A Study of Health Care Practices and Health Beliefs of Puerto Rican Women in Southeastern Pennsylvania

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A STUDY OF HEALTH CARE PRACTICES AND HEALTH BELIEFS OF
PUERTO RICAN WOMEN IN SOUTHEASTERN PENNSYLVANIA

A Dissertation
Submitted to the School of Nursing

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By
Lorraine Martin-Plank

July 2008
HEALTH CARE PRACTICES AND HEALTH BELIEFS
OF PUERTO RICAN WOMEN IN SOUTHEASTERN
PENNSYLVANIA

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ABSTRACT

A STUDY OF HEALTH CARE PRACTICES AND HEALTH BELIEFS OF PUERTO RICAN WOMEN IN SOUTHEASTERN PENNSYLVANIA

By
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August 2008

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The purpose of this focused ethnography was to discover the culturally based health care beliefs and practices of the Puerto Rican population in urban Southeastern Pennsylvania as related by Puerto Rican women. The study also sought to discern the influence of acculturation on the health beliefs and practices of this population. The study used a qualitative methodology to elicit the emic viewpoint of the informants through semi-structured interviews, participant observation, fieldnotes and memos. A quantitative measurement scale was used to measure psychological acculturation; most informants were bicultural although all self-identified Puerto Rico as home. A purposive sampling strategy with snowballing was used to identify 37 informants. Informants provided detailed data on home remedy use. Four themes were abstracted from the data analysis including (a) between two worlds: staying connected to our roots; (b) gardens as
symbols of the motherland: creating the environment; (c) the holistic nature of health; (d) surviving the system: healthcare perspectives in Puerto Rico and Philadelphia. Findings have implications for health professions education and practice in the areas of safe integrative healthcare and health disparities. Policy implications include the need for interdisciplinary education of health professions students in social policy and health disparities and corresponding clinical practice in health disparities areas. Policy implications for third-party health insurers include the need to re-examine current primary care service mandates to reflect client input and needs. Further research is needed in the areas of safety and integrative medicine, health policy and health disparities, creation of healthcare delivery models that are culturally-based and focus on improving health outcomes, and the relationship of acculturation to health beliefs and practices, and ultimately to health outcomes.
DEDICATION

I dedicate this dissertation to my wonderful family whose patience and encouragement has sustained me throughout this effort. To my husband Rick, who has used humor to weather the low times and has cheered me on in the high times; thanks for being you. To our daughter Erin thanks for the hugs, the cuddly stuffed animals, and the pictures. To my brother Frank, whose life in India first sparked my interest in culture, thank you—but please, don’t fall off any more mountains!! To my dear deceased parents who valued education; thanks for planting the seed. To my grandparents, Michael Martin and Mary Cullen, whose cultural journey to America landed them in the same place where my study occurred—I have a new insight into those difficult early days! And to my dear family in Ireland, my life has been enriched by knowing you all; thanks for your prayers and love. Finally, to my dear Aunt Madeleine, my first early childhood teacher—thanks for being with me for part of this journey; I miss you.
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CHAPTER 1

Introduction

In earlier times nurse anthropologists and transcultural nurses traveled to foreign countries and spent months or years studying the lifeways of the inhabitants. However, in the present era, the world is a global community where people from many different cultures and environments coexist in a defined geographic area. While each person is unique, all are influenced in significant ways by their family of origin and their cultural background. This is a dynamic process changing with each succeeding generation (Morse & Richards, 2002).

One important facet of a culture is the ways that it has developed to deal with health and illness. For all cultures, home remedies, other self-care measures, and culturally based folk practices are usually employed as initial attempts to manage health promotion and illness treatment. In highly developed societies, such as the United States (U. S.), 70% to 90% of self-recognized illness episodes are managed outside of the formal health care system (Bushy, 1992; Germain, 1992; Kleinman, 1977). These initial measures taken to care for self reflect the underlying health care beliefs of the culture and are often perpetuated through oral tradition (Harwood, 1971, 1981; O’Connor, 1995; Pachter, 1994; Rubel & Hass, 1996). When these practices are ineffective, professional health care of some type may be sought as complementary to or replacement for the generic or folk measures. However, the underlying health care beliefs persist, and if they
are unknown to the health care professional who treats the patient, they may conflict with
the plan of treatment. This can result in misunderstanding, dissatisfaction, “labeling” as
noncompliant, or adverse outcomes for the patient (Charonko, 1992; Kleinman, 1980).

Studies have demonstrated that most self-care and folk remedies are covert (Adler
& Mukherji, 1995; Baer, Singer, & Susser, 1997; Buckman & Sabbagh, 1995; Bushy,
1992; Clark, 1998; Engebretson, 1993; Gevitz, 1988; Gordon, 1994; Hautman, 1979;
Kleinman, 1980; O’Connor, 1995; Pachter, 1994; Risser & Mazur, 1995; Rubel & Hass,
1996; Wing, 1998). Health care professionals must actively seek out information
regarding these practices in a nonjudgmental manner. This assumes that health care
professionals acknowledge that the medical care system is itself a cultural system, and
that other health systems exist (Cassidy, 1996; Good, 1994; Good & DelVecchio, 1993;
Hahn, 1999; Hufford, 1997; Ledogar, Pencaszadeh, Iglesias Garden, & Garden Acosta,
2000; Maloof, 1991; O’Connor, 1995). The health care professional must endeavor to
understand health from the client perspective in order to provide culturally competent
care and to advocate for patients (Meleis, Isenberg, Koerner, Lacey, & Stern, 1995).

The focus of this ethnographic study is to uncover the culturally based health care
beliefs and health practices of Puerto Ricans, the largest Hispanic subculture in the
Northeastern United States and in Southeastern Pennsylvania (Ramirez & de la Cruz,
2002).

1.1. Need for the Study

Issues of access to care and health disparities for Hispanics continue to be
highlighted by public health authorities. Although progress has been documented since
Healthy People 2000, one of the primary goals of Healthy People 2010 remains the elimination of health disparities (U. S. Department of Health and Human Services, 2000, 2001). One factor often cited as contributing to health disparities is lack of available culturally congruent care (Smedley, Stith, & Nelson, 2002). This deficit in culturally congruent care also impedes the achievement of the other primary goal of Healthy People 2010, to increase quality of life and years of healthy life. Knowledge of culturally based health beliefs and practices is a prerequisite for delivery of culturally congruent care.

Two recently published studies highlight the need for training in cultural competency and the positive effect of this training on health care provider attitudes. Coffman, Shellman and Bernal (2004) reviewed several studies of U.S. nurses that used the Cultural Self-Efficacy Scale and found that subjects lacked confidence in their abilities to care for ethnically diverse clients. Majumdar, Browne, Roberts and Carpio (2004) discovered that Canadian health care providers who completed a cultural sensitivity training program reported better communication with minority clients, expanded knowledge and open-mindedness. This researcher’s current study will uncover new information about cultural health beliefs and practices which can be disseminated to the healthcare community and incorporated into cultural competency training programs.

The Puerto Rican population is the third largest Hispanic subgroup in the U S, and the major Hispanic subgroup in the Northeastern states (Ramirez & de la Cruz, 2002). Puerto Ricans are the dominant Hispanic subgroup in Philadelphia (United States Census Bureau, American Factfinder QT-PL Race, Hispanic or Latino, and Age, 2000). Puerto Ricans are unique from other Hispanic groups because they have United States citizenship as a result of territorial annexation. The ethnohistory of Puerto Rico reveals
that most Puerto Ricans did not desire annexation to the United States (Jimenez de Wagenheim, 1993, 1998; Maldonado-Denis, 1972; Morales Carrion, 1983; Suarez, 1987; Trias Monge, 1997); this in itself can create a cultural conflict, resulting in indecisiveness in seeking health care from non-Puerto Rican providers.

There is an abundance of information pertaining to the historical diaspora of Puerto Ricans to the U. S. mainland but information on health practices is limited and dated (Harwood, 1971, 1981; Pachter, 1994; Pachter, Bernstein & Osorio, 1992; Pachter, Cloutier, & Bernstein, 1995; Pachter, Sumner, Fontan, Sneed & Bernstein, 1998). Both anthropological and nursing sources have addressed the regionalization of cultural health beliefs and practices (Hufford, 1997; Meleis, 1997; O’ Connor, 1995; Rubel & Hass, 1996). Meleis speaks to the need for “situation specific theories” driven by clinical practice and the use of “integrative methodologies to reflect the holistic nature of patients' responses and their embeddedness in their environments” (Meleis, 1997, p.225).

This study will seek to discover new knowledge regarding the health care beliefs and practices of the Puerto Rican population in this urban community to improve the quality of patient care.

1.2 Purpose of the Study

The purpose of this naturalistic, ethnographic study is to discover the culturally based health care beliefs and practices of the Puerto Rican population in urban southeastern Pennsylvania as related by Puerto Rican women. The findings will be made available to nursing, medical, and allied health professionals working with this population to improve patient care.
Women have been chosen as the focus of this study because prior studies with Hispanic cultures have identified women as family health caregivers and gatekeepers as well as culture-bearers (Canabal, 1997; Davis, 1994, 1996; Juarbe, 1995; Stevens, 1994; Zapata & Shippee-Rice, 1999). Additionally, many of the families in this community are single-parent households, headed by women. While the researcher uncovered several intergenerational studies of Hispanic women (Benmayor, Juarbe, Alvarez, & Vazquez, 1987; Benmayor, Torruellas, & Juarbe, 1992), only two were concerned with health beliefs, and the samples for these studies were drawn from Mexicans, not Puerto Ricans (Garcia-Mass, 1999). Much of the literature on Hispanic health issues fails to identify subpopulations or focuses on Mexican Hispanics and generalizes to all Hispanic groups. Anthropologists and transcultural nursing researchers have cautioned against such stereotyping (Schnur et al, 1987; Leininger, 1970, 1991, 1995; Caudle, 1993; Porter & Villarruel, 1993; Zapata & Shippee-Rice, 1999). More recent government sponsored studies have required specific cultural information relating to country of origin.

1.3 Research Questions

The research questions for this study are: What are the health beliefs and cultural health care practices utilized by Puerto Rican women in caring for self and family members? What are the implications of these health beliefs and practices for health professionals who work with this population? Is acculturation a factor influencing the health beliefs and cultural health practices of Puerto Rican women in the Southeastern Pennsylvania area?
The problem derives from the assumption of supremacy of the dominant Western biomedical model of care, a model that is itself culturally based, yet fails to acknowledge its cultural bias or the credibility of other cultural systems (DeSantis, 1994, 1999; Good, 1994; Good & DelVecchio, 1993; Hahn, 1995; Kleinman, 1980, 1995; Romanucci-Ross, Moerman & Tancredi 1997; Weidman, 1979). In this model, the patient is viewed as a passive recipient of the health care provider’s expert knowledge and treatment (Christopher & Eisen, 2006; Wade & Halligan, 2004). When the outcome is not as predicted or the patient fails to follow the treatment plan of the provider, the patient is labeled as “noncompliant” or “unmotivated”. This model treats health and illness as primarily physical entities and fails to recognize the social, cultural, economic, and spiritual milieu in which health and illness occur. Anthropologists, social scientists, transcultural nurses, and some physicians have consistently identified the patient as the active broker of his/her own care within a network of lay or generic care providers and health care professionals (Bushy, 1992; Germain, 1992; Chrisman & Maretzki, 1982; Engebretson, 1994; Gevitz, 1988; Gordon, 1994; Guarnaccia, 1993; Hufford, 1988, 1997; Kleinman, 1980, 1995; Leininger, 1970, 1991, 1995; Lindenberg, Solorzano, Vilaro, & Westbrook, 2001; Micozzi, 1996; O’Connor, 1995; Singer & Garcia, 1991; Zapata & Shippee-Rice, 1999). Some philosophers have extended this further to postulate a cultural philosophy underlying the actions of members of a culture (Northrop & Livingston, 1964).

More recently, official government sources have recognized the need to understand and consider culture as a factor in health care delivery and eliminating health disparities (Meleis, 1999; Smedley, et al, 2002; U.S. Department of Health and Human
Services, Office of Minority Health, 2001). Specific information on the health beliefs and practices of the Puerto Rican population in the urban community of Philadelphia must be discovered. This information can then be disseminated to professional health care providers in the Philadelphia area as an initial step in achieving cultural competency.

1.4 Significance for Nursing

Nursing continuously strives to provide holistic care, that is, care of the whole person. Knowledge of culture, lifeways, and health beliefs and practices related to culture is an essential part of holistic care. The findings of this study will enhance understanding for nurses providing care to Puerto Rican clients in the community. Nursing diagnosis advocates and nurse practice acts have stated that nursing treats human responses to health and illness (Benner, 2004). Use of self-care remedies and culturally based health practices is part of the spectrum of human responses.

Nurse practitioners’ practice incorporates elements of both medical and nursing models. This study will raise the awareness of nurse practitioners to the ethnocentrism of medicine as the predominant cultural health system in the U.S.; it will encourage them to seek a balanced view by tempering the medical model with the holistic approach of nursing. Meleis (1996, 1999) and other nursing theorists have emphasized the role of understanding concepts such as marginalization and vulnerability, culture-specific phenomena, power differentials, communication styles, and contextuality in the evolution of cultural competency.
Many studies have been conducted using the umbrella terms ‘Hispanic/Latino’ but are in fact primarily Mexican or a conglomeration of subgroups for statistical purposes. Schnur et al (1987), Leininger (1970, 1991, 1995), Porter and Villarruel (1993) strongly caution against assuming homogeneity in Hispanic or African American sample grouping. The findings from this study will enable nurses and other health professionals working with this Puerto Rican population to provide care that is culturally appropriate and meaningful.

1.5 Definition of Terms

The following terms have been defined for the purpose of this study:

1. *Health care beliefs* refer to the culturally derived beliefs about health and illness as obtained from informant interview data, participant observation, field notes, data collection and analysis, and systematic observation.

2. *Health care practices* refer to the culturally based actions taken to preserve health or treat illness as assessed from informant self-reports on interview, participant observation, field notes, data collection and analysis, and systematic observation.

3. *Puerto Rican woman* refers to any woman between 18 years and 80 years old and living in Southeastern Pennsylvania who self-identifies as Puerto Rican.

1.6 Assumptions

The following assumptions are recognized for the purpose of this study:
1. The Puerto Rican community has a loosely organized, ethnomedical system which is holistic in nature and encompasses spiritual, emotional, and physical healing modalities. This system is dynamic, varies regionally and is not apparent to outsiders.

2. Participants will respond truthfully to the interview questions.

3. One’s culture influences life experiences, behaviors, and health beliefs and practices.

4. The predominant biomedical model of health care in the United States is culturally derived and hegemonic.

5. Health care that is based upon a culturally congruent model will be more acceptable to clients in that culture.

6. Ethnography is always informed by the concept of culture. Ethnomedicine is known to be loosely organized and to vary regionally (Rubel & Haas, 1996).

1.7 Limitations

The use of English speaking informants may exclude less acculturated participants who may retain more of the Puerto Rican cultural practices.

The focus of this study is limited to Puerto Rican women living in Southeastern Pennsylvania. The findings from this study can be used by health care professionals caring for Puerto Rican clients and their families in this community and its health care institutions, to incorporate culturally appropriate measures into their health care planning and implementation. While findings from this study cannot be generalized to other individuals or groups within the Puerto Rican culture, the study may stimulate health care providers in other communities to undertake research projects that will further the cause of culturally competent care.
1.8 Summary

The population of the United States is growing more culturally diverse, with Puerto Ricans as the predominant Hispanic group in Southeastern Pennsylvania. Studies of Puerto Ricans in Southeastern Pennsylvania have focused primarily on patterns of migration. In depth study of this cultural group is crucial to uncover culturally based health care beliefs and practices which influence their health and well being. The knowledge gained from this study will guide health care providers in the planning and implementation of culturally congruent care for members of the Puerto Rican culture.
Chapter 2

REVIEW OF THE LITERATURE

In Chapter II the researcher will provide a literature review relevant to the proposed research areas. The literature review will address the ethnohistory and culture of Puerto Rico, the Philadelphia Puerto Rican community, Puerto Rican women, Puerto Rican ethnomedical health practices and beliefs, acculturation, and research gaps.

2.1 Ethnohistory and Culture of Puerto Rico

The history and culture of Puerto Rico are complex and multifaceted. Several diverse ethnic groups who were early native inhabitants, such as Taíno Indians, Spanish conquistadors, Africans imported as slaves, and to a lesser extent refugees from neighboring islands and South America, have influenced the culture of Puerto Rico in its early stages. Political events continue to play a paramount role in shaping the history and culture of the island and its inhabitants. Economic factors have contributed to patterns of migration, creating a subculture of the diaspora, or Puerto Ricans living in mainland United States. Religion, particularly the Catholic religion, has had a significant effect upon the Puerto Rican people. Geographic location has been a strategic factor in Puerto Rico’s history. It was initially colonized by Spain as part of its Caribbean empire, but was also sought by the French and Dutch powers. These countries saw the advantage of
its close proximity to North and South America for trade. While the historical recording of factual information is clear and straightforward, the various explanations proffered by interested writers are divergent, and sometimes contradictory.

In the Beginning

At the time of Christopher Columbus’s discovery of Boriquén, the Land of the Noble Lord, an indigenous people known as the Taíno Indians inhabited it. Most sources (Alegria, 1969; Babín, 1971; Encarta, 1997; Jiménez de Wagenheim, 1998; Morales Carrión, 1983) identify them as descendants of the Arawak culture of South America. They lived in villages called yucayeques, each of which was headed by a chieftain called a cacique, or if female, cacica. The villagers lived in huts of wood and straw, called bohios, while the cacique had a more elaborate, rectangular dwelling. The class structure was composed of nitainos, related to caciques, and naborias, a lower class, working group. The village was organized around a central court or field called a batey, used for recreation and ceremonial purposes. Areytos, or ceremonial dances, which conveyed the Taíno historical and cultural practices to succeeding generations, were held in the bateyes. Maracas, güiros (gourds), and drums constructed from hollow tree trunks were used for musical accompaniment (Jiménez de Wagenheim, 1998).

The Taínos were hunter-gatherers, existing on fish, iguanas, guinea pigs, and agricultural crops. Yucca, yams, corn, tobacco, cotton, sweet potatoes, and peanuts were planted. The yucca was poisonous and had a dual purpose; the poisonous material was extracted and used on arrowheads for repelling predators, while non-poisonous material was ground down and used to make casabe, an unleavened bread. Native grown plants such as papaya, pineapple, guava, guanábanas, and tamarind rounded out the Taíno diet.
They also were weavers, making hammocks for sleeping. Several historians (Alegria, 1974; Babín, 1971; Dávila, 1999; Jiménez de Wagenheim, 1998; Samoiloff, 1984) describe the distinctive features of the Taínos, including short stature with a broad forehead which sloped backwards, presumably from binding infants’ heads at birth to achieve this desired appearance, shovel shaped front teeth, copper colored skin, and upward slanting eyes. While most authors relate the roots of the Taíno to South and Central America, Samoiloff (1984) traces their earlier origin to an Asian migration over a previously existing land mass where the Bering Strait is now located. The discovery of Tibes, an archeological site near Ponce, has yielded more information and artifacts about the Pre-Taíno culture and its predecessor, the Igneri (Babín, 1971; Centro Ceremonial Indígena de Tibes, 2002).

Although the Taínos were described as peaceful, there is evidence that a neighboring, cannibalistic tribe called the Carib were attacking them, when Columbus arrived in 1493. The caciques had united into a confederation for protection. They initially welcomed the Spaniards, but when the latter’s plan of subjugation became clear, the Indians banded together in futile attempts to defeat them. Many Taínos were killed and the survivors were forced to work in the mines and as servants to the conquering Spaniards. They were deemed incapable of caring for themselves by the conquistadors, who devised a system of encomiendas, whereby a designated number of Taínos, under a cacique, were assigned to a colonizer, essentially as slaves. The Spanish overseers were charged with indoctrinating the Indians in Catholicism and saving their souls (Alegria, 1974). This encomiendas system established the power structure and dependency mentality that would be perpetuated in subsequent colonialism.
The Taínos worshipped several gods, according the highest honor to a female deity, Atabey or Guanabanex, to whom they attributed much power. They carved stone talismans called “cemies” to remind them of their deities. Women and men were equals in the Taíno society, and the cacique line of succession was matrilineal. Because of their presumed association with the fertility goddess, women were charged with planting and harvesting the crops. The Taínos believed in an afterlife, and also believed that the spirits of the dead returned in the form of spiritual guides, or nighttime agents of terror. Each unit had a behique, or medicine man, whose function was to cure the sick, heal the wounded and meet the expectations of the tribe (Jiménez de Wagenheim, 1998). Because of the scarcity of women for the Spaniards, concubinage or intermarriage occurred. The island was sparsely populated and reproduction was essential for labor; this is another theme that is perpetuated throughout the period of Spanish rule. In 1514, the King of Spain gave official permission for the colonizers to marry the Indians (Alegria, 1974). Dominican friars, especially Padre Bartolomé de Las Cases had been dispatched to convert the Indians and minister to the religious needs of the settlers. The friars advocated for compassionate treatment of the Indians, opposing Juan Ponce de Leon, Diego Columbus and the other colonizers. Eventually the Spanish monarch intervened, but by that time the number of Indians had declined significantly. Interestingly, it was the friars who recommended the importation of African slaves for labor, giving rise to the third root of Puerto Rican culture.

Taíno as Symbolic Identity

The Taínos were not tracked after the census of 1778, the last in which Indios were identified as a distinct group (Dávila, 1999), leading to several assumptions
including extinction, inaccurate statistical recording, or assimilation into the Puerto Rican culture. There was an official revival of interest on the island when artifacts, and later an archeological site, were uncovered. Some authors (Dávila, 1997) feel that this reorientation was a deliberate political strategy in the early years of American colonialism to encourage nationalism and loyalty to Hispanic ideals, and later, to support the pro-Commonwealth party by illustrating the blending of three cultures into Puerto Rican. Most recently the Taíno heritage has come full circle and been reclaimed by mainland Puerto Ricans (Nuyoricans) seeking continuity and connectedness with their island roots. This is the subject of great controversy among Hispanic scholars and others. Dávila, Duany, and others (in Haslip-Viera, 1999) all see the revival of the Taíno identity as a mechanism for ignoring or minimizing racial issues among White and Black mainland Puerto Ricans, and to a lesser extent, on the island. Haslip-Viera (1999) compares the new Taínos with other extremist groups, stating, “. . . all of these movements are competing for the attention of alienated young Puerto Ricans and other Latinos in the Caribbean, and especially in the mainland communities of the United States” (p.6). The opposing viewpoint by Mucaro-Borrero of the United Confederation of Taíno Peoples addresses the heritage of Taínos as holistic, indigenous people living in harmony with nature and the environment.

*Spain as Ruler*

Babin (1971) reports that when the Spanish landed, they named the island San Juan Bautista, and the current city of San Juan was called Porto Rico, or rich port, because of the discovery of gold. The early years of colonization by Spain were fraught with problems. Internal struggles for power between the descendants of Columbus and
Juan Ponce de Leon persisted. Following the defeat of the Taínos, the aggressive Carib Indians attacked, wiping out isolated settlements of Spaniards. The remaining Taíno Indians had been declared “free” in 1542, but some joined with the Carib and continued their efforts to eliminate the Spaniards. Others intermingled; in 1530, fourteen of the seventy-one marriages recorded were between Indian women and Spaniards.

Once the gold supply had been exhausted, other sources of revenue for the motherland had to be found. The rumors of wealth in Peru and Mexico caused some of the settlers to emigrate. In an effort to maintain sovereignty, the monarchy offered land grants to colonizers and some money for the cultivation of sugar plantations. The African slave trade was underway in 1509, prior to the Taino uprising, and more slaves were imported to work on the sugar plantations (Babin, 1971). Spain was well aware of the strategic location of Puerto Rico to its empire building, and did not abandon it despite the economic liability that it posed.

The Catholic Church was a strong influence in religious and social welfare. Dominicans, Franciscans, and Carmelites came to the colonies. They established churches, monasteries, and facilities for basic education, and the first hospital was built in 1524 (Babin, 1971). With the Pope’s blessing, Spain became a leading European power. France and England were disgruntled and formed an alliance to undermine Spain’s domination in the Caribbean.

Initially, Puerto Rico was ill prepared to defend itself from French attacks. The forces of nature also dealt a blow to the island in 1530 when a series of hurricanes occurred. Eventually, El Morro, a fortress at the mouth of San Juan was built, but the rest of the island was unprotected and subject to frequent attacks. Because of its dependence on imports and the infrequent voyages of Spanish supply ships, smuggling was common. Soldiers frequently deserted because of poor
living conditions and lack of pay. The *situado*, an annual payment from Spain to support the Spanish-run government and pay the soldiers, was frequently late or absent.

Both English and Dutch war parties briefly succeeded in taking San Juan; the former were decimated by illness and the latter were successfully repelled, even though they burned the city. Following these episodes, fortifications were increased and a wall enclosed the city of San Juan. There were no additional paid soldiers but residents formed a local militia, volunteering their services in time of need.

In the early 1600s, tobacco cultivation was begun. Piracy and smuggling continued, but actually benefited the settlers by making available needed supplies; in some cases bartering was done. Sugar mills lost business to a monopoly in Spain and to better labor conditions in South America. The islanders returned to farming. Bananas, cocoa, grains, vegetables, tropical fruits, medicinal plants and flowers, and high quality wood were raised. They had accumulated an abundance of livestock imported from Spain, and traded hides and such. Ginger was introduced and initially there was a great demand for the product, but Spanish prohibitions and a supply from Brazil resulted in a decrease in sales.

The Spanish government maintained a tight control over the island to the extent that it was able. However, lack of manpower and piracy prevented regular commerce between the designated port of Seville and the Caribbean. In the 17th and early 18th century privateering and smuggling flourished. An appointed governor with absolute authority and local municipal councils called the Cabildo represented the Crown. The officials were usually chosen from the wealthy hacendados and ganaderos (plantation owners and cattle breeders), and there was much nepotism, thus keeping power within the elite (Morales Carrión, 1983). In violation of the law, the Cabildo made land grants,
usually to a select few. The Cabildo was also responsible for public health and safety, including repair of bridges and roads, control of communicable diseases, maintaining a safe water supply, and inspecting ships transporting slaves.

**Social Stratification and Racial Issues**

Several authors have addressed the social stratification that took place in Puerto Rico during this time. The structure was described as a pyramid with the Spaniards or peninsulares at the top. The next layer consisted of foreign-born immigrants, frequently having “connections” with the wealthy prior to immigrating. The Criollos, or Puerto Rican born population, be they “white” or racially mixed, were the next layer. Below them were the freed people, and at the bottom, the slaves. In 1664 Puerto Rico agreed to accept slaves fleeing from ill treatment in other lands as freed persons (Babín, 1971), while still maintaining their own slaves.

Opinion is sharply divided on the treatment of these slaves, and also on the question of racial prejudice. Babín (1971) refers to Díaz Soler’s study of slavery in Puerto Rico in which he details the significant contribution of Black slaves to Puerto Rican culture, including music, dancing, spiritual feelings and customs of Africa. She states, “The documents [from Díaz Soler] reveal a fairly open situation and explain in great part the absence of true racial prejudice in our land” (p.46). The example of Eugenio María de Hostos’ affectionate description of his Negro house servants and nursemaid as “members of the family” is given as typical. Another illustration from Babin is that of essayist Tomás Blanco who calls the free Negresses and mulatto women of the island “intellectual mothers of a whole generation”, (p. 47) and also lauds the contribution of the Negro cigar-maker, Don Rafael Cordero, who established a free school for poor children.
This contrasts sharply with the commentary of Iñigo Abbad y Lasierra, a Spanish cleric and historian, exiled from Puerto Rico for open criticism of the government in the late 1700s. He felt that Blacks suffered ill treatment by all (De Cordóva, 1988; Maldonado-Denis, 1972).

Mintz (1989) offers yet another perspective on the slavery issue in Puerto Rico. He acknowledges that it shares some aspects in common with other Caribbean nations where African and Creole slaves and freeborn “white” Creoles worked side by side. In all of these cases, ethnic or “racial” difference was the differentiating element in establishing status, and those who were not slaves worked in a complementary fashion with the slaves. However, in Puerto Rico unlike the other colonies, free white colonists who were not landowners were required to perform the “most onerous and debased labor” (Mintz, 1989, p.83). Mintz is referring to the Libreta system whereby any person not owning land was required to work for landowners and carry a journal in which this work was detailed. Another practice which leads this researcher to question the “benign” nature of this slavery, was that of the carimbo, branding slaves on the side of the face, suppressed in 1784 (Babin, 1971).

Kinsbruner (1996) speaks of the subtle nature of racial prejudice in 19th century Puerto Rico and the ignorance of dark-skinned islanders to their African roots. He identifies degrees of “whiteness” from blanco for whites, pardo for the lightest skin shade, usually the free people of color, moreno for those with darker skin, and negro, for the darkest skin color. He comments on “shade” discrimination, leaning towards shades of whiteness. His examples are cases brought before the Regidores of the Cabildo after 1778, when racially mixed marriages were discouraged. Typically these cases involved a proposed marriage of underage partners for which parental permission must be obtained.
The issue of lineage and “limpieza de sangre” are raised; the justice system usually ruled against marriage if there was a question of racial mix. The 1815 Cédula de Gracias, which was given by the Spanish crown to reward immigrants to Puerto Rico, gave land grants to both white and free people of color and their slaves. However the white colonizers received twice the amount of land for their slaves than the people of color. Finally, in 1848, Governor Prim, mindful of the riotous activities of ex-slaves recently freed in other Caribbean colonies, instituted harsh punishment, even death, for all people of the African race in Puerto Rico who became involved in verbal or physical confrontation with a white person, even if the person of color was justified. This flagrant racial discrimination was short-lived but noteworthy, ceasing with the subsequent governor. Conversely, free people of color had access to the local court and the town council, and could purchase land. With the abolition of slavery late in the 19th century all people of color were more accepted. The discrimination became more cultural than racial per se. Kinsbruner (1996) notes that this lenient attitude contrasted sharply with the overt racial prejudice in the United States, and Puerto Rican immigrants to the mainland were ill prepared to deal with this.

Politically, the 17th and 18th century was a time of empire building and seizure with France, England, and Spain as the principals. As France became preoccupied with the Revolution, it was less of a threat. England made its final attempt to seize Puerto Rico in 1797 but this was thwarted by the Criollos with the aid of French privateers. The King of Spain rewarded the Criollos for their bravery with a special seal of commendation and appointed the first native-born bishop, Juan Alejo Arizmendi, to Puerto Rico. Arizmendi and statesman Ramon Power advocated for more participation in
the government for Puerto Rico. The development of Puerto Rican consciousness and nationalism had begun.

During the 1700s, many cities were founded in Puerto Rico, including the town of San Mateo de Cangrejos, specifically for Blacks fleeing from other islands. According to Morales Carrión (1983), by 1800 there were thirty-nine urban centers. The introduction of the coffee crop encouraged movement from the coast into the mountainous interior. The population almost tripled between 1765 and 1795. French Caribbean refugees, European immigrants, and slaves accounted for this in part. José Campeche, a noteworthy artist and musician was born. The division between the wealthy and the poor grew.

Cultural Musings: 19th Century

The 1800s saw increasing political activity and the rise of several noteworthy Puerto Rican writers, poets, statesmen and humanitarians, including the following: Alejandro Tapia y Rivera, Ramon Betances, Eugenio María de Hostos, Román Baldorioty de Castro, Julio Vizcarrondo, Agustín Stahl, Luis Muñoz Rivera, José de Diego, José Celso Barbosa, Lola Rodríguez de Tió, Manuel Alonzo, Pedro Albizu Campos, Manuel Zeno Gandía, Salvador Brau, Rosendo Cintrón, Antonio Pedreira, and Luis Muñoz Marin (Samoiloff, 1984). Historians and writers (Babin, 1971; de Córdova, 1988; Jiménez de Wagenheim, 1998; Maldonado-Denis, 1972; Morales Carrión, 1983; Samoiloff, 1984) concur that the 19th century was a pivotal point in the establishment of Puertoriqueñismo and a separate identity from Spain.
Puertoriqueñismo: A Separate Identity

Samoiloff (1984) traces the beginnings of Puertoriqueñismo to the publication of El Gíbaro, a series of sketches about peasant life, written by Dr. Manuel Alonzo. While the origin of the word gíbaro, later jíbaro, is still in debate, the significance of the term to Puerto Rican culture is unquestionable. The jíbaro was the uneducated peasant who lived in the rural interior forest and mountain areas of early Puerto Rico. At that time, each town was dominated by the Catholic Church and had a patron saint, whose feast day was celebrated. The jíbaro, although uneducated and poor, was loyal to his faith and his country. He tended the farm animals, planted the fields, and used herbs to manufacture home remedies for self, family, and neighbors. He was known as an honorable man, hard-working, but enjoying celebrations and music. (Retrieved June 2, 2008 from http://www.elboricua.com/jibaro.html). Babin (1971) offers an eloquent testimony on the role of the jíbaro, stating that the essence of Puerto Rican nationality is concentrated in the person of the jíbaro. It does not refer merely to a white man from the rural area, but is ripe with moral and spiritual characteristics, representing the purest and most intimate form of Puerto Ricaness. The jíbaro is the Spanish link; the boricua is the Taíno link. Together they are the foundation of Puerto Rican cultural and ideological history, and the core of criollismo.

Guerra (1998) relates how the jíbaro symbol was used by Muñoz Marin for political purposes, and how mainland Puerto Ricans in New York continue to use its symbolism to connect with their roots. The jíbaro, like the Taíno, has become a symbol of national identity.
In the latter half of the 19th century there was a marked emphasis on increasing educational access, and the number of schools on the island quadrupled between 1860 and 1890 (Samoiloff (1984). In the cities, paseos, or walkways were built and theaters were opened. Newspapers were introduced earlier in the century. The Ateneo Puertorriqueño, an intellectual and cultural institution was established in San Juan. Romanticism, poetry, and historical writings predominated in the literature, but patriotism was also involved. Tertulias or discussion groups were held by the intellectual elite; a concert might be offered, or a stimulating discussion on a social issue. The barbershop or drugstore was also a place for social discussion among men living in the city. In the country, cockfights or gatherings at ventorillos, small bars selling alcoholic beverages, were common. Rural women met at the river or water wells to exchange information on childrearing and health remedies. Music and dancing have always played a major role in the culture of Puerto Rico, and the 19th century was no exception. The first symphony concert was given in 1803. Artists of note included Francis Oller, whose paintings depicted social issues of the time. Goldsmiths and silversmiths also plied their trade, although this was in decline by the middle of the century. Women were skilled at needlepoint and lacemaking, with specific geographic areas being identified by certain patterns. The carving of wooden “santos” representing spiritual figures by jíbaros was common.

**Political Issues and Events**

The Napoleonic invasion of Spain in 1808, subsequently split the government into two camps, backed by France and Britain respectively (Morales Carrión, 1983). A ruling Junta was established and declared the equality of the Spanish colonies, and their right to
representation in the Spanish government (Morales Carrión, 1983). Ramón Power, a Spanish educated military officer from a San Juan Criollo family, was chosen to represent Puerto Rico. He consulted with all of the significant Criollos prior to leaving, including Bishop Juan de Arizmendi. He left for Spain with a list of petitions on how to improve relations and conditions between Spain and Puerto Rico (Jiménez de Wagenheim, 1998). Power’s election created more of a division between the Spanish born peninsulares, and the native born Criollos, building the foundation of what was later to become political parties. The Spanish born natives and a few conservative Criollos favored the status quo. This would maintain their political control and economic superiority. The bulk of the Criollos and professionals, as well as the middle and lower class laborers, favored elections and concentration of power within the colony. Another, smaller group was convinced that only total separation from Spain would suffice. (Jiménez de Wagenheim, 1998; Maldonado-Denis, 1972; Morales Carrión, 1983).

In 1812 the Spanish Constitution was drafted, giving some power to colonies for self-rule (Jiménez de Wagenheim, 1998). Reforms in finances, agriculture, land management and industry were instituted and the trade policy with other countries was eventually liberalized. However, the period between 1812 and 1836 was filled with turmoil and frequent power shifts in Spain. Also, Bolivar was active in freeing Venezuela from Spanish rule. The king rewarded Puerto Rico for its loyalty by asking for input from its citizens about reforms. Immigration was opened to any Catholic people from friendly nations who would swear allegiance to Spain. Venezuelan loyalists, French, and others responded, giving the island a broader cultural base and altering the political dynamics in favor of the conservative Spanish born peninsulares; the Criollos
had no role in government. Land reforms were not successful, leading to monopolistic acquisition by the wealthy and the development of large haciendas. The lives of the poor were changed little by these reforms. As technology developed, commercial agriculture replaced subsistence farming. Concurrently, the philosophy towards slavery changed significantly in Europe and the other Caribbean countries, leading to a labor crisis. African slaves were no longer imported, and the French slaves or freemen from local sources were insufficient. The government responded by instituting a passbook system, Libreta, whereby all non-landowners over age 16 years must work for landowners and have their hours and location documented (Jiménez de Wagenheim, 1998; Morales Carrión, 1983).

The fear of slave revolts modeled after those in other Caribbean colonies, caused the governor of Puerto Rico to impose curfews and restrictions. He also developed a spy network to keep abreast of incipient problems. Imprisonment, execution, and exile were the methods used to deal with suspected revolutionaries. He did institute humanitarian reforms, limiting working hours and improving conditions for slaves, but there was no monitoring or enforcement. Conversely, he ordered them locked up at night and limited their contact with other slaves to prevent a conspiracy (Jiménez de Wagenheim, 1998).

In 1837 the Spanish government again reorganized, and Puerto Rico, with Cuba and the Philippines, had no representation. In the mid to late 1800s there were many abuses to keep the slaves and free men indentured to the estate. Landowners advanced money to workers, creating a circular pattern whereby the worker could never be free of owing and was always attached to the estate. Estate owners started their own stores, charging prices far above what workers could afford. Food was a precious commodity to
the workers who could not afford adequate protein sources, resulting in anemia. Tuberculosis and hookworm were spread by the crowded and unsanitary living conditions. Epidemics claimed the lives of many slaves and jornaleros; the cholera epidemic of 1855 was responsible for 30,000 deaths, most of them slaves and laborers.

Many of the Criollo politicians emerging at this time were educated abroad and were physicians, including Betances, Barbosa, and Zeno Gandia. They had a deep love for their country and a desire to see it have more autonomy. All initially worked within the system, hoping with each change in power and each promise of participation that things would change. Maldonado-Denis (1972) believes that Betances and Ruiz Belvis became disillusioned after many empty promises and turned revolutionary. On September 23, 1868, El Grito de Lares, an uprising planned by Betances and other advocates for independence, took place. The government, which had advance notice from informers, promptly quashed it. Betances and his reinforcements were detained at Santo Domingo and never arrived at Lares. He later fled to France and remained there until his death, still advocating freedom for Puerto Rico. Most of the participants in the revolt were ultimately pardoned and released in 1869; eighty died in jail in a yellow fever epidemic. While the revolt was a failure, it established a precedent for later independence seekers.

**Establishment of Political Parties**

In the year following the Lares revolt, Spain offered many concessions and reforms to Puerto Rico, including the ability to organize into political parties. Two parties were established. The Conservative Party represented the Spanish-born
peninsulares, while the Liberal Reform Party represented the Criollos (Jiménez de Wagenheim, 1998).

Political instability in Spain continued. Much was dependent upon the appointed governor, resulting in a seesaw effect in Puerto Rico. Internally, the political parties were involved in a power struggle. The Conservative Party gained much support from Spain and opposed any representation in Spain by the Liberals, who wanted an autonomous government. Slavery was abolished in 1873, with a gradual phase-out and financial incentives to landowners; the Libreta was discontinued. The Liberal Reform Party was dissolved due to irresolvable differences among members surrounding the question of autonomy (Jiménez de Wagenheim, 1998).

