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THE LINGERING ACHE: TEMPORALITIES OF ORAL HEALTH SUFFERING IN UNITED STATES-MEXICO BORDER COMMUNITIES

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Recent scholarship theorizes temporalities as an important part of the migration experience, with temporal insecurity being a crucial element of (im)mobility and inequality via the phenomenon of waiting. In this article, we examine how temporalities and experiences of waiting influence health status and access to care, using ethnographic data to articulate how temporalities impact resources and how a doxa of waiting is enacted, placing some groups at heightened risk of illness and pain compared to others. Drawing upon a sample of 100 immigrant families with mixed legal status living in United States-Mexico border communities, we focus on an understudied area in anthropology: oral health concerns. We illuminate the precarious social contexts of these families and illustrate how they navigate a variety of temporally available dental care options. By centering temporalities in our analysis, we show that the quest for care is characterized by waiting, a state that is naturalized for migrant populations who may be deemed less deserving of resources. Waiting produces forms of violence that are incremental and cumulative yet ultimately rendered invisible precisely because of its long duration. A focus on temporalities highlights the unique strengths, risks, and needs of communities, which are key to addressing health equity.

Keywords: mixed-status families, oral health, dental care, temporalities, undocumented

Recent scholarship theorizes temporalities as an important part of the migration experience since human mobility involves movement across space and encompasses layered, complex experiences with time (De Genova, 2019; Jacobsen et al., 2021). Specifically, the phenomenon of *waiting* emerges as a powerful temporal construction governing the lives of migrants, and ethnographers frequently encounter temporal insecurity as a crucial element of (im)mobility and inequality (Jacobsen et al., 2021).

Here, we examine how temporalities and experiences of waiting due to migrant social and legal status produce differential health outcomes and experiences of access to care. We unravel how migrant vulnerabilities vary across time, using ethnographic data to show how temporalities factor into availability of resources and enact a "doxa of waiting" (Andaya, 2017), placing some at increased risk of illness and pain. Drawing upon a sample of 100 Latino immigrant families with mixed legal status living in United States-Mexico border communities, we focus on an understudied area in anthropology: oral health concerns. We illuminate the precarious social contexts of families and illustrate how they navigate various temporally available care options. By centering temporalities, we illustrate that the quest for dental care is characterized by waiting, a naturalized state for migrant populations deemed less deserving of resources.

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Epidemiological studies have consistently found that Mexican Americans, in particular, have some of the poorest oral health outcomes (Dye et al., 2012). Early childhood caries can influence future oral health status (Casamassimo et al., 2009; Chang et al., 2018; Peretz et al., 2003) and psychosocial well-being (Anil & Anand, 2017; Chang et al., 2018) and has been linked to later chronic illnesses such as heart disease (Beck et al., 1996) and cancer (Michaud et al., 2007). These wide-ranging systematic interactions illustrate that poor oral health is not a bounded affliction in the life course but instead influences future vulnerabilities.

We argue for more attention to the temporal component of dental illness—that is, the social implications of diseased teeth, the lived experience of pain and suffering, and the wait to access care. Waiting, as we show, produces forms of violence that are incremental and cumulative yet rendered invisible precisely because of the long duration of suffering across the life course. A focus on temporalities highlights the disciplinary practices of dental health care regimes that reflect broader structural barriers encountered by mixed-status migrant families. Contextualizing and addressing these health phenomena in relation to the unique strengths, risks, and needs of Latino communities within certain cultural contexts is key to addressing health equity (Ruiz et al., 2016).

Access to Dental Services for Mexican-American Mixed-Status Families

Hispanic children in the United States are nearly twice as likely to have untreated dental caries as their non-Hispanic White counterparts (Dye et al., 2012). These disparities are stark for those of Mexican origin. For instance, 23.8% of Mexican children in the United States experience untreated dental caries versus 16.7% of non-Hispanic White children. Mexican adults fare similarly, at 40.0% versus 27.1% for non-Hispanic Whites (Dye et al., 2012).

