State of Terror, States of Mind:
Ladinas, Mental Health and Systems of Care, in Guatemala City

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Dedication

I want to dedicate this work to the women in my family that have been oppressed by violence and categories of mental illness. I have witness how such powers have deemed their light and I carry their sorrow with me, as it gives me strength and direction. In particular, this work is dedicated to my mother, who fought against the mental health care system of Guatemala and whose struggle opened my eyes to this problem and whose strength drove this research. Also, to my aunt Chantal whose name and freckles I borrow, my uncle Miguel, for TaJulie and Adam, close members of my family and friends who have taken their lives, know that your shine remains bright in my life and directs my path. To my ancestors who have been erased by the stigma of mental illness, this is for you.

Abstract

This ethnography conducted in Guatemala City from October 2012 to April 2013 is based on in-depth interviews of mental health professional and women rights advocates, and the *testimonio*s of Silvia and Teresa, two Ladinas having been diagnosed with a mental illness and having been interned in the system of care. This research brings to light the discrimination of mental health in a context of state terror. I critique the categories of mental illness and call instead to understand them as mental health needs in a context of acute everyday violence of post-peace accords Guatemala. The interviews provide the political context of in which the high demand for mental health services is met with a lack of investment in the mental health field and a neglect of policy and legislation. The *testimonios* of Teresa and Silvia give voice to the gender violence that leads Ladinas' to express mental health needs and the ways in which the system of care perpetrates this violence. I argue that the mental health care system is part of the mechanism of feminicide that discredits and silences Ladinas to secure the impunity of the state. Concluding with the finding that expressing a mental health need in Guatemala is related to the ability to exercise citizenship rights, I call for the development of a gendered citizenship project in order to resist state terror and promote mental health.

Key words: *mental health, mental illness, state terror, stigma, citizenship, Ladina, Guatemala City*

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List of Abbreviations

AIMS: Assessment Instrument for Mental Health Systems

AVANCSO: Asociación Para el Avance de las Ciencias Sociales en Guatemala

CANG: Colegio de Abogados y Notarios de Guatemala

CIDE: Comparative and International Development Education

COPREDHE: La Comisión Presidencial Coordinadora de la Política del Ejecutivo en materia de Derechos Humanos

DRI: Disability Rights International

GGM: Grupo Guatemalteco de Mujeres

IEMS: El Instrumento de Evaluación para Sistemas de Salud Mental

IGSS Instituto Guatemalteco de Seguridad

NMHP: National Mental Health Policy 2007-2020

ODHAG: Organización de Derechos Humanos del Arzobispado de Guatemala

OMS: Organización Mundial de la Salud

OPS: Organización Panamericana de la Salud

PAHO: Pan American Health Organization

PDH: Procurador de Derechos Humanos

PNUD: Programa de las Naciones Unidas para el Desarrollo

PTSD: Post-Traumatic Stress Disorder

REMHI: Proyecto Interdiocesano de Recuperación de la Memoria Histórica

WHO: World Health Organization

Glossary of Terms

Ladina:	Referring to a particular ethnic identity of Guatemalans identifying as non-Mayan. Ladina is a Spanish word and therefore is gendered: Ladina (women) Ladino (men).
Violentizar:	The act of enacting violence onto someone, to *violence* someone.
Desaparecidos:	Political term for the forced disappearances that happen in Latin America under authoritarian dictatorships.
La Violencia:	The most violent period of repressions during the Guatemalan Civil War from 1978 to 1984.
Marianismo:	The cultural Latin American characteristic that assumes the spiritual superiority of women based on the expectation to emulate the Blessed Virgin Mother and that understand women's identity in an essentializing virgin or whore dichotomized.
Testimonios:	Latin American genre similar to life stories but with the political purpose of emancipation by letting the voices of oppressed people speak in resistance

Chapter I

Introduction

"Maldita sea la exitosa dictadura del miedo que nos obliga a creer que la realidad es intocable y la solidaridad es una enfermedad mortal, porque el prójimo siempre es una amenaza y nunca una promesa."

"Damned be the successful dictatorship of fear that makes us believe that reality is untouchable and solidarity is a mortal illness, because our neighbor is always a threat and never a promise."

Eduardo Galeano, February 22nd, 2011

Ladinas' Mental Health in Post-Peace Accords Guatemala.

In Latin America, research often correlates violence and inequality with high occurrence of mental illness (Pedersen, 2010). In Guatemala, which has previously been ranked as the number one most dangerous region in the world (Lopez & Cardona, 2010; UNICEF, 2011) has an estimated 35% of adults considered mentally ill (PanAmerican Health Organization, 2009; Lopez & Cardona, 2010). However, medicalized conceptualizations of mental illness make diagnoses on individuals without referencing the environment in which mental health is constructed (Cía, Córdoba Rojas & Abib Adad, 2010; Martín-Baró, 1989). Even though peace accords ended the Guatemalan civil war, violence is rampant and continues. The continuity of violence, alongside the diagnosis of mental illness, means that (Godoy-Paíz, 2010) medicalized conceptualizations of mental illness need to be challenged and rethought.

There is insufficient research to understand the relationship between mental illness and the social environment of an individual (Yen & Syme, 1999), such as that of

acute violence. In fact, research that attempts to investigate causation between genetic antecedents to mental illness and environments has proven it difficult to isolate one particular cause (Poland and Caplan, 1995; Moffitt, Caspi & Rutter, 2005; Jaffee, Strait & Odgers, 2012). Furthermore, as Conrad and Schneider (1992) have explained, the medicalization of distress is a socially constructed process that creates categories of illness. The medicalization of mental illness allows power structures such as care institutions, to define and give meaning to a certain class of events. These events are dependent on the rules imposed by cultural values and social norms of particular society during specific point in time (Linder, 2004). As such, categories of illness are dropped, changed or added. The most recent example is the questioning of the reliability of the Diagnostic and Statistical Manual of Mental Disorders' 5th edition (DSM-V) by the new director of the National Institute of Mental Health (NIMH). NIMH's questioning of the manual led to the creation of the Research Domain Criteria (RDoc). As a new research framework, the RDoc has been developed in order to introduce categories of illnesses rooted in neuroscience behavior rather than defining these categories and looking for behaviors that fit into them. The RDoc's success lead to the defunding of psychiatric research based on the categories imposed by the DSM-V (http://www.nimh.nih.gov/research-priorities/rdoc/nimh-research-domain-criteria-rdoc.shtml). This call to transform diagnosis with a new classification system based on behavioral neuroscience illustrates how mental illness is in fact a social construct subject to change on the basis of continuous research findings. Another example of categories of mental illness as social constructs is the International Statistical Classification of Diseases and Related Health Problems (ICD) that covers categories of mental illness in

193 countries (http://www.apa.org/monitor/2009/10/diagnosis.aspx). These examples illustrate that categories of mental illness as social constructs become a form of social control, one that enacts power relations that dictates the symptoms and behaviors of diagnosed individuals. Linder (2004) notes that "members of a group in structurally dependent positions endure this invasive form of medicalization more often than members of groups that possess greater social resources" (p. 4). Understanding mental illness as a form of social control is particularly poignant in the context of Guatemala. In Guatemala, medical diagnosis facilitates more overtly coercive social control functions for marginalized groups. For instance, when an individual presents a behavior classified as deviant by the norm, this individual can very easily be diagnosed with a mental illness. For example, during my observations of the mental health hospital Federico Mora, doctors explained that most patients where interned by judicial orders, one of these patients was a prostitute that was sent to the hospital because she was deemed as deviant. Conrad and Schneider (1992), have identified the power relations behind diagnoses: the power a structure of care has on placing a label of deviance onto an individual rather than caring for a health concern. Within the Guatemalan context of state terror violence, the conceptualization of illness as a tool of social control reveals the ways in which violence further oppresses Ladinas, who, while expressing a mental health need, may be labeled as mentally ill and be further subjugated to maltreatment just by the fact that they are women who are susceptible to discrimination.

Throughout this dissertation, I argue that importing medicalized conceptualizations of mental illness enables everyday post-peace accords violence to continue to target women. Thus, I will refrain from using the term "illness" or "disorder"

and rather concentrate on describing mental health *needs*. In so doing, I displace the responsibility of "illness" from the individual during the Guatemalan post-peace accord context. Similar to the ways in which liberation psychology critiques understandings of "illness" that further reproduce oppressive structures by locating trauma and suffering solely within the individual, without a recognition of the history of terror and the structures of oppression that mark Latin American countries (Martín-Baró, 1989), I understand mental health as a relational process. Because defining a mental disorder involves "specifying features of human experience that demarcate where normality shades into abnormality" (Kutchins and Kirk, 1992, p27), liberation psychology allows me to trouble the demarcations of normal and abnormal. In the Guatemalan context, the lens of liberation psychology exposes the ways in which state terror in the field of mental health is normalized. This dissertation, thus, discusses mental health needs and disassociates itself with mental health "illnesses" in order to move away from discourses that further normalize violence. I draw on liberation psychology to continue to support people that have been oppressed through the exposure of everyday forms of state terror in the hopes to reach a critical awareness of that replaces understandings of mental "illnesses" with that of mental health "needs." Thus, for this dissertation, I build on Martín-Baró's own definition of mental health as,

> a dimension of the relations between persons and groups more than an individual state, even though this dimension may take root differently in the body of each of the individuals involved on this relationship, thereby producing a diversity of manifestations 'symptoms' and states 'syndromes' (1989, p. 109).

Because Ladinas in Guatemala are marginalized and continue to be targeted both by violence and diagnoses of mental "illness" (PAHO, 2009), it is important to locate mental health within the 'relations between persons and groups.' As a relational process, this dissertation explicates the mechanisms of state terror that enable violence to be committed under the disguise of mental health care.

Guatemala today is known as a post-conflict society; the expression *post-conflict* can be understood as a break in violence. However, even post-conflict Guatemala suffers from continued violence as a result of the long fought civil war. In order to give name to an era that is violent even in its post-conflict time, I refer to Guatemala as a post-peace accords society. This is a way to mark the change between conflict and peacetime Guatemala while simultaneously capturing the continuation of state terror. In fact, the violence used during the war was targeted towards rural women in order to affect and disrupt community life. The government however, has silenced this history, and a lack of historical memory destroys the capacity of subsequent generations to culturally affirm themselves (Lykes, 2000). Today, in post-peace accord Guatemala, rapes, domestic violence, and homicide are to be considered as a continuation of the tools of war introduced during the civil war. In fact, during this time, the body of women was used to terrorize entire communities, through violent gang rapes of Mayan women, amputation of their pregnant bellies, and other forms of sexual violence, the army was able to perpetrate its authority through terror (Oficina de Derechos Humanos del Azorbispado de Guatemala-ODHAG, 1998). Because women were more likely then man to survive these brutal acts, in post-peace accord Guatemala, state terror continues to dictate women's inter and intra- personal relationships and therefore their construction of

mental health. One drastic difference though is that violence has shifted geographically and now targets women living in *urban* spaces (O'Neil & Thomas 2011; Sanford, 2008). Because only recently have scholars written about the violence that now affects urban post-conflict countries, research of trauma and violence have been in the majority kept within the rural realm.

This shift of violence from rural to urban spaces was a major factor in deciding to only include Ladina women in this study. Research on the mental health of Maya women having been affected by the civil war has been highly documented by scholars such as Briton Lykes (1991, 1998, 1999, 2003, 2007, 2010), however there is little research to elucidate how the violence committed during the civil war and the on-going violence in post-peace accords Guatemala affects Ladinas living in urban Guatemala. Yet, Guatemala City is the only city of Guatemala that houses a public mental health hospital – the Federico Mora and the capital of Guatemala has also the largest concentration of ladino population, therefore, researching the Ladina experience in Guatemala City was the most representative of the population that would have access to the mental health care system.

Ladina identity has been understood as the most privileged in Guatemalan identity politics, however the work of Menjívar (2011) illustrates the nuances of Ladinidad and the ways in which poverty and everyday violence also shapes Ladina identity. In addition, as a Ladina myself, I could not ethically interview Mayan women about their mental health without it being a violent and potentially traumatizing act. In fact, although Guatemala has a multicultural, multilingual society composed of twenty-three linguistic communities (cia.gov, 2012), identity politics have historically dichtomizes national identities. Thus, of the 14 million inhabitants, 40.3% are identified

as Maya and 59.4% as Ladino (cia.gov, 2012). This binary cannot account for the complexity of the cultural makeup of Guatemala: the term Maya encompasses the 21 different indigenous ethnicities while Ladino refers to a Guatemalan with a mix Mayan and European (mainly Spanish) heritage. However, during the war, based on this fundamental dichotomy between Maya and Ladino that parallels the dichotomy between poor and rich, the dynamics of Ladina-Maya relations were intentionally manipulated by the army (Adams, 1964; Nelson, 1999). Thus, as a Ladina scholar I could not develop researcher and participant dynamics without reflecting the power relations of the already racialized identity politics embedded in Mayan and Ladinoness. Although I did not feel I was in the position to research the mental health of Mayan women because of my positionality as a Ladina women, and my lack of understanding of Mayan construction of mental health due to my isolated upbringing in Guatemala City and my inability to speak any of the 23 Mayan languages, I believe that and in-depth understanding of Ladina's experiences provides one important piece to understand how the mental health care system normalizes state terror because all identities in Guatemala have been formed *in relation* to one another (Nelson, 1999). The Ladina experience, this research speaks to the intersections of the fluid articulation of identity. Ladinas are at the intersection of privilege, due to their ethnic identity as non-indigenous, (Taracena, 2002) and oppression, due to their gender (Sanford, 2008; Nelson, 1999). For example, analyzed through the lens of ethnicity, Guatemala is a Ladino state. Through the lens of class, many poor Ladinos have been "often violent excluded" from state decision-making (Nelson, 1999, p. 77). It is because of the assumptions that Ladino identity is entrenched in privilege and power, that Ladinas have remained at the margins of research (Cía, et.

al, 2010; Godoy-Paiz, 2011). Precisely because the needs of women in situations of state terror are overlooked, it is important to understand the experiences of violence from those deemed the most powerful and unaffected by oppression. In addition, as a Ladina scholar I look to contribute to this field of research from my own positionality that forms my experience and lens of the world. I invite and celebrate dialogue between Mayan and Ladina scholars, activist and educators in order to have a better understanding of the Guatemalan experience of mental health in a more complete and inclusive matter. Such as the binaries between "health" and "illness" are contested, the lens of feminist liberation psychology permits blurring other types of binaries in order to highlight the complexities of Guatemalan gendered identity politics and conceptualizations of mental health. In so doing, understandings of Ladina mental "illness" go beyond categories of identity and wellness to address the ways in which Guatemalan women are silenced, and restrained from a critical consciousness.

With this goal in mind, it is to be noted that this research does not include the experiences of the mental health care system of Ladino men. Although I interviewed Ladino mental health professionals and activist, and relied on the insider knowledge of Dan, the youngest Guatemalan having been diagnosed with bipolarity, I excluded the male perspective when trying to understand the experience of the mental health system, in particular because beyond Dan I was not able to recruit any other participants. I met Dan because at the time of my pilot study he was dating my cousin, and although he fit the categories of my research, I found it inappropriate to include him as a participant since I met him at first in the capacity of family. During the years Dan and my cousin became friends and I had established a friendship with Dan, we hung-out weekly during

my field work and it was through his experience of mental health care that I was able to contact participants for interviews and testimonios. However it became very obvious that men refused to come forward of follow up on the interviews and that the friendship I had develop with Dan was particular because of the family circumstances. For that reason, I decided to support my research with Dan's insights and cultural capital rather than center him as a participant. This decision, make this work focus solely on Ladinas experiences of the mental health system, and make my "gendered" understanding of mental health come from a female only perspective. Although when discussing broader policies implications I do include the perspective of Ladino mental health professionals and activist, the experiences remain exclusively centered on women identified Ladinas. It is to be noted, however, that I could not have done this work without the tremendous amount of insider information shared with me by Dan, a perspective that I look to focus on in future work.

Feminist liberation psychology renders trauma dialectic and provides the space to suggest that mental "illness" in post-peace accords contexts is a misrecognized mental health need. In other words, this perspective permits the understanding of trauma to be situated *in between* the environment and the individual and challenges the one-way process that projects an "illness" onto an individual, and separates such individual from a history *and* daily environment of violence. In this dissertation, I look to critically examine the construction of mental health in the specific environment of acute gender violence, by asking: How is mental health cared for and conceptualized in post-peace accords Guatemala City? In particular I ask, how does the Ladina experience of expressing a mental health need render a redefinition of mental health altogether?

Guatemala post-peace accords.

La Violencia, Guatemala City and State-Sponsored Terror.

The civil war shaped Guatemala City's present political and social landscape, which explains contemporary processes of violence. During the conflict violence moved to the countryside, and before 1960 the city itself was a space of confrontation (Godoy-Paiz, 2011). For example, the October 1944 revolution against dictator Úbico found its place among intellectuals that organized in the city, making it a place of politicization and therefore, state terror (Taracena, 2002). Violence during the initial years of the conflict was targeted toward Ladino activists living in the city before moving to indigenous communities in the countryside (AVANCSO, 1992). The worst wave of repression was from 1978 to 1984, and was popularly named "la Violencia" or "the Violence" (AVANCSO, 1992).

During la Violencia from the 1970s to early 1980s, under the regime of General Efrain Rios Montt, military counterinsurgent tactics shifted towards violence against any person suspected to support the guerrillas (Smith, 1990). La Violencia, therefore, was characterized by a brutal governmental campaign against Ladino intellectuals but also Mayan communities, including the complete destruction of more than 600 villages, the rape and torture of indigenous women and the creation of terror as a means to control the entire Guatemalan population (Historical Clarification Commission, 1999; ODHAG, 1998). This period saw high levels of state terror and repression as well as the psychological terror of the population. The culture of state terror was defined by *desaparecidos*, torture, death squads, and massacres that became common practices all over Latin America in the 1970s and 1980s (Godoy-Paiz, 2011). It is important to note that the Guatemalan state engaged in one of the bloodiest counterinsurgency campaigns

of the continent which saw organized violence as part of development strategies aimed at *modernizing* Guatemala (Godoy-Paiz, 2011). In other words, state terror became policy accompanied by systemic and structured production of terror justified through a discourse of development in which the killing of Mayan people would make for a modern and progressive society. Guatemala City as the site of the state apparatus played a significant role in these modernizing efforts. Today public mental health care institutions are still centralized in the city.

Although the fighting ceased in 1994, the thirty-six year long civil war officially came to an end through the signing of peace agreements on December 26th of 1996. A significant drive behind The Peace Accords was the stabilization of Guatemala's economy; thus, the peace accords were motivated more by Guatemala's participation in global economic markets, rather than human rights (Godoy-Paiz, 2011). Although the main purpose of The Peace Accord was to promote Guatemala's incorporation into the world, it also was the first official document to recognize the Maya people as part of a multicultural, multilingual Guatemala.

State-Sponsored gendered violence.

Of the 200,000 civilians killed during the war, 83 % of them were Maya and 17% were Ladinos (Sanford, 2008). With 95 % of the crimes of war committed by the Ladino military elite it was confirmed that the state was responsible for genocide (Sanford, 2008, p. 31). Analyzed by scholars such as Casaús-Arzu (2007) as more than a class-conflict, the horrific extent of the civil war was beyond genocide; it was also a strategy for the *subversion* of an entire country, which included the Ladina population (Nelson, 1999). Today, state terror implemented during the civil war still wounds Guatemalan identity

and cultural practices. For example, the newly established president of Guatemala, Otto Molina Perez, was the general in command during La Violencia. In fact, against the signatory of the Peace Accords, The General has undergone the remilitarization of the country even if in direct violation of this armistice. Also, the heightened killing of women, although now shifted toward urban spaces, (O'Neil & Thomas, 2011; Sanford, 2008) demonstrates how genocidal violence still marks Guatemalan post-peace accords society.

During the civil war specific forms of violence were used against women. Similarly to other Latin American countries where military dictatorships sponsored violence, women were more likely than men to survive, and therefore, face the burden of the psychological consequences of this violence (Lykes, 2000). As survivors, women also speak of resistance and resilience and, as a result, are still considered targets of violence (Lykes, 2000). Gender violence is used in this dissertation to refer to the *gender* disparities in power dynamics in society as well as *gendered* violence, meaning violent acts targeting women specifically. Both are deliberately used as a weapon of social control (Hammar, 1999; Mejivar, 2011) primarily through sexual torture of women and the systematic silencing of these acts (Lykes, Barbeck, Fems & Radan, 1993). For example, during the civil war the army was responsible for 99 % of the rapes committed against women (Guatemala Nunca Jamas, 1999). However, these crimes have yet to be brought to justice (Ertuk, 2005) as exemplified by the dismissal of a guilty verdict in the trial against Efrain Rios Montt and Marico Rodiguez Sanches in 2013 for genocide and crimes against humanity.

Within a sociopolitical and cultural context of patriarchy, women in Latin America are socialized into *marianismo* (Bunster-Burotto, 1986). *Marianismo* refers to the cultural characteristic that assumes the spiritual superiority of women based on the expectation to emulate the Blessed Virgin Mother (Bunster-Burotto, 1986). Marianismo, which goes hand in hand with *machismo,* presumes women's identity primarily as virgins and mothers (Lykes et al. 1993), in particular through "sacrifice, self denial and suffering" (Menjívar, 2011, p. 131). As it pertains to Ladinas, marianismo dictates that men control high culture, "the world of letter, politics, philosophy, modernity and the universal" and thus, reduces women to the body (Nelson, 1999, p. 193). This set of cultural and religious assumptions informs the use of gendered violence as a strategy to diffuse state terror in the society at large. For example, the level of cruelty in the atrocities committed against pregnant women and their babies in Argentina or in Guatemala illustrates how state power is asserted through control or manipulation of female bodies (REMHI-ODHAG, 1999; Lykes 1993). In other words, mass rape is used as a weapon of state terror against community and families that happens through the body of women. The purpose of gendered violence is to transform women's identities from "Madonna to whore" (Bunster-Burotto, 1986, p. 307). Through women's bodies and identities, the state's power is magnified while simultaneously exacerbating the already marginal position of women (Bunster 1986; Lykes et. al, 1993). Machista mechanisms of state-sponsored terror, thus repressive structures, not only place women and their bodies in the frontline as targets of attack but this violence is also an attack directed to women's masculine kin terrorizing the broader community (Lykes et. al, 1993).

As of 2013, although homicide rates have dropped, going from 46.3 in 2009 to

34.03 in 2013 per 10,000 inhabitants, the WHO still considers any homicide rate higher than 10 per 100,000 inhabitants as a public health concern (PNUD, 2013). This epidemic of violence still targets Guatemalan women in more sadistic ways than men. For example, although men are still murdered at double the rate than women, 19.05 % of women that have been killed have signs of torture compared to only 3.89 % of males (PDH, 2006). Further, a third of all women's bodies are found in public spaces (Informe de muertes violentas de mujeres, Grupo Guatemlateco de Mujeres, 2012). The ways in which women are systematically abducted, tortured, killed and their bodies abandoned, reproduce social cleansing practices too similar to those used during the genocide. According to Russell (2001), femicide is more than the killing of women by men because they are women, but encompasses, "a form of terrorism that functions to define gender lines, enact and bolster male dominance, and to render all women chronically and profoundly unsafe" (p. 177). Sandford argues that the term Feminicide best describes the Guatemalan contexts as it accounts for the *institutionalized* killing of women and holds responsible not only the perpetrators of violence but also "the state and, the judicial structures that normalize misogyny, impunity, silence, and indifference " (p. 104). Feminicide accounts for the high murder rate of women, and for the fact that only 1 % of these murders are adequately prosecuted.

> the concept of feminicide reveals the social character of the killing of women as a product of relations of power between men and women. It also allows for an interrogation of legal, political, and cultural analyses of institutional and societal responses to the phenomena. Feminicide leads us back to the structures of power and implicates the state as a responsible party, whether by commission, toleration, or omission. In Guatemala, feminicide is a crime that exists because of the absence of guarantees to protect the rights of women. (Sanford, 2001, p. 113)

Because feminicide reveals the state's permissive mechanisms that allow for the killing of women with impunity, silences in policy and an inability to guarantee the security of female citizens (Menjívar, 2011; Sanford, 2008) I will prefer this term throughout this dissertation. The United Nations (UN) understands the impunity of these crimes as a way in which power structures indoctrinate women into a role in which they remain in the private sphere, reducing civic engagement (2005). The socializing power that violence has on women reminds us that, in fact, feminicide is only one thread of a much broader and complex environment of state-sponsored gendered violence.

Menjívar (2011) coins the term *multisided violence* to include the multiple forms and often hidden sources of violence that, in particular, shape Ladinas' everyday experiences. Ladinas experiences serve as a case study of the governing force post-peace accords violence has over women's everyday life in Guatemala. Menjívar (2011) affirms that multisided violence leaks through every aspect of women's lives to the point of soaking Ladinas' "cognitive frames" (p.226). In other words, because violence entrenches Ladinas lives, multisided violence becomes the lens through which Ladina understands, experiences and views the world. Menjívar's work is important because it complements analyses of macro-level structural gendered violence (i.e feminicide) which takes for granted micro-level everyday aggressions involved in cultural practices (i.e marriage, child bearing, entering the work force, gossip, to name a few). Because multisided violence is woven into Ladina culture, "nonvisible forms of violence become normalized, routinized, and even legitimized and as such, misrecognized" (Menjívar, 2011, p. 227). The violence targeted towards women affects their mental health and reveals the silencing of suffering in post-peace accords Guatemala.

Mental "illness" in Post-peace accords Guatemala.

As previously stated, PAHO (2009) estimates that in post-peace accords Guatemala 25% of adults are diagnosed with some kind of mental "illness", reaching up to 35 % in areas of armed conflict, with depression, post-traumatic stress disorder (PTSD) and anxiety ranking as the top three (Lopez & Cardona, 2010). Of this population, 62 % are women living in urban areas (Lopez & Cardona, 2010). There is, however, an absence of jurisdiction, public policy, campaigns and educational programs that can support this population (IEMS-OMS, 2006). The case of the General Hospital Federico Mora – the only public hospital in Guatemala exclusive for mental health - demonstrates the existence of institutionalized violence against mental health as evidenced by the human rights violations against patients and the conglomeration of patients and prisoners within the hospital (Disability Rights International, 2012). Beyond falling victim to an environment of state-sponsored violence, non-ratified policies and services fail to protect women or support their mental health (Lykes et. al, 1993). For example, only 300 psychiatric beds are available nationally and only 2 % of Guatemalans receive treatment (Lopez & Cardona, 2010). Additionally, some women that do access the mental health system become victims of abuse and other human rights violations once they enter the institutions of care (Prensalibre, 2011; PNUD, 2010).

The national health care scheme offers its services to working adults affiliated with the Guatemalan welfare system or the Guatemalan Institute of Social Security (IGSS). The national health care system provides services only to those Guatemalans that are formally employed, thus only 20 % of adults have access to public social security (Política Nacional de Salúd Mental, 2008). Women, who are largely under-employed or

employed in the non-formal sector, are, therefore, often excluded from the IGSS. The Hospital General constitutes one of two public mental health hospitals available through the IGSS (WHO-AIMS, 2009). Centralized within Guatemala City, it still follows a nineteenth-century asylum model (Lopez & Cardona, 2010; PNUD, 2010; Cía et. al, 2010). The General Hospital is overcrowded (Lopez & Cardona, 2010) and it is estimated that 33 % of the patients residing in its psychiatric ward have been there for more than ten years and can be considered abandoned by their families (OMS, 2011). In addition to this isolation and seclusion of individuals, treatment practices are also problematic. The report entitled "The Right to Physical and Mental Health" (PNUD, 2010) confirms the high prevalence of human rights violations within the General Hospital and other mental health institutions in Guatemala. For example, in order to prevent the sexual assault of underage individuals, patients are placed in unsupervised solitary confinement for "several days" when international guidelines advise that such confinement be limited to two hours maximum (PDH, 2010).

The location, vicinity, and poor infrastructure of the General Hospital building demonstrate the state's valuation of mental health needs. The hospital's dilapidated infrastructure with leaks, lack of windows, running water, or sanitation (PNUD, 2010) could be explained by a lack of economic resources, however as I argue later in this dissertation, represents the stigma placed on mental health. While Guatemala has the largest economy of Central America, it invests the least in mental health among neighboring countries. Guatemala only invests 1.4 % of its gross income in mental health, lower than the Central American average (WHO-AIMS, 2009). The lack of investment in mental health highlights the low priority of this public issue. In addition, the fact that the

hospital is run as a prison mirrors the marginality with which mental health needs are regarded. The general lack of resources such as beds, blankets, food, and medication exemplifies the degree of violence inherent in mental health structures (PDH, 2010). In fact, without an implemented mental health policy, national guidelines or a jurisdiction to protect patients interned in psychiatric wards, patients are subjected to physical, emotional, and sexual abuse (Lopez & Cardona, 2010; PNUD, 2010).

Through the examination of the practices of the General Hospital psychiatric ward, it becomes obvious that human rights violations are permitted against individuals considered mentally ill. The simple act of accessing the General Hospital psychiatric ward further oppresses its patients. Therefore, policy guidelines permit mental health institutions to abuse, victimize, and blame individuals for their mental health needs. In the particular context of Guatemala, state terror has been imposed by the silencing of people through fear (Lykes & Liem, 1990). In addition, constructions of pathologies such as PTSD, anxiety, and depression need to be more intricate and contextualized in order to avoid further individual victimization; rather I suggest that the environment in which mental health is constructed needs to be also taken into account.

Similar to feminicide, which entails the institutionalized killing of women, the lack of mental health policy, and the abuse of inpatients are expressions of violence against mental health. State terror that specifically targets women's bodies also targets their psyches. Menjívar (2011) and Sanford (2008) highlight that structural practices of violence victimize women because they are women. Through the discrimination of mental health diagnoses and care, state-sponsored gendered violence is able to once more silence women and their suffering through an individualization of trauma removed from a

context of violence. Therefore, in an environment of multisided violence, what is considered mental "illness" by medical standards can, in fact, be considered an expression of mental health in the localized everyday experience of Ladinas. The inherent discrimination on the basis of mental health continues to silence women. Especially examining how the context of Guatemala City informs constructions of mental health is crucial, because the majority of feminicides happen in the Departamento (commune) of Guatemala where Guatemala City is located. For example, from January to December 2012, of the 671 violent killings of women, 294 were in the department of Guatemala City, representing 43 % of all murders (GGM, 2012). Thus, not only are Ladinas the target of feminicide, but as a gendered and racialized identity, they are both privileged and oppressed. Ladinas' experience speaks to the intersectionalities of Guatemalan identity and thus of the importance of constructing mental health from an emic and local perspective.

The blurring of mental health and mental "illness" can be further examined through the theory of feminist liberation psychology. Next, I present the conceptual framework structuring this dissertation study. Through the work of Lykes (2000, 1998, 1997, 1993), Martín-Baró (1994, 1990, 1989) and Freire (2004, 1987) the theory of liberation psychology and feminist liberation psychology complicate and contextualize Ladinas' mental health. In so doing, these theories help frame the mechanisms of oppression inherit in the stigmatization of mental "illness" as understood apart from an environment and history of violence. Liberation psychology and feminist liberation psychology, in particular; allow the placement of Ladinas' mental health in relation to the structures of violence that constitute their everyday lives.

Conceptual Framework.

Liberation psychology.

Martín-Baró's contribution to the field of psychology came from his life's work in El Salvador as a call for action suitable for a Latin American reality. As a Jesuit priest, he observed first hand the effects of the civil war on Salvadorians' mental health. Liberation psychology echoes African American or Black psychology and draws from liberation theology and critical pedagogy. Freire developed an approach to education, or what has become referred to as critical pedagogy, particularly as a means for poor and illiterate people to respond to their situations of oppression through *concientização*. For Freire (2004, 1987) critical consciousness or *concientização* refers to one's critical awareness to denounce oppressive relationships, which in turn leads to *praxis* -- the action and reflection upon the world in order to change it (Freire, 2004). Critical pedagogy entails the acquisition of literacy skills, through the process of critical self-reflection. Martín-Baró takes both the concept of concientização and praxis and frames them from a psychosocial perspective.

Within liberation psychology, concientização refers to the cognitive and emotional process through which awareness of the social conditions of ones mental health is attained (Martín-Baró, 1989). Liberation psychology stands on three pillars necessary for critical consciousness. First, liberation needs to encompass the collective as well as the individual; as such, mental health needs need to be examined within the structures of mental health care that have blossomed from the historical grounds of state terror. Secondly, it is necessary to create a new epistemology that allows the truth of the majority to be created and constructed from below rather than accepted from an

authority; thus, diagnosis of mental health needs to be informed by individuals who experience a mental health need. Thirdly, researchers need to create a new praxis to foster critical consciousness that places ourselves in a research-action continuum. In other words, this research is a dialectic practice that brings local experiences and conceptualization of mental health forward in order to resist state terror (Lykes, 2000; Martín-Baró, 1994).

Martín-Baró's work shifted psychologists' gaze from the individual - abstracted from their historical, social cultural, gendered contexts- towards the structural dimensions that frame individual concerns (Lykes, 2000; Martín-Baró, 1996). In so doing, Martín-Baró created a psychology that would respond to the particular context of Latin America, especially within societies submerged in military dictatorships, trauma, violence, terror, and war. Within an environment of state-sponsored terror, individuals are caught between the acceptance and normalization of a situation of violence through the ever-present panic brought forth by that same situation (Lykes, 1997). For example, multisided violence elucidates the degree to which violence is normalized and internalized by Ladinas. In an environment of acute violence in which Ladinas are socialized, trauma becomes an "everyday part of life," which in turn makes the typical person "come to accept these experiences as normal" (Menjívar, 2011; Lykes, 2000, p. 386). Presenting trauma as a psychosocial rather than an individual process discloses the "dehumanizing social relations" to which individuals are subjected (Martín-Baró, 1994, p. 125). In fact, Martín-Baró calls for the reconceptualization of medicalized notions of individual trauma that do not account for state terror, which creates environments of "normal abnormality" (Martín-Baró, 1989, p. 8). It is through mental health concientização that individuals can

reach praxis and liberate themselves from this normalized and individualized acceptance of suffering (Martín-Baró, 1994).

Clinical psychology's *a*historicism and individualism are not conducive for critical mental health consciousness. Martín-Baró (1989) argues that without historical memory, individuals conform, as they cannot learn from past experiences or root their identity. Mental "illness" thus, is seen as a "normal and ahistorical" reaction to environmental causes (p. 30). For example, the effects of poverty need to be acknowledged as they place individuals in a perpetual "psychological present" (Martín-Baró, 1994, p. 126). This psychological present cannot be conducive for concientização if mental health is not considered within a context in which primary necessities have yet to be met and individuals are surviving.

The theory of liberation psychology accounts for the complexities of post-peace accords Guatemala because within this perspective, "social trauma affects individuals precisely in their social character, that is as a totality, as a system" (Martín-Baró, 1994, p. 124). Also, it offers an alternative epistemology that centers Ladinas' construction of mental health and "illness" within the structural context of multisided violence. In particular, through the conceptualization of *traumatogenic structures*, liberation psychology differentiates between the social dimensions of trauma and its socializing forces (Martín-Baró, 1994) from the exclusive effects on the individual (Lykes, 2000). As such, Ladinas' mental health is understood in relation to the structures of feminicide and the environment of multisided violence, allowing for a problematization of mental "illness" as the expression of a mental health need. Throughout this dissertation I will argue that mental health in Guatemala for Ladinas women is tied to the notion of a

gendered citizenship project. A gendered citizenship project speaks of the ability women have to not only know their rights as citizens, but the ability they have to *exercise* such rights. Thus, mental health comes when women are able to voice their concerns, demand justice, and take control over their sexuality and reproductive rights to name but a few examples. It is within the ability to participate in the democracy of an everyday context of state terror, that in this dissertation, mental health is defined as a citizenship project.

Beyond healing the individual, the priority of liberation psychology is to heal cultures of violence through the construction of praxis based on the empirical examination of individual experience (Lykes, 1998; Martín-Baró, 1989). Within this social constructivist understanding, trauma is co-constructed (Lykes, 2000) by those who experience it in relationship to a particular socio-historical and cultural time and place (Lykes, 2000). For this study, focusing on the experiences of Ladinas allows for the theorization of mental health within the dialectics of experience and environment and from the perspective of the bodies targeted by violence, trauma and terror.

