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## **Resistant acts : challenges of older and chronically ill Mexican women living in 21st-century United States**

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## ABSTRACT

### RESISTANT ACTS: CHALLENGES OF OLDER AND CHRONICALLY ILL MEXICAN WOMEN LIVING IN 21<sup>ST</sup>-CENTURY UNITED STATES

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Older and chronically ill Mexican women living in a 21<sup>st</sup>-century working-class neighborhood confront many challenges. The challenge of being older and chronically ill are exacerbated by the multiple socially constructed identities of difference they embody, such as race, gender, class, linguistic competence, immigration and educational status. In their search for health and wellbeing, these embodied differences construct for the women a number of care-searching, care receiving and health-outcome experiences that reveal the effect these differences can have in the lives of members of a vulnerable population. The women's experiences also reveal their determination to gain access to affordable, safe and quality healthcare in spite of challenges and abuses.

Applying the theory of intersectionality and grounded method throughout the analysis of the data reveals the burdensome effect that interlocking systems of domination have on the women's health and wellbeing. Furthermore, applying the theory of intersectionality and grounded method leads to a fuller understanding not only of the women as victims but as resisters of victimization through their acts of everyday resistance. The women's acts of resistance, successful and failed, demonstrate that it is not the individual's behavior nor the women's culture that got in the way of the women accomplishing health and wellbeing. Rather, the culpability for poor or impossible access to affordable, safe and quality healthcare services

and for compromised health and wellbeing is based on social structures supporting the interest of dominant actors and institutions. More precisely, multiple constructs of difference intersect to construct a multiplicity of experiences of inequity and these together impact health and wellbeing outcomes in a number of negative ways. Healthcare professionals, organizations and governments (local, state and national) should include grounded methods and the theory of intersectionality in their analysis of the life experiences of subjugated populations so that barriers can be exposed and best practices in healthcare can be implemented. A more comprehensive and grounded understanding by stakeholders of the lives of those who are systematically excluded from equity in healthcare will bring members of vulnerable populations closer to meeting their health and wellbeing goals.

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RESISTANT ACTS: CHALLENGES OF OLDER AND CHRONICALLY ILL  
MEXICAN WOMEN LIVING IN 21<sup>ST</sup>-CENTURY UNITED STATES

BY

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## DEDICATION

To all the women in the world, past and present, who chose to lose even their lives  
so that other women could gain theirs

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## CHAPTER 1: INTRODUCTION

How do women who are discriminated against because of their race, gender and class and are older and chronically ill accomplish health and wellbeing regardless of the opposition of dominant systems around them? When confronted by challenges and abuses to their health and wellbeing, members of a subjugated group resist in distinct ways. These ways of resisting can be observed in the lives of Mexican women as they attempt to gain access to healthcare resources and treatment methods. This thesis focuses on the ways in which older and chronically ill Mexican women living in a working-class neighborhood in 21<sup>st</sup>-century United States confronted challenges in their pursuit of health and wellbeing and enacted distinct acts of resistance in the context of their care-searching and care receiving experiences. The women's experiences with the healthcare system was influenced by their embodiment of socially constructed categories of difference such as gender, race/ethnicity, class, linguistic competence, immigration and educational status. Rather than giving in to expected "total conformity" (Collins 1986: S24) from agents, institutions and dominant ideologies, the women enacted oppositional acts with the goal of maximizing health and wellbeing. The challenges and abuses the women confronted when working towards maximizing their health and wellbeing were represented by the following resistant acts: they viewed themselves as fully human and therefore became

advocates on their behalf (Collins 1986); they exposed institutional failures by openly “pressing their own claims” (Armstrong & Murphy 2011: 317) and by “self-valuing” (Collins 1986: S16); they used “religious equipment” to “negate dominant ideologies” (Scott 1985: 331); and they adopted a “way of life” (Vinthagen & Johansson 2013: 10) that demonstrated that they valued their bodies and their lives in ways that dominant groups did not.

Thirteen in-depth interviews were used to collect qualitative data over a period of one year and five months. The women in my study suffered from chronic illness as one aspect of their lives. Chronic illnesses often develop slowly, persist over an extended period of time, are complex to solve and may cause death if not treated or as a natural consequence of the disease. Heart disease and stroke, cancer, arthritis, AIDS, diabetes, epilepsy, amyotrophic lateral sclerosis (Lou Gehrig’s disease), alcohol addiction and depression are just some examples of chronic illnesses.

Chronic illnesses are the opposite of acute illnesses. Acute illnesses overtake an individual suddenly and are expected to be brief in duration. They include, for instance, conditions such as strep throat, an asthma attack, a broken bone, and a bladder or ear infection. An acute condition can evolve into a chronic one. For example, someone may injure her back, necessitating surgery, but remain in constant, unsolvable and disruptive pain. While someone having an acute illness can expect recovery, someone suffering with a chronic illness is often uncertain of the outcome.

Because of the often long duration, expense, complexity, care demands, long-term process, outcome uncertainty and debilitating effects of chronic illnesses, sufferers confront social, mental, emotional and economic challenges that may not be faced by acute illness

sufferers. Being of older age can complicate someone's existing health condition with the exacerbation of a chronic illness. "Nationally, 60% to 75% of older adults have multiple (two or more) chronic conditions (MCCs), and the burden is even higher among low-income, racial/ethnic minority populations" (Ralph et al. 2013: 1).

### Care, Care Receiving and Care Receiver

Care receiving is the experience of receiving care. Receiving care is arranged by oneself or others – people or institutions – with the ultimate goal of achieving a balanced wellbeing on behalf of the care receiver. There are many variations (Leininger 2002) of the care receiving experience. The care receiving experience may be formal (institution) or informal (family), emotional or instrumental, or continuous or intermittent. Another key aspect of the variation of care is when the care receiving experience involves a care partner that has "a holistic understanding of what it might be like to be a member of a given cultural group at a given time in history" (Sobo 2009: 298).

Taking all types of care into consideration, what matters most to the care receiver is that the care they receive includes the most important domains of health and wellbeing in their lives as defined by them. While I initially approached the study defining "health" as only physical, the women in my study identified socio-emotional, mental, socio-cultural and religious/spiritual wellbeing as equally important factors of health. Therefore, I had to amend my preconceived ideas about what health meant to the women to include other domains as key components of their health and wellbeing. The women also identified a variety of people and institutions as

key partners in their care-searching and care receiving experiences. For example, a parish nurse, a devoted husband or God were identified as key partners when the women confronted challenges to their health.

One must keep in mind that being cared for and being cured overlap (Jecker & Self 2002). While caring is not curing, however, receiving the care needed and desired by the care receiver can lead to a stable sense of wellbeing. And once the participant accepts in full or in part the limitations imposed by her chronic illness, a stable sense of wellbeing may become the ultimate goal rather than a cure. Finally, agreeing with Tronto (2001:63) and having listened to the women tell their stories, I agree that receiving care “rarely occurs in a perfect way.” Nevertheless, the care the patient receives from any person or institution should reflect the input and the best interest of the care receiver (Leininger 2002).

The care receiving vis-à-vis care giving experiences of the women in my study were fraught with challenges. For the women, care receiving is not a stable and relatively straightforward experience. Moreover, their experiences of asking for care for their chronic illness(es) did not proceed within a healthcare system that was blind to their gender, ethnicity, class, immigration status and language, or one that gave “unbiased” healthcare to these women. Rather, the healthcare system has many “moving parts” composed of contributing or counteracting family members (informal care), interpreters, nurses and doctors and institutional goals, preferences and limitations. The intersectionality of difference, and the reactions this invites, are managed by the women through everyday acts of resistance (Collins 1990; Scott 1985; Vinthagen & Johansson 2013). These acts revealed the women’s knowledge of their

place in life, their knowledge of caring and opposing forces and their determination in believing that there was always another door to achieving health and wellbeing.

## CHAPTER 2: LITERATURE REVIEW

Migration, gender, violence, aging, neighborhood and healthcare access are some of the factors addressed in the literature which relate to the social and cultural lives of women, immigrants, older and chronically ill individuals. Increasingly, more Mexican women are migrating to the United States (Almond 2005; Viveros 2008). Mexican women migrate with or without consent and in spite of the opposition of their families or husbands (Hondagneu-Sotelo 1994). The reasons and challenges for women migrating are varied and are not always associated with historically male-dominated narratives of migration (Richter & Taylor 2007). For example, biased policies that favor the migration of men over women (Kanaiaupuni 2000), the cost of illegal migration – not as affordable for women as it is for men (Viveros 2008) – or the tradition that dictates that women rather than men provide primary and essential care to the household's children (Rodriguez-Scott 2002) are all significant challenges. Some reasons and avenues for female migration are gender inequality back home, economic gain through employment in the United States and well-established migration networks at home and abroad in the United States (Kanaiaupuni 2000). Because of the patriarchal belief system that dominates in Mexican culture, women more than men have to more carefully strategize their migration plans and resist demands for their return back home (Hondagneu-Sotelo 1994). According to Casasa García (2007), Mexican women are often demonized and are opposed in their efforts to migrate; however, for those women who are able to migrate, Hondagneu-Sotelo found that, once in the

United States, the women became more autonomous and assertive and “men’s dominance over women in Mexican families” began to erode (Hondagneu-Sotelo 1994: 14).

Nevertheless, violence against women is still a problem. The prevalence of violence against women in Mexico is well documented (Mendez-Hernandez et al. 2003; Ramirez-Rodriguez 2006; Rivera-Rivera et al. 2004) and violence against Mexican-immigrant and undocumented women is also reported in the United States (Chavira-Prado 1992; Kyriakakis et al. 2012). The migration experience provides the women, however, with opportunities for learning to do men’s work, working for wages, expanding the number of tasks to be learned, administering household income and being freed from daily servicing their husbands (Hondagneu-Sotelo 1994). Therefore, Hondagneu-Sotelo (1994) argues more egalitarian patterns of experiencing marriage are put in place by the women through subversive acts back home for those women who remain behind and in the United States through the acquisition of social power and a new sense of competence and autonomy.

The Hispanic health paradox (also known as morbidity-mortality paradox or epidemiological paradox) claims that regardless of their social and economic disadvantaged status, Hispanics/Mexicans in the U.S. have lower disease prevalence and disease mortality than non-Hispanic Whites (de la Torre & Estrada 2001). De la Torre and Estrada (2001) argue that it may be that Mexicans go back home to Mexico to die and are not counted in the data and that healthy Mexicans are the ones who migrate to the U.S. Morales et al. (2002) espouse that the potential misconception regarding the lower disease prevalence and disease mortality reported for Mexicans may stem from the data, for example, the reliance on questionable mortality data used by researchers – more precisely, race and ethnicity data for Hispanics. Both de La Torre et

al. and Morales et al. (2002) concur that more research should be done to explain the Hispanic health paradox.

In their study, Eschbach and colleagues (2004) found that for older Mexican Americans it is advantageous to their individual health to live in communities highly populated by their compatriots in spite of poverty. This may be due to social cohesion and avoidance of racial discrimination. Similarly, Gerst (2011) found that ethnic homogeneity affects the health of older Mexican Americans positively. In his study, however, Gerst (2011) found that depressive symptoms for women are more prevalent than for men. The social context of destination site and how its elements interact with the type of relationship between the heterosexual couple in the home may determine the type of experiences Mexican women have in the United States (Dreby & Schmalzbauer 2013). For example, the presence of strong social networks and access to employment increase autonomy for women. However, this autonomy may cause conflict between the heterosexual couple as the husband may be resistant to the weakening of his customary ability to dominate. For first-generation Mexican women living in homogeneous ethnic settlements, “othering” and its effect on their health was not an issue as much as it was for the second generation. This may be due to the tendency of first-generation women who speak only Spanish choosing to not venture outside of their neighborhoods and, consequently, avoid racist confrontations (Viruell-Fuentes 2007).

Mexican American women and their families find that cultural beliefs about health and the North American healthcare system are complementary, and Padilla and Villalobos (2006) argue that access to healthcare systems – not cultural beliefs – unduly influence the healthcare decisions Mexican Americans make. Healthcare access is more of a challenge for

undocumented Mexicans than for those women who are citizens (Ortega et al. 2007). For urban undocumented immigrants, stable and increasing gains in social and economic resources, as well as acculturation into the healthcare system, may increase access. However, policy reducing social-net programs and increasing fear of deportation of undocumented immigrants decreases access (Nandi et al 2008). Rural Hispanic immigrants' economic, sociopolitical and language issues also contribute to poor health (Cristancho et al. 2008). In another study, undocumented Mexican women living in California faced three main challenges to healthcare access: language, gender and immigration status. Some research did find that altruistic clinics provided free medical attention, but it was often of poor quality and provided limited care (Deeb-Sossa 2013). More specifically, Deeb-Sossa (2013) found that racialized relations between staff members and their belief that they were "doing good" on behalf of poor Mexicans and other Latinas/os obscured the fact that they were treating their patients unequally. Because of these challenges, Mexican migrant women tend to construct and rely on a network of women to gain information and access to healthcare (Hendrickson 2010). The challenges Mexican immigrants face also sometimes compel them to travel to Mexico in order to receive the medical care they need (Wallace 2009).

In a study of older and chronically ill Puerto Ricans born on the island and living in the United States, Adams and colleagues (2015) used a sociocultural and migration framework to understand the perspectives of patients receiving medical care. The investigators found that taking pills is not just about people's experiences with their physical bodies but about the entirety of the person experiencing chronic illness and treatments within a cultural and social context. Pills demand life changes and mark life transitions, such as how the patient's

relationships with the world change. A family member dispensing medication may be demonstrating care and concern. Taking medications, also, has symbolic meaning for people. If the doctor uses medications as the primary or exclusive treatment method this may represent a lack of interest for the patient's health.

While Puerto Ricans were grateful for access to affordable healthcare in the mainland, their wellbeing was affected by their medical needs, sometimes compelling them to remain in the United States despite their strong desire to return to the island. Puerto Ricans have citizenship status by birth in the commonwealth that enables them to move freely between the island and the mainland. They are able to access affordable healthcare that they may not find on the island (Adams et al. 2015: 912). For some Mexican participants in my study, citizenship status made healthcare access challenging, compromised or impossible.

### Religious/Spiritual Domain of Health

Curlin (2013) found that a majority of physicians think that religion and spirituality have a positive effect on health. Religious doctors – more so than non-religious doctors – held this belief and that belief influenced the interactions between doctor and patient. Further, it influenced the interpretation of medical data, even in controversial clinical practices. Other research has also been done on the positive effects of religion and spirituality on health (Bradshaw & Ellison 2010; Hill & Pargament 2003; Koffman et al. 2008; Ridge et al. 2008).

