NCTSN The National Child Traumatic Stress Network

Addressing the Mental Health Problems of Border and Immigrant Youth

A Culture and Trauma Special Report from the National Child Traumatic Stress Network

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National Child Traumatic Stress Network
Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

The National Child Traumatic Stress Network is coordinated by the National Center for Child Traumatic Stress, Los Angeles, CA, and Durham, NC.

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UNDERSTANDING BORDERLANDERS' LIVES AND CHALLENGES

For health care professionals on the front lines of providing mental health and trauma care to Latino children and families in the United States–Mexico border region, it is crucial to understand the diverse cultural, socioeconomic, environmental, and political factors that daily impact the lives of their clients/patients. Equally important, such clinicians need to implement culturally competent care while simultaneously addressing the families' misconceptions and knowledge gaps about the causes of mental health problems and their treatment.

Cultural Collision versus Interdependence

Along the nearly 2,000-mile long border region of the United States and Mexico, the cultures of Mexico and the United States frequently collide. In *Distant Neighbors*, author Alan Riding (1984) states, "Probably, nowhere in the world do two neighbors understand each other so little. More than by levels of development, the two countries (United States and Mexico) are separated by language, religion, race, philosophy, and history." As a result, borderlanders (*fronterizos*) may experience "mental and emotional states of perplexity" (Anzaldúa, 1987, p. 78) and frequently face "physical isolation, frontier conditions, transnational frictions, ethnic rivalries and a sense of separation from heartland areas" (Martinez, 1994, p. 303).

Yet, **the border region is an area where an estimated 12 million borderlanders live and grow in close interdependence** and where a "dynamic transnational interaction" occurs (Martinez, 1994). The border region is characterized by 14 twin city complexes on both sides of the international boundary, such as San Diego, California, paired with Tijuana, Baja California, and El Paso, Texas, paired with Ciudad Juarez, Chihuahua. The border crossings are among the busiest in the world, with more than half a million people moving legally in both directions each day pursuing jobs, commerce, housing, the arts, and health care (United States-Mexico Border Health Commission [USMBHC], 2005). That interdependence also involves shared problems. San Diego's mayor Jerry Sanders alluded to this circumstance when describing how crime affects both San Diego and Tijuana. He said, "What affects one side affects the other. We're literally one region with a fence down the middle" (Welch, 2007, p. A3).

In the midst of the pull of interdependence and the push of colliding cultures, **borderlanders face identity concerns, challenging socioeconomic and environmental conditions, vulnerability to trauma, stress, substance abuse disorders, depression, and other psychiatric disorders, and multiple barriers to obtaining needed treatment.**

The Question of Identity

Borderlanders are often ridiculed by mainlanders on both sides of the border. U.S. mainlanders frequently characterize the border region as an area plagued by poverty, banditry, racial strife, illegal immigration, drug smuggling, official corruption, violence, and security breaches (Martinez, 2006). Conversely, Latinos in Mexico's heartland frequently view the border as a region excessively reliant on the U.S. economy and American goods and as a source of moral permissiveness stemming from indulgence of American tourists' desires. They may disparage Mexican and Mexican American borderlanders as *agringados*, who have succumbed to Americanization and forsaken their Latino culture.

Acculturation pressures on Latino families are many. While the majority status of bilingual Mexican Americans in border communities allows some respite from the pressures to acculturate, border residents also recognize that not adapting to the host culture may result in significant problems as they interact daily with people, systems, and institutions in the United States. Additionally, those borderlanders who do adopt mainstream U.S. values may feel guilty or ashamed of losing their cultural identity and face disapproval from their significant others and families as being "too American." Sometimes the differences in acculturation levels within families can lead to conflicts. For example, **as children adapt to and absorb the new culture—especially by going to school and learning English—mothers and fathers may encounter difficulty in knowing how to parent their "Americanized" children.**