A large segment of Mexican nationals in the United States, especially those in border states, live in mixed-status families due to the historically close interrelationship between the United States and Mexico and especially to enduring kinship ties on both sides of the border. Currently, an estimated 4.6 million mixed-status families live in the United States. These vary in composition and may include undocumented members, people with United States citizenship, those with permanent legal residency status, and others in legal limbo through temporary protected status or deferred action programs (Wasem, 2012). Mixed-status families now represent a primary and enduring feature of the contemporary immigrant experience. Nationwide, at least 16.7 million people belong to mixed-status families, with at least one undocumented family member in the household (Castañeda, 2019).

Many Mexican and Mexican-American families in the United States encounter barriers to dental treatment. However, mixed-status families experience additional psychosocial stressors on account of their spillover "illegality"—where multiple forms of health care eligibility on account of familial mixed legal status limit opportunities for entire families and households (Castañeda & Melo, 2014), including citizen family members (Castañeda, 2019). In family interactions with bureaucratic officials, children's poor oral health is frequently attributed to their parents' negligence. These underlying, moralistic expectations may brand them with a "stain of backwardness" (Barker & Horton, 2017, p.125), characterizing parents, particularly women, as "bad parents."

This is further complicated when families are constrained by unauthorized status. Research with migrant farmworker families in Florida found that different members within a family often have varying levels of dental care coverage, depending on legal status (Carrion et al., 2011; Castañeda, 2010; Kline, 2013). Furthermore, the type of dental insurance for which family members qualified was so underfunded that dentists were disincentivized from treating patients, effectively creating a two-tiered system of care (Castañeda, 2010; Horton & Barker, 2010).

Children with early childhood caries grow up with "stigmatized biologies," bearing signs of their second-class citizenship which, by adulthood, translates into crooked teeth and social stigma (Horton & Barker, 2016, p. 138). Oral caries is linked to health problems later in life, low self-esteem, feelings of shame, and speech pathologies. In these ways, illegality becomes physically inscribed on the bodies of individuals as forms of difference.

For Latino adults, low utilization of dental services has long been a recurrent pattern (Kiyak & Reichmuth, 2005). Rather than due to lack of knowledge, awareness, or education, low adult utilization is usually influenced by poverty and lack of access. Considering that families reported higher utilization for their children (Quandt et al., 2007), parents serve as buffers against adverse health outcomes, prioritizing their child's health over their own (Doane et al., 2018; Stein et al., 2014).

Dietary patterns are additional factors, with oral caries usually indicating inadequate nutrition, a diet high in sugar and carbohydrates, and poor oral hygiene (Selwitz et al., 2007). Many interventions attempt to ameliorate caries in Latino families by using innovative health education strategies, such as reducing child consumption of energy-dense processed foods (Beck et al., 2018) or using oral health providers to deliver education (Chang et al., 2018). However, these studies found that parents already had extensive knowledge on the topic (Chang et al., 2018) and had actively sought the expertise of health professionals on their own out of concern about their children's weight (Beck et al., 2018). Therefore, dental health literacy may be less of an issue than underfunded dental programs and a lack of providers (Castañeda, 2010).

Discourses that invoke a lack of education often cast Latino families as "unsanitary citizens" (Briggs & Mantini-Briggs, 2003), in which children are racialized, and their parents are shamed and threatened with the intervention of child protective services (Barker & Horton, 2017). A life course perspective, which analyzes people's experiences within shifting structural, cultural, and social contexts, has the potential to confront the issue of parents' health-related knowledge while also addressing discourses around hygiene (Unterberger, 2018). Families experience transitions by entering a new environment with different diets and infant feeding practices, which shift from breastmilk to formula feeding—the latter more easily causes children's teeth to develop caries (Horton & Barker, 2010). Caries add to other social "traumas and illnesses [which] continue to add and build up over time," creating exponential and not merely additive or linear effects on an individual's life chances (Unterberger, 2018, p. 109).

Thus, oral health is not bounded but is linked with other health outcomes, social stigma, and mobility, while also impacted by family legal status, socioeconomic conditions, and other life course events. Here we ask: How are oral health disparities experienced within mixed-status families living in border communities? What can be illuminated using temporality as a framework for understanding structural vulnerabilities and the persistent phenomenon of waiting?