Although liberation psychology places trauma within the structures of suffering that oppress the individual, it does not accurately account for the ways in which women's bodies in Guatemala have become sites of violence. Women's bodies become the vehicle for machista structures, disciplining the Guatemalan society on the ways in which mental health ought to be expressed. The theory of feminist liberation psychology expands on the work of Martín-Baró by critiquing and extending it through the lens of feminist post-structuralism. This theory can best reveal the complexities of Ladina identities and positionalities in the construction of their mental health in post-peace accords Guatemala.

Feminist Liberation Psychology.

Feminist liberation psychology goes beyond a critique of the individual and *a*historical assumptions of clinical psychology and in particular its use of the medical model of Cartesian body-mind dualism (Lykes, 2000). It does so by centering psychology on women's experiences (Lykes, 2009). For example, the diagnosis of PTSD, which emerged form clinical work after the Vietnam War, has been applied to cases of sexual violence (Lykes et. al, 1993). However, even if this diagnosis takes away blame from the victim, locating the trauma *within* the social structure, trauma *itself* is still placed within the individual (Lykes et. al, 1993). Therefore, the diagnosis of PTSD ignores the complex structural, gendered, and societal aspect of women's victimization. By failing to address the trauma women face in the dialectic between social relations and social structures, this diagnosis results in further victimizing and silencing of women (Lykes et. al, 1993). Consequently, feminist liberation psychology argues that particular medicalized mental "illness" diagnoses, such as PTSD, cannot accurately portray the experiences of trauma faced by women (Lykes et. al, 1993).

Similar to the critiques of PTSD, feminist liberation psychology interrogates overall understandings of ethics, norms, and values. For example, Lykes' (2000) work on the mental health of rural Mayan women critiques "universal" understandings of human rights because they are based on the individual and do not take into account the collective nature of indigenous rights. Indeed, when Mayan women gave their testimonies of the atrocities that were committed to their bodies, they spoke of the trauma not referring only to themselves, but to the pain inflicted on the community at large (Lykes, 2009, 2000, 1997). Lykes' (2000) work speaks of the importance of problematizing human rights and mental health from a collective rather than an individual approach because concepts of

justice, for example, vary within local contexts. Through the voices of Mayan women, Lykes (2000) is able to theorize human rights approaches that represent the cultural understandings of the community.

Feminist liberation psychology encourages researchers to theorize from the voices, meanings, and actions of diverse women, in particular those stripped from power (Montero, 2007). As a bottom up, rather than top down approach that focuses on the *in between* places, theory can avoid marginalizing those individuals whose voices are yet to be heard. In other words, instead of theorizing from the general to the particular, feminist liberation psychology urges researchers to focus on the diverse voices of marginalized women and, therefore, extrapolate from these particular experiences that can be applied to the general public. In sum, feminist psychology "urges us to listen closely and not apply universal standards without close attention to local voices"(Lykes, 2009, p. 289).

Precisely because feminist liberation psychology looks beyond binaries such as concepts of "us" versus "them" that are so entrenched into Guatemalan ethnic identity and affirms a hybrid identity in the in between spaces, this theory is most relevant for the study of Ladinas mental health. The intersectionality of Ladinas can be theorized through this theory, with a goal of reaching praxis through the process of *de-alienation*. De-alienation refers to "the process of relating consciousness to the historic and social conditions of living in such a way that one can see the influences between them and the role one plays in their construction"(Montero, 2007, p. 525). Feminist liberation psychology, through the process of de-alienation, supports Ladinas emancipation and transformation through the attainment of critical mental health consciousness. Theorizing the experiences of Ladinas' as both oppressors and oppressed can account for the mental

health of those considered "ill" in Guatemala City. Feminist liberation psychology frames Ladinas' dialectic process between structures of violence and social relations, allowing for a breaking of the silent discrimination existing against women's psyches. Challenging medicalized assumptions of mental health versus mental "illness", this study also transcends binary boundaries that purposefully silence Ladinas of Guatemala City.

Significance of the study.

Identifying the intricacies that construct mental health in an environment of post-peace accords is especially relevant for countries like Guatemala where "peacetime" is woven into mutating violence. For the field of Comparative and International Development Education (CIDE) this work is crucial as it centers mental health concientização at the heart of education and development policy. Beyond responding to the need for localized prevention programs, effective anti-stigma campaigns and information for legislation pertaining to mental health (Salud Publica, 2008), this study reframes the language of mental health through an interdisciplinary engagement with feminicide and multisided violence. In particular, the experiences of Ladinas represent those individuals most prone to be diagnosed with a mental "illness" and to access the public mental health care system. Supported by the *testimonios* of Teresa and Silvia, two Ladinas having being diagnosed with a mental "illness" and institutionalized; and 18 in-depth interviews with mental health care professionals and women advocates this ethnography makes a two-fold argument. First, that de-contextualized mental "illness" diagnoses are "a form of terrorism" that reproduce femicidal practices by destroying Ladinas credibility and dignity and rendering them not only "chronically and profoundly unsafe" (Russell, 2001, p. 177), but also chronically and profoundly silenced. Secondly,

this study includes the mental health care system as another example of state and judicial structures that normalizes gender violence by punishing and abusing women under its care for expressing a mental health need. Concluding with a localized definition of mental health that accounts for the context and everyday experiences of Ladinas my research evidences that the field of mental health is a pertinent and understudied landscape of feminicide.

Chapter 2

Literature Review

Introduction.

In countries like Guatemala, where mental health policy and care is not a priority, individuals suffering from mental "illness" face more severe consequences. They fall deeper into poverty and marginalization because there is no social net that provides adequate treatment. In contexts of state terror, such as in India, Kosovo, or Pakistan, where there is also a shortage of mental health care practitioners, local responses have mushroomed to treat mental health needs. For example, a study in India found that even with minimal training in counseling, individuals sharing the same every day experiences could act as facilitators of support-groups. Women who trained as facilitators were effective in providing mental health treatment because they shared the same local, emic experiences of mental health with their clients. In fact, 44 % of individuals attending these support groups for at least six months no longer showed signs of depression (Patel, Weiss, Chowdhary, Naik, Pednekar, Chatterjee, Bhat, Araya, King, Simon, Verdeli, & Kikwood, 2011). The success of this study highlights the importance of an emic understanding of the context in which mental health is experienced. However, in Guatemala, although mental health needs are widely documented, there is little investment and public interest in support mental health efforts.

When I entered the field I felt that the literature on stigma was a possible explanation for the overall neglect of the structures of mental health care in a country with a high demand for such resources. I identified the following literature because it was helpful to think about the structures shaping mental health, and allowed me to frame my research while revising my argument based on the data to one of systemic and state-sponsored violence. The literature on stigma provides a viable model through which mental health can be conceptualized as a landscape of feminicide because the processes of tagging a discriminatory label onto an individual takes into account the dialectic between structure and individual. Also, because mental illness diagnosis are conceptualized as forms of social control (Caplan & Cosgrove, 2004), I argue that understanding the mental health of Guatemalans through a lens of mental "illness" furthers social control practices imposed by the state to those individuals expressing a mental health need. Three complementary approaches to conceptualizing stigma allow an in-depth examination of the consequences suffered by Ladinas diagnosed as mentally "ill." In so doing, the literature on stigma provides the platform to expose the power dynamics at play allowing a better understanding of Ladinas experiences and conceptualizations of mental health in the context of Guatemala City.

The first body of literature encompasses a *socio-cognitive process*. Although this line of scholarship is the basis for stigma literature in general, its exclusive focus on the individual cannot account for all the complexities of the Guatemalan context. This is especially the case when trying to understand the implications of structural and historical violence as forms of stigmatization. However, the foundational work of Goffman (1963) locates stigma on individuals' emotional processes, which is useful for identifying the

internalization of stigma at the individual level. Goffman's lens explicates why, for example, Teresa understands her mental "illness" as a genetic predisposition rather than a consequence of generational gender violence and abuse (personalcommunication, January 29th, 2013). Conceptualized as a socio-cognitive process stigma is recognized as a cognitive frame at the center of individuals' experiences. The second body of literature builds on the individual focus of stigma to include macro-structures of stigmatization. Scholars such as Corrigan, Markowitz and Watson (2004), Sayce (2003, 2000) and Link and Phelan (2001), provide a broader understanding of this phenomenon as *a sociological process.* Stigma is placed at the intersection of societal and individual expectations. The inclusion of structural factors of discrimination makes this literature pertinent for understanding for example, how structures of feminicide are at play in the mental health care structures of Guatemala and enable stigmatization. The third body of literature comes from anthropological studies that define stigma as a *moral-cultural process*. The work of Kleinman and Hall-Clifford (2009), Kleinman 1988), Yang and Pearson (2002), Yang, Kleinman, Link, Phelan, Lee, and Good, (2007) conceptualize stigma as tied to individuals' moral standing. For these scholars, stigma arises once the individual no longer meets the obligations imposed by the local cultural context, thereby losing moral standing within social networks. Much attention is paid to the responsibilities imposed by the local culture to the individual (i.e gendered roles such as care giving), emphasizing the importance of emic perspectives in order to understand stigma and its development in local contexts. Scholars of this literature contextualize embodiments of distress and social suffering within local meanings of mental health. This body of literature tailors stigma to local meanings of mental health explicates, for example, why in Guatemala the expression

of mental health is tied to exercising citizenship rights.

I rely heavily on the sociological process of stigma to draw on the structural and social dialectics of stigmatization to best capture Ladinas experiences. The moral-cultural process in addition, allows focusing on the everyday lives of Ladinas. In this review of the literature, I first present Goffman's theorization of stigma as an embodied mark. Then, I argue that understanding stigma as a sociological process captures the relevance of the structural environment that accounts for individual experiences. Finally, I complicate the sociological understanding of stigma by contextualizing it through the moral-cultural process that calls for an emic perspective of mental health to be developed.

Stigma as a socio-cognitive process.

For Goffman (1963) stigma resides in a social context that places a *mark* onto an individual. The individual internalizes this mark. As *self-stigma*, stigma becomes an "embodied sign" (Goffman, 1963, p.129). In this process, individuals have no agentic power in the construction of stigma as it is the social context that dictates what constitutes this *mark.* The only power individuals have is to *manage identities* by choosing to disclose the stigmatizing *mark*. For example, Menjívar (2011), suggests that despite embodying multiple signs of distress, Ladinas put great effort to "portray a positive image" of themselves to others (p.77). By "adhering (or seeming to adhere) to prescribed norms of behavior," women manage impressions to the point of "constant awareness of the talk and attention of others, an awareness that conditions their actions, words, postures and movements" (p.78). This talk of others is referred to as gossip. Ladinas work hard at portraying a positive image of themselves by managing their identities to avoid stigmatization through gossip. Menjívar conceptualizes gossip as a form of social control

because it surveils Ladinas' bodies and dictates their movement. Similarly, when diagnosis of mental "illness" are imposed without a real consideration for the cultural or, historical context, identities are managed and diagnosis become processes of social control (Conrad & Schneider, 1992; Linder, 2004). In other words, structures such as systems of care, or categories of diagnoses, have the power to render an individual stigmatiz*able*, which happens once the individual's identity is *spoiled* to the point of embodying a particular sign (Goffman, 1963, p. 129). When stigmatized individuals impose onto themselves the same "identity standards," dictated by their social identity, self-stigma occurs (p. 123). However, Goffman's theorization falls short when accounting for the structures of discrimination. Major and O'Brien (2005) specifically highlight the importance of including power in the process of stigmatization. For them, stigma is relational and therefore is a process negotiated through power. Major and O'Brien's critique highlights that stigma not only occurs in a socio-cognitive frame but is also constructed within sociological context of power (2005). Although the socio-cognitive literature is critiqued for its one-dimensional scope, Goffman's (1963) theorization of the embodied mark is important for any study of stigma as it permits the researcher to recognize stigma at the individual level.

Stigma as a Sociological Process.

The sociological perspective complements the internal micro-conceptualization of stigma brought forth by socio-cognitive literature. Scholars such as Corrigan, Markowitz and Watson (2004), Sayce (2003, 2000) and, Link and Phelan (2001), approach stigma from both a micro and macro level. The structural forces that shape the reality of an individual become relevant for this conceptualization, which calls for a distinction

between *discrimination* and *stigma*. For example, Sayce (2003) makes the following differentiation: *stigma* viewed from the perspective of the stigmatized individual becomes the internalized force of rejection, whereas *discrimination* as a subjecting force emphasizes the cultural and structural forces that produce stigma (p.366). This distinction offers a clear understanding of where the responsibility lies in the process of stigmatization (Sayce, 2000). Understanding stigma as a "tag that others affix on the person" (Link & Phelan, 2001, p.366) provides the theorization to study both the environment of discrimination, as well as the perception and experience of stigma by the rejected individual. According to Link and Phelan (2001) the sociological process of stigmatization can be broken into three dialectic stages between individual and structures. First, macro-structures label and stereotype according to what is considered mental "illness". *Stereotyping* refers to the cultural beliefs that lead to *labeling*. In other words, labeling is the psychological process of becoming stigmatized, which is perceived at individual level, whereas stereotyping refers to the structures (i.e hospitals, policy) that negatively label an individual as "ill" (p.377). The second component alludes to the process of identity development where the stigmatized mark differentiates and separates the "us" versus "them" (p.370). This dichotomy is simultaneously imposed onto the individual by the structure, and internalized by the individual. For example, when Silvia described the women that were internalized with her she said, "alli estaban todas las bien loquitas" ("all the little very crazy women were there," personal communication, February 2nd, 2013). In so doing, she is differentiating herself from them. In addition, she only referred to herself as *loca* when talking about others' perceptions of her. For example, when I asked Silvia why she had not reported the abuse she experienced when

institutionalized she replied, “quien le iba a creer a una loca?” (“who would believe a crazy woman?” Personal communication, February 2nd, 2013). The way in which Silvia uses the term “loca” illustrates how stigma is rooted in the structure while simultaneously residing within the individual.

The third stage of stigma is defined by *status loss* and *discrimination*. Within highly segregated and structured societies, such as Guatemala’s, status loss is directly linked to an individual’s social capital, whereas discrimination refers to restriction of opportunity imposed by the institutions that affect the individual. For example, once Silvia was institutionalized she lost her credibility as a mental health practitioner, which meant the loss of her career. These three stages of the process of stigmatization reveal the importance of power in determining both structures of discrimination and individual internalization of stigma. Link and Phelan (2001), contribute to this literature by arguing that because both the experience and production of stigma depend on power, it is the structure of discrimination that dictate the degree of stigma internalized by the individual (Link & Phelan, 2001). This conceptualization is important when discussing the political power inherent in the public mental health care system as in the ways in which the hospital Federico Mora hospital interns patients and prisoners without differentiation, and how the human rights violations instead of care enable structures of stigma to persist and be internalized by individuals.

Corrigan, Markowitz and Watson (2004), further contribute to this sociological understanding of stigmatization. Central to the structures of discrimination is whether policies intentionally or unintentionally restrict the opportunities of individuals diagnosed with a mental “illness”. Guided by the literature on racial stigma and discrimination, they

examined the implication of policies on individuals. Similar discrimination on the basis of race, policies that are intended to be "neutral" often result in restricting opportunities to a particular group of people, in particular individual diagnosed with a mental "illness". Through the concept of "institutions of discrimination" this study concluded that mental illness "strikes with a two-edge sword" (Corriagan et al, p.481). On the one hand, diagnosed individuals are tagged a series of symptoms brought forth by a category of mental "illness". On the other hand, they battle the stigma attached to this "illness", which in turn further restricts their life opportunities. In Guatemala, for example, the mental health policy has yet to be ratified, making it so that there are no national guidelines that protect the rights of individuals diagnosed with a mental "illness". Thus, abuse and human right violations go unsanctioned within private and public institutions of care. This literature provides the basis to explicate inefficient or inexistent mental health policy as discriminatory structures of stigmatization.

The sociological understanding of stigma calls for a distinction between policy based on disability rights and mental "illness" protection. As of May 2013, Guatemala had only rectified the United Nations Convention on the Rights of Persons with Disabilities[1]. From this perspective, Guatemala has institutional discrimination as it is reflected in the economic, political, and historical neglect of mental health policy. Structural discrimination has direct and profound implications on Ladinas' esteem of themselves and life opportunities. For example, Teresa narrates the first time she was committed to the General Hospital Federico Mora, in the following way, " I told myself, it had happened, I am a charge to my family, a waste of society," ("yo lo tome, dije ya se hizo, soy una carga de la familia una desecho de la sociedad," personal communication, January 29th, 2013).

[1] In May 2013 government of Guatemala signed the W.H.O Global Mental Health Plan

For Teresa, accessing the Federico Mora identified her as the waste of society. Here, the structural discrimination against mental health (lack of resources, dilapidation of the hospital, lack of policy etc.) is internalized as a value system for Teresa's self-worth. In sum, this literature elucidates the importance of tying the internalization of stigma to structural-*isms.*

Corrigan, Markowitz and Watson (2004), Sayce (2003), Link and Phelan (2001), call for more research on stigma to develop effective and informed anti-discrimination strategies. These scholars place great emphasis on the role education plays in the reduction of stigma, which is relevant for Guatemala where inefficient mental health resources, lack of preventive and supportive mental health and education policies enables the marginalization of Ladinas considered mentally ill. The sociological process of stigma allows for an analysis of discriminatory practices within structures and institutions. Accounting for the broader Guatemalan context of feminicide but also the particular state of mental health policy and investment, the sociological literature supports a dialectic analysis of the processes between structural and individual stigmatization, allowing for the broader mechanisms of stigma to be identified. Next, I explore the literature of stigma studied from a moral-cultural perspective.

Stigma as a moral-cultural process.

Kleinman and Hall-Clifford (2009), Kleinman, Wilentz, and Keusch (2006), Kleinman (1988) Yang, Kleinman, Link, Phelan, Lee, and Good, (2007), Yang and Pearson (2002), challenge psychiatric beliefs through international and comparative work. This literature considers stigma a cultural construct bound to a moral process, elucidating local value systems leading to stigmatizing behavior.

Yang, Kleinman, Link, Phelan, Lee and Good (2007) reveal the ways in which stigma threatens what matters most in the life of the stigmatized. Since stigma is culturally bound, moral processes can only become apparent with prolonged participatory observations and qualitative research. The moral-cultural process of stigma allows for research of stigma to be contextualized at the intersection of structural discrimination and Ladinas' daily reality.

In three studies (Kleinman & Hall-Clifford, 2009; Kleinman et. al., 2006; Kleinman 1988), that focused extensive work on patients suffering from schizophrenia and AIDS in China, it was observed that stigma was not only perceived by the individual, but by the family as a whole. The interconnected nature of the individual with the family's identity shaped the perceptions and impact of stigma. Kleinman et al. (2006) noted that in this cultural context, stigma is experienced as a feeling of shame tied to the concept of *face*. Noting the limitations of understandings of stigma such as the ones develop by the socio-cognitive and sociological literatures, this study centers on *face saving* as a salient cultural aspect that explains the process of stigma in China. Face saving is central to the understanding of stigma in China, as it is directly linked to *moral capital* (Yang & Pearson, 2002, p.236). In Chinese society, the experience of stigma is understood as a loss of prestige for both the sufferer and the family in their local context. Yang and Pearson (2002) further explain the connection between *face* and *moral capital* in Chinese culture as "one's moral status in the local community" that can be "had, given or received" among respected others (p.1530). Losing face, hence, suggests an "inability to face others" (Yang & Pearson, 2002, p.1530) and is perceived as deep humiliation and shame. Complementing the work of Kleinman et al. (2006), stigma in this cultural

context becomes a full embodiment of physical and affective social processes that have repercussions on the social status, posture, and positioning of the stigmatized (Yang & Pearson, 2002, p.1530).

Similarly, Menjívar's (2011) discussion of gossip shows the real implications Ladinas would face if they had a bad reputation. Women presented as "dutiful, virtuous and devoted" do so in order to gain access to material or social capital (Menjívar, 2011, p.79). In other words, vigilance (gossip) manifest social control through the maintenance of moral standing. Kleinman et. al (2006) recognizes that stigma threatens what matters most for the individual's life, affecting *moral capital*. Stigma is the process by which a prescribed image that is considered "negative" translates into a loss of moral standing. In fact, the pressure exerted by moral capital highlights the process of stigmatization: that of tagging onto an individual a "flaw" that results in the loss of moral standing. Whether through gossip or diagnosis of mental "illness", Ladinas access to capital is tied to the virtuosity of their reputation. As such, Ladinas' efforts to always be perceived as "dutiful" exemplify *face saving* strategies to keep moral capital (Menjívar, 2011, p.79). In fact, moral capital is an important mechanism for Ladinas who are often marginalized from accessing other forms of capital. Their reputation becomes a crucial way Ladinas' access moral capital making stigma have severe consequences for their livelihood (Menjívar, 2011). For example, Silvia was well aware that she could not afford to divorce her abusive husband because she could easily lose the custody of her children after being diagnosed with a mental "illness" (personal communication, February 2nd, 2013).

The work of Kleinman and Hall-Clifford (2009), Kleinman et. al (2006), suggests that for Chinese patients, stigma is perceived as a *moral-cultural* experience. Indeed, the

physical sensation of losing face cannot be separated from the emotions of humiliation and shame, which are directly tied to social loss and moral standing in one's community. Stigma therefore discredits the stigmatized and the family, and places stigma at the intersection of what is most important for the physical, emotional, social and cultural context of the individual. Viewing stigma as a moral process shapes a more comprehensive, cultural specific understanding. Kleinman provides ethnographic observations of *face* with the data to develop this concept in order to explain, "how social aspects of stigma might incorporate the moral standing of both individual and collective actors defined within a local context" (Yang & Kleinman, 2008, p.2). In this work, Yang, Kleinman, Link, Phelan, Lee and Good, (2007) determine "(1) how one's moral standing is lodged within a local social world; (2) how one's status as a 'moral' community member is contingent upon upholding intrapersonal and social-transactional obligations; and (3) how loss of face and fears of moral contamination might lead to a 'social death' (p.1529)." This literature provides a platform to conceptualize Ladinas' mental health from their everyday lives, as it focuses on cultural cues.

Yang et al. exposes the "severe social consequences that loss of face entails" (2007, p.1529). From this perspective stigma operates by highlighting a change in the moral status of an individual. This symbolic discrimination brought about by stigma takes place in the local context, hence the importance of developing local-level interventions. Moreover, this study argues that stigma jeopardizes the individual's ability to mobilize social capital and obtain social status, threatening what matters most for the individual in her local world, as was the example of Silvia who could not attain a divorce because of the stigma attached to her diagnosis. Another example of centering stigma as a moral issue

is that of Leticia, a woman who died from HIV/AIDS and was perceived as having "lost her mind a little" (Menjívar, 2011, p.67). Menjívar describes these attitudes as "adding insult to injury" and explains it as signs of symbolic violence (2011, p.67). However, viewed through the lens of this literature, Leticia can be seen as being judged on the basis of morality. However it is not solely on the basis of her physical morality (having HIV-AIDS) but also on her mental morality (losing her mind a little) that signals stigma of mental health. This stigma strips away Leticia's moral standing, by shifting her stigmatization from a physical towards a mental commentary for gossip.

Kleinman and Hall-Clifford (2009), Kleinman et. al (2006), and Kleinman (1988), develop this concept by observing that in a local context the stigmatized moral status is affected. Although stigma might be a shared reality across contexts, it has only a concrete consequence in the local context in which moral standing can be lost. Stigma then, affects the local social world of the individual since in order to maintain moral status the individual needs to meet the social obligations and norms imposed by her cultural and local context. When an individual is unable to meet these social obligations because of stigma, her moral status becomes vulnerable. This vulnerability reflects the power of stigma, which can destroy what matters most to the sufferer (i.e. relationships, wealth, status, etc.). In reviewing the case of Leticia once more, a tag was affixed to her as "losing her mind a little," while structural factors discriminated against her for being a woman infected with HIV-AIDS (Menjívar, 2011). Stigma arises, therefore, in a context of structural factors.

Kleinman (2007) acknowledges the dialectic of the individual and the social networks within the process of stigmatization. There are three main stages of

stigmatization between social networks and individuals. First, the socio-somatic perception of stigma is linked to the physical experience of societal norms tied to emotional experience, such as losing face (Yang et. al, 2007). In the Chinese context, stigma causes a loss of social standing, which is felt by the individual as an "overwhelming shame, humiliation and despair" (Yang et. al, 2007, p.1532). Second, stigma is linked to both structural forms of discrimination and individual experience of rejection. Stigma placed at the intersection of interpersonal relations and lived reality expands to include the individual perceptions of stigma and the transactions of tagging and being affixed negative stereotypes (Yang et. al, 2007). Third, stigma destabilizes the lives of the individuals by disrupting relationships and threatening social standing (Yang et. al, 2007). These three characteristics of stigma can be considered a refined version of the conceptualizations of the sociological process of stigma, one that is aware of cultural behavior tied to societal norms. Conceptualizing the sociological process of stigma as a moral-cultural process provides a cultural dimension to effectively interrogate the impact stigma has on Ladinas everyday life.

These anthropologically informed studies demonstrate the relevance of studying stigma in societies such as the Chinese, where stigma has the power to take away what matters most to the individual. With the development of *moral capital*, Kleinman and Hall-Clifford (2009) echoe a concept also used by Menjívar. Although Menjívar uses it within a context of patriarchy, Kleinman does so in an environment of mental "illness" *or embodiments of distress.* For example, Menjívar already recognized the power moral capital has on women, as it allows or restricts access to money or favors. Therefore, this

literature provides the lens to examine the everyday cultural consequences of stigma on the lives of Ladinas.

Conclusion.

Goffman (1963) lays the groundwork to consider stigma as an embodied *mark*. Although there are limitations to this theorization as the structural causes of stigma are not considered, Goffman's work allows for a micro-level analysis of the ways in which Ladinas' lives change after being labeled mentally ill. The sociological literature of stigma builds on Goffman's theorization to incorporate structural factors. This literature focuses on the relationship between individual and structural levels of stigmatization in an environment of power. Precisely because Ladinas' experiences of mental health do not happen in a vacuum, but rather in a particular Guatemalan context of multisided violence, I will also draw from the moral-cultural process of stigma. In so doing, I will focus on the consequences of stigmatization on Ladinas' everyday while also revealing the intrinsic and culturally relevant constructions of mental health.

As a scholar of Comparative and International Development Education, this work identifies the mechanisms through which structural discrimination towards mental health are internalized into Ladinas' identity. It also complicates medicalized categories of mental "illness", as mental health needs. By labeling women as mentally ill without acknowledging their everyday life, Ladinas are further victimized and silenced. I look to critically examine the construction of mental health in a context of multisided violence by presenting the ways in which Ladinas' lives are affected once they are labeled mentally ill. In the next chapter I present the methodology that supports this ethnography.

Chapter 3

Methodology

Introduction.

Given that the abuse suffered by patients institutionalized in the mental health care system is well documented, and that state terror is normalized, this research looks to bring forward the local conceptualizations and experiences of mental health in order to critique medical categories of mental "illness" and further the theorization of feminicide. Guided by the questions: How is mental health cared for and conceptualized in post-peace accords Guatemala City? In particular, How does the Ladina experience of expressing a mental health need reveal that a redefinition of mental health in this context is necessary?

This seven month-long ethnography employed two methods. First, in-depth interviews were used to understand the definitions of mental health from those Ladinas/os working to implement mental health resources and advocate for women's rights. Second, I rely on the *testimonios* of two Ladinas: Silvia and Teresa who have both been at one point in their lives institutionalized in the mental health system. Their *testimonios* gave insight into the experience of being committed and the context that led them to these hospitals, as well as their experiences of the injustice and discrimination in the mental health system. The experiences of Ladinas provided a canvas from which to draw local, urban constructions of mental health because Ladino-ness does not exist in a vacuum but

is an intrinsic piece of multicultural Guatemalan identity.

In this methodology chapter I explicate the data collection process by presenting the rationale of the research design. Then, I describe the data analysis process; in particular I focus on validity constraints and the ethical considerations of this research project in order to unpack and work through predisposed assumptions that might blind the research process. Finally, I discuss the limitations to this research study.

Research Design.

This ethnography was conducted from October 2012 to April 2013 in Guatemala City and informed by a pilot study done in the summer of 2010. During the pilot study it became clear that speaking of a mental health need was not something that was shared easily among strangers and in particular along researcher-participant power structures. Once I returned to Guatemala in 2012 I could contact participants that felt comfortable sharing about their experiences with the mental health care system and was able to sample using peer referral. The methods used to examine the definitions and experiences of mental health were in-depth interviews and *testimonios*. The IRB approval letter can be found in Appendix A. Following IRB guidelines, participant consent was obtained verbally prior to interviewing. Table 1. Summarizes the research design.

Table 1

Table 1. Research Design

Research question	Method	Participants
How does the Ladina experience of expressing a mental health need allow defining mental health in this context?	*Testimonios*	Teresa and Silvia, two Ladinas having been diagnosed with a

		mental illness and institutionalized
How is mental health cared for and conceptualized in post-peace accords Guatemala City?	In-depth interviews	Ten directors of mental health institutions and six coordinators of women's rights organizations

Methods.

Testimonio.

Testimonio emerged from the field of Latin American studies to define non-fiction literature based on a narrative told in the first person by a witness that recounts a significant life event (Beverly, 2008). In contrast to life histories, which focus on the interlocutor, *testimonios* focus on the intention of the narrator. The narrator of *testimonios* bears witness to a life experience and uses the interlocutor to access a public that could not otherwise be reached (Beverly, 2008). As a cultural way of communicating a life history of survival that has had its prominence in religious and truth clarifying processes, it was quite natural for Silvia and Teresa to name their participation in this research as sharing with me their *testimonio*. Since the mental health institutionalization process is in Guatemala one that strips women of their power and is highly stigmatized and drenched in inequality, both *testimonios* are that of surviving the psychiatric system. Both women were powerful as they recounted their stories, and it was clear that their stories testify to a collective memory and identity of the "crazy", "unwanted" secluded Ladinas. Teresa's and Silvia's motivation for lending me their *testimonio* and recounting the traumas that they had lived, was made clear on many occasions; they wanted to set their life story

right, especially in light of those versions told by their family members who had disputed or annulled their lived experience. It was because I had met Teresa and Silvia more than three years ago that they had the trust to share with me their stories. These *testimonios* start from their childhood, but focus mostly on the abuses they lived at multiple times in their lives, which led them to be committed to a mental institution, and how they reconstructed their lives afterwards.

Testimonio is considered an urgency narrative, because the situation that is witnessed is usually one of repression, poverty, marginality, and survival. As Yúdice (1991) defines,

> testimonio is an authentic narrative, told by a witness who is moved to narrate by the urgency of a situation (e.g., war, oppression, revolution, etc.). Emphasizing popular oral discourse, the witness portrays his or her own experience as a representative of a collective memory and identity. Truth is summoned in the cause of denouncing a present situation of exploitation and oppression or exorcising and setting aright-official history (p. 17).

Thus, the witness's experience is agentic. As a form of consciousness-raising, *testimonio* has become a method of liberation psychology that allows truths and data to rise from the grass root level. *Testimonio* advances the goal of "making of the political that which is personal" (Angueira, 1988, p. 70) breaking silence by making a life experience public. As such, Silvia's and Teresa's *testimonios* were possible also because they speak from a place of consciousness, now that they are on the "other side" of mental "illness", of looking to their past experience and realizing they survived. Their *testimonios* speak of the resilience and power of these women and of the urgency to

speak up to protect others from the situation they lived through.

As a method, *testimonio* has been employed in ethnographic and biographic work to bring light to situations of injustice through the perspective and experiences of those who bear it. Perez-Hubert (1988) defines the method of *testimonio* as "a verbal journey of a witness who speaks to reveal the racial, classed, gendered, and nativist injustices they have suffered as a means of healing, empowerment, and advocacy for a more humane present and future" (p. 644). For example, for Angueira's (1988) work on sexual violence and Puerto Rican women, *testimonio* became the platform for women to perceive their own realities. *Testimonio* allowed for, "a key that can unlock the heavy vault of silence that has so effectively smothered emotions ignited by the oppression of sexual politics" (1988, p. 69). As a method, *testimonio* calls for a power-shift, where it is the narrator that denounces injustices and uses the interlocutor to teach others about a specific situation. For the audience, it becomes a pedagogical tool, if one is a survivor that can validate ones experience; if not, it can denounce an unjust situation. In both cases, *testimonio* calls for the skills to respond to these specific victimizations to be developed.

Recruitment.

I met Silvia and Teresa during the summer of 2010 when I was conducting my pilot study. I met Teresa when I did an inventory of the available mental health resources in the city. That summer, only a few hospitals granted me an informational interview, Teresa the director of MALUD (pseudonym), a Christian based recovery house for women suffering from drug addiction and mental "illness", was one of them. When I met Teresa about the work of MALUD and asked her about her motivations and journey that

led her to direct this center she told me that five years prior she herself had been committed to that same center. It was her *testimonio* of recovery that qualified her to direct the center. Teresa's story spoke of a recurrent theme of that pilot study: it was mostly personal experience that led people to advocate and work in mental health. I became very interested in Teresa's story and I visited her in MALUD every time I was back in Guatemala City. Every meeting we became more in-depth in our conversations and she opened to sharing more of her life each time. In 2011 we only met at MALUD center, but then, she would invite me to her church where she sings and plays the guitar. Or, we would meet at cafes, with a much closer bond. Finally, during my dissertation research in 2012-2013, she invited me to her home where I conducted six hours of *testimonio*.

I met Silvia through a reference referral, Dan. Dan had been diagnosed with bipolar disorder since the age of 14 making him the first diagnosed youth of Guatemala with the disorder. Because of his diagnosis of bipolarity from such a young age, he had been committed to most mental health hospitals of Guatemala City. Because he is a Ladino man I did not include him as part of my study but his access and knowledge of mental health centers and culture was very helpful to my study. He told me the story of Silvia, a woman he met while interned in a private mental health hospital. He remembered Silvia because she was acting "crazy" asking him to call her mother if he got out before she did. Every time Silvia wrote her mother's telephone number on a piece of paper and a nurse came into the room she would swallow it- making Dan conclude that Silvia was, in fact, paranoid. When he was released before Silvia, although he laughed at the thought of dialing that number, he had made a promise to her and called. He had

reached Silvia's mother who was looking for Silvia for five months. Dan realized then that Silvia's story was true: she had been kidnapped by her husband and placed in that hospital without her consent and without her family knowing of her whereabouts. Because of this kept promise, Silvia was released with the intervention of the police, and since then, Dan and Silvia had remained good friends. I first spoke with Silvia on the phone and we agreed to meet during her oldest daughter's gym practice. We were introduced and I told her about my research. I saw her two more times that summer where she told me in more detail about how she was institutionalized. Every time I came back to Guatemala I visited her either during one of her daughter's gym practices or for coffee. For my dissertation research, we met first at a local café and then Silvia invited me to her house, where we shared lunch at our second interview and then dinner. During these three meetings totaling nine hours of *testimonio*, she shared with me her life story, starting with her childhood all the way to the present day.

Because of the generosity of their stories and the basis of *testimonio* these conversations where not guided by questions. Rather, I told each of them that I wanted to know about how they came to be institutionalized and then listened carefully to their stories. I left it up to them to tell me what they were comfortable sharing, and only probed for clarification. Teresa and Silvia were generous with their time by welcoming me into their lives, through narration and by hosting me in their homes. It is the trust and relationships that I have built with them over the course of three years, the friendship that we share, that makes these stories truths. I have heard many iterations of their *testimonios*, in pieces and every year, the stories are shared with much more detail, care, and vulnerability. By taking the precaution of getting to know me over three years, to

trust me with the details of abuse, trauma, and despair, with the details of their diagnosis and treatment, I know that I have their trust and respect and that their *testimonios,* even if hard to believe, represent the reality of other Ladinas diagnosed with mental "illness".

In-Depth Interview.

