



Bath time at a Tunkás home.

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11 Migration and Health

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The study of migrant health has focused mainly on migrant populations in the United States, without investigating their nonmigrant counterparts in sending areas. This approach is useful in identifying health problems of Mexican migrants in the United States, but it fails to isolate whether factors associated with migration are the causes of these illnesses. Comparing the health status of migrants with that of nonmigrants from the same hometown provides the control group that has been missing in many previous studies. This chapter discusses health issues specific to Tunkaseño migrants, using nonmigrants as a control group. In our assessment of depression and alcohol abuse among Tunkaseños, we take a different approach, comparing Tunkaseño migrants to previously studied populations of Mexican migrants to understand how their behavior differs.

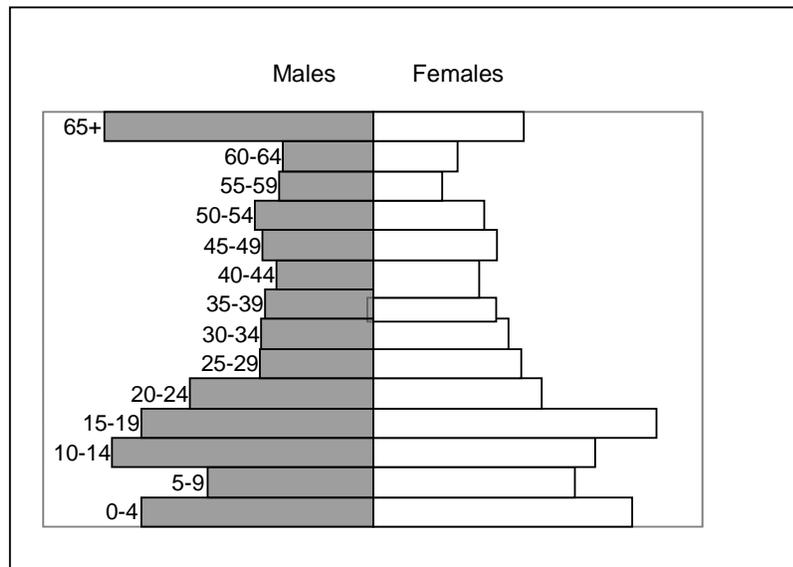
Our work views migrant health as a reflection of the culture and structural conditions from which the migrants come and the milieu in which they are presently immersed. Social, cultural, and environmental conditions are addressed as we examine both the depression and anxiety that underlie the physical conditions of migrants and the traditional medicine that they often employ to address such health concerns.

A DEMOGRAPHIC SNAPSHOT

The population pyramid for Tunkás has a broad base, with the highest proportion of individuals (22 percent) between 10 and 19 years of age. The distribution reveals a narrowing of the male population beginning in the 25–29

age category and continuing through the 40-44 age category, after which the male population reaches the levels of the female population (see figure 11.1). Given that males are more likely to migrate and that the average age of U.S.-bound migrants is 37, it seems likely that the contraction in the male population from 25 to 44 years of age is due to emigration.

Figure 11.1 Population Distribution in Tunkás, 2003, by Gender and Age



The effect of migration on the population distribution of Tunkás was first observed in a 2004 community study, in which Alfonso Martín Gómez Soler, resident medical student at the town's health clinic, noted that the departure of many young men in search of economic opportunities in the United States had removed a "high percentage of males of productive age from Tunkás" (Gómez Soler 2004: 13). The population distribution across age groups suggests that if limited job opportunities and low wages persist in Tunkás, a large proportion of those reaching working age may enter the workforce in the United States rather than in their hometown.

Our survey shows a slight difference between U.S.-bound migrants and nonmigrating Tunkaseños in terms of family planning. Seventy-five percent

of migrating Tunkaseños, compared to 67 percent of nonmigrants, did not plan to have any more children, suggesting that migrants may be receptive to family-planning programs in Mexico and/or the United States, and that fertility behavior changes may occur as early as the first generation. These findings underscore the potential value of family-planning programs targeting first-generation migrants.

NUTRITION AND SERVICES

The Tunkaseño diet consists primarily of three staples: beans, corn tortillas, and chiles. Tunkaseños also eat other foods—generally tomatoes, lettuce, cabbage, and squash—two to three times a week. Households with more economic resources have a wider variety of protein, including beef and venison, in their diets, while lower-income families eat pigs and chickens they raise in their backyards.

Approximately 80 percent of the townspeople raise pigs in their yards for household consumption. Given the rudimentary and crowded housing conditions in Tunkás, the households' outdoor kitchens are usually in close proximity to dogs, cats, pigs, and chickens. The women generally cook on wood-fired stoves raised about a half-meter above the ground, exposing the food to dirt and animals. This arrangement greatly increases the risk of gastrointestinal illnesses and parasite infections, two major health problems in Tunkás.