Cuba was again at war with Spain, and many liberals advocated affiliations with the Cuban autonomy movement. After much internal strife, the liberals reorganized. Those not in agreement left the country to side with the Cuban Autonomist Party, some working out of New York (Jiménez de Wagenheim, 1998). The conservatives mounted a counteroffensive and reorganized. Both parties used all means available to gain the upper hand, including boycotting businesses and committing acts of violence. Episodic violence continued. The party split over the issue of alignment with a Spanish political party. Muñoz Rivera was elected on a platform aligned with the Liberal Fusionist Party in Spain. He was to go to Spain and negotiate with this party for autonomy, hence the new name of his party, The Liberal Fusionist Party. He went to Spain and, aided by the continuing turmoil in Cuba, and escalating tensions in Spain, negotiated “autonomy” for the island. However, before this could be implemented, Spain was at war and the United States invaded Puerto Rico, beginning the period of American colonialism.
Dashed Expectations: Under U. S. Rule

Jiménez de Wagenheim (1998) offers insight into the history of U.S. interest in Puerto Rico, dating back to Thomas Jefferson. As President, he predicted that the Greater Antilles would someday be part of the United States. The Monroe Doctrine, destined to warn France and Spain against further conquests in the Caribbean, followed this in 1823. In the 1850s, the U.S. sought to establish a coal fueling station for its ships in the waters near Santo Domingo and later to purchase Cuba from Spain. The Civil War diverted attention from this project temporarily, but in the ensuing period, the U.S. sought to industrialize and connect East and West Coasts through a network of railroads. It also became a strong financial power, and developed an interest in “empire building”, or expansionism. Cuba was well on its way to independence, so annexation of this island was unlikely. Meanwhile, in New York, Puerto Rican and Cuban independence seekers had joined forces under the heading of Cuban Revolutionary Party (CRP)-Puerto Rican Section (PRS). From France, Betances pledged his support and he was appointed Delegate General of the CRP. Some of the Puerto Rican group withdrew, leaving Dr. José Julio Henna as head of the PRS. The two sections met in Manhattan and designed the Puerto Rican and Cuban flags, respectively. There was talk of a separate revolutionary effort to free Puerto Rico from Spanish control, but the liberals in Puerto Rico, under Muñoz Rivera preferred to negotiate with Spain directly for autonomy. The more pro-independent New York faction then joined with Cuba for the revolution, while Henna and the PRS secretary, Roberto Todd sought the help of U.S. in breaking free from Spain. They met with Henry Cabot Lodge, then Secretary for Foreign Affairs, who pledged his assistance. He asked them for detailed information on the military readiness
of the island, and they complied. Jiménez de Wagenheim (1998) makes the point that the U.S. government already had all of this information since consuls stationed on the island of Puerto Rico had been compiling it since 1815, but to many, it seems as if Henna and Todd were “playing into the U. S. hands” (Jiménez de Wagenheim, 1998). Apparently Betances wrote to them in July 1898, cautioning against full trust and cooperation with the U. S. His fears were realized when the U. S. invaded Puerto Rico.

Historical records show that in some parts of Puerto Rico, native “scouts” led the way for the U. S. invaders, presumably related to political factions and dissatisfactions, also possibly in anticipation of material and political gains. In any case, the period immediately following was marked by looting and rioting by groups known as “partidas”. The targets were usually wealthy Spanish or Criollo hacendados and historians surmise that this was a mechanism for “settling old scores” and eliminating records of debts, since these were burned in the effort.

New Era of Colonialism

With the takeover of Puerto Rico by the United States, a new era of colonialism began. A succession of U.S. administrators alternately supported some of Puerto Rico’s self-rule efforts, and then thwarted them with a paternalistic approach. All felt that Puerto Rico had to “prove” itself capable of self-government through a period of “tutelage” or mentorship. Their goal was to “Americanize” the island. English was to be the official language taught in schools and American teachers were imported to teach. The Foraker Act of 1900 provided for a civilian government, with a governor and Executive Council appointed by the U. S. President, and the lower chamber, the House of Delegates, elected by the people. Both Henna, who had asked for U. S. intervention, and
Muñoz Rivera, protested the implications of this act, stating that it left them with less than they had under Spanish rule. Prominent patriots such as de Hostos, and Betances withdrew from the scene and died within a few years.

Another natural disaster hit in 1899 when Hurricane San Ciriaco struck, leaving many homeless and 3,000 dead, wreaking havoc on the coffee plantations, tobacco fields, and sugar cane mills. The economic situation deteriorated, with U. S. interests buying most of the sugar cane plantations in the early 1900s and earning the name “King Sugar”. New political alliances coalesced. With the advent of the Wilsonian era and World War I, the Jones Act was passed, conferring citizenship on Puerto Ricans. They continued to be exempted from federal income tax while residing on the island (most would not have to pay anyway due to low income). Subsequently when the U. S. became involved in the war, Puerto Rico was called upon to enlist, and did so readily, in part due to the poor economy on the island. De Córdova (1988) offers excerpts from actual letters of enlisted men and their families, portraying the shocking contrasts between life on the island and mainland wartime military efforts. Because of inability to speak or read English, poor living conditions in the military camps, and a more temperate climate, many Puerto Ricans fared poorly, falling ill, being mistreated and underpaid, and generally being appalled by the racial discrimination in the U. S. Some, however, remained in the U. S. after the war effort, becoming part of the first migration.

Between the passage of the Foraker Act and the Jones Act, much was happening on the Puerto Rican political front, including the rise of the labor movement and the socialist party. There were movements for statehood and counter movements for total independence. Although little was accomplished legislatively in the period between the
passage of the Jones Act and the 1947-1952 mandates for self-governance and the establishment of Commonwealth status, the intervening years were anything but quiet. Within Puerto Rico, political parties and alliances rose and fell on a regular basis. The U.S. appointments and attempts at social interventions failed to take into account cultural differences, and were doomed to failure. Economic reforms allowed U.S. industrialists to purchase land cheaply and the laboring class was displaced.

Political protests became more common and often involved students. The Nationalist Party, a socialist group headed by Pedro Albizu Campos, a U.S. educated Puerto Rican, was in the forefront of several uprisings, and he was ultimately jailed for crimes against the Federal government. Muñoz Marin, son of Muñoz Rivera, rode the roller coaster of political party changes in the early years, retreating to the mountains in defeat. In 1938, he returned to found the Popular Democratic Party, for agrarian reform, and the betterment of the majority of the poor islanders. The party emblem was the jíbaro, with the caption, “Bread, Land, and Liberty” to cement the association with concerns of the majority of the population. (Morales Carrion, 1983).

While the majority chose Muñoz Marin, many Independentistas sought refuge in the mainland U.S. Maldonado-Denis (1972), a socialist and former professor at the University of Puerto Rico offered a different picture of the situation. Expressing concerns about the “bridging” concept and cultural assimilation, he was clear that for him, independence was the only solution, and Albizu Campos was the leader of choice. He believed that Albizu Campos created in his fellow Puerto Ricans a sense of pride and belonging, reviving holiday celebrations and attempting to preserve traditions and values in the face of U.S. colonialism. After his initial release from prison, Albizu Campos
continued to advocate for independence, using any means possible. He returned to Puerto Rico and with his Nationalists attempted a takeover of two cities and the Governor’s palace; the intended target was Muñoz Marin. Likewise, two Nationalists in the U. S. attempted to assassinate President Truman. Albizu was jailed again, this time in Puerto Rico, but was pardoned by Muñoz Marin in 1953 because of poor health and mental problems. Once released, he rejoined his efforts with mainland Nationalists who mounted an armed intrusion into the U. S. House of Representatives, wounding five congressmen. Albizu was returned to jail until he suffered a stroke later that year and died.

Operation Bootstrap introduced industrialization to the island by providing tax incentives for U. S. investment in the workforce and work initiatives. This resulted in improvements in roads, sanitation, and the economy initially. However, some of these gains were lost with progression to a heavy industrial base with petrochemicals, one run by technology with limited manpower demands. The agrarian economy became urbanized and industrialized, leaving nowhere for displaced former farm workers to return when they were laid off in the city. Low-income housing called cementos were built in the city for workers.

With the advent of World War II, Puerto Rico assumed strategic importance for U. S. defense efforts, and many Puerto Ricans enlisted. Following the war, the first Puerto Rican born governor was appointed. The Elective Governor Act in 1947 allowed Puerto Ricans to elect their own governor, and Muñoz Marin was elected in 1948. He was re-elected until 1964 when he retired. The postwar boom economy prompted a large migration of unskilled laborers to the mainland U. S. In 1949, Spanish was reinstated as
the primary language of the island and its educational system. In 1952 Puerto Rico was granted the status of Commonwealth, with its own constitution. However, in the documentation of the House and Senate reports, Puerto Rico’s fundamental political, social, and economic relationship to the United States remains unchanged (Trías Monge, 1997). Puerto Ricans still had no voting power in U. S. elections or in Congress. In the ensuing years, Muñoz Marin sought to clarify the compact and increase the self-governing powers of the Commonwealth to no avail. Much was promised in terms of congressional action, but nothing was delivered. The issues of a continuing U. S. military presence in Vieques and advocacy for jailed mainland Puerto Rican activists have been in the forefront of recent protests; it was anticipated that the U. S. will leave Vieques soon, but the military base would then close, dealing a major blow to the Puerto Rican economy.

The most recent plebiscite in 1993 showed that more Puerto Ricans favored Commonwealth status than statehood. At present the balance of power seems evenly divided between the two political parties, one favoring Commonwealth status and the other, statehood. In recent gubernatorial elections, the candidate chosen alternates between these two parties. Puerto Rico recently elected the first woman governor.

Summary

The ethnohistory of Puerto Rico is one of economic and political turmoil, marginalization and dominance by foreign powers, cultural intimidation and imposition, and manipulation of geographic location. Because of this history Puerto Ricans place a
high value on cultural preservation and are suspicious of outsider interest (Colon, 1982; Davila, 1997).

Puerto Rico: Present Tense

Samoiloff (1984) describes a more modern day, post-industrial Puerto Rico. Societal ills such as drug addiction, crime, and violence have not escaped the island. Women’s roles have changed since the advent of industrialization, leading to work outside the home, in some cases upsetting the delicate balance of power and ending in divorce. Consensual unions without the convention of a formal marriage are common but no child is considered “illegitimate.” Under the Puerto Rican system, the child’s surnames include both parents, with the father’s name preceding the mother’s. With the availability of contraception, families are smaller. Extended families are still common, and the godparents have a special role in raising the children if the parents die. Children are treated with great affection. Unemployment is high and there is a circular migration pattern to and from the mainland for some Puerto Ricans. The disparities between affluent and poor have grown. Festivals and celebrations of cultural identity on a local and national level are common.

Working Poor

Issues of culture as class and culture as ethnicity permeate the literature, particularly as it relates to the “common man.” With the exception of Mintz’s life history of a sugar cane worker, little has been recorded about the lives of the poor. Lewis (1965), another anthropologist, has chronicled the day-to-day existence of five generations of the Rios family, a Puerto Rican Black family. Some members of the Rios family live in La Esmeralda, a slum of San Juan, while others have migrated to New York. Lewis’s book
depicts abject poverty and poor living conditions, dysfunctional family relationships, prostitution and numbers rackets as ways of carving out an existence, and multiple informal sexual unions with large numbers of illegitimate children. These children are often ignored or even sexually abused by other family members or friends. Alcohol figures prominently in the lives of some. Lewis feels that the men are passive and controlled by the women, but this is contradicted by other readings (Comas-Diaz, 1998; Juarbe, 1998). Although his book is considered a classic, many mainland Puerto Ricans (Benmayor, Jurabe, Alvarez, & Vażquez, 1987; Flores, 1993) dismiss it as an “outsider” view and not representative.

Santiago (1993, 1998) offers an insightful view of her early life in Macun, a barrio of Santurce. Negi, as she is affectionately called, is the product of a racially mixed union. The poverty, the quarrels and reconciliations between her parents, her father’s infidelity and disappearances, his dabbling in spirituality, her mother’s decision to move to New York after Papi refused to legalize their consensual union, and the ensuing experiences of living in New York, offer her readers a detailed description of the life of a working class, poor family as they transition from island life to the U.S. mainland.

Identity Issues

The issues of culture and identity continue to confound Puerto Rican intellectuals. Dávila (1997) addresses the nationalization of culture initiated by the government sponsored Puerto Rican Cultural Institute in the 1950s. Her anthropological study demonstrates the fluctuations in definitions of Puerto Ricanness over the years, and the shifts in cultural ideology of the dominant political parties over the past five decades. In addition to this, she highlights the promotion of culture to sell products through
advertisements and corporate sponsored festivals on the island. She details the cultural initiatives of local grassroots community groups, in search of a sense of community, and the opposition they encounter if these efforts do not conform to the national definitions of Puerto Rican culture. She believes that as long as culture remains the dominant medium for divergent political or economic interest, it will be difficult to define identity in ways that challenge traditional formulations of national identity.

Duany (2002) concurs with Davila’s stance that culture should not be subverted to politics and prevailing political sentiment. He feels that the distinction between mainland and island dwelling Puerto Ricans is artificial and divisive considering the circular migration pattern, and the fact that both mainland and island dwellers consider themselves primarily as Puerto Ricans. He favors the concept of a nation on the move, with an identity based on cultural continuities, regardless of geographic location.

Comas-Díaz (1998) revisits subtleties of racismo, including the favoring of los blanquitos (the white ones) and the divisions between islanders and mainland Nuyoricans. She feels that Island and mainland Puerto Ricans of all colors must work to repair a “divided society” and fully integrate all of its members. She suggests that the santos-- white, brown, yellow, and black, encompass the multiracial and cultural influences on the island, and offer a vehicle for reclaiming Puerto Rican identity and putting aside divisions based upon geographic location.

Juan Flores (1993) of El Centro de Estudios Puertorriqueños at Hunter College revisits the issue of Puerto Rican identity after mainland migration. Using a sociohistorical approach, he reviews the works of Pedreira and José Luis González, with their contrasting visions of Puerto Ricaness. He criticizes the Spanish intellectual stance
taken by Pedreira, with its racial overtones. He endorses parts of González’s four-tiered approach which recognizes the contribution of the Afro-Caribbean as fundamental to Puerto Rican identity. Flores feels that by adopting this approach and particularly by acknowledging the African root as essential, that liberation efforts and relationships with Blacks and the worker movement in the U. S. will be enhanced.

Clara Rodríguez (1995) highlights the differences in racial perceptions and issues on the island and the mainland. She identifies two options in biracial New York—to be white or black. She feels strongly that these options negate the cultural existence of Puerto Ricans and ignore their insistence on being treated as a culturally intact group, irrespective of race.

*On the Mainland: The other Puerto Ricans*

Much has been written by and about Puerto Ricans who migrated to the U. S. mainland, called Nuyoricans by some, because New York was the principal site of early migration. As a class, most immigrants were unskilled laborers in search of a better lot. Yet the expectations of class, according to Flores (1993), shaped the emigration experience. The early migration in the 1900s to 1930s was small compared to that prompted by Operation Bootstrap industrialization in the 1940s and 1950s and included many artisans.

Colón (1982) describes his initial departure as a stowaway, and various anecdotes of his life, some humorous, some beyond belief—living in a one room flat with his brother and working opposite shifts so that they could share the same set of clothing, since it was the only pair of trousers they had; the community afforded to the poor, working class by belonging to the Communist party; the kindliness of poor-on-poor
relationships in helping a Spaniard who had literally “missed the boat” to find work and food, and in harboring a lost housemaid until her former home and workmates could be located “by the statue of a man on a horse.” Bernardo Vega (Vázquez & Cabañas, 1998) relates his arrival in New York and his struggles to find work. He describes the veritable “tower of Babel” found in the city, and El Barrio in Harlem where he settled, his initial attempts at networking with fellow immigrants from his hometown and its ineffectiveness in yielding employment as a tabaquero. A self-described jibaro, he would later become active in the workers’ movement and return to Puerto Rico to found the Independentistas party (MPI) in 1959.

In a later publication, Cooper (1972) presents a sampling of anecdotal stories by mainland Puerto Rican teens and young adults on their experiences of growing up Puerto Rican in the U. S. during the 1960s. They are stories of survival through stealing, abandonment by a parent--usually the father, struggles to remain drug free and to keep one’s virginity, renewed faith in God and the church, joining revolutionary groups such as the Young Lords. They are also stories of rejection because of ethnicity, ethnic slurs such as “spik,” violence incurred in defending family honor, and attempts at “passing as” white, non-Hispanic. Some are experiencing identity conflict because they were born in the U. S. with a Puerto Rican heritage.

Alicea (1997) reports that mainland Puerto Ricans frequently send their children back to the island to live with relatives because the lifestyle is more family centered and there is less danger of succumbing to crime, drug/alcohol abuse, or sexual promiscuity. Conversely, families who want their children to be well educated, send them to relatives on the mainland.
Piri Thomas (1995), a dark-skinned Puerto Rican, relates the experience of moving to a new neighborhood on Long Island, away from El Barrio in the city. With this upward mobility he experienced rejection at the hands of white people in his new school due to their perception of him as a Negro. Esmeralda Santiago (1998) reports two similar, ethnically based rejections, one at the hands of her fellow classmates who beat her up, and the second while on tour with her children’s theatre troupe in New England. She becomes aware that she is the object of attention because of her color, not black or white, but a “racial middle.”

Abraham Rodriguez (1995) describes the confusing and contradictory events stemming from his refusal to salute the American flag at school in New York. His father had been giving him materials by Albizu Campos to read which condemned imperialism and colonialism. Young Abraham, an honor student at school, decided to act upon this information and take a stance. When he did, he was shocked by the response of his Puerto Rican teachers and principal, who did not support his position. Obedience and conformity to the rules were valued over free expression. Most upsetting, however, was the appearance of his father, who had been summoned by the principal, and his father’s concurrence with the principal and lack of support for Abraham.

Marzán (1997) tells the story of a young man of mixed Irish and Puerto Rican parentage. The two elements in his family are alienated, and he attempts to reconnect with his Hispanic origins, only to experience rejection by a romantic interest who is Puerto Rican but does not date Puerto Rican men.

Many wish to return to Puerto Rico; some are mourning the loss of a beloved grandparent back in Puerto Rico, while others relate stories of mistreatment and false
accusations at the hands of police authority, just because of being Puerto Rican. In the video, “The Color of Fear” a black and a Puerto Rican youth discuss the dangers of being a person of color in certain areas of the city or country, the fear associated with just walking through the areas, of being stalked or profiled by law enforcement officers and of confrontation or false accusations being made and believed on the basis of skin color or race (Wah, 1994).

Language issues also create conflicts for mainland Puerto Ricans. Migration tends to be urban, primarily Northeastern, and the new arrivals establish an ethnic neighborhood within the city, complete with *casitas* (little house, community center) and *bodegas* (ethnic grocery store, community gathering place). While this perpetuates a sense of cultural cohesiveness, employment opportunities and education demand both a grasp of English and moving beyond the confines of the “barrio.” Grassroots programs by organizations such as the Centro de Estudios Puertorriqueños were introduced to educate adults within their communities and in a culturally acceptable context (Torruellas, Benmayor, Goris, & Juarbe, 1991). These programs continue to struggle with the realities of the immediate need to find work and money to survive, versus the long-term benefits of education on employment. The market for unskilled labor declined between 1950 and 1970, throwing many recent Puerto Rican immigrants into the cycle of poverty. They continue to have the lowest socioeconomic status of the three primary Hispanic groups (Mexican, Cuban, & Puerto Rican) in the U. S. (Ramírez & de la Cruz, 2002).

The aforementioned articles give an encapsulated view of mainland Puerto Rican issues: identity issues, lack of education, ethnic and racial discrimination issues, cyclical
employment without benefits, menial jobs, poverty, misunderstanding of cultural mores and sexual taboos, and an overall mistrust and lack of respect worsened by language barriers. Morales (1986) also explores the reasons for the out migration from New York into other areas of the country. His sociocultural study identifies some of the above items, factors relating to colonialism, and the eroding tax base and job base of the city, forcing those at the lowest level, i.e. the Puerto Ricans, to go elsewhere for work, including migrant farm work in the more rural areas of the U. S.

Torre, Vecchini, and Burgos (1994) discuss another phenomenon of the mainland migration—the commuter nation. They identify three groups of migrants: those born on the island who migrate to the U. S. and then return; those who alternate between Puerto Rico and the mainland on a regular basis, and those who are born in the U. S. of Puerto Rican parents and migrate to Puerto Rico. Islanders who have never left Puerto Rico view the circular migration with concern and some suspicion about the motives of the participants. Those born in the U. S. who go to Puerto Rico have difficulty adjusting to the language, education, and employment system. Some have formed a subculture called Ricans or Am e Ricans. In many cases, they are seen as contributing to the Americanization of the culture and taking work from those who never left the island.

Torre, Vecchini, and Burgos (1994) also offer a new insight on the mainland Puerto Ricans, one that sees them as active participants in shaping their own destiny as opposed to passive victims of socioeconomic and cultural oppression. These authors suggest that the current generation of Ricans has annexed their city of residence to Puerto Rico and its culture rather than being swallowed up by the U. S. culture; this view is similar to that of Duany (2002).
2.2 The Puerto Rican Community in Philadelphia

The migration of Puerto Ricans to Philadelphia, PA parallels that of the New York migration, only later and with fewer numbers. The initial settlers in the 1940s were from economically devastated rural areas in Puerto Rico, specifically the towns of San Lorenzo and Salinas, although other areas were represented as well (Whalen, 2001). Typically they were forced out of their rural locale by the need to seek work in the cities, and from the cities they migrated to the mainland in search of work. An early 1954 demographic study for the Human Relations Council of Philadelphia by Siegel (1975) showed a dramatic influx of Puerto Ricans into Philadelphia between 1950 and 1954. The new immigrants usually had larger households and lived in a well-defined area of the city, keeping to themselves because of language and other factors. They worked in manufacturing sectors and were not known by most of their non-Puerto Rican neighbors. Customs that were common in Puerto Rico, such as congregating on street corners to socialize and playing music, were misinterpreted in Philadelphia and often led to unwarranted police intervention (Gonzalez, 1987-88; Whalen, 2001). When factory jobs were relocated to the South because of unionization, many Puerto Ricans were left without work, further contributing to their marginalization and socioeconomic demise; substance abuse and criminal behavior followed. Political unrest was also rampant; Philadelphia had an active chapter of the Young Lords, an activist political group dedicated to the tenets of Pedro Albizu Campos, a socialist and independence proponent (Carolyn, 1997).

Koss’s (1965) early anthropological study of Philadelphia Puerto Ricans in the 1950s provides extensive historical information on how new immigrants were sponsored by other
family members who had preceded them or by close neighbors who had migrated to the mainland. Family relationships, religious affiliations, social interactions, and marriage within the Puerto Rican community are well documented. Low socioeconomic status, issues of acculturation and circular migration, political and legal problems, and the emergence of advocacy groups are also detailed in Koss’s study. Koss mentions the role of bodegas and botanicas in the culture of Philadelphia Puerto Ricans.

Whalen (2001) relies on many of the same historical sources as Koss (1965) for the evolution of the Puerto Rican community in Philadelphia, but focuses heavily on issues of marginalization, socioeconomic deprivation, prejudice, and geographic segregation initiated both from within and without. In the late 1950s and early 1960s, informal leaders within the Puerto Rican community realized the need for supportive services. El Concilio, The Council of Spanish Speaking Organizations of Philadelphia was established in 1962, followed by ASPIRA in 1969. These umbrella organizations sought culturally appropriate social and economic support for the Philadelphia Puerto Rican community, and for its youth.

In 1970 a Spanish language newspaper, La Voz Hispana, was initiated to serve the Latino communities of Philadelphia, the Lehigh Valley and Reading; Harrisburg and Bucks County were later included. Other Latino community organizations evolved, including Taller Puertorriqueño, an arts and cultural center in 1974.

In 1977 Congreso de Latinos Unidos, a social welfare organization established the first bilingual HIV/AIDs program, a mental health and drug/alcohol counseling program, and in 1999, a Latino Workforce Development program. The Catholic Archdiocese of Philadelphia established a social service branch, Casa del Carmen, within the community, and also promoted
the Cursillo program which paired suburban non-Latino parishioners with the North Philadelphia parishes which served most of the Latino population.

Other religious based community initiatives included Nueva Esperanza in 1982 and Lutheran Social Services. In 1987 Taller Puertorriqueño received a Youth Fest grant from the National Endowment for the Arts and conducted a small oral history project, including Puerto Rican born residents of Philadelphia and second-generation residents of Puerto Rican descent. In the summative document, *Batiendo la Ollo* (Stirring the Pot), the conflicts and frustrations in being Puerto Rican and being American are clearly exposed (Gonzalez, 1987-88). Although a follow-up project was recommended, it was never funded or implemented.

Other than a newspaper article about a Puerto Rican healer in Philadelphia (Kim, 1998), nothing has been written about the availability and use of culturally based health care; this is consistent with anthropological theory on the covert nature of ethnomedical systems (Rubel & Haas, 1996). During the 1970s when comprehensive community health clinics were established in neighborhoods, the current emphasis on cultural competency was not apparent. There are presently a few clinics which offer bilingual services in the Puerto Rican area, but they do not serve the entire population and most mainstream hospital and health organizations are still in the initial stages of implementing a cultural competency plan (D. Caputo-Rosen, personal communication, November 2006). The local public broadcasting system, in conjunction with a cable-based Spanish language channel recently presented a series of women’s health education programs geared towards Latinas (WHYY Latina Salud, 2002) underwritten by Glaxo Smith-Kline, a Philadelphia based pharmaceutical firm.
Although other Latinos have come to Philadelphia, Puerto Ricans remain the dominant subgroup (United States Census Bureau, 2000; Congreso de Latinos Unidos fact sheets, 2004). Most Latinos in Philadelphia still live within defined census tracts in North Philadelphia (Philadelphia Census 2000, Congreso de Latinos Unidos fact sheets, 2004) and the bulk of community support organizations serving the Latino population are also located in this area. Current statistical data from a report by Temple University (Adams et al, 1999) and the Latino Workforce Development Taskforce indicate that Latino families continue to be larger than most families in Philadelphia, with a larger percentage of single parent, female-headed households.

Compared to Caucasian, African American, and Asian American communities, the Latino population has the lowest median household income: $12,744 according to data from the Current Population Survey (CPS) in 1998, a decline from the level of $15,255 in 1989 (Adams et al, 1999). This economic finding is confirmed by information collected from the survey of Latino households. Networking continues to be within family and Latino circles and use of childcare resources is primarily limited to family and friends. Issues of education, housing, income, and medical care are of foremost concern to community members.

A recent issue in the news (Burling, 2004) involving a Latino family and a kidnapped child highlights the need for cultural competency training within the Philadelphia community. A baby was kidnapped during a house fire; her body was never recovered. However, the mother spoke only Spanish and the police/fire officials spoke only English, so the mother’s pleas for further investigation went unheeded; she was told that the infant had perished. Recently the mother saw the child at a party and consulted a
Latino legislator who was able to arrange DNA testing, verify the child’s true identity and reunite her with the mother—six years later.

**Summary of Ethnohistory**

The history and culture of Puerto Rico and its people are complex and unique. They are Americans, not by choice, but by conquest. The islanders have no vote in the American legislative system. They pay no income tax, but their per capita income is such that many would be exempt. They seek to maintain their cultural identity without being stereotyped. Many seek a basic living wage, decent working and living conditions. They are a joyful people despite repeated political and economic hardship. They are a people with a history older than America. They are a people who have much to give. Jésus Colon (1982) responds to the rhetorical question of how to know the Puerto Ricans. He says:

> When you come to knock at the door of a Puerto Rican home you will be encountered by this feeling in the Puerto Rican—sometimes unconscious in himself—of having been taken for a ride for centuries. He senses that 99 persons out of a 100 knock at his door because they want something from him and not because they desire to be his friend. That is why you must come many times to that door. You must prove yourself a friend. Only then will the Puerto Rican open his heart to you. Only then will he ask you to have a cup of black coffee with him in his own kitchen. Before you come to understand a person, to deserve a people’s love, you must know them. You must learn to appreciate their history, their culture, their values, their aspirations for human advancement and freedom. There is much you can learn by speaking to the Puerto Ricans every time you get a chance at work or in the casual contact of every day life (p. 148).

### 2.3 Puerto Rican Women
Historical evidence indicates that women in the Taíno society enjoyed equality with men. As stated previously, the line was matrilineal and women functioned as cacicas as well. With the coming of the patriarchal Spaniards, however, the woman’s role changed dramatically. Indios women were raped and mistreated in some cases, married in others. The Spanish expected the woman to manage the home, maintain ideals, and raise the family. Women also served as the spiritual center and initial health care source for the family (Samoiloff, 1984; Stevens, 1994).

A double standard existed for men, whereby sexual promiscuity was permitted, but women were subjected to a strict moral code which prohibited premarital sex. Many Indios and slave women were forced into concubinage, resulting in illegitimate births, and single parent households. In some families, such as the Rios family in Lewis’s (1965) ethnography, prostitution was the profession for several of the women. In families of wealth, women were chaperoned at all times and mothers instructed their daughters in the virtue of chastity. According to Espín (1997), social class and status were the primary correlates with virginity. The Catholic Church’s standards for Latino women impacted harshly on those of lower socioeconomic classes. Stevens (1994) discusses the influence of marianismo, the Latin American Catholic Church’s culturally derived image of the woman as embodiment of the Virgin Mary with emphasis on virginity, spirituality, and suffering. While men were permitted to freely and aggressively express their sexuality (machismo), women were seen as spiritually stronger and morally superior. Their role was clearly defined as wife and mother; their first duty was to the family.
In poor families, women usually worked in the fields along with the men. Despite the emphasis on morality and premarital sexual taboos, the poor working class woman often had an informal, consensual union. Esmeralda Santiago’s mother ultimately left her common-law husband because of his refusal to marry her, and migrated to the U. S. Unfortunately, she was unable to break the cycle of informal, consensual unions and had more children by two subsequent paramours (Santiago, 1993; 1998).

As other women joined the workforce and gender roles began to change following the U. S. takeover and economic initiatives, the emphasis on morality and premarital abstinence often became a source of conflict within the family. Vega (1997) related the story of a brother’s anguish and need for revenge after discovering that his sister had been raped in New York; the irony is that the police could not be called or the victim’s father told, because the victim would be blamed for the attack by both of these sources. The conflict was so deep within the mind of the victim’s brother, that he committed suicide rather than extending the cycle of violence to the perpetrators and further dishonoring his family. Alicea (1997) reported the story of a young wife who migrated to New York with her husband. She stated that she came to the U.S. seeking freedom but her husband locked her up in the apartment from 2 p.m. until 2 a.m. daily while he worked.

Espín (1997) stated that immigrant Latino women often harbor a myth that all American women are sexually promiscuous. In the process of becoming “Americanized” young women may focus on sexuality and parents may harbor fears concerning their daughters’ sexual behaviors.

*Women and Work*
Women were initially employed in home occupations, especially needlework, and in tobacco factories in Puerto Rico after the U. S. invasion. Rios (1995) traced the entry of women into the manufacturing sector on the island concurrently with Operation Bootstrap. She maintained that the structure of industrial development in Puerto Rico supported a gender-based division of labor which perpetuates the subordination of women and serves as a model for industrial development in Third World countries.

The sewing work would transfer with migration to the U. S. as well. Island workers were grossly underpaid, and a corporate effort to increase production limited designs to a few preprinted patterns. Organized labor from outside attempted to gain more money for the workers and to place them in factories; however, the lack of transportation, poor roads, and lack of flexibility for mothers of young children were deterrents. Also, workers realized that by bettering working conditions and raising wages, they would be less competitive with other groups. Ultimately, wages were increased slightly and cheaper labor in Mexico, Central America, and Asian countries was sought. Many skilled needle workers then migrated to the U. S., seeking work in the garment industry in New York. Some continued to work in the home, but many sought employment in factories in the city.

The Jewish and Italian immigrants from the prior migratory wave controlled the unions, and Puertorriqueñas were discriminated against. They received the lower paying work and no one would teach them the skills needed to advance. Eventually they did make some gains, although the garment workers union was not supportive.

In the post-World War II years there was a decline in work as manufacturers relocated in the South and West where labor was cheaper and there were no unions to
content with. Subsequently, multinational firms with cheaply made goods from Third World sweatshops captured the market. Women with no other skills were left without employment. Many were casualties of earlier sex and gender issues stemming from their ability to get work when their male counterparts could not. Some women, along with Puerto Rican men, migrated to other areas of the U. S., some agricultural, some smaller cities, seeking employment. Those with more education were able to secure clerical positions or professional work (Ortiz, 1996).

Another consequence of gender and role transitions was divorce and the increase of female heads of household. Puerto Rican men have always been known for their machismo; according to Torres (1998), the Puerto Rican male gender-socialization process has historically emphasized bravery, strength, male dominance, honor, virility, aggression, and autonomy. Other researchers have suggested that these are combined with softer attributes including caring, tenderness, love, respect for self and others, dignity, and protectiveness of women and children. However, respeto and dignidad are not inherent in the U. S. production driven economy. Consequently, Puerto Rican men, faced with less prospects of employment than their women and with role reversal, suffered a loss of self and masculinity. This was articulated as aggression and socially unacceptable behavior such as alcohol and drug abuse, gambling, violence, and promiscuity. In some cases machismo was expressed as physical, sexual, or psychological abuse towards spouses or companions (Espín, 1997). The high unemployment on the island also contributed to this behavior.

Statistical data from Puerto Rico (U. S. Census of Population and Housing: Puerto Rico 1970--1990 in Rivera-Batiz & Santiago, 1996) indicates that female households and
23.2% in 1990. A similar trend is occurring in the U. S. among Hispanic households; between 1980 and 1990, the number of female-headed households doubled (United States Census Bureau, 2000).

In the New York area, initiatives were instituted for early migrants to develop and maintain a sense of community and heritage in El Barrio. Sister Carmelita, a Puerto Rican born nun helped to establish Casita Maria, a multipurpose community agency and clearinghouse for Puerto Rican migrants (Sánchez Korrol, 1990).

Silva de Cintrón, a former elementary school teacher and a community leader in Rio Piedras, established a monthly journal, Revista de Artes y Letras which informed the community of local and global cultural, social, and political events, and featured works by Puerto Rican writers as well. Luisa Capetillo, a feminist and socialist, worked with social reform issues in the factories. Pura Belpré became the first Puerto Rican librarian in the New York public library system; she was educated in New York, but recognized the need for immigrants to connect with their Puerto Rican heritage. She initiated storytelling sessions for this purpose, followed by a series of cultural events with a Latin theme. She was also active in the community through Casita Maria and other centers to promote literacy and early childhood education, and established a bilingual program within the public library system.

In later years, programs were introduced through the Centro de Estudios Puertorriqueños to promote literacy, affirm cultural identity, and offer support to women displaced by employment shifts (Benmayor, Juarbe, Alvarez, & Vázquez, 1978; Torruellas, Benmayor, Goris, & Juarbe, 1991; Benmayor, Torruellas, & Juarbe, 1992). This resulted in a legacy of oral and written stories of women caught in the crossfire of
changing times. It also disproved the opinions of many that Puerto Rican women just wanted to exist on welfare, because these women had worked, and worked long and hard before being unemployed.

Another New York initiative involving professional Puerto Rican women was the Substitute Auxiliary Teacher (SAT) program. Bilingual Puerto Rican teachers, primarily women, were recruited to work with new immigrants in the school system. The program included a community outreach with visits to parents as well. This gradually segued into a bilingual education program.

Celia Vice (1974) offered a unique perspective from her experience as a Puerto Rican businesswoman in New York. She was obviously from a middle class background with affluent relatives but still encountered discrimination in the workplace because of her gender initially, and her Puerto Rican heritage later. She worked from her teenage years and gained experience in a realty office. When the opportunity arose to buy the business from its Jewish owner, she accepted a family loan. To gain credibility in the community and with male clients, she posed as the secretary, handling all transactions for her absent boss. After many successes she exposed her true identity as a female businesswoman. She was excluded from many “networking” opportunities because of her gender, but was not deterred. She used her position to help other Puerto Ricans to purchase homes in the community; unlike most realtors, she lived in the community as well. As she stated, “I considered my clients as my friends” (p.135). As her career advanced, she became more involved in helping the community. Her goal was to have her own business and to inform the New York community about Puerto Rico and its
people. She did this by starting Puerto Rican Heritage Publications to promote the
writing and craftsmanship of Puerto Rican authors and artists.

Other issues related to women and work in Puerto Rico include a lack of pay equity
between men and women in the same positions, and the preponderance of women in
lower paying jobs, including factory, clerical, education, and nursing. Feminist initiatives
have made some headway in addressing these issues, and also in correcting the
presentation of women in history books.

**Feminism in Puerto Rico**

Acosta-Belén (1986) addresses the history of feminism in Puerto Rico. She traces
its origins to the mid-nineteenth century, when liberal intellectual men advocated for the
education of women of all classes. Salvador Brau, Alejandro Tapia y Rivera, and
Eugenio de Hostos all supported the advancement of women through education. As
stated earlier in this paper, some upper class women mixed freely with male intellectuals,
including Lola Rodriguez de Tio.

Ana Roqué de Duprey was an ardent suffragette, immortalized for her
accomplishments and also in Jesus Colon’s (1982) anecdote. Colon describes her as one
of the most remarkable Puerto Rican women ever born. She was a mathematician,
teacher, astronomer, writer of textbooks, and founder of the first Puerto Rican feminist
society, as well as the magazine, *The Twentieth Century Woman*. She was 77 years old
in 1929 when literate Puerto Rican women were allowed to vote for the first time, but she
was turned away at the polls for failing to register, and died before the next election,
never realizing her lifelong goal. Inés Maria Mendoza, a member of the Nationalist
party, and Isabel Andreu de Aguilar, a graduate of the University of Puerto Rico, were
both active in the feminist movement. Mendoza later married Luis Muñoz Marin and joined the Popular Democratic party. Others, however, remained within the Nationalist party which had groups for women in its structure.

Acosta-Belén (1986) describes the simultaneous but parallel feminist movement emanating from the proletarian sector and aligned with the labor movement. However, after the accomplishment of universal suffrage in 1936, momentum was lost as Operation Bootstrap moved to the forefront. There was a feminist resurgence in the 1960s and 1970s, fueled by a global awareness of the plight of women. Puerto Rican women at this time were more educated and comprised 33% of the workforce, but inequalities in opportunities for advancement and economic inequities continued. There was also a countermovement by more traditional women’s groups which claimed that feminism was another ploy by the U. S. to obtain its ends. Political parties included women’s groups, but the goals of such groups were not always clear.

In the 1980s a women’s movement in Mayagüez sought to raise awareness of permanent environmental health sequelae due to toxic industrial emissions. The efforts to obtain victim compensation failed, but there were gains in understanding the collective action process and influencing future environmental legislation (Muñoz-Vázquez, 1996). According to Acosta-Belén (1986), the causes of women’s emancipation and the emancipation of Puerto Rico itself must be seen as one before the betterment of women can occur.

In addition to exploitation in the workplace, women were also victimized by government sponsored family planning and population control initiatives in the 1950s. Some women participated in clinical trials of the early, high-estrogen birth control pill
and died of pulmonary emboli. Many others were sterilized since other forms of birth control were not made available. Puerto Rican women have the highest sterilization rate in the world, as a result of “la operación” (Acosta-Belén, 1986). Not all of the hysterectomies were state mandated, however. Alicea (1997) describes a woman who left Puerto Rico to escape an abusive marriage. She was the sole provider and had 4 children less than 5 years of age. She relates that all her husband wanted to do was keep having babies, so she “went and got the operation” before leaving the island despite her husband’s refusal to sign for it.

