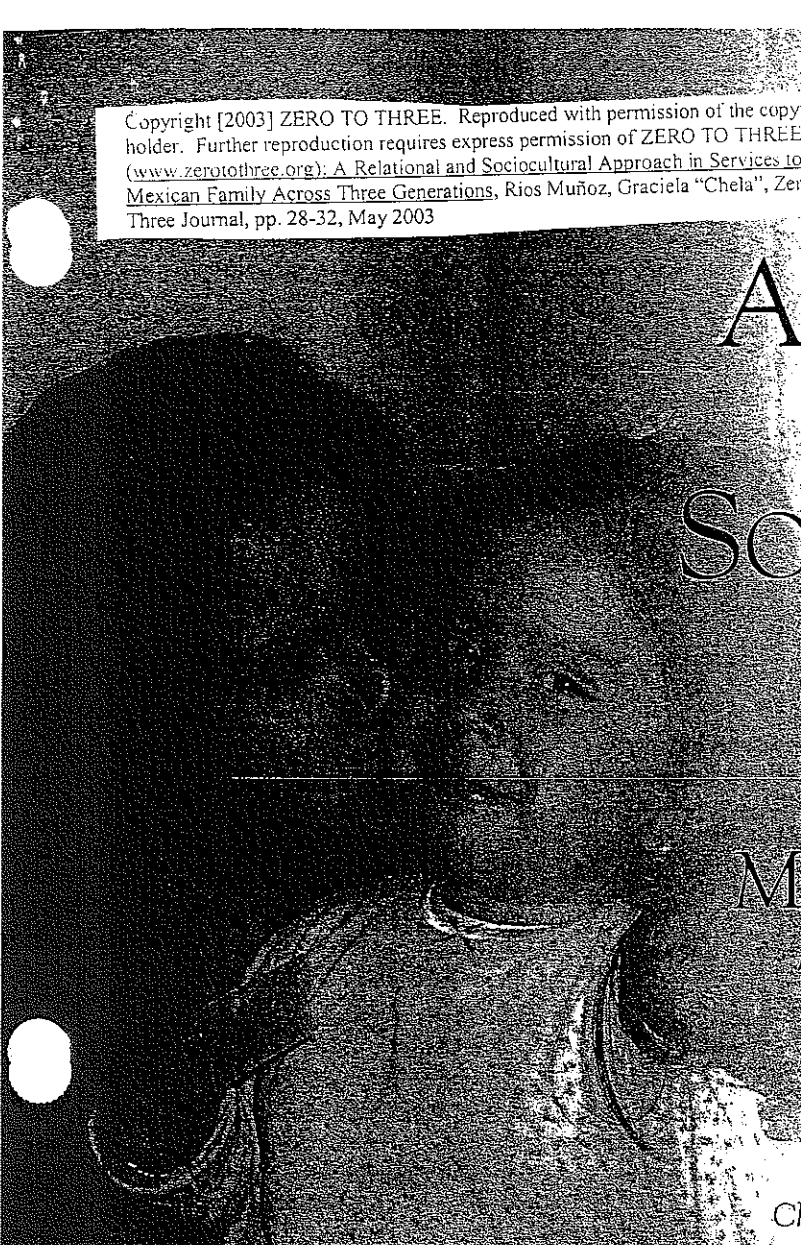


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A RELATIONAL AND SOCIOCULTURAL APPROACH

*in Services to a
Mexican Family Across
Three Generations*

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PHOTO: GRACIELA RIOS MUÑOZ

I am a licensed clinical social worker and the child of Mexican immigrants. I provide home-based early intervention services to babies who were born medically fragile and who have been discharged from neonatal intensive care units; the babies are at both biological and social risk for developmental delay. My identity and life experiences have informed my understanding of my work with the Latino immigrant community. In this article, I hope to further the understanding of some of the issues facing the Latino community and provide practitioners with ideas on how to address them. Practitioners in all parts of the country now serve Latino families. In the last decade alone, the Latino population in the United States has grown by 60%, and Latinos now represent 13% of the total U.S. population. Of children under age 5, 17% are Latino (National Council of La Raza, 2001).