The town's poor economy has restricted the development of infrastructure and urban services. The government has implemented an effective water distribution program, and potable water reaches 88 percent of the population, a fraction comparable to the neighboring municipalities of Cenotillo and Izamal. However, the municipal government has not established a community-wide sewerage system, leaving 80 percent of the population without adequate sanitary resources. This absence of basic infrastructure contributes to the high prevalence of gastrointestinal, urinary tract, and parasite infections in Tunkás. As outdoor fecal excretions dry, they become pulverized and airborne, increasing the risk of respiratory infections from inhalation of these particles. The town's doctors cite these types of infections as the primary reason for Tunkaseños' visits to their offices. The health-care resources available in Tunkás include a government-sponsored health clinic,

three private doctors, two *parteras* (midwives), and one *huesero* (a “bone doctor” who incorporates herbs and spiritual rituals into his healing practices).

TUNKÁS AND THE LATINO HEALTH PARADOX

One might expect that moving from Mexico to the United States would improve migrants’ health, given that the United States is a much richer country with technologically advanced medicine. Yet a large body of research consistently affirms that Latino immigrants are healthier than U.S.-born Latinos and that migrants’ health outcomes decline with the length of time they spend in the United States. This finding has been called the “Latino health paradox” (Sorlie et al. 1993; Abraido-Lanza et al. 1999; Palloni and Arias 2004; Hummer et al. 2000; Weigers and Sherraden 2001).

One possible explanation for this apparent paradox is that migrants are a self-selected group of healthy people. The old, sick, and infirm are clearly less likely to migrate, especially given the harsh conditions of an undocumented border crossing. But some researchers argue that the rising numbers of health problems documented among migrants in the United States simply reflect the settled migrants’ improved access to resources required to diagnose preexisting medical conditions, such as cancer, diabetes, cardiovascular disease, and HIV/AIDS (Burgos et al. 2005). These observers argue that settled migrants’ higher incidence of self-reported disease cannot be unequivocally interpreted as a cause-and-effect relationship between migration and disease. It is difficult to determine whether migrants who are long-term residents of the United States are actually unhealthier or are simply more aware of their medical situation than are newcomers.

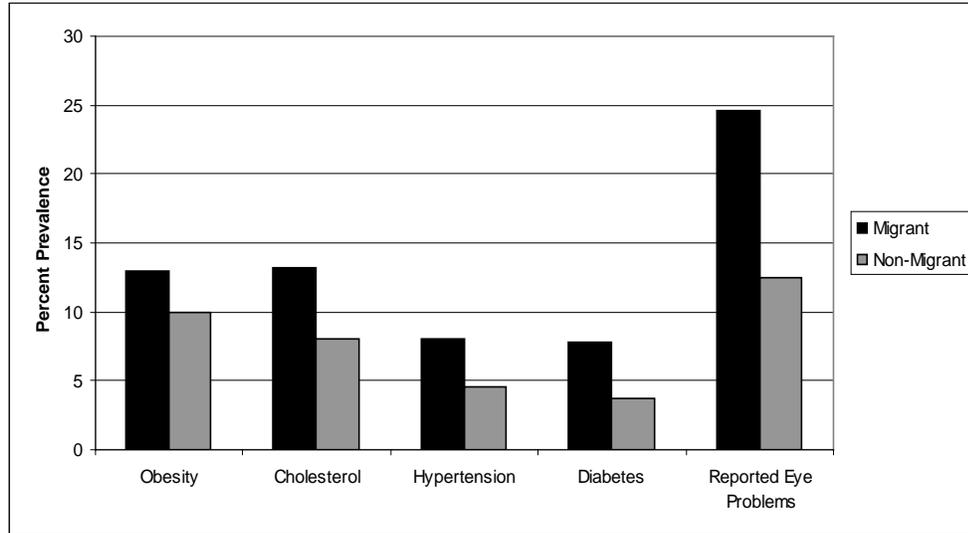
Still other authors argue that Mexican migrants are less willing than other migrant populations to change certain behaviors and that the Latino health paradox reflects their lack of faith in the effectiveness of American health-care practices. Thus they underreport disease relative to the second generation (see, for example, Reichman 2006). These researchers postulate that first-generation immigrants are highly resistant to change and that shifts in attitudes, behaviors, and beliefs can only occur in the second generation. Such resistance to acculturation has been attributed to these migrants’ traditional rural backgrounds, strong family ties, geographic proximity to their place of origin, and the prevalence of “institutionalized discriminatory prac-

tices” that discourage their integration (Reichman 2006: 1–3). Nevertheless, Reichman insists, such measures of acculturation are superficial and fail to employ “behavioral measures of acculturation” that “satisfactorily predict attitudes” (p. 12). Using her own measures, Reichman conducted a study of Mexican migrant women in Santa Fe, New Mexico, and found that many modified their health care-seeking behaviors and attitudes about disease prevention within five to ten years of migration.

