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Authors: Whitney L. Duncan
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Transnational Disorders: Returned Migrants at Oaxaca’s Psychiatric Hospital

This article examines experiences of returned migrants seeking mental health care at the public psychiatric hospital in Oaxaca, Mexico. Approximately one-third of the hospital’s patients have migration experience, and many return to Oaxaca due to mental health crises precipitated by conditions of structural vulnerability and “illegality” in the United States. Once home, migrants, their families, and their doctors struggle to interpret and allay these “transnational disorders”—disorders structurally produced and personally experienced within the borders of more than one country. Considering how space and time shape illness and treatment among transnational migrants, I contend that a critical phenomenology of illegality must incorporate migrant experience and political economy on both sides of the border before, during, and after migration. [migration, mental health, Mexico, illegality, structural vulnerability]

Introduction

In this article, I examine how conditions of structural vulnerability before, during, and after migration contribute to emotional distress and psychiatric emergencies among returned migrants in Oaxaca, Mexico. Bringing together recent anthropological theories on structural vulnerability (Holmes 2013; Quesada et al. 2011), a critical phenomenology of “illegality” (Horton 2009; Willen 2005, 2007), and empirical findings regarding migrant health, the article sheds light on “transnational disorders”—disorders that are experienced, produced, and sometimes treated within the national borders of more than one country. This concept adds spatial and temporal components to understandings of illness and treatment among migrants, thus contributing new means of theorizing health in transnational contexts.

A transnational perspective is particularly important given that global, national, and local forces intersect to shape and constrain migrants’ experiences (Quesada et al. 2014). Moreover, while migrant health disparities in host countries are well documented (though woefully under-addressed), we know less about illness-induced return migration and migrant health outcomes in migrant “sending” communities. Migrants are often structurally vulnerable long before they actually leave their homes; indeed, I show how structural vulnerability can act as both cause and consequence of migration and its associated health outcomes. Particularly for the undocumented, pre-migration vulnerability intersects with marginalization and discrimination in the United States to provoke or exacerbate emotional distress and sickness.

Then, when ill migrants return to their towns of origin, they can face additional barriers as they struggle to communicate their experiences to family members and health care practitioners. All parties seek to reconstruct the migrants’ illness narratives and accounts of treatment-seeking in the United States, but such efforts are complicated by the bewildering circumstances of illness and return migration, competing discourses about the nature of emotional distress, and the lack of infrastructure for transnational health care and record-keeping.
Overall, this article contributes a transnational perspective to the study of migrant health by considering the origins and consequences of illness and structural vulnerability on both sides of the border.

**Critical Phenomenology and Structural Vulnerability**

Over the past decade, anthropological theories have shed light on the everyday experience of unauthorized immigration by examining illegality not as a taken-for-granted, essential status of persons, but as the interface of political-economic and subjective processes. In particular, Sarah Willen (2005, 2007) has proposed a “critical phenomenological approach” to the condition of “migrant illegality” to draw attention to both the “structural inequality and structural violence that shape migrants’ position and status” as well as to the impact of those structural factors upon “experiences of being-in-the-world” (Willen 2007:13). Following Willen’s move toward lived experience, Sarah Horton (2009) explores emotional distress and longing on the part of transnational mothers—and the intersubjective means by which suffering is produced across borders between mothers and their children remaining in El Salvador (Horton 2009).

Both Willen and Horton respond to a call on the part of anthropologists working with undocumented migrants to provide more sophisticated theories of illegality (e.g., De Genova 2002; De Genova and Peutz 2010; Ngai 2004), particularly since the sociopolitical formations that create the condition of illegality (e.g., number of visas issued vs. number of workers needed in an economy, particular laws governing migrant bodies, human rights protocols) vary from site to site. These differences in turn engender a range of experiences among undocumented migrants themselves. The emphasis on phenomenology and embodied suffering is a way of taking ethnographies of migration and illegality in a more experience-near direction through which their complexities may be understood from the perspective of social actors, whose lives are often “stretched across national borders” (Horton 2009:22).

The concept of structural vulnerability is also helpful for understanding unauthorized immigration. Emphasizing one’s position in a mesh of power relations that inflict patterned suffering on particular groups of people, structural vulnerability is “a product of class-based economic exploitation and cultural, gender/sexual, and racialized discrimination as well as complementary processes of depreciated subjectivity formation” (Quesada et al. 2011:340). Political exclusion, institutionalized discrimination, and economic inequality are just a few of the factors that intersect on local, national, and global levels to prevent structurally vulnerable individuals and groups from making choices and shaping their own circumstances (Quesada et al. 2014).

