

The relationship between psychosocial status of immigrant Latino mothers and use of emergency pediatric services

Health & Social Work; Silver Spring; May 1994; Zambrana, Ruth E;Ell, Kathleen;Dorrington, Claudia;Wachsman, Laura;Hodge, Dee;

Volume: 19
Issue: 2
Start Page: 93
ISSN: 03607283
Subject Terms: Pediatrics
Mothers
Immigration
Hispanic Americans
Health care
Children & youth

Abstract:

The sociodemographic and psychosocial characteristics of Latino immigrant mothers who use emergency pediatric services are examined. The results reveal a clear pattern of delayed care for acute problems in the children.

Full Text:

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Young Hispanic families are of growing concern nationally and in Los Angeles. Although families of Mexican origin represent the largest sector of the Spanish-speaking population in California, there are significant numbers of families from El Salvador and Guatemala. In Los Angeles, currently 40 percent of the population is Hispanic, and the public school population is about 60 percent Hispanic (Valdivieso & Davis, 1988), a significant proportion being recent Mexican immigrants. Furthermore, public county facilities for prenatal and child health services are used predominantly by Hispanic women and children. These women tend to be younger (mean age of 23) and have higher fertility rates and lower income and educational levels than the general population (Valdivieso & Davis, 1988).

There has been an increasing recognition of the need to collect data on the fastest growing segment of the U.S. population. A major social problem is the welfare of young children, especially the plight of poor and minority children. In 1988 among all families in Los Angeles, 36.2 percent of Hispanic children lived in poverty, compared with 16 percent of white children. Furthermore, 71 percent of Hispanic children in single-parent households lived in poverty (Ong, 1989). Consistent empirical evidence has demonstrated that Hispanics, especially those of Mexican origin, tend to underutilize health care services in general and are least likely to have a usual source of care (Becerra & Greenblatt, 1983; Cornelius, 1993a, 1993b; Schur, Berstein, & Berk, 1987). These studies attribute low use of services to specific features of the population, namely, low level of education and income, lack of knowledge of available resources, and cultural and linguistic barriers (Council on Scientific Affairs, 1991; De la Rosa, 1989). Lack of health insurance was found to be directly related to lack of regular (or usual) source of care (Marin, Marin, Padilla, & De la Rocha, 1983; Marin, Marin, Padilla, De la Rocha, & Fay, 1981). Institutional barriers, such as high cost of medical care, lack of bilingual or bicultural personnel, discrimination, and immigration laws, have also contributed to low use or inappropriate use of health

services (Becerra & Greenblatt, 1983; Giachello, 1988; Guendelman, 1983).

The purposes of the study described in this article were to identify and describe the sociodemographic and psychosocial characteristics of Latino immigrant mothers who use emergency pediatric services; to assess the association of maternal characteristics with perceived barriers to care; and to examine key predictors of utilization behavior, as measured by total number of pediatric visits in the past year and usual source of care, among immigrant Latino mothers.

FACTORS THAT INFLUENCE USE OF PEDIATRIC HEALTH SERVICES

Few studies have examined the utilization patterns of Latinos in the United States, and relatively little comparative research exists on the health of Latino children (Angel & Worobey, 1991). However, Marin et al. (1983), in a study of utilization patterns among Hispanics, found that 57 percent of the sample had never seen a private physician, and more than half (55 percent) of the respondents had used emergency rooms as their main access point to health care delivery systems. In a recent analysis of Latino mothers, the authors found that 50 percent of the women in single-parent households reported barriers to health care, one-third had no insurance, 20 percent had never had a routine medical exam, and 25 percent reported no physical exam for five years or more (Trevino, Trevino, Stroup, & Ray, 1988). A review of 500 pediatric medical charts for Latino children showed that 69 percent of the cases had only one reported visit in the past year. Physical exams, immunizations, and tuberculosis tests were the principal reasons for the visits, and nearly 20 percent of these visits were made in September for school-related purposes (Marin et al., 1981).

