CITIZENSHIP

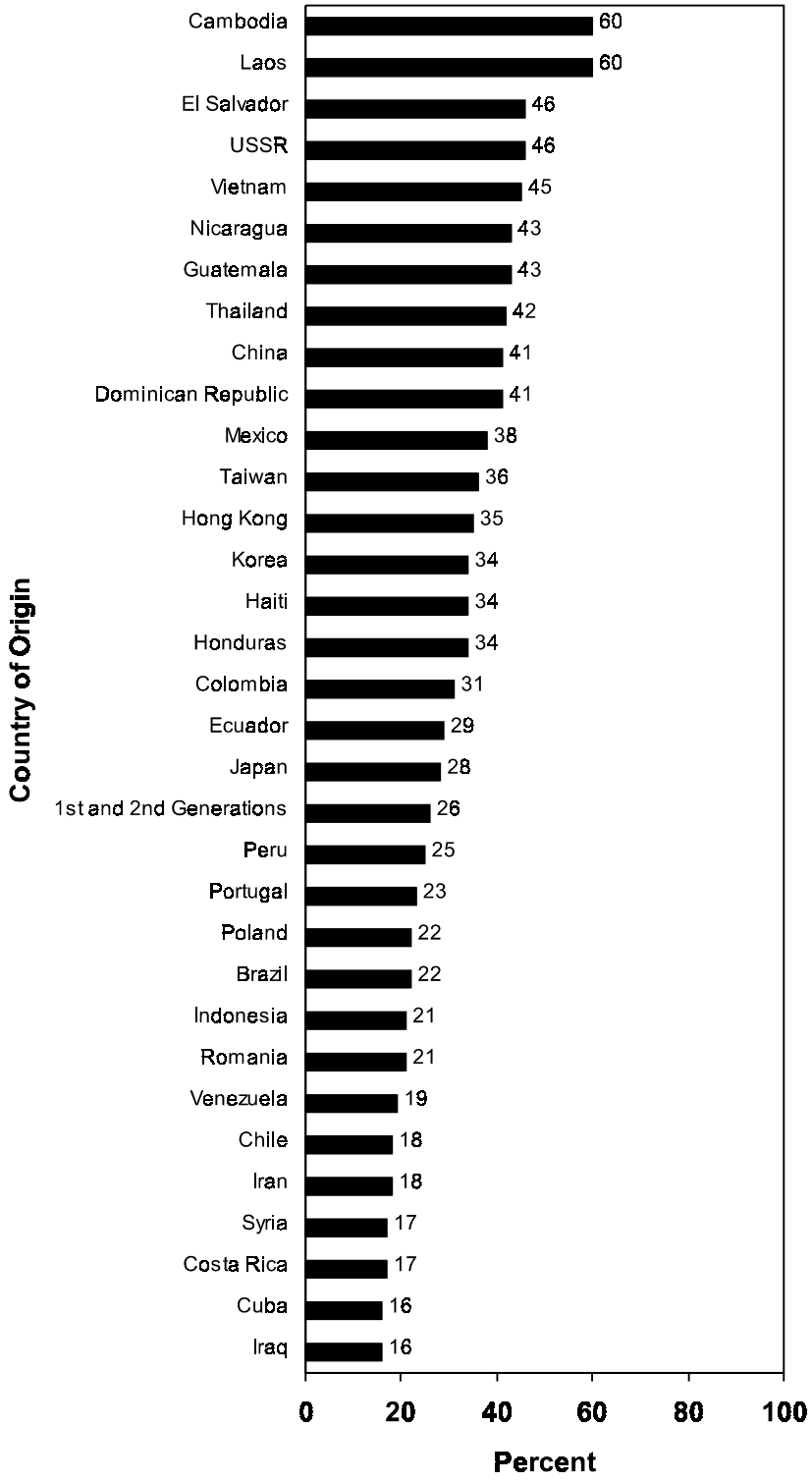
Of the 8.4 million children in immigrant families in 1990, 75 percent were citizens by birth, 4 percent were naturalized citizens, and 21 percent (1.7 million) were not citizens (Hernandez and Darke, 1999). Of the citizen children, about 54 percent had at least one parent in the home who was not a citizen; thus, approximately two-thirds of children in immigrant families in 1990 were either themselves not a citizen or lived with a noncitizen parent.

In the 1990 census, the official poverty rate for noncitizen children was 34 percent, and among citizen children with at least one noncitizen parent the proportion was 23 percent. For all children in immigrant families the proportion was 27 percent. Children in immigrant families from 9 of the 12 countries of origin with high levels of poverty were especially likely to be noncitizens, at 29 percent or more. The proportion was 21 to 23 percent for the remaining high-risk countries (Dominican Republic, Mexico, Haiti). Three additional countries had 29 percent or more of children who were noncitizens and poverty rates greater than among third- and later-generation non-Hispanic whites (Venezuela, Romania, Guyana). Children in immigrant families from only two additional countries had such high proportions who were noncitizens, Japan and South Africa, at 31 and 30 percent, respectively, but they had very low poverty rates.

For children in immigrant families with origins in 2 of the 12 countries with high povety rates, 62 or 63 percent were not citizens or had at least one parent in the home who was not a citizen, and this rose to 73 to 75 percent for 5 of these countries and 81 to 89 percent for the remaining 5 countries. The figure was 50 percent or more for 18 of the other 26 countries of origin with child poverty rates at least as high as for third- and later-generation non-Hispanic whites (11 percent); thus children in immigrant families from countries of origin with high poverty rates also, often, are not citizens or have at least one parent who is not a citizen.

Figure 32 (Part 1)

Percent in Linguistically Isolated Households for First- and Second-Generation Children by Country of Origin: 1990