Lujan and Campbell (2006) found that Mexican Americans' health practices were positively influenced by religion and religious practices and, therefore, recommended that it be included as part of a holistic approach to providing healthcare. Similarly, Benjamins (2007)

found that for a sample of middle-aged and older Mexicans with chronic conditions, those who considered religion to be important in their lives sought and used preventive services. For those attending church, Benjamins hypothesized that this may be due to increased social support, access to health information, lower costs for health screenings and services, as well as access to other instrumental services such as transportation, religious teachings related to health, and for some, the availability of a parish nurse.

In a sample of 60 caregivers and 60 care receivers, Theis and colleagues (2003) found that religion provided social support and meaning to both, and Kleinman (1988) argued that the biomedical model does not provide a rationalization for illness but that religion/spirituality provides meaning in illness which helps people to cope with chronic illness. Krause and Bastida (2009, 2010) surveyed older Mexican Americans and found that those who rated their health more positively did so as a function of their religious belief. In particular, their religious beliefs influenced them to find meaning in suffering. For example, Jesus Christ, understood to be the Son of God, suffered innocently; study participants could relate to that suffering and in the process feel closer to God. In turn, feeling closer to God produced positive feelings and therefore the ability to cope better with their health problems. Attitudes about God held by Mexican Americans living near the Texas-Mexico border were studied by Glover and Blankenship (2007). For 68% of the participants, disability was not considered a punishment from God. Rather, about 25% of those interviewed considered disability to be a moral test and the disability as evidence of some moral failure. This finding was true for Mexican Americans and Mexican Nationals regardless of gender.

## Folk Beliefs and Health

More specific to denominational beliefs and folk traditions, Lujan and Campbell (2006) concluded that Catholicism was a religion imposed on Mexican Indians. Nevertheless, Mexican Indians were able to integrate indigenous religious practices with Catholicism. One example of this integration is the introduction of the Aztec moon goddess of fertility and health widely recognized today as the Virgen de Guadalupe. Supernatural beliefs are believed to be part of the Mexican belief system (e.g., evil eye) and supplemental treatments are based on Mexican folk traditions which have typically been used only by a very small percentage of Mexicans or used only as a secondary strategy (Glover & Blankenship 2007; Hunt et al. 2000).

Keegan (1996), on the other hand, found that 44% of the 213 Mexican Americans he interviewed subscribed to folk beliefs in a number of ways (e.g., consulting the *curanderos* [folk healers]) and an increased use of bilingual nurse-*curanderas* was reported by Luna (2003). Some researchers find Mexican folk healing to be valuable (Arrieta-Baez et al. 2012; Hinojosa 2008; Lozano Applewhite 1995); others remain objective or skeptical and may even consider some so-called healers to be charlatans or dangerous (Mull & Mull 1983). Padilla and Villalobos (2006) concluded that gender, race, ethnicity, acculturation, and socioeconomic status interact to impede healthcare access, influencing a Mexican woman's decision to utilize culturally specific healthcare to meet her or her family's healthcare needs.

Rehm (1999) warned against the further characterization of Mexican families as fatalistic and passive. On the same note but more precisely, contemporary researchers rebuke those in the social sciences for perpetuating the stereotype of the Mexican woman as a submissive wife and a long-suffering maternal figure who willingly evades the public sphere in preference for a

life of servitude (Andrade 1982; Baca-Zinn 1982; Parrado & Flippen 2005). I was cognizant of these concerns as I collected and analyzed data. Strong family ties were anticipated (de la Torre & Estrada 2001; Glover & Blankenship 2007; Lujan & Campbell 2006) and both religion and folk healing practices were included in my study.

#### Overlooked Areas of Health Experiences for Elderly and Chronically Ill Mexican Women

The care receiving experiences of older and chronically ill Mexican women have not been regularly and thoroughly addressed in the literature (Amaro and de la Torre 2002). More precisely, acts of resistance by older and chronically ill Mexican women have not been acknowledged in the context of vulnerable states of health. Rather, older and chronically ill Mexican women and their acts of resistance have been sorely neglected in the academic literature. In addition, when acts of resistance are acknowledged in some way, they are often challenged or misinterpreted (Romero 2005; Salas & Harris 1990). This may be due to the tendency of social science researchers and others in academia to interpret Mexican women as monolithic, submissive and unchanged even after years of inculcation into American culture (Andrade 1982). There also seems to be a lack of wider awareness or acknowledgement of Mexican women's willingness and proven ability to resist powerful others back in their homeland of Mexico (Gray et al. 2012; Lozano 2003) such as the latterly and minimally acknowledged contribution of the *soldaderas* (women soldiers) to the Mexican Revolution (1910) and women's active resistance against foreign powers as couriers, nurses and spies during Mexico's struggle for independence from the U.S. and France (Tuñón Pablos 1987). More recently, the belief that Mexican women in general are monolithic and immutable may be

changing (Hondagneu-Sotelo 1994). It remains, however, in need of broader and empirically based challenges due to the continuous representation and assertions that Mexican women are monolithic and unable or unwilling to resist challenges, abuses and oppression. More discussions regarding their willingness, readiness and capacity to resist oppression in the context and with the cooperation of their cultural community and the state (e.g., policy) should be expanded (Kasturirangan 2004).

Newer research has begun to look at the health of older chronically ill patients through an intersectional perspective. The intersectional perspective states that different types of discrimination interact together – not in isolation from one another – to justify the exclusion of subjugated groups. Crenshaw (1989), who coined the term “intersectionality,” argues that the effect discrimination has on a member of a marginalized group is not fully explained by one social category alone. Rather, the integrated effects of race and gender and class shape the experiences of members of a subjugated group simultaneously. Viruell-Fuentes et al. (2012) claim that experiences of discrimination, residential segregation and immigration policy should be accounted for in terms of their effects on the health outcomes of immigrants. Construction of the “Other,” immigration policies and structural racism seen through the lens of intersectionality redirects efforts away from constraining healthcare access to immigrants towards equal integration of immigrants into the healthcare system. Viruell-Fuentes et al. (2012) advocate for a shift in the literature from “cultural” to “structural” explanations and implore others to account for effects of multiple social factors on the health outcomes of immigrants. Holmes (2012) also demonstrated that structural issues in migrant health are overlooked by too much focus on the culture of the patient. For example, Holmes (2012) found

that several clinicians blamed the poor health of their unauthorized-migrant patients on their use of traditional healers rather than social determinants of health outcomes such as living and working conditions.

Koehn and colleagues (2013) also call for an intersectional approach to understand the cumulative effects of multiple social identities and the specific ways in which immigration for visible minority groups also creates, both in terms of experiences and outcomes, healthcare inequities. They reviewed 3,300 source documents for the time period of 1980-2010 that addressed health and healthcare issues of the two largest ethnocultural groups in Canada: Chinese and South Asians. In their literature sample, they included studies that also included African Americans and Hispanics in the United States in their focus. They believe that both the quantitative and qualitative literatures have shortcomings: qualitative literature focuses too much on culture and quantitative literature on oversimplified variables. They conclude that research needs to be expanded to include an intersectional lens so that healthcare decision makers are informed on the healthcare needs of ethnocultural-minority older adults so that greater equity in healthcare can be achieved.

Literature that looks at patients with a more intersectional lens also tends to discuss patients as being active rather than passive victims. Boneham and Sixsmith (2006: 269) state that in healthcare literature on the disadvantaged, the “health experiences of older women as gendered social beings have yet to be fully explored.” They looked at lower income elderly women living in impoverished neighborhoods. In exploring the relationship between social capital and health for older women living in disadvantaged neighborhoods, they were able to identify the constraints and resources of these older low-income women. They found that these

women actively participated in community life and developed a role in the community as lay health advisors to other women. The women experienced a sense of empowerment due to their active contribution to the community as informal health advisors and givers of care in multiple ways. They not only helped others but also sustained their own health and wellbeing by not being passive but contrarily defiant when necessary and appreciated by friends as well as family and neighbors within their community. Their actions are a challenge to the healthcare system in that they criticized the poor continuity of care with particular concern about doctors and their lack of in-depth relationships with these women patients.

Ideas of patient resistance have also begun to appear in research on healthcare, and this can take many forms, from critiques of care, as Boneham and Sixsmith found (2006), to resistance to medicines (Adams et al. 2015; Chamberlain et al. 2011) and overall rejection of advice and treatment (Armstrong & Murphy 2011). In a study of older and chronically ill Puerto Ricans born on the island and living in the United States, Adams and colleagues (2015) used a sociocultural and migration framework to understand the perspectives of patients receiving medical care. They found that study participants believed that medicine had a rightful place in health treatment, but the personal experience of taking medications evidenced a more negative perspective. A few of the participants felt that their concerns about the effects of medicine were not being heard by their doctors and therefore felt that they were not seen as individuals. The participants frequently avoided new or renewed prescriptions. Chamberlain et al. (2011) showed that older people or chronic illness sufferers within a variety of household compositions expressed resistance to medication intake. The researchers concluded that

resistance was complex and varied. The resistance of medication was situationally specific and the participants considered the nature of the medication and when and why they were taking it.

According to Armstrong and Murphy (2015), public health and health promotion can be used to exercise dominance over individuals. Yet resistance is manifested, although in subtle and nuanced ways. Using Foucault's concepts of regimes of power and resistance, they investigated empirical studies featuring populations involved in accepting or rejecting prenatal tests, Viagra use, mass childhood immunizations, HIV-infected men and other similar studies. People resisted biomedical interventions at the behavioral or conceptual level. For example, breast cancer patients would not resist biomedical treatment (behavioral resistance) but would reconceptualize the treatment.

Overall, this more recent literature finds that the power of the medical regime is not absolute and there are always opportunities for resistance. Dominant knowledge may attempt to impose – through rules and prohibitions – a sense that a moral rule is being broken, but subordinate populations use an alternative discourse based on ethics that justifies their decisions. Armstrong and Murphy (2011) do caution not to celebrate uncritically the ability and willingness of individuals to resist because sometimes the use of alternative discourses to make decisions may provide incomplete or flawed information that has real consequences.

In the 21<sup>st</sup> century, Mexican women are migrating to the United States more than ever before. Regardless of the barriers back home and here in the U.S., women have settled in cities across the U.S. Migrating Mexican women have typically been viewed by researchers as passive companions of their husbands. Some might have viewed this to be the case with the women who crossed the US-Mexican border with their husbands during the *bracero* program.

More recently, however, researchers have acknowledged that migrant women act as their own autonomous agents in myriad migration-related decisions, such as obtaining the money and the documents needed for migration without depending on their husbands (Hondagneu-Sotelo 1994) and, once in the U.S., reforming the marriage pattern. For example, Hondagneu-Sotelo (1994) found that most of the men in her study were more in favor of returning back to Mexico than the women were. This caused conflict between some of the spouses. The women determined that there were more opportunities for them and their families if they remained in the U.S. The women used women's social networks to strengthen their stay. For example, one woman assisted another woman to open a savings account and another one was assisted by a female neighbor to learn to drive after both her husband and sons refused to teach her. Changes in the women's lives are contingent on factors such as networks of social support, neighborhood community life and government policies. It is important that the literature continues to acknowledge factors aside from these women's subjectivities and their cultural commitments as important forces changing or sustaining power dynamics in the home, work and healthcare settings.

More recently, research on health disparities has begun to acknowledge a tendency to blame the victim and invoke a culture of fatalism (Moss 2005), and are calling instead for a focus on structures of power indicative of the responsibility of institutions for health outcomes (Hayes 2013; Holmes 2012; Wade 1997Weber & Hilfinger Messias 2012). In particular, being an older Mexican woman with a chronic illness embodying social constructs of difference contributes to types of healthcare experiences that place the health of these women at risk. These problems, research shows, are amplified when the women are also undocumented. How

do these women cope? Very little research had been done on how these women resist their marginalization in healthcare. What is lacking in the literature is the use of an intersectional lens on the experiences of older chronically ill Mexican women confronting multiple forms of power as they seek optimal health and healthcare access. Most literature overlooks the many ways in which older chronically ill Mexican women resist the many challenges, attempts at oppression and abuses they are subjected to. However, there has been a growing literature on theorizing the relationship between intersectionality and health (Boneham and Sixsmith 2006; Viruell-Fuentes et al. 2012) and also everyday resistance/resistance to healthcare (Chamberlain et al. 2011; Wade 1997). My study adds to this newer literature by showing that intersectionality can expose how these women express day-to-day resistance vis-à-vis the healthcare system to gain optimal health and a stable wellbeing

.

### CHAPTER 3: THEORY AND METHODS

Multiple structures of oppression, such as racism, gender and class, shaped the life experiences of the women in my study. These structures of domination worked simultaneously in making the women's efforts to achieve health and wellbeing challenging or impossible. The women sought consistent access, quality and safety in their interactions with care providers and treatments that could lead to and sustain health and wellbeing. However, intersectional identities such as race, gender, class, linguistic competence, immigration and educational status converged in these women's lives to challenge their goals for good health and wellbeing. In managing or confronting hindrances to the stability of their health and wellbeing the women employed various acts of resistance. The women's acts of resistance reflected the women's knowledge of themselves and knowledge of their world as one that did and could react in opposition to their goals. Their acts of resistance ranged from everyday resistance, which is not public (Scott 1989), to a resistance that is also not politically organized or radical but more visible (Vinthagen & Johansson 2013).

For this study, I use a theory of intersectionality to analyze the multiple challenges and abuses the women confront and the many ways in which they resisted opposition to their goals for stable health and wellbeing. This type of analysis is appropriate for my study because intersectionality theory is a method of inquiry that makes a case for the necessity of evaluating the effect of multiple social categories of difference on the lives of vulnerable populations. The

root of social problems must be understood in comprehensive ways so that equity in daily living can be accomplished. Social categories of difference work together and simultaneously to define members of subordinate groups as inferiors and, therefore, to justify the unequal distribution of resources to them (Collins 1990, 1986). In Crenshaw's (1991) study of domestic violence victims, for example, race, gender and class did not fully account for the many barriers these women confronted when they attempted to escape their abusive husbands. Crenshaw found that immigration status also provided barriers to escape the abuser, and, moreover, because the women could not speak English, the shelter for battered women excluded them from their program. One woman in particular was excluded even after a family member offered to interpret.