Freeman (1995) compares the more traditional gender roles in island life with the complexities of mainland existence. Those who are unable to adapt or organize for change usually return home. Espín (1997) likens the experience of migration to the grieving process; successful adaptation includes resolving feelings of loss, developing decision-making skills, and coping with ambiguities, including sex roles.

Women and Religion

Puerto Rican women are the spiritual centers of the family. Many practice the Catholic religion, brought to Puerto Rico by the Spaniards. However, with the U. S. invasion and the subsequent migration, Protestantism was introduced as well. Many Puerto Ricans espouse the Pentecostal religion; some have no formal religion at all. The practice of Santeria or Spiritism does not preclude having another, formal religion (Gonzalez-Wippler, 1996).

Sanchez-Korrol (1990) relates the life histories of three Puerto Rican women who followed religious vocations in the early migration period. Sister Carmelita has been mentioned previously in conjunction with the founding of Casita Maria Settlement House
in Brooklyn. In addition, she was an early advocate before the official Catholic Church established a ministry to Puerto Ricans in New York. Reverend Leoncia Rosado Rousseau, an island Puerto Rican, began her ministry in the Pentecostal church at age 17 years. She felt that she had received a call from God. After extensive preaching and mission work, she married a church elder and migrated to New York. When her husband was accepted into the military, she was elected by the congregation to serve as minister. She opposed the will of her followers and reached out to drug addicted youth, gangs, alcoholics, and ex-convicts, founding the Christian Youth Crusade and numerous rehabilitation programs. She went out to the streets herself to minister, becoming known affectionately as “Mama Leo.” Approximately 250 participants in the rehabilitation program entered the ministry themselves. A third, mainland born Puerto Rican, Aimee García Cortese, was inspired by Reverend Leoncia and joined the Pentecostal church. She was the first woman chaplain in the New York State Correctional System.

**Women and Health**

There are many areas where themes of women, health, and religion or spirituality overlap in the Puerto Rican culture (Harwood, 1971, 1977, 1981; Koss-Chioino, 1992; Samoiloff, 1984; Stevens, 1994). The following studies address elements of these themes.

Davis (1994, 1996) conducted a phenomenological study to determine the health beliefs and practices of Puerto Rican women in Central Pennsylvania. Davis interviewed 21 women whose ages ranged from 19 years to 43 years. These women identified their primary role in the family as caregiver. They saw this as the unique role of women in their culture, bonding them together. Men expected them to carry the weight of the
family. Women were also the diagnosticians and health managers for the family, utilizing resources available within themselves, the health care delivery system, and the local community including bodegas, churches, and botanicas. For these women, ‘being there’ or the presence of self was seen as more important than the actual treatment or health practitioner. They did not perceive the impersonal, rushed, episodic treatment available via the primary health care delivery system as the best source of care (Davis, 1994; Davis & Flannery, 2001).

The caregiver role of Puerto Rican women is further reinforced in Alicea’s (1997) anthropological study of 30 Puerto Rican migrant and return migrant women. These women transcended geographical boundaries to care for immediate family on the mainland as well as extended family on the island, traveling back and forth, arranging for care, delegating care to other female relatives, or staying to render care themselves.

Fliszar (2004) conducted an ethnonursing study of the culture care beliefs and practices of elderly Puerto Ricans in Bethlehem, PA. The majority of participants were older women. The participants identified family as the center of the Puerto Rican world and pivotal in the generic care role for Puerto Rican elderly. Health encompassed physical, spiritual, and emotional well-being and included the ability to engage in self-care and remain active. The elders in this study followed the professional care practices and dictates of Western medicine for the most part. They mentioned using teas, Vicks Vaporub, and certain plants for skin problems but no other generic home remedies.

Delgado (1996) explored the role of religion as a caregiving system for 214 functionally impaired Puerto Rican elders and 194 of their primary caregivers, in a Northeastern U.S. community. He found that women in the family, either spouses or
daughters, regardless of Church affiliation, provided most caregiving and natural support. Most women felt that it was their responsibility to give care; if they were unavailable, other family members would help out. Religious institutions, particularly the Catholic Church served as a secondary source of support. Pentecostal religious organizations offered spiritual support but no other social support.

Munet-Vilaro (1998) conducted a literature review on grieving and death rituals of Latinos. She found that Puerto Ricans had more intense grief responses to a sudden death than other Latino cultures or Anglos. For all Latinos, religious rituals are very important in the grieving process. Lighting candles and observing the tradition of the Rosary Novena for nine days after the death of a Latino were two such rituals. After each rosary refreshments are served and mourners are encouraged to talk about the deceased.

The exaggerated emotional responses of Puerto Ricans called ataqués de nervios, were also addressed by Harwood (1971, 1981). Peter Guarnaccia (1993), a medical anthropologist, described the evolution of ataqués de nervios, a culturally acceptable response to very stressful experiences including acute grief, family conflict or threats. Settings such as funerals, accident scenes, or family altercations are common with reactions such as crying out, fainting, and seizure-like behavior. Women are affected much more often than men.

Guarnaccia, Canino, Rubio-Stipec, and Bravo (1993) conducted an epidemiological study with 912 Island Puerto Ricans after the mudslides and disasters of 1985, including a question about ataque de nervios. One hundred forty-five respondents reported experiencing ataqués de nervios; of these, 109 met the criteria for a serious psychological symptom. The preponderance of positive respondents were women over
45 years of age, widowed, divorced or separated and having less than a high school education. They were described in the study as socially disadvantaged. This study was significant in that it was the first to utilize an epidemiological approach to examine this syndrome which had previously been mentioned only anecdotally.

Hulme (1996) identified somatization as a common, culturally sanctioned illness presentation, particularly in middle-aged Puerto Rican and Mexican women who are experiencing social distress and powerlessness. These studies highlight the importance of a holistic, culturally sensitive approach in assessing health problems in Puerto Rican women.

Bernal (1986) studied the diabetes self-management strategies in a convenience sample of 74 low-income Puerto Ricans with Type II diabetes mellitus. These New England residents were referred to Visiting Nurse services for non-compliance with their diabetes regime. Sixty-four percent of the study groups were women. Nurse researchers used direct observation and interviews with a modified instrument that was back-translated for accuracy. Measures of compliance were insulin administration, diet, and urine testing. One-third to one-half of the population was judged non-compliant by the research criteria. A major finding was that stress, economic factors, or spontaneity of life events interfered with the regime which subjects had been taught in the clinic and they did not know how to be flexible and make adjustments. Lack of consistency in providers, lack of understanding of sociocultural and economic issues, and a punitive attitude by providers towards Puerto Rican foods were also factors in non-compliance. Bernal proposed a chronic care public health program utilizing nurses who were bilingual and had been schooled in transcultural nursing to serve the needs of this population.
While this study is dated, particularly in the measurement of urine glucose, the implications for consistent, culturally competent care are applicable to the present.

Zaldivar and Smolowitz (1994) surveyed 104 non-Mexican Hispanic adults with diabetes in New York to ascertain their beliefs regarding the role of religion and spirituality in the course of their disease, and also if they used folk remedies as part of their treatment. The subjects were predominantly Puerto Rican and female. In the results, 78% of the participants indicated that it was God’s will that they had diabetes and 81% indicated that only God could control their diabetes; 17% reported using herbs to manage their diabetes.

Quatromoni (1994) and her group of researchers used focus groups to study the health beliefs and nutrition practices of 32 low-income Puerto Rican diabetics and their families in Massachusetts. Most of the subjects were women. Significant findings related to health beliefs included the belief that personal health was controlled by God, that illness and suffering were to be endured, and that traditional, nonmedical remedies were superior to insulin in treating diabetes. These women believed that using “bitter” foods such as lemon juice or grapefruit juice mixed with olive oil would bring blood glucose levels down. These findings are consistent with those of Zaldivar and Smolovitz’s (1994) study of New York diabetics.

Engel and colleagues (1995) conducted a quality assurance study reviewing the diabetes care given to 254 low income Hispanics at public health clinics in New York City. Most patients were Puerto Rican and female. General issues identified were inconsistencies in care and failure to follow current guidelines. Findings specific to the Hispanic population were a need for culturally sensitive dietary education and weight
management programs, Spanish speaking staff, and written materials in Spanish, and an overall need to develop implementation strategies that are culturally sensitive.

Harwood’s ethnographic study of spiritism and *centros* in a Puerto Rican community in New York City (1971, 1977, 1981) involved 79 Latino households, principally Puerto Rican. Since he conducted his fieldwork during the day, most participants were women. The majority were born in Puerto Rico but had lived on the mainland for at least 10 years, remaining in an enculturated community. Harwood described the ethnic flavor of the community, including grocery stores (*bodegas*) and *botanicas* frequented by the residents. *Espiritistas* obtained supplies there or referred clients for candles, herbs, or religious talismans. The *centros* served as a preventive and therapeutic mental health clearinghouse, a center for socializing, and a collaborative modality with Western psychiatrists and primary health care providers. Contrary to assumptions held by biomedical health providers, spiritist followers in Harwood’s study also utilized primary medical care providers for physical health problems. Harwood found that spiritist psychotherapy was very beneficial to those in transitional life stages, was congruent with the culture of the clients and offered “symbolic reeducation” to bring clients back into the mainstream of life. Practically speaking, it was a viable alternative to the limited psychiatric therapy available at community mental health centers. While Harwood’s primary focus was on spiritism and client response, he also commented on the mentorship training of *espiritistas*, including the progression from client to therapist.

In gathering information for the spiritist project Harwood (1981), a medical anthropologist working at a community health center in the Puerto Rican area of New York City, also conducted ethnographic research in the community. Some of this is
described subsequently in the ethnomedical section of this study. Of interest in this section is his clear identification of women as the primary source for health advice and health care within the Puerto Rican family. He states that women not only care for the family, but also choose and evaluate alternate sources of care. He emphasizes the importance of taking the time to listen, show personal caring, and either speak Spanish or have an interpreter. He details the importance of the extended family in caring for the sick.

Sanchez-Ayendez (1988) also found that women’s roles were focused on motherhood and family responsibilities, including interaction with the health care system. Her ethnographic account of sixteen elderly Puerto Rican women in Boston highlights the expectation by these women that the younger generation, and daughters in particular, will treat them with respect.

Koss-Chioino’s ethnography (1976, 1992) on the four year Therapist-Spiritist Training Project in Puerto Rico (1976-1980) details a collaborative project between the government-sponsored mental health system and lay healers, predominantly female spiritists (espiritistas) that recognized the importance of folk healing in the treatment of clients with mental health problems in Puerto Rico. This project studied 990 patients, primarily women, who came for help at primary care and/or mental health clinics and spiritist centros. Espiritistas, therapists, and primary care physicians shared their cases in a peer-based learning experience that impacted both lay and professional healers and patients. In a sub-study of 100 patients/clients, both therapist and spiritist groups had similar outcomes of treatment. Patients rated therapists as better in dealing with
“thought” problems, while spiritist clients reported more satisfaction in dealing with mood and feeling complaints and symptoms.

Koss-Chioino details the difficulty in measuring outcomes for the “cure” oriented biomedical model with the “spirit” oriented spiritist model. This study is significant for the number of participants, the professional and lay healer collaboration, and the intertwining themes of women, health, and spirituality. Koss-Chioino (1992) summarizes her perspective on the impact of this study:

The central thesis of this book is that Puerto Rican women, as healers, often recognize and participate in these essential acts of renewal [of self or spirit] because they are prepared to do so by cultural understandings and expectations regarding their roles and behavior. Puerto Rican culture orients women toward pain, suffering, and caring for others (p. 206).

Singer and Garcia (1991) chronicled the life history of Marta de Jesus, a Puerto Rican espiritista in Hartford, Connecticut. Her story is similar to many of the healers in Harwood’s study and Koss-Chioino’s book—most came from an abusive, disadvantaged background and sought refuge in spirituality to escape their powerlessness, ultimately becoming empowered and using this healing power to help others. Finkler (1998) and Espín (1988) related similar findings in their studies of Latina women healers, although one of Espín’s healers was a well educated, middle-class woman. Espín also saw the role of healer as a socially acceptable way to counter male dominance and to establish financial freedom.

Higgins (1995, 2000) studied the influence of Puerto Rican cultural beliefs on infant feeding practices in western New York, using Leininger’s ethnonursing
methodology. She identified several folk remedies used by the 4 general participants and 10 key informants. Participants reported that their mothers and older sisters were the most significant teachers for feeding and childrearing. The strong intermingling of religious practices and health was also identified; mothers used amulets, bracelets, crosses and scapulars to protect their babies from harm. Themes of family closeness and respect were also highlighted. The study is limited by the extremely small sample size.

Pearce (1998) developed a grounded theory of pregnancy and prenatal care for a group of Hispanic women living in an urban Northeastern city. The 21 subjects were predominantly Puerto Rican and Dominican. The core category that emerged was seeking a healthy baby. Salient subcategories included a) self-care: balancing activity and rest, regular prenatal care, healthy eating, viewing pregnancy as normal; b) receiving support from their network—primarily their mothers, grandmothers, and sisters, and other women in the family; c) accepting care from Western and folk medicine providers. The women who used folk healers did so simultaneously with Western healthcare providers and experienced no conflict with this. Folk healers and family lit candles, gave amulets, medals, and statues, carried out rituals, and said prayers for the health and safety of the baby. Some of the women verbalized that these healers listened and accepted them as they were and made them feel special or important.

Higgins and Learn (1999) studied the health practices of a group of 7 Hispanic women in New Mexico with a higher socioeconomic status. The participants in this focused ethnography did not use any culture specific health promotion practices although some acknowledged a belief in herbal remedies because their mothers had used them. For the most part, the participants followed contemporary American health guidelines,
although they were more likely to attend to the health of family members than their own health. All participants believed in the relationship of body, mind, and spirit in creating balance essential to health.

Harwood (1971, 1981) reported the “hot-cold” theory of health belief and practices from his ethnographic study of Puerto Rico and mainland Puerto Ricans. Since the hot-cold theory involves foods, women were the primary practitioners. Pachter (1994) and colleagues (Pachter, Bernstein & Osorio, 1992; Pachter, Cloutier & Bernstein, 1995; Pachter, Sumner, Fontan, Sneed & Bernstein, 1998) expanded on the hot-cold theme and identified variations; they also described some culture-bound syndromes and home remedies used for asthma and colds (gripe).

**Summary of Research on Puerto Rican Women**

Puerto Rican women have always had a central role in the family as caregivers, health resources, and tradition keepers. Historically they have enjoyed periods of power and recognition both on the island and on the mainland but their primary affiliation has been with home, family, and tradition and male and female roles have been clearly defined (Acosta-Belen, 1986; Samoiloff, 1984). With migration to the mainland, women found more employment opportunities than their male counterparts, leading to role confusion and even domestic violence as the male image of *machismo* clashed with the realities of urban life and economics (Espín, 1997).

Many women sought refuge from abuse in spirituality and the healing arts, although for some, the specter of Catholicism which forbade family planning, offered little comfort (Alicea, 1997). For most Puerto Rican women however, spirituality and health are intertwined and health is seen as a balance of physical, emotional, spiritual,
and cultural factors. Caregiving is part of their role as family health manager (Davis, 1997; Delgado, 1996) and is also associated with use of health traditions and home remedies passed down from mother to daughter. Although single-parent families and informal unions are common among lower socioeconomic classes of Puerto Ricans, the role of the woman remains central to the family (Santiago, 1993).

2.4 Puerto Rican Ethnomedical Beliefs and Practices

In order to be as comprehensive as possible in searching for research in this area, this researcher used the terms “complementary and alternative” or CAM, ethnomedical and “folk” in searching databases. Some of the research grouped all Hispanic/Latino groups together; many of the findings were contradictory.

Struthers and Nichols (2004) reviewed 26 research articles on CAM use in ethnic minorities; 19 of these studies documented CAM use by racial and ethnic minorities. Most studies utilized surveys and self-report; Asians, Hawaiians, African Americans, Mexican, Dominican, and Puerto Rican groups were included. According to these reviewers, 7 studies documented that CAM is not used more in ethnic groups than among White, non-Hispanic populations. None of the research reviewed documented the efficacy of CAM therapies. The authors conclude that CAM use by racial and ethnic minorities occurs as part of their culture. Future directions for research include the construction of a “solid research base” (Struthers & Nichols, p. 310) in the CAM arena, followed by studies identifying cultural foundations of CAM and safety, efficacy, and cost as well as strategies for integrating CAM into a culturally congruent plan of care.
Najm and colleagues (2003) used a structured 24-question survey instrument to interview 525 community dwelling older adults between 65 and 95 years of age regarding CAM use. They sought to determine the prevalence of CAM use in older adults in the community, identify the health conditions for which CAM was used, and discover preferred CAM modalities in the overall sample, and in the ethnically diverse subgroups. The instrument was translated into Spanish and Vietnamese with review by bilingual medical faculty for clarity and quality of translation. Participants were volunteers recruited from local senior centers with an ethnically diverse mix. The instrument was administered in the language preferred by the individual participants. Results indicated that overall CAM users were less educated and lived fewer years in the U.S.; this was particularly significant among the Hispanic participants. Hispanic CAM users reported more physician visits than non-users. The preferred CAM modalities of Hispanic respondents included dietary supplements, home remedies, and curanderos as compared to acupuncture and Oriental medicine in Asians, and chiropractic, massage, vitamins, diet, and psycho-spiritual in white non-Hispanics. While 58% of CAM users were seeing a physician for the same problem, only 37.6% disclosed CAM use to physicians. Reasons given for not informing the physician included no opportunity, fear of disapproval, and feeling that it was unnecessary.

Hispanics in this survey utilized CAM more than the Asian or white non-Hispanics. Male Hispanics had a higher usage than female, which differs from most studies about CAM or folk medicine use. The authors used deliberate over-sampling in the ethnic minorities groups and state that results cannot be generalized beyond the sample group. While the term “Hispanic” is used, the setting for this survey was
Southern California and the discussion section contains several references to Mexican cultural orientation.

Mackenzie and colleagues (2003) used a different methodology to scrutinize the sociodemographic profile of ethnic minority CAM users. They analyzed a pre-existing data subset from the National Comparative Minority Health Survey of the Commonwealth Fund. This survey also employed over-sampling of minorities to allow accurate ethnic population estimates. The types of CAM use surveyed include herbal medicine, chiropractic, traditional healers, home remedies, and acupuncture. The demographic variables being examined include ethnicity, gender, education, income, insurance status, and being foreign born. The initial sample was 3,789 but 77 Native Americans were eliminated from this study because of low sampling. The age range included young, middle, and older adults and the income level spanned $7,500 to over $100,000. All ethnic groups in the sample had a similar percentage of CAM use. Latinos and Asians had the highest use of herbal medicine; African Americans and Latinos had the highest use of home remedies. Limitations of the study included the use of a 10-year old data set, and the limitations in defining CAM posed by the need to use the original questions from that data set. Categories such as religious or spiritual healing, folk remedies, massage, and diet were excluded. The researchers encourage health professionals and researchers to consider not only the linguistic aspects of cultural competence, but also the need for an integrative health delivery system which incorporates cultural health beliefs.

Factor-Litvak and colleagues (2001) conducted a phone survey of women in New York City to ascertain their use of CAM, categories of CAM used, racial and ethnic
differences in CAM use, and perceived efficacy of CAM by users. Phone interviews were conducted, using random digit dialing to obtain participants. The sample size of 300 included equal numbers of women who self-identified as White, African American, and Hispanic/Latina; this group was equally stratified into ages 21-40 years, and 41-80 years to reflect potential health concerns related to menstruation, fertility, and pregnancy in the younger group and menopause and post-reproductive malignancies in the older group. The three categories of CAM surveyed were use of: a) medicinal teas, herbs, vitamins, homeopathic remedies; b) yoga, meditation, spiritual practices; and c) manual therapies such as massage, acupressure, chiropractic. Sociodemographics indicated that most participants were at least high school graduates; Hispanic/Latinas had the most participants without a high school education. Actual incomes could not be determined from sample categories, but 30% were under $20,000/year. African Americans and Hispanic/Latinos had the largest number in the <$20,000 category. Results indicated that both age groups had a similar rate of CAM use, >50% and with minimal racial and ethnic differences in CAM use. The tea, vitamin, herb category was the most frequently used, although manual therapies were rated as most effective. Limitations included the use of English as the only language for interviewing; undoubtedly some Hispanic/Latina women were excluded due to this. The selective use of English may also have eliminated recent immigrants and lower income participants. The grouping of several CAM modalities together may have skewed the reporting. The authors emphasize that this is not a national sample and that a national study is needed.

Owens and Dirksen (2004) reviewed and critiqued the literature on CAM use in Hispanic/Latino women with breast cancer. Breast cancer is the most frequently
occurring cancer in Hispanic women. The 5-year survival rate for Hispanic women is 15% lower than in Caucasian women. The studies outlined in the article deal with a variety of issues, including the role of spirituality, use of complementary and alternative therapy (CAT), and home remedies for symptom treatment. One important concern in this population is the possible unintended use of estrogenic substances in herbal or natural substances and the adverse effect on the disease outcome. The authors emphasized the need to ask about all medications, herbs, and dietary supplements at each encounter. Additionally, the authors presented questions from the Oncology Nursing Society’s cultural competence guidelines that can assist health care personnel in obtaining information about CAT use. The use of interpreters or health care personnel fluent in Spanish is also encouraged. Finally, the authors cited the need for more studies of Hispanic/Latino women with breast cancer.

Bharucha, Morling, and Niesenbaum (2003) used the Theory of Planned Behavior to ascertain how Latinos and non-Latinos in the Lehigh Valley of Pennsylvania defined herbal medicines and what motivated them to use or reject herbals. They used a survey method and listed 26 substances commonly categorized as herbal medicines. Latinos were recruited through the Hispanic American Organization of Allentown, PA. Overall return rate was 41% for Latino and non-Latino. Variables included intent to use herbal medicine in the future, attitudes towards herbal medicine use, influence of physician’s and friends’ attitudes on use, and ability (availability and cost) to use herbal medicine; a Likert scale was used to respond to statements. Findings indicated that Latinos were more likely to include foods in the category of herbal medicines, e.g. garlic, carrots. Ninety-five percent of the Latinos had used herbal medicines in the past, compared to
55% non-Latinos. Latinos were more likely to use herbal medicines in the future, had a more favorable attitude towards herbal use and were more likely to choose herbal medicine use based upon availability and friends’ use than physician attitude. Limitations of the study included sample size and lack of generalizability. Suggestions for pharmacists (and other health professionals) working with Latinos were to clarify the patient’s definition of herbal use.

Davis (1997) researched the meaning of folk remedies in the lived experience of Puerto Rican and African American women in central Pennsylvania. Her initial phenomenological study was with 21 Puerto Rican women; she replicated the study one year later with African American women. She defined folk remedies as those culturally based remedies that are passed down through a family web from generation to generation. She identified women as the vehicle for this transmission. Common findings in both studies were the association of caregiving (receiving and giving) memories with folk remedies. The mother, or a woman designated by her, usually gave the care. The folk remedies varied considerably but three categories were identified: foods, herbals, and over the counter remedies. Participants felt that the folk remedies were effective, easily available, sanctioned by culture and associated with loving memories of being cared for. Davis (1997) concludes that health care providers need to learn more about the influence of culture, inquire about use of folk remedies, and be more holistic in their approach to ethnic women.

Zapata and Shippee-Rice (1999) studied the use of folk medicine and folk healers by 6 Latino adults living in New England. The 3 men and 3 women were from Columbia, Guatemala, and the Dominican Republic. The researchers initially met with
participants in two naturalist shops. Leininger’s framework was utilized, with the shop owners and healers serving as key informants. Subjects were interviewed at home and observed preparing the remedies from the naturalist shops. All participants used physicians as well, but felt that the physicians lacked a holistic approach and a personal interest in healing. Illness was seen as normal or due to an imbalance in the body; folk healers were deemed more holistic in their approach. Women subjects spoke of the role of faith and prayer in healing as well. Small sample size and diversity in country of origin are limiting factors in this preliminary study, but familiar themes include spirituality and healing, and the holistic nature of culturally based healing contrasted with the biomedical model.

Pachter, Sumner, Fontan, Sneed, and Bernstein (1998) studied the use of home remedies for the common cold in children by European American and ethnic minority families in Connecticut. The authors hypothesized that use of personal, home-based treatments for a common childhood illness would occur with a similar frequency in diverse cultural groups and were “complementary” to biomedical care versus “alternative.” A total of 281 parents were interviewed in pediatric clinic settings, using an introductory statement and “free-listing” of remedies or therapies by the parents. Cultural groups surveyed included European Americans, African Americans, Puerto Ricans, and West Indian-Caribbeans. Puerto Ricans dominated the sample (n=108). All groups listed antipyretics as the primary remedy. Puerto Ricans also listed camphor rubs, soups, fluids, vitamins and prayer as therapies. The study found that all groups used home remedies, most therapies were benign, and they varied according to ethnocultural
affiliation. Recommendations were that all providers maintain open communication and inquire non-judgmentally about the use of home remedies.

Roy, Torrez, and Dale (2004) surveyed children’s guardians, examining ethnic variations in use of home remedies for children and the underlying health beliefs. The survey was by phone, using cross-sectional stratified sampling of households with children. Questions were adapted from the National Health Interview Survey with agree-disagree response categories. Questions included acceptability of waiting versus immediate treatment for most childhood illnesses, treating with home remedies versus seeking professional care, belief that some home remedies are better than prescribed drugs for curing illness, and belief that it is safe to give children antibiotics and other prescription medications without getting a doctor’s prescription. The three ethnic groups surveyed were White, African American, and Hispanic; authors note that the overwhelming number of Hispanics in the Dallas area where the survey was conducted is of Mexican origin. Significant findings for this study were that Hispanics were the least likely to say that they would treat their child with home remedies. African Americans were most likely to use home remedies and to delay treatment by a professional in favor of using home remedies. The researchers acknowledge that Mexican Americans who use traditional medicines are less likely to report this. Also the scope of this study was limited; types of remedies used and other traditional health practices were not explored.

Colucciello and Woelfel (1998) sought to learn what types of cultural health care Mexican American mothers provided to their sick children. A convenience sample of 10 Hispanic mothers was selected from the population in an outpatient clinic in Wisconsin. The research tool was an open-ended, structured interview form administered in Spanish
or English. Three specific conditions were surveyed: cold, fever, and ear infection. Tylenol was the most frequently used commercial product. Home remedies used included teas, rubdowns with Vicks Vaporub, tepid baths, chicken soup and favorite foods. When asked whom they consulted initially for health information, most responded “my mother.” Respondents also indicated that when the child was sick, they stayed home from work to care for the child.

Benedetti (2000) interviewed numerous female healers and herbalists practicing in Puerto Rico; her oral history narratives illustrate diversity and regionalization of ethnomedical remedies and practices, all of which were learned from mothers or grandmothers. In certain areas of the country, such as the Afro-Caribbean town of Loiza, spiritual healing remedies predominate whereas in others, plant-based remedies are grown on site and used for specific health conditions.

Harwood (1971, 1981) reported the “hot-cold” theory of health belief and practices from his ethnographic study of Puerto Rico and mainland Puerto Ricans. The hot-cold theory (Harwood, 1971, 1981) is an example of a naturalistic approach which characterizes diseases as either “hot” or “cold.” The goal of treatment is to restore the balance of hot and cold by treating the disease with the appropriate, opposite entity. For example, consuming foods and drink that was “hot” in character, would treat a “cold” illness, and vice versa. The Spaniards invading Puerto Rico introduced the theory underlying this; since women prepare most of the family meals, they are involved in carrying out the hot-cold principles. Harwood (1971) advises physicians to determine the patient’s allegiance to the system and to “work within the system.” He notes that generational acculturation produces variations in the system requiring individual
assessment. Pachter (1994) also identifies broad variability in the interpretation and practice of “hot-cold”, with some areas creating another category designated as “warm.” Pachter (1994) and colleagues (Pachter, Bernstein, and Osorio, 1992; Pachter, Cloutier, and Bernstein, 1995; Pachter, Sumner, Fontan, Sneed, and Bernstein, 1998) expanded on the hot-cold theme and identified variations; they also described some culture-bound syndromes and home remedies used for asthma and colds (gripe).

Espiritismo or spiritism derives from the French model of Allan Kardec, and was introduced to Puerto Rico during the Spanish occupation by intellectuals studying in Paris and Madrid. Kardec believed that everyone had a spirit which passed into a parallel world after death to await reincarnation. Anyone can develop the ability to communicate with these spirits, who become protectors of living persons. Espiritistas are mediums and can assist the troubled client to come into harmony with the spirit world, but do not directly “heal.” In Puerto Rico, a form of spiritism called Mesa Blanca (white table) is prevalent. There are actual gathering places called centros in communities where spiritists hold meetings and pray for clients, in addition to individual sessions (Harwood, 1971; Koss-Chioino, 1992). This researcher also finds some similarities between spiritism and the beliefs of the Taínos about death and afterlife.

Santeria is a group of beliefs and practices brought to Puerto Rico from the Yoruba tribe in Africa. The Yoruba were imported as slaves during the early Spanish occupation. Santeria derives from a combination of magicreligious/supernatural beliefs and healing practices in which specific deities or orishas are invoked. Each orisha is identified with a force of nature, and with a human “interest” or endeavor. To avoid incurring the wrath of the Spaniards, but still maintain their native healing practices, the
Yoruba gave each orisha the name of a Christian saint. Santeria is practiced by *santeros*, who are sought out by clients with a problem of health or spirit. A ritual is performed, usually involving animal blood and cleansing, as well as inducing a trance-like state, to heal the client or rid him of the spiritual illness (Diaz, 2000; González-Whippler, 1984, 1996; Harwood, 1971, 1981).

Esmeralda Santiago (1993, 1998) anecdotally described a dreaded concoction called a tutumá administered by her mother when she was sick. Home remedies with chicken broth for a cold and chamomile tea for an upset stomach were also mentioned. She related the story of being chosen by the curandera to close a dead baby’s eyes so that his soul could be released from his body and fly up to heaven. González-Whippler (1995) recounted the actions and stories of her Yoruba nanny about saints and “orishas” of Santeria.

*Botanicas* or “Puerto Rican folk pharmacies” as they are popularly known (Borrello and Mathias, 1977; Suro, 1991) are a significant fixture in many Puerto Rican communities where they are the only overt evidence of cultural health beliefs and practices. In a Latino neighborhood of New York City this researcher counted more than 10 *botanicas* in close proximity. In Philadelphia there is an area within the Puerto Rican community known as *El Centro de Oro [The Center of Gold]* which is replete with *botanicas* and other cultural venues. *Santeros and espiritistas* can be seen in white robes in both areas. While the role of *botanicas* in Latino health has been written about in popular literature (Borrello and Mathias, 1977; Suro, 1991; Santiago, 1993; Jones et al, 2001; Olmos, 2001; Batcha, 2004), this researcher found very little research in anthropological, social science, and health references. Harwood (1977, 1981) writes
descriptively about the “herb shops” in his community. Suarez and his colleagues (1996) describe the beliefs about folk healing and the folk practices utilized by 76 HIV-positive patients seen in a city clinic in New Jersey. Fifty-eight were men; 90% of the sample was either from Puerto Rico or of Puerto Rican descent. Fifty-six patients stated a belief in good and evil spirits; 48% of these felt that the HIV infection was partially caused by spirits. Two-thirds of all of the respondents used some type of folk healing, most frequently spiritism or Santeria. Most hoped for physical relief, spiritual comfort, or protection from evil forces, although a few were seeking a cure.

Delgado (1998) created a collaborative and educational partnership with two botanicas in Lawrence, Massachusetts, an urban area with a large Puerto Rican population. Acting on the knowledge that Puerto Ricans contract HIV mainly via IV drug abuse, and that they frequent botanicas for social contact, herbal remedies, and referrals to lay healers, he and his social work colleagues trained the botanica owners in the basics of HIV/AIDS, risk factors, safety precautions, and need for testing. The shops posted information on free testing and referred high-risk and symptomatic clients. Delgado concludes that the project was successful in utilizing a cultural institution to disseminate information on HIV/AIDS to those who would not otherwise have access, in using a professional/community partnership, and in increasing referrals for HIV testing.

In an earlier article Delgado (1996) reports on a literature review and survey of key informants with knowledge of botanicas and Puerto Rican culture which concluded that botanicas should be incorporated into a culturally congruent service delivery program for older Puerto Ricans. Two other researchers, Gomez-Beloz and Chavez (2001) interviewed 24 botanica customers in a predominantly Mexican American urban
community to conduct an assessment of the potential of the botanica as a culturally appropriate health care option for Latinos. They used a closed question interview series, including questions about: a) reasons for visiting the botanica, b) use of Latino complementary and alternative medicine (CAM) services and practitioners, and c) type of product being purchased and intended use, and d) use of conventional health care services. Their population was primarily women, with some formal education and income range of $15,000-29,000 per year. Most sought treatment for physical problems, not “folk illnesses.” Sixteen reported use of conventional medical services; eight used only the botanica. Almost all of them came for a physical health problem and were seeking the natural and spiritual approach of the botanica. The researchers concluded that the botanica serves as a culturally suitable Latino health care source. Suggestions for further research include a recommendation for a large-scale, cross-cultural, interdisciplinary study with qualitative and quantitative components seeking to fully understand the role of the botanica in Latino health care choices. These researchers also advocate an approach to health care which integrates conventional medical treatment with culturally-based options (Gomez-Beloz and Chavez, 2001).

Several other ethnomedical modalities are utilized by segments of Puerto Ricans, many on the advice of abuelas or other “wise women”. Professional health care providers who work with Puerto Rican clients must become familiar with cultural health beliefs and practices and incorporate them into history taking and treatment as indicated.

The foregoing studies speak to a diverse, complex, and active ethnomedical system, much of which is accessed through women in the family, and may be practiced by the women as well. The examples also illustrate a holistic approach to health. Herbal
remedies are part of an oral tradition which has been passed down from one generation to another. Availability of herbs and regional patterns are factors in use.

2.5 Acculturation Research

In this section the researcher will briefly review conceptual underpinnings of acculturation. The researcher will discuss the development of acculturation measurement instruments and will review selected studies with Hispanic populations that have measured acculturation and health related issues.

Anthropologists working with indigenous populations initially introduced the construct of acculturation in the 1930s (Thurnwald, 1932). In 1936 the Social Science Research Council defined acculturation as follows: “Acculturation comprehends those phenomena that result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups” (Redfield, Linton & Herskovits, 1936, p. 149). In the ensuing years, social scientists have developed tools to measure various aspects of acculturation, however, there is no clear agreement currently on how to conceptualize and measure acculturation (Berry, 2003). It is associated with racial, ethnic, and cultural concepts but is seen as a related but distinct construct (Phinney, 2003).

Early models depicted acculturation as unidirectional, with the immigrant group being assimilated into the cultural norms of the host group, somewhat akin to the popular concept of the “melting pot” (Gordon, 1964). More recent measures have been multidimensional, including concepts such as biculturalism, variation in responses within cultural subgroups, marginalization, and bidirectionality (Clark and Hofstess, 1998).
Trimble (2003) also uses a term ‘situational acculturation’ to refer to variability in acculturation depending upon the situation or environment.

Berry (2003) describes a framework for linking both cultural and psychological acculturation levels. He emphasizes the need for the researcher to be well versed in the key features of each culture before they came in contact with each other, to understand the nature of the contact associations, and the ensuing changes in each cultural group.

As a health professional, this researcher is interested in studies relating acculturation and health outcomes. A group of public health researchers contend that psychological variables such as changes in values, belief systems, and worldviews need to be addressed in research on acculturation and health outcomes and that it should not be assumed that the immigrant culture is adapting to the White culture (Abraído-Lanza, Armbrister, Flórez & Aguirre, 2006). These researchers (Abraído-Lanza, Armbrister, Flórez & Aguirre, 2006) and other public health researchers (Lara, Gamboa, Kahramanian, Morales & Bautista, 2005) also contend that socioeconomic and political issues may be a stronger influence on health status than acculturation. Ponce and Comer (2003) strongly question the value of acculturation measurement at all for determining health outcomes, but most definitely without considering the effects of socioeconomic status on health and health disparities.

The Hispanic population is the most rapidly growing in the United States; the growth rate of 3.6 in the 12-month period between 2003 and 2004 exceeded three times that of the general population growth rate of 1.0 (http://www.census.gov/Press-release/www/releases/archives/population/005164.htm).
The Hispanic population has been the most widely studied relative to acculturation and several of the acculturation scales that have been developed were initially specific to the Hispanic population of Mexican origin. The Short Acculturation Scale for Hispanics (Marin, Sabogal, Marin, Otero-Sabogal & Perez-Stable, 1987) is one of the most popular and widely used measures of acculturation and has been adapted for use in non-Hispanic populations. This scale relies heavily on use of and preference for language, as a measure, with ethnicity of friends, visitors and such as another measure. While language is a useful measure and easy to measure, critics argue that language measures do not depict the complexity of language use in bicultural individuals (Lara, Gamboa, Kahramanian, Morales & Bautista, 2005). A newer measure, the Bidimensional Acculturation Scale for Hispanics (BAS) has recently been developed, tested, and published; this scale includes 24 items to which the respondent must reply (Marin & Gamba, 1996). The authors of the scale identify its failed attempt to produce an instrument that measures social determinants or behavioral correlates with the power that language-based subscales have.

Yamada, Valle, Barrio, and Jeste (2006) reviewed 15 of the acculturation scales for Hispanics to identify which ones had been validated for use in older adults and which were empirically sound psychometrically. This researcher utilized their summaries to extract information on which scales were used with Puerto Rican populations as well as their critique of these scales. Two scales were developed by Puerto Rican researchers and tested with Puerto Rican populations (Cortés, Rogler & Malgady, 1994; Tropp, Erkut, Coll, Alarcón & García, 1999). The Cortés group scale was designed to measure biculturality in Puerto Ricans in the U. S., using behavioral and language measures similar to other scales but allowing for independent ratings of Latino culture and American culture.
consistency reliability scores for both American and Puerto Rican cultural involvement scales, using alpha coefficients, were significantly lower than for other scales, measuring .78 for American culture and .73 for Puerto Rican culture (Cortés, Rogler, and Malgady, 1994). The scale developed by Tropp (1999) and colleagues, the Psychological Acculturation Scale, was significant in that it measured psychological and affective dimensions of acculturation, often overlooked by other acculturation instruments. Yamada, Valle, Barrio, and Jeste (2006) note that the PAS also measures biculturality but had not been used with adults over 58 years old. This researcher found a subsequent study which utilized the PAS with adults up to age 71 years (Cintrón, Carter & Sbrocco, 2005) with an internal consistency of .93. The researcher will use the PAS Acculturation Scale for this study with Puerto Rican women. See Chapter III—Instruments for further discussion of this scale and Appendix B.

Acculturation Studies with a Health Focus

Garcia-Maas (1999) and Chamorro & Ortiz (2000) both studied dietary patterns in different generations of Mexican American women. Garcia-Maas used mother-daughter dyads and found that the daughters were more acculturated and had poorer eating habits with a higher intake of fat.

Chamorro & Ortiz (2000) did not use families per se, but distinguished by first-generation, second-generation and so forth. The Acculturation Rating Scale for Mexican Americans (ARMSMA) was used to measure acculturation in 139 participants. The EAT-26 Scale was also used to measure eating behavior. Findings indicated that the second-generation women had the highest acculturation rating, and they had the highest level of disordered eating. The researchers concluded that different intergenerational ideals about
weight might subject second-generation Mexican American women—women born in the U. S. to parents born in Mexico—to extreme stress, being the “first born” to immigrant parents. The expectation of the U. S. for a culture of thinness contradicts the traditional Mexican image of *gordita* (a little fat) as healthy and creates a challenge for these second-generation women to bridge the cultural gap.