Our survey in Tunkás sheds new light on the Latino health paradox by comparing migrants to nonmigrants. Across the entire range of self-reported diseases we surveyed, Tunkaseño migrants are sicker than their nonmigrating counterparts. Rates of diabetes, hypertension, and high cholesterol are significantly higher for Tunkaseños with migration experience (see figure 11.2). This shows that migrants are not a self-selected group of healthy people; on the contrary, their health outcomes are worse than those of nonmigrants.

One possible explanation for the disparity between migrants and nonmigrants, as discussed above, may be that migrants are more likely to seek health care and, hence, to have diseases diagnosed. However, we found that the percentage of individuals seeking medical advice is roughly the same among nonmigrants (74 percent) and individuals with U.S. migration experience (77 percent). The share of Tunkaseños who seek no treatment whatsoever is lower for migrants (5 percent) than nonmigrants (8 percent). The remaining migrants and nonmigrants either self-medicate or use traditional medicine. Migrants appear to seek medical care at approximately the same rate in the United States (36 percent) and Mexico (41 percent), which leads us to conclude that Tunkaseño migrants are not simply more likely to report diseases that are equally prevalent among nonmigrants, but rather, that their health is indeed deteriorating as a consequence of migration.¹

¹ However, these data do not allow us to discount the possibility that migrants who visit clinics in the United States are more likely to have a condition diagnosed than are nonmigrants who visit clinics in Mexico, given the more advanced medical infrastructure and training available in the United States.

Figure 11.2 Prevalence of Disease among Migrant and Nonmigrant Tunkaseños

P values: obesity, 0.8968; cholesterol, 0.2254; hypertension, 0.0545; diabetes, 0.0363; eye problems, 0.0309. *N* = 258 (nonmigrants), *N* = 313 (migrants).

USE OF TRADITIONAL MEDICINE

According to the World Health Organization, over 80 percent of the world's population uses some form of traditional medicine, and the majority of traditional medicine therapists come from indigenous societies (WHO 1993). Folk illnesses and traditional therapies are often associated with low economic status and marginalization from public services. Given this scenario, many researchers conclude that the use of traditional therapy is prompted by a lack of access to conventional medical help and that belief in folk illnesses, such as *mal de ojo* (the consequence of a piercing glance) and *mal aire* (bad air), will decline as urbanization advances. For example, Chávez (1984) documents that young Mexican migrants in San Diego, California, sought out traditional therapy in rural areas only when doctors were not available. Once in the United States, these respondents said, they would not visit folk practitioners.

This model is challenged, however, by Nigenda, Cifuentes, and Hill, who studied the increasing use of traditional medicine in Mexico City. According

to Nigenda and colleagues, the availability of conventional medical help does not deter individuals from using traditional medicine as well. That is, the fact that conventional medicine is available does not imply a total shift from traditional to conventional methods. Instead, these authors conclude, “traditional medicine is extensively practiced in Mexico in parallel with the conventional medical system” (Nigenda, Cifuentes, and Hill 2004: 419).

Other researchers point out that the cost of modern health care leads many individuals to seek traditional therapy. Unable to afford visits to the community health clinic or to a private physician, they opt for a cheaper remedy: traditional medicine. Dr. Ignacio Gómez García, attending doctor at the town’s clinic, pointed out that patients in Tunkás commonly go to both the clinic and the *herbatero* (herbalist) for treatment of the same ailment. Dr. Gómez offered as an example the case of a pregnant woman who receives prenatal care at the clinic and also visits a *sobadora* to help position the baby for delivery. He notes, further, that cost is not the deciding factor, given that the clinic does not refuse service to patients who cannot pay.

Our research shows that the prevalence of folk illnesses such as *mal de ojo* and *mal aire* does not differ between migrants and nonmigrants. Despite urbanization and possible acculturation, Tunkaseño migrants believe in the symptoms of *mal de ojo* (weakness and loss of appetite) and the harmful effects of *mal aire* to the same degree as nonmigrating Tunkaseños. Thus, in the Tunkaseños’ case, belief in the power of folk illnesses has not decreased with exposure to U.S. practices and culture.