Undocumented migrants in the United States are structurally vulnerable in a number of ways: They are relied on for labor yet largely viewed as criminals; they work in the most dangerous labor sectors yet are largely excluded from the health care system; they are positioned at the bottom of the socioeconomic ladder yet lack labor rights; and they are blamed by many for the U.S.’s economic ills and viewed as drains on anemic social welfare programs yet simultaneously barred from accessing many such programs. Migrants from Oaxaca are usually not only undocumented, but also indigenous and working at the lowest rungs on the labor hierarchy (see Holmes 2013). Documentation status, ethnicity, race, and class thus come together to subject Oaxacan migrants to a “conjugation of economic exploitation and cultural insult” (Quesada et al. 2011:340).
Such conjugated oppression (Bourgois 1988) and the suffering it entails is no means bound within the borders of one country, however. Often, as in the case of Oaxaca, migrants are structurally vulnerable long before the migrant journey begins—and remain so long after it ends. Therefore, in this article I build on and extend a critical phenomenology of illegality by examining former migrants in their communities of origin, accounting for experiences of structural vulnerability—and their repercussions for health—prior to and following migration.3

Migrant Health and Health Care Seeking across Borders

The present study also adds a new dimension to the main findings from research on health status and practices among U.S.-based Latinos. This research has shown that recently arrived Latino migrants have better overall health than groups with similar socioeconomic statuses like African Americans and U.S.-born Latinos (Hummer et al. 2007; Palloni and Arias 2004). This often-debated finding is known as the Latino Health Paradox, given the epidemiological expectation that low SES will have a positive correlation with mortality rates and health risk factors. Findings regarding mental health are similar (Burnam et al. 1987; Grant et al. 2004; Vega et al. 1998).

Several theories have been advanced to explain this paradox, including the so-called ‘salmon bias’ effect, which suggests that ill migrants may be more likely than healthy migrants to return to their places of origin, and thus are not counted in U.S. epidemiological studies—making the overall Latino population look healthier than it may actually be (Abraido-Lanza et al. 1999; Hummer et al. 2007). However, despite the fact that the ‘salmon bias’ would be a transnational phenomenon—sick U.S.-based migrants returning to their countries of origin—it has rarely been studied as such. While my study does not evaluate the salmon bias or the Latino Health Paradox, it does point to factors that prompt migrants to return home when unwell and examines what happens when they arrive there.

In addition to being more likely to return to Mexico when ill, recent research on “medical returns” suggests that sick migrants sometimes go home expressly to seek treatment (Bergmark et al. 2008; Horton and Cole 2011; Wallace et al. 2009). Importantly, migrants interviewed for the present article did not usually return to Oaxaca specifically to seek treatment; rather, their accounts highlight the debilitating nature of illness itself as the main factor prompting their returns, and treatment-seeking often took place many months after return migration. Thus, the present study highlights a phenomenon similar to but distinct from “medical returns.”

These issues relate to another main finding in the literature on migrant mental health: It appears to decline with time spent in the United States (Alderete et al. 2000; Escobar 1998; Escobar et al. 2000; Grant et al. 2004; Vega et al. 1998). This has been attributed to economic and social marginalization (Vega et al. 2009) and acculturation stress (Rogler et al. 1991), specifically with regard to the deterioration of social and familial bonds, isolation, perceived low social status, and lack of security (Alegria et al. 2008). Given these stresses, in addition to the fact that many migrants lack insurance, it makes sense that migrants—particularly those whose families reside in Mexico—might return home in cases of extreme illness.

The Ethnographic Context: Oaxaca and Migration

Oaxaca ranks very low for almost all socioeconomic and human development indicators: Approximately 30% of households lack running water and plumbing; about 6% lack electricity;
and only about 30% have all three (INEGI 2012). Per capita income is only about $3,500 USD compared to $20,000 USD in Mexico City. Nearly 21% of Oaxaca’s residents have lack of access to health care, 30% have severely limited educational opportunity, and over a quarter of the population lacks adequate nutrition (CONEVAL 2012). Only 10.3% of Oaxaca’s population is not categorized as “poor or vulnerable,” while nearly 62% live in either extreme or moderate poverty (CONEVAL 2012).

Though Oaxaca has a long history of emigration, economic restructuring in Mexico during the 1980s and up to the present has accelerated the forces that drive people out of the state in search of work. During the 1980s and ’90s, Mexico renegotiated its foreign debt and began reforms favoring deregulation, cuts in the public sector, export-centered industrial growth, foreign investment, and free trade (Schmalzbauer 2010:1861). Most state-owned companies and many aspects of welfare provision have been privatized (Haber et al. 2008:18). Such policies have by many accounts exacerbated income inequality and poverty—perhaps particularly in rural areas like Oaxaca.

