

Acculturative trajectories descriptions and implications for health among 12 Mexican deported women who inject drugs

Silvia Rodriguez-Montejano,¹ Victoria D. Ojeda,² Ana M. Valles-Medina,³ Adriana Vargas-Ojeda³

Original article

ABSTRACT

Introduction

Between 1999-2007, the U.S. deported 4.8 million migrants to Mexico; of these, 1.1 million migrants were deported to the border city of Tijuana, Baja California. Deportees are often returned to unfamiliar communities where they may experience emotional and socioeconomic stressors that may raise their risk for engaging in unsafe behaviors.

Objective

This exploratory study describes adaptation to the post-deportation environment among Mexican-born injection drug-using women.

Method

In 2008, we conducted qualitative interviews in Tijuana with 12 women reporting U.S. deportation. Our analytic framework focused on acculturation stress, adaptation and social capital in relation to HIV risk, considering a gender perspective.

Results

We found that the stress caused by the deportation experience and acclimating to the post-deportation community may have contributed to the women's participation in high-risk HIV behaviors (e.g., unprotected sex, sex work). Female deportees reported limited access to post-deportation social capital resources (e.g., social support, healthy social networks). Social factors (e.g., discrimination, lack of a government identification) challenged women's resettlement and likely contributed to economic and health vulnerabilities.

Discussion and conclusion

These preliminary findings suggest that deportees may benefit from organized services at repatriation, including mental health screening. Macro-level interventions that address stigma and facilitate deportees' economic integration may help stem engagement in risk behaviors.

Key words: Hispanic women, deportation, Mexico, acculturation, females IDUs, HIV, mental health.

RESUMEN

Introducción

Entre 1999-2007, EE.UU. deportó a 4.8 millones de migrantes a México; de éstos, 1.1 millones fueron deportados a la ciudad fronteriza de Tijuana, B.C. Los deportados a menudo son devueltos a comunidades desconocidas donde pueden experimentar factores estresantes, emocionales y económicos, que pueden aumentar la probabilidad de involucrarse en conductas de riesgo.

Objetivo

Este estudio exploratorio describe las experiencias de mujeres mexicanas que se inyectan drogas en su proceso de adaptación y su ambiente posterior a su deportación.

Método

En 2008, se realizaron entrevistas cualitativas en Tijuana a 12 mujeres deportadas de EE.UU. El marco teórico utilizado para el análisis de las entrevistas fue el estrés aculturativo y el capital social relacionado con el riesgo para adquirir VIH tomando en cuenta la perspectiva de género.

Resultados

Encontramos que la experiencia del estrés aculturativo causado por la deportación de las mujeres entrevistadas pudo condicionar su participación en conductas de alto riesgo para VIH (ejemplo: sexo sin protección, trabajo sexual). Las mujeres reportaron posteriormente, a su deportación un acceso limitado para apoyo social y redes sociales sanas. La discriminación o la falta de una identificación oficial desafiaron el reasentamiento de las mujeres y probablemente contribuyeron a sus vulnerabilidades económicas y de salud.

Discusión y conclusión

Estos resultados preliminares sugieren que los deportados podrían beneficiarse de los servicios organizados de repatriación, incluidos los exámenes de salud mental. Intervenciones a nivel macro que aborden el estigma y faciliten la integración económica de los deportados podrían ayudar a impedir su participación en conductas de riesgo.

Palabras clave: Mujeres hispanas, deportación, México, aculturación, mujeres UDIs, VIH, salud mental.

¹ BA in Psychology, Master in Public Health Graduate Program of the Universidad Autonoma de Baja California (UABC).

² University of California (UCSD), Div. of Global Public Health, Department of Medicine, UCSD School of Medicine.

³ School of Medicine and Psychology of the UABC.

Correspondence: Victoria D. Ojeda, PhD., Division of Global Public Health, University of California, San Diego School of Medicine. Institute of the Americas 10111 N. Torrey Pines Road, Mail Code 0507. La Jolla, CA 92093-0507, USA. E-mail: vojeda@ucsd.edu

Received first version: May 6th., 2014. Second version: May 13th., 2015. Accepted: May 29th., 2015.

INTRODUCTION

Since 2008, U.S. immigration policies have emphasized deportation, a type of forced return migration of unauthorized and criminal aliens.¹ Between 2008-2011, 1 million Mexicans have been deported.² Most migrants deported from the U.S. are Mexican nationals (86% in 2010),³ and many are returned to border cities such as Tijuana, Baja California, adjacent to San Diego, California. Tijuana is a major deportee receiving community: more than 100 000 persons are annually returned to Mexico via this border city.^{4,5}

Despite the high volume of deportees returned to Mexico, little is known about the health consequences of this type of forced migration. This situation creates an opportunity for studying the conditions of deportation,⁶ and by extension, the post-deportation experience.