Discriminatory experiences have been found to be related to poor mental health outcomes and negative life changes among marginalized communities in the United States (Araújo & Borrell, 2006). Many Latinos in the borderlands feel marginalized by a culture that indirectly pressures them to assimilate while simultaneously rejecting them. Even after achieving assimilation, most Latinos are racially different and, therefore, may not be accepted as easily as "Americans" as European immigrants have been. Discrimination is particularly intense with regard to undocumented workers in the border areas. Undocumented immigrants may experience guilt and shame and are often treated as "second-class" people or pariahs (Sullivan & Rehm, 2005). Discrimination research shows that perceived discrimination correlates positively with psychological distress and negatively with a sense of personal control (Moradi & Risco, 2006) and that experiences of discrimination may lead to symptoms of depression and anxiety among some immigrant populations (Hovey & Magaña, 2000).

Stereotypes also have significant consequences in the lives of individuals who are facing the challenges of defining themselves and their families in a culture that views them unfavorably. **Old and recent racial**

and cultural stereotypes paint people of Mexican ancestry as lazy, oversexed, immature, aggressive, impulsive, dirty, and untrustworthy (e.g., *bandido, greaser, beaner, welfare leech, gang member,* and *wetback*). **Such stereotypes, when internalized, can result in "self-hate," especially in young people.**

Socioeconomic and Environmental Challenges

Many socioeconomic and environmental conditions negatively influence the mental health of borderlanders, including poverty and the lack of resources, drug trafficking, violence, and immigration risks.

While significant economic changes have occurred due to international trade agreements with Mexico, there continue to be extensive problems associated with the widespread poverty of the border region. Three of the ten poorest counties in the United States are located in the border area. Twenty-one of the counties on the border have been designated as economically distressed areas. The unemployment rate along the U.S. side of the Texas-Mexico border is 250% to 300% higher than in the rest of the country. Approximately 432,000 individuals live in 1,200 *colonias* in Texas and New Mexico, which are unincorporated, semi-rural communities marked by substandard housing and a lack of potable water or proper sewage systems (USMBHC, 2005). The *colonias* along the United States–Mexico border are reflective of third-world communities, according to Davidhizar and Bechtel (1999). Even though many of the residents are U.S. citizens, they lack the basic educational and work opportunities found in most parts of the country. Because of limited infrastructure, diseases controlled in most parts of the world are epidemic within these communities.

The vastness of the border makes it very vulnerable to drug trafficking. There are five High Intensity Drug Trafficking Areas in the border region (areas within the United States that exhibit serious drug trafficking problems and harmfully impact other areas of the country), as designated by the White House Office of National Drug Control Policy (ONCDP, 2008). For instance, illicit drugs enter Texas from Mexico through cities such as El Paso, Laredo, McAllen, and Brownsville, as well as through smaller towns along the border. The drugs then move northward for distribution through Dallas/Fort Worth and Houston (Maxwell, 2007). Cocaine and heroin, in particular, are major problems in the border region. Heroin is purer at the border in El Paso and decreases in purity as it moves north, since it is "cut" with other products as it passes through the chain of dealers. Cocaine accounts for a high rate of admissions to treatment facilities. Beyond the prevalence of illicit drugs, corrupt medical practices on the Mexican side of the border make prescription medications, such as the benzodiazepines flunitrazepam (Rohypnol) and diazepam (Valium), easily available. As a result, **the potential for youth in the border region to develop alcohol and other substance abuse disorders is high.**

Recently, the border region has been at the stage where many drug cartels have been fighting for control of smuggling routes and new lines of illicit businesses. The resulting violence, including killings and kidnappings, has created widespread insecurity among border residents. Tijuana, for example, with a

population of 1.2 million, saw one slaying per day in 2006 and roughly two kidnappings a week. Thirty victims were police officers (Welch, 2007). Many **children whose relatives or neighbors were victims of drug-related kidnappings and murders fear that their parents may be killed when they travel across the border to return to Mexico.** The children's insecurity, anxiety, and fear can complicate trauma treatment.