Marks, Solis, Richardson, Collins, Birba, and Hisserich (1987) examined the role of cultural assimilation in 603 older Hispanic women residing in subsidized housing projects for the elderly in Los Angeles in 1984. Their acculturation measurement tool was self-designed but included several items from the ARSMA scale. Health behaviors were assessed by self-report to trained, bilingual, female interviewers and included questions about last physical examination, PAP test, and screening for breast cancer. The researchers found that although the level of cultural assimilation was marginal in most of the population, the majority had been screened for breast cancer within the past year and had a physical examination by a physician. The researchers also noted that in urban Los Angeles there was good access to care and availability of Spanish-speaking providers. The researchers concluded that access, availability of health services, and sociodemographic factors were more useful than cultural factors in understanding Hispanic health-care behavior in this study (Marks, Solis, Richardson, Collins, Birba & Hisserich, 1987).

Hadwiger (2005) studied acculturation and diabetes in a rural Hispanic community, using an ethnographic methodology. The ARSMA-II Acculturation Rating Scale was used to measure and describe the acculturation level of the informants. According to the researcher, the informants were low acculturated and fit the traditional
Mexican typology, despite living in the Midwest for two years. The researcher also uncovered two diverse sets of themes in response to his question:

“Who determines whether a newcomer’s cultural identity is valued or whether positive relations with the host society should be sought?” (Hadwiger, 2005, p.137). Themes reflecting cultural identity included women as family caregivers, denial of the seriousness of diabetes, affirmation of self-care ability and the desirability of care in Mexico (some traveled more than 100 miles back to Mexico for health care). Themes uncovered that related to the current “host society” included feelings of discrimination, lack of Spanish language physicians, increased cost of services and medication, and the discovery of diabetes in this environment. The number of informants was small (N=10) and the question seemed complex to this researcher, but the themes that emerged were clear and consistent with other studies of Mexican immigrants.

Palmer, Fernandez, Tortolero-Luna, Gonzales, and Mullen (2005) conducted a large-scale study to investigate the effect of acculturation on mammography screening practices among Hispanic women and to explore the effect of biculturalism on mammography screening. The research was conducted with 716 women over age 50 years, in rural farmworker communities in Texas, New Mexico, and California. This researcher will limit her comments to the acculturation measure, since the actual study included 265 items. The Bidimensional Acculturation Scale (Marin & Gamba, 1996) was used to measure acculturation; 74.1% of the sample was low acculturated, with the remaining quarter rated as bicultural. None of the sample participants were highly acculturated. Initial logistical regression analysis revealed a high level of adherence to mammography screening guidelines with no difference in acculturation groups when
controlling for sociodemographic variables, access to care, and site. A later, more selective stratified analysis for California and border sites was done; these findings identified biculturalism as more highly associated with mammography compliance. The researchers note that limitations of the acculturation measure, which is highly language focused, may have influenced results and state that more comprehensive measures of acculturation are needed (Palmer, Fernandez, Tortolero-Luna, Gonzales & Mullen, 2005).

**Summary of Acculturation**

Acculturation is a construct originally identified by anthropologists and known to be separate but related to culture, race, and ethnicity. Social and behavioral scientists and measurement experts have sought to reduce acculturation to a measurable entity, however their efforts have been confounded by difficulty in identifying valid and reliable, standardized measurements with the depth and complexity, yet ease of administration needed to fully liberate the construct. Recent efforts have focused on identifying factors related to acculturation and health or health disparities. Unidimensional measures have given way to bidimensional and multidimensional scales. The Hispanic population, as the most rapidly increasing minority, has been studied extensively. Hispanic acculturation has been primarily targeted toward the Mexican population, seeking to measure the effect of acculturation on mental and physical health. Future direction in measuring acculturation is aimed at more complex measures and measures that will reflect psychological acculturation as well as language and behaviors.

2.6 Summary and Gaps in the Literature
The review of the ethnohistory of Puerto Rico establishes it as an island caught in a series of longstanding political battles which challenge its identity and divides its loyalties. Puerto Ricans are Americans, not by choice, and are still fighting for the right to vote in national elections (San Martin, 2005). Relations with the United States have been strained by economic issues, power struggles, and land use issues, leading to an atmosphere of mistrust. This has spilled over into health related issues translating into health disparities, access to care, and cultural competency concerns with the prevailing biomedical model. Puerto Ricans continue to travel between the mainland and the island, maintaining their cultural heritage.

Most studies of Hispanic/Latino health issues use the broad umbrella terms “Hispanic/Latino.” While this is done for statistical convenience, it flies in the very face of cultural competency. A literature search has determined that the primary subgroup studied is the Mexican subculture. This is the dominant Hispanic group in the U.S. overall, however Puerto Ricans are the predominant subgroup in the Northeastern U.S. and in Philadelphia and Southeastern Pennsylvania. An extensive review of the literature reveals few studies related to cultural health beliefs and practices in the Puerto Rican population. Historical documents exist from the time of the Puerto Rican migration and the early 1970s.

There are no studies specific to the cultural health beliefs and practices of Puerto Ricans in Southeastern Pennsylvania. One ethnographic study of Puerto Ricans in Philadelphia exists but this was done in 1959 (Koss); its value is historically significant but does not reflect the current population. While bodegas and botanicas are mentioned in this study, the focus is on migration and accommodation, not health beliefs and
practices. An oral history project of Taller Puertorriqueño in 1978 (Batiendo La Olla=Stirring the Pot) involved a cross-generational study of second generation Puerto Ricans in Philadelphia, but this also is outdated and made only brief mention of cultural/religious issues. It was an excellent oral history project generated to focus Puerto Rican adolescent boys and deter neighborhood teen gang activity at a time when Philadelphia police and Puerto Ricans were in conflict (Gonzalez, 1987-88). A recent publication by Whalen (2001) is also of historical significance but is focused on migration and economy and draws much of its historical data from the Koss (1959) study and sources.

The review of the literature does establish the primary role of Puerto Rican women in caring for the health of the family, from an historical and present day context. The role of the family in health decisions has been identified, but upon closer scrutiny, it is the women in the family who are the primary health care brokers. Literature regarding the use of CAM has been contradictory, however it is well documented that patients often do not share information on CAM use with practitioners (Hufford 1997, Miccozzi 1996, Najm 2003, O’Connor 1995, Roy et al 2004). All studies conclude that further research about CAM use in specific cultural groups is necessary. The role of the botanica in Puerto Rican health care is also supported in the popular media (Borrello & Mathias, 1977; Suro, 1991; Santiago, 1993; Jones et al, 2001; Olmos, 2001; Batcha, 2004); the research literature calls for further study of the botanica as a Puerto Rican health resource (Delgado 1996, 1998; Gomez-Beloz & Chavez, 2001; Harwood, 1997, 1981; Suarez et al 1996).
Studies of acculturation in Hispanic populations are plentiful but focus primarily on the Mexican culture. There are few studies on acculturation in Puerto Ricans and most of the acculturation scales for Hispanics have been validated in Mexican and Central American populations.

In summary, Puerto Ricans are the dominant Hispanic subgroup in Southeastern Pennsylvania. The majority of the Puerto Rican population reside in enculturated areas of Philadelphia. There are no qualitative, ethnographic studies of the cultural health beliefs and practices of Philadelphia Puerto Ricans. It is essential that health care providers working with Puerto Rican families learn the everyday cultural health beliefs and practices to care for this population in a culturally congruent manner. This study will address this need.
Chapter 3

METHODS

3.1 Introduction

This chapter covers the ethnographic research method that was utilized in this study. The discussion begins with an overview of ethnography as a research method, including its historical roots, current perspectives, and challenges as a research method. Included in this overview are definitions related to ethnography, followed by a description of the research design, the setting, the informants, the instruments, the means for protection of human subjects, and the procedure for data collection and data analysis.

3.2 Methodology

Qualitative research is a continually evolving field of inquiry that is holistic in nature and transcends disciplinary boundaries, covering a broad array of topical areas and theoretical schools (Denzin & Lincoln, 2000). Among the more time-honored methods of qualitative inquiry are those dealing with cultural and interpretive issues, foremost among which is ethnography.

Ethnography is defined as “the branch of anthropology that deals with the
scientific description of specific human cultures” *(The American Heritage® Dictionary of the English Language, 2000).* Fetterman (1998) describes it as an art and science used to describe a culture or group.

Ethnography evolved historically from cultural anthropology and has been used by anthropologists and nurse anthropologists to explore the influence of culture on health care, health beliefs and practices (Leininger, 1985; Morse & Field, 1995). Ethnography was initially specific to the disciplines of anthropology and sociology and studied the “other” or “descriptive accounts of non-literate people” (Radcliffe-Brown, 1952, p. 275). The researcher committed to living in the native environment with “primitives” over months or years, such as Margaret Mead (1928) did in her classic *Coming of Age in Samoa: A Psychological Study of Primitive Youth for Western Civilisation.* Since that time, ethnography has evolved in many directions, both as a science and an art form, and has been claimed by many disciplines, leading to multiple variations in form, style, and data analysis.

Denzin and Lincoln (2000) address recent issues of blended boundaries between the positivist philosophy and the naturalistic philosophy in ethnography and other traditionally qualitative methods. Handwerker (2001) advocates an approach to quick ethnography that integrates the standard qualitative ethnographic tools with quantitative tools for a triangulated approach. He proposes that this style is more efficient and yields greater precision in explanations and ethnographic descriptions.

This researcher used triangulation by employing a quantitative instrument in addition to the predominately qualitative, inductive methodology of the study. Morse and Richards (2002) identify several variations for triangulating data, either simultaneously or
separately. They (Morse & Richards, 2002) emphasize that if the main focus of the study is inductive that the qualitative project is the core of the triangulated project. This study was undertaken in the qualitative, discovery mode with triangulation of data to measure a select area of the phenomenon under study.

Morse and Richards (2002) comment on the dramatic changes that ethnography has undergone in recent years and current controversies surrounding its goals. They identify several forms of ethnography, including *traditional* which is also known as classical ethnography where the researcher conducts a study with a single culture that is unfamiliar to the researcher, usually requiring relocation and an extended period of time. The research tends to be broad and comprehensive in scope. *Focused ethnography* is more specific and involves an issue or topic that may be identified by the researcher in advance. There may or may not be fieldwork involved, the informants may be limited to a subculture, and the period of contact with the informants is shorter than that of researchers engaged in *traditional* ethnography (Morse & Richards, 2002).

This researcher used a *focused* ethnography to explore the health beliefs and cultural health practices of Puerto Rican women in Southeastern PA. A *focused* ethnography is the method of choice since this researcher has identified the area of culturally based health beliefs and health practices for study, in contrast to a *traditional* ethnography which studies all aspects of the culture. Also, this researcher interviewed self-identified Puerto Rican women in Philadelphia, a subculture of Puerto Ricans. This researcher had done some preliminary fieldwork in the area, and this study was conducted over several months as opposed to years of study in a *traditional* ethnography.
Spradley (1979) states that the ethnographer must start with an attitude of “almost complete ignorance (p.4)” and a spirit of discovery. The essential core of ethnography is the “concern with the meaning of actions and events to the people we seek to understand (p.5)”. To the question of why one does ethnography, he identifies two reasons: a) to better understand the human species and b) to serve the needs of mankind.

Although ethnography itself has diverged broadly in its scope and definitions of culture, Boyle (1994) identifies several core commonalities among all types of ethnography: all are holistic, contextual, reflexive and involve *emic* and *etic* data. *Emic* refers to the insider or indigenous viewpoint of the Puerto Rican culture. Although this viewpoint is lived by the people in the culture, it may not be apparent to them. One of the goals of the ethnographer is to make this visible; mechanisms for accomplishing this include listening to “hear” data (Rubin & Rubin, 2001) generated in individual interviews, systematically observing behavior (Bernard, 1998), analyzing data for patterns, and returning to informants for validation of meaning. *Etic* refers to the researcher’s assumptions, ideas, and questions about the Puerto Rican culture and health beliefs. Bernard (1998, 2002) cautions the researcher against accepting the *emic* explanations of key informants at face value. He recommends constant validity checking by consciously alternating between *emic* and *etic* viewpoints, and substantiating interview data and observation with more objective data. Using a quantitative measurement instrument and systematically observing behavior helped the researcher to consider both *emic* and *etic* perspectives.

The focus of ethnography is on describing the day-to-day life of the cultural group under study. Spradley (1979, 1980) believes that the researcher actually becomes the
learner and the participants are the teachers as the ethnographic researcher seeks to uncover the meaning of actions and events to the participants. The research instrument is the human researcher him/herself, a participant-observer in the process. The research takes place in a naturalistic setting (Lincoln & Guba, 1985) because the meaning of the phenomena under study is contextual. The primary goal of ethnographic research is to generate *thick description* (Geertz, 1973) that is, rich and detailed narrative that describes in depth the meanings, patterns, and experiences of the cultural group. Ethnographic data consist of observational data, recorded in field notes which may be supplemented by photos or other visual media, interviews which may also be recorded as field notes, audiotapes, or videotapes, the researcher’s journal and reflective, theoretical notes, verbatim quotes from interviews (Morse & Richards, 2002), data generated from direct, systematic observation (Bernard, 1998, 2002), and data from the quantitative measurement tool. The final product can take the form of a book or an extensive report with multiple quotes from the informants.

### 3.3 Research Design

This researcher conducted a *focused ethnography* to uncover the culturally based health beliefs and practices of Puerto Rican women in Southeastern PA. Participant observation and an interview guide were utilized. The researcher also used a demographic profile and a measurement tool, the PAS Acculturation Scale, to obtain information on acculturation (Tropp, Erkut, Coll, Alarcón, & García, 1999). The demographic profile and the acculturation measurement instrument yielded descriptive information that augmented data from interviews. The PAS acculturation scale provided
an analytic lens for interpreting qualitative data and conducting comparisons across acculturation and age group ranges. The researcher used these tools (demographic profile, acculturation measurement tool) to look for any patterns to further illuminate the phenomenon under study.

Spradley (1979, 1980) and Polit and Beck (2008) address the need for the qualitative researcher to identify personal biases and presuppositions. This researcher has worked with Puerto Rican people in Bethlehem, PA in the past and presently in Southeastern PA. In Bethlehem, although the Puerto Rican community was located primarily in one geographic area, there were few visible markings of the culture—one neighborhood grocery store, a Hispanic Senior Center, and some churches. There were no bodegas or botanicas and the Puerto Rican Day celebrations were being phased out. In the Philadelphia area there is a vibrant, visible Puerto Rican area of the city with bodegas, botanicas, many Puerto Rican cultural and civic organizations, medical clinics, and several large Puerto Rican festivals and parades. This could lead the researcher to assume that more cultural health beliefs and practices prevail in Philadelphia. However, the researcher is also aware that Philadelphia is a larger geographic area and has many other Hispanic subgroups who practice similar traditions; persistence of visible cultural artifacts may be due to utilization by other Hispanic groups. The researcher was careful not to assume that more cultural health beliefs and practices prevailed in Philadelphia.

The researcher maintained a journal of her thoughts and observations to record potential bias throughout the study.

3.4 Setting
Fetterman (1998) states that spontaneously beginning fieldwork with no introduction into the community can adversely affect the ethnographer. Preparation and knowledge of the community and key informants can facilitate entry. The researcher has been “in the field” for several years now. The researcher initially conducted preliminary fieldwork in some botanicas in Philadelphia with a member of the community, met with two Puerto Rican healers and a santero, and studied ethnomedical remedies as part of graduate study coursework in 2001. The researcher subsequently returned to the botanicas and the Taller Puertorriqueños with a graduate nursing student who was undertaking a guided study of Puerto Rican cultural health practices. The researcher has contacted key organizational informants in the Philadelphia Puerto Rican community and the public health community and has attended several festivals and church services in the area. The researcher has met with selected resource persons at Temple University Hospital who are associated with the cultural competency project; the researcher also is a member of the Philadelphia chapter of the National Association of Hispanic Nurses and volunteers regularly at community health events. The researcher has met several Puerto Rican women through a neighborhood contact who is an advanced practice nurse. The researcher also traveled to El Centro de Estudios Puertorriqueños at Hunter College in New York City, the primary repository in the area for Puerto Rican cultural studies, and searched their extensive library and dissertation collection.

The setting for this naturalistic study is within the city of Philadelphia, PA. Philadelphia is the largest city in Pennsylvania; it is coextensive with Philadelphia County, and is located in the southeastern part of the state at the junction of the Schuylkill and Delaware Rivers. The total population from the 2000 census is
African Americans are the largest minority group, followed by Hispanic/Latino at 128,928. Puerto Ricans are the largest Hispanic group in Philadelphia, with a total population of 91,527 (Philadelphia Connect, 2000). Philadelphia is host to many ethnic groups; while they are widely disseminated throughout the city, ethnic enclaves are readily identifiable.

An area in North Philadelphia and North Kensington is home to many Puerto Rican residents. A casual observer can readily identify the area because all of the shop names and billboards are in Spanish; even some of the street names have a second level with a Spanish listing. There is a small grocery store or bodega on most corners. Odors of Puerto Rican foods, alcapurrias and tostones, originate from restaurants and take-out cafes. Botanicas display artifacts of folk religion; storefronts in tropical colors advertise goods and services, and recall the comforts of an island home. The Taller Puertorriqueño or Puerto Rican Cultural Center is a prominent building. A banner above one intersection announces that this is El Bloque de Oro, the Golden Block, el corazón del barrio, the heart of the barrio.

The Golden Block is Philadelphia’s specific Latino commercial district in the area with the largest residential concentration of Latinos. Julia de Burgos school, Roberto Clemente middle school, and the headquarters of Congreso de Latinos Unidos, one of the largest Latino agencies nationwide are close by. El barrio is a place to search for support, services, and culture in one’s tongue for many new migrants and immigrants. It is home to many of the community’s largest social, cultural, and service organizations, Casa del Carmen, Aspira, Esperanza, and El
Concilio to mention a few. For established Latinos, it represents a cultural base and a center of activity.

Although the area is one of the more impoverished in the city, streets are clean, row houses are well kept, and flowers adorn the lawn or flowerboxes. In the early summer evening neighbors gather on porches or street corners and music is heard. There are elements of crime, drug-related activity, and domestic violence within the community. Many of the residents are employed in low-paying, blue collar jobs including working in a tire factory, janitorial work, security work, or medical assistant; some have two jobs to support their family. A strong sense of ethnic pride and identity prevails. There are several senior housing projects with adobe facades and red tile roofs that conjure up a Spanish feeling. These spaces are the result of efforts to transform a blighted environment and create safe, culturally meaningful spaces for the community. Murals in the neighborhood mimic island landscapes, celebrate women, highlight culture, and memorialize those whose lives were lost to urban violence.

Many Puerto Ricans who came from rural areas transform vacant lots and side yards into miniature gardens and farms, keeping roosters, chickens, and goats, and planting vegetable gardens. The North Philadelphia Neighborhood Association’s (pseudonym) casita is one such project. Here, amidst las parcelas--community garden plots, a casita (a little house patterned after the traditional jibaro homes on the island) serves as a community center for all generations. Several other themed gardens have emerged in the surrounding area which serves as the hub for the enculturated Puerto Rican community. The Philadelphia Puerto Rican community celebrates Puerto Rican week annually in September, with diverse cultural and social activities culminating in
a parade. In 2005 the National Council of La Raza held its conference in Philadelphia. There is also a weekly television show, Puerto Rican Panorama, which highlights arts and cultural, social, and educational events and accomplishments. The National Council of Hispanic Nurses (NAHN) has a very active Philadelphia area chapter. The Asociación De Puertorriqueños En Marcha operates a housing center and a health center and Maria de la Santos is another health center in the barrio. Temple University has a large family practice center in the area also. This was the area selected by the researcher and community resource persons for the largest concentration of Puerto Rican women.

The majority of interviews took place in the privacy of the informants’ homes. Other interview sites included the large gated community garden, a private office at North Philadelphia Civic Association headquarters, a private room at a senior center, and a private office at the North Philadelphia Neighborhood Project. In each site, the interviewer and the interviewee were alone.

3.5 Informants

Recruitment

Key informants are critical to the success of the ethnographic method (Spradley, 1979, 1980). A key informant is one who is articulate and able to reflect on and describe the culture or cultural phenomenon under study (Morse & Richards, 2002). Key informants can frequently provide direction to the researcher in gaining access to other informants. A fellow member of the Philadelphia chapter of the National Association of Hispanic Nurses who is known and trusted in the community, and another bilingual nurse
practitioner working in the community have been facilitating this researcher’s entry and presence in the community. They introduced this researcher to several Puerto Rican women in the community who served as key informants. The researcher was also in contact with several community organizations which serve the Hispanic community including Congreso de Latinos Unidos, Casa del Carmen, El Concilio, Norris Square, and Asociación De Puertorriqueños En Marcha; these groups were aware of the researcher’s study and served as a backup resource for potential key informants if the initial sources were insufficient for the proposed sample size.

**Sampling Strategies and Size**

The researcher initially used a purposive sampling strategy to obtain key informants and then asked these informants if they knew of other Puerto Rican women who would be interested in talking with the researcher. This is called snowball sampling. Purposive or purposeful sampling is a form of non-probability sampling used frequently in qualitative research. The objective is to select informants specifically for certain reasons such as in depth knowledge of the phenomenon, willingness to participate, ability to communicate clearly, and availability (Morse & Richards, 2002; Polit & Beck, 2008). These are called general informants. Key informants are those who possess all of the aforementioned qualities, work closely with the researcher and provide insights into cultural interpretation (Richards & Morse, 2007). Once these key informants were interviewed, this researcher used snowballing to locate other potential general informants. Snowball sampling is another form of sampling used in qualitative research where the intent is to locate informants who might be difficult to identify. Snowball sampling is a form of informal networking wherein the researcher asks key informants already
interviewed if they know of any contacts who also might have knowledge of the phenomenon under study. The researcher can specify to the key informants what qualities he/she is seeking in further informants and the personal introduction from the referring informants can help to establish trust between the researcher and the newly found informants (Polit & Beck, 2008). Morse & Richards (2002) state that use of appropriate sampling strategies such as purposive sampling and snowball sampling help to insure rigor while executing the study.

The researcher then contacted the other informants by phone to explain the study, to insure that they met the eligibility criteria and were willing to participate. The researcher scheduled a date, time, and place for initial interviews. The researcher called each informant the day before the scheduled interview to reconfirm. Since the researcher did not live in close proximity to the geographic area, and informants had many responsibilities, the pre-interview phone call allowed for last minute changes in schedule and minimized missed opportunities.

Sandelowski (1995) emphasizes the importance of adequate sample size to the success of a qualitative research project. She cites factors such as aim of sampling and research method, coupled with judgment and experience as important. A beginning researcher may need to oversample in order to see or uncover the data (Sandelowski, 1995). Other factors to consider include the number of interviews and the depth of the interview versus actual numbers of participants, in order to obtain rich, thick description. Morse and Richards (2002) suggest establishing a minimum number while emphasizing that the scope of the project is larger than its sample. This researcher sought a sample of 30 women age 18 years and older, with the possibility of increasing or decreasing this
depending upon when saturation is reached. Saturation occurs when the phenomenon of interest has been explored in depth and informants state that there is nothing more to report or there is a duplication of information by several informants (Leininger, 1994) with a concurrent redundancy in data analysis yields (Polit & Beck, 2008). The actual sample of 37 for this study was determined by reaching saturation. One informant had a different pattern of home remedies, so the researcher sought out more informants to see if this was unique or part of another phenomenon. All subsequent informants gave similar information to the earlier ones. The researcher noted that the unique informant was an avid reader and kept up on the latest alternative health trends including flaxseed, soy yogurt, green tea, and probiotics. This was not typical of any other informants.

This researcher selected the potential sample size of 30 after a review of digital dissertation abstracts for recent ethnographic dissertations which returned a range of 13-24 informants in most focused ethnographic studies. Several qualitative research experts also support a sample size of 30 for ethnographic studies (Creswell, 1998; Sandelowski, 2000; Morse & Richards, 2002). Participants may be interviewed one or two times, depending upon the nature of the interview, review of data, and further questions generated. The researcher may specifically request a second interview with some informants after initial data analysis to review content, clarify any questions, and verify trustworthiness of the data (Spradley, 1979; Morse & Richards, 2002).

During the initial interview process this researcher identified six informants who were especially knowledgeable about the domain of inquiry. Four of the six informants initially agreed to a second interview; one declined due to multiple professional and personal commitments and lack of time. Subsequent to the initial interview, the
researcher was contacted by a nurse practitioner colleague and told that one of these informants had died. A second informant died unexpectedly over the December holiday period; this informant was considered a local expert on home remedies. The researcher had informally returned to speak with her during the course of the study to clarify some questions about home remedies, but was unable to schedule a final interview due to her death. The remaining three informants traveled to Puerto Rico for an extended stay after the feast of Tres Reyes, Three Kings’ Day or Epiphany, which is the day in Puerto Rico where holiday presents are exchanged and parades and celebrations occur. Upon the return of two informants, one was hospitalized with a recurrence of cancer, further delaying second interviews. The third informant remained in Puerto Rico caring for a sick relative.

_inclusion and exclusion criteria_

This study included women over 18 years who self-identified as Puerto Rican and lived in the Southeastern PA area. Women over 18 years were selected because they were deemed most likely to be knowledgeable about the phenomenon of interest and may have firsthand knowledge of culturally based health care practices and health beliefs (Davis, 1994, 1996; Higgins & Learn, 1999). Additionally informants had to be: a) willing to participate in the study, b) able to communicate in English, c) available to meet with the researcher. Exclusion criteria included women who: a) did not self-identify as Puerto Rican, b) were under age 18 years, c) had no knowledge of the phenomenon of interest, d) were unavailable or unwilling to commit to the time for the interview, e) were too frail to participate, f) were unable to communicate in English, or g) resided outside of the designated geographic area of the study.
Informant Payment

Informants were given a gift certificate for $25 to a neighborhood grocery store after the completion of the interview; when a second interview occurred, another gift certificate was given. Sears (2001) addresses the paucity of ethical guidelines regarding payment for research participants. She suggests that respect for persons and justice, two principles of the National Commission (1979) be used to guide the researcher. In this researcher’s prior experience with Puerto Rican groups doing surveys, gift certificates were preferred in lieu of money, and tokens of appreciation such as gift certificates were appreciated as a sign of respect for the informant’s time. During the time of data collection, several stores in the local grocery chain were sold, complicating the redemption of gift certificates. The researcher was assured by each branch that the gift certificate would be honored if redeemed within six months; this was told to informants.

The researcher offered to share study findings with informants. Several informants associated with the North Philadelphia Neighborhood Project have requested that the information be shared with the community. The researcher will arrange for this after the study findings are concluded and approved. The researcher has also contacted the director of the cultural competency initiative at Temple University Health Services and plans to meet with her once the study findings are reviewed.

Interviews were conducted in the location of the participant’s choice, including in informants’ homes, a community garden area, a senior center, and the office of the community civic association. Patsdaughter, Christensen, Kelley, Masters, & Ndiwane (2001) emphasize the importance of allowing participants to choose their preferred interview site in both recruitment and success of the interview.
3.6 Instruments

The researcher utilized a demographic profile, an acculturation measurement tool, and a semi-structured interview guide for this study.

*Demographic Profile*

The Demographic Profile is a 4-item questionnaire (Appendix A) designed by the investigator to collect demographic data about the study informants in order to describe their age, place of birth, length of time in the United States and return visits to Puerto Rico. This form was read to the informants at the beginning of the interview. They were given the opportunity to decline to respond to any questions they choose not to answer. The researcher recorded the informants’ responses on the form and verified each response with them. The data from this form were used in coding the primary documents for Atlas ti and generating a description of the sample.

*Acculturation Measurement Tool*

The *Psychological Acculturation Scale* or PAS (Appendix B) is a 10-item Likert scale that is designed to measure psychological acculturation or “changes in individuals’ psychocultural orientations that develop through involvement and interaction within new cultural systems” (Tropp, Erkut, Coll, Alarcón, & García, 1999, p. 351). Each item on the scale is scored separately. Whereas most of the other acculturation scales rely on indicators such as language, length of time in the new culture, generational acculturation, behaviors and such, the PAS scale focuses on individuals’ process of negotiating two cultural systems with strong emphasis on feelings of “emotional attachment to and understanding of both cultures” (Tropp, Erkut, Coll, Alarcón, and García, 1999, p. 353).
The PAS was developed by a group of researchers in the United States and Puerto Rico and was tested extensively for validity and reliability with Puerto Rican participants. The PAS has been administered in English and in Spanish. The Spanish version does not follow Brislin’s (1970) back-translation methodology but employs a dual focus approach (Erkut, Alarcón, García Coll, Tropp & Vázquez García, 1999) wherein researchers from the culture developing the instrument and from the indigenous culture who are familiar with shades of meaning, collaborate “horizontally” on translation. The dual focus is the equal partnership of indigenous and “other” culture and the emphasis on “concept-driven rather than translation-driven approach to attaining conceptual and linguistic equivalence” (Erkut, Alarcón, García Coll, Tropp & Vázquez García, 1999, p. 207).

Internal consistency estimates ranged from .83 to .90 for the Spanish version and from .83 to .85 for the English version (Erkut, Alarcón, García Coll, Tropp & Vázquez García, 1999). Further testing with 36 self-identified bilinguals was done. Subjects were given both the English and Spanish versions, presented in a counterbalanced random order. The correlation between their scores on the English and Spanish version was \( r (35) = .94 \) (Erkut, Alarcón, García Coll, Tropp and Vázquez García, 1999). Convergent and discriminant validity was assessed in two sample groups; predicted relationships between PAS participant scores and established acculturation measures such as place of birth, length of time in mainland US, and cultural behaviors and preferences from other acculturation scales were examined (Tropp, Erkut, Coll, Alarcón, and García, 1999). Overall results established that psychological acculturation correlated more strongly and consistently with participants’ cultural preferences and behaviors than percent of time living in the US.
In this researcher’s prior contact with the Puerto Rican culture, the questions on the PAS scale typify the manner in which Puerto Ricans identify themselves, i.e. biculturally, as both Puerto Ricans and Americans. Additionally, this researcher has been engaged in serious discussions with Puerto Rican adults in both Bethlehem, PA and Philadelphia, PA concerning nuances of translation by someone of Mexican ethnicity for use by Puerto Ricans and also with regards to patient education materials in Spanish that reflected a Mexican population bias.

The PAS was read to each informant at the beginning of the interview, either in English or in Spanish as the informant chose. Informants were told that they did not have to respond to any questions they chose not to answer. One informant declined to respond to any of the questions. She felt that the tool was too limited in scope. The researcher recorded the informants’ responses on the form and verified each response with them.

The Interview Guide

The semi-structured interview guide (Appendix C) was used to elicit an understanding of the domain of inquiry for this study: a) to discover the health beliefs and cultural health care practices utilized by Puerto Rican women in caring for self and family members; and b) to seek out the implications of these health beliefs and practices for health professionals who work with this population. The interview guide consisted of some general questions, followed by specific probes designed to query areas of cultural health beliefs and practices previously attributed to Puerto Rican cultural groups in the literature (Adler, 1995; Davis, 1996; Delgado, 1996; Gonzalez-Wippler, 1996; Guarnaccia, 1993; Harwood, 1971, 1981; Koss-Chioino, 1976, 1992). The interview guide responses were digitally audiotaped and transcribed and were entered into Atlas ti
as primary documents. Information from these documents was used for coding and data analysis and is incorporated into the discussion of findings in Chapter IV.

3.7 Procedures for Protection of Human Subjects

Prior to initiating the study, approval to conduct the research was obtained from the Institutional Review Board at Duquesne University and the official consent form was presented. IRB approval was obtained in July 2007 (Appendix F) and the study commenced. The researcher gave a verbal explanation of the study to the informants. The informants were provided with information about the confidentiality of the study, and offered the freedom to withdraw from the study at any time. The purpose and benefits of the study were explained to the informants. There are no known risks associated with this study. The researcher provided the informants an opportunity to ask questions or clarify concerns about the study or the method of obtaining data. The researcher read and explained the consent form to the informants in English or Spanish, whichever the informant preferred. The informants were requested to sign and date the consent form. The researcher also signed and dated the consent form in the presence of the informant. All informants were able to write and sign their names. A copy of the consent form was given to each informant and the researcher highlighted her contact information for the informant. The original consent form is stored in the researcher’s locked files in her home office.

The researcher obtained permission from the informants to audiotape the interviews with a digital recorder, and to take notes if needed. The researcher assured
confidentiality and anonymity of the informants by randomly assigning a letter code to each of the informants, e.g. interview #1 is A, #2 is B, etc. The confidential code list will look like this: #1=A= informant real name. The alphabet letter for each informant was assigned for using quotations. This code list is presently maintained by the researcher with the true names of the informants in a locked drawer in the researcher’s home office, and will be destroyed upon completion of the study, after information is sent to the informants who requested it. Some of the digital tape files were downloaded to the researcher’s computer and emailed to the transcription agency using a secured email server. The researcher encountered difficulty with the transcription agency due to the heavy accents of some of the informants. Many passages were listed [inaudible] or transcribed inaccurately—e.g. Vitamin B12 was transcribed as Beecham. The researcher had to listen to each transcribed file and edit it. After several files required this extra step, the researcher decided to transcribe the voice files herself. This was a very time-consuming process; each interview of approximately 1 hour required four to six hours to transcribe accurately. However, the researcher benefitted from hearing the tapes and wrote some memos while editing. Tapes are all stored on a dedicated laptop notebook which is locked in the researcher’s home office. Transcribed tapes have been formatted as primary documents in Atlas ti (Scientific Software Development GmbH, 2004), the qualitative software package used by the researcher. One backup CD was made. The transcribed tapes, CD, field notes, and journal entries are in a locked drawer in the researcher’s home office. These materials will be destroyed after completion of the study and publication/presentations. Access to these records is limited to the researcher, dissertation chairperson, and methodology committee member.
Although there were no risks identified in this study, one informant experienced mental anguish stemming from one of the questions, specifically, “Who do you consult for help with family health problems?” The informant, a senior citizen, related to the researcher that her son had married outside of the culture and had abandoned his parents. The informant felt that her son was ashamed of her and said that she never saw her grandchildren even though they lived only one hour away. She told the researcher that she had contemplated suicide by taking an overdose of her pills, but hesitated because of her faith in God. The researcher used active listening and reflection to obtain more information and to allow the informant to tell her story. After ascertaining that she was not actively suicidal at this time and was enrolled in a therapy group at the senior center, the researcher obtained her permission to confer with the social worker at the center as a safety check. The informant also shared that she was seeing a mental health professional and would continue to work with him. The researcher spoke with the social worker the same day. The social worker confirmed that the informant was in a therapy group and that she was responding well to the intervention, also saw a psychiatrist for individual therapy. The social worker said that she would meet with the informant individually to follow up but felt that the question had “touched a tender nerve” which triggered the response. On two subsequent visits to the senior center, the informant greeted me warmly and seemed very interactive with her peer group.

3.8 Procedures for Data Collection

Wolcott (1999) discusses the issues of participant-observation in ethnographic research. Not only is the participant observer involved in observing the population under
study, but the reverse is true as well, and the effect of the researcher’s presence on the sample population must be considered. This effect does diminish over time as the researcher moves from a stranger to a position of trust within the community.

Conversely, Morse and Richards (2002) caution that if the researcher is working in a familiar area, it is helpful to step back, set aside habitual ways of seeing, and re-enter the field as an observer. This researcher is familiar with the area and had met some potential informants, but contact has been episodic and interrupted enough that familiarity was not assumed.

The other issue raised by Wolcott (1999) is whether to ask questions or merely “hang out” and observe the day-to-day happenings of the population under study. This researcher employed a combination of participant-observation (self as instrument) and inquiry, using a demographic tool, an acculturation measurement tool, and a semi-structured interview guide with probes.

The researcher initially entered the community while studying folk and unorthodox healing methodologies. The researcher has kept a field journal of encounters in the community, including a gradual immersion in the culture and social activities through membership in the Philadelphia Chapter of NAHN. The researcher continued to maintain a community presence. Key informants were sought from prior and current contact with community contacts (see Informants section). The researcher introduced herself and explained the purpose of the research to each informant. The researcher verified that the informant met the inclusion criteria of being a self-identified Puerto Rican woman between 18 and 70 years old, living in Philadelphia, and willing to participate. Consent was obtained from each informant, using the official Consent Form. The demographic
was then administered (Appendix A), followed by the PAS Acculturation Scale (Appendix B). The researcher then interviewed the informant, using the Interview Guide (Appendix C). Interviews were conducted in English, were digitally audiotaped and transferred to the researcher’s computer. Initially taped interviews were emailed on a secure server to a digital transcription service in California supplied by a Dissertation Committee member. When transcription problems occurred due to heavy accents of informants, the researcher ceased using the transcription service and transcribed the tapes herself. (See Procedures for the Protection of Human Subjects for further detail). Field notes were recorded on the secure laptop by the researcher immediately after the interview. The researcher maintained a personal journal to record reflections including any bias. Procedures for the protection of human subjects governed data collection, storage, and analysis. The researcher reflectively reviewed the interview questions following the interview and found that no adjustment was needed (LeCompte & Schensul, 1999).

3.9 Data Analysis

First-level ethnographic description positions the researcher in the context of the study and includes data such as maps, photos, historical documents and demographic information (Morse & Richards, 2002). The researcher accumulated some of these data describing the setting prior to the actual study. Photos of the area were taken during the actual data-gathering period of the study. A demographic profile of the informants has been created from the demographic questionnaire and will be used to describe the study population (see Chapter IV- Findings). Information from the demographic profile and
the PAS Acculturation Scale was incorporated into the Atlas ti software analysis database (ATLAS.ti Scientific Software Development GmbH, 2004). After conferring with the expert nurse ethnographer who suggested that the researcher establish categories of high, medium, and low acculturation, the researcher used the information generated from the Psychological Acculturation Scale and entered it into SPSS. There were 10 questions, each with a maximum value of 5, for a possible total range of 10 to 50. Scores were totaled for each informant and ranged from a low of 10 to a high of 39, with a mean of 22. Internal reliability of the instrument was determined by measuring the coefficient alpha which was .85. Scores of 10-17 were assigned a rating of low acculturation, scores of 18-35 were considered medium acculturation, and scores of 36-50 were rated as high acculturation.

The PAS Acculturation Scale scores were incorporated into Atlas ti to serve as one analytic lens for interpreting qualitative data and conducting comparisons across acculturation and age group ranges. Responses to the semi-structured interview guide were entered into Atlas ti and analyzed for categories of health practices and beliefs. These categories were further examined for patterns between levels of acculturation and use of cultural health practices, age, years in U.S., and number of return visits to Puerto Rico.

Ethnographic analysis of content from interviews and field notes for categories, subcategories, and cultural themes was done. Morse and Richards (2002) identify three data analysis strategies to enhance thick description: observation, interviews, and diaries. Bernard (1998, 2002) adds systematic observation to balance the emic and etic perspectives. The researcher incorporated all of these strategies—ethnographic analysis
from interviews, fieldnotes, participant observation, diaries, demographic data, data from
the PAS scale, and systematic observation into data analysis.