I draw from the writings of two feminists who analyze the life experiences of women of color, how they are victimized and how they resist marginalization. The work of Patricia Hill Collins (1990) and Kimberlé Williams Crenshaw (1989, 1991) critique dominant narratives of the lived experiences of women of color and advance a more complete and nuanced exploration of what it means to experience daily life as a member of a subordinated group. Crenshaw (1989; 1991) and Collins (1986) agree that these women's experiences of domination and oppression should not be homogenized. The vulnerabilities women of color experience are not understood through their experiences of racism alone, but other categories of difference must be included in the analysis to better understand the daily struggles and the victories of women of color. Crenshaw elaborates (1991: 1244 -1245):

Intersectionality is not being offered here as some new totalizing theory of identity. Nor do I mean that violence against women of color can be explained only through the specific frameworks of race and gender

considered here. Indeed, factors I address only in part or not at all, such as class or sexuality, are often as critical in shaping the experiences of women of color. My focus on the intersections of race and gender only highlights the need to account for multiple grounds of identity when considering how the social world is constructed.

Patricia Hill Collins (1990) developed the concept of the interlocking “matrix of oppression”— race, gender and class – as a way for analyzing the day-to-day experiences of subordinated groups, most specifically Black women’s. (Currently she uses the term “intersectionality” rather than “matrix of domination.”) Collins identified the structural categories of race, gender and class as affecting the lives of African American women most heavily. Collins rejected previous approaches of understanding the oppressions women of color confronted by exploring only one category of difference independently from another. Rather, she perceives systems of oppression as working together and simultaneously in their efforts to sustain their advantageous position over subordinated groups. In Collins’ (1990:223-224) own words:

The significance of seeing race, class, and gender as interlocking systems of oppression is that such an approach fosters a paradigmatic shift of thinking inclusively about other oppressions, such as age, sexual orientation, religion, and ethnicity. Race, class, and gender represent the three systems of oppression that most heavily affect African-American women. But these systems and the economic, political, and ideological conditions that support them may not be the most fundamental oppressions, and they certainly affect many more groups than Black women. Other people of color, Jews, the poor white women, and gays and lesbians have all had similar ideological justifications offered for their subordination. All categories of humans labeled Others have been equated to one another, to animals, and to nature.

My analysis remains true to Collins’ and Crenshaw’s scholarly work on the interpretation of the women’s lives who embodied aspects of subjectivity often considered worthy of their

subordination. Analysis of the women's lived experiences as told by them through employing the lens of intersectionality exposes the women's many unique experiences with chronic illness, care searching, care receiving, domination/oppression and their efforts of resistance. It is from the women's experiences of oppression that accounts of both victimization and resistance emerge. After all, sites of domination are also sites of resistance (Collins 1990). Chou and Ferree (2010) point out that there can be several styles of intersectionality in sociological research. My analysis is in line with their description of group-centered intersectionality, where the focus is on a group with multiple sites of marginalization. The women in my study occupy multiply marginalized locations as Mexican women detrimentally affected by patriarchy in both Mexico and U.S. and, in the U.S., by racism, socioeconomic status and language competency.

Scott (1985) introduced the concept of everyday acts of resistance. Scott defines everyday acts of resistance as subtle, potentially effective and necessary and used by members of subjugated groups as survival techniques. Although he focused on class relations, the concept has vast applicability to other social categories of difference. Scott believes that these everyday acts of resistance are neglected in research because they are not collective, political, revolutionary or publicly oppositional. Moreover, because everyday acts of resistance do not openly challenge power arrangements, they have this hidden aspect about them, subordinates appear to collude with powerful others in their own subjugation. Scott argues however that open confrontations come with grave consequences to the resister and thus they must proceed with caution. Rather than looking at the peasants he studied as unwilling to be organized and openly confrontational, whether a revolution is sought or not, Scott directs attention to the force and the willingness of dominant structures to repress attempts to downgrade or reduce their

influence and power over their subordinates. Peasants are left, then, with pretending that they are in agreement with the established patterns of interaction, claims of superiority and monopolization of resources. However, this is just an appearance because Scott notes that those who grow up in subordinate groups are socialized to conceal their true feelings because of the risk involved. Therefore, subordinate groups exercise everyday acts of resistance such as tax evasion or poaching while pretending “deference, compliance and loyalty” (1989: 53).

Scott furthermore points out that taking into consideration the risk involved for subjugated groups in open conflict, everyday resistance provides value in “relentless pressure and the safety and anonymity it typically provides its users” (1989: 54). Vinthagen and Johansson found that a common understanding of everyday resistance among researchers is that it is an oppositional act” (2013: 1). They propose, furthermore, that everyday resistance is a practice, entangled with everyday power, intersectional and heterogenic and consistent. They expound that while everyday resistance may be made invisible by society because it does not represent “hegemonic understanding of resistance,” there are ways that everyday acts of resistance are made visible. For example, when people express a different kind of “lifestyle,” like vegans (10). Vinthagen and Johansson espouse that relationships defined by the dynamics of domination and subordination are always negotiating with one another. They add also that resistance is part of that dynamic. Vinthagen and Johansson (2013) point out that subordinate groups will not define their acts of resistance as “resistance” as long as their “nonpolitical” expressions of subjugation *and* resistance continue to be marginalized in public arenas of discourse.

Employing the theory of intersectionality and the concept of everyday resistance in my study is essential because it provides greater clarity when analyzing the lives of vulnerable populations like the women in my study. My study agrees with Collins and Crenshaw that observing only one or even two social identities does not fully capture the effect of interlocking forms of oppression in the lives of the women. For example, Miranda was adversely affected by her immigration status (unauthorized), linguistic competence, gender, disability, class and lack of job skills. Each significantly contributed to her isolation, depression, sense of shame, and labor exploitation. Applying Scott's concept of everyday resistance elevates Miranda's acts as significant. In spite of her son's anger and consistent opposition and in spite of being disabled and not speaking English, Miranda found a job for 10 hours per week. She found this act of opposition to her son's will to be triumphant.

The focus of my thesis on everyday acts of resistance is an attempt to not portray older and chronically ill Mexican women "solely as passive, unfortunate recipients" (Collins 1990: 232) of oppression. While Mexican women do confront and suffer the consequences imposed by interlocking systems of oppression, they also effectively activate changes in their lives through everyday acts of resistance such as when one of the women in my study interjected an advocate in her negotiations with healthcare providers and when another left her husband regardless of the morally and culturally based opposition presented by her parents. Like Collins (1990: 232) stated, writing about African-American women, writing about their oppression and resistance is not an effort to portray women of color as simply victims or heroes, rather:

Black feminist thought's emphasis on the ongoing interplay between Black women's oppression and Black women's activism presents the matrix of domination as responsive to human agency. Such thought views the world as a dynamic place where the goal is not merely to survive or to fit in or to

cope; rather, it becomes a place where we feel ownership and accountability. The existence of Afrocentric feminist thought suggests that there is always choice, and power to act, no matter how bleak the situation may appear to be. Viewing the world as one in the making raises the issue of individual responsibility for bringing about change. It also shows that while individual empowerment is key, only collective action can effectively generate lasting social transformation of political and economic institutions.

### Data Collection

For this study, I interviewed 13 women who represent in some significant degree my interest in the relationship between intersectionality, resistance, health and wellbeing. I chose a purposive sampling method to select participants for this study. More precisely, I gave the parish nurse who had direct access to an Hispanic population a list of preferred but not restricted characteristics for the research participants I wanted to interview. I was interested in older Mexican women confronting chronic illness who were homebound, documented or undocumented, with any marital status and confronting any number of challenges to their health and wellbeing. I did not specify any other characteristics or challenges the women were confronting because the women whom the parish nurse served were disadvantaged Hispanics living in a working-class neighborhood. Therefore, the few specifications I gave her were sufficient.

The parish nurse was hired by the hospital in agreement with the local Catholic churches to serve the Hispanic indigent population in a specified area near the hospital and the churches. The women knew and trusted the parish nurse. This made my introduction and the invitation to participate in my study easier. Most of the interviews were held in the women's homes.

Eleven of the thirteen interviews were conducted in a highly populated city in Illinois with a little over 40% Hispanic composition. One interview was conducted in an affluent neighborhood with a former resident of the same area served by the parish nurse. This one participant was getting her driver's license so that she could reintegrate to some degree into her former community, the same city where 11 of the 13 participants lived. One last interview was conducted in a different city, also with the participant living in a working-class neighborhood and with no connection to the parish nurse.

Each in-depth interview lasted two hours on average and these were conducted over a period of one year and eight months from September 2011 to May 2013. With the consent of the participants, all interviews were recorded by means of a digital recorder. The names of all participants have been changed to provide confidentiality. I transcribed and translated all the interviews myself from Spanish to English.

All women were of Mexican descent. Twelve were born in Mexico and one was born in the U.S. Not including the one participant born in the United States, the average stay for the women in the United States was 15.25 years. The average age of the women was 62 years old, with the youngest participant being 47 years of age and the oldest being 82. Seven of the women were married, two were separated from their husbands, one was divorced and three were widows. Seven of the women are authorized to reside in the United States and five or six of the women were undocumented. Twelve of the 13 women spoke Spanish only and one was bilingual. Nine of the thirteen women did not complete elementary school in Mexico and did not pursue further formal education. One completed high school in the United States. Ten of the women worked unskilled jobs previously and some held those jobs at the time of the interview.

For many of the women, work was very important in their lives as income earners and/or as a purpose in life. Two of 13 women never worked outside of the home. Although all of them were once active and most were once working, about half of the women described themselves as homebound at the time. Twelve of the women were Catholic and one identified as a Christian. All of the women had a chronic illness at the time. Six of the women had numerous chronic illnesses. Two were wheel-chair bound. Eight of the women had no health insurance. Many used mostly two local altruistic clinics. Three had Medicare, one had Medicaid and one had private insurance only (see demographic table in the appendix page 101-102).

The analysis process consisted of the application of grounded theory, an approach to data analysis first introduced by Glaser and Strauss (1967) and made more widely known by Charmaz (2010) and Strauss and Corbin (1990). This approach allows for the collection and analysis of the data that best preserves and connects to the realities of the lived experiences of research participants. For example, the participants expressed their main concern to be access to healthcare rather than one of my initial assumptions, the physical challenges of having a chronic illness; they spoke about the challenges of receiving healthcare and problematized their relationships with healthcare professionals, medical products and services within healthcare institutions. Furthermore, the methodology allowed for the emergence of resistance as an important facet of their healthcare experience. Acts of resistance were used to attempt to solve the various problems the women confronted.

With a grounded theory approach to data analysis I was not constrained by a priori theory. Rather the data spoke for itself. That is, this approach allows for the emergence of phenomena from the participant's point of view. I took each of the 13 interviews and compared

entire sections to one another and then more specific sections as patterns emerged looking for similarities and differences. Each section and line of the data was studied for potential relevance. The approach was inductive; that is to say, I searched for patterns in the data so that substantive codes could emerge. With this approach the issues that concerned the participants emerged and were further analyzed. Studying the data revealed the often nuanced ways people, especially marginalized populations, sought to solve their problems. The participants revealed a number of issues that were important to them and the following codes were generated: autonomy, chronic illness, community, family, healthcare system, migration, religion, resources, wellbeing and work/workplace. Applying an iterative process, I was able to identify the areas of most concern and those most problematic to the participants. These were chronic illness, healthcare system and religion. In addition, I wrote memos throughout the process expanding on their breadth and depth in an effort to understand more fully the meanings behind some of the actions the women took. The iterative process and the writing of the memos allowed for the emergence of a more complex understanding of the women's management of their health and healthcare. The women endured challenges and abuses but they also resisted them.

## CHAPTER 4: FINDINGS

The women I interviewed told me about the extraordinary challenges they were facing as Mexican immigrant women living in the United States. For example, they spoke of many issues concerning health, immigration and family and how these issues affected their lives. They also shared their success in obtaining good health outcomes for themselves. A set of themes emerged from my second-level coding around these issues. Significant themes centered on advocacy as resistance, pressing their own claims for health and wellbeing as resistance, religion as resistance and complementary and alternative medicine as resistance.

Collins's concept of "matrix of domination" (1990) constituted simultaneously by race, class and gender was fleshed out by the women. For example, one of the study participants, Francisca, was detrimentally affected in her search for optimal health by race/ethnicity, gender, class, linguistic competence, educational and immigration status. Based on these variables Francisca's search for optimal health and wellbeing was challenged and, therefore, necessitated her resistance.

### *Advocacy as Resistance*

Some of the women in my study visited the hospital due to their chronic illnesses. The hospital did supply Spanish interpreters but this was not the only need to understand their unique situations, as interpreters could be "poorly trained" (Holmes 2012:877). A parish nurse,

on salary from the hospital, visited the women in their homes on a regular basis and advocated for them at the hospital. Having a parish nurse as an advocate was not imposed on the women but rather the women agreed to incorporate the nurse into their lives. The patient and the nurse developed a plan of action that best met the health and wellbeing goals of the patient. The parish nurse acted as the patient's power broker.

One example of this ally relationship is an incident that happened with one of the women. Alejandra suffered a number of health complications due to her diabetes and, therefore, ended up in the emergency room periodically. Alejandra and the nurse told me, during one of my visits, about a recent emergency room visit. The nurses at the hospital and the Spanish interpreters attempted to piece together Alejandra's situation. As Alejandra explained it, the situation became chaotic. The staff concluded and told Alejandra, "You cannot live alone. Your daughter is not there; your husband is not there." The nurses emphasized that Alejandra was coming to the ER too often and that the place for Alejandra was in a nursing home. The pressure was intense and Alejandra was feeling utterly distraught, powerless and afraid. She was convinced that the staff was going to have their way and send her to a nursing home.

The parish nurse came into the emergency room as a follow up to what she stated was feelings of distress given by God that Alejandra was under distress. After assessing the situation, the parish nurse told the staff that Alejandra did not need to be put away in a nursing home. She placed Alejandra on a wheel-chair and "I wheeled her out of there and into the dialysis clinic." She stated, "Those nurses were visiting nurses. They did not know. They do not communicate effectively. There is also a lot of confusion with interpreters." The nurses stated, erroneously, that Alejandra had rejected the nursing home and the cardiologists. Alejandra

rejected that characterization of her statement: “They said that I rejected the nursing home and the cardiologist. I did reject the nursing home but I did not reject the cardiologist. I would never reject the cardiologist.”

Communication needs to be successful on many levels; this does not happen when the interpretation reflects the ideology of the institution rather than the personal concerns and interests of the patient. The rhetorical interpretation of the hospital’s trained interpreters failed to provide a faithful interpretation of Alejandra’s words and behavior and this could have led to her becoming institutionalized, a decision by the staff that would have devastated her. Another woman, Francisca, explained her own concerns with medical interpreters:

The other problem is that I don’t speak English. The ones that interpret don’t even understand me. They say one thing to the doctor and the doctors say something to them and they don’t tell me the right thing. And that makes things very complicated for me. If I would speak the same language, then I could say, “Listen, this and this and this.” [The interpreters] do not understand what I am telling them.

