, permanent United States residents, and able to participate in two in-depth interviews and a shorter follow-up interview conducted in Eng-

lish. Participants were recruited through a process of direct selection by the researcher, referrals to the researcher from individuals familiar with the aims of the research, and referrals from women already enrolled in the study. The initial sampling goal was 10 participants interviewed three times. Three of the initial 10 women recruited did not return calls to schedule second interviews, and 1 was lost to follow-up after the second interview. Although constancy of story lines was developing, an additional 3 women were recruited to ensure saturation. A disclaimer explaining the purpose of the study, potential benefits, risks, confidentiality, and participants' rights was provided to each participant prior to her involvement in this research.

Consistent with ethnographic methods, data were gathered through ethnographic interviewing (an interview approach that seeks to uncover the contextual and culturally embedded meaning of the phenomenon being studied), participant observation, and field notes. The participants were asked to engage in two in-depth, audiotaped ethnographic interviews that were scheduled approximately 6 to 8 weeks apart. These interviews lasted between 45 minutes and 2.5 hours. A third and shorter interview, which lasted between 10 minutes and 1.75 hours, was scheduled to provide follow-up to topics discussed in previous interviews and to provide a process of closure between the participants and this researcher. Interviews were conducted in a setting of the participant's choice, most frequently in the woman's home. A total of 32 audiotaped interviews were conducted.

The interview guide consisted of several open-ended questions in a semistructured format designed to capture the domains of health described in the WHO definition. The WHO definition of health was used to frame questions related to health perceptions because it situated health into a broad framework of everyday life. It is important to note that the WHO definition was used as a launching point from which to question participants about the totality of experiences that may or may not influence their perceptions of health. At no point was the definition itself held as an exemplar of good health or as the ideal definition of health. However, the global nature of the definition allowed for a broader framework in which to examine the relevant issues.

Participants were encouraged to discuss their health perceptions in the context of their lives, their experiences as family members, and in relationship to their cultural experiences. Because spirituality has long been recognized as an important concept in Mexican American culture (Kay, 1977; Macklin, 1980; Rehm, 1999), questions on spirituality were included, even though they are not part of the WHO definition. An orally administered demographic questionnaire and a language-based acculturation scale supplemented the information gathered through interviewing. Observations regarding the household, household activities that occurred during the interview process, and interactions with family members were recorded as field notes following each interview.

Data analysis, which began with data collection and continued throughout the study, included (a) summarizing each interview, (b) identifying major story lines (Sandelowski, 1995), (c) extracting each participant's narrative (Mishler, 1986), and (d) inductively generating categories, themes, and subthemes (DeSantis & Ugarriza, 2000). Trustworthiness of the findings was assured through a process of prolonged engagement between the participants and this researcher; member checks of the first and second interviews, which had been summarized and provided to the participants; and a review of the data-gathering and analysis procedures by members of this researcher's dissertation committee, who were experienced researchers familiar with the method and the subject matter (Lincoln & Guba, 1985).

The Participants

The participants were a diverse group of moderately to highly acculturated (as measured by language usage) Mexican American women living in a moderate-sized southwestern city. They ranged in age from 26 to 53 (M = 38.23 years; SD = 7.63). Five of the women were married, 3 were divorced, 1 was legally separated, 2 were living with their partners and not married, and 2 were single. Of the 5 women who were married, 2 had been married once before and 1 had been married twice before. One of the divorced women had been divorced three times. All the participants were mothers. One participant had custody of two of her four minor children; the other women had custody of all their minor children. The mean number of children was two (SD = 0.91). Four women were grandmothers; 2 had grandchildren living with them in their homes.

Three women were born in Mexico, and the rest were born in the United States. However, one of the women born in the United States spent her early childhood in Mexico. All the women who participated in this study spoke fluent English. Nine women described themselves as bilingual, and 3 reported some facility speaking Spanish. One woman spoke English only. Moreover, of the 13 women, 12 were more comfortable reading and writing in English.