This article tells the story of my work with one Mexican family—a three-generational household that included Jennifer, a premature infant who weighed 2 pounds, 8 ounces at birth; Patricia, her teen mother; and Elena, the maternal

grandmother. I used a sociocultural and relational perspective to address clinical concerns in my work with this family. This approach embraces the complexity of the social and cultural factors that shaped this family's experiences, while using my

at a glance

- Practitioners in all parts of the U.S. now serve Latino families.
- Work with a three-generational Mexican household illustrates a sociocultural and a relational perspective used by the author, herself a child of Mexican immigrants.
- *Personalismo* is a Latino culture value prescribing warmth, individual attention, some informality, an openness in human interactions; it characterizes a Latino relational approach.

relationship with the family members as a vehicle for the work. By describing the work in three stages, I hope to show the progression of trust with the family, along with a deepening of the levels of intervention. Issues explored include a complicated and persistent problem with Jennifer's weight that defied traditional medical intervention, and the impact of differences in levels of acculturation, intergenerational conflict, and the teen mother's developmental tasks of separation and individuation in the context of her education.

Stage One: Working With the Family's Priorities — Patricia's Education

Within a few days of Jennifer's discharge from the hospital, I began home-based early intervention services. During home visits, Patricia began to tell me about herself. She was American-born, but maintained a strong cultural identification with her Mexican heritage. She spoke Spanish in her home to her mother and visited Mexico frequently. Prior to her pregnancy, Patricia had engaged in many high-risk behaviors, including alcohol use, violence with other teenage girls, late hours, and irregular attendance at school. I noticed a framed picture of Patricia with her "homegirls," wearing gang colors, on display in the bedroom that Patricia and Jennifer shared with Elena. There were also several religious icons and a CD collection that was a mix of contemporary American gangster rap and Mexican music. These items represented the multiple influences in Patricia's quest for identity. In spite of Mexican cultural traditions that value family, respect, and proper behavior, it was clear that prior to her pregnancy, Patricia had been headed toward a life in the streets that many marginalized inner-city youth pursue by default. Despite the many universities and places of cultural and natural beauty in the area surrounding her home, Patricia's life was confined to a neighborhood characterized by high rates of unemployment, drug use, and violence, along with deteriorating houses, inferior schools, and numerous liquor stores.

Soon after Jennifer's birth, Patricia discontinued her relationship with Jennifer's father because he was too much a part of the streets and being with him could return her to a risky lifestyle. However, she still struggles to sort out her ambivalent feelings about him. He has not formed a consistent relationship with Jennifer.

Elena's worries

In the initial phase of my work, Elena was always present during my visits. Patricia often deferred to her, especially in conversations about the baby. I know that in traditional Mexican culture, elders and family hierarchies are respected. Hence, although our program focuses on the parent-child relationship, I needed to be flexible and use a carefully tailored

three-generation approach in my work with this family. In so doing, I was able to acknowledge and respect the grandmother's place in the family and the importance of her relationship with both her daughter and granddaughter.

I soon learned that Elena was quite concerned about Patricia's past and even her present behavior. Her worries resulted in her attempts to control Patricia's activities through rigid disciplinary practices. These well-meaning attempts to protect her daughter through overprotection strained their communication and began to drive them apart. Without intervention, I feared that the pressure on the mother and grandmother's relationship would result in a serious argument, and Patricia would storm out with the baby, back to her street and gang lifestyle. This kind of disruption could put both Patricia and Jennifer at even greater social risk.

In order to form a working alliance with Jennifer and her mother I had to establish relationships that would facilitate trust and communication. I had to carefully attend to each generation's rules of engagement, which were influenced by their respective places on

the continuum of acculturation. I had to understand how, when, and to what degree individual values and behaviors were influenced by traditional Mexican culture, and what was being changed by mainstream American culture.

With the grandmother, a Mexican immigrant, positive engagement included attention to hierarchical roles with particular regard to elders, formal communication, deference, and polite conversation. Through this type of conversation I learned that she had limited formal education and worked two part-time jobs to support her family. The grandmother wanted a better life for her daughter, better than what she had as an unskilled and undocumented immigrant "working like a burro to make ends meet." Her command of the English language was very limited, and she relied on Patricia to be her interpreter and translator in matters involving English. She wanted Patricia to get a good education and to have a career. My initial task was to form an alliance with her, while being careful not to lead her to believe that I was going to collude with her wish to control Patricia.