Francisca clarified that she did not have this issue with all interpreters and that this problem with interpretation represented a fraction of the problem because doctors may not explain things fully to the interpreter. Francisca also empathized with the case load that the interpreters had and identified that as being another part of the problem.

Preconceived ideas about how the women should be responding makes any resistance seen as the women not knowing how to best take care of themselves. Alejandra did not want to live in a nursing home but that resistance became exaggerated to her supposedly rejecting the cardiologist too. Choosing to have a partner in health is extremely important and goes beyond

basic services of interpretation. Alejandra expressed that awareness, “All my luck was because of Aída [parish nurse]. She is everything.”

Another example of this came from Francisca. Francisca’s family is undocumented and lacked health insurance. “The thing that gets complicated for us is English. My boys tell me, ‘Ay, mom is that we don’t speak it well.’” Francisca complained that her prescription was too expensive but couldn’t communicate this barrier to her doctor. She expressed another concern, “What I need is that they give me the pills [prescription medicine] for three months.” The parish nurse explained that the local altruistic clinic can write a prescription for three months rather than one and lower the cost of her prescription from her current cost to \$16.00 per month. The parish nurse assured her, “I can help you with that. They have volunteer interpreters. Call me and I will help you.”

Again, although there are services that can help with providing medical care, they may not have interpreters immediately available or interpreters trusted by the patients. That introduces another problematic layer to the already existing challenges faced by the women. The women’s inclusion of an ally that can provide a way for accessing low-cost medication and negotiation when confronting these challenges presented by institutional agents, institutions and their ideologies serves the women’s purpose of maximizing their health and wellbeing.

When communication is not a problem, another issue for the women may be the poor care they receive during medical interactions. Alejandra experienced this with a countrywoman.

There are gals [nurses] that do not know how to [insert needle into the fistula], no. It hurts over here. The nerve hurts all afternoon. I don’t know what they do because it hurts. Look, there are some that don’t care a bit.

There was a Mexican woman [nurse], a countrywoman, I said to her, ‘Ouch, it hurts me.’ She said, ‘So tell me!’ She was putting it over there, the machines to the – and it hurt here. She said, ‘Raise your hand!’ The needles went to waste. And I said, ‘Listen, what do you know?! Why do you do that with me?!’ She does not like me and I don’t like her. And there she is. Just with that one. The other ones are good.

Another woman, Luisa, talked about her own barriers accessing healthcare. Luisa was undocumented, lacked health insurance, spoke only Spanish and lost her job because of the symptoms of her chronic illness, amyotrophic lateral sclerosis (also known as Lou Gehrig’s disease). Luisa visited a number of medical facilities in order to, first, receive a diagnosis and, second, receive treatment. Her search for affordable services left her disappointed.

Well, recently, a nurse, when I started going [to the local altruistic clinic], told me that I possibly had multiple sclerosis but that the exams were very expensive and she would no longer be able to help me. She told me, ‘I am sorry but we can’t do anything.’ It felt like – she said, ‘I am sorry. We can’t do anything because the exams are too costly and you have no health insurance.’ I was disappointed because I was going there filled with hope and I was not doing so poorly then. That is, it [ALS] was just beginning and I thought that it was anything. That anything that they would give me would make me well. She disappointed me. *What she should have told me was*, ‘Look, there is nothing that can be done here. Look for help in this other place or *something*.’ They just stay like that [doing nothing] and, ‘Well, there is nothing that can be done – I am sorry.’

Regarding not having health insurance Luisa said, “I think that when you don’t have insurance, they don’t pay much attention to you. That is, when people have insurance they will find more resources for you. But if you don’t have insurance, they just don’t do anything. ‘Nothing can be done at this point.’”

Luisa's conclusion that the healthcare system "don't pay much attention to you" is not evidence of a lack of resistance against the system's failure to provide desperately needed medical services for individuals like herself. Rather, this is evidence of the "pragmatic resignation" Scott talks about (1985: 325). Subordinated classes know when they have exhausted all possible ways of reaching a preferred outcome and when they must adapt a new way. In Luisa's case, she resisted the idea that her body was not worthy of medical treatment and acted out that resistance by moving forward with her plans to move back to Mexico where she stated categorically that she will receive free medical care for her condition.

Scott (1985) states that everyday resistance lies somewhere between flight and confrontation. For Silvia this resistance is less dramatic than Luisa's but still representative of what the women value, their health and sense of wellbeing. Silvia talked about her doctor's failure to work with her towards maximizing health outcome. Cost, quality and choice of treatment and the doctor's impassable attitude were challenges she confronted.

If the medicine is more expensive, I pay more. But I don't pay so much for blood pressure and sugar [medicine/products]. For that medicine I pay only six dollars. But when they give me medicine they never give me the good medicine. They give me, what is it called, the cheap one [generic]. That is the only ones they give me. They don't give me the expensive one because I would have to pay a lot. There are medicines that I have paid a lot of money for because they were expensive – and they are useless to me! And that is why they give me only those [the generic ones]. When in the beginning we did not have Salubrity [health insurance], I was paying for the high blood pressure pills 45 dollars. But now that we have Salubrity, they only give me those [generic] one. The ones for 45 dollars were the good ones. That is how much they cost me, 45 dollars but not anymore. But now that I am going with *that* [her tone changes to reveal her disapproval of this doctor] Jose *Malgana*\*, he gives me only that type, the cheap one, and the cheap one and the cheap one. I pay six dollars. In the

\**Malgana* is not the real last name for this doctor. Francisca uses this name-calling for her doctor and her husband. The insult translates to Ill-Will signifying that she thinks both men do not have good will towards her.

beginning I would only pay five and they just raised it by a dollar. And now it is six for the sugar one.”

Silvia emphasized that the medications were not working: “Nothing. Nothing. No. I am just like a rock. I am just [taking the medicine], I say, because they tell me to.

Don’t you see that my blood pressure is high? So there I am taking the pills.” I

asked Silvia if she told her doctor that the pills were not working.

I told him! And what do they give me? Like a rock! It does not make me well. What he gives me, does not make me well. ‘You are going to tell me that there is no medicine that can help me,’ I said, ‘because the medicine is not making me well.’ [Silvia imitated mockingly her doctor’s voice who responded to her challenging statement,] ‘No, because you exhausted my entire repertoire of pills,’ he said to me. That he has given them all to me but not one has made me well.

Vinthagén and Johansson (2013: 38) state,

It becomes almost unthinkable for subalterns to define what they do as ‘resistance’ if their practices are made invisible and marginalized in public debates, mass-media and scientific discourses. If you were to ask them if they ‘do resistance,’ then they will of course say ‘no’. If you ask a woman from Nicaragua why she jokes about the men, she will say she is ‘not an idiot,’ or ‘I am my own,’ or something similar. However, she will not say ‘I do resistance’.

Silvia’s defiant tone and her change to the last name of her doctor and her husband (who has abused her through their 57 years of marriage) to express their “ill-will” toward her is what can be defined as everyday resistance.

The last medication added to Silvia’s “repertoire” of medications is a prescription to alleviate her depression. “I have a lot of depression also. Everyone told me already. I have depression.” The parish nurse responded, “You are taking medications to see if they help you. Keep taking them because in about 30 days you will see a little bit of a difference. But you

have to take them for a month. Don't skip them." Silvia responded with, "The thing is that there is no part of my body that is well."

Silvia's husband abused her for the duration of the 57 years of their marriage. Forms of abuse have included battery for not asking permission to visit her mother and for not serving a meal to his father and shooting at close range at her in the family kitchen when "drowning in wine" and while the young children were present. While Silvia did not identify patriarchy as the system that constructs men like her husband nor did she mention a specific ideology working against her, she did identify one of its manifestations after explaining that her husband learned violence against women from his father who had also shot at his wife, her husband's mother. "*Machistas!* Both men are machistas! Brace yourselves!" Furthermore, she exposed her relationship with other men with relative power in her life as problematic. Silvia explained that she attempted to seek help from the local priest who responded to her exposing of her husband's abuse with condemnation: "A priest came one day, a little guy. The father, he came over and said, 'No, no. He [Silvia's husband] says that you are the one and you say that he is the one [abusing her].' [The priest came so that Silvia would prepare for the coming of Jesus, which entailed a confession of her sins.] And that is why he did not change my mind. No! Look at that! But, there He is, the One Up Above and He knows my entire life." In response to a taunting from her husband to go ahead and divorce him, Silvia reacted, "Shut up! I don't leave you because my children would detest me. Since I married you, I was going to leave you. I don't leave you because my children would detest me. Otherwise, I would leave you."

Leaving her husband was a problem to be solved at many intersections: Silvia completed only up to second grade in Mexico, has never been employed for pay, speaks only Spanish, does

not drive and lived with a controlling and abusive husband whom she had to ask permission to even visit her mother. Interlocking systems of oppression located Silvia “in a setting where total conformity is expected” (Collins 1986: S24). Then, taking into account “the texture of local experience” (Scott 1985: 99), Silvia’s resistance was significant. She confronted and exposed face-to-face the dominant social actors in her life, that is, her husband, her doctor and her priest, as failures within their fields of claimed expertise and refused to pay them deference. Unlike these men of influence, she viewed herself as fully human: “People that view themselves as fully human, as subjects, become activists, no matter how limited the sphere of their activism may be” (Collins 1986: S24).

#### Pressing Their Own Claims for Health and Wellbeing as Resistance

Dealing with insurance companies or having no private or public healthcare coverage, such as Medicare or Medicaid, provides another barrier for the women to overcome. Luisa stated about not having health insurance: “When you don’t have insurance, they don’t pay much attention to you.” Not having insurance and the possibility of being denied access to a local altruistic clinic for inability to pay was an added stressor for another participant, Gabriela: “What worries me is that a time comes when they will not want to take care of us for not having health insurance. Because I do worry – an emergency, one of those things. That is what – yes, I do worry.”

Sometimes even with insurance problems can arise. Maria del Carmen explained her struggle with her health insurance company: “Where I did feel discriminated against was with

the insurance, Salubrity. I went to the first talks – when they first started. I went to a nearby town. The talks were in Spanish and I signed up. They were charging and then they were not charging. Then, I said to myself, if they charge, of course I will be well taken care of and all that. If they don't charge, and they see me even if I don't pay, then I will be the very last one they will see. I said to myself, I rather pay the 19 dollars per month – OK – and they can take it from my check – OK. I told them. Then, they began to withdraw [the payments].” In 2006, Maria del Carmen was contacted by a representative from Salubrity. “That man talks to us, in Spanish at Walmart ... because he was going to have a meeting with all Hispanics.” The representative told the group that they would not be charged in 2006. They would be told when the reinstatement of the coverage payments would begin. The representative assured them that they would receive the same services they have always received up to this point. “The man that gave us the talks was Latino.” Maria del Carmen did not receive a notice of reinstatement of payments nor did she receive any other form of communication so she contacted her health insurance provider. She expressed her main concern: “I don't want to be left without insurance.” She called Salubrity but was told again, “Ma'am, don't worry. If they do not withdraw the payments that means that it will continue to be free.” Maria del Carmen continued to call them “here and there” to be assured that she would not lose her insurance coverage. Then, in July of 2007 her bank called her: “Maria del Carmen, don't write checks because [Salubrity] just withdrew all your money even 100 dollars that were not yours.” Maria del Carmen calculated that her insurance had removed the payments they stated were not due along with an increase in monthly premium she was not told about. Maria del Carmen went to Salubrity's office to solve the situation and was told, ‘You don't speak English so I can't

arrange for you to meet with the person that took your money.’ But why did you take my money? ... Why did you not leave money for food? You will return my money to me at once or you will see!” The bilingual individual stated, “I am very sorry but the man [Salubrity employee] does not want to speak with you because he does not speak Spanish.” Maria del Carmen returned to the Salubrity office with an interpreter:

I told her, ‘You are committing a serious wrong against me because I am Mexican, I don’t know English. But I am not dumb. I have very good friends and you are not going to take advantage of me ... They returned all my money – eh? But that was abusive ... because they said, ‘You don’t have to send payments.’ I said to myself, ‘My God, I leave these things to you, my Lord.’ He who laughs last, laughs best.

Maria del Carmen remained vigilant over her healthcare provider’s transactions and continued to resist and speak against what she determined to be discriminatory practices.

Then I noticed that they were overcharging me. Because I am diabetic they are supposed to give me the products [medicine and related paraphernalia] for free or cheaper. And I would complain and complain. Well, keeping in mind the problem that I had before [with Salubrity], I went to Osco and I got everything [records] from that year. And I went to Walmart and I got everything from the year. I went to Walgreens and I got copies and I sent them by fax. My money is missing. Do you know how much they returned to me? About 1,800.00 because the diabetes pills were being charged at 89.00 and they were supposed to be 3.00 – eh? No, well, they got mad because this one did not let them take advantage of her. Why would I let them take advantage of me? I told them, ‘I don’t know English but I have very good friends. It is not fair. How can it be fair that if you work and all that, uprightly – because never in my life have I liked to take what is not mine and I do it [work] from my heart when I do it – eh? Then, why will I allow them to do that to me? That would be to let them treat me like I am stupid because I am Hispanic!

Margarita was an undocumented stay-at-home grandmother. Her status as an undocumented individual prohibited her enrollment in Medicaid. Medical expenses were paid

out-of-pocket by her husband mostly and some help from her adult children. Margarita and her husband attempted to alleviate the situation: “Look, one day some papers arrived, that health insurance that I don’t know what. We filled it out and paid so much. And they stole our money. And we did not want to know anything about health insurance.” Margarita and her husband lost trust in the health insurance industry. Her daughters and daughter-in-law mediated her access to local healthcare providers for families with low financial resources. While medical resources targeted for low-income families do alleviate some of the financial burden, the services are limited and cost remained a concern for Margarita.

Another woman, Silvia, spoke of a similar problem:

We have some type of insurance. I don’t have Medicare. They have not wanted to give it to me. I just have that Salubrity insurance. In the beginning we were paying 80 and some dollars per month for each one. And for a long time they did not charge us anything. There were so many months that we did not make a payment [Salubrity did not request payment] so my daughter sent a payment – because my daughter is the one that does everything. They returned that payment – that we were not paying anything. But now we are paying again but less. It is not the same amount they were charging us. And Medicare – I get letters all the time. Sofia [daughter] tells me to fill them out so that we get all the benefits from Medicare. So we can have access to all the medicine. But they need my husband to be involved but he is not here to fill it out.

