

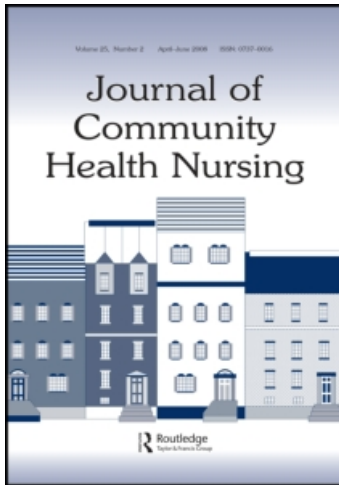
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Living With Diabetes: Perceptions of Hispanic Migrant Farmworkers

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This study¹ focuses on Hispanic migrant farmworkers and their perceptions of living with diabetes. A phenomenological design was utilized with a sample of 12 participants recruited from 2 local migrant health centers. The interview guide was based on questions from Kleinman's Explanatory Model. Data were explored with regard to etiology, onset of symptoms, pathophysiology, and course of illness. Six themes emerged from the analysis: usualness of diabetes, causes of diabetes, symptoms prior to the diagnosis of diabetes, understanding the chronicity of diabetes, impact of diabetes on daily life, and fear of long-term complications related to diabetes. Based on the analysis of the interviews, the individuals' explanations of this chronic disease are compiled within their own perceptions and cultural beliefs. The results of this study can be utilized by providers to adapt their health care and education methods to better meet the needs of this mobile population. In the Hispanic migrant farmworker population, further research is needed to explore the long-term impact of living with diabetes on a daily basis.

This article addresses the perceptions of Hispanic migrant farmworkers who live with diabetes mellitus. Although diabetes is prevalent in all North American populations, the prevalence in Hispanic Americans exceeds the national average (Nash, Shriver, Amos, & Roman-Shriver, 2004). It is twice as common in Hispanic American adults as in non-Hispanic White adults. This chronic disease has become widespread among middle-aged and older Hispanic Americans. For example, in individuals age 50 or older, it is estimated

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that about 25% to 30% have either diagnosed or undiagnosed diabetes (National Diabetes Information Clearinghouse [NDIC], n.d.). Despite the high incidence and prevalence of Type 2 diabetes diagnosed in the Hispanic migrant farmworker population, there is limited research on their experiences of living with diabetes. The purpose of this phenomenological study was to gain insights into the lived experiences of migrant farmworkers with diabetes as they incorporate the meaning of this chronic disease into their day-to-day living. This study provides a basis for health care providers to gain an understanding of Hispanic migrant farmworkers and diabetes. Thus, it will enable them to adapt their health care and education methods to better meet the needs of this population. In this article, the word *Hispanic* is used to designate individuals who have Mexican American or Mexican heritage (Lausch, Heuer, Guasasco, & Bengiamin, 2003).

LITERATURE REVIEW

Understanding the individual's personal, family, social, and cultural beliefs about health and illnesses is essential to provide effective medical care to that person (Kleinman, Eisenberg, & Good, 1978). Each individual has a set of personal views or an explanatory model (EM) that includes his or her beliefs about "1) etiology; 2) onset of symptoms; 3) pathophysiology; 4) course of illness which includes the type of sick role—acute, chronic, impaired—and severity of disorder; and 5) treatment" (Kleinman et al., 1978, p. 256). Through elicitation of the individual's EM, health care providers can define areas of agreement and discrepancies that can influence the clinical management of a disease and impact health outcomes (Mauksch & Roesler, 1990). The EM allows the provider to explore the individual's personal perspective as it relates to health and illness.

Kleinman's concept of an EM can be utilized as a framework for collecting and analyzing data that provides an understanding to the meaning of an illness from the perspective of a group of people who are experiencing the same illness (Jezewski & Poss, 2002). For example, diabetes has become a serious health challenge for Hispanic Americans because of the increased prevalence of this disease in the population. Nevertheless, there is relatively little information about their knowledge, beliefs, and practices related to this disease.