Careful self-disclosure and awareness of the immigrant experience helped form my relationship with the grandmother. I explained to her that I am the child of immigrants, and I offered my understanding and respect for her sacrifices as an immigrant mother on behalf of her child. I inquired about her migration experience and sympathized with the challenges of adaptation to a different culture. I sensitively spoke to her of her vulnerability as an undocumented worker in the U.S., a status which kept her in constant fear of discovery and deportation. These fears obliged the grandmother to operate in a way that kept her invisible. Thus, even though her daughter is a U.S. citizen, the grandmother's

Sometimes sneaking the baby "treats" was a way family members showed their affection, even if it meant sabotaging a parent's plan for infant feeding.

fears, originating from her own undocumented status, made her reluctant to create waves of any kind. Hence, she accepted my offer to help her advocate for Patricia within the educational system. I also knew that she saw me as a successful Mexican-American woman, and this implicitly tapped into her dreams for a better future for her child.

Patricia's individuation

As an adolescent, Patricia was preoccupied with issues of individuation. I had to be vigilant not to interact with her as another nagging mother figure looking over her shoulder with the answers. I had to support her relationship with her baby while helping her to maintain the vision of her dreams. I regularly admired her baby. I noticed how much the baby looked like Patricia, and pointed out how the baby preferred Patricia to me. I consciously built on the growing affection and attachment that Patricia had for Jennifer. In conversations, I encouraged her to think about her dreams for her baby, past, present, and future, and list things she wanted for Jennifer. Not surprisingly, given her adolescence and her poverty, these were material: nice clothes and toys, a house with a yard, a car. Discussion of Patricia's hopes for her baby set the stage to discuss the connection between her current lifestyle choices and these dreams. I helped Patricia enroll in a high school program for teenage mothers and their babies, and constantly praised her for her efforts. I became an on-site presence at her school and helped her advocate for her needs with school staff. Before meeting me, she had never met a Mexican-American who had graduated from college. Becoming Patricia's role model helped build her confidence. I was living proof that somebody like her could succeed in school and have a career.

Stage Two: Failure of a Traditional Medical Approach in Weight Management

In getting to know this family, I learned that the maternal grandfather died from complications related to morbid obesity. Elena, also overweight, had been advised by her physician to lose weight because of medical problems. Although she is healthy, Patricia had been struggling with her weight even before her pregnancy.

Early in the treatment, this family's medical history raised concerns about the potential for weight-related problems for Jennifer. I intervened early, using a preventative medical approach and informing the pediatrician of my concerns. The pediatrician agreed to provide needed nutritional counseling to the family during Jennifer's medical appointments. At these visits with the family, I observed Patricia and

Elena's polite, but silent response to the nutritional information. Culturally, I knew that the nodding did not represent agreement and compliance, but rather a respect for the pediatrician's authority and appreciation for her concern.

Despite the pediatrician's ongoing discussions with the family, by the time Jennifer was 1 year old this low birth-weight baby had surpassed the 95th percentile on premature growth charts. Additionally, Jennifer was not reaching her gross motor developmental milestones; I suspected that her weight was a factor in this delay. The pediatrician and I agreed that nutritional counseling during well-child check-ups was failing to slow Jennifer's rate of weight gain. With the pediatrician's approval, I decided to try what would become my second failed attempt to control Jennifer's weight.

In every Latino household I visited, traditional cultural beliefs about appropriate infant feeding mixed with the advice of professionals, popular culture, time and money constraints, and marketing programs to result in unique parental feeding choices.