Sandelowski (1995) recommends that the researcher initially read each interview as
many times a necessary to gain a sense of the overall picture, making notes and memos as
thoughts arise from the readings. This researcher reflectively reviewed each interview
after the interview was done by listening to the digital tape prior to transcription, making
notes on any thoughts that arose. The researcher reviewed the interview again,
incorporating a review of field notes from that interview, and again making notes on any
thoughts that occurred. The availability of the digital recording from the interview was
advantageous to the researcher because hearing the informant’s voice and inflection
helped the researcher to recall subtle details of the interview that might have been lost by
just reading the transcript. Subsequently, the researcher reviewed the interview, field
notes, and reflective notes, looking for words or phrases related to the research questions.
The researcher followed this process for the initial three interviews, before entering any
data into the computerized data analysis program. Each of these three interviews were
compared with the other interviews to see if any common words or phrases were used
and to look for detailed description (Morse, 1995). Using examples from literature on
qualitative data analysis (Coffey & Atkinson, 1996; LeCompte & Schensul, 1999), the
researcher hand coded data from these three initial interviews. This was a self-test for the
researcher to demonstrate ability to code without early dependence on a computerized
data system. Sandelowski (1995) identifies premature analytic closure associated with
overdependence on computerized data programs as a common problem for beginning
researchers.
The researcher had a phone conference and discussed the results of the interview process and this initial coding effort with the expert nurse ethnographer on her dissertation committee before proceeding to enter data into the computerized data system. According to the literature, data analysis is a dynamic process and may require adjustments in questions, interview techniques, etc (Morse & Richards, 2002); utilizing an early self-check can facilitate this process and avoid potential data collection and analysis problems at a later stage.

The researcher has previously participated in qualitative data analysis of an ethnonursing study under the supervision of Dr. Zoucha while studying qualitative methods in the doctoral program. The researcher also worked with another qualitative research mentor, Dr. Karen Schaefer, doing select portions of data analysis on an early draft of a phenomenological study. The researcher has also read extensively in qualitative research books and articles which present segments of data for analysis and demonstrate analytic processes (Coffey & Atkinson, 1996; DeSantis & Ugarriza, 2000; Good & DelVecchio, 1993; Kleinman, 1985; LeCompte & Schensul, 1999; Morse & Richards, 2002).

The terms code and coding have a variety of meanings in literature on qualitative data analysis. LeCompte and Schensul (1999) define codes as, “names or symbols used to stand for a group of similar items, ideas, or phenomena that the researcher has noticed in his or her data set” (p. 55). Morse and Richards (2002) elaborate on these further, identifying several levels of coding including: a) descriptive coding, or storing information, b) topic coding, where material is grouped by topic or category, and c) analytic coding or abstracting, which facilitates the development of concepts with the
ultimate goal of identifying themes. After the researcher reviewed her hand coding with the expert nurse ethnographer, she entered the data from the interviews, field notes and memos, into Atlas ti. The researcher continued to read each subsequent interview reflectively several times, as previously described, before entering it into the Atlas ti database.

Utilizing Atlas ti, the researcher identified and coded specific, recurrent phrases from interviews, grouping them into broad categories. The software capabilities of Atlas ti facilitates the creation of codes from chunks of data and also the linking of coded data. Once the researcher determined that rich description was present, she established categories of data from the *emic* perspective. These categories were examined with relation to the domain of inquiry and subcategories were created. The researcher also documented any known or suspected biases or inclinations toward expected grouping (*etic*). Emic and etic descriptors were examined for similarities and differences. Recurrent descriptors were examined further for their meanings. Throughout this process the researcher remained close to the data without adopting the perspective of the informants, i.e. “going native”. The researcher returned to select informants to clarify that what she has recorded is true to their information. One informant with specific knowledge of home remedies was consulted midway through the study to verify names and uses of remedies; this informant died before the completion of the study. Two other informants were revisited towards the end of the study; a third informant who had agreed to a second interview stated that she was too busy with professional responsibilities and could not be consulted and another informant went to Puerto Rico to care for a sick
relative. The researcher also used memos within the Atlas ti system to record spontaneous thoughts and data insights that were utilized for tracking and analysis.

Following the descriptive coding and identification of categories and subcategories, the researcher revisited the data in a holistic fashion, and abstracted themes from the data analysis. The act of abstraction is interpretive in nature as compared to descriptive coding and categorization. Sandelowski (1998, 2000b) refers to it as a creative act. Morse & Richards (2002) also emphasize the creativity while cautioning the researcher to remain true to the data. DeSantis and Ugarriza (2000) emphasize the importance of defining the term theme for consistency in qualitative research. They define theme as follows: “A theme is an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole” (p. 362). The researcher identified direct quotes from informant interviews to support themes and enhance the richness of the data analysis.

The researcher consulted with an expert nurse ethnographer throughout the process of data collection and data analysis. Data collection and data analysis were simultaneous. The researcher also revisited two select informants for second interviews for clarification or more detail as needed, and for validation of previous data, to insure trustworthiness. A third informant was consulted about specific questions on home remedies midway through the study, but died before the conclusion of the study so a formal second interview was not conducted.

The researcher utilized the Atlas.ti data analysis software package. The researcher attended a workshop on this software package. The expert nurse ethnographer working
with the researcher also uses this software package. St. John and Johnson (2000) cite the advantages of qualitative data analysis software (CAQDA) in terms of rigor and validity. The researcher remained mindful of the potential pitfalls of CAQDA, including distractibility and distancing the researcher from the data by mechanistic coding (Sandelowski, 1995).

In summary, the researcher initially read each interview several times before doing any type of coding. The researcher hand coded the first three interviews to demonstrate the ability to code independent of CAQDA. The researcher discussed this initial coding with the expert nurse ethnographer. The researcher then entered data from interviews into Atlas ti, descriptively coding chunks of data. The researcher established broad categories from the coded data, returning to the original transcribed data as needed. Subcategories were identified within the broad categories and the data were reviewed for inclusion in these subcategories. The researcher was challenged not to become caught up in creating endless subcategories once the facility of the software to do this became apparent. The researcher attempted to remain grounded in the data. The researcher then returned to the data and reviewed it as a whole, abstracting themes from the data for “re-presentation” (Sandelowski, 1998). The process of data analysis was cyclical and repetitive, with the researcher going back and forth to the data for review and reconsideration, until the researcher was satisfied that it was complete. Data analysis consisted of the following steps: 1) initial coding, 2) categories, and 3) subthemes and themes.

*Insuring Rigor*
The literature is replete with competing criteria purported to insure rigor in qualitative research; areas of controversy continue to the present day. Morse and colleagues (2002) make a strong case for using validity and reliability as the evaluative measures. Morse (2002) decries the “post hoc” evaluation used by many and argues for careful attention during every stage of the research process including methodological congruence. The notion of verification is a prominent issue in Morse’s work, involving flexibility and two-way movement between design and execution to insure congruence around question formulation, literature review, recruitment, data collection strategies and analysis. This researcher has worked diligently with her dissertation committee to refine research questions, conduct a relevant literature search, and plan for recruitment of informants, data collection and analysis consistent with methodology. The researcher continues to self-monitor data collection and analysis as described in the data collection and data analysis sections.

**Trustworthiness and Credibility**

Credibility and trustworthiness refer to the “truth value” (Lincoln & Guba, 1985, p. 294) or believability of the researcher’s findings. This is established by carrying out the research process in such a way as to enhance credibility and to demonstrate trustworthiness by having the findings confirmed by the informants. This researcher insured credibility by consulting with the informants while engaged in the process, reflecting back to them during the interviews, and revisiting select informants for a second interview or during final data analysis to reaffirm that the meaning and beliefs of the informants are portrayed clearly and truly. This was done by clarifying questions during and immediately following the initial interview, by phone conferences with
informants as needed when further questions arose, and during second interviews with two key informants. Morse (1994) emphasizes that the informants are the primary gatekeepers for information and to substantiate findings. Lincoln and Guba (1985) also state that the researcher must be familiar with the culture prior to gathering data. This researcher has studied the Puerto Rican culture extensively and has maintained an episodic presence in the geographic area. The researcher maintained a journal to document her feelings and biases during the process and reviewed this regularly as part of the data analysis to differentiate etic and emic findings. The researcher consulted with an experienced nurse ethnographer and researcher during the data collection and analysis process, to follow the methodological trail and decisions for consistency. Lincoln and Guba (1985) maintain that an audit trail is the most important tool available to the researcher to establish trustworthiness. The researcher also used a quantitative measurement tool, the PAS, to provide another source to validate the interview data. Parts of the audit trial include the raw sources of data (transcribed interviews, field notes, and any related documents), the products of data analysis (codes, concepts, themes and clusters), and the findings.

**Saturation**

As addressed earlier related to informants, the researcher continued with data gathering until redundancy occurred. Saturation was experienced as further informants reporting the same responses as prior informants and no new information was forthcoming. Morse & Richards (2002) address the responsibility of the researcher to seek out negative cases if any are encountered that do not fit the pattern of other informant data, to see if another category emerges or if the negative case is unusual
One case did not fit the pattern for culturally based home remedies; the researcher attempted to seek out similar cases but none were uncovered and this case was deemed to be unique.

**Transferability**

The goal of qualitative research is not to produce generalizations, but to develop in depth knowledge about a phenomenon (Morse, 1994). Since qualitative research is contextual, the researcher described the context and time in which this research occurred (Guba & Lincoln, 1985). The researcher provided thick description; these elements of context and thick description will guide other potential researchers to decide if this study meets the requirements to transfer to a similar contextual setting.

**Dependability**

Morse (1991) takes issue with the term *dependability*, stating that it is analogous to reliability as presented in Guba and Lincoln (1985). One strategy to assess dependability is an inquiry or process audit, similar to the procedures described under *verification*. Additionally, issues related to reliability of data gathering was addressed by having a single interviewer, the principal researcher, interview all of the informants. This minimized variations in the interview style and process other than those generated by probes in response to the semi-structured interview guide.

**3.10 Summary**

The purpose of this study was to discover the culturally based health care beliefs and practices of the Puerto Rican population in Philadelphia, PA as related by Puerto
Rican women. The study also sought information on acculturation from the informants.

The information gathered was examined for patterns and to ascertain if there is a need for further study of the construct as it relates to the health of Puerto Ricans in Southeastern PA.

The study used a naturalistic, ethnographic design approaching the phenomenon under study with intent to discover what is occurring in the population as seen through the eyes of the informants. Quantitative data from the demographic profile and the PAS Acculturation Scale was used for descriptive complementarity. Key informants were identified and leads were generated for further informants. The interviews took place in a setting chosen by the informants, including their homes, a secluded area in a community garden, and private areas in a senior center or office. Ethnographic analysis of content from interviews and fieldnotes for domains, categories, subcategories, and cultural themes was done with a goal of generating thick description. An expert nurse ethnographer worked with the researcher to insure consistency and rigor in data collection and analysis. Findings from this study will be used to generate recommendations for further study as well as to recommend culturally competent practice recommendations for professional health care providers working with Puerto Ricans in Southeastern PA.
CHAPTER 4

FINDINGS

4.1 Introduction

In this chapter, the findings related to the domain of inquiry, health beliefs and culturally based health practices of Puerto Rican women in Philadelphia, PA are presented from the *emic* perspective, in the words of the informants. Data obtained from demographic information, from interviews, and from the Psychological Acculturation Measurement (PAS) Tool are depicted. These findings are supplemented by *etic* data accumulated from fieldnotes, memos, and direct observation to achieve rich description.

4.2 Description of Study Informants

The study informants consisted of 37 self-identified Puerto Rican women over the age of 18 years. Six of these were key informants and the remaining 31 were general informants. The actual age range was 28 years to 79 years. For purposes of data analysis, study informants were grouped into the following age categories: 1) 18 through 35 years, 2) 36 through 70 years, 3) over 70 years of age (Table 1). Study informants were also grouped by acculturation level, birthplace, number of years in mainland U.S., visits to
Puerto Rico in the past five years, and acculturation level (See Chapter 3 for description of acculturation grouping; see Table 3 in Acculturation section of findings). Of the 37 study informants, 28 were born in Puerto Rico and 9 were born in the mainland U.S. Time living in the mainland U.S. for study informants born in Puerto Rico ranged from 16 years to 66 years with an average of 41.6 years. All but 6 of the study informants had visited Puerto Rico at least once in the past five years. Thirty-six of the study informants completed the PAS acculturation measurement tool; 7 study informants were in the low acculturation range, 26 were in the medium acculturation range, and 3 were in the high acculturation range (Table 3). One informant declined to complete the PAS acculturation measurement tool. Although the researcher explained the purpose of the tool, the informant felt that it was limited. The informant objected to the fact that it did not address education. In accordance with the study protocol, the informant was not required to complete the instrument.

Table 1

*Age Ranges of Study Informants (N = 37)*

<table>
<thead>
<tr>
<th>Age Ranges</th>
<th>Number of Study Informants</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 through 35 years</td>
<td>N = 6 (16%)</td>
</tr>
<tr>
<td>36 through 70 years</td>
<td>N = 25 (68%)</td>
</tr>
<tr>
<td>Over 70 years</td>
<td>N = 6 (16%)</td>
</tr>
</tbody>
</table>
A. Findings

Interviews with the study informants yielded many interrelated categories, subcategories and clusters of data related to culturally-based health care beliefs and practices. This researcher initially read and re-read each interview several times, looking for patterns, commonalities, and categories. In the early stages, the structure of the questions offered one way of categorizing data, especially with regard to home remedies. The researcher used Atlas ti software (ATLAS.ti Scientific Software Development GmbH, 2004) for coding, initially identifying 85 codes. Many of these codes were related to the plethora of home remedies supplied by informants. These were reduced to code families based upon their characteristics and this made data analysis of this segment more manageable. Other broad code families were established based upon birthplace and acculturation status.

Richards and Morse (2007) state that it is common especially for beginning researchers, to identify a variety of categories without seeing relationships at the outset. The reader is referred to Appendix I for a representation of early categories identified by this researcher. In addition to the codes entered in Atlas ti from direct quotations, this researcher used data from fieldnotes that were made immediately after the interview and memos entered into Atlas ti. Problems with data transcription at the beginning of the project made it more difficult to get to the data but this researcher listened to the transcripts on her computer wave file and made typed memos and notes on the computer. Some of these were later entered into Atlas ti along with the transcripts.

Broad themes that were abstracted from the data are presented here with supporting quotes from the informants and are subdivided into related subthemes, supplemented with
this researcher’s comments and observation. Major themes included: 1) Between Two Worlds: Staying Connected To Our Roots, 2) Gardens as Symbols of the Motherland: Creating the Environment, 3) The Holistic Nature of Health, 4) Surviving the System: Healthcare Perspectives in Puerto Rico and Philadelphia (Table 2).

Table 2

*Themes and Subthemes Abstracted from Interviews, Fieldnotes, and Memos*

1) Between Two Worlds: Staying Connected to Our Roots
   a. Home Remedies
   b. Acculturation

2) Gardens as Symbols of the Motherland: Creating the Environment
   a. Living Close to Nature
   b. Garden as Community Center and Culture Builder

3) The Holistic Nature of Health
   a. Spirituality and Health
   b. The Role of Women and Families in Health: Caregiving and Familismo

4) Surviving the System: Healthcare Perspectives in Puerto Rico and Philadelphia
   a. Health Practices and Healthcare Providers
   b. Curanderos, Santeros, and Espiritistas
4.3 Theme 1—Between Two Worlds: Staying Connected to Our Roots

All except three of the informants referred to Puerto Rico as “home” during interviews. When asked about visits to Puerto Rico in the past five years, all but six informants had visited at least once; many replied that they would love to go but the cost was prohibitive. Older informants voiced concerns about the healthcare system in Puerto Rico if they became ill; some of these concerns will be discussed in Theme 4.

Using the data from interviews, fieldnotes, and memos from informal conversation this researcher asked herself what the meaning of home was to these informants. The presence of family and traditions was seen as central to the meaning of home. The subcategory of home in Puerto Rico encompassed the reminiscences of the informants about earlier times or recent visits. Traveling back and forth to Puerto Rico, keeping in touch with family there by phone or mail seemed very important to these informants. Some seemed to romanticize the image of home. Informant EE described an idyllic childhood:

When we as kids got home in the middle of the table there was papaya, mango, lots of healthy food . . . and Mami was home to greet us.

She went on to describe the realities of living in Philadelphia where her children came home to an empty house while she and her husband worked for the bare necessities and had McDonald’s for dinner because it was quick and easy.

In contrast, the realities of transatlantic caretaking responsibilities were also verbalized by some informants. Informant D spoke of feeling pulled in two directions:

It is being in between and it is very hard on people. I have two friends; their mothers are there in Puerto Rico. One of them just died. It’s like this person
works here, lives here and her family is here, but her mother is there and her
sisters are there. It is about working and saving and not taking any time off or
vacation so that you can go there for a month to be with them. I have a friend that
she has been there for about 4 months; her mother is . . . almost 90 years old. She
is afraid to leave, that her mother will die when she goes. Another friend she
came back because her husband and her sons are here, and her father died three
days later; she had to go back. . . And it is not cheap to go back.

Another further limitation voiced by informants to home in Puerto Rico was the
limitations of the healthcare system. In the case of the two informants mentioned here,
poor healthcare was the deciding factor in their remaining in Philadelphia.

Informant KK, stated:

I’ve been back to Puerto Rico twice now to live. The last time, I was working as
a farmer there but my father had a stroke. We were in a tiny little town up in the
mountains and we carried him in a Jeep and we drove like nuts to this little
hospital, a religious hospital. And I will say he had excellent care but there was
no rehab and no chance of recovery. So we came back to Philadelphia. We had to.

Informant CC, a cancer survivor, would love to live in Puerto Rico except for the
healthcare:

My mother has a beautiful house in Puerto Rico; I would do well there . . . but the
health care is horrible.

Another informant related that she takes college professors and other
professionals on educational and cultural tours of Puerto Rico in order to return home.
Most informants still have relatives and friends in Puerto Rico; two informants told me
that their mothers were in Puerto Rico taking care of family there. Although all of the
informants become nostalgic when speaking about Puerto Rico, many have admitted to
this researcher that it would be very difficult, if not impossible, to return there to live.

Continuing with the category questioning the meaning of home to these
informants, this researcher found several subcategories related to home in Philadelphia.
The presence of family was one subcategory; all of the informants came to Philadelphia because close family members had come before them. They described the realities of life here as very different from Puerto Rico but have continued to live in a designated geographic area to maintain family closeness. Informant M stated that the support or closeness of family was very important:

The support of your family; the support or your closeness. That’s why I’m not moving anywhere. I have my grandma up the block. My mom’s around the corner. My aunts - I mean, it’s just nice to be close to family.

Mothers and grandmothers were seen as particularly important in the family. All of the informants that I spoke with mentioned mothers and grandmothers in conjunction with traditions. Most informants reported that home remedies were learned from significant women in their family, usually mothers or grandmothers. Because these women were respected and trusted, continuing to use these remedies was seen as a preservation of the culture.

*Home Remedies*

The most commonly used herbal substances included ginger, all types of mint, chamomile, garlic, linden or tilo, orange tree leaf, cinnamon, aloe vera, and rue. Non-herbal remedies in common use included coffee grounds applied to the eyes for conjunctivitis and a mixture of raw egg oil (residue from beaten egg white), almond oil, honey and lemon used to relieve chest congestion. More specific data on home remedies is contained in Table 4, Appendix K.

Informant D speaks of the tradition of home remedies in her family:

My grandmother -- that’s all she did—home remedies, *remedios caseros*. And we - when I was growing up, I didn’t even go to the doctor's. She would know exactly what to do. And I come from a small town where it was all these women talking about these home remedies because we didn’t have access to
doctors. And my mother, she’s here. She’s 78 years old. And when we have a stomachache, or we have diarrhea, or we have something, we go there first. And she will have the remedy from Puerto Rico. And a lot of people, they go there. And most of the time, she helps.

Informant D goes on to discuss the current sharing of home remedies by women in the neighborhood:

And we have sat down with a group of women from the neighborhood, and it’s like - I cut some herbs and put them on the table to dry, and it’s incredible. And I love to do that. It is incredible how these women, they say, "This is good for that, and that is good for that." And it’s, like, new things they were adding to the things we do. But it’s just all these remedies, kind of, that we do. . . . You know when I’m pulling weeds here -- there are weeds here, and we have to pull them because they are growing in the place that they are not supposed to. But those are herbs for us.

Informant F confirms the use of home remedies saying, “My family used to use; other generations are still using home remedies. I use some of them.”

Informant GG reports that she still consults with her mother:

Like I’m not feeling good and I call my Mom and tell her like I have something like bad nerves because I’m going through the change and she’d tell me to get some manzanilla [chamomile] to make tea to calm my nerves.

Informant HH states, “I was raised with my grandmother so I kind of like picked up some of the things that she did.” Likewise, informant J says, “My grandmother knows a lot about medicinal plants and different kinds of oils and that are directly from Puerto Rico. I learned some from her or I’ll call her to ask.” When asked about use of home remedies, informant EE responds, “Yeah, I still use some of the old ways.”

Several other informants voiced similar responses of learning home remedy use from prior generations and continuing to use them. Informant BB related the use of home remedies to caring:

I taught my kids to enjoy the teas when they were little and they used to ask me to
make for them even though they were not sick, for a comfort.

The initial question of the semi-structured interview related to use of home remedies. Five informants reported that they did not use home remedies; the remaining 32 informants provided a variety of information on home remedies, which lends itself more to tabular reporting (see Table 4, Appendix K). Using Atlas ti, this researcher established home remedies as a code family, with related subcategories such as remedies used for headache, remedies used for stomach problems, remedies used for colds and congestion including asthma, remedies used for nerves, remedies used for insomnia, remedies used for diabetes, fungus remedies, burn and skin remedies, remedies for cancer, remedies for muscle aches, and dangerous home remedies. Most of the remedies were herbal remedies but there was a small category of non-herbal remedies. Although the question did not specify herbal remedies or exclude food remedies, no one gave information on food remedies other than chicken soup. One key informant who was consulted for a second interview and preliminary review of findings suggested that a further study with food remedies would be interesting. There was some overlap among categories and some home remedies were reported with greater frequency than others.

All of the herbal remedies are made from fresh herbs whenever possible, or if not, from dried herbs obtained at the Spanish grocery or botanica. Guarapo is the name for any medicinal tea. The official formula consists of 3 or 4 cups of boiling water. A handful of fresh herb is added to this and it is covered and simmered for 15 minutes until the water is a deep color. It can be served with honey or sugar as needed. If dried herbs are used, the amount of herb is cut by one-third. Most informants were making this two
to three times weekly and storing the remainder in the refrigerator, heating just prior to using.

*Malta* is a bottled drink used as a vehicle for putting herbs in or making other home remedies such as raw egg yolk more palatable; there are various ingredients including malt, some have molasses, some have high fructose corn syrup. Informants state that it is not recommended for diabetics due to high sugar content.

Most of the informants reported that they grew their own herbs or purchased them fresh in the Spanish grocery store. One informant took the researcher into her backyard where she had an orange blossom tree from Puerto Rico. She brings this in the house each winter then outside again in the spring. This researcher made several visits to the Spanish grocery store and observed an abundant variety of herbs and plants, including cactus leaves and aloe leaves in the produce section. Other herbs were imported from Puerto Rico on visits and frozen, or mailed by relatives living in Puerto Rico. One informant opened her side-by-side freezer to show this researcher four shelves of frozen herbs and tree bark brought back from Puerto Rico. A large herb supply store in Philadelphia, Penn Herb, was used by two informants who also reported driving to New York where the botanicas sell fresh herbs. The researcher was given samples of some herbs and also sampled some of the medicinal teas and other herbal drinks during interviews and other functions. Vicks Vaporub had a special place in home remedies; it was mentioned almost universally by all informants. As informant D jokingly stated, “Puerto Ricans use Vicks for everything except sex.” Table 4, Appendix K contains a list of home remedies and their uses as reported by informants.

Although home remedies are natural, any food or dietary supplement has the
potential to harm if taken with certain prescribed medications. As a healthcare provider, this researcher was interested in learning if informants discussed use of home remedies with their healthcare provider or withheld this information. Some of this researcher’s questions related to safety of home remedies and disclosure of use to healthcare providers, also if use of home remedies precluded seeking care from healthcare providers. Not all of these questions could be answered by the data but some comments by informants offer direction for future study.

When asked if they knew of any home remedies that were dangerous, only 12 informants were aware of any; this was a concerning pattern.

Some informants had personal experience with a dangerous side effect or had read about possible interactions with drugs. Informant AA replied:

Anamu--that’s a weed that grows wild in the island. I don’t know where else in the world it is. That’s the only weed the goat won’t eat; that’s how nasty it is. My mom put it in a blender and she would take a every day for a long, long time she was taking an ounce or two of it. It arrests cancer according to her, but it can also cause kidney failure if you take it too long or use too much of it.

This informant reported that her mother died of kidney failure and that she would never use any herbal remedy without discussing it with her doctor. This is a safe plan for those who use home remedies and medications.

Informant N also had a safe plan, stating, “But for me I don’t wanna get into too many home remedies -because of all the medicine that I take. . .all the medicine, home remedies, I might get it mixed up.”

Informant CC reported that Kava was “a little bit dangerous, but my sister swears by it and she says that it energizes her and she feels great. I don’t use it.”

Informant CC also reported to this researcher that she worked as a chemist for a
pharmaceutical company so this researcher was disappointed and concerned at her response. The informant also reported using Bodol, a substance that is only approved for veterinary use, for cancer treatment. Further conversation suggested that this informant had a strong need to be in charge of her own treatment, despite safety concerns. This researcher found this to be similar in another informant with cancer, although the other informant did discuss all home remedies with her healthcare provider.

Informant S, a sagacious 73 year-old commented:

Very important-- Many people use ginkgo biloba - you have to be careful if you need surgery. Because ginkgo biloba, you have to suspend three weeks before one surgery because some people don't tell the doctor and they die in the surgery time. Yes. And you have to be careful, because everything natural is no good, too. . . You have to be very careful about the use vitamin, of over-the counter medicines. Because here they don't have any law to restrict this kind of business - I know, because I read everything.

Informant D also read and heeded warnings, stating:

The rue - in Puerto Rico, they use that for women when they had problems with their menstruation and things like that. I have read that it's very strong, and it is toxic. It could be toxic here. So I plant rue because of the color. I like to combine that with other plants, but I don’t use it.

The researcher also asked informants if they told their healthcare providers about their use of home remedies. The responses of the following informants represent a safe approach to integrative medicine.

Informant AA replied, “Actually, yes. Now she [doctor] actually gave me her remedy for when you have diarrhea. She said when you boil your rice, you take the water and you drink it.” Likewise, informant BB responded, “Yes; I tell my liver specialist because he talked about a liver transplant and I was taking Ribavirin and that medication really messed me up.” Informant D reported, “Yes. We fight when I go there because he’s a very good doctor, extremely good. And he knows. He said ‘Well, you
know everything has side effects.’ But we talk about it.” Informant FF, a dialysis patient, states, “I would share the remedies with them because of my kidneys. I have to be careful of what I am taking. They know that the spearmint is okay and that I take it 3 times a week.”

Other informants were less forthcoming and withheld information on use of home remedies from healthcare providers, citing fear of scorn or rejection, also possibly from mistrust of the provider.

Informant E stated:

No, because sometimes in a lot of times, you can let them know that you are taking some kind of remedy from natural stuff, they don’t believe in that. They tell you that that’s impossible or that’s not right, that you got to do medication that they give you.

Informant J spoke about her daughter’s pediatrician saying, “I have mentioned some home remedies to my daughter’s pediatrician. I don’t get support that they believe it. They don’t tell me to stop it. They go - [Makes Noise]. They don’t believe it.”

Informant L concurred, “I tell them very little. . . Some of them don’t believe in the home remedies. But I do them and it helps. It helps.”

Informant D commented during a second interview:

Some of the herbs, you should not mix them with the pills that the doctor is giving you. There should be something in between for many reasons. One of the reasons is that people believe -- we believe that some of these herbs could really cure your illness and also the economics.

Responses from informants are mixed, with some discussing use of home remedies with their healthcare provider, some receiving negative responses from providers, and others not discussing at all. This will be addressed further in Chapter 5.

Acculturation
The concept of acculturation is related to the first-hand contact of two different cultures, in this instance Puerto Rican and mainland U.S., specifically Philadelphia, PA. All except nine of the informants were born in Puerto Rico. Of the nine born in the mainland U.S., all but two had lived in Philadelphia, PA for their entire life. The remaining two born in the U.S. went to live in Puerto Rico for part of their childhood with family, before returning to the mainland U.S. To this researcher, the concept of acculturation is related to the theme of being between two worlds—Puerto Rico and the mainland U.S.

This researcher sought to measure acculturation in the informants using the PAS scale (Chapter 3) to answer the question: Is acculturation a factor influencing the health beliefs and cultural health practices of Puerto Rican women in the Southeastern Pennsylvania area? The PAS measures psychological acculturation or emotional attachment to a culture. As anticipated, most of the informants were in the medium acculturation range, indicating that they were bicultural and were comfortable in both American and Puerto Rican cultures. Of the 36 respondents, 3 were in the high acculturation range and 7 were in the low acculturation range (Table 3).

Table 3

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<th>Informant Age</th>
<th>Birthplace Years in US Mainland</th>
<th>Visits to Puerto Rico In Past 5 Years</th>
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*Summary of Demographic Data on Study Informants by Acculturation Levels as Determined by Measurement Using the Psychological Acculturation Scale (PAS) (N =36)*
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Notes: *Informant JJ, age 54, born in Puerto Rico and living in mainland US for 30 years with 10 visits to Puerto Rico in the past 5 years, declined to complete the PAS. Mean age of informants = 53, Mean years in US = 39
Low acculturation

This researcher reviewed data from informants who had low acculturation. Of particular note were informants J and M, both relatively young at 39 years old and 32 years old respectively, both born in the mainland U.S. Upon reviewing their demographic and interview data, both women came from very close-knit, matriarchal families and were raised by their grandmothers. Both families believed strongly in home remedies and each of these informants stated that they would consult their grandmother first for health care problems; they did respond to the PAS in English.

Informants R and S, both senior citizens, also scored low on the acculturation scale. They both responded to the PAS in Spanish. Both of them were devout Catholics and were faithful to the traditions of remedios caseros, using santos or statues, and candles all of which are strongly associated with the traditional Puerto Rican culture. However, informant S was also the negative case that this researcher encountered in that her newest home remedies were very contemporary and included soy yogurt and soy milk, Benecol margarine for lowering cholesterol, and flaxseed. She did mention that she had been sick and almost died, so this may have contributed to a preoccupation with health foods. She also was very proud of learning to read.

Informant K was a 41 year old who responded to the PAS in English. She was very devoted to her mother and followed some of the old traditions, including the quarantina [staying in bed or close to home for several weeks after childbirth to rest and become strong] and some home remedies. She was committed to educating herself and expressed concerns about the welfare system creating dependency in Puerto Ricans. She
was concerned that the welfare system would end soon or change, leaving those Puerto Ricans who depended on it unprepared to compete with Americans.

Informant F was the oldest informant. She was very dedicated to her homeland traditions and was marginally bilingual. She was the one who had the potted tree from Puerto Rico in her yard and had an extensive garden of herbs which she used for remedios. Her home was full of artifacts from Puerto Rico. She was the grandmother of another low acculturated informant. Other people from the neighborhood came to her for home remedies. She also made and sold Puerto Rican water ice. She died during the course of the study.

**High acculturation**

A review of data from the three highly acculturated informants yielded the following:

Informant L had the highest acculturation scale rating. She was a 48 year old professional woman, a social worker in a healthcare system. She was born in New York but spent her adolescence in Puerto Rico, was married and divorced. Because of her knowledge of both cultures she was very effective in helping clients in Hispanic and other cultures but her worldview was more aligned with the American culture. She had recently remarried and moved out of the North Philadelphia neighborhood where she used to live.

Informant W was a 78 year old woman, marginally bilingual, who responded to the PAS in Spanish. She had a high acculturation rating. This researcher reviewed her interview and responses were very traditional, devout Catholic, lighting candles in church. This finding was a total conundrum. Perhaps she did not understand the
instructions or she might consider herself more acculturated because she has been in the mainland U.S. for 55 years. One could conclude that she met the criteria of psychological acculturation which is individually variable and not dependent upon language.

Informant E was a 41 year old grandmother, born in Puerto Rico and living in the mainland US for 16 years. She responded to the PAS in English. She used some home remedies but also saw a physician regularly for cholesterol management. Mention of family was conspicuously absent from her interview, particularly when asked about health care decisions and family and friends help when sick. In contrast to most of the informants she was dressed in blue jeans and sneakers and looked much younger than her stated age.

Medium acculturation

Measurement of acculturation with the PAS established that most informants were in the medium cultural range, that is, comfortable in either culture. This is consistent with this researcher’s abstracted theme of being between two worlds. Their identification as Puerto Ricans remains strong but they are also adapting to life and the culture of the mainland U.S., particularly Philadelphia. Health behaviors associated with acculturation that are disadvantageous in this adaptation are the culture of fast foods and cars, both contributing to diabetes and heart disease. As informant I, a 67 year old senior said, “Well, Puerto Rico's my country. I love my country. A beautiful place, but I love Philadelphia, too.”
4.4 Theme 2 - Gardens as Symbols of the Motherland: Creating the Environment

Although some of the informants were associated with an urban gardening project almost all informants had a backyard garden. Some had an inside herb garden in their home also. Community areas that had been eyesores previously were now converted to flower and vegetable growing plots. When this researcher entered parts of the area that were known to her seven years ago, she was amazed at the transformation that had taken place. The little *casita* that initially stood in a jungle of weeds was now a centerpiece in a large, gated garden extending over three quarters of a city block. *Las Parcelas*, as it was called, included 40 community garden plots, an herb garden, a shaded area with picnic tables, a faux bridge with a waterfall mural in the background, and a pit for roasting a pig on the spit. The busy major highway on one side was obliterated by the heavy vegetation, although neighborhood sounds such as barking dogs and loud music from passing cars were audible. To this researcher, the area seemed like an oasis in the center of the barrio and a cornerstone in the establishment of community. Was this a bias on the part of this researcher? In her journal she questioned, “There are other areas in Philadelphia that have community gardens; is this area any different from them? If so, how is it different?”

Using data from interviews, fieldnotes, memos, and this researcher’s personal journal, the researcher extracted several categories to yield the subthemes and theme. Informants spoke about the value of all things natural, including home remedies, food, and environment. Most of the informants were originally from the rural interior of Puerto
Rico where they had small farms and barnyard animals. Working the farm was a family affair, associated with teamwork and pride. One informant related that they worked hard and played hard, celebrating Church feast days with festivals and such. There was always plenty of food and closeness with extended family and neighbors. The gardens in Philadelphia, both backyard and community gardens, serve as vehicles to reconnect with Puerto Rico, with nature, and with natural foods and remedies. The gardens also are gathering places for family and neighbors. A few of the informants have chickens for eggs and meat, a pattern reflective of rural living in Puerto Rico.

Living Close to Nature

Many informants spoke about using home remedies and growing their own vegetables as a way of being close to nature as they were when they lived in Puerto Rico. Informant EE stated:

My mother and father were really strong on vegetables and fruits because they were in abundance in the yard or in our town and if you walked from one neighbor to another they would give you, you know apples, oranges, pineapple. . .

She also commented on the availability of home remedies and her family’s knowledge about this:

My father, you could say like he was an herbalist and he knew every plant and he knew what was good for. He never bought soap; he made it out of the plants . . .He had a remedy for everything. If your bones hurt, he used to go up to the mountain, get a snake, cut it open, take the fat out, put the fat on the tin roof where the sun hit it, get the oil, and make some kind of mixture and that was good for arthritis or whatever hurt.

This researcher could picture a very self-sufficient rural family. The account of the father’s use of snake oil was also consistent with that reported by two other informants who were treated by a curandero, presumably after a severe sprain of the ankle or wrist; snake oil, heat and massage cured both of them.
Informant BB recalled:

There were a lot of other things that my mother used to do for us when we were little, like whenever you had stomach upset, she had plants in the back yard [in Puerto Rico], remedies and she used to use a lot of teas.

Informant C commented:

Also, I remember that, they don’t do it too much over here, I guess, but when I was growing up, if there was a fever or whatever, I remember my mother going outside to pick some herbs, boiling some plants, certain kinds of plants, and then giving us like a bath. And the fever would be gone by the next day.

Informants BB and C both have fond memories of their mothers using natural plants, grown in their backyards, to cure their maladies. The association seems to be both with nature as curing and mother as caring.

Informant D said:

And the other day I was watching a program on television. They were talking about health. There was this doctor, they were talking about diabetes and she was saying that Puerto Ricans lived and ate healthy in their own country where there were lots of fruits and vegetables and you have to walk to go anywhere but here in the US we don’t do that.

This comment illustrates the sharp contrast between healthy country living in Puerto Rico evidenced by eating close to nature and walking, as opposed to city living in Philadelphia with cars or public transport, all in close proximity to fast food vendors.

Informant T reported:

When we used to live in the old country we used to take from the plant make some tea like naranjo (orange) I don't know say - Yeah, orange blossom, and when you got stomach pain, we take some mint. And we mix it with bowl put some little milk and you is fine. You don't used to take a lot of medications. No. I'm taking it now because I don't have no choice because of my high blood pressure and - And before, we don't have - see, like, people don't have a lot of cholesterol like now because I remember people used everything they grew. I didn't see no people with cholesterol like now.

This informant, T., clearly remembers a simpler time and place when one lived
off of the land for sustenance, work, and health.

Another informant, L, really experienced a dramatic change when her family moved from New York City to Puerto Rico; although her initial response was one of teen rebellion, she relates her adaptation to country life in Puerto Rico with nostalgia:

When I was 11 years old, my family went back to Puerto Rico, to a rural area. I hated it at first—going from New York City to a nowhere place. I missed all my friends and there was nothing to do. But I got to know my grandparents and after the first year I didn't want to go back. It was beautiful there. Everything was nature. We walked everywhere. We swam in the streams and caught fish. We ate from the garden and picked fruits from the trees. I learned to be a farm girl.

Garden as Community Center and Culture Builder

To this researcher, the gardens seemed more than a return to nature. The planned nature of the gardens, the corresponding murals interspersed throughout the neighborhood on the walls of homes and stores, the cultural programs for children, and the festivals held in the gardens all bespoke of culture building, culture transmission, and culture preservation—creating the environment. The garden also filled a spiritual need for some.

A major component of the North Philadelphia Neighborhood Project is the gardens. In addition to the large garden described above, other gardens that are part of the neighborhood project have also grown up in the area. Each one has a theme drawn from Puerto Rico. One of my informants, a major force in creating the gardens, described them to me. *El Colobó* celebrates the African root of Puerto Rican culture and includes a storytelling room for children. *El Batey* is a retreat garden named after the *batey* or central community gathering place of the Taino Indians in Puerto Rico. *Raíces* or roots, is the children’s garden for a safe place to play. Summer camps and after school programs use these gardens for play and for cultural projects. Orientation for newly hired
officials in Philadelphia City Government includes a tour of the area and the gardens with a focus on culture. The Philadelphia Horticultural Society has sponsored projects with the gardens. Community celebrations are also held in the gardens, including one that this researcher participated in during Puerto Rican Week in Philadelphia. Music and drummers, dancers and singers in native costumes, and abundant Puerto Rican food highlighted this event, including a pig roast. There were toasts to good health, to Puerto Rico, and to life. This celebration occurred in September and many of the fresh vegetables were harvested from the gardens and cooked for the festival.

This researcher also observed that the garden is a hub for connecting with others. The women’s groups that meet for knitting or sewing use the large garden as a meeting place in good weather. According to Informant BB, meeting in the garden served as an impetus for exchanging information on home remedies and inviting herbalist Maria Benedetti to give a presentation. Although this researcher did not specifically focus on the garden in her interview questions, responses from two informants clearly establish the significance of the garden in the community and in their daily lives.

Informant C, a wiry 75-year-old is full of enthusiasm as she says:

The gardens give me that special therapy that - I think is wonderful. If I don’t come here [Las Parcelas], I’m in my garden. And I can’t be inside the house sitting, watching television, or whatever. I do my little jobs. I cook, I clean, and whatever and I’m running back, running to the garden. Or either coming in here and do gardening. Or doing something. . . so for me it’s therapy. . . the garden.