Additional investigations have sought to identify the factors that influence the mother's decision to seek pediatric services. In one study, 90 mothers were interviewed in a pediatrician's office. The results indicated that visits were most likely to occur when the child exhibited multiple symptoms and the mother was employed. Delayed visits were correlated with perceived cost of care. Overall, only 39 percent of the visits were judged to be appropriate (necessary and on time) by pediatricians (Kaftarian & Safer, 1987-88). In another study, Schwarz-Lockinland, McKeever, and Saputa (1989) examined factors that enhanced appropriate use of pediatric care. Their study of compliance with an antibiotic regimen for acute otitis media among Hispanic mothers found that when mother and child couples were seen individually by the same health care provider on separate clinic visits, and when verbal instructions were provided and a skill was acquired (such as drawing up medication into an oral syringe), compliance was high. The authors suggested that the acquisition of a new skill may have increased a mother's self-esteem and feelings of control, which enhanced both compliance and appropriate health-seeking behavior.

PSYCHOLOGICAL FACTORS AND HEALTH-SEEKING BEHAVIORS

A limited number of studies have examined the role that social and psychological factors play in influencing mother's evaluation of her child's health and the decision to seek pediatric services. Several studies raised questions about the role of maternal stress and depression in childhood illness (Orr & James, 1984; Orr, James, Burns, & Thompson, 1989). Conn temporary conceptualizations have proposed that a set of interrelated factors, namely, social class, culture, and psychosocial factors, influence a mother's assessment of the severity of symptoms and constrain her decisions concerning appropriate behavior. Acculturation and English language proficiency have also been found to have strong independent effects on a mother's report of poor health for her child, and these may reflect her own level of distress (Angel & Worobey, 1988). For example, in an analysis of Mexican American mothers, the

data showed that the least acculturated mothers reported their children to be in poorer health than the more acculturated mothers and that single mothers reported poorer health for their children than did married mothers. Furthermore, the authors found that Mexican American mothers who spoke only Spanish reported much higher rates of fair and poor health than either black or white two-parent and female-headed households. These data support the hypothesis that a mother's report of her child's health reflects her own perceptions and is likely to be influenced by her psychosocial status (Angel & Worobey, 1988).

A complex set of social and psychological factors influence a mother's decision to seek pediatric services, including work status of the mother, multiple symptoms in the child, marital status, culture, and emotional status. In addition, organizational or structural characteristics of the current health care delivery system present barriers to appropriate use of services for Latino women and children. Several studies have concluded that racism and discrimination are endemic in the delivery, administration, and planning of health care services. These factors seriously impede access to and use of these services by Hispanic families and their children (De la Rosa, 1989; Giachello, 1988; Ginzberg, 1991).

Currently, major urban areas such as Los Angeles are experiencing organizational strain on their health care systems, in part because of the dramatic increase of low-income and poor families, including immigrants. Mothers and children represent a significant portion of users of health care services. Mothers are the primary caretakers of the family and the primary health decision makers (Combs-Orme, 1990; E11 & Northen, 1990). For immigrant Latino mothers, there is still limited understanding of the constellation of factors that influence use of pediatric services.

METHODS

SAMPLE

A purposive, sequential sampling procedure was used. The sample consisted of 80 Latino mothers. The women selected were between ages 18 and 40; born in Mexico, El Salvador, or Guatemala; had a child between infancy and age five; and had visited a large urban pediatric emergency room in Los Angeles County in 1990. All women who met these criteria were identified through medical charts by intake staff at the hospital and referred to the interviewer over a three-month period. The nature of the study was explained to potential respondents, and their participation was requested by bilingual and bicultural interviewers. When the participants agreed, they signed an informed consent agreement. The study site was selected because about 98 percent of the users of pediatric services were Hispanic children.

INSTRUMENT AND PROCEDURES

The instrument was designed to obtain information on the sociodemographic characteristics of the mother and information about the child's health care including reason for current visit, number of days of illness before current visit, the child's usual source of care, and the mother's perception of the child's overall health and the seriousness of the current illness. In addition, data were collected on the mother's perception of barriers to health care and on her own psychosocial functioning and health status.

