The Effects Of Acculturation On Healthcare In The Mexican-Origin Community: El Paso County, Texas

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THE EFFECTS OF ACCULTURATION ON HEALTHCARE IN THE MEXICAN-ORIGIN COMMUNITY:

EL PASO COUNTY, TEXAS

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Dedicación

Para mi familia, mis padres Aurelio y Yolanda Saldaña, mis hermanos Jorge, Cristina, Claudia, y Abel; y mis sobrinos Isaiah, Jorgito y Abelito. Sin ustedes este humilde soñador no es nadie…
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EL PASO COUNTY, TEXAS

by
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THESIS

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CHAPTER 1

INTRODUCTION

This study was built around the understanding that there is complexity in the “Hispanic”¹ health care/acculturation phenomenon. The El Paso region provides an environment where an array of cultural influences produces an acculturation process whose dynamics appear to be unique but in fact are not dissimilar to other regions where cultures are coming into contact with each other. The way borderland acculturation manifests itself in local “Hispanic” healthcare behaviors contradicts the concept of the neat move from “traditional” to the “formal” biomedical paradigm. The actual behavior observed adds support to the more complex, segmented, multi-dimensional interpretations of healthcare behavior adaptation in the “Hispanic” community.

In the study there was no attempt to propose a causal explanation for healthcare behavioral traits observed in the El Paso area Mexican-origin community. This study was an exploratory endeavor in which distinct acculturative situations in relation to “Hispanic” healthcare behavior observed in El Paso County were brought to light. It concludes with suggestions for analysis of the larger ecological survey in terms of acculturation.

The ultimate goal was to select case studies from the field material that illustrate main issues related to the concept of acculturation. The thesis concludes with considerations for the future study of acculturation as a variable in health care research in the “Hispanic” community.

The “Hispanic” population in the U.S.

This research is important because the “Hispanic” community has recently become the largest minority group in the United States, surpassing the African American community in numbers (Fry, 2008). It is estimated that by the year 2050 if the current growth rate continues the “Hispanic/Latino”
population in the United States will be well over 100 million [103 or 128 million persons depending on what study one is looking at (Tienda & Mitchell, 2006; Fry, 2008)]. The current trends show that “Hispanics” have a higher birth rate compared to non-Hispanic whites and that a steady stream of immigration from Latin America continues to settle in the US; these factors are the main contributors to this growth (Fry, 2008). Furthermore, this group’s median age is relatively young, 65% under the age of 35, which adds to this the fact that a considerable portion of the entire community is made up of children. On the other hand, the non-Hispanic white population shows a steady decline in numbers stemming from low birthrates and the natural aging of the population. This suggests that the future population of America will be constructed with significant portions of persons of “Hispanic” ethnicity.

Thus the country’s future workforce will be made up of significant numbers of “Hispanics”. These future generations of US “Hispanics” must be invested in all sectors including access to education and other vital resources, not excluding healthcare. The aging and declining numbers of the mainstream population will be in need of a well-educated and healthy newer generation to help provide for its needs.

An important point to keep in mind is the validity of classifying such a diverse spectrum of peoples into a convenient, catchall category such as “Hispanic”. As has been contested this governmental concept fails to acknowledge the complexity of the makeup of this mass of humanity. The shortcomings of this label may extend into attempts to understand the afflictions that this “group” is going through particularly in the area of healthcare access.

The concept of acculturation

What is acculturation? The concept of acculturation itself has not been fully deciphered. There are as many conceptualizations of the process as there are research studies. For example, past models of acculturation posited that the transition was clear cut going from a less to a more and ultimately complete assimilation into the mainstream culture. Later models have contested this interpretation
opting to present acculturation as a multi-faceted process manifesting itself in various forms and levels in different traits depending on the particular context being observed. There is no real consensus on interpreting the concept.

In regards to the question of “Hispanic” health and healthcare it could be said that acculturation is just one layer in a multi-layered model of effects on health (Ewart, 2004). At the higher, political economic level factors such as immigration status, income, and lack of insurance influence the “Hispanic” community’s ability to access needed health care. In the middle are factors like language and cultural gaps with service providers, and the acculturation status or level of individuals. And at the base are individual health behaviors which sometimes reflect a more “Hispanic” orientation and at times they do not. How the top and middle levels influence the base dependent variable of individual health behaviors for the moment remains an open question.

How does the acculturation process influence health care behavioral patterns in those groups, in this case “Hispanics”, undergoing cultural restructuring? This is a difficult question to answer when you take into consideration the many distinct measurements of acculturation that have been used. For instance, acculturation measures have utilized different indexes based on proxy variables such as language preference (Akresh, 2007) and nativity and length of residence in the country (Cho, Frisbie, Hummer, & Rogers, 2004; Akresh, 2007). Furthermore, while some researchers have called for a unified conceptualization of acculturation (Kim, 1979) others have even questioned the validity of this concept (Hunt, Schneider, & Comer, 2004). Still others point out the shortcomings of studies that seem to use “incomplete” interpretations of the concept (Chakraborty, 2008).

Research into the association or correlation between acculturation and health care behavior/outcomes in the “Hispanic” community has acknowledged this complexity. The studies understand the shortcomings that simplistic explanations are inherently destined to produce while showing that multi-dimensional models have provided more flexibility in bringing acculturation as a
variable into the study of health-related behaviors/outcomes (Valencia & Johnson, 2008). For instance, Balcazar, Peterson, and Krull (1997) present acculturation influence on “Hispanic” healthcare behavior, specifically that of pregnant Mexican American women, as a co-factor working in correlation with family cohesiveness; the segmented approach allows for multivariate study of the process.

What have the results shown? Studies in the area of “Hispanic” health care using acculturation as a factor have presented different results, some concluding negative outcomes linked to higher levels of acculturation to mainstream American culture (Cho, Frisbie, Hummer, & Rogers, 2004; Marin, Perez-Stable, & Marin, 1989), others finding that increased acculturation promotes more positive healthcare behavior such as seeking preventive healthcare measures (Hu, Covell, 1986; Marks, Garcia, & Solis, 1990). Lower² acculturated “Hispanics” not only tend to abstain from seeking preventive care (Loue, 2006) but also do not seek treatment after symptoms of illness appear (Larkey, Hecht, Miller, & Alatorre, 2001). Still others find mixed results (Lopez-Gonzalez, Aravena, & Hummer, 2005; Abraido-Lanza, Chao, & Florez, 2005; Carvajal, Hanson, Romero, & Coyle, 2002; Akresh, 2007; Ebin, Sneed, Morisky, Rotheram-Borus, Magnusson, & Malotte, 2001).

Another facet of the acculturation and healthcare behavior correlation is that of healthcare or medical paradigm preference in the “Hispanic” community. It has been presumed that the higher the acculturation level the tendency to seek biomedical care will increase and maybe even become the exclusive system of healthcare sought while lower levels of acculturation will tend to lead persons to seek more “traditional” treatments and explanations for illness. A biomedical paradigm interpretation of illness and or health is based on biological or physiological origins (Singer & Baer, 2007) while “traditional” or “folk” paradigms are said to adhere to certain beliefs held in a culture. For example, “Hispanic/Latino” beliefs are said to explain illness in a holistic manner in which both the spiritual and physical aspects come into play (Chavez, 2003).
The study presents cases and analysis of the complex interaction between acculturation and healthcare behaviors in the Mexican-origin community of the El Paso region. Following are several themes or key concerns with acculturation that will be focused on as the case material is analyzed.
CHAPTER 2

THEMES AND KEY CONCERNS

Accessibility and barriers faced by “Hispanics”

In searching for needed healthcare in the US the various “Hispanic” subgroups face distinct obstacles. For example, historically there have been the structural barriers that “legally”, but perhaps unconstitutionally, create impediments for those that do not have the required immigration status. Furthermore, there also exists the interpersonal friction that occurs at “ground level” as “ingroup” and “outgroup” contend for available resources in an increasingly exclusive healthcare system.

Acculturation level may be regarded as a measure or barometer when looking for factors that will affect access to mainstream resources such as formal healthcare. But will achieving a certain level of acculturation actually guarantee access to healthcare? Will the mainstream accept or welcome with open arms the healthcare seeking actions of a “foreign” group or will these attempts be met with resistance? History has shown that although there is clamor from the receiving nation for the rapid assimilation of immigrant groups it is also a fact that there exists a nativist attempt to keep these “others” from getting “too close”. Young (1991: 126) notes that when a dominant class “…defines some groups as different, as the ‘Other’, the members of these groups are imprisoned in their bodies.” Dominant discourse defines them in terms of bodily characteristics and constructs their bodies as ugly, dirty, defiled, impure, contaminated, or sick (Young, 1991). It also rationalizes and justifies their separation in geographical space (Bolin, Grineski, and Collins, 2005).

The “dominant class” cannot be necessarily limited to the non-Hispanic white community as there are some nativist-minded, supposedly higher acculturated minority group members that hold these xenophobic beliefs. The dynamics of this distancing from the perceived “other”, as mentioned, cannot be said is a straight forward “racial” or “racist” based conflict (i.e.; non Hispanic white versus “Hispanics”) as there are divisions based on other factors such as immigration and citizenship status and
also citizenship observed within the ethnically homogeneous population of El Paso county. This perceived social acceptance/receptivity and/or non-acceptance/rejection of the host society should be acknowledged as possible predictors of healthcare utilization and access.

Another factor that has been a prominent figure in the inaccessibility of needed healthcare in the El Paso Mexican-origin community is the prevalence of low income or poverty. The median household income in El Paso County is $16,000 less than the national average (US Census Bureau, 2008). The percentage of those living at or below the poverty level is above the national average, 25.2% to 13.2% respectively (US Census Bureau, 2008). This state has created an environment in which many persons in the borderland are left without one of the most important factors in the procurement of healthcare: insurance coverage. A study by Rivera et al (2009) revealed that in a representative sample 40% of the “Hispanic” population of El Paso was uninsured. This is way above the national average of 15% (Coverage Matters, 2001).

Furthermore, the inability of the receiving nation’s “native” population to relinquish some of its vital resources, in this case healthcare, to those perceived as “outsiders” creates barriers for the “outside” group when they attempt to integrate (Vila, 2000). Policies at the national level appear to “protect national resources” ensuring that these are reserved for citizens only. Immigration status has and continues to be a major barrier for many in the “Hispanic” community in accessing needed healthcare. Federal immigration policies have been put in place so as to curb the use of healthcare and other public assistance programs by the unauthorized. This predicament strongly influences the way both unauthorized and authorized “Hispanics” on the borderland seek healthcare services (Talavera, 2007; Heyman, Nuñez, & Talavera, 2009; Nuñez & Heyman, 2007).

As Jimenez (2008) documents, the tendency for nativist-minded United States-ians to categorize all “Hispanics” as belonging to the same “outside” group regardless of acculturation level, immigration status, etc. bring forward virtual “walls” that simultaneously keep “in” resources “rightfully” belonging
to those deemed as “insiders” and keep “out” all perceived foreigners; out of the country or at least away from the resources. Health care services are not the exception.

Access: social capital, social circle

The need to procure certain life necessities such as healthcare prompts the creative processes within “group” behavior in order to circumnavigate the barriers set up to negate these resources. Social networks have been documented (Talavera, 2007; Nuñez & Heyman, 2007) as being one way that the “outsider Hispanic” has utilized when negotiating a sometimes “hostile” environment in the adopted country.

“If one door is shut another will be opened,” or so goes the saying. Talavera’s (2007) field work documented the resilience exhibited by El Paso borderland “Hispanics” when access to healthcare was made inaccessible to them for a variety of reasons. After federal policies were set in place to negate certain public services to unauthorized immigrants the “group” looked within its circle to circumvent the barriers that blocked the accessibility to needed healthcare.

In theory a higher acculturation into the mainstream allows for the person to more successfully acquire the needed services including healthcare, because of knowledge and connections to the dominant system. For example, when the person lacks this acculturation level there may be someone within the “group” that will come to the aid of the “paisano” and provide the needed orientation so that the individual can enhance their healthcare-seeking endeavor.

Then again, having a lower level of acculturation to the mainstream can be said is not a detriment per se in the borderland milieu. Those that are more oriented in a “Hispanic” lifestyle may lack the cultural capital to navigate the healthcare system in the US (e.g., because of language barriers) but on the other hand may be better able to access alternative sources of healthcare such as the Mexican healthcare system across the border. The social and cultural capital that many borderland “Hispanics”
have will serve as an invaluable resource when the time comes to navigate through institutional and societal obstacles especially those impeding access to healthcare.

**Gender roles: Attitudes towards personal healthcare of men and women in the El Paso Mexican-origin community**

Another area that has garnered much attention is the influence gender has on healthcare behavior in the Mexican-origin community. Gender roles within cultural groups may promote or create distinctions in health care behaviors, beliefs, and health outcomes (Abraido-Lanza et al, 2005; Martinez, 2009; Palinkas, Pierce, Rosbrook, Pickwell, Johnson, and Bal, 1983; Lopez-Gonzalez et al, 2005; Cabassa, 2007). For example, Mullings (2006) uses the concept of the Sojourner Syndrome to bring to light instances of minority healthcare behavior and how gender figures into the picture. African American women, according to Mullings (2006), often sacrifice their own well-being in an effort to provide the best possible outcome for the entire community the way African American activist Sojourner Truth did in the past. This concept is reminiscent of *marianismo* in the Mexican-origin community.

Mexican-origin women, like their African American counterparts, take on a motherly/martyr persona to provide the avenues through which their “children” will be able to survive in a challenging environment. “Hispanic” men have, for the most part, been perceived in a not so positive light. Often they have been labeled reckless, selfish, and *macho*. Studies have contested this catchall conceptualization of the *macho* and present a more complex view (Torres, Scott, Solberg, & Carlstrom, 2002). Far from this negligent *macho* characterization and much more like the Marias and Sojourner Truths there appears to be at least a portion of “Hispanic” men that sacrifice their lives day in and day out in an effort to provide a better life for their “family” (Andrade, 1992).
It has been suggested that “Hispanic” men, especially immigrant men, tend to not seek treatment when needed, to them the concept of preventive care is at best puzzling. Medical care is seen as needed only when symptoms appear (Ramirez, Suarez, Laufman, Barroso, & Chalela, 2000). The ability to work becomes the barometer or gauge from which an illness or injury will be deemed as in need of care or not (Azevedo & Bogue, 2001). So it appears that in the life of some “Hispanic” men personal medical care either treatment or prevention takes a back seat to the needs of the “family” (Brown, 2006), which may include close friends or “compadres”. This worker or provider mentality¹ has had negative consequences in the form of illness, injuries, and even deaths (Brown, 2006).

It is safe to say that factors affecting “Hispanic” healthcare are very complex and that to solely characterize it as simply one thing or another would be simplistic and misrepresented at best and an ethnocentric explanation at worst. For example, the “Hispanic” “starting point” cannot be reduced to a “simple traditional” label and the “ending point” likewise cannot be assumed to be a “formal biomedical” more “American” state. In a complex pluralistic society multiple medical/healthcare systems abound and those persons living in such an environment will make use of many of the available resources by choosing care from several and at times by synthesizing paradigms.

“Hispanic” healthcare characteristics: A “starting point” towards an “end point”

Should we use a pan-ethnic label such as “Hispanic” to categorize such a diverse heterogeneous population? The “group” may in fact be more apt to be called or categorized as a multi-subcultural “mass” with complex, diverse inner behavioral dynamics. For instance, the ethnic-Mexican population in the US cannot be simplistically characterized as “Mexican” as Jimenez (2008) points out. This group is composed of various “subgroups” including immigrants, second-generation individuals, and later-generation descendants of earlier immigrants. Furthermore, the acculturation process, especially in a border environment, occurs within a constant influence of cultural replenishment (Jimenez, 2008) both
in the long-term demographic sense and in the daily transnational interaction/exchange that occurs between borderland communities such as is the case in the El Paso/Ciudad Juárez region (Martinez, 1998; Vila, 2000; Heyman, 2004).

So what is the starting point or what are “traditional” “Hispanics” and where are they heading? Even attempting to conceptualize a “starting base point” and “end point” on this “healthcare continuum” may not be possible or at least not be easily accomplished. To characterize a starting point for “Hispanic” healthcare behavior is at best a daunting task and at worst impossible. What is “Hispanic” healthcare behavior? The question may have as many answers as there are respondents. For that matter what is “American” health care behavior? Again to characterize “American” healthcare as solely biomedical would be simplistic. Are “Hispanics” transitioning into a fully “American” model, whatever that is, or is this group creating (or adapting to) a “hybrid” healthcare behavioral model that manifests itself in distinct forms depending on contextual factors?

Another issue to consider is the very makeup of the sending society itself. For example, how does one characterize “Mexican” healthcare behavior? The Mexican society is as diverse and in a similar constant state of flux as the receiving society in the US so to attempt to give this group a “baseline” label again would fall short in defining such a complex social process. Complexity at both “ends”, which I call a contextual, temporal instant on the continual fluctuating process, in my view, prohibits an actual “starting” or “end” point.

**Transnationalism: binational healthcare consumption**

It is a fact that there exists a massive daily back and forth movement of humanity between the cities of El Paso, Texas and Ciudad Juárez, Chihuahua, Mexico. There is an impressive amount of social and cultural exchange consistently occurring as well as an economic impact in the form of sale and purchase of goods and services by binational consumers from both sides of the border. Healthcare
needs such as treatment and medication are some of the services and products that persons in either
country make use of both in their system and that of the bordering nation (Rivera, Ortiz, & Cardenas,
2009; Talavera, 2007; Heyman, Nuñez, & Talavera, 2009).