Temporalities, Chronicity, and the "Doxa of Waiting"

Dental health literature on migrant families depicts intense vulnerabilities across the life course. The idea that migrants ought to wait for health services is often taken for granted, naturalized through constructions of perceived deservingness based on unauthorized legal status (Willen, 2012). Marginalized populations are often "expected" to wait, as they lack "economic, social, and cultural capital needed to deploy 'flexible citizenship' in a world on the move" (Andersson, 2014, p. 796). Without legal status or health insurance, migrants, including those in mixed-status families, frequently serve in the public imagination as undeserving or imperfect citizens, justifying their lack of prompt care access.

There is disciplinary power in requiring populations to wait for services. Drawing on Auyero (2012), Andaya (2017, p.114) refers to this as "the doxa of waiting," which both marginalizes and socializes people into the hierarchy of health citizenship. In the United States, this results in a discourse about the disposability of poor people's time. There is often an assumption that those in poverty *should* wait for services, particularly if they are receiving them for free or low cost. This often results in a lack of control over their time, as delays occur and appointments are rescheduled, thus reproducing unequal citizenship. We argue that this doxa extends to include mixed-status families who experience similar delays and substandard care regimes that, due to unequal coverage of different family members, serve to compound illegality through its exclusionary practices.

E.P. Thompson (1967) characterized time as exploitative yet culturally accepted, reflecting desired values of mutual respect while operating within a certain economic rationale. By Western standards, the normative lack of respect for certain people's time reflects values surrounding how activities and social classes are evaluated as more or less important and bodies as more or less deserving. Drawing on Bourdieu, Auyero's (2012) "doxa of waiting" explains how making people wait to receive services alters the patient-provider relationship through increased surveillance and adherence practices patients are expected to follow. While doctors expect patients to comply with increasingly intrusive interventions, patients themselves also come to naturalize this process.

Poor populations of color often face lengthy delays in accessing care in addition to receiving lower quality care, hostile treatment in medical settings, and constraints on privacy (Bridges, 2011). They also experience amplified state intervention as government bureaucracy enters people's lives and monitors families, further increasing expectations about the kinds of people deemed "fit for social participation" (Bridges, 2017, p. 11).

"Neoliberal stigma" denotes how those who do not meet Western standards of "individualism, hard work, and personal responsibility" become "marked as irresponsible, unworthy, and 'bad citizens,'" situating migrants within a set of understandings and standards that defines what makes a perfect citizen (De Souza, 2019, p. 17). Not meeting these standards justifies the intrusive, disciplinary role that state institutions play in family life. This may be doubly exclusionary when, in the eyes of bureaucracy and those responsible for enacting it, United States citizen members of mixed-status migrant families may not be seen as citizens at all (Castañeda, 2019).

These standards of citizenship are fundamentally enacted temporally. "Waiting" becomes naturalized, rendering this type of violence invisible altogether. Those who wait are also deemed less deserving, as they do not meet the full criteria of citizenship per neoliberal standards; thus, those individuals ought to wait to uphold notions of fairness according to levels of stratified privilege. This justifies the intervention of bureaucracy in the lives of migrant families and the regulation of their time, especially pertaining to access to care. Rob Nixon (2011) argues that, while we often view violence as "immediate in time, explosive and spectacular in space, and as erupting into instant sensational visibility," "slow violence" is "a violence that occurs gradually and out of sight, a violence of delayed destruction that is dispersed across time and space, an attritional violence that is typically not viewed as violence at all" (p. 2). The cases presented below exemplify this sort of incremental and cumulative slow violence perpetuated through temporalities in which certain types of people are made to wait across the life course.

The preventable and highly treatable nature of many oral health issues highlights how, for migrant families, chronicity may be created primarily through social rather than biological mechanisms (Kleinman & Hall-Clifford, 2010). Time "is not a neutral concept within biomedicine" (Smith-Morris, 2010, p. 22), and its inherently political nature is anchored within specific structural contexts (Ferzacca, 2010). In the case of chronic oral health issues, illness experience moves beyond the biomedical efforts of treatment and becomes entangled with political and economic realities (Smith-Morris, 2010). The stories presented here help disentangle these effects by illuminating temporalities and how they are enacted and used to justify *waiting* for dental care in the United States-Mexico borderlands.