Migrants may be deported from the U.S. for numerous reasons: some are detained while crossing the border, whereas legal permanent residents who violate immigration laws or have legal offenses may be expelled after many years of U.S. residence.* Ruben et al.⁷ conceive return migration as a complex multidimensional process that may be equivalent to arriving in a new place, so the need to acculturate to a new context. Acculturation is considered to be a multi-dimensional process in which individuals and groups undergo stages of adjustment in several domains: language, socioeconomic status, social networks, cultural orientation and status, as they adapt to a new cultural environment.⁸ This process may result in a phase of acculturative stress,^{9,10} which is conceptualized as the sum of factors that contribute to the subjective experience of this transition.**,^{11,12}

Prior studies have documented an association between higher acculturative stress and a poor health status (e.g., anxiety, depression, feelings of marginalization and alienation, increases in psychosomatic symptoms, identity confusion).^{9,13-15}

Different pathways have been identified as migrants cope with the demands resulting from adaptation to a new environment.¹⁶ Early acculturation research focused on studying the individual characteristics,^{17,18} while recent research considers eco-developmental contextual variables (e.g., social networks, neighborhood resources, racial/ethnic discrimination),¹⁹ which can greatly influence an individual's acculturative trajectory.²⁰ Thus, some²¹ suggest analyzing not only individual-level influences (e.g., psychological well-being, perceived discrimination), but also contextual-level factors, including social capital.²² Social capital refers to all cooperative, trusting and reciprocal social relationships, and community resources,²³⁻²⁶ which promote sociocultural adjustment and thus relieve the acculturative stress.²³⁻²⁷

* Passel JS. Unauthorized migrants: Number and characteristics. Background briefing prepared for Task force on immigration and America's future. Washington, 2005.

** Mand K. Social capital and transnational South Asian families: rituals, care and provision. Families & Social Capital ESRC Research Group Working Paper 2006; (18).

Given the dearth of research on deportation and its implications for the health and well-being of migrants, this exploratory qualitative study describes women's experiences in and adaptation to the post-deportation environment; we propose these are their "acculturative trajectories". We also describe instances in the post-deportation environment that may reflect a vulnerability to risk behaviors. Our study may inform areas for future research in a larger population of female deportees.

METHODS

Study population & recruitment

The present study is a secondary analysis of the longitudinal cohort study "*Proyecto El Cuete*" (*cuete* is 'slang' for syringe in Tijuana, and it also means to be drunk or high) of HIV-related risk behaviors and co-morbidities among IDUs living in Tijuana, Mexico. As previously described,²⁸ participants ≥ 18 years old with evidence of recent injection drug use were recruited into a prospective study using respondent-driven sampling.²⁹ For this cross-sectional sub-study focused on deportation and potential implications for drug use and HIV risks, we first generated a list of IDUs in the prospective study which reported deportation from the United States. Of the 1 056 study participants, <15% ($N = 157$) were women, 36 of whom reported being deported from the U.S. In October 2008, outreach workers invited all women who were not lost to follow-up (i.e., moved away, deceased, or could not be located) to participate in the study ($n = 12$). After undergoing voluntary and informed consent, 12 women underwent one-time qualitative interviews and were reimbursed U.S. \$20 for their time. The Human Research Protections Program of the University of California, San Diego, and the Ethics Board of the Tijuana General Hospital approved the study protocols.

Research design

The design was based on constructivist epistemology where a feminist theoretical perspective was adopted. Constructivism states that meaning is constructed not discovered; thus, subjects construct their own meaning in different ways, even in relation to the same phenomenon. Hence, multiple, contradictory but equally valid accounts of the world can exist. Secondly, using gender perspective as an analytic tool³⁰ (not as substitute for women's history), allows us to better understand women's experiences and testimonies from their standpoint.^{31,32}

Qualitative interview data collection

Between October and November 2008, trained bilingual interviewers conducted semi-structured interviews in private interview rooms in Tijuana's *zona roja* (red light district). Inter-

views were conducted either in English or Spanish according to women's preferences and lasted 1-2 hours. Women were queried on their migration, deportation, drug and sex experiences in the United States and Mexico, and they responded to a broad range of questions such as: "Please, tell me why you were deported from the United States," "Tell me about your drug use in the United States," "Describe what happened the last time you were deported" and "What has your life been like in Tijuana?" Interviewers asked women to focus on their most recent deportation because many experienced multiple deportations. Questions were generated in part based on published studies with Mexican migrants in the U.S.^{33,34} Interviews were digitally recorded and transcribed. All transcripts were analyzed in the language of interview in order to preserve participants' means of expression, which was often bilingual and contained terminology specific to the local economic and drug subculture of Tijuana.

Approach to qualitative data analysis

The interview data was analyzed using grounded theory methods³⁵ and context-driven methodology³⁶ to discover underlying concepts and to understand or interpret each participant's narrative.