Even more surprisingly, U.S.-bound migrants are *more* likely to visit a *curandero*, *herbatero*, *sobador*, or *huesero* (29 percent) than their nonmigrating counterparts (22 percent), contradicting assertions that marginalization, lower economic status, and lower education levels are the principal predictors of traditional medicine use. On average, U.S.-bound migrants from Tunkás are more educated, more exposed to modern health-care practices, and of higher economic status than those who do not migrate; yet they are more likely to visit a traditional medicine practitioner.

The reasons for this “traditional medicine paradox” are not known, but our results suggest that researchers must look beyond socioeconomic status and acculturation. As mentioned previously, Mexican migrants are often described as resistant to change, an observation that might lead one to conclude that the use of traditional medicine serves as a “mechanism of resis-

tance." However, 36 percent of our migrant interviewees had visited doctors in the United States within the previous two years. This clearly indicates that migrants are not rejecting modern health-care practices but rather are using them in conjunction with traditional medicine.

We propose that migrants' use of traditional medicine is a coping mechanism that enables them to integrate their cultural identity with their new reality. Traditional therapy, then, symbolizes much more than just a physical cure; it represents a spiritual connection to Tunkaseño land and culture. The fact that migrants hold onto these traditions more tightly than those who do not migrate may indicate that they associate traditional medicine with their homeland. The migrants' more frequent use of traditional therapy is most likely a result of several factors. Although our research is not conclusive in identifying which factors are most influential, it does provide strong evidence that migration to the United States does not depress use of traditional medicine.

MIGRATION AND ALCOHOLISM

Increases in alcohol consumption represent a public health concern in many Mexican migrant communities in the United States. Most studies of Mexican migrant alcohol use focus on male migrant farmworkers. These studies hold relevance for the Tunkaseño case because the majority (65 percent) of our survey interviewees in Tunkás are males; and even though most of our migrants were not employed as farmworkers, they have similar social networks and cultural backgrounds. Therefore, we expect that several of the predictors of migrant alcohol consumption identified in previous studies will apply in Tunkás as well.

In explaining the factors that regulate alcohol consumption in rural Mexico, Castro and Gutierrez are quick to acknowledge the powerful role played by family traditionalism and the institutions that reinforce it. This value system emerged in an agrarian environment where family survival depends upon the members' willingness to make personal sacrifices for the collective well-being. As a result, family traditionalism consistently advocates empowering the group at the cost of the individual, and thereby minimizes the possibility of personal rebellion in the form of misconduct (Castro and Gutierrez 1997: 510). Religion also plays a crucial role in reinforcing the values

of family traditionalism. By urging the faithful to deny their personal desires and devote themselves wholeheartedly to God and Church, religion once also sought to empower the group at the cost of the individual. The Church also represented a fundamental unit of social organization, for it expected the whole community to participate in religious events. These frequent events not only fostered a powerful sense of community responsibility among the congregation; they also made it difficult for those engaging in deviant behaviors, such as excessive alcohol consumption, to escape the censorship of both their families and members of their church (Castro and Gutierrez 1997: 510).

Researchers have confirmed that once an individual migrates, the family continues to play a key role in regulating personal conduct, including alcohol consumption. Two studies in particular, both conducted in migrant labor camps in upstate New York, identified social isolation as the most powerful factor affecting whether an individual would become a heavy or binge drinker (Watson et al. 1985; Chi and McClain 1992, cited in Watson et al. 1985: 446). Watson and colleagues concluded that “the importance of spouse, children, and other relatives cannot be overestimated as a moderating influence on drinking among male migrants” (p. 446). Indeed, high levels of alcohol abuse among male migrants can be partly attributed to the fact that most of them are placed in a social situation that promotes such behavior, and the social pressures that previously served to moderate their alcohol consumption are far away.

Upon arrival in a U.S. receiving community, male migrants often find themselves in an all-male environment with limited forms of entertainment. Heavy drinking is an opportunity to engage in a “sharing of identities and experiences that serve to re-enforce the importance of masculinity” and comes to be the principal activity of the majority of these groups (Watson et al. 1985: 450). Castro and Gutierrez attribute such attitudes toward alcohol abuse principally to the fact that “norms condone it.” Hailing from rural areas where jobs are monotonous and demand substantial physical exertion, many male migrants believe they have the right to use alcohol as a release (Castro and Gutierrez 1997: 503). The disconnect that often arises between migrants and their U.S. host community makes the problem worse, according to Watson et al. (p. 448), because many migrants do not feel restricted by

the kind of social contract that served to moderate alcohol consumption at home.

