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Community Perspectives: Mixed-Methods Investigation of Culture, Stress, Resilience, and Health

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Abstract

Despite well-documented ethnic and socioeconomic disparities, our understanding of child, maternal and family health is based disproportionately on White middle-class populations in the United States. The National Institute of Child Health and Human Development funded the Community Child Health Network (CCHN) in 2004, a partnership of five academic institutions and community organizations, to collaborate in the design and conduct of a study to foster new understandings of these disparities. Reported here are findings from a pilot study conducted at one site to inform CCHN regarding community views of stress, coping resources, family and health. Mixed-methods (qualitative and quantitative) interviews were conducted with 54 adult participants recruited from public healthcare clinics to obtain both their self-reports and their reports of their communities' perspectives. Findings include the pervasiveness of experiences of racism and gender differences in support seeking and coping behavior. There was little recognition of some common health conditions, such as low birth weight and preterm birth, which disproportionately affect poor and minority communities. Many indicators of strength and resilience in individuals, families, and the communities at large emerged in these interviews. Communities were described as valuing achievement and upward mobility. Participants also indicated an intuitive understanding of effective parenting and of the roles of nature (genetics) and nurture (environment and behavior) in determining child health. The results inform intervention and stress research in underrepresented communities.

Keywords

Community; Culture; Stress; Resilience; Family; Health Disparities

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Introduction

Ethnic and socioeconomic disparities in maternal, child, and family health have been extensively documented in the United States.[1,2] African American infants are nearly three times as likely to be born extremely prematurely (>28 weeks gestation) and two times more likely to be low in birth weight (2500g or less) compared to European American or Latino infants.[3] Children from poor families are more likely to have asthma than children from middle- and high-income families.[4] Rates of obesity are also much higher among ethnic minority children.[5,6] Despite a large and growing descriptive literature, ethnic and socioeconomic health disparities persist and, in some cases, are widening.[7] A variety of new research and intervention approaches have arisen in response to this persistence including interdisciplinary models conjointly examining sociocultural and psychobiological factors.[8,9]

A related trend has been a focus on ethnic minority and lower socioeconomic status (SES) communities. The contexts within which individuals live and work are important contributory factors to health disparities.[10–12] Individuals are embedded in families, neighborhoods, sociocultural groups, and larger societies that powerfully influence health, well-being, and success.[10–13] Communities form their own cultural norms including values, beliefs, and perceptions of what is problematic and what is ideal.[14,15] Community-level characteristics such as specific sources of stress exposure and norms and attitudes regarding families, parenting, and coping strategies give us unique insights into how to better investigate health disparities and, ultimately, eliminate them.

Sociocultural contexts can foster resilience, defined here as personal and social resources that enable individuals to manage stress and thrive under chronically stressful circumstances. For instance, interpersonal relational styles, including support seeking, are strongly influenced by culture, as are the availability, use, and effectiveness of coping resources.[16,17] Environmental and neighborhood level factors also shape stressful exposures to unsafe living conditions and limited access to quality goods and services, thereby constraining coping choices and health more broadly.[18–20] Despite considerable knowledge of how context shapes human experience, gaps remain in our understanding of how communities with inadequate socioeconomic resources perceive their environments and how these perceptions affect health and well-being. Furthermore, the large amount of literature on stress and health is not representative of the lives of all Americans.[21] Therefore, the current study aimed to document the unique stressors and resilience resources in communities with disproportionate burdens of disease, disability, and premature death, namely, communities of color and those lacking sufficient socioeconomic resources.

Community-Based Participatory Research

Academic-community partnership models are well suited for research with communities that are underserved.[22] Community-based participatory research (CBPR) involves equal input of scientists and community partners in all stages of research, including hypothesis generation, study design and development of research instruments.[23–25] A benefit of such collaboration is two-way learning between academic entities and communities, including community capacity-building and enhanced scientific rigor and generalizability.

Using the CBPR model, the National Institute of Child Health and Human Development (NICHD) funded the Community Child Health network (CCHN) in 2004 to study maternal, child, and family health disparities. Each of five sites (3 urban, 1 rural, and 1 suburban) formed a collaborative partnership between academic scientists from various disciplines including medicine and psychology and local community-based organizations serving women, children and families. A large multi-level observational study of parents, early childhood, and pregnancy is now in progress and was developed using CBPR methods to investigate relationships among stress, the accumulation of wear and tear on the body (ie, allostatic load), resilience factors, and selected health outcomes (interconceptional interval [ie, the spacing between pregnancies], preterm birth, low birth weight, parental mental health, and child health). The results presented here are from the pilot study conducted at the Los Angeles CCHN site, which gathered preliminary data to inform the development of the larger study.