A list of codes that would enable the researchers to categorize the interview data based on topics included in the interview guide (i.e., a priori codes) was developed. The list of codes also included emergent codes which were created based on the reading of the transcripts and which were reflective of acculturative stress and social capital concepts. Specifically, based on previous literature,²² a consensus list of codes for acculturative stress indicators was built and included: lack of control, financial stress, feelings: depression, loneliness, frustration; lack of social support; and lack of formal ways to earn a living. The same procedure was followed to identify post-deportation social capital resources; these included the following codes: family bonding, social support, community resources. Next, the researchers read several cross-sections of interviews, revising the coding scheme as necessary. The first author, co-author, and Principal Investigator discussed and resolved discrepancies by refining code definitions. Throughout the analysis, emergent themes were discussed and illustrative quotations of key concepts were compiled. All coding of transcripts was done by hand. All Spanish language quotes were translated into English by the first author for brevity.

RESULTS

Participant's characteristics

The participants' ages ranged from 29 to 53 years, with a median of 38 years at the time of the interview; six women were

interviewed in English; and the other six in Spanish. The age in which women migrated to the U.S. ranged from <1 year to 20 years; the median age of U.S. migration was 10 years. Interviews occurred four to 10 years since women's last deportation; on average, participants resided in Tijuana for five years since their last deportation. All participants used drugs in the U.S.; 83% started to inject drugs in the U.S. between the ages of 17 and 27 years. None of the study participants tested positive for HIV at the time of the parent study's baseline interview. All participants had felonies or misdemeanors related to their drug use, as well as other felonies/misdemeanors (e.g., illegal residence in the U.S., drug dealing, armed robbery, domestic violence and murder). Most women spent time in jail and were deported soon thereafter. Three-quarters of participants reported any lifetime experiences in drug rehabilitation programs, with an abstinence period that varied from three months to 10 years (Table 1).

Acculturative stress post-deportation

On average, the 12 women resided in the U.S. for 25 years; the range of residence in the U.S. was from nine to 35 years. Women reported limited contact with Mexico prior to their deportation. Below, we discuss emergent themes related to acculturative post-deportation stress that were identified in women's narratives, highlighting several examples using women's voices. Generally, women experienced an overwhelming affective experience (e.g., intense and painful emotions, such as anxiety, fear, sadness) that may have interfered with their problem-solving and judgment capabilities and which may have made them vulnerable to abusive experiences. For all women, the immediate experience after being released in a Mexican border city was overwhelming, as one expressed: "[...]when I saw myself in Tijuana, it drove me crazy!!! [...]It really messes with your mind 'cause what am I gonna do, how am I gonna pay this?" (41 years old, resided in the U.S. since age 10, was deported three months prior to the interview). The affective experience appeared to interfere with female deportees' capacity to solve problems and seek alternatives; most participants expressed that they felt paralyzed and found drug use to be their only option: "I got drunk [...] I was paranoid. I was scared, so I just stayed there (in a hotel in Tijuana)[...]" (36 years old, resided in the U.S. since age two, was deported four years prior to the interview). Another participant recalled: "I was very scared, a guy offered me drugs so that I could calm down" (53 years old, resided in the U.S. since age three, was deported two years prior to the interview). The emotional impact of the deportation process also seemed to increase female deportees' vulnerability to abusive experiences, as one woman narrated: "[...]after being deported I felt sad and scared, an old man approached me and told me he was going to help me[...] but he kidnapped me[...] he started to inject heroin in my arm so that I could be sold as a prostitute" (31 years

Table 1. Participant characteristics of deported women who inject drugs in Tijuana, Mexico, 2008

	Mean or Percent	N
Language of the interview		
Spanish	50%	6
English	50%	6
Age in years (range)	38.1 (27–50)	12
Birth state		
Baja California	58%	7
Jalisco	25%	3
Chihuahua	8%	1
Guerrero	8%	1
Length of time since last visited the U.S. in years (range)	9.4 (0.5–43)	12
Has lived in Tijuana entire life		
Yes	17%	2
No	83%	10
If not lifetime resident of Tijuana, duration of residence in Tijuana in years (range)	7.3 (0.5–30.2)	12
Self-reported sexually transmitted disease diagnoses, lifetime		
Yes	25%	3
No	75%	9
HIV test result at initiation of study		
Positive	0%	0
Negative	100%	12
Syphilis test result at initiation of study		
Positive	17%	2
Negative	83%	12
Age of initiating drug use in years (range)	14.3 (11–19)	12
First drug(s) used		
Marijuana	67%	8
Marijuana and snorted/smoked cocaine	17%	2
Marijuana and tranquilizer pills	8%	1
Smoked methamphetamine	8%	1
Age of first injection drug use in years (range)	21.6 (12–34)	12
First drug injected		
Heroin	75%	9
Crack/Cocaine	25%	3
Entered drug treatment program, lifetime		
Yes	58%	7
No	42%	5

Note: Some percentages may not add up to 100% due to rounding.

old, resided in the U.S. since age 15, was deported six years prior to the interview).