Chesla, Skaff, Bartz, Mullan, and Fisher (2000) studied the differences in personal models among Latinos and European Americans (EAs). When compared with EAs, a large percentage of Latinos used the experiential model when describing their diabetes. In this type of a model, the informants described their diabetes in terms of symptoms or disease requirements, such as tender feet, fatigue, or increased irritability. In recounting their diabetes, they did not include an explanation of the biological mechanisms that may have caused the symptoms. Their perception of diabetes may be because Latinos experience their diabetes holistically, meaning that when the disease enters their life, it is an undifferentiated psychological, emotional, and biological phenomenon.

A second aspect of personal models that differed between the EAs and the Latinos was the change that they noted in their lives since they had received the diagnosis. The EAs noted changes in exercise and spontaneity, which suggested that they experience the impact of the diabetes regimen. In contrast, the Latino participants experienced symptoms such as fatigue and irritability along with changes in their social lives (Chesla et al., 2000).

In a study completed by Jezewski and Poss (2002), their findings illustrated that individuals' explanations of illness are a compilation of their own cultural beliefs and the lessons learned from the biomedical health care team about their diabetes. In addition, the findings of this study demonstrate that it is crucial to understand clients' viewpoints and to analyze how their EM influences how they manage their illness experience. The biomedical view alone will not help health care providers to provide care for clients with diabetes. To assist clients with diabetes to manage their symptoms and prevent the complications of this chronic illness, providers need to take into consideration the clients' perceptions of this chronic disease (Jezewski & Poss, 2002).

METHOD

Design

Through the use of the phenomenological approach, the researchers studied the lived experience of Hispanic migrant farmworkers with diabetes. In phenomenological inquiry, the researchers identify the meaning of human experiences concerning a phenomenon as described by the participants in the study (Moustakas, 1994). In this study, the research question was, "What is the lived experience of a Hispanic migrant farmworker diagnosed with diabetes?"

Participants

The participants recruited for this research study consisted of a purposeful sample of 12 Hispanic migrant farmworkers diagnosed with diabetes. The criteria for participants to be included in this study were (a) they had to be over the age of 18 years, (b) they had to have been diagnosed with diabetes for 1 year, and (c) they had to be clients of one of two of the nine Migrant Health Service, Inc. nurse-managed centers—one center was located in northeast North Dakota, and the other was in northwestern Minnesota.

The sample consisted of 12 participants who migrated from southern Texas to the Upper Midwest for agricultural work. Participants ranged in age from 34 to 62 years of age with a mean age of 51 years. Of the participants, 6 were men, and 6 were women. Ten were married, 1 was single, and the marital status of 1 individual was unknown.

All of the participants were diagnosed with Type 2 diabetes. The mean age of diagnosis for the participants was 40 years old. The mean years that they lived with this chronic disease was 10. Seven of the 12 participants were prescribed oral medications to control their diabetes, whereas 4 reported the use of insulin. The medication status of 1 individual was unknown.

Interviews

From their clinical experience in practice settings, the researchers knew enough about the phenomenon of migrant farmworkers with diabetes to develop questions about the topic in advance of the interviews, but not enough to be able to anticipate the answers (Morse & Richards, 2002). As a result, to explore the research question, the authors developed and piloted interview questions based on Kleinman's EM. The content of the interview guide consisted of questions related to (a) etiology, (b) onset of symptoms, (c) pathophysiology, (d) course of the illness, and (e) treatment (Kleinman et al., 1978; see Appendix for interview questions).

Data collection took place in one of two migrant health seasonal satellite nurse-managed centers during the summer season between the months of August to October. One tape-recorded, open-ended interview was conducted with each of the 12 participants with diabetes. The interviews conducted lasted 90 min to 2 hr. If the client did not speak English, the interview was completed with the use of a Spanish-English interpreter. Participants were compensated for their time with a \$10.00 gift certificate for a local merchant.

