Illness experience narratives with mental health patients of Tzeltal origin, Mexico

Heleen Kruip
Mexico

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KIT (Royal Tropical Institute)
Vrije Universiteit Amsterdam
Amsterdam, The Netherlands

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by

Heleen Kruip

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Abstract

The World Health Organization proposes decentralization of mental health care for countries with insufficient coverage of mental health services. In the rural Hospital San Carlos in Chiapas a mental health project has been implemented with the objective to train general doctors in mental health care. In order to provide effective and adequate mental health care in this intercultural setting, improved sociocultural understanding of patients is needed. This qualitative research consisted of 8 Tzeltal mental health patients' illness experience narratives guided by the McGill Illness Narrative Interview (MINI) guide, as well as 6 medical practitioner interviews about experiences with mental health patients. Information was triangulated with clinical encounter observations and a focus group discussion with practitioners about the results of the interviews. The results were analysed according to the MINI interview domains and categories were defined to structure and compare the results. The principal conclusion was that the way patients live and express their mental suffering can be interpreted as a thorough language of social life. Therefore, it is necessary to abandon the dichotomy of mind and body in medical practice as is taught in modern medicine. A shift has to take place to see the body as part of a symbol system on individual and social level. Also, training of the practitioners in clinical mental health care, as well as mental health promotion and prevention on community level are necessary. Lastly; patient narratives and practitioners perceptions of patient experiences are important information input for cultural improvement of care.

Key words: mental health care, interculturality, illness experience narrative, Chiapas

Word count: 13022

List of abbreviations

CONEVAL	Consejo Nacional de Evaluacion de la Politica de Desarrollo Social (National Counsil of Social Development Politics)
CSMI	Common Sense Model of Illness
DSM	Diagnostic and Statistic Manual of Mental disorders
EM	Explanatory Model
EZLN	Ejercito Zapatista de Liberacion Nacional
FGD	Focus Group Discussion
GAD7	Generalized Anxiety Disorder 7
HP	Health Problem
HSC	Hospital San Carlos
KIT	Koninklijk Instituut voor de Tropen
mhGAP	Mental health GAP
MINI	McGill Illness Narrative Interview
PHQ9	Patient Health Questionnaire-9
PM+	Problem Management Plus
SP	Seguro Popular
WHO	World Health Organization

Glossary

Alexithymia: difficulty in experiencing, expressing, and describing emotional responses

"Being organized": being a member of the Zapatista Organization

Cleaning (limpia): diagnostic, curative and preventive procedure to detect or/and extinguish the disease, harm, or evil that has happened to a person, usually by rubbing the body with an egg

Costumbre: ritual or religious actions undertaken in the community to treat and prevent disease; for example praying, preparation of herbal teas, rituals of the curandero

Curandero: person who applies healing practices through ritual or/and natural methods

Empacho: disease in infants, characterized by diverse digestive symptoms, caused by food or other ingested substances that stick to the stomach or to the bowel

Gini index: statistical measure of distribution developed by the Italian statistician Corrado Gini, used as a gauge of economic inequality, measuring income distribution among a population. The coefficient ranges from 0 (or 0%) to 1 (or 100%), with 0 representing perfect equality and 1 representing perfect inequality

Illness experiences: the ways in which people define and adjust to perceived interruptions to their health. It concerns how people come to see themselves as ill and their subsequent decision-making about treatment and care, also in relation to socio-cultural norms. Moreover it covers the relationships between ill people and their healers, treatment regimens and adherence, as well as expectations of treatment and coping or adjustment to illnesses.

Junta de Buen Gobierno: the regional representation of the autonomous zapatista community

Mestizo: child of parents of different ethnic

Poverty: a person is in a situation of poverty when he or she suffers at least one social deprivation (education, health services access, social security, housing, food) and insufficient income to provide in basic life needs. (CONEVAL)

Practitioners: general medical doctors, psychologist and psychiatrist who work at Hospital San Carlos

Recuperated land: land claimed in 1994 by the Zapatistas during their upraising

Susto or Espanto: illness caused by a traumatic situation (dangerous animals, falling, drowning, anxiety to die, etc.)

"The organization": the Zapatista organization

WHO mhGAP guide: guide for delivery of evidence-based interventions in non-specialized health-care settings, part of the WHO Mental Health Gap Action Programme (mhGAP) for low- and middle-income countries that has the objective of scaling up care for mental, neurological and substance use disorders.

Introduction

I'm a Dutch medical doctor International Health and Tropical Medicine. Since 2008 I have been working with the indigenous population of Chiapas, in rural Hospital San Carlos (HSC) and in community health work projects. The last years I was involved in the management of the hospital and set up and coordinated a mental health project. From the beginning of my work in Chiapas I have been motivated to obtain knowledge of the socio-political and cultural context of the indigenous population of the region and to understand the way the indigenous population lives and thinks. Staying and working in communities has helped me to improve my medical practice to be more culturally sensitive. Interculturality is a challenge for all health care in this region and especially in mental health, because mental conditions are more difficult to evaluate in other cultures. Therefore, the objective of my research and topic of this thesis is to obtain more knowledge of patient experiences in mental health problems and to use this information as well as opinions of practitioners to improve understanding of and communication with mental health patients in HSC. In Chiapas, there is a lack of accessible and mental qualitative health services. The mhGAP strategy of the World Health Organisation (WHO) is to decentralize mental health care to general medical practice in order to achieve coverage in regions with insufficient public mental health care. With this research I hope to impulse cultural sensitive qualitative mental health care among the general doctors of HSC and hopefully in the future with a larger research be able to work this theme in the Mexican public health care sector.

Chapter 1: Background information

Income inequality and lack of access to health care in Mexico

Mexico is a middle-income country characterized by high-income inequality. This is reflected by the Gini index, which for Mexico in 2014 was 48.21. (1) In 2016 in this country 43.6% of the population was living in poverty and 7.6% in extreme poverty. (2) Structural adjustment policies run by the World Bank in many countries, including Mexico, with the aim to strengthen global economic growth and neoliberal economic policies, have caused a decline of health services in the last decades. A central topic in the global agenda that is in line with World Bank strategies is universal health coverage. Mexico introduced the national health insurance program Seguro Popular (SP) in 2003 and reached universal health coverage in 2012, an experience that is being used as a reference in international work on quality in health. (3) However, there are downsides in this program that are not known internationally. Actually, Mexican specialists have stated that the SP has failed, because it has not improved access for vulnerable population groups and out of pocket spending remains high. (4) The health care package of the SP only covers a basic set of health care interventions, and therefore falsifies the access to health care rights. The SP strategy is to decentralize and focalize the state's functions in health care, which has had the effect of mercantilization and decrease of the regulatory role of the state. (4)

