Migrant trajectories and health experiences: Processes of health/illness/care for drug use among migrants in the Mexico–United States border region

Olga Lidia Olivas Hernández

This chapter discusses the subjective experience related to drug use from the perspective of Mexican migrant men in the US–Mexico border region. Some studies have argued that migrants increase drug use after leaving their places of origin; the purpose of this study is to examine the overlap between their migration trajectory and drug use practices and meanings, analysing how the migration experience and its social, economic and political conditions affects migrants’ mental health.

Migration experience impacts daily life at interpersonal and structural levels. Leaving their places of origin and distancing themselves from family while lacking social networks may emotionally affect some migrants; the lack of language abilities acts as a barrier not only culturally but also economically; not having documents for a legal stay in a country criminalises people and makes them subject to deportations and detentions. Others are simply exploited by a capitalist system seeking cheap labour but offering precarious labour conditions. In general, being a migrant (undocumented or returned) can place a person at the margins of society.

California (CA) has the highest percentage of Mexican immigrants in the United States: they make up 69 per cent of the state’s unauthorised immigrant population, and numbered more than 1.5 million in 2016 – the highest total of any state (González-Barrera and Krogstad
while Baja California (BC), specifically Tijuana, receives the most returned migrants (whether forced or voluntary) in Mexico. In 2018, BC registered 54,625 repatriations from January to October, and around 56 per cent (30,475) of these were repatriated at the receiving point El Chaparral in Tijuana (Secretaría de Gobernación 2018).

Both states (CA and BC) rank among the highest in their respective countries for prevalence of drug use. According to the National Survey of Addictions (Encuesta Nacional de Adicciones), drug use is increasing in the north-western region of Mexico, particularly BC (INPRFM 2012). In CA, specifically Los Angeles County, there has been an increase in methamphetamine use (Brecht 2014). San Diego shows a significant increase in heroin use and a growth in heroin overdose death rates since 2013 as well as an increase in methamphetamine use from 2015 to 2017 (Wagner 2014; Meth Strike Force 2018).

Even though it is possible to identify social conditions in the Western US–Mexico border region that affect the development of health problems related to drug use, in this work I focus on the analysis of the processes of health/illness/care (h/i/c) for drug use through studying people’s life trajectories and focusing on their migratory experience. According to Menéndez (1994), the process of h/i/c constitutes a universal that operates differentially in each society and is diversely experienced among different groups. From Menéndez’ perspective, health conditions – and the societal response to those conditions – generate representations, produce practices and structure specific knowledge of the appropriate ways to understand, treat and whenever possible cure what is socially defined as illness (Menéndez 1994: 71).

Focusing on migrants’ experience to explore the process of h/i/c for drug use allows me to distinguish the different meanings that consumption practices have for Mexican migrants. At the same time, analysing their migratory trajectories makes it possible to identify their understandings, practices and forms of care related to drug use and how these may change throughout their lives in the US–Mexico border zone.

This chapter begins by discussing the theoretical perspectives approached in this study, mainly from psychological/medical and critical medical anthropology, followed by a summary of research studies conducted in Mexico relating to drug use and focused on social perceptions, policies and treatments. The third section describes methodological procedures, giving an account of the different settings where the study was conducted in the US–Mexico border region.

The chapter then analyses the overlap between migratory and drug use trajectories, discussing how the experience of migration from Mexico
to the United States has affected drug use practices and meanings. From a qualitative perspective, some experiences analysed demonstrate an increase and diversification of drug use in the border region in comparison to their homeland, suggesting that in the first stages of their trajectory, drugs use is experienced as a resource to deal with the challenges faced in this context as undocumented migrants. The following section analyses how drug use became a health problem in the later stages of their trajectory, leading them to deportation, homelessness and seeking treatment at the margins of the healthcare system.

Finally, the chapter concludes by synthesising how migratory and drugs use trajectories overlap in the experience of undocumented and returned migrants in the border region. It highlights the processes of marginalisation that exacerbate their health condition as well as their active role in creating therapeutic communities for their peers.

**Theoretical perspective**

The critical medical anthropology (CMA) perspective has made significant contributions to scholarly understanding of the social dimensions of health/illness/care processes. These contributions include analysing 1) the social construction of health and illness in relation to the world economic system; 2) health policies and the distribution of health resources; 3) the state’s role in health fields; 4) contemporary understandings of medical pluralism; 5) the development of a critique of biomedical ideology; and 6) individual health behaviour as well as illness experience in the context of wider structures, processes and relations (Singer 1989). This chapter uses a life trajectories approach centred on the process of migration to analyse how the subjective experience of drug use is affected by the social, political, economic and cultural conditions experienced by migrants in the United States–Mexico border region.

Singer (1989) emphasises the importance of CMA prioritising the micro level of social analysis, specifically individual experience and behaviour, to discuss the conflict and struggles that happen at the macro social level, both inside and outside of healthcare systems. In accordance with this perspective, Scherper-Hughes and Lock (1986) emphasise the necessity of studying the subjective experience of illness and healing processes. In this case study, I examine the relationships people establish with others along their migratory trajectory, within different social contexts (e.g. the family, at work or among religious groups), as well as at institutions providing treatment for drug use. These relationships influence
the lived experience of understanding, interpreting and reacting to drug use. According to Kleinman and Fitz-Henry (2007), this is an intersubjective process involving practices, negotiations and disputes. Therefore, by examining lived experience, I seek to understand collective realities as well as individual transformations and translations of those realities. Through engaging with migrants’ life stories, it is possible to identify periods where their experiences of drug use are not understood as illness but rather as helping address the difficulties they face in daily life. Eventually, turning points in the lives of migrants (such as becoming homeless and starting to experience auditory hallucinations) affect the meaning of the experience as an illness and lead them to seek treatment.