Ethical Considerations

The Internal Review Board of the University of North Dakota approved the study, and participants received the usual assurances about anonymity, confidentiality, and the right to withdraw at any point without prejudice or an impact on the health care that they will be receiving at the migrant health center.

Data Analysis

The interview tapes were transcribed verbatim by a student nurse and a bilingual research assistant. The Spanish interviews were transcribed in English and Spanish to check for accuracy in the translation. All transcripts were reviewed for correctness and then checked for accuracy against the audiotapes. Minor adjustments were made whenever necessary to ensure the accuracy of the transcriptions. The research team developed an initial codebook template based on the interview guide. They coded 2 interviews with

this initial codebook, had in-depth discussion, and made the necessary revisions to insure confirmability and credibility (Rubin & Rubin, 1995). The next stage consisted of reading the transcripts several times to identify the themes of the interviews. Parts of the transcripts were highlighted, and notes were made on the transcripts and separate note cards. The interview data were organized into categories, which led to the identification of major themes (Lausch et al., 2003, p. 71).

FINDINGS

The researchers identified six main themes surrounding the clients' experiences of living with diabetes: usualness of diabetes, causes of diabetes, symptoms prior to the diagnosis of diabetes, understanding the chronicity of diabetes, impact of diabetes on daily life, and the fear of long-term complications related to diabetes.

Theme 1: Usualness of Diabetes

When interviewing participants in this research study, it became evident that they were familiar with diabetes due to the large number of family members and friends who were living with this disease. The usualness of diabetes is demonstrated through quotes in two different ways. First, clients discussed the prevalence of family members who were diagnosed with diabetes. Of the 12 participants, 11 had family members diagnosed with this chronic disease. The majority of the clients had more than one family member with this diagnosis. The prevalence in this population is demonstrated in the following quotes:

“All my family. My grandmother ... All seven of us, and my father and mother.”

“I got one sister so far, and then I got a whole bunch of cousins. I can't count them there's so many.”

“Mother, father, five brothers and sisters out of ten, others may have but not aware, sister-in-law and brother-in-law.”

The second area of usualness was the manner in which the participants described to the interviewer their family members and the severity of family members' complications related to diabetes. Studies in the Mexican American population with diabetes have shown higher rates of long-term diabetes complications such as nephropathy, retinopathy, and peripheral vascular disease (NDIC, n.d.). As a result, the diagnosis of this disease not only causes early mortality but increased morbidity related to chronic

complications. In the following quotes, many of the participants shared experiences of family members and friends who endured the long-term complications of diabetes:

“My mother ... she had six bypasses and then she was on dialysis toward the end ... so that was real hard for her body. You know diabetes advances like that. Seeing her the way she was when she was on dialysis, she was real sick. She only last about a month on dialysis then she passed away.”

“[My mother had] one of her toes got cut off. She couldn’t be outside with family. Then she got real sick. After the bypass she got worse.”

“My mother [had diabetes] and I was the oldest so it was hard. She passed away at the age of 48 but she didn’t talk about it much. She got down, I remember when I was younger though that she had to inject herself and all that.”

“My in-law had two legs amputated.”

“[I] found out that dad had to get his leg chopped.”

“In my family right now, [my brother] is really sick—his leg. And friends, they are blind.”

“My aunt’s blind.”

Theme 2: Causes of Diabetes

Biomedical model. Risk factors for diabetes include family history, gestational diabetes, impaired glucose tolerance, hyperinsulinemia, insulin resistance, obesity, and physical inactivity. According to the findings from the Diabetes Prevention Program, individuals who are at high risk for developing Type 2 diabetes could reduce their chances of developing this chronic disease through diet and exercise (NDIC, n.d.).

Although the majority of the participants exhibited the risk factors of family history and obesity, 6 did not believe that there was anything that they could do to prevent their diagnosis of diabetes, as reflected in the following quote:

“No. They told me it had to do with relatives. More hereditary.”

Whereas the other 6 participants stated beliefs that diabetes may be prevented primarily through better nutrition, as depicted in the following quotes:

“I could have taken better care of myself, not eat as much. I shouldn’t have eaten things like sweets.”