The goal of in-depth interviewing is to understand social behavior without limiting the field of inquiry by imposing fixed categorizations (Rubin & Rubin, 2005). In other words, in-depth interviews seek to understand a phenomenon rather than to explain it. In addition, in-depth interviews permit quality and depth of data rather than quantity allowing for multiple and discrepant perspectives to be discussed rather than glossed over (Krieger, Rowley, Herman Avery & Phillips 1983). As an exploratory study, the interview protocols were open-ended and loosely structured in order to allow participants to share their concerns and definitions regarding mental health. The purpose of these interviews was to guide the conversation towards centering mental health conceptualizations within narratives of state terror from the emic perspective of those professionals and advocates working to implement mental health and women's rights in Guatemala. The question protocol was organized by themes. I wanted to understand participants' experience, perception, definition, and motivation for working in mental health, as well as to have access to more contacts. The interview protocol was framed by the following broad questions:

1. Tell me about your work?
2. What motivates you to work in this organization / in what context?
3. What is your motivation for working in mental health?

4. Where / Who do you turn to for help / support?
5. How do you define mental health?
6. How do you see mental health as relevant for Guatemala?
7. Who do you know works on mental health that I could speak to?

Recruitment.

During the pilot study I conducted in 2011 I made a preliminary inventory of the available resources for mental health and started visiting these centers in order to be in contact with their directors. After a couple of contacts, I was able to interview Marco Garavito, the director of the League for Mental Hygiene, a key contact in the mental health context of Guatemala. In 2010, our conversations resembled monologues about the local context rather than a dialogical interview. I visited and spoke to Garavito the next summer and by the time I was in Guatemala in October 2013 we were having in-depth conversations about his personal motivations to work for mental health in the particular context of Guatemala. Now, Garavito is one of the member checkers of this dissertation to ensure the validity and trustworthiness of the findings. Similarly, I had established contact Dr. Rodriguez after reading his article about mental health in Guatemala. With these contacts it became easy to access other directors working for mental health, but only by referral. Because Guatemalans live in extreme insecurity and as I will illustrate throughout this dissertation mental health is highly political, I was only able to access participants through referral. Other ways of contacting via phone, email, or walk-in did not result in an interview. I therefore relied on referrals to access strategic participants, based on the inventory of the mental health care resources I developed. Of the 18

identified mental health institutions of Guatemala City, I was able to interview the directors of nine of these institutions. The meetings with the director of the Universities' counseling services because of time constraints could not be materialized. Below, I present the table with the inventory I created in order to explicate the sample of institutions that participated in this dissertation.

Table 2

Table 2. System of Mental Health Care

Types of Mental Health Institutions available	**Total Number**	**Institutions part of sample**
Ministry of Health: office for the program of mental health	4	1
Public mental health hospitals	2	1
Private mental health hospitals	1	1
Private hospitals with mental health care professional in their on-call staff	3	1
Private Residential home for the care of mental health	5	2
University based counseling services	3	0
Private associations with a central focus on mental health	2	2
NGO with a focus on human rights working in the mental health sector	2	2
Total	18	9

After interviewing the directors of these centers, it became clear that there was a gender gap: none of the mental health resources had a specific gender focus. Thus, I decided to contact women's organizations that focused on gender violence or women's advocacy and see if they provided mental health services. Because this occurrence happened mid-field work, and I had to schedule meetings directly and not through referrals, I based my inventory on a local NGO's Service Directory of organizations for the attention and prevention of violence against women of 2012. The Director of this NGO had shared with me this resource that was composed of services with which they collaborate. Thus, through this contact I was able to schedule interviews and meetings in a timely fashion. Of the eight centers listed, I was able to interview the mental health coordinator of six organizations. The in-depth interviews followed two sets of participants: the directors of mental health institutions and the mental health coordinators of women's advocacy groups.

I interviewed participants until names of those who were referred to me were already ones I had interviewed. In other words, when participants referred me to two people I had already interviewed I considered my sample to be saturated. Interviews ranged from 45 minutes to 90 minutes depending on availability. Some participants I met with several times. In this study, in order to protect participant's anonymity, all participants except one are referred to using a pseudonym. In addition, participant's institutional affiliation has been omitted and has been described based on the type of work provided. Due to the centrality of La Liga de la Hygiene Mental's work in Guatemala, Marco Garavito could not remain anonymous with a simple change of name as his ideals can be easily recognized. Thus, I contacted him and obtained written

permission to use his name in this dissertation. Moreover, Garavito has member checked the findings chapters in order to approve the information shared about him. Table 3 provides the list of the institutions I visited and the people with whom I interviewed.

Table 3

Table 3. In-depth Interviews, Participants and Affiliations

	Name	Institution	Mission	Profession and Position	Position
Mental Health Resources	Sandra	International Human Rights Organization	This international human rights organization is dedicated to protecting the rights of people with disabilities	Juris doctor	Director
	Roberto	National Human Rights Organization	This organization works to create processes of empowerment for the protection of human rights in order to construct communities that work for a less discriminating society	Researcher and advocate	Director
	Joyce	Health Ministry	The mental health program within the Ministry of Health	Psychologist	Director
	Luther	National Mental Health Hospital – Federico Mora.	Federico Mora is the only public mental health hospital of Guatemala located in Guatemala City	Psychiatrist and Professor	Assistant Director
	Cadelaria	Private Mental Health Hospital	Private mental health hospital for the treatment and evaluations of individuals in crisis	Psychologist	Director
	Keith	Public Youth Correctional	Director of the mental health program in the youth prison system and professor of mental health at the University	Social Psychiatrist and Professor	Director

	Dr. Rodriguez	University and Ministry of Health	Researcher, Professor and Advisor for the Minister of Health	Social Psychiatrist and Professor	Consultant
	Liam	Community based association for mental health	Research Center for the training of mental health professionals to support victims of war	Psychologist	Director
	Perla	Community based association for mental health	Research Center for the training of mental health professionals to support victims of war	Psychologist	Coordinator Mental Health of women victims of war
	Marco Garavito	The League for Mental Hygiene- private association	Private non lucrative association for the training and intervention of mental hygiene in the community affected by war	Psychologist and Professor	Director
Resources for Women's Rights	Kayla	Local Association for the Rights of Guatemalan Women	Feminist organization to promote the sexual and reproductive rights of women with a political focus to develop and advance the legislative efforts to support women	Researcher	Director
	Amanda	Research Center for the Support and Training of Women- Local NGO	Contribute to the prevention, sanction and eradication of violence against women by providing access to justice and psychological assistance	Lawyer	Director
	Carolina	Local Association for the Civic and Political Center for the support of Women	Contribute support women through legal and civil processes. Provide psychological attention and temporary shelter	Lawyer	Director
	Margarita	Local Non Lucrative organization	Develop public policy in favor of women for the reduction and prevention of violence against women. Provide direct attention to women victim of violence	Psychologist	Director

	Miranda	NGO for Justice	Defend victims of sexual violence and support with psychological help	Lawyer	Mental Health coordinator
	Amari	Public office for Women's advocacy	Defend and promote the full right of women to eradicate all forms of violence and discrimination against women	Lawyer	Director of the central office

Because it is culturally inappropriate to avoid eye contact with interviewees, I refrained from taking copious notes while they spoke. Instead with participants' permission, I audio recorded all interviews. I asked probing or clarifying questions and would contact them again later to thank them and also, if needed, complete a follow up interview. After each interview I memoed my first reactions, feelings, overall themes and any other information I needed to research. Then I transcribed all interviews verbatim and uploaded the transcriptions onto the online platform Dedoose to code them. When doing the write up I chose the quotes that were most representative and then translated them from Spanish into English. Throughout the dissertation I present both sets of quotes. Next, I present, in more detail, the analysis process.

Data Analysis

A Grounded Theory Analysis.

This ethnography comprising of in-depth interviews and *testimonios* provides extensive, rich, and meaningful data that was analyzed through a grounded theory framework. Because the questions guiding this research are about understanding a process – that of experiencing, constructing and defining mental health- grounded theory allows for the categories of analysis to be developed from the data (Corbin & Strauss,

2008). When the categories of analysis were refined in light of emergent themes, I drew on grounded theory to develop a matrix to formulate a theory that,

> is able to specify consequences and their related conditions, the theorist can claim predictability for it, in the limited sense that *if e*lsewhere approximately similar conditions obtain, *then approximately* similar consequences should occur. (Strauss & Corbin, 1987, p. 278- original emphasis)

Emergent themes, or codes, allow conceptual categories to rise from the data instead of assumptions being imposed onto the data by the researcher. In this study, attending to emergent and recurrent patterns led new understandings of experienced mental health in the context of state terror. Because grounded theory is guided by the question: "what is happening?", emergent themes from the data have theoretical and practical implications for the participants' everyday lives.

After transcribing interviews and *testimonios* verbatim and coding them using the online platform Dedoose, emergent codes were developed into parent codes to form a matrix. Following this approach, all concepts arose from the data, and there were two levels of concepts: lower level and higher-level concepts. Higher-level themes were umbrella terms that hosted lower level concepts (Maxwell, 2005). In this process, I went through the raw data, then described and named a concept, then organized concepts into families of higher-level concepts. For example, descriptive lower level themes such as: poor infrastructure, too few mental health professionals, were regrouped under a parent code called: lack of investment in mental health. This parent code in turn was coded with higher-level concept 'structures of state terror.'

Beyond open coding (that is, breaking the data apart to stand for blocks of raw data), axial coding was utilized. Axial coding consisted of relating concepts emerging from open coding to each other in order to develop a data matrix (Corbin & Strauss, 2008). In this study, both interview data and *testimonios* were coded using axial coding. Comparisons between categories resulted in the development of abstract ideas about research participants' meanings, action and experiences. I interpreted these emerging conceptual categories. In fact, grounded theory results in an analytic interpretation of participants' worlds and of the processes constituting how these worlds are constructed. This analysis process was iterative. Initial coding highlighted implicit patterns in assumptions or silences in the data; and these initial codes were flexible and active and changed as the analysis became more nuanced. These codes constituted categories and then a data matrix. This data matrix became the blueprint for the findings of this emergent study.

Below I present the codes that were most recurrent along with the number of participants that expressed the code and the total number of excerpts. These lower-level codes were then further categorized into five higher-level themes: stigma, gender violence, state terror/ silent policy, localized reality of mental health, human development and education. I then proceeded to attach a specific color to each higher-level in order to create concept maps that would capture these two levels of analysis. The color-coded themes were matched to the *testimonio* data and are as follow:

 Stigma

 Gender Violence

 State Terror

 Localized reality of Mental Health

 Human Development and Education

These higher-level codes allowed for yet another degree of analysis that bridged both interview and *testimonio* data and structured the write-up of the dissertation. Below I present the names of the most recurrent codes. Recurrence was measured by the total number of participants in which these codes were present and not in the total number of excerpts, as one participant could have repeated one code several times in one interview. There was a total of 118 codes in the interviews, of these, 25 presented more than 4 recurrences and are presented in the table below. For *testimonios*, there were a total of 19 codes, of which only 5 had more than 3 recurrences, which I present in the table below.

Table 4

Table 4. Code Names and Recurrence from Interview Data

Code for Mental Health / Incidence from	Mental Health Practitioners	Women's Right Organization	Total Number of recurrences
Lack of Political Support for Mental Health	7	8	15
Lack of Human Capital in Mental Health	6	8	14
Stigma of Mental "illness"	9	3	12
Impunity's effects on Mental Health	4	8	12
Need of Education and Training in Mental Health	8	4	12

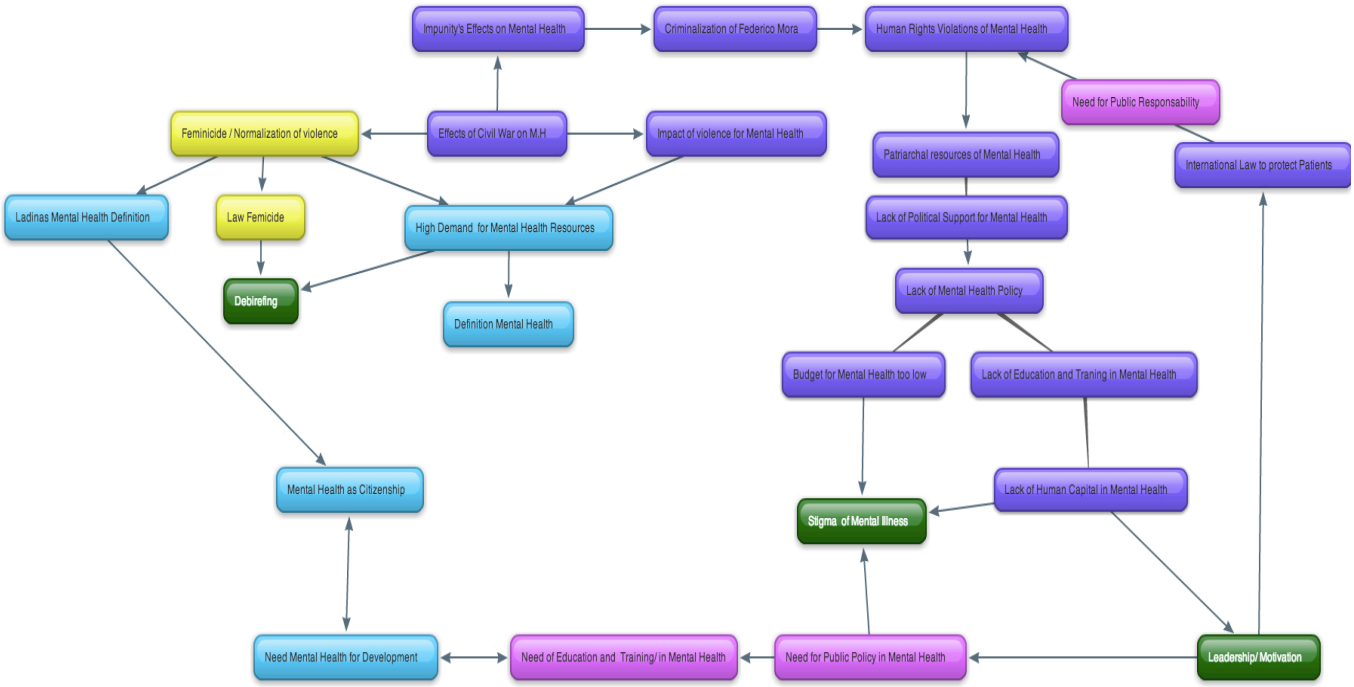
Budget for Mental Health too low	6	7	11
Impact on Violence for Mental Health	4	6	10
Definition of Mental Health pertaining to Guatemalans	7	3	10
Normalization of Gender Violence (feminicide /multisided violence)	3	7	10
Criminalization of Federico Mora	5	4	9
High Demand for Mental Health Resources	4	5	9
Lack of education and training in Mental Health	5	3	8
Need for Public Policy in Mental Health	6	2	8
Allowing Human Rights Violations of Mental Health	5	2	7
It is necessary to have the State responsible for Mental Health	5	2	7
Mental Health Definition pertaining to Ladinas	2	4	6
Need Mental Health for Development	5	1	6
Need International Law to protect individuals	3	3	6
Patriarchal Resources of Mental Health	2	4	6
Law against Feminicide of 2008	2	4	6
The Effects of Civil War on Mental Health	5	0	5

The need of a Personal Motivation/drive to work in Mental Health	5	0	5
Debriefing as only mental health intervention	2	2	4
Lack of Mental Health Policy	3	1	4
A need for Citizenship as Mental Health	4	0	4

Once these codes became clear, I proceeded by creating a concept map to have a visual overall understanding of the relationship between codes. Because each themed code hold two codes (the name of the code and the color), creating a visual map allowed for a clear understanding of the structural forces at play. Figure 1 presents the concept map created for the interview data.

Figure 1. Concept Map for Interview Data

Figure 1



This concept map is a visual representation of the most prominent themes emerging from the interview data. Each theme has further been color coded to account for the five higher-level codes most recurrent in this data: Stigma Gender Violence State terror Localized reality of Mental Health Human Development and Education. What becomes most apparent is the high occurrence of themes relates to state terror and the influence this violence has on the rest of the themes.

Supported by this concept map it becomes clearer that structures of state terror are predominant and affect in some way all other high-level codes: stigma, gender violence, development and education and localized reality of mental health. Furthermore the direct correlation between localized understandings of mental health and education and development also becomes clear in this map. Although not a static process, the reiterative nature of creating a concept map allowed to bring to the surface broad trends. These overall topics inform the organization of the subsequent chapters. For example, Chapter Four, talks about state terror and the institutions of mental health care. Chapter Five is centered on the internalization of gendered violence in the conceptualization of a gendered mental health care. Finally, Chapter Six focuses on a discussion of stigma in an

environment of state terror. I followed the same process-- that of counting the most recurrent themes and creating a concept map-- with the codes emergent from the *testimonio* data.

Although *testimonio* data serves a different purpose then interview data-- that of illustrating with thick description the experiences of the mental health care system, rather then explicating it-- I coded the *testimonios* and present below the most recurrent themes.

Table 5

Table 5. Testimonio Codes and Recurrence

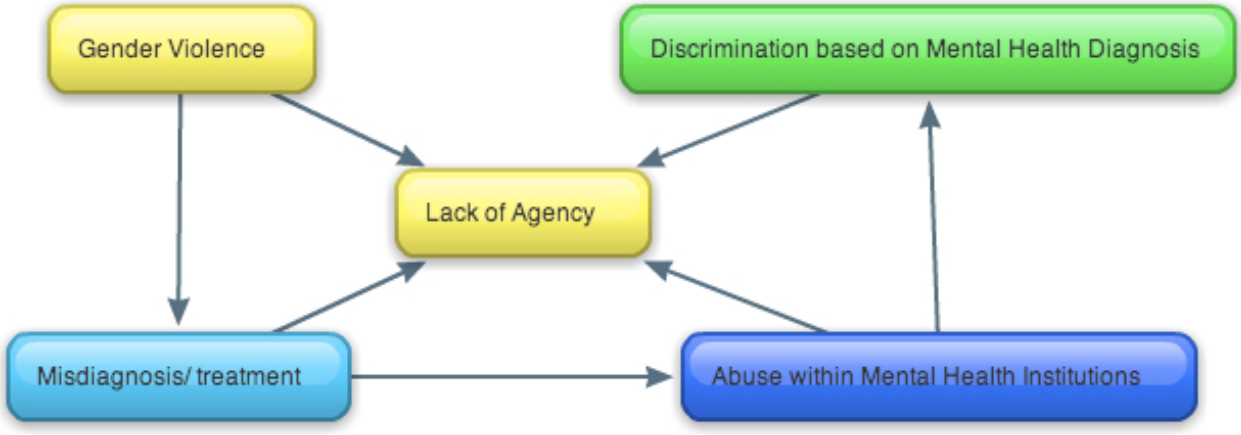
Code	Teresa	Silvia	Total Number of excerpts
Gender violence	30	21	51
Abuse within mental health institutions	22	16	38
Lack of agency over own life decisions	10	12	22
Misdiagnosis/treatment of mental health	8	6	14
Discrimination based on mental health diagnosis	1	2	3

In so doing, I was able to understand once more the broader themes discussed in personal narratives. This exercise allowed disconnecting Teresa's and Silvia's stories from the personal to the political, in order to have a broader vision of the structure at play in their narrative and allowed me to pair their *testimonios* with the interview data. Even if the *testimonios* are used as vignettes to color the environment in which mental health is conceptualized, coding the narratives and aligning under the same process used for the interview data was another way to organize the findings chapters and link *testimonios*

with interviews. Below I present the concept map that portrays the relationship between the codes arising from the interview data.

Figure 2. Concept Map for *Testimonio* Codes

Figure 2



This concept map is a visual representation of the central themes emerging from the testimonios data that have further been color coded to include the most prominent themes from the interview data in order to have a visual understanding of the correlations between the themes of both data sources. In this map, the central theme that emerged from the testimonies was the lack of agency women had over their life opportunities and choices, in particular, their sexualities, this theme was color coded yellow, standing for gender violence. Thus a Lack of Agency steaming already from gender violence makes the heart of both Teresa and Silvia's testimonios. Surrounding the theme "lack of agency" are the four other most prominent themes and their relationship to one another. For example, Teresa recounts she was sexually assaulted as a child. Her lack of agency as a child was further exacerbated by gender violence (rape). Her inability to cope with her rape caused a misdiagnosis of her mental health needs as a mental illness (bipolarity), which in turn is color-coded baby blue that stands for the local realities of mental health. This mistreatment caused Teresa to be interned in the hospital, where she experienced physical and sexual abuse. The theme "abuse within the mental health institutions" is color-coded dark blue, which stands for state terror because it is an institutionalized kind of abuse that is suffered within the mental health care system. After having been released from institutionalization Teresa is now considered "crazy" by society, which is why this theme is color-coded green to represent stigma. Each theme is interconnected and further disempowers Teresa and her ability to be in charge of her life. Thus, this concept map represents the many ways Teresa continues to be discriminated through her gender and her mental health.

The testimonio concept allowed for a theme-appropriated visualization that was more useful than a chronology. Thus, it allowed me to complement interview data with the most relevant vignettes by localizing such quotes by themes. In-depth data encourages the researcher to pursue emergent themes from the field. In fact, defining what is

happening in the field is the first objective of grounded theory (Denzin & Lincoln, 2003), which aligns with the broader research question of this dissertation.

Addressing Constraints to Validity.

Validity has been defined as attached to "truth." Built on Foucault's (1974) understandings of multiplicities of truths, Silverman (2004) defines validity as "the appropriation of research methodologies to those systems of truths that their processes best represent" (p. 91). To achieve "valid" or truthful data, the researcher must make rigorous use of methodologies (Creswell, 1998). Denzin and Lincoln (2003) suggest eight strategies to ensure rigor in a qualitative study. These are: (1) a prolonged and persistent engagement in the field: (2) triangulation, (3) peer review and member debriefing, (4) presentation of counter examples, (5) transparency in the researcher's role, (6) in-member checking, (7) rich thick description when journaling and writing findings, (8) subjecting one's work to external critiques.

The data collection, analysis process, and write up of this dissertation took into consideration these eight strategies. In fact, this ethnographic research was seven months long, concluding after three years of pilot study and relationship building with the participants, using two methods with different populations in order to compare findings. The exploratory component of this work aligns with grounded theory strategies for ensuring validity by letting the participants guide the process, challenging theories with participants' meaning of the phenomena, using participants' words in the exploration of the phenomena, and articulating the researcher's personal insight about the phenomena (Corbin & Strauss, 2008). Because in-depth interviews support participants'

interpretation and meaning making, most of the threats to validity inherent in grounded theory studies are addressed through member checking, prolonged exposure, and thick descriptions. However, *testimonios* have had some particular critiques about ensuring validity.

The most popular *testimonio*, *I, Rigoberta Menchú* begins, "I'd like to stress that it's not only my life, it's also the testimony of my people.... My story is the story of all poor Guatemalans. My personal experience is the reality of a whole people" (1985). Rigoberta Menchú gave her *testimonio* to Venezuelan anthropologist Elisabeth Burgos-Debray as the first account of the genocide that was ravaging Mayan lives in Guatemala in the mid 1980's. Her book was banned from Guatemala in the 1980s, so it was recognized internationally and translated into 11 languages. Rigoberta's testimony became her first step as an activist leader to bring human rights protection to Mayan people. Ten years after the publication of her book, Rigoberta Menchú was awarded with the Nobel Peace Prize. In 1999, American anthropologist David Stroll published *I, Rigoberta Menchú and the Story of All Poor Guatemalans* in which he discredits the validity of Rigoberta Menchú's witnessing and motivations for her *testimonio.* Although this debate has not been resolved, it does point to issues of validity and truth inherent in *testimonio.* The way in which validity in this work is addressed is based on long-term involvement with Teresa and Silvia that allowed for trust and a bond greater than researcher-participant to be established. Especially because these *testimonios* take into account a reflection of past experiences and the perceptions of mental "illness" and institutionalization, a three-year long relationship ensures the validity by restating the stories themselves. In so doing, the *perceptions* and *experiences* of mental health were

shared little by little over the years and particular instances clarified and revisited. In addition, the *testimonios* of Teresa and Silvia will not be understood as speaking of an entire population but rather to exemplify larger phenomena brought to light by the interviews and data stemming from public policy. Next, I explore the researcher's role as one of the most important aspects for reducing validity threats. In particular, reducing *bias* and *reactivity* (Maxwell, 2005).

Researcher's Role.

In ethnographic work the researcher is the tool of analysis. Thus, the researcher's subjectivity or bias cannot be eliminated, rather it needs to be accounted for and rendered explicit in order to minimize *leading* the data. By making assumptions and biases stemming from the researcher's positionality explicit, the researcher's influence on the data can become productive. Reflexivity is the fact that the researcher is part of the world she studies, bringing to light the power and influence inherent in this role (Maxwell, 2005). Understanding how the researcher can influence participants, instruments and protocols minimizes threats to validity. Each researcher's positionality is tied to issues of power and privilege. Self-reflexivity allows the researcher to be aware of this dynamic of power in order to conduct ethical and sensitive research. Because objective observation in ethnographic work is not possible, rather *sensitivity* is sought after. Sensitivity refers to the researcher's ability to pick up nuanced issues and happenings in the data (Corbin & Strauss, 2008).

As a Ladina doing work for mental health this is a very personal motivation as my family has had a history of schizophrenia and depression, resulting in several suicides.

These suicides have barely been discussed and when my mother fell very ill with depression, I was not able to find the care that I would want for her. Unable to care for her myself, I saw from a distance how the mental health care system in Guatemala was punitive for a Ladina that had the privileges to access such resources. Although my mother recovered, the discrimination that she faced because of her diagnoses lingered for many years, losing the networks that prior to her diagnosis were her only support. From my previous research on citizenship education this discrimination looked too familiar, like those from the basis of more visible *isms*. Thus, I embarked on this exploration of mental health constructions with a pilot study in the summer of 2011. Because this research is very close to my positionality as a Ladina and it has personal implications and motivations, I relied heavily on long exposure to the field and member checking as well as different forms of data: policy documents, interviews and *testimonios* to make my analysis. Also, well aware of my bias and in order to reduce my ability to lead the data, I keep a reflexive journal in which I document the assumptions that can bias my understandings and analysis. Throughout the dissertation I paid close attention to counter examples in order to provide a nuanced and complex understanding of mental health and move away from broad and empty overgeneralizations. For example, I had very little critique of the mental health resources available and believed that it was only a matter of Ladinas accessing some type of resource to get support. Throughout the research process I realized that Ladinas had their own critiques about the mental health experience, one rooted in the patriarchal perspective of some mental health professionals. I noted this difference, between my own assumptions and the reality. However, the nuances of a gendered mental health care quality only became clear to me once I sought therapy for

myself and was confronted with *machista* advice. In moments like this one, I present auto-ethnographic narratives throughout the dissertation in order to bring the reader to the thoughts present in that moment and share the nuances of the Guatemalan and Ladina identity formation to which I have an insider's perspective. Because my identity formation racializes and genders me in the same ways as my participants, I pay close attention to class differences.

Being so close to the research has been detrimental to my own mental health. Thus, I took the decision to return to Minneapolis to analyze and write this dissertation, as I believed that I needed geographical and cultural distance to best understand and present my findings. It was my stay in Minneapolis and the fact that I develop this work in English that allowed me the academic distance to cope and ensure the rigor of research done in the field called 'back-home.' Because I am extremely passionate about this subject matter and I am committed to protecting my participants' identities, my findings chapter have been revised by Marco Garavito, a key player in mental health advocacy, and by Kayla, a feminist women's advocate. In so doing, I ensure that the voices of those participants I was unable to render anonymous have consent over their representation while at the same time allowing for a dialogue and reiterative discussion of the findings from those working to advocate for mental health. Finally, I have shared my process with my peers in order to open the discussion about assumptions and welcome critiques to best refine and nuance my analysis. Because the Guatemalan situation is particularly perverse, I also rely heavily on context descriptions and at one point take a historical perspective to contextualize in a macro-level the experiences and definitions of mental

health that otherwise, for those not familiar with Guatemalan history, might seem fictional.

In summary, to ensure *credibility* and present a rich description of the understanding and definitions of mental health, I draw from interviews, *testimonios*, and three different populations: directors of mental health organizations, mental health coordinators of women rights' organizations, and the lived experiences of two Ladinas having been diagnosed with a mental "illness". Second, I ensure *dependability* by making the trace from data collection to interpretation as explicit, transparent, and discernable as possible. Also, member checking helped ensure not only validity but also the protection of those participants' whose opinions do not ensure them absolute anonymity. All through the dissertation I illustrate my arguments with quotes from participants. These were translated from Spanish to English at the moment of write-up. Because of the particularity of Guatemalan Spanish paired in most cases with specific jargon- such as law or psychiatry, both sets of quotes in Spanish and English are presented, so that the nuances of Guatemalan Spanish can be available to bilingual readers. Finally, by combining thick ethnographic description with *testimonios* the findings from this study can be used to elucidate the realities of other urban post-conflict context in which women's mental health has been neglected.

By ensuring sensitivity in the researcher's role, credibility of methods, rigor in study design, and dependability and transferability of findings, this dissertation looks to produce *quality* research. Quality research goes beyond presenting credible data to include innovation. As a participatory method, this study looks to expand on the literature

of feminicide by including mental health as a landscape of violence and in so doing inform public policy by revealing a needs rendering of Ladinas' mental health.

Ethical Considerations.

This section reflects on the ethical considerations of speaking of experiences of social suffering through an ethnographic study in the context of endured violence of Guatemala. This study frames mental health policy as a form of silencing through suffering, and as such it is highly political. One of the goals of this work is to complement education and development policies and complicate indicators that individualize and measure mental health in an environment of violence as an extension of "illness". I intend to employ Kleinman's (1989) recommendations of complicating medicalized understandings of mental health by contextualizing Ladina experiences. Beyond complying with University of Minnesota and local IRB guidelines for working with vulnerable populations, the ethical considerations for this dissertation are that of maintaining participants' safety.

Participants involved in this study can potentially be negatively labeled and, in so doing predispose them to stigmatization. I seek to avoid stigmatizing a population considered to suffer from mental "illness" by ensuring Silvia's and Teresa's anonymity. Thus, their names have been changed and any other information that could reveal their identity has been erased. As for the participants that were interviewed, the names of their institutional affiliations have not been shared. In the cases in which a pseudonym is not enough to ensure anonymity, participant's written consent was given and the dissertation was shared with them so they could be aware of the information shared and provide their written approval.

Limitations.

Although ethnographies are well equipped to provide in-depth thick description of phenomena, they may also be used to oversimplify or exaggerate a situation. It is therefore necessary for the researcher to ensure that generalizations are made through clearly linking data from multiple sources, adherence to high standards of reflection and checking for reliability and validity. The cultural focus of this ethnography recognizes that the research bias cannot be removed; rather it must be accounted for. In order to uncover and disclose my assumptions I have provided a quick overview of my positionality as a Ladina and the implications and motivation for doing this work. Also, I have developed a reflexive research journal to effectively consider the effect that my assumptions have on the interpretation of data. In order to ensure validity, credibility, trustworthiness and transferability of data I have ensured that the concepts and ideas I used are defined and contextualized and are nuanced by a long exposure to the field, peer review, and member checking.

Limitations for this study include the limited number of participants whose testimonios' I draw upon. As Teresa represents a Ladina from a working class and Silvia from an upper class their stories are comparable but more participants would have allowed for a richer comparison for nuanced data applicable to other's situation of mental health. However, it was the particular difficulty of the subject that did not allow for quantity of participants, but rather quality of participants' participation in this study. Thus, I followed Teresa and Silvia for three consecutive years in which I established trust and relationships and we talked about their experiences of mental health beyond the

conclusion of this research. I remain in contact with Silvia and Teresa, at the time of writing.

Other limitations pertain to the short notice in which I sought interviews with the mental health coordinators of women's rights organizations. I was not able to develop a long-term relationship with these organizations since it wasn't until mid- fieldwork that I realized that their perspectives were needed. However, I supported my sampling decision based on NGO's working for women rights that might have skewed the coordinators I interviewed but allowed for some kind of trust to be established in order to have access and allow for in-depth questioning.

Also, there were some institutions that, because of time constraints, I was not able to visit and that could have had provided a different kind of mental health care. In particular, I was not able to access the daytime public mental health system IGSS because of a complicated bureaucracy and non-responsiveness of the director. The one attempt in which I tried to walk in, a security guard escorted me out. Likewise, I had, at different times, interviews scheduled with directors of university counseling centers. Each time the interviewees did not come to our scheduled meetings. Although I consider these perspectives important, I was able to interview directors from an array of mental health institutions and through other participants had a second hand understanding of how these institutions functioned.

Finally a limitation was that I did not foresee the emotional toll that this research would have on my own wellbeing, which caused me to seek for therapy, unsuccessfully, and ultimately with the saturation of data made me decide to shorten my stay in Guatemala. I had initially planed to do a 12-month long ethnography but after having

saturated by sample and because of the density of the subject matter I decided to return to the United States after seven months of study. Before making this decision, I was sure that my entire participant sample had been saturated and that I was not collecting any new information.

Chapter Four examines mental health care, with an emphasis on the history of the Federico Mora Hospital, to highlight the political will behind a lack of mental health policy. Chapter Five concentrates on the way in which Ladinas expressing a mental health care need are further victimized by the system. Chapter Six provides a local perspective of the definition of mental health relevant to the experiences of Ladinas. Chapter Seven expands on the literature of feminicide, psychosocial understandings of mental health, and stigma to argue for the theorizations of mental health as a landscape of feminicide. Finally, Chapter Eight concludes with recommendations that would center mental health prevention and education at the heart of development and education policy studies.

Chapter 4

The Structural Discrimination of Care: The Case of The Federico Mora

"es terrible la situación psiquiátrica en Guatemala y la situación nacional de salud mental es realmente mas terrible." Dr.Luther

" the psychiatric situation in Guatemala is terrible and even more terrible is the national mental health situation." Dr. Luther

Introduction.

On April 26th 1998, Monsignor Juan José Gerardi Conedera, an active participant of the Recovery of Historical Memory Project (REMHI) sponsored by the catholic church, was beaten and killed at his home just weeks after announcing the publication of the report Guatemala: Nunca Mas!-- Guatemala: Never Again. It has been 16 years since the publication of Guatemala Nunca Mas!, which brought to light thousands of *testimonios* of the violence and human rights violations committed during the internal armed conflict. This compilation concluded that beyond the atrocities of war, Guatemalans had lost their voices. One of the main goals of the report was to recognize that these acts had been committed and to give voice and credibility to the victims. Clarifying and explicating what had happened was the first step in documenting the historical memory in order to rescue the collective identity of Guatemala.

As such, this chapter focuses on the aftermath of the civil war on the Guatemalan society, in particular, on mental health care and the consequences of the normalization of state-sponsored gender violence on mental health. In so doing, it

provides the context to understand the experiences and definitions of mental health through the perspective of Ladinas living in Guatemala City. With the purpose of bringing light to the wounds of war that remain raw 16 years later, the findings from this dissertation present mental health as a landscape of state-sponsored gender violence.

The Guatemala public mental health system is comprised of the national mental health hospital Federico Mora, the Instituto Guatemalteco de Seguro Social (IGSS), and ambulatory mental health care units. The day hospital at the IGSS is available only to those individuals having employment with benefits, which represents only about 25 % of the economically active population, thus the IGSS coverage is low and continues to be limited to the urban non-poor (http://www.social-protection.org/gimi/gess/ShowCountryProfile.do?cid=450). Ambulatory units are not considered psychiatric beds. Thus, Federico Mora is the only public institution that makes psychiatric beds available to all Guatemalans, making most mental health care hospitals available only in Guatemala City. This institution holds 33% of all psychiatric beds in the country (OMS, 2011). The private hospitals absorb the rest. Within the private sphere, there are those hospitals that have a mental health staff on-call, the hospital MEDERI that is a psychiatric hospital, and different rehabilitation establishments that offer treatment (OMS, 2011). Rehabilitation establishments are private institutions that function as centers for individuals struggling with substance abuse or with a mental health need. These establishments absorb 49% of institutionalizations (OMS, 2011). In a country where it is estimated that 30% of adults suffer from a mental "illness" (Lopez & Cardona, 2010) and medication costs upwards of 26% of the minimum wage, accessing free mental health care is crucial (OMS, 2011).