A migrant's alcohol abuse can also be affected by the amount of time spent in the United States. As migrants become increasingly acculturated in the United States, rates of alcohol abuse rise. The connection between increased acculturation and increased alcohol consumption becomes clear when one recognizes the enormity of the shift that adjustment to life in the United States requires. Defined by Castro and Gutierrez as the transformation in "values, attitudes, behaviors, language, and lifestyle" involved in accepting the norms and traditions associated with a new cultural environment (p. 15), acculturation exerts a significant strain by forcing an individual to confront issues of class mobility, identity transformations, and warring value systems. In a study conducted in 1987 among Mexican Americans in urban Los Angeles, lifetime prevalence rates for alcohol abuse rose in direct proportion to levels of acculturation. This finding confirms that alcohol is frequently used to cope with the pressures of acculturation (Burnam et al. 1987, cited in Castro and Gutierrez 1997: 16).

Surprisingly, our data from Tunkás show that rates of alcohol consumption did not increase significantly with migration. When asked to self-report their behavior in the United States, 73 percent of migrating Tunkaseños said that their alcohol consumption did not increase. Of these, 38 percent reported no change in their drinking habits upon migrating, and 35 percent reported drinking less alcohol in the United States. Our study suggests that the relative absence of significantly increased alcohol consumption may be due in part to Tunkaseño migrants' strong social networks. Thus the extended kinship network continues to play a role in regulating individual behavior, limiting alcohol consumption in much the same way that it does in Mexico.

Regular sending of remittances is one of the most important ways in which a migrant expresses the depth of his commitment to his family's well-being. For many migrants, the desire to supplement a limited family income with regular remittances represents one of the principal motives for migration. Following local values, the migrant sends home money that he could otherwise use for his own entertainment and comfort. We found that 86 percent of Tunkaseño migrants remitted money to relatives in the town during their most recent trip to the United States.

For many migrants, what most powerfully affected their behavior was the intensity of their connection to their nuclear family. Jesús, an evangelical Christian and father of two, said that despite the depression he experienced in the United States, "I did not allow myself to abuse alcohol because I had to send money home to my wife." Jesús never failed in his responsibility; his loyalty to his family was far more powerful than the pull of his depression. "I said to myself, 'This is why you came. You cannot turn into a drunk here.'" Vicente, another migrant, emphasized that his personal troubles were always subordinate to his concern for his family. Of his bimonthly telephone calls home, he says: "If they tell me they are healthy, I am happy. But when they are sick, you worry. But that is the life of a father, no? You love them a lot, but when you are far away, you can only send them money and hope for the best."

Our interviews with other Tunkaseño migrants confirmed that most were linked to a family system whose needs dictated the course of their life in the United States. Seventy-two percent of the migrants we surveyed were married, and many unmarried migrants were working specifically to accumulate the capital needed to support a family. We also found that 68 percent of Tunkaseños stayed with family members upon arrival in the United States, and 79 percent had relied on a relative or friend to obtain their most recent U.S. job. Our data suggest that maintaining strong ties to the sending community and with family and friends in the receiving community has a powerful effect on controlling alcohol consumption among migrants. In the course of several unstructured interviews we conducted in Tunkás, informants described abusers of alcohol as weak men incapable of upholding their family responsibilities.

MENTAL HEALTH

Many migrants to the United States must overcome depression if they are to succeed in their new environment. As early as 1978, the President's Commission on Mental Health asserted that "many of the objective features associated with Mexican migration to the United States would predispose toward poor mental health" (Vega, Kolody, and Valle 1987: 512). Further, the Commission identified isolation from emotional support systems in Mexico and the strenuous nature of a migrant's life in the United States as the factors

that made migrants highly vulnerable to psychopathology. Though some of the assumptions that Vega, Kolody, and Valle made do not apply in the Tunkaseño case, the psychological strain produced by the factors they identified undoubtedly plays a role in Tunkaseños' depression.

Thirty-nine percent of the Tunkaseño migrants we surveyed reported an increase in feelings of depression during their first sojourn in the United States. We rely on the Fabrega Migration Adaptation Model (Fabrega 1969) to assess rates of depression among Tunkaseños. This model argues that the migration-adaptation process encompasses four "natural domains," each of which can be viewed as "an integral component for conceptualization and measurement" (Vega, Kolody, and Valle 1987: 512). Operating on the assumption that these factors "impinge universally on the migration experience" (p. 513), we will examine how depression among Tunkaseños fits the Fabrega model. Ultimately, our study reveals that the model succeeds in identifying several key causes of Tunkaseño depression, but it fails to identify one of the most fundamental stressors associated with migration: the impact on family members whom the migrant leaves behind. We employ qualitative data gathered in Tunkás to argue that no assessment of the stressors associated with migration is complete without examining the physical and emotional status of those who remain in the home community.