Methods

Participants

Participants were recruited from four medical clinics in Los Angeles serving largely poor African American and Latino communities, based on US Census data for the relevant zip codes.[26] The pilot sample consisted of 47 females and 7 males of childbearing age (aged 18 to 50 years). Fifty-three percent of study participants self-identified as African American, 23% as Latino, and the remainder as European American, Asian or Middle Eastern. The modal family size of three lived on a household income of $10,000 to $20,000. Full- or part-time workers made up 48% of the sample while 39% were not employed; the remainder were students or day workers. One quarter of participants had a high school diploma or GED, 38% had completed some college, and 13% had a college degree.

Procedures

All study procedures were approved by the institutional review boards of participating academic, community and medical organizations. A team of 6 interviewers (5 African American women and 1 Asian man) were recruited from the academic and community sites. Interviewers received 20 hours of group training in recruitment and interview procedures, clinic operations, cultural sensitivity, human subject protection, and other aspects of the study protocol by both the community and academic investigators. Individuals were invited to participate in the study using posters, flyers, and personal communication in the waiting rooms of the clinics and community centers using a standard recruitment script. Those who agreed to participate completed informed consent procedures and were interviewed in a private room or nearby area. Interviews were paused if participants were called for their scheduled medical appointments and, when necessary, interviews were completed once the appointment was finished. Interviews took approximately one hour. Participants were given either a $20 gift card, or a $15 gift card and a $5 parking voucher depending on parking costs at each research site. Interviewers recorded responses by hand. Additionally, all interviews were audiotaped after participant consent was obtained. Qualitative data were fully transcribed by research assistants.

After transcription, interview data were submitted to content analysis. A multicultural research team (including interviewers and other research assistants) representing the ethnicities of study participants compiled data and developed the coding schemes. Coding allowed for participants to provide multiple responses to each item, and for a response to be coded into multiple categories. Two researchers coded each question with high inter-rater agreement (>85% for all interview sections). A third researcher resolved any discrepancies via independent coding. Findings were presented both to CCHN and to the local community advisory group for discussion and interpretation.

Measures

The semi-structured mixed-methods interview was organized into 7 sections that included a range of questions adapted from existing measures or generated by community and academic partners in the Los Angeles and Lake County, Illinois sites. For ease of description, the measures are divided into two categories: 1) community values and norms (community culture), and; 2) stress, coping resources, and health. Included in the latter section are measures of racism (a stressor) and spirituality (a coping resource).

Community Values and Norms (Community Culture)—A series of open-ended questions were designed based on Dressler's[14] cultural consonance methodology in which participants answer questions from the perspective of members of their community. To preface these questions, participants were asked what “community” meant to them. They were also asked to describe who they meant when referring to members of their community, whether they believed they personally were representative of their communities (and why or why not), and how much they identified with their communities. The primary questions concerned why they thought a person or family in their community was (or was not) respected or admired, what made someone a success in the community, what the expectations were of mothers and fathers in the community, and where women and men in the community went for help with personal problems (eg, relationships, family, and finances). Participants were also asked how long they had lived in the greater Los Angeles area, things they liked most about living in Los Angeles, and changes they would like to see in Los Angeles.

Stress, Coping Resources, and Health—Measures for these topics included both open-ended and closed-ended questions. Some questions were answered from the perspective of the community, and some from the individual's perspective. Sample items include, “What helps people stay healthy in your community?”, “What sorts of things cause stress for people in your community?” and “In your community, why do you think some babies are healthy and some are not?” We also asked about use of home or folk remedies, defined as “ways of treating health problems or things people do to maintain their health that are learned from parents or someone else.” Closed-ended questions concerned personal knowledge of specific health problems in the community and availability of health care.