Giving this context, this chapter will be presented in three sections. First, as a case analysis, the history of the Federico Mora Hospital is read as text through which the structural discrimination against mental health can be illustrated. As a site of analysis, the Federico Mora hospital permits an examination of the institutions of care in order to understand the ways in which Ladinas' mental health needs are accounted for by government policy. Secondly, I present the criminalization of mental health and the consequences for Ladinas being diagnosed and institutionalized. Finally, supported by the testimonio of Teresa and Silvia I illustrate the lived experiences of being institutionalized to further explicate the consequences of structural discrimination against mental health.

The Federico Mora Before the War.

The Federico Mora Hospital was founded in 1974 and opened its doors in 1975. Its first name was, *el hospital neurologico tipo granja* "the farm style neuropsychiatric hospital." I interviewed Dr. Luther, the first assistant director of the Federico Mora from the hospital's establishment in 1974 to its opening in 1975 until 1980. When I first met Dr. Luther he asked me if I had been to the Federico Mora, when I said yes, he replied, "you went to hell didn't you" ("estuviste en el infierno verdad?") and I had to agree. He laughed and thanked me for making him remember his younger years. Dr. Luther is a bright psychiatrist in his mid-90s and he still holds a private practice. I came to him to know first-hand the history of the Federico Mora, since other participants remembered the hospital to be a beautiful facility, which was hard to believe given the building I had recently visited. For example, Roberto, the director of the Human Right Commission, spoke of the great beauty of the hospital from his childhood memories. It so happened

that his mother had worked as a psychiatric nurse at the Federico Mora, and when I interviewed him he shared,

> Era un hospital modelo en America Latina y fíjate que fue tan modelo en America Latina que mi mama siendo enfermera fue una de las pocas enfermaras que tuvo especialización en enfermería psiquiatría y trabajaba en las comunidades terapéuticas. Entonces me imagino que cualquier instinto maternal no te iba permitir exponer a sus hijos si era una experiencia desagradable. Yo me acuerdo que algunos sábados porque mi mama era la responsable del trabajo de enfermería y ella llegábamos sábados y me estaba allí, y estaba. Con las personas allí recluidas.
>
> It was a model hospital for Latin America and it was such a model in Latin America that my mother, being a nurse, was one of the few that specialized in psychiatric nursing and worked in the therapeutic communities. So I imagine that any motherly instinct would not let you expose your children if it was an unpleasant experience. And I remember that some Saturdays, because my mother was the chief of nursing, she would bring me and I would hang out with the people held there. (Personal communication, April 9th, 2013).

The thought of a child spending a Saturday at the Federico Mora today is unimaginable; to such degree that even Roberto does not draw from his own experience, but rather from his mother's motherly instinct that the hospital could have been a safe space. The fact that this assumption does not come from the hospital or his experience directly, but rather from memory of his mother's ability to bring him to the hospital as a child, illustrates the difficulty of imagining the Federico Mora as a safe space. Similarly, Dra. Cadelaria, the director of the only private hospital specialized in mental health of Guatemala City explicates similar thoughts.

> Dicen que el Federico Mora cuando empezó era o sea era una belleza. Era una belleza la idea del fundador o co-fundador del Federico era realmente que hubiera un lugar para la gente que tuviera

> la salud mental era a nivel casi Centroamericano, Latinoamericano la idea era muy buena y el lugar era grande y bello.
>
> They said that when the Federico Mora started it was, like it was a beauty. It was a beauty and the idea of the founders or co-founders of the Federico was to really have a place for people's mental health at a Central American, Latin-American level, the idea was great and the place was grand and beautiful. (Personal communication, March, 26th 2013)

The phrase, "dicen que," is an idiosyncratic term used in popular Guatemalan folk tale; it is used to describe the Federico Mora as a beautiful place by stating "dicen que" as a connotation of disbelief that portrays the hospital as a sort of urban legend. In addition, when she repeats the "it was" twice, "era, o sea, era" Dra. Cadelaria is marking a tension between the hospital's beauty and the implausibility of such beauty. As a Guatemalan who has known of the hospital but did not visit it until my fieldwork, I was also incredulous to hear that the Federico Mora could have been a beautiful place. That is why I met with Dr. Luther, I wanted to see the hospital through his experience, as he was part of its inauguration, but even he, when he started recounting his experience at the hospital, started his narrative by stating, "Anécdota: este hospital era tan lindo, tan bonito," ("Anecdote: the hospital was so pretty, so beautiful.") The preamble "anecdote" stripes away the factual beauty of the hospital as truth and rather recounts it as a *once-upon-a-time* memory. The way in which different participants spoke about the Federico Mora's past highlights the discrepancy between what the hospital was and has become. In other words, these figures of speech underscore the difficulty of reconciling two conflicting realities of a same place.

Although the Federico Mora appears to have been a beautiful institution, it was still an exception within the overall context of mental health that Dr. Luther describes as

the, “descuido total de la asistencia psiquiátrica” (“total neglect of psychiatric assistance”). In fact, such a great hospital was possible due to the political pressure from the Guatemalan psychiatric associations of the time in combination with the expertise and financial support of the Pan-American Organization of Health (OPS) and the World Health Organization (OMS). Dr. Luther explains, “Por eso le digo que era un centro excepcional y tenia mucho apoyo internacional” (“that is why I am telling you that this was an exceptional center that had a lot of International support”). Dr. Luther recounts the dream to make a hospital as a regional training center because the only country at the time that had some development in mental health was Costa Rica, but little was done in the rest of Central America. The hospital had been crafted for a maximum of 200 patients and partnered with vocational school training centers to provide patients with a reintegration program. Following International standards the hospital looked to decrease the time spent interned by having fewer patients and allowing only a short stay,

> Que era 30 días máximo de hospitalización. Para esa época talvez en los Estados Unidos andaba en 15 o 20. Y así se empezó a trabajar. Entonces subimos toda una serie de apoyo para poder lograr hacer esto sacar pacientes pronto teníamos una estaff considerable y cada paciente tenia su cama particular de media cabellada digo yo, tenia un closet al lado y una mesita de noche. Y no había uniforme, y no había barreras y era verde.
>
> It was a maximum of 30 days of hospitalization. For the time in the United States they were at 15 to 20 days. And so that is how we started working. So we had a series of supports, in order to achieve shorts stays of patients, we had a considerable staff and each patient had its own bed, a closet and a nightstand, there were no uniforms, no gates and everything was green. (Personal communication, April 8th, 2013)

Although the hospital was a model institution, the idea was still maturing in the overall political context of Guatemala in the mid 1970's. The Federico Mora ran for eight years in parallel to the already established hospital called Hospital Neuropsiquiatrico Miguel F. Molina. This hospital was established in 1946 and was the name given to the "Antiguo Asilo de Dementes," " Old Insane Asylum" that ran since 1890 in Guatemala City (Rojas Limas, 2004, p. 499). In 1985 the Hospital Nacional De Salud Mental Federico Mora was formed from the merger of the Hospital Neuropsiquiatrico Miguel F. Molina and the Hospital Tipo Granja Carlos Federico Mora,

> Entonces abrimos y ya existía el antigua hospital psiquiátrico […] era un campo de concentración mas complicado y terrible. Yo hice mis practicas como estudiante allí. […] Y había el nuevo neuropsiquiátrico y el antiguo, siempre pensamos que no era conveniente mezclarlos, eran dos tipos diferentes de cultura. Cultura adecuada a lo contemporáneo de la época y la cultura de lo antiguo de unos cien años.
>
> So we opened and already an ancient hospital existed […] that was a much terrible and complicated concentration camp. I did my residency there. […] So there was the new neuropsychiatric and the old one, we always knew it was not convenient to merge them, they represented two different cultures. A culture adequate to contemporary trends and a culture of the ancient, of over one hundred years. (Personal communication, April 3rd, 2013)

It became obvious that the internationally funded hospital was praised for its modernity and progress, at the cost of the national hospital Molina that followed an asylum model. This tension between "contemporary" and "ancient" highlights the context in which the Federico Mora tried to blossom. Eight years after its opening, however, in 1982 the Rios Montt administration hired a new director and merged both hospitals. Dr. Luther recounts that day with great regret and anger,

De repente llego la orden "traslado del hospital Viejo psiquiátrico al Nuevo". El Nuevo hospital talvez, talvez no recuerdo tendría entre 50 y 60 pacientes. En el otro hospital habían mil. Y entonces de repente la orden desde allá arriba así que como dicen en Guatemala… los metieron en camioneta, buses no se en que porque no participe en eso y los trasladaron al Federico Mora. En algún momento ha de haber clandestinamente donde habían carpas y pacientes nuevos y pacientes antiguos y personal antiguo y personal nuevo, para mi se volvió un caos no solo de pacientes pero de personal.

Suddenly, came the order from above "relocation of the Old psychiatric to the New one." I can't really remember but maybe, maybe it had 50 or 60 patients. The other one had one thousand. So suddenly the order *from up there* --how we say in Guatemala-- they put everyone in a van or a bus, and they got transferred to the Federico Mora. At some point there were clandestine tents, new patients and old patients, new personnel and old personnel, to me that became chaotic not only for the patients but for the staff as well. (Personal communication, April 3rd, 2013)

Not only was the merger chaotic because it was unplanned, but it also meant dismantling the board of directors. Even though Dr. Luther had been part of the planning committee for the hospital before its construction, like his peers, he too lost his position,

Entonces nomás se asumió Rios Montt la siguiente semana, yo fui despedido del departamento de salud mental "preséntese a las autoridades muchas gracias por su servicio y usted esta fuera, y porfavor no hable nada," una amenaza verbal muy sutil pero directa. Entonces pues ni modo. […] Entonces el departamento de salud mental existió uno o dos años mas y también lo cerraron. […] El hospital se volvió un caos y lentamente empezaron los cambios. Eso fue en el '82 el hospital continuo su curso según yo en decadencia. Ya no hubo lo mismo que antes y con esa cantidad de gente imposible. La conducta mundial el esquema era vaciar el hospital.

The week after Rios Montt took power, I was let go of 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 one or two more years and 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 scheme was to empty the hospital. (Personal communication April 3rd, 2013).

The civil war diverted the Federico Mora's mission and since then has not been recuperated. Roberto affirms that it was the dictator's rule that dismantled the hospital and its original mission has yet to be restored,

> Entonces yo por ejemplo recuerdo porque mi mama lamentablemente después de la experiencia del hospital psiquiátrico del hospital de salud mental paso a trabajar al hospital psiquiátrico en los últimos años después que se fusionara, una decisión política de un dictador. Así que de paso esta siendo enjuiciado en el momento. Yo presencie el trabajo, los electroshock en los que era una cosa desagradable […] el criterio de salud mental en vez de ir mejorando su atención en vez fue un deterioro cual es lo adecuado del uso del electroshock. Cuando en muchos países esta prohibido esta legislado la prohibición, como puede ser?

> So for example I recall because my mother sadly after her experience at the psychiatric hospital had to work in the national mental health hospital after its fusion, a political decision of a dictator that at this moment is being trialed. I witnessed the work of electroshocks that was very unpleasant […] the criteria for mental health instead of improving, got deteriorated what is the adequate use of electroshock? When in many countries there is legislation to prohibited the use of electroshocks, how can that be? (Personal communication, April 9th, 2013).

Roberto's work on human rights centers his concern on the use of electroshocks, however this example highlights the decay in mental health treatment before and after the civil war. Dr. Rodriguez, a social psychiatrists that has been a consultant for the Ministry of Health, also speaks from a place of frustration and anger,

> durante el tiempo de Rios Montt uno de los hijos de Rios Montt que estaba en el ejercito también tomo la brillante decisión de unir el hospital Nacional de Salud Mental con el neuropsiquiátrico. Imagínate la gente que trabajaba en el neuropsiquiátrico o que llegaban a ver a su familia y su hospital ya no estaba. Lo trasladaron todo en un día. Entonces la misma filosofía y concepto desaparecida, se convirtió en lo que es ahora. Entonces porque culpabilizarte al actual hospital y a la gente que trabaja allí es realmente no solo un poco injusto sino esconder las verdaderas causas de que porque las cosas están así.
>
> During the Rios Montt years one of the sons of Rios Montt that was in the army also took 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 translated in one day. So the same philosophy and concept disappeared, it became what it is now. So 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. (Personal communication February 2nd, 2013).

The civil war dismantled the hospital's mission by merging both neuropsychiatric hospitals, which increased the patient numbers, closed the mental health bureau, and the plans to follow international trends. Having a high number of patients, mismanaging the use of therapy such as electroshock, and not focusing on short stays over the years allowed for a "decay" of treatment. Dr. Luther recalls it as a lost dream, in particular because as of 2013, the hospital is under prosecution for human right violations.

The short life of the Federico Mora as a model of attention and a training center for Central America provides a snap shot of the possibilities for mental health when political will abides. However, the war terrorized the advancement of mental health care by causing a "contemporary" hospital to fall into the asylum model of the late 1800s. As an institution of care co-opted by the civil war, the Federico Mora is an example of the prevalence of the power of state terror today.

Next, through the mental health work of Marco Garavito and an exploration of the Federico Mora's current state, I expose the institutional stigma that affects the patients of a neglected hospital. In so doing, the history of the hospital clarifies in more depth the degree to which mental health today is a landscape of state terror.

The Federico Mora Today.

The civil war changed the make-up of mental health from the care provided by the hospital Federico Mora to the way mental health care is conceptualized today in Guatemala. In fact, one of the first massacres at the Universidad San Carlos, during *la Violencia*, was against psychology students at that time who, before the war, had a community-based approach contrary to the more individual understanding of mental health used currently. The story of Garavito helps understand why mental health is a political landscape targeted by the civil war.

Garavito got interested in mental health work from a community, psychosocial perspective from the lessons learnt during the civil war. In the 1970s, as a professor in the rural campus of the Public University San Carlos, he fled to Guatemala City after the army vandalized a mural of workers' rights he had helped paint on campus. Knowing that his colleagues who stayed behind had been murdered, he knew that, "no habia ninguna

otra alternativa," " there was no other choice," it was either the guerilla or "o morirse," "dying," As a guerrilla member, Garavito lived in the mountains and worked along-side countrymen and women. The mountain he said was a solitary place that can become a prison, where coping skills are tested. His life in the mountains became the pedagogical space where he learnt the meaning of resilience, how, "en el marco de realidades muy complicadas uno saca lo mejor y las ventajas a lo que cada momento tiene," ("in the framework of very complicated realities, one takes out the best of each moment and make it into an advantage.")

The guerillas and the mountains became a, "una gran escuela de vida, una gran escuela de salud mental," a ("great school of life, a great school of mental health.") There, he learned to define mental health as, "saber responder a la realidades de la vida," ("knowing how to respond to the realities of life.")

Living in the mountains also allowed him to experience first-hand the consequences that the civil war had on mental health. For Garavito it is clear that mental health in Guatemala is tied to a revolutionary ideology that needs to be translated into every day work for justice and citizenship,

> Unirse a la guerrilla fue un gran proceso de salud mental porque en la ciudad vivía en la inseguridad que lo mataran. Y luego cambian las cosas entonces si por opción de salud mental, la organización, la educación, es la opción y ahora es lo que hacemos es lo que hago, formar procesos como lo que esta acá, es lo que llamo lo que yo defino en el sentido de que tristemente en este país los macro-proyectos políticos no existen. La Liga es solo un micro proyecto.
>
> Joining the guerrilla was a huge process of mental health because in the City one would live in the insecurity of being killed. Then things change, so the option for mental health is organizing, is education those are the options. Now that is what we do and what I do, create processes, like the

> one we have here. It is what I call and define in the sense that sadly this country has no macro-political projects, they do not exist and The League is only a micro-project. (Personal communication, February 18th, 2013).

Becoming a guerrilla member was a personal decision for his mental health. In other words, Garavito could not tolerate living in insecurity and fear, so he joined the guerrilla to fight for justice and therefore make not only a moral commitment but also one that would secure him a healthy, secure life. Once a civilian, Garavito looked to continue this work, especially in the context of post-peace accords Guatemala. Garavito joined the guerrillas as a way to take care of his own mental health and defend his rights as a citizen. Witnessing the war, he knew that the country would have a high demand for mental health, but in particular a mental health that, "nos obliga a los guatemaltecos a reencontranos y reconstruir este país pero solo juntos," ("forces Guatemalans to re-unite and re-construct the country, but only together.") Rather than opening his own NGO, Garavito revived the League for Mental Hygiene that was born from the October revolution of 1944 in the mid-'90s. Within the League he was able to continue focusing on mental hygiene through community organizing and education programs in order to fill the lack of a macro- political mental health project in the country. It was his personal experience and work as a guerrilla member that gave him the insider understanding of the importance of mental health for the Guatemalan population after the signing of peace,

> era obvio que las familias que perdieron sus hijos estaban al margen de apoyo, era necesario hacer una linea directa.

> It became obvious that the families that lost their children were at the margins of support; it was necessary to create a direct line. (Personal communication, February 2nd, 2013)

During 1996-1999, Garavito worked directly with the rural communities most affected by the genocide, without publicizing it. His purpose was to create "a human and social tie" with the families most affected by the war. He explains that the fear was so intense; that getting families to break the silence and voice that their children had been disappeared was the first step for mental health. It was through building personal relationships with 240 families that he created the program that he named *todos por el reencuentro*, "all for the reencounter," with the conviction that mental health comes from,

> esa capacidad de vincularse los unos con los otros por eso que el programa se llama "todos por el reencuentro" verdad? Porque es un tema de todos, no solo de las familias, es un tema de los medios, es un tema de la sociedad."
>
> That capacity to bond with one another that is why the program is called "all for the reencounter," right? Because it is a subject that affects all of us not only the families, it is a subject of the media, a subject of society. (Personal Communication, February 18th, 2013)

What Garavito reminds us with his work and conceptualization of mental health as mental hygiene is that the tactics to dismantle community life employed during the civil war still haunt Guatemalans' ability to organize today. Thus, for Garavito, mental health needs to be equated with the exercise of a critical citizenship,

> todavía es como una voz en el desierto, sabe feo decirlo porque el único que anda clamando soy yo, el tema de salud mental en Guatemala uno casi no encuentra voces que lo acompañen entonces eso tiene una limitación, y yo me doy cuenta que hemos caminado, hemos avanzado pero creo que me voy a morir y como contar las alianzas y los aleros para eso. Porque la salud mental sigue siendo concebida como algo accesorio, como algo accesorio simplemente no es importante usted de salud mental no se muere, si es salud mental hay que curar los locos y puntos no se entiende que la salud mental es un fenómenos de vida cotidiana.

> Still is like a voice in the dessert, it brings a sour taste to my mouth to say that because the only one claiming it is me, the theme of mental health in Guatemala you can hardly find voices that accompany it, so that is a limitation, and I realize that we have made a path, that we have advanced, but I think I will die without knowing who are the allies and wingmen for it. Because mental health is still conceived as something accessory, as something that just does not matter, because one cannot die from mental health, because if it is mental health one should go cure the crazy and that is it. There is no understanding that mental health is a phenomenon of daily living. (Personal communication, February 18th, 2013)

Garavito speaks to a reality that I observed: there is a neglect of mental health in public discourses, advocacy and, investment. Even within development programs, mental health is considered a luxury that cannot trump primary needs. However, Garavito constructs mental health in Guatemala from the perspective of quality of everyday life that entails the ability to break silences, to speak truths, to acknowledge violence, to exercise citizenship, and to fight for freedom. This understanding is nevertheless considered revolutionary in a country where expressions of mental health needs are equated with diagnosis of mental "illness". Such understanding strips mental health from the historical and present state of terror, and instead, renders "illnesses" a-political and an individual concern. Similarly an a-historical analysis of the Federico Mora does not allow holding the structures of state terror responsible for the ways in which the hospital functions today. For that reason, aligned with Garavito's conceptualization of mental health, I continue with the analysis of the Federico Mora as a symbol of the political will behind mental health.

As the only public, free mental health institution, the Federico Mora is mostly seen as the last resource to turn to. Even when considering the fact that 96% of the budget is dedicated to the mental health program, the hospital is in dire condition. With a capacity for 250 psychiatric beds, the hospital houses 334 patients (DRI, 2012). Teresa, a Ladina whose *testimonio* speaks of the discrimination faced when diagnosed as mentally ill, struggled to receive affordable treatment. When her diagnosis left her homeless, and unemployed, her last resort was the Federico Mora,

> Como no tenia trabajo, ni casa, entonces como no tenia a donde ir fui al Federico Mora […].Yo lo tome, dije ya se hizo, soy una carga de la familia una desecho de la sociedad, y allí andaba con esa ropa que te dan que parece que paraste en el infierno.

> Since I had no job, no home, since I had nowhere to go, I went to the Federico Mora. […]. I had to take it, I thought to myself, it has happened, I am a burden to my family, the scum of society so there I was with those clothes they give you that look like you landed in hell. (Personal communication, January 20th, 2013)

Teresa's experience speaks of the stigma allocate to the institution of the Federico Mora. Also, similarly to Dr. Luther who jokingly told me when I confirmed having visited the hospital, "you went to hell didn't you?" Teresa equates the Federico Mora to having "landed in hell." From my own experience I find this comparison, although dramatic, quite accurate. When I first arrived at the hospital, I was greeted by a military like security checkpoint, besides which a two-foot tall sign read, *enter at own risk.* When the barricade opened and I was able to drive to the administration pavilion it took me some time to realize I was driving through the recreational area of the hospital. I passed patients with bloody and black and blue bodies, which were noticeable since most of

them wore torn clothing or were naked. After two years of reading about mental health stigma, I hated myself when I locked the car doors anxiously and rolled my windows up; I felt scared. In particular, I was scared to see so many guards, armed and in full uniform, next to what seemed like defenseless, naked, wounded bodies. As I walked out of the car, a patient that was surrounded by two guards, making me assume he was a prisoner, taunted me with very explicit sexual provocation, joined by the guards who whistled at me. This first impression of the hospital is a snap shot of the tensions and power dynamics present when patients and prisoners are in the same institution where guards out-number medical staff.

In fact, the Federico Mora, is divided into eight pavilions segregated by gender, level of "illness", and judicial status housing prisoners that are diagnosed with a mental "illness". Whereas there is an estimate of two nurses per 60 patients there are approximately 110-armed guards for 50 prisoners. Although the hospital has segregated pavilions, these are not secured, so that patients, prisoners, and guards roam the hospital freely. Kayla, a women's rights activist that lobbies to prevent women from being institutionalized in the Federico Mora explains,

> El Federico Mora esta estructurado para ser una cárcel psiquiátrica. Entonces tenemos criminales interactuando con personas. Entonces no esta perdida. Eso es el hallazgo. Si ese es el hallazgo y es precisamente la razón por la que nosotros peleamos porque nosotros por ejemplo, y se lo cuento con historias de vida porque es mas fácil. Tenemos a una sobreviviente con altísimo riesgo de suicidio las únicas dos opciones: el Federico o el IGCSS. Entonces hicimos todo el lobbying correspondiente para que la ingresaran al IGSS -ella sin tener IGSS- entonces fue mas bien jugar con contactos e influencias pero sino se nos hubiera ido al Federico y allí hubiera sido peor la situación entonces esas son nuestras realidades.

> The Federico Mora is structured as a psychiatric prison. So we have criminals interacting with people. So you are not lost, this is the finding. These findings are exactly what make us fight for what we fight, for example, let me explain it to you with a life story because it is easier. We have a survivor with a very high risk of suicide, we only have two options: the Federico 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 have gone to the Federico and there the situation would've been worst, and those are our realities. (Personal communication, March 21th, 2013)

From model hospital to "psychiatric prison," the Federico Mora's criminalizes its patients to the degree that psychiatric care is equivalent to being institutionalized in hell, and women advocates lobby to prevent patients from being accessing the hospital's care. The conditions of Federico Mora are well known, to such a degree that when I interviewed the director of the mental health program, Dra. Joyce, she explained very candidly,

> No los estamos refiriendo directamente ni al hospital psiquiátrico [Federico Mora], porque si es hospital no se si usted ha tenido la oportunidad de conocer el hospital psiquiátrico de acá de Guatemala es totalmente depresivo mando yo a mi paciente con síntomas de depresión allí lo voy a ir a terminar de acabar.

> 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 of Guatemala, but it is totally depressive. If I send one of my patients with symptoms of depression there, I would finish to end him. (Personal communication, April 8th, 2013)

Even the director of the national program of mental health does not consider the Federico Mora fit for her patients, but more as an institution that would "terminar de

acabar" patients under its care. Although I translated *terminar de acabar* as "finish to end him" it does not capture the rich meaning behind the Spanish expression. What Dra. Joyce is suggesting is that the "care" provided by the Federico Mora would have the opposite effect on someone expressing a mental health concern such as depression, rather it would destroy or "end" such individual. What is also implied in the repetition of two synonyms of the verb to end, *terminar de acabar,* is that the individual would be destroyed through what has brought her to seek care, the illness that already is making the patient not well- in this example, depression. Thus, this expression has a dehumanizing implication similar to that in English of *putting down,* in which an animal is euthanatized as there is no cure for an illness, or to avoid further suffering. In this context, however, *putting down* suggests death or destruction through an unethical inhumane "care." Dra. Joyce, as the director for the national mental health program is well aware of the cruel treatment the national hospital offers as "care," a treatment that she would not provide her own patients and that she implies is one that subdues individuals. The "care" provided by the Federico Mora is so terminal, that a third of its patients are considered abandoned by their family members, having been interned for more than ten years (OMS 20011). In fact, the hospital does not have a reintegration program with only 23% of patients institutionalized for less than a year and 22% staying in the institution for more than 4 years (prensalibre, 2009, OMS 20011). As Sandra, who oversaw and external evaluation of the hospital explains,

> resulta que de un 100 por ciento el 76 por ciento de los pacientes no debería de estar en el hospital y la única razón por la que esta en el hospital es porque no tienen un apoyo social para salir y cuando pasa esto pues el estado no puede decir "bueno como no tienen a nadie pues que se quede en un hospital psiquiátrico."

> We found that of the 100 percent of patients 76 percent should not be in the hospital and that the only reason why they are at the hospital is because they have no social support once they are out and when this happens, the sate cannot say, "well since you have no one, stay in a psychiatric hospital." (Personal communication, May 29th, 2013)

These facts demand a discussion about mental health and the right to citizenship, as it appears that beyond a need to care for their mental health, patients and prisoners are alike in that they are detained in the Federico Mora by desertion or judicial orders. Yet another example of the Federico Mora functioning more as a psychiatric prison than an institution for mental health care are the experiences of Dr. Rodriguez, who worked for some years as the resident doctor,

> Había una prostituta y un juez la mando al hospital. Pero no la podíamos sacar del hospital no la podíamos dar de alta porque estaba allí por orden judicial. Entonces es cierto que a nivel personal las personas pueden hacer hacia otras personas en cuanto su patología. Pero es todo lo que las instituciones y el estado en contra de estas personas […] los aspectos interesantes que tienen que ver con políticas del paciente a la institución psiquiátrica. Cual son los parámetros? Es desde el ingreso del paciente a la institución psiquiátrica cuales son los criterios de un ingreso involuntario quien decide si una persona debe o quiere ingresar a un psiquiátrico la forma en que se hace la forma en que los que tiene algo mas básico que violan los derechos humano, la forma en que miden que comparten una cama dos personas y una cama solo el catre sin el colchoncito, es una cantidad de cosas increíbles. Entonces si, te digo creo que digamos las historia de vida de cómo otros han afrentado como otras personas se convierten en victimarios es muy interesante, y un poco mas de fondo como las instituciones son las que vulneran peor aun instituciones que en teoría deberían de estar para la protección de las personas como estas instituciones se convierten en sus peores verdugos.

> A judge sentenced a prostitute to the hospital. We could not discharge her because she was there under judicial orders. So it is true that at a personal level people can decide other people's pathology. But it is because of the institutions and the state is against these people […] the interesting aspects are those that have to do with the policies that consider the patients of a psychiatric institution. What are the parameters? It is from the institutionalization what are the criteria of involuntary ingress, who decides who needs psychiatric institutionalization, the way that this is done, the way that from a most basic place human rights are violated, the way in which two people are sharing one bed, two people and one bed frame without the mattress, it is a quantity of incredible things. So yes, I think that let's say the life story of how others have confronted, how people become victimizers is interesting and more in depth, how institutions are the ones that render vulnerable, worst those institutions that in theory should be at the protection of the people these institutions become their worst executioners. (Personal communication, February 14th, 2013)

Dr. Rodriguez explicates that mental health care in Guatemala is conceived as a prison where the state can decide individual's pathologies due to their undesirability, or "deviance." In this example, a prostitute was committed not because of a medical diagnosis but rather by judicial orders. As Dr. Rodriguez explains, the state and mental health institutions commit people they are "against." The blurring of the Federico Mora as a care and penitentiary institution seems to entangle "illness" with deviance. This confusion recalls the first asylums of XVII century France, where hospitals were not hospital per say, as they did not offer medical treatment or any medical involvement but rather, functioned as prisons for the poor (Conrad, 1980). As such, the Federico Mora fails to care for the mental health of its patients, and rather becomes their "worst executioners." In so doing, the Federico Mora functions as an invisible arm of state terror

that “finish to end” those who express a mental health need or are considered unwanted individuals.

The Criminalization of Mental Health.

Between 2011 and 2012, Disability Rights International (DRI), led an evaluation of the conditions of the hospital Federico Mora. What they found was a series of human rights violations counting as torture, putting the 334 patients were interned as of 2012 in immediate risk of suffering “serious physical, psychological damage, including losing their lives” and concluded that it was the “most dangerous situation that DRI has reported in all of Latin-American” (Disability Rights, 2012, p.3, p.5). From this evaluation, on October 13, 2012, DRI presented a precautionary measures request to the Inter-American Commission for Human Rights in Washington D.C. where they detailed the context in which the patients are detained. This context can be classified into four categories: decay of living conditions and sanitation, generalized sexual abuse, gang related violence, and inadequate medical treatment.

One of the most striking problems of the Federico Mora is the lack of material capital that reflects the belief that mental illness is not worthy of human conditions. The material conditions that oblige patients to live in deteriorated rooms that have no windows, floors, and sometimes are missing roofs is symbolic of the discrimination and inhumane abuse that is framed as “care.” In fact, there is no potable water on the premises, which makes patients suffer from preventable illnesses and hygiene problems.

The shortage of food, hygiene products, toiletries, beds, clothes, and linens are aggravated because the institution is highly overpopulated. This overpopulation forces the staff to place patients in solitary confinement for long periods of time, in rooms that are deteriorated and have no ventilation or sanitation amenities, leading to the death of seven patients from the lesions caused when in these rooms. Also some women and under aged patients are put into solitary confinement to reduce their risk of sexual assault. Sexual and physical abuse is generalized, putting patients at high risk of contracting HIV/AIDS due the lack of control of the individuals with the virus. It is believed that the guards are the main perpetrators of these abuses.

In fact, the hospital is located in one of the most dangerous zones of Guatemala for being in the territory of the gang *Mara 18*; some staff of the hospital have direct links to this gang and use the hospital and patients for arms, drug, and human trafficking. Doctors and other staff are afraid to report these employees for fear of violent repercussion.

Due to these conditions, DRI concluded that the authorities of the hospital are neither guaranteeing the basic protection or survival of its patients nor provide them with an adequate medical and mental health treatment. DRI observed that patients were given high levels of sedatives that acted more as a way to control patients than to care for their health. For example, Teresa remembers her institutionalization at the Federico Mora,

> Al Federico Mora llegue con un intento de suicidio entonces mi hija desesperada me llevo. La intención era que me medicaran porque entre mas sedada estuviera mejor. Les dije que oía voces que no se que, que no se cuanto, entonces me dijeron que lo que me daban le podían voltear los ojos pero no importo si me ponía en otro mundo.
>
> I got to the Federico Mora because of a suicide attempt, so my daughter in desperation took me there. Their intention was to medicate me, because the more sedated I was the better. I told them I

> heard voices, whatever other things, what they gave me flipped my eyes, and it didn't matter if that put me in another world. (Personal communication, January 29, 2013)

As she recalls, the medicine she was given "put her in another world." On her second visit to the Federico Mora, she was put on lithium, a psychotropic drug used for the treatment of bipolar disorder. Once Teresa got out, she asked the doctor if she had been diagnosed with bipolarity, the doctor replied she was not. When she questioned him about the treatment she had received he responded, "Bueno me dijo porque como vino usted en crisis, estuvo hospitalizada," ("Well, he said, because you came in a crisis and you were hospitalized.") These experiences illustrate that Teresa was not treated for her diagnosis, but rather for the sole fact that she was interned at the Hospital. This is a clear example of the DRI's conclusion that psychiatric treatment is provided by availability rather than on the need of the patient. In fact, DRI has estimated a mortality rate of 20 people a year due to the mistreatment of patients and other malfunctions of the Federico Mora.

The Normalization of the Abuse Against Mental Health Patients.

It is now obvious that the Federico Mora functions more as a prison for the poor than a hospital. Yet without any other public, community services or systems that can support people suffering from disabilities or mental illness, the hospital becomes the only choice for those individuals that are already vulnerable. In 2009, Guatemala ratified the United Nations Convention on the Rights of People with Disabilities, a treaty that stipulates that the disabled, including the mentally ill, must not be arbitrarily detained from society. In May 2013, Guatemala also endorsed the W.H.O. mental health plan that

calls to move centralized mental health hospitals to community based care. Despite these treaties, on December 27, 2013 the government of Guatemala responded to the cautionary measures presented by the DRI report entitled, "informe del estado de Guatemala elaborado por la comisión presidencial coordinadora de la política del ejecutivo en material de derechos humanos COPREDHE" (see Appendix B for document).
The report denies the complaints placed by DRI and responds only by temporarily placing prisoners in a different precinct with a one-time budget increase of 1 million quetzals (roughly 130,000 USD), in order to create a mental health facility within the prison system. It was only because of international pressure that the Guatemalan government pledged to improve conditions at the hospital and for the criminally charged psychiatric prisoners to be separated from civilians.

What the DRI evaluation highlights is that there is an intentional action behind the abuses committed within the institution. The generalized abuse reveals once more that mental health care after the war became a criminalizing process that punishes those individuals expressing a mental health need. The Federico Mora cannot secure the human rights of its patients; even while the government is aware of these violations their mistreatment is normalized. The conditions of the Federico Mora are widely known in Guatemala, making only the most vulnerable of populations enter its doors. When under its care, people get abused and their situation is rendered even more precarious. Contrarily to the founding mission the Federico Mora, since its dismantlement during the Rios Montt coup until now, criminalizes poor and undesirable individuals. As the director of DRI explained, the situation of Guatemalan mental health resources is a vicious cycle,

> en donde no hay servicios para la atención para la comunidad entonces las personas van a dar a un hospital psiquiátrico pero como no pueden salir se alejan de sus familias ya nos les queda otro

> lugar que en el hospital psiquiátrico si no hay servicios en la comunidad no va a hacer un apoyo familiar y como no hay un apoyo familiar tienen que estar en el hospital psiquiátrico.
>
> There are no services that pertain to the community, so people that are interned at the hospital Federico Mora cannot get out and are alienated from their families, and so they have no other place but the hospital. If there are no services within the community there is no support for family members, because there is no family support they have to stay at the psychiatric hospitals. (Personal communication, May 29, 2013)

Similar to the abuse committed within the state structures of care, the lack of options reproduces the abandonment and neglect of mental health. I argue that this neglect is actually a purposeful non-action of a structure that reproduces state terror and victimizes Guatemalans through their expression of a mental health care need. As this study will explore further, abuses towards mental health are not exclusive to the Federico Mora. The private sphere, which absorbs an important demand, mirrors the same abuses committed by the national hospital, which contributes to the normalization of mistreatment. In this context, families and individuals expressing a mental health need are left to choose between exorbitant costs or abuse.

The Cost of Mental Health Treatment.

Beyond the undeniable abuses that occur within the Federico Mora, what I noticed during fieldwork was the overall lack of affordable resources compared to the high demand for these services; a general need for human capital trained in mental health and gender specific mental health care resources. In fact, the mental health professionals I interviewed were well aware of their incapacity to satisfy the demand for these services.

