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Self-care and Subjectivity among Mexican Diabetes Patients in the United States

Type 2 diabetes is considered a public health crisis, particularly among people of Mexican descent in the United States. Clinical approaches to diabetes management increasingly emphasize self-care, which places responsibility for illness on individuals and mandates self-regulation. Using narrative and free-list data from a two-phase study of low-income first- and second-generation Mexican immigrants living with diabetes, we present evidence that self-care among our participants involves emotion regulation as well as maintenance of and care for family. These findings suggest, in turn, that the ideology of selfhood on which these practices are based does not correspond with the ideology of selfhood cultivated in the U.S. clinical sphere. Divergence between these ideologies may lead to self-conflict for patients and the experience of moral blame. We argue that our participants use their explanations of diabetes causality and control as a form of self-making, which both resists such blame and asserts an alternative form of selfhood that may align more closely with the values held by our Mexican-American participants. [diabetes management, emotion, self, family]

Introduction and Background

An estimated 25.8 million people in the United States suffer from Type 2 diabetes (National Institutes of Health 2011), a disproportionate number of whom are of Mexican descent. More than one in 10 people of Mexican descent are diagnosed with the illness—twice the rate of the general population (Cowie et al. 2010). The most pressing health concerns associated with

diabetes are the many complications that occur when it is not well controlled. Severe micro- and macro-vascular complications associated with poor glycemic control include kidney failure, blindness, and lower extremity amputation (Gaster and Hirsch 1998; Hirsch and Brownlee 2005). Compared to the general population, Mexicans in the United States are more likely to have poorly controlled blood sugar (Bonds et al. 2003) and to suffer from long-term diabetes complications (Reimann et al. 2004). According to the U.S. Department of Health and Human Services (2011), individuals of Mexican descent are 50% more likely to die from diabetes than their white counterparts.

These statistics leave no doubt that diabetes is an urgent problem among Mexicans in the United States; it is clear that important and alarming disparities exist in both risk for onset and complications. However, biomedical and public health discourses about this “epidemic” tend to locate responsibility for diabetes within individuals, in the form of genetics and deleterious life styles, while neglecting the role of structural factors that contribute to this health disparity (Montoya 2007, 2011). As a result, discourse about the diabetes epidemic among Mexicans seems to have a moral subtext in which flawed personhood is imputed to Mexicans as a group.

Anthropologists have previously described the ways in which illness and suffering can disrupt or undermine patient “biographies” or understandings and experiences of self (Becker 1997; Hunt 2000; Seligman 2010). The emphasis on individual responsibility for diabetes causality and control suggests that this disease may have particularly potent effects on patient selfhoods (Broom and Whittaker 2004). Moreover, contemporary discourses linking diabetes and Mexican-ness suggest that the effects of diabetes on Mexican experiences and understandings of self in particular bear exploring. Within the anthropological literature, however, the role of the self has rarely been considered as a central part of understanding how patients of Mexican descent live with Type 2 diabetes.

For the purpose of this article, self and selfhood are used to refer to ideas and expectations about who one is in relation to oneself and others as well as one’s experiences of “being in the world ” (Csordas 1994; Seligman 2010). Selfhood is structured in part by cultural expectations that determine whether selves are understood as discrete entities with enduring traits or as context dependent and socially defined (Shweder and Bourne 1984). Cultures also dictate the most valued characteristics of selves and persons: Is successful selfhood associated with control, determination, personal achievement, flexibility, deference, or care for others? Hence, forms of selfhood are closely linked to larger sociomoral worldviews. As numerous scholars have shown, health is also intimately tied to such worldviews (Crawford 1994; Lupton 1995; Rose 2004; Young 1982). It is the complex relationship between these sociomoral aspects of health and selfhood in the context of diabetes care that we discuss in this article.