Analysing the subjective experience of illness also requires consideration of gender and ethnicity, as they can affect the lived realities of health conditions (Jenkins and Schumacher 1999; Jenkins and Cofresi 1998; Jenkins 1997; Lerín 2004; Ramírez Navarro 2010). We can identify differences between men and women regarding drug use and its treatment processes. For example, in Baja California, 75 per cent of rehabilitation centres for drug abuse do not accept women, and the ones that do provide treatment for this group reinforce their gender role as mothers and caregivers since they incentivise internment by offering legal support to get back parental authority (Galaviz 2015). Thus, treatments for women are focused on the recovery of their social function as caregivers, giving special meaning to their role as homemaker, mother, and wife; while for men, the role of caregiver is oriented to their peers, especially to those who are part of their therapeutic community (Galaviz 2015). Women are less prone to following up rehabilitation treatments due to the social demand of taking care of their home rather than being in a process of internment. It is therefore important to point out that the participants in this study are Mexican men since it was more feasible to contact this population on both sides of the border.

The participants of this study have different migratory experiences that have brought them, from various places, to the US–Mexico border region. As part of their migration experience in the United States, this population often lacks housing, language skills, income and a social support network. Thus they often face specific difficulties related to being an undocumented immigrant, and disparities accessing health services (Holmes 2006). Following Holmes (2013), structural, everyday and symbolic forms of violence experienced by migrants, especially in relation to their ethnic origin and their migratory status as undocumented, make them more vulnerable to racism and unjust legal structures operating against them as conjugated forms of oppression, which often affect their
health conditions. In some cases, undocumented migrants are blamed for their own health problems. The different forms of inequality and violence they are subjected to (in labour, health and justice systems) are not considered to affect their health condition, especially when talking about drugs use/abuse, since it has been criminalised rather than truly understood as a health problem. For example, under the Secure Communities Program, drug offences (in many cases, possession) have been one of the causes for deportation.

Therefore, the understanding of migrants’ health problems is also affected by the marginalisation and discrimination they are subjected to, in addition to the stigmatisation that exists towards drug use/abuse. Undocumented migrants have limitations accessing healthcare, and when it comes to drug use problems, the possibility of accessing a treatment is even more difficult: in some cases they are criminalised and blamed for their problem rather than perceived as needing help.

Active drug users face a different set of difficulties related to the social construction of addiction. Possession of illegal drugs sometimes implies that the person engages in illegal behaviours beyond drug use. For this reason, possession of or appearing to be under the influence of illegal drugs contributes to the stigma, marginalisation, criminalisation and social segregation of people who use drugs. The notion that drug use is an illness is sustained by the medical-psychological-psychiatric perspective embedded in the Diagnostic and Statistical Manual of Mental Disorders (DSM) as ‘Substance-Related and Addictive Disorders’, which is based upon a pathological set of behaviours related to the use of a substance (alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, stimulants or tobacco): impaired control, social impairment, risky use and pharmacological criteria (APA 2013).

The association of this health condition with impaired control resulting from drug use has resulted in the development of specialised, temporary residential treatment. The therapeutic models of these treatment centres range from biomedical and psychological to religious and mutual aid. Depending on where the centre is within the US–Mexico border region, patients may enter in-patient treatment voluntarily or involuntarily; however, later on in the treatment process they may move to out-patient care. Each of these therapeutic models represents a different institutionalised form of care based on a specific understanding of the problem to be treated, which leads to particular intervention strategies to support and guide the process of quitting drug use.

In order to discuss participants’ experience through a critical lens rather than as having a psychological disorder, I use the notion of
‘extraordinary conditions’ proposed by Jenkins (2015). According to the author, instead of labelling someone as marginal or abnormal, the extraordinary can be recognised as vital and integral. Therefore, an analysis from the first-person perspective seeks to criticise the notion of mental health problems in categorical versus continuous terms, in order to consider the indeterminate thresholds between the ordinary and the extraordinary, the routine and the extreme, the healthy and the pathological (Jenkins 2015). Jenkins argues the critical need for engagement with individuals’ experience, understanding their problems in terms of daily life struggles and not simply as symptoms defining illnesses.

Following Jenkins, I discuss extraordinary conditions as situations experienced at the limits of precariousness where, in some cases, drug use is involved. For example, the economic pressures experienced by some participants in the study led them to use drugs to do overtime at work. This situation is understood to be the result of a condition of precariousness, a struggle and an extraordinary condition experienced by undocumented migrants who have informal and low-paid jobs, while also having the responsibility of being home providers. Turning to drug use in this specific case can be discussed as a consequence of the structural violence exerted over them by the US immigration system.

The term structural violence is understood as a ‘way of describing social arrangements that put individuals and populations in harm’s way … the arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people’ (Farmer et al. 2006: 1686).

The processes of criminalisation that undocumented migrants experience by being considered ‘illegal immigrants’ by the political-economic system in the United States exacerbates their conditions of precariousness by restricting access to formal jobs, healthcare services, housing and other social and material resources. According to Armenta (2017), the immigration enforcement system has become increasingly punitive, and restrictive immigration policies are the primary mechanism through which people of Mexican descent are excluded and racialised in the United States, subordinating their status in the racial hierarchy, with consequences for their social, cultural, political and economic situation.

