CHAPTER 3

Teaching Toward Decoloniality: A Mental Health Approach for Guatemala

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INTRODUCTION

As with many other Latin American countries, Guatemala was a signatory of the Declaration of Caracas in 1990. This international treaty marked a shift in mental health policy in Latin America. In particular, it focused on reducing the stigmatization of people with psychiatric dis/abilities\(^1\) by including mental health services within primary care and shifting the mental health system toward community-level services (Mascayano et al., 2016; WHO, 2001). On the ground, very little has been achieved toward these goals. For example, the Pan American Health Organization (OPS) estimates that in Latin America the average public investment in mental health is 2% of the health budget, with more than 60% of those monies allocated to the upkeep of psychiatric hospitals (PAHO, 2014). In Guatemala the mental health budget is made of 1.04% of the total health budget, with 94% going toward the operations of the national psychiatric hospital—Hospital National Carlos Federico Mora, known locally as

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Federico Mora (WHO-IEMS, 2011). With the majority of the budget going to Federico Mora, the hospital becomes the only substantial public mental health service available for the country.

The Federico Mora Hospital is an asylum-type psychiatric hospital with a capacity for 250 psychiatric beds, which house approximately 300 patients (DRI, 2012). The hospital is not equipped to absorb the mental health needs of Guatemalans, especially any person living outside of Guatemala City. Further in this chapter, I present the history of the Federico Mora to demonstrate that, as a colonial relic, it also sustains the legacy of the internal armed conflict. Because of the lack of services and the high instance of gender violence, other providers of affordable mental health services include non-profit organizations and public offices working towards women’s rights. As an effort to respond to the high incidence of feminicides in the country, Guatemala passed the 2008 law against femicide, which established the infrastructure and legislation to support women in persecuting their abusers. This law mandates medical and psychological support for survivors. Limiting these services to survivors of gender violence that want to persecute their abuser, these services offer an other avenue to access free or low-cost mental health services beyond those offered at the Federico Mora Hospital.

Although compared to other Latin American countries there is a low predominance of psychiatric disorders, with a 7.6% rate in Guatemala compared to for example to 17% in Chile or 29.6% in Brazil. Yet, of the Americas, Guatemala boasts the highest treatment gap rate when it comes to anxiety disorders (97.1%), affective disorders (95.1%), and substance abuse disorders (97%; Kohn et al., 2018). For example, the national survey estimated that only 2.3% of adult Guatemalans needing mental health services access them (Lopez & Cardona, 2010).

Furthermore, in Guatemala violence is deep-seeded in mental health. A study found that mental health “strongly associated” violence with the prevalence of mental health needs (Lopez & Cardona, 2010). In particular, people that were persecuted during the internal armed conflict, such as Maya Guatemalans, women, and people living in urban areas, were found four times more likely to express “post-violence mental health” needs (Lopez & Cardona, 2010; Puac-Polanco et al., 2015). The survey also revealed that one-fifth of respondents had experienced at least one violent event in their lives (Puac-Polanco et al., 2015) and almost one-third (27.8%) reported presenting at least one mental health need at some point in their lives (Lopez & Cardona, 2010). These findings confirm
that for Guatemalans, mental health cannot be understood apart from experiences of violence, especially those tied to state terror. Also known as state-sponsored political violence, state terror in Guatemala has the particularity to inform interpersonal violence, because the state used civilians to kill other civilians (Ball, Kobark, & Spirer, 1999 in Menjívar, 2011) and because the routinized exposure to state violence made civilians emulate these violent tactics in their lives (Menjívar, 2011). Because of this complex context, this larger ethnography focused on the public psychiatric system of the country to understand how mental health is defined and cared for.

This study specifically is based on eight interviews with different directors of the mental health system and women’s rights organizations who provide mental health in Guatemala City. Findings show that although the demand for mental health services exists and public officials are aware of this demand, mental health services continue to be ineffective. This study brings to light how the ineffectiveness of the Federico Mora Hospital is political because it normalizes state terror. From these findings, I propose that in order to address the mental health needs of the population, mental health can be considered an educational project based on a teaching for decoloniality practice (Carolissen & Duckett, 2018).

**Brief Overview of Guatemala**

Guatemala has a history of violence, since the Spanish colonization and, more recently, the internal armed conflict. The internal armed conflict lasted 36 years and ended in 1996 with the signing of the Peace Accords (ODHAG, 1998). These decades of conflict further imprinted an everyday culture of violence in the country. Especially because the army used “tactics of terror” including psychological forms of violence against the civilian population (ODHAG, 1998) to establish control. One of the tactics of psychological violence used was that of desaparecidos.