In particular, we begin to explore the benefits of thinking about selfhood as a mediator of a number of different processes related to the experience and management of diabetes among the low-income Mexican-origin participants in our study. We use qualitative interview data from our two-phase, exploratory study to demonstrate that the self-care behaviors of our participants are simultaneously social, emotional, and physical. We examine the possibility that the self-care behaviors in which our participants engage and the clinical discourses that they encounter may be based on competing ideologies of selfhood.¹

Second, we argue that participant discussions about diabetes causality and management can be understood as a form of “self-making” (Broom and Whittaker 2004), and that understanding them as such can help illuminate the effects of diabetes on selfhood and selfhood on diabetes. Specifically, we argue that through the ways in which they talk about diabetes, our

Mexican participants assert a form of selfhood aligned with values that differ from those associated with the “modern” self implicitly demanded by medical discourses (Ferzacca 2000). In addition, we suggest that such “self-making” talk may also function to resist the moral implications of flawed selfhood embedded in discourses of diabetes causality and control.

Within a rich medical anthropology literature on diabetes, few studies have focused specifically on the interaction between diabetes and selfhood. Most of the anthropological research on Mexicans with diabetes has concentrated on increasing our understanding of Mexican cultural beliefs about diabetes causality and management (de Alba Garcia et al. 2007; Hunt et al. 1998b; Loewe and Freeman 2000; Jezewski and Poss 2002; Mercado and Vargas 1989). For example, a growing body of research attends to how Mexican and Mexican-American populations understand the relationships among social experiences, emotions, and diabetes onset (Daniulaityte 2004; Mendenhall et al. 2010; Mercado-Martinez and Ramos-Herrera 2002; Weller et al. 1999). These studies have shown that individuals of Mexican descent often link the onset of diabetes to social experiences and strong negative emotions, especially *susto* (fright) (e.g., Poss and Jezewski 2002). Anthropologists have also endeavored to analyze the structural factors associated with high rates of diabetes among Mexicans and other disadvantaged groups in the United States, demonstrating, for instance, that lack of access to healthy foods and opportunities for exercise represent important constraints that contribute to diabetes onset among individuals of Mexican descent (Rock 2003; Schoenberg et al. 2005).

Thus, medical anthropologists have described in depth the role of various cultural and social factors in shaping diabetes among Mexicans, yet although these factors likely influence the relationship between self- and patient-hood, this relationship has not been specifically addressed. The few previous studies that have touched on the interaction between diabetes and aspects of selfhood (Broom and Whittaker 2004; Ferzacca 2000) have not explored these issues among patients of Mexican descent. We contribute to this literature by examining the effects that ideologies of selfhood and efforts at self-making have on the experience and management of diabetes among a sample of low-income Mexicans.

Self-care and Subjectivity

The implications of diabetes for selfhood are underscored by the fact that, from a clinical perspective, good glycemic control is a direct function of self-care. The term “self-care” has been used broadly to refer to preventive health behaviors and management of illness by individuals outside of the clinical sphere. The concept has, in the last several decades, come to dominate the medical literature on patient management of health in general, and diabetes in particular (Dean 1989; Miewald 1997; Rubin et al. 1989; Senécal et al. 2000; Sousa et al. 2005). Contemporary emphasis on self-care may relate to current trends in biomedicine associated with health care policy and insurance, which increasingly emphasize individual control over health. This shift is often framed in terms of patient empowerment, and may, at some level, represent a response to critiques of power dynamics inherent in previous models of medical adherence.

At the same time, some theorists have read this shift as part of a larger system of “biopower” that increasingly frames health in terms of individual risk, responsibility, and moral worth (Crawford 1994; Rose 2007). In other words, these scholars argue, discourses of self-care can be understood as part of a larger system of social control, which, by placing the individual at the center of clinical interventions, makes patients morally liable for their own ill health (Biehl 2001). Some have argued that the dominant modernist ideology of health has become so much a

part of our commonsense understandings of self that issues of self-esteem, individual achievement, and other constructs related to American selfhoods and well-being are deeply entangled with understandings of biological fitness (Adelson 2000; Das 1990; Lupton 1995). Failure to engage in appropriate self-care behaviors is often understood, therefore, to have its roots in a flawed or “unhealthy” sense of self (Crawford 1994).