A series of closed-ended items obtained information on the mother's age, place of birth, marital status, number of years in the United States, level of education, employment status, and health insurance coverage for the child (specifically Medi-Cal). A five-point Likert scale was used to measure the mother's assessment of her child's overall health (1 = excellent, 5 = poor), and a four-point scale measured the mother's perception of seriousness of current symptoms (1 = extremely serious, 4 = not

serious).

Perceived barriers to health care services were measured on a 14-item scale adapted from the Hispanic Health and Nutrition Examination Survey (H-HANES). The respondent indicated yes or no to a series of questions asking whether she had been unable to get medical care for her child during the past year for reasons such as prohibitive cost, lack of child care, or lack of transportation. The sum of the affirmative responses constituted the total score with a range of 0 to 14. The Cronbach alpha for this scale yielded a coefficient of .84.

Five multi-item scales were used to assess the psychosocial functioning and health status of the mothers. The Subjective Self-Rating Health Scale (SSRH) was used to obtain their perceptions of their overall health status on a five-point scale (1 = excellent, 5 = poor). Two items were derived from the Functional Limitations Battery, Dayton Medical History Questionnaire (Stewart, Ware, Brook, & Davies Avery, 1978). The respondents were asked whether their health had limited their ability to carry out normal daily activities or had prevented them from carrying out their normal activities altogether during the past year. These items were rated on a three-point scale (1 = three months or more, 2 = three months or less, and 3 = no).

Five items were derived from the Form A Mental Health Battery, Dayton Medical History Questionnaire (Ware, Johnston, Davies-Avery, & Brook, 1979). The respondents' mental health status for the past month was rated on a six-item scale, with responses rated from 5 = all the time to 1 = never. For example, respondents were asked how much time they had been nervous or depressed during the past month. The sum of the responses to all items resulted in a total score ranging from six to 30. Higher scores indicated a higher level of mental distress over the past month. Reliability analysis of this scale yielded a Cronbach alpha coefficient of .68.

A life problems measure was derived from the Los Angeles County Epidemiological Catchment Area Study (Golding, 1985), which includes 13 life problem areas and asks respondents to indicate on a four-point scale how serious each problem has been in their lives during the past three months (1 = not a problem, 4 = a serious problem). Examples of problems are lack of money, family health problems, or employment difficulties. Scores ranged from 13 to 52, the higher score indicating a higher number of serious problems during the past three months. The reliability analysis yielded an alpha coefficient of .73.

Procidano and Heller's (1983) Perceived Social Support Scale was used to examine the mother's perception of her relationships with family members and friends. The family scale includes 10 items addressing relations with family members--for example, "My family is sensitive to my personal needs." The friend support scale includes 10 items such as "My friends give me moral support when I need it." Each item is measured on a three-point scale (3 = yes, 2 = don't know, and 1 = no). Scores ranged from 10 to 30 for each of the scales. The higher scores indicate a perception of greater social support from family or friends. Reliability analysis yielded an alpha of .67 for the family support scale and .75 for the friend support scale.

The Perceived Stress Scale (Cohen, Kamarck, & Mermelstein, 1983) was used to measure the respondents' perceptions regarding their ability to cope with their lives and their problems and the extent to which they felt in control during the past month. The instrument consists of eight items measured on a five-point scale (1 = never, 5 = always). Total scores ranged from eight to 40, the higher scores indicating that the respondents felt more in control of their lives and were better able to cope with problems. Reliability analysis yielded an alpha of .57, which raised concerns about the cross-cultural

equivalency of this scale.

All measures were modified to incorporate central study concerns and to ensure linguistic and cultural sensitivity to respondents. Interviewers were of Hispanic origin, and all respondents were interviewed in Spanish. Interviews were conducted while the respondents were waiting to see the physician and, on average, took 40 minutes.

ANALYSES

Univariate descriptive statistics and bivariate analyses, including chi-square, t tests, and correlational analysis, were performed depending on the level of measurement of the variables concerned. Respondents from Mexico and Central America were compared to determine any significant differences between the two groups. Multivariate analysis was conducted to assess the independent effects of various factors associated with the major dependent variable, the number of pediatric health care visits during the past year for the total sample.