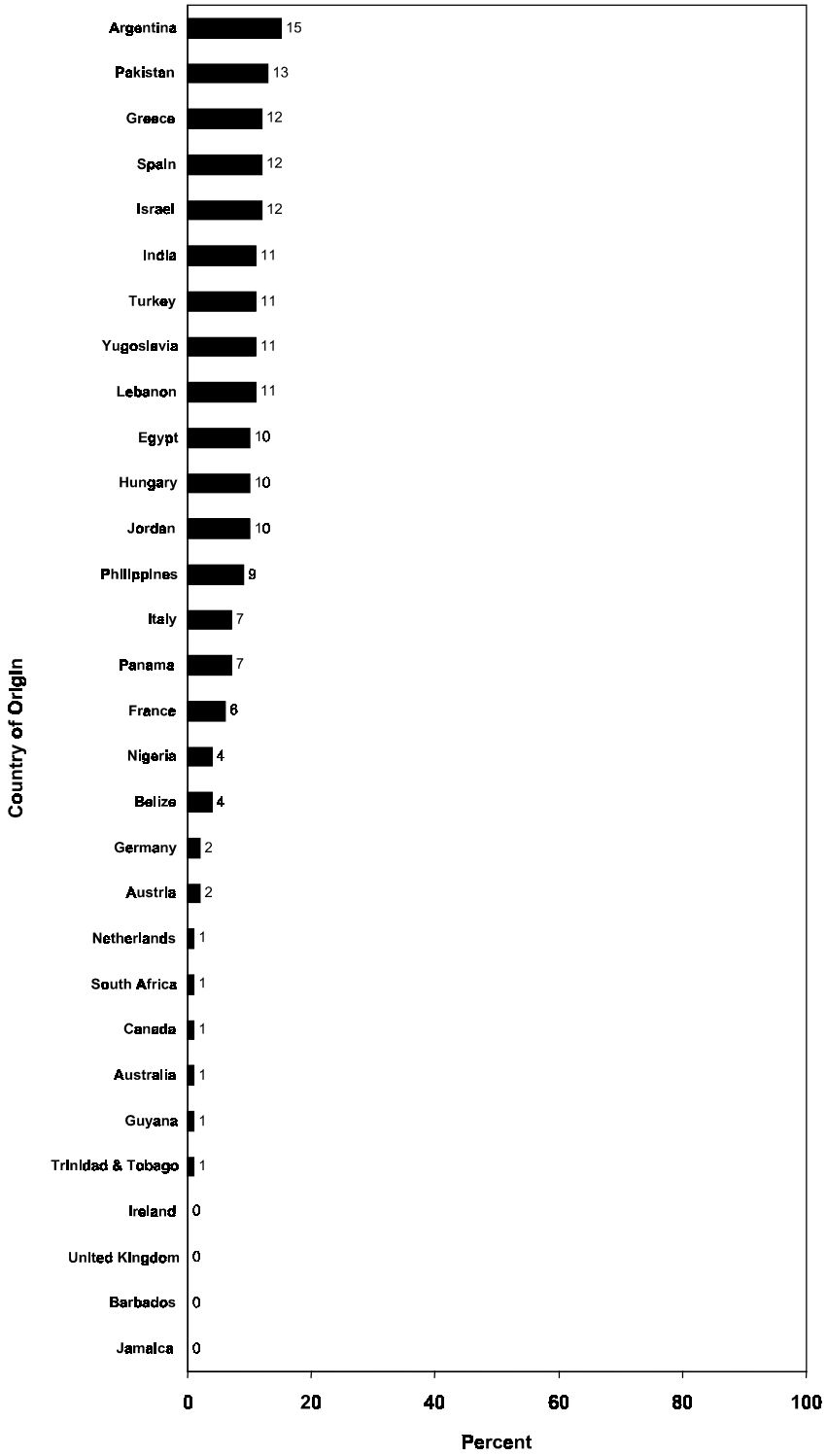


Note: See Technical Appendix for description of variables.

Source: Table A and Hernandez and Darke, 1999.

Figure 32 (Part 2)

Percent in Linguistically Isolated Households for First- and Second-Generation Children by Country of Origin: 1990



Note: See Technical Appendix for description of variables.

Source: Table A and Hernandez and Darke, 1999.

STATE OF RESIDENCE

California accounted for 35 percent of all children in immigrant families in 1990, followed by New York, Texas, Florida, Illinois, and New Jersey, for a total of 74 percent in six states (Figure 33) (Hernandez, 1999). At least 2 percent of children in immigrant families lived in each of an additional 6 states (Arizona, Massachusetts, Michigan, Pennsylvania, Virginia, Washington). Three less populous states (Figure 34) also had comparatively high proportions (higher than the national average) of all children who were children in immigrant families (Hawaii, Rhode Island, and Nevada). These 15 states accounted for 84 percent of all children in immigrant families.