Economic development in Mexico has generally emphasized industrial expansion through export manufacturing plants, or maquiladoras, without providing viable alternatives for agricultural communities—like those in rural Oaxaca—that have been unable to compete in the global market (Stephen 2007:124). In 1994, the passage of NAFTA solidified economic integration between the United States, Mexico, and Canada, and required Mexico to lower its price supports for farmers and reduce import restrictions. Prices of Mexican crops fell, the prices of feed and fertilizers rose, and by 2001, corn farmers and their families were living on less than one-third of what they had earned six years before (Stephen 2007:127).

Oaxaca’s rural and indigenous communities were already extremely marginalized before these modern economic developments, but their vulnerability has arguably intensified in the past 20 years. Structurally positioned at the bottom of the ethnic, class, and occupational hierarchy and without local labor opportunities, members of such communities often have few options but to emigrate. Between 1990 and 2005, the number of Oaxacans residing in the United States almost tripled (oaxaca.gob.mx); by 2009, over 1.2 million people—34% of the state’s total population—lived outside of the state (Ruiz Quiroz and Cruz Vasquez 2009:33), most of these in the United States.

Despite the demand for low-wage laborers in the United States, immigration policy has increasingly criminalized northward labor flows from Mexico and the rest of Latin America. The militarization of the U.S.–Mexican border and a general emphasis on enforcement has created a population of informal, undocumented workers who not only frequently risk their lives to enter the United States, but whose lives are precarious and characterized by extreme structural vulnerability once there (Castañeda 2010; Cornelius 2004; Holmes 2007, 2013; Quesada et al. 2011, 2014; Walter et al. 2004).

Given the ubiquity of emigration in Oaxaca, it is perhaps unsurprising that about a third of patients at the psychiatric hospital have migration experience. More striking is how central the migration experience is to these patients’ experience of illness and distress—and, conversely, how central illness and distress is to their experience of migration.

The Study

The study is part of a larger 20-month investigation of mental health experiences, conceptions, and treatments in Oaxaca. I conducted the bulk of research between January 2010 and January
2011. However, I conducted preliminary studies during 2007 and 2008 and returned to Oaxaca for a follow-up study in 2013. I employed a mixed-methods approach consisting of 156 qualitative interviews (58 with mental health practitioners and healers; 56 with hospital patients; 42 with community members), analysis of media materials and institutional documents, participant observation, and a large-scale survey (N=995).

I draw the bulk of data in the present article from participant observation and interviews with outpatients and practitioners at Oaxaca’s public psychiatric hospital, Cruz del Sur. All eight regions of Oaxaca are represented in the hospital sample, including 24 females and 32 males. Thirty-two percent of the sample (n=18) had migration experience, and several additional patients attributed illness to migration of a family member. I conducted all interviews in Spanish; when patients were monolingual in an indigenous language, family members translated to Spanish. Four Oaxacan research assistants assisted in interview transcription and all translations are my own. The study received approval from Oaxaca’s Ministry of Health, psychiatrists at Cruz del Sur, and the institutional review boards at the University of California–San Diego and the University of Northern Colorado.

Of the 18 returned migrants in my sample, all but two attributed their psychiatric problems at least in part to the migration experience itself, in particular, experiences of solitude, discrimination, unremitting anxiety and stress, and drug and alcohol use in the United States. Most of the returned migrants reported that they had never had any kind of mental health problem before leaving for the United States; two, however, did report a history of disturbing symptoms but see undocumented migration as the factor that put them over the edge.

In the following sections, I explore some of the main themes evoked by return migrants and the mental health practitioners who treat them in Oaxaca. I begin with the story of a migrant named Bartólo because it touches on a number of important and paradigmatic issues for understanding transnational disorders. From there, I draw from other migrants’ stories of their time in the United States and Mexico and incorporate Oaxacan psychiatrists’ perspectives, as well.

**Bartólo: “Treated as if We Were Animals”**

Bartólo is from the indigenous Mixteca region of Oaxaca, about six hours from the hospital, and had been seeing a psychiatrist at Cruz del Sur for five years when we met. His problems began while he was crossing the Mexico–U.S. border to harvest tomatoes in Madera, California. He went there to earn money to pay for his daughter’s medical treatment; she was very ill when he left, and the family had already sold their land. Bartólo described the border-crossing experience as terrifying: He suffered from hunger, dehydration, and heat exhaustion; he encountered snakes and other animals; and once he arrived in the United States he was constantly afraid of being apprehended by immigration authorities (la migra) and sent back to Mexico:

Even when we knew [la migra] wasn’t going to catch up with us, this is a fear. We were always afraid we’d come across a snake—there’s a lot of risk [at the border], a lot. … I suffered from hunger, from thirst, and that’s another huge thing—you’re dying of hunger because you can’t go out and buy something to eat, for fear that they’d send you back to Mexico, right? … The truth is we weren’t doing anything wrong, just looking for work. But it’s a question of the laws of both countries. … So that’s what I felt most, and that’s why I got this
illness. So much fear on the border and the worry that there wouldn’t be enough money for the family.