Methods

We base this article on five years of ethnographic study in South Texas's Rio Grande Valley, drawing from several interrelated studies investigating the experiences of mixed-status families in a county where 11.7% of the population is estimated to be undocumented, 98% of whom are from neighboring Mexico (MPI, 2018). Due to transnationally enmeshed lives, over half (51.3%) of all United States citizen children in this county live with at least one immigrant parent (USCB, 2016).

Our analysis draws from 252 interview transcripts with members of mixed-status families conducted by Castañeda and Melo from 2012 to 2017. The primary methodology critical to the study of temporality and chronicity was longitudinal interviewing. Seventy-five of the 167 individuals interviewed completed an additional follow-up interview up to two years after their first. Ten participants were tracked for over four years with two follow-up interviews. Participants were recruited using purposive referral (snowball) sampling after individuals meeting inclusion criteria were identified through local community-based organizations. Screening ensured that individuals were a minimum of 14 years of age and lived in a household where different legal statuses were present, with at least one undocumented person in the home. A $20 gift card to a local retailer was provided as compensation. Interviews lasted between 35 minutes and two hours and took place at a location of the participant's choice, typically in their homes. Thirty-four questions focused on experiences living in a mixed-status family and with health care access. Interviews were conducted in Spanish (n=94), English (n=61), or both languages (n=12) and were audio-recorded with the participant's consent.

Another source of data was interviews with health care providers, navigators, social workers, public health officials, and other key stakeholders (n=62). Five of these were conducted in Spanish, and the rest were in English. These interviews provided background information about historic efforts at improving health care, availability of services, and major challenges and successes. Finally, participant observation was used to supplement findings with data collected from community interactions ranging from meals in family homes, visits to local clinic outreach events, and public participation in immigration rights activities.

Following transcription, data were analyzed using MAXQDA, a data analysis software program, using iterative coding techniques to capture domains of interest relevant to research questions. The coding

process utilized both deductively and inductively derived codes emerging from the data, reflecting the responses of participants. Descriptive coding was further utilized to draw out major words, phrases, and concepts and to compare data points across interviews. All names presented here are pseudonyms. Our analyses focus on text segments coded as experiences with oral health and dental care. We highlight elements of the dental care odysseys of mixed-status families as they relate to temporalities.

Making Time to Keep Teeth Healthy

One of the most common strategies employed by mixed-status families was to prevent the need to seek out a dentist. For instance, Rosa is a 51-year-old undocumented woman and mother of three who has been living in the United States since 1998. She stated that it often takes several months to get a dental appointment, forcing her family to "tak[e] care of ourselves as much as we can, because we have no right to a doctor." Similarly, Veronica, a 38-year-old mother of five, spelled out her salutogenic practices, emphasizing how she kept everyone in her family healthy by serving fresh, healthy foods and encouraging them to stay active. "We can't afford to get sick. So, we eat lots of fruit and vegetables. We teach the kids to brush their teeth after every meal, floss every night. Dentists are just too expensive here."

A primary strategy, therefore, was simply to remain healthy. To avoid expending time and money for dental services, families exerted their independence by making time to keep everyone healthy. By controlling dental health in the more accessible temporal present, they were able to lessen the chances of encountering a future filled with cost-prohibitive treatments. In the United States, compared to other health care sectors, out-of-pocket dental expenditures are extraordinarily high (Wall & Guay, 2016). As much as 41% of dental spending is out-of-pocket (CMS, 2017), raising questions about accessibility for most citizens, regardless of legal status. Sarah, a 44-year-old undocumented mother of two United States citizen children, explained, "I went to the emergency room for a very swollen molar. Very, very swollen. It hurt way back there. It cost me $2,000." Mixed-status families, whose daily experiences are frequently marked by precarity, limited opportunities in the job market, and poverty, can find it difficult to pay for such unexpected expenses. Simply staying as healthy as possible simply makes sense to prevent cost-prohibitive visits or accumulating medical debt, which would increase family vulnerability.

