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Models of acculturation and health behaviors among Latino immigrants to the US

E. Arcia[a,*], M. Skinner[b], D. Bailey[b], V. Correa[c]

[a] *Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, NC, USA*
[b] *Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill, Chapel Hill, NC, USA*
[c] *Department of Special Education, University of Florida, Gainesville, FL, USA*

Abstract

A basic premise of much of the health research conducted with immigrant groups is that culturally based behaviors change over time as a result of acculturation, i.e., interaction with the mainstream US culture. However, models of acculturation have not taken into account how group-specific characteristics and the varying social and political contexts immigrant groups face may impact the acculturation process. In this study of 150 families, we examined the inter-relationship of indicators of acculturation among two Latino groups to discern the impact of gender and country of origin on the relationship between variables. Results indicated that increased years of residence in the United States had the predictable impact of increased competence in English and increased use of English, but had differing impact by country of origin on the cultural orientation of the respondents' environment and on ethnic identification. Also, gender was associated with differing levels of English language use and with perceived social acceptance, such that males used more English and reported less social acceptance than females. Loading separately from the language and cultural behavior variables, this factor, perceived social acceptance, merits research as a predictor of service use given that respondents understood non-acceptance as resulting from being identified as Latino, not from behaving differently from the mainstream. The differing patterns of association by country of origin and by gender and the measurement issues these raise, highlight the importance of specifying more complex models of acculturation than is done typically in research with Latinos. © 2001 Elsevier Science Ltd. All rights reserved.

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Cultural characteristics shared by many Latino families and the way in which these characteristics change over years of residence in the United States are assumed to be key determinants of the discrepancies observed in health status, health behaviors, and service use between Latinos and white Anglo-Americans (Chesney, Chavira, Hall, & Gary, 1982; Kirkman-Liff & Mondragon, 1991; Wells, Hough, Golding, Burnam, & Karno, 1987; Shetterly, Baxter, Mason, & Hamman, 1996). (See Vega & Amaro, 1994; Flores & Vega, 1998 for a review on Latino health). Consequently, the health literature on ethnicity is replete with references to acculturation and its association with health status or with service use.

Latinos with low levels of acculturation tend to have lower self-rated health than more acculturated peers (Angel & Worobey, 1988; Markides & Lee, 1991). However, the low self-ratings of this population have not been borne out by medical examinations (Angel & Worobey, 1988). Also, for Mexican-Americans in particular, actual health indicators tend to favor Latinos with low acculturation over their counterparts with high acculturation (Balcazar & Krull, 1999; English, Kharrazi, & Guendelman, 1997; Ontiveros, Miller, Markides, & Espino, 1999; Sundquist & Winkleby, 1999). These two

*Corresponding author. 5333 Collins Avenue, #1401, Miami Beach, FL 33140, USA. Tel.: +1-305-867-1894; fax: +1-305-865-3483.

E-mail address: earcia@aol.com (E. Arcia).

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sets of findings are counter-intuitive given the lower than average income and low service use of recent immigrants. The first, the discrepancy between self-reported health and actual morbidity appears to result from culturally based definitions of health (Angel & Thoits, 1987) that in part take into account resolved medical problems when evaluating current health status (Arcia, 1998). The second finding, the comparative advantage of Mexicans with low acculturation, given the preponderance of illegal migration among immigrants, speaks to the good to excellent health status necessary to undertake an illegal immigration experience and to the long-term damaging effect of social marginalization (Vega & Amaro, 1994).

Use of health services has also been associated with acculturation. With some minor exceptions (Prislin, Suarez, Simspon & Dyer, 1998), the literature is fairly consistent in reporting that low levels of acculturation are associated with lower than average service use across a wide range of services (Kirkman-Liff & Mondragon, 1991; Moore & Hepworth, 1994; O'Malley, Kerner, Johnson, & Mandelblatt, 1999; Wells et al., 1987).