Racism—Seven closed-ended questions were adapted from the Reaction to Race questionnaire to measure racism.[27] In the preface to these questions, participants were given a standardized definition of racism as “an instance of someone being treated differently from

others based on their race or ethnicity." Participants were then asked, "To what degree do you think racism is a problem in the United States?" Additional questions assessed the average frequency, in the past 12 months, of participants having: thought about their race; noticed other individuals being treated differently because of their race, or; experienced physical symptoms (eg, upset stomach, muscle tension) and/or emotions (eg, angry, sad) as a result of being treated differently because of their race.

Spirituality—These questions were developed from multiple existing measures to assess individual- and community-level religious and spiritual values and experiences, particularly the use of spiritual coping in the face of stress.[28–30] Sample items included: "Would you describe yourself as religious, spiritual, both, or neither?", "Do your religious or spiritual beliefs bring you comfort in times of stress?", and "Do you think your community is religious or spiritual?"

Results

Results of the pilot study are organized within the two broad themes: community norms and values (community culture), and; stress, coping resources, and health. The percentages reported below represent the frequency with which participants spontaneously volunteered a particular response.

Community Norms and Values (Community Culture)

When describing their concept of community, the majority of participants mentioned their neighborhoods or similar geographical areas. Neighborhood residents were generally thought of as community members. Eighty-five percent indicated they knew their neighbors, and 79% reported they helped neighbors occasionally. However, 63% were not involved in community activities and 20% lived at more than one address in the past year. Participants most often reported cultural diversity, temperate weather, job opportunities, and recreational activities as the most favorable aspects of living in Los Angeles. The most frequently cited negative aspects were crime, violence and gang activity, racism, traffic, inadequate public transportation, homelessness, pollution, and the high cost of living.

Respected and Admired Families—Respect and admiration were expressed for families with a positive, stable home life and good parenting skills (42%), those who exhibited pro-social behavior (31%) (eg, "[Someone who] looks out for other people's kids"), and those whose material possessions such as car or house indicated socioeconomic success (31%). Other admirable qualities included positive personality characteristics (25%), those who presented themselves well (5%), showed respect for others (5%), and had parties or other social gatherings (4%). Common responses included: "They have a happy home," "They are not divorced," "They have moral values" and "They live the American dream."

Conversely, families were not respected or admired if they were perceived to have bad parenting skills or a troubled family life (33%), use or sell drugs (29%), demonstrate a lack of concern for the community (25%) (eg, "just take and don't give back"), or act selfishly, dishonestly, or inconsiderately (24%). Other behaviors included involvement in gangs (18%), causing trouble or fighting (18%), being disrespectful of others and their property

(15%), showing laziness or a lack of ambition (11%), general involvement in illegal activities (9%), and making too much noise (7%). Notably, 1 out of 10 responses included indicators of low socioeconomic status (eg, clothes, cars, or homes of poor quality) as sources of contempt.

Successful Community Members—Sixty-two percent of participants viewed successful individuals as those displaying conventional indicators of socioeconomic attainment (eg, good education, good job and money, owning a business). Tangible material possessions such as luxury cars, houses, and name-brand clothing were also perceived as indicating higher success (53%). A pleasing physical appearance, confidence, speaking articulately (45%), and goal-setting and attainment (31%) were other characteristics of success. Successful community members were those whose "kids seem like they're going to go to college," who "make something of themselves from nothing," and who "[live] up to their potential."

Parenting—Three common themes emerged for fathers' roles: "being there" (58%), providing material or financial support (55%), and being a positive role model or teaching life skills (40%). The most frequently mentioned duties of mothers were general caretaking (56%), such as feeding and bathing, and promoting education (36%). More than two-thirds (69%) felt that childrearing responsibilities differed for mothers and fathers.

Participants were asked about parenting styles that seemed effective or worked well. The most common response was that effective parents participate in the care of their children (46%), for example "spending time with them, taking them places, telling them they love them more than usual," and "showing them a lot of love and attention…that's what really matters, letting them know that the parents care about them."

The second most frequent theme, mentioned by 41%, involved teaching and providing guidance, support, and encouragement for children. This included helping children with school-work, teaching them to distinguish right from wrong, teaching social skills, and teaching about family culture and the world. This also included encouraging involvement in after-school programs, sports, churches, community organizations, and other recreational activities. One participant described effective parenting as: "Teaching children to be courteous, raising them to have manners and have respect for others." Another added that parents should be "making sure to motivate [their children] to get out of the community that we live in, encourage them to be what they want to be, [and] not discouraging them when they dream."