Social and economic adaptation to deportation

Following their deportation, women generally reported a dearth of social and economic resources. Six female deportees stayed with other female deportees following their repatriation and rented a room; other three were homeless and stayed on the streets as they waited for their families to send them money; three accepted shelter from men who offered them assistance. Women often found themselves in Tijuana,

a foreign city, and Mexico, a country where they had not lived for many years. Women reported that the stigma of being a deportee was equal to being perceived as a criminal; feelings of stigmatization were amplified by the track marks (i.e., injection stigmata) resulting from their drug use. These factors reportedly made that our sample of female deportees who are IDUs vulnerable to discrimination and constant police harassment.

The lack of financial resources following their deportation became an important stressor. Most women had limited amounts of money at the time of deportation and some were helped by their families. However, over time, they found that employment in the formal economy and, more generally, income-generating opportunities were limited. One factor that complicated women's access to employment opportunities and their integration to the Mexican society was their lack of access to an official government identification. Notably, most participants lacked legal documents to establish their identity as Mexican nationals. Consequently, women typically worked in the informal economy as waitresses, dancers, shoe shiners, and some women established relationships with people who took care of them. All participants engaged in sex-work in order to earn money: "[...]I had to sell myself because I didn't have money to survive" (52 years old, resided in the U.S. since age 10).

Long-term adaptation: developing post-deportation social networks

Following their deportation, female deportees described building social networks, mainly with other IDUs in Tijuana. Nearly all women (92%) established romantic relationships with other drug users in the immediate post-deportation period. As one woman narrated: "In the border I met a guy who offered me drugs[...] he became my partner, we have fought for drugs, he even has sent me to other males in order to bring him drugs" (39 years old, taken to the U.S. by her husband at age 20, was deported 10 years prior to the interview). Another participant expressed: "[...]I got involved with this guy, as addicted as me to drugs, and it has been a life of suffering, he messes with my plans, and I can't get rid of him, because he threatens me[...]" (40 years old, migrated to the U.S. at age 12, was deported three years prior to the interview).

Chronic mental health problems

Women's narratives suggest that their mental health was compromised, since all women reported "negative affectivity" (i.e., a general disposition to experience negative mood states: fear, sadness, guilt, hostility, fatigue, shame, irritability, distress)* that contributes to their cycling between sobri-

* Watson, David & Clark, Lee-Anna. (1994). THE PANAS-X Manual for the Positive and Negative Affect Schedule- Expanded form (pp. 27). Retrieved from <http://www.psychology.uiowa.edu/faculty/clark/panas-x.pdf>

ety and drug addiction. As one narrative exemplifies: "[...] the more sober you are, the more pain you feel in your heart, and by using [drugs], it numbs the pain" (38 years old, taken to the U.S. at one month, was deported five years prior to the interview).

Sex work further compounded women's negative affectivity: "[...]I felt dirty, because I was selling my body, I never thought that I was going to do this, I had a perfect life, and that's one of the reasons why I started using heroin: To deal with the fact that I have to have somebody getting on top of me for money" (36 years old, taken to the U.S. at age two, was deported four years prior to the interview). We found also a pattern of negative self-criticism and shame related to their drug use that in turn influences their social relationships: "[...]You know, I could get in touch with my family, but I feel so ashamed if they found out that I'm in heavy drugs" (39 years old, taken to the U.S. at age 20 by her husband, was deported 10 years prior to the interview).

Social capital

Loss of family networks

All participants belonged to an extended family (i.e., husband, children, parents, uncles, cousins) that lived in the U.S. All women had trouble with their family members while they lived in the U.S. due to their drug use. Nevertheless, women's families continued to support them in their daily living (e.g., paying rent, taking care of their children, bailing them out of jail, enrolling or financing rehabilitation programs, among others). All participants' families were interested in helping them in the post-deportation period: some sent money or searched for them in Tijuana and helped to situate them in a safe place. As one woman narrated: "My family came to look for me, they had flyers with my picture everywhere in *Zona Norte* [Tijuana's red light district near the U.S.-Mexico border], and they actually found me that same day" (53 years old, resided in the U.S. since age three, was deported two years prior to the interview). However, when women got involved in drugs and sex-work, most female deportees became isolated from their families: "When I started using [drugs], what my mom used to send me wasn't enough, I started working in bars, and then I lost communication with my family, I don't know where they're at, they don't know where I'm at" (36 years old, taken to the U.S. at age two, was deported four years prior to the interview). Negative affectivity in relation to women's drug use was reported as a central factor leading to women's isolation from family networks:

"My habit is getting too much, and I don't want them to see me like this. Because I don't want to lose the little respect they still have for me [...]I know they're worried, because they don't know where I'm at, but I'd rather prefer whatever they're thinking, it's better than knowing that I'm getting loaded and living in Tj" (33 years old, lived in the U.S. since age 11, was deported six years prior to the interview).