However, uptake of an individualized notion of health, and success of related discourses of self-care, may depend on socially and culturally mediated understandings and experiences of selfhood. This has not been considered within the clinical literature, where the emphasis on patient empowerment in self-care discourses and related interventions may obscure continued barriers to effective communication and interfere with adherence to treatment recommendations among patients with differing notions of selfhood. In this article, we build on previous work in anthropology exploring how patients manage clinical recommendations in the face of the demands and constraints of their everyday lives, by demonstrating that our low-income Mexican participants engage in “hybrid” self-care practices oriented toward caring for social and emotional aspects of health. We argue that these hybrid practices diverge from dominant clinical models of self-care that are based on modernist notions of individual responsibility and self-discipline (Ferzacca 2000). In addition, we endeavor to show that the way in which our participants talk about diabetes causality and management represents a form of “self-making” (Broom and Whittaker 2004) through which these patients assert an alternative form of selfhood.

Research Design and Methods

As part of a larger study on diabetes, immigration, and barriers to care in safety-net health care settings (Mendenhall et al. 2010), we conducted a two-phase, exploratory mixed-methods study of low-income Mexicans in the United States with Type 2 diabetes to explore cultural influences on experiences, beliefs, and practices associated with diabetes in this population. In the first phase, we examined the relationship of understandings of diabetes causality to experiences with diabetes and depression. In the second phase, we explored in more depth several themes that emerged from the phase-one interviews, including links between cultural influences on lifestyle and values and diabetes management. Both phases were reviewed and approved by the institutional review boards of the public hospital system where the research took place and the first author’s university.

Participants

In each phase, a convenience sample of participants were recruited from the waiting rooms of the general medicine and diabetes clinics of a public safety-net health system located in a large urban center with a large Mexican population. Approximately 25–30% of the patients seen at these public hospital clinics self-identify as Latino, and the overwhelming majority are low income. Participants were eligible for recruitment into our study if they had a diagnosis of Type 2 diabetes, were 18 years of age or older, self-identified as either Mexican or Mexican-American, and were able to provide informed consent in either Spanish or English. Twenty-six participants were recruited in Phase 1 and 18 participants in Phase 2. Because participants were all recruited from a public, safety-net hospital, our sample is biased toward low-income, uninsured or under-insured participants. However, this should be viewed in context of the fact

that, according to the U.S. census, 70.6% of Hispanics in the United States earn less than \$35,000 per year (Ramirez 2004).

Procedures

During Phase One, basic demographic information was collected, followed by a semi-structured interview used to generate data on patient understandings of diabetes causality. The semi-structured interview guide was translated into Spanish by a bilingual, bicultural research assistant (RA), reviewed by another bilingual RA, and piloted before the study began. Adjustments to wording were made based on responses of pilot participants. The interviews were conducted by the second author, a bilingual graduate RA trained in qualitative interview methods. Interviews took place either outside the health care setting in a location of the participant's choosing or in a private room at one of the clinics. Participants were interviewed in either Spanish or English, depending on their preference. In Phase One, 15 out of 26 interviews were conducted in Spanish. Interviews lasted one to two hours and were tape-recorded.

During Phase Two, a new sample of participants was recruited. The third author, a bilingual RA, administered a semi-structured interview designed to explore some of the themes generated in Phase One. Questions focused on cultural beliefs, values, and practices associated with diabetes management. In addition, we used a free listing exercise that asked participants to generate a rank-ordered list of their "life priorities," as a way of looking at the relative importance of family, self, health, and work in participants' lives, and the relation of such values to ideas about diabetes management. The advantage of this approach is that it does not make a priori assumptions about participant values, instead allowing participants to generate their own list of rank-ordered priorities. Participants were also given a second free listing task in which they were asked to rank order their most important sources of diabetes management. Finally, participants were asked to self-report the number of diabetes complications from which they suffered at the time of the interview. In Phase Two, 14 out of 18 interviews were conducted in Spanish. Interviews lasted one to two hours and were tape-recorded. During both phases, participants were compensated for their participation.