*Desaparecidos* refers to the forced disappearance of an estimated 250,000 Guatemalans (ODHAG, 1998). This practice entails kidnapping, torturing, killing, and ultimately disappearing the body of an individual considered a political “enemy.” This practice was particularly cruel and effective in a predominantly Catholic country that finds peace in and has traditions around burying the body of a loved one (Menjívar, 2011). This psychological torment and inability to have closure was the ultimate goal of desaparecidos. Because desaparecidos was a political strategy, public
institutions, such as the Federico Mora Hospital, actively participated in these crimes as I will demonstrate later in this chapter. Today, violence in the country follows a “multisided” pattern, meaning it happens everyday and in a variety of environments and circumstances, both at a personal and structural level (Menjívar, 2011). Violence in Guatemala is omnipresent and as such, becomes “routinized, and even legitimized and as such, misrecognized” (Menjívar, 2011, p. 227). These tactics of terror are meant to impact the mental health of Guatemalans. In other words, oppression in Guatemala can be defined as the intentional concentration of trauma onto specific communities (Hemphill, 2020) such as Mayan Guatemalans, women and healers.

As I will illustrate, the Federico Mora Hospital is an arm of the state’s oppression, and as such, concentrates trauma on specific people both by action and inaction. The violence that gave way to the internal armed conflict is rooted in the racism that is at the core of the establishment of Guatemala as a State. For example, it was not until the signing of the Peace Accords in 1996 that Guatemala was recognized as a pluricultural and plurilingual country. This demonstrates how Guatemala has always been a Ladino state project (Taracena, 2002). For example, Casaús-Arzú (2007) concluded she could not untangle the creation of the state of Guatemala with racist ideologies that justified the domination of the Ladino patriarch. Specifically in a country with a high level of inequality and the continuous existence of an oligarchical elite (Casaús-Arzú, 2007) it is clear that public institutions continue to preserve the colonial legacy.

**Teaching Toward decoloniality**

Teaching toward decoloniality calls to move away from the pathologization of crip and mad subjectivities (Thorneycroft, 2020) and provides a path to unlearning violence, in order to heal from generational trauma and terror inflicted during the internal armed conflict. Mental health in Guatemala cannot be relegated to health services only. For example, the local organization, La Liga Guatemalteca de Higiene Mental focuses on reunifying families separated during the internal armed conflict—especially through forced international adoptions—as a mental health project. So, in Guatemala, mental health is attached to ways of being, of becoming, of demanding justice. For this reason, I propose mental health as a teaching toward decoloniality practice. I take this teaching practice to be based on the ten markers for teaching toward decoloniality presented
by Carolissen and Duckett (2018) in the special issue “Teaching Toward Decoloniality in Community Psychology and Allied Disciplines” (p. 244).

These markers acknowledge that teaching toward decoloniality draws from local knowledge, centers pedagogical tools that result in critical reflexivity and links learning to activism (Freire, 2000). Teaching toward decoloniality also intentionally decenters western epistemology, takes on a historical approach, especially from the perspective of people omitted from histories, and, as such, it focuses on counter-narratives and the stories of silenced and marginalized communities. By purposefully “decentering” western epistemologies, “reclaiming” Indigeneity and Indigenous knowledge and their histories, and “foregrounding” power relations (Carolissen & Duckett, 2018), teaching toward decoloniality means denaturalizing the coloniality of power (Quijano, 2000) inherent in public institutions of care.

Mental health as a teaching toward decoloniality practice is a process of healing from state violence through self-reflexivity, the unlearning of violence, and the recentering of local mental health practices and knowledges. In Guatemala, teaching toward decoloniality carves a blueprint to heal from trauma by unlearning the violence that has been normalized since colonization and reinforced during the internal armed conflict. Based on the findings that show that although a demand for mental health services exists and public officials are aware of this demand, mental health services continue to be ineffective. When analyzing the Guatemalan public mental health system is a technology of power it becomes clear that the inefficiency of services is by design. For example, building on Foucault’s (2006) work, Rose defined technology as “a way of making visible and intelligible certain features of persons, their conduct, and their relations with one another” (Rose, 1999, p. 11, in Petersen & Millei, 2016). This definition aligns with Martín-Baró’s definition of mental health as being “more than an individual state” but established within the relational, meaning in the ability we have to relate between individuals, groups, states, institutions, histories (Martín-Baró, 1989, p. 109). The care practices of the Federico Mora Hospital—as in the majority of the public mental health system—are a technology of power (Rose, 1999), one that creates a standard of mental health care meant to normalize state terror, as I will demonstrate in this chapter.
Positionality