When he did manage to cross successfully, Bartólo and other workers had to flee border enforcement repeatedly, running into the woods to hide from helicopters or officers in vans chasing them. He said they were treated “as if we were animals.”

Living in an agitated state of insecurity in the United States, Bartólo began developing symptoms he had never felt before, which he characterized as sadness, anxiety, and crippling fear. One day on the way to the fields, Bartólo began to feel dizzy and asked if the van could stop so he could step outside for fresh air. He was told that if they stopped it would be his fault if they were all apprehended, so they left him there in the middle of nowhere. The boss came and picked him up later, but from then on Bartólo’s symptoms became chronic. Despite his health problems, though, he had to continue working to pay off a debt in his village.

Bartólo’s first language is Mixteco, but he also taught himself Spanish. When he sought help in the United States, however, he found no Spanish-speaking doctors or nurses. These practitioners sent him home with a hydrating beverage and no further recommendations. He said:

I couldn’t tell them that what I felt was sadness, fear, that I felt nostalgia, fear of being alone, sadness, that I wanted to cry. And all of this alone. … I felt so much fear [miedo bastantísimo]. Fear, that’s what I felt. And that’s what I tried to tell the doctor but I couldn’t—I couldn’t speak English.

What’s more, Bartólo said he received no help from his boss on the farm:

There, they want us when we can work. But when you don’t work, they don’t want you. [Work is] what they want. It shouldn’t be this way, but hey. … There are so many people who need work, so when someone gets sick, well, they have to figure it out. So I got no support from the boss, the contractor. No support at all … [they said] we can’t help you because you’re a wetback [mojado].

Bartólo finally made enough money to return to the Mixteca, but he was incapacitated by his symptoms for five years after he arrived there. He had never heard of mental health problems like anxiety and depression, so it did not occur to him to seek psychological or psychiatric treatment. He and his family initially thought someone had cursed him with witchcraft, and he received a number of limpias (spiritual cleanses offered by a healer, or curandero) and other curative treatments. None of this helped, however, and he was bedridden when finally an aunt of his suggested going to Cruz del Sur for treatment.

The Cruz del Sur psychiatrist prescribed a benzodiazepine and an antidepressant, which Bartólo reported were great reliefs. Because he had such success with pharmaceuticals and therapy—in addition to his trips to Cruz del Sur, he was traveling several hours each week to see a therapist in a nearby town—Bartólo took it upon himself to teach fellow Mixtecos about mental health treatment and the emotional dangers of migration. In conjunction with his local Catholic church, Bartólo was giving talks in Mixteco about depression and other mental health problems.
Transnational Disorders

Bartólo’s narrative illuminates the three main themes that emerged in interviews with returned migrants at the psychiatric hospital: (1) conditions of structural vulnerability both in Mexico and the United States, which migrants understand as central to illness experience; (2) the unique challenges migration presents for mental health practitioners and families in migrant sending communities; and (3) the transnational dimensions of distress and disorder. I will discuss each of these themes in turn, highlighting additional patient narratives in the process.

Transborder Vulnerabilities

Bartólo’s experience vividly illustrates the expendability of migrant bodies (Holmes 2007), which represent cheap labor in the context of economic globalization. Bartólo is not only marginalized in the global economy but also in the local economy of Oaxaca’s Mixteca region: To pay for his daughter’s medical treatment, Bartólo sold his family’s land, then incurred debts with community members in one of the poorest regions within one of Mexico’s poorest states. Although his symptoms began in the United States, his structural vulnerability is deeply rooted in Mexico and shaped by the transnational economic, legal, and political factors contributing to poverty in rural Mexico and the imperative to emigrate. After risking his life crossing the border, Bartólo is positioned at the bottom of the labor market and the social hierarchy, routinely devalued, and unentitled to basic rights due to his unauthorized status.

Crossing the Border. Bartólo spoke at length of the intense fear he experienced as he crossed the U.S.–Mexico border, running and hiding from helicopters and vans that were pursuing his group as they attempted to cross. He said he thought he would have been apprehended if he were not “used to walking through hills”: “I come from a very hilly, mountainous region, so la migra never caught us even though they tried—we know how to run and hide.” Stories of running and hiding in the mountains are a common feature of immigration narratives among those without papers. Angel, a 20-year-old returned migrant at the hospital who first crossed the border when he was 13, described running from the border patrol and being left by his group:

We hid between the most dangerous hills so the helicopters wouldn’t see us. …They almost caught me on the mountain at night because we were on an embankment when the migra suddenly came—we started running and my brother left me. … I had to find the trail where everyone else had gone, but since I was little I couldn’t run at the same speed as everyone else. It was really hard, but I managed to cross.