The indigenous population of Chiapas

In Chiapas, a southern state of Mexico, 76.2% of the population lives in poverty. (5) Approximately one fourth of the population is of indigenous Mayan origin and lives from agricultural auto-sufficiency. (5) The indigenous population of the Selva region speaks different original languages; the most prevalent are Tzeltal, Tzotzil, Ch'ol, and Tojolabal. These population groups, principally self-subsistent farmers, live in the most marginalized circumstances of the country. (6) Migration for work to the coast regions and USA helps families to have more economic resources. Poverty-reduction programs of the government have been altruistic and have not lead to significant poverty decline for the indigenous population. (7)
Gender inequity and alcoholism are important social problems. (8,9)
Structural violence is of influence on the local patterns of distress and suffering in the rural indigenous communities. These situations of chronic political conflict lead to short- and long-term psychosocial consequences in this population group. (10) Many agricultural and indigenous organizations have emerged since the last century and have played different roles in the local social and political dynamics of the region. The organization that has played the most prominent role is the Ejercito Zapatista de Liberación

Nacional (EZLN) (Annex 1) that made obvious to the world the struggle of the indigenous population of Chiapas and is up till now important for its anti-neoliberal and autonomous character. The research setting is situated in the municipality of Altamirano, on the border of the jungle region. In Altamirano the majority of the indigenous population is of Tzeltal origin and a considerate part of the indigenous families is member of the Zapatista organization.

Mental health and mental health care

The most important morbidities of the indigenous population in Chiapas are infectious diseases, but also chronic diseases like hypertension and diabetes mellitus are part of the top-20 most frequent morbidities. (11) Neuropsychiatric disorders take the third place in Disability-Adjusted Life Years burden, after 1. cardiovascular disease and 2. diabetes and other non-communicable diseases. (12) Neuro-psychiatric diseases cause most years of healthy life lost due to disability nationwide. (13) It is estimated that less then 20% of patients with an affective disorder seek help in the official health system. (14) Moreover, for Mexican people who seek medical attention for affective disorders the median period of delay to receive specialized treatment is 14 years. (15) These data illustrate the low coverage of mental health services. An evaluation of the Mexican mental health system showed that from total national health budget only 2% was designated to mental health, of which 80% to psychiatric referral hospitals. (13) Even though Mexico ratified the United Nation's Convention on the Rights of People with Disabilities in 2007, no successful strategies have been implemented to improve the mental health care provision in rural settings. In Chiapas, a state with more than 4 million inhabitants, there is only one ambulatory mental health centre in the capital and the remaining of the psychiatric care is concentrated in a few regional hospitals and the private sector.

In order to achieve higher coverage of clinical mental health services in low resource countries, the WHO proposed decentralization of diagnostics and treatment to first level care. Therefore it developed in 2008 the Mental health gap (mhGAP) action programme that is aimed at the scaling up of services for mental, neurological and substance abuse disorders for low- and middle-income countries. (16) According to the programme, a non-specialist health workforce can make quality mental health care available for the global population. (16) The attempt of mhGAP training in first level care has been minimal in Chiapas (17) In the Mexican national mental health action plan it is not mentioned either that the proposed mhGAP training for medical doctors will consider local sociocultural factors of influence on mental health problems in specific contexts. (18) This, however, is very important in order to achieve quality mental health care and is a specific challenge for the sociocultural

diverse Chiapas, where traditional healers are a considerate part of the local health care system. (19)

Hospital San Carlos is a rural private non-profit hospital in Chiapas that serves for 80% indigenous patient population. Because the hospital is non-governmental, it is a principal clinic to visit for members of the Zapatista organization. In 2014 the clinic included mental health care as one of its strategic priorities. A mental health project was started with the aim to provide psychology and psychiatry services, according to the mhGAP program. All patients are first evaluated by a general doctor and only referred to the psychologist or psychiatrist when specialized attention is necessary. According to HSC health statistics, mental health problems take sixth place in most frequent diagnostics of HSC outpatient clinic. (20) The most prevalent mental health problems are anxiety disorders and depressive disorders, diagnosed each in about one third of all mental health patients that attend the hospital. (21)

Chapter 2: Problem statement, general and specific objectives, methodology

2.1 Problem statement

Maxwell defined six dimensions of quality in health care; access to services, relevance to need, effectiveness, equity, social acceptability, efficiency and economy. (22) Health care practitioners' knowledge of local perceptions and explanations of disease play a role in effectiveness and social acceptability of health care. In mental health care the most commonly used diagnostic tool in psychiatry in western Medicine is the Diagnostic and Statistic Manual of Mental disorders (DSM), though there exists a broad criticism. The DSM has a focus on a biologist and technical approximation of mental problems, with a particular normal- abnormal notion to mental illness. (23) Because of this approach the DSM withdraws attention of social and cultural contexts of influence on mental health problems. (23) Actually, there have been concerns about the impact of the DSM tool with its biomedical approach on non-western societies. (24) Therefore, an attempt has been made by the Latin American Psychiatry Association to integrate cultural syndromes into the DSM classification, in order to capture cultural elements in the classification. (25) More attempts have been made to compare psychiatric categories with cultural concepts of distress. In 2013 Kohrt and Rasmussen conducted a literature review on this theme. The conclusion was that "cultural concepts of distress research can enhance detection of mental health problems, reduce cultural biases in diagnostic criteria and increase cultural salience of intervention trial outcomes". (26) The Mexican National Institute of Psychiatry has been working on the applicability of psychiatric diagnostic instruments to evaluate its usefulness in rural indigenous population. In one of its studies, the link between symptoms expressed by the indigenous population and the symptoms evaluated by using the depression scale of the centre of epidemiologic studies (CES-D) was studied. The result was that the scale is applicable, but that persons with outcomes indicating depression not necessarily need specialized attention, but guidance to deal with daily life stressing factors. (27) The Mexican National Institute of Public Health conducted a study on health seeking behaviour of rural population with mental health problems in the state of Jalisco. The general result was that this population group first relies on self-help strategies. If this is not sufficient, the social network is consulted for emotional and material help. In case symptoms still persist, the local traditional healer is asked for his or her services. Only if symptoms do not remit or when one of the social network actors insists, a medical doctor will be consulted, after taking into account all costs that will be involved. (28) Another approach to improve effectiveness of mental health care was a mixed method study in order to understand depression in rural Chiapas and to contextualize the Patient Health