Even though some undocumented immigrants manage to get a job and find a place to live, their social rights are undermined due to their situation as undocumented; their labour and housing conditions may increase their fear of deportation, leading to other social and, in many cases, health problems related to poverty, marginalisation and discrimination. The jobs they acquire are often temporary, unskilled, low-paid,
and do not provide healthcare or other work benefits. Some of the participants in this study reported that they had jobs where they did not receive a salary, but instead were compensated with a place to live or with drugs (alcohol and marijuana). In some cases, they work extended hours or have two different jobs to earn enough money to cover their basic needs in the US as well as send some money to their families in Mexico. Using drugs may become a way to relieve the pressures of daily life. Such precarious conditions show how structural violence is embodied in the experience of people living in poverty or marginalised by social inequality (Farmer 2004).

The situation Mexican migrants face in the process of aiming to live in the United States affects their health. Thus it is relevant to discuss the way migration affects the h/i/c processes for drug use. Through this analysis, I argue it is possible to identify the hegemonic ways of understanding and caring for drug use. There are different forms of care configured by social structures and health institutions at the macro level, as well as the strategies that people living in socially and economically precarious conditions use to deal with problems related to drug use at the micro level. Menéndez (2003) suggests that it is possible to identify forms of care that individuals and groups use to address their illnesses beyond the biomedical, traditional or alternative perspectives used by health specialists, in what he describes as self-care. Therefore, analysing the h/i/c processes for drug use through life trajectories allows us to discuss the different interpretations of drug use as an illness, a habit, a vice and a self-care strategy to face the difficulties experienced under conditions of precariousness, among others. Likewise, it sheds light on the institutional forms of care sought by the participants.

Analysis of the life trajectory centred on the forms of understanding and caring for problems related to drug use allows us to identify how different healthcare and self-care practices intervene to reduce, solve or exacerbate health problems.

Self-care practices synthesise the activities developed by social groups regarding the h/i/c process (Menéndez 2003), that is, the different strategies they use to deal with and care for their health condition. In some cases, self-care practices are related to institutional healthcare practices, due to migrants’ past experiences of specific forms of treatment, or to other drug users’ self-care practices. When participants discussed their drug use prior to their migration, they did not consider it as problematic; it was not until they found themselves in certain critical situations in the United States as undocumented migrants or returned migrants in Mexico that they felt their drug use became problematic and
sought out care for it. In this sense, it is relevant to analyse the way in which their condition as migrants in the border region has impacted their intersubjective experience related to drug use, not only associated with consumption but also the forms of care they turn to.

Social perspectives on drug use practices, meanings and treatments in Mexico

Researchers have investigated a variety of problems related to drug use from both an anthropological and a sociological perspective. Some of these studies have analysed how different therapeutic models of treatment shape both conceptions of illness and the recovery or healing process. Although this paper is not focused on analysing a particular treatment model, it is relevant to review the studies that investigate the impact of cultural conceptions of the problem understood as drug abuse in Mexico, since it helps to understand personal, social, cultural, economic and political situations faced by people dealing with drug use problems in the border region between Mexico and the US.

Some scholars have studied residential self-help groups, in which people live together with the aim of mutually guiding each other’s recovery process. This is one of the main forms of help for drug abuse problems in Mexico; it is modelled on Alcoholics Anonymous (AA), or the Twelve Steps. Since the early 1980s, Menéndez (1983, 2003, 2009) has analysed alcohol use and the role of AA therapeutic communities in Mexico. He discusses the relevance of religious aspects in the processes of h/i/c for drug use, highlighting the role these therapeutic communities have in the development of support networks for different stigmatised populations, from those labelled as ‘drug addicts’ to migrant populations. Menéndez (2009) also analyses the way AA as a therapeutic model understands the illness and recovery process through social and cultural aspects related to the alcoholic identity, which differs vastly from the biomedical perspective of drug abuse as brain disease. Módena (2009) specifically studies the group dynamics within AA therapeutic communities; she pays special attention to the processes of identity, power relations and differences in the meanings of treatment among groups in the process of recovery. Similarly, Palacios Ramírez (2009) discusses the self-transformations during the recovery process among an AA community. On the other hand, Rosovsky (2009) gives a historical account of AA in Mexico, analysing the fragmentations of this treatment model over the last century.
Self-help treatments have been the most extensively used and affordable source of help for people dealing with drug use problems. Living the process of recovery in a community setting is meaningful for the experience of quitting drugs and building new social and cultural contexts where this can be sustained. Thus, these models of treatment are relationally based, which is fundamental especially when the people going through this process are marginalised or stigmatised, not only due to drug use in itself but because of their cultural, economic, ethnic and political condition, such as being an undocumented migrant or returned migrant of Mexican descent in the border region.

Another kind of therapeutic community that has been analysed in northern Mexico, specifically in Tijuana, is religiously oriented: Evangelical-Pentecostal rehabilitation centres. García Hernández (2014) has studied the dynamic narrative identities of people undergoing religious conversion through analysing their testimonies of recovery, which are stories about personal transformation showing how a person reached sobriety with God’s help. González Tamayo (2016) and Velázquez Fernández (2016) have analysed the process of recovery in relation to gender, while Kozelka (2015) has studied the way the social environment of rehabilitation centres contributes to certain cultural conceptions of the illness ‘drug addiction’ and the people who have it. Other scholars have analysed the processes of subjectivation through the paradigm of embodiment (Olivas Hernandez and Odgers Ortiz 2015) and the hope for the recovery during in-patient treatment in these religiously oriented centres (Galaviz and Odgers Ortiz 2014).

