THE EFFECTS OF ACCULTURATION ON HEALTHCARE IN THE MEXICAN-ORIGIN COMMUNITY: EL PASO COUNTY, TEXAS

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Dedication

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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by

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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). Lower[2] 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 "*compadre*s". This worker or provider mentality[1] 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 misrepresentative 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.