National Hispanic & Latino MHTTC

Mental Health Technology Transfer Center Network

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¿Quiénes somos y de dónde venimos?

A Historical Context to Inform Mental Health Services with Latinx Populations

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The National Hispanic and Latino MHTTC recognizes the complexities associated with gender and ethnic identification. With the intention of both facilitating a fluent reading of the text and supporting an inclusive and respectful language, this document uses terms that are linguistically neutral and inclusive of diverse gender groups and identities. In this book, we also use the term Latinx to encompass ethnic identity as well as non-binary gender identification.

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The opinions expressed herein are the view of the authors and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this document is intended or should be inferred.

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Institute of Research, Education and Services in Addiction (IRESA)

The Institute of Research, Education and Services in Addiction (IRESA) of the Universidad Central del Caribe leads the National Hispanic and Latino MHTTC. The Center serves as a national subject matter expert and a key resource for the workforce and communities seeking to address mental illness prevention, treatment, and recovery support to reduce health care disparities among Hispanic and Latino populations across the United States and its territories. In partnership with state and local governments, mental health providers, consumers and family organizations, Hispanic stakeholders, Substance Abuse Mental Health Services Administration (SAMHSA) regional administrators, and the MHTTC Network, the Center seeks to accelerate the adoption and implementation of mental health-related evidence-based practices.

National Hispanic and Latino Mental Health Technology Transfer Center

The mission of the National Hispanic and Latino Mental Health Technology Transfer Center is to provide high-quality training and technical assistance to improve the capacity of the workforce serving Hispanic and Latino communities in behavioral health prevention, treatment, and recovery. We disseminate and support the implementation of evidence-based and promising practices to enhance service delivery, promote the growth of a diverse, culturally competent workforce, and bridge access to quality behavioral health services. We are committed to increasing health equity and access to adequate culturally and linguistically grounded approaches.

The School-Based Mental Health Project (SMH)

The School-Based Mental Health Project (SMH) of the National Hispanic and Latino MHTTC works specifically with schools, organizations, and professionals to strengthen their capacity to provide culturally and linguistically responsive school mental health services.
This initiative facilitates training, technical assistance, and capacity building efforts led by experts in the field. Our goal is to increase awareness to attend to Latino students' mental health needs, promote the implementation of school mental health services that are culturally appropriate, encourage the use of promising and evidence-based practices, and disseminate information on practical strategies and implementation efforts of mental health services within a cultural context.

¿Quiénes somos y de dónde venimos?
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TABLE OF CONTENTS

List of Tables

Chapter I

List of Figures

Chapter II

Chapter III

Chapter IV

Chapter V

Chapter VI

Preface

Latinx psychologists wrote this book from the perspective of Latinx Psychology, social justice, and inclusivity. Our hope is for this book to further inform clinical practice with Latinx communities and be utilized in training programs. In our efforts to be inclusive of ALL people from Latin American backgrounds, we intentionally used the term *Latinx* throughout this book. We additionally recognize the complexity of describing individuals who have entered the United States without legal documents. Based on discussions, readings, and consultations, we agreed on *undocumented immigrant(s)* over the various terms available. Finally, we use mental health providers as an umbrella term to include all professionals (e.g., psychologists, social workers, clinical mental health clinicians, psychiatrists, etc.) in the mental health field. The purpose of this book is to provide mental health providers with historical content, context, and a foundational understanding of mental health considerations when working with Latinx communities with ethnic backgrounds from Mexico, and the three Northern Triangle countries which includes Guatemala, El Salvador, and Honduras.

SETTING THE STAGE:

An Introduction to Understanding the Diversity within Latinx Communities in the United States

I

Terminology

Latinx

Various terms are used to identify individuals from Latin America. Yet, given the heterogeneity within Latin America, ranging from language and dialect, cultural heritage, nationalities, race, and ethnicities, these terms can cause controversy (Delgado-Romero et al., 2007; Garcia, 2020). Several of these terms include Hispanic, Latin@, Latina/o, Latine, and Latinx. The term *Hispanic* is inclusive of individuals from "Mexican, Puerto Rican, Cuban, or Other Spanish/Hispanic/Latino origin" (p. 36; Delgado-Romero et al., 2007), and it describes individuals from Spanish-speaking countries (e.g., Latin America and Spain) or descendants (Martinez & Gonzalez, 2020). These terms relate to ethnicity with individuals from Hispanic and Latino background identifying with multiple races. The term *Latina/o* relates to individuals that have Latin American heritage but not necessarily Spaniard ancestry or those that come from a Spanish-speaking country of origin (e.g., Brazil and Portuguese) (Cardemil et al., 2019). Finally, the term *Latinx* is used to describe individuals from Latin America in a way that honors and respects all genders beyond the binary of men and women (Scharron-del Rio & Aja, 2020). It is an inclusive term that centers respect, appreciation, and affirmation for sexual and gender-diverse individuals from Latin America (Demby, 2014; Simón, 2020).

Research studies suggest differences in preferred self-identification with these terms. For example, Hispanic is one of the more popular terms that individuals from Latin America use to identify themselves (roughly 33%), followed by Latino (about 15%) and Latinx (about 2-3%; Garcia, 2020). Some scholars have argued that the preferences for how individuals identify are socioculturally based. For example, Garcia (2020) writes that the term Hispanic might be preferred by individuals who are wealthier, middle-class and with conservative political

ideologies, whereas individuals that are working-class and liberal might use Latina/o. Yet, the data broadly supports that individuals prefer to identify by their country of origin (e.g., Guatemalan, Nicaraguan; Lopez, 2013).

In considering the diversity and heterogeneity of individuals from Latin America, we intentionally use the term *Latinx* throughout this book. We believe it is helpful for the reader to understand the context of Latinx and its history. The term Latinx was developed in the early 2000s within the online queer spaces by sexual and gender diverse individuals due to feeling excluded from the gendered and binary terminology of Latina/o (Scharron-del Rio & Aja, 2020). It has been widely adopted within academic and queer spaces, but disagreement regarding its use remains. Some scholars have argued that the term Latinx is a form of "linguistic imperialism," and it further marginalizes non-English speaking immigrants (Scharron-del Rio & Aja, 2020). While others have argued that its use prevents further marginalization and erasure of sexual and gender diverse populations with Latin American origin. Multiple efforts have been made to make the Spanish language more inclusive (Schimdt, 2019).

Despite these tensions, we use the term *Latinx* to stand in solidarity with our sexual and gender minority siblings. By using the term Latinx we hope to challenge heteronormative understandings of gender binaries and celebrate the diversity of Latinx individuals. Mental health providers should not assume how their patients choose to identify. As a recommendation, we strongly encourage mental health providers to ask their patients how they identify and use their preferred terminology, given the various terms' complexity. For example, the LGBTQIA+ Health education Center provides resources including examples of questions on gender identity and sexual orientation for patients (National LGBTQIA+ Health and Education Center, 2021).

Intersectionality

The term *intersectionality* was developed by legal scholar Dr. Kimberle Crenshaw (1990), and it draws from critical race and feminist theory. It was initially developed to understand the experiences of Black women given the interlocking forms of systemic oppression they experience – racism and sexism. Further, intersectionality recognizes the dynamic between power and privilege, and how it shapes individuals' daily lives (Parent et al., 2013). Intersectionality has since been expanded to include individuals at the nexus of other interlocking forms of discrimination such as heterosexism, transphobia, classism, documentation status, etc. Intersectionality scholars posit that social identities need to be considered within the context of inequality and power dynamics (Torres et al., 2018).

Latinx individuals experience mounting forms of discrimination based on their social positionality and disenfranchised identities. For example, Latinx trans women must function within racist, transphobic, and sexist systems of oppression, and there are numerous subsequent iterations of systems of oppression that influence the daily lives of the community. Latinx individuals pose multiple intersecting privileges and oppressed identities. As such, intersectionality provides a framework and context to examine potential risk and protective factors, bring to light social inequities to reach health equity, and create change at the individual and systems levels (Torres et al., 2018).

Further, Purdie-Vaughs and Eibach (2008) coined the term *intersectional invisibility* which was developed to capture the experiences of individuals that do not hold prototypical identities (e.g., White, male, cisgender, Christian) and are subjugated to increased marginalization with the more socially stigmatized identities they possess. The ramifications of experiences of discrimination have been linked to increased levels of substance use and

deleterious effects on mental health functioning (e.g., Vu et al., 2019). Additionally, research has identified *positive intersectionality* as an emerging theme for individuals with marginalized identities (Ghabrial, 2017). Positive intersectionality refers to the strength found within experiences of adversity and from possessing socially stigmatized identities where individuals believe in their power to create change. Therefore, both the risk (e.g., harmful effects on mental health and increased substance use) and resilience (e.g., strength) associated with intersecting identities (Ghabrial, 2017) should be considered when working with Latinx individuals and how systems of oppression influence their daily lives.

AfroLatinidad

Latinxs can trace their rich history to three primary racial groups: Black, Indigenous, and White (Adames et al., 2020). As Díaz (2018) explains, "Latinidad is an all-inclusive term describing people with roots in Latin America" (p. 13). Following racial mixing due to rape of African slaves, Latinxs exhibit a broad range of physical characteristics (Adames al., 2020; Chavez-Dueñas et al., 2014). Among the many communities subjected to mass colonialization, Mexican-origin individuals have a 500-year legacy of colonialization and subordination by the Spanish, English, Portuguese, French, and Anglo Americans (Adames et al., 2020; Estrada, 2009). As a result, many of the issues facing disenfranchised Latinx communities including cyclical poverty, substance abuse, and violence, reflect the on-going and unaddressed impacts of colonialization (Pizarro, 2016). However, the experiences of Black Latinxs are readily overlooked (Adames et al., 2020).

European colonialization resulted in women and girls becoming sexual commodities (Anzaldúa, 2009; Hernandez-Wolfe, 2013). The early rape and abuse of women laid the foundation of violation for generations (Adames et al., 2020; Anzaldúa, 2007; Hernandez-Wolfe,

2013). Many scholars postulate that to survive the colonialization and dehumanization of their peoples, Indigenous communities had to embrace (and ultimately internalize) a colonial mentality that women are inferior to men (Anzaldúa, 2009; García, 2014). The Spaniards institutionalized racial inequity and dominance that placed individuals with White and lighter skin color at the top, and Black and darker-skin people at the bottom of the social hierarchy (Adames & Chavez-Dueñas, 2017). From its commencement, the creation of race influenced racism and racial superiority (Bonilla-Silva, 2014). The classification of race is utilized to justify the dehumanization, exploitation, and segregation of Black and Indigenous populations in the Americas (Chavez-Dueñas et al., 2014; Soler-Castillo & Pardo Abril, 2009).

Racism preserved limited opportunities for Indigenous and Afro-descendant communities for centuries (Adames et al., 2020). These two groups have historically been the poorest segments of Latin American societies (Casaus Arzu, 2009; Castellanos Guerrero et al., 2009; Soler Castillo & Pardo Abril, 2009). In addition to the glaring lack of resources among Black and dark-skinned Latinxs, notions of *Mestizaje* resulted in the erasure of Blackness in Latin America (Adames et al., 2020). The absence of Blackness in Latinx Psychology is due in part to *Mestizaj*e Racial Ideologies (MRIs), or the belief that all people of Latin American ancestry are racially mixed, and therefore, skin-color and phenotypical differences do not matter (Adames et al., 2020). A goal of *mestizaje* was the assimilation of Indigenous and African people into a culturally standardized society. *Mestizaje* is hypothesized as an intentional use by the *conquistadores* to vanish Indigenous and African cultures from Latin America (Soler Castillo & Pardo Abril, 2009). MRIs' anti-Blackness and preference for white supremacy has influenced Latinx values and priorities (Adames et al., 2020). Furthermore, MRIs contribute to the denial of within-group racial privilege, colorism, and the silencing of Black Latinxs (Adames et al., 2020).

Assimilation was further reinforced by "whitening policies" in Latin America (Castellano- Guerrero et al., 2009; Gates, 2011; Soler Castillo & Pardo Abril, 2009). These policies include: (1) European immigration being encouraged, particularly to areas with high Indigenous and African populations (e.g., in Northern Mexico; Castellanos Guerrero et al., 2009); and (2) White prostitutes sent to areas with a high concentration of Afro-descendants (e.g., in Colombia; Soler Castillo & Pardo Abril, 2009). The White elites believed that through interracial reproduction, they would "*mejorar la raza*" [improve the race] - such values are still prevalent today (Adames et al., 2020; Castellanos Guerrero et al., 2009; Soler Castillo & Pardo Abril, 2009).

Darker skin-color prejudice negatively impacts mental health (Montalvo, 2004; Montalvo & Codina, 2001; Ramos et al., 2003), education, and income (Arce et al., 1987) of Afro-Latinx communities. Epidemiological studies reveal high rates of health problems, low literacy, and formal education, and increased poverty (Hall & Patrinos, 2012; Ñopo, 2012) among Afro-Latinx groups. In their seminal article examining the impact of skin color and phenotype on the life chances of Mexican Americans, Arce et al. (1987) found that darker and more Indigenous looking participants receive less educational attainment (9.5 and 7.8 years, respectively), lower income (US$12,721 and US$10,450, respectively), and reported more experiences of discrimination.

Mestizaje Racial Ideologies are also prevalent in the field of Latinx Psychology (Adames et al., 2020). Despite the diversity of Latinxs in the United States, most of the scientific literature does not address or consider the unique experiences of Black Latinxs expressly and explicitly (Adames et al., 2020). Latinx Psychology often studies, describes, and conceptualizes *Latinidad* through racially homogenous (*mestizaje*) or color-blind paradigms (Adames & Chavez-Dueñas,

2017; Adames et al., 2016; Chavez-Dueñas et al., 2014). Subsequently, Latinx Psychology is not only white-centered, but indirectly upholds White supremacy through the lack of acknowledgment of anti-Blackness in the Latinx community, which further creates erasure of *AfroLatinidad* and centers white Latinx Psychology as the norm. (Adames et al., 2020; Chavez-Dueñas et al., 2014; Helms & Cook, 1999). Therefore, mental health clinicians need to be cognizant and aware of the complexity regarding *AfroLatinidad* in working with Latinx patients.

Latinx in the United States

Outside of Latin America, the United States is home to the largest Latinx population. The Latinx community has grown in the past decade, surpassing 60 million in 2019 (Noe-Bustamante et al., 2020). Today, the Latinx population accounts for 18% of all people in the United States (Noe-Bustamante et al., 2020; U.S. Census Bureau, 2017). It is estimated that the Latinx community will make up nearly 30% of the country's population by the year 2050 (Padford & Budiman, 2018). Despite the slowdown in migration, Latinx immigrants continue to make up most of the foreign-born population in the United States (US Census Bureau, 2017), with individuals of Mexican descent representing about half of all undocumented immigrants (Radford & Budiman, 2018). Latinx individuals from Mexico, Central America, and South America represent approximately 45% of the foreign-born population. Their children account for 22% of all children under the age of 18 in the United States (Passel, 2006). Given such demographic trends, mental health providers and researchers have made a call for the field of psychology to consider all immigrant populations in research studies to inform clinical practice and policy (APA, 2012). The purpose of this book is to provide mental health providers with historical content, context, and a foundational understanding of mental health considerations

when working with Latinx communities with ethnic backgrounds from Mexico, and the three Northern Triangle countries which include Guatemala, El Salvador, and Honduras.

Historical Trauma and Violence

The information presented throughout this book reveals a deep connection between historical oppression and the mental health of people of Latin America ancestry. Recognizing the interlocking effects of colonialization, oppression, and marginalization as they relate to presenting mental health and substance use concerns amongst people of Latin American ancestry is an important step in connecting structural causes to contemporary identity development, mental health presenting concerns, intergenerational trauma, experiences of colorism, health, and overall well-being. This book highlights several important historical and present-day events that can inform clinical conceptualization. For example, the 500-year legacy of domination and subordination by European power and Anglo Americans may explain the internalization process of racial inferiority experienced amongst some people of Mexican ancestry, which can provide clinical information related to identity development and the impact on presenting mental health and substance use concerns. Furthermore, the many years of forced assimilation by Spaniards in Latin America and Anglo Americans in the United States may also explain why prior generations and even present-day communities adopt and incorporate dominant cultural values, language, beliefs, and behaviors. While the adoption and incorporation of dominant culture may have and continue to cause harm, it is important to also recognize that prior generations saw this adoption as a form of survival in a potentially hostile host community. Therefore, it is essential to acknowledge that the overwhelming pressure to conform to the dominant culture for many years may play a role in present-day decisions and practices that encourage the suppression of mother tongues, culture, and wellness traditions. The information presented suggests that the impact of

broad historical oppression and trauma may continue to have contemporary effects on wellness and mental health, in addition to the generational consequences of violence and oppression. Being aware of such information can aid mental health providers in patient conceptualization, identity exploration and development, and treatment engagement practices, interventions and considerations.

Proximal stress, in the form of present-day income inequality and daily experiences of discriminations can also be associated with poor levels of mental health amongst people of Latin American ancestry. The daily stressors and inequalities impacting the mental health of individuals can also be associated with poor U.S. and Latin America relations. It is not only historical trauma, violence, or contemporary stress that give rise to negative mental health outcomes, but the consequence of U.S. and Latin America relations that also directly and indirectly impact the mental health of the Latinx community in Latin America and the United States. For example, the treaty of Guadalupe Hidalgo, which ended the war between the United States and Mexico, continues to impact Mexico's economy, resulting in negative mental health outcomes among the Mexican community. The result is Mexicans immigrating to the United States where many will continue to be discriminated, exploited, and vilified. In addition to the residual impact of U.S. and Latin America relations, the dehumanization of the Latinx community in the United States, harsh anti-immigration policy, negative experiences with militarized border patrol and law enforcement, and experiences of trauma and violence throughout the immigration process must also be considered when working across clinical milieus. Thus, the underlying factors that give rise to poor mental health outcomes experienced by individuals may be found both in the past and the current relationship between the United States and Latin America.

Overall, mental health providers need to be well-informed of the historical context and content that has shaped people of Latin American ancestry to better recognize pathways towards healing that capitalize on existing strengths and resources at various levels. Additionally, it is important that mental health providers be aware of their own unconscious biases in efforts to not further perpetuate systems of oppression. As people of Latin American ancestry have experienced serious physical and psychological distress, mental health providers must be better equipped to provide culturally responsive care. More effort should be made to enhance resilience, protective factors, and social supports which may protect against negative mental health outcomes. Finally, highlighting potential causes of poor mental health, such as historical oppression, violence, and exploitation, need to be addressed and integrated into clinical conceptualizations, prevention frameworks, engagement processes, and treatment models.

Mental Health Background

Mental health disorders represent a costly public health crisis in the United States. The risk for mental health concerns may be even higher for minoritized groups, such as Latinxs (Calzada et al., 2019a; Martínez & Rhodes, 2019). Although research suggests that the Latinx population is healthier than their non-white Latinx counterparts, they endure many negative experiences affecting their mental health (Calzada et al., 2019a). Data from the National Survey on Drug Use and Health revealed that the Latinx community made up 5.1% of adults with a serious mental illness (SMI) (SAMHSA, 2019). Among Latinx aged 18 or older, 18% had a mental illness (SAMHSA, 2019). Such rates also need to be examined within the context of acculturation and immigration journeys. For instance, one in every two Mexican American adults is susceptible to mental health struggles, a 2.5 increase over their immigrant counterparts (Vega

et., 1991). The immigrant paradox (Alegria et al., 2008) highlights the stark differences among U.S.-born, immigrant, and/or acculturated Latinxs in their mental health struggles.

Although the research literature on Latinx mental health has increased over the years, it remains sparse. Considering such glaring inequities in the mental health treatment of minoritized individuals, strategic plans from the National Institutes of Health (e.g., National Institute of Minority Health and Health Disparities) have emerged. However, data on the prevalence rates of mental health disorders among the Latinx population is scarce (Vega & Alegria, 2001). Several studies suggest that the prevalence of mental health disorders within the immigrant population differs depending on the age of arrival to the United States (Alegria et al., 2007). Of the current regional and national studies on mental health, ethnic-specific research examining the experiences of U.S.-born Latinxs and Latinx immigrants is still lacking (Martínez & Rhodes, 2019). Not only do Latinxs experience multiple stressors affecting their mental health, but they experience barriers to culturally responsive treatment and care. Such barriers result in an influx of untreated mental health concerns and disorders within a heterogenous Latinx community (Calzada et al., 2019a; Martínez & Rhodes, 2019).

In addition to the need for culture-specific research on U.S.-born Latinxs and Latinx immigrants, most clinical training, DSM-5 diagnoses, and clinical theoretical orientations are heavily influenced by westernized notions of psychopathology (Martínez & Rhodes, 2019). Imposing a westernized conceptualization of mental health on Latinx populations is problematic, as cultural variations, ethnic differences, and lived experiences are indirectly dismissed (Arellano-Morales et al., 2016). Therefore, a critical understanding of the mental health processes and outcomes of all Latinxs through a culturally focused lens is essential.

The lack of research, unclear incidence and prevalence rates, and an overall understanding of mental health experiences through a westernized lens translates into a lack of resources available for mental health providers to implement culturally responsive psychological interventions (Calzada et al., 2019b; Martínez & Rhodes, 2019). The new wave of immigrant communities migrating to non-traditionally Latinx states, coupled with the rise of xenophobia, is also vital to consider within the context of access and availability (e.g., fewer bilingual and culturally responsive mental health providers) to Latinx-centered care (Calzada et al., 2019b). Given the growing body of evidence that cultural factors shape prevalence rates, etiology, and assessment of mental illness, mental health providers need additional tools to meet the demands of this growing population (Calzada, 2019a).

Latinx Immigrants and Mental Health

An increasing volume of research has demonstrated that immigrants, regardless of legal status, encounter significant stress prior, during, and following migration (Crocker, 2015; Hovey & King, 1996; Sullivan & Rehm, 2005). The immigration experience is linked to lower levels of well-being due to family separation, discrimination, loss of social status, and exposure to traumatic events (Potochnick & Perreira, 2010). Research also shows that Latinxs residing in the United States, whether U.S.-born, undocumented, or documented, face additional challenges, including marginalization; socioeconomic inequality; reduced social and physical integration to the broader community; and stigma associated with the "illegal" status (Brindis et al., 2014; Gleeson & Gonzales, 2012; Hacker et al., 2011; Menjivar, 2006; Perez & Fortuna, 2005; Stacciarini et al., 2015; Sullivan & Rehm, 2005). Poor mental health outcomes (e.g., depression, anxiety, trauma) are further magnified for undocumented immigrants (Organista, 2007; Perez & Fortuna, 2005). For instance, Deferred Action for Childhood Arrivals (DACA) recipients, who

struggle with the perpetual fear of deportation and family separation, faced increased stress due to restrictive exclusionary immigration policies including the termination of DACA in 2017; a decision that the Supreme Court overturned on June 18, 2020.

Undocumented Immigrants

The Pew Research Center reports that approximately 44.8 million people residing in the United States were born in another country, making up one-fifth of the world's migrant population (Budiman, 2020). In 2018, the U.S. foreign-born community accounted for an estimated 13.7% of the nation's populace (Budiman, 2020). Of the U.S. foreign-born population reported in 2018, 44% (19.8 million people) were reported to be of Latinx origin (Batalova et al., 2020). Between 2017 and 2018, the Mexican community made up 25% of all immigrants. Further, Puerto Ricans accounted for 10% of the population (the second-largest group of Latinxs in the United States). This was subsequently followed by immigrants from El Salvador, Cuba, and the Dominican Republic at 3% of the population, immigrants from Guatemala at 2%, Honduras at 1.4%, and Nicaragua at .5% (Batalova et al., 2020; Noe-Bustamante et al., 2019; O'Connor et al., 2019). However, it is essential to note, the number of undocumented immigrants living in the United States has significantly dropped in the last decade, with the decrease attributed to the economic downturn between 2007 and 2009 (Krogstad et al., 2019).

Undocumented migration remains a timely public policy and social justice issue in the United States. From a mental health perspective, it is well recognized that the 11 million undocumented immigrants in the United States are at risk for poor mental health outcomes, experiences of xenophobia and discrimination, and acculturative stress (American Psychological Association, 2012; Devi, 2009; Passel, 2019; Ruiz et al., 2013). Additionally, results from various studies suggest that harsh anti-immigrant policies in the United States increase the risk of

deportation and place limits on legal and social services, thus affecting mental health outcomes and contributing to the mistrust in the health care system (Garcini et al., 2017; Hacker et al., 2011; Hacker et al., 2012; Hatzenbuehler et al., 2017; Sommers, 2013). As the government enacts more restrictive and exclusionary immigration policies targeting the Latinx immigrant community—in particular the Mexican and Central American communities (Press Office, 2017a)—we argue that such policies negatively affected the mental health of undocumented Latinxs between 2016 and 2020when undocumented Latinxs were dehumanized and vilified, and this led to an increase in immigration raids, mass deportation at alarming rates, and experiences of discrimination. It may take many years for all Latinxs, but particularly the undocumented Latinx community and their families, to heal from the trauma, anxiety, depression, and the overall sense of despair, fear, and rejection brought forth by anti-immigration policies and procedures.

Deferred Action for Childhood Arrivals

The increasingly stringent changes in immigration policy also had a significant impact on individuals enrolled in the DACA program. The DACA program is an executive order issued on June 15, 2012, giving qualified undocumented young people access to temporary relief from deportation, renewable work permits, and temporary Social Security numbers (see Table 1 for eligibility criteria for DACA; Gonzales et al., 2014; U.S. Citizenship and Immigration Services, 2017). The most recent data suggest there is an estimated 700,000 active DACA recipients residing in the United States (U.S. Citizenship and Immigration Services, 2019). While the program provides temporary relief to recipients, the absence of recognized “legal status” by the United States government can have adverse psychological and social outcomes (Renteria et al.,

2020). In the past few years, several articles have summarized the experiences, risk factors, and mental health of DACA recipients (Benuto et al., 2018; Garcini et al., 2017; Hipsman et al., 2016). Researchers and mental health providers increasingly emphasize the emotional and psychological components of being undocumented, DACAmented, and DACAlimited (Benuto et al., 2018). Specifically, the experience of DACA recipients has been linked to high psychological distress, identity development confusion, and trauma (Paat & Pellebon, 2012; Von Blum, 2017).

Table 1. Eligibility criteria for Deferred Action for Childhood Arrivals (DACA)[a].

✓	Under 31 years of age as of June 15, 2012
✓	Arrived to the U.S. before 16th birthday
✓	Continuously resided in the U.S. since June 15, 2007
✓	Arrived in the U.S. without inspection before June 15, 2012, or if lawful immigration status expired, as of June 15, 2012
✓	No lawful status and physically present in the U.S. as of June 15, 2012
✓	Currently in school, have graduated or obtained a certificate of completion from high school, have obtained general education development certificate, or honorably discharged veteran of Armed Forces
✓	Have not been convicted of a felony, significant misdemeanor (or more than two other misdemeanors), and/or otherwise do not pose a threat to public safety or security

[a]Citizenship and Immigration Services, U.S. Department of Homeland Security (2017).

Investigators have begun to research the micro and macro benefits of being DACA eligible and having DACA status. Results on DACA's short-term impacts suggest that the program has increased young people's access to education, new opportunities and temporarily removed the fear of deportation (Batalova et al., 2014; Gonzales & Bautista-Chavez, 2014; Gonzales et al., 2014). Yet, these young adults remain in a state of uncertainty, emotionally and psychologically worried about their time and future in the United States. For instance, months of

anti-immigrant rhetoric and actions (e.g., increase in Immigration and Customs Enforcement [ICE] raids), resulted in the rescission of DACA, which had an impact on the mental health of DACA recipients (Uwemedimo et al., 2017). Such events fueled distress and fears among the Latinx undocumented community. Although on June 18, 2020, the Supreme Court rejected the government's efforts to rescind DACA, which suspended the deportation of approximately 900,000 individuals, the distress and fear remain for many, if not all, DACA recipients and their families (Eastman, 2021). Although the program is not a pathway to citizenship, it has shown that DACA-eligible individuals are likely to experience a reduction in feeling nervous, hopeless, depressed, restless, and less likely to meet screening criteria for moderate or worsening psychological distress (Venkataramani et al., 2017). As more undocumented individuals gain DACA status, mental health professionals are asked to become familiar with risk factors and legal issues that may impact the mental health of the undocumented and DACA community (Cadenas et al., 2020).

Migration Realities

Sociopolitical factors and legislation

The history of Latinx migration to the United States is complex and rooted in its territorial and economic expansion, greed for world dominance, involvement in suppression of leftist reform in parts of Latin America (e.g., Guatemala, El Salvador, Honduras) for self-interest, foreign policy, and mass deportation policies. Yet, Latinx migration to the United States in popular discourse is often described as a personal decision made by an individual or family (Garcia Bedolla, 2009). What is often overlooked and left out of the discussion are structural factors; macroeconomic context that influence the decision; and U.S. political and economic involvement in the country of origin (Garcia Bedolla, 2009). In addition, it is essential to

recognize the influence primary U.S. legislation (see Table 2; adopted from Tienda & Sanchez [2013] and slightly modified) has had on Latinx migration. Take, for example, the Nicaraguan Adjustment and Central American Relief Act (NACARA), which allowed Salvadorans, Guatemalans, and Nicaraguans who had fled violence and poverty during the political instability of the 1980s to file for asylum (Tienda & Sanchez, 2013; U.S. Citizenship and Immigration Services, 2017). The sociopolitical factors and legislation influencing undocumented migration must be considered to help mental health providers understand attitudes, beliefs, cognitions, behaviors, realities, expectations, and the Latinx immigrants' lived experiences in the United States.

Table 2. Major U.S. legislation concerning Latin American immigration: 1952 – 2012[a].

Legislation	Date	Key Provisions
Immigration and Nationality Act (INA)	1952	Established the first preference system. Retained national origins quotas favoring Western Europe. Imposed ceiling of 154K plus 2k persons from Asia-Pacific Triangle.
Immigration Act (Amendments to INA)	1965	Repealed national origin quotas. Set a maximum limit on immigration from the West (120K) and Eastern Hemisphere (170K). Revised visa preference system to favor family reunification. Established uniform per-country limit of 20,000 visas for the Eastern Hemisphere.
Cuban Adjustment Act (CAA)	1966	Allowed undocumented Cubans who had lived in the United States for at least one year to apply for permanent residence.
Refugee Act	1980	Adopted UN protocol definition of refugee.

Legislation	Date	Key Provisions
		Created systematic procedures for refugee admission. Established resettlement procedures. Eliminated refugee from the preference system. Instituted the first asylum provision.
Immigration Reform and Control Act (IRCA)	1986	Instituted employer sanctions for hiring undocumented immigrants. Legalized undocumented immigrants. Increased border enforcement. Established "wet foot/dry foot" policy.
Cuban Migration Agreement (CMA)	1994-1995	Set up a minimum of 20,000 visas annually. Conducted in-country refugee processing.
Illegal Immigration Reform and Immigration Responsibility Act (IIRIRA)	1996	Strengthened border enforcement and raised penalties for unauthorized entry and smuggling. Expanded criteria for exclusion and deportation. Initiated the employment verification pilot programs.
Nicaraguan Adjustment and Central American Relief Act (NACARA)	1997	Legalized Nicaraguans and Cubans. It later legalized ABC class members (Salvadorans and Guatemalans).
Temporary Protected Status (TPS)		Granted temporary legal status to nationals of countries that experienced an armed conflict or a major natural disaster.
	1990	TPS granted to Salvadorans due to the civil war (lasted 18 months).
	1998	TPS granted to Hondurans and Nicaraguans due to damages caused by Hurricane Mitch (expired 2013).

Legislation	Date	Key Provisions
	2001	TPS granted to Salvadorans following an earthquake (expired 2013).
	2021	TPS granted to Venezuelans following a severe humanitarian crisis (expires 2022).
Deferred Action for Childhood Arrivals (DACA)	2012	DACA provides a 2-year deferment for deportation action and provides eligibility for work permit.

[a]Citizenship and Immigration Services, U.S. Department of Homeland Security, 2021; Passel & Fix 1994; Jasso & Rosenzweig, 1990; Tienda & Sanchez, 2013; Wasem, 2009.

Migration process

Research shows that most Latinxs immigrate as a result of supply-push factors (e.g., poverty, violence, gender inequality, persecution based on sexual and gender identity, political corruption, lack of access to adequate health care and education) and demand-pull factors (e.g., economic opportunity, family reunification, access to adequate health care and education; Fisher & Lewin, 2018; Rosenblum & Brick, 2011). Yet, each individual and family might have different reasons or life circumstances that prompt their departure to the United States. Following the decision to leave, research shows that most Latinx immigrants do so with a strong sense of hope, optimism, and self-determination (American Psychological Association, 2012; Guthey, 2001). Despite the stark realities experienced during migration (e.g., dangerous conditions, robbery, sexual and physical abuse, illness, and exploitation; DeLuca et al., 2010; Massey et al., 2002; Moynihan et al., 2008; Rasmussen et al., 2007) and after arriving in the United States (e.g., racial and ethnic discrimination, language challenges, acculturation, poverty; Marrow, 2009), Latinx immigrants and their families often display resilience and optimism, set roots despite adversity, and are resourceful in navigating an unfamiliar and sometimes anti-immigrant legal

system (American Psychological Association, 2012; Cardoso & Thompson, 2010; Casas & Cabrera, 2011; Hagelskramp et al., 2010). In addition to magnifying resilience and persistence of Latinx immigrants and their families prior to and during migration, it is critical to also understand their lived experience post arrival to obtain a holistic understanding of their physical and mental health.

Throughout this nation's history, Latinx immigrants' lived realities are quite different from what is televised and commonly understood. For example, the challenges of adjusting to an anti-immigrant context, interpreting state and federal anti-immigrant legislation, changes in family structures, and racial and ethnic discrimination are often omitted (Marrow, 2009). Additional postmigration stressors include racial segregation in neighborhoods, reduced access to economic opportunities, and increased vulnerability to crime, poverty, and exploitation (Feldmeyer, 2009; Iceland & Scopilliti, 2008). Immigration policy, segregation, and the various societal inequities are products of structural racism that are often minimized in the stories of Latinx immigrants and their families in the United States. As a result, it is critical for mental health providers to incorporate the impact of structural racism, documentation status stressors, and additional forms of oppression in patient conceptualizations when providing care to undocumented Latinxs and their families.

The psychological implications associated with the experience of being an immigrant (undocumented, DACAmented, documented) may lead to poor mental health outcomes for Latinxs. Mental health providers are encouraged to incorporate a holistic conceptual approach that considers sociopolitical factors in the country of origin and the United States, and the context of structural racism to better understand the lived experience of Latinx immigrants. Documenting their experience may require mental health providers to ask questions about pre-,

during, and post-migration experiences (Silva et al., 2017). In sum, mental health providers are encouraged to expand their conceptual framework and treatment modalities when providing care to individuals with immigrant backgrounds.