Lack of Timely Appointments

At the same time, Constancia explained how even getting in the door at a low-cost public clinic requires extended waiting periods. "Even getting an appointment takes too long. I understand that there are a lot of people, but at [Federally Qualified Health Center (FQHC)], there aren't enough dentists. They once gave me an appointment for like six or seven months later." The local FQHC represents one of the few reliable dental care resources for low-income mixed-status families because they operate on a sliding scale fee basis. However, while FQHCs contribute greatly to reducing health disparities by providing care to underserved communities, these safety-net clinics face chronic staff shortages and turnover, leading to long waits for appointments. They also offer only limited dental services for undocumented or uninsured families (two distinct yet overlapping categories). While the federal government has been increasingly urging FQHCs to incorporate services for people with insurance to help pay for those who cannot afford them, this model does not work well in border areas where there are far too many limited-income and uninsured people to serve compared with the number of safety-net providers.

Many families described being unable to get a timely dental care appointment and/or care limited to extractions instead of higher quality treatments or preventive measures. Olivia, a 26-year-old woman with Deferred Action for Childhood Arrivals (DACA) status, explained that her undocumented mother wanted basic dental services, but extended waiting periods precluded her ability to do so: "My mom wants to get a routine cleaning, and she can't. She tried a couple times, but they literally gave her the appointment four years later, because it's very hard to get a dentist." Families do not have reasonable, timely access to dentists, even when they are entitled to services or willing to pay. This has created a habitus of self-sufficiency in which they must seek out resources on their own. It also highlights how legal status, high cost, and limited services are deeply entangled. Thus, many families sought alternative avenues of care, including unlicensed individuals offering services informally. The lack of consistency and safety that families turning to this kind of care can expect places them at increased risk due to a lack of administrative and hygienic protections with which standard dental practices must comply.

In addition, resources cycle temporally. Services are rarely consistent, in addition to forcing upon populations a "doxa of waiting" (Auyero, 2012).

This naturalizes the expectation that those with precarious social standing, such as unauthorized legal status, must wait for care, reflecting broader socializations that certain people *should* occupy a position of political inferiority. This is especially salient considering how time, waiting, and these temporalities of care produce multi-tiered forms of care that are enacted and define oral health experiences.

Time-Limited Humanitarian Models of Care

Another option for families in this region is Operation Border Health Preparedness (OBHP). This program was formerly (during data collection) named "Operation Lone Star," but its name was changed in 2021 when Governor Abbott repurposed the name for his program of border militarization. Thus, what was once a program to aid all people residing on the United States side of the border suddenly had its name appropriated to arrest undocumented people (THHS, 2022).

OBHP is an annual emergency preparedness exercise coordinated by the Texas Department of State Health Services, offering free medical and dental services. It represents an opportunity for first responders and military personnel to practice setting up and operating clinics in the event of a public health emergency. Like other humanitarian models focusing on short-term disaster relief, the delivery model is necessarily time-limited. Although it arrives at consistent intervals, usually at the start of the school year, OBHP requires a full year of waiting for the next opportunity.

Although there is no guarantee that a person will be seen or receive comprehensive treatment, these services offer an opportunity for much-needed dental health care. For instance, Melanie, a 22-year-old United States citizen with undocumented parents and siblings with DACA, shares, "Recently, now that we're older, every so often they have this thing called [OBHP], and we've done that. We've gone to that. My brother got several teeth taken out." OBHP draws thousands of individuals who are seen on a first-come, first-served basis, with lines of people waiting outside of high school gymnasiums as early as the evening of the day before. Dental services are limited to one treatment per day, so if a person needs several cavities filled or teeth extracted, they can only get one taken care of at a time, requiring them to get back in line for the next day's service. As a result of these and other such limitations, 17-year-old Michael expressed that one cannot rely on such temporary care. "Those people with that organization didn't come back, right, so we eventually found a doctor from Mexico. He lives here, but he has his office in Mexico. He came and he had all his stuff in his house, and he did the dental work for her at her house…it was a good price." As Michael notes, some families seek out unlicensed dental professionals, continuing unfinished care at reasonable prices due to the long waiting periods and limbo that this temporary service places on patients.

Temporal Disruptions: Temporary Benefits and "Timing Out" of Dental Coverage

Having consistent coverage is ideal; however, participants who had any dental benefits mostly experienced temporary coverage. Perla, a United States citizen with undocumented parents, no longer qualifies for Medicaid due to her age. She explained how she had gone from frequent appointments to being wholly uninsured, disrupting her sense of time. "I've had a dentist all my life. They would remind me every six months, 'You have an appointment.' I had Medicaid and they'd notify me. 'You have an appointment, and you need this, and this done.' Right now, I don't have Medicaid or any of that. They don't talk to me; they don't look for me." Perla described a distortion in her personal sense of time, one that also has left her feeling "unseen."