Analysis

Tape-recorded interviews were transcribed and Spanish-language interviews were translated into English by an experienced translator. Transcribed and translated interviews were checked for accuracy by the original bilingual interviewer. Initial review of the interviews by researchers trained in qualitative data analysis was used to develop codes. In each phase, coding was completed by a single coder (the second and third authors respectively), then checked by other members of the research team. Interviews were coded for a priori themes derived from literature reviews. In addition, a grounded theory approach was taken to identify emergent themes. In both phases, the coder continued to discuss emergent themes with other members of the research team, and final codes were arrived at by consensus.

Analyses from the first phase of interviews were geared toward identifying and describing recurrent themes and dominant explanations associated with the causes of diabetes and factors affecting blood sugar levels. Data from the Phase 2 interviews were coded for recurring themes involving the relationship of diabetes management to the values, assumptions, and practices probed by the interview. Free list responses were analyzed to determine dominant

ideas about diabetes management responsibility and life priorities. Participants were asked to rank order their free lists, and our analysis simply counted the number of individuals who listed an item first, second, third, and so on. Life priorities listed by participants included family, work, economics/lifestyle, and health. Free list items related to responsibility for diabetes management included self, family, friends, doctors, and community.

Free list data were analyzed in the context of the broader interview, in which individuals talked in more depth about the place of diabetes management in their lives. Nevertheless, a limitation of such methods is the possibility that participant answers are colored by socially normative biases. Phase Two interviews were conducted by a young, bicultural research assistant (the third author) to help minimize perceived power differentials that might contribute to social desirability biases.

Results

The majority of the study participants in both phases were first-generation immigrants and identified themselves as Mexican, but almost all had lived in the United States for more than 10 years. More than half of the combined participants had not completed high school and more than three-quarters were unemployed (Table 1).

Table 1: Demographics of Study Population

	Phase 1 Sample (N=26)	Phase 2 Sample (N=18)	Total (N=44)
Female	16 (62)	11 (61)	27 (61)
Median Age	52	62	-
Born in Mexico	21 (81)	15 (83)	36 (82)
Attended secondary school	13 (50)	8 (44)	21 (48)
Average number of years in the United States	26	34	30
Average years with diabetes	10.6	11.5	-
Married	12 (46)	13 (72)	25 (57)
Unemployed	21 (81)	14 (78)	35 (80)

Emotional Distress and Diabetes Causality

The majority of our Phase 1 participants (20/26) associated stress or emotional distress with diabetes causality. In addition, half of all respondents, and more than half of the women, associated diabetes onset with a form of prolonged stress, such as family stress, betrayal, or abuse. Most strikingly, half of the women interviewed reported having experienced physical, sexual, or emotional abuse. Many participants also associated negative emotion with difficulties in managing the disease and poor glycemic control.

Material from our in-depth interviews provides insight into the connections drawn by Mexican-Americans between traumatic and stressful events, emotional distress, diabetes onset,

and diabetes control. For example, Rosa¹ associated diabetes with fright and with grief. She described how her daughter's three-day old baby died from SIDS: "I feel that I developed my diabetes from that. From a fright (susto). ... She [the daughter] screamed to me, "Mom!" and so then I got up, all crazy and I ran towards her. ... And she goes and gives me the baby boy. He had died."

Many women associated diabetes with domestic violence or abuse. Ana, a divorced mother of four, described the anger she experienced in response to domestic violence and abuse during her childhood:

My father was very bad to my mother and used to beat her with a belt, and he cut me there, and there I would defend myself. I was about 12 years old then, and I said from that day forward you will not hit my mother, because if you were going to hit her, you were going to kill me. Imagine the anger I felt, that I was able to see how the women were mistreated.

Silvia also associated diabetes with domestic violence: "It [diabetes] was because of many problems. My husband hit me, he humiliated me. ... He earned \$300 ... he arrived at the house with twenty or thirty. He spent the rest of the money on alcohol. So, it's too much."

And Jorge associated diabetes with financial stress: "You don't have money to eat, to pay rent, to pay bills. That is sufficient to cause it. ... Yes, it influenced it a lot. Too much work, too much pressure."

Thus, many participants associated diabetes onset with various kinds of social experiences and the strong emotions they precipitated. Participants also conceptualized the relationship between emotion and diabetes as bi-directional. Many felt that their diabetes made them extra emotional. For example, Mari and Gabriella talked in similar terms about changes in their emotions as a result of diabetes:

M: Everything changed. Everything. You feel more angry sometimes. You feel upset sometimes. You feel like you want to cry for everything.