Participants indicated the importance of providing discipline (22%) and supervision (17%), including "grounding," strict rules, keeping a close eye on children, setting appropriate curfews, and paying attention to peer groups. A participant explained that "Strict parents… are hard on their kids, but it's because they love them." Fifteen percent explicitly mentioned communicating with children as part of effective parenting. Said one participant, "If you want to know what is going on [with your children], you have to ask them. If you are not willing to be open and truthful with your child, you can't expect them to be that way with you."

Stress, Coping Resources, and Health

Racism—The results on racism reflect that it was a prevalent form of stress in the community. More than two-thirds of all participants (72%) rated racism a “serious” or “very serious” problem in the United States today. The remainder of participants classified it as a “moderate” (17%), “minor” (7%), or “very minor” (4%) problem. There were no participants who said that racism was “not at all a problem.”

Table 1 presents the frequency of responses regarding thoughts about one's race. Approximately one-fifth (21%) of participants reported thinking about their race “constantly,” 17% “once a day”, 13% “once a week”, and 21% “once a month.” Table 1 also displays how often participants observed racist treatment of others and felt physical/emotional symptoms as a result of personal experiences with racism. As reported by participants, 43% noticed other individuals receiving differential treatment based on race “once a week” or more frequently. Only 15% had “never” noticed differential treatment of others on the basis of race within the past year. Overall, 41% experienced physical symptoms and 79% experienced emotional symptoms in response to an experience of racism during the prior 12 months.

Other Sources of Stressors—Other major stressors identified by participants included finances (22%), relationships (17%), violence, usually gang-related (12%), unemployment (10%), substance abuse (8%), and work-related issues (7%). Well before the current economic downturn, one person said, “Not being able to get a job. Prices are going up, but salaries remain the same.” Additional sources of stress for community members were traffic and parking, noise pollution, lack of assistance in caring for one's family members, and healthcare concerns.

Most participants (78%) reported a neighbor's stress level was easy to see, although 11% thought community members' stress levels were not readily apparent and 6% acknowledged that stress exists but that people hide it well. Participants reported that teens (35%) and parents (28%) are under the most stress, followed by children (19%), women (17%), and the elderly (15%). Participants suggested the stress felt by teens was generated from conflicting pressures to conform to the ideals of other teens and to the ideals of their parents. Parental stress was generally thought to be related to financial and emotional responsibilities to family, which often proved very difficult to meet.

Coping Behavior—Many methods of coping were mentioned but no single coping behavior was mentioned by a majority of the sample. As shown in Figure 1, our community assessment revealed notable perceptions of sex differences in methods of coping with stress. Women were reported to most frequently talk to friends and family members while men most often used alcohol to reduce stress. Some women also engaged in exercise as a means of coping. A typical description of female coping was: “Work out at the gym. Sometimes having some `down time' with the girls helps. Just talking.” Another woman expanded upon this idea by explaining that to reduce stress, many women “get together with one another, they visit each other, get out of the house and do something, make plans for a girls' night out, make the father stay home with the kids and get out of the house.” Participants described the

following male coping methods: “Watch sports, talk, try to forget about their jobs. Sometimes they spend time with their children and have some family time together,” and “Some of them do alcohol or drugs.”

Religiosity and Spirituality—Religiosity and spirituality were important coping mechanisms in these communities. Eighty-seven percent of participants identified themselves as spiritual (47%), religious (17%), or both (23%). Among those practicing a specific religion, most were Christian (81%). Half (50%) of the participants viewed their communities as religious and/or spiritual. Ninety percent of participants identifying as religious or spiritual indicated their beliefs were a source of comfort during times of stress. Participants commonly mentioned gaining strength from their faith. As one woman said, “[W]hen you are going through something, you should ask God and He will help.” Seventy-seven percent of participants who identified as either spiritual or religious indicated their beliefs guided the choices they make in their lives. One individual explained, “Without religion, I don't think you could make the right decisions.”

Social Support and Help-Seeking—Participants sought support from a range of sources, rather than relying solely on family or any one single source of support. As with coping mechanisms, perceptions of sex differences in sources of support were apparent (Figure 2). For men, the most common source was friends and neighbors (33%), while women most commonly sought social support from family members (55%). An equal percentage of men and women were reported to keep problems to themselves. Problem-solving strategies involving getting a job, stealing, or selling drugs were also reported for men (38%), but not for women. The high frequency of this response category was reported to be indicative of the high burden of financial strain for men in these communities.