The participants' personal income included their salary, food stamps, payments from Aid to Families with Dependent Children, and child support. Household income included the participants' personal income and other income that benefited the family or household unit. Although this generally included income from partners and parents, it excluded the income of children who lived at home. Personal income ranged from approximately $5,200 per year to approximately $38,000 per year, and household income ranged from $5,200 per year to more than $115,000 per year.

THE CONTEXTUAL FOUNDATION FOR HEALTH PERCEPTIONS

The women's stories and experiences of health perceptions arose from the context of their households and were framed by their spirituality and their experiences as children, as mothers, and as partners. Spirituality permeated the participants' discussion of health perceptions. All the women believed in God, and 10 of the women incorporated their spiritual beliefs into their daily routine. The participants developed their sense of spirituality over time, often incorporating traditional teachings from childhood with their personal beliefs, which resulted in a spiritually meaningful and personal relationship with God. Although several participants enjoyed going to church, none found church central to their religious beliefs.

If spirituality was the frame for the women's stories, then raising children formed the background. The participants were mothers first and foremost. They discussed the difficulty of raising children and suffered greatly when their children experienced problems. Throughout the interviews, their desires to be deliberate and thoughtful parents or grandparents was apparent; they kept their children and their role as parents at the forefront of their discussion of health perceptions.

Because participants were asked to discuss their health experiences from childhood to the present, their stories reflected the influence of childhood experiences on the formation of their health perceptions. For many of the participants, childhood was a bittersweet time, marked by difficult adolescent periods and troubling family relationships that followed them into adulthood. They frequently contrasted their childhood families with an idealized notion of how they thought their family should have been. Consequently, they were disappointed with many aspects of their childhood family experiences yet were unable to create the ideal family as adults. For several participants, this resulted in a strong sense of the value of family but not a clear sense of how to create this family.

Childhood difficulties manifest themselves most strongly in the participants' choice of partners. The biggest source of stress in the participants' lives involved their relationship with their partners and, to a lesser extent, other family members. For the women who participated in this research, multiple relationships were the norm, and the stress of problematic relationships both past and present permeated their narratives. These problems were so pervasive that descriptions of ill health often occurred in the context of a bad marriage or failing relationship.

RESULTS

Through the discovery process of in-depth ethnographic interviewing and the analysis process described in the Method section, key elements of the participants' health perceptions were identified. The participants generally perceived health as a compilation of good physical health, sound mental health, and a socially and spiritually satisfying life. However, health exceeded the sum of these components; it was an embodied experience that transcended illness and was grounded in their relationships with their family and supported by their spirituality. The dynamic of this integrated notion of health is best illustrated by discussing the participants' health perceptions in relationship to their physical body, where illness and vulnerability could be manifest; their emotional state, which was heavily influenced by relationships with family and supported by their belief in God; and the embodiment of the physical and emotional experience of health.

The Physical Component of Health Perceptions: Illness and Vulnerability

Health was noncorporeal and transcended the physical body. Illness, on the other hand, was grounded in the body and was conceptualized as a breakdown in the ability to fulfill functional roles. Illness had the following three characteristics: (a) it was tangible, (b) it was associated with functional limitations, and (c) it could coexist with a state of health. Moreover, the participants made distinctions between acute illness, in which recovery and a resumption of normal life activities were the norm, and chronic illness, in which illness was incorporated into the daily routine of life.

Illness, although different from health, was not the opposite of health. For example, one could remain healthy despite the presence of chronic illness. A participant who contrasted her experiences with pneumonia and breast cancer best exemplifies this notion. Consistent with Kagawa-Singer's (1993) findings in which people with cancer still considered themselves healthy because their illness did not interfere with their sense of productivity and value within their social groups, she perceived the pneumonia as an illness, because she was bedridden and unable to care for her children. She described her experience with cancer as follows:

> I didn't think that I was ill. You know, when people say I was ill; I didn't think that that matched up at all. To me, that meant that I was in bed, and I couldn't get up and that sort of thing. I thought of it as more of a—just like an occurrence. If you break your leg, you are not ill, you just broke your leg, kind of like that.