Her weathered face comes alive and her dark eyes sparkle as she speaks of the garden.

Informant D is even more passionate as she describes the influence of the gardens:

I can tell you yes, being with depression for five years and now I’m feeling better but, I would say, First is God and then second is being in those gardens;
especially the big one. You are transformed and your mind is not in Filadelfia.

As this researcher spent time in the Puerto Rican areas of Philadelphia, she observed the external environment with murals, gardens, homes with distinctive front porches or canopies, grocery stores, bakeries, farmacias, and restaurants with signs in Spanish. Current housing restorations have a distinct Caribbean character. The neighborhood civic association is supporting Puerto Rican families who want to buy or rent homes in the area. The area is also undergoing gentrification with more affluent Puerto Ricans remodeling houses. There are several Puerto Rican cultural groups, including Taller Puertorriqueño which present speakers, plays and musical events as well as events specifically for children. The North Philadelphia Neighborhood Project is working with the City of Philadelphia to reclaim vacant lots for local ownership and conversion to gardens and to create jobs for local resident in this area. This researcher believes that informants and other residents of the area are creating a community which blends the best of Puerto Rico and Philadelphia and keeps them connected to their roots.

4.5 Theme 3 – The Holistic Nature of Health

Several items on the researcher’s semi-structured interview guide related to health. Many informants referred to balance as important while admitting that this was difficult to accomplish. This pattern of balance was sought out in areas of dietary intake, exercise, connecting with others and taking time for self. Spiritual health was also rated as an important component of overall health, although the researcher’s semi-structured interview guide asked about spirituality and health as a separate question.
When asked what was important to keep her health or stay healthy, informant AA responded:

Everything in moderation, nothing to excess. And exercise—you gotta exercise, too. . . Me as a female, a Latina female, I always put my family first.

The example of the Latina woman putting family ahead of self is also a frequent refrain. Informant R, a 67-year-old great-grandmother reports on her reasons for staying healthy:

Well, I think it's very good, to stay healthy because like that you could be more. . . helpful for somebody else that needs you. Or for the family. I have four children. I got 13 grandkids. And I got 12 great-grand. So I help when they need - I help. When they are sick or something . . .

Informant BB thought:

Definitely our peace of mind because I think stress is related to a lot of the illnesses we see today. I guess eating healthy, eating plenty of fruits and vegetables. . . My parents always told me that you need to exercise, get enough exercise in by working hard and then rest enough.

This informant and most others include stress relief along with diet and exercise as essential to good health.

Informant CC, a cancer survivor adds the elements of movement therapy with Yoga, and avoidance of negative influences:

Well, I’ve been fighting cancer for 30 years and I’ve somehow managed to get it right. Yoga. I do it here with tapes every morning and every night. I have a cancer that metastasized to my lungs and they can’t believe how good I am breathing. I think movement . . . I stay away from negative people, because you know people who look at the glass half empty are not people that I feel comfortable around. Very positive people, so that’s who I connect with.

Informant D, who suffers from depression, commented that she feels isolated here in the winter:

And one thing that I really believe that will help is to be able to sit down with
friends and talk because one of the things that we do in Puerto Rico is all these conversations. And we are always surrounded by family. And here, especially in the wintertime, you feel lonely. And that is a space that depression will find very suitable, attacking you.

In a similar vein, one of the younger informants, 32-year-old informant M commented on what was important to keep her health as follows:

Physical and mental wellbeing, the environment that you live in, and maybe your family. The support of your family.

Emotional health and patterns of depression were mentioned by several informants. This researcher observed that many informants were either widowed, divorced, or single. There was a strong network among women in the community but some informants needed professional services for mental health. Contrary to the literature which suggests that mental health issues are not discussed, these informants were candid about their depression or other mental health problems.

Informant EE also weighed in on the difference between diet in Puerto Rico and the U.S.:

Well, you know, we actually eat good. The Latino people usually eat good. Our food is staple, we have our viandes, our roots, our pumpkin, our yucca and starchy vegetables. We eat rice with every meal, we eat beans with every meal, we eat chicken with every meal or pork or beef. And we always have vegetables because when we make our own sofrito, especially if you are from the old days, sofrito has a lot of garlic which is good for you, has a lot of onions which is good for you, has a lot of bell peppers, different types, so you got your yellows, reds, greens. So in itself it is healthy. So it’s not until you come to the United States, not to knock it, you got your cheesesteaks, your fries, your cheeseburgers . . .

The easy availability of cheap, fast food and the prohibitive cost of fresh fruits and vegetables in the mainland U.S. were frequently cited by informants as justification for obesity and poor dietary habits.

All of the informants identified diet and exercise as key to good health. The ideas
of balance and stress reduction, connection to others, and mental and physical well-being were also cited frequently. However, in reality many Puerto Rican customs and gatherings are centered upon sharing food, eating and drinking and as some informants commented, knowing what is important and putting it into practice are two different things. Many informants have diabetes and many are obese. This researcher believes that diet, exercise, and health are areas where creative and culturally congruent health intervention could promote health.

_Spirituality and Health_

One aspect of health that this researcher was interested in, and that several informants commented on prior to the interview question, was the role of spirituality in health. This researcher was biased in assuming that most informants would either be Roman Catholic or Pentecostal and that those who practiced Santeria would not be involved in another religion. These biases were disproved during the course of interviews with informants. Patterns that emerged from the interviews, fieldnotes, and memos, as presented here, are the importance of faith and spirituality as a core value in everyday life, and the importance of spirituality in health and sickness, regardless of whether the informants attended a particular church or subscribed to a specific religious sect. For some informants, a feminist secular spiritual network was also evident, masked in the guise of Santeria. This group network was organized by a Santera with a prior background in community organizing and women’s empowerment. The group was not confined to Santeria believers or Puerto Rican women and was open to any woman seeking the support of a network. From what this researcher could glean from the leader and the participants, the group was eclectic and met once monthly for healing. Other
group activities were loosely organized and participation was voluntary. This researcher was “invited” to attend a meeting but was never contacted. The group leader initially expressed some concern that this researcher would attempt to draw group members into a study. Although this researcher assured her that this was unethical and would not be done, concerns must have persisted and the researcher heard nothing further.

Informant T, a senior citizen, reports that she prays every day and it helps her to deal with emotions:

What I do, like, sometimes when I need a lift for myself, I feel like a little - I would say sad or whatever, you know? So I start praying. Uh huh, I talk to my God. And I read the Bible. And that helps me, you know, to feel more at ease.

Most of the senior citizens interviewed had similar patterns of daily prayer. Interestingly, some informants identified a connection between prayer, the doctor, and healing.

Informant I, an older woman, relates spirituality and health to her medical care and use of home remedies:

I think about God. So I ask God for help for me. It’s the first thing. Pray to the Lord. Pass it on to the doctor. Go to the doctor. Then, my tea. Like now, I'm drinking green tea. That's what I do. But I always ask the Lord to help me first and last.

Informant L also relates spirituality and health to using the healthcare system:

My spirituality - well, it’s hard to say because I believe in God. I believe in God’s powers, but I believe, also, that if God gave the knowledge for the man to make science and make medicines for the people, we should go to the doctors, too. So I believe 100 percent that if God gave you that knowledge, use it for the best.

Informant Y, a younger 38 year-old relates spirituality and healthcare saying, “I am Pentecostal and I pray to God. And if he can’t help you, then you figure, the next best
thing is a doctor.”

So for several of the informants, the hierarchy of spirituality and health includes God first, then the doctor, as God’s designated healer, then home remedies.

Informant D, one of the garden organizers, is equally passionate but has somewhat different priorities in her spiritual life:

The garden is second for me but the first is God because for me it doesn’t matter, For me it is a circle, I start with God and I have to finish there . . . Because I believe that my mother could do so many things for me. My friends could do so many things for me. The doctor could do so many things for me. Technology could do so many things for me. But I believe that I have to have that faith and trust in somebody else that is not here.

Informant CC, a cancer survivor, belongs to a support group facilitated by a Santera. She believes that the support of the group, and her commitment to spiritual and mental health are healing her:

I pray a lot. There are certain women-certain female friends and male friends that are very positive people. . .spiritually connecting-I go to a support group. Very spiritual; the leader of our group is a Santera and she is very spiritual and you know-taking care of your mind. You take care of your body but you also have to take care of your spirit. And it’s all kinds of women, not just Puerto Rican women, and from different kinds of walks of life. I mean we have doctors, psychiatrists, teachers, waitress, you know, so I think connecting-the main thing is connecting as women. And that’s something that you find in Santeria—there’s a connection to a higher power that is—that connects all the women. I think that that connection is healthier spiritually and mentally. I really believe that.

She comments further:

You have to be well spiritually. Okay, I’m physically you know, my health sucks. But mentally and spiritually I’m in a very good place so and I think that’s what kept me going. Also so that I have loving people around me, my daughter, and that just helps mentally and spiritually. But I really believe that 75% of getting well and staying—at least not getting worse- is mental-mental and spiritual.

As this researcher read and re-read the transcript of this informant, the researcher was struck by the adaptation. As the body fails, the mind becomes stronger, changing the balance, inviting support, and also, ultimately preparing this informant for healing, if not
Informant JJ, a practitioner of Santeria, comments on spirituality and health in her life:

It is very important. Although I am a santera, I also attend a Christian church, the Episcopal church in North Phila. The priest there is very accepting of everyone and preaches compassion and caring for others. I see spirituality as holistic and the core of my being.

Another view on Santeria and spirituality is offered by informant AA, whose mother formerly practiced Santeria comments:

There was a point where if you have faith, a certain faith, you believe everybody’s doing you harm and you would do stuff to ward off evil because it was evil---there was a time I was like that. But then I learned that that’s backwards. I believe the body gets sick now and it’s not because somebody wishes it on you or casts a spell on you. So my faith now has changed. I’m a Catholic but I also like to go to the Protestant church so I have the best of both worlds. And I’ve been exposed to everything so I feel that the Lord will heal me and if there is somebody that wants harm for me, I just pray.

Informant AA’s perspective on Santeria is the one that this researcher is familiar with from reading the literature.

Informant HH demonstrates that spirituality is not connected to any specific religion or church as she traces the path of spiritual growth in her life:

Well, I mean I have a strong faith so I guess that keeps me spiritually, mentally, physically strong. My belief in God, you know; I can call upon Him in my times of difficulty in any realm of my life. I grew up Pentecostal because that was my grandmother’s religion, but when you’re growing up you kind of veer. I wanted my daughter to go to Catholic school and then when I married, I married in the Catholic Church so then I kind of veered towards that. But then as I got older, it really didn’t do anything for me, being Catholic, for my spirituality, in any way, shape or form. So now I actually am going to Episcopalian. Because the church that I go to, the pastor is accepting of everyone.

Another informant, N, who suffers from multiple health problems and severe depression and is currently in treatment, has a distorted view of religion and mental health issues:
To me, last year - a couple years ago, I start having like - hearing voices. I kept hearing things telling like jump 'cause I was getting depressed. Jump in front of the train and I kept checking it - - so I talk my doctor and that’s when he sent me to see a therapist. And - I stayed in therapy since then. And so I think that’s either the devil or something. Because when I - one time I try to - I look at the drawer where I keep all my pills. I was so depressed; I just felt like I wanted to take all them pills. But then I look up and saw this thing that I have of the Last Supper -- and I look at, that made me stop -- thinking to what I was doing. So I didn't go to church because I didn't feel like I was worthy of going to church and getting communion. I went back and go to confession. That’s how I feel.

Hopefully, with the help of her mental health provider, informant N will come to a peaceful resolution of her mental health issues and will realize that ongoing help is indicated.

Although there was diversity in belief systems and opinions about spirituality and health among informants, all informants had a core spiritual belief system which they accessed in health and illness.

*The Role of Women and Families in Health: Caregiving and Familismo*

The influence of women in passing on home remedies within the family has been presented in Theme 1 and informants also spoke of women’s groups as vehicles for promoting connectedness via gardening, knitting, and support groups. This researcher sought information on the role of families and women in families in the health-illness continuum and in making decisions regarding health. One interview question asked informants who cared for them when they were sick and several patterns emerged in response. Most informants reported that family members cared for them, specifically mother, grandmother, or granddaughter, although informant AA reported, “Everybody in the family pitches in.” From informants’ responses it was clear that family, particularly women in the family when available, were the primary caretakers for informants.

Informants were also asked who cares for family members when they are sick and
who is consulted for help with family health problems and with making decisions about health care for family members. In Puerto Rico these decisions are usually handled by the family but the women are the caretakers and the oldest is responsible. This researcher sought to explore patterns of health decision-making here in Philadelphia, PA.

Informant B responded, “My grandmom... and I have two children so we both take care of them. I live with my grandmom all my life.”

Informant BB, also the oldest in the family, a patient with hepatic carcinoma, reported, “I usually take care of everyone in my immediate family if I’m not sick.”

The idea of having older, possibly sick women caring for younger, more capable, seems foreign to the concept of respect for mothers and grandmothers, yet it is consistent with tradition in the Puerto Rican culture.

Informant CC introduced the concept of the oldest being responsible stating, “I’m the oldest, the one with the medical background so probably most of the decision would be mine although we’d do it together. They always come to me for information.”

Informant D, also the oldest, commented, “It’s my mother and me because I’m the oldest of ten children. So it’s a responsibility that it was given to me when I was little.”

Informant DD has no extended family in Philadelphia. She reported:

I do or my husband. I mean we do go to the hospitals and we do visit doctor’s offices but if it is just something little like a cough or a stomach ache, we go first with the natural remedies but if we see that instead of a little stomachache it comes to a stabbing pain then it has to go beyond, like going to the hospital to get labs and ultrasounds and all this other stuff. So we try to figure things out and if it doesn’t work, we go to the hospital.

Similarly, informant FF, who has a handicapped child and is on dialysis herself, has no family in the area. Her situation is unique in that she has a home health aide to care for her daughter, who is wheel-chair bound. She said, “If I have a major thing like
surgery, probably my mother-in-law, she will come from Puerto Rico, like she did before.”

Informant F said, “In our family everybody takes care of each other.” Informant G responded similarly, “We kind of -we’re a pretty big family and we just take care of each other.” This pattern was also identified among some other informants.

Informant HH commented:

The elders [care for sick family]. You know like for instance like I was saying I was raised by my grandmother. It’s kind of interesting because my role has been like sort of from my aunts’ perspective I’m sort of like their sister, their niece, and their daughter all rolled into one. So it was interesting when my grandmother passed away, she always lived with me and I was very close to her. She actually passed away here. So this family, our family is very strong in that. And we believe in taking care of our own and not putting them anywhere. In our culture we believe that we don’t put our elders or anyone in an institution. We take care of them at home.

Informant K’s response also reflects the tradition of caring for elders and having responsibility as the oldest:

I want to say that the Puerto Rican culture, we - not so much into - like, the older people - we will try and take care of the older people, the younger ones will. The other people like for us to send an older family member to a nursing home. We have to feel like we've done everything we could- everything we could, and it’s out of our hands. But we always feel like we don’t want to do that. We feel that they took care of us, they brought into this world, and then it’s our turn to take care of them and make sure that they have what they need. For some reason, I noticed in our culture is usually no matter how many kids you have and, back in the days, people had a lot of kids. My mother only had five. But her mother had 13. So it’s like, it always falls more on the older child.

Informant L commented:

Each other . . . like mother takes care of sisters and - it’s a traditional stuff, and it’s a shame that it’s getting lost. But it used to be like that. The kids take care of the grandparents, and the grandparents take - it’s a generation - every generation takes care of the next generation coming up or the ones that’s leaving. We never - I never heard about when I was a child about nursing homes or nothing like that because everybody took care of grandpa or grandma until they die and that’s way it was.
Informant M stated, “We all chip in. My mom is the oldest so she would make the decisions; it would fall on her.” Informant S related that her daughters and the doctor would make her decisions.

Informant N tearfully responded:

I get so upset just thinking about that. My son-he married and his wife is not Puerto Rican. They moved away to Collegeville and we never see him. Two beautiful grandchildren and we never see them. I think he is ashamed of his roots. She is very close to her mother and the grandchildren are close to her also. His father is sick and I am sick and we never see him. It’s like we have no family. My heart is broken.

As this researcher reflected on the responses of this informant it occurred to the researcher that this was indeed a unique situation in this community and undoubtedly contributed to the informant’s mental health problems—or perhaps came about as a result of the informant’s mental health problems? Other informants had family living in close geographic proximity and sharing emotional closeness.

Informant X, a young Puerto Rican woman had a unique perspective on women and caregiving:

I would say I would take care of my own. My mother sometimes helps. She's actually in Puerto Rico right now, taking care of her parents. I think we basically kind of, as much as we can, help each other. The women do the most. And I also feel that when the woman is ill, it's basically - when someone else gets sick in the family, the woman takes the burden of taking care of that person and also does everything else. But now when the woman gets sick, I feel as though not only do we have to take care of ourselves, but there is no one there to take care of the rest of our burdens. If you're sick, you have to try to get better and do everything that you do on your regular routine anyway. So we do have a strong load.

This illustrates a dilemma for the woman in the Puerto Rican culture—trying to care for others and for self, even when she is sick herself.

In a second interview, informant D commented on difficulties that the oldest can
encounter in trying to gather the remaining family for decision-making:

When my mother died, I am the oldest in the family so I have to make decisions. So I get my brothers together and we talk but they don’t want to make any decisions. So yes, it is me, my sister and my nieces who get together and make the decisions. The men, they are off somewhere and they don’t want to talk about it.

Several of the informants cited the role of a nurse practitioner who lives in the neighborhood as a trusted health consultant, confidant, family friend, and emergency contact. The nurse practitioner is not Hispanic but is bilingual and a community activist. She has lived in the community for over 10 years and is a community board member of the local neighborhood organization. Informant BB stated, “Nancy (pseudonym), she is like a sister to me. We can talk about my health, my family, anything. We are so fortunate to have her here.” Informant M, when asked who the family consults for health care decisions replied, “Nancy—we go to her first for help.”

Informant D supported this also

She has been very helpful. It’s a blessing to have a nurse practitioner in the neighborhood. She’s -She’s there, like, 24 hours. And I had - like, when I start here in my family, I have called her 2:00 a.m., 3:00 a.m., 4:00 a.m. She said, “I’ll be there.” And she goes and then, she check that person and she says, ‘You will be okay,’ or ‘I think you should take that person to the hospital.’ She saved my ex-husband’s life when he was having a heart attack.

Informant J related:

And Nancy is the woman that we can call her at 2:00 in the morning, 3:00 in the morning and she comes to us. She comes to us. So other than a hospital, she is the person that we call. We’ve even spoken to Nancy for a second opinion of hospitalization for my grandmother, ‘What do you think we should do?’ And then I had an aunt by marriage that had breast cancer and lived right next door to Nancy. Well, yeah. So Nancy is -She’s wonderful.

From the responses of the informants it is clear that in this group of Puerto Rican women have a primary role in both caretaking and decision-making for family members.
The oldest in the family traditionally has this responsibility and the expectation is that sick family members will be cared for at home and not placed in a nursing home. Older women also assume the responsibility of caring for younger generations until they are unable to do this. When this occurs, the younger generation reciprocate by caring for elders at home, as noted above.

4.6 Theme 4- Surviving the System: Healthcare Perspectives in Puerto Rico and Philadelphia

This researcher has never been to Puerto Rico and is unfamiliar with the healthcare system there. It was the researcher’s intent to seek comparative information on the healthcare system there and in the mainland U.S. The interview questions were: 1) Have you ever received health care in Puerto Rico or in Philadelphia? 2) Is there any difference in the care or treatment that you receive when you are sick in Puerto Rico or in Philadelphia? The number of informants who could respond to these questions was limited, however the responses were significant in that decisions were made to relocate because of limited healthcare quality and resources. Based upon informant dialogues, problems and conflicts exist in both healthcare systems. Patterns reported in Puerto Rico are absence of primary care providers and facilities in rural areas, outdated equipment, need for families to bring linens and meals, short supply of specialty physicians prolonging time in hospital, but good communication. In contrast, hospital care in mainland U.S. is technologically efficient, easily available 24 hours per day and seven
days per week, however communication is poor, providers lack understanding of the
culture, and wait times may be prolonged.

Informant AA reported on her experience in Puerto Rico:

For what I had, they’re easy to give you drugs; they’re very easy. For what I had, the
controlled drugs, they’re easy to get there. Actually I had muscle spasm and they gave
me Flexeril which I love. And my child was sick and I took her and they gave her
antibiotics. But the health care system—it’s awful. If you don’t have a good private
insurance they give you pink liquid for everything. They’re underpaid. If you have to
go to the hospital you have to take your own sheets, your own blankets, your own
IVs—it’s really bad. But I can’t complain; when I went there for my problem I was
treated good.

Informant C related an experience that changed her family’s life and home:

Yes. In 1982, my husband decided that he wanted to move back to Puerto Rico. We
rent a trailer -- with everything in it. Moved back to Puerto Rico, we had a house
built. We sold our house, and we moved to Puerto Rico. My youngest son was only
15 years old and he had to change schools and everything. We lived there two years.
My husband was a merchant seaman, at the time. And he was traveling all over. I
was there all by myself with my son most of the time, with our hats on, trying to do
everything. And like after one year during Christmas, I got very sick. I passed out. I
almost fainted, I guess from the sun, and then - so they took me to the hospital. I
could hear people talking but I couldn’t open my eyes. So they took me in for
emergency. It was two days before Christmas or something like that. It was no
doctors in the community. It was a little town. No doctors in the community only a
nurse. And I remember I hear them. They laid me down on the bed and there was no
doctors or anything. . . I was all night in the hospital. Only one of my neighbors
stayed with me overnight. I woke up the next day in the evening. Then I saw a doctor
and I came through. And I said, oh my goodness, where am I? And they said that
derhydration. So they told me what to do and all that, and then they sent me home.
Well, that was my worst experience where I’ve been bound in. And then we started to
figure things out and it was too much work for me by myself and my son, being 15
years old being he didn't want to stay either. And so we decided and came back. I
moved back and then my husband stayed back and sold the house or whatever we
owned. And that was a big loss. So that was it. But that was the most terrible
experience I had. And it was a little - it’s not the city - a little clinic and there’s no
doctors. I could have died that night and I wouldn’t even know it. But that was big
experience for me, you know. I’m not crazy about it, you know. The people who live
there are used to it. And that’s okay. But because here it’s so different. That we walk
to the hospital and you have emergency and you have everything right away. So it
was a big difference for me--different than here.

Informant D reported on a recent encounter with the Puerto Rican healthcare system:
Yes. The difference - there are many, many differences. And I'm just gonna say to you, we went - this is August. We went in March because my aunt, she was diagnosed with cancer. And my mother went there. Two of my brothers and I went there to be with the family, and it was incredible. We - the room is nothing like here, and she was in a very good hospital. It’s nothing like here. We have to provide pillows and sheets and other things that we take for granted that the hospitals don’t provide. The beds they were outdated. It was nothing like here, fancy. And if it’s not that fancy, then you complain. And then, she had to wait. So we were here, desperate, because she had to wait for one doctor that was the only one that could perform that kind of surgery. And he was in another hospital, and they needed to bring him from that hospital to the next hospital. And then, he goes, like - the doctor - so you know that she was a very lucky woman because the doctor that could perform the surgery was a friend of her doctor. So then, she - it was a big mess. And it was suppose to be a big mass in her stomach that he was taking - they had to remove, practically, her uterus and ovaries and the big mass, because it was - and then, they told her that it was not cancer. After she had the surgery, they said that the pathology - pathologist - he said that it was not cancerous. So here we are still - that was in March. Here we are, but we are glad that it was not cancer, but how did it happen? Because it’s - what about if it is cancer? So we are – still not knowing. Yeah. That’s one reason why my mother - we don’t want her to go to Puerto Rico. Because she receives - she has very good doctors here. She doesn’t want to go back. But sometimes, we think, "Why don’t you go and stay there for three, four months," with her two sisters. And it is the healthcare that stops us. That’s the thing that is stopping her.

Informant DD has a different viewpoint; she does not condone the lack of knowledge or inferior facilities in Puerto Rico but she finds these tolerable to the intolerance and ignorance of staff in Philadelphia hospitals. She states:

Puerto Rico doesn’t have the facilities-the scientific machines, the technology. But here they can have great knowledge, but staffing is poor. In Puerto Rico, knowledge is poor but staffing is good. Why? Because maybe I might say that because we speak in the same language and speak on the same page. But it’s not the doctors but staffing [here in US]. They don’t understand what you’re trying to tell them or they ignore you, so you get annoyed so you just get to the point where you try not to be in the hospitals anytime.

Informant I spoke as a grieving mother. She recently lost her son in Puerto Rico to diabetes:

I think here is better. It’s better. You know why I'm telling you? My son - he died - of diabetes. He was a - his age was 42. And if he would have been here - - they would have prescribed insulin. But in Puerto Rico, they didn't do that. His sugar went up to
And he died. I feel - and a lot of people feel that here is better. It's better here. Another informant explained the Puerto Rican equivalent of our welfare system to this researcher.

Informant KK reported having excellent medical care in Puerto Rico saying, “My uncle was a doctor in Puerto Rico so we had excellent medical care because we were family.” This researcher believes that would be the same in Puerto Rico and Philadelphia—relatives of physicians get special treatment. However KK’s experiences with the Philadelphia healthcare system were less than satisfactory:

What I have seen here, it’s sad. My oldest sister had given blood for her upcoming knee surgery. She was at the veterinarian with her pet when she suddenly she said she didn’t feel good and she started getting cold and couldn’t see and flopped on me like this and she knows; this is not a hypochondriac. So we end up calling ambulance and they said no, it was because of the blood. Her BP had gone down to 80/60 so sure enough they put her in the ambulance and took her to the emergency room and put her in a little room. They hung an IV and took a little blood out and two hours later I went to check her out and she said they’ve done absolutely nothing to check me out . . . . So I took her home. So it’s hard to figure. On the other hand when I’ve taken her to X hospital with the knee thing, where she screamed bloody murder, they took x-rays and everything. So I think it depends on the hospital that you go to and the condition that you have. And I think that if you’ve fainted, or your blood pressure is low and you go the emergency room you are kind of low on their list. Mind you there weren’t any others in the emergency room who were screaming or active trauma so it’s a mixed bag. It doesn’t make sense; I’m not sure. I’m convinced that they are excellent doctors but the health system sucks.

Although this informant is less than satisfied with the healthcare system in Philadelphia, in an earlier scenario she brought her father back from Puerto Rico after a stroke because the opportunities for care were better here.

The responses of informants are varied, but most have had difficulties with the healthcare system in Puerto Rico due to the lack of care in the rural areas. This aspect of the study was a complete surprise to the researcher and opened up another area to explore. The pattern displayed in Philadelphia appears related to access to care issues and
lack of culturally competent care.

*Health Practices and Healthcare Providers*

Healthcare providers are an integral part of the healthcare delivery system. In order to obtain healthcare, one must schedule a visit with a provider and follow certain rules. Access to some providers is limited or facilitated by the health insurance that the patient has. Language differences can also limit access to care, although providers are legally required to deliver services in the language of the patient. Cultural differences, including health beliefs can present a more subtle but real barriers to care. One of the areas that this researcher sought to explore was the culturally based health practices of Puerto Rican women in the Philadelphia area. Utilization of healthcare providers and interactions with them are part of these health practices.

Most informants had a primary healthcare provider, usually a physician. Patterns of use varied with older informants generally seeking regular care for chronic health conditions. Most informants were satisfied with the care that they were receiving. For example, informant B commented:

> Well, actually I don’t have a complaint about him. He’s very good. He listens. . . . and he does a great job. He listens to any problems that I have and if I think that I should start something he’ll agree with me and we’ll get started working on it. Listening is very important to me.

Most informants valued a physician who took the time and listened, displaying *personalismo*.

Informant CC, a cancer survivor, had another perspective on doctors:

> I used to go to Dr. B. He’s a naturopath. I’d still be going to him if he was closer but he moved. And there’s this Chinese lady out in Lafayette Hill and I would love to be able to afford to go to her but it’s very expensive. It’s very expensive. But if I had a problem with a pinched nerve, I’ll go to a chiropractor or Dr. B.[realizes he] is a chiropractor. I’ll go to him before I go to a doctor. Because doctors just give you
pills to cover up the pain; they don’t get rid of it. When I sprained—I really, really sprained my back real bad and I went to the doctor and they started giving me pills and I just didn’t feel right and I knew it was wrong so I started to go to Dr.B. First it was 3 times a week and it was a whole different approach—holistic—heat and massage and in 6 weeks I was without medication; it was fine. It probably still would have been plaguing me by now [if I had gone to a “regular” doctor].

This researcher uncovered a pattern of problems with taking pills. Informants did not like to take pills. The problem did not seem to be a lack of trust for the provider.

Informant P reported frustration with taking so many pills:

I’m happy with the way he [doctor] treats people, but I’m sick and tired of this medicine. I hate too many.

This informant went on to recount taking medication for hypertension, diabetes mellitus, and high cholesterol.

Informant D also had some issues with taking pills:

Yeah, I go to a doctor. . . I used to go to a chiropractor once a year before I started the gardening. So to see how I’m feeling now, I need to go, - but she moved. So I’m looking for a chiropractor that will be gentle. I don’t like when they twist. Gentle one. And this woman I met, she said that she worked with a Chinese doctor - that he does a lot of herbs and acupuncture. And I wanna to give it a try. . .I don’t like when they prescribe all these medicines. And if I read - and I don’t want to take it. So for me, it’s just wasted. I don’t like all the secondary effects. The side effects, no. No, it’s just - I don’t like to take medications. I take them at the last minute.

When queried further, informant D admitted that she did not know the side effects of the medication but objected to taking it, “just in case” she would have a side effect. She did not seem to realize that herbal remedies could also cause side effects. Several informants reported taking prescribed medication and home remedies at the same time, particularly if the prescribed medication did not work. This establishes the potential for a drug-herb interaction that could jeopardize the patient’s condition.

Informant HH did not use the healthcare system unless it is “extreme”. She stated:
I’m not a believer in traditional Western medicine. I don’t even take a pill. So I’m kind of the philosophy if I have a headache, the way it came, it will go. It’s kind of rare that I take any medication at all.

This behavior of avoiding the healthcare system is troubling to this researcher. Informant HH is 45 years old and several risk factors for women emerge near that time. She does not even have routine female health exams or blood pressure screening.

Two other reasons for avoiding the healthcare system were identified by this researcher after speaking with informants. One reason is that care is fragmented and when a patient is referred to a specialist or needs lab work and a referral, the patient must take time off from work for each of these. For people such as this researcher’s informants who are working two jobs just to subsist, it is very challenging to get time off for lab work, specialty visits and such. A second reason for avoiding the healthcare system is also related to fragmentation of care. Because of changes in benefits or job changes, many informants seek care at the Free Clinic of the Philadelphia Health Dept. It can take months to get an appointment and even longer to get a referral for a specialist. Patients rarely see the same provider twice and care is limited. Informant X reported a concern with going to the free clinic and having her health problems discounted:

I just had a physical not too long ago, and this was a new doctor, because right now I'm just basically going to the free clinic because I lost my health insurance. So I felt as though she didn't ask me if I had any problems or if there was anything that was bothering me that I wanted to tell her about. I basically just had to go out there and tell her listen, this has been bothering me; I want to know why this happens to me. You know, what can we do about it? And I don't know, maybe just because it was a free clinic or what, but she kind of blew me off in the sentence and the intake.

Informant J was recently diagnosed with diabetes. She is grateful for the care of her physician:

Yes. I see her in the hospital. Wonderful. Wonderful. Like I said, I was diagnosed in December with diabetes. I didn’t know I had it. And I was just so weak, and them
people pamper you from head to toe. I had nothing bad. I do have a diabetic specialist that I go to. She’s at X hospital and my primary physician is also in X. So I recommend them highly.

Many informants have hypertension and diabetes as well as obesity. One of the informants is a *promotora* who works with an endocrinologist in the community. She spoke of the challenges of doing community outreach and getting patients to commit to a plan of care with regular follow up. Informant L, below, identifies one of the dilemmas confronting a new diabetic.

Informant L, a newly-diagnosed diabetic, while being satisfied, felt that her doctor could be more understanding about dietary issues:

I have my own primary doctor. Right now, I’m kind of struggling because I’m diabetic and I have to keep with diet, and it’s so hard to keep with diet because we Hispanics eat a lot of pork chops and fried chicken. When you are the main source of the cooking in the house, it’s very easy to pick when you’re cooking, and it’s hard to keep a diet. So I’m struggling real hard with this now because a lot of Latino women have a lot of diabetes or I will say the Latinos, in general, are very susceptible to diabetes, because of this, because of our poor diet. Because we eat a lot, but not a lot of healthy stuff, or we don’t try to make it healthier. I’m pretty comfortable with my doctor but sometimes I think they can’t understand how hard it is to keep a diet.

Two encouraging patterns that this researcher observed were informant initiatives for self-care and patterns of open communication with providers. No one reported any problems with language in communicating with their healthcare provider.

Informant D, in a second interview was frustrated with the lack of cultural competence of providers. She voiced her concern about the expected side effect of a prescribed medication that interfered with her working and earning her livelihood:
Because that is another situation, some of these people, doctors and nurses, they don’t understand. It’s not even the language; they don’t understand the culture. And that creates instead of vehicles for healing, barriers. The medicine, like antivert for dizziness, it has side effects. I know if I take it that I will have to sleep; it makes me tired. And I can’t sleep; I need to work. So if there could be something else to help without the side effects. And sometimes you don’t even need the medicine. It’s just someone taking time to listen and to be with you and you feel better. And that is not there; I think that is very important for people to hear, that human touch. I read somewhere, or heard on the news-I watch the Spanish news-that there is a university somewhere, I think it is in California, that they are requiring that the doctors and the nurses take an intense course in cultures.

In summary, almost all of the informants had a primary doctor and many were satisfied with the care. They experienced a problem with taking medications; to this researcher the problem seemed as much resistance to taking pills at all as concerns with side effects. The issue did not seem to be lack of trust in the healthcare provider but more with the pills. Other frustrations involved long waits and not feeling listened to, particularly in the free care arena. Fragmentation of care and the need to make multiple appointments to see specialists in lieu of “one stop shopping” was also frustrating.

Curanderos, Santeros, and Espiritistas

Curanderos, Santeros, and Espiritistas are cultural religious and health icons of Hispanic cultures. Several informants were descendants of those who practiced these healing arts while other informants also knew of them. Two informants were practicing santeras. One santera who has facilitated women’s empowerment groups in the past is now branching out to moderate a multicultural healing group for women with cancer and other health problems. Most other informants equated curanderos, santeros and espiritistas with black magic or the dark side. Some felt that the practitioners were money seeking charlatans. Other than those involved in the women’s support group, most informants had no admitted dealings with these practitioners although many
disclosed that they had consulted with them upon occasion.

This researcher had studied the role of healers in the Puerto Rican cultural health system in anthropology and transcultural nursing literature. On prior visits to the area in North Philadelphia the researcher had met with a santero and had observed a Santeria altar in one of the botanicas. In the early part of this study, the researcher encountered a conversation regarding a Santeria ceremony in a Spanish store and subsequently encountered a potential informant who participated in ceremonies but she declined to be interviewed. The researcher did interview two santeras, was invited to their homes to view their altars, and received a thorough explanation of the religion and health practices from each of them. Very few of the informants in the study subscribed to these belief systems and many stated that it was against their religion or was aligned with voodoo, so it did not assume much importance in the data collection. Informants did state that many Puerto Ricans subscribe to this belief system however, and the researcher is saw evidence that it is active in North Philadelphia. convinced that it is active in North Philadelphia.

Comments from some informants who were familiar with it are presented here.

Informant AA stated:

I grew up -like where we would have séances in our home. We did all that stuff. And then everything changed along the way; that passed. My mom was a born again Christian. But my mom she used to see her spiritual guide. And he would actually talk through her. I witnessed that. And he would warn her when danger was coming. And every single time it was true, danger was coming. I was just a young girl and we were with my aunt. We were having a conversation with her and all of a sudden, out of the blue she became this other person. . . her facial, her features changed and her voice changed and she started to talk to my aunt and to the person and he said who he was and what he was to my mom and everything. It was really interesting. Interesting and scary. . . Well there’s different types. There’s the spiritists and also there’s the santeros. The santeros believe in sacrifices and they have these big altars where they offer food and they do bongos; that’s a religion. Ah, I’ve been to a few, just out of curiosity, but I’m afraid of it.
Informant BB reported on her experience in a women’s healing group facilitated by a santera:

Well I’m in the group now that is basically a group of women looking for ways to spiritually heal ourselves. I wouldn’t say it is specifically santeras or espiritistas because the group is multiethnic and different religious beliefs. But it is very, very -it is very rewarding to be in this group. My sister is a santera; she runs her own groups. This is the very first time I attend one of her sessions. And I really like it. I also like to see that I was not the only one dealing with very important health issues-other women from very different backgrounds-and we share information and we learn a lot.

Informant CC was also a member of the healing group but had other experiences as well:

There was a curandero who used to come from NY to Phila. He did the cleaning ritual with the herbs, they brush you and the smoke and all that. I just did it out of curiosity; actually I felt much more relaxed. It was at somebody’s house-a friend’s house. A santera moderates our group. Other than the one who moderates our group, no. There’s a side of Santeria that is evil and I don’t know, the idea of worshipping other gods doesn’t sit well with me. [laughing]. I’m Christian—I was raised a Catholic—I’m anti-Catholic but I’m Christian and I just think that I can’t be worshipping other gods. But the curiosity—I love mingling with these people because they’re so open and so you know whatever you say it doesn’t really matter; they’re so open. And it’s just something it’s always been there even though it’s been off limits to me all my life, it’s still-you know—it’s there and it’s part of our culture. And I accept it and you can believe whatever you want. Si, I have visited an espiritista for a reading--just a couple of months ago. Actually he’s very good but to do it on a consistent basis and have them as a guide, a constant guide in my life and my decisions are based on them-No; just occasionally.

Informant DD is a santera herself:

Visiting a santera means working with Orishas. This is based on faith, based on spirit and I practice myself Santeria. Yes-spiritual counselor, if I feel that there is something wrong in my environment, I visit what is called my godfather cause in Santeria you have a godfather Ofa who leads you and we do cleansing with eggs actually with eggs and we do cleansing with pidgeons. Most of them they do skip sacrifice, some of them don’t. It all depends what you’re going for. Being a santera is most likely being a spiritualist because you work with the spirits. So it’s almost the same thing, It links in the same path even if it’s divided by three steps-espiritista, Palo mayombe, and santera. Palo mayombe they work with African
congos and we work with herbs. We do a lot with herbs.

Informant G stated:

No-a lot of Spanish people do go to espiritistas and santeros and like that stuff, to find out certain things like are they going to have good fortune or meet someone, get married or something like that. But then there’s other people that believe that nothing good really comes out of visiting those types of places and they just want you to give them money and business and they’re really going to sell you dreams. . . and what’s going to happen to you in life is going to happen. They really can’t predict the future—and that’s just how I feel.

Many informants seemed to have a fascination for Santeria or Espiritismo, or at least for telling stories about them. Informant KK stated:

I know very little about it except that a curiosity that I have about it. I was medical power of attorney for a friend and coworker who had AIDS. He was in the hospital and was not doing well and they tried all kinds of things without success. There was something with his stomach and the doctors did not know what was going on. So having gone to all the doctors, somebody suggested that I should get him somebody who, in fact it was _________’s sister, one of them is a curandero or santero, I don’t know which. They sent one who does deep massages but also those hocus-pocus mind games, She says to me you know he’s your son. In another life, he was your son. So I said oh, okay, whatever. She asked that we bring chicken soup but not chicken, it was a dove, paloma, and to make olive oil. So sure enough she gave the massage with olive oil on the stomach and the thing cleared up and there was a doctor who came; it was at X hospital and everyone said we would get in trouble for doing medicine. But the doctor was from Romania and he said that we do that there too. Whatever works. It worked. So that was one incident. There may be some people, who their brain is structured in such a way that instead of being very gifted at say, playing the violin, they’re very gifted at picking up spirit energy form.