Implications

The goal of this chapter and subsequent sections is for mental health providers and clinical educators to gain a deeper understanding of the various forms of oppression, colonialization, and sociopolitical and sociocultural factors that continue to influence the mental health of Latinxs (e.g., with ethnic roots in Mexico, Guatemala, El Salvador, and Honduras) in the United States. While this book is not intended to be comprehensive (and is limited in scope at times) of all Latinx groups in the United States, we hope mental health providers and clinical educators will gain an appreciation of the complexity and heterogeneity that exists within Latinx communities. For example, the vastly different opportunities and lived experiences of U.S.-born, undocumented, or documented Latinx groups. Furthermore, we offer mental health providers and clinical educators' significant historical content and context that covers periods of colonialization to present-day mental health concerns of Latinxs in the United States. In addition, we hope that mental health providers and clinical educators use the information presented through this book to understand how historical events have and continue to shape intersecting identities, ethnic pride, status, positionality, attitudes, beliefs, cognitions, behaviors, realities, and expectations of the four abovementioned Latinx groups in the United States.

Finally, we share closing thoughts that may enhance clinical practice and education when working with Latinx communities with ties to the four abovementioned countries. First, Latinx communities have endured centuries of colonialization, oppression, and hardship, and yet they persist and show immense resilience. Second, instead of asking what is wrong with members of

the Latinx community, we need to be asking how structural racism is impacting the well-being of our Latinx patients and challenge assumptions that pathologize normative individual reactions to systemic injustice. Third, it is critical to look beyond a western deficit model of mental health to conceptualize the behavioral, emotional, and cognitive functioning of Latinx groups. Fourth, we recommend using strength-based clinical conceptual models that recognize the endurance, optimism, resilience, cultural values, spirituality, and intersecting identities of Latinx groups. Lastly, given Latinxs' complex history and heterogeneity, we strongly suggest that mental health providers incorporate an emic, social justice, and liberation approach when providing clinical care to Latinx communities in the United States.

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CLINICAL CONSIDERATIONS

for Working with Latinx Communities in the United States

II

Introduction

The clinical considerations below are not intended to be exhaustive and it would be presumptuous to assume we have addressed every clinical concern. Our literature review led us to identify idioms of distress; treatment engagement strategies; culturally responsive clinical interview tools and interventions; approaches to reduce mental health stigma; and methods to address loss and grief when working with Latinx communities in the United States. Each clinical area addressed has some empirical support, strengths, and limitations. We hope that the strategies, models, and frameworks discussed in this chapter help mental health providers increase treatment engagement, utilization, adherence, and retention with Latinx patients.

Idioms of Distress

Across various mental health disciplines (e.g., psychology, social work, psychiatry), it has been highly contended that cultures influence the way distress is experienced and expressed. The presentation of psychological distress in non-western cultural contexts is manifested through bodily distress and symptoms or somatization (Guarnaccia et al., 2003; Guarnaccia et al., 2005). The bodily symptoms have been found to be clinically informative and described as idioms of distress. Cultural idioms of distress are adaptive responses through which distress is communicated in relation to personal and cultural meaning (Desai & Chaturvedi, 2017; Dura-Vila & Hodes, 2012). The presentation of bodily symptoms alone does not fulfill all the criteria laid out by the current Diagnostic and Statistical Manual of Mental Disorders-5 (DSM 5); yet they are clinically vital as they are often associated with psychiatric disorders such as mood and anxiety disorders, and psychosis (Cintron et al., 2005; Desai & Chaturvedi, 2017).

Amongst Latinxs, the experience and expression of emotional distress is manifested through physical complaints and idioms of distress (Angel & Guarnaccia, 1989). As noted by

various authors, common cultural idioms of distress among the Latinx community include *nervios* (nerves), *sustos* (fright), and *ataque de nervios* (attack of nerves; Dura-Vila & Hodes, 2012; Guarnaccia et al., 2003; Guarnaccia et al., 2005; Silva et al., 2017). Each of these include physical as well as psychological symptoms (National Hispanic and Latino MHTTC, 2019). Silva et al. (2017) provide queries to effectively and responsively obtain information on idioms of distress and resilience amongst Latinxs. Given that as a community Latinxs have been recognized to somaticize, mental health providers are highly encouraged to become familiar with somatic signs and symptoms manifested by Latinx patients to better understand mental health presenting concerns.

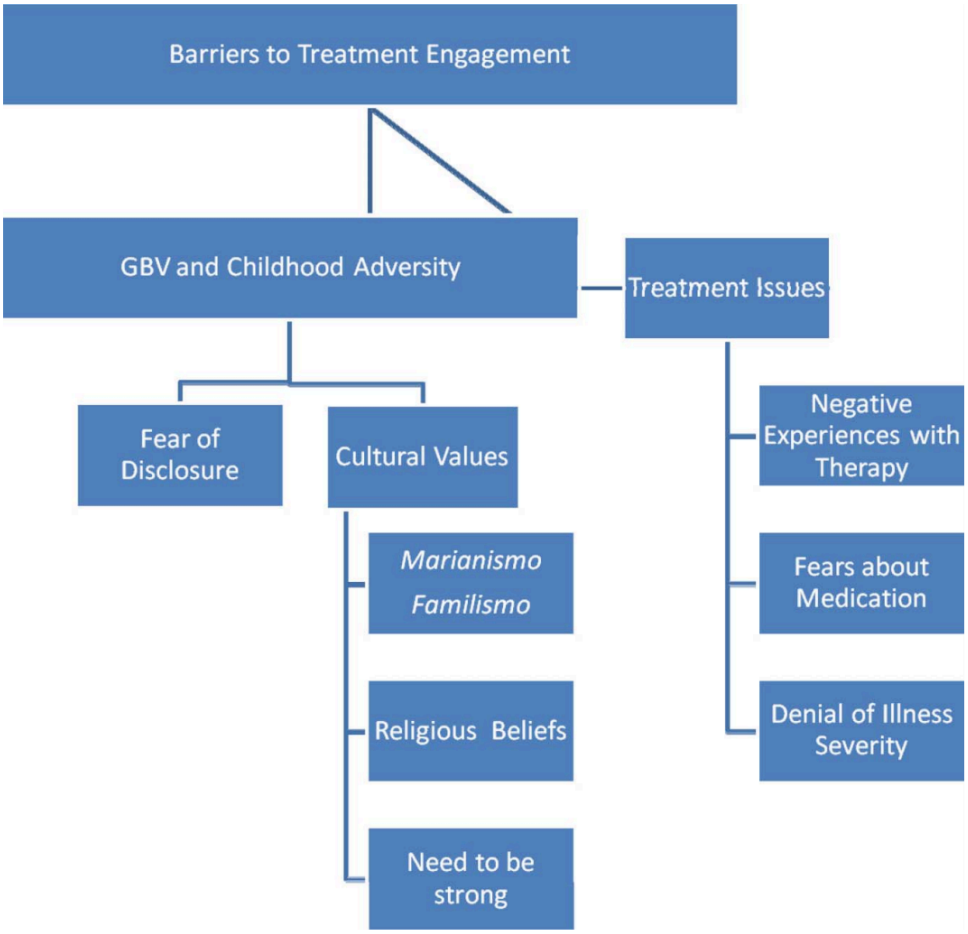
Treatment Engagement and Suggestions

Treatment engagement is a concept that encompasses identifying a mental health concern, deciding to seek professional care, maintaining participation in care, adhering to treatment, and minimizing dropout (Dixon et al., 2011). Treatment engagement for Latinxs is enhanced by the presence of bilingual, bicultural therapists and therapeutic relationships that incorporate cultural values and prior positive experiences with treatment (Aguilera et al., 2010; Cardemil et al., 2010 Piedra & Byoun, 2012). Treatment engagement is also enhanced by providing resources and decreasing barriers to care, such as bus passes, childcare, and assistance with making appointments (Dwight et al., 2004). Barriers to treatment engagement include lack of insurance, language barriers, lack of access to Medicaid specialty services in Latinx neighborhoods, lower levels of acculturation, self-reliant attitudes, and cultural differences that impact the recognition of mental health issues (Alegria et al., 2002). Stigma from society and family members, and the internalization of these perceptions, are often cited as a significant deterrent to treatment engagement, yet few studies are examining the quality of care from patient

perspectives (Cabassa et al., 2007; Interian et al., 2007; Nadeem et al., 2007; Vega et al., 2010). In addition, previous experiences with lower quality mental health care may discourage continued treatment engagement (Alegria et al., 2002).

Caplan and Whittemore (2013) explored the barriers to treatment engagement and how childhood adversity and gender-based violence contribute to a lack of perceived support for treatment engagement. A qualitative descriptive methodology was used to understand the experiences of Latinas who were part of a diabetes prevention study and had been referred for treatment because of elevated symptoms of depression. Barriers related to treatment engagement and perceived lack of support from family and religious leaders in the decision to seek help were predominantly driven by gender-based violence (GBV) and adverse childhood experiences, which engendered stigma and fear of disclosure. Cultural values and religiosity, personal values, and perceptions of the effectiveness of treatment for depression took on a different meaning in the context of GBV and adverse childhood experiences. Caplan and Whittemore (2013) created a framework to explain barriers to treatment engagement (see Figure 1). Such a framework can be used to assess a patient's level of treatment engagement.

Figure 1. Barriers to treatment engagement.



Culturally Responsive Interview Guides

The lack of culturally responsive clinical interview guides is a significant obstacle in the overall mental health treatment of Latinx patients. Despite the increased interest in providing culturally responsive clinical services, the challenge continues to lie in the various professions desire to prioritize clinically responsive over culturally responsive services (Gallardo et al., 2009). Unfortunately, many clinically responsive evidence-based diagnostic interview guides (e.g., Mini International Neuropsychiatric Interview [MINI], The Structured Clinical Interview for DSM-5 [SCID-5]) are developed, validated, and standardized on a non-Latinx White, middle-class population (Cervantes & Bui, 2015). As a result, selecting the appropriate clinical interview

guide may challenge mental health providers working with Latinx communities. As stated by Silva et al. (2017), "selecting the appropriate treatment relies on a correct assessment of the individual" (p. 454). However, most evidence-based diagnostic interview guides lack cultural responsiveness and may not capture Latinxs' cultural realities or lived experiences. To improve diagnosis and treatment planning with Latinx communities, we recommend incorporating culturally responsive clinical interview guides (see Table 3) into existing practice.

Table 3. Culturally responsive interview guides.

Interview guide	Authors	Components
Cultural Formulation Interview	American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (*DSM-5*®). American Psychiatric Pub.	Assesses cultural factors affecting the clinical encounter. Core components: (1) The cultural identity of the individual (2) Cultural conceptualizations of distress (3) Psychosocial stressors and cultural features of vulnerability and resilience (4) Cultural features of the relationship between the individual and the mental health provider (5) Overall cultural assessment
CAMINO	Silva, M. A., Paris, M., & Añez, L. M. (2017). CAMINO: Integrating context in the	Assesses aspects of the immigrant experience.

Interview guide	Authors	Components
	mental health assessment of immigrant Latinos. *Professional Psychology: Research and Practice*, *48*, 453-460. https://doi.org/10.1037/pro0000170	Core components: (1) (C)ommunity and family support (2) (A)cculturative stress (3) (M)igration history (4) (I)dioms of distress and resilience (5) (N)ative language and preferences (6) (O)rigin
A Guide for Conducting Cultural Assessment of Hispanic and Latino Clients	National Hispanic and Latino ATTC. (2017). *A Guide for conducting clinical assessment of Hispanic and Latino Clients.* Bayamón, PR: Universidad Central del Caribe.	Assesses acculturation and related stress factors. Core components: (1) Discrimination stress (2) Material stress (3) Health stress (4) Family related stress (5) Parental stress (6) Occupational stress (7) Unemployment and economic stress (8) Immigration stress
Assessment Algorithm	Manoleas, P., & Garcia, B. (2003). Clinical algorithms as a tool for psychotherapy with Latino clients. *American journal of orthopsychiatry*, *73*, 154-166. https://doi.org/10.1037/0002-9432.73.2.154	Assesses and prioritizes presenting concerns. Core components: (1) Crisis/urgent concerns

Interview guide	Authors	Components
		(2) Culturally responsive standard assessment
Clinical Ethnographic Interview	Arnault, D. S., & Shimabukuro, S. (2012). The clinical ethnographic interview: A user-friendly guide to the cultural formulation of distress and help seeking. *Transcultural psychiatry*, *49*, 302-322. https://doi.org/10.1177/1363461511425877	Assesses and gathers clinical information beyond verbal expression of symptoms. Core components: (1) Grand tour (2) Body map (3) Lifeline (4) Efforts to relive distress and symptoms

Cultural Formulation Interview

To better understand the mental health challenges many Latinx communities face, mental health providers are encouraged to engage in culturally responsive clinical interviewing (Gallardo, 2013; McAuliffe et al., 2006). The practice of culturally responsive clinical interviewing includes assessing the importance of culture for the patient, understanding perceptions of presenting mental health concerns and identifying cultural values and practices that shape the patient's life (McAuliffe et al., 2006). The Cultural Formulation Interview (CFI; 16-question semi-structured interview protocol) in the DSM-5 is an excellent example of a culturally responsive clinical interview guide that elicits individual explanations and perspectives within a social context, therefore, enhancing communication and understanding between the provider and patient from diverse racial and ethnic-cultural backgrounds, including Latinxs (Aggarwal et al., 2015; Lewis-Fernandez et al., 2017). The CFI was designed to capture the patient's voice during diagnostic evaluation and clarify cultural versus idiosyncratic details (Diaz

et al., 2017). The CFI is intended to improve culturally responsive diagnosis and treatment by focusing attention on relevant clinical information and social context (Jarvis et al., 2020). Research evaluations of the CFI have found the interview guide to be clinically acceptable and helpful in the United States and internationally (Aggarwal et al., 2015; Aggarwal et al., 2014; Lewis-Fernandez et al., 2017; Paralikar et al., 2015; Ramirez Stege & Yarris, 2017). Specific to a Latinx cultural context (in the United States and Mexico), the CFI was found to be clinically beneficial with Latinx patients in outpatient settings for diagnosis and treatment planning; decreasing mistrust during sessions; addressing the stigma of mental illness; and eliciting additional information related to social network and support (Diaz et al., 2017; Ramirez Stege & Yarris, 2017). In sum, the CFI can be used to engage in culturally responsive interviewing to gain a better understanding of culture and intersecting factors impacting a patient's clinical presentation.

CAMINO

Innovative clinical tools such as the CFI have demonstrated the benefits of engaging in culturally responsive interviewing. However, like with most clinical interviewing guides, caution must be taken as mental health providers run the risk of stereotyping and simplifying cultural material when using the CFI (Rousseau et al., 2020). In addition, in a migration context, the CFI may not effectively recognize or capture the complexity of the immigrant experience, particularly that of undocumented Latinx immigrants (Silva et al., 2017). Therefore, mental health providers must have access to culturally responsive interviewing guides that assess aspects of the immigrant experience that may not be easily elicited in standard Eurocentric clinical interview protocols. The psychosocial interview guideline, acronym CAMINO (Silva et al., 2017), is a culturally informed tool intended to facilitate the probing of contextual information

related to pre- and post-migration experiences of Latinx immigrants. Specifically, CAMINO is meant to prompt mental health providers to inquire about (**C**)ommunity and family support, (**A**)cculturative stress, (**M**)igration history, (**I**)dioms of distress and resilience, (**N**)ative language and preferences, and (**O**)rigin. It is important to note that CAMINO was designed to complement information gathered in a clinical interview, and not intended to be a diagnostic tool. Overall, CAMINO can uncover cultural assets of healing often overlooked by Eurocentric interview guides focused on identifying pathology.

Guide for Conducting Cultural Assessment for Hispanics and Latino Clients

Another culturally responsive interview guide that can help shed light on the role of culture, language, acculturation, and stress in the lives of Latinxs is the Guide for Conducting Cultural Assessment for Hispanics and Latino patients (Cervantes & Bui, 2015). This tool offers practical guidelines for assessing acculturation and related stress factors for both adolescents and adults. In addition, the guide is designed to improve and contribute to the cultural formulation and treatment planning of Latinx patients. Specifically, it prompts mental health providers to ask recommended questions on eight stress/risk domains: (1) discrimination, (2) marital, (3) health, (4) family, (5) parental, (6) occupation, (7) unemployment and economic, and (8) immigration. Furthermore, the interview guide is also intended to assist mental health providers in identifying protective factors, strengths, and resources that can be used to enhance coping strategies. Finally, it can be used to tailor and/or adapt interventions.

Assessment Algorithm

In beginning any clinical interview, it is critical to recognize the dangers of making diagnostic errors when the patient's culture and lived experience is not considered (Guarnaccia & Rogler, 1999; Mezzich et al., 2001). A culturally responsive clinical interview involves going

beyond both psychiatric symptoms and the effects of culture, and should inform the selection, development, and adaptation of treatment (Manoleas & Garcia, 2003; National Hispanic and Latino Mental Health Technology Transfer Center, 2017). As a result, the Assessment Algorithm is a clinical tool that can assist mental health providers in identifying and prioritizing presenting concerns related to individual behavior, family dynamics, and/or the effects of external environmental factors (e.g., experience of internalized racism, social iniquities, community and home violence, immigration policy, etc.; Manoleas & Garcia, 2003). The first part of the Assessment Algorithm involves gathering information to determine if the patient and/or the patient's family is experiencing a crisis. The second part includes identifying presenting concerns and symptoms using standard culturally responsive clinical interview guides. Information gathering in the second phase involves inquiring about physical health concerns. Once information on physical complaints is obtained, mental health providers (at their discretion or after receiving consultation regarding next steps) are then tasked with determining whether physical complaints require a medical referral or are the expression of somatic psychological distress (Escobar et al., 1987; Kirmayer & Young, 1998). Additionally, the authors of the Assessment Algorithm stress that the "diagnostic interview with Latinx patients often appear more like a *charla* (informal conversation) than like a structured interview" (Manoleas & Garcia, 2003; p. 161). The Assessment Algorithm is often helpful during the initial evaluation of a patient and/or family and can inform the treatment plan.

Clinical Ethnographic Interview

The Clinical Ethnographic Interview (CEI) is another culturally responsive interview framework and interview guide that can be used to assess and gather information beyond verbal expressions of symptoms (Arnault & Shimabukuro, 2012). In fact, according to Gallardo and

Gomez (2015), "relying only on the expression of symptoms and concerns through verbal communication can limit many Latina/o patients in fully expressing their lived experience, thereby providing insufficient data to clinicians" (p. 179). Therefore, it is important for mental health providers to have access to frameworks and clinical interview guides that inquire about sensations in the body, especially when working with Latinx patients who often express psychological concerns through somatic experiences (Kirmayer & Young, 1998). Therefore, the CEI is an effective clinical interview guide to use with Latinx patients, given its emphasis on the social implications of sensations and experiences. The CEI focuses on various tenets and asks about social roles and personal identity, and how these influence social interactions; social significance of sensations or symptoms; and social support and social exchange (Arnault & Shimabukuro, 2012). The first section in the CEI asks patients to provide information of their social networks, which is meant to mobilize social support. The "body map" is the second section in the CEI, allowing patients to express their experience and how they feel through a visual representation. The third section is the "lifeline," a graphic representation of the patient's past and present life, aimed at connecting past experiences and current behaviors. The last section of the CEI asks about efforts and behaviors implemented to relieve distress or symptoms. Similar to the above-mentioned clinical interview guides, the CEI is meant to complement diagnostic interview tools.

Culturally Adapted Evidence-Based Interventions

Research has suggested that the cultural adaptation of existing evidence-based treatments (EBT) can help to address disparities in treatment utilization among Latinx communities (Smith et al., 2011; Substance Abuse and Mental Health Service Administration, 2017). A review of existing treatment outcome research showed that when treatment is congruent with the cultural

worldview of the patient, the more likely treatment is to be effective (Smith et al., 2011). While there is evidence to demonstrate the effectiveness of culturally adapted EBTs with Latinx communities (e.g., Rodriguez et al., 2011; Paris et al., 2018), caution must be taken not to generalize culturally adapted treatment across Latinx communities. As a result, before implementing a culturally adapted EBT, mental health providers are encouraged to consider the heterogeneity that exists within the Latinx community.

The Cultural Adaptations of Evidence-Based Interventions for Latinx Populations Toolkit pending for publication (National Hispanic and Latino Mental Health Technology Transfer Center, 2022), is a great resource designed to train mental health providers to adapt existing EBTs for Latinx communities. The toolkit also provides a collection of cultural adaptation models, frameworks, and methods, in addition to a discussion on the benefits and challenges of cultural adaptation. Furthermore, this toolkit offers recommendations and resources that can help in the cultural transformation and implementation of existing EBTs, such as Motivational Interviewing, Cognitive-Behavioral Therapy, and family interventions. The authors also suggest to culturally adapt individual therapy elements, pharmacological aspects, systems therapy components, and parent and child development intervention elements. The use of this resource can have a significant impact on the delivery of culturally adapted EBTs and help overcome treatment utilization barriers among Latinx communities.

Mental Health Stigma

One of the most significant barriers for accessing behavioral health services among Latinx communities is stigma (Eghaneyan et al., 2020; Shim et al., 2009). Corrigan and colleagues (2014) describe two forms of stigma related to accessing care: 1) *person-level barriers* described as a set of beliefs, attitudes, and knowledge that prevent individuals from

seeking care and also affects retention in treatment, a negative perception of mental health (e.g., belief that treatments will not be effective, it is not culturally appropriate and relevant), and lack of social support that encourages seeking treatment; and 2) *provider and system-level barriers* described as systemic forces that prevent individuals from accessing care due to financial constraints, insurance coverage, documentation status, and lack of cultural competency among providers. Further, stigma related to mental health can manifest through *public stigma* and *self-stigma*. *Public stigma* consists of discriminatory stereotypes and prejudices towards people with mental health concerns such as labeling them as dangerous and incompetent which hinders receiving mental health care (Corrigan et al., 2014). *Self-stigma* occurs when individuals with mental health concerns internalize the discriminatory stereotypes and prejudices from the public which affects their self-esteem, perception of self, increases shame, and prevents individuals from accessing care (Corrigan et al., 2014).

Researchers argue that it is important to consider stigma within a cultural context when working with diverse populations (e.g., Abdullah & Brown, 2011). Within the Latinx community many cultural values are linked to stigma and access to care (for a detailed review of Latinx cultural values and barriers to accessing care we suggest reading *Examining Cultural Mental Health Care Barriers Among Latinos* authored by Barrera and Longoria [2018]). Researchers suggest that some Latinx individuals may view people with mental health concerns as weak, useless, and dangerous. These viewpoints are contradictory to Latinx cultural values of *marianismo* (e.g., emphasizes that women should be passive, self-sacrificing, withstand suffering, be nurturing, and morally just; Nuñez et al., 2016) and *machismo* (e.g., emphasizes that men should be strong, brave, dominant, protectors of the family; Abdullah & Brown, 2011; Nuñez et al., 2016), as a Latinx individual with mental health concerns highlight the opposite of

these values (e.g., men need to be strong and admitting mental health concerns may be viewed as weakness and women need to be nurturing and having mental health concerns may be viewed as uselessness). Additionally, Kouyoumdjian and colleagues (2003) highlight several themes that often prevent Latinx individuals from accessing care due to stigma, such as socioeconomic status (e.g., living in poverty, unemployment, educational attainment), low levels of mental health literacy, perceptions of mental illness, and *familismo* (valuing of family over individual needs and the emphasis on privacy).

Further, stigma among Latinx individuals has been associated with lower rates of anti-depressant medication adherence (Interian et al., 2007); decreased likelihood to use any type of psychotropic medication (Blanco et al., 2007; Paulose-Ram et al., 2007); and increased likelihood to report higher levels of shame and embarrassment related to having mental health concerns compared to non-Latinx Whites (Jimenez et al., 2013). Additionally, Latinx individuals are more likely to terminate treatment prematurely (Olfson et al., 2009). Analogous research has found that perceived barriers to treatment, parental education, higher levels of Latinx identity, and Spanish language preference were related to lower mental health service utilization and dropout rates (Keyes et al., 2011; McCabe, 2002). Substance use behavioral health utilization is even lower than mood-related behavioral health for Latinx individuals (Keyes et al., 2011), further highlighting health disparities compounded by stigma. Fundamentally, it is important to consider both the heterogeneity of the Latinx community, and how a patient's multiple intersecting identities can influence stigma and help-seeking behaviors (Eghaneyan & Murphy, 2020).

Latinx individuals are more likely to seek treatment for physical and mental health concerns from their primary care provider. For Latinx individuals living with a mental health

concern, less than one in eleven has contacted a mental health provider, and that rate is even lower for Latinx immigrants (Herman et al., 2016; Rios, 2005). Therefore, it is essential to incorporate and discuss mental health specialty care within this clinical milieu given the relationship between stigma and mental health for Latinx individuals (Vega et al., 2007). There are also training implications for providers as they may be the first to detect a mental health concern during a routine visit and are in a position to educate individuals about the connection between physical well-being and emotional distress.

Eghaneyan and Murphy (2020) argue that to decrease and eliminate stigma related to behavioral health utilization, providers need to assess stigma and barriers to care. To address this need, they conducted a systematic review of various stigma-related measures commonly used within the Latinx community (see Table 2). In addition, Vega, and colleagues (2010) developed a stigma checklist for treating English -and Spanish-speaking Latinx patients within a primary care setting. The stigma checklist helps to assess stigma related to depression and treatment. The prompt for the checklist begins with:

> *"People have different opinions about depression and what it means for their life. I'm interested in your feelings about this. Can you tell me whether you:"* and example items include: "*Are concerned about receiving treatment for depression because people will think less of you?*" and "*Believe people who take medication for depression have difficulties solving their problems?*"

The authors recommend that mental health providers use this scale to examine perceptions of stigma and facilitate a conversation with patients that will help decrease stigma and encourage them to pursue needed treatment.

Table 4. Stigma-related measures.

Instrument	Stigma construct(s) measured	Source(s)
Stigma Tolerance subscale of Attitudes toward Seeking Professional Psychological Help (ATSPPH-ST)	Stigma tolerance in seeking professional psychological services	Fischer, E. H., & Turner, J. L. (1970). Orientations to seeking professional help: Development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology, 35,* 79–90. https://dx.doi.org/10.1037/h0029636
Modified Perceived Discrimination and Devaluation Scale (PDD)	How others discriminate/ devalue patients with depression	Link, B. G., Struening, E. L., Neese-Todd, S., Asmussen, S., & Phelan, J. C. (2001). Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric Services, 52,* 1621–1626. https://dx.doi.org/10.1176/appi.ps.52.12.1621
Versions of the Social Distance Scale	Stigma towards mental illness Suicide stigma Desired social distance from someone with depression	Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). The social rejection of former mental patients: Understanding why labels matter. *American Journal of Sociology, 92,* 1461–1500. https://dx.doi.org/10.1086/228672 Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A., & Pescosolido, B. A. (1999). Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *American Journal of Public Health, 89,* 1328–1333. https://dx.doi.org/10.2105/AJPH.89.9.1328
Beliefs Toward Mental Illness Scale (BTMI)	Stigma toward mental illness	Hirai, M., & Clum, G. A. (2000). Development, reliability, and validity of the Beliefs Toward Mental Illness Scale. *Journal of Psychopathology and Behavioral Assessment, 22,* 221–236. https://dx.doi.org/10.1023/A:1007548432472
Stigma Scale for Receiving Psychological Help (SSRPH)	Stigma toward psychological help	Komiya, N., Good, G. E., & Sherrod, N. B. (2000). Emotional openness as a predictor of college students' attitudes toward seeking psychological help. *Journal of Counseling*

		Psychology, 47, 138 143. https://dx.doi.org/10.1037/0022-0167.47.1.138
Attribution Questionnaire (AQ-27)	Mental illness stigma (schizophrenia)	Corrigan, P., Markowitz, F. E., Watson, A., Rowan, D., & Kubiak, M. A. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal of Health and Social Behavior, 44,* 162–179. https://dx.doi.org/10.2307/1519806
Subscale of Inventory of Attitudes Toward Seeking Mental Health Services Scale (IASMHS)	Indifference to stigma	Mackenzie, C. S., Knox, V. J., Gekoski, W. L., & Macaulay, H. L. (2004). An adaptation and extension of the attitudes toward seeking professional psychological help scale. *Journal of Applied Social Psychology, 34,* 2410–2433. https://dx.doi.org/10.1111/j.1559-1816.2004.tb01984.x
Self-Stigma of Seeking Psychological Help Scale (SSOSH)	Self-stigma of seeking psychological help	Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53,* 325–337. https://dx.doi.org/10.1037/0022-0167.53.3.325
Modified Perceptions of Stigmatization by Others for Seeking Help Scale (PSOSH)	Perceived stigmatization by others for seeking psychological help	Vogel, D. L., Wade, N. G., & Ascheman, P. L. (2009). Measuring perceptions of stigmatization by others for seeking psychological help: Reliability and validity of a new stigma scale with college students. *Journal of Counseling Psychology, 56,* 301–308. https://dx.doi.org/10.1037/a0014903
Stigma Concerns about Mental Health Care Scale (SCMHC)	Stigma toward depression treatment/mental health care	Interian, A., Ang, A., Gara, M. A., Link, B. G., Rodriguez, M. A., & Vega, W. A. (2010). Stigma and depression treatment utilization among Latinos: Utility of four stigma measures. *Psychiatric Services, 61,* 373–379. https://dx.doi.org/10.1176/ps.2010.61.4.373
Versions of the Latino Scale for Antidepressant Stigma (LSAS)	Antidepressant stigma	Interian, A., Ang, A., Gara, M. A., Link, B. G., Rodriguez, M. A., & Vega, W. A. (2010). Stigma and depression treatment utilization among Latinos: Utility of four stigma measures. *Psychiatric Services, 61,* 373–379. https://dx.doi.org/10.1176/ps.2010.61.4.373

Self-Stigma of Depression Scale (SSDS)	Self-stigma of depression	Barney, L. J., Griffiths, K. M., Christensen, H., & Jorm, A. F. (2010). The Self-Stigma of Depression Scale (SSDS): Development and psychometric evaluation of a new instrument. *International Journal of Methods in Psychiatric Research, 19,* 243–254. https://dx.doi.org/10.1002/mpr.325
Stigmatizing Attitudes - Believability Scale (SAB)	Mental health stigmatizing attitudes	Masuda, A., & Latzman, R. D. (2011). Examining associations among factor-analytically derived components of mental health stigma, distress, and psychological flexibility. *Personality and Individual Differences, 51,* 435–438. https://dx.doi.org/10.1016/j.paid.2011.04.008 Masuda, A., Price, M., Anderson, P. L., Schmertz, S. K., & Calamaras, M. R. (2009). The role of psychological flexibility in mental health stigma and psychological distress for the stigmatizer. *Journal of Social and Clinical Psychology, 28,* 1244–1262. https://dx.doi.org/10.1521/jscp.2009.28.10.1244

Additionally, another way to decrease stigma-related concerns with Latinx individuals is by having mental health providers develop *confianza* (trust) with their Latinx patients by normalizing mental health concerns (e.g., providing prevalence rates), offering culturally and linguistic focused services, and exploring ways to reduce the financial burden of mental health treatment (Rios, 2005). Training key community stakeholders (e.g., educators) in promoting mental health services has been shown to be an effective intervention to decrease stigma and an essential component for recovery (Liana & Windarwati, 2021; Rios, 2005). Furthermore, *promotores,* or peer educators, can serve as a bridge between the individual and services, and normalize treatment seeking behaviors (Balcazar et al., 2010; Rios, 2005).

Kouyoumdjian and colleagues (2003) discuss several ways to increase behavioral health access and utilization for Latinx communities. They begin with highlighting the need to have flexible hours and meeting times (e.g., weeknights and weekends) for Latinx working-class communities, removing transportation as a barrier, having mental health clinics within predominantly Latinx communities, and offering child-care services during mental health office visits. Additionally, disseminating information related to culturally and linguistically competent care, providing psychoeducational workshops related to mental illness, and highlighting services available are key interventions to increase utilization. Further, disseminating information at local community spaces, religious organizations, and accessibility to Spanish language materials are important considerations for decreasing stigma.

Añez and colleagues (2005) provide a detailed list of important cultural considerations (e.g., *familimso*, *personalismo*, *respeto*, *confianza*, *dichos*, *fatalismo controlarse*, *aguantarse*, *sobreponerse*) and guidelines when working with Latinx individuals that can help providers decrease perceived stigma and help retain Latinx patients in treatment. Finally, Hatzenbuehler and colleagues (2017) found that Latinx individuals living in states with harmful immigration policies experienced lower levels of mental health than Latinx individuals living in states with more affirming immigration policies. These findings are compounded by self-stigma and public stigma creating a confluence of psychosocial and mental health concerns for Latinx communities. As such, mental health providers and researchers must advocate against harmful policies and call their legislative representatives for improved mental health care access and equity (Holder et al., 2019). The National Alliance on Mental Illness and Mental Health America have focused their efforts on decreasing mental health stigma through education, advocacy, and dissemination, yet more is needed to target the unique needs of Latinx individuals. The state of

California passed the *Mental Health Services Act* (2004) aimed at funding statewide initiatives to decrease mental health stigma and discrimination at the institutional, societal, and individual level in efforts to change the public perception of individuals living with mental illness (Clark et al., 2013). This type of initiative addresses the self-stigma and public stigma discussed in Corrigan and colleagues (2014) by targeting stigma at the micro and macro level of society, which are salient and important aspects of the lives of Latinx individuals.

Loss and Grief

The threat of deportation looms over the heads of some 40 million foreign-born individuals and families living in the United States (Pew Research Center, 2018). According to the United States Immigration and Customs Enforcement, 226,000 undocumented immigrants were deported in 2017, continuing a streak of increased immigration enforcement and resulting in more than 3 million deportations since 2008. Restrictive immigration policies in the United States promote hostile attitudes towards undocumented immigrants and place children at risk of forced family separation (Androff et al., 2011). More than 5.9 million citizen children live with at least one undocumented family member (Mathema, 2017). Between July 2010 and September 2012, 205,000 deportees reported having at least one U.S.-born child resulting in an estimated annual average of approximately 90,000 parental deportations (Wessler, 2011).

Despite their heterogeneity, most Latinx immigrants, like immigrants everywhere, confront loss, grief, and mourning related to their experience (Falicov, 2014). To help families cope with feelings of loss, mental health providers must account for the phenomenon of forced family separation in their assessments and clinical treatment processes as well as the experience of ambiguous loss. Once symptoms of ambiguous loss (prolonged grief, depression, and anxiety

to name a few) have been identified by a mental health provider, they can assist families in the process of change by creating/promoting a safe environment to explore their feelings.