For example, Dra. Joyce estimates the demand for one ambulatory clinic that provides free counseling services as part of the national mental health program,

> yo le diría que si grosso modo no llegan menos de 150 gentes diarias […]Porque la demanda ahorita en las clínicas hace que la gente esta peleando primero el espacio, hay gente que esta esperando cita asta dentro de tres meses y para ser escuchados.
>
> 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 in three months, just to be heard. (Personal communication, April 8th, 2013)

A three-month waiting list to accommodate 150 patients daily highlights the need for human capital and affordable care. Also, it reveals the scarcity model from which mental health care functions in Guatemala City, a model that enables abuses to continue. Carolina attorney for a women's advocacy group corroborates,

> La demanda es latente esta allí permanentemente aunque no se sabe que es salud mental un psicólogo etc. porque además eso no es prioridad
>
> The demand is implied it is there permanently even if there is no understanding of what mental health is, what a psychologist is etc. because on top of that it is not a priority. (Personal communication, April 20th, 2013)

For Dra. Cadelaria it was the demand for care that she noticed while training as a psychologist, that led her to open a private and exclusive mental health hospital,

> sabiendo que si hay demanda y realmente hay poca oferta hay pocos hospitales psiquiátricos aquí en Guatemala.

> Knowing that there is a demand and that really there is little offer, there are few psychiatric hospitals in Guatemala. (Personal communication, April 26th, 2013)

Although this hospital is exclusive to mental health, its prices are very high, and in Guatemala health insurance does not cover any mental health expenses. Thus, as with the example of the hospital run by Dra. Cadelaria, most hospitals run under their own for-profit guidelines force families to pay exuberant out-of-pocket costs for "packages" that include food, board and medical attention. Because there are no national regulations, private institutions follow internal policies that in most cases make patients oblige to a 15 to 20 day internalization without any visitations that come in an all inclusive monthly fee. The harm in this model is explained by Roberto,

> hay otros hospitales que por la mensualidad o la pensión alimenticia [el costo] es menor. Para eso se presta, se prestan para abusos y sobre todo la experiencia en Guatemala se ha documentado.
>
> There are other hospitals that according to the monthly fee, or the food stipend [the costs] are less. But that lends itself to abuse, the particular experience of Guatemala has been documented. (Personal communication, April 9th, 2013)

The high demand for mental health permits yet another form of abuse by creating out of reach resources, for example, compared to the monthly minimum wage salary for 2014 that is of 2,346 [2] quetzales, a private consultation with a mental health professional can range from 250 to 1000 quetzals an hour. As for institutionalizations, these come at monthly rates and their prices vary according to the care provided. As Dr. Luther explains,

[2] 1 USD equals approximately 8 quetzales, prices listed for 2013

> Existen hoteles de 5 estrellas, 4 estrellas y pedacitos de piso, pedacitos de estrella. Eso pasa en los hospitales privados también. En Guatemala hay dos hospitales privados tipo A- le llamo yo- Los Pinos y MEDERI los que usted conoció. Después hay B y C esos se encuentran que también son los mas caros económicamente hablando. Y son los que se ven en la ciudad. Fuera de aquí no hay. El mas y donde la categoría D porque eso no se ha es que en los hospitales no psiquiátricos- no se si usted conoce algunos, solo hay 3 A: el Centro Medico, el Herrera Guillandi que es donde yo trabajo, he Nuestra Señora del Pilar- no se si conoce.[…]ningún hospital de esos tienen asistencia psiquiátrica propia no, todos cuentan con psiquiatrías en su staff. […]Somos consultados y llamados pero muy poco.
>
> There are 5 and 4 star Hotels and little pieces of floor, pieces of stars. The same happens with private hospitals. In Guatemala there are two types of private hospitals, type A – that is what I call it- *Los Pinos* and *MEDERI* that you've visited. Then type B and C those are also the most expensive, and are the ones within the City. Outside the City there is nothing. Then the category D would be those hospitals with no psychiatric units, there are only three: *El Centro Medico*, el *Herrera Guillandi* -where I worked- and *Nuestra Señora del Pilar*. None of those hospitals has a psychiatric assistance of their own but they have psychiatrists on their on call staff. […] We are consulted and called but rarely. (Personal communication, April 3rd, 2013)

Dr. Luther correlates mental health care to hotel ratings, alluding once more to mental health care as a luxury that only few can afford. In fact, according to the law of supply and demand, the higher the demand, and the lower the cost. However, in Guatemala, it becomes apparent that it is the supply of quality care -- and not the high demand for mental health care-- that is scarce, making prices very high. In addition, quality care is Table 6 provides a list of the hospitals that I observed including their capacity and costs.

Table 6

Table 6. Price Range of Mental Health Resources Crisis and Consultation

		Name	Capacity/ status	Cost
Mental Health Resources: Crisis	**Private Mental Health Hospitals**	MEDERI Los Pinos	Private hospitals, capacity of 9 people	650- 850 Q/day depending on room (room and board) + psychiatrist charge of 1,500/day of consultation + drugs
		Private Hospitals with Psychiatric Staff on call	Herrandi Centro Medico El Pilar	Only for cases of emergency 5,000 Q/ night
		Rehabilitation houses	From registered to non-registered	800- 15,000 Q /month
	Public Mental Health Hospitals	IGSS	Social Security Institution	Free with proof of employment
		Federico Mora	By judicial order 250 beds, more than 300 patients.	Free
Mental Health Resources: consultation	**Therapy Resources**	Ambulant Clinics	One hour mental health consultation	3-month waiting list with a maximum of 3 sessions.
		University Centers for Mental Health University Landivar and Marroquin (private) University San Carlos (public)	One hour mental health clinic	3 month waiting list Free consultation with student practitioner
		Private Clinics	Mental health	250- 1000 Q an hour
		Women's rights NGOS	Mental health therapy	Free 10 sessions maximum

According to these prices, an individual undergoing a crisis that does not want to be institutionalized at the Federico Mora, will have to pay a minimum of 5,000 quetzales out of pocket- whether for one night at a medical hospital or for two weeks of

institutionalization. The option for people looking for mental health resources gets reduced given the exorbitant prices of private hospitals. The lack of affordable care further enables an environment of abuse where patients are either criminalized because of their class status or seen as opportunities for profit gain. The criminalization of poverty doubly criminalizes a person who is poor and experiences distress. The system of "care" is a punitive one with a high human cost. Patients pay either with high prices or with their dignity and safety. The mental health care system in Guatemala City exploits and criminalizes a demand that, due to the circumstances of violence, continues to grow.

Experiencing the Mental Health "Care."

The experiences of Silvia and Teresa bears witness to the abuse committed within private and public mental health institutions illustrating the ways in which mental health "care" is a criminalizing and abusive process. What differentiates Silva and Teresa most is their class backgrounds.

Teresa comes from a poor background whereas Silvia comes from a middle class family and married into a wealthy family making her now part of the Guatemalan elite. Their class has dictated the type of care they have been able to receive when in crisis. However, as I will show below, their experiences are quite similar; their stories speak to the lack of resources within institutions, the high costs of their "illness", the abuse they survived when under care, and the ways in which they were able to get out of these institutions once interned- all of which happened with the help of the police. Through the details of their experiences, the similarities with the Federico Mora and other mental health care institutions are stark even when the prices are not.

Teresa has been diagnosed with borderline personality and extreme depression, although these diagnoses have mutated over the years. It was between 1998 and 2004 that Teresa was in and out of mental health institutions either because of alcohol abuse or suicide attempts. Teresa has been institutionalized at the Federico Mora twice. Before hitting "rock bottom" as she calls her institutionalization into the Federico Mora, her daughters tried to provide her with the best care they could afford. After her first suicide attempt, desperate to find a place to help Teresa, her family committed her into one of the healing rehabilitation homes that are called "casas de sanamiento."

These are private "healing homes" that work as rehabilitation centers for drug, alcohol addiction, or mental "illness". The majority of these homes are religion based, funded by donations, and follow a strict treatment based solely on prayers. These are, in the majority, part of an evangelical church, administered by someone who has successfully become sober from the program, and are segregated by gender. These homes also follow a strict hierarchy of prices, making them much more cost effective then hospitals as the prices range from 500 to 15,000 quetzales a month. There are also some rehabilitation homes that are run by doctors. These healing centers follow no particular guidelines, as the only requirement to have an enrolled rehabilitation home with the municipality is a business and sanitation license. Of the healing centers I visited, the staff was minimal, generally just one general resident student and a nurse, and the facilities were deplorable. Facilities vary according to the price range. Some of them offer an all-inclusive package, with food and, board, therapy, and even medication; others make family members responsible for the food and medication.

Silvia was diagnosed with bipolar disorder following a "crisis" in which she started dancing in the middle of a super market and announced she was leaving her husband. She was held for 90 consecutive days in one of the most expensive rehabilitation homes of Guatemala City. It was her husband that brought her there and paid 15,000 quetzales a month for her room, board, and medication.

There is a difference of 10,000 quetzales between Teresa and Silvia's institutionalization costs. However their experiences are quite similar as they both experienced: abuse, starvation, involuntary detention, and exit from the institution with the help of the police. Below I present excerpts from their *testimonios* that illustrate their experiences during their institutionalization.

Accommodations.

Teresa was institutionalized in an unregistered rehabilitation house of Guatemala City. When she first arrived the director of the hospital came to sedate her, when she fought back the director shoved her into her room and she fell on the floor, she recounts,

> El director de allí que cuando me vio allí me empujo en le cuarto y no habían camas, en el suelo en unas colchonetas mugrientas y llenas de pulgas. Y mi cama? Hay no señora aquí la *preta*! Es una frase de las casa de restauración que la aguantes. "Aquí las camas se ganan"

> The director when he saw me he pushed me into the room and there was no bed, there were just some grim mats on the floor, and they were filled with fleas. [When I asked] "And my bed?" " Oh no ma'm, here *la preta*[3] !" That is a phrase that these homes use to say you need to suck it up. "Here beds are earned". (Personal communication, January 29th, 2013)

[3] La preta of "apretar" to "tightened up" meaning to endure.

She was interned with 16 other patients: eight men and eight women who shared a two-story house. Teresa's family paid a small fortune for her stay and had to provide her mattress, linens, clothes and food- of which she saw very little. Teresa recounts sleeping on the floor or on dirty mats and not the ones that her family had purchased for her. Contrarily, Silvia's had been institutionalized in a more expensive home. However, she came to be there because her husband refused her wanting a divorce and for the 90 days she was institutionalized she did not receive any visitors and was unable to make a phone call. When she first arrived she recounts being put in a straitjacket and sedated for several days. However, the facilities were comfortable and on the weekends all patients were taken out of the City for a trip,

> Los domingos nos llevaban en bus a Amatitlán y nos compraban helado de McDonald, como si fuéramos niños.
>
> On Sundays they would take us to Amatitlán on a bus and buy us McDonald's soft serve, as if we were children. (Personal communication, February 22nd, 2013)

The material accommodations affected Teresa and Silvia's treatment and care, yet they both were submitted to some type of abuse while in these institutions. Teresa recounts very vividly being beaten, humiliated, and starved. In particular, the first night she was institutionalized, when she did not cooperate to being sedated she narrates,

> Empecé a gritar "no, no!" y por decirle no me agarra y me va a paleando con el palo de piñata, no pude decirle nada, solo le dije "no me vaya decir que usted es el que me va a predicar del amor de dios que no le voy a creer nadad" le dije yo le dije que habían casa clandestinas pero pensé que era mentira pero esto no me diga que es una casa de restauración es una cárcel clandestina "sho, me

decía y me dio" tanto que cuando el hermano Rios me fue a sacar de allí a los 18 días con la policía llevaba las marcas en todo esto de acá [de lado del cuerpo y cara]. Y me dijo "mire señora las mujeres como usted me gusta componerla que de una cosa q de aquí la compongo vieja porque sus hijas están harta de usted su marido ya no la quiero, aquí la compongo, no sea bruta.

I started screaming, "no! no!" and for resisting don't you see he takes a piñata stick and beats me with it. I could no longer say anything, I just said "don't come and tell if it will be you who is going to give me the gospel for the Love of God I won't believe you at all." And I told him "I knew there were clandestine houses but I thought those were lies, don't come and tell me this is a rehabilitation home this is a clandestine prison." "Shut up" he would tell me, and he beat me so much that when brother Rios came to take me out 18 days later with the police, I had all the marks in all of here [points to the side of her face and body]. He even told me " look ma'am women like you I love to repair and that is one thing here I will repair you old hag because your daughters are sick of you and your husband doesn't want you anymore, here I will repair you don't be an idiot." (Personal communication, January 29th, 2013)

This harsh beating was also met with humiliation and emotional abuse as the director of the house referred to her as a "vieja" or "old lady" more equivalent to "hag." But also she was insulted by her failed femininity when told "your husband does not want you anymore." Teresa is abused by her gender first and foremost but this gender violence is understood as part of her mental health "care." It is Teresa's defiance of this "care" that justifies the director's use of physical abuse. This patronizing and patriarchal violence committed for Teresa's own good, permeates the gender violence committed onto Ladinas' in everyday life. So common is this violence, that Teresa had internalized this constant humiliation as she told me she became the scum of society one she was interned at the Federico Mora. Silvia's abuse was of another kind, she was not submitted to

beatings but to sexual harassment from the psychiatrist that worked at the residency. She tells me,

> El doctor me empezó a enamorar, y en vez de darme mi diagnostico, mi medicamento me decía " Usted como esta de linda, yo me quisiera casar con usted." De noche el se quitaba los zapatos y entraba a los cuartos.
>
> The doctor started to flirt with me, instead of giving me my diagnosis he would tell me "oh you are so pretty today, you know I really want to marry you." At night he would take off his shoes and come into the rooms. (Personal communication, February 22nd, 2013)

Both women also recall suffering from hunger while interned, Silvia shares,

> el almuerzo dos coliflores envueltos en huevo y ensalada de acelga y una tortilla . Me moría del hambre. Yo nunca había pasado hambre en mi vida.
>
> For lunch, two pieces of cauliflower fried in egg, a chard salad and a tortilla. I was dying of hunger. I had never starved in my life. (Personal communication, February 22nd, 2013)

Teresa's mistreatment was harsher,

> El trato de ese hombre para nosotras era inhumano en la mañana nos daba un vaso de atol tenias que decir un versículo de la Biblia con un pan de manteca, el almuerzo eran unos güisquiles partidos y ya. Dormías en el suelo no podías prender la luz, si hacías ejercicio y te equivocabas porque era la mas vieja hacia que los demás tuvieran que hacer ejercicio para que nos odiaran. Los hombres arriba y las mujeres abajo, 16 personas. Y nos dejaba echar agua asta que la ultima entrar nos bañábamos de 3 en 3.
>
> The treatment of that man towards us was inhumane, in the mornings he would give me a glass of *atol*, you had to recite a verse of the bible for one sweetbread, and for lunch it was some pieces of squash that was all. You would sleep on the floor, you could not turn on the light, if you exercised

and did it wrong because I was the old one, he would make everyone else repeat the exercise so they would hate me. Men upstairs, women downstairs, 16 people total. We could not flush the toilet until the last person used the bathroom and they would shower us in threes. (Personal communication, January 1st, 2013)

Lastly, paralleling the abuses received by the patients of the Federico Mora, both Teresa and Silvia feared for their lives when interned. Teresa shares with me the different ways in which she tried to ask for help,

Yo lo que hice que asta dentro de un mes tenias visita yo empecé a coser unas cositas que así hice que tenían como unos cuadritos pero yo escribí "me están pegando, no me dan de comer, pregunta que es esta casa" y lo doble y encima de la tela le puse un papelito y le cosí así y nadie vio que es un papelito, porque te ponían un custodio. Pero nunca lo pude hacer eso, se quedo todo cocido porque ese día llega la nena a dejarme medicamento y mas cosas, es mi hija verdad, y las muchachas no me hablaban me hizo seña que si, dije ahorita es cuando. O me mata este viejo o me voy con la nena. Entonces llegue "¡nena aquí me están pegando este hombre me pego vos sabes que no soy mentirosa nena sácame de aquí!" pero cuando yo estaba pegando estos gritos todo se me me ponía negro cuando la puerta PANG me avienta el hombre y me llega a decir "sho" y le dijo a Sandra, agarrala y si no se calla a vos te somato y Sandra "cállese por amor de Dios nos van a pegar y me agarra, me empujo el hombre" entonce la nena se puso así "neuróticas, vieja estupida, esta loca, asta le quería sacar si estaba loca. Entonces la nena le pregunta "entonces usted no le esta pegando?" "como va a creer, si su mama esta mal, su mama no esta bien con su mama así pasa."

Because you only had visits after a month, what I did is that I started sewing little things: "they are beating me, they don't feed me, please ask what is this place." And I would fold it and sow it under a shirt because a custodian always supervised us. But I was never able to deliver it, because one day my daughter came to leave me some medicine and other supplies and I heard her voice, I

> said it is now or never, or that old man kills me or I leave with my daughter. So I screamed "baby they are beating me! this man is beating me you know I am not a liar take me out of here!" But when I was screaming like that PAM everything turned black, that man hit me and told me "shut up." And he tells my daughter "neurotic, old stupid women, she is crazy, why would you want to take her out if she is crazy." So my daughter asks him "so you are not beating her?" "of course not, how can you believe her? your mother is not well, she is not well this is how she is doing." (Personal communication, January 29th, 2013)

It becomes obvious that mental health is used as mechanism for impunity. Re-victimizing Teresa by discrediting her provides more power to a structure that perpetrates gender violence. Because the state does not protect the rights of women expressing a mental health need, mental illness becomes a dangerous and effective way to justify and reproduce gender state terror without any accountability. In fact, the types of treatment submitted by Teresa are comparable to the ones observed by DRI at the Federico Mora, a mental health care that abuses its patients while stripping them of their voice, dignity and credibility. Silvia, who was forcefully interned by her husband after requesting a divorce, without informing her family of her whereabouts, lived the 90 days of her internalization fearing for her life, "los 90 días que estuve allí pensé que me querían matar de parte de mi marido," ("The 90 days that I was there I thought I was going to be killed on behalf of my husband"). Under a mental "illness" diagnosis Teresa and Silvia could be suffering from a number of disorders, in the broader reality however, they are victims of gender violence that continues within the walls of these institutions and acts in even more perverse ways as it discredits them from their truth and impedes any form of reparation.

In fact, both Teresa and Silvia had to be removed from the premises of their internalization with the help of the police or the Ministerio Público because each

institution follows an internal policy, like for example, not allowing visitors in the first 30 days. Teresa got released after risking her safety by screaming for help to her daughter,

> no podía dejar de decir "existe, el vive," no podía dejar de decir eso, estaba saliendo de un lugar donde me habían amenazado no iba a salir nunca. Y con la policía y todo.
>
> I couldn't stop saying "He exist, He lives" I couldn't stop saying that, I was leaving a place I had been threatened I would never leave. With the police and everything. (Personal communication, January 29th, 2013)

Silvia's situation was a little more complicated because she was under the legal custody of her husband. Once Silva's mother knew of her whereabouts she brought two agents from the Ministerio Público to evaluate her. Silvia had to follow strict gendered rules of "proper behavior" in order to be considered fit for her release. Ultimately, because neither the director of the house nor her husband agreed to Silvia's discharge, her mother had no other choice but to remove her with the help of the police, as she recounts,

> Me pusieron allí pero no les permitieron la llamada ni ir a ver. Cuando mi mama llamo al Ministerio Público para evaluarme y sacarme de allí, llegaron dos veces dos personas. Que se tiene que hacer para estar mejor: ponéte la falda mas larga, no cantes, no te pongas flores en la cabeza. Hace lo que te dicen. Amárrate el pelo. Un señor me dijo que no podía llevar el pelo así, entonces al día siguiente baje con una colita. Anulada. Pura anulada. Del Ministerio Público llego pero el señor no dejo que me entrevistara. No querían que sacaran porque pagábamos 15 mil al mes. Nunca me hubiera sacado sin la policía.
>
> I was placed there and I wasn't allowed any phone calls or visits. When my mom received the call of where I was she called the Ministerio Público. They came twice with two people to evaluate me. One of them told me that to be better I should wear a longer skirt; stop singing, not put

> flowers in my hair, do what they tell me to do. Put my hair in a pony tale. One of the men told me I could not keep my hair like that, so the next day I put it up. I was annulled. Purely annulled. From the Ministerio Público they came to interview me but the man did not allow it. They did not want me out because he [her husband] was paying 15 thousand quetzales a month, they would have never taken me out without the police. (Personal communication, February 22nd, 2013)

Silvia's experience speaks of the constraints placed on women when they lose their rights, specifically through incarceration, as it was her husband's wishes that got her committed and his payment that did not allow for her discharge. Silvia was at the mercy of men: her husband, the hospital director, the Ministerio Publico's staff and, the policy, as it is to be noted that the majority of mental health professionals are men, as opposed to the majority of patients who are women. In this gender dynamic, Silvia had to modulate everything about her appearance and her behavior as a woman to perform the part of being "sane." From her *testimonio*, it looks like sanity was to be performed as the part of a conservative femininity, that implied wearing a "longer skirt" pulling her hair back, not accessorizing, being obedient and literally not having a voice, were all deemed signs of sanity by a male staff. Her internalization succeeded her husband's goal, that of punishing Silvia for requesting a divorce. This experience was so successful that until today Silvia remains married and lives with her husband. Silvia's experiences echo the purpose of the abuses suffered by the patients of mental health care in Guatemala that seem to violence and castigate as treatment in order to annul women considered defiant to the patriarchy.

As the only national mental health hospital, the Federico Mora presents the country's standard for care, which is mirrored within other private institutions. The

abuses perpetrated onto Silvia and Teresa were allowed because Guatemala does not have a law that protects the rights of individuals diagnosed with a mental "illness", but also because the mental health care is punitive. In that context, individuals considered mentally ill lose their rights and thus enter institutions that treat them like non-citizens. A lack of legislation enables the criminalization and routine abuse of mental health patients.

Conclusion.

Teresa and Silvia are survivors of the structures of discrimination present in the mental health care system of Guatemala, and of the predatory society that fosters gendered violence. A non-ratified mental health policy and non-existent legislation to protect the rights of individuals considered mentally ill further marginalized Ladinas who enter this system of care, by continuing the abuse and corrupting their dignity and credibility. As Amari, for women's advocacy explains,

> No no existe ninguna ley todavía los avances del país son pocos. No existe en su momento inclusive las personas en Guatemala han considerado la atención psicológica como una acción discriminatoria, castigadora, sinónimo de locura y todo tal que va al psicólogo se considera de hecho como una persona enferma […].Entonces hablar de higiene mental hay una liga de higiene mental pero la liga de higiene mental es una organización no gubernamental no es ente del estado que este brindando servicios, son servicios particulares que se brindan pero que no son parte del estado y no se han establecido como parte del estado.
>
> No, there is no law yet [of mental health] and the advances in the country are few. At the moment even people in Guatemala consider psychological attention as a discriminatory, punitive action that they equate with insanity, and every person that goes to the psychologist is considered in fact

> a sick person […]. We are still not there, that is why we only talk about mental hygiene, there is a league of mental hygiene, but this is a non governmental organization, it is not part of the government, it is not this entity that is providing services, these are private services that are not established as part of the state. (Personal communication, March 11th, 2013)

The decay of the hospital Federico is the standard the Guatemalan government provides, which judging from its care criminalizes individuals expressing a mental health need. In this particular context where care is a "discriminatory and punitive practice" conceptualizations of mental health need to be linked to citizenship rights. The only organization that considers mental health to be intrinsic to citizenship is La Liga de la Hygiene Mental. Thus, Garavito's work critiques the Guatemalan structures as "a political system that does not deem mental health central to reconstruction." However, as the experiences of Teresa and Silvia demonstrate a gendered citizenship needs to be developed, one that accounts for the perverse ways in which Ladinas are annulled on the basis of their mental health. Therefore, in the next chapter, I examine the available mental health resources tailored particularly for Ladinas.

Chapter 5

Gendered Mental Health "Care" Services

Introduction.

State terror committed during the civil war was so successful at destroying community life through the terror inflicted on Mayan women's bodies, that today this violence has been incorporated into Guatemalan culture and is normalized in the everyday life of both Mayan and Ladina women. This chapter demonstrates the ways the mental health care system is complicit with state terror and gender violence and further discredits and marginalizes female survivors of trauma. Given that much of the war atrocities were directed towards women's bodies, it is no coincidence that of the 28.6% of adult Guatemalans with a mental illness, 62% are women (Lopez & Cardona, 2010). As research shows, women are more likely than men to seek treatment for mental illness (Cia, Cordoba Rojas & Abib Adad, 2010), a trend noticed by Dra. Joyce in her experience working for the national mental health program,

> son las mujeres las que mas están demandando los servicios, eso si es cierto […]. Nos estamos dando cuenta que la mujeres, mas la mujer, la que esta buscando mas el servicio de salud mental.

> It is true that women are who are demanding these services […]. We are noticing that women, more women, are looking for these services of mental health. (Personal communication, April 8th, 2013).

Services provided by Guatemala's social security system, such as the day hospital at the IGSS or private care hospitals are less attainable for women than men, as women are more likely to be unemployed or under-employed. In addition, the general mental health care field in Guatemala does not tailor its services to women. Most institutions are abusive to their patients and further marginalize already vulnerable populations such as Ladinas. In this chapter I examine the mental health resources available to Ladinas living in Guatemala City.

The 2008 Law Against Femicide and its Implications for Mental Health.

From my observations, there is little to no specific care tailored to women's mental health. Subsequently, I turned to the wide range of public and private women's advocacy organizations mushrooming in Guatemala City, which are arising from the ratification of the 2008 law against femicide and other forms of violence against women (decree 22-2008). This law provided fertile ground for organizations to advocate for women's rights. These organizations primarily provide legal counsel for women who want to prosecute an instance of gender violence as defined under this law. Amari, the head of the psychosocial team for the public women's advocacy office, explains the implications of the law,

> En el año 2008 y en el marco de la ley se establece obligaciones para cada una de las instituciones que conforman el sector justicia así al organismo judicial se le impone la obligación de la creación de los órganos especializados de la atención de la violencia contra la mujer, cinco hay a la fecha.

En el ministerio publico se le impone la obligación la creación de una fiscalía especializada contra delitos contra la vida e integridad física de la mujer. Pues todavía no lo ha hecho. El ministerio publico ya contaba con una fiscalía de la mujer se quedo tal cual. Los delitos de femicidio siguen siendo conocidos por las mismas fiscalías que conocen todos los delitos contra de la vida, se asignaron cuatro pero eso no dice que ya sean especializadas o que atiendan con exclusividad los delitos de femicidio sino solamente se atienden también por ello también entre otras cosas. Al instituto de defensa publica se le otorga la obligación de brindar abogadas y abogados defensoras publicas para la atención y seguimiento de las reclamaciones de los derechos de las mujeres a la fecha solamente hay 10 sedes de 37 que tendrían que existir a nivel nacional por lo tanto tampoco hemos cumplido. La condición ha estado en que si viene cierto nace la ley la ley no lleva aparejada de la mano la responsabilidad que la misma impone, que es la erogación de los recursos necesarios para que cada una de estas instituciones cumpla con sus mandatos respectivos. No quiero referirme a otras instituciones no es mi tema yo me refiero al instituto de la defensa publica. Por lo tanto tampoco es una política de estado que se fortalezcan los procesos de atención a las mujeres que a la fecha no han habido un incremento en los presupuestos para que se pueda hablar del cumplimiento tal cual debe de hacerse en relación de establecimiento de las sedes respectivas en cada una de las localidades que debiera de existir conforme a la asistencia a las mujeres.

In the year 2008 and in the framework of the law it is established the obligations of every institution in accordance with the justice sector, as so, to the judicial organism it imposed the obligation to create specialized institutions for the attention of violence against women, to this date there are five. The Ministerio Publico, imposed the obligation of creating a prosecutor's office specialized in crimes against life and the physical integrity of women. This has not been accomplished. The Ministerio Publico already had a women's prosecutor's office and it stayed as is. The crimes of femicide are still reviewed by the state prosecutor's office that reviews the crimes against life, there were four that were assigned but that does not mean that they are specialized or that they review exclusively crimes of femicide but only that they also review them among other ones. To the institute of pubic defense it was granted the obligation to provide public

> defense lawyers for the attention and pursuit of the claims under the rights of women, to this date there are only 10 offices of the 37 that should exist at the national level, therefore [the requirement under the law] it has not yet been delivered. The condition has been in that although it is true that the law was born this does not go hand in hand with the responsibility that the law imposes, that is the dispensing of the necessary resources so that each of these institutions carry out their respective mandates. I do not want to refer to other institutions that is not my specialty; I am referring to the institute of public defense. Hence strengthening the processes of attention for women it is yet a public policy since to date there has not been a budget increase so that we can speak of the fulfillment that should be done in relation to the establishment of the respective offices that should exist in each locality in agreement for women's assistance. (Personal communication, February 20th, 2013).

The law against femicide aims to eradicate violence against women by defining what constitutes gendered violence (which includes psychological violence), implementing preventive measures, having harsher sentences for perpetrators, and compensating women who are victims of such actions. However, as stated by Amari, the resources to properly implement the law have yet to be supplied. Nevertheless, Chapter II, section 3d of the law against femicide reads,

> Asistencia integral: La mujer víctima de violencia, sus hijas e hijos, tienen derecho a servicios sociales de atención, de emergencia, de apoyo, de refugio, así como de recuperación. La atención multidisciplinaria implicará especialmente:
>
> 1. Atención médica y psicológica.
> 2. Apoyo social.
> 3. Seguimiento legal de las reclamaciones de los derechos de la mujer.
> 4. Apoyo a la formación e inserción laboral

Comprehensive assistance: the woman victim of violence and her children have the right to social services of care, of emergency, of support and shelter, and of recovery. This multidisciplinary attention includes especially:

1. Medical and psychological attention
2. Social assistance
3. Legal support in the reclamation of women's rights
4. Support for professional development and reintegration to the workforce

Because the law stipulates medical and mental health attention as the first priority, "psychological accompaniment"/"acompañamiento psicológico" is provided within legal counsel. For example, in the organization where Miranda works,

> si se han dado cuenta que si la mejor respuesta es de una abogada porque caso siempre las personas viene por consultas legales. Entonces son dos compañeras abogadas que atienden a la gente entonces la persona dice mire vengo porque X cosa, mi esposo me golpeo ayer entonces yo salí de casa entonces ya le indica, mira lo que usted tiene que hacer es pedir medidas de seguridad y le dan todas las referencias [telefono] entonces ella le indica le da la accesoria legal y le dice mire tenemos atención psicología y a veces la misma persona le dice mire quiero atención psicológicas pero sino le dice mire esto también es bueno que reciba apoyo psicológico y todo y ya lo pasa por acá.
>
> We have noticed that the best response is from a lawyer because it is always the case that people come for legal consults. So we have two lawyers that are responsible to respond to people so the person says "look I come here because of X thing, my husband beat me yesterday so I got out of the house." Then they reply "look what you have to do is ask for security measures" and they give her all the references [interruption, phone rang] so then it is indicated to her the legal assistance and she is told "look we have psychological attention," or sometimes the same person says "look I want some psychological attention" but if they don't we tell me " looks this is also good for you to receive psychological attention, come this way." (Personalcommunication, March 18th, 2013).

Because the state has yet to institutionalize the functioning of the law, private organizations and NGOs are advocating for women's rights and providing legal support for the application of the law. Each of the five organizations I visited, and whose mental health coordinators I interviewed, provided some type of mental health resource. What I observed, however, is that the mental health support is provided mostly because it guarantees a higher retention rate of clients with court proceedings, as stated by Amari,

> la victima y una vez en proceso de restitución de derechos y de reparación del daño emocional o por lo meno una vez iniciado el proceso de atención psicológica con el convencimiento del primer lugar la atención de su autoestima la atención de la comprensión de que esa no es una situación de la que ella sea responsable sino que son responsables otras personas e inclusive la propia sociedad de lo que ha sucedido es también un elemento que sirve de fortaleza dentro del proceso y ha servido como un instrumento que ha evitado la desestimación de los caso o la renuncia de derechos. Cuando una victima acude a los procesos penales y los acompañamientos apropiados uno de las grandes incidencias que tiene las otras instituciones es el alto índice de renuncias o de retractaciones de las denuncias de los procesos.
>
> The victim once the process of restitution of the rights and reparation of the emotional damage or at least once the counseling process has begun with the conviction in the first place of the attention of her self-esteem, the attention of the knowledge that she is not in a situation that she is responsible for but that there are other people and even society itself that is responsible for what has happened to her, it is also an element that serves to strengthen within the process and has helped as an instrument to avoid the rejection of the cases or the resignation of their rights. When a victim turns to criminal proceedings the right support one of the largest incidents that other institutions have is the high index of abandonment or retraction of allegations of processes. (Personal communication, February 20th, 2013).

Although mental health resources are available, these are still understood as instrumental, a means to an end for justice. Mental health is considered a complement to judicial proceedings, not a goal in and of itself. Thus, in Guatemala, mental health must be conceptualized as part of a justice system, in which impunity can be considered a societal "illness".

High Demand for Women's Advocacy Organizations.

The lack of overall mental health resources trickles down to impact women's advocacy organizations and the resources they are able to provide. Margarita speaks of the overwhelming demand and the coping strategies undertaken by her organization,

> no nos hacemos mucha promoción también porque la demanda sube pero ya con lo que tenemos nos conocen mas que suficiente.
>
> We do not promote ourselves that much, because demand increases and already with who knows us, we have enough. (Personal Communication, March 18th, 2013).

Only by word to mouth, these services are saturated. In particular, Margarita explains,

> Si muchísima fijate. Eh…[busca documento en su computadora], en estos dos meses si queres te doy una cantidad: 160 Hemos tenido en lo que va del año, 160 referencias para psiquiatría.
>
> Look, yes, there is a lot of demand. Um… [looks for a file in her computer] in these two months, if you want I can give you the quantity: 160. We have had of what is of the year, 160 references for psychiatry. (Personal communication, March 18th, 2013).

As of February 2013, of the clients that had come to Margarita's organization for legal counsel, 160 women needed a referral for psychiatric care, a service unavailable in that organization. These women are transferred to the Federico Mora, depending on their resources. Since the services offered by Margarita are free, one can assume that most of these women had no other choice but to access the Federico Mora for treatment. As Marisol illustrates, the lack of mental health resources in Guatemala, paired with the high incidence of gender violence, make it difficult for these organizations to absorb the demand for both mental health support and legal counsel. Amari, who works in the central office of the public advocacy center for women, illustrates the magnitude of this demand:

> Entonces la afluencia acá es alta. Solo en esta cede central dependiendo de los momentos a diario se reciben de 60 a 80 mujeres diarias. Y dependiendo de las épocas recibimos de 80 a 100 mujeres diarias solo en esta cede central. Solo aquí en la capital. Entonces la cantidad de casos que requieren atenciones especializada es mucha. Nosotros le damos a las mujeres opciones de solución dentro de las vías que establece la ley y muchas mujeres al ser asesoradas conocer de sus derechos conocer de sus procesos conocer de las consecuencias legales que genera accionar de determinada forma deciden que no quieren hacerlo por la vía penal y entonces no son presentadas las denuncias. Como nuestro trabajo no es presentar denuncias sino acompañar a la victima y darle sus derechos probablemente yo este acompañando a una victima por reclamo de pensión alimenticia para sus hijos pero no en el reclamo de la acción penal que correspondería porque eso implicaría que se multiplicarían por muchísimo los procesos.
>
> Here the affluence is high. Only in this central office depending of the moment, we receive up to 60 or 80 women daily. And depending on the season, we receive 80 to 100 women daily only in this central office, only here in the capital. So the quantity of cases that require specialized attention is a lot. We give women options and solutions within the track that the law establishes

and many women when they are counseled and know their rights and know the processes know the legal consequences that are generated when acting in determined way decide that they do not want to proceed through the penal way so the claims are not presented. Because our job is not to present claims but to support the victim and give her her rights probably I am supporting a victim that is claiming child support for her children but the claim for penal action that would correspond is not being considered because that would imply a multitude of processes. (Personal communication, March 11th, 2013).

In the circumstances of generalized gender violence, it is difficult to distinguish between a demand for mental health care and demand for legal services. As it seems like in the particular historical and current context of Guatemala, prosecuting a case against femicide can be considered an exercise of mental health.

A Crisis Intervention Model for Mental Health "Care."