The transcripts above offer the reader a variety of perspectives on curanderos, santeros, and espiritistas as related by informants.

4.7 Findings from Direct Systematic Observation of Behavior
Direct systematic observation is an anthropological strategy advocated by Johnson & Sackett (1998) to supplement the participant observation, interviewing, and fieldnotes used by ethnographers. The authors point out that most of the informants’ time is spent in everyday activities such as cleaning, shopping, working, eating, and such but the typical ethnographic focus is on a specific topic. Unless the researcher seeks out information on everyday activities by direct systematic observation, the picture that will emerge is uneven and distorted (Johnson & Sackett, 1998). Direct systematic observation is a tactic to “keep participant observation honest” by comparing observed behavior and timeline to interview data for consistency and bias (Johnson & Sackett, p.309). This researcher used random interval instantaneous sampling, also known as spot sampling to focus objectively on observed behaviors of two key informants. These informants were chosen randomly but had high visibility in the community so were easily observed.

Informant C was observed on a Sunday walking to church and attending a bilingual Mass, then interacting with other Mass attendees. She was unaccompanied walking from home, was warmly greeted by other parishioners and sat with them. She went to Communion. She lingered in the church after Mass, mingling with other parishioners and talking with the pastor. Another parishioner from the neighborhood accompanied her home. After ½ hour in her house, she emerged in different clothing and crossed the street to enter the large community garden where she remained working in the garden, watering plants, singing to herself for the next hour. After this she returned to her home and was lost to systematic observation.

Informant D was observed on a weekday coming to work at the neighborhood garden project office. She walked to work and upon entering the building, she embraced
the cleaning lady and they exchanged a friendly conversation in Spanish. She took a personal call on her cell phone from a family member. Following this the director of the center arrived and they conversed about a downtown event occurring later today and transportation arrangements. Another staff member arrived and the three of them dialogued about an upcoming presentation. Informant D then observed the cleaning lady departing and again embraced her, speaking in Spanish. At that point this researcher emerged from the arboretum and greeted the informant, ending the systematic observation.

This researcher initially wondered what was to be gained by this systematic observation. It seems that it would be more valuable in the context of a full ethnography; however, it did validate for this researcher that the informants were presenting themselves accurately.

4.8 Relationship of Themes to Each Other

Four themes were abstracted from the grouping of categories, subcategories, and subthemes: 1) Between Two Worlds: Staying Connected to Our Roots, 2) Gardens as Symbols of the Motherland: Creating the Environment, 3) The Holistic Nature of Health, 4) Surviving the System: Healthcare Perspectives in Puerto Rico and Philadelphia. This section will address the relationship of the themes to each other.

Theme 1 deals with informants’ loyalties to Puerto Rico, their ancestral home, where many still have family and friends, while living in Philadelphia. Informants maintain some treasured traditions from Puerto Rico in their Philadelphia home,
including closeness to family, valuing traditions, and honoring mothers and
grandmothers. They also travel back and forth to Puerto Rico to maintain ties to kin and
country. One of the traditions which the Puerto Rican community in Philadelphia has
chosen to keep is that of growing and using home remedies. These remedies were readily
available in rural areas of Puerto Rico and are now being transplanted into gardens in the
North Philadelphia Neighborhood Project. Members of the gardening community are
still bringing plants back on their trips to Puerto Rico.

The gardens in Theme 2 serve as a vehicle for maintaining cultural ties to Puerto
Rican roots, both literally and figuratively. From small beginnings years ago, the garden
project has grown with planning and deliberation into several garden plots extending over
six city blocks, each with a theme representing some aspect of Puerto Rican culture. The
large garden also serves as a community gathering place for celebrations and festivals.
There is a women’s knitting circle and a variety of other groups that meet in the garden
during the Spring through Fall months. The Children’s after school and summer camp
groups also use the garden and there are classes in gardening, dancing, drumming, and
mask-making as well as storytelling. All of these activities are designed to highlight
Puerto Rican traditions. The accompanying mural arts project provides a backdrop of
Puerto Rican countryside scenes that complement the gardens. So the gardens are a
conduit for connecting with Puerto Rican roots. The garden project has also motivated
those in the neighborhood to cultivate their own backyard gardens and to reclaim vacant
lots for gardening and growing fresh food for consumption.

The holistic nature of health in Theme 3 speaks to healthy eating, exercise, stress
relief and spiritual health, including connectedness to God, self, and other women. One of
the ways that Philadelphia Puerto Ricans obtain stress relief is by maintaining
connectedness with friends and family in Puerto Rico and returning there for visits.
Many of the informants go back every year after Christmas for the traditional celebration
of the Three Kings Day or *Tres Reyes*. There are parades, festivals, and visiting. For
some this is their only vacation but they stay for a month, trading the cold weather of
Philadelphia for the more inviting tropical climate. For the women there are also the
“other” visits to Puerto Rico to care for sick relatives, even bringing them to Philadelphia
if they will get better care here. At other times, family or friends in Puerto Rico may
send packages of plants or herbs to those in Philadelphia, or Philadelphia visitors may
bring plants back with them. Some of the dedicated gardeners go to Puerto Rico to meet
with herbalists and bring back traditional medicinal plants for growing here. The gardens
in the Philadelphia Neighborhood Project provide for individual family plots to grow
vegetables for healthy eating. The community center sponsors a series of cooking classes
around cultural themes. The neighborhood chain of Spanish grocery stores sponsors a
community Sugar Cane Festival every June, with ethnic foods, health information and
screening, dancing and singing. Churches in the area all offer services in Spanish and
celebrate feast days of special saints, similar to the festivals held in rural Puerto Rico on
Saints days. The center of the Philadelphia community is dominated by a large square
block of treed park land with a children’s playground and park benches, offering the
opportunity for walking and being outdoors. There is a Hispanic Senior Center and senior
housing adjacent to the square and next to the offices of the Neighborhood Project. Small
bodegas abound on corners and there is also a Puerto Rican bakery nearby. The
Neighborhood Project also sponsors teen dances and gatherings monthly.
Theme 4 refers to challenges that Philadelphia Puerto Ricans have in accessing healthcare. This researcher found that barriers existed in both Puerto Rico and Philadelphia, although different in nature. Some of the barriers in Philadelphia were cultural, and informants did not feel safe to discuss home remedies with providers or were rebuffed by providers for using home remedies. Other barriers were a mistrust of pills or medications or a concern with possible side effects which deterred informants from using them. Some informants would like to see a dialogue opened between healthcare providers and herbalists so that efficacious home remedies could be used in place of expensive medications; this potentially impacts issues within Themes 1, 2, and 3 since the home remedies are part of the Puerto Rican tradition, are grown in the gardens, and are used for health conditions. One of the other barriers to care delivery identified by informants was the lack of *personalismo* on the part of healthcare providers. This translates into the 15 minute visit where essential information is exchanged and diagnostic and/or therapeutic management is instituted. If this requires a referral or a visit to another facility that is during work hours, it may not be followed up due to time constraints. Using the sense of connectedness engendered by group events, gardening, and health fairs may offer a partial solution to this problem and is another way of connecting with the other themes.

4.9 Summary

In sum, four themes were abstracted from the analysis of emic and etic data: 1) Between Two Worlds: Staying Connected to Our Roots, 2) Gardens as Symbols of the Motherland: Creating the Environment, 3) The Holistic Nature of Health, 4) Surviving
the System: Healthcare Perspectives in Puerto Rico and Philadelphia. The themes are related to each other and to the researcher’s questions about culturally based health beliefs and practices, implications of health beliefs and practices for health professionals, and the influence of acculturation on health beliefs and practices.
CHAPTER 5

DISCUSSION, SUMMARY AND RECOMMENDATIONS

This study sought to answer the following research questions: 1) What are the health beliefs and cultural health practices utilized by Puerto Rican women in caring for self and family members? 2) What are the implications of these health beliefs and practices for health professionals who work with this population? 3) Is acculturation a factor influencing the health beliefs and cultural health practices of Puerto Rican women in Southeastern Pennsylvania?

In this chapter the study findings are discussed in the context of research questions and related themes, drawing upon extant literature. Implications for nursing and healthcare practice and recommendations for future study are addressed.

5.1 Discussion of Research Questions and Findings

*Question 1-What are the health beliefs and cultural health practices utilized by Puerto Rican women in caring for self and family members?*

Through interviews with informants and participant observation this researcher
established that there is a deliberate pattern of growing and using herbs as medicinal substances based upon oral tradition primarily from mothers and grandmothers. This oral tradition has been augmented by information from books and workshops by Maria Benedetti (2000), a Nuyorican herbalist who moved to Puerto Rico and wrote several books after interviews with local healers from various areas in Puerto Rico. The work of herbalist Stephen Harrod Buhner (2002, 2004) has also influenced some of the informants. Informal exchanges among informants in a knitting group and other informants in a support group for women with cancer have contributed to current practice as well.

The use of home remedies by Puerto Ricans in the mainland U. S. was documented by Harwood (1971, 1981) in earlier decades. More recent studies have tended to group all Hispanic subgroups under the term “Hispanic” making it difficult to elicit specific information on Puerto Ricans. The term “home remedies” has also been subsumed under the umbrella of CAM or Complementary and Alternative Medicine, making it more difficult to isolate. A recent survey estimated that 72 million Americans use CAM (Tindle, Davis, Phillips, & Eisenberg, 2005).

Flizar (2004) conducted an ethnonursing study of 33 elderly Puerto Ricans in Bethlehem, Pa. The focus of her study was the discovery of the meanings and practices of folk and professional health care of elderly Puerto Ricans. Her informants, primarily older Puerto Rican women, mentioned using teas, Vicks, and certain plants for skin problems but no other generic home remedies. They received health care from physicians in the area.

Davis (1997) conducted a phenomenological study with Puerto Rican women in
central Pennsylvania to understand their use of ethnic pharmacopeia; her group of 21 women used herbs, foods, and over-the-counter remedies. Reasons for use included association with being loved or cared for by mother or grandmother, easy availability, and connection with culture. This corresponds to the comments of one informant in this researcher’s study who reported that her children requested the remedies as comfort measures even when they were not ill. Also, when this researcher interviewed informants about home remedies, it seemed to unleash a flood of nostalgia as they reminisced about mothers and grandmothers and childhood memories. The researcher then refocused informants on the present day. Without a doubt, the use of home remedies in this researcher’s informant group, is related to culture. The table of remedies presented in this study identifies present use (See Table 4, Appendix K).

Initial contact and interviews with this researcher’s informants might lead an outsider to casually dismiss the use of home remedies as “only teas.” However, upon further investigation it is clear that fresh and dried concentrated herbs are being ingested by many informants as medicinal substances and that many in the group are conflicted about revealing this use to their healthcare provider or have been discounted when they broached the topic with their healthcare provider. This mirrors the findings of a recent review of 12 studies on CAM use by Robinson & McGrail (2004). These researchers found that 40% to 77% of people who use CAM therapies do not divulge CAM use because healthcare providers do not ask, because they feel that it is natural, therefore safe, or because they are apprehensive that healthcare providers will respond negatively.

To this researcher it is a time of danger and opportunity. The danger that this researcher foresees is that well-meaning but uninformed leaders in the neighborhood
project could be exploited by commercial entities promoting products to the Hispanic community or could pursue further educational workshops with uncredentialed presenters and unproven remedies. Cancer patients, an unanticipated subgroup of this researcher’s study, are especially vulnerable; a recent Google search for “home remedies for cancer patients” produced an abundance of unregulated sites. Additionally, CAM therapy use in cancer patients has been reported in 50% to 83% by researchers (Basch & Ulbricht, 2004).

This researcher obtained an abundance of information on home remedies from informants, possibly due to the fact that the initial question in the semi-structured interview guide asked about use of home remedies. However, health practices related to home remedies seemed to dominate the interview, leading the researcher to reflect on what other health beliefs and practices might have been brought out if the initial question was rephrased to omit the example of home remedies, or conversely, if home remedies would have been divulged at all if not specifically mentioned.

Opportunities exist with the expansion of the gardens, for possible funding sources to create a healing garden as a joint project with the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health, an Hispanic cultural organization, and informants who are part of the North Philadelphia Neighborhood Project focusing on safe use of home remedies in Hispanic cultures. Informant D, who is a leader in the garden project, is interested in pursuing this idea. With the assistance of an entrepreneur, herbs grown in the gardens could be sold to local restaurants and profits returned to the Neighborhood Project.

For cancer patients, The Wellness Community of Philadelphia currently offers
workshops including mind-body connections. There has been outreach to the African American community in Philadelphia, but none specifically targeting the Hispanic community. Connections could be established with the cancer support group moderated by the Santera that would focus on safe and unsafe use of herbal remedies for cancer and offer other holistic support modalities while preserving the integrity of the group.

This researcher sees the development of home gardens as a positive step toward health for Puerto Rican women and their families. Many informants equated health with living close to nature in Puerto Rico and having access to food and herbs in their backyard. If it is natural or from nature, it must be good was the mantra of many. Other informants realized the importance of discussing the use of natural remedies with healthcare providers and validating their effectiveness or benign nature.

Negative consequences of coming to Philadelphia included city living with crime, urban crowding, no space for a garden, cheap and available fast foods, limited availability of “fresh” foods and prohibitive costs. The North Philadelphia Neighborhood Project has gradually made available vacant lots for planting and growing food. Continued grants for land reclamation can have both health and economic advantages. This will require ongoing commitment by the community to urban gardening and culturally focused nutrition education for habits to change.

Obesity is a significant problem both in Puerto Rico and in Puerto Ricans in mainland U.S. A recent study demonstrated that island dwelling and mainland US Puerto Ricans had a similar prevalence of obesity at 21% and 22 % respectively (Ho et al, 2006). Diabetes was also rampant in both island dwelling and mainland Puerto Ricans; prevalence was higher in mainland Puerto Ricans, but mortality was higher in Puerto
Rico (Ho et al, 2006). Further advantages from home gardening in Philadelphia could occur in terms of mental and physical health from the activities of gardening and producing food for the family. Since many of the informants have close connections with family and friends in Puerto Rico, a hermanamiento program could be established with a community in Puerto Rico to encourage motivation and support.

Another health belief and health practice among Puerto Rican women is that of the traditional role of the woman as caregiver. Since the time of the Spanish occupation of Puerto Rico, women have been expected to manage the home and raise the family (Acosta-Belen, 1986; Stevens, 1994; Torres, 1998). In recent years this has grown more difficult both in Puerto Rico and the mainland U.S. as the economy has created the expectation of the two-wage earner family. This is further complicated in the Philadelphia Puerto Rican population where the majority of households are occupied by single women and children or several generations of women and children (Adams et al, 1999). Continuation of this caregiving tradition has caused a lot of stress for informants of all ages. Older women are still caring for grandchildren and helping children so that they can work. Some younger, married women are staying home with children, often sacrificing health insurance coverage, with the support of other women in their family. One young informant was very grateful for the geographic closeness and support of extended family. This was not the norm, however. Several informants reported having no close family.

This is very different from the “early Philadelphia migration” described in Koss’s urban ethnography (1965) where the Puerto Rican community was isolated from the rest of the city, but new immigrants formed a close-knit community with mutual support
mechanisms. Boardman (2004) identified neighborhood stability and cohesiveness as an important differential in minimizing the effects of stress on physical health in low socioeconomic communities. The Neighborhood Project and other similar programs are attempting to replicate this closeness and support, but poverty and other social issues present difficult challenges and the infrastructure is fragmented. Other single parents have low-paying jobs which require long hours away from family. Some children are latchkey children, left on their own after school; some are enrolled in an after-school program in the Neighborhood Project or elsewhere. Several informants also spoke of continuing the traditional responsibility of the oldest to care for others in the family.

As reported by some informants, their mothers were traveling back and forth to Puerto Rico caring for sick family members. According to Alicea (1997), a feminist sociologist, this transnational migration for caregiving perpetuates the subsistence work and gender oppression that women sought to escape in leaving Puerto Rico. However, in her viewpoint it also creates a unique sense of transnational community and family ties that allows them the best use of resources available in each place; this could not be confirmed through informants.

Sociological studies have identified familism or familismo as a strong value in Puerto Rican groups (Cortés, 1995). Three components of familismo include living close together, sharing resources and support, and believing that the family is more important than the individual (Landale, Oropesa, & Bradatan, 2006). Although women are responsible for most caregiving in the family, this is subsumed under the umbrella of family caregiving and decision-making that is ultimately part of familismo. The values of familismo were reported by some informants, but there were several informants who...
replied that they had no family nearby. This is a change from the “old” ways and probably reflects the stress of adapting to a new environment and culture, particularly in the scenario with informant N whose son married a non-Hispanic and abandoned his parents. In contrast, other informants were married to or cohabiting with Puerto Rican men. Informant L also implied that things were changing and that older Puerto Ricans might be placed in nursing homes in lieu of family care. This researcher noted that there are several senior citizen apartment complexes in the area with a Caribbean theme; this may represent an attempt to keep aging family close while not being burdened with caring for them.

This researcher is also aware that the youngest informant in this study was 28 years old. This could be coincidental since most interviews were conducted when older teens and single young adults would be working; one 19 year old volunteered to be interviewed, but he was a male, so did not meet the inclusion criteria. However two key informants spoke sadly of the younger generation. One referred to them as “the lost generation” and qualified that drugs were responsible for this. Her adopted son was in jail for dealing drugs at the time. She had terminal cancer but was attempting to gain custody of her only grandson, an 18-month old on life support in California. He had been beaten by his mother’s boyfriend. The other key informant expressed frustration for her 15 year old granddaughter who wanted to be a physician. The informant said, “How do we get these children, with their dreams and goals, through adolescence without becoming pregnant and giving up everything?” These comments and other observations in the field make this researcher aware of broader issues and concerns facing the North Philadelphia Hispanic community.
This researcher believes that acculturation and stress have contributed to environmental, economic, and social issues and significantly impact on the health of Puerto Rican women and their families. Health problems including obesity, diabetes, hyperlipidemia, hypertension, heart disease and mental health problems are known physiological manifestations associated with long-term stress.

Without exception, all informants spoke of spirituality and a relationship with God as essential to health; the researcher was profoundly moved by the passion and conviction in their disclosure. Spirituality was expressed in daily prayer and was not associated with any one religious sect. Some were Catholic, some Pentecostal or born again Christians, some were Jehovah Witnesses, others Protestant and a few practiced Santeria as a religion. Some used meditation to connect with God and self while others had a pantheistic connection between God and nature.

The connection of spirituality to health in Puerto Ricans was also noted by Fliszar (2004) in her ethnonursing study of Puerto Rican elders; health was expressed as physical well-being coupled with spiritual and emotional satisfaction. Campesino & Schwartz (2006) studied spirituality within a cultural context of Latina values and found that it was closely connected to personalismo and familismo. Their sample consisted of 95 Latino nurses; 47% were Puerto Rican. An instrument called the LSPS or Latina Spiritual Perspective Scale was used to measure various aspects of spirituality. Highest rated items were ones that equated spirituality with helping family, and reported using spirituality to get through hard times.

All informants believed that a good diet and regular exercise were important to health. The concept of balance in life accompanied diet and exercise. Most informants
admitted that these components of health were something that they were striving towards but had not yet achieved. As one informant explained, the need to work coupled with the easy availability of fast food has not helped. Obesity rates in Puerto Rico now parallel those of mainland Puerto Ricans (Ho et al, 2006).

Most informants had a primary healthcare provider; older women tended to see healthcare providers more regularly while others went for their “annual.” This researcher noted that some middle-aged women did not believe in “traditional Western medicine” and did not use the healthcare system at all. This is concerning because the benefits of prevention, and possibly early intervention, are lost to those who do not access the healthcare system. Some women also were more comfortable with naturopaths than allopathic physicians. Access to care issues were obvious in transitioning from one job to another; health benefits were too expensive so the Free Clinic system aka the City of Philadelphia Ambulatory Health Centers was utilized. Clients in this system may wait up to 6 months for an appointment; there is little continuity in providers and although clientele are culturally diverse and language services are available by trained interpreters or language line, it is a basic, “no frills” healthcare delivery system with little time or attention to personalismo. Appointments are scheduled, but clients may wait for hours to see a healthcare provider; continuity of providers is limited. Services are primarily available during daytime, weekday hours requiring clients to take off from work or school. When clients do get health insurance, it is difficult to obtain clinic records, resulting in fragmentation or duplication of services. The Behavioral Health system is even more difficult to access due to the lengthy waiting period before an appointment can be made. The inefficiency of the system is a disincentive to accessing healthcare services.
Many informants voiced problems with taking medications. Puerto Ricans usually say that they “drink” their pills, meaning that they take pills with water or another liquid. Some had problems swallowing pills but most were resistant to taking pills due to side effects or “secondary effects” as they called them. One informant told this researcher that pills are poison. Another felt that healthcare providers prescribe pills instead of actually treating the source of the problem with more holistic modalities. In the second example here, the problem was back pain and the informant subsequently sought chiropractic care and massage for relief instead of “getting hooked on pain pills.” No one experienced problems using home remedies even if they tasted “nasty” because it was believed that they would help.

Problems with Puerto Ricans using medication are not unique to this study, but they do impact significantly on the plan of treatment and health outcomes. Davis (1997) studied Puerto Rican women’s experience with pharmacopeia. Her sample, from central Pennsylvania, had a mistrust of pills because of the unknown of what was in them; they did feel confident in using aspirin, ibuprofen, and acetaminophen. Several informants in this researcher’s study also used Tylenol or Motrin as self-care treatments. Hatcher & Whittemore (2006) reviewed the literature on Hispanic adult beliefs about Type II diabetes; Mexican, Puerto Rican, Cuban, and other Hispanic subcultures were included in this review. They found that herbal treatments for diabetes were preferred by some and that using insulin was seen as associated with amputations and even mortality. Strategies for dealing with pill avoidance will be discussed under Recommendations.

Question 2- What are the implications of these health beliefs and practices for
One of the primary implications for health professionals is the importance of delivering healthcare within the context of culture. Health professionals can be experts in their respective discipline and can practice evidence-based healthcare, but if their practice is not informed by cultural knowledge and delivered in a manner that is acceptable to the culture of the clients, it will not be effective and health outcomes will be compromised (Meleis, et al, 1995). Informants have stated that listening skills and spending time with them are important requirements for their healthcare providers; this need for *personalismo* has been identified in several studies and can be extended to all health professionals dealing with Puerto Ricans in Southeastern Pennsylvania (Andrés-Hyman, Ortiz, Añez, Paris, & Davidson, 2006; Davis, 1996; Fliszar, 2004; Henley & Peters, 2004). This begs the question of how to listen and take time with clients in the context of the tightly scheduled healthcare arena where billing and income generated are measured in time increments of 15 minute visits.

For clients with a chronic illness, such as diabetes, the concept of the group visit provides a possible solution to the time crunch and the need for *personalismo*. In this model, a group of health professionals which can include a medical provider, nurse, nutritionist, pharmacist, podiatrist, or others, meets with a group of clients for healthcare management and education, to discuss problems, and to offer support, usually every three months (Allweis & Short, 2004; Robert Wood Johnson Foundation, 2006). Ideally, clients remain in the same group over time. This model, or an adaptation of it with culturally sensitive health professionals, could meet the stated needs of informants for listening and personalized care and also offer them a sense of connectedness and support.
with others. Another issue of concern to informants was the need to take pills for illness management; group visits with a focus on pharmaceuticals, using an Hispanic clinical pharmacist, could open up a dialogue to resolve some of the issues or empower clients to feel more in control of their drug therapy. Many pharmaceuticals also have plant-based origins; making the connection between natural substances and pharmaceuticals could facilitate adherence to prescribed medications.

Informants felt that home remedies were helpful and will continue to use them. Some of the implications were discussed in Question 1. Health professionals working with this population must ask about use of home remedies in a non-judgmental manner. Health professionals must inform themselves about home remedy use and seek out unbiased, professional resources such as the website of the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health, and the Natural Medicines Comprehensive Database. Whenever possible, collaborating with clients on an integrative health management plan including home remedies and broad, holistic modalities such as massage, acupressure and such may empower the client and contribute towards adherence. For nurses working with clients in an inpatient setting, offering a backrub or other comfort measure may be helpful. The goal is to support remedies that do no harm.

Returning to the concept of personalismo, health professionals must be mindful that each client is an individual and must really listen and ascertain the individual’s health beliefs and practices. Membership in an ethnic group, such as Puerto Ricans, does not automatically confer cultural beliefs and practices associated with the group in published literature.
Question 3- Is acculturation a factor influencing the health beliefs and cultural health practices of Puerto Rican women in Southeastern Pennsylvania?

Using the objective data from the PAS, this researcher can affirm that acculturation is a factor influencing the health beliefs and cultural health practices of these Puerto Rican women. This researcher also believes that the PAS scale was the best instrument to use with this population. Although the researcher grouped informants into low-medium-high acculturation categories, the data clearly show individual variations in responses to each question, consistent with the concept of psychological acculturation (Appendix H). The informants were bicultural and felt comfortable in either culture. The researcher is aware of a potential bias towards biculturalism from the inclusion criteria for the study which required that informants be able to participate in the semi-structured interview in English. However, unlike some acculturation measurement instruments, the PAS scale does not use language as a measurement criterion. Two of the youngest informants, both fluent in English and born in the mainland U.S. but very much enmeshed in their extended families, scored in the low range on the PAS. In looking at conceptual approaches to acculturation, this researcher found one definition of acculturation which speaks of reactive acculturation where individuals reject the dominant cultural influence and change to a more traditional way of life (Social Science Research Council, 1954). This researcher believes that the focus on the gardens with their traditional themes may be reflective of this concept; also the environmental composition of the main neighborhood with a large open square and park in the center where everyone gathers in the daytime is reminiscent of the central gathering area in Taino villages. At the present time, the area is starting to become gentrified with more
affluent Puerto Ricans moving back and remodeling homes to resemble Caribbean villas. Shopping centers nearby cater to the Puerto Rican population. There is even a general store, called the Puerto Rican store, which sells memorabilia, home remedies, even flags and beachwear from Puerto Rico.

The researcher also observed signs of stress, possibly related to acculturation and change, in the lives of participants. Many are single parents with limited incomes struggling to remain loyal to the concept of *familismo* and community only to discover that their children are truant while they are working or volunteering at the Neighborhood Center. Obesity and diabetes are very common. Some residents of the area have moved away or rejected their cultural roots as they became more affluent.

While working on this chapter, the researcher was made aware of an article by Hunt, Schneider, and Comer (2004) questioning the basic tenets of acculturation as a construct and likening it to ethnic stereotyping due to its focus solely on minority groups and the exclusivity of its association with health inequalities. The article raised many excellent questions about categorizing or labeling, including the lack of standardization of “mainstream” society against which the minority culture is being compared, and the challenge of identifying two unambiguously “different” cultures to compare when exposure to mainstream culture via media is a given. After reading this article, the researcher concluded that the work of these authors should be considered if a researcher seeks to study acculturation as a variable in health disparities, so that other relevant influences suggested by these authors, such as political and socioeconomic status are also included as variables.
5.2 Summary

This focused ethnography explored the health beliefs and cultural health practices of Puerto Rican women in Southeastern Pennsylvania. *Emic* and *etic* data were gathered using participant interviews, fieldnotes, observational data, memos, direct systematic observation, and a quantitative acculturation measurement instrument with the goal of generating thick description. Four themes were abstracted from data analysis: 1) Between Two Worlds: Staying Connected to Our Roots; 2) Gardens as Symbols of the Motherland: Creating the Environment; 3) The Holistic Nature of Health; 4) Surviving the System: Healthcare Perspectives in Puerto Rico and Philadelphia.

5.3 Limitations

The nature of qualitative research is to explore an aspect of a phenomenon for which there is limited knowledge, to increase understanding of the phenomenon in the context in which it occurs. Because this research is contextual, depth of understanding rather than generalizability is the goal (Polit & Beck, 2008). The focus of this study was limited to Puerto Rican women living in Southeastern Pennsylvania. The findings from this study can be used by health care professionals caring for Puerto Rican clients and their families in this community and its health care institutions, to incorporate culturally appropriate measures into their health care planning and implementation.

While findings from this study cannot be generalized to other individuals or groups within the Puerto Rican culture, the study may stimulate health care providers in other
communities to undertake research projects that will further the cause of culturally competent care. The exclusive use of English speaking informants in this study may have excluded less acculturated participants who may retain more of the Puerto Rican cultural practices.

5.4 Recommendations for Further Study

Recommendations for Further Research

Although the concepts of cultural competence and culturally sensitive care have existed for several decades now, multiple models and confusion exists regarding implementation of theoretical concepts in the clinical practice arena (Drevdahl, Canales, & Dorsy, 2008). Members of the American Academy of Nursing Expert Panel on Cultural Competence recently concluded that the “conceptualization, implementation, and evaluation of cultural competence remains unclear” (Giger, Davidhizar, Purnell, Harden, Phillips, & Strickland, p. 96), based upon lack of consistent and sustained action on earlier recommendations of the 1992 Expert Panel on Cultural Competence. Cultural competence and health disparities have been linked together; however three comprehensive review and analysis studies, two from the medical field (Brach & Fraser, 2000; Beach et al, 2005), and one from nursing (Drevdahl, Canales, & Dorsy, 2008) failed to uncover any studies in which educating health professionals in cultural competence reduced health disparities or resulted in improved health outcomes. This was also borne out by the findings of Giger and colleagues cited above (2007).

In one medical review article, Beach and colleagues (2005) found that cultural
competence training improved the knowledge, attitude, and skills of health professionals and positively impacted patient satisfaction. There were no studies found that demonstrated better adherence to treatment regime, superior health outcomes, or more equitable distribution of healthcare services across racial and ethnic groups. Drevdal, Canales, & Dorsy (2008) used an historical perspective to trace the evolution of cultural competency in nursing, including cultural assessment models and tools. They maintain that the real issues of addressing health care disparities should occur through a broader view of power differentials and social and economic inequities and requires nurses to participate in health policy and social justice initiatives. This stance is supported by the work of Hunt, Schneider, and Comer (2004) on the limits of acculturation as a health variable. The need for social action has been ignored by the focus on cultural competence as the solution to health disparities according to the authors (Drevdal, Canales, & Dorsy, 2008).

Further research is needed in the areas of translational research to guide health professionals in integrating cultural competency and health disparities with a focus on improving health outcomes for Puerto Rican clients. Measureable results in health outcomes must be linked to cultural competency initiatives. Participative action research would also help to address health, social, and economic inequities contributing to access to care issues in the Puerto Rican population. Further research is also needed to crystallize the relationship of acculturation to health beliefs and practices, and ultimately, to health outcomes.

Recommendations for Nursing Education

Nursing theorists and educators have developed models and tools for
understanding culture. Some of these have proved helpful in a theoretical sense, while others can be applied to research with select cultural groups. Some nursing education programs have addressed culture in a very limited way, if at all, giving lip service to the concept. This researcher recommends that students be involved in the culture of the clients they are serving, through community health, service learning, or cultural immersion projects. This interaction at the student level minimizes the “us-them” barriers that can be erected in the process of becoming a health professional. It also allows the students to see the everyday life challenges faced by their clients. This researcher further recommends that interdisciplinary programs such as Bridging the Gaps be incorporated to provide structure and a team approach to solving health problems as recommended in the Institute of Medicine monographs on Health Professions Education: A Bridge to Quality (2003) and Crossing the Quality Chasm: A New Health System for the 21st Century (2001).

Recommendations for Nursing Practice

One of the most important mandates for nursing practices is the need to deliver healthcare within the context of culture (Meleis, 1995). Much lip service has been given to cultural competency and many programs have been developed but the importance of considering the individual as a person, a member of a family, and a member of a cultural group, cannot be overstated.

In the Puerto Rican culture, the concept of personalismo is very important (Andrés-Hyman, Ortiz, Añez, Paris, & Davidson, 2006; Davis, 1996; Fliszar, 2004; Henley & Peters, 2004); relationships between health care providers and patients and families are a key part of care delivery. Time spent with the patient and family is also
highly valued. This researcher recommends group visits and support groups for chronic illness for patients and families as one strategy to meet the need for both time and connectedness (Allweis & Short, 2004; Robert Wood Johnson Foundation, 2006). Collaboration between primary care providers, pharmacists, and clients for safe integrative health and a solution to the problem of not taking prescribed pills is also essential and fulfills one of the mandates of the Institute of Medicine for avoiding medical errors.

Policy Recommendations

Many of the informants in this study had no health insurance or experienced fragmentation of services due to changes in healthcare coverage and need to access the free clinic system. A basic level of healthcare services, including health maintenance and acute illness care should be available for all.

The government mandated standards for the provision of culturally appropriate linguistic services need to be enforced. Although the Joint Commission on the Accreditation of Healthcare Organizations (JACHO) has facilitated this accomplishment in the institutional setting, outpatient and ambulatory family practices are delinquent in providing this service to clients or inappropriately place the burden of providing this service on the client as a condition for delivering care. This is a disincentive to accessing healthcare.

5.4 Conclusions

This focused ethnography explored the health beliefs and cultural health practices
of a group of Puerto Rican women in Southeastern Pennsylvania. The findings of the study suggest that this community is committed to the preservation of cultural health beliefs and practices and cultural heritage, while adapting to life in urban Philadelphia. Through the eyes of the informants this researcher saw how the knowledge of nature and natural remedies learned from parents and grandparents in Puerto Rico, has been modified and transformed into a way of life in Philadelphia that supports the “old ways,” but includes elements of the new environment. Stress is evident in informants’ efforts to remain close and connected despite the assaults of urban violence, poverty, and the drug culture. This stress is also manifested in increased levels of chronic diseases such as obesity, diabetes mellitus, cancer, and heart disease. Fragmentation of health care is common due to insurance issues and the caregiver role still assumed by most women. Although most trust their healthcare provider, the reluctance to use pills due to “secondary effects” and “chemicals” is a deterrent to positive healthcare outcomes. A strong spiritual core belief system persists and gives them strength.
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Appendix A

Demographic Questionnaire (DQ)

Interviewer Script: “Thank you for agreeing to participate in this study.”

Interviewer: “Before I ask you some questions about your health and culture and how you take care of your health, I would like to ask you some general demographic questions. If there are any questions you prefer not to answer, you don’t have to answer them.

“My first questions are…

1. What is your age?

2. Where were you born?

3. How long have you lived on the mainland USA?

4. How often have you visited Puerto Rico in the past 5 years?

Interviewer closing: “Thank you. This is the end of the questions for the first part of the interview. Now I would like to move on to a few questions about your cultural preferences.”
Appendix B

Interviewer Script:

“Thank you for completing the demographic questionnaire. Now I would like to move on to some questions about your feelings about belonging to the Puerto Rican culture and the U.S. culture. There are no right or wrong answers to these questions, only the answers that are true for you. Your answers are confidential and at any time, if there are any questions you prefer not to answer, you don’t have to answer them.”

The interviewer will show the questions to the informant and explain the rating scale

Psychological Acculturation Scale – English Version
(Tropp, Erkut, Garcia Coll, Alarcon, & Vazquez-Garcia, 1999)

Appendix B

Psychological Acculturation Scale – English Version
(Tropp, Erkut, Garcia Coll, Alarcon, & Vazquez-Garcia, 1999)

1. With which group of people do you feel you share most of your beliefs and values?

1--------2-----------3-----------4------------5
Only with Hispanics/Latinos Equally with Hispanics/Latinos and Anglos (Americans) Only with Anglos (Americans)

2. With which group of people do you feel you have the most in common?

1--------2-----------3-----------4------------5
Only with Hispanics/Latinos Equally with Hispanics/Latinos and Anglos (Americans) Only with Anglos (Americans)
3. With which group of people do you feel most comfortable?

1-----------2------------3------------4--------------5
Only with Hispanics/Latinos
Equally with Hispanics/Latinos and Anglos (Americans)
Only with Anglos (Americans)

4. In your opinion, which group of people best understands your ideas (your way of thinking)?

1-----------2------------3------------4--------------5
Only with Hispanics/Latinos
Equally with Hispanics/Latinos and Anglos (Americans)
Only with Anglos (Americans)

5. Which culture do you feel proud to be a part of?

1-----------2------------3------------4--------------5
Only with Hispanics/Latinos
Equally with Hispanics/Latinos and Anglos (Americans)
Only with Anglos (Americans)

6. In what culture do you know how things are done and feel that you can do them easily?

1-----------2------------3------------4--------------5
Only with Hispanics/Latinos
Equally with Hispanics/Latinos and Anglos (Americans)
Only with Anglos (Americans)

7. In what culture do you feel confident you know how to act?

1-----------2------------3------------4--------------5
Only with Hispanics/Latinos
Equally with Hispanics/Latinos and Anglos (Americans)
Only with Anglos (Americans)

8. In your opinion, which group of people do you understand best?

1-----------2------------3------------4--------------5
Only with Hispanics/Latinos
Equally with Hispanics/Latinos and Anglos (Americans)
Only with Anglos (Americans)
9. In what culture do you know **what is expected of a person in various situations**?

1----------2----------3----------4----------5

- Only with Hispanics/Latinos
- Equally with Hispanics/Latinos and Anglos (Americans)
- Only with Anglos (Americans)

10. Which culture do you **know the most about** (for example: its history, traditions, and customs)?

1----------2----------3----------4----------5

- Only with Hispanics/Latinos
- Equally with Hispanics/Latinos and Anglos (Americans)
- Only with Anglos (Americans)
Appendix B

Psychological Acculturation Scale – Spanish Version
(Tropp, Erkut, García Coll, Alarcon, & Vásquez-García, 1999)

1. ¿Con qué grupo de personas siente que comparte la mayoría de sus creencias y valores?

   1-----------2------------3------------4--------------5
   Sólo con  Con Hispanos/ Sólo con Anglés
   Hispanos/Latinos Latinos y Anglés (Americanos)
                        Americanos ambos por
                        igual

2. ¿Con qué grupo de personas siente que tiene lo más en común?

   1-----------2------------3------------4--------------5
   Sólo con  Con Hispanos/ Sólo con Anglés
   Hispanos/Latinos Latinos y Anglés (Americanos)
                        Americanos ambos por
                        igual

3. ¿Con qué grupo de personas se siente cómodo(a)?

   1-----------2------------3------------4--------------5
   Sólo con  Con Hispanos/ Sólo con Anglés
   Hispanos/Latinos Latinos y Anglés (Americanos)
                        Americanos ambos por
                        igual

4. En su opinión, ¿qué grupo de personas mejor entiende sus ideas (su forma de pensar)?

   1-----------2------------3------------4--------------5
   Sólo con  Con Hispanos/ Sólo con Anglés
   Hispanos/Latinos Latinos y Anglés (Americanos)
                        Americanos ambos por
                        igual

5. ¿De qué cultura se siente orgulloso(a) de ser miembro?

   1-----------2------------3------------4--------------5
   Sólo con  Con Hispanos/ Sólo con Anglés
   Hispanos/Latinos Latinos y Anglés (Americanos)
                        Americanos ambos por
                        igual
6. ¿En qué cultura sabe cómo hacen las cosas y siente que **puede hacerlas con facilidad**?

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7. ¿En qué cultura se siente seguro(a) de que **sabe cómo comportarse**?

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8. En su opinión, ¿a qué grupo de personas **entiende** mejor?

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9. ¿En qué cultura sabe **lo que se espera** de una persona en varias situaciones?

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10. ¿De qué cultura **conoce más** (por ejemplo: su historia, sus tradiciones, y sus costumbres)?

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Appendix C
The Semi-Structured Interview Guide

Interviewer Script:

“Thank you for completing the demographic and the cultural preference questionnaires. I am interested in learning about your health and your family’s health and some health practices that you might have. At any time, if there are any questions you prefer not to answer, you don’t have to answer them.”