I offered the family home-based consultation from our program nutritionist. The family politely agreed. The nutritionist asked the family to keep feeding records over the course of 3 days. She then computed Jennifer's caloric intake based on the food diary. Everybody became puzzled because the intake presented

could not have accounted for Jennifer's level of weight gain. It became obvious that nobody was accounting for the role the extended family members played in Jennifer's food intake. Although the mother and grandmother provided Jennifer with her formal meals, the extended family offered Jennifer many snacks throughout the day as they shared their food with her. As this pattern emerged, I felt prematurely successful. Once we had uncovered the problem, solving it would surely follow. The program nutritionist and I met with Patricia, Elena, and other family members to discuss Jennifer's nutrition. Everyone politely agreed to follow our advice. But Jennifer's weight continued its ever-upward curve.

By now, Jennifer's family nickname had become "gorda" which translates to "chubby." (It is a common practice in Mexican culture to give a person a nickname that describes a characteristic of the person.) Because many Mexicans think of a chubby baby as a healthy baby, I explored Patricia's and Elena's feelings about Jennifer's weight. Both said that they did not want her to be a fat child. They anticipated the future and felt that Jennifer would "suffer" in school by being teased and not being able to keep up with the other children.

At this point I realized that Jennifer's feeding issues were linked to complex family dynamics and would require more than conventional nutritional intervention. It was clear that Jennifer was a much-loved child who ruled the roost. Jennifer had learned that protesting, crying, or tantrums eventually got her what she wanted, particularly from her grandmother. Often what she wanted was a sweet or a soda.

Stage Three: Infant Mental Health and *Personalismo*¹: A Latino Relational Approach

I decided to take a risk and lead Patricia and her mother somewhere where I wasn't sure they wanted to go. I approached the weight issues head-on and asked Patricia why she thought all our interventions around weight gain had not made a difference. She didn't know. I then told her that I thought the weight issues were more complicated than just food intake. I explained that I felt that limit setting and Patricia's relationship with her own mother were important areas to explore in order to make progress towards Jennifer's weight management. I added that this exploration would have to include Elena. I hoped that the history of our relationship would help me to pursue this intervention. I gave Patricia a few days to think about my offer, understanding that she needed to be the decision-maker. She agreed to explore these issues and she gave me permission to first meet with Elena.

In meeting alone with this grandmother, I tapped into the strength of her love for her family and her hopes for the future for her daughter and granddaughter. I realized I had to offer her something that was relevant and important to her. I talked about improving communication between the generations, because the grandmother had often expressed her frustration and worry about her teen daughter's behavior. For example, Patricia had once again started the worrisome habit of staying out late at night and not coming home. She was again mingling with friends who, in Elena's opinion, were not pursuing healthy lifestyles. Elena worried that Patricia would get off track and that both of their dreams for a successful future would be lost.

It was apparent that the grandmother had successfully been able to pass on her dreams for a better future to her daughter. However, she did not have the necessary skills or resources to help Patricia navigate the institutional and social obstacles that could keep her from realizing those dreams. She resented Patricia any time she felt the teen was not taking advantage of the opportunities that the grandmother had worked hard to provide.

Patricia did want a better future. But, as an adolescent, she lacked the maturity and experience to know how to make

The grandmother had successfully been able to pass on her dreams for a better future to her daughter. However, she did not have the skills or resources to help Patricia navigate the institutional and social obstacles that could keep her from realizing her dreams.

dreams into reality. She knew of her mother's dreams and sacrifices, but felt that her mother was too worried about her and didn't trust her judgment. She was unhappy with her mother's constant nagging.

I feared that without proper support, the dreams of both generations would remain unfulfilled.

Because Elena and Patricia were not communicating well together, I used a strategy of meeting with them individually and containing and holding each one's worries and frustrations while always seeking permission to meet with the other and share concerns. This strategy allowed me to better understand their problem and to form the conduit for the beginning of communication between mother and daughter.

I commented to both Patricia and Elena that the style of communication that they shared with each other was likely to be the one they would each use with Jennifer. They each agreed that they were not satisfied with their communication, and wanted something better for Jennifer. I used this common love for Jennifer as motivation for them to commit to the work.