The first two domains of the migratory experience involve severing one's physical and emotional ties to the home country. Though Vega, Kolody, and Valle argue that each domain encompasses "intrapsychic and interpersonal elements," the first domain—in which the migrant experiences a sudden "break with a familiar sociocultural system" and disruption of those "family and other supportive ties" that have hitherto sustained him—seems to involve these elements more profoundly than the rest (p. 514). Feelings of fear, loss, and anxiety endemic to this state are often exacerbated by the migrant's undocumented status, which restricts his ability to visit his family once he has exited the home country (p. 515). The second domain of Fabrega's model encompasses the challenges of migratory passage. The degree of hardship varies significantly among undocumented Mexicans entering the United States, with the journey proving relatively uneventful for some and fraught with hunger and exhaustion for others. For some, it is even fatal (p. 515).

The third and fourth domains examine the migrant's interactions within the host country and his or her perceptions of those interactions. Adaptation

factors, such as procuring shelter and viable employment, represent a migrant's foremost concern in the third domain. Many Mexican migrants rely upon extended family networks to facilitate this transition. Despite migrants' ties to a larger support system, Vega, Kolody, and Valle observe that several factors inhibit the adaptation process in the Mexican case: "Mexican migrants are often segregated, destitute, minimally educated, and are often seeking employment under marginal circumstances ... that render them highly exploitable" and therefore vulnerable to the types of stressors that stimulate depression (p. 516).

In the fourth and final domain of the Fabrega model, the migrant must assess whether he has achieved the improved living standard that was the object of his migration. Operating on the assumption that unfulfilled expectations frequently precipitate negative mental health outcomes, Fabrega emphasizes that it is "neither the structure of opportunity nor the level of goal striving" in the social and work environment that most affects migrant depression, but rather how socially and materially successful the migrant perceives himself to be in those environments (Vega, Kolody, and Valle 1987: 516).

An analysis of Tunkaseños' struggles and successes in terms of this model demonstrates that although transnational social networks have a powerful stabilizing influence on the migrant, they cannot shield him or her from the multiple stresses associated with migration to the United States. Among the stressors exerting a strong impact on Tunkaseños are estrangement from family, difficult border crossings, and loneliness. Most Tunkaseños we interviewed described the consistent efforts they made to connect with their families and offset the stresses associated with the disruption of family ties. Ninety-four percent contacted their family in Tunkás at least once a month while they were in the United States. Jesús, who was quoted above, explained how his frequent calls home and the time he spent with members of his extended family in the United States alleviated his depression. He credited his wife's constant support for sustaining him throughout his U.S. sojourn: "My wife and I have been together for a long time.... We met in elementary school.... We've always kept in contact; we talk about everything. We are very close."

Despite their desire to maintain close ties with the home community, Tunkaseño migrants in the United States make infrequent visits to their hometown. Sixty-one percent of the migrants we interviewed reported spend-

ing more time in the United States than in Tunkás. Nineteen percent return once a year; 17 percent return less than once every four years; and 41 percent have not returned at all since leaving Tunkás. With 45 percent of migrants citing financial constraints (including the cost of a smuggler to help them reenter the United States after a home visit) and the risks associated with clandestine border crossings as the main reasons for their infrequent visits home, we can infer that undocumented status is a key deterrent to return migration.

An added stressor associated with the infrequency of trips home is the migrant's awareness of what his family endures during his absence. When asked about this, Don Clemente noted how difficult it was to be separated from his wife and children: "The children are growing up, and they need their father." And about his wife: "She had it very hard because one of the children got sick, and she had to find a solution." Ultimately the struggles of his family impelled him to return, but not before he himself had experienced significant mental and emotional hardship.

Our examination of the migrant's relationship to his nuclear family and the suffering that his absence often engenders reveals the crucial role these factors play in migrants' depression. Even though many migrants demonstrate a desire to remain connected to their hometown, the relative infrequency with which they actually return home appears to have a fundamental impact on their rates of depression.

Eighty-one percent of the Tunkaseño migrants surveyed cross the border without papers or with false or borrowed papers. Sebastián vividly described the arduous journey he undertook over the mountains in order to circumvent areas more heavily surveilled by the Border Patrol. Once on the U.S. side, a tire on the minivan his group was traveling in blew out. According to Sebastián, "Half of the people with us were picked up by the Border Patrol. The rest of us went with another *coyote*. Our *coyote* escaped." Sebastián spoke with sadness about two women who "almost didn't make it" across the border; they were in the group seized by "la Migra." When asked what enabled him to avoid apprehension, he alluded to his determination: "Right there I said, 'I am going to get out of this.'"