The first time I visited the Federico Mora was in 2013. When I first arrived at the hospital I was greeted by a security checkpoint, the guard, after reviewing my identity documents and noting who I came to visit and why, opened the gate, and I drove in. I could not help but notice the hand-painted blue-letter sign that read *enter at your own risk* and the barbed wire that laced the perimeter of the walls as I drove into the hospital.

I drove and found the administration office. When I got out of the car, my eyes met those of three penitentiary guards. The Federico Mora Hospital has the particularity that among its patients, the hospital houses individuals charged with criminal offenses requiring psychiatric care. Which is why there are penitentiary guards that work at the hospital. In 2012, there were approximately 50 convicted patients, and 110 penitentiary guards (personal conversation, February 2013). As I walked by, the three guards started harassing me. I walked quickly into the administrative building. When I met with my interviewee, I did not mention the incident, even though I was flustered. This incident is an example of how sexual harassment is normalized in everyday Guatemala even on a Wednesday at 11 a.m by public servants. That moment reminded me that existing as a woman in Guatemala is a continuous invitation for rape.

Yet, as a Ladina Guatemalan I hold many privileges. For example, one of the most concrete privileges has manifested into my ability to graduate with a PhD from an institution of higher education in the United States. This does not mean I do not experience racism, misogyny and homophobia in the academy, but rather, I want to highlight that the opportunity to access education is a testament of this privilege. In fact, I believe that the intersection of my identities—in particular, being a cisgender Ladina woman who passes as straight, and a doctoral student in the United States—played a part in accessing the Federico Mora Hospital.

I want to note that I am intentionally using the term Ladina to describe myself, as opposed to the term *mestiza* to highlight the colonial social structures that continue to shape the Guatemalan state and from which I have benefited. The term Ladino has evolved over the years, describing different groups of people and as such it is a complex term (Menjívar, 2011). However, I want to call on the fact that Guatemala as a pluricultural and plurilingual country continues to be a Ladino project, meaning that ethnic groups such as Garifuna, Maya, or Xinca continue
to be excluded from the state and its institutions. In other words, I want to highlight the functioning of the state and how I fit into the colonial Maya/Ladina binary (Taracena, 2002), rather than my personal experience of Guatemalan identity as a Ladina-mestiza (Aguilar, 2019).

**Methods**

This chapter is based on interviews from a larger ethnographic study of the Guatemalan mental health system, conducted from 2012 to 2013, as part of my dissertation work. As a subset of this larger data set, I focus on eight in-depth interviews of directors of organizations working to provide mental health services at the national level.

It is to be noted that because mental health services are scarce, participants can be easily identifiable which is why the use of a pseudonym is not enough. The participants’ institutional affiliation has been omitted and their titles will only be referred to as directors of organizations providing mental health services. Participants’ professions were varied, some were psychologists or psychiatrists, while others lawyers or human rights advocates. What these participants have in common is that they are the directors of organizations that run the mental health services in the country. For the sake of their anonymity, the eight participants have the following pseudonyms: Maria, Marta, Carolina, Julia, Luis, Rodrigo, Roberto, and Mario.

Interviews ranged from 45 to 90 minutes were audio recorded and manually transcribed. Because all interviews were done in Spanish, only selected quotes that have been reported have been translated to English. In addition, I asked probing or clarifying questions, and after each interview I wrote reactions, feelings, and overall patterns that I had noticed and any other information in my field notes.

For analysis, I uploaded interview transcripts onto the online qualitative data analysis platform Dedoose. I then coded each interview using open coding, meaning, breaking data apart to stand for smaller bits of raw data. After this initial coding, I moved onto axial coding. Axial coding consisted of relating concepts emerging from open coding to each other in order to develop a data matrix (Corbin & Strauss, 2008). From this data matrix emerged patterns on how the mental health system operates in Guatemala. In this chapter, I present the most common themes that were present in all participants’ interviews in order to evidence how mental health in Guatemala is a political issue.
Findings

Demand for Mental Health Services

Findings highlighted a tension between a high demand for mental health services, while at the same time, an active effort to avoid the services at the Federico Mora. In particular, participants shared how they must circumnavigate the hospital and advocate for other mental health services. For example, Maria spoke of the overwhelming demand for mental health services in the public organization she led, and how they coped with the limited resources and personnel: “we do not promote ourselves much, because then demand increases and already with those who know of us, we have enough work” (Personal Communication, March 18, 2013).