RESULTS

SOCIODEMOGRAPHIC CHARACTERISTICS OF MOTHERS

The sample consisted of 80 Hispanic immigrant mothers, of whom 59 were Mexican immigrants and 21 Central American (Salvadoran and Guatemalan) immigrants. Table 1 presents the characteristics of respondents by place of origin. (Table 1 omitted) The mean age of the respondents was 25.61 years ($SD = 5.080$). The mean educational level of respondents was 7.56 years ($SD = 3.73$). About two-fifths (43.8 percent) of all respondents were married, and 29.6 percent of all respondents reported working full-time. The mean number of household members was 5.70 ($SD = 2.08$). The average length of time in the United States for all respondents was 6.90 years ($SD = 5.11$). More than half (51.25 percent, $n = 41$) of the respondents had been in the Los Angeles area less than five years. Almost half (47.6 percent) of the Central American immigrants reported ability to speak English, compared with 29.3 percent of the Mexican immigrants. MediCal coverage was reported by 42.4 percent of the Mexican immigrants but by only 30.0 percent of the Central Americans. There were no significant differences by immigrant group on the major sociodemographic factors including age of mother and child, level of education, marital status, employment, and number of persons per household. Thus, all further analyses were conducted on the total sample, but differences by place of origin are noted.

As expected, the respondents' ages were significantly associated with length of time in the United States ($r = .34$, $p < .01$), and the mothers' ability to speak English was positively associated with their level of education ($r = .37$, $p < .010$) and length of time in the United States ($r = .52$, $p < .01$). Mothers who spoke English had an average of 9.52 years of education and had been in the country for an average of 10% years. In contrast, non-English-speaking respondents had an average of 6.67 years of education ($F = 12.17$, $p < .01$) and had lived in the United States for an average of five years ($F = 27.87$, $p < .01$).

HEALTH-RELATED CHARACTERISTICS OF CHILD

The mean age of the children was 18.52 months ($SD = 19.74$) (Table 2). (Table 2 omitted) All children were born in the United States. Overall, 62.5 percent of respondents reported that their children's health was good or very good, and 5.0 percent reported that their children's health was poor. The principal reasons given for the physician visit were ear, nose, and throat problems; flu-related symptoms such as stuffy nose, coughing, or fever; intestinal-related problems such as diarrhea or vomiting; and accidents.

The mothers reported that their children had been sick for an average of 9.73 days (SD = 18.98) before the current visit.

Respondents evaluated the seriousness of the symptoms for the current visit. One-third (34.6 percent) rated the symptoms as extremely or very serious. An almost equal percentage rated the children's symptoms as serious, and 29.5 percent (35.9 percent) rated the symptoms as not serious. The mean for seriousness of symptom evaluation was 2.24 (SD = 1.08). Correlation analyses showed no significant relationships between total number of visits during the past year and child-related variables--that is, age of child, number of days sick before current visit, mothers' perception of children's health overall, or existence of children's usual source of care.

HEALTH CARE UTILIZATION PATTERNS AND BARRIERS

Four items, with forced-choice response options, asked the respondents to indicate if they had a usual source of care for their children. Two items asked where they usually took their children for routine checkups and immunizations and where they usually took their children when they were sick. One item asked for the number of pediatric visits in the past year. Respondents reported an average of 6.29 (SD = 12.33) child health care visits during the past year (Table 3). (Table 3 omitted) Sixty-five percent (n = 52) of the sample reported a usual source of care. Central Americans were equally as likely to report a usual source of care as Mexican immigrants. The data revealed two major sources of regular health care for children: 36.2 percent (n = 29) identified the pediatric emergency room, and 42.5 percent (n = 34) reported other public health facilities. Only 7.5 percent (n = 6) reported a private physician, and 13.7 percent (n = 11) reported other sources. Mexican immigrants were 1.7 times more likely than Central American immigrants to report use of the emergency room as a regular source of care. Almost half (47.5 percent, n = 38) reported the emergency room as usual health care source for a sick child, whereas 36.2 percent (n = 29) reported other public health facilities. Trends were similar for both groups.