Questionnaire (PHQ-9), a diagnostic tool for depression. The result of this study was that the PHQ-9 tool doesn't capture the sociocultural aspects of depression and needs to be adapted to a broader bio-sociocultural model. (29)

Apart from the inclusion of Latin American cultural syndromes in the DSM manual, various studies have been conducted in order to achieve a cultural approximation in mental health care in Mexico. (25-29) Some studies focused on the comparison of psychiatric categories with cultural concepts of distress, others studied the concept of cultural competency from the health services perspective or the applicability of diagnostic scales. However, one of the important aspects needed to improve the connection between western mental health care and the local illness experiences is a deeper understanding. This can be achieved by an ethnographic approach. In order to be able to attend people with mental health problems adequately, social relationships between patients, healers and other community members, as well as cultural contexts need to be considered in order to obtain knowledge of the illness experience. (30) According to Swartz cultural re-labelling' – a form of 'repackaging' the person in 'cultural' as opposed to 'psychiatric' ways is necessary, in order to provide an illness narrative that is more appropriate and therefore amenable to meaningful interventive care; and hopefully, less stigmatizing. (31) As Arthur Kleinmann commented; "A medical doctor and a patient evaluate a clinical problem in different ways. The discrepancies between these different visions lead to inadequate medical attention. A medical doctor needs to elucidate about explanatory models of the patients in order to be able to enter into a negotiation about perceptions and treatment options". (32)

In Hospital San Carlos the medical team has expressed the need of more sociocultural understanding of the patient population of the hospital in order to provide qualitative contextualized mental health care. Therefore illness experiences of mental health patients need to be explored, as well as existing perceptions of practitioners of these patients. By comparing perceptions of patients and practitioners, issues for interculturality in medical practice can be defined.

2.2 General and specific objectives

General objective:
To study illness experiences of mental health patients of Hospital San Carlos and the perceptions of the treating medical doctors, psychiatrist and psychologist concerning patient illness experiences, in order to define recommendations that can help to strengthen sociocultural understanding and communication during the clinical encounter with mental health patients.

Specific objectives:

1. To explore the illness experiences of Tzeltal mental health patients of HSC
2. To explore the perceptions of the medical doctors, psychiatrist and the psychologist concerning illness experiences of Tzeltal mental health patients of HSC
3. To study similarities and differences in illness experiences of mental health patients and perceptions of the medical doctors, psychiatrist and psychologist
4. To provide recommendations to the HSC mental health program to strengthen sociocultural understanding and communication during the clinical encounter with mental health patients

2.3 Methodology

In order to gather most information about patient illness experiences and practitioner's perceptions of patient illness experiences, an exploratory qualitative research was conducted to obtain in depth information.

The phenomenological approach of this study to understand caring, healing and suffering of individuals, is from a hermeneutic (interpretive) point of view. (33) The guiding principle here is that the researcher and participant have different structures of understanding, shaped by their specific social context, culture and historical period in which they live. The meanings behind life experiences in their contexts are not always obvious to individuals, but can be gathered from the narratives they produce. (34)

The psychological framework to study and analyze health behaviour that is in line with this study is the Common Sense Model of Illness (CSMI), as demonstrated in figure 1. (35) This model sees the individual as an active problem solver who processes perceived reality of health threats and proper emotional reactions in a parallel manner. The individual seeks information and actions to test his or her hypothesis about the meaning of his symptoms or health condition. Internal and external stimuli evoke illness representations that are highly individualized and often not in line with medical facts.

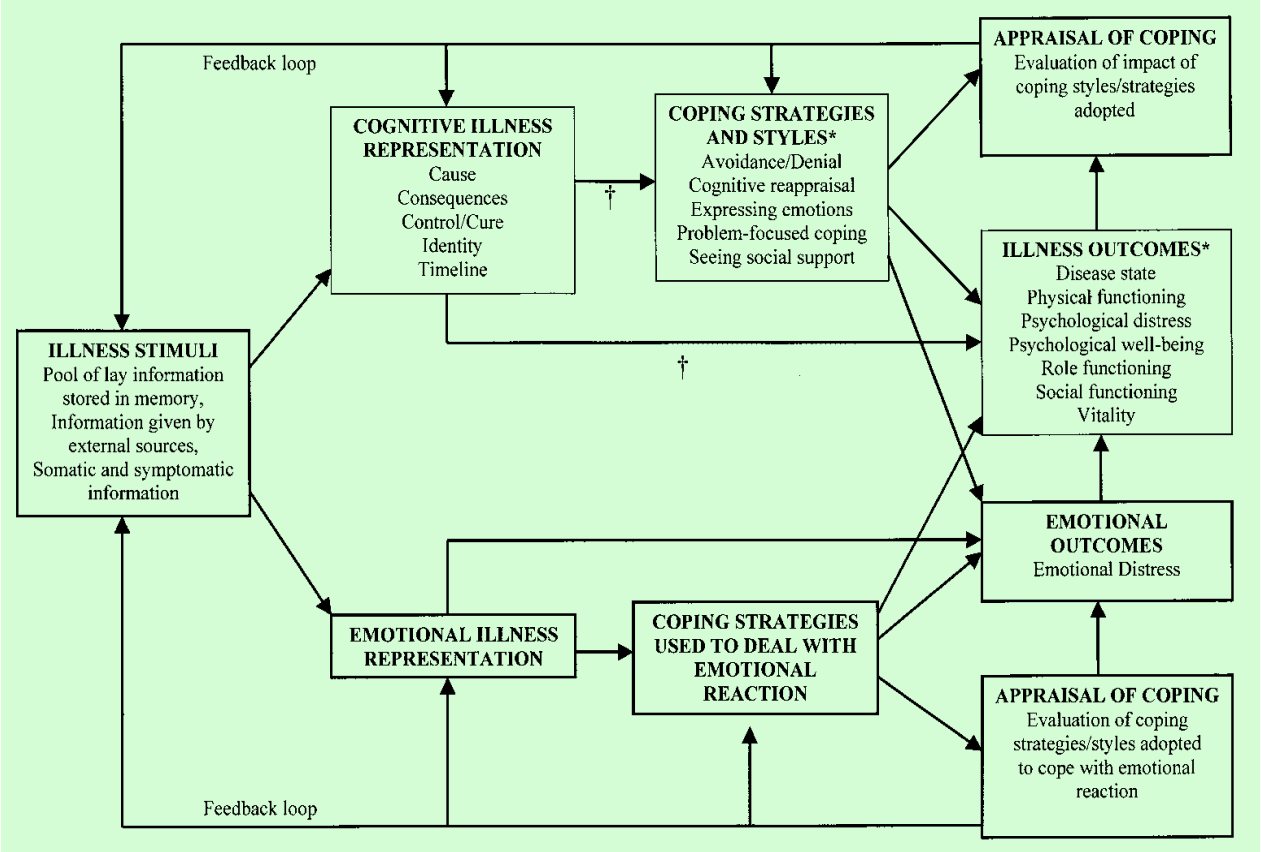

Figure 1. Common Sense Model of Illness
Diefenbach MA, Leventhal H. The Common-Sense Model of Illness Representation: Theoretical and Practical Considerations. Journal of Social Distress and the Homeless 1996;5(1):11-38