How a person’s acculturation level will affect the utilization of healthcare services on the
Mexican side particularly by those “Hispanics” living in El Paso is an area that needs more research. As
immigration policies and policing has increased along the border both authorized and unauthorized
“Hispanics” have been affected in the way that a once (and still) viable source for healthcare acquisition
is undertaken. This study will look at the actions, taking into consideration peoples’ acculturation state,
some El Paso “Hispanics” take on the ground in accessing healthcare in Mexico in order to clarify this
transnational phenomenon.
CHAPTER 3

HYPOTHESES OR POSSIBLE FINDINGS

What did I expect to find in the case study material? The complexity that characterizes the interaction between acculturation and healthcare behavior prohibits a simple explanation. Several layers of the cultural or traditional beliefs and healthcare behaviors would still be there but the effect these have on actual healthcare seeking actions are not limited or expanded by acculturation level alone. “Hispanic” individuals will exhibit the same health-seeking patterns of the so-called “American” mainstream: that of the utilization of a mixture of healthcare paradigms and treatment and preventive options. Moreover, it should be kept in mind that this mix more than likely has its own characteristics depending on the distinct factors that influence individuals and groups alike.

Gender factors I propose would play a significant role in the way that “Hispanics” choose to seek or not seek treatment or preventive measures. Studies have shown that acculturation as a factor in healthcare behavior and outcomes in the “Hispanic” community will tend to be different for men and women. When acculturation level is similar in “Hispanic” men and women, just as has been seen in other studies, men will tend not to seek care as often as women and not because of the “macho”-I-am-invincible-persona but because of the provider/caballero attitude some “Hispanic” men have which is to provide for the family no matter what their personal health status is.

The “starting point” and/or the base “Hispanic” stage from where characteristic behaviors will stem are fluid. There is so much diversity within the “Hispanic” community, so much generational variation, and so much distinction even within generations of immigrant and long time US “Hispanic” residents that exact points are not easy to find. Furthermore, one can add to this the utilization and integration of the many kinds of healthcare paradigms that it would be a disservice to say that because a person has a certain “level” of acculturation then it is more likely that their healthcare belief system consists of a certain paradigm (e.g.; strictly biomedical or a mixture of biomedical and traditional).
Wherever the person may be on the acculturation continuum in conjunction with other factors may influence what kind of care he or she will use but again the utilization will be complex. In group dynamics it would be convenient to infer that as a group becomes more like the mainstream the tendency would be to become more like it in behavioral preference especially when seeking healthcare but once again what would that mainstream behavior be. I suggest that there is no “Hispanic” starting point and that what is being seen as the group becomes more “American” is the expansion of an integrative healthcare paradigm where the mix of different systems is used by them.

In the matter of access and barriers to needed healthcare my proposition is that in general those “Hispanics” that hold a higher acculturation level will be better able to access these resources than those at a lower acculturation. Looking at acculturation as a level of acquired cultural capital, the more capital acquired the more able one is to negotiate the environment. Moreover, those “Hispanics” that have lower acculturation will circumvent these barriers and enhance their accessibility through the help of their social circle or social capital. Furthermore, those “Hispanics” with the financial means no matter their level of acculturation will have more access to the healthcare system of their choice in either Mexico or the United States.

Transnationalism in relation to healthcare utilization in a border context particularly on the El Paso/Ciudad Juárez biosphere demonstrates that there is a constant international consumption of services by both Mexicans and United Statesians on the opposite side of the river. Those Mexicans that can access the care available in the US will many times do so in search of a cure for the malady and then there are those Americans that will seek care in Mexico because of affordability/financial benefits (bargain healthcare) or just because “it’s there”.

It is my hypothesis that the more acculturated “Hispanics” with the financial means especially those that have healthcare insurance coverage will not seek care in the Mexican system opting to get treatment in the US healthcare system because they feel comfortable navigating in it, because of a sense
that the US system is “better”, and because they would have trouble navigating a system they know little about in Mexico. Those “Hispanics” although with a relatively high acculturation level but without the financial means to access the US healthcare system will look to other alternative sources of care especially those in the more affordable Mexican system. Those with lower acculturation levels will either seek care in the US or in Mexico depending on their financial status and the knowledge of the dynamics of the systems that their social circle has.
CHAPTER 4

METHODOLOGY

The survey was conducted by the Hispanic Health Disparities Research Center (HHDRC) a joint research study by the University of Texas at El Paso and the U T School of Public Health at Houston. The HHDRC study utilized the methodology used in the ARCH asthma study and the Encuentros lead contamination study conducted in El Paso County that included both urban and rural areas. The ARCH-Encuentros projects produced detailed maps of soil pollution and other toxins; the projects shared a common data base of El Paso County.

The entire county was broken down into 50 strata composed of roughly 20,000 inhabitants each; these strata were then broken down into individual blocks. Ten blocks were randomly selected from each strata and assigned arbitrary numbers. Two of the selected blocks in each stratum were randomly selected for participating in an in-depth survey and in home dust collection; the other eight blocks served as collection sites for soil samples.

The HHDRC study used the same randomly selected blocks to draw the study sample. The study sample consisted of 1000 households or 20 households from each stratum. Using the arbitrary numbers assigned to each block they were subsequently given priority numbers from 1 through 10; 1 being the first priority and 10 being the last. This was done in two stages, the two ARCH-Encuentro blocks where the in-depth surveys were done were randomly assigned using an online random number generator with a 1 or a 2 meaning that these were the priority blocks where the selection of the 20 households from the strata would begin. The remaining eight were also prioritized from 3 through 10 using the same online random number generator. These last eight blocks served as the supplemental frame from which other households would be selected if the needed 20 household surveys were not collected from the priority blocks.
The actual participants had to meet certain requirements to participate in the study these included 1) to be at least 18 years of age, 2) to self-identify as “Hispanic”, and 3) be the person in the household who met the first two requirements and be the one whose birthday was the closest to the survey date. The last requirement was not followed to the letter as many times the person celebrating a birthday closest to the survey date did not want to participate so anyone meeting the first two requirements willing to take the survey was selected. Surveys lasted between 30 minutes and 1 hour in one session. The participants were given a one-time compensation of a 30 dollar gift certificate to a national chain store. Approximately every third participant was asked to answer an additional open-ended questionnaire dealing with medical pathways in which they were asked about past experiences with the healthcare system. Those selected for this additional pathway section were compensated with a 10 dollar gift card to the same store. The actual selection of the household did not follow any particular protocol as the surveyors went door-to-door looking for participants.

The HHDRC study produced 1003 total surveys from the “Hispanic” community in El Paso County. I sat in on 37 of these surveys. The 37 cases in this study were taken in a semi-random fashion; I collected the data by following surveyors from the HHDRC study in no particular order or preference. The 37 cases were categorized or coded into the proposed themes Gender, Access and Barriers, Starting Point and End Point, and Transnationalism. The cases were given the appropriate label depending on the issue or context each most strongly presented. After much consideration, and heartache I must add, those cases that did not fully capture the aforementioned themes were discarded leaving a total of 6 cases to be analyzed at a deeper level. Personal information in the cases utilized was altered, including names and employment type.

The concept of acculturation, as was presented in the literature, has for the most part not been fully deciphered or has not been defined in a consensual manner so no “solid” attempt has been made to do so in this study. The approach chosen is to present examples or observational behavior which could
somehow give a sense of the concept in action as it plays a factor in the healthcare decisions taken by El Paso region “Hispanics” and in particular those of Mexican-origin. The “fuzzy” nature of the factor in question could be better “defined” using examples than to try and bring forward a catchall proposal that in the long run would fall short as many other similar attempts have done. At the end, I will propose or suggest areas in the study of acculturation and its influence on El Paso “Hispanic” healthcare in need of further elucidation both using data from the El Paso survey and in other future work.
CHAPTER 5

A COMPLEX ISSUE: ACCULTURATION, GENDER, AND
THE CULTURAL “STARTING” POINTS

In attempting to disentangle such a complexity-laden correlation as is acculturation and healthcare behavior it is best to keep in mind the various factors that affect such a relationship. For instance, when speaking of “Hispanic” healthcare behavior research has shown that gender plays a big part in the health-seeking actions taken on by both men and women. Health outcomes are also affected differently depending if one is a “Hispanic” male or a “Hispanic” female.

Moreover, distinguishing between what is more “traditional”/”Hispanic” and what is more mainstream/ “American” is filled with oversimplifications. The starting points, "Mexico" and "Mexican culture," cannot simply be assumed to be all “traditional”, with no exposure to biomedical or "new age" practices. Likewise, the end point, a relatively acculturated person's health culture, cannot be assumed to be purely biomedical. In this section, I will examine the more complicated reality of starting points of health culture in several life histories, and in a later section will examine variations in ending points.

Acculturation and gender appear to have an interacting influence in the way “Hispanic” men and women interpret health and illness, in the way they seek healthcare, and even in the way that a certain episode is dealt with or not. “Hispanic” men, especially less acculturated “Hispanic” men, have been portrayed as being of the macho type who seek to fulfill their needs through self-promoting actions. In the area of healthcare it has been assumed that the “Hispanic” man does not seek needed care because of the macho personality. It could appear that these men will be reckless with their health because they want to prove their manhood but as has been documented by some researchers (Saez, Casado, & Wade, 2009) the macho phenomenon is not “traditional” selfishness (Torres et al, 2002). There exists the possibility that this “macho” behavior is due to a deep sense of personal pride that may be deep rooted in cultural gender expectations in which the man is supposed to be the protector and provider of the family
(Sobralske, 2006). In fact it has been hypothesized that there are many reasons within the realm of *machismo* that lead “Hispanic” men to not seek care including putting the well being of others before the needs of the self.

“Hispanic” women, on the other hand, have been portrayed as motherly and martyr-like. This conceptualization carries the religious or spiritual connotations associated with the Virgin Mary or *La Virgen de Guadalupe* both being the one and same symbol for the mother of Christ hence the name given to this cultural personality trait *marianismo*. Again this concept is said to be characteristic of those “Hispanics” that have lower acculturation levels. It could be suggested that as acculturation levels rise this “motherly” persona is lost as the person takes on the more “American” individualistic personal traits. The “Hispanic” woman with a more traditional, less acculturated state will put her family’s, especially her children’s, healthcare needs ahead of hers even when symptoms have become of concern.

The following cases have been selected to provide a deeper look into the dynamics of how gender and the concepts of *machismo, caballerismo*, and *marianismo* may influence healthcare behavior in the “Hispanic” community. In them I will address male and female gender roles as they affect healthcare behaviors and beliefs. Furthermore, these cases will also serve to question the “traditional”/“Hispanic” to “modern”/“American” linear model detailing the complex starting point of acculturation processes. What do people, with strongly Mexican roots (e.g., immigrants to the United States) actually begin with in earlier periods of their life histories? The actual “ground level” healthcare behaviors exhibited by the borderland’s “Hispanic” community are sometimes quite distinct and at other times exactly like what has at times been presumed. The complexity and diversity observed paints a colorful picture.

**“Hispanic” men**

Saturday, October 10, 2009.
This home we had visited earlier in the afternoon. A lady had answered and had said that they would be interested in taking part in the study but that at the moment her husband was not at home and that only he was the one that could answer our survey. A few hours later we return to the home and knock on the door. This time a well-dressed man sipping on a soda answers the door. He appears to have already been waiting for us, as he invites us in. Something catches my attention right away he speaks very proper Spanish unlike what we have heard in other interviews this person sounds like he has had formal education in the language.

We step inside following the participant. The home is very well furnished; the floors are covered in nice shiny tile, pink and beige in color. There is a chimney and leather sofas in the living room, a new HD television, and an elegant glass coffee table that add to the impeccable setting. In the next room, the kitchen, there is a china cabinet with what looks like real chinaware. We move into this next room and sit in the solid wood chairs. Why so much attention to this? In prior observation it appears that a somewhat telltale sign of how well a household is doing is by the way the home is furnished and how well it is constructed. The lady that earlier had answered the door joins us at the table and sits next to her husband. She offers us some water, we accept. “¡Está haciendo calor verdad?, ("It’s hot isn’t it?") the man asks rhetorically. “¿Gustan que ponga el aire acondicionado?, (“Would you like me to turn on the air conditioning?”) he continues. “No así está bien,” (“No, it’s fine”) the interviewer and I answer in unison.

The participant is 42 year-old Mauricio Rojas, a native of Mexico. He grew up just across the river in Ciudad Juárez and 12 years ago in 1997 he decided to move his family to the US in search of better opportunities for his two children, Josefina and Mauricio Jr. Mauricio’s wife is also a Mexican national but has now become an authorized resident of the US. Since coming to El Paso the participant has become a naturalized US citizen.
My initial inference on the participant’s Spanish language fluency was confirmed when he said that all his formal schooling was completed in Mexico. Mauricio achieved a preparatoria education, which is the equivalent of a high school diploma in the US. As would be expected the primary language spoken in the home is Spanish but as can also be expected in a highly bicultural/bilingual environment as is the US-Mexico border there exists lingual usage differentiation among the generations, “Nosotros hablamos solo español pero los niños entre ellos se hablan en inglés.” (“We [the adults] solely speak [communicate] in Spanish but the children amongst themselves speak [communicate] in English.”)

Slowly the acculturation process has begun to seep deeper into the Rojas household as Mauricio explains that one of the required skills in his line of work, which necessitates a constant back and forth daily commute between the twin cities of El Paso and Ciudad Juárez, is to be bilingual to communicate effectively with a binational consumer base, “Tengo clientes aqui y alla” (“I have customers here and there”) referring to having both English and Spanish speaking clients in the US and in Mexico. Another indicative behavior of the move towards becoming more “American” or of the acculturation process making its presence known is Mauricio’s acknowledgement that he has almost unconsciously picked up on the border lingo, Spanglish. With a big smile on his face he answered the Spanglish usage question, “Si, claro, ocasionalmente si en el trabajo si lo hablo” (“Yes, certainly, occasionally yes at work I do speak it”). Spanglish can be said is an indicator of the gradual or even rapid transition (or synthesizing of languages) from Spanish to English (or vice-versa) usage in the “Hispanic” community. A further indicator of the gradual “move” to the mainstream culture or better yet of the incorporation of mainstream popular culture is the family’s media (i.e.; radio and television) intake being a combination, according to Mauricio an equal or balanced combination, of both Spanish media from Mexico and English media from the United States.

It has been presumed that one of the perks of becoming more acculturated or assimilated into a receiving society is that of achieving betterment in a financial sense; that is a higher income. The Rojas
household has an approximate yearly income between $40 and $50 thousand which in the El Paso region would be considered relatively well off. This current state in the family’s financial situation cannot be readily attributed to a higher acculturation but more than likely to the participant’s biculturality. It could be inferred that having a relatively high income would seemingly allow for access to needed healthcare, especially the procurement of healthcare insurance in the US, but this has not been the case for the participant.

Access to healthcare

As mentioned, Mauricio works in “a good-paying” binational employment but even with the income generated by this employment he says he cannot afford to purchase healthcare insurance; he adds that this has been the case for at least the past year. Although he says that cost has not been a barrier for him when seeking needed healthcare, his actions speak otherwise.

The participant says that he makes no use of the US medical system because of the high cost and his non-insured status so he resorts to crossing into Mexico to seek affordable healthcare. Mauricio also gets his medication in Mexico for the same reason he gets other healthcare treatments there; the lower cost enables him to pay for his healthcare and medication out of pocket. One of the untold factors that comes into play here in the participant’s choice to seek care in Ciudad Juárez is his trust in the Mexican system. Growing up his parents took him to the Instituto Mexicano del Seguro Social (IMSS) doctors only and never made use of traditional healthcare practices. So in effect not only is the cost affordable but Mauricio was also socialized into the Mexican healthcare/medical system; these are strong reasons why he opts to seek care in Ciudad Juárez. The only reason he would ever seek care in the US would be in case of an emergency.

At this particular moment Mauricio is dealing with constant spells of migraine headaches that have become so unbearable that have lead him to seek healthcare. In order to treat this illness he has
decided to seek care in Ciudad Juárez again for certain reasons, care in the US is “unaffordable”, he has no healthcare insurance coverage, and he feels comfortable with the Mexican healthcare system.

The doctor he sees in Ciudad Juárez has told him the headaches stem from elevated levels of stress. He has been told that the high stress is due to his daily commute from his home in El Paso to his work in Ciudad Juárez a community that at the moment is under a constant barrage of violence. The treatment Mauricio is currently under is not of the biomedical kind. The Mexican doctor he is seeing has prescribed him a natural/homeopathic medication regimen based on concentrated caffeine. This is sort of a break from his medical socialization as he had mentioned that growing up his parents would make use of mostly or only biomedical care (i.e.; IMSS care) when he fell ill. Mauricio’s choice to seek care from an alternative/new age healthcare provider also puts the “traditional” Mexican “baseline” into question. Not all Mexicans or less acculturated “Hispanics” seek “traditional” healthcare; the healthcare services available and sought out in the “home” country are as diverse as are the ones available in the adopted land.