Post-deportation access to non-governmental and governmental programs

Women knew of some programs that provide condoms, HIV testing, or syringe exchange. Other non-governmental programs provide women with shelter and food, and one participant reported that an organization had helped her to re-establish contact with her family and supported her with employment options: "I was in this shelter where I felt safe; they provided me with food and employment options, and also were interested in locating my family again to remain in touch" (53 years old, resided in the U.S. since age three, was deported two years prior to the interview).

DISCUSSION AND CONCLUSION

This exploratory qualitative study describes women's experiences in adapting to the post-deportation environment, specifically in the U.S.-Mexico border city of Tijuana. While none of the participants in this study tested positive for HIV at the baseline interview, the data nevertheless provide insight into moments in the post-deportation environment that may rise female deportees' risk for HIV. To understand Mexican women's post-deportation experiences, we found that participants' acculturative trajectories²⁰ to life in Tijuana are complicated by several issues, including affective reactions to the deportation process and social barriers to resettlement. These women's local and personal experiences should be seen as both global and political experiences.^{31,37}

Our data suggest that the deportation experience creates an affective reaction that may increase the likelihood that women will engage in high-risk behaviors (e.g., drug use, unprotected sex), as documented elsewhere.³⁸⁻⁴¹ Studies with refugees have identified a relationship between depressive symptomatology and cognitive impairment that makes the acculturation process difficult.⁴²⁻⁴⁸ High-risk behaviors have also been associated with the dissolution of family support networks, homelessness, long-term unemployment and poverty.⁴⁹⁻⁵² We found that women's reduced access to social capital resources, including their social networks, may have played a role in their engagement in unsafe behaviors. Our findings also underscore the need for epidemiological data on the mental health status of female deportees, particularly among those affected by substance dependence. Mental health services are scarce in Mexico.⁵³ However, additional studies of the impact of mental health services on deportees' health outcomes are needed as targeted programs may serve to reduce deportees' participation in high-risk behaviors. We utilized a feminist perspective and believe that the testimonies are not simply anecdotal evidence, a perspective which would minimize the significance of these events. Instead, through their testimonies it can be seen how women live the phenomenon of deportation.^{31,37}

Analyzing the risk environments where deportation and (re)acculturation to Mexican society occur, we found that being deported is a reason for being discriminated, victimized and stigmatized; these social responses are exacerbated by women's drug use and the resulting stigmata (i.e., injection marks) from injecting drugs. Tijuana's Secretary of Government recently stated: "It is a constant problem, when they [deportees] come back, they are in an unknown place, with no acquaintances, no money, so they are easy prey for the mob who has been recruiting them".⁵⁴ In our study, deportation and drug use challenge women's post-deportation relationships with their families and society and contribute to their marginalization, thus reducing deportees' access to social capital and related resources. Others have documented that drug use and incarceration are frequently stigmatized,^{55,56} although the degree of stigma is greater for women because of gender-based stereotypes that hold women to different standards.^{57,58} Stigma may result in prejudice and discrimination that can be direct, structural or internalized,⁵⁹ the latter may be expressed as "shame and guilt" that limits help-seeking intentions and compromises access to health care, drug treatment, employment and housing. Thus, the possibility of drug use relapse and individuals' mental health problems may be exacerbated by stigma experienced by deportees. These behaviors and conditions were observed in our participants' narratives. Participants engaging in undesirable activities (e.g., drug use, deportation) are often punished,⁶⁰ which may increase the risk of victimization or exploitation or may force individuals to return to dangerous situations.⁶¹ Stigmatizing experiences were reported by all participants and have been previously documented in Tijuana.⁶²

Community responses to the influx of deported migrants merit consideration as they may affect policy development and resource allocation at local, state and federal levels.⁶³ The number of deportations of unauthorized and criminal aliens has increased annually since 2008¹ and includes 1 million Mexican deportees in the 2008-11 period.² The large volume of deportees (300 to 500 daily) arriving to Tijuana⁵⁴ may overwhelm governmental and non-governmental agencies' capacities to meet their needs. In response, Mexico's National Institute of Migration recently implemented a program that enables deportees to return home. Yet, this service may be limited to those carrying an official government identification. Thus, for example, few migrants (<400) arriving to Baja California utilized this service during the first six months of 2011.⁶⁴ The well-being of deportees will remain a significant issue for Tijuana and other border communities especially as many deportees stay in Tijuana to await U.S. re-entry or form new lives.⁶⁵ A combination of macro- and micro-level interventions may be warranted in order to aid deportees' reintegration into Mexican society and ensure their health and well-being. In particular, mechanisms that enable deportees' to re-establish their identity

appear to be needed; access to these documents may reduce social and economic vulnerabilities post-deportation.