“Many cultural groups have home remedies or health practices. Some of these are for treating certain health problems or conditions, and some are for general health. Do you know of some of these home remedies or health practices in your community here?”

Probe: “Are there any others?”

Specification: “Of all these home remedies/health practices you talked about, which ones do you use in your family? What ones do you not use? Why?”

What do you believe is important to help you keep your health or stay healthy?

When you are sick, what do you do to feel better?

Who takes care of you when you are sick?

What do your family and friends do to help you when you are sick?

Do you go to a health professional [doctor, nurse practitioner, physician assistant] for care when you are sick? [If yes, what kind of treatment do you want from them? If you had the opportunity to tell them, is there anything that they could do to care for you better?]

Have you ever visited a curandero . . .?

Have you ever visited a santero . . .?

Have you ever visited an espiritista?

[If yes, what type of treatment or advice did you receive?]

How is this different than going to a health professional?]

Do you ever go to a botanica for health products or consultation?

What role, if any, does your faith or spirituality have in your health or sickness?
[If you use herbs or home remedies, or if you visit a healer, do you tell your health professional about this? If not, why not?]

Who cares for family members when they are sick?

Who do you consult for help with family health problems?

Is there any difference in the care that you receive when you are sick in Philadelphia and in Puerto Rico?

[For those who have been to Puerto Rico] Is there any difference in the treatment that you receive?

At the end of the interview, the interviewer will ask if the informant has any questions for the interviewer, will thank the informant and offer the $25 gift certificate to a neighborhood grocery store.
Appendix D

A Study of Health Care Practices and Health Beliefs of Puerto Rican Women in Southeastern Pennsylvania

CONFIDENTIALITY STATEMENT

I understand that in the course of my experience in this research study I may have access to confidential information about study participants. I understand that this information has been obtained and recorded for the purpose of research. I agree that I will use this information only for the purpose of this research study under the Duquesne University Internal Review Board protocol and under no circumstances will I disclose any information about any study participant to non-authorized individuals.

I understand that violation of this policy constitutes breach of study participant confidentiality and the Duquesne University Internal Review Board policies. I agree that if I have any questions about this Confidentiality Statement, I will consult the principal investigator of this project.

__________________________________________________________

(Date) (Name: Please Print)

__________________________________________________________

(Signature)

__________________________________________________________

Lori Martin-Plank, Principal Investigator
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: A Study of Health Care Practices and Health Beliefs of Puerto Rican Women in Southeastern Pennsylvania

INVESTIGATOR: Lori (Lorraine) Martin-Plank
90 Ervin Road, Pipersville, PA 18947-09391
215-766-2344 or 267-614-5716

ADVISOR: Joan Such Lockhart, PhD, RN, CORLN, AOCN, CNE, FAAN
Professor and Associate Dean for Academic Affairs
Duquesne University School of Nursing
412-396-6540

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the Doctor of Philosophy degree in The School of Nursing at Duquesne University

PURPOSE: You are being asked to participate in a research project that seeks to discover the culturally based health care beliefs and practices of Puerto Ricans in Southeastern PA as related by Puerto Rican women. In addition, you will be asked to allow me to interview you. Interviews will be conducted one to two times and each interview may last from 1 to 2 hours. During these interviews, you will be asked about your cultural beliefs and practices. The
interviews will be audiotaped and transcribed. These are the only requests that will be made of you.

**RISKS AND BENEFITS:** There are no risks greater than those encountered in everyday life. The benefit of participation is that you will be providing information that can contribute to culturally competent patient care and health professional education after the study is complete.

**COMPENSATION:** For your time, a gift certificate worth $25 and redeemable at any local market will be given to you at the time of each interview. However, participation in the project will require no monetary cost to you.

**CONFIDENTIALITY:** If you indicate willingness to participate in the study, your identity will remain confidential. The signed consent form will be reviewed only by the researcher. Only the researcher and participants will participate in the interviews. Your name will not appear on any transcript. Both audio-tapes and transcripts will be kept confidential. Audio-recordings made during interviews will be destroyed after transcription. Transcription of audiotapes will be conducted by a researcher or researcher-trained transcriptionist who has signed a confidentiality statement. Transcriptions of tapes will delete all identifiers of subjects or anyone subjects talk about. De-identified quotes will be used both in publications and presentation. All materials, including audiotapes and raw data will be stored in a locked box at the researcher’s home. All materials will be destroyed when all activities related to the research are completed.

**RIGHT TO WITHDRAW:** You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time. The withdrawal from the study will not affect your relationship with the project or future involvement.
SUMMARY OF RESULTS: A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project. I understand that should I have any further questions about my participation in this study, I may call Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board (412-396-6326) or the Principal Investigator, Lori Martin-Plank (267-614-5716) or Dr. Joan S. Lockhart (412-396-6540).

Participant's Signature ____________________________ Date ____________________________

Researcher's Signature ____________________________ Date ____________________________
Autorización para participar en un estudio de investigación

**Título:** Un estudio de las prácticas del cuidado de la salud y las creencias de la salud de las puertorriqueñas del sudeste del estado de Pensilvania

**Investigadora:** Lori Martin Plank, RN, MSPH, MSN, APRN, BC  
90 Ervin Road  
Pipersville, PA 18947  
215-707-4874 or 215-766-2344

**El Consejero:** Dr. Joan Such Lockhart, PhD, RN, CORLN, AOCN, CNE, FAAN  
School of Nursing  
412-396-6540

**La Fuente Del Soporte:** Se está realizando este estudio como parte de los requisitos para el título de doctorado en la enfermería en la Universidad de Duquesne.

**El Propósito:** A Ud. la invito a participar en un proyecto de estudio para descubrir las creencias de salud y prácticas culturales de puertorriqueñas en el sudeste del estado de Pensilvania. Además, le pido que me deje entrevistarla. La entrevistaré 1 o 2 veces e cada entrevista durará 1 a 2 horas. Durante estas entrevistas le preguntaré sobre sus creencias culturales y sus prácticas. Las entrevistas serán grabadas y transcritas. Estas son las únicas peticiones que le haré.

**Riesgos y Beneficios:** No hay ningún riesgo más grande que aquellos que se encuentran en la vida diaria. El beneficio de su participación es que Ud. proveerá información que sería competente culturalmente del cuidado de los pacientes y la educación de los profesionales de la salud después de la conclusión de este estudio.
La Compensación: Por participar en este estudio, a la hora de cada entrevista usted recibirá un cheque de regalo de $25 que se puede redimir en cualquier supermercado local. Si le seleccionan para una segunda entrevista, después usted recibirá un vale adicional $25 por su tiempo. Sin embargo, participación en este estudio será gratis para Ud.

En confianza: Si Ud. decide participar en el estudio, su identidad será confidencial. Sólo la investigadora leerá las solicitudes de consentimiento. Sólo la investigadora y las participantes participarán en las entrevistas. Su nombre tampoco aparecerá en ninguna transcripción. Las grabaciones y transcripciones serán confidenciales. Se destruirán las grabaciones después de hacer las transcripciones de las mismas. Las transcripciones serán transcritas por un investigador o transcriptor especializado en las investigaciones que ha firmado un acuerdo de confidencialidad. Las transcripciones eliminarán todos los identificadores de las participantes y los mencionados por las mismas. Citas sin identificación se usarán en las publicaciones y la presentación. Todos los materiales, incluyendo las grabaciones y los datos serán encerrados en una caja fuerte en la casa de la investigadora. Todos los materiales serán destruidos cuando se acaben todas las actividades relacionadas con el estudio.

Su derecho de no participar: Usted no tiene que participar en este estudio. Usted puede terminar su participación en cualquier momento. Su decisión de dejar de participar no afectará su relación con el proyecto ni su participación en el futuro.

Sumario de los resultados: Le proporcionaré un resumen de los resultados de este estudio gratis, si Ud. desea.

Permiso Voluntario: Yo he leído todos los puntos de este documento y entiendo lo que ustedes esperan de mí. También, entiendo que mi participación es voluntaria y que tengo el derecho de terminar mi participación en cualquier momento y por cualquier razón. Debajo de estos términos, yo certifico que todavía quiero participar en esta investigación.

Finalmente, yo entiendo que si yo tuviera preguntas sobre este estudio, yo tendría el derecho de llamar al director, el Dr. Paul Richer. Me dará la oportunidad de discutir, en
confianza, cualquier pregunta. El Dr. Paul Richer es el director del Comité Institucional de Repaso de la Universidad de Duquesne (412-396-6326).

______________________________
Firma de la participante       Fecha

______________________________
Firma de la investigadora       Fecha
Appendix F—IRB Approval

DUQUESNE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
424 RANGOS BUILDING • PITTSBURGH, PA 15282-0202

Dr. Paul Richer
Chair, Institutional Review Board
Human Protections Administrator
Phone (412) 396-6598 Fax (412) 396-5176
e-mail: richer@duq.edu

July 5, 2007

Re: A study of health care practices and health beliefs of Puerto Rican women in southwestern Pennsylvania (Protocol # 07-65)

Ms. Lori Martin-Plank
90 Erwin Road
Pipersville PA 18947

Dear Ms. Martin-Plank:

Thank you for submitting your research proposal to the IRB.

Based upon the recommendation of IRB member, Dr. Linda Goodfellow, along with my own review, I have determined that your research proposal is consistent with the requirements of the appropriate sections of the 45-Code of Federal Regulations-46, known as the federal Common Rule. The intended research poses no greater than minimal risk to human subjects. Consequently, the research is approved under 45CFR46.101 and 46.111 on an expedited basis under 45CFR46.110.

Enclosed are the consent forms stamped with approval and expiration dates. You should use them as originals for signed copies that you and subjects hold.

This approval must be renewed in one year as part of the IRB’s continuing review. You will need to submit a progress report to the IRB in response to a questionnaire that we will send. In addition, if you are still utilizing your consent form in one year, you will need to have it renewed. In correspondence please refer to the protocol number shown after the title above.

If, prior to the annual review, you propose any changes in your procedure or consent process, you must inform the IRB of those changes and wait for approval before implementing them. In addition, if any unanticipated problems or adverse effects on subjects are discovered before the annual review, they must be reported to the IRB Chair before proceeding with the study.
When the study is complete, please provide us with a summary, approximately one page. Often the completed study’s Abstract suffices. You should retain a copy of your research records, other than those you have agreed to destroy for confidentiality, over a period of five years after the study’s completion.

Thank you for contributing to Duquesne’s research endeavors.

If you have any questions, feel free to contact me at any time.

Sincerely yours,

Paul Richer, Ph.D.

Cc:
Dr. Linda Goodfellow
Dr. Joan Lockhart
Appendix G

Permissions

Print Message

From: "permissions" <permissions@sagepub.com>
Date: 2007/02/21 Wed PM 06:19:13 EST
To: <lmp@epix.net>
Subject: RE: Permission Request

Dear Lori,

Please consider this written permission to republish the PAS scale in your thesis. Please include proper attribution to the original source. This permission does not include any 3rd party material found within our work.

You must notify us upon publication of your thesis.

Good luck,
Ellen

Ellen Salvador
Permissions Department
Sage Publications
2455 Teller Road
Thousand Oaks, CA 91320
805-375-1718 (f)

-----Original Message-----
From: lmp@epix.net [mailto:lmp@epix.net]
Sent: Monday, January 22, 2007 10:26 AM
To: permissions
Subject: Permission Request

Permissions Request

Requestor's Information

Name: Lori Martin-Plank
Affiliation: Duquesne University
Street Address: 90 Ervin Rd
City: Pipersville
Zip/Postal Code: 18947-9391
State: PA
Country: USA
Phone: 267-614-5616 [cell]
Reference Code:
Publication Information for the material that Requestor Intends to Use:
- Publication Title: Education and Psychological Measurement
  Publication Type: Journal
  ISBN/ISSN: 0013-1644
  Publication Date: 1999
  Volume and Issue: Vol. 59 No. 2, April 1999 351-367
  Title of Material: PSYCHOLOGICAL ACCULTURATION:
  Authors of Material: Tropp, L.R., Ercut, S., Garcia Coll, C., Alarcon, O., & Vazquez Garcia, H.
  Title of Material: PSYCHOLOGICAL ACCULTURATION:
  Publication Type: Journal
  Page Range Material: p.355 [scale with questions]

Requestor's Use of the Material
- Type of Use: republish in a thesis/dissertation
  Purpose of Use: Academic
  Distribution Quantity: administer to 30-40 informants

Requestor's Publication
- Title: A STUDY OF HEALTH CARE PRACTICES AND HEALTH BELIEFS OF PUERTO RICAN WOMEN IN SOUTHEASTERN PENNSYLVANIA
  Type: Dissertation
  Author/Editor: Lori Martin-Plank
  Publisher: Still working on dissertation so unsure of final publisher. Will be posted internally on Duquesne University electronic dissertations website upon completion
  Publication Date: 2008
  Entire Publication: Other: PAS Acculturation Scale

Author Permission
Date: Mon 29 Jan 08:20:29 EST 2007
From: "Linda R. Tropp" <tropp@psych.umass.edu>
Subject: Re: SPN Profile Message: PAS Scale
To: lmartinp@temple.edu

Hi Lori -- thanks for your interest in our work -- a number of researchers have used our scale successfully, both with Latino/a communities and with members of other groups -- I would recommend conducting a search for our article in PsychInfo and then looking at the entries of other papers who have cited this article -- these articles should also help to bolster your claims regarding the utility of the measure for your own research also, you have my permission to use the PAS measure, and attached are the Spanish and English versions in case they might be useful for your research

Best wishes,

Linda R. Tropp, Ph.D.
Quoting Lori Martin-Plank <lmartinp@temple.edu>:

> Considering the use of your PAS scale for my dissertation with Puerto Rican women in Philadelphia. My questions:
> Permissions--you or Sage?
> Has it been used outside of the three studies that were in the Sage article [Ed and Psych Measurement, April 1999]
> Where can I obtain a copy of the scale in English and in Spanish?
> Gracias!
> Lori Martin-Plank, MSPH, MSN, APRN, BC
> Family and Gerontological Nurse Practitioner
## Appendix H—PAS Calculations

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Appendix J
Sample of Categories with notations

The meaning of home
Home in Puerto Rico
Home in Philadelphia
Family presence as central to home
Importance of mothers and grandmothers in the family
Growing herbs and using home remedies
Significance of the gardens—working in the garden is a way of being close to home/nature/Puerto Rico/roots
Gardens
Close to nature
Home grown food
Family closeness and caring
Creating the Environment
Murals
Cultural programs
Gardens
Community
Traveling back and forth to Puerto Rico, keeping in touch with family there
Failure of the health care system
We can’t go back: yearning for home tempered by the realities of healthcare and life here
Holistic nature of health
Living close to nature [as they did in Puerto Rico], growing own food, walking everywhere, working the fields—image of the jibaro
Eating well
Exercise
Using herbs and natural substances readily available because of lack of health care providers
Using alternative health providers and methods “pills are poison”
Spiritual health—feeling connected to God and each other
Connectedness as women, supporting each other
Importance of being close to family
Vestiges of traditional religion—what is the meaning?—Keeping us safe from harm by outsiders
Relationship with God and self/others more important than actual church affiliation
Feeling betrayed by Catholic church
Family [and extended family/neighbors in Puerto Rico]
Influence of mothers and grandmothers
Role of women in caring for others
Home: What is the meaning of home?
Home in Puerto Rico

Reminiscing, romanticizing the image of home FN: D. born in Loiza, PR, home of Afro-Carribbean root—I remember this from a friend in Bethlehem who always talked
about that town. D. has met two healer/herbalists there. She goes back as often as she can. Family are there; her aunts and cousins. She would like to take me there someday. Very hot there.

AA: Also grandmom would make us— at one time we had the whooping cough—we were in Puerto Rico—she made us a cactus drink—it wasn’t really the aloe cactus but you put honey in it. And she would make us soups out of pidgeons or doves and she even made a soup for my brother—he was asthmatic—out of a mouse. It wasn’t like a regular mouse—she went and got it. My mother used fresh-killed chickens for soup. I remember Thanksgiving, I was out there in Puerto Rico, I was 9 years old, my grandmom killed the turkey—the female turkey—it was very violent; very tasty though. We lived close to nature; everything was right there and if we didn't have it, our neighbor did.

When I was 11 years old, my family went back to Puerto Rico, to a rural area. I hated it at first—going from New York city to a nowhere place. But I got to know my grandparents and after the first year I didn't want to go back. It was beautiful there. Everything was so natural. We walked everywhere. We swam in the streams. We ate from the garden and picked fruits from the trees. I learned to be a farm girl.

BB: So I told my doctor that I was going to Puerto Rico for a while. And when I come back after 5 weeks and I saw my doctor he couldn't believe it. He said I looked like a different person and he said don’t even tell me what you’re doing. Whatever you’re doing, just keep on doing it. I did tell him what I was doing in Puerto Rico with plants. And I tried different alternatives and I also try meditation. Meditation worked wonders for me. Just being home is enough

Realities of caretaking responsibilities
Traveling back and forth to Puerto Rico, keeping in touch with family there FN:
In PR you need a car to go anywhere
But it is important for me to be healthy for my daughter, for myself, for my husband, for my family. They don’t expect me to die. Constantly we need to maintain contact. I was not on dialysis when I was in PR in 2004 but I had lost one of my eyes, in 2003. But still they could see me and I looked well. Now, I think it would be difficult for them to see me with all the things that I have.

Failure of the health care system
We can’t go back: yearning for home tempered by the realities of healthcare and life here
Home in Philadelphia
Presence of family as central to home FN: Carmen tells me that she came to Phila as a teenager in the 1950s and lived with an uncle. Later she brought her mother over from PR. She describes the opposition to Puerto Ricans even by the local Catholic Church which was then a “German” parish. She met and married her husband, also from PR here.
FN: Here families are closer, and yes, everyone stays in at night but you know your neighbors and can call them

Importance of mothers and grandmothers in the family  FN: She loves caring for her grandchild and tending the garden. She loves the neighborhood here and has lots of friends. As I am interviewing her in the garden

Traditions as important to home and family

Home remedies as a tradition  FN: Dora arrives and it is immediately clear that she is an expert on the topic of home remedies. I can see that she is also “sizing me up” as we converse. She has learned a lot from her mother who also lives nearby. She says that a group of Puerto Rican women also took a course in using herbs from Maria Benedetti, a “doctor” from Puerto Rico who was in Philadelphia for a prolonged stay a few years ago. I have her book

FN: Ana tells me that I will not learn anything about remedies unless I speak to the older ones and they only speak Spanish!

I-67-PR-33-3-Med: We use yerba buena.

Yerba buena?

I-67-PR-33-3-Med: We use it for the stomach.

I-67-PR-33-3-Med: I learned it from my mother, too.

FF Well I practice some home remedies that were passed on from my mother.

HH: I was raised with my grandmother so I kind of like picked up some of the things that she did. Do you want examples?

J-39-US-1-low: My grandmother knows a lot about medicinal plants and different kinds of oils and that are directly from Puerto Rico. So I know that my daughter used to catch chest colds really bad, and my grandmother would get almond oil – she would get the almond oil, and she would get the white part of the egg and beat it, beat it, beat it until the oil would come out, and she would

Growing herbs and using home remedies

CC: And I was using something called Bodol—it’s a tea for cancer. And it’s really a diuretic and an antioxidant. I got it in New York in a botanica. The ginger and the mint I grow. And I make teas out of them. You have to get the hang of them—the ginger in particular. If you make it too strong, you’ll be going to the bathroom #2 all day long but once you get the balance of it, it helps a lot with your stomach.

Home remedies as caring  EE A malta is a beverage that we use; it’s the black one, it comes in a bottle that you buy at the store. Malta. My kids, even myself, we always took cod liver oil, that was like something we took. My mom used to say, it takes the worms away so I know there’s no worms but we took it and I used to say it takes the worms away. Laughing. We did it for her.

Acculturation
Significance of the gardens—working in the garden is a way of being close to home
/roots
Gardens
Garden as a spiritual place
Garden as a connection with nature
Garden as a connection with Puerto Rico
Close to nature
Home grown food
Family closeness and caring
Jibaro in Puerto Rico, what he did, what families in rural PR did [and do]
Creating the Environment—making it seem like home
- Murals
- Cultural programs
- Gardens
- Community

Health, Home Remedies, and healthcare Providers
The Role of Women and Families in Health: Caregiving and Familismo
Being or Staying Healthy
Living close to nature [as they did in Puerto Rico], growing own food, walking everywhere, working the fields
Eating well
Exercise
Using herbs and natural substances readily available because of lack of health care providers [in Puerto Rico] Doing this here is a way of staying close to “home”, valuing tradition
Using alternative health providers and methods “pills are poison”
Being in control of own health: choosing providers
- Using a naturopath or chiropractor
- Using Santeria
  FN: She says there are lots of santeros and espiritistas around but you must be careful and only work with a few or it will get confusing. Some, she says, are only in it for the money.

  Revealing use of home remedies to doctors—fear of rejection or scorn—Don’t understand our culture
Botanica
Spiritual health—feeling connected to God and each other
- Connectedness as women, supporting each other
- Importance of being close to family
Vestiges of traditional religion [Santeria]—what is the meaning?—Keeping us safe from harm by outsiders
Relationship with God and self/others more important than actual church affiliation
Feeling betrayed by Catholic Church—too rigid
Family [and extended family/neighbors in Puerto Rico]
Influence of mothers and grandmothers
Everybody in the family pitches in to help.
as a female, a Latina female, I always put my family first.

Now who takes care of other people in the family when they’re sick?

My grandmom. And I have two children, so we both take care of them.

Does your grandmom live with you? Yes, I live with my grandmom all my life.

when I was growing up, if there was a fever or whatever, I remember my mother boiling some plants, certain kinds of plants, and then give us like a bath.

Role of women in caring for others
INT: Okay. And who takes care of family members in your family when they’re sick?

L-48-US-37-1-high: Each other. Like mother takes care of sisters and - it’s a traditional stuff, and it’s a shame that it’s getting lost. But it used to be like that. The kids take care of the grandparents, and the grandparents take - it’s a generation - every generation takes care of the next generation coming up or the ones that’s leaving. We never - I never heard about when I was a child about nursing homes or nothing like that because everybody took care of grandpa or grandma until they die and that’s way it was.

Caring for Sick Family

Healthcare Perspectives in PR and US: Surviving the System
CC: My mother has a beautiful house in Puerto Rico; I would do well there but-everything grows on the land there -fruits and vegetables all year round, it would be great and I’m not a meat eater, but the health care is horrible. My nephew went to Puerto Rico and he dislocated his shoulder and when he came here he went to the emergency room because it was still bothering him and they asked him what third world country he had been in because of the way they wrapped it. It’s bad. Most of the little towns don’t even have a clinic now. If you have a heart attack in the middle of the night, the doctors work from 9-5.

Is there any difference in the care that you receive when you are sick in Philadelphia and in Puerto Rico?

GG-48-PR-38-4-Med: I’m not a hospital person. When I was over there I was almost always in the ER there with asthma for a day or two with IVs.

INT: Okay. Is there any difference in treatment between Puerto Rico and here do you think?

L-48-US-37-1-high Interviewee: There was less equipment. The hospitals are more crowded. It’s less private. I think the doctors over there - They didn’t identify with the patient as much as they do now like the ones I have here now. They would do, it’s just a doctor, they saw you, you were sick. They give you the prescription and go and buy it. Now it’s more like they get to know you more and you get a chance to talk to them.

Health Practices and Healthcare Providers
Curanderos, Santeros, and Espiritistas

INT: Have you ever visited a curandero . . .?

EE-49-PR-40-1-Med: Yes; in Philadelphia. I went for aches. I believe it was more spiritual.

INT: Have you ever visited a santero . . .?

EE-49-PR-40-1-Med: No but I know they are here. I know a lot of them. I know them personally and I know their practices.

INT: Have you ever visited an espiritista?

EE-49-PR-40-1-Med: No but I grew up in that. My father was an espiritisto.

Have you ever visited a santero . . .?

HH-45-PR-40-1-Med: Well it’s interesting because in our family we have a couple of people who are. My mother was a santera and I have another aunt, so I guess not gone to one but in the family circle I have them

INT: Okay. So you’ve never visited like an espiritista or a santero.

L-48-US-37-1-high: No. But we do have a lot of people that believe in that in Puerto Rico. My grandfather used to be a espiritisto. Yeah. Both of my grandparents. And they had their idols and they had their saints and they put candles and they prayed to them and all that stuff and they said that they could get healed by that. But I never practiced that kind of religion.

Filadelfia
Puerto Rico
Making Health Decisions
Self
Family
Comments about doctors
Conflicts with medicine and culture
Connections with others and women
Curandero, santero, espiritista FN: We also spoke about Luis, a healer that I had visited awhile ago as a person of interest. Ana told me that he is also a Phila. Cop and that the “horns” over his door are dragon horns to protect him and his family and not devil horns.
Dangerous home remedies
Family and friends role in sickness
Health care Puerto Rico vs Phila FN: Ana-- The medical care in PR is not as good as here.
Influence of mother or grandmother
Pills
Revealing use of home remedies to doctors—fear of rejection or scorn—“Won’t understand”
Role of spirituality in health
Using a curandero
Using a naturopath or chiropractor
Using Santeria or espiritismo

Earlier Version of Coding/Categorizing with Interview Questions

Thoughts from interviews
Home remedies category
Subcategories: herbal remedies
Remedies used for stomach problems
Remedies used for respiratory problems
Remedies used to regulate blood sugar
Remedies used for anxiety or nervios
Remedies used for sleep
Remedies used for colds
Remedies used for earache
Remedies used for headache
Dangerous remedies
Remedies used for skin problems
Remedies used for babies
Remedies found only in Puerto Rico
Being healthy: category
Subcategories: Diet
Exercise
Spiritual health
Ginger
Chamomile
Tilo or linden tea
Bruja plant
Yerba Buena
Llantos
Naranja leaves
Insulin plant
Platinos de Brasil
Cinnamon
Malta
Guanapo
Anamu
Mir Rosado
Hidionda
Verdolaga
Berro
Campana blanca
Burdock root
Almasigo blanco
Pasote or basolte or basote
Prenetara
higuerta
Alcholado
Agua de Florida
Camphor
Yellow alcohol
Vicks Vaporub
Coffee grounds for eye or wound healing
Pamper for chest congestion
Almond oil and egg for chest congestion
Orange blossom leaves for tea to sleep or relax
Living close to nature and growing your own food/ herbs is good and desirable
The garden as a symbol of the motherland—working in the garden is a way of being close to home/nature/Puerto Rico/roots
The garden as a vehicle for informing outsiders of culture
The garden as a vehicle for passing on culture to younger generations
Yearning for the motherland tempered by realities of health care and life here
Strong sense of spirituality
Health—eating well, exercise, spiritual health
Most liked their doctors
Failure of system—many without insurance, long waits for care at free clinics, providers ignoring health maintenance or unresolved issues—lack of continuity of care due to frequent back and forth with insurance/no insurance
Most don’t like curanderos/santeros/espiritistas—equate with black magic, witchcraft
Help each other when sick—oldest in family responsible—woman most often makes decisions or cares for others
Closeness of families still—going back to PR to care for older relatives
No nursing home
Botaniccas—availability of getting herbs at Spanish grocery store or from relatives in PR or from traveling back and forth to PR
Many cultural groups have home remedies or health practices. Some of these are for treating certain health problems or conditions, and some are for general health. Do you know of some of these home remedies or health practices in your community here?”

Probe: “Are there any others?”

Specification: “Of all these home remedies/health practices you talked about, which ones do you use in your family? What ones do you not use? Why?”

What do you believe is important to help you keep your health or stay healthy?

When you are sick, what do you do to feel better?

Who takes care of you when you are sick?

What do your family and friends do to help you when you are sick?

Do you go to a health professional [doctor, nurse practitioner, physician assistant] for care when you are sick? [If yes, what kind of treatment do you want from them? If you had the opportunity to tell them, is there anything that they could do to care for you better?]

Have you ever visited a *curandero* . . .?

Have you ever visited a *santero* . . .?

Have you ever visited an *espiritista*?

[If yes, what type of treatment or advice did you receive?

How is this different than going to a health professional?]

Do you ever go to a *botanica* for health products or consultation?

What role, if any, does your faith or spirituality have in your health or sickness?

[If you use herbs or home remedies, or if you visit a healer, do you tell your health professional about this? If not, why not?]

Who cares for family members when they are sick?

Who do you consult for help with family health problems?

Is there any difference in the care that you receive when you are sick in Philadelphia and in Puerto Rico?

[For those who have been to Puerto Rico] Is there any difference in the treatment that you receive?
### Table 4

*Home Remedies and Uses Grouped by Scientific Name As Reported by Puerto Rican Women in Philadelphia, PA*

<table>
<thead>
<tr>
<th>Herb or Plant Scientific Name</th>
<th>Common Names</th>
<th>Preparation</th>
<th>Use</th>
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<tbody>
<tr>
<td><strong>Aloe Vera</strong></td>
<td>Aloe plant</td>
<td>Topical; Gel is extracted from the spine of the plant</td>
<td>Gel is applied to cuts, head lice, burns; has anti-inflammatory qualities</td>
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<tr>
<td><strong>Arctium lappa</strong></td>
<td>Burdock Root*</td>
<td>Oral; root is ground into a powder made into a tea (guarapo)</td>
<td>Used by cancer patients to detoxify the liver; antioxidant</td>
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<tr>
<td><strong>Armoracia rusticana</strong></td>
<td>Rábano Yodado Horseradish Root</td>
<td>Oral; root is sliced or shredded, steeped in water, strained and drunk</td>
<td>Throat pain, congestion</td>
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<td><strong>Atropa Belladonna</strong></td>
<td>Belladonna Salve</td>
<td>Topical; Tar based drawing salve made as an ointment</td>
<td>Tar based drawing salve used for boils. Also mixed with chopped castor bean leaf in a poultice for relief of edema or inflammation.</td>
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<tr>
<td><strong>Busera simaruba</strong></td>
<td>Almasigo blanca*</td>
<td>Oral; Bark is made into a guarapo tea Leaf is made into a tisane, a medicated drink that is not boiled</td>
<td>Bark of tree is peeled and rolled like cinnamon, into a tea for anemia. Leaf is pounded, mixed with water, sugar and ice as a cooling drink</td>
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<td><strong>Carica papaya</strong></td>
<td>Papaya, Lechosa</td>
<td>Oral; green papaya is available processed with sugar and water Topical, leaf</td>
<td>Digestive problems male plant has blood pressure lowering abilities. To soften skin</td>
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<tr>
<td>Plant Name</td>
<td>Part Used</td>
<td>Preparation Method</td>
<td>Uses</td>
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<tr>
<td>Chenopodium ambrosioides</td>
<td>Oral; leaves</td>
<td>Used for bowel cleanser and parasites</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cut up and soaked in water</td>
<td></td>
</tr>
<tr>
<td>Cinnamomum zeylanicum</td>
<td>Oral; bark</td>
<td>Used for lowering blood sugar in Type II diabetes mellitus</td>
<td></td>
</tr>
<tr>
<td>or aromaticum</td>
<td></td>
<td>Is ground up into a guarapo tea</td>
<td></td>
</tr>
<tr>
<td>Cinnamomum aromaticum</td>
<td>Oral; mix is simmered</td>
<td>Used for relieving a cold</td>
<td></td>
</tr>
<tr>
<td></td>
<td>with water and made into</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a tea (guarapo)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illicium anisatum</td>
<td>Oral; leaf is boiled</td>
<td>Used for calming and for insomnia, also used for colic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>with water and made into a</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Guarapo tea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citrus sinensis</td>
<td>Oral; mix is simmered</td>
<td>Used for relieving a cold</td>
<td></td>
</tr>
<tr>
<td></td>
<td>with water and made into</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a tea (guarapo)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eucalyptus Globules</td>
<td>Oral; leaves</td>
<td>Drunk to lower blood sugar</td>
<td></td>
</tr>
<tr>
<td></td>
<td>are steeped and refrigerated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>guarapo tea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haematoxylon brasiletto</td>
<td>Oral</td>
<td>Used to lower blood sugar</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hamamelis Virginiana</td>
<td>Topical or Oral</td>
<td>Used as an astringent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>virginiana</td>
<td>some forms can be mixed with other herbs and taken internally.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Comes prepared with herbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kalanchoe pinnatum</td>
<td>Oral ingestion drops in</td>
<td>Heat the leaf of the plant and infuse squeezed liquid drops in ear for earache;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ear for earache; place</td>
<td>place plant leaf head or behind ear for headache.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>plant leaf behind ear for</td>
<td>Lowers blood pressure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>headache.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matricaria</td>
<td>Oral; flowers</td>
<td>Calms the nerves, settles</td>
<td></td>
</tr>
</tbody>
</table>

*Note: *Euphorbiaceae** Wormseed**
<table>
<thead>
<tr>
<th>Species</th>
<th>Common Name</th>
<th>Part Used</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>recutita</td>
<td>Manzanilla</td>
<td>used in a tea guarpapo</td>
<td>promotes the stomach, promotes sleep; can also fight off Infection, so used for Colds</td>
</tr>
<tr>
<td>Mentha nemorosa,</td>
<td>Mint</td>
<td>Oral: leaves made into a guarapo tea</td>
<td>For stomach problems; mixed Mixed with water for mouthwash</td>
</tr>
<tr>
<td>Mentha piperata</td>
<td>Peppermint</td>
<td>Topical/oral</td>
<td></td>
</tr>
<tr>
<td>Nasturtium officinale</td>
<td>Berro (watercress)</td>
<td>Oral</td>
<td>Has iron for anemia Leaves are made into a tea</td>
</tr>
<tr>
<td>Passiflora edulis</td>
<td>Passion fruit leaves</td>
<td>Oral, leaf</td>
<td>Lower blood pressure calming, induce sleep</td>
</tr>
<tr>
<td>Neperomia pellucida</td>
<td>Paletaria, Prenetaria</td>
<td>Oral, leaves</td>
<td>stomach ulcers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>are made into a tea (guarapo)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Leaves are soaked overnight and water is drunk</td>
<td></td>
</tr>
<tr>
<td>Petiveria alliacea</td>
<td>Anamu** (garlic weed, Congo weed)</td>
<td>Oral; root is boiled and made into a tea. Leaves are Crushed in a blender with water strained and made Into a tea.</td>
<td>Abortifascient, bring on menses. Used for internal pain/cancer pain Prevent cancer, cleanses toxins, asthma, antioxidant</td>
</tr>
<tr>
<td>Peumus Boldus</td>
<td>Boldo*</td>
<td>Oral</td>
<td>Antioxidant herbal blend used by cancer patients</td>
</tr>
<tr>
<td>Plantago major</td>
<td>Llantén* Plantain weed</td>
<td>Oral; boil leaves in a tea. Topical application to the eyes</td>
<td>Used for cancer, gout. For “pink eye,” boil the leaves in hot water, cool and wash eyes with water.</td>
</tr>
<tr>
<td>Pluchea</td>
<td>Salvia</td>
<td>Leaf, topical</td>
<td>Apply the warmed leaf to</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Plant</th>
<th>Part(s)</th>
<th>Preparation/Usage</th>
<th>Benefits/Uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symphytifolia (olorosa)</td>
<td></td>
<td>area of musculoskeletal pain; also used on forehead for headache</td>
<td></td>
</tr>
<tr>
<td>Ricinus communis</td>
<td>Higuera</td>
<td>Castor bean, castor oil is extracted from the beans, harsh cathartic for severe</td>
<td>Castor oil, harsh cathartic for severe constipation</td>
</tr>
<tr>
<td></td>
<td>Rosemary</td>
<td>Topical, mixed with coconut oil, applied to hair and scalp</td>
<td>Applied to hair and scalp when hair is falling out</td>
</tr>
<tr>
<td>Ruta Chalepensis Ruta Graveolens</td>
<td>Oral, leaves are brewed into a tea, oil is sometimes used also</td>
<td>Used for stomach problems, muscle pains. Also used to induce late menses, used by midwives for labor induction; abortifascient</td>
<td></td>
</tr>
<tr>
<td>Sanguinaria canadensis</td>
<td>Oral</td>
<td>Unknown</td>
<td>Used to detoxify the liver in cancer patients</td>
</tr>
<tr>
<td>Senna occidentalis</td>
<td>Hidionda**</td>
<td>Oral, flowers and leaves are steeped in a tea (guarapo)</td>
<td>Relieves intestinal bloating</td>
</tr>
<tr>
<td>Silybum marianum</td>
<td>Silymarin</td>
<td>Oral, prepared extract</td>
<td>Detoxifies the liver; used by cancer patients</td>
</tr>
<tr>
<td>Solanum Melongena</td>
<td>Eggplant</td>
<td>Oral</td>
<td>Vegetable is cut up and soaked in water for a week or more. Water is drunk for blood sugar control.</td>
</tr>
<tr>
<td>Syzygium Aromaticum</td>
<td>Cloves</td>
<td>Topical/poultice, crushed and made into a poultice for the cheek around an aching tooth or inserted directly into the tooth if open</td>
<td>Pain relief for a toothache</td>
</tr>
<tr>
<td>Terminilia</td>
<td>Almond</td>
<td>Oral</td>
<td>taken internally</td>
</tr>
<tr>
<td>Ingredient</td>
<td>Description</td>
<td>Benefits</td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Catappa</td>
<td>Raw egg oil, Almond oil, Honey and lemon</td>
<td>Relieves congestion; asthma remedy</td>
<td></td>
</tr>
<tr>
<td>Tilia spp (or Tilo)</td>
<td>Linden flower Oral; flowers are dried and made into a tea guarapo</td>
<td>Used for anxiety or insomnia related to nerves; used for relaxation</td>
<td></td>
</tr>
<tr>
<td>Zingiber officinale</td>
<td>Ginger root Oral; root is ground up and steeped in water and made into a tea (guarapo); Mixed with honey and lime Piece of root held in buccal mucosa</td>
<td>Soothing to the stomach. Also used to increase contractions in labor Alleviates “cold” symptoms Fends off feeling cold Used for everything</td>
<td></td>
</tr>
</tbody>
</table>

Note: *Used only by cancer patients **Past use in Puerto Rico; not used now


Other Home Remedies

<table>
<thead>
<tr>
<th>Ingredient</th>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agua de Florida (Florida Water)</td>
<td>None Topical or Oral Purchased at a Local grocery, pharmacy, or Puerto Rican store</td>
<td>Poured over head and body for stress relief; can also be drunk</td>
</tr>
<tr>
<td>Alcholado (Rubbing alcohol)</td>
<td>Isopropyl Alcohol Topical Comes prepared With camphor, oil of eucalyptus, menthol, and pine needles; another preparation has Bay Rum as a base.</td>
<td>Rubbing alcohol with herbs added for various uses, including camphor, wintergreen, and others. Used for a “rub down” in muscle aches, leg cramps, or for arthritis/rheumatism. A cloth soaked in alcholado with camphor is also used as a base and applied to the chest prior to putting on a poultice for chest congestion, asthma, or bronchitis.</td>
</tr>
<tr>
<td>Item</td>
<td>Route</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Cod liver oil or Scott's Emulsion</td>
<td>Oral</td>
<td>Omega-3 rich oil; high in Vitamins A and D</td>
</tr>
<tr>
<td>Flour, water, sugar and lemon mix</td>
<td>N/A</td>
<td>Oral as a thick mixture</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To alleviate cramps (abdominal) and diarrhea</td>
</tr>
<tr>
<td>Miel Rosada (Pink Honey)</td>
<td>None</td>
<td>Topical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>spread on roof of mouth with gauze for candida</td>
</tr>
<tr>
<td>Vicks Vaporub</td>
<td>Topical</td>
<td>Musculoskeletal problems, also for congestion and headaches</td>
</tr>
</tbody>
</table>