Grief symptomology is assumed to be universal; however, bereavement varies across cultures and ethnicities (Rosenblatt, 2008). Therefore, to provide culturally responsive treatment specific to grief because of family separation, it is important to understand the bereavement and mourning experiences of Latinxs. Results from a study examining mental health concerns due to bereavement indicated that despite experiencing similar rates of mental health concerns as other ethnic groups, Latinxs underutilize mental health services (Hacker et al., 2015).

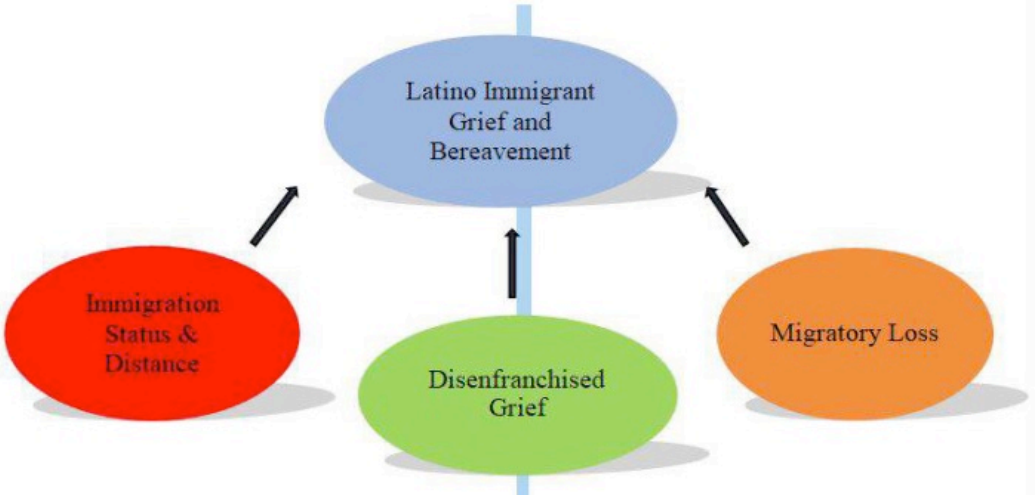
A qualitative study conducted by Nesteruk (2017) examining immigrants' experiences of coping with the deaths of family members in their home country found three related themes. The first theme pertained to the stressors of caregiving for aging parents in their country of origin. Participants described a sense of duty to provide direct care or financially contribute to the care of their aging loved ones in their home countries. The second theme was distance and its impact on their ability to participate in death-related rituals. Many participants reported grieving alone in their adoptive country because of distance and a lack of familial support. The third theme was anticipatory grief and resiliency due to coping with migratory losses earlier in life. Another qualitative study conducted by Bravo (2017) focused on undocumented immigrants' experiences dealing with deaths in their home country. Bravo (2017) found that the grieving process of the undocumented population was unique to those who are documented because for undocumented immigrants there is no option to return. As a result, the author found that more undocumented immigrants were using online platforms like Skype, Facebook, and WhatsApp to achieve a virtual co-presence and the illusion of 'being there' when they experienced the death of a loved one in their home country. Although communication technologies did not replace the closure

face-to-face interactions provided, participants in this study reported it made life more bearable during challenging times.

Findings from Nesteruk (2017) and Bravo (2017) suggest that earlier life experiences such as migratory loss, relationships and contact with family in home countries, and immigration status impact immigrant's grief and bereavement journey. They also note that an immigrant's grief can be further prolonged or disenfranchised by the demands of family, jobs, social networks, and other roles in their host country. Mortell (2015) defines disenfranchised grief as the individual grief that cannot be openly acknowledged. This type of grief has also been correlated with complicated grief which is grief that remains unresolved. Therefore, an immigrant's grief and bereavement journey can be prolonged if the immigrant cannot cope with the loss of a loved one and unable to re-engage with their life in their host country. An immigrant's grief and bereavement journey can also be disenfranchised when the loss is not understood, acknowledged, or socially validated by people in their host country.

In sum, the grief and bereavement experiences of Latinx immigrants can be impacted by many factors including cultural perspectives; previous loss experiences; immigration status; and available resources and support (Lipscomb, 2020). The grieving and bereavement experiences of Latinx immigrants in this country can be represented by a preliminary model (see Figure 2) and discussed using three related themes (immigrant status and distance, disenfranchised grief, and migratory loss; Lipscomb, 2020). Exploring the grieving and bereavement experiences of Latinx immigrants can increase the visibility and needs of Latinxs coping with transnational deaths (Lipscomb, 2020).

Figure 2. Model of transnational grief and bereavement experiences in the Latinx immigrant population.



Conclusion

Our literature review on clinical considerations with Latinx communities suggest that there are various contextual and cultural factors that must be considered when engaging in clinical work with this population. In addition, we recognize the complexity of working with Latinx communities, that results from the heterogeneity of the community and intersecting identities. While there is no overarching framework for organizing every clinical concern, intersecting identities, ethnic differences, or perspectives, we hope that the information presented throughout this chapter serves as a guide for mental health providers working with Latinx communities. Furthermore, the resources offered are intended to enhance clinical practice; improve diagnosis and treatment planning; and be used in conjunction with existing practices. Although this chapter covered much ground, we highly encourage mental health providers to review original referenced work for a deeper understanding of the models and frameworks.

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FRICTION AT THE BORDER:

How a Historical Insight into Mexico and Mexican-Origin People in the United States can Inform Mental Health Services for Mexicans

III

Introduction

The Mexican and Mexican American community occupies a complex position in the United States. Knowing the history of Mexicans and Mexican Americans in the United States is crucial to a better understanding of the issues they may be facing. The next section will help clinicians understand and empathize with the Mexican-origin community by discussing historical contexts that may inform clinical practices:

1. the colonialization and history of Mexico;
2. waves of migration, U.S.-Mexico relations, settlement patterns, and current demographics; and
3. present-day experiences of Mexican-heritage individuals and families

We also provide a brief overview of Indigenous Mexican communities in the United States, employment and educational experiences, and religious and cultural background. Finally, we close out the chapter discussing colorism, stigma, historical trauma, mental health and substance use, and intersectionality within a Mexican and Mexican American context. Overall, this chapter aims to provide mental health providers with context and content that contributes to the rich culture of Mexican-heritage individuals and families in the United States, which in turn can inform mental health practices and treatment planning.

Historical Events

The invasion of Precolonial Mexico (1519-1521)

Individuals of Mexican ancestry have had a 500-year legacy of domination and subordination by European powers, including the Spanish, English, Portuguese, and French, and Anglo Americans in what is now the southwestern United States. Before the arrival of Hernán

Cortés and the Conquest of Mexico in 1521, there was a flourishing civilization in the Americas. Three hundred years of Spanish colonialism led to the oppression and exploitation of Indigenous populations; the establishment of a colonial relationship to serve the social and economic interests of the Spanish; the institutionalization of social classes based on race and place of birth; and the internalization of racial inferiority. The latter is evidenced by the perceived insult of the word "Indio" (Indian) in present-day Mexico and colorism within the Latinx community. The invasion of pre-colonial Mexico by the Spanish (1519-1521) unleashed mass death and disease, exterminating over 90% of the Native population in Mexico and across the Americas. Many Indigenous communities perished through violent encounters, and others due to exposure to infectious diseases introduced by the colonizers, for which the native people had no immunity (Estrada, 2009; Zentella, 2009). Before the arrival of the colonizers, the Indigenous groups were sovereign nations, each group having its own government, social systems, language, and cultural traditions. Although there was conflict among some of these groups, others held amicable exchanges (de la Peña, 2006). After the invasion, all were united by a collective experience of suffering and oppression (Estrada, 2009).

Impacts of the invasion and colonialization of Mexico

The impacts of the invasion of Mexico by Spain, and the colonial period that followed, have caused great physical, psychological, and socioeconomic distress in survivors and their descendants (Talebreza-May, 2015; Zentella, 2004). Perhaps the most insidious wounds from the colonialization affecting all Native people across the Americas were the processes of acculturation/assimilation and the cultural and intellectual violence, also known as "cultural and epistemological genocide" (Kirmayer et al., 2014). In Mexico, the epistemological genocide started with the destruction of the Indigenous architecture, artifacts, and records of their

intellectual legacy (de la Peña, 2006; Zentella, 2009). This continued with suppressing mother tongues, culture, and wellness traditions (Anzaldúa et al., 2003; Hoskins & Padrón, 2018). The surviving Indigenous peoples, along with new racially mixed groups (e.g., Mestizo, Castizo, Mulato, etc.), were forced to assimilate into Spanish culture, religion, and values, in a process that promoted the erasure of their Indigenous heritage and identities (de la Peña, 2006). However, the erasure of Indigenous heritage did not end with the War of Independence from Spain (1821). Until a few decades ago, the public educational system of Mexico promoted the idea that the Indigenous people had been decimated during the Spanish invasion (Churchill, 2000; Gutiérrez, 2015), whereas 10% of the Mexican population identifies as non-mixed Indigenous, and 20% claim Indigenous heritage. Moreover, newer DNA research indicates that the actual rate of Indigenous ancestry is much higher. Approximately 75% of the population has Indigenous mitochondrial DNA, meaning that the actual rate of Indigenous ancestry is at least 75% and may be even greater (de la Peña, 2006; Kumar et al., 2011).

Colonialization of Mexico (1521-1821)

Four processes characterized the period of colonial rule by the Spanish monarchy: (a) physical, sexual, psychological, spiritual, and intellectual violence against the native people (Anzaldúa et al., 2003; Brave Heart et al., 2011; Estrada, 2009; Zentella, 2009); (b) land displacement and eradication of economic, social, medical, and religious systems (Anzaldúa et al., 2003; Estrada, 2009); (c) *mestizaje* (inter-breeding); and (d) assimilation/acculturation processes. During this period, the colonizers tried to eradicate Indigenous people and their way of life (e.g., values, language, social systems, etc.). They also forced native women to interbreed with them, which led to the formation of a new race, Indigenous Spanish (e.g., Mestizo). These individuals from the new mixed race were indoctrinated with the values of the colonizers, such

as the Spanish language and the Catholic religion. Their Indigenous heritage was diminished and devalued, and those who embraced their ancestral ways became a target for further marginalization. When the nation of Mexico came into being (1821), a new identity was promoted by the government under the name *Mexicano* to encompass all ethnic groups. However, the core values of this identity were still those of the Spanish colonizers, and equality was only extended to those who embraced them.

The establishment of the *Encomienda* system forced Indians to become laborers on the lands of the Spanish ruling class. The *Hacienda* system further exploited Indians as forced labor made them indentured servants to the owners of various *haciendas* through credit advancement, also known as ‘‘debt peonage.’’ Indians who wished to move up the social ladder had to adapt to mainstream Spanish culture, while those with a European phenotype could enjoy the fruits of Spanish colonialism. Those with an Indian phenotype had little chance of climbing the social ladder and were typically relegated to the lower classes. The history of Latinx communities is rooted in, and defined by, colonialism, genocide, slavery, empire-building, occupations, anti-immigration, and violence towards Black and Indigenous communities (Hernandez-Wolfe, 2013).

The U.S.-Mexican War (1846-1848)

The conflict between Mexico and the United States commenced after New Spain (precolonial Mexico) gained independence from Spanish rule in 1821. Current Texas, then a part of Mexico, opened its doors to many Anglo Americans from the Southeast United States who brought with them a slave-based economy. People were welcomed under the condition that they did not have slaves and identified as Catholic; however, settlers brought slaves. When Mexico outlawed slavery, the economy of the new immigrants was compromised. Rebellion against the

new law led to their secession in 1836 and independence from Mexico as the Republic of Texas in 1837, which Mexico disputed. In 1845, the United States annexed Texas, setting off the U.S.-Mexican War in 1846. Mexico not only lost Texas, but half of its territory, including present-day Arizona, California, Colorado, Nevada, New Mexico, Utah, and Wyoming (see Figure 1 and 2). This transaction was ratified with the Treaty of Guadalupe in 1848 (Estrada, 2009; Ramirez & Hammack, 2014; Talebreza-May 2015; Zentella, 2004).

Figure 3. Mexico before the Treaty of Guadalupe Hidalgo.

Figure 4. Mexico after the Treaty of Guadalupe Hidalgo.

The United States won the war, and a treaty was signed in 1848 (The Treaty of Guadalupe Hidalgo). However, a key omission to the Treaty ratified by the United States Senate was the exclusion of Article X, which protected the rights of Mexican citizens in lands ceded to the United States. As a result of the Guadalupe Hidalgo Treaty, Mexico ceded almost half of its territory for 15 million dollars (Acuna, 2004). Mexicans became a conquered people, and many were soon displaced from their lands. Those who decided to stay in what was now the United States would become U.S. citizens after one year, thus resulting in the origins of Mexican Americans. Both Mexicans and Mexican Americans were discriminated against, exploited as cheap labor, and not given the same political and land rights as Anglo Americans. For many generations, Mexicans and Mexican Americans have endured being scapegoated in times of

economic downturns and viewed as a source of cheap, expendable labor in economic upturns. Mexican-origin people living in the United States were subjected to deportation if they could not provide documentation that they were U.S. citizens. They were forced to attend segregated schools (Mexican Schools), live in segregated neighborhoods, and were often viewed as inferior to Anglo Americans (Estrada, 2009).

Consequences of U.S. and Mexico relationship

The westward expansion of the United States brought about the peculiar notion of ‘‘manifest destiny’’ (e.g., belief that the expansion of the United States throughout the American continents was both justified and inevitable). In 1836, a mini-revolt among a group of settlers turned into a large-scale conflict for the possession of Tejas (Texas), a northern state of Mexico, which was eventually won by the settlers and shortly afterward became an independent republic. Even though they had fought beside the rebels, many Mexican citizens were dispossessed of their lands, and human rights violations were perpetrated, especially by the Texas Rangers, who killed Mexicans and Mexican Americans with impunity (Acuna, 2004; Rosenbaum, 1998).

Impacts of the U.S.-Mexican War

The movement of the border between Mexico and the United States brought about land displacement, forced assimilation, and marginalization to the original inhabitants of these territories (e.g., Indigenous and non-Indigenous Mexican communities and descendants from the Spanish settlers; Anzaldúa et al., 2003; Estrada, 2009; Ramirez & Hammack, 2014; Talebreza-May, 2015). The original inhabitants of the present-southwest were allowed to keep their land and become U.S. citizens or relocate to Mexico across the new southern border (Massey et al., 1990). The majority of Mexican nationals stayed in their residences and were granted U.S. citizenship, but their new citizenship was nominal; their status did not include all the social

privileges and rights accorded to full U.S. citizens, and the property rights were violated for many, which led to the loss of their land (Anzaldúa et al., 2003; Estrada, 2009; Massey et al., 1990; Ramirez & Hammack, 2014; Talebreza-May, 2015; Zentella, 2004).

Post-U.S.-Mexican War era (1848-1852)

Prior to the singing of the Treaty of Guadalupe in 1848, Mexican workers had discovered gold in California. The ensuing California Gold Rush brought thousands of prospectors and changed the demographics of the region. The consequences were displacement and the use of Mexican people, Native American groups, and Asian individuals for labor (Chan, 2000). However, they were especially devastating for the Indigenous communities in California. The governor of California issued an executive order authorizing bounty for Indian scalps, a policy that led to the killing and death of thousands of California Indians (Ramirez & Hammack, 2014). It has been estimated that by the end of this period over 50% of Californian Indians also died in the Spanish mission system, federal Indian reservations, or while running from persecution, and many others were enslaved and worked to death (Ramirez & Hammack, 2014).

Impacts of the post-U.S.-Mexican War era

There has been little recognition that the first occupants of the southwest were Mexican and Mexican Indigenous peoples, whose ancestors resided there for thousands of years before the arrival of the Europeans (Estrada, 2009; Ramirez & Hammack, 2014). This misinformation has fostered the widespread assumption that the majority of people of Indigenous ancestry living in the United States are foreign immigrants, whereas nearly 70% are natural-born citizens of this country (Stepler & Brown, 2016; Velasco-Mondragon et al., 2016). Since half of the Mexican territory was annexed to the United States, the rightful inhabitants of these territories have been treated as second-class citizens and subjected to institutional marginalization and hostile anti-

immigrant sentiments. They were portrayed as violent, criminal, lazy, and ignorant, traits later used to justify racial discrimination and forced assimilation/acculturation (Estrada, 2009). Many of these communities had already been displaced and colonized by Spain and were again subjected to a new wave of displacement and forced assimilation so they could mirror the values and culture of the Anglo population (Anzaldúa et al., 2003; Estrada, 2009). Some groups, like the Californian Indians underwent assimilation three times: first by Spain, then by the postcolonial government of Mexico, and later by the United States. Despite promises from their new government to safeguard their property rights, language, and culture, this territorial transaction led to many historical losses: land, original identities, language, cultural knowledge, social networks, and family relationships (Ramirez & Hammack, 2014; Zentella, 2009). This critical moment in the lifetime trauma of this population once again fractured their ethnic identity. However, the struggles associated with these losses were transformed into powerful social movements, such as those led by Dolores Huerta and Cesar Chavez, as documented by Zentella (2004, 2009, 2014).

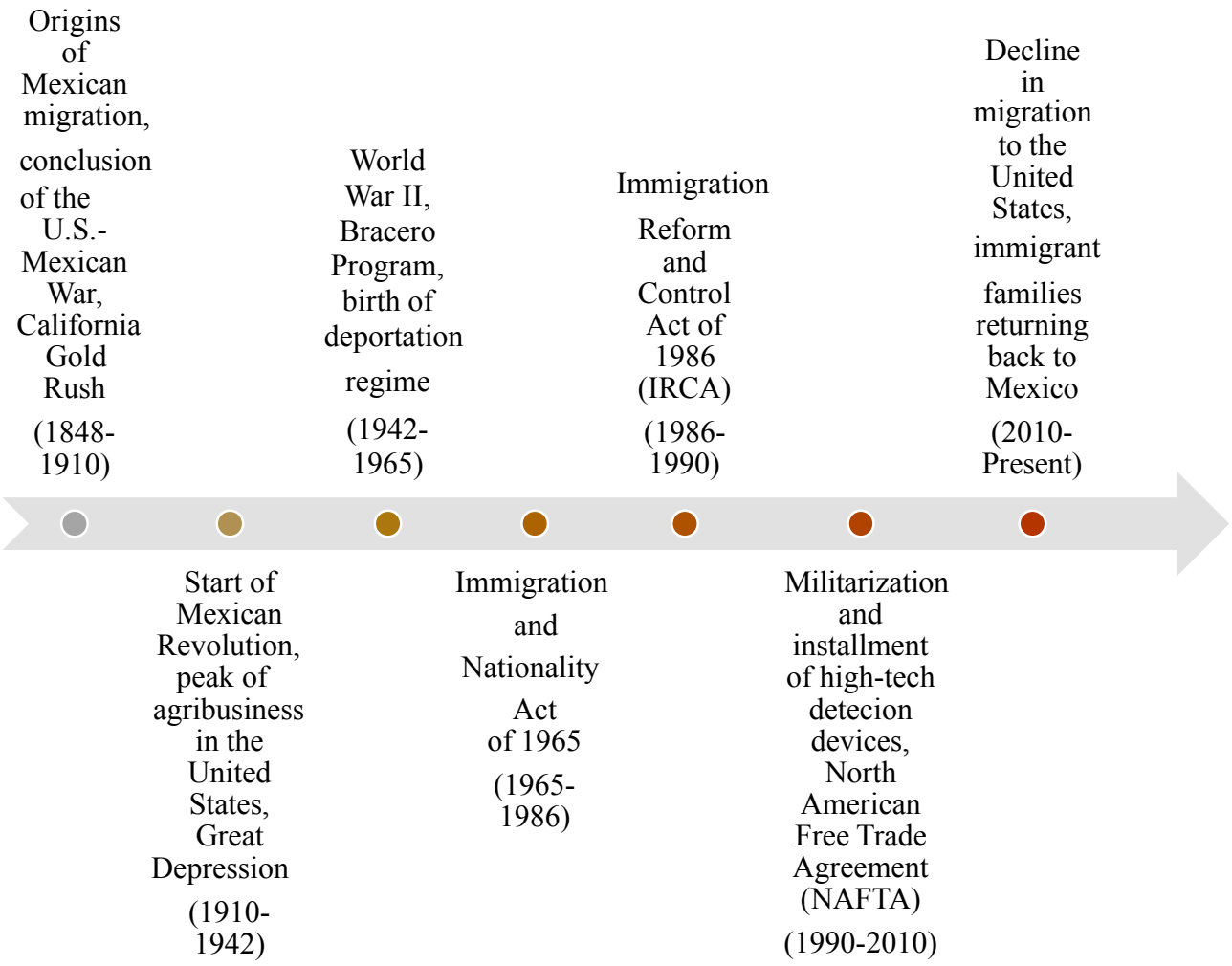
From what is now New Mexico, people of Mexican descent have endured two colonial periods, first under the Spanish and later under the United States (Estrada, 2009; Talebreza-May, 2015). Throughout these periods, they have struggled to develop and retain their culture. Their cultural practices currently resemble a fusion between traditions from American Indians, Mexican immigrants, Spaniards, and Anglo Americans. The colonialization and deaths of Indigenous, Black, and Asian ancestors are deeply felt physically, spiritually, and genetically (Anzaldúa, 2007; Estrada, 2009). Among the many communities subjected to mass colonialization, Mexican-origin individuals have a 500-year legacy of massacre and subordination by the Spanish, English, Portuguese, and French, and by Anglo Americans

(Estrada, 2009). The conquering and obliteration of cultures and communities, deaths, colonialization of Indigenous people—such as the Aztecs—that fuels Mexican mind-body-spirit-soul connection (Anzaldúa, 2009). The cultural genocide experienced by Mexican communities created a soul wound passed on for generations. Their ancestors' entire understanding of who they were as a people (their educational systems, philosophy, religion, and lifeways and beliefs) was deemed inferior and amoral (Anzaldúa, 2009). As a result, many of the issues facing disenfranchised Mexican communities, including cyclical poverty, substance use, and violence, reflect the unaddressed and persistent impacts of historical trauma (Pizarro, 2016).

Migration Patterns: A Historical Perspective

Mexican immigration to the United States has continued to be a topic of intense debate for many reasons ranging from economic to political justifications. The history of Mexican immigration to the United States has been centered on three causes: (1) demand-pull (e.g., includes recruitment by U.S. employers or significant job availability), (2) supply-push (e.g., poor performance of the Mexican economy and substantial regional socioeconomic inequalities in Mexico), and (3) networks (e.g., includes reunification with family members and friends who already live in the United States; Aguila et al., 2012). Historically, Mexico's economic conditions have been critical in people's decision to migrate North, as millions of Mexican residents have left seeking to improve their lives. The following section will provide a brief review on Mexican migration to the United States (see Figure 5).

Figure 5. Mexican migration patterns.



First wave (1848-1910)

The history of Mexican migration to the United States dates back to 1848, at the conclusion of the U.S.-Mexican War, ignited by the annexation of Texas and ending with the signing of The Treaty of Guadalupe Hidalgo (Del Castillo, 1992; Gutiérrez, 2019; Samora, 2019). Scholars suggest that the first great waves of Mexican migration to the United States started in the early months of 1848, sparked by the discovery of gold at James Sutter's Mill in

the Sacramento Valley of California, known as The California Gold Rush (Rojas, 2007). The discovery of gold brought skilled Mexican men with extensive mining expertise to Californian mines, doubling the Mexican population in the United States to approximately 14,000 by 1850 (Martinez, 1975). Soon after, due to high rates of unemployment in Mexico and high wages in the United States, Mexican residents (primarily men) living in poverty began their journey North. Employment opportunities in the United States were concentrated in the mining, railroad, and farming industries, with wages ranging from one dollar to $1.50 a day, a significant increase from the 20 cents earned in Mexico (Gutiérrez, 2019). Although uncommon, Mexican women who migrated with their partners often worked as nannies or in the service sector (e.g., restaurants, hotels, laundries; Gutiérrez, 2019).

The second wave (1910-1942)

The second wave of migration from Mexico to the United States has been suggested to have begun during 1910 at the start of the Mexican Revolution, which ended a dictatorship in Mexico leading to the establishment of a constitutional republic (Gonzales, 2002; Steinhauer & Young, 2015). According to the Annual Report of the Commissioner-General of Immigration, between 400,000-600,000 Mexican citizens entered the United States from 1910 to 1930. The Mexican Revolution led to mass migration, as war refugees and political exiles fled to the United States to escape violence and the social and economic instability (Gonzales, 2002). The employment demand in the United States also contributed to the ebb and flow of Mexican migration to the United States during the early 1900s (Taylor, 1933). An estimated 80% of Mexican immigrants entering the United States between 1910 and 1920 settled in California and throughout the Southwest filling the demand in agricultural labor (Gutiérrez, 2019). Notably, during the 1920s, at the peak of the agribusiness, Mexican citizens saw the birth of the Border

Patrol, which introduced harsh disciplinary practices against the Mexican workforce such as deportation, deportation raids, and segregation (Balderrama & Rodriguez, 2006). The Great Depression further enforced the implementation of rapid deportation and deportation raids, as both Mexican and Mexican Americans were rounded up and deported, which resulted in the cessation of Mexican migration between 1930 and 1942 (Balderrama & Rodriguez, 2006).

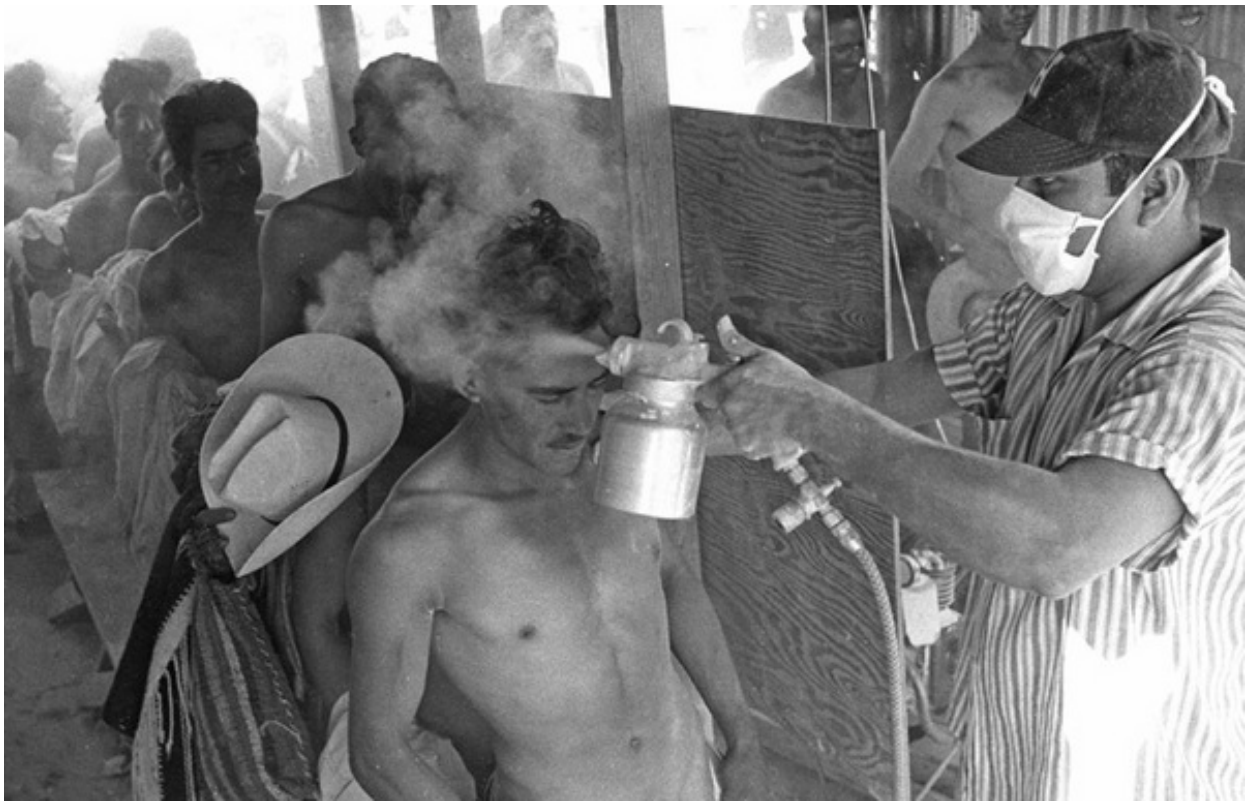
The third wave (1942-1965)

With the ending of the Great Depression and the start of World War II, Mexican labor once again became vital to the survival of the United States agricultural industry and economy. Scholars suggest that the attack on Pearl Harbor, which led to the United States' involvement in the war, marked the beginnings of the third wave of Mexican migration to the United States (Cohen, 2011; Gutiérrez, 2019; Snodgrass, 2011). In response to the labor shortage, the United States government responded by negotiating expansive mutual labor agreements with Mexico, which brought to life the *Bracero Program* (importation of Mexican guest labor to the United States; Cohen, 2011). It has been reported that Braceros prevented the disruption of agriculture production during wartime and minimized food price inflation in the United States (Gutiérrez, 2019). Statistics suggest that an estimated 4.5 million labor contracts were signed between 1942 to 1964, representing approximately 2 million Mexican workers (Chomsky, 2014). While it appeared that Mexican guest workers would be treated humanely and fair on paper, the reality was different. Braceros were exploited, forced to reside in harsh living conditions (e.g., cramped housing with poor plumbing), prohibited from unionizing, and sprayed with Dichlorodiphenyltrichloroethane (DDT; an insecticide used in agriculture; see Figure 6) upon entry to the United States (Calavita, 2010). A significant drawback to the Bracero Program included a “massive bilateral deportation policy,” which limited the number of Bracero contracts

and increased deportation of Mexican guest workers by the early 1950s (Chomsky, 2014). However, the need for what America considers "cheap labor" resulted in an influx of unauthorized Mexican immigrants settling in U.S. border towns (Gutiérrez, 2019). The increase in unauthorized Mexican immigrant workers led to the rhetoric that the Mexican community was depleting relief for the poor and stealing jobs from Americans, which prompted the initiation of "Operation Wetback," a massive military-style deportation practice of anyone who appeared to be of Mexican ancestry (Chomsky, 2014; Gutiérrez, 2019). Anthropologist Nicholas De Genova has argued that the development of the Bracero Program initiated what he termed a *deportation regime* intended to benefit the interests of American companies while exempting employers from sanctions and criminalizing the Mexican workforce.

Figure 6. Guest workers sprayed with DDT.

Source: Photography by Leonard Nadel, 1956, National Museum of American History.



The fourth wave (1965-1986)

The Bracero Program came to an end during the early 1960s and only Mexicans with green cards (approximately 40,000) were "allowed" to commute to work in the United States (Chomsky, 2014; Henderson, 2011). In an effort to limit Mexican migration, President Kennedy, as part of his promise to the American people, advanced the agenda on immigration reform. Still, President Kennedy's successor, Lyndon B. Johnson, signed the Immigration and Nationality Act of 1965 into law on October 3, 1965, which is said to have ignited the fourth wave of Mexican migration/immigration to the United States (Chomsky, 2014; Gutiérrez, 2019). While the rhetoric behind the Immigration and Nationality Act of 1965 appeared egalitarian, welcoming, and anti-racist, in practice and for the first time ever, it placed numerical limits on Mexican immigration (Chomsky, 2014; Gutiérrez, 2019). With the shutdown of the Bracero Program and limited number of available visas to the Western Hemisphere compared to the Eastern Hemisphere, legal migration for Mexican citizens was closed off though demand for Mexican workers in the United States continued (Chomsky, 2014). The essentiality of Mexican workers to the United States labor market prompted the development of a smaller scale guest worker program. This H-2 (Temporary Agricultural Workers; allows U.S. employers or U.S. agents who meets specific regulatory requirement to bring foreign nationals to the United States to fill temporary agricultural job) program did not meet the demands once filled by the Bracero Program (Chomsky, 2014). Although visa caps were put in place to limit legal migration from Mexico, it did not discourage or stop unauthorized Mexican immigrants from entering the United States to meet the labor demand. However, unauthorized Mexican workers were increasingly

vilified as the law "intensified the institutional framework that further enabled the codification of Mexicans as *illegals*" (Overmyer-Velazquez, 2011). The vilification of unauthorized Mexican immigrants led to an increase in apprehensions and deportations; on the other hand, the American employer suffered no significant consequence for the contracting and hiring of unauthorized workers (Gutiérrez, 2019; Martinez, 2011). Estimates suggest that between 1968 and the mid-1970s, over one million unauthorized Mexicans were deported yearly (Chavez, 2012). With concerns over the increasing visibility of unauthorized Mexican immigrants, Congress followed the Immigration and Nationality Act of 1965 with The Immigration Reform and Control Act of 1986 (IRCA), which both increased Border Patrol and the number of U.S. citizenship applications by Mexican immigrants (Caldera et al., 2014; Chomsky, 2014; Gutiérrez, 2019; Henderson, 2011).

The fifth wave (1986-1990)

Congress had passed IRCA to manage what many Americans referred to as the "out of control southern border," and while it was intended to end unauthorized immigration from Mexico to the United States, it had the opposite effect. Under IRCA, undocumented Mexican immigrants in the United States could legalize their status, creating a pathway to citizenship (Marrow 1986). Gutiérrez (2019) suggests that IRCA marked the fifth wave of Mexican migration to the United States, with an estimated 2.3 million Mexican immigrants qualifying for legal documentation status under IRCA's provisions. To be considered eligible, unauthorized immigrants needed documents that proved their continuous presence in the United States prior to January 1982, or documents that demonstrated their involvement in seasonal agricultural work (Chomsky, 2014; Gutiérrez, 2019). The opportunity to gain documented status in the United States led to the practice of manufacturing fraudulent documents, therefore, increasing the

number of undocumented immigrants applying for Special Agricultural Worker (SAW) status (Chomsky, 2014; Gutiérrez, 2019; Martin, 1994). IRCA also had an impact on the hiring of unauthorized non-U.S.-born workers, specifically Mexicans. For the first time, the 1986 law made it illegal to hire an employee without proper documents, making it a requirement for employers to verify the legal status of employees (Chomsky, 2014; De Genova, 2005; Gutiérrez, 2019). Historian and author Aviva Chomsky notes that "IRCA contributed to what could perhaps be called illegal legalization-people using false documents attesting to their status as agricultural workers to apply for, and obtain, legal status in the United States" (pp. 61-62). Once in the United States, both documented and undocumented immigrants began extending their stays and sending for their family, which for many was a solution to circumvent enhanced border militarization (Durand & Massey, 2004).