G: What has happened is that there have been various changes in my life, changes in my thoughts and all of that. I get very depressed. All of a sudden I start sweating, I get tired, my mouth gets dry and above all my temperament/mood changes a lot...

Many participants also felt that their emotions, and associated psychosocial stressors, were directly linked to fluctuations in their blood sugar and were a cause of poor glycemic control. For example, Rosa told us: "A diabetic person who is angry is going to affect their diabetes. Yes, it (sugar) rises. I feel it. In other words when I am angry, I feel ill. My vision gets foggy or I feel more tired."

Finally, Barbara, Ramona, and Victor all linked stress and depression explicitly to blood sugar:

B: I had not finished cleaning the house or I had not finished the meal for lunch and my husband comes and that is a kind of pressure. So I think that is when my sugar level goes

¹ Participants are referred to with pseudonyms.

up. So stress is one part, I mean for diabetes. It could be one reason that sugar levels can rise.

R: When I get depressed it does affect my diabetes because sometimes my sugar rises. Yes, sometimes my blood sugar rises when I have stress or when I am depressed.

V: Problems make me depressed, and this causes my blood sugar to rise.

Both diabetes onset and diabetes control were thus associated with stress and emotional distress, and stress and emotional distress most often had their source in social relationships, especially among female participants.

Perceptions of Responsibility and Life Priorities: The Roles of Family and Self

In the free listing task on life priorities, participants were asked to list “the most important things in life.” Of the seven different life priorities listed by more than one participant, the two mentioned most frequently were family and health (Table 2). Over three-quarters of our participants (14/18) mentioned family, while less than half (8/18) identified individual health. Hence, more than half of the sample of diabetic patients did not list individual health as a priority in their lives. Of those who did list health as a priority, the majority also ranked it more highly than other priorities. However, in many cases where individual health was mentioned, it was prioritized mainly because it was seen as necessary for individuals to be able to fulfill their commitments to their families and ensure family wellbeing.

Table 2: Free List Descriptive Statistics for Responsibility for Diabetes Management and Life Priorities (N=18)

Diabetes Responsibility Item	Frequency	Average Rank
Family	15	1.5
Patient	8	1.3
Doctors	6	3
Friends	5	3.4
No one outside family	2	2.5
Community	2	2
Other	2	1.5
Life Priorities Item		
Family	14	1.6
Health	8	1.4
Work	5	2.6
Economic matters	5	2.6
Living well	3	2.7
Friends	2	2
Religion	2	3.5
Other	6	2.8

Note: Table of all free list items in the two domains. The category Other collapses the idiosyncratic items listed in each domain by only one individual. Most of these items (four out of six additional life priority items and both additional diabetes responsibility items) came from a single respondent.

Material from our interviews provides additional data on how participants conceptualized these priorities. For example, Beatriz explained: “The most important things in life to a Mexican or Mexican-American are work and providing for the family. One doesn’t stop working not even to go to the doctor.” And Luz told us: “One worries more about the health of one’s family than one’s own health.”

The effects of the prioritization of family on self-care behaviors is made especially clear in the way that females with diabetes talked about their ability and willingness to implement dietary changes.³

Many worried about the effect that changes would have on the family’s well-being and happiness. Lourdes complained: “If I serve that [Lean Cuisine] to my husband then the next hour he’ll be like, ‘I’m hungry,’ and I’ll be like, ‘You just ate!’ He and my son are the same. I feel like telling them, ‘I’m hungry too, but we just ate. Can you just chill?’” Similarly, Beatriz stated: “In order to change your way of cooking you have to first get the family to become accustomed to it.” Such results underscore the fact that family relationships are a central concern for participants, especially females. Managing these relationships thus represents a competing demand that may constrain the ability of patients to adhere to medical recommendations.