Although there are definite associations between acculturation and health status, health behavior, and service use, models of acculturation have remained implicit or poorly specified. Indeed, the concept of acculturation itself is subject to some controversy (Rouse, 1992; Gutierrez, 1995). The lack of model specificity appears to result in discrepant findings and may lead to inadequate generalizations to immigrant populations. For instance, the advantage that low acculturation appears to provide to birth outcomes is primarily true with Mexican-Americans (Scribner & Dwyer, 1989).

So, what are the premises of acculturation models? The basic premise is that immigrant groups adapt their cultural practices as a result of interactions with the culture that they encounter. Earlier American models considered acculturation to be inevitable and because they valued Anglo cultural characteristics over those of immigrant groups, acculturation implied assimilation and unquestionably favorable outcomes (Teske & Nelson, 1974). Current assumptions about acculturation are less dogmatic about the inevitability and direction of change of the adaptive process. Therefore, they allow for diverse outcomes and suppose that individuals have some choice in determining these outcomes (Berry, 1980; LaFromboise, Coleman, & Gerton, 1993; Szapocznik, Kurtines, & Fernandez, 1980). They also recognize that many immigrants are grounded in two or more cultures, such that successful adaptation is currently more likely to be defined as the ability to participate effectively in each culture (Chavez, 1994; Cortes, Rogler, & Malgady, 1994; LaFromboise et al., 1993).

Acculturation has been measured by various proxies. Language facility and use is the most frequently used and most robust indicator (Cuellar, Harris, & Jasso, 1980; Burnam et al., 1987; Marks et al., 1987; Mendoza, 1989; Padilla, 1980). Others are measures of length of residence in the host country such as: generation status, years of residence in the United States, proportion of the respondent's life lived in the United States, or age at arrival (Leclere, Jensen, & Biddlecom, 1994; Scribner & Dwyer, 1989; Becerra, Hogue, Atrash, & Perez, 1991). And, in an attempt to assess more process factors, several acculturation scales have included the cultural orientation of daily life interactions and practices such as foods, friends, and businesses (Burnam et al., 1987; Marks et al., 1987; Mendoza, 1989; Szapocznik et al., 1980). Last, many instruments of acculturation include ethnic self-identification (Montgomery, 1992).

Regrettably, most indicators of acculturation overlap with indicators of social and economic status (Negy & Woods, 1992; Suarez & Pulley, 1995) and only recently has research attempted to assess the independent effects of each (Canabal & Quiles, 1995; Harwood, Schoelmerich, Ventura-Cook, Schulze, & Wilson, 1996; Ruiz, Marks, & Richardson, 1992; Suarez & Pulley, 1995). The implications for health behaviors and services are substantial. For instance, lack of a working knowledge of English may tap into acculturation by signaling culturally based health behaviors that differ from the Anglo mainstream, but may also represent an economic disadvantage that bars use of health services, and/or a barrier to attaining information about relevant services (Schreiber & Homiak, 1981). In addition, lack of English proficiency may be expected to interact with factors such as gender, education, and race. The health service experience of non-English speakers who are white and college educated must differ from those of multi-racial farm workers. Thus, the various indicators of acculturation may explain some variance, but also fail to clarify the nature of relationships.

In addition to the fact that measures of acculturation may also be proxies for other factors, the current understanding that acculturation is a process with substantial variability has not led to an examination of the factors that may explain that variability. Rarely does research compare more than one measure of acculturation (Balcazar & Krull, 1999). Also, the diversity of the social and political contexts faced by various immigrant groups is typically ignored. It is often assumed that increased length of residence in the host country has the same or comparable effects across groups from varying countries of origin despite the fact that substantial heterogeneity has been observed in the health outcomes of Latino groups (Arcia, Keyes, & Gallagher, 1994; Becerra et al., 1991; Scribner & Dwyer, 1989). The wide discrepancies in the initial cultural, social, economic, and educational characteristics between immigrant groups, and the effect that these initial differences may

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