Jesús adopted a similar attitude when crossing the border. Though aware of the enormous risks involved, he knew that he could not let his fear paralyze him. When asked what he was thinking as he walked across the border,

he responded: "Just about walking, about continuing. We focused on the main goal. There was no time for anything else." Such testimony confirms that the border presents truly formidable challenges to Tunkaseño migrants and that their success depends largely on their determination. Whether the stresses of the crossing represent a potential source of depression appears largely dependent on the individual migrant's mental preparedness for the journey.

Another important stressor is linked to the cost of crossing the border, which often runs to several thousand dollars. Vicente alluded to the burden of knowing that he needed to repay everyone who had loaned him money for his most recent border crossing. He noted that when a migrant arrives in the United States, he is not free to work for himself. The debt weighs heavily: "They loan you money, and you have to repay what they gave you. Then there are the fees for crossing the border.... You have to pay all of the people; you owe the money. If you don't pay it back, you're a *mala paga* [deadbeat]." For Vicente, his sense of personal security rested upon his ability to repay those who had helped him. Until he discharged those debts, he feared becoming a "*mala paga*" and experienced all the anxiety and depression that such fears engender.

A majority of the Tunkaseños whom we observed in Anaheim and Inglewood, California, eased the adaptation process by living in ethnic enclaves dominated, if not by Tunkaseños, at least by other Yucatecans. In one apartment complex in Anaheim, groups of Tunkaseño men drink beer, fix each others' cars, and watch television together. Fifty-nine percent of the migrants surveyed reported having Tunkaseños as neighbors. More than any other factor, proximity to friends and relatives from Tunkás determined migrants' choice of destination within the United States: 93 percent chose their most recent destination because they had relatives or friends there.

Nevertheless, many immigrants coming from small towns like Tunkás struggle to find their way in U.S. cities. Don Clemente described the bewilderment he felt when arriving in the United States. Simple tasks like crossing the street were a struggle. The noise and the challenge of getting around almost overwhelmed him, but he relied on a group of friends from Tunkás. "They helped me, and I gradually became more accustomed." Don Clemente's case illustrates how reliance on a transnational social network enables migrants to fend off depression.

For Vicente, the most difficult aspect of adjustment to life in the United States was overcoming his fear of the Border Patrol. When asked if he would consider settling permanently in the United States, he responded: "With papers, yes.... How can I put it? La Migra persecutes you. I don't like it. It means you are not free." Vicente's fear of deportation was constant: "Sometimes they say the Migra is seizing undocumented workers. That makes me afraid."

Jesús is a good example of an immigrant who used available social infrastructure to facilitate his adaptation to the receiving community. For example, he enthusiastically described the difference his church in the United States made for his sense of connectedness and mental well-being. For a time his work consumed him, and his religious commitment began to wane. Then he started attending Evangelical church services, and he says that the change he experienced was significant. "I see the difference because it brings spiritual comfort ... because you go and pray, and when you leave you feel peaceful, happy, and not worried anymore." Ultimately, by attending church three times a week, Jesús was able to alleviate the anxiety and depression that had afflicted him in the course of his stay.

Finally, a migrant's mental health is affected by the subjective perception of whether he has achieved the social and financial success he initially sought through migration. Sebastián described his job in the United States with great pride, eagerly showing photographs of himself and his co-workers:

I worked in the Hilton with the Americans. I also worked with blacks; in fact, I worked with everybody. I had a lot of responsibility. That's why the boss was so upset when I left. It was a lot of responsibility to walk away from. "Bring your family here," my boss told me. "I need you here," he said. One day I cooked for four thousand people. That's a lot of people.

Vicente also speaks with pride when describing his relationship to his job in the United States: "I was very willing to work. I like it when they tell me I've done a good job.... I like to keep busy, even if I work slowly, until the job is finished and done well." For both Vicente and Sebastián, work provided a stimulating challenge in addition to the financial compensation for

their efforts. Such experiences can help alleviate symptoms of depression and improve a migrant's sense of self-worth.

But what of the family members who stay behind? Despite the intense commitment of men like Don Clemente and Vicente to support their families, our findings and previous research both confirm that the absence of the male head of household disrupts a family. Because the migrant's decision to migrate depends on the emotional and economic support of his family, migration's impacts are rarely restricted to the migrant alone. Our survey data reveal that nearly 40 percent of individuals who borrowed money to migrate borrowed from family members. Almost inevitably, migration requires economic sacrifice by the entire family and a restructuring of the family system to accommodate the migrant's absence. By not exploring such a crucial component of the migratory process, Fabrega fails to address all of the factors that "impinge universally on the migration experience" (Vega, Kolody, and Valle 1987: 513).