Other participants described "timing out" of dental coverage, particularly the Children's Health Insurance Program (CHIP), designed for families that earn too much to qualify for Medicaid. Consuelo, a United States citizen with undocumented parents, explained how when she was 15 years old, she was fully covered by Medicaid and able to get braces; this changed when she was moved to coverage by CHIP:

> At the time, we had Medicaid, but I had to get them [braces] off because all my baby teeth had fallen out. When we were able to get it [braces] again, they changed us to CHIP, so then we didn't qualify anymore. The cost for the braces was a lot, so we're holding back on that…even though I am a U.S. citizen and I do have CHIP, it doesn't cover everything that it used to. I guess that's just the way the cookie crumbles. You got to work with it. Hopefully, I get them soon.

CHIP serves to subsidize dental care costs. It was "better than nothing," Javier explained; his parents pay in cash and are grateful that CHIP "pays for half, and you pay the rest." However, Javier also indicated that for undocumented children "without

a social security number," this was a reprieve from the vulnerabilities that most families can expect. In both cases, CHIP was "better than nothing," but to significantly different degrees. Consuelo experienced it after having more comprehensive health coverage, while Javier previously had none. Thus, despite varying levels of support for citizen children, CHIP continues to render undocumented children ineligible for full coverage.

The disciplinary tendencies of health care become enacted through differential temporalities. For some, like Perla, being uninsured can result in effective invisibility. She went from being in contact with health care providers to seeing how, without insurance, "They don't talk to me; they don't look for me."

Baby Teeth, Childhood Timelines, and the Life Course

Teeth themselves have an interesting temporal life: for children, teeth fall out as part of the life cycle and then re-appear. But sometimes, this renewal is threatened through chronic lack of care. Michael, a 17-year-old United States citizen with undocumented parents, explained the vulnerability experienced by a friend who has *dientes picados,* or cavities. "He's like eight years old… They're actually like cracked and open. It's really serious. And he doesn't have Medicaid, because he's not a citizen, so it's difficult for him. Right now, his parents are happy, because his [baby] teeth are falling out and he's getting new ones. But you know, the new ones will get that way too. I feel really sorry for him."

This child will likely experience the lasting social effects reproduced through his "stigmatized biology" (Horton & Barker, 2010). Children with dental pain are less able to concentrate in school, and the resulting disadvantages are not easily reversed by legalization. These are embodied differences expressed through "bad teeth" that reproduce systems of social inequality. As children with poor oral age, their teeth reveal the cumulative effects of their disadvantage, heightening self-consciousness and impeding social mobility. Unequal access to care consequently has lasting effects on well-being, social mobility, and life success.

Timely Exchanges: Reciprocity, Bartering, and the Moral Economy of Care

In this environment of cost-prohibitive care, a moral economy emerges. While not always for purposes of social bonding (see Bourgois, 1998), these exchanges result from the morality embedded in social networks in an environment of scarce resources. This economy is nonmarket-oriented, functioning from social and moral rationalities. Rather than being founded on formal legal notions of entitlement, a moral economy is based on various forces, including political, economic, social, cultural, and personal values and relationships (Fassin, 2012).

Service providers nestled within the bureaucratic surveillance regime—such as dentists and teachers—assist undocumented and/or uninsured families so that they can receive the oral health care they "deserve." This health-related deservingness is "articulated in a vernacular moral register that is situationally specific and often context-dependent" (Willen, 2012, p. 814). For example, Abel explained how, rather than pay the dentist $1,500 for getting a tooth fixed, "we paid him with furniture." Similarly, Bettina described, "I was in elementary school, and my school principal actually helped pay for some of my dental work." Considering that school officials can serve as an extension of the disciplinary functions of the health care bureaucracy (Barker & Horton, 2017), this example indicates the complexity of social networks on the ground motivated by moral responsibility.