Immigration, whether it is legal or not, generally increases the stress on Latino families. As of March 2005, the Pew Hispanic Center estimated that of the 11 million undocumented immigrants living in the United States, six million came from Mexico (Sullivan & Rehm, 2005). Many undocumented Mexican immigrants experience abusive treatment, pressures to work for below-market or uncertain wages, and threats of deportation. They may also suffer the trauma of violent immigration experiences (e.g., rape and seeing others murdered), but be afraid to seek help for fear of deportation. Many report feeling lonely, isolated, trapped, sad, and depressed. Recent immigration raids in different areas of the United States and harsher penalties for immigration violations also increase anxieties among those separated from their children and other family members.

One Child's Story

Many families in the United States–Mexico border region experience multiple forms of trauma that greatly increase anxiety levels, especially in children.

Such is the case of Hector, a 10-year-old boy whose father died in an accident. A year later, a favorite uncle disappeared, a victim of problems related to drug smuggling.

Today, every time Hector's mother plans to go across the Rio Grande river to visit family in Mexico, Hector experiences anxiety and fear and clings to her. This behavior is common among children whose relatives or neighbors have been victims of drug-related kidnappings and murders.

Many immigrants come to the United States alone and leave their children in Mexico, usually being cared for by grandparents or extended family. **The inability of undocumented immigrants to freely go back and forth between the two countries can lead to emotional distance between adults who come to the United States for work and any children who remain behind.** Also, mothers who have left their children back home may experience guilt and shame, because they may feel they are not fulfilling their roles as mothers (Williams, 1990), since in most Latino families, women are viewed as the carriers of the culture and the primary nurturing figures. Another form of separation occurs along the border when some parents send their U.S.-born children to school in the United States. During school days they stay on the United States side under the care of extended family members and during the weekends reunite with their parents. This practice requires these children to adapt to two different sets of rules and structures.

Trauma, Substance Abuse, and Mental Health Issues

Children living in the border region are often deeply affected by the violence and uncertainty that exists there. Because of the prevalence of illicit drugs and easy access to benzodiazepines, substance abuse in the border region is high, particularly among teenagers. Maxwell (2007) reported that students (grades 7 to 12) in schools on the Texas border reported higher levels of powder or crack cocaine use (12%, lifetime use; 5%, past month use) as compared to students in non-border counties (7%, lifetime use; 2%, past month use). Cocaine use among adults on the border is also higher. Maxwell found that 26% of all admissions to treatment programs on the Texas side and 22% of all admissions on the Mexico side in 2003 were for powder or crack cocaine. The average age of those admitted for cocaine use was 35 years.

Students from the border schools also report higher current (past month) use of tobacco, alcohol, inhalants, and multiple illicit drugs (Texas Department of State Health Services [DSHS], 2005).

Rohypnol abuse also is prevalent: in a 2004 survey of substance use among 51,285 border secondary school students (93.7% of whom were Hispanic) and 84,377 nonborder students, students from the border area were almost four times more likely to report Rohypnol use than those living elsewhere in the state (9.1% versus 2.5%, lifetime use, and 3.5% versus 0.9%, past month use). Among adults, dramatic increases in the use of methamphetamines have been found among Latinos in and around the United States–Mexico border, in part because methamphetamine use enables many to work longer hours at a faster speed and therefore make more money. Some users report that dealers regularly travel to work sites, including agricultural fields (National Council of La Raza [NCLA], 2005).

Individuals who feel unsafe in their environments are more likely to use tobacco, alcohol, marijuana, and other illicit drugs than those who are comfortable with their surroundings. In the secondary school survey, researchers found there was little difference between the border and non-border students in their perceptions of being safe at home, but the border students were less likely than non-border students to feel very safe in their neighborhoods (31% versus 43%) or at school (33% versus 37%) (Texas DSHS, 2005).