Another example of the physical component of health perceptions was the notion of bodily vulnerability or a sense that one's body has a proclivity to certain types of ailments. One participant explained it as follows:

> The only thing that concerns me is that okay, you know, like some bodies are very prone to cholesterol or clogging arteries, and some bodies are very prone to growing cancer. And, you know, it just depends on your body's vulnerability.

Other participants discussed similar sentiments, especially in regard to chronic conditions such as asthma, headaches, fibrocystic disease, and depression. Responding to the body's vulnerability led to increased watchfulness and wondering. The participants adopting this attitude looked for ways to alter their body's vulnerability, such as changing their diet, eliminating or decreasing exposure to factors that cause problems, and increasing vigilance over how the body reacts to environmental factors.

The Emotional Component of Health Perceptions: Distress and Coping

Emotional balance was an intrinsic part of the overall perception of health. Coming to terms with one's emotional challenges was an essential component of maintaining health. The participants discussed the influences of a wide range of difficult situations and coping mechanisms on their health. Two especially compelling findings, the participants' difficult relationships with their mothers as a source of distress and their reliance on their spirituality to maintain or restore a sense of emotional balance, will be presented as examples of the emotional component of health perceptions.

Although family was a significant component of the participants' social network, all the women described distance and difficulties in their family relationships. The amount and degree of discord in the participants' relationships with their mothers was unexpected because the literature generally portrays the Mexican American family as a source of emotional support (Niska, 1999) and a hedge against mental illness (Keefe & Padilla, 1987). Of the 10 women who completed at least two interviews, only 3 characterized their relationships with their mothers as generally good and close. Two participants did not identify their mothers when asked to list people whom they considered "family." Nevertheless, the participants were well aware of the cultural importance of family and suffered over intrafamilial discord. When discussing problems with their mothers, they frequently qualified the discussion with a statement similar to the following, in which they professed love for their mothers:

> My mother, I think, was, oh, gee, how can I put this, um, she—I had a, not a real good childhood because my mother, she was um, very negative, very verbally and emotionally abusive. I didn't know that at the time, until I started getting counseling in my older years . . . But she's the only mother I ever had and so I do love her.

Problems between the participants and their mothers usually started in childhood and continued into adulthood. The nature of the problems ranged from a perceived lack of support to deep-seated feelings associated with an absence of nurturance, love, and value. One participant expressed angst about not being closer to her mother and how she, along with her sisters, struggled to stay connected to her.

> I love my mother very, very much, and I'm just now having—a lot of feelings are going through my mind with my mother and my sisters. I tell them that we have to make a way, even though it wasn't there for us when we were growing up. I still believe that my mother loved us very much and she loves us now, but she didn't know how to love us, I want to believe. She doesn't come around us. Therefore, we don't go around her.

Another participant's description of her childhood was punctuated by multiple instances of physical and emotional abuse at the hand of her mother. Her mother was seriously ill when this researcher met her for the first interview and had passed away shortly before the third interview. During her mother's illness, the participant was present on a daily basis to provide her with companionship, emotional support, and physical assistance. However, she did not feel that her mother acknowledged these efforts, which compounded old childhood wounds. During the final interview, the participant was struggling with the fact that she had not cried since her mother's death.

> I always wanted to have [her] not accept me but acknowledge [me]. She would acknowledge everyone else except for me . . . Like I said at the beginning, was that it (her mother's death) hurt me, but it's not hurting as much as with my dad, as when he died. I don't know if it is because there was no acceptance and that I was left behind. And she never acknowledged what I did and what I tried to do and how I always wanted her to be a part of my life.

Regardless of the nature or the extent of the problems, all the participants felt a sense of family obligation that transcended the conflict and compelled them to try to maintain a meaningful relationship with their mothers. One participant, for example, was her mother's primary caretaker during her terminal illness despite a lifetime of rejection. Another participant did not identify her mother as a member of her family, yet she customized her new home to include an apartment for her. She explained the situation by saying, "You never hear me complaining about my mother. She was an alcoholic. She was this; she was that. I don't complain for what she did and for what she didn't do. Instead I'm here helping her."