“I suppose I could’ve ate better, you know, my habit of eating or whatever. I don’t know, exercise some more might help, I don’t know.”

“Yes, stop eating bread with the grandchildren.”

When the participants were asked to describe the cause of their diabetes, the majority of the participants identified hereditary and dietary factors:

“Well, my father also has it, he inherited it from his mother. He has it just a little, it’s not too much. He has it controlled.”

“I told the doctors, I said I don’t eat that much kind of sweets. He said, no, it’s from generation. Well I don’t eat too much sweets, you know I thought it was from sweets you know.”

“I drank too much soda and ate too much sweet bread.”

Two other participants stated that they did not know, but they speculated that it was related to heredity or dietary factors:

“Really [I] don’t know but maybe because my mom and the family has it.”

“I don’t know. I don’t know if it’s the food I eat or it’s just hereditary you know, it had to show up sometime.”

Whereas 4 of the 12 participants stated that they did not know the cause of diabetes, as indicated in the following quotes:

“I am not sure. I had a stroke. I went to the hospital and that is when I knew, the doctor said I was a diabetic.”

“I don’t know. I didn’t feel anything.”

Folk belief model. In addition to identifying genetic and environmental risk factors for diabetes, many of the participants discussed major life stressors at the time of their diagnosis, such as divorce, death of a loved one, or accidents. These life stressors were seen as a “trigger” or precipitating event, as reflected in the following quotes:

“At that time, my son went to the Marines, I lost my husband at that time, and I got into ... I got into an accident. Then ... in another six months, I got into another accident. I think that triggers. I got into the second accident in November and by January 1st, I was diagnosed with diabetes.”

“It did, it went away at that time ... My dad passed away by then, my mother passed away just about ... just about that time ... then I got diabetes.”

Another participant believed that ongoing stress and worry about the many losses in his life precipitated his diabetes, as eloquently described in the following quote:

“My dad you know ... we’re so close. But, uh—my dad died a long time ago but ... I keep remembering Dad, he comes in my dreams. And then ... I keep remembering my kids you know that died in a fire ... and sometimes you know I am in the tractor alone, thinking about my kids and crying ... and I say a little prayer ... Like, it’s my fault, you know. In my subconscious it keeps bothering me. One was four and the other ten months ... A little kid, I keep thinking about it you know, you never forget your kids. And then our son, the third one. He was thirty-seven, thirty-eight. He died over in California [in a car accident], about two years—three years ago. I had to go to see him.”

Theme 3: Symptoms Prior to Diagnosis of Diabetes

Participants experienced the medically recognized prediagnosis symptoms of diabetes, as depicted in the following quotes:

“I was going to the bathroom a lot and that’s when they diagnosed [me] with diabetes.”

“When my diabetes started then I was eating a lot and I was losing weight.”

Many participants discussed their feelings of anger and irritability prior to their diagnoses of diabetes and the impact that it had on their relationships. These feelings of anger and irritability ultimately led to increasing arguments and family discord, as noted in the following quotes:

“Before [diagnosis] it was just—there was just, you know anger ... if you looked at a person, it just seemed like you didn’t like them and you would just get into an argument with that person.”

“[Family members] couldn’t even pass by the TV because I’d get angry, or the kids couldn’t even say something too loud because I’d get angry, everything bothered me. [My wife said] it was the doctor or a broken marriage, one of the two.”

Theme 4: Understanding the Diagnosis of Diabetes as a Chronic Disease

When diagnosed with diabetes, many participants reflected that they did not understand that diabetes was a chronic disease that would require lifelong management. Initially, they perceived diabetes to be an acute illness instead of a chronic disease, as described in the following quotes:

“Yeah, it went away but then it came back again. I thought it was just like the appendicitis, when they took the appendix out, that was it. I thought it was just, you know, I had it and I was gonna get it over, I mean, get well and that was it. I never even—I never thought it was gonna stay.”

“It took five years to understand I had it. I went and they gave me pills and treatment and they said to take the pills. I thought it would go away [when I took the pills].”