Both modalities of treatment, based on the Twelve Steps (AA) and religiously oriented, can be understood as self-help approaches offering alternative ways of understanding and treating drug users and drug use problems. In some cases, these therapeutic communities permit upward social mobility due to the role as guides or leaders that some people develop in the task of supporting others in their processes; this can positively benefit their own process of recovery.

Finally, some studies have discussed the problems associated with the social marginalisation of drug users. For example, París Pombo (2013) analyses the way the enforcement of legal policies against drug trafficking actually affects the human rights of drug users in Tijuana. She argues that poverty has increased drug users’ vulnerability since the criminalisation of poverty has been added to the ‘war on drugs’. In a similar sense, Cajas Castro (2013) analyses how drug prohibition in Mexico as a result of the ‘war on drugs’ has had a paradoxical effect of stimulating the use of illegal substances, highlighting the failure of prohibition
policies. Thus, analysing drug use is not limited to the understanding of it as a health problem, but involves conceptions of it as a condition affected by social, cultural, economic and political issues embedded in the use of drugs.

Muñoz, Morales, Fernandez and Brower (in this book) analyse the conditions of vulnerability under which Central American migrants live in the southern border of Mexico and the inequalities they face in a system that marginalises them. These forms of economic, social and political inequalities place migrant people at risk in relation not only to their health (drug use, STI, interpersonal violence) but also to the spaces and networks they become linked to, undermining their social security as a result of the structural and interpersonal violence they are subject to as sex workers, migrants and drug users.

Thus, analysing migration in relation to drug use in the border regions shows the structural violence exerted towards those who, in the process of seeking life improvement through migration, are placed at the margins of nation states, and their health, social and political condition is worsened in these contexts. The aforementioned studies address different aspects and levels of analysis concerning the experience of drug use in contemporary Mexican society. Using migrants’ experiences as starting point, this chapter aims to articulate, from a CMA perspective, the interactions between the migratory condition and the subjective experience of drug use (practices, meanings and forms of care) in the border region between Mexico and the United States.

Methodological approach

This research is based on a qualitative longitudinal study that explores different participants’ life stages related to the overlapping aspects of the migration experience, drug use and its forms of care, from leaving their places of origin until their settlement in the border region. This approach considers different variables (social, personal, cultural, economic and political, among others) as intertwined over a period of time, qualitatively paying attention to the subjective dimension of those variables from participants’ experience. The study systematically analyses migrants’ trajectories, from leaving their place of origin to settling in the border region between Mexico and the United States, and engaging with a form of treatment for drug use in California or Baja California.

The trajectory, as a theoretical and methodological tool, contributes to the systematisation of multi-spatiality during the migration
experience (Rivera Sánchez 2012). It also aids understanding of changes, continuities and breakdowns in social, cultural, political, economic and personal aspects of individuals’ life experiences. Specifically, the migratory trajectory approach permits the selection of an analytical period in the biography, allowing the order, systematisation and interpretation of drug use during a specific time interval, in this case migration between Mexico and the United States. Thus, this study discusses the relationship between personal situations and the context in which these experiences occur.

The study included 24 men between the ages of 25 and 65. Most of them reported methamphetamine, heroin or alcohol as the principal drug used. The majority of them were born in Mexico City and Tijuana, while a minority were from Nayarit, Jalisco, Michoacán and Durango. A few of those born in Tijuana emigrated to the United States with their parents or a relative during their childhood. However, the majority emigrated alone between the ages of 15 to 25, escaping from problematic situations in their places of origin, mainly drug use and violence, as well as economic and familial problems.

During the study, participants were recruited from three institutions providing low-cost self-help group services for drug use in the border region, which is the principal form of care in the Mexican side of the border (Galaviz and Odgers Ortiz 2014). Most of the people were of Mexican descent and treatment was provided in Spanish. Importantly, the people providing treatment have often had or are concurrently experiencing treatment as well. These self-help organisations outlined below were selected because they are more accessible for people with social and economic conditions of precariousness.

The first organisation is a religious rehabilitation centre located in Los Angeles that provides voluntary residential treatment for drug use. The religious approach to drug use rehabilitation understands the problem as spiritual and has the idea of God as saviour (Olivas Hernandez and Odgers Ortiz 2015). The second, located in San Diego, is a 24-hour AA group, which provides both out-patient and residential (in-patient) treatment. Even though it is an AA group, the users of this service have used drugs beyond alcohol, such as methamphetamine, alcohol, heroin and psychotropic pills, among others. The study participants attend out-patient self-help group sessions based on the Twelve Steps model. Finally, the third organisation located in Tijuana, is a rehabilitation centre also based on the Twelve Steps model, providing voluntary and involuntary residential treatment. The participants interviewed at this centre are returned migrants deported from the US.
During 2016, I conducted semi-structured interviews with 24 participants receiving treatment in each one of these organisations. In the interviews, I explored changes in their patterns of drug use and other familial, economic, emotional and social events that they had experienced after leaving their places of origin until their current involvement in the treatment. I specifically focused interviews on changes in drug use, their notions of health and illness, as well as the forms of care used to diminish their drug use, as most of the time they did not turn to specialised treatments. I also conducted observations of daily activities in the centres.

The migratory process and drug use

Some quantitative studies that have focused on the experience of migration between Mexico and the United States in relation to drug use have argued that people migrating from Mexico increase drug use once they are in the United States, while among returned migrants drug use diminishes once they are back in Mexico (Caetano and Medina Mora 1988; Sánchez-Huesca et al. 2006; Sanchez-Huesca and Arellanez-Hernández 2011). However, the quantity of consumption in Mexico continues to be high compared with their drug use practices before leaving their home country.