Silvia spoke only Spanish and did not drive. Being of older age and having multiple chronic conditions that included severe depression kept her homebound. While her daughter (a single mother of two young children holding a low-paying job) was able to assist her in some areas, Silvia still required her husband’s intervention in filling out important documentation to increase her access to healthcare services. Their marriage was a traditional one where she remained in the home to care for her husband and their children and he was the only financial provider. They’ve

been married for 57 years. As a matter of routine, her husband traveled to Mexico and stayed for months at a time and Silvia was irritated by how this affected her personally and her healthcare access:

Listen, when he left again, he told my daughter, Sofia, he said, [Silvia recollecting, “I feel all of those words.”], he said, ‘I am leaving because I don’t love this woman and she is a nuisance to me.’ He says that I am a nuisance to him. ‘She is a nuisance to me. And I want to live my life alone for four months over there. He wants to live his life alone. He leaves for four or five months so he does not have to be concerned about anything. He wants to live his life happy because he – thank God – has money.

Silvia underlined that the reason why she couldn’t complete the Medicare forms was because, “He is not here and that is the reason why.”

Right after Silvia made this statement I asked her to repeat her name and she responded, “Silvia Castilla Colón. The thing is that they name you ‘of Granada’ because of the husband. But I am Silvia Castilla Colón.” Silvia understood that she is oppressed and the reasons for her oppression – machismo. She, not her doctor nor the priest, identified her husband as the one individual in her home who oppressed her to the point of affecting her physical and mental health. Silvia did not seek a revolutionary change, that is, to deinstitutionalize patriarchy. Rather her “goals of resistance are as modest as” (Scott 1985: 348) what she values: health and wellbeing. But because of the oppression she confronted all of her life, optimal health remained elusive. Nevertheless, she persisted in her efforts to attain optimal health and wellbeing. This sense of wellbeing included protecting to whatever degree possible her sense of autonomy and self-respect: “But I am Silvia Castilla Colón.” This act of resistance represented a rejection of the traditional sense of being owned by the husband when wives take the husband’s family name

(rather than the wife's) and adding the preposition "de/of." This preposition links in private and public life the wife's identity to her husband's. Moreover, "in our society, women's names have been treated differently from men's names. Women's names have been dispensable" (Howe Hamblen 1979). Precisely the way Silvia felt, disposable. A study by Twenge et al. (1996: 417) found that women who stated a preference for keeping their last name "score higher on instrumentality/agency, and are more likely to be immigrants and/or women of color." By replacing a traditional marriage institutional practice and within a space where she is expected to exercise "total conformity" (Collins 1986: S24) Silvia introduced herself as "self-defined" (Collins 1990: 221): "I am Silvia Castilla Colón."

In another situation, the hospitals offered Gabriela financial assistance to meet a large fee for a procedure; however, she did not have insurance or any other assistance for follow-up care. Gabriela attributed her ability to cope with assistance from family, God and the parish nurse:

Look, my husband is very understanding and my daughters – both live here with me [and say], 'Oh, leave that alone Mom, don't do that.' My son is the same also, he says, 'Here, I am giving you this [money], so that it helps you in some way.' And, well, sometimes, yes. It does not mean that I don't have [money] for my medicine all the time but sometimes there is none [no money]. So he helps me and with the little that he gives me, then that's it. I adjust according to what I have to buy and as you can see everything has a cost, that the needles, that the strips [diabetes test strips], everything. So there is a cost, you see that everything has a cost. That the needles, that the strips and everything! Everything, everything has a cost. Then well, I grab help from one side and the other, from here and here, and that's it. I complete. But I am very grateful, well, with God and everyone. With [the parish nurse] also. She is a very good person and she sometimes gives me strips and like that. There is no other way! The fact is that we have no other help, like Medicare or – no, I don't have it.

Gabriela describes herself as resourceful in that she will “grab help from one side and the other, from here and here” but also notes that these allies help her maintain her health given she does not have insurance or Medicare to pay for the basic costs involved for her chronic illness treatments.

### Religion as Resistance

As a way of resisting institutional exploitation again, Margarita used alternative resources (e.g., free medical screenings at the church) and altruistic medical clinics in her area rather than pursuing the services of an insurance company. Another form of resistance enacted by Margarita was to *include with* her medical routines the use of alternative practices such as religious drama, prayer, diet and vitamins. Religion in particular provided Margarita a sense of ownership over her body rather than give in to “taking and taking more medicine.”

I would plead with God so much, that he would take from me all that I had. That he would send me my relief. Because taking and taking more medicine – how could it be possible? And last year, around August I said, ‘My God, I feel good. I will no longer take medicine. I feel well.’ Every time that I was participating [in church drama activity], I would feel [a spiritual experience] ... and I cry. I plead with God. And this I do for You, help me.

Margarita recounted her healing journey and her conversations about it with her doctor, including her faith in God to work together with her in her efforts to improve her health. Her presentation of God as her healthcare partner provided her with the justification and confidence she needed to resist the intake of prescriptions she did not trust. Margarita’s account began

when the doctor asked her, “Are you taking your medicines. I have here that you are not taking your medicines.” Margarita described her response and the ensuing dialogue:

I said to her, Doctor, I feel very well. She said, Really? [Margarita said, Yes.] What did you take? What did you do? I said, Nothing. I am just asking from the One Up Above and participating in what I want to participate with Him. And she said, Let’s see. And she pulled her machine. I am going to do the test from over the past three months. [After getting a reading of Margarita’s blood sugar level, her doctor stated,] Your blood is good. I said, Yes, doctor. Yes, she [the doctor] responded. Are you sure you are not taking anything? I am taking – I told you that not chicken nor milk agrees with me. She said, No. What are you taking? I said, I am taking the iron [supplement] like you told me, calcium and now I am taking vitamin C for the cold. She said, Oh, that is very good. And my daughter just bought me drops for my eyes. No, she said, that is very good. You are well, she said.

Francisca, another participant, expressed a belief in a positive link between health and religion also. Regarding the successful knee treatment she received, she declared, “Thanks be to God, I say. God has protected me from so many things.” Despite the devastating effect failed attempts to secure desperately needed healthcare treatments can have on an individual, Luisa’s religious ideology provided her a needed sense of comfort: “It [religion] helps me. It helps me to see things more calmly, that I should not worry about it so much. These are things that God sends. It helps me to think that, well, that I should not worry too much.” Marta, who was recovering from a triple bypass and a catastrophic fall that rendered her wheel-chair bound, expressed a similar belief in God’s involvement with her health: “I have come a long way. And I think that God has given me more years because he has some work for me.” In the following statement, Marta represented the thought processes and behaviors of the women in my study about not giving up: “They [doctors] told me from day one when I had the accident that it was

going to take a while. It would take years to walk and to do everything that I – but I will never quit trying and I haven't quit trying and I do not intend to quit trying.”

Like many women in my study who expressed a deep faith in God, statements that appeared to give evidence of fatalism (higher power has full control of outcomes) were rather an expression of the knowledge the women had acquired about the world, the healthcare system, more precisely – that their sphere of influence was limited. However hard they tried to optimize their health and wellbeing, institutions and their agents had the last say. Beyond that reality, what could the women do?

Silvia gave testimony of that reality:

I am ready for whatever God sends me. I say that He sent me all these illnesses. Right now, just, ‘Thank you for the life you have given me, every day.’ That is what I give Him thanks for. That’s all. What is there for me to do at this point? I already have all these illnesses. What can I do? He is the One in charge. There He is. He will know what He will do with me. Like this arthritis, this one really has – because it causes me a lot of pain. And there are times that the pain is unbearable. Here, listen, my neck, the cords here, everything. And what do I get? I apply pain ointments – everything, everything. They have also massaged me. They have done everything. Nothing helps me. Whatever God wills. It is my destiny. What else is there. I go to my appointments but only so that they don’t say anything. I go to ask about refills so my daughter gets my pills – right? ‘You have this many refills left. You are running out of refills. We will call the doctor.’ That is the only reason why. They don’t make me well at all. Not one has made me well.

Regarding everyday resistance and subordinated groups, Scott (1990: 79) pointed out that one should not neglect to “underestimate the power arrayed against them.” In addition, Scott (331) states that thoughts that do not support dominant ideologies, such as the ones that hold strong adherence to religious practices, are “revolutionary” thoughts that “imagine

reversing the distribution of status and rewards within that social order,” as it is in the case of Marta who believed that God had a personal interest in her improved health: “To give up is the worst thing you can do. I don’t know. I just pray to God every day to find the courage and the energy for what I need, my health. Right now, I can move. I can at least move my legs a little bit and stuff. When the accident happened I wasn’t able to do anything – not even move my legs.” Silvia’s statement, “What can I do? He is the One in charge,” is not incompatible with her fighting spirit. To Silvia, illness was grounded in everyday physical aspects of life: “Because God sent them [illnesses] to me and the anxieties (*nervios*) ... because I was a worrier ... I remember everything.” Therefore, the physical and mental health cures and pain-mitigating pills were also grounded in the physical world. Furthermore, Silvia defined the situation as one where the doctors failed her – not God. Throughout my interview, it was obvious that Silvia attempted all she could to find some measurable physical relief for her conditions and mitigation of pain and resisted the idea that there could be no alternative medical treatment that could help her.

In the end, her spiritual relationship with God remained intact, as did her overall sense of wellbeing: “God wanted it that way – that I would suffer [with chronic illnesses]. But God gives me everything in life. Look at other people ... I have my house and everything to live. And what greater happiness than my children? All of them visit me and all that. They are so good. Well, I will receive strength and patience to suffer what He sends me.” This was an attitude most of the women in the study embraced once they “reconciled” (tolerable accommodation; Charmaz 1997: 48) with their illness. Their ultimate goal was to establish a stable wellbeing in spite all their chronic illness and the challenges and abuses they confronted.

Maria del Carmen discussed her struggle with diabetes and with God after her niece – a nurse – revealed her condition. Maria del Carmen believed God gave her the condition and became so angry at Him she lost considerable weight: “I was angry because, because I had diabetes. I got mad with God, oh dear, later I did not even know how to ask Him for forgiveness. But one day I heard on the television that it was an illness. That if you do not control it, that if you don’t take care of it, you could die.” After Maria del Carmen found out the facts about diabetes, that God did not send it to her, she “went and confessed and asked God to forgive me and I cried so much with Him.” Maria del Carmen asked God to forgive her for her “ignorance” because she “thought He was punishing me but when they told me – my niece told me the facts. Then I said, ‘My God, forgive me because you want what is best for your children. Ignorance, Celestial Father.’ I cried so much. I confessed and I confessed with Father Bosco.”

These women, contrary to what is stated in some of the academic literature, did not use God as an excuse for not taking care of their bodies. Rather, God was interjected in their relations to others and medical processes as someone that would back their use of conventional approaches to health *with* spiritual practices/rituals. The use of God as the women’s healthcare partner provided the women with opportunities for self-valuing (Collins 1986: S16) – “namely, replacing externally-derived images” of their bodies as deserving punishment and undeserving of healthcare services and treatment models that did not rely so much on too many prescription medications with the idea that they deserved health and wellbeing.

The women viewed God as a “beneficent, rewarding and just entity” (Glover & Blankenship 2007: 41). When all else failed, God was always on the women’s side. His

teachings justified their acts of resistance and He gave them strength to sustain a decision to not allow “so many pills” to cause ongoing discomfort and harm. The women did not use their faith as an excuse to be ignorant of health practices and treatments. Religion was not for the women an ideology that encouraged them to give in to their illness. Rather, the knowledge they had about their faith and the trusting relationship they had with God informed them that God wanted them to maximize their health and sense of wellbeing and that these required action.

Literature on the relationship between health and religion/spiritual life had found that health practices and wellbeing improve with religion (Kleinman 1988; Krause & Bastida 2009, 2010; Lujan & Campbell 2006). And, as Benjamins (2007) hypothesized, the women benefitted from increased social support, access to health information and lower-cost health screenings and services and other instrumental services such as transportation, religious teachings related to health and the availability of a parish nurse.

Isabel was undocumented and lacked health insurance, spoke Spanish only and had limited resources. She provided another example of how religion and resistance combined to give her the strength to both detox – on her own – from her addiction to alcohol and from the belief that she must remain with her husband who abused her routinely.

“I started drinking since I got together with my husband, because my mother-in-law drank, my godmother. We were in the house and all of us drank and if we did not drink my husband would hit us on the head – that is traditional. But I knew that I could stop because I did not like it. Then, when I got together with Miguel – the one that is my husband now – we both drank. And if I did not drink he would get mad, he would mistreat me. And sometimes I drank because I could not stand him because he talked a lot. That I am this and I am that.”

She recalled another form of abuse: “To do it that way [sex], well, that he is going to [rape] me. I feel that that is the way he is – just by force [sex]. It was horrible. Worse yet, he would beat me after and talk bad about me. I am looking at his face, that he wants to be with me. It’s the most horrible thing to see.” Her family did not want her to leave him: “Oh, I endured it because of my parents. ‘Ah, you are going to be with another man that who knows what! That that type of women – nooo, no.’ I came to my senses – my God.” I asked Isabel how did she come to her senses. She responded, “By talking to my Heavenly Father, a lot, and asking Him, what should I do? And He said to me, “Why are you feeling overwhelmed, my daughter, if I love you? And you can remove what does not serve you.” Isabel did leave her abusive husband and concluded, “I am not sold to anyone. That is what my Father tells me.”

Isabel also relied on God to help her quit her addiction to alcohol. She detoxed in her home and without medical supervision: “What happened is that I stopped drinking [detoxing] and I was doing it with determination and I stopped drinking and I said, ‘My God, then this happened [detoxing side effects] because I stopped drinking. I felt this way, all depressed. I didn’t want to eat. I couldn’t sleep.” I asked Isabel how did she feel not drinking anymore.

Believe me, I still feel that it is there. Evil. But because I am always in prayer and I know that my Father, every time that Evil is there, it is like the Bad Angel and the Good Angel. God is there ... I am also going to tell you this. When I said, If I stop drinking, when will I smile? Hahaha. When will I be happy? When will I smile? When will I be able to have a conversation with a person?! As I am doing here. When? When, my God? If I was so stupid when talking and everything, and He said to me, like, He told me in my mind and my heart, ‘Ah, that is what you are looking for, my daughter? Now you will see [that God will stop her from been addicted to alcohol].’ Now I smile. I speak with people, even too much. And the Lord taught me to speak even more. I couldn’t tell this to anyone until now that I am telling you.