Even without promotion, public mental health services were saturated, this meant offices often did not have enough personnel or resources to absorb the demand. This made the office not disclose or advertise their services. For instance, when I came for the interview, I got lost because the office did not have any signs that differentiated it as a public office; it looked like a residential house, with a black door and a bell. It was not until I confirmed the house number that I reluctantly rang the bell to find that, I was in the right place. What I learned during the interview is that their decision to go unnoticed was a strategy to cope with the demand for mental health services. Maria further explained that one time, after one run of advertisements on public buses, the office collapsed because of the increase in demand. Because of this experience, and their limited budget, the office coped by becoming as unnoticeable as possible. Another strategy Maria used in her organization to cope with demand was to limit the number of mental health sessions a client could have access to, she explained, “look we provide therapy, but here we provide punctual therapy. We can call it ‘brief’; we try not to exceed some ten sessions because the demand is quite strong” (Personal communication, March 18, 2013). Maria put the situation of her organization in numbers. In the first two and a half months of 2013, they had “160 psychiatric referrals” (Personal communication, March 18, 2013).

Similarly, Marta, who led a public women’s rights organization, further evidenced the magnitude of the demand for mental health services, stating:

Here the influx is high. In this central office alone, depending on the moment, we receive up to 60 to 80 women daily. And, depending on the
season, we receive 80 to 100 women daily only in this one central office, only here in the capital. (Personal communication, March 11, 2013)

The demand was also high for “ambulatorio” services, meaning public mental health services in primary clinics. For example, Julia, director of a public program, estimated that in the few primary care clinics that have a psychologist on their staff, the demand for counseling services would be 150 people daily in one clinic. She explained, “I would say that yes grosso modo there are no less than 150 people that come to the clinic daily [...] Because the demand right now in the clinic makes people first and foremost fight for the space, there are people that are waiting for an appointment three months from now, just to be heard” (Personal communication, April 8, 2013).

It became quite clear that public organizations that provided affordable or free mental health services were saturated. By “mental health services,” directors referred to talk therapy with counselors or psychologists or referrals to psychiatrists as the most common. Some examples of strategies employed by offices that constitute the mental health services of the country were: not advertising services; limiting the amount of therapy sessions by only providing “brief interventions”; and, having month-long waiting lists for a first consultation. Findings consistently revealed that there is an active demand for mental health services in Guatemala City, which is the place were mental health services are centralized. In addition, I observed that organizations were not planning to expand services to absorb the demand but rather they reduced their visibility or availability of services as the strategy to cope with this high demand.

**Circumventing the Federico Mora Hospital**

A second finding showed that this need for services is met by circumventing the Federico Mora Hospital. Directors also reported a credible fear of accessing mental health services by those individuals who sought out services. For example, Carolina, the director of a locally run women’s rights organization, used her personal contacts to prevent women with a psychiatric referral from being transferred to the Federico Mora Hospital. Instead, she lobbied for them to be transferred to the Guatemalan Institute of Social Security (IGSS), even when they did not qualify for these services. The IGSS is the national healthcare system that provides public
health services to Guatemalans that are formally employed, which constitutes 20% of adults (Política Nacional de Salúd Mental, 2008). Women, who are largely underemployed or employed in the non-formal sector, are often excluded from the IGSS services. Carolina explained,

We have a survivor with a very high risk of suicide, we only have two options: the Federico [Mora] or the IGSS. We did all the corresponding lobbying so that she would be interned at the IGSS—without her having access to it—so it was about playing with contacts and influences, without it she would’ve gone to the Federico [Mora] and there the situation would’ve been worse, and those are our realities. (Personal communication, March 21, 2013)

Lobbying so that individuals do not access mental health services at the Federico Mora Hospital was not uncommon because the conditions of care at the hospital were well known by public officials or leaders of organizations that have to coordinate with the hospital. Julia explained that in her organization, as per internal guidelines, they stopped transferring to the Federico Mora when needing psychiatric services. She said very candidly,