The most prevalent resource for mental health stems from the crisis intervention model. This model is characterized for being brief, ranging from three to a maximum often therapy sessions. For example, in the women's rights organization directed by Miranda, it is mandatory for clients to attend a set number of crisis intervention therapy sessions in order to receive legal counsel,

- Miranda: Hay un contrato terapéutica que hay que hacer de las cinco sesiones.
- Chantal: ¿Son cinco?
- Miranda: Son cinco de la psicoterapia breve hay una evaluación que hacen ellas, que hace la psicóloga. Cada sesión lleva objetivos, se alcanzan o no se alcanzan, cada sesión tiene un paso particular que cumplir, si no se cumple hay que volverlo a retomar. Identificamos,

informamos, orientamos se solicita. Toda la parte de las decisiones ya esta estructurado y se hace una historia clínica.

- Miranda: We have a therapeutic contract of five sessions.
- Chantal: There are five sessions?
- Miranda: There are five brief psychotherapies and an evaluation that they do, that the psychologist does. Each season has objectives, whether reached or not, each session has a particular goal to be achieved, if it is not, it has to be retaken. We identify, inform, orient, and it is mandatory. All the decision have already been structured and from there we create a clinical history. (Personal communication, March 18th, 2013).

In this particular organization, women are given little choice about their participation in therapy. In fact, because Miranda's organization is focused on providing justice for women, mental health becomes part of a contract to develop the client's mental health history, to be used in court proceedings. Because these organizations' main focus is success in court, these therapy sessions are based on the crisis intervention model called "debriefing." Of the five women's organizations that work for women's rights, only one did not employ this method. In addition, the only mental health resource with a gender component also favored the *debriefing* model. Amanda, director of a women's organization that focuses on legal representation and the training and empowerment of women, illustrates this position,

> Esta la psicoterapia breve de emergencia que s la que mas nos ha funcionado. En el caso de la violencia sexual a veces se usa la técnica del debriefing.

> It is the brief emergency psychotherapy what has functioned the most. In the case of sexual violence, we sometime use the technique of debriefing. (Personal communication, March 2nd, 2013)

Critical Incident Stress Debriefing is used to reduce the incidence of Post-Traumatic Stress Disorder (PTSD) and was imported to Guatemala by international NGOs after the war. The debriefing model calls for an emergency intervention to reduce the trauma experienced by a victim within one to three sessions. This method does not call for any follow-up sessions. Robert explains,

> El debriefing es una prevención del estrés post traumático prácticamente sobre X acontecimiento que ha vivido la persona. El *debriefing* se atiende el evento traumático de la persona en el hospital para evitar un estrés post traumático. No se atiende la problemática que puede estar viviendo la persona por cuestiones X que atienda el trabajo que buscamos X pero que se busca este, se acompaña de un psicólogo psicóloga pero el *debriefing* es ayudar y acompañar el evento traumático que acaba de vivir si la violaron, si la secuestraron, si la atentaron, que si le golpearon que si fueron amenazar. Hemos atendido unos casos que iba en la calle y vio que pum pum pum 3 hombres mataron a una persona, o iba en el bus y ta ta ta mataron al chofer. O lo que paso que llegaron unos hombres desconocidos y de los maestros y alumnos que habían allí, pum pum mataron a el X maestro. Se dio *debriefing* individual y grupal con los maestros, con los alumnos y los papas de los alumnos para sacarlos de este evento traumático.

> Debriefing is a prevention of PTSD on X event that the person has lived. Debriefing attends the traumatic event of the person in the hospital to avoid a posttraumatic stress. The work looks for X but does not look into the problem that the person can be living for X reasons, there is a psychological support but debriefing is to help and accompany the traumatic event that has just been lived, whether she has been raped, or kidnapped or she has witness an attack, or was she beaten or threatened. We have worked in some cases where the person was on the street and pum pum pum three men killed a person, or on the bus and ta ta ta the driver was killed. Or what

> happened when that some unknown men came and of the teachers and student that were there pum pum they killed the X teacher. Debriefing was given to the individual and to the group of teachers, with the students and the students' parents to take them out of the traumatic event. (Personal communication, March 9th, 2013).

The problem with *debriefing* is that it is not a long-term solution, rather a bandage to cover a hemorrhage that does not, as Robert said, account for the problem that created the trauma in the first place. Similarly, debriefing sessions are just the first step toward a long-term recovery process that is not accounted for in this model. Although this technique can be effective in moments of crisis, what I observed was that *debriefing* was used to overcome the gap between lack of resources and high demand for mental health services. Margarita is very frank in illustrating this issue,

> mira damos terapia psicológicas, pero aquí damos una terapia psicológica puntual. Breve podríamos decir, tratamos de no sobre pasar unas diez sesiones porque la demanda es bastante fuerte.

> Look we provide psychological therapy, but here we provide a punctual psychological therapy. We can call it "brief"; we try not to exceed some ten sessions because the demand is quite strong. (Personal communication, March 18th, 2013).

The unmanageable demand for these services reveals a crisis of gender-based violence that Guatemala's system is unable to sustain, neither through mental health care nor organizations advocating for women's rights. The mechanisms to contain the violence and provide any sort of retribution are saturated. In these circumstances, advocacy groups have no choice but to place women's mental health on the back burner and try to contain it rather than care for it. The limited resources doubly discriminate

against women. First, gender violence discriminates against women due to their gender; second, expressing a mental health need allows punitive or inadequate mental health "care" to discriminate against women for expressing such concerns. It would seem that violence has become a unifying force for women's experiences in Guatemala, as Carolina remarks through her work,

> Confirmamos la teoría que todas las mujeres fuimos fruto de algún momento objeto de violencia por nuestro genero ya sea como niñas, estudiantes, trabajadoras de alguna forma una exclusión.
>
> We confirm the theory that all women, we have been at some moment the fruit of the object of violence because of our gender, whether as girls, students, workers, in a way discriminated. (Personal communication, March 20th, 2013).

In the context where gender based violence is normalized and the precursor for mental health care, the resources available are re-victimizing. Because women arrive at mental health care resources through seeking justice after surviving violence, and because advocacy organizations favor debriefing to any other therapy, this process is re-victimizing. Amari best explains how debriefing can be construed as helpful in the micro-level but becomes harmful in the overall judicial system,

> -Amari: De las investigaciones que realizamos nos dimos cuenta que la atención psicológica en crisis solo sirve para re-victimizar aun mas a la victima. Mucho mas cuando analizamos la ruta critica de la victima y nos encontramos con que la victima este no es el primer lugar al que visita. Generalmente la victima el primer lugar que visita si no es el hospital si no es un centro [interrumpen] Perdone. En este caso yo le comentaba que a través del análisis y de la propia atención del ejercicio que realizamos nos dimos cuenta que la ruta critica nos indicaba que era un fracaso los modelos establecidos en Guatemala

-Chantal: que visitaban me contaba?

-Amari: primero la policía y la policía tiene un modelo que brinda atención en crisis. La policía traslada al Ministerio Público. Y el Ministerio Publico tiene un modelo con atención a crisis. Traslada al organismo judicial y el organismo judicial tiene un modelo de atención en crisis el organismo judicial traslada casos a determinados organismo no gubernamentales y brinda atención en crisis y después me lo trasladaban a mi para el seguimiento del caso para asignar un abogado y yo también brindando atención en crisis. Cuando veníamos a investigar esta victima había recibido cinco, seis y asta siete sesiones de atención en crisis. Ninguna responsable de la atención de seguimiento del caso. Entonces pues lo único que se hacia eran preguntar y preguntar y preguntar a la victima que le había pasado y ninguna podía atender la situaciones. A partir de este análisis y la confrontación de esta terrible realidad comenzamos a hacer las gestiones necesarias para tener personal permanente y suficiente que se encargue de brindar la atención de caso de seguimiento.

-Amari: From the research we conducted, it became clear that psychological attention for crisis intervention only serves to re-victimize the victim. Even more so when we analyze critically the route from the perspective of the victim, we find that the victim this is not the first place she visits. Generally the victim the first place she visits if it is not a hospital, or a health center. [interruption.] I apologize. So in this case as I was telling you, through the analysis of the own attention the exercise we realize allowed us to see that the critical route indicates that it is a failure the models of attention established in Guatemala.

-Chantal: what is it that they visit first, you were telling me…

-Amari: First the police, and the police has a model that provides crisis intervention. The police transfers to the Ministerio Público. The Ministerio Público has a model of crisis intervention and transfers to the judicial organisms and the judicial organism has a model of crisis intervention that

> transfers determined cases to non governmental organisms that provided crisis intervention and then they are transferred to me for the following of the case to assign an attorney and I also provide crisis intervention, so when we did the research the victim had received five, six or even seven sessions of crisis intervention none of which responsible for a follow-up session. So the only thing we were doing then was to ask and ask and ask the victim what had happened and no one could respond to the situation. From this analysis and confronting this terrible reality we started to make the necessary efforts to have permanent and sufficient staff in charge to provide follow-up attention (personal communication, March 11th, 2013).

The lack of resources makes it such that debriefing is the most used intervention. However, it further victimizes women because mental health care is still not prioritized and debriefing can only contain trauma, rather than heal it.

Lack of Preventive Measures.

Even though the law against femicide and other forms of violence stipulates the creation of preventive care, these have yet to be developed. The lack of preventive resources affects Ladinas in two ways. First, it creates systems of care that are focused on containing trauma and seeking reparation post-violence, in this way, it only provides support for women looking to prosecute their aggressors. Secondly, the available resources do not meet the increasing demand. These services can be described as 'too little, too late' as Amari explains,

> En la medida en que el daño sea mínimo la atención que se va a necesitar es menor y creemos en la prevención mas que la atención. creemos que la atención que hoy brindamos desborda cualquier capacidad, es preferible comenzar a invertir en la prevención.

> In the measure that the damage is minimum the attention required will be minor, and we believe in prevention more so then attention. We believe that the support that we bring today overflows any capacity, it would be preferable to start investing in prevention (Personal communication, March 11th, 2013).

Understanding mental health needs as mental "illness" centers the responsibility of trauma onto the individual in an a-historical and a-political fashion. Similarly, applying the law of femicide only as a prosecution platform places the responsibility of justice onto the victim. Folding systems of mental health care onto structures of feminicide allow a broader perspective of the perverse mechanisms of state terror and gender violence that successfully continue to marginalize women through their systems of care and justice, while simultaneously holding them responsible for the structures' biased and violent shortcomings. Well aware of these mechanisms of state terror and gender violence, Kayla's organization, led by a group of Guatemalan women, actively lobbies against the use of any psychiatric diagnosis, clinical histories, or even debriefing methods in women's legal counsel. This organization argues that any kind of mental health support, which has been imported to Guatemala can only be used to re-victimize and further disadvantage women, because it does not take into consideration the locality in which mental health is experienced. Kayla compares the shortcomings of the mental health diagnosis to the judicial system when she explains,

> La escucha activa. Nosotros no hacemos mas, y eso tiene una razón Chantal, Guatemala todavía no entiende en su sistema jurídico que la evaluación no es un diagnostico negativo entonces que pasa, si nosotros usamos un tipo de evaluación el sistema de justicia rápidamente lo cuestiona. Entonces esta deprimida entonces tiene una escala baja de relacionamiento, o por ejemplo, en Estados Unidos ustedes usan escalas de violencia escalas de interrelación si nosotros llegáramos de usar un tipo de estos instrumentos seria mal interpretador por el medio punto. Y dos, ninguno

de esos instrumentos esta validado aquí en Guatemala. Entonces no tienen la credibilidad para ser aplicados porque no son normas ni Latinas ni Guatemaltecas. Entonces no podemos usar instrumentos que no han sido efectuados en nuestro medio. Entonces que hacemos en nuestra primera sesión única, tenemos una estructura básica como le decía la escucha activa, desarrollar con ellas la capacidad de cuestionamiento y de visualizar la violencia y empoderarla a través de acciones que ella puede realizar. Por ejemplo acciones tan sencillas como el valor requerida para pedir esa cita, que haya llegado que este dispuesta a trabajar en su problemática entonces nosotros probamos en esas sesión única darle el conocimiento sobre la base legal. Y dos contarles el empoderamiento para que ellas puedan enfrentarse a este medio.

We engage in active listening. We do not do more and that has a reason Chantal, because Guatemala has yet a judicial system in which evaluation is not a negative diagnosis so what happens, if we utilize a type of evaluation the justice system will question it very fast. So if you are depressed and have a low scale of interrelationship or, for example, in the United States, you use scales of violence, scale of interrelationship if we came to use these types of an instrument they would be badly interpreted and that is the end of it. And two, none of those instruments are validated in Guatemala. So they do not have the credibility to be applied because they are not based in Latin or Guatemalan norms. So we cannot utilize instruments that have not been developed in our environment. So what do we do in our first and only session, we have a base structure as I was telling you of active listening, developing with them the capacities of questioning and to visualize the violence to empower them through actions she can carry out. For example, simple actions like the courage required to ask for this appointment, the fact that she made it, the fact that she is ready to work through her problem, so we try in this only session to give her a basic legal knowledge. And two, provide empowerment so that they can confront this environment. (Personal communication, March 21st, 2013).

Kayla's mission is to create safe spaces for women and support their empowerment to redeem justice. "Active listening" in the patriarchal system, a system

constructed to silence women and stain their dignity and credibility, becomes an act of advocacy for Ladinas' mental health. As Amari explained, the law created the resources but not the responsibility to implement them. Thus, victims of feminicide become doubly discriminated once they raise their voices. In fact, gender bias further castigates, as clinical histories do not take into account the everyday experience of violence and can be detrimental to women's cases. Kayla provides a poignant example of this disempowering system,

> -Kayla: Nosotros tenemos una sobreviviente que fue diagnosticada con una depresión severa y para ella funcionar en su cotidianidad tenia que tomar antidepresivos. En el procedimiento de custodia de sus hijos el esposo saco el uso de antidepresivos y dijo ella no esta capacitada para cuidar a mis hijos. Y se le dio la custodia al papa. Cuando precisamente su aceptación de su diagnostico y su buen uso del medicamento la tenían funcionando, estaba trabajando estaba viniendo pero el miedo no tuvo la capacidad de entender eso.

> -Kayla: We have a survivor that was diagnosed with severe depression, and for her to function in her daily life she needed to take anti-depressants. In the proceedings of child custody her husband brought to light her usage of antidepressants and argued that she was therefore not capable of taking care of her children. And the custody went to the father. When precisely the acceptance of her diagnosis and her good use of medication had her functional, she was working, she was living independently but the environment did not have the capacity to understand this. (Personal communication, March 21st, 2013).

Here, structural gender bias doubly discriminates against Kayla's client for being a woman and for being a woman that expresses a mental health need. As Kayla illustrated, mental "illness" diagnoses disfavor women in concrete ways, making the law failing the protection of their mental health. Rather, accepting a mental health care need becomes a

detriment in the plea for their rights. Kayla and Dr. Rodriguez both agree that 5% of individuals in Guatemala express a psychiatric mental illness however, the other 95 % are diagnosed without an examination of their everyday experience. Dr. Rodriguez explains,

> Hay enfermedad mental no estoy diciendo que no existe pero del 100 que nos quieren vender, un cinco existe, un cinco necesita el acercamiento el tratamiento medico siempre va a ver alguien que necesita una medicina para ayudarse.
>
> There is mental illness, I am not saying that it does not exist, but of 100 that they want to sell us, five exist, there are five that need a medication treatment approach, there will always be someone that needs medication to help themselves (Personal Communication, February 14th, 2013).

Kayla corroborates with the percentage,

> Sabemos que el un 5 % de sobrevivientes si presentan algún problema psiquiátrico. Pero tenemos que tener sumo cuidado en el uso legal de este historial porque aquí si la penalizan.
>
> We know that 5% of survivors do present some sort of psychiatric problem. But we have to be very careful in the legal usage of this medical history because here that is penalized. (Personal Communication, March 21st, 2013).

Nevertheless, the high number of women who seek mental health support highlights the systemic ways in which gender violence abuses Ladinas, and how the same system continues to discriminate against them on the basis of their mental health. As Kayla expresses, the legal system penalizes women, which in the context of mental health care further strips them of rights. What is observed is that both the mental health care system and the judicial system are "penalizing." A penalizing judicial system implements the law against femicide as one for prosecution and not one to support preventive measures to eradicate gender violence. The mental health care system is in parallel where

the application of the law against femicide illustrates the state of mental health in Guatemala. Here the investment is on punishment rather than care or prevention. Although the law against femicide is a step in the right direction, it is still only one document within a broader patriarchal structure: as Amanda explains,

> Para mi la ley es la ley y es un proceso mecánico donde allí no hay vuelta de hoja ni siquiera condicionamos la presencia de ellas en los juzgados porque la justicia en este país es castigante. […] la justicia que tenemos es una justicia confrontativa en donde le tenemos que ver la cara al hombre, donde mecanismos de conciliación no se puede […] que el proceso sea menos desgastante […] El derecho es mecánico. Mecánico mecánico entonces mientras menos la podamos confrontar lo evitamos.
>
> For me the law is the law and it a mechanic process where there is no turning back we don't even condition their presence in the courtroom because the justice system in this country is punitive […] The justice that we have is a confrontational one where we have to see the face of the man, where mediation cannot happen […] the process should be less depleting [...] The law is mechanical, mechanical, mechanical so as long as we can avoid confrontation, we avoid it. (Personal communication, February 4th 2013).

This mechanical law comes from a patriarchal system that even in the legal proceeding does not support Ladinas' mental health. Illustrating how violent a gender-blind mental health system is, is the fact that women have to face their aggressor in the courtroom that mediation is seen as an unsuccessful process, and advocacy for women comes from "avoiding confrontation."

Patriarchal Institutions and Their Consequences for Women's Mental Health.

One of the most flagrant examples of the judicial structures being part of the overall patriarchal system is the difficulty with which sexual violence is prosecuted. Rape was a systematic tool of war used during the conflict, which terrorized women and their communities. As of 2014, not one aggressor has been put on trial. Consequently, sexual violence continues to shape women's daily lives and experiences within the justice system. Perla, who coordinates psychosocial initiatives for victims of rape, explains,

> pienso que la sociedad a aprendido de un sistema patriarcal de hecho las leyes son hechas por hombres. […]Entonces hay un esquema allí bastante arraigado que es muy complicado resolver. Las mujeres cuando son atendidas con los jueces victimas de violencia sexual son muy mal atendidas, re-victimizadas. Lo mismo nos paso en el programa de resarcimiento en los testimonios, no les creían eran re-victimizadas después de tantos años y sin prueba medica, todas esas complicaciones son aprendidas en la sociedad por un sistema agresivo.

> I think that society has learned from a patriarchal system in fact the laws are written by men […] so there is a framework that is quite ingrained that is very complicated to resolve. Women when judges see them are treated poorly; victims of sexual violence are re-victimized. The same thing happened to us during the project of compensation with *testimonios*, they were not believed, they were re-victimized after so many years and without medical proof, all those complication are learnt in the society by an aggressive system. (Personal communication, February 18th, 2013).

This "aggressive system" has historically disbelieved the *testimonios* of female survivors of war and continues this mechanism by discrediting Ladinas on the basis of their mental health. This aggressive system first silences Ladinas, and as the distress of violence is expressed as a mental health need, Ladinas' experiences are made inaudible through

mechanisms of mental health "care." Ladinas are well aware of the precariousness of their credibility and of the potential implications of expressing a mental health concern. Amari goes to great lengths to disguise the word "psychologists" when referring a client to mental health support because,

> Porque si yo le digo va ir a atención psicológica "le estoy diciendo la verdad no tiene porque no creerme, o yo no estoy loca a mi no me trate así." Entonces inclusive a los protocolos de atención dicen que se le va ofrecer la atención psicológica pero no llamándole como tal […] Se obvia la palabra psicología por el puro contexto cultural que se le ha asignado a este tema. Todavía no se valora apropiadamente la labor fundamenta que realizan los psicológicos.
>
> If I tell them [women] that they are going to the psychologist [they will reply]: "I am telling you the truth you have to believe me, I am not crazy, don't treat me like that." So even the protocols of attention say that we are going to offer psychological attention but without calling it that [...] The word psychology is avoided just for the pure cultural context assigned to this theme. (Personal communication, March 11th, 2013).

Given the examination of the mental health care system, this "cultural context" is actually a very material one as has been examined previously. Gendered in a patriarchal system, Ladinas are well aware of their vulnerable position. Thus it is understandable that in a judicial setting, being referred to a psychologist would not be interpreted as a support but rather as a mechanism to discredit their experience. The danger in constructing this context as a cultural one is perverse in different ways. First, it absolves the structures of care from the responsibility they bear for reproducing and enabling state terror and gender violence. Then, by inflicting more violence onto the women who chose to speak against it, gender violence is further normalized as being "cultural." Whereas some may

argue that violence is so entrenched in Guatemalans' everyday life and cognitive frames that it might as well be an important thread of culture, what is important to note is that gender violence is particularly cruel to women who exercise their agency and citizenship rights (rights to justice, rights to health). What can be observed is that the patriarchal structures of Guatemala find women with a voice particularly dangerous. The experiences of Silvia speak of the oppression of a patriarchal system.

Silvia experienced both the patriarchal values that annulled her agency and the consequences of being diagnosed with a mental "illness". In fact, Silvia is a child psychologist trained in the United States with the support of a Fulbright scholarship. Her depression started in the early years of her marriage when her husband became an alcoholic and forbade her from continuing with her private practice and her singing lessons. Her husband diminished, suppressed, and annulled her, all while demanding she became a " la mujer perfecta," "perfect woman" the proper wife. Silvia recalls her life before she married with great joy and how she noticed the changes after she got married,

> Después de la clínica me iba a mis clases de canto. Estaba viviendo mi vida. Estaba haciendo la psicología, me metía a sesiones de neuropsicología, salí en un congreso con ellos. Y de repente como que se te juntan las cosas porque con este hombre no me dejo [...] ya no me dejaba ir a clases de canto. Como que empieza a mermar tus sueños.

> After the clinic I would go to my singing lessons. I was living my life. I was doing psychology, I would get into neuropsychology sessions, I would go to conferences with them. And suddenly, it is like when it rains it pours because with that man he did not let me […] he no longer let me go to singing lessons. He was like starting to squander my dreams. (Personal communication, March 11th,2013).

As an independent woman, she started feeling isolated and controlled, so she looked for help. She sought out a psychiatrist to get the courage to divorce her husband. The psychiatrist responded that it was "una idea terrible," "a horrible thing" and gave her anti-depressants. The first time I met Silvia in 2011 she told me "no necesitaba un diagnostico, necesitaba un divorcio," ("I did not need a diagnosis, I needed a divorce,") as she explains,

> Yo era objeto, como que tu dueño, entonces paso el tiempo. Le hable a una amiga, porque pensaba que tenia depresión la amiga me dijo, "sabes que pasa te volviste un mueble mas en la casa, tu sos como la lavadora. Ya no salís, ya no amigas."
>
> I was an object, it was like having an owner, and time went by. I spoke with a friend because I suspected I had depression, and my friend said, "you know you became another piece of furniture in the house, you are like the washing machine. No going out anymore, no friends." (Personalcommunication March 11th, 2013).

Once she expressed wanting a divorce, her husband institutionalized her without any legal consequences, and she was diagnosed bipolar. When I asked her why she had not placed a complaint she explained,

> El cuate es el dueño de ese lugar y nadie lo denuncia. ¡Si yo cuento eso a quien le van a creer! ¡En una sociedad como esta! Después de los 90 días no pude regresar me fui donde mi mama. Que si me vuelve a pasar el me va a corte por la custodia total y ganaría […] Un año estuve donde mi mama y eso me hizo regresar para cuidar a mis hijos
>
> The dude is the owner of that place and no one denounces it. If I tell that who are they going to believe?! In a society like this one! After the 90 days I could not go back, I went to my mom's. If this happens again he would take me to court for the full custody and he would win […] A year

> later of being with my mom he made me come back to take care of my children. (Personal communication, March 11th, 2013).

When I visited Silvia she was still living with her husband, and she fears he might try to kill her, causing her to sleep in the same room as her youngest daughter. She is well aware that she remains the "washing machine" of her household, as she was "brought back" by her husband because he could not take care of the children. What is most perverse about Silvia's situation is that she is one of the most privileged Ladinas I know, with an American graduate education in psychology, and she is well aware of her situation and of the processes that led her to accept her submissive position. In her case, her diagnosis as bipolar allowed her husband absolute power over her life by providing him with the ammunition to threaten her with the custody of her children. During the three years that she invited me into her home to tell me her *testimonio*, she never failed to whisper when she told me her story, even when she knew her husband was at work and that no one could possibly hear us in the echoing walls of her mansion. Silvia does not like to think of the time when her children will go to college, as she knows the amnesty she has depends on her children being by her side. Silvia's life is a reminder of how effective the patriarchal structures are to annul the life of an assertive and strong Ladina.

The Internalization of Gender Violence.

The penalization of women in the legal process can be observed in the mental health resources offered by women's rights organizations that favor a crisis intervention model only, or are unable to protect women against the bias of a mental health diagnosis in court. The normalized double discrimination against gendered mental health allows yet

another platform in which violence against women goes unnoticed or accepted as the norm, because patriarchal institutions are quite successful at re-victimizing Ladinas and punishing them by stripping them of their rights, dignity, and voice.

What became apparent throughout this study is that state terror and gender violence is a routine and normalized experience among Ladinas. This reality has to be taken into account when discussing women's mental health. This generalized violence is reflected in patriarchal care systems and resources, but mostly in the causes that drive women to express a mental health concern. It is no mystery that violence impacts mental health, however, in the Guatemalan context, violence is only considered at the critical moment, the crisis, and not in the everyday. The daily experience of violence is discredited to the point that even when violence is generational it is routinized. The experiences of Silvia and Teresa speak to the internalization of gender violence and the harm in ignoring such violence when conceptualizing mental health. What was most telling about the *testimonio* of Teresa was the degree to which she understood her mental "illness" as a genetic predisposition and not one stemming from the generations of abuse she had endured,

> porque mi mama se hizo fármacodependiente después yo tenia que llevar a mi mama a psiquiatría también porque era fármacodependiente a las diazepinas porque mi mama también traía esa predisposición genética.
>
> My mom became a drug addict; afterwards I had to take my mother to the psychiatrist also because she was addicted to diazepines, because my mom also brought with her that genetic predisposition (Personalcommunication, January 29th, 2013)

Teresa internalizes the language of diagnosis and has given me a complete list of medications and prognoses that have affected her. However, she does not correlate the abuse faced by her mother, or her own self, to explain her depression or drug addiction. In this example, Teresa recounts how her mother, who was Honduran, was raped and sent to Guatemala to hide her pregnancy and give birth,

> Mi mama allí tuvo un fracaso con el pastor. El pastor le enseñaba a unas jovencitas a tocar piano. Entre esas jovencitas mi mama salio verdad. Ese señor la abusaba a todas las jovencitas y en ese abuso estuvo mi mama y ella fue la que salio premiada.
>
> My mother had a failure with the pastor there. The pastor taught all the young ladies how to play the piano. Between the young ladies my mom got it, you know. That man abused all these young ladies and in that abuse there was my mom and she was the one who got the gift (Personalcommunication, January 29th, 2013).

What is interesting about this narration is the way in which Teresa provides positive euphemisms to describe a situation of sexual violence while simultaneously making her mother the subject of action. This quote is very hard to translate, in particular because of the last sentence, when Teresa said, "ella fue la que salio premiada," I have translated this literally to "she was the one who got the gift," but what Teresa means is that her mother got "knocked up." The particular word *premiada* references a positive and lucky moment. For example, when one wins the lottery, it is because one has purchased the lucky ticket, or because the ticket is "premiado" that one gets the prize. Literately translated, *premiada* means awarded, but it implies gifted with a lucky connotation. To use such positive euphemism to describe a violent situation works two fold. First, it sugar coats a difficult and awkward conversation. Secondly, it normalizes

the situation by avoiding framing the rape and pregnancy as violent, while simultaneously deflecting the responsibility from the perpetrator of abuse onto the victim, while still labeling his actions as abuse. Because Teresa narrates her mother's rape, as "my mother had a failure with a pastor there" *failure* becomes part of the mother's doing, which re-victimizes her mother rather than accounting for pastor's violence. Moreover, the term *allí* makes the situation even more banal as it is used to recall something in the past of little importance, *alli* functions as a diminutive of the circumstance.

Yet another example of how violence is not linked to mental "illness" or drug addiction is the way Teresa continues to describe the relationship between her mother and her father as one of great love, even when the events suggest that her mother was sent to Guatemala under the care of a much older married man after she was raped. After almost a year, this man married her mother in what seems to be an agreement lacking consent. Understanding a forced marriage with one's caretaker while recovering from rape as a true love story highlights the perversity to which patriarchy and its reproduction of gender violence is normalized. Internalizing a mental "illness" diagnosis as a matter of genetic predisposition enables the context of feminicide to go unexamined as it is illustrated by this quote,

> Pero para ese tiempo mi papa y mi mama se enamoraron pero mas mi papa de ella. Porque mi mama dice que para quitárselo de encima dijo ese viejito quiere que le de porque tanto le había ayudado que bueno, mi mama se embaraza de mi hermana y para mi mama fue la muerte y mi mama trabajaba en traumatología mi mama no quería, ni el matrimonio con mi papa ni los hijos [...] Y de allí vine yo, y para ella fue un rechazo por cierto creo que de por si allí tenemos ese choque. Era conflicto emocional porque mi mama asta me quiso abortar[…] y se unió a mi mama, mi papa amo a mi mama como no tenés una idea yo jamás he visto un amor tan grande. Que por

> eso a mi casa hombre me queda corto porque vi que era ser amada, ese era el amor genuino, mi papa le decía "yo te amo" y ella decía "yo no" yo no se como mi papa aguanto. Y mi papa la amaba, le traiga rosas.
>
> At that time my mother and father fell in love, but more my dad with her. Because my mother says she wanted to shake him off, she said "oh this old man wants me to give it to him" because he had helped her so much, my mom becomes pregnant with my sister and for my mother that was death, and my mother worked in traumatology and my mother did not want, the marriage with my father or the kids […] And then I came along, and for her that was a rejection in fact I think that is why we had a shock. It was an emotional conflict because my mom even considered aborting me […]. So he married my mother, my dad loved my mother so much you have no idea, I have never seen such a great love. That is why in my house every men falls short because I saw what it was to be loved, it was the genuine love, my father would say "I love you," and she would reply "I don't" I don't know how my father endured. And my father loved her he would bring her roses. (Personalcommunication, January 29th, 2013).

Teresa narrative of her parent's love further exemplifies the degree to which her mother's suffering is invisible, and colors the highly entrenched patriarchal culture in which men are exempted from committing violence. For example, Teresa narrates her mother's rejection of her father to exemplify what she believes to be an injustice committed to him, and only shows empathy for her father's non-reciprocal love. Teresa illustrates my argument by understanding her mother's drug addiction as a genetic predisposition rather than a consequence of her experience, where gender violence is further normalized and the context in which mental health is constructed is not accounted for. In so doing, mental health becomes a landscape of feminicide in which women are *violentizadas* "violenced" with the support of the structures deemed to protect them.

Conclusion.

Because Ladinas who have access to resources of justice and mental health care are those who have been either victims of violence or are expressing serious mental health needs, a gendered mental health care [system, process, etc.] needs to first and foremost fight against the routine and normalized context of feminicide. Allowing women to realize they have internalized these repressions, and supporting their agency and right to justice and citizenship, is also necessary. Ladinas enduring everyday violence are not encouraged to seek help because counseling is out of reach due to a high demand and a lack of services. Thus, Guatemala's mental health "care" reproduced gender violence and is therefore inadequate to deal with mental health needs or the particular necessities of Ladinas.

In fact, I experienced the inadequate mental health care system myself after seeking counseling to cope with the realities of Guatemala in February 2013. Through several recommendations I chose a young therapist who was affordable and seemed eager to work within my price range. I was to meet him once a week and he would help me with techniques to cope with the environment and the everyday tension of studying and living in Guatemalan culture. To reach his office, I would walk four blocks to the bus and then three blocks from the bus to his office. As I did this, I began to realize there were no women on the street and I started keeping a tally of how many catcalls I would receive each trip. I soon realized that every single man that was on the street would harass me, and the number of catcalls depended on the number of men on the street that particular day. In general, I would receive more than eight catcalls per trip, a total of 32 in a round trip to the counselor.

The night of January 16, 2013, one week after president Otto Perez Molina's annual report in which he celebrated the decrease of gender violence and feminicide, two girls aged two and 11, and two women aged 30 were killed in Guatemala City. A few hours later, two more women's bodies were found at the outskirts of the city (http://voces.huffingtonpost.com/2013/01/16/muertes-mujeres-guatemala_n_2489924.html), for a total of six feminicides in one night. Marco Garavito, the director of the League for Mental Hygiene, presented the following statement the next morning (taken from huffingtonpost.com):

> Hay dos cosas que preocupan, este tipo de hechos sigue complicando el estado emocional de una población que todos los días se levanta con tragedia, muerte y sangre y tiene una implicación en el estado emocional y sensación de inseguridad, lo otro es que no vemos que haya respuesta desde el punto de vista social; la sociedad ya no podemos estar al margen de esto esperando que solos las autoridades hagan algo, hay un rol ciudadano que hay que ejercer, estas tragedias las estamos viviendo en soledad y eso no contribuye a cambiar.
>
> There are two things that worry me, these kinds of facts continue to complicate the emotional state of a population that everyday gets up with tragedy, death and blood, and has an implication for the emotional state and feeling of insecurity, the other is that we do not see a response from the point of view of the social; society can no longer be at the margins of this, waiting only for the authorities to do something, there is a citizen role that we must exercise, we are living these tragedies in solitude and that does not contribute to change.

These words resonated with my experience of fieldwork. In the six months I had been in Guatemala, I had already witnessed multiple robberies, had been robbed at gunpoint twice, and had seen two dead bodies on the street my first day of fieldwork. I was overwhelmed with fear and the news from that morning made me feel particularly

hopeless. That same morning I went to therapy. As I recounted to the counselor the ways in which street harassment and the particular news of the morning were making me feel, he listened and then offered three particular pieces of advice. First, he expressed surprise, as *he* had not noticed how bad sexual harassment was in the streets when he walked to work. Then, he offered his analysis: I had yet to culturally acclimate to Guatemala, where hissing and catcalling are not considered sexual harassment, but rather an appreciation of my beauty. His advice was for me to work on my self-esteem in order to accept these compliments without fear. Politely I told him he should consider the fact he was a man and that he did not wake up to read that six men had been killed, but rather it was a gender difference. To this he replied, *as a coup de grace,* that I should abstain myself from reading so much, as that was causing my anxiety. At that point I was filled with anger and was reminded of the practical implications of my own work. I realized I was in a battle zone and that the structure was truly built to victimize women who, like me in that moment, were expressing a *gendered* mental health concern. There is a particular perversion to this experience, where I was constantly persuaded of the responsibility of my individual mental health and the environment as a whole was simply disregarded as the norm. This perversion is what my participants referred to, and that I experienced in a microcosm in my third and last session of therapy. What is troubled about Garavito's discourse is that Ladinas do not have the same access to citizenship as Ladinos like himself. Living "tragedies in solitude" is particularly true for women that cannot find justice and reparation in the institutions built to provide such services. Just as this counselor made it my responsibility to accept catcalls as compliments, the "exercise of citizenship" as mental health needs to come from a gendered conceptualization.

Dismantling the structures of machismo inherent in the mental health field of Guatemala is a priority.

My personal experience, even from a place of privilege in which I was able to pay for mental health support while also holding knowledge about the topic, exemplified the degree to which patriarchy victimizes women in everyday Guatemala. Supported by the exploration of women's advocacy centers and the *testimonios* of Teresa and Silvia, this chapter uncovers the systemic violence that builds the mental health care system. There are many ways in which mental health resources fail Ladinas, however, this chapter explicates the ways in which state institutions, such as the judicial and mental health care system, punish, annul, and use women's mental health needs as landscapes of feminicide. By importing medicalized understandings of mental "illness", having a lack of resources, and a permissive culture of abuse towards Ladinas' mental health concerns, women are rendered responsible and re-victimized for the violence(s) that accrue onto them while simultaneously exempting these same resources of their perpetuation of violence. In addition, the crisis intervention model serves to only contain violence rather than prevent it. Thus, in the next chapter I examine the consequences of a non-ratified mental health policy in caring for mental health, explore the different ways stigma against mental health perpetuates violence, and finish the chapter with a localized and gendered perspective of mental health as it pertains to Ladinas' everyday life.

