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Mental Illness and Recovery in the Western Highlands of Guatemala

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Across the globe, worsening social and economic conditions are intensifying the suffering of the mentally ill. This dynamic is all too clear in contemporary Latin America, where many residents face political turmoil, ethnic marginalization, and economic and social oppression by elites. This mixture results in poor and often detrimental living conditions for the mentally ill. While adequate healthcare is officially declared a human right throughout Latin America (PAHO 2008), local governments typically dedicate only 2% of their overall health budget to mental health care (Alarcón 2003). The majority of professional services and resources are concentrated in urban areas, leaving close to 45% of the total population medically underserved (Alarcón 2003; Alarcón and Gaxiola 2000; Rodriguez et al. 2007). Some underserved communities find alternate means to cope with illness and demonstrate resiliency through innovative, grassroots approaches (e.g., Foxen 2007). More often than not, however, communities are at a loss with lack of resources, and mentally ill community members are continuously pushed to the margins of society.

In this paper, I present some of the challenges faced by the mentally ill in Panajachel, an indigenous Maya town in the Western Highlands of Guatemala. Based on 15 months of fieldwork that I conducted in Panajachel, I will present the actual situation of mental health services as noted by archival research, local medical professionals, and observations of patient-provider interactions. Through survey data, I will also present the current mental health needs of Panajachelenses. These data will be situated with examples of individual and family member experiences of seeking adequate mental health care and confronting institutional barriers. I will end with a discussion on how mentally ill residents of Panajachel continue to fall victim to the structural violence implicit in the low prioritization of mental health care and the historical violence aimed at indigenous Guatemalans.

Structural Violence Within the State of Mental Health in Guatemala

In a recent national survey conducted by the University of San Carlos in Guatemala, 27.8% of Guatemalans suffer from mental health disorders (USAC 2009). Potential reasons for such high rates of mental illness include conditions of social violence and insecurity, after-effects of political violence...
during the armed conflict, extreme conditions of poverty, and high rates of social fragmentation primarily caused by the 36-year long civil war. The most prevalent condition, post-traumatic stress disorder (PTSD), was found in 6.9% of the population (USAC 2009). The study does not indicate if traumatic events related to the civil war were the most common stressors or if more recent personal traumas are the primary indicators. Gender-based analysis show higher rates of mental illness in women; they are most likely to suffer from an anxiety disorder (USAC 2009). Suicidal ideation was found in 5% of the sample, of which 56% had previously attempted suicide (USAC 2009). Given the high rates of mental health disorders in Guatemala, only 2.3% of the mentally ill seek any kind of professional help (USAC 2009). This includes seeing a psychiatrist, medical doctor, or spiritual guide. Curanderos, common non-biomedical healing practitioners for medical illnesses, while included as an option in the survey were not reported as a mental health care resource (USAC 2009). There are no explanatory data reported for the low level of care-seeking behavior.

The Ministry of Health has officially designated mental health care as a priority, yet it ranks 10th on the list of priorities (PDH 2010). There is one state-run hospital in Guatemala specializing in psychiatric care: El Hospital Nacional de Salud Mental (The National Hospital of Mental Health). This hospital receives the smallest budget for any branch of the national health system (PDH 2010), and it is consistently reported as insufficient (PDH 2010). Moreover, the majority of human rights violations reported to the Procurador de los Derechos Humanos (Attorney for Human Rights Offices) are in direct reference to this hospital. These reports indicate safety abuses by personnel, inadequate patient nutrition, insufficient availability of medications, deteriorating equipment, and general inadequate conditions (PDH 2010). The Procurador de los Derechos Humanos recommends that the treatment and conditions of the hospital be reviewed and defined to meet the basic respect of human rights and to give proper training to the medical staff, which reportedly is all under qualified (PDH 2010). However, the Procurador de los Derechos Humanos do not have authoritative power to ensure that recommendations are being implemented, leaving them as pure lip service. With the recent 2011 elections, presidential candidate
debates on health focused on issues of child nutrition and maternal health, neglecting mental health care entirely. As such, mental health care remains a low budgetary and political priority.

Local Mental Health Needs

While the national survey is helpful to understand general conditions in Guatemala, Panajachel does not fit neatly within the statistics. Panajachel provides a particularly interesting study site due to its pivotal status as a primary tourist destination, where economic opportunities transcend cultural norms and provoke social tensions between foreigners and locals. These tensions are further compounded by a politically violent history that promoted the marginalization of local people. Current social violence, primarily connected to alcoholism and increasing drug use, contributes to further disintegration of ethnic identities and familial connectedness. Economic inequalities and a decrease in social cohesion combine to promote an environment of structural violence and insecurity. This psychosocial environment increases the potential for the expression of mental illness by those who may be neurologically vulnerable.