There is a paucity of studies on the mental health issues of borderlanders. To explore cultural beliefs and mental health among Mexican Americans, Chavez and Guerra (2006) conducted focus groups among Mexican Americans living along the southern border of Texas. The discussions were transcribed and themes identified. Among themes identified were concern about lack of resources (economical

and provider), knowledge deficits about the causes of and treatment for mental health problems, legal problems when seeking care in Mexico, the importance of kinship among Hispanics, and the presumed lack of providers who understand their needs.

Another recent study looked at health-related quality of life among Mexican Americans living in *colonias* at the Texas-Mexico border (Mier et al., 2008). Women were more likely than men to report worse mental health status. The authors suggested this difference may be related to domestic violence issues or perceived high levels of discrimination. In addition, increased length of time living in the *colonia* (10 years or more), having three or more comorbid health conditions, and perceived problems with health care access, were associated with lower mental health status in both men and women.

Indicators of mental health issues encountered by borderlanders can be extracted from some U.S. prevalence studies that address the mental health of Latinos. Researchers used the National Institute on Alcohol Abuse and Alcoholism's Epidemiologic Survey on Alcohol and Related Conditions (NESARC) to examine lifetime prevalence of DSM-IV disorders among 2,227 foreign-born and 2,331 U.S.-born Mexican Americans (Grant et al., 2004). With few exceptions, foreign-born Mexican Americans were at significantly lower risk of DSM-IV disorders compared to their U.S.-born counterparts (any disorder: 28.5%, foreign-born, compared to 47.6%, U.S.-born). By diagnostic category, 10.2% of foreign-born had a mood disorder, compared to 19.3% of U.S.-born; and 9.1% of foreign-born had an anxiety disorder compared to 16.3% U.S.-born. These results prompted the researchers to suggest that **traditional cultural retention may be a "protective factor of the mental health of individuals of Mexican descent."**

Other researchers using data from the National Health and Nutrition Examination Survey III (NHANES III) found that, compared to White Americans, Mexican American individuals have higher lifetime prevalence rates of dysthymic disorder but lower rates of major depressive disorder. Lack of education remained a significant risk factor for dysthymic disorder (Riolo, Nguyen, Greden, & King, 2004). More recently, researchers combined and examined data from the National Latino and Asian American Study (NLAAS) and the National Comorbidity Survey Replication (NCS-R). In the aggregate, they found that the risk for most psychiatric disorders was lower for Latino individuals than for non-Latino White individuals. Also, using the NLAAS data, the researchers found that U.S.-born Latinos reported higher lifetime rates for most psychiatric disorders than Latino immigrants (Alegría et al., 2008). For instance, U.S.-born Latino individuals were at significantly higher risk than immigrant Latinos for a major depressive episode (18.6% versus 13.4%), for any depressive disorder (19.8% versus 14.8%), for any anxiety disorder (18.9% versus 15.2%), and for any substance abuse disorder (20.4% versus 7%).

Latino youth are at risk for psychiatric disorders as well. According to the Youth Risk Behavior Surveillance study, **the prevalence of having felt sad or hopeless almost every day for two or more weeks was higher among Hispanic (36.2%) than White (25.8%) or Black (28.4%) students** (Eaton et al.,

2006). The prevalence of having actually attempted suicide in the past year was higher among Hispanic (11.3%) than White (7.3%) or Black (7.6%) students, and higher in Hispanic females (14.9%) than Hispanic males (7.9%). The prevalence of having vomited or taken laxatives to lose weight or to keep from gaining weight was also higher among Hispanic (5.4%) than Black (3.4%) students.

Barriers to Care

Even when borderlanders suffer mental health problems due to acculturative stress or the loss of their culture, environment and language, they may not be able to access treatment due to their illegal status, lack of resources and fear of detection. **Many immigrant mothers with U.S.-born children are reluctant to access public assistance for their children for fear of detection or being perceived as a public charge when applying for citizenship** (Padilla, Radey, Hummer, & Kim, 2006).