Immigration patterns from 1990 – 2000

The 1990s marked the beginning of a new landscape, one that forced undocumented Mexican immigrants to start taking more dangerous routes northward across the Sonora Desert into Arizona or across the dangerous Rio Grande into Texas to evade border inspection (Gutiérrez, 2019). The new routes northward resulted from increased militarization and installment of high-tech detection devices along the border wall, which was extended between 1990 and 1993 along the San Diego-Tijuana border (Carcamo, 2018; Henderson, 2011). The intensified surveillance along the border also contributed to the rise in unauthorized migrants becoming increasingly dependent on *coyotes* (smugglers) to cross the border (Spender, 2004). During the 1990s, the United States also saw an increase in Mexican migrants from the heavily Indigenous region of Southern Mexico (Bacon, 2008; Cohen, 2004). Scholars suggest that the rise in migration from Indigenous communities resulted from the North American Free Trade

Agreement (NAFTA), which caused millions of Indigenous families to lose their land (Bacon, 2008; Cohen, 2004; Overmyer-Velazquez, 2011). The influx of Indigenous families to the United States is said to have contributed to the diversification of the Mexican population in the United States (Bacon, 2008; Cohen, 2004; Overmyer-Velazquez). While on paper, it appeared that NAFTA would benefit Canada, Mexico, and the United States, in reality, it led to increased poverty rates in Mexico (Henderson, 2011). Therefore, migration North increased with estimates from the Migration Policy Institute (2012), suggesting that by 2000 approximately 31,107,900 Mexican immigrants were living in the United States.

Immigration patterns from 2010 –2022

Since the late 2000s, migration from Mexico has steadily declined due to the great recession, and currently from anti-immigration policy that has continued to vilify Mexican immigrants. As a result of the great recession, employment opportunities for Mexican workers declined significantly, leaving many immigrants with limited choices to include a return home. Estimates suggest that between 2009 and 2014, there were more Mexicans and their families leaving the United States than Mexican immigrants coming to the United States (Gonzalez-Barrera, 2015). As reported by Gonzalez-Barrera (2015), data from the 2014 Mexican National Survey of Demographic Dynamics (ENADID) reported that 1.4 million Mexicans and their families (including U.S.-born children) returned to Mexico from the United States, while data from the U.S. Census estimated that 870,000 Mexican citizens left Mexico to come to the United States. In addition, between 2016 and 2017 there was another significant decline in the Mexican immigration population (Zong & Batalova, 2018). While these data points highlight that migration patterns continue to shift, it is important to recognize the many contributions by Mexican immigrants to the United States economy and development over time.

Indigenous Mexican Communities in the United States

In addition to its mainstream population, Mexico is home to more than 60 ethnic minority groups. While only 10% of the population claim Indigenous heritage, it is estimated that 40% to 70% of Mexicans are direct descendants from the precolonial Indigenous people of Mexico (de la Peña, 2006; Kumar et al., 2011). Recently, the migration influx from Mexico to the United States has been changing and recent trends reveal a growing number of Mexican Indigenous people migrating to the United States for the first time (Zúñiga et al., 2014).

Historically, individuals of Indigenous ancestry — from Mexico and other Latin American countries — have experienced harsher social conditions than their non-Indigenous counterparts. They often receive disproportionately lower wages (Ortiz & Telles, 2012), even lower quality medical care (Wallace & Castañeda, 2010) and educational services (Gurrola, Ayón, & Moya Salas; 2016). They are also more likely to encounter greater anti-immigration sentiments, such as profiling and race-based violence (Gurrola et al., 2016).

Many of these communities have also experienced unlawful deportation, forced family separation, threats of mass deportation (Estrada, 2009) and abuse during immigration-related detention (Brabeck & Xu, 2010). Such prolonged exposure to social adversity has negatively affected their physical, psychological, and socio-economic health (Vigil & Lopez, 2004). This pattern of discriminatory practices against immigrants and refugees reflects what has been described as a global trend of xenophobia.

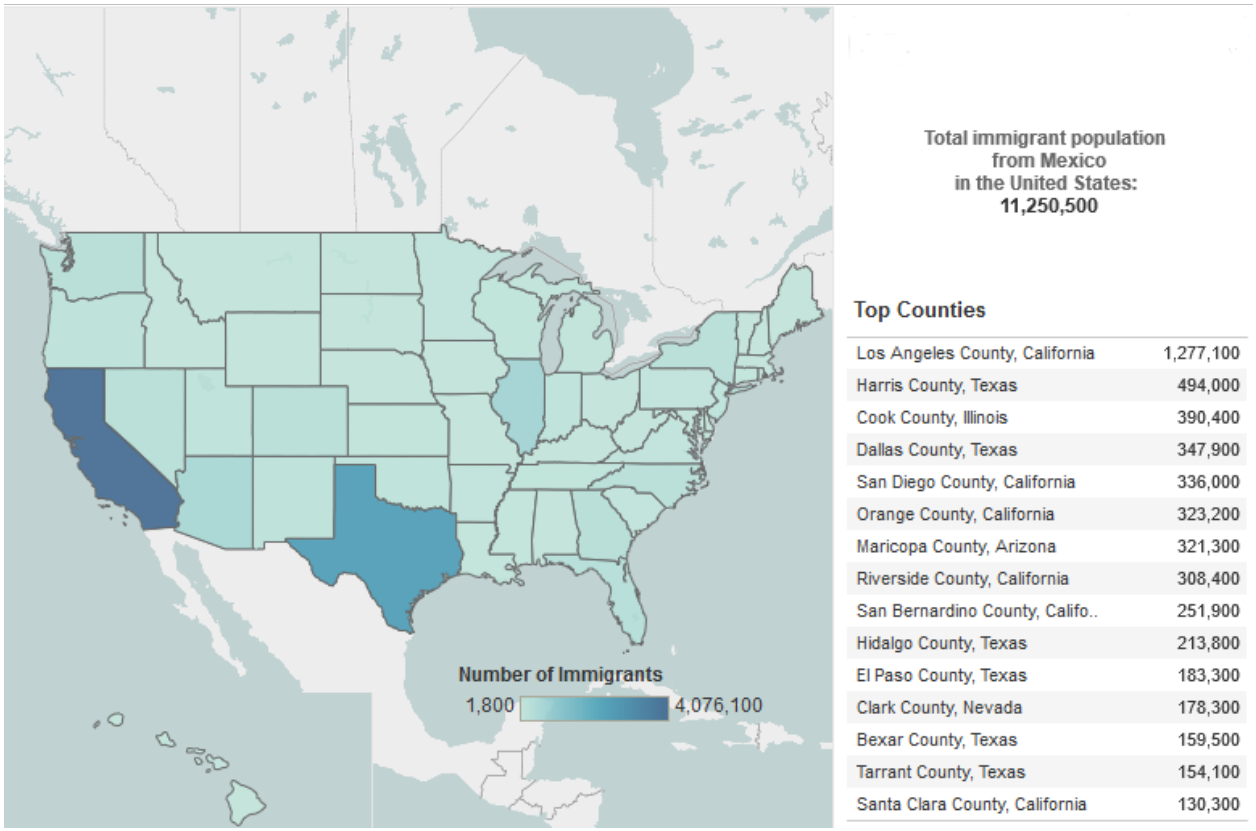
Mexicans in the United States

Settlement points

Data from the Mexican Migration Project (a collaborative research project based at Princeton University and the University of Guadalajara) suggest that between 1940 and 1980 the vast majority of Mexican migrants, during their last trip to the United States, settled in California, Texas, or Illinois.[1] Fifty-one percent of people of Mexican ancestry are said to reside in the western region of the United States, with 35% living in California (Lopez, 2015), and a sizeable representation in Arizona and Colorado (Ennies et al., 2011). Over the past twenty years, work opportunities in the agricultural and poultry sectors resulted in a growing population of individuals of Mexican ancestry residing in parts of the South and Midwest (Hipolito-Delgado, 2018; U.S. Census Bureau, 2020). Today, Los Angeles County (1,277,100), Harris County (494,000), Cook County (390,000), Dallas County (347,400), San Diego County (336,000), and Orange County (323,200) are home to the largest number of Mexican immigrants (see Figure 7; U.S. Census Bureau, 2020). While more than half of the Mexican population in the United States is said to reside in the Westcoast and parts of the Southwest, there is also a small representation of Mexicans in the Northeast with estimates suggesting 2.9% (Ennies et al., 2011).

[1] The animations on this site are offered in QuickTime format. QuickTime content is available through a QuickTime plug-in installed in your browser's "plug-in" folder. If you do not have the plug-in, you may download it for free from the Apple Computer QuickTime website by clicking the image to the right.

Figure 7. Mexican immigrant population by state and county, 2015 – 2019.



Total immigrant population from Mexico in the United States: **11,250,500**

Top Counties

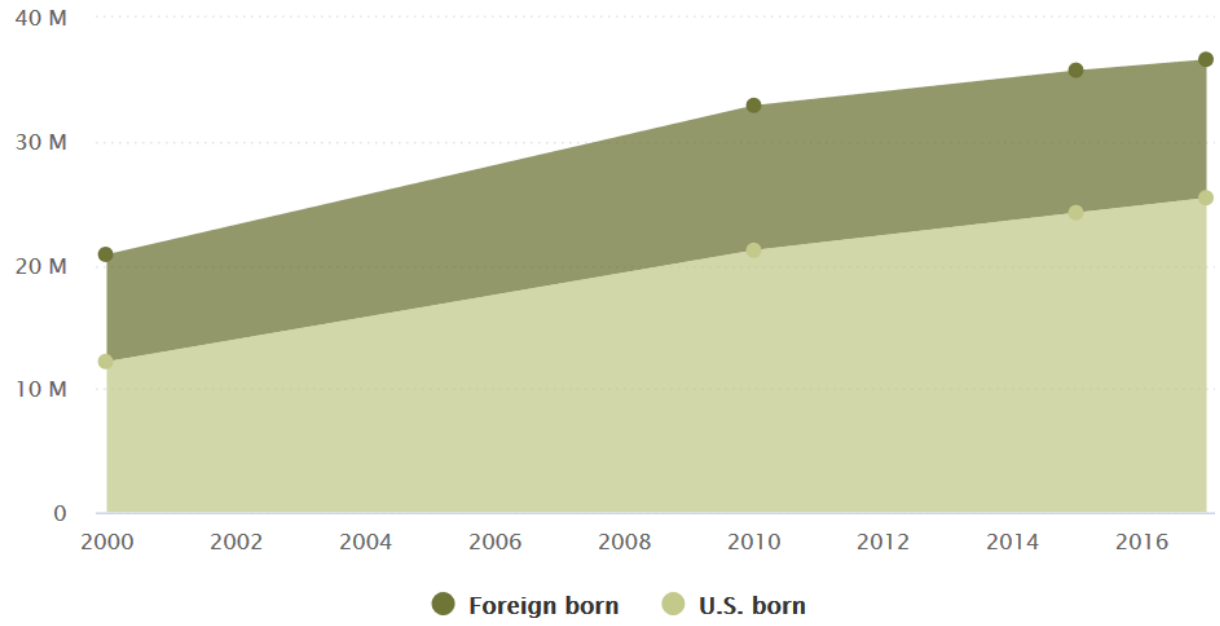
Los Angeles County, California	1,277,100
Harris County, Texas	494,000
Cook County, Illinois	390,400
Dallas County, Texas	347,900
San Diego County, California	336,000
Orange County, California	323,200
Maricopa County, Arizona	321,300
Riverside County, California	308,400
San Bernardino County, Califo..	251,900
Hidalgo County, Texas	213,800
El Paso County, Texas	183,300
Clark County, Nevada	178,300
Bexar County, Texas	159,500
Tarrant County, Texas	154,100
Santa Clara County, California	130,300

Demographics

Today, at nearly 37 million, the Mexican community is the largest origin group in the United States, and accounts for 62% of the Latinx population (see Figure 8; Gutiérrez, 2019; Noe-Bustamante et al., 2019). In 2018, approximately 11.2 million immigrants living in the United States were of Mexican background (Budiman, 2020). As noted earlier, research studies evaluating migration patterns from Mexico to the United States have shown a slow decline in the last decade, particularly between 2016 and 2017. The Mexican immigrant population shrunk by about 300,000 (Zong & Batalova, 2018). The change in migration patterns to the United States is hypothesized to be a result of an improved Mexican economy, unforgiving U.S. immigration

enforcement regulations, and the long-term drop in Mexico's birth rates (Zong & Batalova, 2018). Additional factors include increased apprehensions of Mexican citizens at the U.S.-Mexico border, and mass deportation stemming from strict anti-immigrant policies that have portrayed Mexican immigrants as a significant security threat to the nation (Gutiérrez, 2019).

Figure 8. Mexican-origin population in the United States, 2000-2017.



Note: Latino origin is based on self-described ancestry, lineage, heritage, nationality group or country of birth.
Source: Pew Research Center tabulations of 2000 census (5% IPUMS) and 2010, 2015 and 2017 American Community Surveys (1% IPUMS).

Employment

Work opportunities have been crucial to the Mexican experience in the United States, and Mexican workers have been essential and foundational pillars that continue to sustain the United States economy. The latest data on Latinx workers in the United States suggest that workers of

Mexican ancestry make up 14.9 million of the Latinx workforce in the United States (Bucknor, 2016). By gender, Mexican women account for 43.4% of the workforce, while men make up 56.6% (Bucknor, 2016). Moreover, when compared to the native- and overall non-U.S.-born populations, the Mexican community has been suggested to participate in the labor force at much higher rates (Zong & Batalova, 2018). Specific to the Mexican immigrant community, reports indicate that they made up approximately 68% of workers in the civilian labor force in 2017 (Zong & Batalova, 2018). From history, we know that the Mexican community in the United States has been an essential part of the mining, railroad, and agricultural industries, which have always had lower status and pay. In present-day, individuals of Mexican background continue to be employed in primary and secondary sectors. Specifically, the Mexican community has been reported to be more likely employed in construction, landscaping, and maintenance occupations; service occupations and nanny services; and production, transportation, and material moving occupations, which are often described as low-status and low-wage jobs (Zong & Batalova, 2018).

Education

Among the Latinx subgroups, it has been reported that about 55% of Mexican adults in the United States lacked a high school diploma in 2017, and 67% reported limited-English proficiency (Zong & Batalova, 2018). Among the Mexican community ages 25 and older, about 12% were reported to hold at least a bachelor's degree (Noe-Bustamante et al., 2019). Furthermore, among Mexicans ages 25 and older, Mexican Americans were more likely than the non-U.S.-born population to have a bachelor's degree or higher (17% vs 7%; Noe-Bustamante et al., 2019). Specific to the Mexican immigrant population, the vast majority (87%) have been reported to hold a high school degree or less (Krogstad & Radford, 2018). Furthermore, 2016

data indicated that Mexican immigrants made up 12.6% of individuals with a two-year degree or some college (Krogstad & Radford, 2018). Data also suggest that Mexican immigrants with a bachelor's degree or higher slightly increased since 1980, and reached 6.2% in 2016 (Krogstad & Radford, 2018).

Religion

The Pew Research Center (Donoso, 2014) reports that both Mexican and Mexican Americans hold strong religious identities; yet there are significant differences in terms of identification. For example, the percentage of Catholics is 20% higher in Mexicans (81%) than Mexican Americans (61%). Furthermore, the percentage of Protestants is higher among Mexican Americans (18%) compared to Mexicans (9%), or identifying as unaffiliated (e.g., no religious affiliation), with Mexican Americans (17%) being higher than Mexicans (7%). The Pew Research Center also found that Mexicans tend to hold more traditional Catholic views than Mexican Americans on issues related to allowing priests to marry and birth control (Pew Research Center, 2014).

It is important that mental health providers be aware of holistic and Indigenous practices that might influence an individual's perception of mental health. For example, a healing tradition found in Mexico and other Latin American countries is the practice of *curanderismo*. Traditional forms of *curanderismo* follow three healing interventions: "1) material approaches to healing (physical treatments and supernatural healing practices), 2) spiritual healing and spiritualism, and 3) psychic healing" (Trotter, 2001, p. 130). It incorporates aspects of the medical model approach to treating diseases, herbal remedies, and an acknowledgement of the supernatural as a source of illness (Trotter, 2001). One qualitative study examined *curanderismo* within elderly Mexican Americans found that while they still rely on modern medicine, they continue to

consider traditional forms of healing when modern medicine might be unsatisfactory or ineffective (Applewhite, 1995). In light of different belief system related to mental health, authors have also argued that when considering the mental health of Mexicans and Mexican Americans it is important to consider mental health etiology beliefs, both biological (due to genetics and heredity) and spiritual (due to disobeying God and sin; Choi et al., 2019) in order to be culturally sensitive.

Cultural Values

Research supports the need to focus on specific cultural values when considering protective factors against mental health. For example, one study conducted with young Mexican American heroin using men who had higher levels of familism (*familismo*)— defined as a Latinx cultural factor where individuals prioritize the needs of the family (and extended family) before oneself (Piña-Watson et al., 2019)— and fatalism, or fatalistic beliefs, were less likely to experience depressive symptoms. Whereas those with lower levels of traditional Latinx cultural values had higher levels of depression and were at increased risk for more dangerous drug use (Villareal et al., 2019). The researchers of the study recommend that interventions should be tailored to incorporate and cultivate these cultural values. Analogous findings have also found that *familismo* was a protective factor against depressive symptoms within Mexican-descent adolescents (Piña-Watson et al., 2019).

Colorism

Colorism is systematically embedded in political, cultural, and economic practices, limiting democratic and inclusive practices for all (Perez Lopez, 2017). The legacy of Spanish colonialism compounded by Anglo American neo-colonialism has led to the internalization of

negative perceptions and stereotypes by Mexican Americans, leading to self-hate and alienation, lowered self-esteem, ethnic identity conflict, discrimination, racism, marginalization, and high levels of depression (Estrada, 2009; Hunter, 2016). *El sistema de castas* (caste system) was basically organized from highest to lowest: *peninsulares* (Spaniards born in Spain), *criolles* (Spaniards born in the Americas), *mestizes* (mixed Spaniard and Indigenous), *indígenas* (Indigenous people), *mulates* (mixed African and Spaniard), *zambes* (mixed African and Indigenous), and *negres* (African). Status in *el sistema* was according to one's proximity to Europeanness (racial cleansing), with Africans being seen as the most distant.

In Mexico, 64.6% of people consider themselves to be brown skinned and 54.8% report to have been insulted by the color of their skin (CONAPRED, 2010). *Dichos,* or folk sayings, implying or indirectly relating to skin color or race, such as "*hay que mejorar la raza*" (we need to improve the race), "*traes el nopal en la frente*" (the cactus is on your forehead) and "*mijito quítate del sol*" (get out of the sun) are examples of colorism or the preference for light skin color within a group (Tummala-Narra, 2007) due to skin color being associated with higher status, success, and happiness (Jablonski, 2012). The above sayings highlight that Mexican people often "do not" talk about race or color directly, unless it is in the form of a *cariñito* (term of endearment), joke, or a folk saying. The use of humor supports an overall perception that racism and colorism issues do not exist in Mexico (Lopez, 2017).

Stigma

There is longstanding research evidence that stigma is a significant barrier to accessing mental health for Latinx communities, including individuals from Mexico (Vega et al., 1999). For example, Mexican Americans with lower levels of acculturation have significantly lower

rates of accessing outpatient behavioral health services than non-Hispanic communities (Wells et al., 1987). Furthermore, self-stigma is a salient variable that prevents Mexican and Mexican Americans from seeking behavioral health services. Individuals might fear being stigmatized from their family of origin or religious groups (Choi et al., 2019). It is also important to highlight the heterogeneity of the population within the United States. A literature review synthesizing the experiences of undocumented Mexican immigrants highlights the unique stressors and associated stigma they face (Sullivan & Rehm, 2005). The authors argue that the challenges undocumented Mexican immigrants face are vastly different to the challenges faced by documented Mexican Americans. For example, undocumented Mexican immigrants have more limited resources and mobility; encounter more discrimination and vulnerability; and face increased levels of mental health concerns (Sullivan & Rehm, 2005).

Additionally, authors have argued that undocumented immigrants from Mexico are more stigmatized than other groups as they are often characterized as threatening the fabric of America by taking jobs, straining social services, and not paying taxes (Del Real, 2019). A qualitative study of 52 undocumented immigrants from Mexico found that they all reported being socially rejected and discriminated against for their documentation status, which in turn affected their mental health and well-being (Del Real, 2019). As highlighted by previous research, mental health concerns are prevalent among individuals from Mexico, yet access to behavioral health services remains a concern that further contributes to the health disparities gap.

Historical Trauma

Understanding the effects of historical trauma is essential within the context of colonial liberation (see Figure 9). Historical trauma (also referred to as generational trauma) refers to a

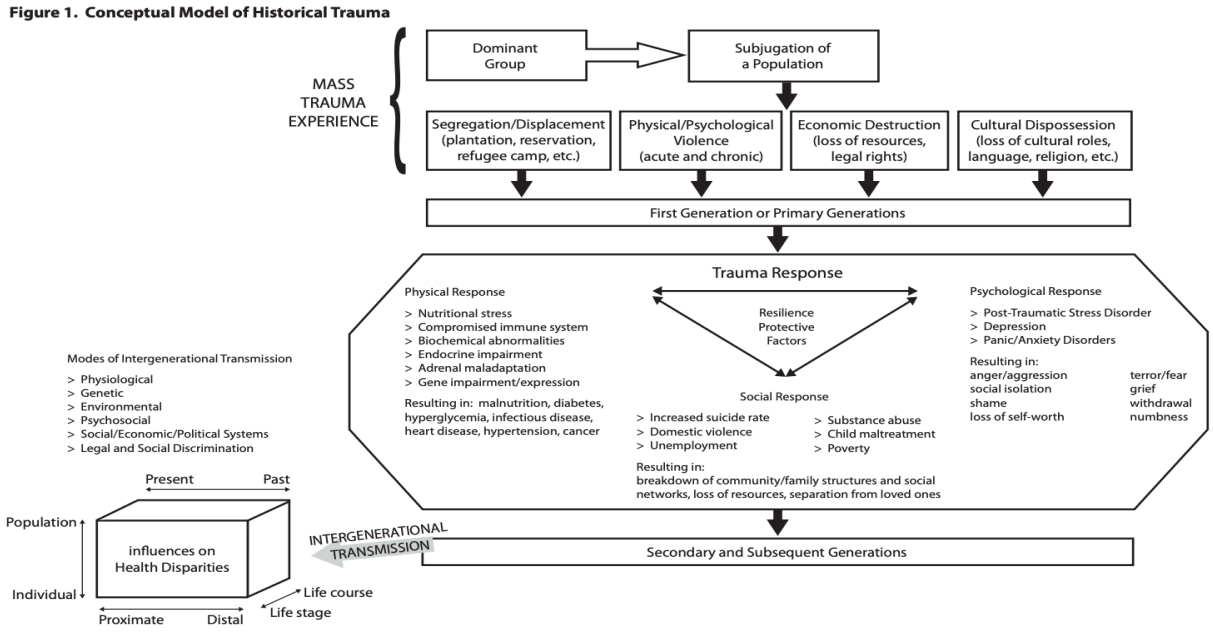
complex and collective trauma experienced over time and across generations by a group of people sharing identity, affiliation, or circumstance (Brave Heart, 1999; Brave Heart & DeBruyn, 1998). The effects are substantial (Brave Heart, 2006), multigenerational, and cumulative over time (Duran et al., 1998). As Lambert (2008) explained in reflecting on this process, "defeating a people has as much to do with destroying their sense of purpose—their confidence in their worldview and meaning system—as it does with physical conquest" (p. 42). Sotero (2006) developed a conceptual model of historical trauma that includes three sequential stages:

> (1) A mass trauma experience where the dominant group subjugates a population, resulting in segregation and displacement, physical and psychological violence, economic destruction, and cultural dispossession;
>
> (2) A trauma response is elicited in the first or primary generation that includes physical, social, and psychological responses; and
>
> (3) The responses are transmitted to subsequent generations through environmental factors, psychosocial factors, social-economic-political systems, and legal and social discrimination (see Figure 10).

Figure 9. Major historical traumatic events.

Events	Years
The Spanish invasion	1519-1521
The Spanish colonialization	1521-1821
The U.S.-Mexican War	1846-1848
The French invasion	1862
The Mexican Revolution	1910-1920
The Mexican Civil War (period one)	1926-1929
The Mexican Civil War (period two)	1931-1933

Figure 10. Conceptual model of historical trauma.

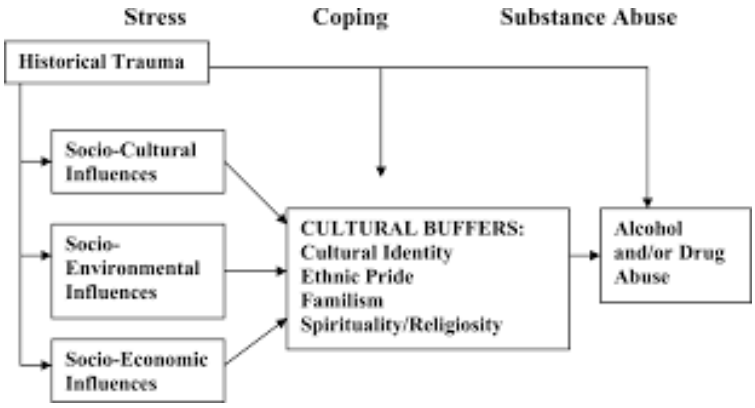


Source: Sotero, M. M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. Journal of Health Disparities Research and Practice, 1, 93–108. https://ssrn.com/abstract=1350062

Estrada (2009) presented how historical trauma influences substance use among Mexicans and Mexican Americans (see Figure 9). Adapted from the Indigenist Stress-Coping Model developed by Walters and Simoni (2002), historical trauma (negative social and historical events) has laid a foundation for the socioeconomic characteristics of Mexicans and Mexican Americans, including poverty, underemployment, and low educational attainment, through structured and institutionalized oppression, discrimination, and racism. Sociocultural and socioenvironmental influences include targeted marketing of alcohol, accessibility to drugs, disorganized neighborhoods, and increased police surveillance. Potential cultural buffers include such concepts as ethnic pride and cultural identity, which are potentially eroded by

discrimination and racism. These factors are hypothesized to influence alcohol and drug use among Mexican Americans.

Figure 11. Etiological model of historical trauma and substance use among Mexican and Mexican Americans in the United States.



Source: Antonio L. Estrada (2009) Mexican Americans and Historical Trauma Theory: A Theoretical Perspective, Journal of Ethnicity in Substance Abuse, 8:3, 330-340, doi: 10.1080/15332640903110500

Historical Trauma Responses

Historical trauma responses (Brave Heart, 1998), also known as colonial responses (Evans-Campbell, 2008; Walters & Simoni, 2002), refer to behavioral health reactions to the atrocities of this era, including mistrust in governmental institutions (Cromer et al., 2018; Estrada, 2009; Talebreza-May, 2015), unresolved/ambiguous grief (Anzaldúa et al., 2003; Grayshield et al., 2015; Ramirez & Hammack, 2014), anger (Anzaldúa et al., 2003; Estrada, 2009; Talebreza-May, 2015), identity fragmentation (Anzaldúa et al., 2003; Talebreza-May, 2015), and land attachment disorders (Talebreza-May, 2015; Zentella, 2004, 2009, 2014). Several sources also emphasize resilient responses, including narratives of survival, pride in ethnic heritage and identities, cultural practices (e.g., kinship, oral tradition, dance, storytelling, traditional health practices), and the role of the elders, especially the grandmother (Cromer et al., 2018; Grayshield et al., 2015; Ramirez & Hammack, 2014; Talebreza-May, 2015). As many

sources within the historical trauma research indicate, while it is difficult to establish any direct links between past historical traumatic events and current clinical issues in the affected populations (Gone, 2013), the reminders of prior traumatic experiences can trigger adverse reactions (Estrada, 2009; Hanna et al., 2017; Perez & Arnold-Berkovits, 2018; Talebreza-May, 2015).

Mental Health and Substance Use

Mental health concerns and substance use disorders (SUDs) have been linked to historical trauma in several populations. However, the direct relationship between these behavioral issues —presumed historical trauma responses— and their traumatic past is not fully understood (Brave Heart, 1998; Okazaki et al., 2008; Pokhrel & Herzog, 2014; Stevens et al., 2015; Walters, 2012; Les Whitbeck et al., 2004). Mental health historical trauma responses including: depression, self-destructive behavior, suicidal thoughts and gestures, anxiety, low self-esteem, anger, difficulty recognizing and expressing emotions, and unresolved grief, among others (Brave Heart et al., 2011).

Mental health

In the United States, Mexican Americans face unique challenges that affect their mental health. Previous research has found evidence for a relationship between time spent in the United States and increased mental health concerns within Hispanic populations (Cho et al., 2004). Furthermore, we would be remiss not to mention the impact of an anti-immigrant political climate and its influence on the mental health of immigrants. One qualitative study examined the impact of immigration legislation within Mexican immigrants and found themes of chronic stress, fear of being deported, and a sense of powerlessness coupled with the trauma of risking their lives through the dangerous migratory journey (Salas et al., 2013). Another study of

undocumented Mexican immigrants found that they are at increased risk for mood and anxiety disorders (Garcini et al., 2017).

In Mexico, the general population also faces mental health disparities. The 2005 Mexican National Comorbidity Survey, a survey to evaluate the rates of psychiatric disorders, found that the most common psychiatric disorders were specific phobias, followed by major depressive disorder and alcohol use disorders. Additionally, there were various sociocultural factors that exacerbated symptomatology, for example, lower average income was associated with the severity of a disorder and women reported more mood and anxiety disorders (with widowed/divorced/separated individuals reporting greater mood and impulse control disorders). The survey also found severe underutilization of behavioral health services influenced by various factors such as stigma and access (Medina-Mora, 2005). For example, as of 2005 there were 1451 psychiatrists registered with the National Board of Psychiatrists, representing between 1.5 and 2.7 psychiatrists per 100,000 population. Similarly, data also indicated the number of available psychiatric nurses was fewer than 1 per 100,000 population (Borges et al., 2007). Additionally, as of 2014, the mental health workforce rate per 100,000 population in Mexico was reported as follow: psychiatrists (0.67%), nurses (2.80%), psychologists (2.11%), social workers (0.52%), occupational therapists (0.18%), and other mental health workers (2.67%; World Health Organization, 2014). The shortage of providers highlights the mental health and substance use disparities encountered by individuals in Mexico (Borges et al., 2007). Other factors that influence these disparities are financial burdens, health care infrastructure, lacking psychoeducation of mental health concerns, the need for destigmatization, and the allocation of resources by the government (Borges et al., 2007).

There are also unique mental health challenges related to the migratory journey that are important to be considered. One study examined the mental health of Central American men in their migration journey to the United States via Mexico (Alman et al., 2018). The authors found high levels of migratory stress, major depressive episodes, and alcohol use disorders. Additionally, other factors affecting the mental health of individuals from Mexico and often begin prior to the arrival in the United States and are exacerbated during the migratory journey. A study based on the National Survey of Discrimination in Mexico explored the association between colorism, occupation, and income level. The authors note that Mexico continues to struggle with a "highly stratified society from its colonial past" (Reeskens & Velasco-Aguilar, 2020, p. 5) and discuss the varying levels of privilege associated with being lighter skinned vs. darker skinned and its relationship with income, which influences the ability to access mental health services. Further studies have examined the experiences of university students in Mexico City and found that students with brown skin had lower levels of self-esteem and higher levels of alcohol use compared to individuals of white and light brown skin color (Ortiz-Hernandez et al., 2011). Additionally, it is estimated that individuals with lighter skin on average tend to have two to three more years of education than their darker skin peers (Telles, 2014). This study illustrates the pervasive impact of racism and links to mental health.

Substance use

One study using data from the National Epidemiologic Survey on Alcohol and Related Conditions (B. F. Grant et al., 2004) reported that the average lifetime prevalence of any psychiatric or substance abuse disorder for individuals of Mexican descent was 36.7%. The prevalence rate for those born in the United States was higher, with an estimated rate of 47.6%, compared to 28.5% for those born in Mexico. More specifically, the lifetime prevalence of mood

disorders for people of Mexican descent born in the United States was estimated at 19.3%, while the prevalence for the foreign-born Mexican group was 10.2%. Similarly, the prevalence of anxiety disorders was estimated at 16.3% for the US-born group, while the foreign-born group reported a prevalence of 9.1% (B. F. Grant et al., 2004).

Related studies have reported that the incidence of alcohol and substance use disorders is particularly high within Mexican migrant workers and Mexican Indigenous groups. One study from California, which included both Indigenous and non-Indigenous Mexican farm workers, indicated that the Indigenous group reported a 9.9% prevalence of alcohol abuse, while the rate for non-Indigenous workers was 6.2% (Catalano et al., 2000).

Intersectionality and Violence

Given the dangerous migratory journey for individuals from Mexico, and from other Latin America countries that use Mexico as an entry point, it is important to consider identity-based forms of violence and discrimination. For example, women might encounter various forms of sexual assault (Clark, 2017), and LGBTQ people may encounter extreme forms of physical violence (Bennet, 2020). Even prior to starting the migration journey, individuals with stigmatized identities are likely to be targets of heinous crimes. One of the most disturbing forms of violence currently affecting women from Mexico and from Mexican descent is femicide – the act of violently murdering women on the basis of their gender– which has been highlighted following the atrocities in Ciudad Juarez (Albuquerue & Vemala, 2008). Further studies have found that Mexican border cities have femicide rates of 50% or higher when compared to non-Mexican border U.S. cities (Albuquerue & Vemala, 2008).

In Mexico, Indigenous people make up approximately 22% of the population and they encounter “historical and structural discrimination” (p. 3) through marginalization in the legal

system, social cleansing, overt forms of violence, climate change, and forced displacement, among others (UN Human Rights Committee, 2019). Indigenous women are particularly vulnerable due to gender-based violence, obstetric violence, and arbitrary detentions. Additionally, it is estimated that 40% of Indigenous communities in Mexico live below the poverty line compared to 10% of non-Indigenous communities (Coneval, 2012).

Notwithstanding the LGBTQ strides made regarding same-sex marriage in Mexico as of 2006, and anti-discrimination laws protecting sexual minorities as of 2003, transgender women remain highly targeted, persecuted, and murdered without any formal governmental protection (Transgender Law Center, 2016). One study examining the experiences of transgender individuals in Mexico found that 70% reported suicidal ideation, 50% shared experiences of threats and insults, 30% reported discrimination from family and friends, 24% reported physical violence, and 17% reported sexual violence (Lozano-Verduzco & Melendez, 2019).

There is a strong intersection between religion and mental health for Mexicans and Mexican Americans suggesting that religion might serve as a protective factor against mental health concerns. An investigation conducted from the National Latino and Asian American Study (NLAAS) showed that attending religious services was a protective factor against mental health and substance use disorders. Two reasons for these results include the strong social support associated with being affiliated with an organized religion, and the moral codes associated with leading a healthy lifestyle (Moreno & Cardemil, 2018). Furthermore, there is evidence to suggest that help-seeking behaviors might be influenced by religious beliefs where individuals believe that God will help resolve their psychiatric symptomatology or that they must endure the burden of such symptoms. Similarly, individuals with strong religious beliefs might

attempt to conceptualize their mental illness through religious or supernatural causes (Choi et al., 2019).