After conducting preliminary interviews with medical professionals and lay community members, I derived a diagnostic survey from the Mini International Neuropsychiatric Interview (MINI) (Sheehan et al. 1998). Medical professionals commonly cited three primary mental health disorders as the most prevalent in Panajachel: depression, anxiety, and alcoholism. Two medical professionals also cited cases of anorexia and bulimia nervosa as emerging mental health concerns as a consequence of a globalizing economy. In contrast to the professional view on mental illness, community members view the primary mental health disorders based on personal experiences rather than frequency of observed cases. For example, a recovering alcoholic with narcissistic tendencies identified narcissism as being the primary mental health issue in the region. According to him, todos creen que son estrellas (everyone thinks they are a star). While egotism was often considered a major contributing factor to general familial and social disturbances, no other interviewee considered it to be a primary mental health issue.

Based on interview responses and the reported USAC results, I tested for the following mental health disorders: Major Depressive Episode, Suicidality, Manic Episode, Panic Disorder, Agoraphobia, Social Anxiety Disorder, Obsessive-Compulsive Disorder, Post-Traumatic Stress Disorder, Alcohol
Dependence and Abuse, Substance Dependence and Abuse, Psychotic Disorders, Anorexia Nervosa, Bulimia Nervosa, Generalized Anxiety Disorder, and Antisocial Personality Disorder. Three local research assistants were employed to assist with the administration of the survey. This ensured that a broad cross-section of the population was interviewed and with greater response reliability due to already established rapport. A total of 375 community members were surveyed. Overall survey results showed a 39.1% prevalence rate of mental illness based on diagnostic questions and self-report. Due to informed consent parameters and accessibility issues, community members with an active severe mental illness, such as a psychotic disorder, were not interviewed.

Of the 375 individuals interviewed, alcohol abuse and dependence (14.29%) is the most prevalent mental health issue in Panajachel. The national survey showed an alcohol abuse rate of 5.20%. Reasons for such drastic differences include poor economic and social conditions found in rural regions of the country and are explored further in my dissertation. Survey results also showed a prevalence rate of 1.19% for PTSD. The lower prevalence of this disorder from the national level (6.9%) could be due to the fact that, while violent acts still occurred, Panajachel remained a relatively neutral presence in the middle of the armed conflict (Hinshaw 1988). Recent security movements to combat local kidnapping and extortion rings may also provide an empowering coping mechanism for individuals who have suffered a socially violent traumatic event. Rates of depression were equal among men and women at 4.48%. Men were slightly more likely to suffer from anxiety than women at 4.76% and 3.57%, respectively. This also indicates that depression is slightly more prevalent than anxiety in Panajachel women. Overall suicidal ideation rate was at 12.84%. This is significantly higher than what is reported in the USAC study (5%). In this present study, suicidal risk rankings were at low risk 6.27%, moderate risk 2.09%, and high risk 4.48%, of which 54% included a previous suicide attempt. Further studies are necessary to explore reasons for such high rates of suicidal ideation. Less than 1% of those surveyed had ever received treatment or counseling of any kind for mental health issues.

Experiencing Barriers to Mental Health Care

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Similar to the national situation, available mental health care resources in Panajachel are scarce for poor community members. Based on interviews, mental health care is situated within four different institutions: the local general hospital and biomedical system, pharmacies, medical mission trips and non-governmental organizations (NGO), and religious institutions. While some people interviewed mentioned going to a curandero or Mayan spiritualist for their mental health needs, they all reported these attempts as unsuccessful and ultimately sought care elsewhere.

- **The General Hospital and Biomedical System**

  Healthcare practices in Panajachel have overwhelmingly shifted to biomedical services. However, fear of discrimination makes the local general hospital and public health center a last resort for most indigenous people. Yet the only public mental health professional for the whole region can be found at the general hospital, usually only during typical work hours for patients. Psychology students at the stage of licenciatura (roughly equivalent to a bachelor’s degree) have on occasion conducted their practice experience hours at the local public health center. However, the clinic director indicates that students are more likely to complete their hours in an urban psychology center where there is more potential to be hired on afterward. Officials in the public health department do not foresee hiring a psychologist on a permanent basis (personal interviews). In the afternoons, a psychiatrist does hold office hours in town and charges anywhere from 200-300 Quetzales an hour, for a primarily foreign resident patient base. A private psychologist clinic did open in early 2011. However, the clinic is often found closed, and informants indicate that the 100Q hourly fee is too much given that a treatment program usually consists of a minimum of six hours in a relatively short time period.