Health—Participants were asked if the following were serious concerns for the infants and children in their communities: asthma, obesity, being born too early (preterm birth) or too small (low birth weight), not growing enough (growth retardation), diabetes, and learning problems. As shown in Table 2, people most commonly recognized problems with learning as an issue for youth (67%). The majority believed obesity and asthma were serious health conditions among children (65% each). Participants less frequently perceived diabetes (38%), preterm birth (28%), low birth weight (28%), and growth retardation (19%) to be problems. Participants were asked if other childhood health concerns were particularly relevant to their communities, but no additional health issues were raised.

When asked, “Why do you think some babies in your community are healthy and some are not?” participant responses generally fell into three themes: prenatal care, child and pediatric care, and a predisposition for physical health or illness. Participants stressed the importance of prenatal care, healthy eating, and stress management in pregnancy. Some indicated that child and pediatric care are important components of maintaining a child's good health. This included healthy eating habits and proper hygiene, timely immunizations, and a non-smoking living environment. Participants also volunteered that parents cannot control all aspects of a child's health. In particular, they expressed an understanding that familial risk factors, both genetic and environmental, were important contributors to the childhood health status.

The majority of participants (68%) said they visited medical facilities such as a primary care physician or neighborhood clinic for healthcare. Participants also frequently reported using home remedies — nearly half (43%) indicated using food or beverages, often tea, to treat ailments or maintain health. Participants also reported behavioral home remedies (27%), such as soaking swollen feet in hot water and Epsom salts, using a hot water bottle, and getting adequate sleep. Approximately half of all participants (53%) reported having family members who use home remedies.

Discussion

The purpose and value of this work is to inform researchers of some of the unique perspectives on stress, coping resources, families and health of communities that are most affected by maternal, child, and family health disparities. A novel feature of the study is the method of obtaining participants' perspectives of the communities in which they live in their own words using the cultural consonance approach of Dressler and colleagues.[14] This technique enabled us to obtain unique insights into the norms and values and broader cultural landscape of these urban communities. There was consensus among those interviewed about the nature of their communities as places where education, income, and material success are valued, and where lack of socioeconomic progress or success is often viewed negatively. Similarly, avoiding substances, staying within the law, demonstrating concern for the community, and responsible parenting emerged as strong community values. These were among the many signs of strength and resilience that were evident in perspectives of the poor Los Angeles communities that we studied.

Notable in the present findings was the overwhelming consensus that racism is a serious problem in the United States today and the high frequency of thoughts about one's own racial and ethnic background. In addition, experiences of racism were common and frequently elicited physiological and emotional response. Ethnic differences were examined in a larger CCHN pilot dataset including greater representation of Latinos from Lake County, IL, and we found that racism was more often experienced by African Americans whereas thoughts of one's race/ethnicity were as high or higher among Latinos.[31] Based on these results and others in the literature,[32] the ongoing CCHN study is examining racism as a distinct form of chronic stress in African Americans and Latinos that is hypothesized to contribute to premature biological aging and indirectly influence the health and well being of mothers, fathers and their children.

Few participants were aware of the range of health problems disproportionately affecting the children in their communities. Clearly, more education can be provided through community fairs, churches, culturally-tailored public service campaigns, and other avenues to inform communities about health disparities in rates of preterm delivery and low birth weight and their long-term consequences. Our partnership in Los Angeles is already addressing this need in innovative ways such as by informing community members about how to care for a pregnant woman.[33]

Our results further revealed both commonalities and differences between women and men in sources of support, ways of coping, and expectations regarding the roles of parents. The

commonalities suggest that some forms of intervention such as parenting groups may be useful for men and women together. The differences, on the other hand, may help us understand and intervene to assist men and women separately using, for example, men's groups on fathering and women's groups on healthy pregnancy. A combination of these seems optimal.