Other studies have focused on Mexican immigrants settled in the US. For example, one study argued that labour discrimination and exclusion are associated with alcohol abuse and dependence. In this case, social support did not act as a source of help among the people living with high to moderate rates of labour frustration and feeling unsatisfied (Finch et al., cited in Alvarez et al. 2007). Other research has shown that Latin American people living in the US have unequal access to treatments for drug use (SAMHSA, cited in Alvarez et al. 2007). Even if the possibility of accessing healthcare exists, they wait long periods of time to receive care, which they ultimately find unsatisfactory (Wells et al. cited in Alvarez et al. 2007). Finally, some studies discuss treatments’ characteristics, emphasising that culturally specific out-patient and residential treatments could have better results for drug use among Latin American people settled in the US (Cervantes et al.; Hohman and Gait; Waters et al. – all cited in Alvarez et al. 2007).

Although the condition of Mexican immigrants in the US or returned migrants in Mexico is different due to their migratory status, they share some difficulties related to the process of mobility (voluntary or forced) between Mexico and the US. As stated before, the majority
of participants in this study migrated from Mexico to the US when they were 15 to 25 years old; most of them were using marijuana or alcohol at the time. Even though some of them had a relative or friend living in the US, they did not contact them, or if they did, the relationship was temporary.

Some of the reasons to migrate from Mexico to the US were related to family problems (mainly with parents), substance consumption, situations of violence in their places of origin and economic difficulties. In most of the cases analysed, moving to a new context was framed as an attempt to modify and improve their social, cultural and economic condition, in comparison to their lifestyle in their places of origin.

Nevertheless, undocumented migrants in the US face conditions of precariousness in terms of their labour, economic and social needs, which are reinforced by their experience of social isolation. In the border region, migrants deal with adversities that affect the possibility of gaining social and material resources to integrate themselves in their new context, ultimately impacting their mental, emotional and physical health.

Participants’ migratory experiences were often characterised by a change in their drug use patterns. During the mobility from their places of origin and their first weeks in the border region, there was a decrease in drug use. However, once they became employed and established relationships with other users, their drug use increased. Additionally, most of them demonstrated a diversification of the type of drugs used, such as using methamphetamine, crack, psychotropic pills, cocaine or heroin for the first time. Valentin, for example, was born in Durango, México and emigrated to the US alone after ending a relationship, when he was 23 years old. He used to consume alcohol in Mexico, but in the US, crack was the main substance of consumption.

When I arrived [in the US], I was looking at everything differently. For example, it was easy for me to get into drug addiction here, because if you were on the street with a beer or a cigarette [marijuana], you just needed to hide it when the police were passing by, they were not aware of it … that made it easier for me (to use drugs) because being alone here is how I became addicted to marijuana. I was using meth, pills, PCP, crack, and I didn’t know about all that until I arrived in this country.³

For most participants, their increased drug use was affected by their life circumstances in the border region, related to their working conditions,
social isolation and living at the margins with other people in the same condition as undocumented migrants. Even though the kind of jobs they acquired have precarious conditions and low pay, most of them report an increased income, allowing them to have more access to drugs. They also find more social tolerance of drug use in the US, particularly among those sharing an apartment with other migrant men or in jobs where drugs were used to improve performance over long work shifts, like one of the participants describes.

Ricardo was born in Mexico State and migrated to the border region at 21 due to problems of gang violence in his neighbourhood. Even though the main drugs he used before starting rehabilitation were alcohol and cocaine, he describes the shifts from one drug to another and his experience with marijuana during his first employment in agriculture, where most undocumented migrants work in the US.

Ricardo did not have social networks when he first arrived in the US and he relied on other migrants to help him to settle in Los Angeles, California. The neighbourhood where he arrived was poor, with gang and drug use problems. Even though he met other undocumented migrant men in the US with whom he shared an apartment, he felt alone. Problematic emotional experiences on arriving at their migratory destination affected the increase and diversification of drug use among participants in this study, especially when settling into segregated neighbourhoods where drug trafficking is common. The feelings of loneliness and sadness experienced as a consequence of being away from their social networks in Mexico often caused an increase in drug use. In addition to the lack
of affective bonds in the US, work stress, economic difficulties and marital problems influenced their emotional experience. For these men, drug use became a strategy to face the emotional challenges of living in these situations. As such, drug use could be understood as a form of ‘self-care’ in Menéndez’s sense, to deal with the emotional pain, as another participant argues.

Dario was contacted in a rehabilitation centre in Mexico after being deported. It was his first experience of treatment. He was born in Tijuana and emigrated with an aunt to the US at the age of three months after his mother passed away. At the age of eight, he started to have problems with his aunt and left home. Later on, he started using drugs and was incarcerated many times, but not in rehabilitation centres, demonstrating how drug abuse is often criminalised but not understood as a health problem. Dario describes the experience of being away from his family as the reason for beginning and continuing his drug use:

When I started using more drugs, it was because I was falling into a kind of depression; I started missing my brothers, my aunt and my cousins. At the beginning with the marijuana, you are always laughing, but as it gets inside of you, you are more focused on your thoughts, and you will be there just thinking about the problem. Later I tried mushrooms and I would hallucinate … then the LSD, and later the pills. The pills (Rohypnol) started helping me more … in the way that they blocked my thoughts … I just started to think a little bit about my family and I would take three or four pills and that’s how I was living.5

Even though many participants increased their drug use after the migratory experience, it was not perceived as problematic, because they felt capable of regulating their use by themselves. This notion was also associated with the benefits they were experiencing from drug use; it became a resource to deal with different situations in their lives. Moreover, some participants noticed that using drugs helped them to deal with their emotions. They registered an improvement in their social skills as they became self-confident and were able to work for longer periods under the influence of drugs, improving their income. They were also, however, spending more money on drugs, which later became a difficulty for some.