We are not even referring directly to the psychiatric hospital [Federico Mora], because I don’t know if you’ve had a chance to visit the psychiatric hospital here in Guatemala, but it is totally depressive. If I send one of my patients with symptoms of depression there, I would be ensuring their end. (Personal communication, April 8, 2013)

Other organizations employed more subtle strategies to manage the fear individuals had of receiving mental health services at the Federico Mora Hospital. Marta, for example, as part of her organization’s protocol, must omit the word “psychologists” when referring clients to mental health services. These referrals are required by the 2008 law against femicides. She explained, “the protocols of attention say that we are going to offer psychological attention but without calling it that […] The word psychology is avoided because of the pure cultural context assigned to this issue” (Personal communication, March 11, 2013). I interpret “pure cultural context” to mean the services provided by the Federico Mora Hospital, because Marta was referring to public services and the Federico Mora constitutes the majority of services. She could have also meant by “cultural context” the history of the Federico Mora, which participants
who knew about it made sure to share it to provide a broader context to explain the current state of the hospital.

The services provided at the Federico Mora were consistently circumvented by different organizations that had to coordinate with the hospital. These strategies included direct lobbying, internal protocols that established that no referral would be made to the Federico Mora or by curating the discourse that shaped mental health referrals, such as avoiding the word “psychology,” so that patients wouldn’t resist a psychiatric transfer. These findings revealed how much institutions coordinating with the Federico Mora work to avoid their services. In addition, organizations are able to avoid the hospital by creating internal guidelines that impede these transfers, highlighting that it is the lack of national policies and regulations that allows organizations to avoid the Federico Mora. In other words, a lack of mental health regulations benefits a government that does not have to respond to the mental health needs of the population by diverting the demand for services elsewhere. The omission of mental health services and of mental health policies work hand in hand to enable the Federico Mora Hospital to continue operating with inertia, maintaining the status quo.

**INTENTIONAL INERTIA**

The Federico Mora Hospital, as we know it today, was born from the internal armed conflict; this origin explains much of the credible fear the general public has of accessing their services. Up until 1982, Guatemala had two public mental health hospitals: the “Asylum F. Molina” established in 1886 and the “farm-style neurological hospital” established in 1974. The Asylum F. Molina was a replica of the Spanish asylum-type model meant to lock away individuals considered “undesirable.” The Neurologico hospital was established with the support of the Pan-American Association of Health and built within a farm, and was described by my participants as being beautiful, green, and vast. Its mission was to move away from the asylum model and center the mental health goals of the time. For example, one of the goals of the hospital was to have patients for a 90-day maximum stay, which was the international standard of the time (interview with participant, April 26, 2013). The hospital ran parallel to the asylum for eight years. However, in 1982, the Government of Guatemala, at the time led by Efrain Rios Montt, merged both the Asylum F. Molina and the Neurologico hospital and, created
what is now the National Hospital of Mental Health Carlos Federico Mora (or as it is known, Federico Mora Hospital). Luis remembered the merger,

The week after Ríos Montt took power, I was let go from the bureau of mental health, and had to present myself to the authorities. They thanked me for my service, told me I was out and asked me to keep quiet, a very subtle but direct threat. So I had no other choice. [...] So the mental health bureau existed for one or two more years and then was also closed. [...] The hospital became a complete chaos and slowly changes began. That was in ‘82, the hospital followed its course in my view in decay. It was no longer the same as before, and with that quantity of people, impossible. The international trends, the goal was to empty the hospital. (Personal communication April 3, 2013)

Similarly, Rodrigo also recalled,

During the Ríos Montt years, one of the sons of Ríos Montt that was in the army also made the brilliant decision to unify the National Mental Health Hospital with the Neuropsychiatric. Imagine the people that worked in the Neuropsychiatric or that would come and visit their families and the hospital was no longer there. Everything was moved in one day. So the same philosophy and concept disappeared, it became what it is now. (Personal communication February 2, 2013)

Rodrigo affirmed that, since the merger, the “criteria of mental health deteriorated instead of improved” and highlighted that “to blame the actual hospital and its staff is not only unfair, but it is also to hide the true causes behind why the situation is the way it is now.”

Similarly, Roberto called the merger a “political decision of a dictator” and shared, “I witnessed the work of electroshocks […] When in many countries there is legislation that prohibits the use of electroshocks, how can that still be [here]?” (Personal communication, April 9, 2013).