Like the other women in the study, Isabel did not use her strong belief in God to not take care of herself but rather to have God be her partner in health because she believed fully that He wanted her to be healthy and have a stable wellbeing.

Scott (1985:331) argued that religion and religious/cultural rituals are a way that subordinated groups can “imagine reversing the distribution of status and rewards within that social order.” He lists rituals such as the Feast of Krishna in India and Carnival, a Roman Catholic ritual in Western and Latin America as “breaking the routine codes of deference.” Therefore, religion is viewed not as the opposite of resistance, but as a way to undermine dominant knowledge and practices. In fact, “the imaginative capacity of subordinate groups to reverse and/or negate dominant ideologies is so widespread – if not universal – that it might be considered part and parcel of their standard cultural and religious equipment” (Scott 1985:331).

#### Complementary and Alternative Medicine as Resistance

Practicing complementary and alternative medicine was another way that the women resisted not taking care of their bodies because of the lack of affordability or the discomfort the pills created for their bodies. In Margarita’s account, she mentioned that her doctor had prescribed vitamins as an acceptable approach to healthcare. Other women in the study also used vitamins and other alternatives to healthcare that they chose on their own. Some of the women lacked health insurance but used local altruistic clinics together with vitamins.

Gabriela gained citizenship through the Immigration Reform and Control Act signed by Ronald Reagan in 1986 and was able to reunite with her husband after 16 years of separation.

She completed up to ninth grade in Mexico, spoke only Spanish and held a job that paid nine dollars an hour. She was not eager to move to the U.S. but she followed her mother's advice to, "follow him because he was my husband." She never adjusted to life in the U.S.: "To tell you the truth, I've never liked it here. I have never liked it."

Margarita and her husband could not afford private insurance but neither did they qualify for Medicaid. However, even the altruistic clinic was unaffordable: "I pay 25 dollars. Ten dollars the day of my visit. What I owe accumulates – no? Because [my payment] does not cover all the cost, that is, I pay 25. They charge me according to my income. So when I go [to the clinic] I pay a 50-dollar installment payment. That is how I manage." Moreover, as stated by Deeb-Sossa (2013), altruistic clinics may not provide the quality of care patients require. "I am an anxious [*nerviosa*] person – I am very – if something worries me, I don't sleep. I think that affects my diabetes." Gabriela ran out of pills and needed another three-month prescription. She complained about her experiences getting refills:

Right now I am paying more [for prescription medication] because [the doctor] changed my pills and he was not my doctor. That is what I don't like – because my doctor was not there. And I see her because I have to, I don't have medicine. They just give any doctor ... and I was feeling very bad for a month because of the medicine – I don't know. But I was feeling bad ... And it happens often that I can't sleep for three, four hours.

At the time of the interview her husband was unemployed for six months. To generate income, he began to sell for HealthLand – a nutrition and personal care products company that is similar to Tupperware in that people can become clients and sell the products to friends and family. She talked about the products with enthusiasm: "Have you heard about HealthLand? They are a large company in 70 countries. [Gabriela gets excited and slapps her hands together as she

enumerates the products available.] Vitamins! Everything! Vitamins, calcium, teas, aloe vera – all of that. I use the HealthLand tea or apple tea – teas, the ones like that, yes.”

Francisca complained also about the lack of continuity of care she experienced and appreciated having access to natural vitamins to complement conventional treatments. “I didn’t want so many pills. That is why I don’t feel well. I don’t feel well because of [taking] so many pills. Besides, because of my gastritis, they affect my stomach – too much medicine. But, no, I had to take them. But my stomach would feel really bad. Sometimes the pills make me nauseated. I have been taking pills for a very long time.” When I asked Francisca the brand name of the vitamins she just mentioned, her demeanor changed from pessimism to enthusiasm. Francisca described the pills as “natural, like from herbs,” and that she goes “to naturist pharmacies and find them there.” She got up from her couch with some effort but obvious eagerness, grabbed the bottle from the ledge and brought it to me so that I could read the label: [Translated from Spanish:] “‘Ortiga – dietary supplement. Oh, for osteoporosis.’ Oh, that is why you said [that she suffered from anything that ends in – osis.] Osteoporosis – this is for the bones. Osteoarthritis. Muscle pain. Chronic rheumatism. Hernia. Take one tablet per day. And this does help you.” Francisca responded, “Yes! That is what has been helping me!” “And it says that it prevents cancer in the ...” Francisca completed my reading of the label on the bottle, “Bones.”

The government of the U.S. released a warning for this specific brand of vitamins that Francisca showed me. For individuals having a vitamin deficiency acquired through food intake, some researchers and doctors recommend supplements. However, this particular brand could hurt Francisca according to this government warning. Another participant in the study

who took a risk – without the knowledge that she was – was Miranda. A year after she crossed the border without the authorization of the U.S. and being unfamiliar with the dangers lying below the snow, that is, ice, Miranda fell. Her son drove her to a mother-son pair of *healers* rather than the hospital. [Miranda also complained that her son never took his wife to the healers but, rather, took her to the hospital as a matter of practice]. The *sobadores* dislocated Miranda's arm. The parish nurse was told about Miranda's ordeal and exhausted all possible medical institutions that would be willing to assist – she found none. The parish nurse expressed to me, repeatedly, her deep disappointment at the medical community's dismissal of Miranda's need to recover the use of her arm. Miranda (and I for that matter) viewed the recovery of the use of her arm as a way for Miranda to escape the exploitation of labor through child care she was providing for her son's son and isolation that had rendered her feeling like she “did not exist.” Regarding medical care. Miranda stopped asking her son to take her to the hospital so that her arm would be rehabilitated through surgical intervention and to alleviate the daily pain she felt. He responded, “What do you want me to do?! I am not a doctor!” Regarding what she experienced with the healers she said of her son and daughter-in-law, “They should have taken me [to the hospital] but they did not want to. Then they told me it was my fault. But I am not familiar with here [U.S.]”

Miranda expressed that she had one more hope: to seek medical care from an established hospital for the indigent. After multiple visits Miranda was diagnosed with “chronic disability of the right arm” and was denied surgery and rehabilitation because she did not live in that particular city. Her address, however, was given to the hospital from the very beginning of our

interactions with them and Miranda and I found this “reason” questionable. While a doctor at the hospital interjected that “she should not have gone to the healer,” an employee offered a backdoor to getting services. At this time, I detached myself from the process. Miranda attempted the backdoor strategy but family and friends declined involvement. Miranda stopped seeking medical relief for her condition concluding that there was no solution to her problem. Miranda, knowing what she knew by then about the U.S. healthcare system, stated that that the one hospital built precisely for marginalized individuals needing healthcare was her “last hope” and, then, services were denied again. What was she to do?

At this junction, it is important to say that one aspect of resistance is that resistance comes with risks, especially for members of a subordinated group (Hayes 2013; Scott 1985, 1990). It may be failed resistance attempts like Francisca’s and Miranda’s and the fact that everyday resistance acts are not collective or socially or politically organized nor revolutionary in the terms of group size and force, intent and outcome – and therefore loud and highly visible – that diminishes or makes invisible the women’s acts of resistance. Collins would disagree with measurements such as these. The women resisted giving up their bodies to others as expected, with “total conformity,” and rather “viewed themselves as fully human, as subjects” (1986: S24) and became “advocates” on their own behalf. Lupton concurs with Collins’s idea on expected conformity of individuals vis-à-vis power: “In the medical encounter, caring is mediated overtly through professional duty and the exchange of money rather than through the love of an intimate relationship, but the patient’s gratitude, docility and compliance are also expected” (Lupton 1996: 165). Consideration must be given to the possibility that there may be

a bias that places the women's knowledge of themselves and their bodies as deficient vis-à-vis the doctor's knowledge of medicine and the impressive institutions that frame these professionals as always sensible and trustworthy. One must not be negligent, however, to remain mindful of the historical failures of the medical community to treat black and brown bodies with equity vis-à-vis white ones (LaVeist 2002).

Drawing from Scott's significant concept of everyday resistance as disguised (e.g., hidden transcripts) but traceable (Scott 1989) and therefore not fully invisible, Vinthagen and Johansson add, "It may be necessary to identify everyday resistance also when parties themselves call it something else" (2013: 1), for example, when Margarita did not call her resistance to "taking and taking more medicine" *resistance* but told her doctors that she was "just asking from the One Up Above" to justify her resistance.

Vinthagen and Johansson argue also that some combined practices that may sometimes be acts of resistance are avoiding/escaping (power/domination), survival techniques, coping and accommodation. "Theories within emerging 'resistance studies' differ but they agree that resistance is an *oppositional act*" (Vinthagen & Johansson 2013: 1) that must be assessed always in relation to power); then, in the case of avoidance, the criteria for what is resistance is met because its practice makes the exercise of power impossible. Importantly, when attempting to recognize resistance in women's lives, it must be recognized that "intersectionality shapes the experiences of many women of color" (Crenshaw 1991:2). Hayes concurs that intersectionality influences the way women suffer and strategize, how they survive in a society that is at every location and space patriarchal: "[G]ender oppression is just one form of

oppression women experience. A woman's race, gender, religion, ethnicity, and/or sexual orientation can influence the resistance strategies available to her" (Hayes 2013 1).

Neither the process of care (Tronto 2001) nor acts of everyday resistance are without fault lines (Armstrong & Murphy 2011). The women's knowledge on what is to be known about their condition is limited and therefore treatment can be compromised. This is Armstrong and Murphy's concern precisely: "Individual resistance to medical expertise may be characterized as being based on incomplete or flawed evidence" (2011:324). My argument is, rather, that the women, as subordinated bodies, resisted in the ways available to them the devaluation of their chronically ill bodies. When the quality of care was determined by them to be absent, inadequate, compromised or risky, they forged forward with resistant acts that they believed would make a way for them to maximize health outcomes and wellbeing. Then the women evidenced through their acts of resistance that neither they as individuals nor their culture, but systems of oppression (e.g., racism, sexism, classism) got in their way when they tried to reach optimal health and wellbeing.

Some but not all the women recognized or acknowledged the term *curandero*. In his study, Hinojosa (2008) identified two terms used by his participants to describe *sobaderos*: *curandero* (curer) and *masajistas* (massagers). He uses the term *sobadero* throughout his article. I will use the *sobadero* term because some of the women described their understanding and interactions with these folk healers as massagers. One woman described *curanderos* as witchdoctors. The term *sobador* was used more favorably. Francisca described her experience with a *sobador*: "I hurt my knee. This bone came out this way out. I was on a ladder and who knows how I bent it. I think it went to the side and the bone came out from here but thank God a

person readjusted it, a woman called, what is her name, I think Doña Pilar. No, yeah. No, man. I won't be able to walk any more [she told herself at that time]." She explained the process used by the folk manual therapist. "This device – she was massaging [*sobando*], massaging, massaging. Like she warmed up my bone. She warmed it up. She warmed it up until I felt that she adjusted it." Francisca recovered after that intervention. Before the *sobadas* (massages) provided by the folk manual therapist, Francisca said, "I was dragging myself to go to the bathroom. My knee was very bad. And they [her sons] had to bring me upstairs."

Two of the women expressed that they used *sobadores* as needed. They spoke Spanish only. Both women lacked health insurance due to their immigrant status: one was unauthorized to be in the U.S. (crossed the border illegally) and the other had a temporary visa that had expired. Neither could afford private health insurance nor did either one qualify for public health coverage. Francisca was homebound by the weight of her chronic illnesses and anxieties over her adult children's possible deportation. Another study participant, Miranda, was isolated from the wider community by her son's demand for child care for his son and her shame over her chronically dislocated arm. Miranda's son and wife were unauthorized immigrants but were able to hold jobs. Both women mentioned accessibility, provider reputation and cost with length of treatment as reasons for using *sobadores* rather than conventional treatments. Francisca stated that she paid "forty dollars. One [visit] was enough. There are people that charge 20 but you have to go two or three times." Another reason for Francisca to use *sobadores* is her adherence to an attitude of healing that seeks to minimize risk. When I asked Francisca why she did not go to a conventional doctor, she answered:

Because they put a plaster cast on you and they leave your bone out of place and all that. That is my impression -- with my aunt, may she be in heaven with God, she died. They left her foot bone like that and it stayed that way, all out of place – also a hand. The thing is that [the doctors] put a cast on you right away. They put a cast on you, don't adjust you and nothing. No, the doctors right away put a cast on you. They do not even adjust [the bone]. And here, well, these people adjust [the bone]. And, then a bandage and that's it. And, no, I ended up well.

Francisca, like all the women in the study, sought conventional medical care in proportion to what their specific chronic illness required. Their strategies – even if assessed as inadequate – make sense in the context of their socioeconomically constructed experiences.

Only two of the thirteen women in the study stopped seeking medical care for their specific chronic illness: Miranda and Luisa. Both women were relentless in their efforts to improve, mitigate or delay the effect of their conditions. The last hope, as Miranda herself described it, was a medical institution serving the indigent. A backdoor – unethical as it was – was offered to Miranda by an empathetic employee at an institution serving indigent patients. But that door was closed to her also. There is no universal care for individuals living at the intersectionality of multiple constructions of difference. Miranda was left to manage, without structural relief, the challenges and even abuses she lived with daily. The fact that Miranda needed her disability attended to medically so that she could remove the stigma of her disability and could gain some significant degree of independence from abuse and labor exploitation was marginalized. Like Miranda, Luisa was also undocumented, of low socioeconomic status, and either did not complete middle school or high school. After exhausting all possibilities, she and her family decided to move back to Mexico to rely on the State's social service system.