Purposeful sampling was used in order to achieve most information possible on the research objective. A number of 8 patients; 4 men and 4 women, recruited from the outpatient department of HSC were interviewed. The selection criteria were; Tzeltal origin, diagnosed with a moderate or severe Axis 1 disorder of DSM-V, adult patients between age of 18 and 60 of both sexes, the probability of active participation in order to obtain sufficient information, and competence to participate. Excluded from selection were employees of the hospital, acquaintances or family members and patients of the investigator, as well as patients going through a manic or psychotic episode or anxiety attack, since competence to participate would be compromised. Furthermore, 4 medical doctors, the psychiatrist and the psychologist of HSC were interviewed. 20 random clinical encounters of the practitioners were observed to triangulate data from the interviews. After the analysis of the interviews and clinical encounter observations a focus group discussion (FGD) took place with the practitioner team of HSC in order to discuss the results of the analysis. The investigator realized all data collection.

The McGill Illness Narrative Interview (MINI), which is validated in Spanish, was used for this research in order to achieve a deeper and more structured understanding of the patient narrative of his illness experience. (Annex 2) It captures the complexities of the individual's knowledge and experience of illness and symptoms. (36) The MINI has a structure to elicit three different types of reasoning according to basic assumptions about the nature of knowledge structures underlying illness narratives; explanatory models, prototypes and chain complexes. Also the practitioner's interviews followed the general structure of the MINI. The interviews with the patients were translated during the interviews by a Tzeltal translator who speaks fluent Spanish and Tzeltal. All interviews were recorded and a university student transcribed the recordings afterwards. The translator and the transcriber received a fee for their work. The clinical encounter observations and FGD were not recorded; notes were taken by the investigator.

The analysis took place by the investigator following the structure of the MINI. Categories; broad groups of similar concepts that resulted from the interpretation of the data by the investigator and that could be used to generate a theory, were defined. Furthermore, the CSMI model was used throughout the analysis in order to understand the patient's health behaviour. The use of the MINI interview, as well as the CSMI model facilitated the structuring and the capturing of the complexity of the individual's knowledge and experience of illness and symptoms. Then, patient narratives were compared with the practitioner's interviews, as well as with the findings of the clinical encounter observations and FGD.

During the sampling all participants went through an informed consent procedure. (Annex 3) The interviews and FGDs took place in a confident and private place that assured anonymity of the participants. The names used in the writing of the thesis are not the real names. Documents and recordings were saved in a locked place and stored on the computer of the PI with a password. All recordings and notes will be destroyed within 5 years after the research ended. The possibility of extra psychological counselling was offered to participants who expressed the need during the interviews. Furthermore, the translator was trained and supervised to treat the participants with respect and in an equal manner. Ethical approval was obtained from the ethical review committee of KIT and approval of HSC was obtained to realize the data collection. Since the research will take place in a private setting, no ethical approval could be obtained from the state health secretary.

The research had various limitations. Due to time- and budget, as well as translation restraints, the study was only with Tzeltal psychiatric patients, since this is by far the largest indigenous group. Because this research was hospital-centred, only patients from Hospital San Carlos were included. This

group is just a small part of patients with mental health problems in the region and no information was obtained concerning illness experiences of people with mental health problems in the community setting. Also there was a selection bias in the sense that only patients who were willing to participate were included. No information was gathered on patients who didn't want to participate. The data were interpreted by one investigator, who works at the hospital since several years. This was of influence on the data interpretation. Because of the mentioned limitations the results of this small-scale study cannot be generalized to other settings, but are of interest for other similar settings.

Chapter 3: Results and discussion

In this chapter the categories that were defined in the MINI domains are described and discussed for the patient illness experiences and next for the practitioners interviews. Most results were obtained from the interviews, but also results of the clinical encounter observations and FGD are included in these sections. The comparison of the results of patients and practitioners are described and discussed in the last section.

3.1 Patient illness experiences

Illness narrative

Expression of suffering

The interviewed patients presented their suffering in somatic terms and those symptoms as the reason to seek medical help. Two patients first narrated about impacting life events they lived and following mentioned their physical condition, seemingly in order to contextualize the somatic presentation. Headache was one of the principal symptoms, combined with lack of strength as if the body is not able to work anymore. Also coldness of the body was mentioned several times. The experience of anxiety was expressed through chest oppression, lack of air, feeling something in the throat, food that doesn't lower to the stomach, jumping of the heart, not being able to move and fainting.

Juan, 28 years old, is homosexual. Three years ago he started to suffer many symptoms. He felt his body very cold and he couldn't speak. He started to think a lot and his mind didn't let him sleep. He felt a lot of chills and his heart would tell him that he wanted to kill himself. He also commented: *"My head looks like a mill that twists me and my blood jumps strongly, I see it in my arms that move everything and it looks like my veins where the blood passes are going to tear apart."* Juan and his family were displaced from their original community in the Zapatista conflict in 1994 and since then have been living in different places. During his youth he suffered various situations of sexual abuse by cousins. When he studied secondary school he lived with an aunt in Ocosingo and he suffered hunger. Since his puberty he has doubts if homosexuality is a disease that needs treatment. He sees his symptoms as a result of his homosexuality. His family disapproves of him engaging with men and he thinks the cure of his symptoms is to be straight. He wants to return to his wife who left him a time ago, but at the same time he doesn't know if he will be able to comply with the relationship if they would reunite. Juan's narrative demonstrates how, according to the CSMI, his cognitive illness representation is formed by different illness stimuli. His symptoms are

embedded and explained by himself as part of his social context. As Rebhun describes "The human body is not only an object, but also part of a symbol system functioning both in the microcosmo of self and in the macrocosm of the social world." (37) Juan's bodily symptoms are an expression of him suffering his socially not accepted homosexuality. His symptoms seem to be part of the "micro politics" of his social interaction. (37) They might even be explained as a way for him to disclose to his social surrounding that he will be straight and the symptoms express his homosexuality as a disease.