Additionally, most border communities have many gaps in services that can affect if and when families will be able to receive services, if the family will stay in treatment, and where the family can receive treatment. Some immigrant parents may not understand the many service systems in the United States because there may not be counterparts of those agencies in their country of origin or those agencies may have limited resources and reach. Also, participants may feel intimidated about initiating contact because they think they might be reported to immigration authorities and deported. Due to scarcity of resources and of clinical staff, available programs may have long waiting lists that may discourage access to services, and participants may have problems with treatment adherence because of the high degree of instability in their lives. Therapy may not be a priority when families are facing homelessness, poverty, food, violence, and other problems.

There is also a distressing shortage of Latinos working as professional mental health providers (National Council of La Raza, 2005) and a general shortage of mental health professionals in the border region. In Texas, for instance, the border counties have lower supply ratios than Texas as a whole for psychiatrists and many other mental health professions. While there are 5.6 psychiatrists per 100,000 inhabitants in Texas generally, the ratio in border counties is 5 for every 100,000, and in rural border counties, it is 4.1 per 100,000 (Texas Department of State Health Services Center for Health Statistics, 2006). Differences in supply ratios of psychologists by region also exist (e.g., 24.2 psychologists per 100,000 population for entire state, 19.1 per 100,000, border, 9.0 per 100,000, rural border). The same is true for social workers (e.g., 68.2 per 100,000 for entire state, 61.0 per 100,000, border, 34.8 per 100,000, rural border).

Serious problems can also emerge when attempting to select and use materials in English or Spanish, and particularly when translating materials, surveys, measures, graphs, and other products into Spanish. Inappropriate translations and use of materials may lead to inadequate or awkwardly conveyed information and collection of inaccurate data. The results can be misidentification of needs, poor resource utilization, negative repercussions on the families' physical and emotional well-being, poor engagement and retention of patients/clients, inaccurate survey conclusions about Hispanics/Latinos and their needs, and biased or discriminatory results (Araújo & Borrell, 2006; Berkanovic, 1980; Krozy & McCarthy, 1999; Fernandez, Boccaccini & Noland, 2007; Flores, Abreu, Olivar & Kastner, 1998; Marin & Marin, 1991; Mazor et al., 2002; Taylor & Lurie, 2004).

Families feel the impact of these communication barriers. **In a survey conducted among Latinos about the barriers to care they experienced when accessing services for their children, parents reported that language problems and cultural differences were the greatest barriers,** followed by poverty, lack of health insurance, transportation problems and long waiting times. More than one quarter (26%) of the parents cited language problems as the most important access barrier (Flores et al., 1998).

Communicative competence becomes even more important in the treatment of Latino children and families who have experienced trauma. Latino families experiencing traumatic stress require services through which they can effectively communicate their wants and wishes, particularly after a traumatic event when the need to experience understanding, safety and empowerment becomes imperative. Latino families experiencing trauma may be grieving the loss of their country of origin and their *lengua materna* (mother tongue) and may face challenges in conveying their *dolor* and *duelo* (pain and grief). Traumatic events are fragmenting and disorganizing and require interventions that can allow children and families to integrate their experiences and incorporate the traumatic event in their lives. In that way, the traumatic event ceases to be the lens through which they view and interpret the world. Trauma treatment services for Latino families should strive towards helping families find their *voz*, the most congruent expressions of their experience that can effectively and safely allow them to heal. If Latino families cannot fully express their experiences, if there are limits to their opportunities to wholly "tell their story," if the therapeutic relationship cannot guide this process (or worse, hinders it) due to communication limitations, Latino families may then fail to benefit from treatment and may experience adverse consequences.

Preparing Families to Receive Services

Assessing clients' level of acculturation can aid staff in tailoring interventions for Latinos. Instruments such as the Acculturation Rating Scale for Mexican Americans (ARSMA) can be helpful in identifying acculturation levels and in broaching with clients/patients those experiences of acculturative stress that may impact treatment (Cuéllar, Arnold, & Maldonado, 1995). Assessment should also include attention to socioeconomic and environmental conditions, such as poverty and class exploitation, that may influence treatment responsiveness and engagement.