On average the respondents identified four barriers (M= 4.14, SD = 3.51) to obtaining health care for their children during the past year. Central American mothers reported a significantly higher number of barriers (M= 5.52, SD = 3.16) than Mexican immigrant mothers (M= 3.64, SD = 3.52, p < .05). The most frequently reported barriers were too long a wait in the clinic (56.2 percent, n = 45); too long to wait for an appointment (50.0 percent, n = 40); the cost of care (40.0 percent, n = 32); the staff not speaking Spanish (35.0 percent, n = 28); the lack of Latino staff (31.2 percent, n = 25); and lack of confidence in health care staff (31.2 percent, n = 25).

PSYCHOSOCIAL PROFILE OF MOTHERS

More than half (56.2 percent, n = 45) of the women reported that their own physical health was only fair or poor, 27.5 percent (n = 22) reported generally good health, and 16.2 percent (n = 13) reported very good or excellent health. Almost 14 percent (n = 11) indicated that their health had affected their ability to carry out their usual daily activities, either at work or at home, for more than three months during the past year, and 11.2 percent (n = 9) were unable to go to work at all for more than three months. Another 11.2 percent (n = 9) had been affected by health-related problems for three months or less.

The average score on the life problems scale for all respondents was 24.0 (SD = 6.36). The women identified an average of 5.67 problems that had caused them some difficulty during the preceding three months, ranging from minor to serious. The difficulties most frequently reported as a major or serious problem included lack of English skills (60.0 percent, n = 48), lack of money (58.7 percent, n = 47),

difficulty finding or keeping a job (41.2 percent, $n = 33$), difficulty finding an affordable place to live (38.7 percent, $n = 31$), and difficulty finding a safe place to live (36.2 percent, $n = 29$). Major or serious problems with family health or discrimination against family members were reported by 18.7 percent ($n = 15$) of the respondents.

In addition, the respondents reported high levels of mental distress during the past month, specifically feelings of nervousness and depression ($M = 14.34$, $SD = 5.00$). Almost one-third (32.5 percent, $n = 26$) reported being nervous, and 25.0 percent ($n = 20$) reported feeling sad or depressed most or all of the time during the past month. Central American women tended to report a higher degree of mental distress ($M = 16.19$, $SD = 4.97$) than Mexican immigrant women ($M = 13.68$, $SD = 4.89$, $p = .053$). The scores on the Perceived Stress Scale ($M = 26.64$, $SD = 4.71$) indicated that generally the respondents felt that they had been "able to manage or be in control of their lives" and their problems only some of the time during the past month. Moreover, 21.2 percent ($n = 17$) reported that they "never or hardly ever felt that they could manage," and only 15 percent ($n = 12$) reported that they "felt they could cope with their lives and their problems most of the time. On the other hand, the respondents reported relatively high levels of support from both family ($M = 21.98$, $SD = 5.24$) and friends ($M = 19.43$, $SD = 5.23$).

Correlation analyses were conducted to assess the associations between maternal characteristics and perceived barriers to care. A significant positive relationship existed between the scores on the life problems scale and the measure of mental health status ($r = .43$, $p < .01$) and perceived barriers to health care ($r = .49$, $p < .01$). Alternatively, significant negative associations existed between the scores on the Perceived Stress Scale and mental health status ($r = -.32$, $p < .01$), life problems ($r = -.23$, $p < .05$), and perceived barriers to health care ($r = -.25$, $p < .05$). The relationship between the variables showed that those with a greater sense of control over their lives reported fewer difficulties; those reporting fewer difficulties over the past three months or who felt in greater control of their lives experienced lower levels of mental distress and also perceived fewer barriers to health care.

MULTIVARIATE ANALYSES

Five independent variables were included in a multiple regression model to assess the influence of these factors on the total number of pediatric visits during the past year. Two dummy variables were created: Medi-Cal coverage (1 = yes, 0 = no) and usual source of health care. Three continuous variables were included: age of child, number of years in the United States, and perceived barriers to health care.