  Given financial constraints to attend the local private clinics, the psychiatrist at the general hospital becomes the primary source for mental health care in Panajachel. Yet the experience of seeking care at the general hospital receives mixed responses from those interviewed. Sara vi provides a seemingly positive example of when she went to the hospital complaining of headaches. When she explained that her headaches were worse when her alcoholic husband returned home, the triage nurse automatically referred her to the psychiatrist. He ultimately diagnosed her with stress-induced headaches due to coping
with an alcoholic husband. He wrote her a prescription for an anti-anxiety medication, and after a several month regimen, she began to feel better. She is no longer taking the medication, and she can feel her ansiedad (anxiety) growing. Here, her positive experiences with the biomedical care system shifts to the more common story: a change in her employment prevents her from going to the hospital during regular attending hours, and since separating from her husband, she can no longer afford her medication.

As a further example of the typical experience, Gustavo shared with me his struggles with attempting to access adequate care. Over a six month period, he went to the general hospital nearly once a month. His chief complaint was radiating abdominal pain coupled with numbing and tingling sensations in his extremities. During a couple of visits, he also complained of pain starting in the base of his skull and radiating to the middle of his forehead. Each visit he was referred to the gastroenterologist only and diagnosed with nervous gastritis. During my interviews with Gustavo, we decided to go to the hospital together to specifically meet with the psychiatrist to address Gustavo’s nervios (nerves). When we reached the front reception desk, Gustavo turned to me for help when the receptionist did not appear to understand what he meant when he asked to see el medico de los nervios (the nerves doctor), a moniker commonly used for the psychiatrist according to the psychiatrist himself (personal interview). I jumped in saying the psychiatrist, and she eventually gave us the permission to enter the waiting room. After approximately five minutes with the psychiatrist, Gustavo was diagnosed with general anxiety disorder. At the time of this writing, he continues to take his prescribed medication and reports significant improvement in his quality of life. He also firmly believes that he would never have been able to maneuver the hospital system on his own to see the psychiatrist.

Incidentally, the majority of people interviewed (~98%) stated that they did not know that there were any psychological/psychiatric services at the hospital. In general, the public hospital was avoided because of the perception that discriminating nurses and physicians provided poor quality of care to indigenous Maya patients. Lack of both human and material resources, including necessary medications, also made going to the hospital seem like wasted time. Inexpensive private clinic physicians, pharmacies, and medical mission trips based through NGO’s help to fill in some biomedical treatment gaps for general
health concerns. Nonetheless, all private clinic physicians interviewed (n=7) acknowledged that they did not feel comfortable addressing psychological/psychiatric issues. Pharmacies and medical mission trips are also limited in psychological/psychiatric services as will be discussed below.

- **Pharmacies**

Throughout Latin America, pharmacies often provide the first line of biomedical treatment. Many pharmacists are also medical doctors that have received their licenciatura. However, none of the pharmacists in Panajachel has received extensive training in psychotropic medications. Moreover, small pharmacies are often family run businesses where a non-licensed relative who is only familiar with the most common medications may be attending.

I interviewed two pharmacists who worked at different pharmacies. Both estimated that psychotropic medication sales made up less than 5% of total sales. More often than not, it was foreign tourists who came in looking for specific medications, such as Valium and Xanax. However, local residents frequently complained of sleeping troubles, and sleeping pills made up close to 50% of the most common medications administered to local residents. For patients who may come in with a prescription from the psychiatrist, the local discount pharmacy stores do not keep many psychotropic medications in stock, making it difficult to adhere to a continuous regimen.

According to one of the pharmacists, most major mental health issues were often considered a spiritual problem, not necessarily medical, and were often resolved in the church. This sentiment was repeated by other community members interviewed; however, interviewees that endorsed some form of psychological distress did not consider it to be a spiritual problem. For these people, the church was not an appropriate mechanism for treatment. No specific cases were presented where this particular pharmacist or any others who promote spiritual treatment for mental illness created a barrier to accessing pharmaceutical care. Limited information on available medications and limited economic resources for medications are more common barriers to accessing pharmaceutical care.

- **Medical Mission Trips and NGO’s**
NGO’s function in the region to help fill certain gaps by providing needed services and resources, such as scholarships for children, business opportunities for women, and low-cost medical services. The NGO medical services provided in Panajachel are primarily in the form of medical mission groups that partner with local organizations. Unfortunately, these services are generally limited to basic medical and/or surgical needs. These groups are primarily foreign, non-Spanish speaking medical professionals. Language barriers coupled with the short-term nature of these trips hinders the incorporation of adequate mental health care into the mission objective.

At the time of this writing, there is no known organization in Panajachel or the surrounding region that has mental health as a primary component of their mission statement. Given the high rates of mental illness nationally, this is a major shortcoming in the non-governmental network of organizations. While one organization does have a psychologist on call to work with women in domestic abuse cases, their primary objective is to provide legal counseling and services to encourage women to press charges against their abusers. One faith-based NGO in Panajachel often provides financial support for alcoholics and drug addicts wanting to enter into a rehabilitation center. However, their primary purpose is to build houses for low-resource families, and none of the current or past staff members have had experience working with alcoholic or addict populations. As such, the director of the organization recognizes that the assistance they are able to provide is limited and falls short of being successful due to the lack of follow-up services once an individual leaves the rehab center.