The example of electroshock being used reminds us that, as a technology of power (Rose, 1999), the Federico Mora was executed because the hospital was born of a political decision during the internal armed conflict. Some of these practices are steeped into the culture of the hospital. As Julia explained, “people in Guatemala have considered psychological help as a discriminatory and punitive action” (Personal
communication, March 11, 2013), evidencing once more how the Federico Mora Hospital continues to be used as a site of state terror.

Discussion

Three findings were uncovered by the interviews with the directors of the mental health system of Guatemala. First, that the state of Guatemala is aware of the demand for services and knowingly underfunds these services. In fact, a high demand for mental health services exists, and services are saturated. For example, annulling advertisements and not signaling the office as a response to the high demand for mental health services is a political strategy of inaction. This is not an isolated incident but a mechanism in which the state operates. For example, the term femicide was created to grasp how the state of Guatemala is implicated in the killing of women by action or inaction (Sanford, 2008). As a political term, it highlights how these crimes remained unresolved and the situation unchanged, in many instances “blaming the victim” for her own murder (Menjívar, 2011; Sanford, 2008). In other words, the state rewards the killing of women, with impunity. Similarly, when analyzing the public mental health system of Guatemala with a historical lens, it becomes clear that mental health continues to be used against the civilian population. During the internal armed conflict, trauma was used as a weapon, now the weapon of war is the lack of response to the mental health needs of the population either by action—through the violence of “care”—or inaction—ignoring the demand for services. This abuse of Guatemalans needing and/or accessing public mental health services is perpetuated by the state through the Federico Mora Hospital. As a technology of power (Rose, 1999), this abuse further normalizes state terror in everyday life because it uses torture as a practice of mental health care.

Second, the avoidance of accessing the Federico Mora by other organizations reveals that it is the lack of mental health policies that benefit the hospital. In fact, because the country has not ratified national guidelines, policies, or jurisdiction protecting the rights of psychiatrically dis/abled individuals, organizations develop their own internal guidelines. These internal guidelines allow organizations providing mental health services to prohibit referrals to the Federico Mora, successfully circumventing the hospital. And, thus, exemplifying how a lack of national protocols that involve the Federico Mora Hospital absolves the hospital from the responsibility of providing mental health services.
Third, the Federico Mora has been operating with apathy since its creation with the merger of the two hospitals in 1982 at the height of *la Violencia*. The double-bind of inflicting trauma as a form of oppression and the inadequacy of public mental health services assures a long-lasting grasp on the population. *La Violencia* refers to a violent period of repressions during the Guatemalan internal armed conflict, from 1978 to 1984, in which psychological violence and sexual violence were used as warfare against the civilian population.

As the merger of both the Asylum F. Molina and the Federico Mora hospitals shows, efforts to provide community-based mental health services were actively stopped and the Federico Mora Hospital was used during the civil war as a technology of power. This “political decision of a dictator” assured that the asylum-type model of mental health “care” remained, while simultaneously using psychological violence as a weapon of war. In other words, the Federico Mora Hospital is a relic of both the colonial asylum model of psychiatric care and the internal armed conflict and, as such, operates as a detention facility meant to punish individuals persecuted by the state and/or individuals diagnosed with a psychiatric dis/ability. For example, the United Nations’ Committee against Torture (2018) stated that individuals detained at the Federico Mora Hospital are still being subjected to sexual and physical abuse. On May 8, 2020, Disability Rights International issued a letter to the Human Rights Commissioner in Geneva with an urgent call for the immediate release of all individuals institutionalized at the hospital for fear of “imminent risk of death” given the COVID-19 pandemic (DRI, 2020, p. 6), proving that inhumane practices of asylum care persist.

As this research has demonstrated, the Federico Mora Hospital is part of the colonial project and as such cannot be a model for mental health services, especially when other paradigms of mental health exist in the country. For example, the Maya cosmovision recognizes a set of mental illnesses (Chavez, Pol, Morales, & Barone, 2015). Yet, to this day, Ajq’ijab’ continue to be persecuted. Ajq’ijab’ are traditional therapists trained in the Mayan Cosmovision who are specialized in a variety of healing practices, and who continue to be persecuted. For example, Ajq’ij and Aj’ilonel (specialist in plant medicine) Tat Domingo Choc Ché was murdered on June 6, 2020 and was accused of being a “sorcerer” for practicing from his own cosmovision. The political repression toward healing practices and knowledge continues to demonstrate that mental health is political because trauma is and continues to be a tool of oppression and
repression. In this context, healing is an act of rebellion against these colonial legacies. As this work shows, in Guatemala, healing automatically entails the ability individuals have to recognize violence, which is why a repressive mental health system becomes a political strategy to preserve the naturalization of state terror.