 Though some migrants report having few problems crossing, concentrated border enforcement initiatives since 1994 have pushed migrants into the most dangerous areas of the desert and have contributed to significant spikes in mortality rates (Cornelius 2004, Doty 2011; Eschbach et al. 1998; Holmes 2013). Migrants are frequently exposed to sunstroke and dehydration; possible exploitation and abandonment by people-smugglers (coyotes); the threat of drowning in the Rio Grande; and the danger of crossing busy interstates once on the U.S. side.

 Other returned migrants in my hospital sample focused more on the experience of living in the United States than the border-crossing experience, but the topic of frightful border
crossings comes up frequently in Oaxaca. One hospital psychiatrist, Dr. González, discussed his own experiences crossing the border as a young man:

You go alone with the little money that you have, confronting a series of risks on the trip … that the coyote tricks or abandons you. … One time, we had to walk a long ways and could see ahead of us that cholos were raping women. … So we ran and hid and were quiet, because there’s always the risk that they’ll catch up with you. … You have to risk it without thinking too much—the thing is to achieve an objective, risking your life.

Given his own experience, Dr. González is able to empathize with return migrants to an unusual degree. However, he was one of many mental health practitioners who understood the border as a site of vulnerability, stress, and danger where mental health problems can begin.

Living in the United States. Many undocumented migrants’ fears do not subside on successfully reaching the United States. In Bartólo’s case, he continued to live in a state of vigilance and heightened anxiety related to his constant fear of apprehension by immigration authorities; his poor treatment by employers; and his worry that he would not have enough money to provide for his family and pay back the debts he had incurred to his coyote and to acquaintances in Oaxaca. “So many expenses, so I was under a great deal of pressure,” Bartólo said. “I started thinking that this [the pressure] is why this [illness] happened to me.”

With little recourse to social services of any kind, migrants like Bartólo are forced to endure on their own. As discussed above, Bartólo found little support from his coworkers or his employer, who considered him a “wetback” undeserving of support or medical care. Until Bartólo had made enough money to repay his debts and get his family back on its feet, returning to Oaxaca was not a viable option—he said he “forced himself” to continue working even in the throes of a dramatic breakdown. Bartólo was essentially immobilized in the United States, consigned to a zone “of legal, social, and political marginality and vulnerability” (Willen 2005:60).

Other returned migrants and their family members described similar preoccupations that they posited as causal factors contributing to mental health crises. Gloria described how her mother, Paulina, had lived and worked alone in the United States for 10 years, subject to “what [our family] now understands as pressure—that of extreme worry, stress, living alone … and really—so much discrimination.” Paulina said she had done nothing in the United States but work: “Pure work is what it was, and then I sent money to the bank and to my family,” eventually returning to the Mixteca region. “But I had already lost my mind,” she said. Once back in Oaxaca, she began to experience hallucinations, and eventually sought treatment at the psychiatric hospital.

Similarly, a returned migrant named Tomás, whom I interviewed during his first visit to the hospital for debilitating depression, described an intense pressure to financially support his family: “It’s killing me,” he said, “that I can’t provide even the basic necessities for my family to live.” When Tomás lost his job at a bank in Oaxaca, he decided he had no choice but to go work in the United States. Living there without documents, he felt an intense sense of “stress, solitude, and lack of love.” Being in the United States, his wife added, was what “finished him.” “I saw everything in a negative light,” Tomás explained. “My nerves betrayed me. No, it was really
bad.” Formerly healthy, Tomás now suffers from what he and his wife referred to as chronic depression, low self-esteem, and a feeling of worthlessness. “I’m afraid of life,” he said.

Return Migration. For several migrants in my sample, including Tomás and Bartólo, financial pressures ultimately proved overwhelming—and they also prevented migrants from going home when illness struck. Like Bartólo, most patients used expensive human smugglers, or coyotes, to cross the border, so they were already in thousands of dollars of debt when they arrived in the United States. Unsurprisingly, then, few of the migrants in the current sample could return to Mexico immediately upon falling ill; more often, they had to wait until they had saved enough money to afford the trip, to send remittances, and to repay debts. These constraints added to feelings of powerlessness and spatial immobility that surfaced in their descriptions of distress and disorder.

For example, Tomás and his family decided he would have return to the U.S. for a second time because they could not make ends meet. After only 15 days, though, his wife said Tomás’s symptoms reemerged and he wanted to return home. “But I told him, you have to endure there, you have to pay down your debt if you want to come back. Pay your coyote debt, then do what you want. … I was angry with him … that he’d come back in the same situation as before.” At the time we spoke, Tomás continued to feel profoundly inadequate for not being able to provide for his family, saying his hopes and dreams had been “trashed.”