This situation gives an account of the levels of labour exploitation that some undocumented migrants face in the US. Since they have low-paid and irregular jobs and are always at risk of being deported, some of them try to make the highest profit from their time in the US, sometimes
at the cost of their health and safety. Even though they experienced challenges due to drug use, most of them developed strategies to diminish those effects, reducing the quantity and frequency of use. One of the strategies was to change their place of residence in the US, as some started to have illegal trans-border mobility between Mexico and the US (mainly those who were born in Tijuana), especially during the 1990s, before the militarisation of the border (Heyman and Campbell 2012). The mobility allowed them to move away from the drug users’ networks, although sometimes only temporarily.

Another strategy was to manage their money differently, spending more on their family, homes and personal belongings and less on drugs. Entering into romantic relationships and having a child were other strategies related to more responsibility or being aware of it. Another strategy was to diminish the adverse effects of drug use. For example, when they felt a lack of control over their drug use, they replaced one drug with another, or diminished the use of one drug while increasing another. These adjustments in drug use patterns can also be understood as forms of self-care. These strategies were undertaken to avoid being in a critical condition, as one participant describes.

Martín was born in Mexico City and migrated to the US when he was 20 due to family economic problems. He used to work seasonally in the US and go back with his family (parents and brothers) to Mexico. But when the militarisation of the border was enforced after 9/11, he stayed in the US and never went back to Mexico. The jobs he got were in small markets, with precarious labour conditions, such as low payment and no access to healthcare, but with minimal supervision, allowing him to drink alcohol at work. He began consuming alcohol at the age of 15 and explains why he replaced alcohol with methamphetamine while working.

Here [in the US] I had the chance to drink at my job, there was a lot of freedom … since I used to work in small markets, I was able to do what I wanted in my place of work, and if the boss noticed, there was no big trouble. I used to drink a little bit, I never was falling [due to the alcohol use] and I drank more after my job, and I never fell, I could drink a lot and keep working. But when I started with meth, I had tocado fondo [touched bottom] with alcoholism, I was not able to work any more, it was very hard. On one occasion, I couldn’t handle the hangover, I felt bad physically, but I was working, and someone told me that if I wanted to feel good, he had something for me to get better. I knew what he was talking about, but I had never tried meth; the guy left me some lines [of meth] on the table and I was
so desperate because I was not feeling good, so the first time that I used it, I just started and immediately I was feeling good, the physical discomfort disappeared. That experience was what attracted me and captured me more. The meth consumption made me a sociable person, what I couldn’t do or say I did it under the effects of meth. I remember that I quit alcohol and I started to use meth regularly … I turned to my normal activities again and I was feeling better because, in the beginning, that’s how it was.6

From the participants’ perspective, using drugs for some years without experiencing negative consequences shaped their perceptions of not considering drug use to be a problem. Rather, drug use was a means to deal with their problems. The use of as a form of self-care to address their needs and discomforts reveals their perception and experience of drug use as a solution to problems, not an illness. Even though they experienced difficulties related to their drug consumption, those were lived and understood as extraordinary conditions that they have to struggle with constantly, in efforts to improve their lives. However, not perceiving their situation with drug use as a health problem is in some cases a result of the indifference of employers towards undocumented workers’ conditions, in addition to the difficulty of accessing healthcare.

**The notion of drug use as a problem**

As mentioned earlier, the majority of participants identified different stages in their life trajectory where they managed drug use difficulties through self-care strategies, such as maintaining relative stability in their family relationships, job performance and economic position. However, in all the cases analysed, there are later stages where they experienced more difficulty in regulating the patterns of drug use, even if they were using the same self-care strategies, such as transitioning between different drugs or moving to a new context. These different conditions changed their perception and experiences related to drug use.

Once they were experiencing more difficulties in keeping a job or getting a new one if they were fired, they started to consider their drug use as a problem. In these cases, they were experiencing the situation of being at the margins of the system, which was expelling them once they were not economically functional for the employers. They often found themselves unable to provide for their families, which impacted their familial relationships and economic position. For participants in this
study, the duty of being the worker and main provider is closely associated with gendered social expectations of them as the man of the house. Accordingly, when they were unable to perform their social role as provider, their family relationships broke down. Some of them found themselves in failing relationships, losing contact with their family members and eventually becoming homeless, as Alan recounts.

Alan was born in Guadalajara, Jalisco, and emigrated to the US at the age of 21. He tried to reunite with his wife in the US after having marital problems. His first employment in Texas was in agriculture, where he constantly experienced fear of deportation, leading him to live in precarious conditions in the field for some years. Later he reunited with his wife in Los Angeles, where he managed to get a job in upholstery. He was using alcohol in Mexico but began using meth in the US to do overtime and improve his performance at work. Eventually he started to lose control over his drug use.