Conclusion

People of Mexican ancestry have been in the United States longer than any other Latinx subgroup. In addition, for hundreds of years, people of Mexican ancestry have faced and endured significant pain from colonialization to modern-day oppression both in Mexico and the United States. They have confronted, and continue to confront various forms of discrimination, public ridicule, and assaults, to which the Mexican community has responded with resilience. Indeed, disparities, social and ethnic injustices, and the vilification of Mexicans and Mexican Americans have overshadowed the remarkable strength, transcendence, and contributions of the Mexican community. The overfocus on deficits and slander of people of Mexican ancestry further perpetuate the marginalization of a community that has been historically excluded and oppressed; therefore, making invisible their profound contributions, which have built and sustained the survival of the United States. While we agree the focus needs to be on the strengths and contributions of people of Mexican ancestry, it is also important to address the social, physical, psychological, and spiritual harm waged against the Mexican community by European Americans since colonialization, which continues today. As a result, we urge mental health providers to become familiar with their history and experiences to better understand the behavioral and psychological processes that have historically contributed to their survival in an unjust society.

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UN PARAÍSO DE PRIMAVERA

(A Spring Paradise):
How a Historical Insight into Guatemala
and Guatemala-Origin People in the United States
can Inform Mental Health Services for Guatemalans

IV

Introduction

The presence of Guatemalans and Guatemalan Americans in the United States to a large extent results from a 36-year civil war and most recently, climate change. Therefore, knowing the history of Guatemalans and Guatemalan Americans in the United States is important to understanding mental health and substance use presenting concerns. The purpose of this chapter is to provide mental health providers with a foundational understanding of the Guatemalan and Guatemalan American communities in the United States. The subsequent sections introduce:

(1) the colonialization history of Guatemala;

(2) waves of migration, Indigenous Guatemalan communities; and

(3) settlement patterns and current demographics, as this informs the experience of present-day Guatemalan-heritage individuals and families.

We also provide a brief overview of Guatemalan employment, education, and religious cultural background. We end the chapter with a discussion on mental health considerations; stressors in present-day Guatemala affecting the mental health of immigrants (e.g., violence); the impact of COVID-19 on immigration and deportation; and family separation. Overall, this chapter aims to provide mental health providers with context and content that contribute to the rich culture of Guatemalan-heritage individuals and families in the United States, which in turn can inform mental health practices and treatment planning.

Historical Events

Like other countries in Central America, the history of Guatemala is marked by the murder of Indigenous communities from Spanish colonial conquistadores and present-day Guatemalan military, a constant fight for independence, and civil unrest. Guatemala is a diverse nation (e.g., multiethnic and multilingual) with multicultural people from varying backgrounds

representing Spanish, African, and Maya descent (Söchtig et al., 2015). While Spanish is the official language of Guatemala, it still has over 20 different ethnic groups with diverse native languages and cultures (Söchtig et al., 2015; Wearne & Calvert, 1989).

Pre-colonial Guatemala and invasion

Before colonial invasion, the Maya civilization dominated most of Mesoamerica (Mexico and Central America). The Maya civilization lasted over a millennium and has been described as one of the most advanced civilizations in the New World (Söchtig et al., 2015). It reached its peak during the classic period (AD 250-900) as one of the most dominant societies (Söchtig et al., 2015). The K'iche and Kaqchikel people were the heirs to the Maya civilization before the Spanish arrival. While the K'iche and Kachikel people were the dominant groups, other Indigenous communities were present such as the Tz'utujil around Lake Atitlan, the Mams, and the Poqomams (Restall & Asselbergs, 2007). The Maya civilization was made up of numerous kingdoms and cities that often lacked a common identity and political cohesion (Restall & Asselbergs, 2007).

Colonialization of Guatemala

The colonial period of Guatemala lasted from 1523 to 1821 (Dougherty & Rubin, 2016; Estrada & Torres Flores, 2018). In 1523, Pedro de Alvarado led the Spanish conquistadores to invade Guatemala (Estrada & Torres Flores, 2018). The invasion spread quickly throughout the land, yet the northern part of the country was the last Maya territory to fall under Spanish rule some 200 years after initial contact in 1523 (Freiwald & Pugh, 2016). Historians write that de Alvarado invaded Guatemala with Spanish military, African slaves, and roughly three thousand Nahua warriors from Mexico (Restall & Asselbergs, 2007). The Spanish conquistadores benefited from steel swords, occasional cannons, and horses (Restall & Asselbergs, 2007).

Further, the lack of unity across multiple kingdoms and villages of the Maya civilization allowed the Spanish to conquer one kingdom at a time (Restall & Asselbergs, 2007). The K'iche people fought multiple wars with a strong resistance against Spanish forces (Restall & Asselbergs, 2007). Yet, Mayan communities were hit with high causalities during war, routine massacre of civilians, and disease (Restall & Asselbergs, 2007). After defeat, the K'iche people attempted to bring peace, yet de Alvarado, thinking it was a trap, burned the two K'iche kings alive and destroyed their cities (Restall & Asselbergs, 2007). It is documented that the Maya's swore loyalty to the Spanish crown in 1522, but accounts suggest that this was done in efforts to learn about their opponents and defeat the Spaniards (Restall & Asselbergs, 2007). The invasion roughly ended in 1526, marking the start of the colonial period in Guatemala (Restall & Asselbergs, 2007).

During this colonial invasion, Indigenous people were exposed to diseases, murdered, and forced to assimilate to Christianity while leaving behind their rich Indigenous roots and culture. The Spanish gained control over Mayan communities through their superior weaponry and military strategy (Dougherty & Rubin, 2016). Furthermore, Guatemala's precious metals and natural resources were exploited for the benefit of the Spanish conquistadores. Exploitation was further exacerbated during the colonial period as Spanish conquistadores forced Maya people to buy back their land (Castro & Picq, 2017). Like the rest of Central America during the colonial period, the *encomienda* system (starting in 1525 and lasting from the sixteenth to seventeenth century) served to colonize further, control, and oppress Mayan communities (Kramer, Lovell, & Lutz, 1990). The *encomienda* system benefited the Spaniards and their kin by receiving goods harvested from the land (e.g., silver, gold, cacao) by Indigenous people under their control (Kramer et al., 1990). The *encomienda* system deeply exploited labor of Indigenous people

(Dougherty & Rubin, 2016), and the harsh labor and slavery further led to their death (Smith, 1984). Additionally, a social hierarchy was quickly implemented across the land where Spaniards had the highest rank, followed by their kin born in the Americas, Ladinos (Spaniards and Indigenous offspring), and Indigenous people (Estrada & Torres Flores, 2018).

During the colonial period, Indigenous communities were forced to pay taxes, yet Ladinos who spoke Spanish and were not part of Indigenous villages did not have to do so (Wearne & Calvert, 1989). Guatemala was finally able to claim independence from Colonial rule in 1821 (Smith, 1984). Yet, the country continued to be in a constant internal struggle between liberal and conservative political forces, and the dispute over land and distributions (Dougherty & Rubin, 2016).

Independence of Guatemala

Following independence from Spain in 1823, Guatemala became part of the Federal Republic of Central America until 1840 when it was dissolved (Estrada & Torres Flores, 2018). The subsequent century was a constant internal struggle between liberal and conservative political parties. Additionally, Mayan communities were further subjugated to being treated as second-class citizens due to a lack of protection from the government (Lovell, 1994). Between 1821-1871, Guatemala's economy relied heavily on the exportation of goods and coffee, which further exploited Indigenous labor (Smith, 1984). From 1839 to 1848, Guatemala was under the harsh rule of conservative dictator Rafael Carrera who embraced Spanish colonial systems and the Catholic church. He ruled with force and constant threats (Miceli, 1974). He was followed by Vicente Cerna, who maintained Carrera's status quo (Miceli, 1974). This period was marked by constant disputes over land, violent carnage, and inequity (Lovell, 1994). Under the leadership and presidency of Justo Rufino Barrios, Guatemala became a modern capitalistic country

focused on exporting coffee. While this represented progress and advancement, it was a repeat of colonialization (Lovell, 1994).

Modern-day Guatemala

In 1899, Guatemala continued to be plagued by colonialization and imperialism from the United States through the American multinational United Fruit Company (UFC; Bucheli, 2008). The UFC was a producer and distributor of bananas in Central America to the United States. From this period, the derogatory term "banana republic" originated and was used to describe poor and politically corrupt developing countries (Bucheli, 2008). The UFC had close ties to dictators throughout Central America, including in Guatemala with Jorge Ubico (Bucheli, 2008; Estrada & Flores, 2018), which supported the exploitation of labor and inhumane treatment of workers, usually Indigenous people. The UFC played a role in developing railways, hospitals, and housing in port areas for distribution (Bucheli, 2008).

A brief respite came to Guatemala between 1944 and 1954; a time known as "10 years of Spring" under the presidency of Juan José Arévalo (1945-1951) and subsequently Jacobo Árbenz (1951-1954) after the dictator Jorge Ubico was overthrown (Estrada & Torres Flores, 2018). Jorge Ubico was known for his strong military and for sustaining unequal social hierarchies where the political elite held most of the power (Bucheli, 2008; Weaver, 1969). The "10 years of Spring" has been referred to as one of the few periods of true democracy in the country when slave labor was abolished, and land was returned to Indigenous communities (Estrada & Torres Flores, 2018). During this period, President Arévalo, and President Árbenz, attempted to usurp power from the UFC as it owned a majority of the land utilized for banana production (Estrada & Torres Flores, 2018). Presidents Arévalo and Árbenz mobilized Indigenous communities to create labor unions, form strikes, reform laws, and increase social welfare programs (Weaver,

1969). Yet, this backfired as it ultimately led to an alliance between the United States government, Guatemalan military, and other invested parties to overthrow Árbenz (Bucheli, 2008).

Following the overthrow of Árbenz in 1954, Carlos Castillo Armas assumed power of Guatemala, becoming a military dictator where his priority was to abolish any sort of communist supporters or idealists (Estrada & Torres Flores, 2018). Armas led with censorship and threats to silence the revolutionary movement that started during the "10 years of Spring," though he was murdered in 1957 (Estrada & Torres Flores, 2018; Weaver, 1969). His successor was General Ydigoras Fuentes, who attempted to decrease the repressive rule of Armas through increased funding to social programs yet, was unsuccessful, and only exacerbated tensions between progressives and conservatives (Weaver, 1969).

From 1960-1996, Guatemala experienced a vicious civil war described as the longest and most violent civil war of Central America between liberals and conservatives (Jonas, 2013). The first part of the civil war (1966-1968) was motivated by counterinsurgency military forces, which focused on targeting opposition leaders (Jonas, 2013). The most affected people during the civil war were Indigenous communities. The Guatemalan army reports that between the years of 1980 and 1985, an estimated 60,000-150,000 Indigenous people were murdered (or disappeared), 440 villages destroyed, and over a million Indigenous people were displaced by the Guatemalan army when they attacked communities in the Maya highlands (Jonas, 2013; Painter, 1987). Guatemala's economy greatly suffered during this time and the period from 1980-1990 has been described as the "lost decade" (Jonas, 2013). On December 29, 1996, a peace agreement was finally reached with mediation from the United Nations (Estrada & Torres Flores, 2018; Jonas 2013).

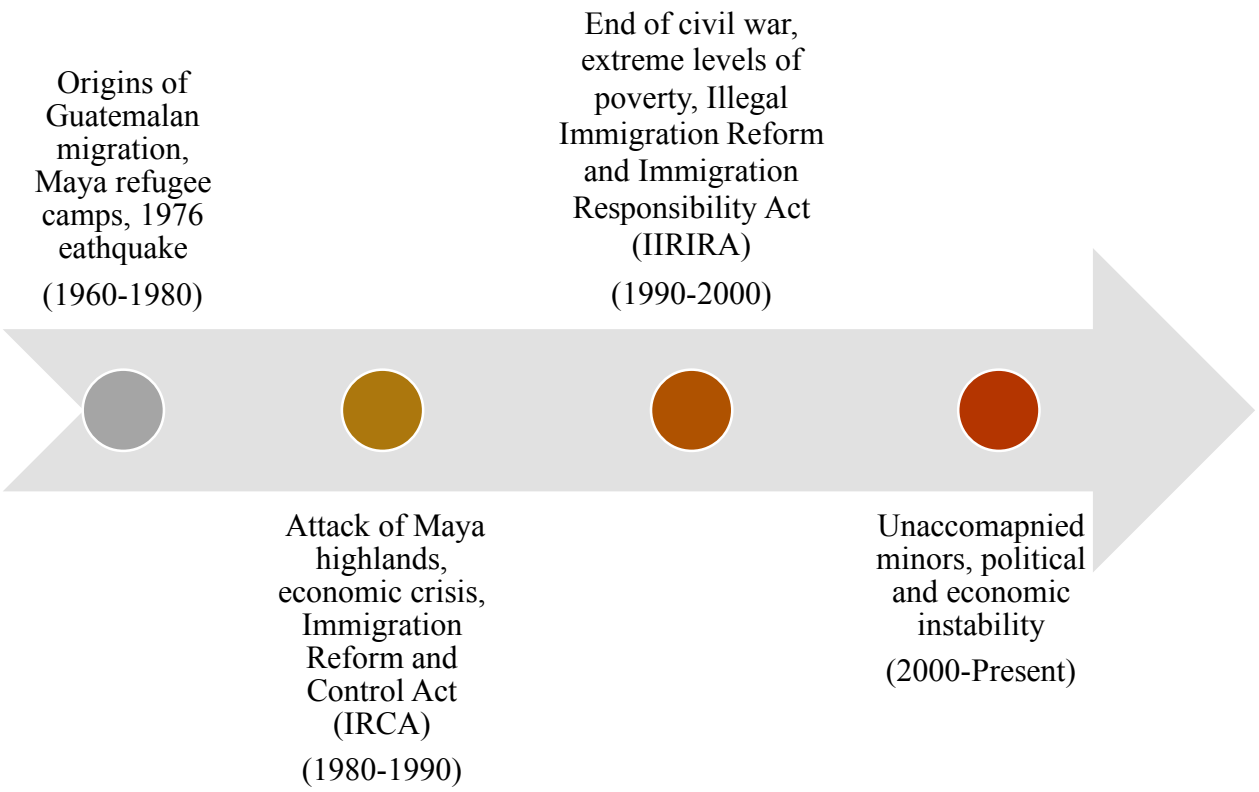
Structural inequities remain deeply ingrained, likely stemming from the colonial history and social hierarchy during the Spanish invasion, across the sociocultural fabric of Guatemala. For example, the World Bank estimates that Ladino children complete an average of 6.3 years of schooling compared to 3.5 years of schooling completed by Indigenous children (Dougherty & Rubin, 2016). Literacy disparities are vast and Indigenous people tend to be the most affected. For example, Indigenous women (ages 15-64) tend to have the lowest levels of literacy (39%) compared to Indigenous men (68%), Ladino women (77%), and Ladino men (87%; Hallman & Peracca, 2007; Dougherty & Rubin, 2016). Poverty and violence continue to plague Guatemala, with the most vulnerable often being the victims. For example, femicide (violence and murder against women) is a salient and heinous issue that impacts Guatemalan society (Estrada & Torres Flores, 2018). Taken together, it is important to consider the historical trauma and current violence in Guatemala when working with patients of Guatemalan ancestry.

Migration Patterns: A Historical Perspective

Similar to other Central American communities, Guatemalan migration to the United States has been shaped by civil unrest, social inequities, displacement, structural racism, and most recently, transnational crime and violence and two category 5 hurricanes (e.g., Hurricanes Eta and Lota) that struck Central America in the fall of 2020. The history of Guatemalan migration to the United States has been linked to (1) a 36-year civil war, (2) political and economic instability, (3) extortion, (4) military force, (5) family separation, (6) gender-based violence, (7) climate change, (8) unemployment, and (9) political ties with the United States (Jonas & Rodriguez, 2014; Pardilla, 2016; Pons, 2021; Ziff, 2019). Historically, Guatemala's socioeconomic problems, state-sponsored violence, and weak state have been instrumental in people's decision to migrate North, as more than a million Guatemalan residents have sought

refuge, jobs, family reunification, and safety in the United States. The following section provides a brief review of Guatemalan migration to the United States (see Figure 11).

Figure 11. Guatemalan migration patterns.



The first wave (1960-1980)

Migration from Guatemala to the United States, similar to other Latinx migrant groups, has been characterized by waves. Accounts of migration to the United States from Guatemala date back to the 1930s. However, the first small scale Guatemalan migration to Northern countries, such as Mexico and the United States, reportedly occurred during the first ten years of the civil war (1960-1970; Jonas, 2013). This wave of migrants mostly settled in Mexico, joining a pre-existing diaspora of mostly professional, middle-class Guatemalan political exiles (Jonas,

2013). However, during the mid-to-late 1960s, there was a small increase in Guatemalan residents migrating to the United States with data suggesting that the foreign-born from Central America represented 6% of the total U.S. foreign-born population (Grieco et al., 2012; U.S. Census Bureau, 2010).

The initial phase of the Guatemalan civil war marked the first moderate-to-large scale migration/exodus of Guatemalans to Mexico and the United States. During the 1970s, an overwhelming number of Mayan refugees crossed into Mexico and settled in refugee camps backed by the United Nations High Commissioner for Refugees (Jonas, 2013). A small number of Guatemalans continued to the United States seeking asylum from political and ethnic persecution (Jonas, 2013; Jonas & Rodriguez, 2014). Data suggest that by 1970 there were an estimated 15,356 Guatemalans in the United States, including 5,381 Guatemalan immigrants counted in the 1960 census (Gibson & Jung, 2006). Concerning conditions resulting from the war, and a 7.5 magnitude earthquake that killed approximately 23,000 people in 1976, contributed to the large-scale migration of Guatemalans to the United States in the late 1970s. Research suggests that approximately 13,000 documented and undocumented Guatemalan migrants began entering the United States yearly during the latter part of the 1970s into the early 1980s (Jonas, 2013; Jonas & Rodriguez, 2014). This wave of Guatemalan migrants is credited for having developed transnational linkages between Guatemalan communities in the United States and Guatemala via Mexico, initiating a sustained pattern of large-scale migration and settlement, and establishing Guatemalan immigrant settlements across the United States (Jonas & Rodriguez, 2014).

The second wave (1980-1990)

The dramatic increase in political violence and sharp decline of economic conditions during the first ten years of the war, led to the second phase of migration to the United States during the 1980s. State violence, increased disappearances of leaders, and repression of Maya peoples in the Maya highlands prompted people to flee and seek refuge abroad. In addition to war conditions, the Guatemalan economic crisis further pushed people to the United States, with unemployment rates reaching more than 40% by the mid-1980s (Gallardo & Lopez, 1986). The economic crisis further oppressed Indigenous communities as political violence severely restricted mobility to marketplaces where people would buy and sell artisan products. While economic conditions worsened in Guatemala, the United States service industry continued to surge. The service industry attracted migrant workers, especially Guatemalan migrants looking to establish roots and work in the United States (Estrada & Torres Flores, 2018). In addition to a flourishing economy, the 1980s also brought change to immigration policies in the United States (e.g., Immigration Reform and Control Act [IRCA] of 1986), contributing to an increase in undocumented migration from Guatemala. The war in Guatemala and economic crisis were no longer the only factors influencing migration to the United States. According to U.S. Citizenship and Immigration Services (USCIS), an estimated 70,953 Guatemalan migrants submitted applications to gain amnesty and the possibility of legalization under IRCA (Jonas & Rodriguez, 2014). Data suggest that of the 70,953 applications submitted, about 50,000 applicants were granted legal permanent resident status, representing 2% of the undocumented migrant population (Jonas & Rodriguez, 2014; Kerwin, 2010).

The third wave (1990-2000)

The intense political repression lived by Guatemalans during the 1970s and early 1980s decreased towards the latter part of the 1980s. The start of the 1990s marked the beginning of phase 3 of Guatemalan migration to the United States. As stated above, an estimated 50,000 migrants received legal permanent visas through IRCA, which increased the average annual volume of Guatemalan migrants at the start of the 1990s (Estrada & Torres Flores, 2018; Jonas & Rodriguez, 2014). However, with the large number of Central Americans entering the United States during the early part of the 1990s, the United States government increased its efforts to prevent additional Central Americans from reaching the states (Jonas & Rodriguez, 2014). Nevertheless, Guatemalan migration to the United States continued as the country recovered from the aftermath of the war. According to the World Bank, poverty levels in Guatemala reached 65%, with 40% of the people living in extreme poverty during the early 1990s. The 1990s also brought forth additional immigration policies including the Immigration Act of 1990, which set the annual level of immigrants admitted into the country to an estimated 700,000 (Jonas & Rodriguez, 2014). According to USCIS, approximately 143,000 Guatemalan immigrants were admitted into the United States between 1988 and 1998.

Immigration patterns from 2000 – 2022

During the late 1990s and early 2000s, a rise in fear surged due to a perceived and uncontrolled increase in migration (Jonas & Rodriguez, 2014). The fear around undocumented immigrants ignited an anti-immigrant movement that focused on immigration restrictions and policies that criminalized immigration related activity. For example, the Illegal Immigrant Reform and Immigrant Responsibility Act of 1996 (IIRIRA) criminalized racketeering, the smuggling of undocumented immigrants, and the use or development of fraudulent immigration

documents (Estrada & Torres Flores, 2018). However, changes in immigration policy did not discourage Guatemalans from making the journey to the United States. Data suggest that between 2004 and 2011, the estimated total of Guatemalan (documented and undocumented) immigrants to the United States reached a mean annual of 56,737, a significant increase from prior years (Jonas & Rodriguez, 2014).

Similarly, data from the U.S. Department of Homeland Security suggested that approximately 160,000 Guatemalans obtained legal permanent resident status between 2001 and 2010. However, migration from Guatemala to the United States and remittances from the United States to Guatemala decreased as a result of the 2009 economic crisis. Nevertheless, by 2012 with the U.S. economy rebounding, migration from Guatemala resumed. Since then, migration patterns have been led by unaccompanied minors (children traveling without any legal documentation or caregivers with the purpose of crossing into the United States) fleeing gang-related violence, natural disasters, and political and economic instability. Data from U.S. Border Patrol suggest that between 2015 and 2019, the number of Guatemalan-born unaccompanied minors migrating to the United States rose from 13,589 to 30,329. *La Bestia* (freight trains) has been one of the only options for traveling through Mexico to border towns such as Ciudad Juarez for many of these unaccompanied minors. Readers should refer to the *El Salvador* chapter (*A Constant State of War: How a Historical Insight into El Salvador and Salvadoran-Origin People in the United States Can Inform Mental Health Services for Salvadorans*) for additional information on *La Bestia*. Recent data suggest that during the 2020 fiscal year, Guatemalan children made up 48% of all unaccompanied minors, making them the largest group of children traveling without an adult (U.S. Department of Health & Human Services, 2021). Today, with the two category five hurricanes (e.g., Eta and Lota) that hit Central America in December of

2020, a hunger crisis, violence, and shifting weather patterns, the number of Guatemalans apprehended at the United States-Mexico border has increased (Angelo, 2021; Kitroeff, 2020; Sieff, 2021). Current fiscal data from the U.S. Customs and Border Protection suggest that as of March 2021, there has been 18,372 unaccompanied Guatemalan children apprehended at the Southwest border, 18,769 family units, and 60,000 single adults. Being aware of current migration patterns can help mental health providers attend to the unmet needs, vulnerabilities, and potential priority areas for intervention among Guatemalan families.

Indigenous Guatemalan Communities

The history of Guatemalan Indigenous communities is rooted in, and defined by, colonialism, genocide, structural racism, dispossession, and dislocation (International Work Group for Indigenous Affairs, 2021). Guatemala was once the epicenter of Maya civilization. Today, Guatemala is home to an estimated 6.5 million (43.75%) individuals who belong to the 22 Mayan communities (Achi', Akatec, Awakatec, Chalchitec, Ch'ortí, Chuj, Itzá, Ixil, Jacaltec, Kaq-chikel, K'iche, Mam, Mopan, Poqomam, Poqomchí, Q'anjob'al, Q'eqchí, Sakapultec, Sipakapense, Tektitek, Tz'utujil, and Us-pantek; International Work Group for Indigenous Affairs, 2021). In addition, Guatemala is also home to three African-Indigenous communities, which include Garífuna, Xinca and Creole. According to the 2020 Minority Rights Group International, K'iche (11%), Q'eqchi' (8.3%), Man (5.2%), and Kaqchikel (7.8%) make up most of the Indigenous peoples in Guatemala. Like Indigenous peoples in other parts of Latin America, Guatemalan Indigenous communities continue to lag behind the majority of Guatemalan society. The inequities encountered by the Indigenous peoples are rooted in structural racism, which has led to social exclusion and violation of their fundamental rights. Despite being recognized by the Political Constitution of the Republic of Guatemala and the

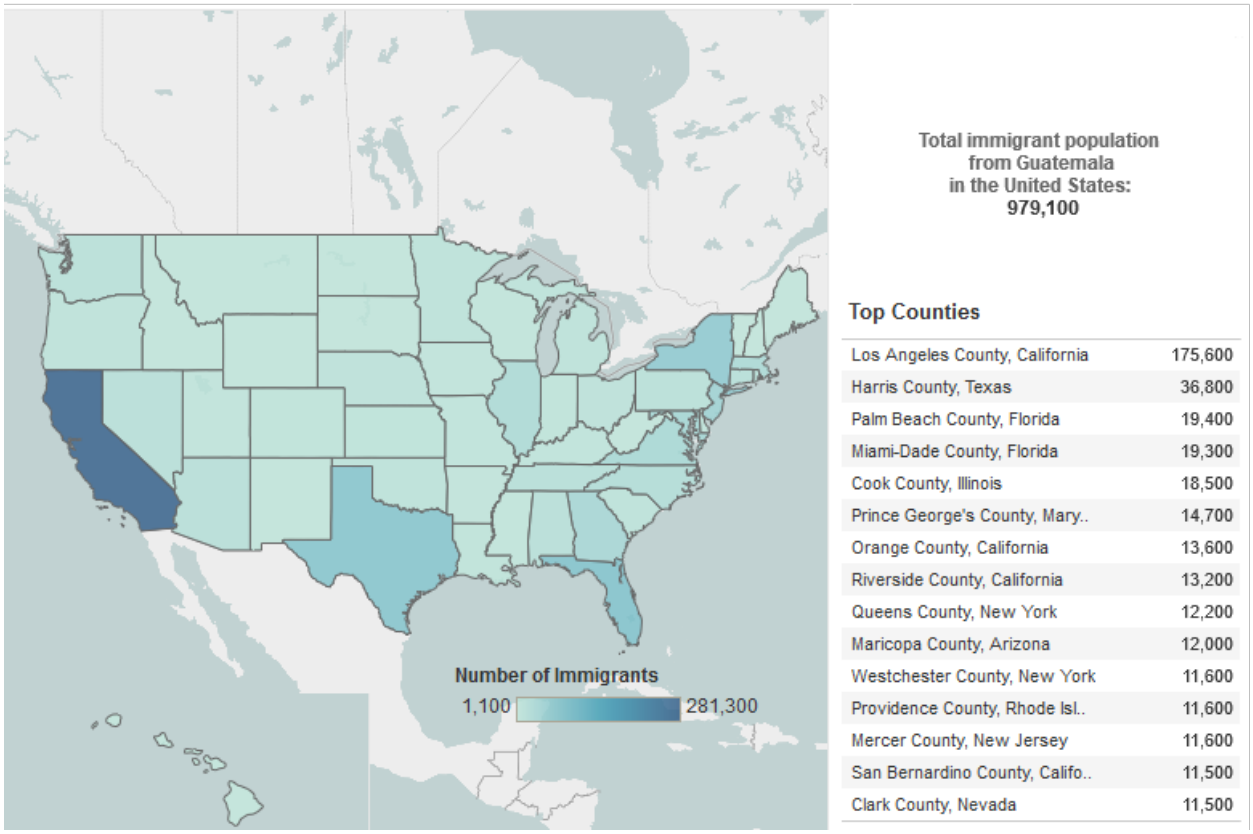
country's ratification of internal agreement on the rights of Indigenous people, the Indigenous community continues to face social and economic challenges compared to the population at large. For example, poverty affects 75% of the Indigenous people compared to 36% of non-Indigenous people; and chronic malnutrition affects 58% of Indigenous people versus 38% of non-Indigenous people (International Work Group for Indigenous Affairs, 2021). These disparities along with displacement have prompted approximately 864,000 Maya to migrate from Guatemala to the United States (CDC, 2017). Given this increase in Mayan migration, it is important for clinicians to learn more about their culture to increase engagement in mental health services (National Hispanic and Latino MHTTC, 2020).

Guatemalans in the United States

Settlement points

Between 1990 and early 2000s, approximately 80,000 Guatemalans migrated to the United States (Jonas & Rodrigues, 2014). The vast majority, between 1990 and early 2000s, settled in large cities where the service industry continued to grow, such places included Los Angeles, Chicago, and Houston (Jonas & Rodriguez, 2014). Today, Los Angeles (175,600), Harris County (36,800), Palm Beach County (19,400), Miami-Dade County (19,300), and Cook County (18,500) are home to the most significant number of Guatemalan immigrants (see Figure 12; Census Bureau, 2020). Similar to other Latinx immigrant groups, Guatemalan immigrants are now settling in rural parts of Midwestern (e.g., Nebraska, Ohio, Kansas, Indiana) and Southern states (e.g., Alabama, North Carolina, Tennessee, Georgia; U.S. Census Bureau, 2020). Notably, the context of violence, natural disasters, and a hunger crisis has recently contributed to the constant flow of Guatemalans leaving the country in an effort to survive.

Figure 12. Guatemalan immigrant population by state and county, 2015 – 2019.

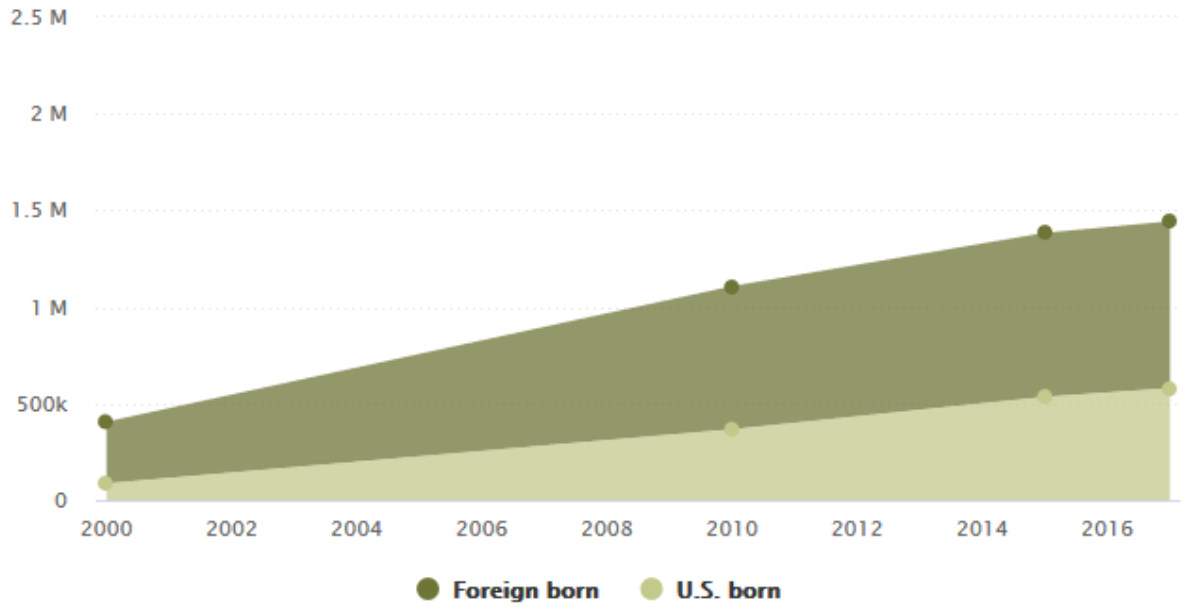


Demographics

Today, at nearly 1.4 million, the Guatemalan community is the sixth-largest origin group in the United States, and accounts for 2% of the Latinx population (see Figure 13; Noe-Bustamante et al., 2019). In 2019, the Guatemalan foreign-born population reached 979,100, making it the second-largest Central American immigrant group in the United States (see Figure 4; U.S. Census Bureau, 2020). Research studies evaluating migration patterns from Guatemala to the United States have shown a significant increase in the last two decades, a growth of 171% from 2000 (Cohen et al., 2017; Noe-Bustamante et al., 2019). The increase in migration patterns to the United States are said to be a result of high homicide rates; gang activity; violence in the home; economic opportunity; and reunification efforts with family in the United States (Cohen et al., 2017). Additional factors include climate change; poverty; food insecurity; economic

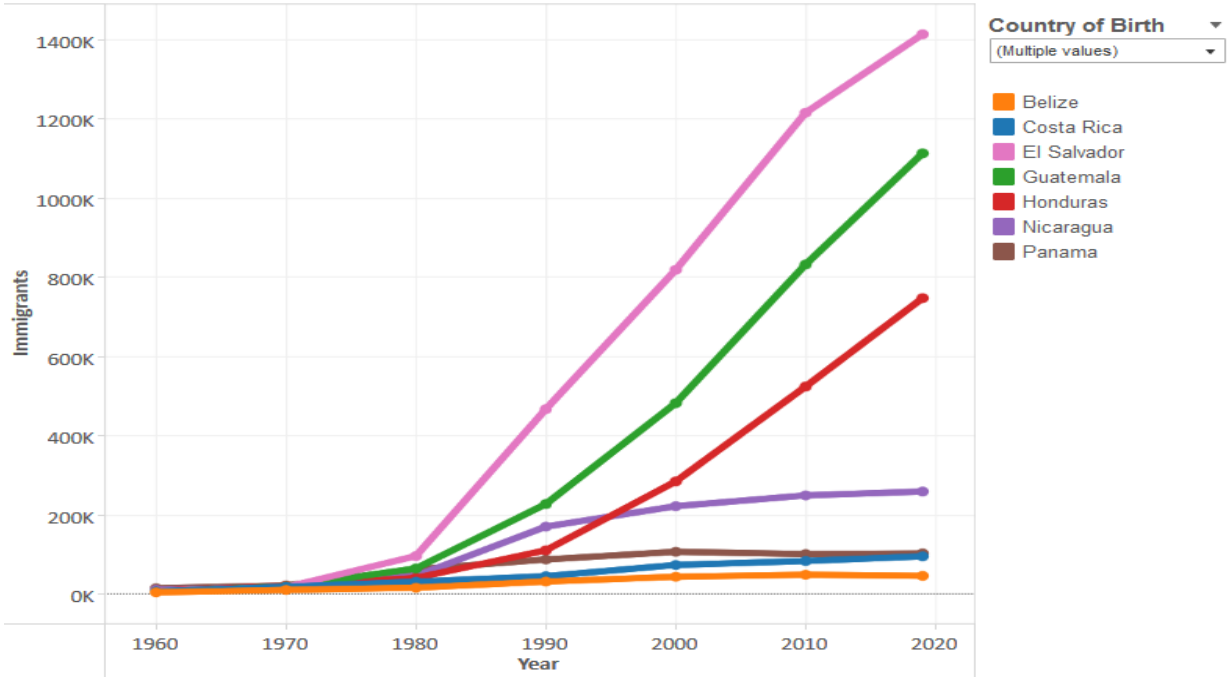
precariousness; government corruption; and U.S. involvement in the region and immigration policies (Angelo, 2021; Pons, 2021; Semple & Wirtz, 2021).