Results of the free listing task on responsibility for diabetes management (Table 2), in which patients were asked to list their most important sources of diabetes management, revealed that the vast majority felt that their families were central to their diabetes management: More than three-quarters (15/18) of participants listed family as an important source of diabetes care. Less than half (8/18) mentioned the individual him- or herself as an important source of diabetes management. Among those who mentioned individual responsibility, almost all ranked it as most important.

While there was some overlap between those who mentioned individual health as a priority and those who said the individual should be responsible for his or her own diabetes management, no single group of participants who said both. The majority of those who ranked the individual as most responsible for diabetes management were women (5/7), and they generally reported fewer health complications: Three of the seven who considered themselves most responsible for diabetes management self-reported two or more diabetes complications, while 100% of those who thought their families should be primarily responsible had two or more complications. Only a third of our participants mentioned doctors as a source of diabetes care, and only two participants mentioned doctors within their top two. It is also noteworthy that there were only six different items listed by more than one individual in response to the question about who should be responsible for diabetes management, suggesting a shared expectation among this group for the involvement of a limited set of people in their diabetes care.

Beatriz told us: “The family members are the ones who first and foremost help one manage one’s diabetes. ... They help one remember to take one’s medicine because in the beginning that is sometimes difficult and one doesn’t want to take the medicine.”

Yolanda echoed the important role of her husband in helping her manage her diabetes: “When my husband sees that I am eating too much he says to me, ‘You need to stop it [eating].’ Yes, it is him who is there constantly reminding me that I can’t eat a lot.”

Finally, Hector stated emphatically that: “No one outside the family should be involved in the care of a Mexican diabetic.”

Family relationships thus represent a high degree of responsibility for individuals and even a key source of emotional distress, but they are also perceived as the central source of support in managing diabetes. Even for individuals who rated individual responsibility for health

over family responsibility, family was still an important factor—it simply figured differently in diabetes management. Participants either described a supportive, intimate relationship with a specific family member who helped facilitate their focus on themselves, or described distance from family that meant they could only rely on themselves for diabetes care. While these participants still invoked the importance of emotion in diabetes, they did not focus on the links among social/familial experiences, negative emotion, and diabetes causality. Instead, they mentioned the importance of “positivity” for facilitating self-care.

Discussion

Consistent with the results from other recent research, our findings suggest that the majority of our participants conceptualize a set of causal relationships among social experiences, emotion, and diabetes causality and control (Cabassa et al. 2008; Daniulaityte 2004; de Alba Garcia et al. 2007; Hunt et al. 1989; Hunt et al. 1998a; Mercado-Martinez and Ramos-Herrera 2002). For instance, half of the women interviewed had experienced some form of family or intimate partner abuse (physical, sexual, or emotional), which they linked causally to diabetes onset via their emotional responses (Mendenhall et al. 2010).

Participants in our study also associated poor glycemic control with negative emotion. In fact, they conceptualized a bi-directional relationship between negative emotion and diabetes: They felt that their emotions and associated psychosocial stressors were directly linked to fluctuations in their blood sugar and a main cause of poor glycemic control. In addition, they felt that their diabetes made them extra emotional and talked about negative emotion as if it were a symptom of diabetes, like blurred vision or frequent urination.

We argue that this model of diabetes as tightly linked to social and emotional experience, is indicative of an underlying ideology of selfhood that differs from the dominant, modernist ideology of selfhood in important respects (Ferzacca 2000). The normative selfhood cultivated by conventional medicine emphasizes self-discipline and productivity as a means to good health, and good health as a means to successful selfhood (Ferzacca 2000; Lupton 1995). Our participants’ experience of continuity between emotional processes and metabolic ones, by contrast, suggests that they understand *emotion management* as a means both to good health and successful selfhood. Thus for our participants, emotion management actually constitutes a form of diabetes self-care.