“It has been 5 years that I have had it and it won’t go away.”

Theme 5: Impact of Diabetes on Daily Life

Physical impact of diabetes. Many of the participants discussed how easily they became fatigued and related their lack of energy to their diabetes. This fatigue or lack of energy impacts their social time:

“When I lived in Houston [ten years ago], I just did my job and I wanted to [drive] to Mexico and I said to my wife, come on let’s go, it’s time to go, and it didn’t matter that it was dawn. I never felt tired for working so many hours and I never felt tired or languid. Ten, eleven hours, I didn’t mind. No differ—in the night in the day, with me. I went to Washington DC or Texas, forty hours—forty-eight hours straight. And now, I can only drive two to three hours and then you know I stop.”

“It makes me feel old, wasted. I use to go dancing every weekend. I wouldn’t stop dancing. If I go to the dance hall, I would dance all the time and now, I cannot.”

This lack of energy also influenced their ability to work:

“I want to work, I want to do what I use to do before I got the diabetes.”

“I want to go to work and I don’t think I can manage a whole day of work.”

Another area impacted by fatigue was the mother–child relationship:

“Taking care of the kids. I want to have energy for them. You know I take them to the park and they want to play and I don’t have enough energy to get up and play with them. Now it is like God leave me alone. Then I wish that I could go, I see other mothers and they have the energy to go and jump up and down. They have the energy to do things with their kids and that is what I wish I had. I can’t do it. My body won’t handle it.”

“The other one is, I am not there so much now for my kids. They ask me what I am doing in that bed, if I am just going to stay there and watch TV? I don’t have the energy to get ready. They say, ‘Gee mom you are not that old’. I say, ‘I know’.”

In addition, participants shared concern regarding their sexual relationships with their spouses. They believe that the long-term effects of diabetes impeded their intimate relationship, as stated in the following quotes:

“You know love life is not very good.”

“Sometimes sexual problems. There are times that I want to but I can’t. I use to get a lot of [yeast] infections. I don’t know, he has all the energy and wants to be sexually active and I am not. So that too, wanting to have that energy for that and I can’t.”

Emotional impact of diabetes. Since their diagnosis with diabetes, several participants related experiencing feelings of depression:

“They say diabetes will kill me sooner than the normal people who don’t have diabetes and I started getting very depressed. I cried a lot.”

“Bad. I feel bad. I am the youngest one of the family and I am the one that got diabetes.”

“Very sad [for] about a year. It scared me.”

“I feel uh, sometimes I cry, I just didn’t understand what’s wrong with me.”

“Yes, I am depressed ... You keep thinking about—you know what diabetes is about.”

Theme 6: The Fear of Long-Term Complications Related to Diabetes

Many participants expressed their personal fears regarding chronic complications of diabetes. These fears included kidney disease, blindness, amputations, and death. The participants stated most often that they feared kidney disease and dialysis:

“To get worst. Like, to get on the machine, the dialysis machine. I don’t want that.”

“Like I—I wouldn’t like to be hooked up to a machine you know that cleans my kidneys. Yeah that would—I—I would be afraid of it.”

Another complication frequently mentioned by the participants was blindness, as reflected in the following quotes:

“Well, it makes you blind.”

“Everything, because you get blind, with blind.”

Some participants worried about amputations because they had friends or relatives who had experienced a loss of a limb. One participant worried about amputations, stating his fear was:

“Amputations, sometimes it would be better just to die.”

Many of the participants expressed their beliefs that diabetes could eventually lead to their death if they did not self-manage this disease:

“I guess—I think that diabetes can kill you. Yeah if you don’t take care of yourself it’ll kill you.”

“Not right now. I mean, it’s if I don’t take care of myself you know, it’ll probably be my time.”

Whereas other participants viewed their course of this chronic disease as being in the hands of God:

“I’d say whatever God sends me. God—if—if God wants me to stop living tomorrow, or next month or next day.”