Figure 13. Guatemalan-origin population in the U.S., 2000-2017.



Note: Latino origin is based on self-described ancestry, lineage, heritage, nationality group or country of birth.
Source: Pew Research Center tabulations of 2000 census (5% IPUMS) and 2010, 2015 and 2017 American Community Surveys (1% IPUMS).

Figure 14. U.S. Central American immigrant population, 1960 – 2019.



Source: *Countries of birth for U.S. immigrants, 1960-present*. migrationpolicy.org. (2021, February 15). Retrieved from https://www.migrationpolicy.org/programs/data-hub/charts/immigrants-countries-birth-over-time?width=1000&height=850&iframe=true

Employment

Precarious employment opportunities in Guatemala and a stable U.S. economy have been crucial to the Guatemalan experience in the United States. Similar to other Latinx immigrant groups, Guatemalan workers have been essential to the sustainability of two economies (e.g., U.S. & Guatemala). Today, remittances play an important role in Guatemala's economy, totaling close to $11.4 billion U.S. dollars at the end of 2020 (Focus Economics, 2021; Noe-Bustamante, 2020). The latest employment data indicate that workers of Guatemalan background make up close to 700,000 of the Latinx workforce in the United States (Bucknor, 2016). In terms of gender difference, Guatemalan men account for 66.7% of the workforce, while women make up

33.3% (Bucknor, 2016). According to the 2015 American Community Survey and Puerto Rico Community Survey, Guatemalan workers are least likely to hold employment in the public sector (e.g., education, armed services, public transit). Finally, the median family income of Guatemalans in 2014 was less than $40,000 (Bucknor, 2016).

Education

Among the Latinx community, data suggest that approximately 50% of employed Guatemalan adults in the United States lacked a high school diploma in 2015, and 40% reported residing in a limited English-speaking household (Bucknor, 2016). Additionally, among the Guatemalan community ages 25 and older, approximately 10% reported obtaining at least a bachelor's degree (Noe-Bustamante et al., 2019). Among Guatemalans ages 25 and older, U.S.-born Guatemalans were more likely than the non-U.S.-born Guatemalans to have a bachelor's degree or higher (26% vs 8%; Noe-Bustamante et al., 2019). Moreover, 2016 data suggest that the high school status dropout rate for Guatemalans between the ages 16-to-24 years was the highest compared to all other Latinx groups at 22.9% (de Brey et al., 2019). Finally, according to the Pew Research Center on Hispanic Trends, 58% of Guatemalan immigrants ages 25 and older had not completed high school, making them the largest Central American community without a high school diploma (Cohen et al., 2017).

Religion

According to the 2019 Report on International Religious Freedom: Guatemalan, 45% of the Guatemalan community in Guatemala identified as Catholic and 42% Protestant. An estimated 11% identified no religious affiliation, while 2% endorsed "other," including Buddhism, Hinduism, Islam, Judaism, and adherents of the Maya, Xinca, and African-Indigenous Garifuna religions. To date, there is limited data on the religious affiliation of

Guatemalans in the United States. However, one study examining the effects of immigration on religious beliefs and practices of immigrant groups in the United States found that 52.2% of Guatemalans identified as Catholic, 27% as Protestant, and 9.3% as Orthodox (Massey & Espinoza Higgins, 2011). Furthermore, 10.4% endorsed "none," and none of the participants identified as Muslim, Jewish, Buddhist, or Hindu (Massey & Espinoza Higgins, 2011).

Mental Health Considerations

Central American migrants are suffering from record levels of mental health issues, amid a rise in violent attacks after a U.S.-sponsored immigration crackdown forced them to use more perilous routes through Mexico (Grazioso & Mejía Alvarez, 2021; Lakhani, 2016). In Guatemala, more than 25% (3,250,000 people) of the population will suffer from a mental illness in their lifetime. Still, less than 1% of health care expenditures by the Ministry of Health are directed towards mental health care (Klie & Grazioso, 2020). Approximately one in four Guatemalans between the ages of 18 and 65 are suspected to experience at least one mental disorder (Jacobo, 2020). Guatemalan mental health providers are not able to attend to the significant mental health needs. There are 0.54 psychiatrists per 100,000 inhabitants, only five psychiatrists working outside the urban center of Guatemala City, and approximately 13,000 psychologists for an estimated population of 15 million (National Center for Education Statistics, 2018).

The mental health needs among Guatemalans persist outside the county of origin. Lakhani (2016) noted that nine out of 10 migrants are at risk for anxiety or depression symptoms caused by rape, assault, or kidnapping. Eisenman and colleagues (2003) examined the effects of violence in 638 immigrants. The sample had a mean age of 46.1 years (47.5 years among those exposed to political violence, 45.1 years among those not exposed). Twenty-five percent were

male (25.6% of those exposed to violence, 24.9% were not exposed). Two hundred sixty-five (41.5%) immigrated from Mexico (14.6% of those exposed to violence, 62.8% of the nonexposed), 207 (32.5%) from El Salvador (54.8% of those exposed to violence, 14.9% of the nonexposed), and 113 (17.7%) from Guatemala (22.4% of those exposed, 14.0% of the nonexposed). Compared with patients from Mexico, patients from Central America reported on average increased exposure to political violence events.

Furthermore, fear of deportation may prevent families from enrolling in and using available services, even when they possess valid immigration documents, especially in areas with increased proportions of deportations (Watson, 2010). Families may be reluctant to enter their information into health center records, even if their children are U.S.-born, due to fear of having this information shared with law enforcement agencies (Page & Polk, 2017). In addition to fear and isolation, lack of awareness may limit access to health care, as has been noted among Guatemalan immigrants residing in the United States for extended periods of time (Schapiro et al., 2018). In a study in Cincinnati, OH, researchers found that although Mexicans and Guatemalans reported significant barriers to health care, Guatemalans endorsed more barriers and had less access to information regarding health care than their Mexican counterparts (Zhen-Duang et al., 2017).

Stressors in Guatemala Affecting Mental Health of Immigrants

Sexual- and gender-based violence

Sexual- and gender-based violence has increased throughout Central America and Mexico. El Salvador, Guatemala, and Honduras report incredibly high rates of femicide, with rates up to five times higher than overall homicide rates in the majority of Northern, Western, and Southern European countries (CDC, 2021). According to Amnesty International (2020),

women are often murdered in Guatemala after being sexually assaulted. Guatemala has a rate of 2 femicides per 100,000 women (Burog, 2019). Overall, Guatemala is one of the most dangerous places on earth to be a woman. Perpetrators of gender-based violence readily go unpunished, as Guatemala is a country where less than four percent of all homicides result in convictions (Verza, 2018). According to the United Nations, 88% of reported crimes against women in Guatemala are not brought to justice. Guatemalan women also suffer from some of the highest rates of interfamilial violence in the world (Verza, 2018).

Women and girls face discrimination and violence in Guatemala. Although Guatemalan law establishes the principle of gender equality and criminalizes discrimination, Guatemala has the highest gender inequality index in the region (Nivette, 2013). Women experience soaring rates of sexual violence, exclusion from political and economic participation, and rigid gender norms that often limit their vocational and educational options. In 2017, gender-based violence (GBV) was the most reported crime, overwhelming Guatemalan courts' ability to provide justice to women due to lack of prosecutors (Schacher & Schmidtke, 2020). Indigenous women experience violence and discrimination within their intersectional, ethnicity, gender, and Indigenous identity.

Violence, Homicides, and Corruption

Guatemala is one of the most dangerous countries in the world (The UN Refugee Agency, 2020; World Report, 2020, 2021). Violence and extortion by powerful criminal organizations, which the government has often been unable or unwilling to control, continues to be a major problem in Guatemala (World Report, 2020, 2021). A survey by the UN Refugee Agency (2020) found that 20% of over 3,100 Central American interviews noted that violence – including death threats, extortion, gang recruitment, and domestic violence – influenced their

decision to leave their communities. Crime in Guatemala stems from various issues such as corruption, an inadequate justice system, and the prevalence of both gang and drug activity across the country (UN Refugee Agency, 2020). As of 2020, the U.S. Department of State declared Guatemala City as a critical threat location for crime (Overseas Security Advisory Council, 2020). Many robberies occur during daylight hours while victims walk or drive in well-known, well-traveled areas, including markets, public parks, and popular restaurant districts. Even the most upscale residential and commercial areas of Guatemala City (Zones 4, 10, 14, 15, and 16) experience violent crimes in broad daylight (OSEA, 2020). The COVID-19 pandemic has currently added more stressors to Guatemalans. Strict restrictions on movement and border closures have limited the options for Guatemalans to flee, and to successfully immigrate to the United States (The UN Refugee Agency, 2020).

Homicides

Guatemala's homicide rate peaked at 45 deaths per 100,000 inhabitants in 2009, but by the end of 2018 had dropped to about 22. In 2018, the police reported 3,881 homicides, a figure slightly higher than the 3,578 homicides reported for 2019 (Overseas Security Advisory Council, 2020). Guatemala closed out 2020 with a total of 2,574 homicides and a murder rate of 15.3 per 100,000 during President Alejandro Giammattei's first year in office (Assman & Jones, 2021). Overall, the 2020 rates suggest a 28% drop from 2019's death rate. The COVID-19 pandemic is hypothesized to have further decreased death rates (Assman & Jones, 2021).

Gang violence

Violence stemming from gang rivalries and extortion by influential criminal organizations remain severe problems in Guatemala. Gang-related violence is an essential factor prompting people, including unaccompanied children and young adults, to leave the country

(World Report, 2020). For instance, gangs will use forms of extreme violence to intimidate and extort money (World Report, 2020). One is through the use of improvised explosive devices (IEDs), used against public transportation and business to extort targeted individuals. For instance, the Overseas Security Advisory Council (2020), reported the following incident:

> "On January 21, 2019, at approximately 1045hrs, an IED exploded in the doorway of a public bus traveling through Zone 7 in Guatemala City, located 3.5 miles from the United States Embassy. Reports indicate the bus driver was the victim of gang-related extortion operations. As retaliation for non-payment, a confirmed associate of the gang Barrio 18 set off an IED approximately the size of a grenade inside the bus. In addition to the perpetrator, five victims went to local hospitals for treatment of injuries."

Overall, death threats, gang recruitment, extortion, and other forms of targeted violence are driving more families in northern Central America to flee their homes and seek safety in other countries (The UN Refugee Agency, 2020).

Corruption

The International Commission against Impunity in Guatemala (CICIG) led Guatemalans through dozens of high-impact cases against some of the most politically and economically powerful people in the country (Hite & Montenegro, 2020). The CICIG carried out more than 100 corruption investigations that implicated high-profile people and prosecuted 660 individuals, resulting in 400 convictions to date (World Report, 2021). CICIG exposed more than 60 corruption schemes, implicating officials in all three branches of government, and prompting the resignation and arrest, in 2015, of the country's then-president and vice-president (World Report, 2021). Intimidation of judges and prosecutors and corruption in the justice system remain problematic (Hite & Montenegro, 2020). Due to former President Jimmy Morales and other

notable Guatemalans with financial and political power, the CICIG closed its doors in September 2019 after a decade of unprecedented and historic work in Guatemala (Hite & Montenegro, 2020).

COVID-19's Effects on Immigration and Deportation

Generally, Guatemalans are profoundly affected by violence, insecurity, lack of employment, natural disasters, and/or the loss of loved ones; such stressors were and continue to be exacerbated by COVID-19 (Grazioso, M. & Mejía Alvarez, 2021). The pandemic has compounded the current and historical issues of corruption, violence, and homicides. For instance, Guatemalans deported and exposed to COVID-19 do not have access to proper health care services, or adequate shelter to allow for quarantine or isolation. Guatemalans deported during the pandemic return to rising levels of food insecurity, and a stagnant economy further hobbled by border closures and movement restrictions. Adults and children alike face stigma, and a growing risk of violent attack as fear and misinformation about the disease continue to spread (Schacher & Schmidtke, 2020).

Family Separation and Detention of Children

Over the last decade, the number of Guatemalan children deported from the United States and Mexico has increased nine-fold (Schacher & Schmidtke, 2020). Most Guatemalan youth flee Guatemala for survival (fleeing extortion, poverty, and violence), or to reunite with family in the United States. Many are Indigenous youth from communities in the highlands and along the Mexican-Guatemalan border (Heidbrink, 2020). Within the context of COVID-19, Guatemalan migrants are in an immigration "limbo." Guatemalans in ICE custody awaiting deportation worry that they will be infected while in detention centers. ICE has begun to ask asylum-seeking

parents currently detained with their children in family detention centers to give up custody in exchange for the children's release from detention (Schacher & Schmidtke, 2020).

Detained Guatemalan youth encounter significant stressors. For instance, *Casa Nuestras Raíces* is one of only two government-run shelters operated by the Secretariat of Social Welfare for returned unaccompanied minors in Guatemala. Stationed in Quetzaltenango, *Casas Nuestras Raiíes* receives children deported from Mexico by land. In February 2020, they received about 100 children. Many children are traumatized or sick from having spent a month or more in detention in Mexico, deprived of sufficient showers and food. Notably, 30% of children returnees had parents in the United States and 10% had been neglected, abandoned, or abused (Schacher & Schmidtke, 2020).

Conclusion

People of Guatemalan ancestry have migrated to the United States and Mexico as a result of various push and pull factors (e.g., economic crisis, family reunification, war, climate change). In addition, for hundreds of years, people of Guatemalan ancestry have encountered and endured significant pain from colonialization, which continues to have a major impact on the Guatemalan people, especially the Mayan community. Similar to other Latinx communities, people of Guatemalan ancestry, especially the Indigenous communities, continue to confront various forms of discrimination, aggression, anti-immigrant policies, and hate, to which the community has responded with resilience and productivity. Despite their strengths and resilience, the mental health of Guatemalans and Guatemalan Americans needs to be at the forefront given the social, political, physical, psychological, and spiritual harm waged against them in Guatemala and the United States. Therefore, we encourage mental health providers to familiarize themselves with the experiences of individuals of Guatemalan ancestry to better understand behavioral and

psychological processes in a context of historical trauma, and to recognize their inherent resilience and resourcefulness.

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A CONSTANT STATE OF WAR:

How A Historical Insight into El Salvador and Salvadoran-Origin People in the United States can Inform Mental Health Services for Salvadorans

Introduction

The presence of Salvadoran and Salvadoran Americans in the United States results from El Salvador being in a constant state of war. Therefore, knowing the history of Salvadorans and Salvadoran Americans in the United States is essential to understanding their experiences, particularly as it pertains to trauma. The purpose of this chapter is to promote a greater understanding of how to serve the Salvadoran community in the United States, and as such introduce:

1. the colonialization history of El Salvador;
2. waves of migration; Indigenous Salvadoran communities; and
3. settlement patterns and current demographics, as this informs the experience of present-day Salvadoran-heritage individuals and families.

Additionally, we present a brief overview of Salvadoran employment, education, religion, and cultural background. We end the chapter with a discussion on gender-based violence, unaccompanied minors, mental health and substance use concerns of Salvadoran immigrants, and models of resilience and coping.

Historical Events

Invasion and pre-colonial El Salvador

The history of El Salvador is similar to that of other Latin and Central American countries rooted in Spanish colonial invasion, the massacre of Indigenous communities, and political turmoil. Currently, El Salvador is the smallest and most densely populated country in the mainland Americas (Arce & Escoto, 2018; Browning, 1971). Historical research suggests that the Pipil people, a Nahua group escaping from Xoconochco, Mexico and Olmec's oppressive rule, settled in modern-day El Salvador and Central America between IX and XII

centuries AD or about 700 years before Spanish rule. Numerous other diverse Indigenous communities were living in El Salvador in addition to the Nahua Pipil people, such as the Lenca, Maya Chortí, Maya Pocomam, and Cacaopera (Arce & Escoto, 2018; White, 2008). Before the Spanish conquest, there were a multitude of languages spoken throughout El Salvador, such as Pipil, Lenca, Cacaopera, Chorti, Mame, and Pokomam (Lemus, 2003). In 1522, the Spanish first attempted to conquer El Salvador, but lost to Pipil resistance. Next, the Spanish took over El Salvador and Pedro de Alvarado invaded in 1524; in 1525, Gustavo de Alvarado founded San Salvador. Finally, in 1528, Gonzalo de Alvarado took control of the western part of El Salvador by conquering the remaining Pipil communities (White, 2008). The Pipil community drastically decreased following Spanish rule, with some accounts noting that 20% of the Pipil population had been killed by warfare and disease by 1590 (Lemus, 2003). As of 2003, one scholar estimates there are roughly 200 surviving Pipil speakers in El Salvador, all bilingual with Spanish being their dominant language (Lemus, 2003).

The historical account regarding the conquering of El Salvador is mainly from documents written by the conquerors. Capitan Don Pedro de Alvarado was a deputy of Hernán Cortez, and he began the invasion of El Salvador in 1524 with an army of 200 soldiers and roughly 2000 Indigenous people from Guatemala. He was outnumbered by Pipil warriors dressed in "their war costumes, with spears and arrows, and heavy cotton armors" (p. 2; Lemus, 2003). Subsequently, de Alvarado retreated to the mountains and counterattacked, thus defeating the Pipil people with military strategy. Accounts of the battle note that the Pipil's cotton armor was so heavy that they had difficulty getting up when they fell, and they were murdered on the ground. It is also noteworthy that smallpox had been ravaging the area, killing countless of the Pipil people as they did not have immunity. De Alvarado then trailed towards Kuskatan, which was the main city of

the Pipil people, where he was met with peace and no resistance. They offered de Alvarado and his army fruit, copper axes, and other goods. Ultimately, de Alvarado was unsatisfied with the terrain and lack of gold, and subsequently enslaved the Pipil people to the Spanish army, hung Kuskatan leaders, and sold others into slavery (Lemus, 2003).

Colonialization of El Salvador

Pedro de Alvarado gave present-day El Salvador the name "*Provincia De Nuestro Señor Jesucristo, El Salvador Del Mundo*," meaning "The Savior," to reference Jesus Christ, and he served as governor until his death in 1541 (White, 2008). During the nearly 300-year colonial period (1524-1821), Indigenous populations in El Salvador were drastically reduced due to disease, territorial invasion, forced labor, and battles (White, 2008). Starting in 1542, El Salvador, along with the rest of Central America, was governed under the Kingdom of Guatemala. The Kingdom of Guatemala consisted of 15 municipalities appointed by the Spanish Crown starting the *encomienda system*. The *encomienda* was the system used by the Spanish crown to distribute land and utilize Indigenous people for labor and the production of goods, and in return, the Indigenous people received protection, conversion to Catholicism, and were subjected to taxation by the Spanish Crown (Yaeger, 1995). During this period, Indigenous missionaries and conquistadores set out to convert and control Indigenous communities. El Salvador was met with many plagues and pandemics in the sixteenth century that increased the decline of Indigenous populations. The Indigenous population began to stabilize in the 17th century when they started to develop immunities from European diseases.

The production of goods during the colonial period also influenced the political and sociocultural landscape of El Salvador. The products most commonly produced were cacao, cotton, cochineal, and indigo. An indigo boom in El Salvador increased labor demands causing

the country to become one of the most densely populated areas in Central America. The production of these goods came from exploiting and oppressing Indigenous communities. The slave trade also reached El Salvador, although in much smaller numbers compared to the Caribbean, where African slaves were forced to work in the mines. Spanish conquistadores viewed African slaves as more likely to revolt than Indigenous slaves and by the end of the eighteenth century, only 600 African slaves remained in El Salvador. In 1821, El Salvador and the rest of Central America declared independence from Spain. The independence of Central America occurred through a transition away from the Spanish crown, forming local municipality sovereignty. Yet, as El Salvador gained its independence, Guatemala worked with Mexico in an unsuccessful attempt to invade El Salvador in 1822.

The Central American Federation: 1823-1838

In 1823, Manuel José Arce, a liberal from El Salvador, became president of the Central American Federation, consisting of present-day Costa Rica, El Salvador, Honduras, Guatemala, and Nicaragua. The period of the Central American Federation was met with tensions between countries and civil war due to the lack of infrastructure and unification (White, 2008). There were numerous uprisings and revolts from Indigenous populations during the Central American Federation period as Indigenous communities continued to be oppressed, lacked representation in government, and experienced poverty and inhumane labor conditions. Tensions between liberal and conservative forces ultimately led to the dissolvement of the Central American Federation in 1839 (Arce & Escoto, 2018). Finally, in 1839 El Salvador gained its true independence as a republic, which would prove to be in constant struggle.

Independence of El Salvador

Following the independence of El Salvador in 1839 the nation continued to experience internal and external turmoil. The first few decades of independence consisted of instability due to increased hierarchical government power structures and the creation of oligarchies. Between the years of 1841 and 1890, El Salvador had 13 military coups and fought Honduras (four times), Guatemala (five times), and Nicaragua (one time). The result was an increase in military legislation and funding for police and military forces. In 1871, all males between 18 and 50 were forced to join the military, and by 1880, there were over 20,000 trained military soldiers in El Salvador.

Modern-day events and trauma

La Matazana of 1932 and the civil war that lasted for over a decade are part of a collective historical trauma that affects people from El Salvador. These two major events devastated entire communities and tore families apart. El Salvador is the smallest country in Central America, and it is also the most densely populated country; therefore, when large events, such as a 12-year civil war occur, the ramifications impact nearly every citizen (White, 2008).

La Matanza (The Massacre) in El Salvador: 1932

La Matanza, which occurred in January 1932, was the killing of tens of thousands of Indigenous men, women, and children, with some sources noting upwards of 30,000 dead, by El Salvadoran military led by President Maximiliano Hernández Martínez (Arce & Escoto, 2018; Taylor & Vanden, 1982). *La Matanza* was in response to Indigenous communities rebelling and protesting against President Hernández Martínez. The rebellion armed with machetes and sticks, led by revolutionaries Faribundo Martí and other members of the communist party in El

Salvador, was a combination of Indigenous communities wanting to improve their working conditions and rural dissatisfaction (Arce & Escoto, 2018; Taylor & Vanden, 1982).

During this period, President Hernández Martínez targeted Indigenous communities by banning Indigenous dress, language, and culture. These policies went even further to include Indigenous people being shot on sight for wearing traditional dress or even having Indigenous features. Indigenous people were seized and executed with machine guns by the hundreds (Ching & Tilley, 1998). These heinous attacks were also intended to intimidate and prevent a future uprising from Indigenous communities (Taylor & Vanden, 1982) with a standard expression saying "*muerto el perro, se acabó la rabia*" (roughly translated to "with the dog dead so is the rabies;" (Taylor & Vanden, 1982). The genocide during *La Matanza* forced assimilation of Indigenous people into mestizo and Spanish culture and resulted in them giving up their language (Nawat), dress, and culture in order to ensure survival (Arce & Escoto, 2018). Following *La Matanza* it was assumed that no more Indigenous people existed in El Salvador due to the forced assimilation for survival (Ching & Tilley, 1998). *La Matanza* has been described as the "end to Indian culture in El Salvador"; yet, scholars have noted that Indigenous people remain, but try to be invisible and "ghostly" to prevent further persecution (Ching & Tilley, 1998).

Civil war of El Salvador: 1980-1992

The civil war of El Salvador was a culmination of centuries of oppression, human rights violations, and political tension. The civil war lasted over ten years and took the lives of over 100,000 people (DeLugan, 2005; Mason, 1999; White, 2008). It was marked with "death squads, extrajudicial executions, and forced disappearances" (p. 235; DeLugan, 2005). International codes of war of conduct were routinely violated by the government and military forces by the

killing and massacre of vulnerable populations such as women, children, and the elderly, wounded and sick people in hospitals, and execution of prisoners (Ugalde et al., 2000). During the civil war, most of the casualties were civilians, not members of the guerillas or military (Dickson- Gõmez, 2002). The mutilation and massacre of innocent people during the civil war was used as a form of intimidation to further suppress civil unrest (Dickson- Gõmez, 2002). Children often witnessed these atrocious attacks on their family and neighbors, they were often victims themselves, and they were recruited by the military and guerillas to be child soldiers (Dickson- Gõmez, 2002). Some argue that the involvement of children and youth during the civil war resulted in the formation of gangs made up of ex-guerillas or soldiers. There was an influx of youth joining gangs after the civil war ended (Dickson- Gõmez, 2002). The Farabundo Martí National Liberation Front (*Frente Farabudo Martí para la Liberación Nacional;* FMLN) was one of the first movements to challenge and resist military forces composed of five other leftist resistance groups: Communist Party of El Salvador (PCS), the Central American Workers' Party (PRTC), National Resistance (RN), People's Revolutionary Army (ERP), and the Popular Forces of Liberation (FPL; Almeida, 2013). Conflicts between the FMLN and military forces would continue until 1992.

Inequalities surrounding land ownership, income disparities, and poverty fueled tensions between the government and revolutionary forces (Mason, 1999). Sources note that tensions regarding agricultural conflict further exacerbated the civil war (McKinney, 2015). Additionally, the presidency of Arturo Armando Molina in 1972 set into motion a series of events that would create the conditions for a brutal civil war (White, 2008). President Molina enticed anti-communist nationalism, guerrillas began to take over the countryside, and university students were targeted by the government (White, 2008). Military forces targeted university professors

and students accusing them of embracing communist ideology. This targeting led many young students to join the guerrillas (White, 2008). President Molina massacred 37 university students who were protesting military occupation at universities. Additionally, military armed forces constantly targeted Indigenous communities and villages (White, 2008) as well as Catholic Jesuit priests, archbishops, and nuns (DeLugan, 2005). Priests encouraged non-violent resistance groups in the spirit of activism for democratic change, but were met with death squads and violence (White, 2008). The assassination of San Salvador's archbishop, Monsignor Oscar Arnulfo Romero (an outspoken advocate for the poor and peaceful resistance) in 1980, while he was giving mass further increased tensions (McKinney, 2015). It is worth noting that it is believed by the United Nations that Monsignor Oscar Arnulfo Romero was killed by a right-wing death squad.

The United States played a significant role in El Salvador's civil war. Under President Jimmy Carter's administration, the United States supplied weapons and intelligence to the military of El Salvador in hopes to contain the spread of communism (White, 2008). During the Reagan administration, the United States worked with El Salvador to hold free and fair elections; yet results from the election further perpetuated the deep relationship between oligarchs of El Salvador and the military (White, 2008). Additionally, the United States provided over $4.5 billion in aid, and trained soldiers from El Salvador in military tactics and torture (McKinney, 2015).

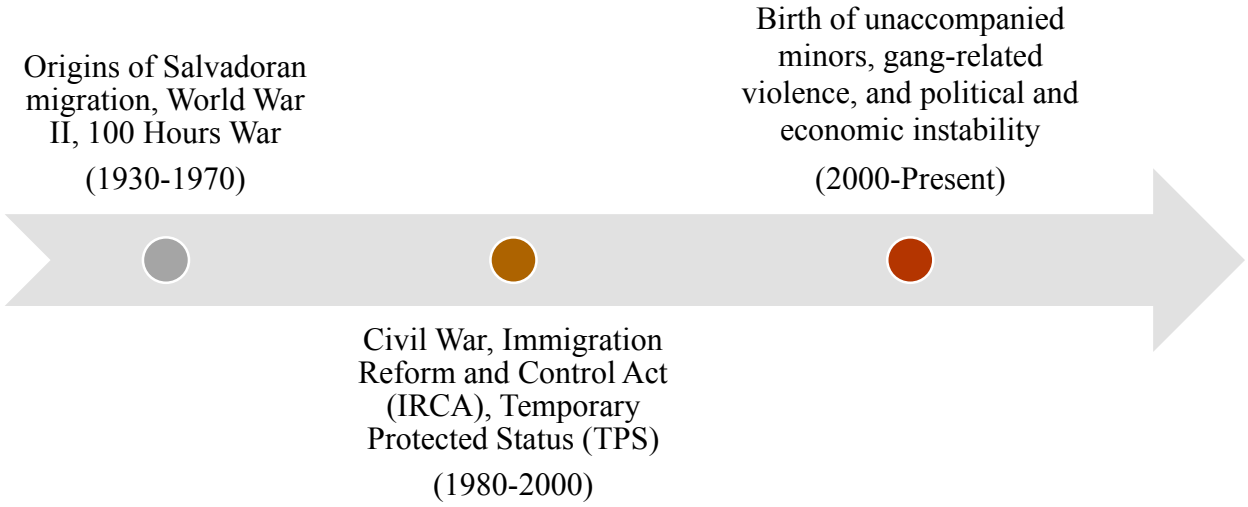
The civil war resulted in a mass exodus of people from El Salvador. Many fled searching for jobs and refuge in the United States and neighboring countries (Arce & Escoto, 2018) with some sources citing over two million people being displaced (Ugalde et al., 2000). The civil war finally ended on January 16, 1992, with a peace treaty signed by the government and leftist

revolutionary forces (Cardenal, 1992). President Alfredo Cristiani, from the Nationalist Republican Alliance (ARENA) is largely credited with leading the peace efforts (Allison, 2010; Colburn, 2009).

Migration Patterns: A Historical Perspective

Salvadoran migration to the United States has been shaped by civil unrest, social inequities, and most recently, transnational crime and violence organized by the *Mara Salvatrucha,* or MS-13, and 18th Street gang (gangs with origins in the United States). The history of Salvadoran migration to the United States has been linked to: (1) political and economic instability, (2) extortion, (3) international drug trafficking, (4) military force, (5) family separation, (6) internalized endemic violence with lacking government protections, (7) gender-based violence, (8) climate change, and (9) political ties with the United States (Menjivar & Gomez Cervantes, 2018; Moodie, 2010; Pons, 2021; Ziff, 2019). Historically, El Salvador's deep political and socioeconomic inequities have been critical in the decision to migrate North, as more than a million Salvadoran residents have sought refuge, jobs, and psychological and physical safety in the United States (Menjivar & Gomez Cervantes, 2018). The following sections provide a brief review of Salvadoran migration to the United States (see Figure 15).

Figure 15. Salvadoran migration patterns.



The first wave (1930-1970)

The first mass exodus of Salvadorans dates back to the early 1930s, prompted by the Great Depression of 1930 (dropping El Salvador's coffee export by 54%) and *La Matanza* of 1932 (Menjivar & Gomez Cervantes, 2018; North, 1982; Patrick, 2004). Research suggests that an estimated 25,000 Salvadorans migrated to Honduras to work in the banana plantations (Menjivar & Gomez Cervantes, 2018). The destructive cycle of economic hardship and political forces pushed an additional 15,000 Salvadorans to their Northern neighbors (Menjivar & Gomez Cervantes, 2018). By the 1940s, an estimated 40,000 Salvadorans were residing in Honduras (Menjivar & Gomez Cervantes, 2018). Soon after, as a result of World War II, Salvadoran residents began migrating to Panama and the United States (Menjivar, 2006; North, 1981). Employment opportunities in Panama and the United States were concentrated in labor-scarce industries (e.g., shipyards, Panama Canal), with wages being significantly higher than in El Salvador (Menjivar, 2006). Notably, the employment demands contributed to the reshaping of the Salvadoran family structure as women balanced the roles of providers and homemakers in the absence of Salvadoran men.

Research suggests that between the 1950s and 1960s approximately 300,000 Salvadorans were living in Honduras (Bailey & Hane, 1995). The land shortage in El Salvador made Honduras an attractive destination. However, a combination of border disputes, class tensions, and Honduran resentment towards Salvadoran workers changed diplomatic relations between the two countries (Bailey & Hane, 1995; Barrett et al., 2013). Their economic and political differences set the stage for the so-called "Soccer War," also known as "100 Hours War" (Bailey & Hane, 1995; Barrett et al., 2013). The three 1969 World Cup qualifying matches (for the 1970 Mexico City World Cup) between El Salvador and Honduras were the "catalyst which helped to ignite an already inflammable situation" (Bailey & Hane, 1995; Barrett et al., 2013; Cable, 1969). The war ended with Honduras expelling between 200,000 and 300,000 Salvadorans (Ferris, 1987; Flores-Yeffal & Pren, 2018). Research suggests that a large number of Salvadorans returned home where they encountered economic instability, insufficient labor opportunities, unavailable agricultural land, and political chaos (Barrett et al., 2013; Flores-Yeffal & Pren, 2018). Due to the dire situation in El Salvador, Salvadoran migration to the United States "increased from 45,000 between 1951 and 1960, to more than 100,000 between 1961 and 1970, exceeding 134,000 during the 1970s" (U.S. Bureau of the Census 1980 in Menjivar, 2000, p. 54).

The second wave (1980-2000)

The second wave of migration from El Salvador to the United States has been well-documented and said to have begun in the early 1980s, as Salvadorans caught in the middle of a violent civil war sought refuge and peace abroad (Bailey & Hane, 1995; Cienfuegos, 2008; Moodie, 2010). While the exact number of migrants from El Salvador to the United States between the 1980s and 1990s is unknown, it is estimated that less than 3% of Salvadoran asylum

applications were approved (U.S. Committee for Refugees and Immigrants, 1986). Additional evidence suggests that the U.S. Immigration and Naturalization Services (INS) denied more than 95% of asylum applications until the Immigration Reform and Control Act (IRCA) of 1986, when the United States began to grant legal status to Salvadorans who entered the country without legal documentation since 1982 (Gammage, 2007; Gzesh, 2006; Jones, 1989; Terrazas, 2010). An estimated 146,000 Salvadoran refugees became eligible to obtain legal status under IRCA (Gammage, 2007; Gzesh, 2006; Terrazas, 2010; U.S. Committee for Refugee and Immigrants, 2013). Furthermore, with U.S. legislation granting Salvadorans the right to apply for Temporary Protected Status (TPS; a temporary status given to eligible nationals of designated countries due to conditions in the country that temporarily prevent the country's nationals from returning safely) in 1990, the number of Salvadorans residing in the United States with some form of temporary legal status increased to an estimated 500,000 (Arce & Escoto, 2018; U.S. Citizenship and Immigration Services, 2021). With TPS ending in 1992, the same year peace agreements were reached between the Salvadoran government and the guerrilla forces, it became difficult for Salvadorans to be considered "refugees." However, some Salvadorans were able to legalize their status under the 1997 Nicaraguan Adjustment and Central American Relief Act (NACARA) and a second designation for TPS because of Hurricane Mitch in 1998 and two earthquakes that hit in 2001(Gammage, 2007; Terrazas, 2010; Terrazas, 2011; Zong & Batalova 2015).