In the diabetes literature, self-care is often used interchangeably with the terms adherence and compliance (Wilson et al. 1986). Like adherence, the quality of self-care is measured in terms of the extent to which patient behaviors coincide with medical recommendations (Hernandez-Ronquillo et al. 2003; Trostle 1988). In the case of diabetes, such recommendations center around medication use, diet, exercise, and foot-care regimens (Nelson et al. 2002). Medical anthropology research has made clear, however, that patient engagement in this kind of self-care is not strictly a matter of choice (Miewald 1997; Mol 2008). Self-care is constrained by and adapted to the practicalities and exigencies of daily life (Hunt et al. 1989; Mol 2008), which, in turn, are shaped in important ways by cultural and social factors, including economic hardship, family, and gender dynamics (de Alba Garcia et al. 2007). This is crucial to understanding the effects of diabetes on patient selfhoods since within the lived worlds of individual patients, successful selfhood may be defined more by the ways in which these competing demands and constraints are managed than by compliance with medical recommendations or the maintenance of “good” diabetes control.

Ferzacca has demonstrated that, in practice, often both patients and clinicians respond to these “lived actualities” by developing idiosyncratic, hybrid self-care practices. However, for the Euro-American patients he studied, these practices are still based on a set of values shared by clinicians and patients, including a shared ideology of selfhood informed by these “American middle-class values” (Ferzacca 2000). Thus, although the hybrid self-care practices of Ferzacca’s study participants did not adhere strictly to medical recommendations, they still contributed to the “cultivation of an ideal, normative selfhood.” However, for patients who do not share this ideology of selfhood, and we argue that many of our low-income Mexican participants do not, the idiosyncratic self-care practices developed may be less intelligible from a clinical standpoint.

Findings from this research suggest that the ideology of selfhood among our participants has a familistic emphasis. Mexican culture, while complex and evolving, has been characterized as strongly familistic, with reference to the centrality of family relationships in individuals’ social worlds, the dominance of family priorities in governing behavior, and the role of family in shaping what has been described as a distributed, sociocentric understanding of selfhood (Dick 2009; Marsiglia et al. 2009; Romero et al. 2004; Sabogal et al. 1987; Valenzuela and Dombusch 1994; Zayas et al. 2005). Over three-fourths of the participants in our study identified family as a life priority, whereas less than half identified individual health as a priority. In addition, in many cases where individual health was mentioned as a priority, participants explained that its importance related to the role health plays in allowing individuals to fulfill their commitments to their families and ensure family well-being.

These findings suggest that family is prioritized in such a manner that it may supersede the importance of individual health, especially if achieving individual health and family well-being conflict with one another. For Mexican women in particular, researchers have noted that their own needs are often so tightly rooted in family well-being and the stability of family relations that threats to the integrity of the family function as a primary source of emotional distress and ill-health (Finkler 1994, 1997; Zayas et al. 2005). As potent sources of both positive and negative emotion, family relationships thus need to be managed as part of the emotion management aspect of self-care. In addition, a familistic sense of selfhood means that family-care—that is, care for family members and the familial unit, and management of familial relationships—is also a form of self-care.

It is important to note, however, that our research design prevents us from knowing whether the emphasis on emotional and familistic forms of self-care among our participants is specific to Mexican culture. Although these forms of self-care are consistent with the way that traditional Mexican values have been characterized, as well as with well-documented Mexican ethnomedical models linking social, emotional, and physical health (Castro et al. 1998; Finkler 1989; Rubel 1984), other patient populations may also embrace forms of self-care that privilege emotional and social well-being and diverge from dominant clinical models of individual responsibility (Baer 1996; Yates-Doerr 2012). There is evidence, for instance, that social class is a particularly important factor in shaping both ideologies of selfhood and health beliefs and behaviors (Kusserow 2004; Wardle and Steptoe 2003). This is well illustrated by Schoenberg and colleagues’ (2005) finding that low SES diabetes patients of diverse ethnic backgrounds share a stress model of diabetes causality. Moreover, researchers have demonstrated that as a source of additional life stresses, social adversity associated with structural inequality may create circumstances in which family support, interpersonal closeness, and stability are particularly critical to disease management (Fisher et al. 2000). In other words, low status may contribute to more familistic approaches to health. Hence, patient groups occupying structural positions

similar to the low-income Mexican participants in our study may also adopt forms of self-care in which emotional and social concerns are central.