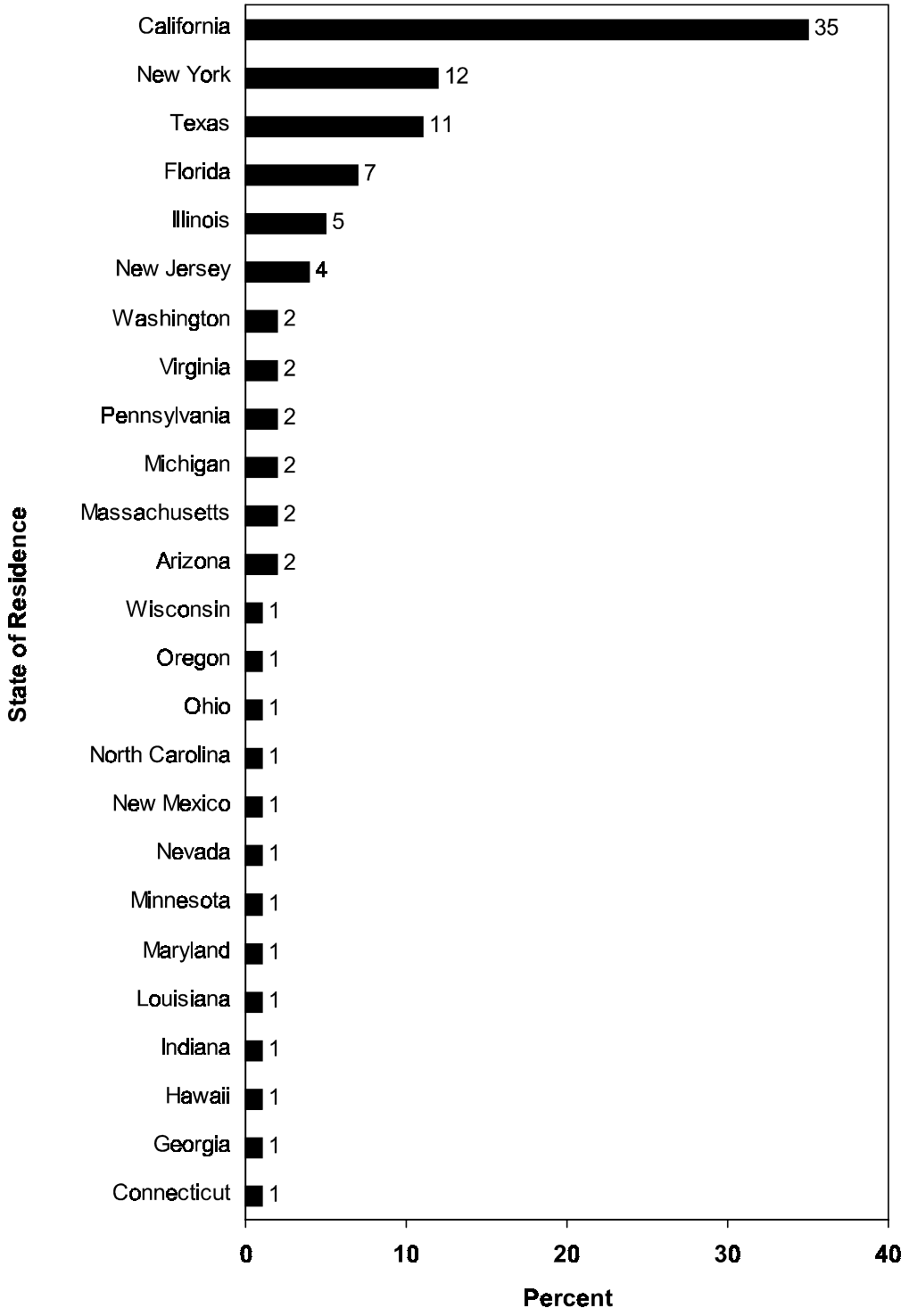
PHYSICAL HEALTH

The physical health of children and youth in immigrant families encompasses a wide range of issues. Because few surveys or health monitoring systems in the United States distinguish among first-, second-, and third- and later-generation children, scientific evidence is limited; nevertheless, available evidence along several important dimensions suggests that children and adolescents in immigrant families experience better health than do third- and later-generation children and youth, a finding that is counterintuitive in light of the racial and ethnic minority status, overall lower socioeconomic status, and higher poverty rates that characterize children in immigrant families.

Evidence on this issue is patchy, focusing on some immigrant groups and some age groups and frequently relying on parental or adolescent reports rather than direct medical examinations, but the research that exists is quite consistent; however, the relative advantage of children in immigrant families appears to decline with length of time in the United States and from one generation to the next. Moreover, immigrant children may be at particular risk for selected health conditions including parasitic infections, some of which may be unfamiliar to many U.S. physicians and most of which, if left untreated, can lead to serious conditions. Care must be taken not to overgeneralize, however, because children and youth from various countries of origin differ greatly, and available evidence is often for children from only a few countries of origin.

Figure 33

Percent of First- and Second-Generation Children Living in Specified States: 1990 (for states including at least 1 percent of these children)

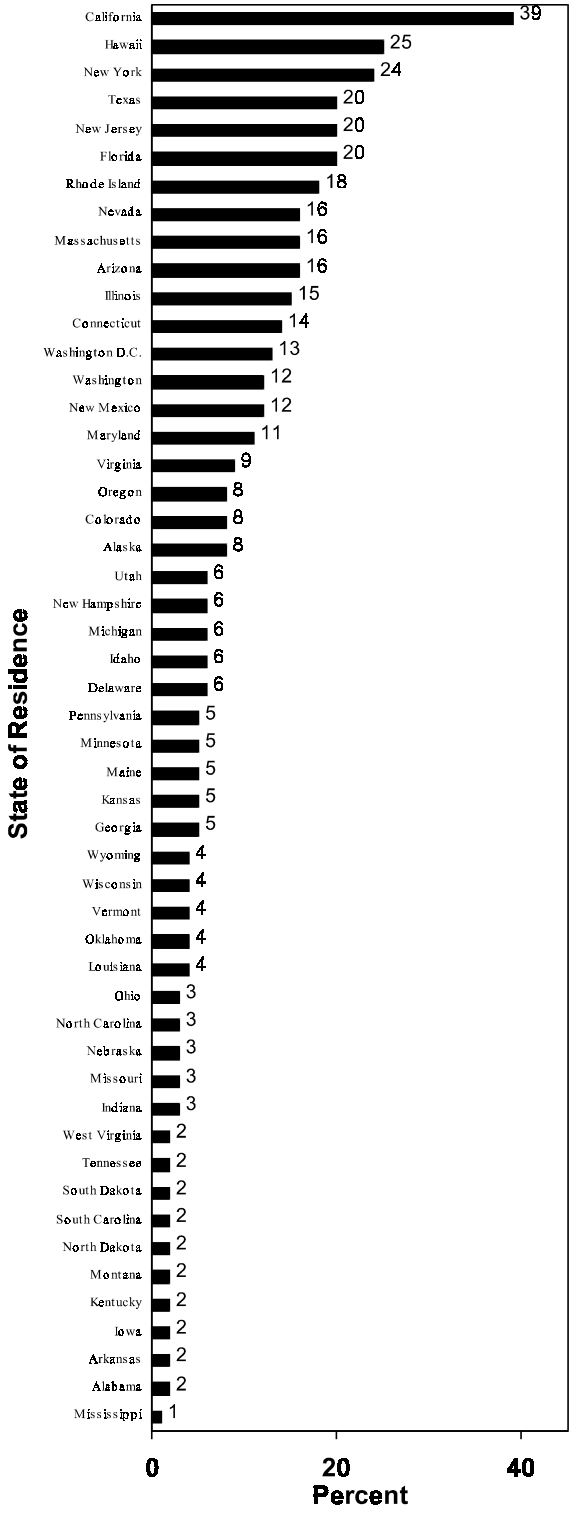


Note: See Technical Appendix for description of variables.

Source: Hernandez and Darke, 1999.

Figure 34

Percent of Total State Child Population Who Are First- or Second-Generation: 1990



Note: See Technical Appendix for description of variables.