Immigration patterns from 2000 – 2022

Since 2001, after the United States again designated El Salvador for TPS, migration from El Salvador has steadily increased (see Figure 2). TPS designation for Salvadorans was consecutively renewed nine times prior to the Trump administration efforts to end TPS for El

Salvador on September 9, 2019 (TPS designation renewal still pending; U.S. Citizenship and Immigration Services, 2021). Subsequently, migration patterns from El Salvador to the United States have looked different since 2010. Starting in 2011, migration patterns have been led by unaccompanied minors (children traveling without any legal documentation or caregivers with the purpose of crossing into the United States) fleeing gang-related violence, and political and economic instability in El Salvador. Data from the United States Department of Health and Human Services Office of Refugee Resettlement suggest that between 2011 and 2016, the number of Salvadoran-born unaccompanied minors migrating to the United States rose from 3,678 to 20,117. *La Bestia* (freight trains) has been one of the only options for traveling through Mexico to border towns, such as Ciudad Juarez (see Figure 16) for many of these unaccompanied minors (Domínguez Villegas, 2014).

During the 2020 fiscal year, Salvadoran children made up 14% of all unaccompanied minors (U.S. Department of Health & Human Services, 2021). Currently, the US government is revising immigration restrictions, including the Remain in Mexico policy (returning certain asylum-seekers to Mexico to wait through the duration of their case pending in the U.S. immigration court system). Current fiscal data from the U.S. Customs and Border Protection suggest that as of February 2021, there have been 2,185 unaccompanied Salvadoran children apprehended at the border, 3,665 family units, and 13,632 adults. Being aware of current migration patterns can aid mental health providers in understanding the experiences of Salvadoran families and define potential priorities for treatment planning.

Figure 16. Contemporary migration from El Salvador.

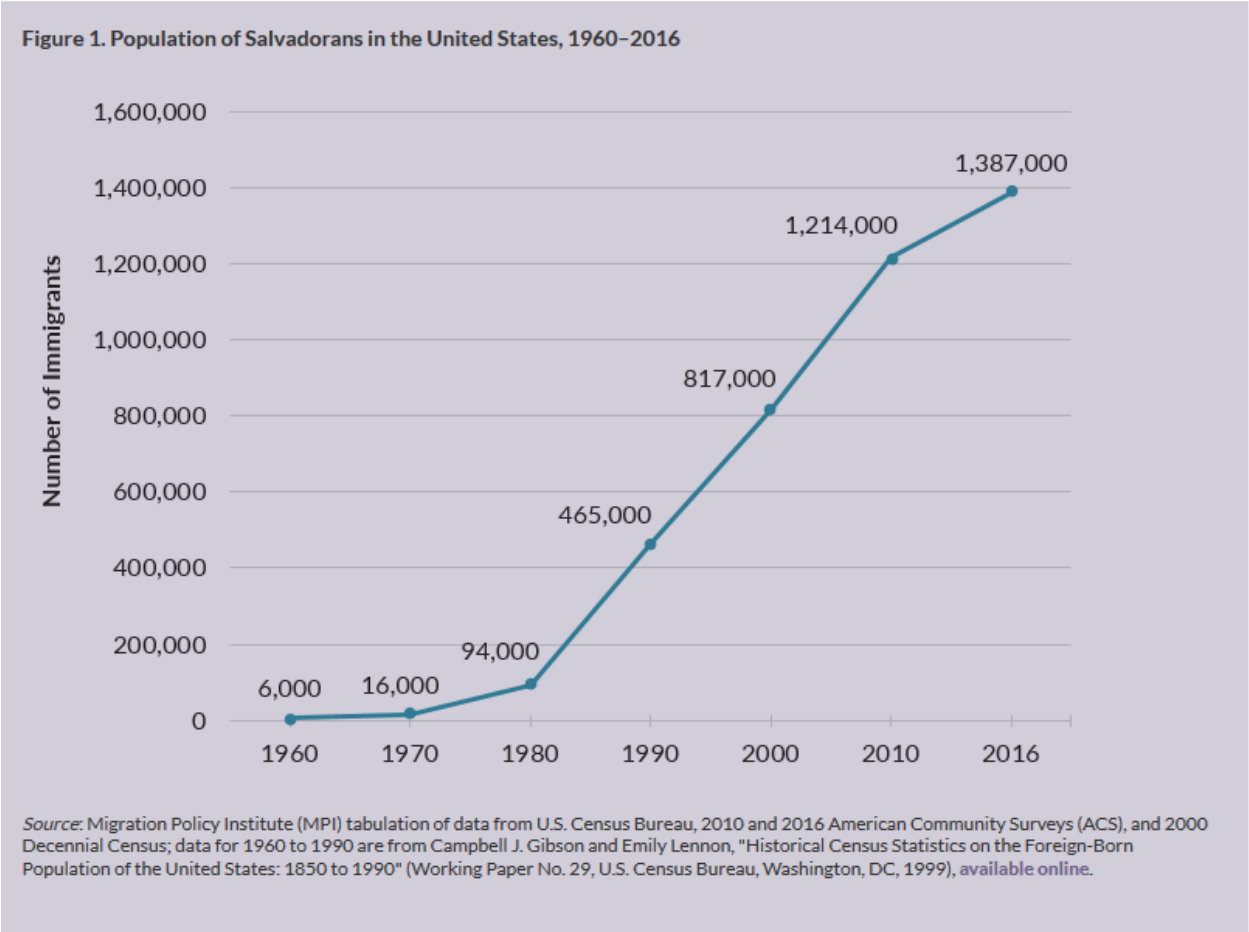


Figure 17. Train routes used by Central American migrants in Mexico.

Source: Martin Gabriel Barron Cruz, *La Bestia: La tenue linea entre la migracion y la trata de personas* (Mexico: Instituto Nacional de Ciencias Penales, 2013), www.inacipe.gob.mx/stories/publicaciones/temas_selectos/LaBestia.pdf.

Indigenous Salvadoran Communities

In addition to its history of civil unrest, El Salvador is home to approximately 600,000 individuals who self-identify as Indigenous (Minority Rights Group International, 2017). The majority of the Salvadoran Indigenous communities claim direct Indigenous heritage to Nahua-Pipiles, Lencas, Mayas, or Cacaoperas (Minority Rights Group International, 2017, Patrick, 2004). Today, most of the Salvadoran Indigenous communities identify as Nahua-Pipiles or Kakawira. Similar to Indigenous communities in other parts of Latin America, Salvadoran Indigenous groups continue to face significant inequities. For example, despite being recognized in the constitution in 2014, Salvadoran Indigenous groups continue to be disproportionately

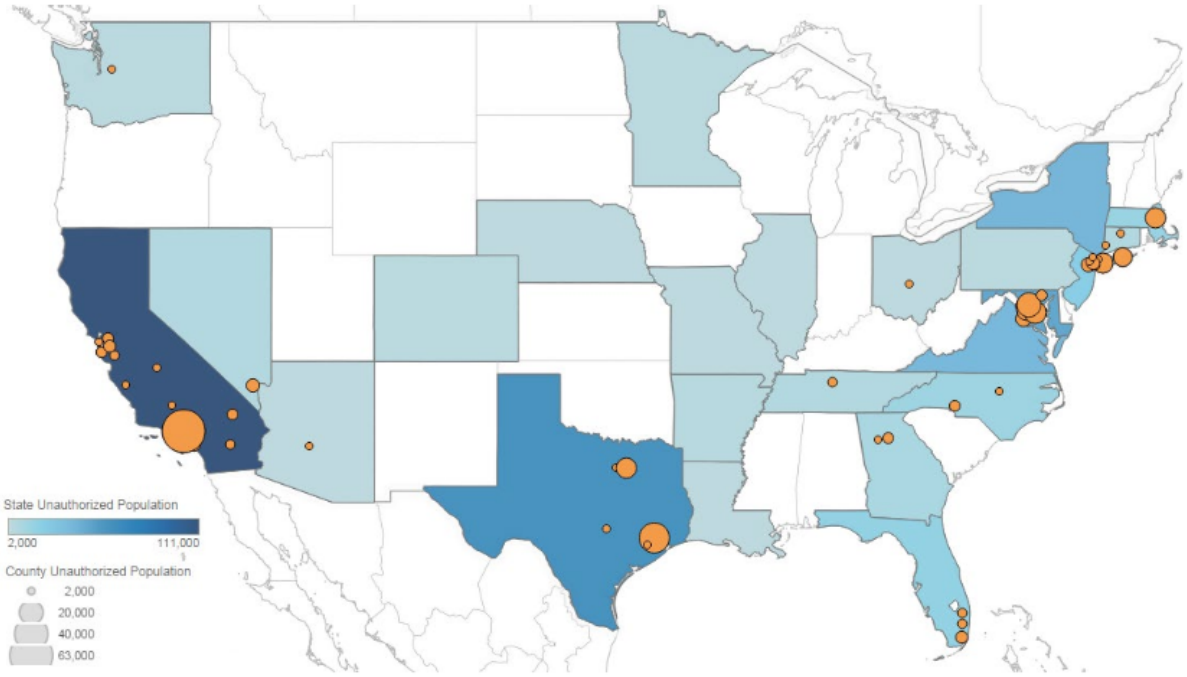
represented among El Salvador's poorest communities, discriminated against, and vulnerable to displacement, have minimal access to essential water and sanitation services, and lack secure land tenure (Anaya, 2013; Ayala, 2012; Minority Rights Group International, 2017; Pan American Health Organization, 2007). These disparities have prompted many to consider migrating to the United States. Estimates on the number of Salvadoran Indigenous communities residing in the United States are unknown.

Salvadorans in the United States

Settlement points

Data from the Migration Policy Institute indicates that between 1980 and 1990, the Salvadoran immigrant community in the United States rose nearly fivefold from 94,000 to 465,000 (Terrazas, 2010). The vast majority of Salvadoran immigrants, between 1980 and 2000, settled in California and Texas (Terrazas, 2010). Today, California (281,616), Washington, DC (210,870), and New York (156,763) are home to the largest numbers of Salvadoran immigrants (George Mason University Institute for Immigration Research, 2021, Noe-Bustamante et al., 2019). However, over the past ten years there has been a growth of undocumented Salvadoran immigrants settling in parts of the South including Tennessee, Georgia, and North Carolina (see Figure 18; Rosenblum & Ruiz Soto, 2015). Notably, the context of violence has contributed to the constant flow of Salvadorans leaving the country to survive.

Figure 18. Undocumented Salvadoran immigrants, by state and county, 2009-2013.



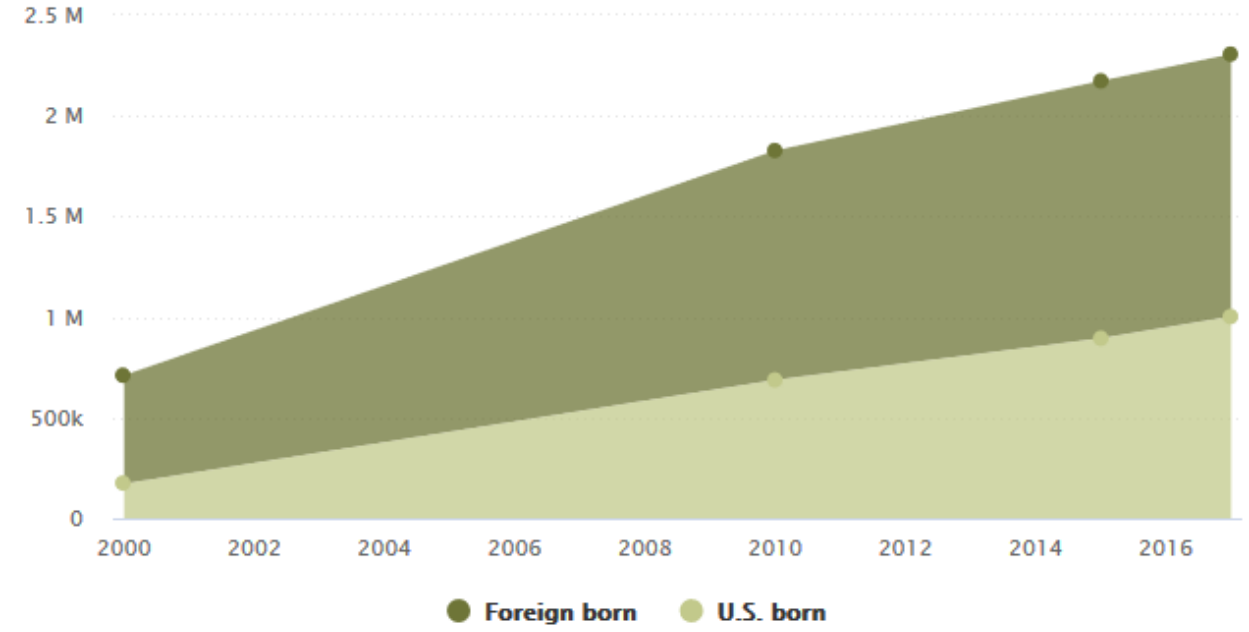
Source: MPI analysis of 2009-13 ACS and 2008 SIPP data by Hammar, Bachmeier, and Van Hook.

Demographics

Today, at nearly 2.3 million, the Salvadoran community is the third-largest (tied with Cubans) origin group in the United States, and accounts for 4% of the Latinx population (see Figure 5; Noe-Bustamante et al., 2019). In 2017, the Salvadoran foreign-born population reached 1.4 million, making them the largest Central American immigrant group in the United States (Menjivar & Gomez Cervantes, 2018; Noe-Bustamante et al., 2019). Research studies evaluating migration patterns from El Salvador to the United States have shown a significant increase in the last two decades, a growth of 142% from 2000 (George Mason University Institute for Immigration Research, 2021; Noe-Bustamante et al., 2019). The increase in migration patterns to the United States is hypothesized to be the result of a stagnant economy, the prospect of a better

life in the United States or reunification with relatives, natural disasters, gender-based violence, climate change, and severe violence (Menjivar & Gomez Cervantes, 2018; Pons, 2021; Ziff, 2019). Additional factors include deeply rooted social inequalities, U.S. involvement in the region, U.S. immigration policies, and the Salvadoran government's failure to address systemic social problems (Menjivar & Gomez Cervantes, 2018).

Figure 19. Salvadoran-origin population in the U.S., 2000-2017.



Note: Latino origin is based on self-described ancestry, lineage, heritage, nationality group or country of birth.
Source: Pew Research Center tabulations of 2000 census (5% IPUMS) and 2010, 2015 and 2017 American Community Surveys (1% IPUMS).

Employment

Work opportunities have been crucial to the Salvadoran experience in the United States, and Salvadoran workers have been essential and foundational pillars that continue to sustain two economies (e.g., U.S. & El Salvador). Today, remittances have become one of the most

extensive supplies of foreign exchange in El Salvador, totaling $5.92 billion U.S. dollars by the end of 2020 (Associated Press, 2021). The latest data suggest that workers of Salvadoran ancestry make up 1.1 million of the Latinx workforce in the United States (Bucknor, 2016). By gender, Salvadoran women account for 41.4% of the workforce, while men make up 58.6% (Bucknor, 2016). Moreover, most Salvadoran men (94%) and women (82%) with TPS participate in the labor force, with the majority working full-time jobs (Menjivar & Gomez Cervantes, 2018). Similar to other Latinx groups, individuals of Salvadoran background continue to be employed in primary and secondary sectors. Salvadoran men are more likely to be employed in construction, extraction, and transportation, while Salvadoran women have been associated with service occupations and administrative support (Bucknor, 2016; Terrazas, 2010). Finally, the median family income of Salvadorans in 2014 was less than $40,000 (Bucknor, 2016).

Education

Among the Latinx communities, it has been reported that about 42.3% of employed Salvadoran adults in the United States lacked a high school diploma in 2014, and 29% reported living in a limited English-speaking household (Bucknor, 2016). Among the Salvadorans ages 25 and older, about 10% reported holding at least a bachelor's degree (Noe-Bustamante et al., 2019). Furthermore, among Salvadorans ages 25 and older, the U.S.-born were more likely than the non-U.S.-born community to have a bachelor's degree or higher (24% vs. 8%; Noe-Bustamante et al., 2019). Furthermore, 2016 data indicated that the high school status dropout rate for Salvadorans between the ages of 16 to 24 years was 13.3% (de Brey et al., 2019). Among Salvadoran immigrants ages 25 and older, data suggested that 54% had not completed high school (Cohn et al., 2017).

Religion

The University of Central American's Institute of Public Opinion 2019 survey found that 44.9% of the Salvadoran community in El Salvador identified as Catholic, 31.8% as Evangelical Protestant, 18% reported no religious affiliation, and 5.2% endorsed "other," which included Jehovah's Witnesses, Muslims, and additional religious groups (Report on International Religious Freedom-El Salvador, 2019). However, in the United States, there are slight differences in terms of identification. Data from the Pew Research Center suggest that 42% of Salvadorans in the United States identify as Catholic, 37% as Protestant (5% mainline Protestant, 32% Evangelical Protestant), and 15% reported no religious affiliation (Lopez, 2015). Broadly, religious institutions have a history of providing psychological comfort to immigrants who are often marginalized from other formal institutions (Menjivar, 2003; Sanchez et al., 2019). In addition, religious institutions have played a significant role in the lives of many undocumented immigrants. Specific to the Salvadoran documented and undocumented immigrant community, research has found religious institutions to be a source of social and economic support, and social capital (Menjivar, 2003; Sanchez et al., 2019). Understanding the role of religion in the lives of Salvadoran patients can aid mental health providers in patient conceptualization, treatment planning, and recognition of possible protective factors.

Trauma and Mental Health Considerations for Salvadoran Immigrants

Gender-based violence and femicide

It is estimated that about 1 in 3 women will experience physical and/or sexual-based violence worldwide. According to the 2017 *Encuesta Nacional de Violencia Contra las Mujeres*, 67% of Salvadoran women suffered some form of violence in their lifetime, including sexual assault, intimate partner violence, and abuse by family members (Nugent, 2019). Compared to

other Central American countries, El Salvador has one of the highest femicide rates (Bott, et al., 2018; Nóchez & Guzmán, 2020; news.un.org). Unfortunately, the COVID-19 pandemic has not deterred the current rates of gender-based violence or femicide. As noted by Nóchez and Guzmán, (2020), "Between March 11 and April 27, preliminary figures from the National Civil Police (PNC) showed a 30 percent increase in activity on domestic violence hotlines…". Overall, the historical upholding of patriarchy, structural machismo, and normalization of gendered violence is detrimental to Salvadoran women.

Lack of support from authorities

Historically, the Salvadoran government, authorities, and lawmakers have not taken the proper steps to ease the historical and current gender-based violence and femicide rates. The government and existing law enforcement systems are often criticized for their collective failure to protect the human rights and safety of women and girls (Nóchez & Guzmán, 2020). For instance, Zanzinger and colleagues (2021) note that authorities readily do not support victims because they uphold patriarchal norms via beliefs that domestic violence is a family matter. Therefore, prosecutions are often overshadowed by authorities' patriarchal and *machista*-based values. The lack of support for women, violence and femicide rates, and the current COVID-19 pandemic and increased isolation, have further resulted in a deadly combination for Salvadoran women.

Therefore, gender-based violence and femicide are readily reasons for asylum in the United States (Zanzinger et al., 2021). As of 2020, the rates have increased, with an estimated 1 in 7 Salvadoran women suspected of experience gender-based violence (unitednations.org). Baranowski and colleagues (2019) used archival de-identified data to understand the experiences of asylum seekers from 70 women from Honduras, El Salvador, and Guatemala who participated

in a pro bono psychological evaluation. Results showed that the main contributors to immigration were severe intimate partner violence, physical and sexual assaults, and death threats by organized criminal groups in their communities. Over a third of women reported experiences of violence during their migration. The majority of asylum seekers endorsed symptoms associated with anxiety (80%) and depression (91%), as well as trauma-and stress-related symptoms (80%; Baranowski et al., 2019).

Unaccompanied Minors

The Council on Foreign Relations defines an unaccompanied child as anyone under 18 years of age who immigrates to the United States with no parent or legal guardian available to care for them. Although children and adolescents attempting to cross the border has been occurring for decades, it was not until 2014 that news coverage became more extensive (Chavez-Dueñas et al., 2014; MacLean et al., 2019). Over the last four years, there has been an increase in the number of unaccompanied minors with U.S. Customs and Border Protection statistics noting a 28% increase in migrants between January and February of 2021. The number of unaccompanied minors from Central America increased by 60% over January to more than 9,400 (CBP, 2021). As of 2020, Salvadoran children are the third-largest group of unaccompanied minors immigrating to the United States, with Guatemalan and Honduran children as first- and second-largest, respectively (Cheatham, 2020; Office of Refugee Resettlement, 2021; Paris et al., 2018). Boys have been more likely to travel as unaccompanied minors than their counterparts (Office of Refugee Resettlement, 2021). Violence, natural disasters, food insecurity, and poverty are among the most significant contributors of migration as of April 2020 (Romo, 2021). Due to the growing dangers in the region, the decision to migrate is often a final attempt at survival (Muñoz & Venta, 2018; Paris et al., 2018; Torres Fernández et al., 2015).

Unfortunately, the migration journey is riddled with additional trauma and stressors (Cheatham, 2020; MacLean et al., 2019; Muñoz & Venta, 2018). Unaccompanied minors are at risk of gang violence along the migration route, kidnapping, or delayed release from U.S. Customs and Border Protection detention facilities (Baily et al., 2016; Cheatham, 2020). Since the Obama administration, efforts to attend to the ongoing rates of child migrants from Central America have been unsuccessful (Romo, 2021). For instance, the U.S. Customs and Border Protection apprehended approximately 52% more unaccompanied minors at or near the U.S.-Mexico border during 2019 compared to 2018. In combination with the continual increase in immigration rates, immigration policies continue to result in unaccompanied children experiencing deplorable conditions at detention centers (Cheatham, 2020). Exposure to violence, displacement from their home countries, immigration journey, and detention needs are all harmful to their emotional, mental, and physical well-being (MacLean et al., 2019). The result is readily complex posttraumatic stress disorder and secondary mental health conditions (MacLean et al., 2019; Muñoz & Venta, 2018). Therefore, many minors migrating to the United States and seeking asylum must manage complex trauma, loss, grief, depression, among other mental health concerns (Mares, 2020; Paris et al., 2018; Torres Fernández et al., 2015).

Mental Health Models and Guidelines

Falicov's considerations when working with Latin American immigrants

Falicov (2007) encourages mental health providers to think ecosystemically, identifying three essential factors for working with immigrating populations: relational, community, and cultural-sociopolitical. Falicov notes the importance of considering grief and the connection lost due to migration.

Relational

Falicov (2007) describes relational stress as "stress brought about by separations and reunions between parents and children" and believed to be "at the center of the new immigrant experience and thus deserve special attention" (p. 160). For instance, migrant women from Latin America may find themselves reframing the experience of separation as providing long-distance care to their loved ones, and often relying on other caregivers in the family to provide ongoing support for the members left behind. As such, Falicov (2007) suggests mental health providers encourage immigrants to maintain connections with their family members back home via phone, email, and letters, and maintain rituals of providing for their families back home.

Community

Immigrants in the United States may also experience a sense of loss of their community. Mental health providers working with immigrants, particularly immigrants from collectivist cultures, may find it helpful to recognize and identify the importance of maintaining community and relationships. Community can continue to be re-created through spiritual and religious affiliations (Falicov, 2007). These opportunities may provide immigrants with a sense of connection and community, as well as support them in making "empowering changes" (Falicov, 2007).

Cultural-sociopolitical

Mental health providers must remain aware of the issues of oppression, power, and diversity impacting patient health and the therapeutic relationship. "Cultural diversity positions question therapists' uncritical imposition of normative mainstream values and encourage therapists' cultural examination of the person and conceptual preferences" (p. 166; Falicov, 2007). Mental health providers are encouraged to acknowledge the power

dynamics inherent in the therapeutic relationship and apply interventions of critical consciousness, empowerment, and accountability (Falicov, 2007).

Guidelines for Working with Detained, Unaccompanied, Asylum-seeking Minors

In 2015, The National Latinx Psychological Association (NLPA) released mental health guideline considerations to support young unaccompanied refugees detained and held at centers. Below are condensed highlights from the guidelines developed from NLPA's Torres Fernández et al. (2015):

1) Being transparent, open, and honest about confidentiality limits.
2) Mental health screeners address complex trauma, loss, grief, immigration journey, and secondary symptoms in the context of challenges faced. Further, it is essential to consider cultural limitation and cultural validity of current screeners.
3) Consideration that minors may experience understandable distrust of adults due to the history of violence and trauma faced. Therefore, clinical and mental health providers are asked to understand and empathize with possible denial or resistance from minors to cooperate.
4) Particular awareness and sensitivity to culture and context.
5) Consideration of extensive trauma history.
6) Consideration of eventual incorporation of family therapy using a family systems approach can help support the healing of both minors and family members.
7) Understand and incorporate principles from Liberation Psychology to understand the role of oppression and marginalization of unaccompanied minor asylum seekers.
8) The evidence demonstrating the effectiveness of Trauma-Focused CBT (TF-CBT) may be appropriate for children with an extensive stay at detention centers. Brief,

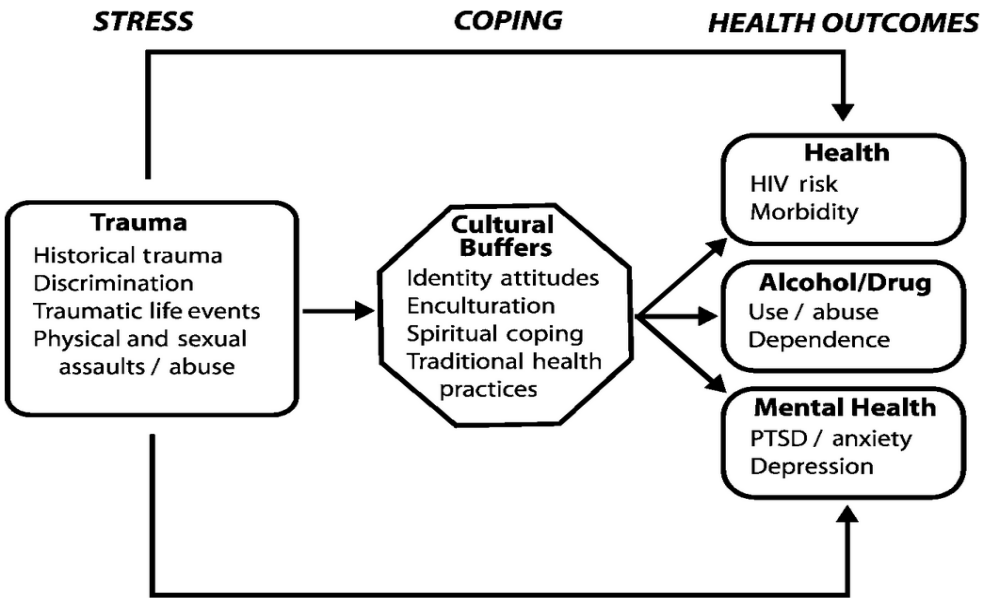
solution-focused work may be more suitable for children with shorter stays at a detention center/shelter.

9) Narrative and play therapy may be constructive for children with extensive trauma histories, subsequently experiencing depression and loss.

The Indigenist Stress-Coping Model

The "Indigenist" Stress-Coping Model (Krieger, 1990) considers how Indigenous or displaced people cope with life stressors in the face of historical trauma and notes the effects life stressors have on their health. Krieger (1990) proposes that the only way to conduct a meaningful psychological and health assessment on a displaced individual is by including questions about stressful and traumatic life events. Environmental contexts and personal factors are possible mediators of stressful life events and wellness outcomes. In the model, the effects of discrimination and the types of trauma experienced by marginalized populations, in this case, Salvadoran refugees, are shown to be related to psychosocial distress, depressive symptoms, anxiety symptoms, poor physical health, and PTSD (Michultka et al., 1998; Duran, 2006).

Figure 20. The Indigenist Stress-Coping model.



The Transnational Resilience and Resistance Model

In a study conducted by Turner and Simmons (2006), the authors defined and utilized the Transnational Resilience and Resistance Model among Salvadoran and Guatemalan refugees residing in Canada. Turner and Simmons (2006) described the concept of relational resilience as a process "[i]nvolving adaptive accommodation and transformation to loss, dislocation, and radically changed circumstances" (p. 3). An example used to illustrate this concept was the involvement of refugee families whose members live in different countries and face increased difficulty maintaining family connection and cohesion across borders. From a relational perspective, resilience is evident in behaviors that allow for "[i]increasing interpersonal connection, communications, sharing values, ability to express feelings, providing mutual support, and having an optimistic orientation to sustain and build mutual support" (Turner & Simmons, 2006, p. 8).

Conclusion

People of Salvadoran ancestry have migrated to the United States and additional parts of the world due to being in a constant state of war. In addition, for hundreds of years, people of Salvadoran ancestry have encountered and endured significant pain from colonialization to modern-day transnational crime and violence in El Salvador, and oppression in the United States. Similar to other Latinx communities, people of Salvadoran ancestry have and continue to confront various forms of discrimination, aggression, anti-immigrant policies, and hate, to which the Salvadoran community has responded with resilience. Indeed, disparities, social and ethnic injustices, and the vilification of Salvadorans and Salvadoran Americans have overshadowed the remarkable strength, transcendence, and contributions of the community. While we agree the

focus needs to be on the strengths of people of Salvadoran ancestry, it is also important to address the social, political, physical, psychological, and spiritual harm waged against the Salvadoran community by European Americans, colonialization, and neighboring Latinx countries (e.g., Honduras, Guatemala, Mexico), which continues today. Therefore, we encourage mental health providers to familiarize themselves with the history and experiences of individuals of Salvadoran ancestry to better understand the behavioral and psychological processes that have historically contributed to their survival.

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FROM STABILITY TO UNCERTAINTY:

How A Historical Insight into Honduras and Honduran-Origin People in the United States can inform Mental Health Services for Hondurans

VI

Introduction

The presence of Honduran and Honduran Americans in the United States is in large part a result of natural disasters in the form of hurricanes, economic conditions, and violence. Consequently, knowing the history of Hondurans in Honduras and Honduran Americans in the United States is critical to understanding mental health and substance use presenting concerns. The purpose of this chapter is to provide mental health providers with a greater understanding of the lived experience of the Honduran and Honduran American community in the United States. The following information will allow providers to better understand, provide care, and serve the Honduran-origin community:

1. the colonialization history of Honduras;
2. waves of migration, Indigenous Honduran communities; and
3. settlement patterns and current demographics, as this can inform the experience, mental health and substance use, of present-day Honduran-heritage individuals and families in the United States.

Furthermore, mental health providers will have access to brief overviews of Honduran employment, education, and religious cultural background. Finally, we close the chapter with a discussion of mental health considerations, stressors in present-day Honduras affecting the mental health of immigrants (e.g., violence), the impact of corruption on immigration, and violence based on gender and sexual orientation. Overall, the purpose of this chapter is to provide mental health professionals with context and content that can contribute to the lived experience of Honduran-heritage individuals and families in the United States and help to inform mental health practice and treatment planning.

Historical Events

Honduras has a history marked by centuries of colonialization, violence, and political turmoil which has implications for historical and generational trauma that influences the current mental health of Hondurans. Honduras is approximately 43,277 square miles (roughly the size of the state of Tennessee) and is the second-largest country in Central America (Leonard, 2011). Present-day Honduras is one of the poorest countries in the western hemisphere and the majority of its economy is dependent on the export of bananas and coffee (Leonard, 2011). The topography and geography of Honduras has significantly influenced its wars, economy, and within-country cultural differences. Honduras is mountainous with numerous highlands, it has flat-floor valleys, and coastal lowlands on the Pacific Ocean and the Caribbean Sea (Leonard, 2011). Present-day Honduran people are mostly mestizos (offspring or descendants of Spanish and Indigenous people), a small percentage have African ancestry, and roughly only six percent are truly Indigenous (Leonard, 2011).

Pre-colonial Honduras and invasion

Leonard (2011) writes that from 435-950 A.D. the Maya city of Copán was flourishing, and in 763 A.D., K'inich Yax K'uk Mo' transitioned rule of the Mayan dynasty to Yax Pasah, the last ruler of the Mayan dynasty before colonial invasion. Prior to Spanish invasion, scholars estimate that roughly 500,000 to two million Indigenous people inhabited Honduras representing a diversity of cultures and languages (Leonard, 2011). At the start of fifth century A.D., the Mayan dynasty migrated into present-day Honduras building historical Copán. During the subsequent three centuries, Copán became a cultural center for art and astronomy (Leonard, 2011). Copán began to decline in 822 A.D, yet its decline remains unknown given a lack of data. Researchers hypothesize that the decline could have been due to soil depletion, internal conflicts,

and unsustainable population growth. Indigenous groups present during the pre-colonial invasion included the Pech, the Pipil and Nahautl (that likely came from El Salvador and Guatemala), the Miskitos (who subsequently moved into Nicaragua), the Sumu (accounts suggest that roughly 1,000 remain in present-day Honduras), the Lencas (who likely came from Colombia), the Paya, the Chorotega (who likely came from Mexico fleeing Olmec oppression), and the Xicaque/Jicaque (Leonard, 2011; Newson, 1987). These communities were characterized by their agricultural and religious practices (priests, temples, and idols with the faces of jaguars or other animals; Newson, 1987). The men mostly hunted and focused on agriculture and the women tended to fish and collect fruits and vegetables (Newson, 1987). Social structure of the various Indigenous communities centered on chiefdom being hereditary, and villages had ministers of justice, priests, and warfare ambassadors (Newson, 1987). The weapons commonly used by Honduran Indigenous communities were shields made of cane, bows and arrows, and swords made from poisoned wood (Newson, 1987).