Chapter 6

Stigma of Mental "Illness"?

Introduction.

In Latin America, mental health standards are derived from the declaration of Caracas (1990) and the Brasilia conference (2005). These documents have a community and prevention focus that calls for mental health education. Supported by these international standards, in 2006 the WHO presented the first evaluation of the mental health system of Guatemala (Informe del systema de salud de Guatemala, 2006). Notably, this report highlighted that since 2006, Guatemala has lacked a substantive mental health policy as well as a legal framework to develop mental health legislation that protects the rights of individuals diagnosed with a mental illness. In addition, due to lack of funding, the existing national mental health program has not met Latin American standards. In fact, this program is allocated 0.04 % of the Ministry of Health budget (MoH). Based on the WHO report, in 2007, the director of the Ministry of Public Health and Social Assistance, with the support of the Ministry of Culture, drafted the National Mental Health Policy 2007-2020 (NMHP) (see Appendix). This policy takes into consideration the Latin American standards as well as the contextual reality of Guatemala. It has a specific focus on gender, pluriculturality, and the everyday context of violence. The National Mental Health Policy 2007-2020 seeks to implement the following: a mental health community-based approach, decentralization of the mental

health care system, inclusion of mental health services within primary care units, an increase in human capital, the overall promotion of mental health services, and broadening access to these services. As a multidisciplinary policy, the document calls for the Ministry of Sports and Culture to improve the overall quality of life through the enhancement of parks and culture (Política, 2007, OMS, 2011). However, as of 2014, the Ministry of Health has failed to ratify the NMHP (OMS, 2011, interview with mental health program coordinator on March 8th, 2013). Because the policy has been drafted but not implemented, it is clear that mental health is not prioritized as a macro-political project. A non-ratified policy fails to protect the right of people diagnosed with a mental "illness", or to ensure the appropriate treatment of patients in public and private mental health care institutions. Guatemala does have a national mental health program within the Ministry of Health (MoH). However, of the 18 health programs, mental health is ranked at number 16 (Interview with the coordinator of the national mental health program on March 8th, 2013). As the third to last priority, the government prescribes the least amount of budget to this program. With no increase since 2006, the annual budget allotted to the mental health program continues to be 1% of the MoH's budget, with 96% of that 1% going directly to the up-keep of the Federico Mora (OMS 2006, Lopez & Cardona 2010, OMS 2011). Compared to other countries like Costa Rica, which allocate an average of 3 % of their national budget to mental health (DRI, 2012), it becomes apparent that mental health is not a concern warranting public investment in Guatemala, even when 28.6 % of adult Guatemalans are considered to have a mental "illness" (Lopez & Cardona, 2010).

The literature on stigma explains the discrepancy between the high demand for mental health services and the neglect of policy, legislation, and overall allocation of

resources to a structural discrimination against mental health. However, given the multiple ways in which state-sponsored violence is manifested through mental health care, in this context, stigma might be an oversimplification of a broader and deeper historical mechanism of repression. Thus, in this chapter I examine the causes and consequences of stigmatization in Ladinas' everyday experience in order to localize the concept of stigma. Based on this analysis, I proceed to develop a gendered perspective of the construction of mental health as it pertains to Ladinas living in Guatemala City.

The Structure of Stigma.

As I have presented, the mental health care system in Guatemala abuses and therefore silences patients. When it comes to Ladinas in particular, their diagnosis strips them of their rights and dignity, tainting their credibility. Once a Ladina is tagged with a diagnosis of mental "illness", her voice is no longer audible. The consequent discrimination on the basis of a diagnosis can be understood as a stigma of mental "illness". Stigma reduces individuals to stereotypes that portray them generally as violent and dangerous. From my participants, I learned that referring to people diagnosed as "locos" was the most common occurrence of stigma. There were numerous examples, as the one stated by Perla,

> La gente lamentablemente tiene la idea que al psicólogo solo van los locos es un esquema que se tiene muy generalizado "yo no estoy loco para ir a los psicólogos."
>
> Sadly people have the idea that only the crazies go to the psychologist, it is a very generalized framework "I am not crazy to go to the psychologist." (Personal communication, February 18th, 2013).

The particular and recurrent expression of "locos" as a plural further discriminates against individuals who are constructed as a type of people. Amanda further captures this alienating expression, when she explains, "Es que recordate que el tema de la psicología siempre se había visto como una cosa de locos" (Remember that the topic of psychology has always been seen as a thing of crazies, personal communication, April 2nd, 2013). "A thing of crazies" not only discriminates against the individual but also against the institutions of mental health care. Dra. Cadelaria's observation troubles the discrimination of mental health as stigma,

> si es que es horrible o sea si se cometen abusos. Entonces si eso hace mas difícil que uno trate de quitar esos estigmas porque es real. La verdad es que si es parte de verdad.
>
> Yes it is horrible, like there are abuses that are committed. So it makes it harder to take that stigma away because it is real. To tell you the truth part of it is real. (Personal communication, March 26th, 2013).

Dra. Candelaria highlights an important fact: in Guatemala, stigma against mental "illness" is based on the reality of treatment. Patients of the Federico Mora, for example, are interned with prisoners; both populations are mistreated and abused. In this context, is it stigma to consider individuals with a mental "illness" as criminals? Or is it mainly a reflection of the reality of the care system? What Dra. Cadelaria highlights, is that the process of stigmatization is rooted within the structure. It is the mental health care system that, through the human rights violations committed towards its patients, acts as a punitive and therefore stigmatizing mechanism. It is for that reason that Amanda states that psychology is a "thing of crazies." "Una cosa de locos" is an idiosyncratic expression that refers to something out of this world with a positive connotation, used here for its

literal sense – that of placing psychology in the realm of individuals considered crazy. Amanda links the stigmatized identity "crazies" to the system of mental health "psychology at large," as something that in Guatemala is in fact "out of this world." Particularly because the abuse of patients has been recorded and is known to the state, and that there is a drafted policy to reform the mental health institution that has yet to be ratified, this void of guidelines can only be considered a deliberate policy of its own.

It becomes clear that the state does not consider mental health in the realm of public responsibility, or rather that the state does not want to be held responsible for the mental health concerns of the Guatemalan public. In fact, the National Mental Health Policy 2007-2020 has a psychosocial characteristic that conceptualizes the need for mental health policy in the following way,

> Los problemas de salud mental no se conocen a profundidad en el país, sin embargo se presentan como una mezcla de sufrimientos psicosociales colectivos, derivados no sólo de los problemas propios de la enfermedad mental, sino de una serie de eventos traumatizantes a los que se ha visto expuesta la población guatemalteca, consistentes en pobreza, marginalidad, desastres naturales, violencia producida por el conflicto armado interno y una situación de creciente inseguridad, violencia social, cultural e intrafamiliar que actualmente resultan ser los problema más graves a tratar, por la sociedad guatemalteca, con un carácter intersectorial.
>
> Mental health problems in this country are not understood in-depth, however they present a mixture of collective psychosocial suffering derived not only from mental illness itself but from a series of traumatizing events to which the Guatemalan population has been exposed, consisted of poverty, marginality, natural disasters, violence produced during the internal armed conflict and an increasing situation of insecurity, social, cultural and domestic violence that currently result as the most serious problems to solve by the Guatemalan society from an intersectional perspective. (Política de Salud Mental, 2007, p.21)

Corrigan, Markowitz and Watson (2002) expand on the sociological framework of structural discrimination of mental illness. As an analysis of stigma from the structure, their work differentiates between *intentional* structural discrimination —referring to those policies that restrict the opportunities of people with mental illness—and *unintentional* structures of discrimination —referring to the negative consequences that still hinder the options for people with mental illness. Their work looks into how intentional and unintentional structural discrimination affects attitudes that people with mental illness have about themselves. Although a differentiation between intentional and unintentional structures is important, their work does not account for policies that do not exist and yet cause direct or indirect harm. As in the context of Guatemala, a non-ratified policy, a lack of legislation, an almost non-existent budget creates an environment of permissiveness where stigmatizing individuals as "locos" is the least harmful of consequences. As I will present, it becomes evident that macro structures of stigmatization affect Ladinas' self-stigma. However, the concept of stigma cannot fully capture the reality of the Guatemalan structures of mental health care because discrimination is rooted in a real threat that surpasses stigma and reaches levels of state terror. As the Mental Health Policy states, mental health concerns are "derived not only from mental illness itself but from a series of traumatizing events," stigma can only account for mental "illness", but a broader concept needs to be developed to take into consideration the discrimination suffered from a punitive structure that destroys the dignity of individuals expressing a mental health concern and refuses to acknowledge the "traumatizing events" experienced by the majority of Guatemalans. Moreover, an un-ratified mental health policy cannot be categorized in either and intentional or

unintentional structural discrimination, but rather, in an intentional un-accountability of the state that I argue represents state terror. A lack of mental health policy can be understood as inaction. However, I argue that this inaction is an intentional action because it enables the state to remain unaccountable, reproducing the context that roots many of the mental health concerns, as Amari states,

> usted va y hace una encuesta y le pregunta a una persona si ha ido al psicólogo le dice "usted me esta mirando cara de loco" o sea esta son cuestiones que todavía están en panales en Guatemala entonces esperar que contemos con un servicio de atención mental para la ciudadanía de higiene mental de salud mental no es algo que vaya a pasar en el estado. En el estado no hay una institución… precisamente por una situación cultural por la situación cultural […] no no existe ninguna ley todavía los avances del país son pocos. No existe en su momento inclusive las personas en Guatemala han considerado la atención psicológica como una acción discriminatoria, castigadora, sinónimo de locura y todo tal que va al psicólogo se considera de hecho como una persona enferma.

> You go and you do a survey and you ask a person if they've been to the psychologist and they will tell you "you are looking at me like I have a crazy face" like these are issues that are still in diapers in Guatemala, so to think that we can count with a mental health care service for the citizenship of mental hygiene, of mental health that is not something that will happen in the state. In the state in the institution there is nothing, precisely because of the cultural situation, the cultural situation […] No no there is no law still and the advancements in the country are few. At the moment there is no, even people in Guatemala have considered psychological attention as a discriminatory, punitive, synonymy of madness and every person that goes to the psychologist in fact is considered a sick person. (Personalcommunication, March 11th, 2013).

The Guatemalan situation is "still in diapers," as the precariousness of the Federico Mora as a project independent from politics, for example, was shown when the hospital was

dismantled by the dictatorship of Rios Montt and its mission never restored. Again, the harm in understanding the mental health situation as a "cultural" one is that the involvement of the state in topics of mental health becomes a passive one. However, when looking closely the state's involvement, it can be characterized as active permissiveness, which allows for the suppression of mental health advocacy from multiple fronts. In what follows, I present the different ways in which a demand for mental health care is ignored through processes of stigmatization. Underscoring the causes of discrimination to public active structures, stigma becomes another mechanism of state terror that works to render the state unaccountable for its intentional lack of investment in mental health. In so doing, I expand the concept of structural stigma to account for mechanisms of state terror.

The Stigma Against Mental Health Education.

A stark observation during fieldwork was the lack of mental health professionals. What was not as apparent was how little attention mental health is given in medical curricula. For example, only 4% of medical students receive some type of training on mental health, and it accounts for only 2.2 % of the total hours of the medical curriculum (OMS, 2006, OMS 2012). In addition, there is an average of only four psychiatrists who graduate per year (OMS, 2006). This lack of investment in education is more than just structural, it is a series of deterrents that make individuals' choices about pursuing a career in mental health difficult. Dr. Rodriguez, a social psychiatrist, struggled to choose psychiatry as his medical specialty because of the negative connotation attached to this specialty. Psychiatry was not considered a suitable path for a bright young medical student,

> por ejemplo cuando yo me decidí hacer psiquiatra: Le comente a mis compañeros de promoción y me decían "psiquiatría pero si vos eras bueno," " vos eras un buen estudiante" " que te paso, que onda?" O sea estaba el estigma que en psiquiatra van los no muy buenos los que no admitieron en otros programas.
>
> For example, when I decided to continue with psychiatry: I would comment it to my peer of the cohort and they would tell me "psychiatry, but you were good," "you were a good student, what happen, what's up?" So they had the stigma that psychiatry was the place where the not so good student who did not get admission into other programs would go. (Personalcommunication, February 14th, 2013).

The implication that a "good student" would not choose psychiatry made Dr. Rodriguez question his passion. It deterred him from pursuing psychiatry, instead pursuing the much better regarded specialization in pediatrics,

> al momento de tomar una decisión de que especialidad a seguir cuestione esto: porque la salud mental la psiquiatría tienen un gran estigma. Y es un estigma que en el momento de la decisión peso y dije mejor no voy a ser psiquiatra voy a ser pediatra. Y empecé pediatría.
>
> At the moment of making a choice about what specialty to pursue, I questioned it because of that: because mental health and psychiatry have a great stigma. And it was a stigma that in that moment of decision weighted and I though maybe I won't be a psychiatrist I would be a pediatrician. And I started pediatrics. (Personalcommunication, February 14th, 2013).

Because the pediatrics residency was regarded with more prestige and was considered competitive, it was not until his mother passed away that Dr. Rodriguez found the courage to realize he was passionate about psychiatry, and that pediatrics was simply a way to validate his own ability against the stigma attached to psychiatry,

> Para mi fue como una competencia personal y para demostrarme y demostrar talvez que podía tener acceso a eso y después me pase a psiquiatría en algún momento necesitas una validación de esas incluso para ti mismo.
>
> For me it was like a personal competition to demonstrate to myself and demonstrate maybe that I could have access and then I transferred to psychiatry at some point you need a validation even for yourself. (Personalcommunication, February 14th, 2013).

Similarly, three generations prior, Dr. Luther remembers the stigma he faced as a student and which continued through his career. He still refers to psychiatry as, "la Cenicienta del cuento de la medicina" (the Cinderella of the medical fairy tale, personal communication, April 3rd, 2013). Psychologists have also fought against similar deterrents. For example, Dra. Cadelaria attests to the stigma of choosing a career in mental health, and how she had to battle it within her education, "mi experiencia viene desde mi formación es algo que ha sido un estigma que hasta lo puedo pensar que lo tienen los trabajadores de salud mental porque desde la formación" (my experience comes from my training and it is something that has been a stigma that I can think even mental health workers have it because it starts from the formation, personal communication, April 26th, 2013).

The examples of Dra. Cadelaria, Dr. Rodriguez and Dr. Luther allow one to conceptualize the stigma against mental health education as a lack of structural and moral support for pursuing such professions in this field. This stigma entails a lack of resources as well as lack of prestige pertaining to mental health education. For example, Dr. Rodriguez first chose the pediatrics specialty before committing to psychiatry because pediatrics was the highest ranked, versus psychiatry, which had lower ranking and fewer

resources. All these mental health professionals corroborate the stigma related to mental health education as rooted in the education system itself. In fact, it wasn't until 2009 that psychiatric training became a requirement of the medical school curriculum. Psychiatric training is still only one month long, as opposed to other specialties, which require a minimum of three months. An active lack of funds, encouragement, and exposure to mental health constitutes stigma, which in turn creates penuries of qualified mental health professionals and ignores the high demand for this type of care. It is the fact that the demand for mental health professionals exists which makes the obstacles to pursuing a mental health education more than just stigma. Education reflects the value system of a society, as it is a social and cultural practice. Discouraging passionate and bright students from pursuing mental health careers points to something beyond just a lack of funds. Rather, it is an active impediment to fostering human capital in this field. Next, I continue with the professional development of Dr. Rodriguez to further illustrate why in Guatemala, stigma needs to be conceptualized as a mechanism of state terror.

(Stigma Against) Advocating for Mental Health.

The career of Dr. Rodriguez illustrates the many sacrifices entailed in advocating for mental health. Dr. Rodriguez graduated from an American university in social psychiatry and returned to Guatemala with the conviction of doing something better for the country. Now looking back at the tenured professorship he left behind, he regrets not choosing a more financially secure path. He left generous resources in the U.S. to lobby within the MoH to implement policy and to work at the Universidad San Carlos after he secured an international grant to fund a two-year research project. By making it mandatory for all medical students to participate in this research as part of their thesis project, with meager

resources he was able to implement a nation-wide survey to understand the state of Guatemalan's mental health. It was obvious that Dr. Rodriguez achieved a large-scale project primarily because of his drive to contribute to Guatemalans' understanding of mental health,

> eso fue mi personal *commitment* […] yo tenia mi agenda, mi agenda era crear los espacios de discusión que se crearon. Yo creo que es justamente eso, un compromiso que esta basado en algo mas personal.
>
> That was my personal commitment [...], I had an agenda, and my agenda was to create spaces of discussion that were created. I think it is just that, a commitment that is based in something very personal. (Personal communication, February 14th, 2013).

Dr. Rodriguez believes that spaces of dialogue are key in the fight against the stigma of mental health. Thus, his research resulted in a law that establishes the second week of October as a week for mental health awareness. However, his drive in advocating for mental health came with severe consequences. In fact, a few weeks after having published the results of this study, Dr. Rodriguez and his family received multiple death threats that forced him to take a step back from his work in order to protect his family,

> Saque a mi familia. ya la tengo protegida me siento mas tranquilo puede seguir haciendo lo que hacia antes, no se si al mismo nivel, y eso de alguna manera por lo menos para mi me produce salud, saber que estoy participando que estoy haciendo. Pero no quedarme con las brazos cruzados que estoy haciendo algo.
>
> I took my family out, I have them protected, I feel more calm, I can continue doing what I was doing, not at the same level, and that at least produces some kind of health, knowing that I am participating, I am producing, not staying with my arms crossed, that I am doing something. (Personal communication, February, 14th, 2013).

These intimidations lead Dr. Rodriguez to leave Guatemala and turn down long-term employment. Now, he only comes to Guatemala sporadically and for a short period of time. The picture of mental health in Guatemala is a lack of encouragement to pursue mental health professions, a staggering demand for counseling services, a refusal to implement national guidelines, an international lawsuit against the human rights violations of patients of the Federico Mora, and the intimidation of researchers committed to assessing the mental health situation of Guatemala. This picture does not look like a structural discrimination which stereotypes individuals as criminals, but rather a successful mechanism of state terror that terrorizes individuals for expressing a mental health concern or a concern for mental health services. Similarly, another example of terrorism against mental health happened during fieldwork, on January 17th 2013, when the Association for the Advancement of Social Sciences (AVANCSO) headquarters was broken into, vandalized, and plundered (http://www.frontlinedefenders.org/node/21359, accessed 01/22/14). AVANCSO lost immeasurable amounts of data, and the safety of their staff was breached. The message sent to Dr. Rodriguez and AVANCSO is that in post-peace accord Guatemala, researchers, scholars, or think-thanks engaging in knowledge production and dissemination of critical work are a political threat. Thus, Dr. Rodriguez's experience reminds us that understanding mental health from a psychosocial perspective is a political act that renders the state undeniably responsible for the "series of traumatizing events to which the Guatemalan population has been exposed," (Política de Salud Mental, 2007, p.21). Thinking in terms of stigma, this cannot successfully account for the ways in which state terror becomes a social determinant rooted not only

in the structures of care but also in the conceptualization of mental health, which will be explored in the next chapter.

The sociological understanding of structural stigma does provide a useful lens through which to understand why the structures of discrimination successfully become exempt from the state terror they enact. Corrgian et. al (2002) develop a model to understand how structural discrimination may affect attitudes that people with mental "illness" have about themselves. In other words, self-stigma is seen as a successful mechanism through which individuals internalize the stereotypes pertaining to mental "illness" developed by the structure. The ways in which Teresa and Silvia refer to women in their same situation illustrates these mechanisms more clearly.

Internalizing Stigmatization.

Teresa and Silvia attest to the discrimination and abuse experienced within structures of care and the consequences of being diagnosed with a mental "illness". When recounting their experiences, both Ladinas constantly described the women with whom they were interned as "locas". Labeling others in their same situation as "crazy" has a double function. First, it illustrates a resistance to the internalization of structural stigma. Secondly, it is a strategy employed to demarcate themselves from the "other" by stigmatizing women in their same situation. Both strategies illustrate the perversity of having such severe consequences of being labeled *loca*.

Teresa and Silvia find different opportunities to demote the "other" as the ill one in order to become, by contrast, the norm. The way in which Teresa describes the other women in her therapy sessions, for example, illustrates the perversity of the stigma attached to individuals suffering from a mental "illness",

> Eso fue en el '99 en el grupo de sobrevivientes ellas estaban bien locas, no estaba acostumbrada a esas [mujeres].
>
> That was in '99 with the group of survivors they were really crazy, I was not used to those [women] (personalcommunication, January 29th, 2013).

Here Teresa differentiates herself from other women in multiple ways. First, by referring to participants of therapy as "they" or "those," even when she was also part of the group. Secondly, she uses the superlative "really crazy" to highlight the state of their mental health as compared to hers, and further detaches herself by emphasizing she was "not used to those." Not being used to "those women" highlights her normalcy as compared to much crazier women, creating a hierarchy in which "those" are considered lesser than she is.

Another example is when Teresa narrates an altercation she had with another woman when interned at the Federico Mora, "y me pego la loquita, estaba bien loquita," (and the little crazy woman hit me, she was very crazy, personalcommunication, January 29th, 2013). Teresa continues to use the term "loca," but in a diminutive form "loquita," which has a tone of condescension. The diminutive does not make the woman seem less "crazy," rather it allows Teresa to positions herself in a moral hierarchy where she can express pity for the other woman. Teresa further separates herself from other institutionalized individuals by calling on the doctor's view of herself, when she describes, "cuando hablaba con los doctores me miraban que había bastante lucidez que no estaba loca," (when I would speak to the doctors they would look at me like there was a lot of lucidity, like I was not crazy, personalcommunication, January 29th, 2013). Teresa uses what seems to be two objective powers to further detach herself from the term *loca*: lucidity and the doctors' authority. These strategies exemplify the power of resisting a

label that has harsh consequences, but also the violence inherent in this stigmatization, in which others must be terrorized, in order to survive. This individual process of stigmatization is a reflection of the structures of discrimination, where Teresa illustrates how much detaching oneself from this label is part of one's survival from the structures of terror. The label *loca* terrorizes Ladinas to the point of losing their humanity.

After being institutionalized, Silvia's husband became much more violent and would verbally abuse her by calling her, "loca, huevona, enferma, cocha" (crazy, lazy, sick, pig, personalcommunication February 2nd, 2013). Here "loca" is the first insult and "pig" the last. As the first insult, "loca" opens the opportunity for Silvia's husband to dehumanize her. Similar to structures of mental health, Silvia's husband's string of insults renders him unaccountable for this dehumanizing process. In other words, "lazy" and "sick" place the burden of dehumanization onto Silvia's character. By calling her "crazy, lazy, sick, pig*"* Silvia's abuse is similar to that experienced within the structures of mental health care, she is victimized for expressing a mental health need, which in turns enables her dehumanization.

Mechanisms of state terror are successful at creating pathologies that do not account for the environment in which Ladinas are expressing mental health needs. Because Ladinas are punished for expressing a mental health concern, it becomes apparent that mental health is a political realm that causes a threat to the state. As the mechanisms of state terror work to control and silence a population against their aggressor, those individuals who express a mental health need are further abused, re-victimized, and mistreated. Moreover, a stigma is attached to their dignity as one of crazed individuals who become inaudible, which further oppresses and marginalizes

them. In parallel, mental health education and training is underdeveloped, creating a scarcity of human capital. Those few individuals who advocate for mental health are directly intimidated, thus, in Guatemala, one cannot speak only of a stigma attached to mental "illness", but rather of a state apparatus that historically has oppressed the mental health of a people. In this context, mental health needs to be conceptualized as an exercise of citizenship resisting a context of state terror.

Chapter 7

Mental Health: A Gendered Citizenship Project

Introduction.

The state of Guatemala has used mental "illness" as a justification to exercise its power over individuals deemed dispensable. For example, between 1946 and 1948 the state of Guatemala gave consent to the United States government to conduct human experiments on approximately 2,082[4] Guatemalan women and men (Consentir el Daño: informe sobre la comisión presidencial de los experimentos practicados con humanos en, Consenting Damage: presidential commission report on experiments performed on humans, Guatemala, 2011). Of these individuals, 424 were patients interned in Asylum F. Molina, 205 were prisoners of the Central Penitentiary, 524 were low ranking soldiers of the military base Guardia de Honor and 7 were prostitutes interned in the hospital of Sexual Prophylaxis (Consentir el Daño, 2011). All were infected with syphilis, gonorrhea and/or cancroids, and only one individual of each group received adequate treatment. Of the patients with mental "illness" forced into the experiment, 71 lost their lives due to their infection (Consentir el Daño, 2011). Simultaneous to these experiments, the Nuremberg trials were being conducted during which time the concept of "crimes against humanity" was also being developed. Perhaps for this reason, the Guatemalan authorities

[4] This number represents the people who's identities were established but based on the documents there were more

deliberately and intentionally hid the evidence, protected the directors behind this operation, and misinformed international authorities of the time. It wasn't until 2011 that the United States in collaboration with the vice-presidency of Guatemala published the findings of the truth committee formed in 2010 in which they concluded that crimes against humanity had indeed occurred and recommended that the ethic legislation for the protection of vulnerable populations be revised. Yet in 2013, Disability Rights International placed a complaint with the Inter-American Commission on Human Rights in Washington D.C, that human right violations were occurring on behalf of the patients of the Federico Mora—hospital born of the merger of the Asylum F. Molina and the Neuropsiquitarico Tipo Granja, where patients, prisoners, guards and prostitutes are detained.

The DRI complaint highlights the current precariousness of citizenship and human rights of vulnerable Guatemalans, especially women and mentally ill individuals, who have historically been a marginal population with conditional rights and citizenship status.

Citizenship is commonly seen as a member of the modern nation state, which is why, for example, in Guatemala only women who were literate in Spanish obtained the right to vote in 1945. It wasn't until 1965 that all Guatemalan women acquired this right. Although citizenship includes active participation in formal politics, in recent years citizenship has been linked to human rights to also include rights such as: access to a standard of living, to health services, to bodily integrity and freedom from fear of violence, to name a few (Munday, 2009). However citizenship has in the most part been reserved for the white, heterosexual, non-disabled man who is rational, unemotional and

thus able to transcend his own body, in the interest of impartiality (Lister, 1997). Thus, women have historically been regarded as second-class citizens under the assumption that they, as emotional, rather than rational beings, could never embody the identity of the citizen.

The need to pathologize women's emotionality and to subsequently justify their second-class citizen status comes in part from the field of psychiatry (Micale, 1995). At the end of the 19th century hysteria was imported from Europe to Mexico and consequently Central America. As a mental disorder linking the uterus to the brain, hysteria was believed to affect those women that dealt poorly with "over-civilization" (Gorbach, 2005). In a perceived continuum of savaged to civilized, hysteria embodied the distress of succumbing to the process of civilization. As such, women expressed more difficulty becoming modern, and therefore, citizens. Hysteria exemplifies the ways in which the unequal distribution of rights between genders has been justified by the medicalization of the feminine through the creation of diagnosis of mental "illness." Gender and mental "illness" become categories divergent from the model citizen and thus are subjected to social control in order to achieve the modern nation state (Conrad, 1980).

The Guatemalan state has been described as a "reactionary despotic regime" because it has historically met demands for modernization with repression (Kruckewitt, 2005, p.171). Traditional structures of power enact state terror onto deviant categories, such as gender and mental health, excluding them from full citizenship. For example, during the internal armed conflict it was estimated 45,000 people were *desaparecidos* (REMHI, 1998). When women would report the disappearances of their partners to the police, it was established by national policy to provide the same explanation: the male

partner had simply run away with his mistresses (Robles, 2012). In so doing, the state created a reality in which there were no *desaparecidos*, but rather abandoned women. Torres (2005) argues that in Guatemala "the naturalization of political violence into a cultural fact was produced in part through the creation and promotion of a language or pattern of political violence that – while generated terrors- at the same time obfuscated the political economy of its own production" (p.144). The creation of political violence into "cultural fact" was in part rooted in the "pattern of political violence" of discrediting women's reality and thus, negating the exercise of a *gendered* citizenship. One of the most important assumptions about citizenship is that it relies on a public/private distinction that locates citizenship in the realm of the public (Lister, 1997). The "pattern of political violence" successfully terrorized women through their gender and mental health by turning the systemic matter of *desaparecidos* into a problem of the private sphere and in so doing blaming women for their failure to keep a husband. A failed femininity is enough to successfully discredit women's concerns, and annul their citizenship while "obfuscating the political economy" of state terror (Torres, 2005). In reference to this history, this chapter presents the reasons why expressing a mental health concern in the Guatemalan context needs to be conceptualized as an exercise of gendered citizenship.

Defining Mental Health as Citizenship.

Femicide accounts for the widespread and systemic gender-based violence that not only occurs during armed conflict, but continues post-conflict at an equally mass scale (Russell, 2001). In fact, violence does not end when the hostilities do but expands to affect women disproportionally as opposed to men. As illustrated by Menjívar (2011),

Ladinas in post-peace accords Guatemala experience violence as the "order of things" (as conceptualized by Bourdieu and Wacquant, 2004). State terror as a cultural pattern is embedded in Ladinas' "cognitive frames", becoming central to conceptualizing gendered mental health. Mental health defined by Martín-Baró (1989) includes a critical awareness of the context in which mental health is constructed and, therefore becomes a political matter. In contrast to this understanding, what I have observed in Guatemala is a punitive approach that enables the reproduction of a "normal abnormality," in which Ladinas who express a mental health concern are abused, because they are speaking out in a context of state terror. In this context Garavito asks,

> exactamente quien es el loco. Quien es el que esta equivocado. Lo que es realmente enfermo es ser funcional en una sociedad que esta tontamente enferma porque entonces quien es el disfuncional? […] pero en esta sociedad realmente esta fuera de si, quienes son los funcionales, quienes son los sanos?
>
> Who is crazy exactly? Who is wrong? What really is ill is to be functional in a society that is totally sick, because then who is the dysfunctional? […] but in this society that is really out of its wits, who are the functional ones, who are the healthy? (Personalcommunication, February 14th 2013).

Garavitos' conceptualization of mental health is psychosocial and reframed as "mental hygiene." The distinction between *mental health* and *mental hygiene,* is important because it places the burden of "illness" onto the context in which the individual is constructing their mental health. Also, by focusing on *hygiene* the dichotomy of health and "illness" is critiqued and rather 'mental health' is understood as an everyday preventive exercise. For example, feelings of anxiety or paranoia cannot be taken for granted without an examination of the environment, because in Guatemala

many people have been victims of kidnapping. Feeling persecuted in this context, cannot be so easily explained to an "illness" within the individual, but rather, when contextualized, it becomes a normal reaction to an unsafe environment or a traumatic experience. However, as discussed earlier, structures go beyond their means to justify and normalize gender violence within their systems of care. Similar to Torres's (2005) analysis of cadaver reports as artifacts of political violence where the focus of rape is *on* the victim rather than on the victimizer thus reinforcing the individual's feelings of vulnerability and the power of the state. Similarly, the abuse and violence experienced by Ladinas interned in mental health care structures are placed *on* women's mental "illness," which further reinforces feelings of shame, secrecy brought forth by discrimination. Thus, just as rape as a tool of war "implied the divergence of behavioral norms was punished more heavily for women than men precisely because the moral costs of "defilement" were higher" (p. 163), expressing a mental health need is heavily punished because it disrupts the normalization of gender state terror. As Russell (2001) reminds us, all instances of terror serve as lessons for all women; in an environment of feminicide, the killing of a woman is a reminder of their heightened vulnerability due to their gendered social relations. Similarly, a punitive and discriminatory mental health care results in the annulment of patients' citizenship rights, thereby reminding all women of the vulnerability of their citizen status. For example, Garavito believes that violence is not a cultural determinant but rather a reproduced social practice. As such, violence impacts everyday life in the following way:

> estamos enfermos pero esta dañada nuestra salud mental porque aquí el ciudadano por ejemplo para poner un indicador no es bueno, la gente empieza encerrarse en 3 cuadras a la redonda poner una garita con una talanquera, eso es insano, si están seguros allá dentro entonces todos los fines

> de semana hacen churrascos y parranda con los vecinos y los patojos juegan en la calle ni se conocen ni se hablan. Es una fantasía. Eso es lo que hay que estar. Es la salida fácil. Individual además. Pero es la expresión que no hay colectividad.
>
> We are all sick, people start closing themselves off in three square blocks, putting gates and barricades, that is unhealthy, if they were secure inside on the weekend you would have BBQs and parties with the neighbors and the kids would be playing on the street, but they don't even know or speak to each other. It is a fantasy; it is the easy exit and an individualistic one, nonetheless. It is the expression of a lack of collectivity. (Personal communication, February 18th, 2013).

Garavito calls upon the community to resist isolation and individual solutions to violence such as living in gated communities because even within these residences individuals are "not secure inside." For women this reality goes beyond having a BBQ with a neighbor because women living in Guatemala City are affected equally by gender violence in private and public spheres. In other words, gated communities do not protect women from gender violence. For example, of the 294 violent murders of women in the commune of Guatemala in 2012, 51% happened in public spaces—such as roads, abandoned field, public hospitals—and, 49% in private spheres—such as personal domicile, or inside a business (Grupo Guatemalteco de Mujeres, 2012). The case of Cristina Siekavizza is an illustrative example. Cristina an upper class Ladina was last seen on July 6th, 2011 (Fundacion Sobrevivientes.org). Because she lived in a gated community it was first believed that she had been kidnapped. For more than a month her husband led a rescue search, appearing on television promising a ransom and covering the entire city in pink ribbons as symbols of hope for her rescue. However, investigations revealed that it was he who had murdered Cristina inside her home. Cristina's class

background and life within a gated community did not protect her from gender violence; rather it provided her husband an alibi that granted him enough time to flee the country.

Thus, gender violence specifically needs to be accounted for when conceptualizing mental health. Although Dr. Rodriguez highlights the role violence plays in everyday Guatemala, it is not enough to account for the Ladinas' experiences,

> La violencia. La violencia no es una patología. Pero es un problema de salud mental es un problema de salud mental en donde vos tenes un rol que tienen una influencia sobre vos. Vos tenes un rol porque como ciudadano podes ejercer ciertos derechos, ciertas acciones para prevenir la violencia pero tienen efectos sobre vos también porque obviamente la violencia de todos los días aunque no te estén asaltando a vos no podes vivir en colectivo de una manera saludable entonces a eso me refiero con como la dinámica social influencia la dinámica personal pero como también la posibilidad de tu dinámica personal puede influenciar la dinámica social. […] para mi esos son los puntos mas importantes, como podes ejercer ciudadanía y el como uno puede de alguna manera ser mente de cambio en su propio contexto. […]Vos tenes un rol como persona. Como profesional. Como ciudadano. De tener una influencia para condenar la violencia para prevenirla, para detenerla, entonces como siendo activo, uniéndote a grupos de presión desde la sociedad civil etc. etc., pero la violencia es tanto, y tiene raíces sociales importantes de control de manipulación de sanción que decís "Puta, yo no me meto a nada porque me van a matar, verdad?" Entonces eso es a lo que yo me refiero que esta es una dinámica es una simbiosis dialéctica donde vos influencias pero a la ves esto te influencia y si cambias esto y eso te aumenta. Lo que me paso a mi de alguna forma, tratando de hacer, cosas me vi de alguna manera disminuido no?
>
> Violence is a pathology. It is a mental health problem it is a mental health problem where you have a role that has an influence over you. You have a role as a citizen to exercise certain rights certain actions to prevent violence but those have effects over you. Also because obviously everyday violence impacts you, even if you are not being robbed you cannot live in collectivity in a healthy way so that is what I am referring to as the social dynamic that influences personal

> dynamic but also how the possibility of a personal dynamic can influence the social dynamic. […] To me those are the most important issues, how you can exercise citizenship and how in a way you can become a mind of change in your own context. […] You have a role as a person, as a professional, as a citizen, to have an influence to condemn violence, to prevent it, to stop it, so being active, becoming part of pressure groups from the civil society, etc. But violence is such, and has such socially rooted components of control and manipulation of sensations that you say […] "Fuck! I don't want to get involved in anything because they are going to kill me, right?" So that is what I am referring to, that is the dynamic, a symbiotic dialectic where you influence but at the same time you are being influenced as well. What happen to me, I saw myself diminished, no? (Personal communication, February 14th, 2013).