When working with borderlanders, it is important for health professionals and their staff to collect information about separations, issues related to living in a seemingly alien environment, traumatic experiences linked to border crossings, and emotional factors such as guilt and shame.

Often immigrant families, who come from disadvantaged backgrounds, need to receive simple explanations about treatment to de-stigmatize services. They may need lengthy and specific information about the counseling process and the differences between a psychiatrist, psychologist, and counselor. Sometimes they expect that the counselor will immediately diagnose the situation and give them a solution to their problems in the form of advice. Often children and adolescents are dragged to therapy because parents believe that the counselor will "convince" the child to stop behaving or feeling a certain way. This tendency is motivated by the perception of the mental health professional as an authority who is able to solve problems in the same manner that a physician prescribes medication, a priest gives advice, or a folk healer performs a healing ritual.

When rapport is established with the clinician, the family may return for added guidance for other family problems and concerns. Once the relationship is established, the family will feel close to the clinician and will integrate her or him into their support system. It is important to ensure that families feel welcomed even if they are no longer receiving services. Families may bring small gifts as an expression of gratitude. It is recommended that small gifts be accepted or shared if possible, since families may perceive refusal to accept gifts as rejection.

Integrating Evidence-Based Practices

Cultural adaptations of evidence-based practices are necessary for treatment interventions to meet the cultural needs of families, to impact treatment engagement and treatment adherence, and to improve treatment outcomes. Current cultural modifications of evidence-based practices for Latino populations appear to be efficacious and are important in retention, consumer-satisfaction, and treatment improvement (Lau, 2006; Miranda et al., 2005). Health care professionals need to adopt evidence-based practices

that best fit the needs of their community and targeted populations. To address the specific community needs of Webb County, Texas, for example, the project team selected Trauma-Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy, Trauma Systems Therapy for substance abuse, and Child-Parent Psychotherapy. These interventions meet the cultural and resource needs of the community, either because they are flexible or because important adaptations have already been made.

Achieving Biculturalism

As families struggle to adapt to living in the United States, health care professionals can help guide them toward achieving biculturalism. **Biculturalism is the best model for achieving positive mental health outcomes,** since it addresses the need to develop strong ethnic pride and connection to one's culture while mastering the language, customs, and skills needed to be successful in the mainstream culture. Therapists, in particular, can help families pay attention to the varying levels of acculturation among family members, and develop ways to manage conflicts ensuing from acculturative stress. Falicov (1998) recommends that conflicts related to integrating cultural values follow these steps:

- **Draw attention to value differences:** make family aware of the specific issues where the differences are manifested
- **Contextualize the differences:** normalize the conflict caused by the differences so that families can contemplate the choices available to them
- **Reframe the presenting problem:** allow families to form a hypothesis about the problem
- **Preview future family patterns:** help families visualize how they will respond to their challenges, either by blending values or alternating through value systems

Case Management, Inter-Agency Coalitions, and the Importance of Outreach

Case management combined with therapeutic services can lead to client/patient engagement and retention. Such approaches include home visitation, transportation to appointments, and support in accessing community support services. It is vital that health care providers and organizations join in inter-agency coalitions and partnerships to facilitate families, having access to comprehensive services for help with food, housing, and other resources.

Some Latinos may avoid receiving needed trauma and mental health services because they fear a possible connection to immigration authorities. Health care professionals and organizations need to develop outreach strategies, including home or school visitation to engage families.

Public services campaigns are important as well, especially those addressing disasters, terrorism, domestic violence, and other forms of trauma. Health care professionals and organizations need to work with Latino organizations and community leaders to ensure that psychoeducation and safety information reaches all Latino audiences, regardless of immigration status. They need to recognize that undocumented workers' tendency to avoid detection may place them in positions of risk during disasters and other traumatic events.

In the final analysis, borderlanders must learn to live with the differences and contradictions that exist in the border region. But culturally competent clinicians and systems of care can help them develop bicultural skills for addressing those differences, help them obtain appropriate treatment for their trauma and comprehensive needs, and help them live more satisfying and productive lives.

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