Moreover, there is likely to be significant variability within social groups in terms of the degree to which individuals have internalized the modernist neoliberal model of health as an individual responsibility. Among our sample, though the majority rated family over individual responsibility for diabetes self-care, nevertheless a nontrivial number of participants mentioned individual responsibility for diabetes self-care, and some (one-third) even rated it as more important than family. Notably, those who mentioned individual responsibility for self-care tended to have fewer diabetes complications. These findings are consistent with those from a study by de Alba Garcia et al. (2007), which also demonstrated that Mexican diabetes patients who embrace a more individualistic approach to diabetes care tend to have better glycemic control. Among our participants, those who focused on individual responsibility came closer to clinical model of self-care, emphasizing behaviors like diet, exercise, and rigorous medication adherence. These individuals seemed more in line with clinical ideologies of selfhood more broadly, since mention of family and emotion were discussed in terms of their relevance to increasing individual capacities for self-care.

These results seem to support the idea that for those whose models of successful selfhood privilege fulfillment of family responsibilities over maintenance of individual health, engaging in behaviors necessary to cultivate a successful self by their own standards may interfere with the ability to maintain good control of their diabetes by clinical standards. The social values of our participants and others who share a similar ideology of selfhood may thus contribute to the experience of competing moral demands in the clinical setting, where they risk moral blame and the imputation of flawed personhood for their failure to manage their disease successfully. Such experiences may fuel stress and emotional distress and further undermine efforts at diabetes management among patients who understand a causal link between emotional state and diabetes control.

Nevertheless, our participants had only partially incorporated the social values embedded in contemporary medical discourses. Instead, they continued to emphasize emotional and familial well-being over responsibility for their own physical health in their talk about diabetes. Following on previous scholarship that examines the “self-making” functions of lay explanations of diabetes causality and control (Broom and Whittaker 2004), we argue that our participants’ talk linking diabetes causality and control to social and emotional experiences, and diabetes management to family, may serve as a form of self-making through which they assert an alternate type of selfhood—one that points outward, to relationships and interactions between individual and social world. In so doing, our participants resist a clinical selfhood that would reduce their identities to being diabetics and would define their primary moral responsibility in terms of diabetes self-care. They may thus resist the moral blame that accompanies narrow focus on the individual as the primary factor in both diabetes causality and control. Anthropologists have demonstrated that such processes of self-making have the capacity to transform experience, and may even act therapeutically by reducing emotional distress associated with disrupted biographies and spoiled identities (Becker 1997; Hunt 2000; Mattingly 1998; Seligman 2005, 2010; Yang et al. 2007).

Conclusion

The findings from this exploratory study of diabetes among low-income patients of Mexican descent demonstrate that these patients understand diabetes causality and control as closely linked to social and emotional experiences. In addition, our findings indicate that our participants prioritize family relationships over individual health and view family as a central part of diabetes management. These findings are consistent with the existing literature on cultural differences in understandings of diabetes causality, management, and the role of family. However, we make an important contribution to this literature by exploring selfhood as a crucial mediator of these differences.

It has been well established in the medical anthropology literature that contemporary medical discourses both count on and cultivate a particular modernist form of selfhood. Therefore, examining patient behaviors and beliefs in terms of their relationship to this ideology is also crucial. In this article, we have argued that explanations of diabetes causality and control among our participants represent a form of self-making that is best understood in terms of conflicting cultural ideologies of selfhood. While some of these ideas have previously been touched on, they have not been thoroughly investigated among patients of Mexican descent in the United States. We use our results to begin exploring these issues, but a more extended ethnographic study is needed to further illuminate this area of inquiry. In particular, research comparing across different ethnic and social groups can help shed light on whether emphasis on social and emotional aspects of self-care is linked to Mexican cultural background or varies as a function of other patient characteristics.

Notes

1. We point out when and how this might affect diabetes management, but this preliminary research does not include direct data on the clinical care that our participants received, and therefore we do not attempt to make specific recommendations for changes to clinical practice.
2. Free listing has been widely applied in medical anthropology research as part of the cultural consensus method and there is good evidence that it effectively taps into cognitive models (Dressler et al. 2005).
3. These findings are consistent with a study on gender differences in diabetes control (Mercado and Vargas 1989), which found that family support for dietary changes accounted for better diabetes control among males in a Mexican sample.

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