Our findings must be interpreted in the light of the following limitations. We selected participants based on self-reported deportation and cannot confirm removal events. The small sample did not permit us to achieve saturation of themes. The self-reported data may have been affected by recall bias. Participants' lengthy histories of drug use could compromise their capacity to recall the chronology of life events. This exploratory study is a secondary analysis and the interviews were not addressed to inquire about their mental health or risk behaviors in specific. Data on factors that limited women's access to a government identification are unavailable as we did not probe for this topic. However, we are exploring this issue in ongoing studies given the importance of legal documentation to resettlement experiences.

Given the pilot nature of this study and its focus on understanding the deportation process and its health and social implications, we were unable to conduct additional HIV testing to assess seroconversion; the data suggest that longitudinal studies with deportees are needed. Although we did not assess participants' mental health status, women's narratives suggest that their mental health is compromised. Future studies should assess the mental health status of deportees to determine the nature and scope of services needed; such services may potentially reduce opportunities for illicit drug use but this requires further study. Despite these limitations, our participants' stories provide a compelling view of the diverse challenges female migrants face in a post-deportation society as they attempt to re-establish their lives. Our study provides important novel data that can inform the development of additional studies examining the psychosocial impacts associated with deportation, particularly vis-à-vis HIV risk behaviors and transmission.

Our preliminary findings suggest that following deportation female deportees are in need of organized assistance which may help them reduce their engagement in HIV risk behaviors (e.g., sex work). Ruben et al.⁷ argue that the forced return can only become sustainable when returnees are provided with possibilities to become re-embedded in terms of economic, social network and psychosocial dimensions. In working with refugees, Ruben et al. find that post-return assistance by a non-governmental organization was particularly helpful when financial support is combined with human guidance and practical information.⁷ Without access to post-deportation health, social, and economic services, deportees in border communities, such as Tijuana, may continue to be stigmatized and marginalized.⁶⁵ Deportees may benefit from programs that aid them in accessing social capital resources in Mexico and the U.S. as social capital may be important in mitigating the negative effect resulting from deportation and may limit deportees' engagement in high-risk behaviors that may contribute to their acquisition of blood-borne infections.

This research gave voice to women who are marginalized in our society. It shows the multidimensional problems they face. Also, most of the women no longer identify themselves as Mexican or as Americans. We might say they feel they belong to non-place, and society itself considers them neither from here nor from there, a situation which Mark Augé describes as "if a place can be defined as relational, historical and concerned with identity, then a space which cannot be defined as relational, or historical or concerned with identity will be a non-place".⁶⁶ Additional qualitative research with a larger sample of female deportees is needed to understand these complex issues. We suggest that this population would be an excellent group to include in future research that focuses on the concept of intersectionality, which has been posed more as a nodal point than as a closed system, a gathering place for open-ended investigations of the overlapping and conflicting dynamics of race, gender, class, sexuality, nation, and other inequalities.⁶⁷

Funding

None.

Conflict of interests

The authors declared no conflicts of interest with respect to the authorship and/or publication of this article.

Acknowledgements

We thank the women who shared their lives with us by participating in this study. Funding for this study was provided by: the AIDS International Training Research Program (AITRP) Funded by FIC & NIDA. Grant 1D43TW008633-01, the UCSD Academic Senate Grant RI296H-OJEDA, and the National Institutes of Health, National Institute on Drug Abuse Grants K01DA025504 and R01 DA019829. We also acknowledge funding from the following sources: the UC Global Fellowship funded by the Fogarty International Center of the National Institutes of Health under Award Number R25TW009343.