As shown in Table 4, the multivariate model was significant, accounting for 19 percent of the variation in pediatric health care visits during the past year (model $R^2 = .19$, standard error of estimate = 2.95, $F < .01$). (Table 4 omitted) However, when using the backward method of selection, only one variable, Medi-Cal coverage, was found to be a significant predictor of the total number of pediatric health care visits (model $R^2 = .14$, standard error of estimate = 2.99, $F < .01$). Additional multivariate analyses were conducted that included mother's education level instead of length of time in the United States (model $R^2 = .16$, standard error of estimate = 3.07, $F = .058$). A second set of analyses were conducted using the mother's psychosocial variables (life problems scale, mental health status, Perceived Stress Scale, and family and friend support scales) as independent predictors. These models were not significant.

DISCUSSION

The unprecedented growth of Latino immigrant groups in the Los Angeles area is contributing to a crisis

for both the health care system and Latino families. The use of health care services by Latino families has been consistently documented as inadequate, especially in poor families (De la Rosa, 1989). Differential utilization patterns within Hispanic groups have also consistently demonstrated that Mexican-origin populations are the least likely to have public or private health insurance and show the lowest use of health care services (Cornelius, 1993a, 1993b; Trevino, Moyer, Valdez, & Stroup-Benham, 1991).

In comparing the social characteristics of our study sample to Mexican American respondents (Spanish interview) from the national H-HANES, our respondents were less likely to be in two-parent families (43.8 percent of our study sample versus 78.7 percent of the H-HANES study sample), although the data show similar household size (5.7 versus 5.5). In comparing parental assessment of child's health, 5.0 percent of the study respondents rated their children's health as poor compared with 1.2 percent of national sample; 32.5 percent of study sample compared with 22.9 percent of the national sample rated their children's health as fair; 40 percent of both samples rated their children's health as good. Only 22.5 percent of the study sample rated their children's health as very good to excellent compared with 34.1 percent of the national sample.

These data show that the study sample is more likely to be in female-headed households, and nearly 40 percent reported their children's health as poor to fair, confirming the relationships among acculturation, socioeconomic status, and single parenthood (Angel & Wrobley, 1988, 1991). Clearly, the small sample size and the urban context in which this study was conducted represent limitations with respect to representativeness of the study participants. Thus, caution needs to be exercised in the interpretation and generalization of these findings to all Latino subgroups in different geographic regions.

Overall, this group of immigrant women demonstrated a fairly high incidence of mental distress, specifically feeling nervous or depressed. The women had to cope with a relatively high number of life problems, the most serious ones relating to their socioeconomic conditions. The psychosocial profiles show that as a group, the respondents felt overwhelmed and unable to cope with everyday life and experienced limited physical and mental health functioning. Not surprisingly, the data confirmed the reported high levels of anxiety and depression found among Mexican and Central American immigrants due to barriers to care such as lack of English language proficiency, lack of adequate employment, undocumented status, and perceived societal discrimination (Cervantes, Salgado de Snyder, & Padilla, 1988; Leslie & Leitch, 1989; Padilla, Cervantes, Maldonado, & Garcia, 1987; Padilla, Ruiz, & Alvarez, 1975). Social support from both family and friends was generally perceived by respondents as being available. However, other studies have found that Mexican immigrant mothers have a greater number of life problems and fewer family and social support resources than Mexican American mothers, a fact that may also contribute to their mental distress (Vega, 1990; Zambrana, Silva-Palacios, & Powell, 1992).

The physical and mental health status of the mothers was positively correlated with reported significant barriers to access to health care services for their children. For example, although 65 percent of the respondents reported a usual source of care, 36 percent also reported the emergency room as the site for usual care; these data suggest that respondents may perceive the emergency room as a primary and preventive health care site or that they find it to be most available and accessible site for routine pediatric care. Alternatively, the mothers' psychosocial health status may influence the delayed use of pediatric services. The delay may be related to the respondents' inability to manage everyday tasks due to mental distress.