“Not really. I tell my working buddies, I say Hey, it’s time for me to go and I go, there’s nothing I can do about it ... that’s the way I deal anyway, know.”

DISCUSSION

In this article, the researchers explored the participants’ perceptions about being a migrant farmworker living with diabetes. They described how prevalent this chronic disease is in the studied population. All of the participants migrated from southern Texas, where research has documented a high rate of diabetes. According to Bastida, Cuéllar, and Villas (2001), they sampled 849 Mexican Americans in southern Texas and found an overall prevalence rate of diabetes of 23.2%. Their results indicate that almost one in four from their study reported having diabetes. As a result of this high prevalence rate of diabetes, the participants in the study presented here were very familiar with the diagnosis of diabetes and its long-term complications.

Although diabetes was prevalent in this population, some of the participants reflected that they did not know the cause of the diabetes, whereas others provided combined beliefs of biomedical and folk models. Consistent with our findings, participants in studies by Coronado, Thompson, Tejada, and Godina (2004) and Jezewski and Poss (2002) interwove aspects of both Western biomedicine and traditional Mexican folk beliefs into their EM of diabetes. Coronado et al. interviewed 42 Mexican Americans with diabetes in six focus groups. These participants identified both biomedical risk factors (including a diet high in fat and sugar, lack of exercise, and heredity) and folk beliefs, such as experiencing strong emotions like fright or anger as causal factors for diabetes. Jezewski and Poss interviewed 22 Mexican Americans with diabetes and found that the participants used the two belief systems and ranked heredity and lack of proper self-care as the two most important causes of diabetes, with other causes including feeling stress and worry and experiencing *susto*. Participants in their study used the word *susto* to describe a very frightening experience. They did not view *susto* as a specific illness, but saw it as a specific condition that caused their diabetes (Jezewski & Poss, 2002).

The participants in our study also drew from a biomedical and folk belief system in their attempt to describe the causes of their diabetes. In relation to the biomedical model, half of the participants did not think that they could have done anything to prevent their diabetes because they believed that it was a disease related to heredity. The other half of the participants, who believed that they could have done something to help prevent their diabetes, thought that it could have been done through better management of their diet. When the interviewer asked about the cause of their diabetes, the majority of the participants identified heredity and diet as contributing to the cause of their diabetes.

Although most of the participants discussed biomedical risk factors as causing their diabetes, they also eluded to a folk belief model in which life stressors were seen as a trigger or precipitating event to this disease. Consistent with our findings, other research studies found Mexican Americans with diabetes identified specific emotional experiences such as the death of a loved one, an accident, or other tragic events in their life as contributing to their diagnosis of this disease. This population integrates factors from the biomedical system and the folk belief system to understand the cause of their diabetes (Coronado et al., 2004; Hunt, Valenzuela, & Pugh, 1998; Jezewski & Poss, 2002).

Participants in this study described the biomedically recognized symptoms of diabetes as being present prior to their diagnosis. These symptoms included increased urination, dizziness, increased thirst, increased hunger, increased fatigue, and irritability. This irritability was even further discussed by how it impacted their family relationships, with 2 participants even discussing the potential threat of divorce. According to Chelsa et al. (2000), Latinos experience their diabetes holistically by viewing it as a psychological, emotional, and biological process versus EAs, who tend to view their diabetes from a biomedical framework in which there is a distinct separation of mind and body. Although participants in this study described biomedical symptoms prior to diagnosis, they elaborated on how these symptoms impacted all areas of their life, including their interpersonal relationships with spouses, family, and friends.

The impact of the physical and emotional symptoms of diabetes described by these participants affected their daily living. According to Chelsa et al. (2000), Latinos experienced increased fatigue and mood changes as the most frequent symptoms affecting their daily living, whereas EAs discussed the impact of the diabetes regimen on their daily living. The participants in this study discussed at length how increased fatigue and lack of energy influenced their ability to work, their family relationships, and their intimate relationships.