This current malady was not deemed as in need of care until, as mentioned, the symptoms became too strong to ignore or work through. “Hasta que me dio bien fuerte el dolor de cabeza entonces fui a Juárez.” (“It was not until the headache became unbearable then I went to [seek care in] Juárez.”) During these visits to the doctor in Ciudad Juárez Mauricio received several tests including blood pressure, cholesterol, and blood sugar level. These tests are not preventive since he only went after symptoms became severe enough to keep him from working. A very interesting observation was made during this interview there appears to be a social difference in the way the participant and US society interpret certain social and health/healthcare issues such as access:

“Si mi empleo ofreciera seguro de salud o si el costo médico fuera accesible aquí en Estados Unidos no fuera necesario ir a México a buscar cuidado médico. El salario en Estados Unidos es sobrevaluado por eso las compañías se van a otros lados. Así podemos comprar todo más barato por eso
se van a donde el sueldo es más bajo. Si el salario aumenta los precios también se incrementan. En México el salario aumenta cada año pero todas las cosas cuestan mucho más. Por ejemplo yo gano un buen salario y no puedo comprar seguro.” (“If my job offered healthcare insurance or if the cost of healthcare was accessible here in the United States it would not be necessary to seek medical care in Mexico. The wages are overvalued in the United States that is why companies go abroad. We can purchase things at a cheaper price because they go where the wages are lower. If salaries are increased the price of products and services also increase. In Mexico salaries increase every year but everything also becomes more expensive. For example, I make a good salary but I cannot afford [healthcare] insurance.”) In this he is not alone.

“Hispanic” women

Thursday June 11, 2009

The household is situated in the central area of El Paso in a neighborhood that, judging from home exteriors, appears to be of working to middle class status. The home itself is modest in appearance, red brick not unlike the color and style of old schoolhouses. The front yard is not kept up, and the grass is dry. No landscaping has been done in some time. There is a full-size conversion van grey in color that appears to be in working condition resting in the yard on the west side of the property. The participant meets us at the front door; she unties a string that apparently is the “lock” to the home.

Inside the modest household is furnished with old but clean furnishings; a set of flowered sofas, an old computer those with the big box TV set-like monitor rests in the living room, and a mattress lays up against the south wall of the room. Pictures of the children are situated throughout the room; each of these is garnished by religious figurines. This room probably serves as sleeping quarters for someone or some people and is now put up for the day later to be set as a bed. The wood floors appear to be the
original ones installed when the home was built as they are scraped and rough showing years of use and
the inability to maintain them in good condition.

The participant is Celestina Márquez born in Ciudad Juárez in 1977 but who has lived in the US
since she was 5 years of age. Celestina says she has been in El Paso since 1995; it appears that she came
to live in the Sun City at a young age but then moved to another area within the US and later in life
returned to the border region. The participant is an authorized US resident and the only thing that is
keeping her from becoming a US citizen are financial reasons: “No, I am not a US citizen”, she responds
with a giggle/laugh, “You need money to become a US citizen.”

At the moment there are 7 members in the household, which include the participant and her 6
young children ranging in ages from 13 to 1 ½ years old. Celestina says that she has divorced from the
children’s father and that although he helps financially the only people helping her raise the children are
her immediate family and the people with whom she attends church. Inferring from her dress this lady
appears to be a highly religious individual. The way she chooses to wardrobe herself is not unlike that
of the born again Christians opting to wear long skirt, long-sleeved blouse, colored in conservative hues,
nothing extravagant. She often makes references to her fictive, religious kin as “brothers and sisters”
further giving credence to this spiritual side of her life. Celestina proudly announces that she has named
all her children with biblical names. Curiously though when later speaking of her health difficulties she
never made reference to a spiritual or religious factor or connection; it is as though there is the spiritual
side of her life and then there is the physical side where health is more of a practical, biological facet
something to be dealt with here in the physical world with physical (monetary) means not through
spiritual tactics.

In the middle of the interview a young boy walked indoors playing with some stringed-toy,
perhaps a small car or truck. As he stepped inside he gallantly pulled this toy behind him leaving the
door wide open. His mother in a half lazy tone promptly scolded him, “Andale close the door bien.” A
sudden but normal reaction brings forth the common, everyday speech patterns. The entire interview has been conducted in English maybe as a lingua franca or as a respectful gesture towards “professionals”. The participant has used the language throughout but as soon as the need to communicate “normally” Spanglish takes over automatically. Celestina’s lexical level may have come across as limited but this “limitation” may be misleading to those not quite aware of the way biculturality or bilingualism is expressed in the real world especially in a biosphere where a polycultural being is the norm.

By the way she communicated with us and by the way she fully understood the questions asked during the session it could be inferred that Celestina learned or was exposed to not just the English language but Spanish since her formative years. She had received all of her schooling in the United States since she arrived as a young girl but at the same time “schooling” in the “native” language, albeit not the “formal” structured form, was being transmitted in the home by her family members. It could be said that although Celestina did not finish her high school education dropping out after reaching 11th grade, this cannot be construed as a failure in receiving an effective education. Why? The overall learning process was not limited to a “formal” mainstream education the “curriculum” learned in the home from “traditional native” teachers enabled her to understand what was needed to navigate a world filled with limitations. Celestina went on to get her GED and a vocational training this was achieved using both the education she got from the “formal” educational system and the “training” she received from the “experienced native” people around her.

Times have not been optimal so at the moment Celestina is not employed and her only income is the one she gets from her children’s father. The finances are relatively low, but many in the borderland have lower incomes. The participant calculates that her total household income is between $10,000 and $15,000 per year. This income is supplemented by public assistance including a Lone Star card (“food stamps”) and since this puts her in a certain income bracket this allows for her children to be insured
through Medicaid. Although she herself is uninsured, what gives Celestina some peace of mind is that her children are covered by this “government-funded program”. This does in no way diminish the mounting fears and frustrations Celestina feels day after day. Funding for many things including formal healthcare cause much stress for the participant as she solemnly reminds herself, “It is always about the cost.” It appears, she says, that she is working miracles making the limited income stretch; she is paying for a vehicle, probably the van parked to the side of the house, her mortgage, utility bills, and for “things the children need”.

**Access to healthcare: “It is always about the cost, always about money.”**

Celestina is looking up at the ceiling. Her young daughter is sitting on her lap. A look of defeat masks this young woman’s face. “Are you eligible for insurance Mrs. Marquez?”, the interviewer asks softly. The question seems to have a dual offensive/comedic effect on the participant. Celestina looks down from the “rafters” and answers, “Well I may be eligible but I can’t afford it.” A faint smile can be perceived as she says this but then the solemn look returns. “Even if they would offer me to pay in payments or even if I only had to pay a percentage for a doctor’s appointment I need to use the money for my kids.” The question takes on the form of a jest as in the participant’s mind it is bound by the naïveté of a system, which includes us, that does not really understand “ground level” realities. There have been times when Celestina has had to do without needed healthcare, for example, she has not followed on doctors’ recommendations to seek further testing and treatment because of lack of funds, “It is always the cost”. “I can’t afford to go. It is hard to go places here when you can’t pay.”

One of the alternatives that are consistently sought along the US-Mexico border by both “Hispanics” and non-Hispanics alike is to seek healthcare in bordering Mexican cities. This is certainly the case in the El Paso/Ciudad Juárez borderland. Our participant is one of hundreds if not thousands of
binational healthcare consumers that make use of these services. The Mexican healthcare system not
only is affordable she says it is also familiar and in her mind it is also trustworthy and effective: “I have
confidence in it”, she says with a serious look. The young child has moved from her mother’s lap and
begun to toy with some papers on the floor.

Celestina says that when she has gone to see her Mexican doctor she has either driven herself
there or has had a family member give her “a ride to the bridge” where she walks across to the doctor’s
office. The cost she must pay out of pocket has not been a problem, “it is not a problem to pay $25 per
visit”, that is if she does not have to do it several times per month. She could probably pay once a
month but not more.

“That is what I usually pay for a visit to the doctor in Juárez but like I told you only once in a
while not often I need the money for my kids, to buy them things. I can pay for the doctor’s visit but
let’s say he recommends medication and I have to go to the pharmacy then it is a problem, I have to pay
more.” Celestina then has several recollections of when she has had to do without needed medication
because she cannot pay for it.

It is a given that travel into Ciudad Juárez is a permanent part of her life. While speaking with
many other participants throughout the region the current state of violence in Ciudad Juárez came to the
forefront time and time again. This volatile situation has drastically changed the way binational
borderlanders seek to make use of their environment. Binational borderlanders have a consumer sense
that is not limited or fully influenced by the existence of a state boundary between El Paso and Ciudad
Juárez. It appears that to these individuals or groups of individuals the available resources, services,
markets, social activities, and individual opportunities are there for consumption no matter on which
side of the border they are found.

Celestina, perhaps because of her current financial or familial state, is one of these binational
consumers especially when it comes to the issue of healthcare. When asked if she sought care in
Mexico there was not even mention of the violence in Ciudad Juárez that for others is a barrier. She needs to go there and the things that loom large for others to her do not even merit a second thought; it is as if the cartel wars are not even occurring. It could be said that the personal problems she is dealing with are larger than the ills society is going through. I was going to ask her if she saw the violence in Ciudad Juárez as a barrier in seeking needed healthcare in Mexico but the fact that she did not even mention it was all the answer I needed.

Recently Celestina has been plagued by various health issues the one most pressing is a thyroid problem that was diagnosed by a Ciudad Juárez doctor. The medication she is taking for this affliction she buys in Ciudad Juárez at an “affordable price.” She says she had been feeling very tired and getting heart palpitations when she went to see a “naturista” doctor. Dr. Yoshida, the “naturista”, has a somewhat peculiar diagnostic method. According to our participant, the doctor will look into the patients’ eyes and by the condition of the iris or retina he can tell what is medically wrong with them. This is reminiscent of the curandero in “Hispanic” “folk” medicine but it is an alternative or new age approach, not a “traditional” one. Again this is an example of a break from the traditional conceptualization of the lower acculturated “Hispanic”.

Dr. Yoshida was the one that said she had a thyroid problem so he recommended she take “algas marin as” (seaweed) in powdered form, which would then be mixed with water and consumed. She says she did not believe him at first thinking it was somewhat “weird” that by looking at one’s eyes a sickness could be diagnosed. He had told her she needed to take several medications that he would sell her. Failing to do so he had told her would either affect or damage other vital organs and that if left untreated she could even develop diabetes. Feeling a little uneasy Celestina opted to get a second opinion at great monetary sacrifice and she went to the “real” doctor in Ciudad Juárez to see what was wrong.
“After they got the blood and got the tests then he [second doctor] said there was something wrong with my thyroid. I was surprised the first doctor was right about what was wrong.” She continued taking the “algas marinas” because of the inexpensive costs but when she saw they were not helping then she sought biomedical medication. “Maybe if I had believed him from the start they would have helped but I did not really think that what he was saying was true then I did not follow his instructions or got all the other natural medications he prescribed.” It is good to note here that Celestina is not totally isolated from the formal system; even though she gets healthcare treatment primarily in Mexico this care is of the biomedical kind.

Although she has resorted to seeking care in the Mexican healthcare system because of the financial factors there have been times when Celestina did get help here in the US. For instance, she took part in a program called Matria Healthcare. She was pregnant with her youngest child and the pregnancy was of high risk and a Dr. Tomasino in El Paso referred her to this program based in New Mexico. Celestina had gotten early contractions and had to call the ambulance and was charged $600 to go to the hospital. The ailment relegated her to mandatory bed rest so the option of the Mexican healthcare system was out of the question.

At this juncture it is important to bring up the participant’s sense of responsibility; even though she was and is going through a tough financial situation she made payment arrangements and paid back $10 a month until she cleared the balance. “Now I know I paid them and I feel good calling them [emergency units] if I need them again knowing I paid them for the last time they came to take me.”

She says it is very important to take her medication and that the only ones she does follow through are the doctor-recommended ones. The only time she has stopped taking her medication was when, “I could not afford it.” Most if not all medication for her is purchased in a Ciudad Juárez pharmacy and only bought in the US when US doctors recommended it. Testing or preventive testing appears to be done only when other “more pressing” healthcare issues are at hand. For example, when
asked about her last check up Celestina said it had been about 1½ years ago. At around the same time she got a pap smear and had her cholesterol level checked. These tests coincide with the birth of her youngest child so it appears that the tests were probably done then. Furthermore, she has never had a health professional examine her breasts; although she does perform a self exam once a month. Preventive care takes a back seat to present matters.

As we proceed there is one theme that recurs throughout the interview: the cost of life in general but more specifically the cost of healthcare. “It is always about the cost. It is always about the cost,” the beaten young woman repeats often. “In Mexico I never feel afraid to seek care because of cost but here in the US, yes, I feel afraid to go because I can’t pay. If they send me to a doctor and he charges $60 then I can’t go. I need to use the money for the kids.”

The roar of a car engine breaks an instance of silence. The one thing that looms large and is a cause of much angst in Celestina’s mind, as Talavera (2007) found in his research, is the large medical debt accrued in the US that has been accumulating for the household. Emergencies have forced the participant to seek care in El Paso. When asked how much the debt was the participant answered in a perceivable, embarrassment-filled voice, “I am not sure I am just barely viewing the bills. I don’t know when I went to the emergency room. Last time it was $14,000 so I don’t know for sure.” As she looked to the floor she continued, “I think for the Providence hospital visit it is around $68,000.”

Unlike what has been propagated in many news outlets this immigrant does see it as her responsibility to pay this debt. It appears that at any moment the tears will flow from her eyes as she says she is “very worried” over her inability to pay this balance. “It is very expensive and they do not understand. You see I called to make arrangements but they said they wanted everything at once or that I had to send $50 dollars here, $80 dollars there, and another $50 here and so on. I told them I can’t pay $400 a month I am a single mother. The most I can give you is $50 a month total and I can pay you even if it takes for ever. I can pay like I paid the ambulance $10 a month but they said no that they
could not take $50 a month. That was a couple of years ago and I could have been paying them since then that would have been better than nothing but they could not understand. Now all this is still on my credit. Now I am two months behind on my mortgage but I am still making payments even though I am behind. You see I am responsible and I want to pay but hospitals are not compassionate and they do not understand how one lives, they need to see that and be understanding. If they can make good arrangements that would help [people in similar situations]; maybe like I say $50 a month payments would be better than nothing.”

The interviewer hands her the gift card, “Thank you with this I can get my kids something to eat and buy detergent so I can do the laundry, thank you very much.” A fleeting smile jokes with her and then reality beckons. It appears that the interviewer has just swallowed the knot in his throat. He looks away. There is no need to hide this; I just swallowed the knot in my throat as well.

**Discussion**

In the first case dealing with the Rojas family and specifically with Mauricio there appears to exist a sense of male *marianismo* or what has been called *caballerismo*. Just as has been posited by Torres, Scott, Solberg, & Carlstrom (2002) the traditional concept of the *macho* does in no way detail the complexity of the definition of “malehood” within the “Hispanic” community. There are “Hispanic” men, as can also be found in other cultures, that may be labeled as “reckless, selfish, and *macho*” but then again there are those that can be said are at the other extreme where the self takes a back seat to the needs of the family (Sobralske, 2006).

Mauricio has come, to a certain extent, to neglect his health in order to keep working in a job which, according to his medical provider, is the cause of his malady. And even when symptoms appeared the participant put off seeking healthcare for several reasons including his inability to secure healthcare insurance coverage. But what jumps out even more than Mauricio’s non-coverage is that an
alternative source of affordable care is available for this binational consumer: the Mexican healthcare system which he consciously chose not to visit.

Mauricio’s knowledge of the Mexican healthcare system, a system he was socialized into, even with the US system being inaccessible, would have allowed him to seek the needed care when symptoms first appeared. Although healthcare in the US according to the participant is “unaffordable”, the care available in Ciudad Juárez which he can pay “en efectivo” (“pay out of pocket”) was not sought out either. As mentioned, the participant kept on working and dealing with the migraines until they became just too unbearable to continue working.

So how would acculturation level come into play? Mauricio has spent his entire life living along the US-Mexico border. The participant is in the process or has been exposed to the process of acculturation throughout his entire life. He speaks both languages, Spanish and English, and his bicultural upbringing provides a feeling of comfort living as he works on both sides of the border engaging in social situations which require both “American” and “Hispanic” cultural capital. Mauricio’s level of acculturation is more “Hispanic” since his socialization has been primarily in the Mexican environment; but in health matters his upbringing socialized him into a biomedical paradigm.

The participant says he has had some tests done a trait characteristic of higher acculturated individuals but Mauricio did not seek to get these tests done as preventive measures but as diagnostic to unravel what was causing his severe headaches. The severity was gauged using the ability to work as a barometer so when the pain became “muy fuerte” (“too strong [unbearable]”) that is when he decided to go. The caballerismo exhibited here is consistent with some of the propositions concerned with “Hispanic” men’s health¹. But even when this may give support for the less acculturated “Hispanic” healthcare belief paradigm this is only one facet of this individual’s healthcare behavior.

Exactly how acculturation is influencing the participant’s behavior cannot be easily deciphered. Mauricio follows what has been postulated as the tendency of the lower acculturated “Hispanic” male
tendency to not seek preventive and curative healthcare. What makes this case complex is the fact that Mauricio does not appear to be following the neat or simple move from less to more acculturated paradigm or the move from “traditional” to the more mainstream biomedical paradigm. The participant, as mentioned, was socialized into the biomedical system in his home country of Mexico as his parents opted to seek care in the Mexican biomedical system exclusively. In fact it appears that Mauricio is moving or living in between cultures or better yet combining both cultures into one biosphere that includes two national systems of biomedical healthcare. As Martinez (1998) would say Mauricio is a truly binational, bicultural individual.