In the beginning, I was using meth, and everything was fine. I even wanted to work and to be more active and used to do overtime at work. But as time passed, everything changed … When I started using meth I was able to work, I was not using too much, around $20 per week. I was using just on Friday, Saturday and Sunday, when the party was over, and I was well rested and ready to work on Monday. For five years that’s how it was, I didn’t have economic or relationship problems. But when I started to spend the night with my friends drinking, I became more focused on drug use. That was when I began to have problems with my wife, and due to those problems with her, I increased my use. But what happened with that drug [meth] is that it is stronger than others. At the beginning I said, ‘I control it’, but later I lost control. I was using it to go to work and increased the quantity [of the drug]. Later, I started to miss work and had bad job performance. My social, labour and emotional responsibilities were affected. I said to my wife, ‘I need help because I am not controlling it [the drug use]’, and my wife said, ‘That’s your problem, don’t count on me, because I didn’t send you to use drugs’, so I felt rebuffed. One time I heard her telling her sister, ‘As long as he gives me what I need, he can do what he wants’, but three years ago was when I was hitting bottom [having critical problems due to drug use]. My wife didn’t want to be with me any more. I lost my job and became untrustworthy for other people and started falling down … I was still living with my wife, but our relationship was very hard, we were having economic problems, until the moment that she and her
family threw me out of my house. I lived 15 days in the street and a friend of mine who was also using drugs let me stay in his garage. I got a job in an upholstery where I was known, but I was lost already. I continued using every day … to the point where in the morning if I got up, and I didn’t drink a beer, I couldn’t even walk. During the morning, I used to drink five beers and do meth at around noon, to reduce the beer effect so the boss couldn’t notice. I was not using a lot of meth, the alcohol was what was disturbing me. The last 15 days were the heaviest because I started hallucinating and couldn’t sleep at night. Those two weeks I was struggling with myself, due to the hallucinations.7

Alan’s experience shows that failure as a provider (as a result of difficulties in keeping his job), and its consequences in the family context (being rejected by his family and becoming homeless), worsened his drug use problem, thereby exacerbating his conditions of precariousness. Most of the participants resorted to treatment once they were struggling with different problems or extraordinary conditions at the same time, such as the experiences of hearing voices, being homeless, lacking social support and suicidal ideation or attempting suicide.

The participants who had settled in Tijuana as returned migrants did not report seeking any treatment in the US. Compared with migrants arriving in the US for the first time, returned migrants with drug use problems experience conditions that are highly precarious once they are back in Mexico: a lack of social support networks, economic instability, limited employment and housing possibilities, as well as restrictions on receiving help in migrant shelters due to their drug use problems. This partially relates to their physical and mental health conditions stemming from their deportation (Rosales Martínez et al. 2017). Most of the participants interviewed on the Mexican side of the border reported that they become involved in treatment after their deportation. Their health conditions had worsened during their time in the US, due to their increased drug use. Once deported, they did not feel socially and economically able to integrate themselves in Mexico, leading them to voluntarily seek residential treatment as a temporary shelter.

From participants’ perspectives, one critical consequence of drug use was the experience of auditory hallucinations, particularly when combined with suicidal ideation. For help with this they mainly turned to religious treatment, primarily because of social, economic and cultural difficulties in accessing any other sources of help. While some participants turned to psychiatric treatment, they did not feel comfortable being
categorised as having a mental illness nor were they willing to begin psycho-pharmacological treatment. Therefore the preferred option was to seek religious support, where their hallucination experiences were interpreted as the presence of demons trying to bother them, rather than as a stigmatising mental problem. Alan recounted how he had turned to a charismatic Catholic group to take care of his problems related to drug use once he became homeless.

When I couldn’t keep my job, was when the voices [auditory hallucinations] were bothering me more. I talked with a person from the Catholic group … he told me that he knew what was going on with me. Then, the same day, I heard the voices again, telling me that I had broken the rules, that I wasn’t supposed to have talked with them [the Catholics], it was something between them [the voices] and me. Later, I arrived here [at the religious rehabilitation centre] and understood that what we face is a spiritual struggle. While reading the Bible, I found that seven demons attack us. I made sense of all that because I was listening to seven different voices by that time.⁸

All the participants sought institutionalised care based on the Twelve Steps or religious therapeutic models. This was in part because their economic condition prevented access to other kinds of treatments, since most of them only sought treatment once they became homeless. Furthermore, they identified with the community that constitutes those forms of care and the way they collectively addressed and understood their situation.

It is relevant to underline that Twelve Step treatments and religious models can be categorised as forms of care based on the self-help ethos, because service providers for those forms of care are often people who are also living through or have already undergone a rehabilitation process. In many cases, this caregiving community also provides social, cultural and sometimes economic support networks that migrants had been missing. This leads to two conclusions. First, turning to a form of low- or no-cost care sheds light on the conditions of social and economic precariousness that undocumented migrants with drug use problems often experience. Second, it allows us to analyse the way in which the social group that constitutes the therapeutic community has taken a position on understanding, defining and caring for drug use problems contrasting with other hegemonic forms (medical, psychological, psychiatric) of treating their health condition.
According to Singer (1989), analysing the life course both inside and outside the health arena reveals disputes between individuals and groups whose social interests conflict; further, the fact that these different social groups (i.e. therapeutic communities and biomedical/psychological professionals) have unequal abilities legitimises certain forms of care and meanings attributed to illness. From this perspective, Singer suggests that we need to pay attention to the implicit and explicit social struggles that manifest in illness meanings and experiences, clinical interactions and the relationship between health systems and healthcare providers, as well as organised efforts by patients, workers and oppressed populations, such as self-help groups.

The wide dissemination of alternative forms of care (religious and Twelve Step) categorised as mutual-aid groups, as opposed to state-sponsored psychological services, makes visible the tension between the state as the provider of public healthcare services and its inability to meet the community’s needs. Because of this, alternative forms of care have emerged within civil society (Galaviz and Odgers Ortiz 2014).