REFERENCES

1. Transactional Records Access Clearinghouse (TRAC). Immigration enforcement since 9/11: A reality check. Syracuse, New York: Syracuse University, 2011.
2. Cave D. Crossing over, and over. New York Times; October 3; 2011.
3. US Department of Homeland Security. 2009 Yearbook of immigration statistics. Washington: 2010.
4. Rangel MGM-D, Hovell MF, Santibanez J, Sipan CL et al. "Prevalence of risk factors for HIV infection among Mexican Migrants and Immigrants: Probability Survey in the north border of Mexico", *Salud Pública Mexicana* 2006;48(1):3-12.
5. Secretaría de Gobernación de México. Encuesta sobre migración en la frontera norte de México EMIF. Ciudad de México. México: 2007.
6. Black RGS. Sustainable return in post-conflict contexts. *International Migration* 2006;44(3):15-38.
7. Ruben RV-H, Davids T. What determines the embeddedness of forced-return migrants? Rethinking the role of pre and post return assistance. *International Migration Review* 2009;43(4):908-937.
8. Olmedo E. Acculturation: a psychometric perspective. *American Psychologist* 1979;34(11):1061-1070.
9. Berry JWK, Minde T, Mok DC. Comparative studies of acculturative stress. *Int Mig Rev* 1987;21:491-511.
10. Berry JW. Conceptual approaches to acculturation. In: Chun KM, Marin G (eds.). *Acculturation: Advances in theory, measurement and applied research*. Washington, DC: American Psychological Association; 2003; pp.17-37.
11. Cohen SM. Social support, stress and the buffering hypothesis: A theoretical analysis. In: Baum A, TSEaSJE (ed.). *Handbook of psychology and health*. Hillsdale, NJ.: Erlbaum; 1984: pp.253-267.
12. Williams CB, Jonh W. Primary prevention of acculturative stress among refugees: Application of psychological theory and practice. *American Psychologist* 1991;46:632-641.
13. Crockett LJ, Iturbide MI, Torres Stone RA, McGinley M et al. Acculturative stress, social support, and coping: Relations to psychological adjustment among Mexican-American college students. *Cultural Diversity and Ethnic Minority Psychology* 2007;13(4):347-355.
14. Hovey JDM. Acculturative stress, anxiety and depression among Mexican immigrant farmworkers in the Midwest United States. *J Immigr Health* 2000;2:119-131.
15. Walker RL, Wingate LR, Obasi EM, Joiner TE Jr. An empirical investigation of acculturative stress and ethnic identity as moderators for depression and suicidal ideation in college students. *Cultural Diversity and Ethnic Minority Psychology* 2008;14(1):75-82.
16. Wandersman A, Naton M. Urban neighborhoods and mental health: psychological contributions to understanding toxicity, resilience, and interventions. *American Psychologist* 1998;53(6):647-656.
17. Cuellar IAB, Maldonado R. Acculturation rating scale for Mexican Americans-II: a revision of the original ARMSA scale. *Hispanic J Behavioral Sciences* 1995;17(3):275-304.
18. Cuellar IHL, Jasso R. An acculturation scale for Mexican American normal and clinical populations. *Hispanic J Behavioral Sciences* 1980;2(3):199-217.
19. Lopez-Class MG-C, Ramirez A. Conceptions of acculturation: A review and statement of critical issues. *Social Science Medicine* 2011;72:1555-1562.
20. Castro FG, Marsiglia FF, Kulis S, Kellison JG. Lifetime segmented assimilation trajectories and health outcomes in Latino and other community residents. *American J Public Health* 2010;100(4):669-676.
21. McLeroy KR, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. *Health Promotion Quarterly* 1988;15(4):351-377.
22. Bhattacharya G. Global contexts, social capital, and acculturative stress: Experiences of Indian immigrant men in New York City. *J Immigrant Minority Health* 2011;13(4):756.
23. Coleman J. *The foundations of social theory*. Cambridge, MA: Harvard University Press; 1990.
24. Institute of Medicine. *The future of public health in the 21st century*. Washington, DC: National Academy Press; 2001.
25. Holtgrave DC. Social capital, poverty, and income inequality as predictors of gonorrhea, syphilis, chlamydia, and AIDS case rates in the United States *Sex Trans Infect* 2003;79:62-64.
26. Portes AL. The downside of social capital. *The American Prospect* 1996;26:18-21.
27. Campbell CJ. Health, community and development: Towards a social psychology of participation. *J Community Applied Social Psychology* 2000;10:255-270.
28. Strathdee SA, Lozada R, Pollini RA, Brouwer KC et al. Individual, social, and environmental influences associated with HIV infection among injection drug users in Tijuana, Mexico. *J Acquir Immune Defic Syndr* 2008;47(3):369-376.
29. Heckathorn D. Respondent-driven sampling: a new approach to the study of hidden populations. *Soc Probl* 1997;44(2):174-199.
30. Scott JW. Reflections on women and gender in twentieth-Century Mexico: Introduction. *Gender History* 2008;20(1):149-151.