The work of Menjívar (2011) reminds us that Ladinas' everyday life is controlled by multisided violence; gender violence centers the understanding of citizenship. In fact, women during the war were and have been using their "role as a person" to stop violence and yet, they are the ones whose behavior is most scrutinized and controlled. True to his words, Dr. Rodriguez' continued to advocate for mental health even after receiving death threats. However, he was only able to regain this work once his family (his wife and children) was no longer residing in Guatemala, proving once more how successful the state is at terrorizing through the bodies of woman. Dr. Rodriguez' choice is important because it reminds us of the materiality of exercising citizenship in the Guatemalan context. In the material dialectic of action that differentiates between citizen and citizen*ship* resides the construction of mental health for Guatemalans,

> salud mental es un derivado y es un factor en términos de la relación social digamos de la relación laboral, de la relación ciudadana, es decir en la mediad que las personas estamos inmersos en proyectos colectivos, en sueños colectivos, en acciones colectivas, sean familiares comunitarias

> laborales, hay mayores posibilidades de tener cierta estabilidad digamos en la vida. Estar satisfecho con lo que uno hace.
>
> Mental health is derivative, it is a factor in terms of social relationships, let's say of labor or citizen relationships, I mean as we are immerse in collective projects, in collective dreams, in collective actions, whether familial, communal or occupational, there are bigger possibilities to obtain a certain stability let's say in one's life. To be satisfied with what one does. (Garavito, Personal communication February 18th, 2013).

Conceptualizing mental health as the ultimate expression of citizenship accounts for the ways in which relate to one another and structures of the state. Conceptualizing mental health as a right for citizenry becomes an educational project. This research shows that mental health is linked to political and citizen action because to express a mental health need in the context of Guatemala is to disrupt the normalization of state terror. Therefore, the ways in which Ladinas are socialized by violence to relate to social structures, and the ways that social relations are impacted by gender violence need to be central to the understanding of mental health.

Gendered Mental Health Needs.

Teresa's experiences of gender violence led her to be interned in the Federico Mora. Although she does not link the root of her substance abuse and suicidal attempts to the sexual abuse she suffered as a child and throughout her life, the multiple ways in which she denied agency about her life illustrates the necessity to have a gendered understanding of citizenship linked to a gendered mental health. Teresa never received

help for being molested as a child, "jamás lo conté, le trate de contar a mi esposo pero a lo contrario mi esposo siguió una línea de abuso," ("I never told, I tried telling my husband but to the contrary my husband continued the line of abuse," personal communication, January 29th, 2013). Despite the distress provoked by her sexual abuse, it was the uncertainty surrounding her virginity that haunted her,

> me empezaba a molestar el papa de mis hijos, el que es mi ex esposo. Entonces le decía como le digo, como le digo si soy virgen o no soy virgen en esa época se le daba mucha importancia a la virginidad. Tenia 14 años. Me creo mucho conflicto porque me sentía totalmente diferente y marcada.
>
> The father of my children, the one who is my ex-husband started bothering me. So I would ask myself, how do I tell him, how do I tell him if I am a virgin or if I am not a virgin, in that time virginity was allotted a lot of importance. I was 14 years old. It created in me much conflict because I felt completely different and marked. (Personal communication, January 1st, 2013).

Teresa's lack of agency throughout her life, in particular when it came to her sexuality is explicit in this quote. The uncertainty surrounding her virginity terrorized her because of the value virginity is placed onto women. Because womanhood is constructed according to *marianismo*, the virgin/whore dichotomy, the harm of Teresa's abuse was most effective in robbing her of her worth as a virgin. Her sexuality was something that happened to her, from men that she did not consent on dating, men that would *bother* her. This lack of control over her life and the decisions men made over her sexuality became, as in the case of her mother, a pattern in Teresa's life where it seemed that her only agency was to control her drug and alcohol intake to escape the impotence she

continuously faced. In her teenage years, Teresa sniffed shoe glue when she felt overwhelmed by the consequences of having lost her virginity through rape,

> Y mi hermano "papa Teresa esta drogándose" y se hizo un caso. Me sentaron en la mesa, mi papa nunca fue un hombre violento, me sentó y me dijo que "Teresita que le esta pasando, ábrame su corazón" pero no le pude decir [de la violacion], sino que ellos se dieron cuenta que le papa de mis hijos, Raúl ya me gustaba, y me dice "quiere tener novio, quiere que le de permiso" pero no me imagine que a los días me fue a traer el papa de mis hijos al colegio y le dije que me dejara aquí antes de la casa y me dijo, "Teresa le cuento que ya somos novios; si tu papa nos dio permiso" y me sentí contenta porque estaba enamorada de el pero no me gusto que la iniciativa de mi papa y llegue y mi papa no cuidaba como chaperon. Entonces el noviazgo empezó yo estaba como contenta pero no era lo que quería yo me había planificado tener novio asta los 18 años yo quería seguir la Universidad, seguir la Universidad, seguir la Universidad.
>
> And my brother told, "Dad, Teresa is taking drugs" and that became chaos. I was sat on the table, my dad was never a violent man, he sat me down and asked me: "little Teresa, what is happening? open you heart to me." But I couldn't tell him [about the rape], rather they realized that I already liked the father of my children, Raul, and so he told me "you want to have a boyfriend, you want permission?" But I never imagined that some days later he came, the father of my children came to get me at school and when I told him to leave me outside the house he said "Teresa let me tell you that we are already boyfriend and girlfriend; your father gave us permission" and I felt like happy because I was in love but I didn't really like the initiative that my dad had taken and so I went in and there was my dad that looking after us as a chaperon. So the courtship started and I was happy but it wasn't what I wanted, I had planned to have a boyfriend until I became 18 years old because I wanted to go to college, go to college, go to college. (Personal communication, January 1st, 2013).

It is obvious that Teresa had little control over the major decisions in her life, and that she was unable to find support or help for her abuse because to disclose this reality would put in danger her worth as a woman. Teresa is aware of her feelings, that she did not appreciate being placed in a relationship by her father, and expressed frustration against her father's decision. Moreover, her repetition of "go to college" underscores the drive she had about her education and her understanding that dating before the realization of that goal would result in her not being able to attend college. In fact, of the most explicit moments of Teresa's lack of agency over the decisions surrounding her life was her marriage. Her father took the decision to get her married after he found out that Teresa was being sexually active with her boyfriend Raul, and communicated this decision to her during the New-Year Celebration at her church,

> Mi papa me dice disfrute con los jóvenes que el tres la caso. Mira con lo que yo sabia de Dios, y conocía de Dios me fui a las cortinas en los altares y le dije "Dios mío, papa si me ama no me case, no estoy embarazada, no oyeron suplicas, no oyeron nada" el dos trate de llamar la atención cortándome, no oyeron nada, me pusieron unas margaritas, mi mama me hizo una faldona toda fea una blusa de vieja y con eso me fueron a casar. El 3 de enero yo era la señora de Ramírez, mi mama se fue para Honduras creyendo que estaba embarazada, mi papa lloraba.

> My dad tells me "enjoy yourself with the youth because on the third I am marrying you." Look, with everything I learned of God, and knew of God I went to the drapes of the altar and I said "My God, dad if you love me don't marry me, I am not pregnant!" They did not hear pleas, they didn't hear anything. The Second I tried to call attention by cutting myself, they didn't hear anything, they put some daisies in my hair, my mom made me a long ugly skirt and a blouse that looked like an old lady's and that is how they married me. January 3rd I was miss Ramirez and my mother left

> for Honduras thinking I was pregnant and my dad cried. (Personal communication, January 29th, 2013).

Teresa's marriage meant becoming a housewife at age 16 and, not being able to pursue a college education. Her experience captures the way in which patriarchal structures strip women of their agencies and highlights the different mechanisms of re-victimization. Teresa's lack of agency over her life mirrors the lives of many other Ladinas who come to women's advocacy organizations for legal and mental health support only to be held responsible for the violence committed onto them. Ladinas' sense of self is constantly depleted by the unaccounted abuse of male family members or partners. Teresa's life depicts the lives of other Ladinas who have come to normalize generations of gender violence to the point of not considering it consequential to alcohol abuse or suicide attempts. For example, Carmen highlights the urgency to focus on gendered mental health support that empower women through an emancipation of the patriarchal norms that women internalize,

> en el momento en el que uno va a la iglesia, para una atención, la familia, o algo, en la mayoría de veces redefinida por sus demandas por esa atención psicológica, por lo mismo que puede uno que la atención que le puedan dar uno no es la adecuada. Ha pasado que unas dicen "¿mira yo fui pero este la señora empezó a decirme que la me aguantara que era parte de mi vida como mujer, entonces a que voy?
>
> From the moment one goes to church for counseling, the family or something, the majority of times redefined by her demands for a psychological attention, but at the same time the attention that one is given is not the adequate. It has happened that some of them say, "look I went but the woman told me to endure, that it was part of life as a women, so why do I go?" (Personal communication, March 2nd, 2013).

As discussed earlier, the mental health support that exists is not trained to have a gendered understanding of the realities of Ladinas. In fact, once Teresa was interned in different mental health care institutions, she was further humiliated, abused, and harmed, allowing for gender violence to continue to be normalized under the umbrella of care. If Teresa decided to press charges against her abusers, her drug addictions and institutionalization would be used against her under Guatemalan law, risking the custody of her children and future employment. Mental health resources that do not account for gender violence become predatory spaces that allow the reproduction and justification of feminicidal practices. In particular, this research proves that the structures of mental health care, as well as the judicial system are part of the same mechanisms of feminicide.

Sandford (2008) differentiates between femicide and feminicide because "feminicide leads us back to the structures of power and implicates the state as a responsible party, whether by commission, toleration, or omission. In Guatemala, feminicide is a crime that exists because of the absence of guarantees to protect the rights of women" (p.112) and as this research has proven the structures of power fail to protect Ladinas' right to health care. Moreover, mental health becomes a neglected issue that under the disguise of a "cultural pattern" of stigma against mental "illness" absolves the state from the abuse that leads Ladinas to be internalized and the abuse received when under the care of the state. In other words, the stigma against mental "illness" provides a cultural excuse that masks feminicidal practices by normalizing state terror from the violence that leads Ladinas to express a mental health need to the care they receive for these concerns. Stigma allows the state to automatically be exempt from committing gender violence. Ladinas' mental health becomes an unexamined space in which state

terror is perpetrated and in so doing, simultaneously normalized. From an emic perspective, in particular, mental health in Guatemala is constructed as the exercise of citizenship and the ability to relate to structures and others, even as mental health is the avenue through which state terror annuls Ladinas' right to rights. As such, mental health becomes the landscape that enables feminicidal practices to go undisrupted because it discredits Ladinas in what matters most: their mental health.

A Gendered Citizenship Project.

A gendered citizenship comes from the understanding that, in Guatemala, women have to resist violence in every part of their lives while at the same time having to negotiate structures of power that actively reproduce and justify such violence. Thus, a gendered citizenship is tied to the concept of justice, in the sense of fighting against impunity in the private and public sphere, both equally potential threats for the expression of women's rights. In so doing a gendered citizenship secures justice to access and exercise rights. Overall, Perla states the problem very clearly,

> Yo siempre he dicho que uno tiene el enemigo en casa, su pareja, su papa, yo pienso que todo el esquema cambiaria si hubiera una sensibilización para el machismo político porque la raíz del problema es le machismo eso que las mujeres son pertenencia de, y la ley lo permite teniendo que poner "de" en su firma. Todo eso es un estigma es el sistema patriarcal reproducido en el machismo. Cuando eso cambie están complicado porque hay que cambiar asta las leyes pero las sensibilización es un ente determinante y es tan difícil cambiar las mente de la gente grande apostarle a la población, que tenga la oportunidad de cambiar el esquema que ha vivido y poder tener una experiencia nueva una nueva sociedad. Y una estructura de poder tan complicada como la de Guatemala donde todo el sistema capitalista hace que los recursos sean para la gente rica y no para la gente pobre. Guatemala tiene avances en materia de derechos humano es el primer país

que condena a un genocida en su país, la mayoría en cortes interamericanas. O en cortes internacionales pero es difícil el paso para cambiar el estigma hacia las mujeres concientizar a la población como vivimos diferentes hombres y mujeres que no vivimos igual que de palabra de diente a labio se diga que somos iguales pero no. Cuando uno crece las niñas normalmente crecen a los 12 años a toda su plenitud su desarrollo desarrollamos primero valorar a la mujer porque esta en su casa no es la calle, porque hay ciertos esquemas muy deciles de romper, entonces estas complicaciones.

I have always said that one has the enemy at home, one's partner, one's father I think that if the entire framework would change if there was an awareness of the political *machismo* because the root of the problem is the *machismo* that believes that women are belongings of, the law allows it having to put "of"[5] in one's signature. All of this is a stigma it is the patriarchal system reproducing *machismo*. When that changes it will be complex because we will have to even change the laws but awareness is a determinant entity and it is very hard to change the mind of older people to take a chance on the population. To have the opportunity to change the framework they have lived and be able to have a new experiences a new society. And with a structure of power as complicated as the Guatemalan, where the capital system makes resources be for the rich and not the poor. Guatemala has advances in the theme of human rights it is the first country to condemn a genocidal in its own country, the majority in Inter-American courts. Or in international courts but the step to change the stigma against women is hard to make the population aware of how we live differently than men and women don't have the same tongue to check approach, it is said that we are equal but we are not. When one grows up, girls normally grow up at 12 years old to their full development, we develop first women are valued because they are in their homes not on the street because there are some frameworks that are very difficult to break. So these sorts of complexities, I believe I think they can happen through awareness campaigns. (Personal communication, February 18th, 2013).

[5] In Spanish when a woman takes her husband's last name she incorporates preposition *of* before her husband's last name

Ladinas and Guatemalan women continue to be silenced and policed and their citizenship is still considered one to be exercised in the private sphere. Such as Silvia had to be quiet and conservative to perform sanity, Ladinas "are valued because they are in their homes not on the street." Machismo oppresses women constantly, through their mental health however, state terror and gender violence becomes justifiable. Mental health is used as a mechanism of impunity, in particular when it comes to protecting the rights of women. For example, Guatemala became the first country to trial soldiers in their own country for crimes against humanity and genocide. In November 2012 began the trial against Efraín Ríos Montt former dictator and José Rodríguez Sánchez head of intelligence, on the account of genocide of the Ixíl peoples. On May 10th, 2013, judge Iris Yassmin Barrios delivered the verdict in which José Rodríguez Sánchez was absolved and Efrain Rios Montt was found guilty and sentenced to 50 years on account of genocide and 30 for crimes against humanity. This trial was a first step for the mental health of the Guatemalan people in which for the first time it was being brought to light that Guatemala had in fact had lived through genocide. However, ten days later, the Corte de Constitutionalidad, the highest instance of justice in Guatemala, with the support of two out of the three magistrates annulled the trial on the basis of a technicality and asked for a new trial to begin on January 2015. In addition the Tribunal de Honor del Colegio de Abogados y Notarios de Guatemala (CANG) (the Honor Court of the College of Lawyers and Notaries of Guatemala) suspended judge Yassmin Barrios from practicing law for a year (http://www.prensalibre.com/noticias/justicia/Yassmin_Barrios-Tribunal_de_honor-CANG_0_1118288379.html). This example illustrates the precariousness of Ladinas' authority and ability to exercise their rights as citizens. In

particular, revoking Barrio's license is a continuous reminder that although Ladinas can access power because of their ethnicity, they cannot exercise such power. When the structures so blatantly repress Ladinas who are most privileged among women, it is a reminder that women in the state of Guatemala do not belong. Thus a gendered citizenship project reclaims citizen rights for women while simultaneously resisting the structures of state terror by holding them accountable. Reaching critical mental health awareness in Guatemala comes from an understanding that state terror is affirmed through individuals' mental health. Thus, mental health becomes an exercise of gendered citizenship, one that re-imagines a system for justice and education.

Chapter 8

Conclusion

This research has been an attempt to make the abuse committed by the mental health care system visible in order to move toward transparency and accountability of the discrimination women face on the name of care and mental health. Rooted in a critical pedagogy and feminist praxis, this research looks to resist structures of oppression by working alongside Ladinas for the emancipation from patriarchal structures of terror. This research has direct implication for education practice as it centers mental health as an essential component of development in post-conflict societies. In this dissertation, mental health needs to be understood from an interdisciplinary and multilayered approach that does not only pertain to the realm of health but rather makes mental health a political matter that is a constant thread for education, development, and policy.

In the particular context of Guatemala where violence is an everyday occurrence to the point of informing individuals cognitive frames (Menjívar, 2011), mental health is to be understood as a citizenship project. In other words, mental health becomes the barometer of citizenship. Thus, statistics that claim that 28.6 of Guatemalans are mentally ill with 62 percent representing women (Lopez & Cordoba, 2010), have to be read as the percentage of Guatemalans that are not able to exercise their rights as citizens and thus express a mental health need in the form of anxiety or, depression. Because the majority of adults considered mentally ill are women, and women are more likely then men to ask

for help, it is of outmost importance to develop mental health services that are gender sensitive.

The lives of Silvia and Teresa remind us that gender violence is a routine reality of Ladinas in which machista understandings and internalized gender roles shape decision-making and access to opportunities, and therefore influence Ladinas' constructions and experiences of mental health. In the case of Silvia, who came from an upper middle class family, her access to a higher education and independence through a career was a threat to her husband who "annulled" all of Silvia's dreams and controlled her life so that she could fulfill the expected gender role of a housewife. In contrast, Teresa was controlled by the sexual violence committed against her as a child that marked the remainder of her life, in which partners continued to abuse her and motherhood kept her away from her dream of an education. In both cases the machista structures allowed gender violence to be inflicted onto them with the consequence of minimizing their life options and their agency. The continuous gender violence that was endured by Teresa and Silvia, were in turn internalized as "the order of things" and thus normalized and invisiblized. Gender violence as a normal occurrence does not allow for a critical concientização of mental health. When both Teresa and Silvia tried to take control over their lives, either by attempting suicide- in the case of Teresa- or asking for a divorce- in the case of Silvia- they both saw themselves institutionalized and further discriminated through the abuse received within the system of care, or the stigma attached to them as being "crazy" for having been institutionalized. The constant violence that drove to their institutionalization as well as the process of "caring" for their mental health was so successful, that they both internalized the medical explanation for their

mental health. Understanding thus, their depressions as a "genetic predisposition" rather than a continuous and constant endurance of gender violence, enables the structures of state terror to continue to discipline women into silence and a second class citizenship status, where having agency over ones lives is reason enough for abuse and punishment. It is no coincidence that both Ladinas experienced mistreatment and abuse in mental health care institutions of different types, ranging from public hospitals to private *casas de sanamiento* and that the results were the same: taming their agentic power.

Silvia's experience illustrates the effectiveness of a system that continues to silence women into accepting gender violence as the order to things. When I first met Silvia she was very clear when she told me half jokingly, half dead serious " I did not need anti-depressants, I needed a divorce" (personal communication, March 2010). During her forced six-month long internalization that followed her asking for a divorce, Silvia's masters degree in child psychology made her hyper-aware of the abuse she was receiving due to the over-medicalization practiced in this institution. Her expertise in psychology and inquiry on the medication that was forced upon her only caused her harsher treatment within the hospital as she was considered uncompliant. From her perspective it becomes clear that she was kidnapped and detained in a mental health institution and was diagnosed as "mentally ill" because she asked for a divorce, this diagnosis caused her, her professional credibility and career as a child psychologist. Her institutionalization was also successful at squandering Silvia's hope for a better life outside her marriage, as the abuse within the mental health institution transformed her into a submissive housewife that now relies on anti-anxiety medication and sleeping pills to get through the day. Silvia can no longer dream of a divorce as she is reminded by her

traumatic experience of the consequences of such a choice. For many years after she was released from the hospital Silvia lived in fear of her husband, and at the time of the research, what I saw in Silvia was mostly the resignation of someone who had once fought for her dreams and the consequences were so harsh and violent that she was forced into subjugation.

The mental health care system also disciplined Teresa into subjugation. In the many hours of our conversations, she would speak of the sexual violence her mother and her had faced several times as the natural condition of womanhood, yet she explained her depression as a "genetic predisposition" that she had inherited. Teresa's years of experience being interned in the Federico Mora, *casas de sanamiento* and other rehabilitation centers had made her understand her depression and anxiety as an "illness" she carried within herself. By understanding her genetics to be entirely responsible for her depressions and anxiety, the environment that generationally had abused Teresa was normalized making her the sole responsible for carrying an "illness."

The testimonios of Teresa and Silvia highlight the danger of importing diagnoses of mental illness, because it provides the structures of care a medical justification to discriminate against women while simultaneously making patients internalize their "illnessese." By turning a blind eye to the context of acute gender violence and state terror, the system of care enables violence to continue. In turn, by turning a blind eye to the abusive system of care the state enable the abuse and mistreatment of mentally ill patients. That is why, this work proves that the system of care is a landscape of feminicide and the same mechanisms that produce and reproduce state terror. The stories of Silvia and Teresa represent the thousand of women that in the hands of the state are

further victimized and subjugated into their second class citizenship status, in which, to ask for help or express a mental health need is reprimanded as heath is still not a right but a privilege and, empowerment over ones lives is seen as dangerous in a country where women's bodies have historically been used to assert the power of the *machista* and repressive state. Mental health, thus, becomes the avenue in which the terror of such state asserts itself by defining the norm. In other words, to express a mental health need in a context of state terror becomes a critique of an ill environment, and thus, a critique of the political state, and a disruptive act that incites a violent reprimand in the name of "care." The criminalization of mental health, the documented abuse done to patients, the lack of guidelines, policies and legislations protecting the dignity and integrity of individuals diagnosed as mentally "ill" speaks of the mechanisms of the state put in place to crush those individuals who speak against an everyday life within a repressive and totalitarian state. In a way, the treatment of individuals diagnosed with a mental "illness" mimics the violent acts of *desaparecidos* of any person that considered speaking against the State. In fact, without any legal protection, individuals who can randomly be diagnosed with a mental "illness" are systematically abused with no mechanisms in place to protect them, women can be kidnapped and their voices muffled by categorizations of "illnesses" that ignore the conditions that brought them those institutions, or their overall health. It is no coincidence that the restorative system of mental health put in place in the 1970's was dismantled during the civil war by the regime of Rios Montt, and that today that same regime ignores the abuses committed within the hospital it once dismantled. Thus, I call for patients committed into the mental health care to be considered the new wave of *desaparecidos*, those individuals abandoned and forgotten and who have been forced to

silence, because their mental health speaks of the terror of the everyday life of the Guatemalan regime.

The disciplining experiences of Teresa and Silvia did not happen in a vacuum. The mental health care and the educational system also disciplines Guatemalans that want to become mental health professionals. What became apparent in my interviews with mental health professionals is that the field of medicine does not consider mental health prestigious enough to impart quality mental health education or to encourage student to pursue this specialization. Stories of doctors struggling to specialize in mental health are the most common. Choosing a mental health profession was discouraged by lack of opportunities, funding or disparagement by peers and mentors. The determent of students to follow a profession in mental health becomes apparent in the number of graduating professionals, to give but one example, Guatemala only graduates one psychiatrist per year and providing only 0.57 psychiatrists per 100,000 inhabitants (IEMS, 2006). The fact that the demand for mental health services is exorbitant, it makes little sense that mental health professions are discouraged. Of the few mental health professionals I interviewed, it became clear that what got them into the field was an tremendous passion and conviction that allowed them to overcome lack of funding, and lack of support from peers and mentors. The two most prominent leaders of mental health in Guatemala have both received death threats over the course of their careers and as recent as of 2012. State terror also targets the mental health professionals by omitting any investment in mental health training education, and persecuting any advancement in the field of research or policy creation. Historically the state has acted in violent repression against mental health development, in the 1980's with the merger of the Federico Mora and the

Neuropsiquiátrico hospitals, the personnel that became unemployed by the fusion of both hospitals were threatened directly. Most recently, the truth committee revealed the sate's participation in the human experiments done on the patients of the Federico Mora. Mental health in environments of state terror must be considered a political matter.

Overall, this research found that mental health becomes a justifiable avenue to abuse individuals for ones "own good," sending the message that violence on the basis of care is an appropriate mechanism. However, from a different perspective in which mental "illness" is considered the expression of a mental health need in an "ill" environment, these mechanisms of abuse have to be understood as the continuation of state terror in order to maintain the control of a *machista* and repressive state. In so doing, the body of women, through their mental health, continues to be abused in order to terrorize an entire population into silence.

Another pertinent finding of this dissertation is the fact that in Guatemala one cannot consider a stigma of mental health, because abuses and violence committed against individuals considered mentally "ill" do not stem from stereotypes, but rather from the reality of the system of care. Thus, what can be read as stigma is in fact the psychological message send from the state to other individuals of the consequences of expressing a mental health need. Mental health professionals confirmed that when referring women to mental health institutions they had to avoid words such as "psychologist," "mental health," "Federico Mora," in order to have their clients' compliance. The fear of women to be referred to the system of mental health care comes not from a stigma attached to mental "illness" but rather of the fear of the abuses that could be committed onto them, as the conditions of the Federico Mora and other mental

health institutions are well known. The fact that the state has yet to evaluate and change these abusive practices sends a message to the population that is not to be confused with a stigma of mental "illness." In the same way as the *disappearances* of thousands of Guatemalans that spoke against the state served to control a population with terror, the knowledge of the abuses committed in mental health institutions terrorizes those individuals that cannot cope with the everyday violence and are looking for mental health support.

The national system of mental health care is an expression of the repression of the state that treats individuals without dignity and integrity and looks to strip them of their voice in order to maintain authority and control. Because mental health is such an immaterial concept that is linked to the quality and wellness of life, psychological violence is hard to track down. However, literature on torture suggests that the goal of psychological violence is to change the personality of the individual being tortured (Roth, Worden & Bernstein, 2005), in the same way, Teresa and Silvia as well as the 80 percent of the patients of the Federico Mora that have been abandoned by their families are unrecognizable after their treatment, they have lost their voice and control over their own lives.

This dissertation proves that mental health is yet another landscape of feminicide. Sandford (2008) develops the concept of feminicide because: "feminicide leads us back to the structures of power and implicates the state as a responsible party, whether by commission, toleration, or omission. In Guatemala, feminicide is a crime that exists because of the absence of guarantees to protect the rights of women" (p.112). The system of mental health care enables the silencing of women by commanding abusive

practices in the name of "care," tolerating the criminalization of mental health and, omitting to produce services that can absorb the demand for mental health services or laws that protect the rights of individuals being diagnosed with mental "illnesses." The structures of mental health not only fail to protect the rights of women and patients but go further into justifying their abuse.

In order to successfully care for the mental health of the Guatemalan population and of women in particular the investment in mental health needs to be threefold: invest in education for citizenship, develop human development of mental health professionals, and create gender-sensitive training for professionals working in justice and health. The work of development agencies such as the World Health Organization, that have been moving towards understanding mental health from a more holistic perspective that includes the everyday lives of individuals is important to include for Guatemala, because the system of care is part of the state and in cases of human rights violations a third party is necessary to evaluate and re-define standards. However, these standards should be crafted with the Guatemalan local reality in mind and with the purpose of creating structural changes that render the state and the system of care accountable for the abuses committed historically onto the Guatemalan population so that they are not repeated. Therefore, the recommendations of this dissertation align with the World Health Organization's Mental Health plan of action 2013-2020 signed by the Guatemalan state but also include recommendations steaming for the lessons learned from this study.

Recommendations for Policy.

Given that Guatemala has signed the action plan of the WHO for 2013-2020 endeavors for mental health care should follow the six cross-cultural principles stated by this plan, which are:

1. Universal health coverage: regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.
2. Human rights: mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.
3. Evidence-based practice: mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural considerations into account.
4. Life course approach: policies, plans and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age.
5. Multisectoral approach: a comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector, as appropriate to the country situation.

> 6. Empowerment of persons with mental disorders and psychosocial disabilities: persons with mental disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation. (WHO, 2013, p. 12)

The National Mental Health Policy 2007-2020 is a document that already incorporates these six principles as well as the standards imposed by the Declaration of Caracas (1990) and by the Conference of Brasilia (2005), with a particular focus on gender violence, ethnicity and race. The State of Guatemala needs to ratify the NMH policy and create a legal framework to develop a law for the protection of the right of individuals considered mentally ill independently from the United Nations Convention on the Rights of Persons with Disabilities. This framework should have a focus on the decriminalization of mental "illness." In so doing, the Guatemalan state will be compliant with the WHO 2013-2020 action plan.

Based on DRI precautionary measures, the Federico Mora should be under international monitoring to foresee the development of a ward for prisoners outside of the hospital and implement appropriate care for the interned patients. Simultaneously, as dictated by the DRI recommendation, the state of Guatemala should develop community-based resources to support individuals suffering from mental illness.

Mental health is a cross-disciplinary endeavor that centers on human rights, access and prevention. The international community can hold the Guatemalan state accountable for the neglect of mental health policy because Guatemala is a member of the United Nations and a signatory of the WHO mental health action plan 2013-2020. I believe that Guatemala would benefit from complying with these international standards

as we are working with very little legislation and policy as of now. However, these policies have not been developed with the reality of the conceptualization and understanding of mental health from a local perspective. Thus, although I believe that the field of mental health would benefit from these policies, I propose to include recommendations steaming from the findings of this dissertation. I suggest incorporating policies that follow three avenues: invest in education for citizenship, produce mental health professionals, and create gender-sensitive training for professionals working in justice and health.

Investment in Education for Citizenship.

Following the conceptualization that mental health is a barometer of citizenship developed by Marco Garavito, this dissertation shows that mental health in Guatemala can be defiened as the ability Guatemalans and in particular Ladinas have to exercise their citizenship rights. In other words, the ability to demand justice, to access education, to control their sexuality or to ask for a divorce are all aspects that contribute to the mental health of women. The abuse committed in the mental heath care system as well as the violence that brings women to express a mental health need speaks of the lack of agency women have over their owns lives. Thus is Guatemala it is not enough to teach for citizenship rights, i.e show students what rights are available to them, but rather develop a culture of participatory democracy in which students and women are expected to learn by doing. It is *in* the ability to exercise citizenship that mental health --in Guatemala and other countries that are living in post-conflict-- lays. Citizenship education should be at the center of education curricula and in particular that of empowering women to take action and exercise their rights to battle against gender

violence and state terror. Curricula should foment critical thinking and writing paired with a non-censored history of the civil war. Moreover, education should have the goal to un-teach violence. For example, La Liga implements the program "no nacemos violentos," "we are not born violent," in which students are encouraged to become aware of the normalization of violence and empowered to stop this cycle. Cultivating a citizenship project with empowered, critical, engaged and aware Guatemalans will secure a long-lasting mental health.

Production of Mental Health Professionals

One of the most flagrant findings from the dissertation and the literature of mental health in Guatemala is the lack of mental health professionals vis-à-vis the demand for such services. It is estimated that 35 % of the adult populations will suffer from a mental "illness" and yet only 2% of this population will access services (Lopez & Cordoba, 2010). As I had discussed earlier the unwillingness to access the system of mental health care by women might well come from the knowledge of the abuses committed within these institutions. However, I believe the country is in a good place to develop mental health professional training with a community focus that is tailored to the reality of Guatemala. Research in India (Patel et. all, 2011), has shown that training lay individuals into becoming support group facilitators reduced the incident of depression and anxiety of participants' within 6 months. This research shows that facilitators' same lived experience as participants expressing a mental health need is more effective than training highly educated mental health professional. Thus in Guatemala, a similar training could become an opportunity to empower women as leaders in healing their own communities. Training similar to the ones created by Patel et. all, place women at the center of their

own health. This empowerment would not only address the mental health need of a larger portion of the population that cannot afford medicalized mental health services, but would create employment from a bottom-up initiative build to resist the structures of violence and therefore break the cycle of state terror.

Gender sensitivity training for professionals working in justice and health

One of the avenues in which gender violence was reproduced in the mental health care system was in the lack of gender sensitivity from mental health care professional and professionals working in the justice system. In fact, there is little awareness that everyday life is different from men than for women. Beyond a flagrant need for mental health professionals in general, there is already a scarcity in gender sensitivity in professionals working in gender related issues of mental health and justice. The consequence of this lack of gender awareness is the reproduction of gender violence in which women entering the justice system or the mental health system continue to be abused and revictimized by the same systems that are created to support them. Therefore, educating for mental health has to come hand in hand with training for gender bias sensitivity in all areas of administration, but in particular, those that focus health and justice.

Areas for future research.

There are plenty of areas for future research. In particular for the field of CIDE, research that centers mental health within the realm of politics and not exclusively of health is important. Supported by the data from this research project I encourage work that further examines mental health from a Ladino perspective. The male perspective is

an important one in order to complement and further understand the experiences of Ladinas being diagnosed with a mental illness and further dissect the reasons behind the abuse experienced within the system of care. Overall future research needs to look at the conceptualization of gendered mental health from both male and female perspectives, and take into consideration the current struggles between the civil society and state terror.

Although this work is focused on gender, little attention was given to the Ladino perspective. I have collected data from the lived experience of Dan. During research Dan became my native informant I met through my cousin. I interviewed Dan because he had always wanted to affect change in the area of mental health. We met for coffee three times during 2010 and then each time I would come to Guatemala we would meet often. The story of Dan made me more interested in working with a Ladina focused because I could not believe the discrimination he lives continuously and that made me interested in understanding the experiences Ladinas might face. Dan at age 17 following a suicide attempt became the youngest Guatemalan to be diagnosed with bipolarity. Since then Dan has been going to therapy and follows a strict medication regime. However, the fact that mental health is not covered by insurance and the taboo of speaking of this subject has placed him in an extreme amount of financial instability and his diagnoses also has forced him into isolation. He has few people he trusts that can support him. Dan has been very active in the mental health community, but I have seen his initiatives been halted with time. He has tried to create a support group with people suffering from bipolarity, with little success, as individuals do not want to be marked by pertaining to such a group. Also, he was in the process being interviewed on radio to speak of the illness and have some time of conversation to break the stigma. However his grandfather who told him he

was going to "stain the name for the family" stopped this opportunity. Wanting to bring attention to his illness to have some sort of understanding came at a high cost, Dan narrates having lost both his jobs after having mentioned his diagnosis. As the head chef for a high end hotel he needed to take some days off because he was feeling low. Once he got back to work HR manager asked him why he had taken 2 days off, he did not feel like lying and explained he suffered from bipolarity and was not himself but that a few days off a high pressure job was enough or recuperate. Dan described how the HR manager's face changed and he was fired immediately with these words: "I cannot believe we gave a knife to a crazy person." After loosing his job, the high cost of his medicine that equals to 80 % of his monthly paycheck made it impossible for him to make ends meet, and his family could not take the financial burden of his medical expenses and living costs. Thus, in 2012 when I met Dan, he was living in his car and was unemployed. When I saw him again in 2013 he was back on his feet, with a small apartment to himself. However, the particular experience of Dan, a middle class, young Ladino man highlights the need to consider the consequences of mental health diagnoses from both a male and female perspective.

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Appendix

IRB

This e-mail confirmation is your official University of Minnesota HRPP notification of continuing review approval. You will not receive a hard copy or letter. This secure electronic notification between password protected authentications has been deemed by the University of Minnesota to constitute a legal signature.

You may go to the View Completed section of http://eresearch.umn.edu/ to view or print your continuing review submission.

For grant certification purposes you will need this date and the Assurance of Compliance number, which is FWA00000312 (Fairview Health Systems Research FWA00000325, Gillette Childrens Specialty Healthcare FWA00004003). Approval will expire one year from that date. You will receive a report form two months before the expiration date.

In the event that you submitted a consent document with the continuing review form, it has also been reviewed and approved. If you provided a summary of subjects' experience to include non-UPIRTSO events, these are hereby acknowledged.

As Principal Investigator of this project, you are required by federal regulations to inform the IRB of any proposed changes in your research that will affect human subjects. Changes should not be initiated until written IRB approval is received. Unanticipated problems and adverse events should be reported to the IRB as they occur. Results of inspections by any external regulatory agency (i.e. FDA) must be reported immediately to the IRB. Research projects are subject to continuing review.

If you have any questions, please call the IRB office at (612) 626-5654.

The IRB wishes you continuing success with your research.