The power of the participants' spirituality helped them to weather difficult situations and acted as a mechanism to maintain or restore emotional balance. Similar to Rehm's (1999) experience researching Mexican American families coping with chronically ill children, the participants voluntarily spoke about their spiritual beliefs with little or no prompting. Elements of spirituality were woven throughout their narratives. All the participants believed in a higher power, and most drew daily comfort from this belief. Their childhood experiences with religion varied; some had always found comfort in their religious beliefs, whereas others had fearful recollections of their religious experiences. Consistently, though, the women transformed their childhood reli-

gious beliefs into a relationship with God as a loving, forgiving source of support from which they drew comfort through prayer.

Most of the participants identified prayer and conversations with God as a part of their daily routines and a powerful factor in their perceptions of health, because it provided a stable source of unqualified emotional support.

> You can talk to people in general, like . . . you know, that's a form of relief. It's true, it, it's something else when, when, when you sit down and you talk to Jesus and, and you ask Him for help, and, and you know, and you know, you talk to Him like He's your best friend. He's your Father, you know. You can't see Him, but He is, He is your best friend. And He's not gonna take care of things right there, now and then, but, but you know, eventually, He, He comes through like He does for everybody else.

Prayer was a manifestation of the participants' faith and spirituality. Most of the women had personal and ongoing relationships with God that can best be described as dialogue through prayer. Casual conversations with God, the Virgin of Guadalupe, and St. Francis as well as reading the bible were are all viewed as expressions of spirituality equal to or stronger than worship at church. Prayer served as a conduit through which the participants were able to draw support and give thanks, develop personal strengths, and make decisions. A feeling of peace came from having this source of strength, and a sense of confidence came from knowing that answers would be provided. It was through the process of prayer and spiritual reflection that most of the women restored emotional balance and dealt with the stressors in their lives. The importance of spirituality within this sample of women was so powerful that a definition of health that did not include a spiritual aspect would be incomplete.

Finding Balance: The Embodiment of Health

The participants discussed the relationships between mental and emotional health issues, such as stress and disappointments, their overall perception of health, and the embodied experience of being both physically well and ill. The participants felt the best physically when their lives were balanced. Imbalance occurred when the social and emotional aspects of their lives were unstable. During these periods of instability, not only did they feel emotionally unhealthy but they also developed a wide range of physical ailments. Problems frequently associated with mental health, such as stress and lack of social support, precluded having a sense of health in general. Stress and emotional upset were a strain on the higher-level concept of health, leading a participant, for example, to develop pneumonia, a physical illness.

Three explanations for the interaction between physical and mental health were identified. First, mental or emotional stress caused stress-related illnesses, such as headaches or stomach problems. Second, a physical ailment was a message to look deeper into your life and find the problem.

> When I was with my ex-husband, I was experiencing a lot of anemia and weight loss. I went to a hematologist, and it was anemic, anemic, anemic. And he just told me that I had some kind of blood disorder and it will just come out and there is nothing that I can do. If you have leukemia or whatever or some blood disease, it will just come. That didn't make me feel real good. So every month I would go in for blood tests, anemic, anemic, white count low, you know. This went on and on, you know. It was really bad, bad, bad circumstances. I remember we had a real bitter divorce, and when I moved here, I went back for a blood test a week later and it was normal. I said, "This is amazing." What I figure with myself is, I was talking myself into some kind of terminal illness. I either had to get out of the marriage or else I would die getting out. Once I got out, it was just amazing that my labs were normal.

Third, mental stress caused physical deterioration until the body experienced a breaking point and became ill.

> I knew he was having an affair when I was 9 months pregnant. I figured it out that he was having an affair. And you see, I thought we were beyond all that. But we weren't and so it devastated me and it took 6 months to totally deteriorate to the point where I finally came down with double pneumonia.