Health seeking pathway

The narrative of Feliciano, age 33, shows us a dramatic health seeking history of him and his family. His suffering seems to be engrafted in the uncertain evolution of disease and not finding remedies. First his mother was sick and they searched for three years. *"We went with doctors who did not detect what it is, we went with yerbateros (herb healers), but my mother didn't get cured, we only spend money. But in Ocosingo in a laboratory they found out that she has typhoid, it gives a lot of fever and she feels as if she will die and she took pills, but the pills didn't control her, they gave her injections, but then she got gastritis and ulcer. Yes, it got very complicated; she stayed about three years in Ocosingo. I was working in my house those three years and then I got sick as well."* Here Feliciano refers to a herpes infection of his eye that was the start of his illness and the myriad of health actors he had to visit. When his eye vision got worse and he didn't find an ophthalmologist to attend, he suddenly started to feel very bad, with fast heart beating and lack of strength. He thought he would die. In the following weeks he attended several doctors from different facilities with the diagnostics of high blood pressure, gastritis, and drug abuse. The treatments didn't work; the symptoms of fast heart beating and chest oppression didn't resolve. When an acquaintance arrived to the house and told him that she just accompanied a woman to the hospital in a very bad health condition, almost dying, the symptoms of Feliciano also got worse. He was afraid the same might happen to him. His father had to take him to the emergency department of the hospital in Ocosingo. He was referred to a psychologist and he had to tell his life story. However, he just went once, because he felt his situation was critical and would not be resolved by talking. *"The psychologist started to ask me how my life is and I told her everything. I will give you a task she said. You have to write your life story. But I didn't bear and she didn't give me medication. Drink a lot of water she said to me, but don't worry, its not your heart. You're very preoccupied. Yes I said, I'm preoccupied, I feel I'm dying, because my heart beats very fast"*

The uncertainty of finding a remedy, the generalized lack of confidence in health practitioners and the absence of mutual understanding in encounters

with health practitioners play an important role in Feliciano's suffering and possibly are a cause of the symptoms. The symptoms became worse every time Feliciano was exposed to an adverse encounter to attend his problem. In this logic, the symptoms were not only an expression of his personal internal suffering, but also of the lack of effectiveness of the health system in his context. The bodily expressions can be seen then as a communication medium between Feliciano and his surrounding. This is also described by Good in an analysis of symptoms related to the heart in Iran. He describes that the symptoms the Iranian people express of their hearts, convert the heart from a concrete organ into an expression of personal and social experiences. (38) As illustrated by the CSMI, the coping strategies of Feliciano to seek help every time with different health practitioners as a reaction to the worsening of his symptoms and adverse results of his help seeking, is like a repeating circle that is fuelled by his proper emotional illness representation.

Social norms

Maria, age 45, is from a family that is member of the Zapatista organization and she and her husband were insurgents of the EZLN. She had various impacting life events in the last years; the deaths of her father and uncle and two companions of the organization. She was witness of one of the deaths; she saw how her companion fell of a car and died. After a cousin got very sick and was hospitalized she felt she couldn't handle anything anymore. There was also a land conflict in the community of her family, they had to defend their recuperated lands, and neighbours died in the conflict. Also in her family there is conflict concerning land heritage. *"I have a brother who is inheritor of my father, who died. My father was organized (Zapatista) and never received help from the government. That's why when he almost died he said he didn't want his family to receive government help, or that they would use his land for government projects. My sister in law is "partidista" (from a government party) and my brother also went with a government party, but my mother is organized. When I go to visit my mother, sometimes I see her cry."* Often Maria is very preoccupied and has no strength, suffers headaches, feels irritable and is not motivated to do anything. Her affliction can be explained as an embodiment of the land conflicts and deaths of close ones.

Isidro, a man of 22 years, had a girlfriend, but she was not accepted by his family for the reason that the family didn't want to pay an amount of money to the family of the girl in order for them to be together and get married. Then the girl ran away with him without arrangement and he was accused of having robbed her. His affliction was that he suffered fainting in several occasions and his family had to take him to the emergency department various times. In this narrative, community tradition that follows customary

patterns are in conflict with contemporary forms of relationships in which the individual decides whom to marry. The fainting can be explained as an expression of this intergenerational conflict situation.

Guadalupe of 58 years is "organized". Her role in the community is to coordinate the bread baking collective work. She speaks about the social stigma concerning her mental illness. *"The headache really started when my son left to live with the family of his wife. From that moment on I got worse, because I missed him a lot. I was the coordinator of the bread baking collective. When I got worse also my uterus problem was worsening and I got urine incontinence and I didn't want to go out of the house anymore because my skirt would get wet and I would feel embarrassed. I started to fail to the collective work and the people started to gossip about me, that I would be faking a disease, because I don't look sick. This made me feel even more preoccupied."* Guadalupe was operated on her uterus prolapse. After the surgery her mental health condition worsened, she started to hear voices of her children that told her that her husband killed someone or that one of her children was put into jail or expulsed from the community. Since there was no visible disease she was judged for not wanting to comply with her collective duties. Her suffering of the judgement of the community possibly was represented by her hallucinations.

Tomas is a 40 years old patient whose wife got sick. She was hospitalized for one and a half month, and was diagnosed with leukaemia. He had to go searching for blood donors in the family, and then take them for the long trip to the state capital Tuxtla Gutierrez to withdraw blood. Many persons he asked to donate rejected because they thought they could die or become sick if their blood would be withdrawn. He himself therefore had to give blood every two weeks during her hospitalization; at the end he didn't have strength anymore. Then his wife died in the hospital. This was two years ago. Since he got a lot of debts he started working hard cutting wood in order to pay and to take care alone of his 6 children. His youngest child is two years old and didn't start walking on time. He was very preoccupied, but by training him to walk he is improving. A year after the death of his wife Tomas started with headaches, dizziness ad lack of strength, he couldn't work anymore. Little by little he got very anxious, and heard a lot of noise in his ear. He almost has no contact with the family of his dead wife, because he feels very sorry for her death. In the community people keep watching him when he passes by and he feels embarrassed, more when he goes to meetings where only women are represented and he feels he has to join because he has no wife to go. People have commented that he should get a wife again because he's young, but he thinks it won't be the same. *"That is how it started; I felt embarrassed and I got anxious. My heart would beat fast when I would hear that they are talking, then my heart starts jumping as if I want to kill myself"*

According to the social standard Tomas is expected to find a new wife, something he mentions not to be ready for. Apart from feeling sorry for the family of his wife, he is also suffering the stigma that he has no wife. He has to take care alone of his children and assume household activities that normally the woman would do, therefore he feels affected in his masculinity.