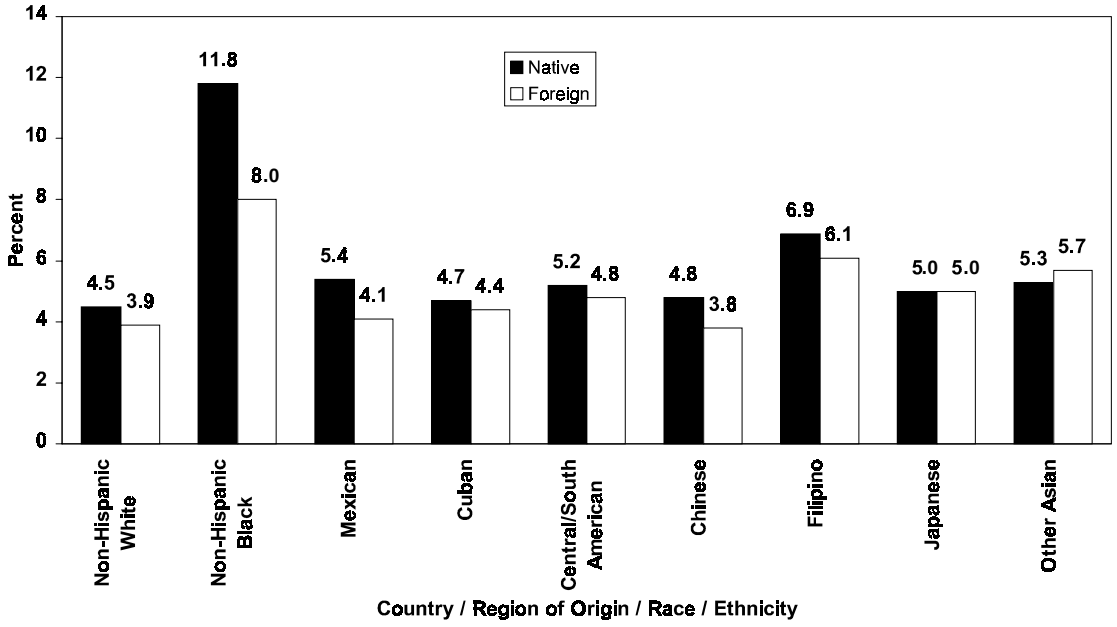
Source: Hernandez and Darke, 1999.

INFANT BIRTHWEIGHT AND MORTALITY

Two commonly used indicators of infant health are the rate of low birthweight (less than 2500 grams) and infant mortality (deaths in the first year of life)(Institute of Medicine, 1985; U.S. Department of Health and Human Services, 1986). Significantly lower rates for these two indicators have been found among the immigrant population than among native-born mothers for the Mexican-American population, despite the lower socioeconomic status of the immigrants (Guendelman, 1995; Guendelman and English, 1995; Guendelman et al. 1995; Markides and Coreil, 1986; Williams et al., 1986; Scribner and Dwyer, 1989; Ventura, 1983; 1984). Research across immigrant groups based on single births in the 1989-91 Linked Birth/Infant Death Data Sets (Landale et al, 1998) found similar patterns for other ethnic groups. The nativity differentials in birthweight and infant mortality in these groups are often smaller than they are for Mexican Americans, however, and are sometimes consistent with expectations based on socioeconomic differences between immigrant and native-born women (Figures 35 and 36). Differences in rates of cigarette smoking are one important determinant of the differences between immigrant and native-born women.

Figure 35

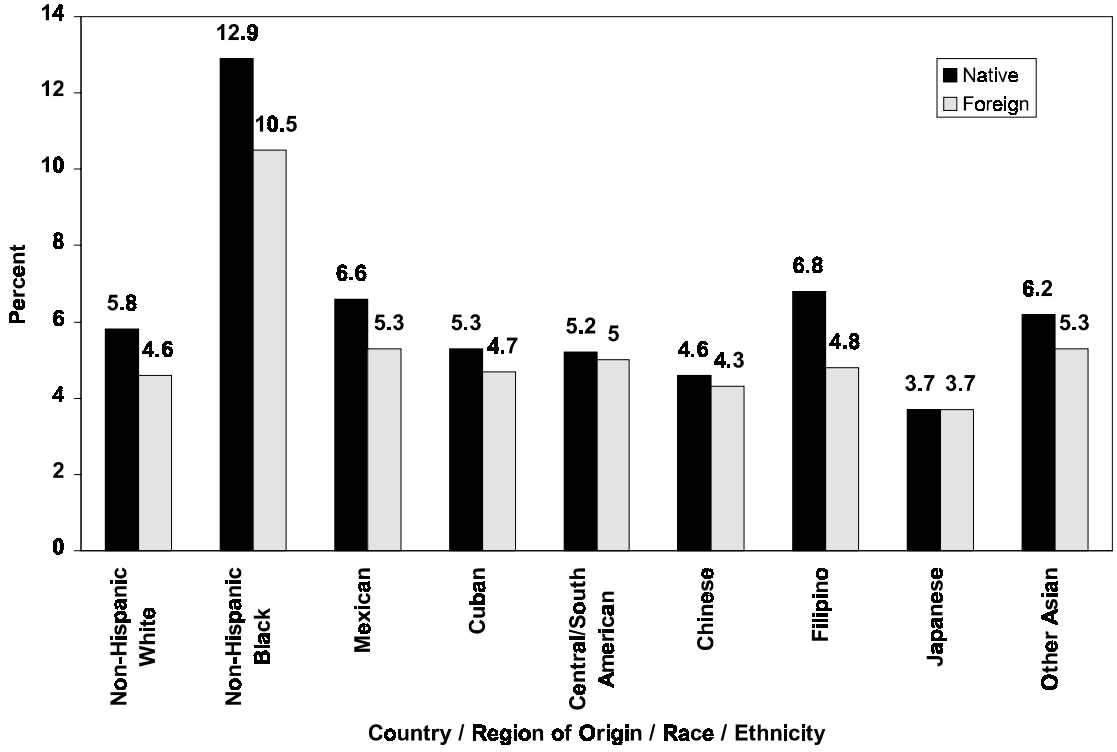
Percent with Low Birth Weights among Births to Immigrant and Native-Born Women by Country or Region of Origin, and Race or Ethnicity: 1990



Source: Landale, Oropesa, and Gorman, 1999.

Figure 36

Infant Mortality Rate for Children of Immigrant and Native-Born Women by Country or Region of Origin, and Race or Ethnicity: 1990



Source: Landale, Oropesa, and Gorman, 1999.

CHILD AND ADOLESCENT HEALTH

Analyses of the 1994 National Health Interview Survey (NHIS) find from parent reports of children in immmigrant families that their children experience fewer acute and chronic health problems compared to third- and later-generation children, including infectious and parasitic diseases; acute ear infections; injuries; chronic respiratory conditions such as bronchitis, asthma, and hay fever; chronic hearing, speech, and deformity impairments (Table 3) (Brown et al 1998; Hernandez and Charney, 1998). Additional estimates for children of Mexican origin using the 1996 National Health and Nutrition Examination Survey (NHANES III), which also rely on parent reporting, similarly indicate that noncitizen children and citizen children with foreign-born parent have fewer injuries and poisonings and fewer major activity limitations than third- and later-generation children (Table 4) (Mendoza and Dixon, 1999; Hernandez and Charney, 1998).