So Mauricio, although not highly acculturated, has educational background and socialization into the biomedical system and this should provide knowledge so he can navigate a biomedical healthcare system. The fact that he shows traits characteristic of a less acculturated “Hispanic” when he withholds from healthcare until he can no longer work Mauricio cannot be readily described as thoroughly a more “traditional” “Hispanic” in the healthcare behavioral sense because like mentioned there are other facets in his healthcare seeking actions that have a more formal, biomedical characteristic such as his choice to seek care primarily in the biomedical system. The intersection of what is more “Hispanic” and what is more “American” is ambiguous in this case. Where does one draw the line? The mere reality that he seeks care in a “biomedical/alternative” Mexican healthcare institution because he cannot afford to get care in his adopted home country puts all these suppositions on their head. As Mauricio said, if the access was there he would not have to resort to care outside of the US so it can be inferred then that if Mauricio had the means he would access needed healthcare exclusively in the US biomedical system.

Adding to this confusion may be the fact that there may be a socialization friction here. In Mexico healthcare treatment is available to everyone at low or no cost while in the US one has to buy healthcare insurance once one reaches a certain level of income. With his relatively prosperous income Mauricio could in theory purchase insurance but coming from a socialized system of care he may not
only see the cost of care as “too high” but also as unjust. From his last comment it seems he believes that healthcare in the US should be offered for free or at an affordable price if one is a contributing worker in the system.

The second case shows what appears to be a strong indication of the marianismo that is supposedly a characteristic of the less acculturated, more traditional “Hispanic” woman. Celestina has like Mauricio chosen to seek healthcare in Ciudad Juárez because of its affordable cost. Although there have been instances when an emergency has pushed her to seek care in the US the cost and the accumulating debt has prompted Celestina to either postpone seeking needed healthcare and even opt to not seek care at all. In her mind and as she kept reminding us, her children came before anything and everything including her own health.

As mentioned, Celestina was born in Mexico but came to the US at an early age. She was raised and educated in the US from the age of 5 so it is fair to say that she was enculturated into or was exposed to the “American” lifestyle since her formative years. The way in which she communicated with us showed she had a strong knowledge and comprehension of not just the English language and other “American” characteristics but also of the biomedical system in the US as well. To further support the existence of a relatively higher level of acculturation in this household than often found in low income homes was the fact that although Celestina said the primary language used in the household was Spanish in our limited observations during the survey it was apparent that the members communicated in a bilingual manner. But as in the prior case the existence of an abundance of “Hispanic” cultural traits is such that the household and the participant is a “mix” or in a bicultural/bilingual “stage”.

The participant shows traits of a more acculturated “Hispanic” in that she chooses to seek biomedical care over “traditional” measures. The healthcare sought in the “affordable” Mexican healthcare system was a combination of alternative and biomedical care. Celestina went to see Dr. Yoshida, the naturalist doctor, when first dealing with her symptoms but even after being diagnosed, and
unknowingly given the correct diagnosis, the “weird” technique did not sit well with her. Her socialization in the more “American” biomedical paradigm put doubt into this unorthodox healthcare alternative so she opted to get the opinion of the “real” doctor in the Mexican biomedical healthcare system.

This behavior shows how the mix of available healthcare options and the participant’s financial situation and even her hybrid healthcare orientation produce a complex healthcare behavior. Her choice to look to Ciudad Juárez for care was prompted because of her uninsured state, her choice of a naturalist shows that she has at least some belief in this alternative healthcare system, but the rejection of the naturalist’s diagnosis shows strong adherence to a biomedical paradigm. She chose to withhold from needed healthcare because she would rather use the little money she had to provide for her children; a trait more often associated with the concept of marianismo or of those individuals with lower acculturation levels.

This agglomeration of “incompatible” cultural traits demonstrated by one individual is indicative of how complex the healthcare behavioral patterns exhibited by “Hispanics” in the borderland are. There appear to be actions characteristic of high acculturation intertwined with behaviors supposedly characteristic of low acculturation. The lines between low and high acculturation could be crossed at any time or any juncture depending on the situation and even the specific ailment the person is experiencing at the moment.
CHAPTER 6

STARTING POINT/ ENDING POINT: WHEN IS ONE MORE “HISPANIC”
AND WHEN IS ONE MORE “AMERICAN”?

“Where does ‘Hispanicity’ begin and where does it end? Where does it begin to merge with the ‘American’ and where does it challenge this merger? When is it ‘American’ and when is it not?” The concepts of “group”¹ and “border” present a task so daunting that the bold researcher ends up maintaining and promoting the categorizing shortcomings of the past. The differences within the Mexican-origin community may disallow a specific “base” behavior from which a person “starts” the journey towards becoming more like the “other”. Add to this the complexity observed, as was seen in the previous section, when attempting to identify a “starting” point for those persons coming from a “Mexican” healthcare paradigm. The move from the “inside” to the “outside” and into another cultural being is one that may be conceptualized theoretically but is hard to document empirically.

But when everything seems to be complex and the “neat” linear move through the process of acculturation appears to be a myth a person that exhibits such a life history emerges. The “linear” move that has been hypothesized possibly occurs in some instances side by side with the more complex segmented move apparently in the same cultural environment. The following cases show just how difficult it is to identify a general starting point and/ or end point for the “Hispanic” cultural world.

The first shows what seems to be a linear model of acculturation where the individual went from a lower acculturated, more “traditional” lifestyle to that of a higher acculturated, more “American” mainstream. The second case counters this linear model showing an individual that “ended” up at a different point along the continuum of acculturation. The person is somehow caught “in between” cultures even though she has lived in a similar El Paso environment.
“Linear” acculturation
Saturday June 6, 2009

A glimpse of how the other “half” lives. The household is situated on the west side of El Paso an area that is heavily middle to upper class. El Pasoans throughout the city jokingly and seriously note that “the Westside” is the area of town where the “ricachones” or “rich folk” live. The home itself shows the economic level that the family enjoys, the floors are covered by what looks like clear-coated mahogany, and the furniture is of solid wood not unlike the kind that is custom-made. There are several antique decorations: an old oak chest that looks like a pirate’s booty chest, an antique cabinet, and an old camera from the early part of the past century that make part of the living room décor. These pieces give the room a museum-like aspect, very classy and stylish.

In the hallway leading to the next room several small dogs have been “caged” to prevent them from having access to the two “strangers” that have entered their property. The breeds of the dogs seem to indicate, in my opinion and although I am not an expert in canine pedigree, that they were probably purchased from a kennel. The small pets are all impeccably groomed and from the house’s clean smell it is obvious that they are very well taken care of. This indicates that the family has the financial means not only to purchase the expensive pets but that it is also able to give them more than adequate care.

The family consists of the participant Josefina Hernandez-Johnson, 58 years of age, and her husband Alfred Johnson, 64. She says both her and her husband are US citizens; she is a native El Pasoan, “born and raised here”, while her husband is a native of the American Northeast. While she works as a counselor at a local school her husband works as a school administrator. Josefina is continuing her education from home as she is currently working on a doctorates degree from an online program. The participant says that working for her doctorate online is better because, “I can work at my own pace plus I have someone guiding me step by step, it is if as though someone was right there with me giving the advice and guidance I need to get this done.” She said that maybe that is why she would “help us” with the survey. “I do not really need a gift certificate but I guess I will be doing this pretty
soon so this might give me good karma.” She does not have any children; it’s only her and her husband and the pets. The participant’s demeanor comes across as carefree, nonchalant. The puffiness around her eyes says that she might have just woken up. Josefina appears a little groggy.

She says that the household income gives her and her husband a chance to live a “good life.” The total income made between her and her husband is around $100,000 a year. She says they have never had a need to go on public assistance or have had to use public transportation, “Hell, we own three cars [referring to the late model vehicles in the driveway] and there are only two of us. We don’t have to use public transportation, thank God.” I suddenly think of other persons we have interviewed and the heat they must endure in their homes at this time of year. As mentioned above, the home and its furnishings are indicative of the socioeconomic status the family enjoys; the temperature outside is raging in the 90’s while inside the home it is cool and comfortable; this is a temperature controlled/air conditioned home.

The participant gives insight right away into the acculturation level her life world operates in. Josefina emphatically says that the primary language used in the home is and has always been English. She says that even entertainment from the mass media (i.e.; television and radio programming) is preferred entirely in English. As has been noted, this pop cultural/ superficial preference for things “American” may not be an in depth indicator of the person’s actual acculturative state but it can be inferred that these demonstrate the acculturation process in action on the “ground”. As for the “native” language the participant says she can speak Spanish but not in a fluent manner, “I can read a book in Spanish if they gave me a year to read it.” As has been observed from other formal educators Josefina says she tries to avoid using Spanglish, the “language of the US-Mexican border”. She also says that when she was still at the head of the classroom she would discourage her students from using the code-switching lingo, “I tried to get my students to speak either or, but not mix the languages.”
A deeper look into her childhood shows snapshots of Josefina’s formative years in the integration journey that is acculturation. From the things she said up to this point in the interview it could be said that there is a sort of distancing from her “Hispanicity” but then again, as has been seen time and time again, deciphering this world of polyculturalists is not as clear cut as it may seem.

Growing up, she says, English was the primary language, “I did speak some Spanish since my aunts and grandmother spoke only Spanish and so did our maid. But at home we only spoke English.” Her parents were also El Paso natives both US citizens; her mother, a high school graduate, worked for the city and her father, a college graduate, was employed by the government. Again looking at this one could easily be swayed into labeling this person as one that harbors ill feelings towards her cultural roots but then the interviewer asks about her ethnic pride. Josefina says in a joyous tone, “I am extremely proud of my heritage!” If language usage is any indicator of cultural adherence then the primary use of the English language at home and in fact a preference for English language for most of her life plus a tinge of disdain or dislike in her voice when answering questions regarding Spanish and other things “Mexican” may be interpreted by some as counter to what she says about her feelings towards her “Hispanicity” but this is what she had to say,

“English is what we spoke growing up at home, not that we did not want to speak Spanish it was just that way. I am grateful to my parents. They did a great job seeing where they came from.” She did not specify but it appears that both her parents may have come from impoverished backgrounds and pushed their way up the socioeconomic ladder. Extrapolating from her age it appears that her parents grew up in an El Paso atmosphere geared towards integrating those from minority groups who “wanted to be” “American” while segregating those that did not want to give into the Americanization forces. Seeing that both of her parents achieved the educational and financial levels they did in such an era tells of how they decided to integrate into the mainstream culture and possibly distance themselves and their
children from the “native” culture and language so that they did not have to go through the same hassles of assimilation they experienced.

**Access to healthcare**

The participant says that both she and her husband have had continuous healthcare insurance for the last year. Having this private insurance coverage allows them to have a regular source of care. This regular source of care is provided by a family doctor at a clinic on the west side. Instead of resorting to the emergency room for care as is seen in other cases in the El Paso/Ciudad Juárez borderland Josefina goes to the doctor’s office, “If I get sick I go to the doctor. I need no appointment. I just go.”

When the need has arisen this family doctor has referred her for further checkup to an area clinic for lab work. “I don’t recall the name of the place I’m not sure. It’s behind a bowling alley.” When asked about seeking care in Mexico, the participant said in an assertive tone almost sounding as chiding that she would only go to doctors in the US and never in Mexico. “Are you kidding? I will get shot. There is nothing in Mexico for me.” She continued, “first of all nothing in Mexico is regulated especially the medical system. There is just no reason to go.” This appears to be similar to Vila’s (2000) findings on how some Mexican Americans carry the belief that “all that is Mexican is negative or backward.”

Medications are only purchased in the US because she says she has the financial means to pay and because, “Mexico is not trustworthy and like I say medications are not regulated in Mexico, you don’t know what you are taking.” Being “fully” insured cost is not a barrier to access healthcare in the world’s most expensive healthcare system. She always gets the needed medications and treatment; she says that if she had no insurance paying up to $1000 dollars for a doctor’s appointment would not be a problem for her.
As mentioned the only instructions and medications Josefina follows and/or takes are those prescribed by her biomedical doctor in the US system. Although she says she takes no herbs or seeks natural healing treatments she recalls that growing up her mother and grandmother would make “yerba buena” for her stomach aches. Josefina remembers, “I would fake stomach aches so that they would fix me yerba buena because it tasted good.” This shows that at one point the participant, or at least her parents, made use of the “traditional” healthcare paradigm; a supposed more “Hispanic” cultural trait.

Josefina believes that it is important to take care of one’s health through diet and exercise and by following medication intake as instructed but, “I only threaten to diet and I only threaten to exercise. As for the medication it is important but I guess it is more important for my doctor, actually I am not very good with it myself.” This appears to be a trait of the lower acculturated “Hispanic” population; a contradictory facet of the sociocultural makeup of this acculturated “Hispanic”.

Even though she appears to take her health in a nonchalant manner Josefina does follow a consistent screening regimen. Some of the testing Josefina gets on a regular basis includes pap smears, mammograms, cholesterol, blood sugar, and blood pressure testing. Furthermore, the participant follows personal home checks as she performs weekly breast exams looking for lumps and other irregularities.

Recently Josefina was diagnosed with high cholesterol and is currently taking medication to lower it. The preventive tests were done at the same place “behind the bowling alley”. Another ailment she has dealt with in the last year that also sent her to the doctor’s office was a chronic problem in her neck. Again she was referred to the “behind the bowling alley” place and a battery of tests was conducted, “everything [tests performed] they could think of because they did not know what was going on.” Finally, her private physician referred her to a specialist for physical therapy, “for a pinched nerve in my neck.” She does not specify how that ordeal ended but it appears she is doing much better with
her pinched nerve. Her private insurance covered the cost so as of the moment there are no medical debts pending in the household.

The final stretch of the interview provides a look at the participant’s binational consumer behavior if there is any to detail. Josefina closes by saying that she only shops for groceries and other products in the US and never in Ciudad Juárez. With a look of boredom she says that there may be some relatives in Mexico she does not know about and which she could or should visit but, “I never go to Juárez, you have the long lines and then there is nothing there that I really need.” The interviewer hands her a gift card. The small token so precious and valuable for other participants is tossed onto the brown leather sofa where a family pet had been sprawled when we arrived, “I do not need this but I will give it to my husband, he might use it.”

The following case shows another “product” of the acculturation process. While Josefina, a later generation “Hispanic”, has become highly “Americanized”, Juana Martinez although having grown up in the “same” sociocultural area has integrated in a distinct manner especially when it comes to the issue of healthcare beliefs and behavior.

“In-between” cultures

Saturday, October 3, 2009

The apartment complex we will work in today rests in an area of town characterized by a working class population. Again the menace of rain is in the air. The first few households we visit support this inference into the inhabitants’ financial status as they were inhabited by persons of modest economic level. After finding willing participants in the first units the next couple of households give no response. Maybe the rain will put a damper on our interview sessions. But then on our next try a lady answers the door. The interviewer describes the study and she decides to take part in the research. “Yo pensaba que era mi esposo,” (“I actually thought it was my husband”) she says, “Pasele” (“Come in”). We walk into the living room, there are many religious artifacts adorning the small room. A
Virgen de Guadalupe rests on a mantle, a Sagrado Corazon de Cristo hangs on the wall, while many other religious statuettes are positioned throughout the room each with lit candles at their feet. There is a religious program on TV, a man probably a minister or priest speaks to a congregation. The dwelling is modestly furnished; brown carpeting that has seen better days covers the floors. A US flag adorns the northern wall, and a photo of a young man in military uniform rests at the base.

The participant is 59 year-old Juana Martinez a life-long resident of El Paso. “Yo pensaba que era mi esposo por eso abrí, si no ni abro. Pensé que había salido temprano del trabajo. Yo soy housewife y mi esposo trabaja. ¿De donde son? De UTEP. ¡O! Mi nieta va ahí a UTEP, entro este año.” (“I thought it was my husband that’s why I opened if I had known it wasn’t I would not have answered. I thought he was let out from work early. I am a housewife and my husband works. Where are you from? From UTEP, oh, my granddaughter goes to UTEP, she just started this year.”) The interviewer explains the instructions and asks in what language she would feel more comfortable getting the interview. “Pues leo mejor inglés” (“Well I read better in English’”), Juana answers with a slight smile on her face. It is good to note here that the instructions from the interviewer are being conveyed in Spanglish although she said she preferred the English version of the survey. The conversation flows. It is fluid as if they communicate better in this language mix.

The participant appears to be one that is caught in between languages and/or cultures. She cannot dominate or communicate exclusively in either language. Although Juana can communicate effectively with us one cannot help but notice that she mispronounces many Spanish words for example, “Esta no sire (sirve)” (“This is expired”) when referring to her old insurance card, “¿Oyes apá, estas muy cuapó (ocupado)? No hallo (encuentro) mi trajeta (tarjeta) de seguranza (aseguranza)” (“Hey dad are you busy? I can’t find my insurance card”) when she called her husband at work to ask him for some information. “Ese cuadrito (cuadrito)” (“that small photo”) when pointing out a photo in the room. Her English was better but there was still some accent present and also many mispronunciations when she
spoke. Her fluency in either language is not complete but the way she can communicate with us, a couple of bilingual, bicultural borderlanders, is just like a normal conversation.

As mentioned, Juana says she was born in El Paso while her husband was born in Ciudad Juárez. She proudly says that he has since become a naturalized US citizen. Filling out the household roster she finds out that she can’t spell Juárez so the interviewer helps her, “With a Z like zebra”. She smiles. Looking back up from the form she says that she speaks more fluent in English than her husband. “I speak mas en inglés y el mas Spanish” (I speak more English and he speaks more Spanish”). They are not married by “the law” she says, “Es common-law, tenemos muchos años juntos”. (It’s a common-law marriage. We have been together for many years”).