Francisca's visa had expired and she was of very low socioeconomic status. She could access medical care only through the altruistic efforts of the local social services community. She gauged her experiences with doctors, processes and treatment outcomes as incompatible with her ideas about quality of care. Francisca described, as many of the other women in the study did, a dissatisfaction with the interpersonal aspects of care, efficiency/coordination of care and outcome of care. She mentioned that she preferred to move back to Mexico where she believed her deep sense of isolation could be alleviated with the presence of family, friends and culture. Francisca explained her reason for remaining in the U.S.:

“We are waiting to see what happens [immigration reform under the Obama administration], reform and all that – for my [adult] children. There they are, my poor children. May they go with the blessing of God because they do not have a driver's license – they don't have, well, there they are ... That is why they are all stressed out, filled with anxiety. We worry about our family [Francisca lives with her adult children] because we see how many things happen to so many families. So we are filled with anxiety. But we want to be here. Well, *my children want to be here.*”

The social constructs of gender, race, class, immigration status, geography and language intersected to affect the health and wellbeing of Francisca. Francisca understood this: “When anything happens to my [adult, undocumented] children, my anxieties are high. I think that is what they [the doctors] should control, my anxieties [*nervios*], because my high blood pressure makes me take and take pills.” I asked Francisca what could control her anxiety. She stated, “There is nothing else; I have to take complex B. It has helped me. Before, the desperation was horrible. Yes, very desperate. But I started taking them [vitamins] and that's it. But when my children are out of a job I worry about them. And also my daughter who works very far away. She works at night and it is dawn when she is traveling back home alone.” Her experiences as a

member of a subjugated group have left Francisca with few options. She explained, “I go to the doctors and they make me ill all over. Then, they are not very adequate – hahaha ... And I also have arthritis and it causes me sudden pain. And now I have to take pills [for arthritis besides the other pills she takes for other conditions].” She explained why she is taking natural vitamins rather than her doctor’s prescription: “They took me to a specialist and, no-no-no. The pills were very strong and were not taking the pain away.” How pills affected her kidneys was also a concern: “A doctor that I used to see told me, ‘I am not giving you pills anymore because taking so many pills is affecting your liver.’ He ran some tests that showed my kidneys were very inflamed.” She complained that she did not receive an update on the situation or a treatment plan to address the inflammation of her kidneys.

Alejandra also expressed her concerns about how prescription medication intake could affect health. In her case, Alejandra remained suspicious that taking pills had damaged her kidneys to the point that she had no choice but to submit her body to the process of dialysis.

She explained:

The family doctor sent us to a kidney specialist. He is at [Name of Hospital]. He [the specialist] ordered an ultrasound and he told me that one kidney was small and other one big. I said to myself, ‘How strange.’ He gave me some pills. He told me to take some pills. And those pills made me feel so bad that I said to myself, ‘I blame those pills. Because my kidneys were normal. My kidneys were never in pain. Stones – nothing, no pain. They say the pain [from affected kidneys] is terrible. I don’t know what kidney pain is. Oh, my Lord. We went back [to the doctor] and he said to me, ‘Look, you have to go to dialysis.’ ... I came out of the hospital crying ...”

Alejandra told her husband, “Leave me as I am. I want to die.” Just as Alejandra was determined to die, her husband was determined to help her live. He coerced her into the hospital and she’s been in dialysis ever since.

The women resisted treatment in ways that represented what they know about themselves, through their bodies, and what they know about the world and the opportunities it did not provide, through their experiences. In the case of Francisca, she chose to combine conventional medicine with alternative treatments such as *sobadores*. Hinojosa argues that *sobadores*’ clients seek them out because of the “structural delegitimation” (2008: 195) their clients confront. Contrary to this delegitimation, Hinojosa (2008: 203) found:

The *sobador* discussed disease and the body in ways that help seekers can recognize, vocalizing a shared or convergent view of the body. He does this convincingly because he accepts their pain reports, validating their suffering. This explains why Mexican Americans often welcome *sobadores* as adjunct, or even primary, caregivers.

Adriana left the U.S. after raising her children to retire in Mexico. However, one of her children, now an adult man and alcoholic, was exploiting and bullying her. The situation was so severe she had solid plans to move into a nursing home after selling her home. However, compelled by her daughter, she returned to the U.S. to live under the protection of her daughter’s home. Arguably, being a descendant of European colonizers in Mexico and with parents that owned land and a local shop in Mexico, provided her with a legacy of having stable healthcare services. “Medicare pays 80% and I pay 20%. They withdraw payments from my pension, that is what I have.” I asked her if she had used *curanderos* (curers). *Curanderos* seemed to be defined by the women as witches and *sobaderos* as unlicensed

chiropractors/massagers. Adriana responded, “No, curers, I never went to see them. I went to botanical shops and naturist pharmacies.” I asked her why she did not use the services of curers. She said, “Look, I don’t believe in that too much. They are going to come up with some strange stuff and hahaha. People will say, ‘Haha! Look at her in there!?’ And I would be, ‘What is this!?’ Because they [curers] come up with things that are not good, they go the wrong way ... And then they come up with the idea that you are under a dark spell. You know. That was used a lot in the past, the witches. They come up with stuff like that. I never liked it.”

Experiences of lack of or limited healthcare access for subjugated groups are transferable from the sending country to the receiving one. Rosa talked about her experience in Mexico with healthcare providers. First, I asked her why she did not use *curanderos*. She stated, “I think that doctors know best.” In Mexico she did not use *curanderos* either. Rosa explained, “I grew up in a ranch and back then when I was a little girl there were no male or female doctors, only [midwives].” Less than 100 people lived in her town.

There were about two [midwives] at a ranch farther away, a bigger ranch. In that one, there was a midwife that would give the women injections, to help them, to give them strength [during labor]. But the ones that lived in my ranch would get nothing – they would just have the baby. There were no *curanderos* in my town. The midwives would give us herbs; they knew how to give them. There were many scorpions at the ranch and they would bite you.” [One bit her between her toes. She was taken to the city because there was no herb or localized doctor to help her.] “The doctor in Mexico healed me.

Services made available to Rosa’s community were the bare minimum and while she did have more access to altruistic medical care in the U.S. it still remained limited. The point is that Rosa, once she found out a way to optimize her health, she pursued it just like her family

pursued healthcare in Mexico on her behalf and contingent on how healthcare was made available. The parish nurse connected her to the local hospital, altruistic clinic and transports to medical appointments. Rosa followed a diet as advised by her doctor and the parish nurse; she took vitamins and used herbs she learned about during her time in Mexico. All the women consistently demonstrated their willingness to use all resources that could provide for their health and wellbeing.

In the study by Hunt et al. (2000), although Mexican American women with diabetes showed interest in herbal remedies and religious support, none of the women in the study used *curanderos*. “For these patients, it also cannot be assumed that belief in alternative treatments and God's intervention indicate fatalism or noncompliance but instead require consideration of individual treatment behaviors” (Hunt 2000: 216). Rather, the women responded to structural barriers to health and wellbeing by resisting in various ways: by advocating for themselves, by pressing their own claims, by exposing institutional failures, by valuing themselves, by introducing religion as their strength and shield vis-à-vis dominant figures and their ideologies and by adopting a way of life that evidenced that they valued their health and wellbeing in ways that others did not.

## CHAPTER 5: DISCUSSION

My findings reject victim blaming of older and chronically ill Mexican women and rather demonstrate that the women resisted the personal and professional preferences and ideologies of actors and the institutions they represented (e.g., family, corporate, medical) when these were defined by the women as barriers to their health and wellbeing. By placing older and chronically ill Mexican women at the center of analysis rather than claims about institutional goals that purport to serve with equity indigent populations or individual (e.g., refusal to learn English) and cultural factors (e.g., religion, fatalism) as key explanations for poor health outcomes, the women's voices account for the effects dominant systems have on their health and wellbeing. The women know that what is expected of them is "total conformity" (Collins 1986: S24) and that their social location as Other in society "render[s] them vulnerable" (Crenshaw 1991: 3) to contrary ideologies and coercive forces. Through their voicing of their experiences in their search for positive care receiving experiences and health and wellbeing, the women told of their challenges and the distinct ways they resisted. Moreover, the women pointed to structural failures in society for inequity in health and wellbeing embedded in their everyday life experiences, such as labor exploitation by a family member and years of domestic violence. More specific to the healthcare system, as more recent academic literature states (Holmes 2012; Kleinman 1988; Lupton 1996; Reichman 2006), the women described structural failures within

the system as barriers to the optimization of their health, such as inadequate relationships with healthcare workers and economic exploitation by a health insurance provider.

Another point some researchers argued (Angel and Guamaccia 1989; Holmes 2012; Kleinman 1988; Lupton 1996; Rehm 1999; Reichman 2006) was the conclusion that some researchers made that cultural beliefs and behaviors exercised by Hispanics/Latinas/os or other marginalized groups – such as fatalism (higher power has full control of outcomes), reliance on traditional healers (e.g., cleansings), somatization/*nervios* (exaggerating physical symptoms when depressed or anxious) and reliance on religious practices (e.g., prayer) – were culpable, to some significant degree, for Hispanics/Mexicans' poor health outcomes. These authors instead concur with the women in my study that the root of the problem is structural. Angel and Guamaccia (1989: 1235) concluded that medical professionals' reliance on Hispanic patients reporting *nervios* "is problematic because of the fact that poverty increases risk for *both* psychological and physical illness." Holmes (2012:879) estimated that "the genesis of the patient's sickness is subtly located in the patient herself – her biology or her behavior. These rushed, confusing and often blaming interactions are part of the experience of medical care leading unauthorized migrants to conclude repeatedly that "los médicos no saben nada" (the doctors don't know anything).

The women expressed knowing that the ideas dominant actors and institutions had of them justified the challenges and abuses they introduced into the women's lives: "because I am Mexican"; "because I am not from here"; "because I shut my mouth, if not he would hit me"; "because I don't have a job"; "because I was a woman [he abused her]"; "because I don't have health insurance"; "because I don't speak English"; "because I did not have the knowledge";

“because I don’t know this place [U.S.]” The women shaped their everyday acts of resistance accordingly. The women are not focused on forming a revolution or becoming politically involved. Rather, the women are focused on developing positive experiences with the healthcare system so that they may sustain reasonable health and maximize wellbeing, and therefore, when confronted with barriers to those goals, they developed the required resistance strategies to mitigate or eliminate those barriers. Regarding advocacy, for example, Alejandra’s health deteriorated dramatically after her husband refused “being my husband” (e.g., not sleeping in the same bed) as a punishment for Alejandra’s refusal to abandon Catholicism. This is when the parish nurse introduced herself and Alejandra accepted her medical, spiritual and advocacy services. The parish nurse worked with Alejandra so that she could gain citizenship, then health coverage through Medicaid and Social Security benefits.

Healthcare allies provide the women with needed social capital, as Bourdieu states, “possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition – or in other words, to membership in a group – which provides each of its members with the backing of the collectivity-owned capital, a ‘credential’ which entitles them to credit, in the various senses of the word” (Bourdieu 1986: 249). Regarding pressing her claim for health and wellbeing, despite not speaking English and not driving, Maria del Carmen was able to secure employment *and* health coverage. When her insurance company overcharged her with no justification on the premium price and medications, apparently in an effort to exploit her financially, Maria del Carmen secured an interpreter to warn the insurance agent that there would be consequences for their behavior. All her money was returned. Regarding religion as resistance, Isabel drew strength from her belief that God

wanted her to be free of detrimental forces represented by her abusive husband and her addiction to alcohol. Through her belief in God she found the justification and inner strength to remain healthy and with a stable wellbeing. Regarding complementary and alternative practices as resistance, when Francisca used vitamins and *sobaderos*, she adopted what Vinthagen and Johansson called a “way of life that makes visible every day resistance to certain norms and discourses” (2013:10). Advocacy performed by the women individually, speaking their minds to power, the use of religion and *sobadores* may be “made invisible by society” and not be recognized as resistance. However, Vinthagen and Johansson conclude that acts of resistance like these women’s are made invisible because “acts that deviate from hegemonic understandings of resistance tend to achieve non-recognition” (2013: 10).

Many of the women evaluated their stories as narratives worthy of being shared with other women. For example, Maria del Carmen expressed that her years of suffering since she was a little girl was due to a lack of knowledge, so she shared, passionately and consistently, what she knew about successful living with other women in the community. Alejandra became profoundly depressed due to the dramatic losses in her marriage and health but she learned to be happy and wanted to share that experience with other women. Alejandra also shared with her daughters her ideas about marriage and education: “If the man is not responsible, leave him! Don’t ask him for a penny! I tell my daughters, ‘Go forward with your studies’ ... When I was very young, I could not study. I would go with my father to the fields.” Isabel wanted to start a religious support group for women where she could encourage them to escape their abusive relationships with men because in her opinion, “God did not make us to take abuse.” She also taught the boys and men in her family about domestic violence and rape: “Please, this chain [of

abuse], you have to break it, you should not be that way.” And, most of the women, when they found the opportunity to do so during our conversations, shared their love and pride in their Mexican culture with me.

As the women in my study demonstrated, Collins (1986: S24) noted that where there are multiple oppressive structures there are also opportunities for actions opposing that oppression:

[I]f Black women simultaneously use all resources available to them – their roles as mothers, their participation in churches, their support of one another in Black female networks, their creative expression – to be self-defined and self-evaluating and to encourage others to reject objectification, then Black women’s everyday behavior itself is a form of activism. People who view themselves as fully human, as subjects, become activists, no matter how limited their sphere of activism may be.

A particular religious space that provided the women in my study a site for activism was the church. There is a generalized idea in the 21<sup>st</sup> century that religious institutions are of little use to women. This view is most prevalent from outsiders looking in and even more prevalent when the women locating themselves within the walls of religious institutions are members of a minority group. The women in my study, those who hold insider knowledge, would disagree. The women, together with Ram (2013: 240), would agree that churches are “important sites of female culture.” Throughout the interviews, the women underscored that the church was a site/place with people, practices and opportunities where the “women could withstand ... forms of seclusion and isolation occasioned by migration” (Ram 2013: 240; Sigfrid Gronseth 2010) and also as a place to “negate dominant ideologies” (Scott 1985: 331). The following were some of the positive experiences and uses the women mentioned about the church. For the women the church was a place where a link to past cultural-religious practices they missed

could be found, they gathered with family, they felt they belonged, cultural identity could be proudly shared through Mexican cuisine, volunteer opportunities and paid employment were located, they could learn English as a second language free of charge, Spanish could be spoken freely and without scolding, comfort and renewed strength could be found after the death of a husband, they could have positive religious experiences through art expressions (drama and sculpting, singing), through the practice of confession anxieties – even if temporarily – could be released, they located a context from which to evaluate personal moral growth, the parish nurse (holding offices in three different churches) could be accessed, community events and health fairs with free health screenings targeting their needs in their language could be found, where the women could network with other women and gain additional access to resources such as sorely needed transportation and information regarding health and wellbeing, and they were being watched over by other members if their health deteriorated. Ridge et al. (2008: 413) would concur with the women that religious/spiritual practices have benefits for practitioners and concludes, “That people with HIV report specific subjective benefits from prayer or meditation presents a challenge to secular healthcare professionals and sociologists.” Bradshaw and Ellison (2010), Koffman et. al. (2008) and Hill and Pargament (2003) reported similar findings. In conclusion, the church as a place and religious/spiritual experiences and practices made a way for the women to resist isolation and not be overcome by dominant ideologies and therefore was a form of resistance that provided the women with tools for health and wellbeing.