Table 3

Percent with Acute and Chronic Conditions During the Year for Children by Immigration Status and Type of Condition: 1994

	Non-Citizen	Citizen in Immigrant Family	Citizen in U.S. Born Family	Total All Children in Age Group
Infections and Parasitic Diseases (acute)				
Common Childhood Diseases	4.4	3.2	4.7	4.8
Intestinal Virus	0	3.7	11	9.7
Viral Infections, Unspecified	0	6.4	16.3	15.1
Other Infections or Parasitic Diseases	4.4	10.2	19.8	16.6
Respiratory Conditions (acute)				
Influenza	42	55.8	42.7	46.1
Pneumonia	0	2.8	2.2	2.6
Respiratory Conditions (chronic)				
Chronic Bronchitis	2.8	3.8	6.2	5.8
Asthma	6.5	5.7	6.9	7.3
Hay Fever	4.3	5.3	6.5	6.4
Other Acute Conditions				
Acute Ear Infections	1.8	22.4	30.5	29.5
Acute Injuries	15.1	15.2	27.8	27.4
Chronic Hearing Impairment	0.4	0.5	1.9	1.8
Chronic Speech Impairment	1.9	1	2.2	2.2
Chronic Deformity Impairment	0	0.2	1.4	1.2

Source: Brown et al., 1999.

Table 4

Percent with Selected Reported Health Conditions for First- and Second-Generation Children by Generation and for Third-and-Later-Generation Children by Race and Ethnicity: 1996

Percent with Reported Condition[a]	First Generation Mexican American	Second Generation Mexican American	Third Generation Mexican American	Non-Hispanic African American	Non-Hispanic White	Non-Hispanic Other
Perceived health to be fair or poor as assessed by parent						
< 5yrs.	23.9 (3.33)	16.8 (1.05)	6.3 (0.83)	4.9 (0.73)	1.8 (0.35)	7.4(1.25)
6-11 yrs.	27.6 (7.70)	20.0 (2.28)	6.6 (1.43)	6.9 (0.91)	2.0 (0.47)	3.5 (1.36)
12-16 yrs.	28.7 (4.99)	15.4 (2.52)	6.8 (1.63)	7.4 (1.20)	3.5 (0.79)	8.4 (4.25)
Asthma						
< 5 yrs	2.2 (1.20)	5.2 (0.88)	8.1 (1.72)	9.0 (0.75)	5.1 (0.55)	6.6 (1.40)
6-11 yrs	3.8 (2.74)	9.8 (2.71)	15.0 (4.09)	9.4 (1.00)	10.6 (1.41)	12.4 (6.12)
12-16 yrs	3.1 (1.77)	6.6 (1.91)	8.5 (1.92)	12.6 (1.63)	12.8 (1.67)	12.9 (4.59)
Possible active infection on physical examination at time of survey[b]						
< 5 yrs.	8.3 (2.68)	9.1 (1.42)	12.3 (1.93)	12.1 (1.74)	7.1 (1.25)	5.1 (1.35)
6-11 yrs.	8.6 (3.66)	5.3 (1.43)	5.9 (1.57)	5.9 (0.94)	5.0 (1.31)	16.0 (6.77)
12-16 yrs.	4.0 (1.13)	2.1 (1.12)	4.7 (1.49)	3.0 (0.83)	4.6 (1.67)	4.4 (3.25)
Ever had anemia						
<5 yrs	9.7 (2.18)	14.5 (1.09)	11.0 (1.60)	11.2 (1.06)	6.4 (0.67)	10.7 (1.97)
6-11yrs	9.2 (3.14)	11.7 (2.08)	2.8 (0.93)	7.4 (0.74)	7.2 (1.11)	7.4 (3.00)
12-16 yrs	8.7 (2.64)	7.2 (1.88)	4.3 (1.12)	6.4 (1.17)	8.4 (1.55)	3.6 (2.24)
Past 12 months any accidents, injury, or poisoning						
<5 yrs	3.7 (1.65)	5.5 (0.58)	10.0 (1.16)	6.3 (0.61)	12.8 (0.89)	7.4(1.69)
6-11 yrs	4.2 (3.26)	5.0 (1.16)	8.1 (1.95)	7.0 (0.96)	19.3 (2.31)	4.2 (1.92)
12-16 yrs	3.6 (1.58)	7.5 (1.40)	10.7 (2.63)	11.0 (1.15)	18.5 (2.15)	9.7 (3.33)
Condition of Teeth - Fair to Poor						
<5 yrs.	39.3 (5.10)	26.0 (2.49)	21.0 (1.80)	13.7 (1.37)	6.9 (0.89)	17.3 (2.37)
6-11 yrs.	60.1 (8.15)	42.6 (2.92)	23.5 (3.68)	22.7 (1.52)	12.2 (1.20)	18.4 (4.36)
12-16 yrs.	50.8 (4.65)	36.3 (3.24)	16.4 (1.99)	20.2 (2.05)	11.5 (1.64)	8.6 (3.23)
Problems seeing						
<5 yrs.	0.2 (0.24)	1.1 (0.35)	0.7 (0.30)	1.8 (0.35)	1.5 (0.34)	1.6 (1.06)
6-11 yrs.	6.8 (2.42)	13.2 (2.42)	7.9 (1.19)	9.8 (1.17)	7.6 (1.07)	4.5 (2.19)
12-16 yrs.	18.8 (2.97)	15.2 (1.86)	13.3 (2.05)	15.2 (1.63)	12.5 (1.80)	16.4 (6.77)

[a]Parental reported condition from Household Youth Questionnaire NHANES III

[b]Assessed by survey physicians by standardized physical examinations

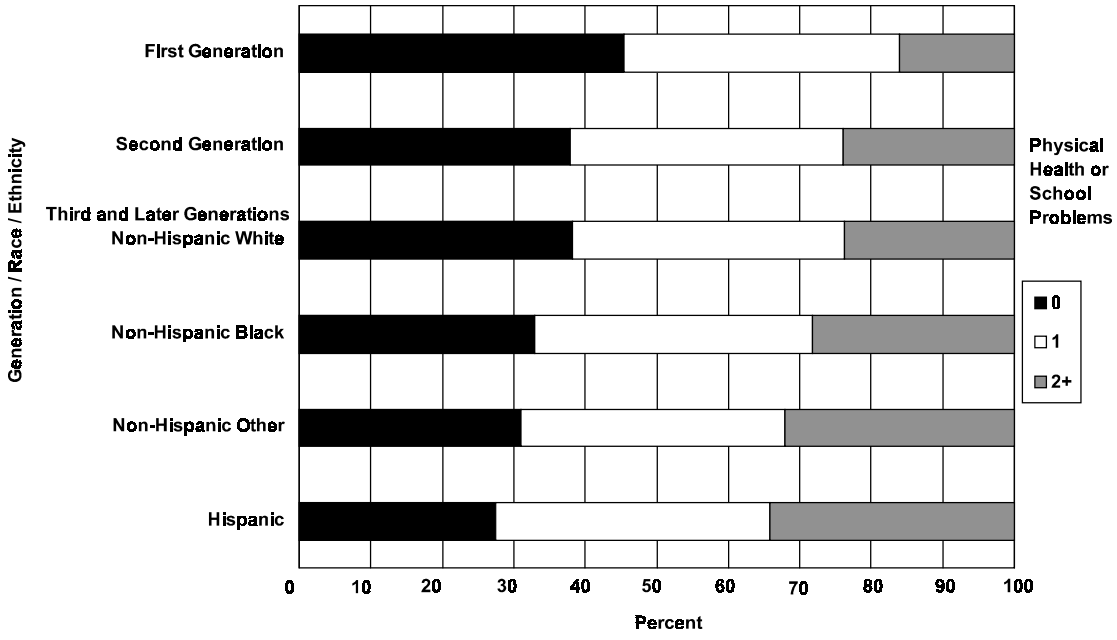
NOTE: Non-Hispanic Asians are not included because of small sample size.