The literature shows that a parent's absence increases the stress on the remaining parent and the children. The remaining parent tries to compensate by shouldering more responsibilities, a decision that often compromises their emotional and physical well-being (Amato and Gilbreth 1999). Nobles (2006) points out that migration often involves a long period of parent-child separation, sometimes longer than what follows the dissolution of a union. Paradoxically, migration, which increases household income through remittances, often makes family members who stay behind more susceptible to depression, anxiety, and poor overall health.

Fifty-six-year-old Eligia, whose husband migrated to Anaheim when she was twenty-eight in order to "build this humble house," describes her distress during her husband's absence: "I felt so sad. All I did was cry, and I think I also carried lots of anxiety (*nervios*) inside.... I didn't know if he was going to return alive, and I was pregnant. What was I going to do?" Eligia attributes six miscarriages to the anxiety that her husband's absence caused. She feels guilty, believing that her crying angered God and eventually led to her last miscarriage: "I think God said that I was crying all the time and that's why my child was born dead." Despite her husband's periodic visits, Eligia says she missed out on a normal married life. Twenty-eight years later, she is still affected by her husband's absence as she considers the prospect of

growing old alone. Eligia attributes her current physical illnesses to the depression that her husband's migration triggered.

Celmy, a 28-year-old housewife, noted a similar pattern of physical consequences in her 6-year-old son who, at age 3, got sick when her husband migrated:

They told me it was emotional, because he wouldn't eat. He was sad and got sick a lot. I don't know how much medicine he took, but nothing worked. I took him to another doctor, and he said that there was nothing wrong with the child. All I could do was cry because I saw how thin my child was getting.... He almost died from the same emotional illness. He started vomiting; he turned pale, pale. He didn't have any color. So much medicine he was taking, and nothing made him better.

Marcos, Eligia's 17-year-old son, also described his childhood longing for his father:

When I went to school, my friend's father would pick him up, and my mom couldn't pick me up. I walked home from school alone. Sometimes the bullies would make fun of me, saying I didn't have a dad. My mom said I did have a dad, that he would be back soon, but I had my doubts. The kid next door would ride a horse to the fields with his dad, and I would ask my mom when my dad would be back because I wanted to go out on a horse and do all the things that a boy does with his dad.

Marcos recalled the moment he realized that his father would never be able to give him what he needed: "It was a total change. I learned to move forward in life alone, not to count on anyone."

Research has shown that children in single-parent households tend to have less access to capital, which impairs their educational and health outcomes (McLanahan and Sandefur 2006). This explanation does not generally apply to children's outcomes in Tunkás, however, because most single-parent Tunkaseño households receive remittances, so migrants' children

actually have more access to resources than their counterparts in two-parent households. The poor mental health and educational outcomes of the children of migrants are most likely attributable, then, to parental separation stress (Strohschein 2005). Lamb and Tamis-Lemonda (2004) suggest ways that the simple presence of the male parent in a household facilitates a child's development and provides emotional support. Marcos asserts that his father was never around to teach him how to work like a man, to explain the physical changes he was undergoing, or simply to play with him. A child's developmental pathways are significantly altered when a parent is gone.

Ultimately, several factors—including the stress associated with clandestine border crossings and estrangement from family members—stand out as powerful catalysts of migrant depression, while the absence of the migrant has a profound effect on the family left behind.

CONCLUSION

Despite its status as a recent sending community, Tunkás cannot escape the pervasive influence of American culture. Tunkaseños display many of the health issues that characterize more experienced migrants from other parts of Mexico. Consistent with the "Latino health paradox," it does appear that Tunkaseño migrants are getting sicker in the United States: they exhibit higher levels of diabetes, hypertension, high cholesterol, and self-reported eye problems than nonmigrating Tunkaseños. As in the case of mestizo migrants, the pressures of border crossing, family separation, and adjustment to life in the United States can induce stress and spur a decline in physical and emotional health. Both our quantitative and qualitative data show that migration's impacts extend well beyond the migrant, altering the structure of the family that stays behind.

On the other hand, Tunkaseño migrants benefit from strong ties to social networks based on kinship and common origin. By remitting money home regularly and relying heavily on social networks in the United States, Tunkaseños retain stronger family ties than many of their mestizo counterparts. The strength of these family ties explains why many Tunkaseños stay in the United States only for a short time, citing as their principal reason for returning home their desire to be with their families. Their use of traditional Yucatecan medicine may also represent a coping mechanism, enabling Tunka-

seños to retain their cultural heritage despite acculturative pressures in the United States. Thus Tunkaseños rely on both social networks and traditional medicine in their efforts to cope with the many stressors of migration.

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