In my conversations with Elena, I inquired about her own childhood experiences, as I suspected that these might be influencing her difficulties in limit setting with both Jennifer and Patricia. The grandmother told me of a childhood of emotional deprivation and physical abuse. She had made great efforts to create a different reality for her children and now her grandchild. She emphatically knew she wanted to spare her family the pain and suffering she experienced as a child, so she intentionally did not use corporal punishment with either generation. She showed her love by indulging them and hardly ever saying no. I admired the grandmother for her success with her children in breaking the cycle of physical and emotional abuse that she had endured as a child. Over several conversations, Elena was able to see that by indulging her children, she was trying to make up for what she didn't get, but had always wanted, as a child. I commented that, given her upbringing, she had never had a chance to learn alternatives to harsh discipline such as positive limit setting, communication skills, or problem solving, and that this made it hard to achieve her wish for well-behaved children. She reported having difficulty dealing with Jennifer's increasing tantrums and disobedience. I made the link to some of her present difficulties controlling Patricia's behavior as well. She quickly made the connection between her own experiences and current difficulties, and agreed to work on these issues in our family sessions with Patricia.

As a result of the family work, communication between the mother and grandmother improved. We were now ready to make the link back to Jennifer's weight. It became evident

¹Personalismo' This definition refers to the client-provider relationship. However, the same features are present in all interpersonal interactions. "The ability to relate to consumers in such a way that consumers feel at home and among people who value them, who care about their problems, and who will assist them with finding solutions within their own reality. A Latino cultural value which prescribes warmth, individual attention, and a certain level of informality and openness in human interactions. There is a distinction between bringing personal attention to a mental health treatment exchange and in being overly familiar, which is characterized by this term." (Western Interstate Commission for Higher Education)

that it was painful for grandmother to see Jennifer in distress, so she did whatever necessary to keep her happy. This included giving in to all of Jennifer's food requests, especially for soda, sweets, and nighttime bottles. Although she cognitively understood the nutritional impact of these foods, emotionally she had not been able to set limits with Jennifer without feeling she was being harsh, and without worrying that by setting limits, she might risk losing her granddaughter's love. With her new understanding of the effects of her own traumatic childhood, Elena became able to approach feeding differently.

The use of language has been crucial in the intergenerational work. It was necessary to be able to switch back and forth between Spanish and English. In this way, I kept everyone actively informed and involved while bridging differences in levels of acculturation. For example, although Patricia spoke Spanish to her mother and knew that her mother was not fluent in English, Patricia always spoke to me in English, even in her mother's presence. This left out Elena. I understood that Patricia was working on individuation and that leaving her mother out of the conversation might have been a way to separate. To keep my alliance with Patricia, I had to follow her lead and respond to her in English. I summarized to Elena in Spanish what Patricia had said to me in English, regularly checking in with Patricia to see that I got it right. Even though Patricia understood Spanish, I also summarized the grandmother's responses. Thus, I held each relationship separately while working to improve communication between the generations.

In addition to the teenager's developmental task of separation, Patricia was concurrently adapting to her new role as a mother. As the relationship between mother and grandmother improved, the grandmother's faith in her daughter's future was restored. The grandmother has also gained confidence in her daughter's parenting and, over time, Patricia is becoming the primary decision-maker in matters regarding Jennifer, with close involvement from the grandmother.

Jennifer is receiving developmental infant services both at her child care site and at home. She will soon begin preschool. I reintroduced the nutritionist, and we are currently working more effectively to manage Jennifer's weight. Patricia has graduated from high school and is in her second semester of community college. Greatly affected by Jennifer's experience in the intensive care nursery, she hopes to become a nurse and work with premature babies. Seeing the strength of this family's love for each other and the benefits from the family work they have done, I, too, am hopeful about their dreams for their future.

Conclusion

In this article, I have illustrated the application of a socio-cultural and relational approach in clinical practice with a multigenerational immigrant family. In Jennifer's family, as well as in many other Latino immigrant families, the socio-cultural context is extremely complex and includes the impact of

migration, issues of acculturation, prior family legacies, language, and the effect of marginalization and socioeconomic status on the family's opportunity to create the life they want.

I believe that in order to insure the effectiveness of clinical practice with families, we must use a sociocultural and relational approach in a meaningful way with all families. Furthermore, given the demographic reality of the nation, we must prioritize this multicultural agenda in all areas of early intervention including training, hiring practices, service delivery, research, program design, program evaluation, and policy. §

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