The difficulties experienced by undocumented and returnee migrants which ultimately lead to them accessing these forms of care reveal conditions of structural violence, social marginalisation and inequality. Being an undocumented or returnee migrant in the border region limits their labour possibilities to low-paid jobs with difficulties accessing healthcare, and with precarious housing conditions in segregated neighbourhoods, where drug use and violence are often community problems. These conditions worsen their problems with drug use, putting them in critical situations that make seeking treatment with mutual-aid groups a means to survive.

Conclusions

The problems that Mexican migrants face in their efforts to achieve social, economic, political and cultural inclusion in the border region significantly shape their mental and emotional health. The lived experience of the migration process increased the problems that these men were already experiencing in their places of origin, such as drug use. It is important to highlight that the participants in this study migrated to the border region under conditions of extreme precariousness. Most of them were children or young adults experiencing social and economic problems that motivated their migration; thus, they did not have a network that could act as an emotional, social and economic support in the border region.
As mentioned previously, this chapter used a life trajectories approach centred on the process of migration to analyse the subjective experience of drug use (changes, continuities, practices and meanings) and to address its relationship with the social, political, economic and cultural environment in the United States–Mexico border region. In the first stages of their trajectory, mainly in their places of origin, drug use (mainly marijuana and alcohol) was perceived as a recreational practice, but in some cases it was causing family problems because their parents perceived such practices as immoral. Once they migrated to the border region and faced different challenges related to the process of economic and social integration as an undocumented migrant in the US, it is possible to identify drug use (mainly methamphetamine, alcohol, psychotropic pills and crack) as a form of self-care to manage the (emotional and social) difficulties they faced at their destination. They also found social tolerance and easy access to drug use in low-paid informal jobs, since it helped them to improve their performance by working for long periods of time, to the employer’s advantage.

From participants’ perspective, drug use was part of their coping strategies, and it helped them to achieve economic, social and emotional stability. Changing patterns of consumption, like increasing drug use or substituting one drug for another, facilitated their adaptation to their new context for some years. From this perspective, drug use in daily life was among the resources and strategies they had to cope with the challenges of living as an undocumented migrant in the US, such as the fear of deportation, the high cost of living combined with low wages, lack of healthcare access and difficulties with social and cultural integration beyond the margins.

Undocumented migrants in the US were trying to be functional in the economic system and deal with emotional instability – in some cases as a result of not being able to visit their family in Mexico due to the militarisation of the border. Analysing the subjective experience of drug use from the participants’ perspective, I argue, reveals that their understanding of their condition escapes the social framing of drug use as an illness. Focusing attention on their struggles allows us to identify the precarious conditions they faced when settling in the border region. Moreover, their experiences illuminate the lack of support in this region and the easy access to drugs, which reduced the discomfort they experienced in the process of settling into a new context. Yet their drug use experience transforms in later stages after the settlement process in the US, when they experience adverse social, cultural, economic and personal consequences of drug use.

When the experience of using drugs started to lead to other problems, such as not being socially and economically functional, not being
productive at any job and unemployed, unable to be a provider and accomplish the role of the man of the house, and finally becoming homeless, the participants started to seek help and the meaning of using drugs changed. The marginalisation they experienced, not only at structural levels but also interpersonally, led them to seek residential mutual-aid treatment. This was the main source of help that the participants of this study had access to in the border region. The intersubjective experience of treatments that were based on the Twelve Steps and/or religiously oriented shaped their notion of drug use as an illness or suffering related to a spiritual problem; they then realised that they needed help from a therapeutic community to overcome this condition. The social network aiding these people was composed of those who were also marginalised and discriminated against by the health, political and economic system in the US.

Since having a sense of belonging (to a therapeutic community or, in this case, a self-help group) has a significant meaning in the process of recovery, joining this kind of community has improved their experience of social inclusion at the border region. The cases presented in this chapter shed light on the processes of marginalisation that drug users undergo in contemporary society. Furthermore, it reveals migrant men’s capacity to assume active roles in the process of managing the problems associated with drug use through self-care strategies, and their ability to be part of a community that delineates alternative forms of understanding and caring for their health conditions.

Analysing this phenomenon from a CMA perspective contributes to scholarly understandings of the meanings that drug use practices can have in the daily lives of people living in conditions of precariousness, such as migrants in the US–Mexico border zone. This chapter has provided a window on the process of pathologising or criminalising drug use practices alongside an account of how drug use can be a strategy for self-care under stressful and emotional extraordinary conditions. The systematic, structural violence experienced in the border region sheds light on migrants’ lack of resources for help in relation to their mental and emotional well-being, leading to the embodiment of illness experiences related to drug use.

Notes

1. The US Immigration and Customs Enforcement (ICE) implemented a Secure Communities Program from 2008 prioritising the removal of public safety and national security threats – people who have violated the nation’s immigration laws, including those who have failed to comply with a final order removal. This deportation programme relies on partnership among federal, state, and local law enforcement agencies. Nonetheless, most of the people deported have committed minor offences and do not represent a threat to public safety and national security.
2. The original twelve-step programme was devised by Alcoholics Anonymous, founded in 1935 by Bill Wilson and Robert Holbrook Smith. The programme consisted of a set of guiding principles outlining a course of action for alcohol abuse problems. Later it was adapted to address a wide range of alcoholism, substance abuse and dependency problems and has been expanded worldwide.

3. Interview with Valentin in a religious rehabilitation centre in Los Angeles.

4. Interview with Ricardo in a religious rehabilitation centre in Los Angeles.

5. Interview with Dario in a Twelve Step rehabilitation centre in Tijuana.

6. Interview with Martín in an AA group in San Diego.

7. Interview with Alan in a religious rehabilitation centre in Los Angeles.

8. Interview with Alan in a religious rehabilitation centre in Los Angeles.

References