Source: Mendoza and Dixon, 1999.

Although these difference are not always statistically significant because of the limited samples sizes of available data sets, they are quite consistent. Analyses from the National Longitudinal Survey of Adolescent Health (Add Health) for adolescents in grades 7 through 12 in 1995 found the same generational pattern of deterioration of health over time, based on self-reports of neurological impairment, obesity, asthma; and health risk behaviors such as early sexual activity; use of cigarettes, alcohol, marijuana, or hard drugs; delinquency; and use of violence (Harris, 1999) (See Figures 37, 38, 39, 40, and Table 5). These estimates raise the intriguing possibility that immigrant children and youth are somewhat protected, albeit temporarily, from the deleterious health consequences that typically accompany poverty, minority status, and other indicators of disadvantage in the United States.

Figure 37

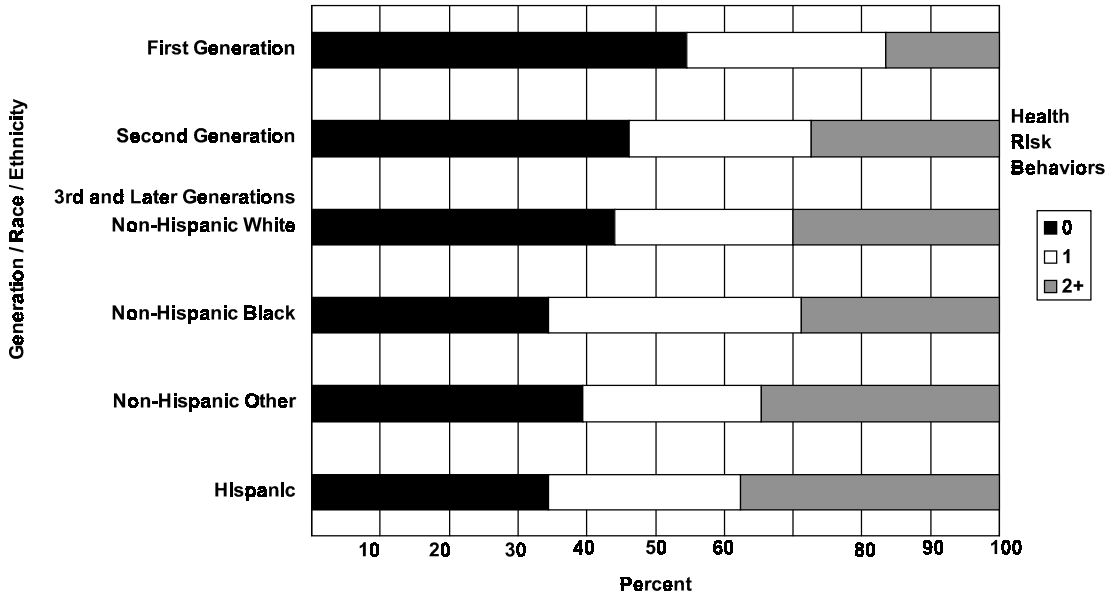
Percent with Physical Health or School Problems for First- and Second-Generation Adolescents by Generation and Third-and-Later-Generation Adolescents by Race and Ethnicity: 1995



Source: Harris, 1999.

Figure 38

Percent Engaging in Health Risk Behavior for First- and Second-Generation Adolescents by Generation and Third-and-Later-Generation Adolescents by Race and Ethnicity: 1995

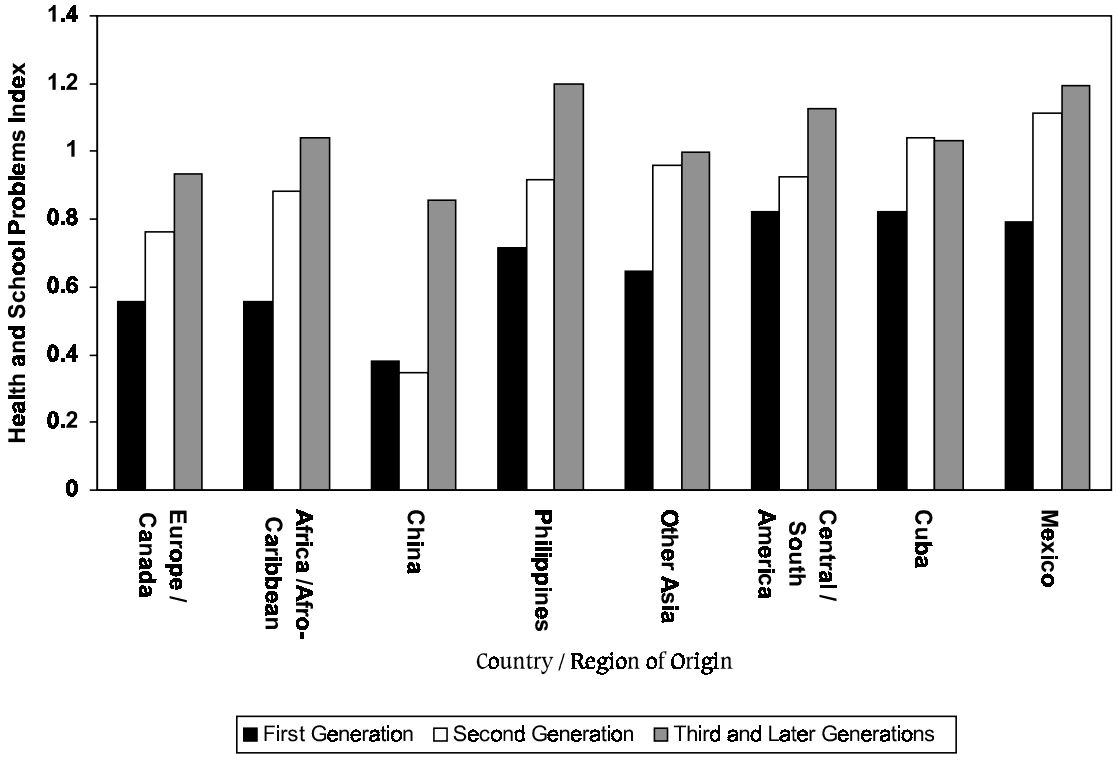


* Native-born with native-born parents.