**Conclusion**

Findings reveal that the public mental health system of Guatemala remains violently ineffective by: neglecting the demand for mental health services; circumventing the Federico Mora Hospital; and, continuing the practices established during the internal armed conflict. In other words, the mental health needs steaming from the trauma inflicted onto many Guatemalans during the war are ignored and in so doing the population is gaslit into normalizing the abuse of state terror. Because mental health is tied to healing from state violence, these services cannot come from the state. It is for these reasons I propose a paradigm shift where mental health becomes a teaching practice, specifically, one centered on teaching toward decoloniality.

The four pillars of liberation psychology are: (1) valuing all paradigms and theories of mental health, (2) understanding mental health as relational and therefore from a communal approach, (3) contextualizing trauma from a historical lens, and, (4) working toward social justice as an act of mental health. These pillars, together with the ten markers of teaching toward decoloniality, which are based on practice purposefully “decentering” western epistemologies, “reclaiming” Indigeneity and Indigenous knowledge and their histories, and “foregrounding” power relations (Carolissen & Duckett, 2018 p. 244) comprise of this teaching toward decoloniality model. Mental health as a teaching toward decoloniality practice can effectively respond to the demand for mental health services, while denaturalizing the violence of the public mental health care system. Learning about the history of violence in order to denaturalize state terror, centering local paradigms of mental health care, and becoming self-reflexive are avenues that can allow Guatemalans to heal from the trauma instilled during the internal armed conflict. Because of this history, healing is an act of liberation from state terror and state oppression. Moving away from the pathologization of oppressed groups (Carolissen & Duckett, 2018) is a first step toward creating a comprehensive mental health system that effectively supports the mental health and
healing process of Guatemalans and, in particular, those persecuted during the internal armed conflict, such as Maya Guatemalans and women.

**Note**

1. Also, please see Introduction for a longer conceptualization of the term dis/ability.

**References**

Aguilar, Y. (2019). Femestizajes Cuerpos y sexualidades racializados de ladinas-mestizas. F&G Editores Guatemala.

Ball, P., Kobrak, P., & Spirer H. F. (1999). *State violence in Guatemala, 1960–1996: A qualitative reflection*. Washington, DC: International Center for Human Rights Research, American Association for the Advancement of Science.

Butler, J. (1993). *Bodies that matter: On the discursive limits of ‘sex’*. New York, NY: Routledge.

Campbell, F. K. (2009). *Contours of ableism: The production of disability and abledness*. New York, NY: Palgrave Macmillan.

Carney, D., Jr., & Torrez, G. (2010). Precursors to femicide: Guatemalan women in a vortex of violence. *Latin American Research Review, 45*(3), 142–164.

Carolissen, R. L., & Duckett, P. S. (2018). Teaching toward decoloniality in community psychology and allied disciplines: Editorial introduction. *American Journal of Community Psychology, 62*(3–4), 241–249.

Casaús-Arzú, M. (2007). *Lineaje y Racismo* (3rd ed.). New York, NY: F&G Editores.

Chavez Alvarado, C., Pol Molares, F., Morales Panto, E., & Barone, P. (2015). *¿Tab’il Xane K’oqil? ¿Enfermedades o Consecuencias? Psicopatologías identificadas y tratadas por los terapeutas Maya K’iche* [edicion ilustrada]. Guatemala: Médicos Descalzos, Cholsamaj. Chinique, Quiché.

Coleborne, C. (2018). Madness uncontained. In J. M. Kilty & E. Dej (Eds.), *Containing madness: Gender and ‘psy’ in institutional contexts* (pp. v–vii). New York, NY: Palgrave Macmillan.

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research* (3rd Ed.). New York, NY: Sage.

Disability Rights International. (2012). *Solicitud de medidas cautelares a favor de las 334 personas con discapacidad mental internadas en el Hospital Federico Mora, en Guatemala, Guatemala*. Comisión Interamericana de Derechos Humanos.
Disability Rights International. (2020). *Urgent Appeal: Life-Threatening Institutionalization due to COVID 19 infection at the National Mental Health Hospital “Federico Mora” in Guatemala.* Comisión Interamericana de Derechos Humanos.