31. Bach AM. El rescate del conocimiento. *Temas Mujeres: Revista CE-HIM* 2010;6(6):6-31.
32. Harding S. *Feminism & methodology*. Bloomington, IN: Indiana University Press; 1987.
33. Apostolopoulos Y, Sonmez S, Kronenfeld J, Castillo E et al. STI/HIV risks for Mexican migrant laborers: exploratory ethnographies. *J Immigr Minor Health* 2006;8(3):291-302.
34. Chavez LR. *Shadowed lives: Undocumented Immigrants in American Society*. Third ed. Belmont, CA: Wadsworth Cengage Learning; 2013.
35. Strauss ACJ. *Basics of qualitative research: grounded theory procedures and techniques*. Newbury Park, CA: SAGE; 1990.
36. Denzin NLY. *Handbook of qualitative research*. Thousand Oaks, CA: Sage Publishers; 2000.
37. Haraway DJ. Leyendo a BuchiEmecheta: "Pugnas por la experiencia de las mujeres en los estudios de mujer". *Ciencia, cyborgs y mujeres. La reivención de la naturaleza*. Madrid: Ediciones Cátedra. Universitat de Valencia. Instituto de la Mujer; 1995: pp.183-2012.
38. Marlatt AGG. *Relapse prevention: maintenance strategies in the treatment of addictive behaviors*. New York: Guilford Press; 1985.
39. Kressin NS 3rd, Skinner KM. Negative affectivity and health-related quality of life. *Med Care* 2000;38(8):858-867.
40. Denner JO, Dupree JD, Thrush G. Predictors of HIV transmission among migrant and marginally housed Latinos. *AIDS Behav* 2005;9:201-210.
41. Kim-Goodwin VB. Stress among migrant and seasonal farmworkers in rural southeast North Carolina. *J Rural Health* 2004;20:271-278.
42. Beiser M, Hou F. Language acquisition, unemployment and depressive disorder among Southeast Asian refugees: 10-year study. *Social Science Medicine* 2001;53:1321-1334.
43. Chung RC, Kagawa-Singer M. Predictors of psychological distress among Southeast Asian refugee. *Social Science Medicine* 1993;36:631-639.
44. Hinton WL, Tiet Q, Tran CG, Chesney M. Predictors of depression among refugees from Vietnam: A longitudinal study of new arrivals. *J Nervous Mental Disease* 1997;185:39-45.
45. Nicassio PM, Soloman G, Guest S, McCullough JE. Emigration stress and language proficiency as correlates of depression in a sample of Southeast Asian Refugees. *International J Social Psychiatry* 1986;32:22-28.
46. Sondergaard HP, Theorell T. Language acquisition in relation to cumulative posttraumatic stress disorder symptom load over time in a sample of resettled refugees. *Psychotherapy Psychosomatic* 2004;73:320-323.
47. Westermeyer J, Neider J, Callies A. Psychosocial adjustment among refugees during their first decade in the United States. *J Nervous Mental Disease* 1989;177:132-139.
48. Ying Y, Akursu PD. Psychological adjustment of Southeast Asian refugees: The contribution of sense of coherence. *J Community Psychology* 1997;25:125-139.
49. Soskolne VSR. Migration and HIV prevention programmes: linking structural factors, culture, and individual behaviour-an Israeli experience. *Soc Sci Med* 2002;55:1297-1307.
50. McMichael A. Environmental and social influences on emerging infectious diseases: past, present and future. *Philos Trans R Soc Lond B Biol Sci* 2004;359:1049-1058.
51. Mayer J. Geography, ecology and emerging infectious diseases. *Soc Sci Med* 2000;50:937-952.
52. Hawkes SHG. Travel, migration and HIV. *AIDS Care* 1993;5:207-214.
53. Borges G, Wang PS, Medina-Mora ME, Lara C et al. Delay of first treatment of mental and substance use disorders in Mexico. *Am J Public Health* 2007;97(9):1638-1643.
54. Gomez Sevilla K. Tijuana no quiere repatriados: Alcide. *El Sol Tijuana*; 2011.
55. Link BS, Rahav M, Phelan JC, Nuttbrock L. On stigma and its consequences: evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *J Health Soc Behav* 1997;38:177-190.
56. Luoma JT, Waltz T, Hayes SC, Roget N et al. An investigation of stigma in individuals receiving treatment for substance abuse. *Addict Behav* 2007;32:1331-1346.
57. O'Brien P. *Making it in the free world: Women in transition from prison*. Albany, NY: SUNY Press; 2001.
58. Haraway D. Situated knowledges: The science question in feminism and the privileged of partial perspective. *Feminist Studies* 1988;14(3):575-599.
59. Link BPJ. Conceptualizing stigma. *Annu Rev Sociol* 2001;27:363-85.
60. Van-Olphen J, Eliason MJ, Freudenberg N, Barnes M. Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment, Prevention and Policy* 2009;4(10):1-10.
61. Aidala AC, Stall R, Harre D, Sumartojo E. Housing status and HIV risk behaviors: Implications for prevention and policy. *AIDS Behavior* 2005;9(3):251-265.
62. Strathdee SA, Fraga WD, Case P, Firestone M et al. "Vivo para consumirla y la consumo para vivir" : high-risk injection behaviors in Tijuana, Mexico. *J Urban Health* 2005;82(3):58-73.
63. El Universal. Migrantes 'engorsan' problemas de ciudades. México: El Universal; 2011.
64. Millan O. In Tijuana, deported migrants struggle to survive. *Associated Press*. August, 5; 2011.
65. Strathdee SA, Magis-Rodriguez C. Mexico's evolving HIV epidemic. *JAMA* 2008;300(5):571-573.
66. Augé M. *Los no lugares: Espacios de anonimato. Una antropología de la sobremodernidad*. Barcelona: Gedisa; 2000.
67. Cho S, Crenshaw KW, McCall L. Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: J Women Culture Society* 2013;38(4):785-810.