The results presented here are limited by a relatively small sample including few men, the latter of which was anticipated since the recruitment sites were providing mostly prenatal care. However, these pilot study results were valuable in formulating and refining questions and hypotheses, study design and procedures, and measurement approaches in the larger CCHN study. They also enabled us to practice CBPR methods and become familiar with some of the challenges and rewards involved. Furthermore, the findings provided valuable insights into perceptions of stress, coping, parenting, health and resilience within these particular poor Los Angeles communities. Community perspectives show promise in helping to advance scientific understanding of health in diverse populations. These results also underscore the need for scientific approaches to the study of stress, resilience, families, and health that include a wider diversity of perspectives and experiences.

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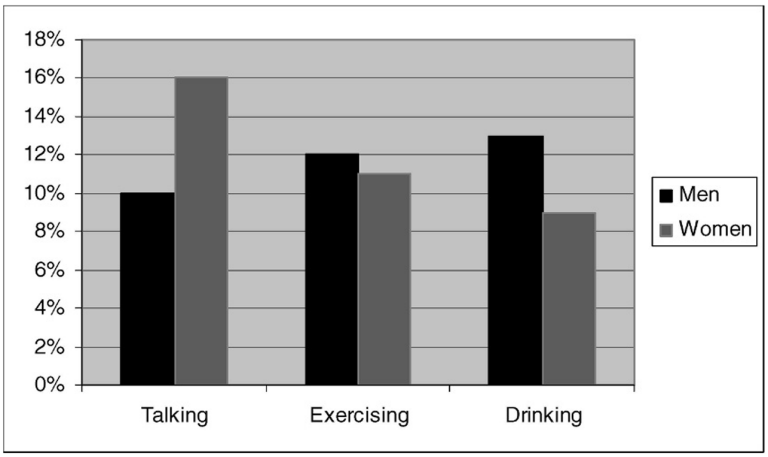

Fig 1.
Perceived sex differences in coping strategies

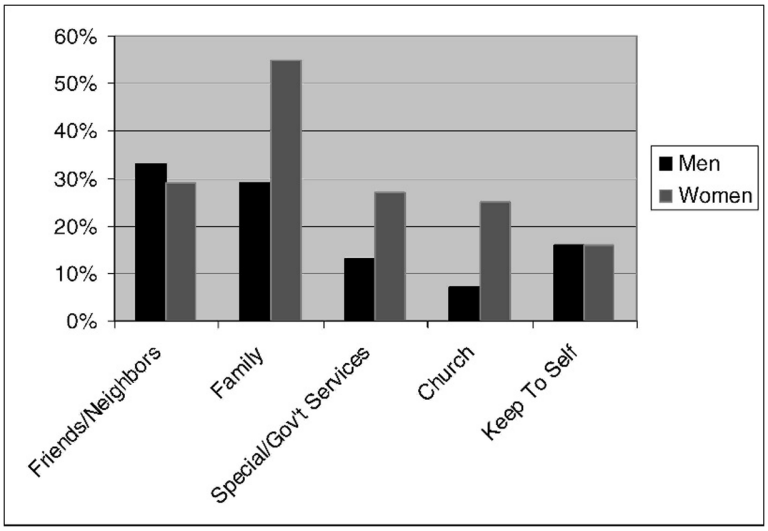

Fig 2.
Perceived sex differences in sources of support

Table 1

How often participants thought about their own race, observed racist treatment of others, and experienced physical and/or emotional symptoms due to racism (%)

	Think of own race* (*n*=53)	Others treated differently* (*n*=54)	Physical symptoms* (*n*=54)	Emotional symptoms* (*n*=52)
Never	18.9	14.8	57.4	21.1
Once/year	7.5	9.3	16.7	34.6
Once/month	20.8	29.6	13.0	15.4
Once/week	13.2	22.2	7.4	17.3
Once/day	17.0	7.4	1.9	5.8
Once/hour	—	1.9	1.9	1.9
Constantly	20.8	11.1	—	3.8
Don't know	1.9	3.7	1.9	—

*Within the past 12 months, on average.

Table 2

Percentage of respondents who believed that these health conditions were serious problems in their communities

	Yes	No	Don't Know
Asthma	64.8%	18.5%	16.7%
Obesity	64.8%	25.9%	9.3%
Being born too early	27.8%	42.6%	29.6%
Being born too late	27.8%	44.4%	27.8%
Not growing enough	18.5%	51.9%	29.6%
Diabetes	38.9%	29.6%	31.5%
Problems with learning	66.7%	22.2%	11.1%

N = 54.