Here, we can see how gender roles and constructions of masculinity can play an important part in migrants’ experiences of anxiety. As Walter et al. (2004) discuss in their study of undocumented Latino laborers in California, finding work and sending remittances “legitimates [male migrants] as patriarchs and providers” and justifies the dangerous trip north (p. 1163). When migrants are debilitated by injury, sickness, or simply cannot find employment, both their well-being and their identities as hard-working breadwinners can come under fire.

Indeed, despite the fact that they were often stuck in the United States for protracted periods while seriously ill, only third of the migrants in the current sample (six of 18) received medical attention there. As Bartólo’s story illustrates and as a large body of scholarship has demonstrated, undocumented migrants often face significant barriers to health care access: language barriers, economic constraints, transportation problems, lack of ‘culturally competent’ care, and fear of deportation (Arcury and Quandt 2007; Cabassa and Zayas 2007; Castañeda 2010; Chávez 2012).

Bartólo’s main complaint about his medical treatment in the United States was the language barrier: He was not able to communicate his feelings and was misdiagnosed, sent home with a hydrating beverage rather than treatment targeting his emotional complaints. Two of the patients who did access some form of psychiatric treatment in the United States did so in correctional facilities, though neither of those patients knew for what crime they were being charged. Several other patients reported wanting to seek treatment while there but being deterred by cost or by fear of deportation. When symptoms of depression, anxiety, or psychosis start to manifest, both health care seeking and return migration can be thwarted by political–economic factors.

Treating Transnational Disorders in Mexico

The question of why, given that they often live in similar conditions both in the sending and receiving communities, some migrants experience emotional and psychiatric symptoms and
others do not merits further examination in future studies. Few of the returned migrants in my sample had experiences of psychiatric symptoms prior to leaving for the United States, and as the cases above demonstrate, patients and their family members often believed the pressures of migration caused the problems for which they eventually sought psychiatric treatment. It is possible that some of them were predisposed to psychiatric disorder, though, and the stress of migration brought out latent symptomatology (see below).

Oaxacan psychiatrists and psychologists routinely discussed this possibility and the mental health risks migration poses, particularly for undocumented migrants whose positionality in the United States—and the harrowing experiences they may endure before they even arrive there—exacerbate stresses inherent to immigration. In their view, migration is a main determinant of poor mental health among their patients, and they report commonly treating migration-related distress and disorder in the clinical context.

For instance, Dr. Tolentino, a psychiatrist in both public and private settings, discussed how migration-related psychiatric illness is “more frequent every day” in Oaxaca, from depression generated by family separation to psychosis generated by extreme culture shock. He believed—perhaps naively—that in small Oaxacan communities, people do not often confront “destabilizing” experiences. However,

when, for economic necessity, they have to leave for the United States to work, they have a very different life. … This constitutes a series of stressors that cause them to develop a pathology. Maybe it was already present before and the person was constitutionally predisposed to it, but it hadn’t developed [until migration]. This can then generate psychosis.

Dr. Sánchez, another Oaxacan psychiatrist, also emphasized how frequently he sees patients who sicken in the United States. Like Dr. Tolentino, he said that migrants “experience an extreme clash of cultures” when they arrive in the United States: “Imagine, you come from a tiny village and you’ve never even gone to Oaxaca City. … Suddenly you get to the U.S. and this causes huge culture shock.” He said migrants “live in constant stress, which adds to the problem of post-traumatic stress disorder” (PTSD). In Dr. Sánchez’s opinion, PTSD—from “social trauma and the clash of cultures”—is under-diagnosed among returned migrants.

Different forms of psychosis and schizophrenia were the most common diagnoses among my returned migrant sample, though several (like Bartólo and Tomás) were diagnosed with depression and/or anxiety, one with obsessive compulsive disorder, one with PTSD, and one with a learning disability. The stress of migration was noted in nearly all their psychiatric files as a contributing factor to illness onset; in about a third of the cases, the phrase “difficulty adapting to another culture” accompanied patients’ psychosocial evaluations. As Dr. Tolentino’s and Dr. Sánchez’s remarks suggest, the idea that traumatic culture shock can either generate mental illness or bring latent vulnerabilities to the surface was common among psychiatrists. A few even utilize the diagnosis “transcultural psychosis,” or psicosis transcultural, to describe the type of reactive psychosis caused by culture shock in migration cases.