After fumbling for a while in her purse she finally gave up and said that she could not recall the name of her insurance provider. Juana does say that both she and her husband are covered by his employer. Once she found no luck looking through her purse that’s when she called him at work but he was busy so he told her he would call back in a moment to give her the information. The same occurred when she was asked about his time of residency in the US, again she called him and when she could not get him to answer she called her mother-in-law, “tiene aquí desde los 14 (fourteen), como 45 (forty five) years” (“he’s been here since he was fourteen, about forty five years”). The code-switching continues without even a hitch.

A look at her family dynamics demonstrates the complexity of the Mexican American experience in the US. The participant says she has never lived outside the US; she has lived in El Paso all her life except for a short stint up north. Juana received her education up to 9th grade all in the US while her husband has obtained a GED; his education was a combination of Mexican and US formal schooling. All of her 5 children were born in the US. She proudly says that all five children are grown up, “el mas chico tiene 27 (twenty seven)” (“the youngest one is 27”). Looking at her family tree it shows how even a generational measure or proxy for acculturation can come up short. While her father
was from east Texas near the coast her mother was from right across the “charco” (“puddle”), a native of Ciudad Juárez. The participant could either be classified as a second generation Mexican American using her mother’s nationality as a “base” to gauge from but if her father was used as the “start” then Juana would more than likely be considered a third or later generation Mexican American. The constant back and forth migration patterns in the Mexican-origin community between two countries in the same biosphere puts pressure on the neat classification schemas.

Looking at one of the facets of acculturation, language, one can see the gradual change the individual has undergone within a lifetime. Juana says that growing up her primary language was more Spanish but now as an adult she speaks both languages. Again we must note that she speaks in a hybrid language not fully either English or Spanish. She says that she has more fluency in English than in Spanish, “Some words I get stuck,” she says in English. The same goes for her literacy level as she says she reads more English than Spanish and just like with her language proficiency she has “some problems with some words”.

When asked about Spanglish she was perplexed, “What do you mean?” The interviewer explains the language mix in lay words and concepts. “O sí, sometimes I do” (“Oh, yes, sometimes I do”), she answers laughing. Unknowingly she speaks the language mix or hybrid lingo often and in fact it could be said that Spanglish is the main language she communicates in. It is quite astonishing that throughout the interview she used Spanglish but when asked about it she did not even know what it was. The way she speaks is just the way she speaks no second thought is given to this mode of speech or communication (i.e., code-switching). To her it is how she has communicated for the better part of her life no questions asked or analyzing is required, it just is what it is.

In her mass media consumption, again reminding all that this is a superficial view of the acculturation process and not a deep engrained manifestation of the person’s psychosocial makeup, Juana says that television programming is preferred by her in English. Her husband meanwhile prefers
Spanish language television. On the other hand, radio programming preference she says is a mixture that she utterly enjoys, “En las weekends pues las Oldies en inglés y entre semana pues Spanish” (“On weekends it’s the oldies in English and during the week well it’s Spanish”). The mass media consumption shows how preferences are influenced by the two “mother” cultures, there appears to be a hybrid enjoyment not really swaying to either the more “Hispanic” or the more “American” art form but a love of both simultaneously².

To gain a sense of the household’s financial situation several questions dealing with income and other figures are asked of the participant. Juana says the household income is relatively low between $10k and $20k per year, “Gana como unos $728 (said in English) cada two weeks” (“He makes about $728 every two weeks”). In an effort to confirm her answer again she digs deep into her large purse; she takes her time with this section and looks for the confirming check stubs. Although the income level is low the employment her husband holds enables them both to be insured through the employer-based carrier. Juana recalls that they have been insured for the past year first through CIGNA and now with a change in carrier by the employer it is through Aetna. The household does not receive public assistance of any kind, “No me han dado nada” (“They have not given me anything”), she says with an offended look on her face.

Access to healthcare

Although the couple does have this employer-based healthcare insurance coverage, Juana says that cost in accessing the needed treatments has been a factor. For example, when asked about medical debt she answered, “Yo debo como $400 (four hundred) maybe $1000 (mil) with interest. Mi esposo el debe mucho.” (“I owe about $400 maybe $1000 with interest. My husband owes a lot”.) Juana continued giving examples of the problems encountered when seeking healthcare and other related services. Juana says she cannot afford to purchase a medical device she so desperately needs, “sabe
estoy medio sorda pero ta no compro un hearing aid, mis hijos dicen que me lo van a comprar” (“you know I am hard of hearing but I still have not purchased a hearing aid, my sons and daughters say they are going to buy it for me”). As of that day she was still doing without that needed hearing aid.

One of the perks of being insured is the availability of a regular source of care so although Juana has had to visit the emergency room, a place frequented by those that are uninsured, she does have her regular doctor who she sees in his private office. When she is ill she visits Dr. Miguel Tarango but that same belief that cost is an issue causes her to see this in a negative light, “me cobra $20 cada vez que voy a verlo” (“He charges me $20 every time I go see him”), Juana says in a shocked voice.

Taking a closer look at other potential barriers in accessing healthcare one finds out that the participant has help or different sources of agency in her immediate social circle. For example, she does not own her own vehicle but her husband does so he will drive her to appointments. Another way she combats the potential transportation barrier is through the use of public transportation. Furthermore, financial or economic issues that may arise in the procurement of healthcare are handled by her husband so when the need has arisen, “He pays todo” (“He pays [for] everything”). And just in case the situation necessitates further assistance her daughters, who live nearby, also provide help when she falls ill.

In matters of immigration status her US citizenship makes this a non-issue. The only issue with immigration is the recent requirement placed by federal homeland security policies. The new passport requirement for US citizens has become a barrier for some El Paso borderlanders, especially those that use the Mexican healthcare system, as they seek to make use of the binational services offered on the El Paso/Ciudad Juárez border. “No tengo el pasaporte pero ya tengo 15 (fifteen) years que no voy para el doctor en Juárez,” (“I don’t have the passport but anyway it has been 15 years since I have been to the doctor in Juárez”) the participant says explaining her current binational or transnational healthcare-seeking behavior. One of the reasons that the visits across the border were halted is the fear for her safety; Ciudad Juárez has increasingly become an area where violence has become the norm.
Although language is not a barrier in communicating with healthcare providers, again it is good to recall that a considerable number of healthcare providers on the border are bilingual; there are times when she does have trouble understanding arrangements and labels. The labels are marked in either formal English or formal Spanish and this has created problems for the participant who apparently thinks and interprets her surroundings in a mixture of language and culture; not fully Spanish/“Hispanic” or fully English/“American”. This is an area that is in need of further research in healthcare studies in populations that are highly bicultural and/or bilingual.

The participant says she only uses the US medical/healthcare system. Again she says that the last time she used the Mexican healthcare system was 15 years ago. Juana feels that she can trust the US system plus the services needed are available here so why should she go to Mexico to seek care. Furthermore, the employer-based insurance coverage allows the participant to access the US biomedical system, a system that is not accessible to many borderlanders.

Juana gives some insight into the healthcare or medical paradigms her family has followed throughout her life. She says that growing up her parents only or primarily used “traditional” remedies when ill, “fuimos nomas unas cuantas veces al Thomason” (“We went to Thomason just a couple of times”). Today as an adult the participant does say that she makes use of both the biomedical system, covered by her insurance, and “traditional” home remedies, “Sí, yerba buena que crece afuera o lo compro aquí en la tienda ya seco” (“Yes, yerba buena [mint] that grows right outside or that I buy at the local store already dry [in a form ready to be prepared]”), she points towards the door of her apartment. One of the uses for this remedy is for upset stomach, “Cuando no aguanto el estómago” (“For when I can’t stand [the ache in] my stomach”). And like other respondents have mentioned this “traditional” home remedy she learned from her mother; recipes that are passed down from generation to generation particularly from mother or grandmother to daughter or granddaughter. Juana looks across time
remembering her deceased mother, “ella murio hace como 30 o 40 años” (“she passed away about 30 or 40 years ago”). The thought subsides and she is back with us in the fall of 2009.

Juana is currently dealing with a couple of illnesses. First she was told at the hospital that she has kidney problems stemming from an infection of some kind but, “el doctor dice que ya estoy bien pero todavía no estoy sure” (“the doctor says I am doing okay now but I am still not sure”). Her second ailment is rheumatoid arthritis in her leg and spine that she has been dealing with for the last 12 years. To combat the constant pain the participant takes Aleve daily, “Tomo mis pastillas todos los días en la mañana sino no puedo mover los dedos” (“I take my pills everyday in the morning if not I can’t move my fingers”). As long as she “keeps moving” it will not bother her so she keeps busy at different tasks around the home. “El doctor de Juárez me dijo que tenia arthritis (said in English), dijo que yo debería estar en silla de ruedas” (“The Juárez doctor told me I had arthritis and that I should already be in a wheelchair”). It appears that Juana contradicts her story of not having been to Ciudad Juárez for healthcare in more than 15 years but then again maybe she forgets the exact dates.

Looking even further into the participant’s healthcare behavioral patterns it is apparent that once again there exists a complex contradiction-filled health belief system at work at least in the life of this individual. When asked about family planning methods or strategies used Juana answered, “Oh yeah hace como 27 años usaba birth control pills y despues el tubule ligation” (“Oh, yeah, about 27 years ago I would use the birth control pill and then I got a tubule ligation.”). Juana says she is by all means a heavy smoker with a nonchalant demeanor she answered the question on tobacco usage, “Fumamos todos los días, mucho” (“We smoke everyday, a lot”). The tone was sort of a “Yeah, we smoke but doesn’t everybody else?” It seems that to her smoking is just a part of life and maybe the norm in society. She promptly answers the follow up question, Interviewer: “Mrs. Martinez have you ever stopped smoking for at least one day in the last 12 months?”
Juana: “No emos para’o” (“No, we have never stopped [smoking]”).
A small gentle laugh leaves her throat. She must really enjoy her smoking I think to myself.

Continuing with this area of health behavior the questions turn to alcohol consumption. The participant is, in her own words, an “occasional” or social drinker, “no es muy raro, allá cuando hay quinceañera para poder bailar si no ahí estoy sentada toda la noche” (“It is very rare that I drink maybe at a quinceañera [Mexican equivalent of a ‘sweet sixteen’ party] so that I can dance if not I will just sit there all night”). She laughs. Interviewer: “Do you see this drinking as a problem?” Juana: “No, no es un problem [in English].” (“No, no it is not a problem”) The mischievous look is still on her face. This expression promptly changes when she is asked the follow up question.

Interviewer: “Does anyone in your family have a drinking problem? Usted sabe alguien que se le pasan las copas, las Budweisers?” (“You know, someone that drinks too much, too many Budweisers perhaps?”) She answers, “Si” (“Yes”) but then retracts, “Mejor dejelo blank.” (“It’s better you leave it blank.”)

In the area of preventive care again we find an inconsistent behavioral pattern. It appears that Juana follows a lower acculturated “Hispanic’s” tendencies in some areas while in others she looks more like the mainstream. For example, although she has not been referred for care in the last couple of years she has had some preventive tests or screening done. Testing that included blood samples for analysis she says she has undergone in the last 3 years. She had a check up about 2 years ago; this seems to be quite some time ago especially when she has a regular source of care and healthcare insurance coverage. Juana has not had a breast exam but she does check herself for potential growths every “2 o 3 mons aquí at home” (“2 or 3 months here at home”). It is a supposedly more acculturated healthcare behavior to perform even simple home self tests. But then she shows the complexity of the healthcare belief system that guides her actions when dealing with her health.
The participant says she has not had a pap smear in about 4 years. Why? “I just, la decidía, que mañana, que esto que el otro, así somos los Mexicanos. Hasta que se esta muriendo uno then we go.” (“I just, just haven’t gotten around to it, we say tomorrow, that this that that, that’s how we Mexicans are. It’s not until we are dying that we go [to seek care]”). She does say that she had a mammogram performed 5 years ago. Why so long ago? Juana answers in a snapping mode, “Can’t afford the cost”. The participant does say she has had her blood pressure checked, “Yes, hace como 2 years. Y mi daughter does it every time I feel sin fuerzas o el heart esta beeping not right. Como once a month.” (“Yes, about 2 years ago. And my daughter does it every time I feel like I have lost my strength [feel weak] or when my heart is not beeping [beating] right. She does that about once a month”). When asked about her blood sugar and cholesterol level testing again Juana in a relaxed almost tired tone answered, “no esos no, por decidía. Esta caro es pura perdida de money y tiempo” (“no, not those, I still have not gotten around to getting them. It’s expensive plus it’s just a waste of money and time”).

Towards the end of the interview her husband gets home from work. The slim man comes into the living room, shakes our hand, and then promptly excuses himself and goes upstairs. “Va upstairs para rezar, le dice gracias a nuestro padre dios por haberle dado otro dia de vida” (“He is going upstairs to give thanks to God for providing him with one more day of life [i.e., extending his life one more day]”), Juana says with a serious look on her face. This is just another day in the life of a borderland household.

Discussion

After meeting a person like Josefina and her highly acculturated lifestyle again beckons that question, “Where exactly is the ‘starting point’ and where exactly is the ‘end point’ on this acculturation ‘ride’?” By all means Josefina is culturally an “American”, a “Hispanic” woman that thinks fluently in a culture that is supposed to be “foreign”, a cultural influence coming from without. For all matters the
“starting point” for Josefina’s “Hispanicity” can be classified as a “traditional” lower acculturated that
then moved to a higher level on the continuum. For that matter her parents can be said were also at a
lower acculturation rung since they appear to have made a conscious effort to engage in more
mainstream behavior including English language preference.

The subtractive measures that appeared to be utilized by Josefina especially when discussing the
healthcare systems available on the US-Mexico border but more specifically the El Paso-Ciudad Juárez
borderland can add credence to this suggestion that the participant is higher on the acculturation “scale”.
The complexity of the process can be appreciated further when this highly acculturated participant
proclaims her deep pride in her cultural background. “It is not that we did not want to speak Spanish it
was just the way it was.” There is a sort of balancing act that occurs within the individual as the distinct
cultures become integrated into the person’s psychological makeup and how these are made manifest in
observable behavior thus will exhibit this sometimes contradictory characteristic.

Josefina adamantly says that the only healthcare she will use is the one offered in the United
States in the formal biomedical system and never in the “unregulated” and questionable Mexican
healthcare system. This appears to be a case of what Vila (2000) found in his research on border
narratives; that some El Pasoans of “Hispanic” and particularly of Mexican descent make a concerted
effort to distance themselves from what they have come to deem as lesser towards what they perceive as
better. The “attempt” to create a gap between what she feels as “not as good” may be due to her ability
to access the needed healthcare here in the United States. The formal medical care available in the
neighboring Mexican city consists of modern biomedical services not unlike what could be found in
most US cities the only difference would be the patient’s perception of the quality of care that is given
there. So the beliefs held by this participant may be based on misinformation or biased prejudgments
and not on actual experience or first hand knowledge. The ability to access healthcare in the US
afforded to the participant because of her financial status helps create this hierarchical ranking of the available healthcare systems.

But can this view of the Mexican healthcare system be blamed on a higher acculturation? Well looking at Josefina’s socialization into the biomedical system this “acculturation-as-the-sole-culprit” explanation may fall short. As research has shown there are other factors such as family cohesiveness (Balcazar et al, 1997) and education level (Balcazar, Castro, & Krull, 1995) in conjunction with acculturation that influence the way “Hispanics” will make use of the healthcare systems around them. In this case it is the participant’s acculturation level plus the financial means that the household enjoys that help create this belief that the American healthcare system is better and its Mexican counterpart is suspect.

Josefina’s preventive care regimen of prescreening tests and other testing measures help present the participant as having characteristics of a higher acculturated individual. Lower acculturated “Hispanics” have been documented as having a lesser tendency to seek this type of care and as noted above Josefina makes no use of “traditional” home remedies such as “yerbas” a supposed typical trait of low acculturation. Research by Martinez (2009) appears to support this notion that the tendency to use “traditional” remedies occurs more often in the lower acculturated and even when the higher acculturated use alternative medicines these tend to be more of a “mainstream” type of alternative care. If research into “Hispanicity” and complementary and alternative medicine is correct then this highly acculturated individual is not at the “end point” but still on the move in the process of acculturation. The nature of cultural transitions is to always continue not just “forward” or “backwards” but in directions that are dictated by the distinct factors that interact in the person’s and the group’s life world.

In the case of Juana we find an individual that grew up in roughly the same time period and lived in the same city for a similar amount of time as did the previous participant but developed or acculturated in a different path. The “end point” that the previous cases present are good examples of
what is being proposed in this study that is that the acculturation process manifests itself “on the
ground” as a complex phenomenon where the behavior exhibited is at times seemingly simple even uni-
linear while at other times it appears to be multi-faceted, complex, inconsistent, and even contradictory.
What makes this so much more interesting is that the “inconsistent” and “contradictory” behavior
sometimes is acted out by the same individual.

Juana in many ways fits this second description where the acculturation process has “guided”
this individual in a path that is so dissimilar from what was seen in the case of Josefina. The latter has
arrived at a point where she can be classified as a highly acculturated individual exhibiting what could
primarily be called an “American” cultural makeup. In the case of Juana she can be said is not fully
acculturated in either the more “Mexican/Hispanic” culture or the more “mainstream/American” culture.
It is as if she is “caught” in between cultures somehow.