Enrique Eroza Solano describes in his book about illness narratives of the Tzotzil population of San Juan Chamula that everything that is being lived in terms of pains and bodily symptoms has the capacity to be a thorough language of social life. (39) This becomes clear from the narratives of Maria, Isidro, Guadalupe and Tomas. Social norms and values are of influence on their suffering and their suffering can be understood in these term and can be explained from that angle of view. The cognitive illness representation is not only a result from somatic symptoms, but of a variety of illness stimuli stored in the memory and from external sources. (Figure 1)

Prototypes

Questions about prototypes are part of the MINI interview. Prototypes are "salient episodes or events in one's own or other's experiences which allow individuals to elaborate the meaning of their illness through analogy" Prototypes that were mentioned by the patients and that have its origin in the communities, are described here.

Gloria is 27 years old. Three years ago when she was eating a taco on a party, she got the first nerve attack (ataque de nervios). She couldn't swallow her food, she couldn't move anymore. Her family took her to the "costumbre", which is a ritual undertaken in the community to treat and prevent disease. Since the nerve attack she cannot work anymore as before, because often she feels as if her heart starts to jump rapidly and her tummy stops functioning. One year later she got another attack in which her whole body got stiff and cold. In the pharmacy they gave her vitamins. Her family decided for "costumbre" again and they came home with a man who cleaned her with an egg. This is a diagnostic, curative and preventive procedure to detect or/and extinguish the disease, harm, or evil that has happened to a person, usually by rubbing the body with an egg. Since the cleaning anything that happens makes her body feel cold. *"I'm very worried that it will not go away, because every time someone speaks strongly or there is a strong noise or anything my heart gets like a strong electric shock."* Since long she has a conflictuous relation with her mother who always comments that her sons would inherit land and her daughters not. She has a sick brother (sick of too much thinking) who lives with the mother and whom she helps out a lot. Another sister also lives in the parental house with her husband and children and is claiming to inherit land. She says the husband doesn't work at all and

is just eating all the food. She thinks the family situation is not fair, but her mother says she is bewitched ("le enviaron mal"), because last year she went to work in Tuxtla to earn money (to be able to build a house) and left her baby child with her. Since she came back her mother doesn't want to return the child, she says he's not her child anymore.

Possibly the mother of Gloria says she is bewitched, because she thinks Gloria is jealous of her brothers and sister. One of her brothers or her sister might have send her bad luck and disease. It could also be that the mother uses the witchcraft as a medium to justify socially that she is keeping her grandchild with her. The susto seems to be a reaction to the conflict she has with her mother. The background of the conflict is survival in a context of little economy to provide in basic needs and gender inequity. Scheper-Hughes also shows how in the desperately poor favelas in Brazil, physical symptoms of hunger and anxiety caused by scarcity are represented by "nervos". According to her, medicalization of nervos hides the social and economic roots of distress. The unequitative class system of Brazil is ironically expressed by nervos people who blame themselves for weakness and spend money on pharmaceuticals, instead of urgently needed food. The significance of the nerve attacks can be understood as a way to cope with social and wider contextual situations at moments that these are unbearable for a person. (40) In Chiapas, witchcraft represents a lack of confidence in close ones and the uncertainty with which people seem to live. (39) This becomes clear from the story of Gloria and other stories, in which family relations are complicated and permeated with distrust. The social significance of illness is also represented in the CSMI, where social functioning and psychological wellbeing are illness outcomes. These outcomes are input for appraisal of coping strategies and therefore of influence on illness stimuli. (figure 1)

During the interviews and clinical encounter observations I noticed that patients often commented the fear to die suddenly. "Chamel", according to the Tzeltales, is the general word for disease, and means that there is a misbalance of an organ of the body that contains the "ch'ulel", which is the spirit that was collocated in the embryo by the ancestor Gods. (41) Chamel therefore is seen as a misbalance between visible and invisible aspects in the world and the body. The word "chamel" is derived from "to die" in Tzeltal language, because any disease is a step towards death. All diseases are considered very dangerous and have the possibility to lead to an immediate death. (41) In the narrative of Feliciano and other patients the fear of death was predominant. For Feliciano this fear seemed to be of important influence for him to decide every time to go to another health facility.

Explanatory model

Apart from the used prototypes to explain their suffering, the patients use a variety of explanations. Feliciano explains the feeling in his chest is caused by something that grows in his heart. Juan has a continuous internal conflict concerning homosexuality, if it is the cause of his affliction. He has four sisters and thinks that he has turned out to be a little bit of a woman as well, like his sisters. He doesn't seem to link the life events he lived, of the continuous ambiguous fight for and against homosexuality, to the anxiety problem he developed. He does mention that the ways people have treated him are of influence on his mind, that if people don't treat him well he becomes sad.

The other patients do relate their physical suffering more directly to the problems and situations they have been living, but the explanations are multicausal. An example is the narrative of Guadalupe who was operated from a uterus prolapse and presented hallucinations after the surgery. She connects the surgery to her condition as a principal cause, because her body was not normal anymore afterwards. Her uterus was taken out and possibly she feels incomplete in her femininity. The secuence of the events and the evolution of her symptom presentation might have indicated the surgery as triggering event for her. Maria, who had had a difficult life fighting for the organization, saw as principal cause of her anxiety the confrontation with a snake in the field. Carod, who at the end of the last century explored mental pathology in Tzeltales, describes this. He found that the majority of all diseases are acquired on the way, during work on the field or on the way to the field. (41) Also Juan suffered a susto when he found a snake on the riverside and another patient when she fell into the water. Generally the cause of the susto acquired on the way is supernatural and can be caused by jealousy, madness and loss of the soul. (19) Gloria, who has a longstanding conflict with her mother who is withholding a child from her, sees this as the most preoccupying event in her life. However, she describes that the anxiety she lives came over her as something external, something strange that happened to her. In a similar way Tomas tells us the sad history of the death of his wife, but as a possible cause of his physical symptoms he mentions that he might be having the same disease as his wife:*"I found a person who I asked to donate blood and I told her that my wife was sick and that she has leukaemia and that they are asking me for a lot of blood donors. She told me that the same situation had happened to her and that I would better not give more blood because the same could happen to me as to my wife and that it has no cure. I got discouraged, I thought I had the same."* Recently he started with pain in his knees, the same complaint as his wife had when she was sick. He got more frightened that he might have the same disease.