**Negotiating Explanatory Frameworks**

While experience of illness was a central factor prompting these migrants eventually to return to Mexico, upon arriving they did not usually receive immediate psychiatric care. Several reported
waiting long periods before seeing any type of physician, therapist, or healer, and others said they sought non-psychiatric and non-biomedical forms of care such as curanderismo first. Bartólo lived essentially bed-ridden for five years in Oaxaca after returning from the United States; he received treatment from a curandero in that time, but did not find relief until winding up at Cruz del Sur years later.

Valerio, a returned migrant from a village near the Zapotec town of Tlacolula, had a similar experience. He had suffered psychological disturbances prior to migration, but when they abated he went to the United States without papers and worked with his uncle in California. Soon his symptoms—frightening thoughts, excessive hand washing, and debilitating worry about contracting AIDS—returned. Valerio’s uncle sent him back to Mexico, saying they could not seek medical care in the United States because they could get deported. Then, as Valerio puts it, “When I got back to Mexico we still didn’t know what my illness was, so we went to a curandero. … The man told us to go to the psychiatric hospital”—which is where he ended up.

Valerio and Bartolo’s treatment-seeking stories bring up an important dimension of transnational disorders: In part because discourses and practices around “mental health” are only recently becoming commonplace in Oaxaca (Duncan 2012a), Oaxacan migrants may be unlikely to identify their symptoms as indicative of psychological problems. Several described how bewildered they were by the sensations they were experiencing, emphasizing they had never heard of other people with similar symptoms. Not having been exposed to psychological and psychiatric concepts, they struggled to interpret these experiences within their existing explanatory frameworks.10

Granted, many encounters with psychiatric disorder are bewildering, even for those with access to services and readiness to interpret problems in a psychiatric framework. Additionally, a good number of returned migrants with health problems likely do find relief from curanderos and other healers.11 However, among migrants in my hospital sample, a central part of the illness experience was the challenge of identifying problems within multiple and sometimes competing explanatory models in the context of medical pluralism (Kleinman 1978). When patients and their families arrived at Cruz del Sur, most were hearing words like “depression” and “psychiatrist” for the first time. Many had pursued healing through various pathways prior to setting foot in the psychiatric hospital; therefore, for many patients the process of obtaining a psychiatric diagnosis and treatment was protracted.

Reconstructing Migration Narratives

Add migration to the mix and things become even more complicated. Not only are patients and their family members often sifting through a variety of possible explanations for the problem and pursuing different forms of care, they are also attempting to sort out what exactly happened in the United States. For patients whose illnesses began there, both the nature of the problem and the circumstances in which it began are often extremely hazy, confounded by dramatic circumstances of departure—sometimes in the form of deportation—and the disorienting nature of the illness itself.

Patients attempt to recount their experiences: when the illness started; how it started; what circumstances may have precipitated it; whether they received a diagnosis, treatment, or medications in the United States; and how they wound up back in Oaxaca. I witnessed several returned migrants struggle mightily as they attempted to convey these narratives and piece
together an explanation providing clues to those trying to help them. At times, this process contributed to overwhelming self-doubt and recriminations from family members.

As several Oaxacan psychologists pointed out and as Tomás’s case above suggests, migrants are not always welcomed home with open arms: Sometimes family and community members reject them for not coming home with enough money, allegedly using drugs or alcohol in the United States, or adopting American customs. Oaxacan psychologist Dr. Pérez said that returned migrants are “from neither here nor there. … They don’t feel accepted here, and there’s a [sense of] confusion in them. There’s a permanent rejection from both their own people and from others [in the U.S.]”

Manolo and Humberto, brothers from the Mixteca region, were wrangling with these issues when we spoke. Humberto described how Manolo had been fine until he suddenly fell ill while living undocumented in the United States. They did not seek treatment there, thinking it would be too expensive; instead, they returned to Oaxaca and eventually sought care at Cruz del Sur. Manolo was undergoing treatment for schizophrenia, a disorder neither of them had heard of prior to his diagnosis. The two seemed confounded by what could have brought on such an extreme change in character, and they were frustrated by not having a satisfactory explanation. Many family members thought the problem was caused by witchcraft, that Manolo had damaged himself by working too hard in the United States, or—in Humberto’s opinion—that he had used drugs. Drawing on the common assertion that migrants are susceptible to the lure of addiction, Humberto subtly accused his brother of having brought his illness upon himself by abusing substances. Manolo firmly denied this, and Humberto gently conceded, looking unconvinced.

Discussion: Transnational Dimensions of Health And Illness

The narratives of returned migrants at Oaxaca’s psychiatric hospital provide important insights into migrant health, structural vulnerability, and the lived experience of illegality. First, they show how undocumented migrants’ positionalities in both Mexico and the United States—positionalities shaped by powerful local, national, and transnational forces, from global market imbalances to immigration law to class- and ethnicity-based inequality—can translate into intimate suffering. This suffering is transnationally shaped and transnationally felt by migrants and the family members who struggle to support them.