As mentioned, Juana’s acculturation status or level cannot be easily classified using a
generational approach since the family dynamics in migratory terms is one that shows the distinct
generations of “Hispanics” intermarrying and bringing forth “mixed generation” offspring. The new
“mixed generation” generation cannot be easily categorized utilizing the classical 1st, 1.5, 2nd, 3rd, and so
forth schemas. In some cases such as the one just seen there will be individuals that in fact could fall in
between the 1.5 perhaps even see persons that could be “fractioned” into 3.25 and 2.75. The constant
migration and intermarrying between generations in a notoriously endogamous group puts the
acculturation proxies based on generation or time of residency in the US in question.

Using language, again only one of the many facets that make up the acculturation process, as a
barometer we find that Juana does not have a clear fluency in either the “native” language, which ever
one that might be, or the “new, outside” idiom. The fact that she cannot fully understand what is being
asked of her or in the way that she cannot hold a conversation in entirely one or the other language says
that this individual is or could be categorized as a “hybri-culturalist” not a bicultural individual. Being
bicultural or being labeled a bicultural and bilingual individual assumes that there is a certain measure of competence or fluency in either language or in both languages (e.g.; English and Spanish). Hearing the participant converse it appears that she is an individual that not only speaks but thinks in a “blend” of two cultures not one more than the other but a mix of both.

This “hybri-cultural” psyche somehow is manifested in the way she chooses to or withhold from seeking needed healthcare. The healthcare behavior exhibited by Juana is one that also shows an integrative model where both the “traditional” and the formal, biomedical systems are used in conjunction. Growing up she says that the primary source for care had been “traditional” home remedies and that the biomedical care had only been used “unas cuantas veces [en el] Thomason” (“a couple of times [at] Thomason”) but gradually as the years went by the “other” healthcare system became a part of her healthcare paradigm. As an adult Juana now makes use of both systems in a seemingly “hybrid” fashion utilizing either or at times and at other times utilizing both at the simultaneously.

This shows how the individual in this case exhibits both traits of lower and higher acculturation apparently, again, simultaneously or at least within the same context. For example, the use of herbs such as yerba buena shows a trait associated with lower acculturation and then her use of the biomedical system tells of her other healthcare behavioral traits that are more in sync with a higher acculturation level. The use of over-the-counter medication for her arthritis is an example of this preference for biomedicine but then she says that she complements this medication with a more “traditional” home “remedy” for combating aching joints: exercise. As long as she “keeps moving” and as long as she takes her “pastillas” (“pills”) in the morning she will be fine and her arthritis will be kept at bay. Again the “blend” of cultures or systems occurs even in this minute or simple action to combat a physical malady.
To further show the complex nature of this “cultural hybrid” we look at the way Juana goes about getting or withholding from preventive tests. The tests have been performed although not at regular intervals so the behavior does not fully follow the prescribed biomedical scheduling of such testing but it is not fully a lower acculturated tendency either. The mere fact that she engages in such healthcare behavior (i.e.; seeking at least some preventive care) goes against what would be expected from a lower acculturated individual. One last observation, maybe a more superficial but much more apparent, is the seemingly contradictory behaviors that the participant engages in. Juana is a self-defined heavy smoker a trait that Marin, Perez-Stable, and Marin (1989) associated with higher acculturated Hispanic women but she is also a highly religious individual which has been correlated with those Hispanics of lower acculturation level (Chavez, 2003).
CHAPTER 7

ACCESS AND BARRIERS: BARRIERS, AGENCY, AND RESILIENCE

It can be suggested that a solid measure of an individual’s or a group’s level of assimilation would be the level of access to needed resources the person or persons has achieved within a society. As was proposed above acculturation status may be regarded as a barometer when looking for factors that will ease or deny accessing mainstream resources such as formal healthcare. Achieving a higher acculturation and the supposed eventual full assimilation that comes with it may in fact mean achieving not only a certain level of competence in the new culture but also a certain measure of self confidence and sense of belonging so as to believe that there is entitlement to specific rights such as the right to access needed healthcare in the new society.

Again there are those persons within the receiving society that will oppose the “spreading” or sharing of the “limited” resources available. This opposition is created at different levels from the federal down to the interpersonal everyday stratum. Government policies and nativist-minded individuals, which of course includes other “Hispanics”, have created this atmosphere of intolerance that has had a significant influence on the way “Hispanics”, both authorized and not, use the available resources such as healthcare in the country. How the “outside” group perceives and acts on these barriers when in search of needed healthcare will be influenced by several factors including the level of acculturation that has been achieved.

Facing obstacles in the new home
Thursday July 16, 2009

When we arrive at the block rain clouds begin to accumulate in the desert sky. As we walk from house to house the brewing storm suddenly lets out a roar. We rush around the corner of the block as the wind picks up. By now the dust has begun to fly. There are several mobile homes on the block; we
knock at a door but we get no answer. We continue to move along one step ahead of the storm. The next house on the block is another mobile unit. There are several people in front of the house, some young kids and a woman in her mid to late 20s. “Buenas tardes, somos de UTEP…” (“Good afternoon, we are from UTEP…”), begins the interviewer. The lady rushes inside carrying a small child in her arms. The other child, a young boy, stands at the doorway and invites us in, “¿Esta tu papa o tu mama en la casa?” (“Is your dad or mom home?”) The young woman returns to the door, “Pasele pasele, yo no soy la dueña pero ahorita sale.” (“Come on in, come on in, I am not the owner [woman of the house] but she will be out soon.”) We walk inside. The home is in disarray. There are empty containers on the sink and some lining the table. There are toys on the floor, and a baby in a car seat napping in the middle of the living room. A case of baby formula shares a mantle top with some bottles of booze including a half empty bottle of what appears to be vodka.

Outside before we came in I noticed two vehicles in running condition, a pickup and a sedan possibly a Chevrolet model both from the late 1990s. The home furnishings are humble but still in good shape; one thing did stand out the television set in the living room. The set is one of those new flat screen plasma units. Relative to the other furnishings this apparatus seems to have been just recently purchased. The high quality resolution almost makes the actors appear to be in the same room with us. A Mexican telenovela was on. What else, right?

The woman sits at the table and appears interested in taking the questionnaire herself. But she says she is only a visiting relative. A man walks by and the interviewer asks if he is the head of the household. “No, el es el cuñado de mi hermana el se queda aquí.” (“No, he is my sister’s brother-in-law he stays here.”) “Can she take the survey?” the interviewer asks. “I don’t think she can. She says she is only a visitor here,” I respond quietly. As soon as I said this “the woman of the house” steps in from the next room. She has a big smile on her face. The study seems to be a good idea to her so she agrees to participate. A small child joins us at the table and the first woman moves over to the sink and begins to
do some of the dishes already stacked there. A quick observation comes to mind: this is a perfect example of the extended “Hispanic” family so often referred to in the literature. This also appears to be an example of the US-established kin helping out those that just got here as documented by Nuñez and Heyman (2007).

The participant is 37 year-old Pilar Montez, originally from northern Chihuahua in Mexico. The current situation of the neighboring country to the south created the push factors that ultimately drove the Lopez-Montez’ to seek a better future in the north. At the moment Pilar is working on her immigration status. An ambiguously worried smile comes across her face when she says this, perhaps this information is too personal to divulge to these university researchers but perhaps the uneasiness that appears to be lingering behind that smile comes from knowing that certain life-enhancing activities such as holding a job are currently prohibited. Although she currently holds a “full-time” job as a homemaker here in her household unfortunately there is no financial return for the work done.

In these past few years this has been her only home and because of her immigration status as documented in other border studies (Talavera, 2007; Nuñez & Heyman, 2007) she cannot leave the country and/or not free to move around within the US. Her husband 47 year-old Humberto Lopez, a freelance laborer, is also from Mexico and he has been here for approximately 15 years. Both are uninsured and she is not sure if she or her husband are eligible for coverage. There are three children in the household, 11 year-old Martin Montez, 8 year-old Saul Lopez, and 2 year-old Eduardo Lopez. Pilar is on her way to bearing another child as she is visibly pregnant. No mention is made of the other persons living in the home. An interesting observation here is that the oldest child Martin was born in Mexico and unlike the rest of the children who were born in the US he is uninsured. While the younger boys are insured by El Paso First, Martin has no such coverage. Barriers in healthcare access can be seen here as part of the family is fully covered there are those that for whatever reason, perhaps immigration status, are kept from receiving needed healthcare. It can be inferred that this unequal
coverage may cause some psychological stress in the uninsured child as pointed out by Talavera (2007) in his findings.

Looking for indicators of acculturation level one can say that the work of cultural change or integration can be seen all around the home. Pilar says her formal education was for the most part received in Mexico while she was growing up. There she completed her prep school studies equivalent to a US high school diploma and in the time she has lived here Pilar has achieved in completing her GED. This is quite fascinating, at least to me, the participant has been here for a relatively short time 5 years and she has already achieved her high school equivalency diploma. In a group notoriously known for its high drop out rates this person shows much drive. She also says she is currently working on improving her English skills, “Ya hablo un poco de inglés mi esposo también lo habla un poquito.” (“I speak some English now and my husband can speak some as well.”) Furthermore, this shows a conscious effort to become integrated into the American lifestyle where academic achievement is seen as key to success and assimilation.

Pilar does say that the language spoken in the home is primarily Spanish. This could be said shows that the household “still” holds a more “Hispanic” orientation but then again this may not show entirely the changes that the family is undergoing. For example, although as mentioned the family communicates primarily in Spanish mass media consumption consists of both English and Spanish language programming and in fact English music/radio from the US is preferred over its Spanish language counterpart. Again this may be said is just a pop culture/superficial preference that does little to show the deeper more engrained cultural dynamics of the persons in question but this can also be interpreted as facets of or the movement through the process of acculturation.

As we sat there in the middle of the small kitchen area several other behaviors could be observed that would in some way be indicative of the acculturation process at work. The adults did communicate exclusively in Spanish and the children would do so as well but now and then they would throw in an
English word into their talk. Perhaps the beginnings of Spanglish were what we were observing here in this modest household. The participant elaborated on the children’s language usage; her eldest child is bilingual, the middle child speaks Spanish primarily but is learning English [as we witnessed], and the youngest child speaks Spanish only; at the home where Spanish is spoken primarily this could be expected, once he starts school his bilingual training or his transition into or the integration of the English idiom will more than likely go into full effect.

The family’s involvement in the social institutions such as El Paso First can also be seen as an action towards integration influenced by the household’s children. The parents are somehow “forced” to engage in the formal system to fulfill their boys’ healthcare necessities. The children help move the process of acculturation from the educational/enculturative system to the home and also create an almost mandatory engagement in the social institutions exposing their elder family members to the culture of the receiving country. The Lopez-Montez boys, like many other “Hispanic” children throughout the country serve as acculturation agents¹ promoting cultural integration and change in their homes.

As has been seen in prior surveys the participant laughs when asked about her ethnic heritage. Her guest also laughs when she hears the question. “Sí, estoy muy orgullosa de ser Hispán”, she answers (“Yes, I am very proud to be ‘Hispanic’”). The other lady teases, “O, sí esta muy orgullosa”, (“Oh, yes, she is very proud!”) and laughs as she continues with the dishes. Again this is quite interesting the recent arrival has done a relatively strong effort to integrate into US society (i.e.; getting her GED and learning English) while at the same time feeling a strong sense of pride in her roots. The laughs may be due to the somewhat naïve nature of the survey question. The question here is will this sense of belonging to an ethnic group (i.e.; keeping and maintaining an ethnic identity) gradually diminish as the assimilation/integration into US society becomes more “complete”. The acculturation agent sitting next to me hands me a small toy. The child babbles something. I think to myself one day I will understand you.
Access to healthcare: A “divided” household

Pilar, as mentioned, is not covered by any type of healthcare insurance. The household is receiving public assistance in the form of WIC (Women, Infants, and Children public health program), the program that provides among other things baby formula and milk for pregnant women and children. There was a case of baby formula in the kitchen. The household income may not allow for certain necessities such as healthcare insurance but she says that cost has not been a barrier in her care seeking. Pilar says that at Clinica La Fe care can be procured at a discount or arranged payment plan. The same was said to us by participants in prior interviews. But she does say that there have been times when she has stopped taking medication because she could not afford the cost.

An alternative that has been used by other borderlanders such as seeking medical or healthcare in Mexico is out of the question since her current immigration status does not allow her to leave the country, “Con los trámites para el pasaporte no puedo ir para allá. Para andar aquí no tengo problemas pero si voy no me dejan pasar después.” (“With the legal requirements for acquiring my passport still pending I cannot go over there. I have no problems traveling here but if I go over there they will not allow me to cross back again.”) She says she may be able to move about in the US but then again she may be in some ways restricted from “moving about” or navigating the healthcare system.

The participant says that she has not really had any illness in the recent past but does go for “simple atención” probably preventive checkup measures at La Fe clinic. There are no language barriers or problems understanding on how to go by navigating the required paths towards receiving healthcare in the US. There are bilingual staff members throughout the majority of the borderland’s healthcare-providing institutions.

In Pilar’s case a “friend” advised her on how to go by getting the needed help and on the good that preventive tests do for a person’s health. Just a week ago she had several tests performed at La Fe. These included blood and urine testing which she paid for in cash. Pilar says that she has had several
preventive tests done in the last 6 months including for blood pressure, blood sugar level, and cholesterol level tests. One year ago she says she had a pap smear and a breast examination performed. Furthermore, Pilar performs self examination of her breasts at least once a month. She says that the only prescriptions and instructions she follows are those given by medical doctors here in the US only because she cannot leave the country.

Although she says she follows only biomedical doctor’s prescribed instructions Pilar does keep practicing the home remedies she learned as a child from her mother. Back in Mexico as a child when Pilar was ill her mother would use a combination of biomedicine from doctors and herbs she prepared at home. The participant says, “Sí, uso plantas o yerbas como la manzanilla. La preparo aquí y la tomo para poder dormir. La compro aquí de este lado en las tiendas. Es una tradición de la casa usar yerbas.” (“Yes, I use plants and herbs like chamomile. I prepare it here and take it so I can sleep. I buy it here on this side [US] at the local stores. It’s a traditional home remedy to use herbs.”) The lady doing the dishes at the sink in a jokingly manner suggests that Pilar take a yerba to prevent another pregnancy since the pill appears not to be working at all. The mother looks at her abdomen and says, “…parece que no da resultado.” (“…I believe it did not produce the expected result.”) There is a little sign of worry on her face as she forces a laugh. “Sali esperando otra vez. Creo que se me olvido tomar las pastillas o algo.” (“I became pregnant again. Perhaps I forgot to take the pill or something.”) More worried laughs.

Discussion

The preceding case shows how persons at “ground level” meet with barriers in their quest for needed healthcare. As has been documented there exist road blocks in accessing healthcare created both at the lower levels and the higher echelons of the US nation. At the lower levels, as Young (1991) found, barriers may be created when nativist-minded persons aim to deny those seen as “outsiders” from
receiving the needed services and resources that they believe should be limited to the US citizen population. It would seem that this rejection of the “outsider” would almost exclusively come from those US citizens that are more “like the mainstream” especially from the non-colored population but this is not the case. Instances where other “Hispanics”, and not necessarily more acculturated or more phenotypically mainstream², can be observed when issues such as healthcare are being discussed. For example, one of the participants had very strong opinions on the accessibility of resources such as healthcare and other forms of public assistance. This is what he had to say:

“You know it is us that have to pay for all those people that want to live off [of] the system, they abuse the system and get what they want like food stamps. You have young people 25-26 years old having kids and not being able to support them and they abuse the system and keep having kids. Some people deserve to be helped I don’t deny that but there are some that don’t; there are those that work hard and pay taxes and don’t get the healthcare they need while others just come here to milk the system. I respect the ones that want to come here and work but most [immigrants] abuse the system, they don’t pay into anything and get free services. Some just get the money and send it back [home country] and pay no taxes. So that Obama plan hopefully works, well maybe everybody deserves help but I think that some maybe don’t and some deserve it more than others. It is not fair.” (Javier Portillo; self-identified “Hispanic” from El Paso, Texas.)

The question of who merits the use of services and resources here in the US is quite the delicate subject as can be seen in the quote by Mr. Portillo. At the lower level we have people from the “same” group explicitly vocal on what they believe should be done to those that are “here to milk the system”. This mentality was not wide spread, at least not in the cases examined, only the preceding rant put up by a nativist-minded El Pasoan. What was seen was the influence or barriers that were created by the decisions made at a higher level. At the upper levels where federal policies are made the barriers are
solidified in the form of immigration status requirements in order to be eligible for certain public assistance including healthcare.

In the case of the Lopez-Montez family there was the immigration status barrier creating an imbalance in healthcare coverage within the household. As mentioned, the eldest child because he was born in Mexico and still not having legal authorization was ineligible for public healthcare. His parents were also in the same predicament as they did not have healthcare coverage; the monetary issue impeded the father’s coverage while his mother’s inability to get coverage was compounded by both cost and immigration status. His younger brothers being US-born citizens had full healthcare insurance coverage through public healthcare programs.

This barrier was extended even to alternative sources of healthcare as is the Mexican healthcare system for many borderlanders; Talavera (2007) found this to be the case in his work in a border community. The inability to cross back and forth into Mexico because of the immigration status issue prohibits the household members from seeking care in that system. Even though the cost of healthcare in the US is not affordable with the current household income it is probable that the cost of care in Mexico could be more financially accessible for Pilar and other household members.