Source: Harris, 1999.

Figure 39

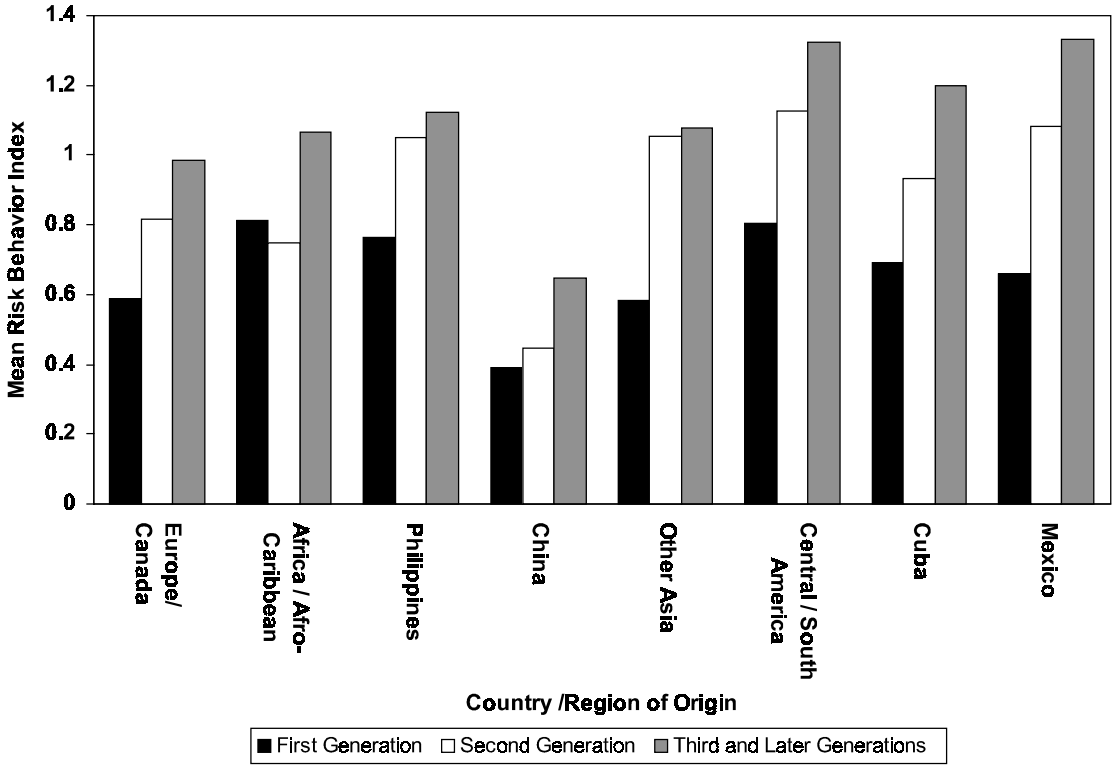
Mean Physical Health and School Problems Index for Adolescents by Generation and by Country or Region of Origin: 1995



Source: Harris, 1999.

Figure 40

Mean Risk Behavior Index for Adolescents by Generation and by Country or Region of Origin: 1995



Source: Harris, 1999.

Table 5

Health Indicators for First- and Second-Generation Adolescents by Generation and for Third-and-Later-Generation Adolescents by Race and Ethnicity: 1995 (means)

	First Generation	Second Generation	Non-Hispanic White, Third and Later Generations	Non-Hispanic Black, Third and Later Generations	Non-Hispanic Other, Third and Later Generations	Hispanic Third and Later Generations	Total
Physical Health							
General health fair or poor	9.2	10.7	8.1	11.5	14.3	13.1	9.7
Missed school due to a health or emotional problem	33.5	36.5	33.6	37.1	40.2	41.1	35.4
Learning difficulties	9.3	12.5	16.9	14.3	15.6	18.3	15.4
Obesity	17	26.7	23.4	29.9	31.5	31	25.3
Asthma	4.8	8.1	12.2	13.5	14.9	15.7	11.8
Health and school problems index	0.74	0.94	0.93	1.05	1.17	1.2	0.97
Emotional Health							
Psychological distress	1.54	1.52	1.45	1.52	1.54	1.54	1.49
Positive well-being	2.85	2.87	3.06	2.99	2.89	2.89	2.99
Health Risk Behavior							
Ever had sex	31.3	33.9	36.7	54.8	39.2	45.3	40.4
Age at 1st intercourse	15.1	14.9	14.8	13.8	14.4	14.2	14.5
Birth control/1st intercourse	56.2	57.3	67.1	64.2	60.5	58.3	63.8
4 or more delinquent acts	15.8	25	21.9	18	26.3	29.6	21.6
3 or more acts of violence	14.6	21.3	19.4	27.2	26.4	31.5	21.9
Use of 3 or more substances	8.3	17.4	25.1	8.6	24.3	25.3	19.4
Risk behavior index	0.7	0.98	1.03	1.09	1.17	1.32	1.03
N	1,651	2,526	10,248	4,312	456	1,429	20,622

NOTE: With the exception of age at first intercourse and emotional health, all differences are statistically significant at the .001 level.

NOTE: Non-Hispanic Asians are not included because of small sample size.

Source: Harris, 1999.

However, not all conclusions that can be drawn about the health of immigrant children are favorable. Children in immigrant families from Mexico, for example, are more likely to be reported by parents as having teeth in only fair to poor condition, with improvements between the first, second, and third and later generations, and those over age 6 are reported much more likely to ever have had anemia and, especially for those age 12 to 16, to have vision problems (Mendoza and Dixon, 1999). In addition, epidemiological evidence as well as physician reports indicate that children of recently arrived immigrants, and particularly those from selected high risk countries of origin, are at elevated risk of harboring or acquiring tuberculosis, hepatitis A, and parasitic infections, and of having unsafe levels of lead in the blood (Hernandez and Charney, 1998).