DISCUSSION

Early in this research, it became apparent that many of the experiences described by the participants differed from the traditional portrayal of Mexican American women in the literature. This discrepancy is most likely due to the level of acculturation of the participants. The acculturation patterns for Mexican Americans are different from those of Americans of European descent (Chavez, Hubbell, & Mishra, 1999; Rueschenberg & Buriel, 1989). Rueschenberg and Buriel (1989) suggested that the historic connections between the Southwest and Mexico and a constant influx of immigrants with traditional values has resulted in a bicultural form of acculturation in which Mexican Americans maintain traditional values within the home while incorporating values consistent with European American society in the workplace. Likewise, Chavez et al. (1999) found that American-born Mexican Americans had health beliefs reflective of exposure to both American society and Mexican culture that they had "integrated into a coherent view of the world" (p. 139).

The participants, although reflective of this pattern, were struggling with the process of integrating the various factors that framed their health perceptions. They were actively confronting the contemporary issues of women in American society; reconciling past and present family configurations and expectations; raising children in a dangerous world; and struggling with the uncertainty of marriage. They were trying

to operate fully in the society in which they lived without losing the depth of their cultural connections.

For the women who participated in this research, health was perceived as an integrated and embodied experience that incorporated emotional elements of well-being with bodily manifestations into an overarching concept of "being healthy" or "having health." Health was experienced as wholeness or being in balance and harmony. Health included maintenance of the physical body, the mind, and the spirit. Consistent with Kay (1977) and Kagawa-Singer's (1993) findings, perceptions of physical illness occurred when symptoms interfered with role expectations. However, although Kay found illness to be exclusive of health, the women in this research believed that health and illness could co-occur as long as one continues to maintain the body at the highest level possible and retains a positive mental attitude and a nurturing spirit.

Conversely, the integrated and embodied experience of health privileged the emotional component. Individuals without any biomedical indicators of physical illness often perceived themselves as not healthy when they were experiencing stress or other forms of turbulence in their lives. Consistent with Angel and Guarnaccia's (1989) supposition that discrepancies between emic health perceptions and etic health status may be a function of cultural interpretations of physical and emotional symptoms, the findings from this study strongly suggest that health perceptions have more to do with social and emotional factors than with physical indicators of the presence or absence of illness.

The strongest influences on the emotional components of health perceptions were rooted in family dynamics. Although the concept of familism was strong among the participants, the support that they were able to draw from their families was, at best, limited. They described estrangement and lack of support from their mothers and siblings, which is inconsistent with the literature that casts the Mexican American family as the primary source of emotional support (Niska, 1999) and a hedge against mental illness (Keefe, 1980; Sabogal, Marin, Otero-Sabogal, Marin, & Perez-Stable, 1987; Sena-Rivera, 1980). Once again, the likely explanation for this discrepancy lies in the changing relationships between this sample of women and their families. A small but growing body of literature describes changes in the support system provided by the Mexican American family (Facio, 1996; Roschelle, 1997; Vega, Kolody, Valle, & Wier, 1991) and provides examples of family members seeking support and role models beyond the family network. The participants, although analytical of their individual family experiences, were also reflective of the cultural ideal of family support that they felt was missing and struggled to reconcile their experiences with their expectations. This struggle weighed heavily on their perceptions of health.

SUMMARY

Using an ethnographic approach and an interview guide based on the World Health Organization definition of health, 13 Mexican American women discussed how the events in their lives, from childhood to present, influenced and defined their perceptions of health. Health was an embodied and integrated experience that had both physical and emotional manifestations. Although health was possible in the presence of physical illness, health was not attainable in the presence of emotional turbulence. Family problems negatively influenced the participants' personal perceptions of health. The participants often sought support outside of the family network and relied heavily on their spirituality to guide them through difficult times. This research provides further insight into the complexity of the health perceptions of Mexican American women and lends support to the importance of working with clients from a holistic perspective that is mindful of the multiple influences and multiple perceptions of health both cross-culturally and intra-culturally.

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