The effort being made by Pilar to integrate into US society such as pursuing her high school equivalency education and learning the mainstream language can be seen as the individual’s participation in the acculturation process. It will probably take years and perhaps generations to actually even begin to analyze, if possible, what the process of acculturation forges in an individual’s and a group’s actions especially when it comes to health and healthcare behaviors. The Lopez-Montez household may one day achieve a higher acculturation level and maybe even assimilation into the mainstream but again what the actual benefits and or detriments higher acculturation will have on this family is only something that can be speculated on.
Although Pilar insists that the only healthcare indications she uses are those of the US biomedical establishment, a trait assumed to be that of a higher acculturated individual, there is still the presence of “traditional” remedies in the home which are deemed to be characteristic of a lower acculturated individual. The process of acculturation into a more “formal” medical paradigm appears to be taking on a slow integrative path instead of a subtractive change. The “lesser acculturated”, “folk”, or “traditional” remedies are not readily discarded or are the “formal”, “more mainstream”, or “higher acculturated” treatments completely chosen by those in the process of cultural restructuring.

What was observed here was the influence social capital has on the beliefs and subsequent actions taken on by this lower acculturated individual. Pilar may lack the mainstream cultural capital, immigration status, and the financial position to fully access the US healthcare system but through the knowledge acquired by others in her social circle these barriers that are deemed as traits of lower acculturation have somewhat been circumvented. It was through the advice of her friend that she learned about the Clinica La Fe’s program to pay for healthcare in installments and it was also through her friend that she learned about the benefits of seeking preventive care a concept that is rarely embraced by those less acculturated and seen as a trait of those holding more “American” healthcare beliefs. Pilar’s family may not be fully insured but through the help of her social circle they could find a way to access a source for the needed healthcare.
CHAPTER 8

TRANSNATIONALISM: BINATIONAL HEALTHCARE CONSUMPTION

The El Paso-Ciudad Juárez region is marked by a high level of interaction both commercial-economic and probably more important social-cultural. The “twin cities” have millions of back and forth commuters every year allowing for the flow of ideas and ideologies into and out of the country and the consumption of products and services by an “army” of binational consumers--what Martinez (1998) idealized as the existence of a highly transnational population. The continued influence of or the connection to the “mother” culture by the ethnic Mexican community of the US side creates a unique environment and a sort of “laboratory” where an issue such as the influence acculturation has on “Hispanic” healthcare behavior can be observed in action.

An affordable option: Seeking healthcare in the Mexican healthcare system

Thursday June 18, 2009

The home is situated in the central area of the city in what is known as El Segundo Barrio. The neighborhood is characterized by a working-class economic level and the homes throughout are indicative of this, most being modest and humble in their construction. This particular home was not unlike those on the rest of the block, small, nothing luxurious with a clean front yard.

The participant, a young woman, probably alone at the time gave us the interview in the front porch outside of the home. There were a couple of lawn chairs and an old sofa where we sat down to get her information. There were no cars parked up front these were probably being used by other family members for work at the moment. Some kids could be seen playing basketball on the courts of an apartment complex just down the street. This area is supposed to be a “tough” part of El Paso but maybe the “tough” can be seen at another time of day because at the time of the interview it was actually
very calm; not many people outside and those that were catching the afternoon sun were quite friendly and courteous even the so called “vatos” that passed by said a silent “hey” or head nod meaning “que hubo” (“What’s up?”).

The participant is named Amanda Juárez who just turned 18 recently and also just graduated from high school in May. She is single, never been married, and has no children. The household consists of Ana Juárez the participant’s mother, a housewife, Joel Juárez her father, a professional (the participant did not specify what kind), and Javier Juárez her brother, a student. She did not know what her parents’ actual ages were; both were born in northern Mexico and have been living in El Paso for over 20 years. Their education was also a mystery she only knew that her mother had around a 4th grade education but her father’s schooling was completely unknown to her. Her brother Javier, like her, was born in El Paso. She says she has lived in El Paso all her life and nowhere else since she was 8 years old. That was the last time she lived outside the US, “I was born here then I went to live over there in J-town [Ciudad Juárez] when I was little. I stayed there ‘til I was 8 then I came here.” This back and forth movement puts the generational explanations or proxies for acculturation level in question.

Her primary language is equally both English and Spanish and from the way the interview was conducted it can be inferred that this is true since she had no problems both understanding the questions from the English format survey and holding conversation in fluent Spanish. The participant prefers English but it can be said that Amanda is thoroughly bilingual. The interview started out entirely in English but just like occurred in many other interviews I sat in on these slowly became conversations in an “interlingual” mode where both English and Spanish was used interchangeably. In the household the primary language she says is about equal English and Spanish but taking into consideration that her parents’ primary language is Spanish this assertion of hers could be only in her own perceptions. More than likely, because the heads of the household are Spanish speakers, it could be said that most conversation is in that language and perhaps, because her younger brother is also bilingual,
conversations between the siblings is in English. Then again this is only my interpretation using my own experiences as reference.

The young woman is wearing the typical attire of the “rocker” or “goth”: all in black from head-to-toe. She sports what appears to be a razor blade-shaped pendant on the leather necklace complimenting her look. Her horn-rimmed glasses give her an air of intellect kind of what John Davis the lead singer of the rock band Korn exudes with his eye-glassed stare. This is probably the look the participant is going for, an-all-American-kid-I-don’t-really-care mystique. It appears that Amanda has acculturated but not in the way that some theorists have interpreted the path towards integration. Amanda says that growing up her primary language was Spanish; growing up in Mexico even though it was at the border with the English-speaking colossus (Heyman, 2004) it seems that “frontier” Mexicans make a “heroic” effort to maintain at least a vestige of their “Mexicaness” and speaking the “native” idiom is a strong way to do this. It can be inferred that at that time Amanda, even at her young age, more than likely identified probably as “Mexican” even though she is a US-born citizen.

It could be said that her “goth” dress reflects that non-linear acculturation concept; again she dresses up like American rock stars all in black, natural hairstyle (no curling or styling etc) a far cry from what would be expected. The look is not unlike what is worn by millions of other youth across the country: mainstream. This of course is a subjective interpretation but this view is supported by the answer the participant gave when asked about her feelings on her “Hispanic” background:

Interviewer: “How do you feel about your ‘Hispanic’ heritage?” and he goes on giving the participant the choice of answers, “proud, very proud...” etc etc. The participant has a somewhat perplexed look on her face and before the interviewer continues gives this answer,

Amanda: “I don’t know. I don’t care. I don’t feel bad about it. It just is.” Unlike other participants especially from those of prior generations there is no sense of overt pride or excitement; being “Hispanic/Latino” or “Mexican” is no big deal “it just is”. Although she is someone that could be
classified as a bicultural borderlander, using Martinez’ (1998) classification schemas, there is no clear cut way of telling where and when and in what aspects of her life she is more “American” or where she is more “Mexican” and where the areas of hybrid cultural synthesis begin and end.

**Access to healthcare: Treatment in “J-town”**

As mentioned the modest dwelling indicates that the family is of working-class level although the participant does say her father works as a professional. The actual household yearly income is not known by the participant. Amanda does say that the only income coming in is that from her father’s work and from her brother’s employment at McDonald’s. At the moment the participant is still living at home and is for the most part dependent on her parents for her housing, food, and other needs. She is not employed. The participant said she was not sure if she was insured, “I used to have Medicaid but I am not sure if I have insurance now.” She does say both her parents and her brother are insured but she could not recall the name of the provider. There is no public assistance being received by the family at the moment

Amanda has been dealing with asthma since she was a child. The symptoms appear especially when she exercises and when other triggers are present; she was not clear on these but more than likely air pollution such as smoke and dust are the culprits. So being uninsured she says she usually goes to Ciudad Juárez for care and to purchase her medication. The asthma medication available in the US has become inaccessible since she lost her Medicaid coverage. Although she was not specific on her earlier experiences with the US healthcare/medical system it appears that as a child she was treated for her condition entirely here in the US. Since turning 18 and now ineligible for the government program she must either get private health insurance or acquire the needed medication and other healthcare treatments on her own or with help from her parents.
This parental aid in acquiring the vital healthcare needs may not be extensive enough because while Amanda’s mother and father can help with some things (e.g., transportation) other needs (e.g., US healthcare) are out of the question. For instance, she says she makes trips into the neighboring city to seek healthcare. This does not create a problem even though Amanda does not own an automobile or even knows how to operate one for that matter. In the past she has used public transportation to get to the port of entry and then walked across into Mexico but more often her family is there, “I don’t have a car but my family does,” she says a little solemn, “I don’t drive. If I get sick my family helps with everything, money, transportation all those things.” This alternative to the “expensive” U.S. medical system is available to many but not all borderlanders as barriers of different kinds block off this avenue.

Amanda says she almost never goes to US doctors and, as mentioned, prefers to go to Ciudad Juárez because, “it is cheaper.” There is some apprehension in visiting U.S. doctors because of cost so only in an emergency she says would she resort to seeking healthcare in El Paso. For example, she says a cost of $25 for care would not be an issue, “$25 would not be bad that is what I usually pay over there in Juárez when I go, about $20.” But a higher cost may cause a problem, “maybe yes but maybe not if it could be paid in payments.”

Other “cultural” barriers such as language are dealt with in an efficient manner by many binational, bicultural, bilingual healthcare consumers such as our participant. Amanda’s bilingualism makes such barriers non-issues when she goes to seek healthcare in the Mexican system; she can speak Spanish and knows the system enough to navigate the healthcare system there. So as of today she has had no problems reading and filling out forms or understanding instructions from her Mexican doctor.

In the recent past she had some medical tests done in Ciudad Juárez which she paid for in cash. The tests would have been “too expensive” here in El Paso but there in Ciudad Juárez she could cover the cost with help from her parents. This avenue to accessing care for her asthmatic condition may also be subject to a considerable barrier. Amanda notes that her trips into Ciudad Juárez have become less
frequent because of the violence ravaging the city. Another factor affecting her decision to continue going to the “sister city” is “the long lines on the bridge”. The collateral effects of the “War on Drugs” and the “War on Terror” are manifesting themselves in different aspects in the lives of both Juarenzes and El Pasoans; healthcare-seeking behaviors included.

The participant’s beliefs and adherence to healthcare paradigms seem to follow the pattern seen in many other borderland households: that of a mix of healthcare systems which are used depending on contextual factors. Growing up she says that the family sought out “traditional” healthcare such as herbs (yerbas) and the holistic care from “folk” medicine men or curanderos. This “traditional” healthcare was integrated with the formal biomedical establishment of doctors and pharmacists in Mexico. Today she only goes to the “real” doctor to get treatment and medication this care is supplemented with self-prescribed over-the-counter medication (“some pills”). The days of visiting the spiritual healer, at least in the life of Amanda, are over and now the visits are made to a new technologically-enhanced ethno healthcare provider: the biomedical doctor.

A look into Amanda’s preventive healthcare habits gave some surprising insight into her health knowledge or lack of it. When asked if she had ever had a pap smear the participant looked puzzled, “No, what is that?” The nature of the question is sensitive to begin with and having two men touch upon the theme with a young woman made the situation a little more uncomfortable. When this section is read in the future it will be discussed and questioned as to why two trained (or researchers in training) would feel uneasy asking any questions during a survey but again the differences in cultural or social upbringing will come into play. Certain subjects, such as the one on women’s health, in sections of the “Hispanic” community are understood to be discussed only by women with other women. After the interviewer gave a brief explanation Amanda, with an embarrassment-filled look, said she had not.

Continuing on with this area of the participant’s healthcare behavior we found out that although not very knowledgeable about health and healthcare she actually did follow certain preventive measures.
Then again we also see how complex an individual’s healthcare habits and understanding of health in general are. What we find appears to be irregularities in the person’s behavior. When Amanda was asked if she had ever had a breast exam she answered, “Yes, in a physical” the surprise here was that when she had been asked about checkups she said she was not sure if she had ever had one. She may have had a professional checkup but then she also says she does not perform self-examination of her breasts as a preventive healthcare measure.

A glimpse of what is deemed as a positive health habit is presented when she says her blood pressure was checked about 4 months ago but then a countering trait is revealed when asked about blood sugar level tests. For the question on this test she responded, “No, cause I don’t know. I didn’t think I did [needed it].” The response for cholesterol tests was similar, “No, I guess because of the same thing (reason).” Perhaps at this age Amanda has not had to deal with any illness other than asthma that required treatment or preventive care. Being relatively healthy has kept her from seeking other healthcare and when she has had to, including her asthma, her parents have been there to help and guide her through the borderland’s healthcare system.

Discussion

Living on the border allows for the daily interaction that both exports and imports different goods, services, and cultural expressions. The US-Mexico border has been said is quite unique in the world since this is the place where a developing nation comes face to face with the planet’s superpower. The differences between the two nation states abound but none could be any larger than the discrepancies in economic level. At the border this difference creates the opportunity for the sudden change in value to be taking advantage of by those consumers whose mentality is of a binational or international nature (Heyman, 2004). Goods and services that may be inexpensive in one country may garner a much higher monetary return by crossing the international boundary and likewise a service that
is expensive even unaffordable for many in one country just across the bridge there exists a financially accessible alternative. Healthcare services fall within this “step down in value” (Heyman, 2004).

This case is not unique as throughout the US-Mexico border the use of both the US healthcare system and the Mexican healthcare system by persons on both sides of the border is an everyday occurrence. Persons living on the US side make use of the medical system in Mexico and Mexican residents go across the border to seek healthcare services in the United States. The use of healthcare of distinct kinds is not limited to the formal biomedical as even alternative and “folk” “traditional” remedies are sought out by American and Mexican consumers. The purchase of medication also occurs as has been documented by some studies (Rivera, Ortiz, & Cardenas, 2009). The participant is one of these binational healthcare consumers.

Amanda exhibits cultural characteristics that may be associated with the more acculturated “Hispanic” population such as in her preference for the English language and the indifference in the way that she talks about her ethnic identity. Her acculturation in action can be seen in the more superficial layers of the pop culture but what Amanda actually does in her healthcare-seeking endeavors is more telling of the influence her cultural environment and her psycho-cultural makeup has on her actions.

In order to access the needed treatment for her asthmatic condition the participant has been going into Mexico where the cost is affordable for her. A recent high school graduate, Amanda does not have the financial means to get healthcare coverage or to pay for her treatment in the United States. So with the help of her family this participant circumvents the financial barrier encountered in El Paso by making the best of the borderland’s healthcare pluralism. The ability to navigate both cultural spheres in Mexico and the US (i.e., her biculturalism) allows her to access this vital resource. She feels competent enough in her “Hispanic” cultural capital that she is comfortable going into Ciudad Juárez to seek care. Bilingual healthcare providers more than likely exist in the northern Mexican city but in order to
navigate the system effectively, especially for a young inexperienced person, a certain measure of cultural competence is needed.

Amanda’s complex cultural makeup is further displayed in the way she goes by seeking and withholding from preventive healthcare services. The participant’s irregular checkup schedule and even her lack of knowledge of the existence of certain healthcare procedures appears to show a person of low acculturation level but then again her exclusive use of the biomedical system even if it is in Mexico is characteristic of a higher acculturated individual.
CHAPTER 9

SUMMARY

The multi-layered nature of the association between acculturation and “Hispanic” healthcare behavior, in particular those “Hispanics” living in the El Paso/Ciudad Juárez region, can be seen in the different case scenarios that have been presented. There is ample evidence to support the occurrence of overlap in the case material collected that is that more than one theme was observed in the households during the data collection and analysis.

In the area of access and barriers the case study supported the hypothesized outcome where the person with a lower level of acculturation used social capital to circumvent barriers that lower cultural capital and structural factors created when searching needed healthcare. Looking at other cases in the study we find that it is relatively easier for those with higher levels of acculturation to access healthcare in the US biomedical system. There is also support for the suggestion that those with the financial means will be able to access needed care in the US especially when this financial capital provides the ability to purchase healthcare insurance coverage.

When looking at gender we saw case studies where both men and women withheld from needed care because they saw it as their responsibility to provide for their families first. In the case of women this supports the view of the martyr woman or maria that has been propagated as being an integral part of “Hispanicity” but looking at other case material in the study one sees that this marianismo is not present in every context. Some of the women that were interviewed found it necessary to take care of themselves even when caring for children or other household members. These “Hispanic” women know that the health of the family is related to their own personal well-being so it is in the best interest of the entire family for her to maintain her health. Acculturation level may have a say in what actions they took healthcare-wise but it in no way fully determine what was undertaken.
The concept of *machismo* was again put to the test by the case study observed. The participant’s actions showed what has been attributed to lower levels of acculturation when he held out from receiving healthcare even when symptoms appeared. And then the case shows how the participant’s actions then contradicted “traditional” interpretations of the macho when he continued to work in an effort to continue providing for his family even though it was his employment that was causing the affliction in the first place.

Furthermore, these cases showed how defining a starting point for “Hispanic” healthcare beliefs/utilization preference can be a daunting task. The participants, Mauricio and Celestina, were not only socialized or enculturated into a biomedical paradigm but as grownups chose to seek care in a new age healthcare system; “traditional” healthcare was not part of the participants’ healthcare belief and utilization system.