Several studies have documented that lack of health insurance is a major barrier to timely and appropriate use of health care services (Behrman & Larson, 1991; Council on Scientific Affairs, 1991; Trevino et al., 1991). In this study, Medi-Cal health insurance coverage was the most significant predictor of the total number of pediatric care visits. Yet immigrants whose children are eligible for Medi-Cal by virtue of their birth in the United States tend not to use these benefits. Medi-Cal was not a sufficient variable in and of itself to influence timely and appropriate use of pediatric health care services. In fact, it appears that perceived barriers, which are highly associated with reported psychosocial stressors, contribute to delayed use of pediatric care.

These preliminary findings reveal a pattern of delayed care for children, use of emergency room services for primary care needs, that is, acute health problems, and respondents who are experiencing serious psychosocial difficulties in their everyday lives. The reported barriers to use of pediatric services show limited accessibility to nonemergency room preventive and primary care services in the Latino community.

CONCLUSION

The sociodemographic characteristics and psychosocial attributes of the Latino immigrant mothers in this study placed this group at high risk of delaying pediatric health care for their children. In fact, these data point to the need to systematically explore the interactive effect of sociodemographic characteristics, perception of seriousness of child's illness, mother's psychosocial status, and perceived barriers to care on Latino immigrant women's use of emergency pediatric health services. Several questions for future research emerged from this study. Is the evidence of overall poor health in Latino children related to this delayed care? What effect does delayed care have on the long-range health status of Latino children? What effect does the mother's mental and physical status have on children's mental and developmental status? What types of psychosocial interventions would be most appropriate for these mothers to decrease the delay in care! These questions can serve to guide future research in this area, research that needs to be formulated within a family context (Combs-Orme, 1990; Ell & Northen, 1990).

Latino mothers, by and large, have been marginal participants in the mainstream pediatric health care system; therefore, they have had little access to biomedical knowledge. For this reason, social workers (and other health care practitioners) can have a significant influence on the health of Latino mothers and children by taking their educational role seriously. Specifically, there are three steps that can be taken: (1) inform (through an interpreter, if necessary) Latino mothers in health care settings about the need for preventive and prompt care, diagnostic tests, and prodromal symptoms of major treatable diseases; (2) initiate and facilitate family support programs (Hutchins & Walch, 1989; Powell, Zambrana, & Silva-Palacios, 1990); and (3) promote community education on acute pediatric illnesses and preventive measures (for example, by providing a list of nonemergency pediatric resources in the residential community of the mother). Social workers practicing in pediatric programs should pay particular attention to the psychosocial needs of poor Latino mothers. A need for methods to routinely screen these women with respect to general psychosocial needs and psychological distress is strongly indicated. A variety of methods including the use of brief questionnaires might be instituted (Orr, James, & Charney, 1989). Efforts on the part of social workers to assist these mothers will not influence environmental conditions that can be addressed only at a social policy level. However, such efforts can reduce the negative subjective experiences of the mothers (Halpern, 1990) and ultimately influence the children's lives and health.

Closely related is the need for social workers to encourage the development of and training in cross-cultural education and awareness within the medical services arena and for an increase in the number of bicultural, bilingual staff among social services providers in urban facilities. In this way, the goal of providing culturally and linguistically sensitive delivery of pediatric health care services to Latinos can be attained. Social workers can also help Latinos by directing them to classes in English as a second language in community-sponsored programs so they can develop new language proficiency skills to improve communication with mainstream pediatric health care providers. Last, health care providers can initiate, support, and encourage legislative proposals to fund and increase the number of community-based health care centers in Latino communities, thus improving accessibility to primary and preventive health care services for this population.

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ABOUT THE AUTHORS

Ruth E. Zambrana, PhD is professor and Enoch chair, College of Nursing and Health Sciences, and director, Center for Child Welfare, George Mason University, 4400 University Drive, Mailbox 2E8, Fairfax, VA 22030-4444. Kathleen Ell, DSW, is professor, School of Social Work, University of Southern California, Los Angeles. Claudia Dorrington, PhD, is lecturer, Department of Sociology and Social Work, Azusa Pacific University, Azusa, CA. Laura Wachsmann, MD, and Dee Hodge, MD, are physicians, Department of Pediatrics, University of Southern California, Los Angeles.

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