Fernando, S. (2003). *Cultural diversity, mental health and psychiatry: The struggle against racism.* Hove and New York: Brunner-Routledge.

Foucault, M. (2006). *History of madness* (J. Murphy & J. Khalfa, Trans.). New York, NY: Routledge.

Freire, P., & Macedo, D. P. (1987). *Literacy: Reading the word & the world.* New York, NY: Routledge & Kegan Paul.

Freire, P. (2000). *Pedagogy of the oppressed* (30th anniversary ed., p. 35). New York, NY: Continuum.

Hemphill, P. (2020). Healing, resilience, and power [Webinar]. www.frontlinewellnessnetwork.com.

Kohn, R., Ahsan Ali, A., Puac-Polanco, V., Figueroa, C., López-Soto, V., Morgan, K., Saldivia, S., … Vicente, B. (2018). Mental health in the Americas: An overview of the treatment gap. *Pan American Journal of Public Health, 42*(1).

Le Grange, L. (2016). Decolonising the university curriculum. *South African Journal of Higher Education, 30*(2), 1–12.

Liegghio, M. (2013). A denial of being: Psychiatrization as epistemic violence. In B. A. LeFrançios, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian mad studies* (pp. 122–129). Toronto, ON: Canadian Scholars’ Press.

López, V., & Cardona, S. (2010). *Encuesta Nacional de Salud Mental: Resumen Ejecutivo.* Ministro De Salud Pública, República de Guatemala.

Martín-Baró, I. (1989/1994). *Writings for a liberation psychology.* Cambridge, MA: Harvard University Press.

Mascayano, F., Tapia, T., Schilling, S., Alvarado, R., Tapia, E., Lips, W., & Yang, L. H. (2016). Stigma toward mental illness in Latin America and the Caribbean: A systematic review. *Revista Brasileira de Psiquiatria, 38*(1), 73–85.

Menjívar, C. (2011). *Enduring violence: Ladina women’s lives in Guatemala.* Berkeley, CA: University of California Press.

Oficina de Derechos Humanos del Azorbispado de Guatemala-ODHAG. (1998). *Guatemala Nunca Mas! Guatemala: Never Again! Archdiocese of Guatemala.* Organización Panamericana de la Salud (PAHO). (2014). *Datos Claves de Salud Mental.* https://www.paho.org/es/temas/salud-mental.

Petersen, E. B., & Millei, Z. (2016). Introduction. In E. B. Petersen & Z. Millei (Eds.), *Interrupting the psy-disciplines in education* (pp. 1–12). New York, NY: Palgrave Macmillan.
Puac-Polanco, V. D., Lopez-Soto, A. V., Kohn, R., Xie, D., Richmond, S. T., & Branas, C. C. (2015). Previous violent events and mental health outcomes in Guatemala. *American Journal of Public Health, 105*(4).

Quijano, A. (2000). *Coloniality of power, Eurocentrism, and Latin America. Nepantla: Views from South*. Durham, NC: Duke University Press.

Rose, N. (1999). *Governing the soul: The shaping of the private self*. London: Routledge.

Sanford, V. (2008). From genocide to femincide: Impunity and human rights in twenty-first century guatemala. *Journal of Human Rights*. 104–122.

Taracena, A. (2002). *Etnicidad, estado y nación*. Centro de Investigaciones Regionales de Mesoamérica, Antigua Guatemala.

Thorneycroft, R. (2020). Crip theory and mad studies: Intersections and points of departure. *Canadian Journal of Disability Studies, 9*(1), 91–121.

United Nations. (2018). *Convention against torture and other cruel, inhuman or degrading treatment or punishment*. Concluding Observation on the Seventh Periodic Report of Guatemala.

Yang, L. H., Kleinman, A., Link, B. G., Phelan, J. C., Lee, S., & Good, B. (2007). Culture and stigma: Adding moral experience to stigma theory. *Social Science and Medicine, 64*(7), 1524–1535.

World Health Organization (WHO). (2001). *The world health report 2001—Mental health: New understanding, new hope*. Geneva, Switzerland.

World Health Organization-Assessment Instrument for Mental Health Systems. (2011). Report on Mental Health System in Guatemala. https://www.mindbank.info/item/2089.