- Religious Institutions

Religious institutions and faith-based organizations are often cited by community members and in the literature to provide spiritual healing for physical and mental ailments. While most everyone interviewed agreed that church attendance and spiritual development were necessary to maintain overall health, psychologically distressed individuals and their family members did not support the notion that the church was an adequate source of treatment. In some cases, the treatment of the mentally ill within the church was perceived to be more discouraging than helpful. For example, Maria is a 27-year old who has been suffering from schizophrenia for over ten years. According to her father Tobias, Maria’s mother
went to one of the largest Evangelical churches in Panajachel to seek spiritual guidance for her daughter. Maria's mother was told that she and her husband were sinners and being punished by God. According to the pastor, Maria would not recover until her parents developed a better relationship with God. A mixture of pain and sorrow flash through his eyes when Tobias retells the story. "How could they say that to her?" he asks. His wife is *una gran mujer, muy trabajadora* (a great woman, hard working), who does not drink or have any vices. His wife did not leave the house for several days after that encounter due to the shame she felt, and she no longer turns to the church for her children's health needs.

**Discussion**

High rates of mental illness endorsed by survey data and limited availability of professional services clearly depict the need for more adequate mental health services. Experiential data reflecting barriers to care indicate the desire for professional services and begin to expose the suffering responses as individuals negotiate health care systems to improve their mental states. The failure of authorities to respond to known abuses and shortcomings in the public health system reflects the continued structural violence perpetrated by the state toward poor Guatemalans, particularly in rural, indigenous communities like Panajachel.

The recommendations of national and international health and human rights organizations should not remain just on paper. There is an ethical responsibility to ensure that treatment objectives are being met appropriately within a human rights framework. With the recent election of the first military president since the signing of the Peace Accords in 1996, the future for health and human rights remains unclear. *El General* (The General), as President Otto Perez Molina is commonly referred to, ran on a platform to bring security from increasing drug and gang related violence. Nevertheless, he continues to deny that genocide ever occurred during the time of the civil war, making it difficult to appreciate what costs and what lengths will be taken to provide this increase in security. His direct involvement in military operations against indigenous communities during the civil war cause fear in many rural communities that there will be a return to the days of *La Violencia* (The Violence), where neighbors turned on neighbors and death squads were a common physical and mental health threat.
The mental health effects of the civil war are still being felt, not only through the diagnosable mental illnesses but also through the disintegrating social cohesion. Indeed, a primary objective of the civil war was to break community bonds so that civilians would report any guerilla actions being taken by their neighbors. This lasting effect in social fragmentation may be a contributing factor to the feelings of desperation and solitude commonly noted in suicidal ideation. These continued mental health issues, as well as emerging ones from current social violence and increasing globalized economies, need to be addressed to ensure the mental well-being and improved quality of life for all Guatemalans.

In Panajachel, of greatest concern are the significantly higher rates of alcohol abuse and suicidality than at the national level. Considering the high degrees of suicidal ideation, barriers to care can have a devastating impact on someone who is in an active crisis. Professional services need to be made readily available through public health centers and at an affordable cost within the private arena. Pharmaceutical therapies need to also be made consistently available and more affordable. NGOs and medical mission trips should further consider filling in this treatment gap to provide greater success in meeting their other objectives. Community education programs should be targeted to private physicians, pharmacists, spiritual and religious guides, as well as lay community members, to decrease stigmatization and increase understanding and adequate care.

\[^1\] For the purposes of this paper, structural violence is defined as the indirect or systemic violence of social orders that propagate oppressive conditions (Galtung 1969).

\[^{ii}\] As a basis for comparison, the US has a reported prevalence rate of 27% (Peking 2009).

\[^{iii}\] These are no doubt important health factors that need to be addressed. Guatemala continues to have significantly high rates of infant and maternal mortality, even though several initiatives have been funded to combat these rates. The mismanagement of funds by both governmental and non-governmental institutions is a major concern for the health of the nation. Local leaders interviewed suggest that less than 20% of funds designated for social projects go to the actual project itself.

\[^{iv}\] For validation purposes, the MINI Entrevista Neuropsiquiatrica Internacional, Spanish version 5.0.0, translated by Ferrando et al. was used.

\[^{v}\] The equivalent to approximately $25-37.50 at 8 quetzales to the dollar. This also equates to approximately one-third the monthly salary of the average employed Panajachelense.

\[^{vi}\] All names have been changed to protect confidentiality.

\[^{vii}\] This confirmed the diagnosis of anxiety that was endorsed in his survey.

\[^{viii}\] The psychiatrist has been attending at the general hospital for approximately three years.
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