Exposure to pesticides is an additional health risk of great concern for children of migrant farm workers in light of its documented links to specific ailments and chronic health conditions (Hernandez and Charney, 1998). Mines (1999) reports analyses from the National Agricultural Workers Survey (NAWS), for example, that 29 percent of U.S.-based children with a migrant farm worker parent (250,000 out of 900,000) in any given year between 1993 and 1995 had a parent who mixed or applied pesticides, or they themselves mixed or applied pesticides. These children may, as harvesters, encounter pesticide residues on crops; they may eat, drink, or smoke in the fields, and thereby ingest pesticides; or they may be exposed to direct spray or drift while working in the field or at home in adjacent migrant labor camps. These chemicals cause acute ailments such as skin rashes, eye irritation, flu-like symptoms, and even death. They may also cause chronic harms such as birth defects, sterility, neurological damage, liver and kidney disease, and cancer (Wilk, 1993). Children are more likely to be harmed by pesticide exposures than are adults because children have lower body weight, higher metabolism, and immature immune and neurological systems (National Research Council, 1993).

PSYCHOLOGICAL ADJUSTMENT

New estimates of psychological adjustment are available from the National Educational Longitudinal Survey (NELS) of 1988 for 8th graders from China, the Philippines, Mexico, and other Hispanic countries (Kao, 1999) and the National Longitudinal Study of Adolescent Health (Add Health) for adolescents in grades 7 through 12 in 1995 with origins in Mexico, Cuba, Central-South America, China, the Philippines, Japan, Vietnam, Africa/Afro-Caribbean, and Europe/Canada (Harris, 1999). The Add Health measured psychological distress and psychological well-being; the NELS measured feelings of having control over the direction of one's life (self-efficacy), self-esteem, and feelings of being popular or unpopular among school peers (alienation).

The NELS analyses (Kao, 1999) found that first- and second-generation adolescents had significantly lower feelings of self-efficacy and higher feelings of alienation from their schoolmates as compared to third- and later-generation children. In contrast, adolescents in immigrant families and third- and later-generation adolescents did not differ in their self-esteem. The Add Health analyses (Harris, 1999) found no differences between youth in immigrant families and third- and later-generation adolescents in psychological well-being and psychological distress (Table 5). Taken together, these results suggest that adolescents in immigrant families may be able to maintain positive feelings about themselves and their general well-being despite perceiving that they have relatively less control over their lives and are less well accepted by their school peers.

Important differences among adolescents in immigrant families emerge, however, in analyses distinguishing youth by country of origin and racial and ethnic group, and when controls for socioeconomic status are added. In the NELS data, lower levels of feeling control over their own life occurred among first- and second-generation Mexican-origin and other Hispanic-origin adolescents, and among first-generation Chinese, Filipino, and black adolescents, but not among the second generation of the latter groups, and first- or second-generation white youth in immigrant families (Kao, 1999). The lack of popularity of adolescents in immigrant families, compared to third- and later-genration youth, was found specifically among first- and second-generation Mexican and Chinese youth, not but not among other groups. Although adolescents in immigrant families, overall, do not experience greater psychological distress in the Add Health data than third- and later-generation adolescents, first- and second-generation

Mexican and Filipino youth are more likely to feel such distress than are white non-Hispanic adolescents (Harris, 1999).

Once controls for socioeconomic status are added, the NELS data continue to show relatively lower self-efficacy and greater feelings of alienation among most of the Hispanic, Asian, and black generational groups experiencing these disadvantages, compared to third- and later-generation non-Hispanic whites. Socioeconomic controls have little effect on the magnitude of the disadvantage for Asian youth (both Chinese and Filipino), but forty to sixty percent of the disadvantage for Hispanic and black youth is accounted for by their lower parental education and income; moreover, the lower self-esteem of first- and second-generation Mexican adolescents, compared to third- and later-generation non-Hispanic whites, is accounted for entirely by the lower socioeconomic status of these Mexican-origin youth (Kao, 1999).

When controls for socioeconomic influences, such as family poverty and disadvantaged neighborhood circumstances, are introduced in the Add Health data, these factors were found to be very influential predictors of psychological distress for all adolescents, and especially for Mexican-origin youth. This pattern of results suggests, with the noteworthy partial exception of Mexican youth, a protective influence of immigrant status among adolescents who, for reasons of exposure to poverty and inner-city neighborhoods, would be expected to show poor psychological health (Harris, 1999).

The Children of Immigrants Longitudinal Study (CILS), conducted in Southern California (San Diego) and South Florida (Miami and Fort Lauderdale), is the first large-scale survey of changes in the family, community, and educational experiences of children and youth in immigrant families from nine countries of origin in the Western hemisphere and Asia (see Portes, 1995; 1996; Portes and MacLeod, 1996; Portes and Rumbaut, 1996; Rumbaut, 1994a; 1994b; 1995; 1997a; 1997b). Although it does not provide nationally representative estimates for children from these countries of origin and does not include comparative data from third- and later-generation children, the survey is a rich source of psychological data and provides insights into the processes that might underlie patterns in the psychological well-being of immigrant youth.

New research results focused first on children and youth in immigrant families living in San Diego who were from Mexico, the Philippines, Vietnam, Cambodia, and Laos (Rumbaut, 1999). This research assessed possible risk and protective factors for low self-esteem and depressive symptoms, including gender, country of origin, intrafamily and extrafamily contexts and stressors, educational aspirations and achievement, language preference and skills, and physical looks and popularity with the opposite sex.

The study found lower self-esteem and higher depressive symptoms among immigrant youth for females and for children experiencing high parent-child conflict, low family cohesion, recent serious illness or disability in the family, a high proportion of English-only spoken in the neighborhood, a school perceived as unsafe, dissatisfaction with physical looks, and lack of popularity with the opposite sex. Seven additional factors associated with higher depression were a later age at arrival in the United States, a nonintact family, a recent worsening of the family's economic situation, perceptions of poor teaching quality or unfairness, experience with stress in school, high proportion of friends not planning to attend college, and experience with racial or ethnic discrimination. Also associated with low self-esteem were being of Filipino or Vietnamese origin, a recent family move to another home, low grades and educational aspirations, limited English proficiency (LEP), and LEP status in 1991. The NELS data discussed above also revealed the importance of language factors and school experiences for feelings of self-efficacy among Hispanic and Black immigrant youth, but not for Asian immigrant youth (Kao, 1999).

Despite the potential importance of these factors for enhancing or reducing self-esteem and depression among children in immigrant families, national estimates of the prevalence of experience with most of these factors are not available for children and youth in immigrant families.