To further support the complexity of the “Hispanic” “starting” and “ending” point we saw a case where the move from a lower level acculturation to a higher level of acculturation appeared to follow the conceptualizations used in uni-linear models. The simple move from more “traditional”/ “Hispanic” to more biomedical/ “American” seems to be evidenced by the case but then we examined a different case of a person who has “reached” a distinct “end” on the acculturation continuum--an end point that might be described as a bicultural mix rather than pure assimilation. The healthcare behavior exhibited by the two case participants present just how difficult it is to explain the correlation between acculturation and healthcare in the “Hispanic” population.

In several of the cases we saw how much transnational movement affects the way El Paso “Hispanics” make use of the medical/healthcare services available to them here on the border. When the needed services cannot be accessed in one country or the other, those that have the financial means and/or the cultural capital turn to the neighboring healthcare system to alleviate their maladies; the binational consumer makes use of many of the services that their borderland biosphere offers.
CHAPTER 10

SUGGESTIONS FOR FUTURE RESEARCH

One of the most intriguing observations made during the study was the language used during the interview sessions. The interviews were intended to be conducted in either English or Spanish and surveys were created in both languages. The surveyors carried both survey versions with them on their house to house ventures giving the participants a choice as to which language they felt more comfortable taking the survey in. The high percentage of ethnic “Hispanics”, many of whom are bilingual, in El Paso County would probably lead one to believe that the two versions would cover most if not all the language barriers that could be encountered in the field.

The 37 interviews that were observed all began in either language English or Spanish depending on what the participant chose but in many cases there occurred what might be expected in a highly bilingual and bicultural community: the persons not only speak in a mix of the languages but also appear to think and conceptualize in two cultures simultaneously. In these cases the interview started in English or Spanish but as the interviews progressed the language used to fully convey the message being sent from interviewer to interviewee, and vice-versa, gradually took on the form of the borderland idiom: Spanglish.

When questions became confusing for some of the interviewees the more seasoned surveyor would break down the question into parts explaining some of the question in Spanish and others in English. This strategy was observed several times throughout several interview sessions. It appeared that when interviewers with either less experience or with less bilingual/bicultural skills presented the questions straight from the survey as they were in either language those interviewees became perplexed and just answered the question “to fill in the blank”.

This is reminiscent of what happens when mainstream healthcare providers and non-mainstream patients come into contact in the healthcare system. Language barriers only account for some of the
obstacles that are encountered since there are the deeper meanings embedded in the language and/or belief systems of the two actors. In order to get a deep understanding of what the patient is undergoing health-wise there needs to be both a linguistic and a cultural avenue of communication. When interviewing a bilingual and bicultural (intercultural) population this break in communication also appears to occur. In order to reveal the actual beliefs and/or behaviors that the group takes part in everyday life, especially in healthcare matters, the interviewer must not only be bilingual but also at least be aware that such cultural differences exist. A preferred action would be to have interviewers/surveyors that are “ingroup” members or that are highly acculturated in the culture of the group that is being studied.

Another area that needs to be further looked into is the sometimes unperceived and perhaps underestimated occurrence of discrimination against “Hispanics”, especially against those with lower levels of acculturation, by healthcare providers and healthcare institutions.¹ The question in the survey used for the study from where the data for this paper was taken from was a straightforward quantitative approach. A “yes” or “no” answer was recorded when the participants were asked “When you go for medical treatment in the US, do you feel you are treated respectfully?” (¿Cuando va a un tratamiento médico aquí en los Estados Unidos, siente que la/o tratan respetuosamente?). This quantitative approach may somehow miss or underestimate the actual occurrences where discrimination acts as a barrier in accessing care for those of Mexican-origin especially those with a lower level of acculturation.

To get a better sense, in my opinion, a qualitative approach detailing the individual’s life experience with the healthcare system in the US would be a better approach. Through narratives given by the participants the sometimes subtle or hidden episodes of discrimination can be brought to light. With a “yes” and “no” format the tendency to “look good for the researcher” may impede the person from divulging certain negative experiences with other “professionals” like the researcher. In other words they may not want to talk bad about persons that are “similar” to those asking the question on
discrimination. By allowing the participant to tell a more detailed account of the experience the person is given the opportunity to explain what transgressed in a not so straight forward manner.

The pathway section attempted to capture some of the experiences but there needs to be more specific questions dealing with discrimination or perceived discrimination presented in this section. Not only would we ask “how did you deem the quality of the care?” but also “how was the interaction between you and the healthcare provider?” The question is simple and not “guiding” or “goading” the participant in a specific direction.

Another suggestion, the question on “Hispanic” men’s health on prostate cancer screening can be cross-tabulated with the acculturation level index calculated from the various proxies used in the survey. This again needs to take into consideration the multiple factors that compose “acculturation”. There might be a belief that lower acculturated “Hispanic” men will tend to have fewer instances of preventive screening especially in this area. For many Mexican-origin men, and probably most men in general, it is considered highly taboo when certain areas of the body are “violated” or “penetrated” and none is more taboo than the rectal area.

Will lower acculturated “Hispanic” men actually have lower instances of preventive prostate cancer screening compared to those higher acculturated? Does this “cultural” tendency actually exist or is it just a presumption? Answers to these questions are vital to implementing a culturally-sensitive program aimed at improving preventive care in this very important area of men’s health in the El Paso Mexican-origin community.

Finally, the question on family planning methods brought out what I believe is a strong influence of cultural gender expectations in the Mexican-origin population of El Paso. Several of the male participants answered in the almost same exact form when asked about the family planning strategies, if any, that were followed by them. The answer given was “la señora es la que sabe” or “eso
es cosa de mujeres” (“my wife is the one that knows” or “that is a woman’s issue”). It appears that “Hispanic” men have been socialized to leave this area of health entirely in the hands of “their women”.

A deeper look into this gender influence could provide details into the sexual behavioral patterns of Mexican-origin persons in the El Paso borderland. By using the acculturation level index the correlation, if any exists, between acculturation and sexual health practices will be better understood. Do attitudes on sexual health change with the differing levels of acculturation and in what contexts? This information may provide data that can serve to create culturally-sensitive and relevant programs to combat sexually-transmitted diseases such as HIV/AIDS in this community.
CHAPTER 11

CONCLUSION

It would be prudent to recall Ewart’s (2004) conceptualization of a multi-layered model when looking at the correlation between acculturation and health. Acculturation as has been proposed is just one factor in a complex web of interactions that may facilitate or impede access to needed healthcare. Although this is only a case study the shaping forces that the higher, political economic level factors such as immigration status, income, and lack of insurance were consistently seen as a major influence on the healthcare behavior of the households analyzed. At the middle level we saw how an acculturation status composed of distinct facets, although not alone, played a role in the way persons chose to handle their healthcare needs. These in turn were observed in the manner individuals exhibited complex, even contradictory behavior. The actions taken by the persons may or may not have taken on a more “Hispanic” or “American” approach. A complex, integrative paradigm came to the forefront time and time again.

“Hispanic” is a neat label where many peoples are grouped into in an effort to minimize “confusion” in a system intent on being cost-efficient. A bureaucratic attempt to fit nicely diversity into uniform groupings in the long run falls short in maintaining a healthy social balance. This can be appreciated in the way certain groups are left out when it comes to appropriating certain resources such as healthcare. In the world’s strongest economy, where resources abound, there exists pockets of humanity that in matters of access to healthcare are not better off than many people living in Third World countries. As a group “Hispanics” in the US fall into one of these healthcare-deprived pockets. Is the main factor due to a cultural trait? Could it be due to the level of acculturation into the “more healthy culture”? Is it because the structure of society has inadvertently been molded into a shape that is geared to benefit some and shun others?
As aforementioned, there was no attempt to pinpoint a definition for the concept of acculturation. The aim was to present distinct facets of what can be deemed as acculturation in action that is behavior that appears to show different levels of acculturation in the different facets or segments that make up the process such as language preference, pop culture integration, ethnic identification, and more importantly healthcare beliefs and utilization. Using the participants’ actions we could see that the people observed have a complex cultural makeup not fully expressing one culture or the other but actually making use of a segmented form of acculturation. Individuals appear to pick and choose the best available actions or cultural manifestations depending on the context or the situation both in and outside the household in order to access the needed resources including healthcare. These different “points” on the acculturation continuum equal different, but all useful, sets of cultural and social capital. Becoming acculturated means not just learning the mainstream language, distancing from or embracing an ethnic identity, preferring a certain type of food or mass media, arriving at a certain point on the continuum, or changing healthcare paradigms in fact these are all facets of an overall synthesis that will fluctuate through time and place at a group or an individual level.

So if the actual concept itself is a challenge to define and or isolate, the influence this “illusory” construct has on access to health care can be even more challenging. But even when such a conceptualization problem is confronted there is no denial that the process of acculturation exists and is having an influence in the way “Hispanics” and other “immigrant” groups are utilizing healthcare services in the US (Chavez, McMullin, Mishra, & Hubell, 2001). Acculturation serves as cultural capital that the individual or group can look to when navigating a new environment; the more or higher the level of cultural capital/acculturation the better the individual or group can negotiate their surroundings.

A multi-dimensional framework of acculturation can be appreciated in the way individuals went by utilizing the array of available healthcare resources in the borderland. Areas in a person’s life that
lacked “American” cultural capital, that is where a lower level of acculturation was found, was compensated for in other areas so as to circumvent the barriers created by the upper layers in the healthcare behavior accessibility model. A prime example of this can be appreciated in the way some Mexican-origin persons, as well as those of non-Hispanic background, make use of the available healthcare sources in the El Paso/Ciudad Juárez borderland. The change in value especially the “step down” (Heyman, 2004) in the cost of healthcare the two neighboring states created by global economic structures is utilized in an advantageous manner by those “Hispanics” that do not fare off as well in accessing resources in their homeland USA.

As mentioned throughout a multi-dimensional, segmented approach gives a much better understanding of the various other factors that come into play in conjunction to affect healthcare behavior and access in the US “Hispanic” community. Acculturation cannot and should not stand alone as a determining factor when researching health and healthcare in immigrant/acculturating groups. All the levels that affect healthcare as proposed by Ewart (2004) must be acknowledged and accounted for. For instance, a community’s racial relations both present and past must be taken into account when studying a group’s inability to access needed resources such as healthcare. Lingering effects of a segregated past may still unconsciously factor into this equation.

Even when there is evidence to support the existence of such a phenomenon as acculturation it is unwise to believe that the major factors leading to healthcare disparities in the Mexican-origin community are culturally-based. Falling in this pitfall would relegate the study of acculturation as a factor in healthcare to the racially or biologically based medical paradigms of the past. Research (Budrys, 2003) has proposed that we look at the structural factors that have historically created an atmosphere where the minority and many times marginalized communities have been negated full access participation in the mainstream society. Others even propose that acculturation in fact makes the
integrating group aware of the structural violence in the society thus helping to create a stressful and unhealthy situation for these (Viruell-Fuentes, 2007).

Structural factors within and throughout a society must be accounted for when looking into the supposed health/healthcare characteristics of a group. Too many times actions coming from “within” a group or deemed “cultural” behaviors are magnified and pointed out as the causal effects for the presence and promulgation of illness within the said group and too many times the structural factors are not given their just weight or are altogether ignored in the discussion. Group members themselves sometimes say that it is a “Mexican” behavior to not seek healthcare until it is already to late ignoring the facts such as a prevalence of low healthcare insurance coverage in the community.

What was observed though from those facing the brunt of structural forces were actions demonstrating both agency and resilience. Social capital made up for the lack of cultural capital gained through the process of acculturation. When healthcare access was impeded persons looked to their social circle such as seeking advice from friends and family to get the needed care. Moreover, borderland “Hispanics” looked to their own cultural capital to combat barriers such was the case with those that maintained use of “traditional” home remedies. Furthermore, those that have achieved a certain level of competence in the borderlands multicultural environment (e.g., those that are bicultural, bilingual, and binational) made use of the healthcare paradigms available both in El Paso and Ciudad Juárez. A competent level of borderland cultural capital enables them to seek healthcare in Ciudad Juárez and a strong level of social capital brings information that allows for care in the US at places such as Clinica Familiar La Fe. A multi-dimensional framework of acculturation enables “Hispanics” of Mexican-origin in the El Paso region to live and even thrive in a complexity-laden multicultural environment.
NOTES

CHAPTER 1

1) "Hispanic" will be in quotes throughout as a questioning of the governmental catchall label. The “group” that would best describe the people in the study are better defined as “of Mexican-origin” since the makeup of the El Paso “Hispanic” population is composed primarily of persons with an ethnic Mexican background.

2) The use of the words “less”, “lower”, and “higher” when referring to acculturation level is not intended to propose a hierarchical ranking of cultural traits. “Superior” and “inferior” cultures are human inventions that have no place in this work.

CHAPTER 4

1) To call this a “worker” mentality is degrading but it appears that generations, centuries even, of molding persons into “manageable” workers has somehow been integrated into our socialization/rearing practices and as such the mentality is perpetuated from parent to child. The “worker” has been denied access for so long that he/she has internalized this behavior as “their own” as a “cultural” trait: a hard worker persona. The problem is that patients from minority groups only say that they would use healthcare if there was access to it but in reality they will not. It is true that some actually do seek care but there are many instances when this answer is only given to make the researcher think that they would. Over and over I have seen Mexican men all over the valley that avoid going to the doctor unless it is absolutely necessary and that is when the pain is so unbearable that they cannot go to work. My opinion was formulated in a family upbringing tied to agricultural work.

2) One theme, Religiosity, was not in my view significantly supported by any of the cases in the study so the issue was not looked into in more detail. Although evidence did not appear to support or oppose influence by religiosity on “Hispanic” healthcare behavior this in no way means that it is not a factor.
The nature of the survey was not geared towards detailing the influence or non-influence religion or spirituality has in healthcare behaviors of the “Hispanic” community, i.e., the questions asked did not probe into this facet of the participants’ life.

CHAPTER 5

1) It is important to note here that Mauricio’s case further questions the “traditional” macho interpretation when we find out that this proud Mexican man has opted to undergo a procedure that has been associated by many men, and not just “Hispanic” men but many men in general, as a form of emasculation. Mauricio has undergone a vasectomy as a “metodo mas efectivo de planeación familiar” (“a more effective family planning method”). In an effort to ensure that his family does not grow in number and in the hopes of providing a better life for his two children, Mauricio has gone against the supposed prevalent belief in the “Hispanic” male population that to have more children is to be a “bigger” man.

CHAPTER 6

1) A “group” is like the wind, travelling unimpeded through space, immersing into new arenas through crevices and at times by tearing down walls some virtual, others concretized.

2) The participant made a quick comment on the music of the legendary Ritchie Valens. The rock n roll legend from the late 50’s has been an icon in the Mexican American/Chicano community for generations now. This is somehow related to this acculturation phenomenon in that this son of Mexican-origin parents synthesized two cultures in order to reach the American masses. Richard Steven Valenzuela became Ritchie Valens and the “traditional” Mexican anthem “La Bamba” became ingrained into the “American”, non-Hispanic white psyche.
CHAPTER 7

1) Thanks to Nicholas Emerick for his invaluable input when discussing the acculturation process. An *acculturation agent* may sometimes be thought of as an institution or a federal policy aimed at hastening “Americanization” but perhaps the most highly influential instigators or catalysts of cultural change are the young, inquisitive, and innocent minds of children.

2) In a time where there is much uncertainty in the borderland there appears to be a heightened sense or belief in “group” mentality. There is a tendency to hear and see ethnic Mexicans labeling each other in an effort to distinguish and distance themselves from the perceived “bad” type of “Mexican”; a sort of intra-racial profiling is occurring.

Borders, barriers, and boundaries physical but more often social and psychological divisors that peoples build around themselves and the “other” so as to give the “self” meaning vis à vis “those” unlike “us”. In the home we erect walls so as to tell the neighbor “this is my space so respect it” and the neighbor somehow reciprocates the thought and constructs a wall of his own. “That is your space? Well then this is mine.” Words that may never be uttered but are subtly conveyed through these protective barriers that we construct not only in the physical realm but also and, maybe more debilitating, in our minds. The current world situation where long standing walls have began to be breeched in the name of the global economy has seen a resurgence in the need “to be protected from the outsiders” and “the would be nation-destroying influences” these might bring into “our” space, into the very center of “our” being.

Aurelio Saldaña Jr.-Spring 2009 (Thank you for your insights on border phenomena Dr. Heyman.)

CHAPTER 10

1) The city of El Paso can be said is an ethnic Mexican enclave where much of the discriminatory experiences felt in other areas of the country are not as widespread. But because the city’s demographic
makeup is composed primarily by “Hispanics” of Mexican descent this in no way means that discrimination does not occur within the “group”. This intra group discrimination in relation to healthcare needs further exploration.
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CURRICULUM VITA

Aurelio Saldaña Jr. was born in Fabens, Texas. The first son of Mexican immigrants, Aurelio and Yolanda Saldaña, he graduated with honors from Fort Hancock High School, Fort Hancock, Texas and entered The University of Texas at El Paso the subsequent fall semester. After an unsuccessful first attempt at a higher education, Aurelio took an extended hiatus from education joining the workforce finding employment in both the agricultural and manufacturing sectors. In the fall of 2003 he once again undertook his academic endeavor enrolling in El Paso Community College where he concentrated in the discipline of psychology earning an Associate of Arts degree in the fall of 2005. In the spring of 2006 Aurelio re-entered the halls of the University of Texas at El Paso with solid determination this time achieving a Bachelor of Arts degree in psychology in the fall of 2007 and a Bachelor of Arts degree in anthropology in the summer of 2008. In the fall of 2008, he entered the Graduate School pursuing a Master of Arts degree in sociology at the University of Texas at El Paso.

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