Colonialization of Honduras

Honduras first gained contact with colonizers in 1502 during Christopher Columbus' fourth and final voyage, where he landed in the northern coast of Honduras (Leonard, 2011). Initial colonialization of Honduras was characterized by rival expeditions with various invaders seeking to gain control of the land (e.g., González Dávila and Cristóbal Olida). In 1524, Hernán Cortés deployed military forces under Francisco de las Casas to establish order and rule, and he encountered expeditions led by Pedro de Alvarado from Guatemala and Hernando de Soto from Nicaragua. Cortés prevailed over Spanish rivals and left his cousin Hernando de Saavedra to oversee further colonialization of Honduras (Leonard, 2011). Subsequently, Diego López de Salcedo was appointed the first royal governor, but his inhumane policies towards Indigenous

people ignited revolts and resistance. Increased Indigenous exploitation of labor resulted in a significant uprising in 1537 led by Lempira, a Lenca chief. The resistance led by Lempira encouraged other Indigenous groups to join his efforts in rising against Spanish rule (Leonard, 2011). Lempira was able to unite 30,000 warriors from over 200 different villages, which was likely the first time a collective effort had been organized within Indigenous communities to fight Spanish invasion (Newson, 1987). During an attempt to negotiate peace with Lempira, the Spanish invaders murdered him, and resistance efforts disintegrated (Leonard, 2011). Following the assassination of Lempira, Spanish invaders quickly massacred numerous Indigenous communities. In 1539, there were roughly 15,000 Indigenous people, and by 1541, only 5,000 remained (Leonard, 2011).

The decline of Indigenous communities during the Spanish invasion was due to labor exploitation, disease (e.g., smallpox, measles, typhus, yellow fever), and to a lesser extent the Indian slave trade (which was higher in Nicaragua; Newson, 1987). Of note, the decline of Indigenous populations differed between communities living in the highlands and the coastal lowlands (Newson, 1987). For example, Indigenous populations living in the lowlands likely suffered more from tropical fevers, as higher incidence of diseases, such as malaria and yellow fever, were more common in warmer climates. Also, given that the lowlands tended to have more economic activity, Indigenous people had more contact with Spanish colonizers, resulting in increased Indian slave trade (Newson, 1987).

Like in many other Central American countries under Spanish rule, Indigenous communities were forced into the *encomienda* system led by Spanish *encomenderos* tasked with converting Indigenous people to Catholicism and overseeing the Indigenous exploitation of labor and harvesting the land (Leonard, 2011). *Encomiendas* in Honduras were small and generated

little income, with most of the revenue coming from Indian slaves, minerals, and metal (Newson, 1987). Leonard (2011) writes that "Spanish government regulations and incompetence" (p. 24) coupled with the land being overly harvested, the mining of silver depleted by 1584, and the rapid decline of Indigenous communities resulting in less available laborers for the land, culminated in Honduras becoming a neglected Spanish colonial empire by 1700 (Leonard, 2011; Newson, 1987).

Independence of Honduras

The path to independence for Honduras was gradual. The first protest against Spanish rule came in 1812 as Hondurans fought for increased representation in government and an outcry against keeping Spaniards in public office (Leonard, 2011). Leonard (2011) writes that the significance of the demonstrations was twofold: the wish for independence from Spain and the frustration of the special privileges the Spanish received. September 15, 1821, marked Central America's independence from Spanish rule (Leonard, 2011). Destabilization ensued in Central America as the countries attempted to grapple with its colonial past related to tensions between sociocultural groups (e.g., *criollos* vs *mestizos* vs Indigenous people). Political instability plagued Honduras immediately following independence with various political figures unsuccessfully fighting for the leadership of Honduras and numerous failed attempts of unity in Central America. From 1821 to 1823, Honduras briefly fell to Mexican rule and subsequently, from 1823-1838, the United Provinces of Central America emerged. The United Provinces of Central America period was marked by a lack of unity, civil war, and conflicts between liberals, conservatives, and the church. The ultimate dissolution of the United Provinces of Central America was due to a lack of experience in public office; no centralized form of government; a weakened economy; poor communication; lack of transportation systems; and a lack of

nationhood (Leonard, 2011). The dissolution resulted in Honduras' true independence as a country, yet tensions between liberals and conservatives persisted and were a foreshadowing of problems to come (Leonard, 2011).

Honduras in the Banana Republic era

From 1900-1933, like many other countries in Central America, the banana industry spread through Honduras resulting in political tension with the United States, further exploitation of labor, and a sense that Honduras had become an "American colony" (Leonard, 2011). While the banana companies developed railroads, irrigation systems, and pest control, it came with a cost of low wages and harsh working conditions for the Honduran people. There were numerous efforts by Hondurans to protest the labor exploitation by banana companies resulting in unsuccessful efforts as they were routinely suppressed by the Honduran military (Leonard, 2011). Finally, in 1954, roughly 60,000 banana workers engaged in a labor strike for improved working conditions. This period marked concerted efforts for labor rights, and the creation of the Honduras Workers Federation in 1921 and the Honduran Worker's Syndicate in 1929 (Leonard, 2011). Scholars argue that the banana republic period of Honduras negatively influenced its economy by preventing agricultural diversification, and it further drove local farmers out of business as the banana companies controlled the land and transportation systems (Leonard, 2011). Additionally, corrupted politics added to the monetary gain of banana companies as the they provided financial support to politicians in return for tax-exemptions resulting in little economic growth for Honduras (Leonard, 2011).

Modern-day Honduras

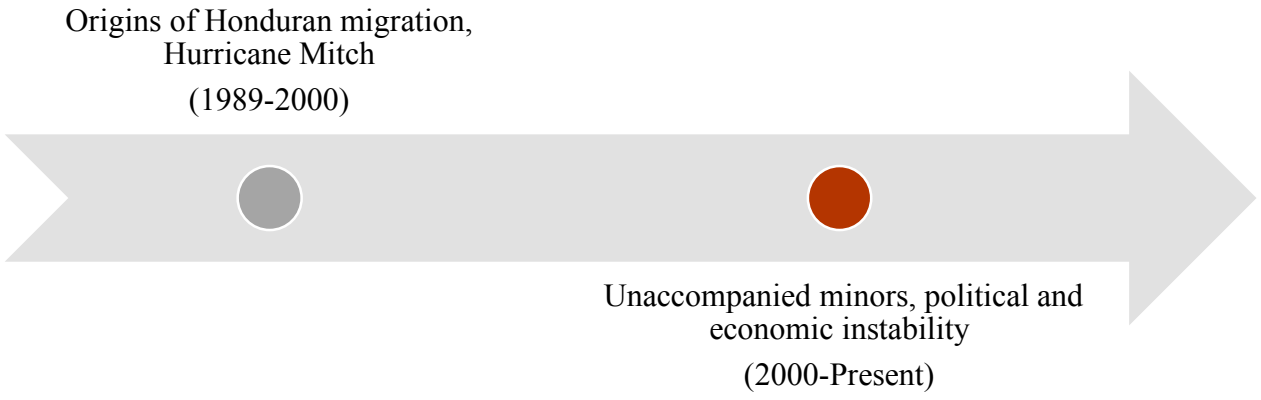
Starting in 1932, Tiburcio Carías Andino had a 16-year dictatorship marked by intimidation tactics, jailing and exiling of his opponents, censorship, and a strong military to

suppress dissent. During this period, Honduras provided support to the United States Army during World War II. Conflict between political parties continued after Carías Andino, yet notably in the modern history of Honduras is the Soccer War, or the 100-hour war, with El Salvador in 1969 (Chirinos, 2018; Leonard, 2011). The war occurred after a qualifying game for the 1970 FIFA World Cup where El Salvador beat Honduras 3-2. Following the game, El Salvador broke diplomatic relations with Honduras by invading Honduras on July 14th, 1969 (Chirinos, 2018). Tensions were high between El Salvador and Honduras due to land disputes and ill treatment of El Salvadoran immigrants in Honduras (Cable, 1969; Chirinos, 2018). Given Honduras' fragile economy, Chirinos (2018) writes that Honduras was ill-equipped to handle the surge of migrants from El Salvador that were leaving due to land scarcity. El Salvador closed its border to its citizens in efforts to make Honduras engage in conversations regarding land disputes. Three games were played, the first game in Honduras, where Honduran fans set off firecrackers all night in front of the hotel where the Salvadoran team was staying in efforts to disrupt sleep. The second game took place in El Salvador, where the Honduran soccer team had to be transported in armored cars to prevent violence from Salvadoran fans. Following the defeat, fans from El Salvador rioted in the capital and attacked Honduran cars leaving the game resulting in two deaths. In retaliation, Hondurans attacked shops and homes of Salvadoran people living in Honduras forcing them to return to El Salvador. The final match took place in Mexico City, and following the game, El Salvador began air striking Honduras starting with the national airport in Tegucigalpa. The Soccer War claimed the lives of over 1,000 people (Cable, 1969). El Salvador justified its actions due to the treatment of its immigrants in Honduras. A peace treaty was signed on July 18, 1969, resulting in El Salvador withdrawing troops, and Honduras agreeing to protect Salvadoran immigrants.

Migration Patterns: A Historical Perspective

Honduran migration to the United States has been influenced by political crises, and most recently, transnational crime and violence, economic hardships made worse by the COVID-19 pandemic, and deadly storms. Similar to other Central American communities, the history of Honduran migration to the United States has been linked to: (1) political and economic conditions, (2) U.S. military involvement, (3) gang violence, (4) climate change, and (5) U.S. immigration policy (Hovring, 2021; Pons, 2021; Reichman, 2013). Unlike its three neighbors, migration from Honduras to the United States was less frequent prior to the 1990s, as a result of its fairly stable economy and uninterrupted civilian democratic rule (Reichman, 2013). However, the 1990s and early 2000s brought military defiance, economic challenges, and Hurricane Mitch, which led to the rise of migration from Honduras to the United States. The following section provides a brief review of Honduran migration to the United States (see Figure 21).

Figure 21. Honduran migration patterns.



The first wave

Migration origins from Honduras to the United States can be traced back to the early 1950s, during the peak of the banana economy. However, the number of Hondurans making their way to the United States was small and made up of individuals in the fruit industry. Internal migration within Honduras was far more common than migration to the United States prior to the 1990s. The Honduras banana economy of the 1950s, coffee industry of the 1960s, cattle and cotton production of the 1970s, and the *maquila* (foreign-owned factory) sector of the 1980s were the main reasons people remained in Honduras (Reichman, 2013). Another reason why migration out of Honduras was unusual had to do with Honduras being able to avoid a civil war during the last half of the 20th century (Blanchard et al., 2011; Reichman, 2013). Unlike its neighbors that *pushed* people out, the Honduran economy and uninterrupted civilian democracy *pulled* migrants from other parts of Central America (e.g., Salvadorans).

Research suggests that the shift from internal to international migration for the Honduran community can be traced back to the end of the Cold War in 1989, which led to the prioritization of an export-oriented economy in Honduras (Blanchard et al., 2011; Reichman, 2013). The shift to an export-oriented economy took focus from improving social conditions in the countryside, making it difficult for an already struggling rural population (Reichman, 2013). As a result, migration to the United States became an increasingly common path for survival. Data suggest that between 1990 and 2000, an estimated 174,000 Honduran migrants entered the United States (U.S. Census, 2010). Research shows that by 2000 there were approximately 283,000 Honduran immigrants living in the United States, doubling in size from a decade earlier (Reichman, 2013). The surge in migration was the result of Hondurans being granted Temporary Protected Status (TPS; provides protection against deportation and confers work authorization) following

Hurricane Mitch, which at the time allowed them to remain authorized in the United States until 2002.

Immigration patterns from 2000 –2022

Hurricane Mitch struck in October 1998, displacing an estimated 1.5 million Hondurans (Reichman, 2013). The hurricane had a significant impact on lowland areas, damaging tobacco and banana crops, with most damage affecting the coffee-growing region (Morris et al., 2002; Reichman, 2013). Official records also show that an estimated 35,000 homes were completely destroyed, with another 50,000 seriously damaged (Economic Commission for Latin America and the Caribbean, 1999). The aftermath of Hurricane Mitch resulted in large numbers of Hondurans migrating North, with data suggesting that the number of Hondurans apprehended at the southern U.S. border increased from 10,600 to 18,000 between fiscal year 1998 and 1999 (U.S. Citizenship and Immigration Services, 2002). Additional data from federal statistics suggest that between 2004 and 2008, approximately 109,972 Hondurans had been deported (U.S. DHS, 2010). Furthermore, by 2010, more than 60% of the 573,000 Honduran immigrants in the United States were reported to have been unauthorized (Desilver, 2013). Despite the large number of Hondurans being deported between 2000 and 2010, Hondurans continued to migrate in large numbers, especially unaccompanied minors.

According to the World Bank, in 2013, 64.5% of the Honduran community in Honduras were living in poverty. Similarly, in 2012, Honduras led the world with the highest homicide rate; 90 people were murdered for every 100,000 citizens (Gao, 2014). Over the past ten years, poverty, climate change, and gang violence have become primary reasons for increased migration rates. Data suggest that between 2012 and 2019, apprehension of Honduran family units at the southern U.S. border increased from 513 to 188,368 (U.S. Customs and Border

Protection, 2020). Similar to its neighbors, unaccompanied minors (children traveling without any legal documentation, or caregivers, with the purpose of crossing into the United States) have led to the most recent waves of migration from Honduras to the United States. Data from U.S. Border Patrol suggests that between 2015 and 2019, the number of Honduran-born unaccompanied minors migrating to the United States rose from 5,409 to 20,398. Similar to other Latinx immigrant unaccompanied minors, *La Bestia* (freight trains) has been one of the only options for traveling through Mexico to border towns such as Ciudad Juarez. Readers should refer to the *El Salvador* section (*A Constant State of War: How a Historical Insight into El Salvador and Salvadoran-Origin People in the United States Can Inform Mental Health Services for Salvadorans*) for additional information on *La Bestia*. Recent data suggest that during the 2020 fiscal year, Honduran children made up 25% of all unaccompanied minors, making them the second-largest group of children traveling without an adult (U.S. Department of Health & Human Services, 2021). Recent events such as Hurricanes ETA and Iota, and the pandemic have crippled the economy forcing thousands of Hondurans to leave in caravans. Current fiscal data from the U.S. Customs and Border Protection suggest that as of March 2021 there has been 11,949 unaccompanied Honduran children apprehended at the Southwest border, 38,921 family units, and 47,684 single adults. Being aware of current migration patterns can help mental health providers attend to the unmet needs, vulnerabilities, and potential priority areas for intervention among Honduran families.

Indigenous Honduran Communities

The history of Honduran Indigenous communities has been defined by gradual disappearance through colonialization, genocide, enslavement, ethnic and racial discrimination, dislocation, and dispossession (Cultural Survival and Grassroots International, 2014). The latest

on the number of Indigenous people residing in Honduras is mixed. For example, according to the 2013 Census, approximately 717,618 (9%) individuals were identified as a member of an Indigenous or minority community (Minority Rights Group International, 2018). However, a 2007 census survey conducted by Honduran Indigenous organizations found that 1.27 million (20%) of individuals self-identified as Indigenous or African Indigenous (Cultural Survival and Grassroots International, 2014; Minority Rights Group International, 2018). According to the Cultural Survival and Grassroots International (2014) report, the 20% is divided among the following groups: Lenca (720,000), Miskito (87,000), Tolupan (47,500), Nahua (20,000), Maya Ch'orti (10,500), Pech (3,800), Tawahka (1,500), Garifuna (mixed Afro-Caribbean origin, 380,000); and Bay Creoles (mixed Afro-Caribbean origin, 12,337). Like Indigenous communities in other parts of Central America, Honduran Indigenous groups continue to face an upsurge of Indigenous cultural struggles, particularly around land tenure ownership. The inequities encountered by Indigenous communities are rooted in colonial mentality and power, which has led to social exclusion and violation of ancestral rights and sovereignty over land and territories. Despite Honduras' ratification of International Labour Organization Convention No. 169 (ILO), Indigenous communities continue to be left out of decision-making around development and ancestral land ownership (Business & Human Rights Resource Centre, 2018; Minority Rights Group International, 2018). Since the signing of ILO in 1994, and the signing of the UN Declaration on the Rights of Indigenous People (UNDRIP), the Honduran government constructed the Río Blanco without the consent of local Indigenous people, suspended moratoriums on mining concessions that had been in effect since 2005, and approved a contract with the Chinese company SinoHydo to build dams on the Patuca River (Business & Human Rights Resource Centre, 2018; Cultural Survival and Grassroots International, 2014). These

projects have threatened the livelihood of Indigenous communities, violated Indigenous human rights, and led to the assassinations of Indigenous people (Cultural Survival and Grassroots International, 2014; Minority Rights Group International, 2018).

Present-day issues impacting the well-being of Indigenous and Afro-descendant communities include discrimination and marginalization; social exclusion; poverty and intimidation; and limited access to health care and education. Limited access to quality education has led to 19% of the Indigenous communities being identified as illiterate, compared to 13% of the general population (Minority Rights Group International, 2018). Similarly, only about 10% of Indigenous people have a government-accredited land title, which has forced many to migrate to the cities and other parts of the world in search for security and employment (Minority Rights Group International, 2018). In addition to socioeconomic challenges, many Indigenous communities have been forcibly displaced. For example, in 2015, five Indigenous communities were forced to abandon their land after they were seized by drug traffickers (Minority Rights Group International, 2018). The violence experienced by the Honduran Indigenous communities and the general population has led to Honduras being named the country with the highest murder rate in the world for the past ten years. These challenges along with forced displacement have prompted thousands of Hondurans, most recently children, to migrate to the United States. Considering these changes, clinicians will benefit from learning about engagement strategies for these communities (National Hispanic and Latino MHTTC, 2021).

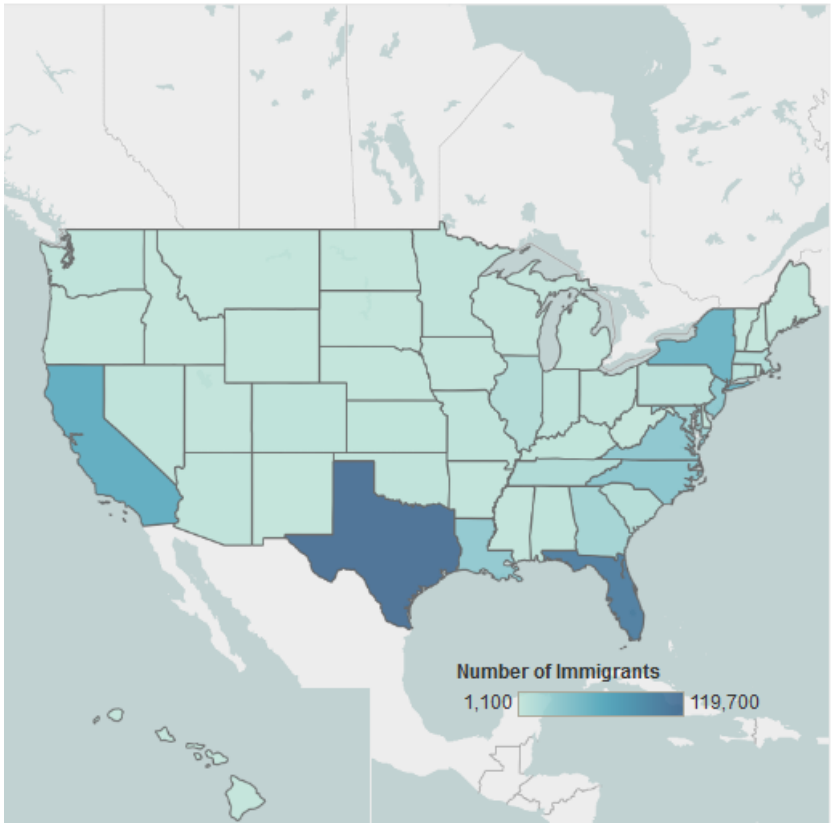
Hondurans in the United States

Settlement points

Data suggest that between 1990 and 2010, approximately 400,000 Hondurans migrated to the United States (U.S. Census Bureau, 2010, 2020). The vast majority, between 1990 and 2010,

settled in large cities in California, Texas, and Florida (O'Connor et al., 2019). Today, Harris County (62,000), Miami-Dade County (47,900), Los Angeles (35,100), Jefferson Parish (16,400), and Dallas County (16,200) are home to the largest number of Honduran immigrants (see Figure 22; U.S. Census Bureau, 2020). Similar to other Central American immigrant groups, Honduran immigrants are now settling in rural parts of the Midwestern (e.g., Chicago, Ohio, Nebraska) and Southern states (e.g., Louisiana, North Carolina, Georgia, Tennessee; U.S. Census Bureau, 2020). Notably, the context of violence and insecurity, socioeconomic conditions, natural disasters in the form of hurricanes, and family reunification have recently contributed to the constant flow of Hondurans leaving the country in hopes of a better future.

Figure 22. Honduran immigrant population by state and county, 2015 – 2019.



Total immigrant population from Honduras in the United States: **651,100**

Top Counties

Harris County, Texas	62,200
Miami-Dade County, Florida	47,900
Los Angeles County, California	35,100
Jefferson Parish, Louisiana	16,400
Dallas County, Texas	16,200
Broward County, Florida	14,800
Bronx County, New York	13,400
Mecklenburg County, North C..	11,300
Fairfax County, Virginia	9,800
Suffolk County, New York	9,000
Hudson County, New Jersey	9,000
Palm Beach County, Florida	8,500
Nassau County, New York	8,400
Montgomery County, Maryland	8,100
Queens County, New York	7,700

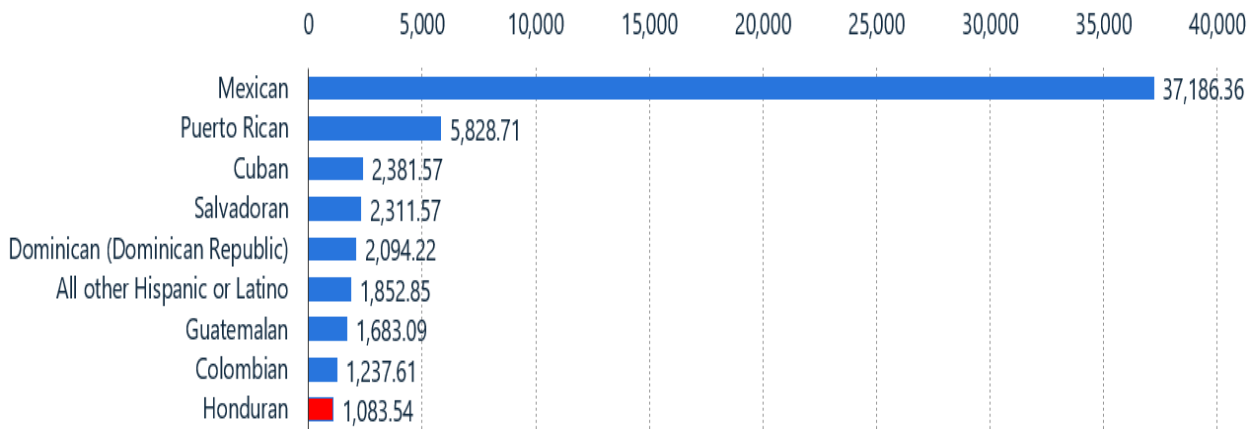
Source: Migration Policy Institute tabulation of data from the U.S. Census Bureau's pooled 2015-2019 American Community Survey. Retrieved from https://www.migrationpolicy.org/programs/data-hub/charts/us-immigrant-population-state-and-county

Demographics

Today, at over 1 million, Honduran communities are the eighth-largest population of Latinx-origin people residing in the United States, and account for 2% of the Latinx population (see Figure 23; Noe-Bustamante et al., 2019; U.S. Census Bureau, 2020). In 2019, the Honduran foreign-born population reached 651,100, making them the third-largest Central American immigrant group in the United States (see Figure 24; U.S. Census Bureau, 2020).

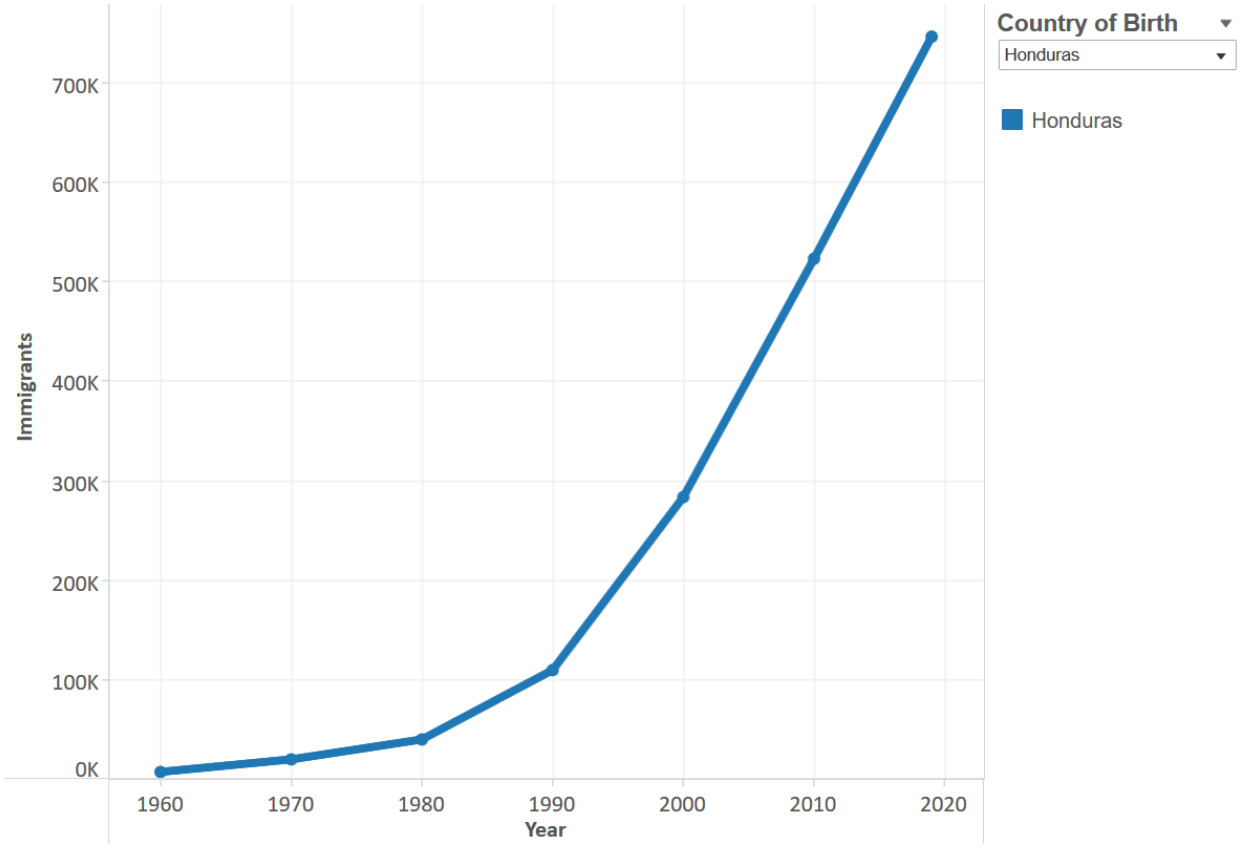
Studies evaluating migration patterns from Honduras to the United States have shown a significant increase in the last two decades, a growth of 296% since 2000 (Noe-Bustamante et al., 2019). Like other Central American migrant groups, the increase in migration of Hondurans to the United States is a result of several natural disasters (notably Hurricane Mitch); gang violence; lack of economic opportunities; and most recently pressure from the COVID-19 pandemic (Martinez & Escalon, 2021). Additional factors include climate change; land ownership inequality and widespread poverty; government corruption; U.S. involvement in the region; and U.S. immigration policies (Angelo, 2021; Peter & Taft-Morales, 2021; O'Connor et al., 2019; Pons, 2021).

Figure 23. Honduran-origin population in the U.S., 2020.



Source: *Countries of birth for U.S. immigrants, 1960-present*. migrationpolicy.org. (2021, February 15). Retrieved from https://www.migrationpolicy.org/programs/data-hub/charts/immigrants-countries-birth-over-time?width=1000&height=850&iframe=true

Figure 24. U.S. Honduran immigrant population, 1960 – 2019.



Source: *Countries of birth for U.S. immigrants, 1960-present*. migrationpolicy.org. (2021, February 15). Retrieved from https://www.migrationpolicy.org/programs/data-hub/charts/immigrants-countries-birth-over-time?width=1000&height=850&iframe=true

Employment

Land ownership and economic power in Honduras, similar to other parts of Latin America, has and continues to be concentrated in the hands of a small group of elites. As a result, 61.9% of Hondurans live below the national poverty line (World Bank, 2019). Lack of economic

opportunities in Honduras has forced people to seek work in the United States and other parts of the world. Similar to other Central American groups, Honduran workers in the United States are instrumental in the sustainability of two economies (e.g., U.S. & Honduras). For example, remittances play an important role in Honduras' economy, totaling close to 5.4 billion U.S. dollars (20% GDP) at the end of 2020 (Cova, 2020; Orozco & Spanswick, 2021). In the United States, workers of Honduran background make up close to 400,000 of the Latinx workforce (Bucknor, 2016). Specific to gender differences, Honduran men account for 59.5% of the workforce, while women make up 40.5% (Bucknor, 2016). In recent years, work opportunities for Hondurans in the United States have increased, in particular with the rise in H-2A and H-2B visas available to Hondurans resulting from an agreement between the U.S. Department of Labor and the Ministry of Labor of Honduras (Shepardson et al., 2019). Data suggest that Latinx workers of Honduran background are most likely to be immigrants (86.8%; Bucknor, 2016). Finally, the median family income of Hondurans in 2014 was approximately $30,000 (Bucknor, 2016).

Education

Data suggest that an estimated 43.3% of employed Honduran adults in the United States had less than a high school diploma in 2014, and 38.5% reported residing in a limited English-speaking household (Bucknor, 2016). Additionally, within Honduran communities ages 25 and older, an estimated 11% reported obtaining at least a bachelor's degree (Noe-Bustamante et al., 2019). Among Hondurans ages 25 and older, the U.S.-born population was more likely than the non-U.S.-born community to have a bachelor's degree or higher (21% vs. 9%). Moreover, 2016 data suggest that the high school status dropout rate for Hondurans between ages 16-to-24 years was the second highest compared to other Latinx groups at 16.7% (de Brey et al., 2019). Finally,

data from the Pew Research Center on Hispanic Trends suggest that 51% of Honduran immigrants ages 25 and older do not have a high school diploma (Cohn et al., 2017).

Religion

Data from the 2019 Report on International Religious Freedom: Honduras, suggest that 45% of Honduran communities in Honduras self-identified as Roman Catholic, and 40% as Protestant, including Evangelical Protestant groups. Additional religious groups, each respectfully representing less than 5% include: The Church of Jesus Christ of Latter-day Saints (Church of Jesus Christ), Episcopalians, Lutherans, Antiochian Orthodox Apostolic Catholic Church, Muslims, Jews, Baha'is, Moravian Church, and several Anabaptist and Mennonite groups. To date, there is limited information on religious affiliation of Hondurans in the United States. However, a source suggests that the majority of Hondurans in the United States identify as Catholic, while a sizeable population identify as Evangelical Protestants (Neu, 2009).

Traumatic Experience Prior to Immigration: Considerations for Mental Health Providers

Gangs

Gang violence is widespread in and around urban areas. The Mara Salvatrucha (MS-13) and the 18th Street (Barrio 18) gangs greatly contribute to the murder rate in Honduras, and are infamous for extortion and drug peddling. Estimates of the number of active gang members range from 5,000 to 40,000 (Human Rights Watch, 2021). Gangs exercise territorial control over neighborhoods and extort residents throughout the country. They forcibly recruit children and sexually abuse women, girls, and LGBTQ people. Gangs kill, disappear, rape, or displace those who resist, and children face harassment and intimidation to join gangs. Gang harassment and

forced recruitment continues to be one of the main immigration push factors (Human Rights Watch, 2019).

Violence and corruption

The murder rate remains among the highest in the world (Human Rights Watch, 2020, 2021). Violent organized crime continues to disrupt Honduran society and pushes many people to leave the country. Journalists, environmental activists, LGBTQ individuals, and people with disabilities are among the groups targeted for violence. Since January 1, 2021, there have been 45 massacres in which 157 people lost their lives (Education Development Center, 2020).

As of June 2019, almost half or more than 13,500 police officers were evaluated by the commission and removed for acts committed during their tenure as officers (Human Rights Watch, 2020). However, corruption is an ongoing and endemic issue in Honduras. The COVID-19 pandemic only increased instances of violence. For instance, many Hondurans reported numerous cases of abuse by police enforcement during the COVID-19 lockdown. In April 2020, Public Order Military Police (PMOP) officers severely beat three brothers and shot two of them—one fatally—for allegedly violating a curfew in El Paraíso in order to sell bread (Human Rights Watch, 2021).

Violence based on gender and sexual orientation

The LGBTQ communities face violence from gangs, police and the military police, members of the public, and their own families. Additionally, they are suspected to be highly vulnerable to acts of extortion by gangs, and face discrimination in schools and in the workplace (Human Rights Watch, 2021). The Honduran government does not keep data on killings based on sexual orientation or gender identity; however, it is estimated that between January and August 2019, at least 26 LGBTQ people had been killed (Winstead, 2019). In one case

documented by the Human Rights Watch in June 2019, a transgender woman was killed and mutilated near San Pedro Sula in an apparent hate crime (Human Rights Watch, 2019). Violence against LGBTQ individuals forces many to leave their homes, fleeing internally, or leaving the country to seek asylum. As of 2019, same sex couples were not permitted to adopt (Human Rights Watch, 2020, 2021).

Honduras has the second-highest femicide rate in Latin America and the lowest conviction rates. Between 2010 and 2019, only 35% of femicide cases were brought before the courts. Of the 104 cases of femicide that reached the Supreme Court of Justice between 2014 and 2019, only 23 have been adjudicated (Herrera, 2020). Since Honduras criminalized femicide in 2013, only 15 have resulted in convictions (Herrera, 2020). As of November 16, 2020, Honduras has registered 240 femicides for the year, of which 171 have occurred during the pandemic (Centro de Derechos de Mujeres, 2020). Since the pandemic, there's been a 4.1% increase in domestic and intra-family violence (Education Development Center, 2020).

Conclusion

Migration from Honduras to the United States is recent, and prompted by natural disasters, extreme violence, and economic hardship. Like Salvadorans, Guatemalans, and Mexicans, people of Honduran ancestry have experienced and endured significant pain from colonialization to recent gang violence. Similar to other Latinx communities, people of Honduran ancestry, especially the African Indigenous communities, continue to experience various forms of discrimination, violence, and hate crimes to which the Honduran community has responded with resilience and perseverance. Despite their strengths and methods of survival, the mental health of Hondurans and Honduran Americans needs to be at the forefront given the social, political, physical, psychological, and spiritual harm they have endured in Honduras and

in the United States. As a result, we encourage mental health service providers to familiarize themselves with the history and lived experience of individuals of Honduran ancestry to better understand the behavioral and psychological processes that have historically forced them to be resilient and resourceful.

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SAMHSA

Substance Abuse and Mental Health
Services Administration