Informal practices are widespread, as the region is a well-known hub for new migrants, and many individuals know, or know of, undocumented individuals who might have difficulty obtaining health services. For instance, Martin described how his daughter received a voucher at her school, "and because the doctor saw that we had no way of paying, and that she needed work on her teeth, he did it for free." Here, the school and medical bureaucracy intersect, each contributing to the moral work of keeping community members healthy.

Exchanges like these illustrate how those providing services are aware of financial constraints and find ways to facilitate services through systems of barter and reciprocity. In another example, Hector described how his mother worked cleaning the home of an orthodontist, who later offered his services to them for free. "I had some problems with my tooth, so I went to the orthodontist. That was a special case because my mom works with the orthodontist, so he gave us a free treatment. Braces and everything. He didn't finish it, but at least it was something." Even if they were unable to obtain the entire treatment course, as Hector noted, "At least it was for free." Through the goodwill of others, resources have a time limit and limited availability for specific individuals, highlighting the importance of care temporalities.

Temporalities of Care Associated with Expired/Overstayed Visas

Another temporal issue impacting dental services occurs when individuals have overstayed the authorized duration of their visit and their visa has expired. In this region, a common form of mobility is via a Border Crossing Card (BCC; also called a "laser visa" or *mica*, B1/B2 visitor's visa issued for 10 years at a time), allowing Mexican nationals to cross back and forth frequently to work and visit relatives, acknowledging the interdependence of border communities. Holders are allowed to travel inside the current BCC border zone for up to 30 days. Even so, overstaying results in slippage into "illegality." Low-cost care on the Mexican side of the border—only a few miles away—would be most affordable and practical for many families. However, those who are undocumented are unable to re-enter the United States once they have traveled to Mexico. Valentin, a 46-year-old undocumented male, described this dilemma:

> My doctor told me, "I'll pull the teeth for you, but you need to find an outside doctor, a dentist to deal with the plaque because you need that done." Well yeah, but I don't have Medicaid, so it's really expensive. So, I tell him, "Check my teeth and pull them if they are that bad, otherwise just leave them. Even though they're loose, I still have to eat." You understand? The problem is that I don't have anywhere to go in the meantime. Lots of people get their teeth pulled over in Reynosa [city in Mexico right across the border] because it's cheaper and everything. But like I tell you, I can't go there because of that issue. So, I ride it out.

On the other hand, members of some families were able to travel to Mexico for dental services. Sisters Nelda and Imelda, one a DACA recipient and the other a United States citizen, explained that when their mother needed dental care, "she could go to Mexico, we went to a dentist in Monterrey. And it's ridiculous, it's like $20." For migrants who still have active border crossing cards (B1/B2 visitor's visa), going to Mexico may be a viable option. However, for those whose BCC or visas may have expired, crossing the border means putting themselves at risk of detainment and deportation.

Care also flows the opposite way. Mexican dentists offer low-cost services in the United States, generally without a license to practice there. Pursuing informal dental care also occurs when other forms of care are unavailable due to high costs. Rosa explained how a family friend is "married to a dentist from Mexico, so she comes over here and the price is lower compared to a dentist because she does her job at your house." Beatriz, a DACA recipient and daughter of undocumented parents, similarly expressed the value of such social networks:

> My mom knows this server at a place and she's like, "Oh, where did you get your braces?" Then the girl said, "A dentist comes over to my house." She's like, okay. Because my mom used to have a dentist come to her house and clean her teeth and everything. I gave a down payment of $380 for I guess the installation of the braces. Then each month I give $80. I wanted them because they [my teeth] were getting crooked. I'm like no, no, no, I want them.

The locations of these informal services vary. Some are at a home: Gina, a DACA recipient, explained that her mother and her friends have gatherings where they and their children all receive much-needed dental services. Eugenia's mother took her to the dentist in a hair salon, where the doctor would "lean us back and work on their teeth. That's where he would do this work." By accessing this kind of care, families utilize available resources to attend to their family's health.

Even so, some participants were frustrated at these limited dental options, stating they might as well take care of the issues themselves. For example, Tomas and Ursula, two undocumented parents, explained dental extraction by a United States dentist only added cost without very many benefits. "If it's loose, I'll take it out myself. Why would I pay $100 for that? Last time a tooth cracked, I took it out myself." For some families, self-surgery can seem both reasonable and pragmatic when dealing with precarious and cumulatively expensive care options. Here, temporality is inextricable with familial vulnerability.