Thus, the patient's explanations of their suffering are of varying and multiple origins. This can be due to the evolution of the disease and events that the patients live on the way, that are assigned by them as causative. It also is related to the uncertainty of social life itself, as Eroza Solano exposes. (39) In the course of the suffering intervene illness stimuli that are a proper evaluation of moral origin concerning personal and other values. Uncertainty of the values of the other in general is therefore of influence on the patient's cognitive illness representation and coping strategies (Figure 1)

Health services

When Gloria, the patient who has a conflict with her mother, got a nerve attack, she was taken directly by her family to apply the costumbre. This means that her family would pray for her, she was cleaned with an egg (limpia) and they gave her herbal tea. The costumbre was also applied in the story of Maria and Juan. It seems to be a general denomination for all the therapeutic actions that can be applied within the community and also the rituals of the curandero can be part of it. In general, the patients see these therapies as important, necessary and protective. In the case of Juan however, he expressed doubt about the diagnostics of the curandero who said he received envy from someone. Also, one curandero had sexual intercourse with him as part of the therapy and afterwards Juan decided not to return, because he didn't trust the curandero anymore.

Several patients didn't go for follow up appointments with the psychologist, because they didn't believe the therapy would take away the physical complaints. One patient said that the talking would not improve the attacks of lack of air, but with the medication it would. Another patient said the exercises of the psychologist would worsen his headaches. This finding suggests that the patients come to the hospital with the expectation to receive medication; therefore it is difficult to find patients motivated for psychological therapy.

None of the patients mention the medical diagnosis of their suffering. However, they do narrate that the psychiatrist has given them short advises of how to improve their daily living and the importance of not suspending the medication. In all patients the psychiatric medication has had a positive effect on their problem. However, several comment that they don't know how long they will be able to take the medication, because of the cost of it. One patient mentioned he felt tired and bored of having to take it, however it has helped him a lot so he thinks he must try to continue.

About treatments of medical doctors within and outside HSC there were several comments. Isidro, whose girlfriend was not accepted by his family,

arrived several times to the emergency department because he had fainted. The doctors would tell him he has nothing, only "nervios". He says: *"When they told me I don't have anything, I wondered what is it that I have then? I didn't know and I was worried about where I would be able to find medication to get cured or if I could get cured still, because every time I go to the hospital they say everything is fine."* Aida, age 52, started 4 months ago with nervio and a lot of headache. A nurse put 2 vitamin injections but the disease got worse with trembling, no strength in the body and she thought she would die. The medication of the health centre didn't work. In Esquipulas clinic they gave her vitamins that she didn't take because in the health centre they said she should not mix medication. She fainted a lot in that time, sometimes during two hours. She took medical plants. She wanted to walk far away and complained day and night. Then her brother took her to HSC. She passed 3 times with general doctors but the medications they prescribed didn't work. *"They did a lot of studies in San Cristobal, Oxchuc, in private consult rooms, we went for ultrasounds and we went to Hospital San Carlos, but all say I don't have any disease, only nervios"* Then one of the nuns who works at the hospital saw she was very sick and gave her an appointment with the psychiatrist.

Apart from the conclusion that the patient has nothing, frequent diagnosis that were made by private general doctors in Ocosingo or at the public hospital are gastritis, high cholesterol or high triglycerides, high blood pressure, colitis, or typhoid fever. All patients have received one of these mentioned diagnostics and they repeatedly expressed in the interviews or in medical consults that were observed that the medications they received for these problems did not help. From the results of these health services experiences it becomes clear that the patients are active problem solvers who evaluate illness outcomes after receiving health attention and according to those outcomes adapt their emotional and cognitive illness representation and define subsecuent coping strategies. (Figure 1)

Impact on life

The most important impact the suffering has had on the life of the patients is not being able to work. Likewise, being able to work again is for them the parameter of impact of treatment. Feliciano also refers to an advise from the psychiatrist: *"But now I sleep fine, and I wake up quietly, I just have some pains when I wake up, but I do get up, because that is what the doctor said; if you have pain try not to think too much about it and that's what I do. I drink my coffee, my chamomile tea and then I sit down a bit and think of what to do."* He also comments that at the beginning he could not go to the consult alone, because he was afraid he would die during the travelling and that nobody would be there. Now he can go alone.

The medication, according to the patients, seems to have effect on decision-making about important life issues. Juan says he has improved with the medication and now he has been able to decide he will not be homosexual in order not to loose his family. He hopes he will reunite with his wife. He wonders if there exists a medication to cure from homosexuality. Gloria, who is bewitched according to her mother, says:*"When I was better my mom started to come to my house telling me that her daughter in law was steeling things. She wanted me to defend her, but I told her that if she has a problem in her house, that she has to solve it herself, because I don't want to be affected".*

3.2 Practitioners' perceptions

Illness narrative

Initial illness presentation

According to the practitioners, patients with mental health problems generally present with somatised generalized body pains; principally abdominal pain, headaches and chest oppression. The motivation for medical consultations is often based on the last symptom that happened to them and that is the departure point. The psychologist mentioned that frequently patients are very preoccupied of the pains they feel. They think they have a grave disease and that they might die of it. The psychiatrist commented that the people of indigenous ethnics seem to have a certain degree of alexithymia; they are not able to express their feelings and therefore have a somatic presentation of their mental health problems.

Health seeking pathways

Most Tzeltal mental health patients have been seeking help for several months or years, with variable pathways. One practitioner comments that if the patient has money he or she goes to the medical doctor, if not, he seeks help of the shaman or tries to rely on his religion. *"People search for help, and in the majority we get to know about their medical care seeking. But, I think that in reality they first go to what is more nearby and cheaper and most of all in what they trust or what is tradition. So I think that before they come to this hospital it is not only with the medical prescriptions they present from other places, but also after having tried out many other things like traditional medicine and things they believe in."* The somatic expression of mental health problems according to the psychiatrist leads to delays in receiving adequate medical attention and a lot of medicalization because of large health seeking pathways.

Alternative healers

One practitioner mentions she doesn't feel comfortable to ask if the patient has gone with traditional healers, because she doesn't have any knowledge about it. Another says the patients don't mention it and he also doesn't really ask. Patients might not tell, because they are afraid the medical doctor will not approve it. Another medical doctor says she usually tells her patients that if they feel comfortable with any alternative remedy or herb that she doesn't know, that it's ok if it makes them feel better. But, they also have to adhere tot their medical treatment. If the patient believes that a certain person is causing his suffering ("alguien le esta haciendo mal"), as a doctor she thinks that this belief will not change anything to the situation of the patient. However, on the other hand if this is a belief that at the end helps the patient to explain his problem and to feel better, then it has its place. The psychiatrist refers to some shamans as not trustworthy, because they ask a lot of money from the patients.