The women in my study are located at the intersections of multiple social categories of difference. Therefore, I used intersectionality as a method of analysis for understanding their experiences. The use of intersectionality in healthcare research allows for categories of

differences to not be ignored or downplayed or considered separately. Examining categories of difference simultaneously demonstrated, in my study, that the women's culture did not influence health outcomes but structural forces determined health access and outcomes just as Viruell-Fuentes et al. (2012) found in their study of immigrants. Consistent with Koehn's and colleagues' (2013) health inequalities among immigrants, particularly the undocumented, are not explained by cultural influences and individual behavior. Rather, multiple forms of inequality oppressed the women in my study and challenged their efforts to gain healthcare access, optimal health and a stable wellbeing. Race/ethnicity, class, gender, linguistic competence, educational and immigration status shaped these women's experiences of healthcare. The women lived in a city that provided a sense of homogeneity; however, the women were also segregated into a neighborhood where the most accessible source of healthcare was altruistic clinics with limited healthcare services. In addition, 11 of the 13 women lived in the same neighborhood and of those 11 women 9 relied on others for transportation to these clinics; the two other women living outside that city also relied on others for transportation. While the placement of interpreters by clinics and hospitals is well intentioned, the interpreters may lack training or empathy and may be overburdened, like Francisca said, with too many patients. When communication is clear and professionals truly care for their patients, lives can potentially be saved as was the case of Alejandra in her alliance with the parish nurse and with Maria del Carmen. A piece of equipment fell on Maria del Carmen's head. She was sent to the clinic by her employer. The hospital wanted an MRI test to be approved by Maria del Carmen's employers but they did not approve the test. "They brought me to the clinic with a bad attitude." She was instructed to not fall asleep by the medical

professionals that assisted her. They remained concerned about Maria del Carmen and how the denial of the MRI could affect her. Therefore, the hospital staff instructed Maria del Carmen to tell the factory staff that she was feeling worse than what she had previously told them. The strategy worked; the MRI was approved. After the results came back, the doctor told Maria del Carmen that she was well but that they wanted to keep an eye on her still. To this day she only suffers minor pains in the area.

Studies focused on the experiences of vulnerable populations vis-à-vis the healthcare system should use the method of intersectionality in their inquiry so that trivializations of vulnerable populations' experiences may be given their importance and be, therefore, addressed and to achieve evidence-based knowledge that can bring these populations closer to having equity in their experiences and outcomes of health.

Koehn et al. (2013) found as I did that social constructions of difference interact with each other in meaningful ways to negatively affect the health of vulnerable populations. An intersectional lens refocuses attention away from the effect of one social category such as ethnicity to the simultaneous effect of multiple identity categories such as race/ethnicity, gender and class on the outcome of health. For example, Silvia complained about the many prescriptions she was taking to address her multiple chronic health issues, including one prescription for depression, and how these prescriptions “do not help at all.” Silvia relied on doctors, clergy, her husband and family to contribute to the optimization of her health and wellbeing. However, 57 years of domestic abuse were blatantly ignored. When Silvia talked simultaneously about her physical illnesses and about the problems she confronted with her husband, she was given prescriptions for physical and mental health symptoms rather than

address the domestic abuse she lived with. Failure to apply an intersectional lens neglects to address and amend or at least reasonably mitigate the poor health outcomes suffered by the challenges confronted by vulnerable populations.

The study by Adams et al. (2015) is useful in pointing out the challenges immigrants in the U.S. face when attempting to optimize their healthcare experiences and their health. For some Puerto Rican patients in Adams et al.'s study and the Mexican women in my study, taking prescribed medications defined their relationship to the healthcare system and their agents as questionable. For the doctors, it seemed that prescribed medications solved the physical and mental health challenges the women had to live with daily. The relationships between the women and their doctors, for the women who discussed this particular issue, was frustrating for the lack of both substantive communication and evidence that these professionals cared. In both studies, participants were concerned about the ways in which prescriptions could and were harming them and felt that the amount of pills they took and the side effects these had on their bodies and overall feelings of wellbeing were not normal. Adams et al.'s study participants as well as the participants in my study recognized the importance of the prescriptions as part of their health routines. However, some study participants felt that the doctors did not listen to real concerns they had regarding their health. This was the case of Gabriela, who was able to sleep only four hours a night: "The last time I went [to see my doctor] my sugar was high so I asked the doctor if the [chronic] lack of sleep affects me [her health in relation to diabetes]. The doctor said no, that that does not affect me, but [the parish nurse] told me that it does." The overreliance of doctors on prescription medication made both populations feel that they were not being related to as individuals. In Adams et al. (2015:915),

the investigators found that many participants “placed all medical authority firmly in the hands of physicians” due to a sense of moral obligation felt by their sample of Puerto Ricans. The women in my study were very conscious of the effect of pills, and when they assessed that the risk of taking pills was too high, the women found other alternatives. In other words, they resisted the authority of the doctors.

My perspective on resistance and healthcare is more in line with Armstrong and Murphy (2011) in that public health programs and institutions act as regimes of power but also that they do not hold the absolute obedience of individuals. It is significant to point out also that my study shows – just like Armstrong and Murphy’s – that the rejection of one piece of medical advice or treatment methods does not signify the absolute rejection of mainstream medical advice and treatment by the women. Chamberlain et al. (2011: 305) found that defining people as resisters or rejecters of medication is an oversimplification of the meaning of resistance “because resistance to medications is complex and varied” – that was true for the women in my study. In the case of Francisca, she was not able to communicate with her doctor and the interpreters were inefficient; that is, they were misinterpreting Francisca’s concerns. Francisca made the observation also that the interpreters were overbooked. Rather than giving in to feeling unhealthy, Francisca added as a remedy the use of a vitamin to her medical routine. The Spanish label seemed to have given Francisca the assurance that she was taking the right vitamins for her conditions. Taking the women’s lives in context – with the limited options they have – it makes sense that Francisca resisted the prescribed medication she determined was affecting her since information she could trust regarding the prescribed medication and how it related to her feeling bad after taking it was not provided in the language she could understand.

There are research studies addressing Mexican women and migration, violence, gender, family, mental health and other social constructs and statuses as standalone constructs (Arbona et al. 2010; Barron Cabrera et al. 2008; Boyd & Grieco 2003; Dreby & Schmalzabauer 2013; Heilemann et al. 2004; Kyriakakis et al. 2012; Mendez-Hernandez et al. 2003; Padilla & Villalobos 2006). There are also studies on Mexican women's healthcare and chronic illness experiences (Angeles-Llerenas 2016). Also in the literature we find a critique (Andrade 1982; Baca-Zinn 1982; Hondagneu-Sotelo 1994; Murphy 2011; Parrado & Flippen 2005) of the way some researchers describe Mexican women in ways as that can be summarized as self-sacrificing. My research attempts to further understand the challenges Mexican women confront by applying the theory of intersectionality and the concept of everyday resistance to the analysis of their experiences.

This study is important because the women demonstrated that they as individuals and their culture are not to blame for the full force of the effect of healthcare experiences that placed the women at a disadvantage vis à vis healthcare professionals and for healthcare outcomes that could have been avoided if evidence-based healthcare practices included an assessment of the women's multiple barriers.

My future work could expand this study by looking at women and the Mexican healthcare system simultaneously with the U.S. healthcare system. A better understanding of the experiences of older and chronically ill Mexican women migrating from Mexico to the United States could be gained by exploring the ways in which the interlocking systems of oppression interact with systems of healthcare in Mexico and then the U.S. and studying how the women

resisted these systems. The study would be transnational and comparative. The data could be compared to the same women having lived and then arrived and settled in the United States and confronting “new” systems of oppression, a new healthcare system and the potential for new ways of everyday resistance.

## CHAPTER 6: CONCLUSION

The women's everyday acts of resistance demonstrate that they consistently sought experiences of care that could secure for them health and wellbeing. Their embodiment of multiple social identities of difference made their experiences challenging and the outcomes they hoped for did not always manifest. Nevertheless, they continued to advocate for themselves, use ideology as barriers to dominant ones, protest injustice and find alternative ways to care for themselves.

Through their acts of resistance, the women demonstrated that they understood "that their goal was not merely to survive" (Collins 1990: 232), but that places of oppression are also places for resistance with or without the cooperation of others. Marta represented the women's intentions when she stated, "They told me from day one when I had the accident that it was going to take a while. It would take years to – to walk and to do everything that I ... but I never quit trying and I haven't quit trying and I do not intend to quit trying."

The women demonstrated that they valued their overall health and their relationships with healthcare professionals and institutions. As many researchers concurred, it is not individuals and culture that are to blame for health outcomes, but a healthcare system and healthcare policies that fail to accommodate the effects marginalized identities have on vulnerable populations.

Think of the healthcare system as composed by, to mention a few, healthcare providers such as hospitals, health departments such as county health departments (e.g., disease prevention), community health centers for the indigent; health insurers such as private health insurance companies and federal programs such as Medicare and Medicaid; nursing facilities; pharmaceuticals companies; research organizations and health policy. How do they connect their services to those who are poor, uninsured, members of a minority group and immigrants? There is a very complex but traceable answer to this question. The point of the matter is that however knowledgeable, efficient and all-encompassing this system is, its effect is disparately experienced by minority women (Glanz et al. 2003; Horton 2006; Wahid 2003).

Through their efforts to gain access to quality healthcare, the women displayed some of the problematic issues vulnerable populations may confront in their search for health and wellbeing: high-cost healthcare, limited care in local altruistic clinics, discrimination, overreliance on prescription medications, inattention to expressed concerns about effect of prescribed medications, inadequate communication between healthcare providers and other staff and patients, doctors who do not develop relationships of trust with their patients, institutionalization of the old and chronically ill as an immediate solution to a complex problem involving multiple stakeholders, health insurance exploitation of vulnerable populations, and a shortage of parish nurses as advocates who link indigent populations to the healthcare system and strongly advocate for the best interests of these women. Case in point: the only parish nurse assigned to assist the Hispanic population in the area, and who introduced me to the women in my study, quit the position because in her own words, "I'm burned out." The healthcare system is a cumbersome and complex place for anyone, but especially for members of subjugated

groups. Healthcare professionals, organizations and governments (local, state and national) should include grounded methods and the theory of intersectionality in their analysis of the life experiences of subjugated populations so that barriers can be exposed and best practices in healthcare can be implemented. A more comprehensive and grounded understanding by stakeholders of the lives of those who are systematically excluded from equity in healthcare will bring members of vulnerable populations closer to meeting their health and wellbeing goals.

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APPENDIX

DEMOGRAPHICS TABLE

## Subject Demographics

Name	Visits	Age	Education	Language	Marital status	Work status	Housing / Homebound
Miranda	multiple	52	4 <sup>th</sup> elementary in MX	Spanish	divorced	child care with low wages for family and then part-time	living with adult married son, one grandson and a second on the way
Maria del Carmen	1	82	4 <sup>th</sup> elementary MX	Spanish	Widow to second husband	retired	living with married daughter, adult son and grandchild
Margarita	1	64	3 <sup>rd</sup> elementary MX	Spanish	48 years married	no	owned home with husband
Alejandra	4	63	6 <sup>th</sup> elementary MX	Spanish	25 years married	worked but not currently	husband and one college student daughter
Maria Elena	1	49	?	Spanish	married	yes	sister's, daughter & nephew – at risk of foreclosure
Gabriela	1	50	9 <sup>th</sup> MX	Spanish	married	yes	with husband & 2 adult daughters
Marta	1	70-ish	High School	English/Spanish	50 years married	no due to accident	husband, adult son, college student granddaughter
Silvia	2	77	2 <sup>nd</sup> elementary MX	Spanish	57 years married	never	house with husband
Isabel	2	52	?	Spanish / can't read / write in Spanish	3 <sup>rd</sup> marriage = separated	worked in the past & looking for employment	daughter & grandchildren (2)
Francisca	2	66	6 <sup>th</sup> MX	Spanish / can't read/write	20-year widow	no	son and wife and children + adult daughter
Luisa	1	47	10 <sup>th</sup> MX	Spanish	married	no	house with husband and child
Rosa	1	61	3 <sup>rd</sup> elementary MX	Spanish	undeclared	not currently	daughter + husband + child + adult son
Adriana	2	77	3 <sup>rd</sup> elementary	Spanish	widow (at 44)	retired	daughter + husband + child

(Continued on following page)

Name	Religion	Years on us	Immigration/citizenship status	Driver	Homebound	Health insurance / health	Wanted more visits
Miranda	catholic	2	unauthorized	no / reliance on family & friends	Yes: childcare for family	no health insurance: dislocation of the arm	no
Maria del Carmen	catholic	35	authorized	no / reliance on F & F	no	Medicare: disability & age-related deterioration	yes
Margarita	catholic	20	unauthorized	no	no	no health insurance: diabetes	no
Alejandra	Catholic	16	authorized	no	yes	Medicare: diabetes (20 yrs), high blood pressure, cholesterol, legally blind, disabled (highly restricted body mobility and arm), dialysis, heart condition, wheelchair	yes
Maria Elena	catholic	2	unauthorized	yes – learned recently	no	no health insurance: diabetes	no
Gabriela	Catholic	16	authorized	yes	no	no health insurance: diabetes, cholesterol, anxiety, depression	no
Marta	Christian / non-Catholic	Born in US	Born in the US	no (due to disability)	no	Medicaid: triple bypass surgery, brain surgery, disabled (cane & wheelchair user), diabetes	Yes
Silvia	Catholic	20	Maybe no “don’t send my mother to jail” – brother-in-law threatened so to get divorce.	no	yes	Humana: multiple physical illnesses: diabetes, high blood pressure, cholesterol, arthritis of the spine, pancreatitis, painful varicose veins, pain all over her body: brain, foot, leg, neck, hands, eyes, toes; other physical conditions; depression & anxiety.	yes
Isabel	Catholic	10	Unauthorized	no	no	no hi: addiction – formerly alcohol abuse & addiction	
Francisca	Catholic	8	authorized	no	yes	no hi: high cholesterol, high blood pressure, arthritis, thyroid problems, gastritis, pain in her legs, depression, anxiety	
Luisa	catholic	8	unauthorized	no	Not yet	no hi: Lou Gehrig’s (8 months diagnosed by the time I interviewed) using cane	
Rosa	Catholic	5	Authorized	no	Yes	no hi: diabetes	yes
Adriana	Catholic	2 most recently but since	Authorized	getting driver’s license	Yes	Medicare: chronic arthritis, osteoporosis	