Discussion

Temporality can provide critical insights about the experiences and sociocultural dynamics of contemporary migration (Jacobsen et al., 2021). This lens helps extend notions of moral deservingness, moral economy, and the concept of stigmatized biologies by illustrating how time shapes the difficulties (and solutions) experienced by mixed-status families. As the ethnographic data here illustrate, a multi-tiered care complex is required as families navigate their various temporally available options regarding dental needs. A few families were able to travel to Mexico to receive care or were able to receive care from Mexican dentists practicing in the United States without a license. Here, families neither waited

nor paid high out-of-pocket prices. However, this kind of care is fraught with temporal vulnerabilities, as availability, quality, and safety vary widely. Other participants described utilizing time-limited events, such as OBHP, with varying levels of availability and inherent trade-offs. In this cyclical, high-cost, multi-tiered complex, some families resorted to extracting teeth themselves.

These tiers of care produce various social dynamics. Families utilize their networks and resources to obtain care. Many learned of unlicensed dentists through their social connections, were able to receive high-quality care for free, or bartered to pay for dental services. Such arrangements are ephemeral, betraying the vulnerability that families might have experienced had their social network lacked such short-lasting opportunities for affordable health care. But these strategies are fleeting and impermanent, and families' inability to reliably tap into those resources again in the future highlights the precarity of dental care access.

The families described here are affected by a complex system that socializes them into certain neoliberal sensibilities, particularly around deservingness and waiting. Yet, social relationships also provide resources that migrant families can draw upon to ameliorate their vulnerability. When families cannot obtain timely or affordable care, they turn to local, temporally available resources. The repercussions of a tiered system of care must be considered across the life course. Given the consistently poor oral health outcomes experienced by children in mixed-status families, exploring how these vulnerabilities manifest themselves in particular socioecological contexts can greatly benefit future research. As we have shown, "free" or affordable services come with the caveat of unreliability and ephemerality. Temporalities influence vulnerability, and for mixed-status families, waiting becomes "a strategy of domination without a strategist" (Bourdieu & Wacquant, 1992, p. 25). In this context, the doxa of waiting is shifting, invisible, and all-encompassing, putting the most vulnerable at risk.

High cost, temporary availability, lack of timely appointments, and alternative strategies create an environment where multiple forms of care coexist, contingent on particular temporalities. People turn to "band-aid" solutions (Sangaramoorthy, 2018), reflecting strategies of access while also communicating that a social and legal hierarchy exists. This, in turn, places families at increased risk within a particular kind of temporality that becomes "a tool for social control" (Ferzacca, 2010, p. 157).

The findings we have presented undermine health education as a primary intervention. When migration is viewed as an aberrant practice, it serves to justify the kinds of precarious experiences described here (Hanefeld et al., 2017). Here, care is coupled with racially charged political discourses that stigmatize migrants as resource drains, perpetuating rhetoric that validates discriminatory policies (Fleischman et al., 2015; Larchanché, 2012). Applied anthropology is uniquely positioned to address such discourses by highlighting everyday forms of struggle and resistance experienced by vulnerable populations, such as mixed-status migrant families, where temporality influences dental care access and other health issues (Lopez et al., 2017; Rhodes et al., 2015). Anthropology must confront anti-immigrant rhetoric and stigma that both mediate oral health experience and care for Mexican-American families and shape the policies that perpetuate illegality in general.

Programs targeting health disparities should integrate several components, including cultural, socioeconomic, and transnational considerations across the life course (Arellano-Morales et al., 2015). Given that mixed-status families experience familial rather than individual vulnerabilities (Logan et al., 2021), tailoring health resources to entire families could partially address the kind of slow, attritional violence that extends pain and oral health vulnerabilities through a lack of efficient, comprehensive oral health care. We recommend an applied anthropological focus on temporalities as the phenomenon of waiting elucidates a particular form of violence often rendered invisible. This focus, combined with robust ethnographic data, may serve to highlight the disciplinary practices of health care regimes embedded within larger social and moral systems that may provide band-aid care for some while leaving many mixed-status families vulnerable.

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