Theoretically, then, my analyses of narratives of illness-induced return migration provide a new angle on the critical phenomenology of unauthorized migration, illustrating how conditions of structural vulnerability can have important implications before, during, and after migration. Thus, transnational disorders have important spatial and temporal dimensions: spatial in the sense that they both exist and impact lives on both sides of the border, and temporal in the sense that the vulnerabilities at their core are produced and experienced not only while these migrants live undocumented in the United States, but also in Mexican migrant-sending communities prior to and following migration.

Empirically, these findings constitute an aspect of the migration-health connection that has not been explored. These patients’ narratives provide clues as to why migrant health might decline with more time spent in the United States (see Alderete et al. 2000; Escobar et al. 2000; Grant et al. 2004; Vega et al. 1998) and why migrants might return home when ill (e.g., the “salmon bias”). The migrants seeking care at Cruz del Sur had not returned to Oaxaca for the explicit purpose of seeking mental health care; thus, they cannot be counted as medical returns, per se. Rather, they returned because they were incapacitated by illness and saw no other option.
As discussed above, some of them wanted to go home sooner but were effectively trapped in the United States due to immigration policies; financial desperation; resistance to the idea of going home empty-handed; and the knowledge that returning to the United States would be prohibitively expensive.

Once home, the process of health care–seeking can be protracted due to limited access to care and competing explanations regarding the nature of the problem. Mental health practitioners, like migrants’ family members, must re-create migrants’ stories based on quite fragmentary information. If migrants bring medical records back from the United States—a relatively rare phenomenon given how few migrants received treatment there—psychiatrists attempt to translate them and integrate them into treatment plans. However, to my knowledge, practitioners in the United States and Oaxaca never collaborated to understand a migrant’s case. All of the aforementioned factors combine to create a context in which treating migration-related distress is exceedingly difficult.

Although undocumented migrants are by no means a unified group and often exert forms of creative agency, they are frequently constrained by structural forces that produce intimate and intersubjective suffering and limit options for healing. Importantly, patients, family members, and health care practitioners in Oaxaca seem acutely aware of these structural forces. Although sometimes obscured by claims of personal biology, weakness, or vice (Holmes 2013), the transnational social asymmetries that characterize the migrant experience are quite present in the experience and treatment of transnational disorders in Oaxaca. I suggest that to understand fully and begin to address these problems, it is essential to consider migrant health as a truly transnational phenomenon—one that is often produced and experienced within the borders of more than one country. As such, it is only through transnational research, programs, and policies that we can fully understand and begin to address the impacts of migration on health.

Notes

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1. I thank two anonymous reviewers for encouraging me to emphasize the spatial and temporal components of transnational disorders.

2. All of the returned migrants interviewed for this article entered the United States without legal immigration documents and thus made the often-harrowing Mexico–U.S. border crossing (as opposed to overstaying visas). They are therefore both “undocumented” and “unauthorized”—in the sense of not being legally authorized to live or work in the United States—so I use the two terms interchangeably here.

3. The concept of “transnational disorders” may also be productively applied to understand the emotional consequences of migration and structural vulnerability among non-migrants in communities with high rates of out-migration. While this topic is beyond the scope of the present article, readers may consult Calvario (et al. 2013) and Duncan (2012a, 2012b).
4. As an anonymous reviewer suggested, it is possible that Bartólo’s dizziness could be related to pesticide exposure.

5. Being derogatorily referred to as a “wetback” or *mojado* is often part of the experience of illegality: It emphasizes migrants’ illegitimacy and marginal outsider status in the United States.


7. See Willen (2012) for discussion of health care and “deservingness” among migrant populations.

8. Indigenous Oaxacan migrants often speak a language other than Spanish (e.g., Mixtec, Zapotec, Triqui), and are disproportionately likely to be undocumented (Holmes 2013).

9. Additionally, when I returned to Oaxaca two years after these initial interviews, some of the returned migrants’ diagnoses had changed and many of them had ceased coming for treatment altogether.

10. Elsewhere (Duncan 2012a, Forthcoming), I consider the implications of globalizing psychological and psychiatric ideologies and practice, which can provide access to much-needed services but can interfere with cultural meaning-making.

11. Additionally, hospital patients are often discouraged by doctors from seeking care from curanderos, so they may be hesitant to discuss such experiences in the hospital setting. However, I conducted a large-scale survey (*N* = 995) on mental health experience, understandings, and treatment practices in Oaxaca, and fewer than 1% of respondents reported they would choose curanderos as their first treatment options for emotional problems (Duncan 2014).

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