In the study presented here, all but 4 participants self-reported developing depression secondary to being diagnosed with diabetes. According to Anderson, Freedland, Clouse, and Lustman (2001), individuals with diabetes are twice as likely to be depressed than otherwise similar nondiabetic individuals in similar settings. Black, Markides, and Ray (2003) studied 2,830 elderly Mexican Americans in Texas, Colorado, New Mexico, Arizona, and California. Forty-seven percent of those diagnosed with diabetes were also diagnosed with minor depressive symptoms. As a result, they found that the interaction between diabetes and depression, whether clinically diagnosed or self-reported, predicts increased mortality, complications, and disability.

On diagnosis, the majority of the participants' believed, as with an acute illness, that if they took the prescribed medication, their disease would "go away." They did not have a concrete understanding that diabetes was a chronic disease. Yet, a basic understanding or knowledge of diabetes is crucial because of the need for pronounced lifestyle changes, psychosocial adjustment for the individual, and extensive health care expenses (Whittemore, Chase, Mandle, & Roy, 2002). Without these lifestyle changes, an individual with diabetes is at higher risk for long-term complications.

Fear of long-term complications is a major concern of individuals diagnosed with diabetes. In a study by Hendricks and Hendricks (1998), both Type 1 and Type 2 patients of African American, White, and Hispanic races reported fears of long-term complications that included amputation, cardiovascular disease, nephropathy, neuropathy, retinopathy, or stroke. Among Type 2 participants, retinopathy emerged as the most feared complication (Hendricks & Hendricks, 1998). In support of these findings, the majority of the participants in the study presented here discussed their fears of long-term complications. But in contrast to Hendricks and Hendricks, who found that the most feared complication was retinopathy, the Hispanic migrant participants primarily feared kidney disease and dialysis. The prevention of long-term complications is of utmost importance in this population because when an amputation or the need for dialysis occurs, it becomes almost impossible for migrant farmworkers to travel for employment. When their income, migrant lifestyle, and close family connections are affected or lost, their physical, psychological, and emotional well-being, along with their quality of life, are impacted.

The findings of this study demonstrate the perceptions of Hispanic migrant farmworkers and their view that diabetes is more than a biomedical disease. The biomedical framework alone will not enable health care providers to effectively manage this chronic disease in the Hispanic migrant farmworker population. But through the inclusion of the folk belief model, health care providers can begin to understand the realities of what it is like for this mobile population to live with diabetes.

With the utilization of Kleinman's EM, health care providers can use specific questions to elicit client perceptions of illness. Questions include (a) What do you think has caused your problem? (b) Why do you think it started when it did? (c) What do think your sickness does to you? (d) How severe is your sickness? (e) What kind of treatment do you think you should receive? (Kleinman et al., 1978, p. 256). By gathering this type of information, the health care provider can effectively assess their clients' perceptions of this illness within a holistic framework.

The results of this study contribute to the body of literature of Hispanic migrant farmworkers and how they incorporate the meaning of this chronic disease into their day-to-day living. Based on the analysis of the interviews with the study participants, the individuals' explanations of this chronic disease are compiled within their own perceptions and cultural beliefs. For the Hispanic migrant farmworker, diabetes is an illness that affects their physical, psychological, emotional, and spiritual well-being.

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APPENDIX

Interview Questions

1. Who of your family have diabetes?
2. How long have you had diabetes?
3. Why do you think your diabetes started when it did?
4. Do you think there was anything that you could have done to prevent getting diabetes?
5. When you found out that you had diabetes, what was going on in your life?
6. How did you feel when you found out that you had diabetes?
 - a. Physically
 - b. Emotionally
7. What does your diabetes do to you physically? Emotionally?
8. What do you fear most about having diabetes?

9. Do you have a difficult time making changes necessary for the treatment of your diabetes?
 - a. Blood sugar monitoring
 - b. Dietary changes
 - c. Exercise
 - d. Obtaining medications
 - e. Cost of medications
 - f. Medical visits
10. Do you use any home remedies to treat your diabetes?
11. Is there anything else about your diabetes that you would like to tell me?