The above comments indicate a dichotomy of judgement of practitioners concerning alternative healers; they are good or bad, effective or ineffective, rational or irrational. More knowledge of alternative practices could lead to increased openness of patients and a more integrative approach to other therapies than the biomedical approach.

Risk factors for mental disease

The practitioners mention that it's important to distinguish between the social suffering and the mental diseases. It's necessary to delineate where one starts and the other begins. Lack of education, economic poverty, machismo, sexual abuse, polygamy, living conditions, alcoholism; all these conditions are related and make life harder and cause suffering. Migration of men and women for work is an increasingly common circumstance that encompasses departure of children or partners to far away and during uncertain time periods. Not unfrequently the people who migrate for work abandon their families. Also, various men have returned home in a psychotic state after having experimented drugs. The social network and religion can be protective, but can also generate stress factors for mental problems to initiate or get worse. For example, the collective work in the communities can give stress because sometimes there is a lot of responsibility and people have too many duties that are above their capacity. Also there exists stigma of mental conditions, when someone is not fulfilling his collective duty. Since there is no system of mental health promotion and prevention, people don't recognize mental health problems.

The practitioners comment a wide range of risk factors that determine social

life of the Tzeltal people and make life propensive to suffering and disease. However, evaluation in terms of risk factors can withdraw attention from patient specific histories. Precaution is needed with generalizations by risk factors, because patient understanding and communication in clinical encounters depends on interest in the specific patient situation.

Prototype narrative

The majority of the practitioners comment that the term "nervios" (nerves) and "susto" (being scared) is widely used. Also "mal de ojo" (bad eye) and that someone is hurting you or exercising witchcraft (brujeria) are common. The psychologist mentions "shibel" as a term for anxiety, and "perdida de alma" that causes physical symptoms that little by little worsen and even can lead to death. She also explains that according to her perception many medical doctors use the term "nervios" when talking to the patient, but they don't explain what it is to the patient and the patient doesn't get informed. "Melotan" means sadness in Tzeltal.

About the influence of media on the presentation of the mental suffering there are opposite answers. Regularly patients with conversive crisis arrive to the HSC outpatient clinic. The conversive crisis is a presentation of fainting but goes along with normal vital signs. One medical doctor denominates this condition as "commercial crisis", because it is what people see happening in the soap series. In the FGD the practitioners mentioned that the conversive crisis sometimes is the only way women in this gender unequitative society can show how bad their mental condition is. Here two comments have to be made. The conversive crisis by doctors generally is seen as an imitation of a condition. However, emotions are genuine, even if they are manipulative or imitating, and have to be taken serious. The conversive crisis has a social meaning as was mentioned by the practitioners in the FGD and if this condition is evaluated in the context of the social meaning the practitioner can have a better understanding and approach. This needs to be an important issue for reflection on professional medical attitude in attending patients with conversive crisis, in order to be able to attend the condition well.

Explanatory model

Witchcraft is mentioned as a cause of illness that patients consider. Also when there was a major life event like the death of a nearby one, people relate their mental suffering to this event. But when it is a chronic condition, like domestic violence, patients almost never see this as causative of the mental suffering. An emotional condition is always accompanied by a physical perception, but the suffering person usually does not connect this. It would

be necessary to learn Tzeltal in order to know exactly if there is any connection made. A practitioner explains he started to treat a woman for migraine. *"Then one day, I don't remember why, I asked her if she had any problems. She nodded and told him that a couple of years ago she was pregnant and then she lost her baby and in the caesarean they had to sterilize her. Then her husband started to change and to drink a lot of alcohol, and she felt very guilty because they would never have children. But she never came for that problem, she only came for the headache to the medical consult."* This fragment demonstrates the difficulty of the medical doctor to obtain information of the emotions of the patient.

Health services and response to treatment

Anamnesis and diagnostics

One doctor mentions he first has to exclude all possible organic causes of the symptoms before starting an antidepressive drug. Another doctor mentions he has an intuition when something is a mental problem and sometimes he leads the patients towards the diagnosis. *"I am like biased, because if a woman age 40-45 comes for headache and other pains; I check if she is not diabetic or hypertensive, and then if she has problems with her husband, I'm like very biased"*

The use of psychiatric diagnostic scales is variable among the medical doctors. The doctor has to be experienced to be able to apply them usefully. It is necessary to contextualize the questions of the scales to every patient, in order for him or her to understand the question well. It is also important to interpret the answers well in order to know which score to apply. This information helps to understand that the scales are not only a facilitating tool to be able to diagnose depression or anxiety. To be able to apply them correctly, cultural understanding is needed in order to formulate the questions well and to understand the answers.

According to the practitioners it is difficult to explain a mental diagnosis to the patient: *"I explain for example that anxiety is as if being preoccupied, thinking in something constantly and that it doesn't let sleep or realize the daily activities. Depression is more difficult to explain, only like 25% understands. I think that many physical complaints have a mental problem underneath, for example chronic headache or stomach complaints are caused when someone has a lot of stress. But you need many consultations to get to that. It seems that there is no penetration of (knowledge of) mental health problems in the Tzeltal population, contrary to other medical diagnosis of which people know exactly what it is, like uric acid for example. Therefore, it*

is important to mention the names; depression, anxiety and to explain what they mean."

Division of body and mind

The psychologist explains that when she asks the patients why they came, they always refer to the somatic complaints. Then she starts to ask more about their lives and explains why the problems someone lives can affect the body. But she thinks it is difficult for them to understand, however more in "mestizos" (mixed race) than in Tzeltal patients. The Tzeltal do have the perception that there is something more in the body. However, with them she finds it very difficult to explain that there is no medication for the somatic complaints, that changes in life are needed to feel better. Maybe the treatment should always be combined; some medical or alternative remedy and therapy. One medical doctor makes drawings of the brain and explains that it produces many substances. "*There is one that makes you happy which is called serotonin, that helps us to affront problems. But sometimes there is not enough of this substance and we start to feel sad and then the body also starts to feel bad with pains, like headaches, back pains, lack of taste of the food, not being able to sleep etcetera."* The psychiatrist mentions that the division between body and mind in medicine inhibits an integral approach. The psychiatric medication helps to improve some processes in the brain and therefore the patients can affront their problems better and make better decisions in life.

Treatment

There is a lot of difference between the medical doctors in interest to take charge of patients with mental health problems. The majority refers the patients to the psychologist or psychiatrist, more in case of anxiety then in depression. The decision to start treating the patient depends on how much opening and confidence there is. Most doctors don't start antidepressive treatment in a first consult, because they think they have to see the patient several times to be able to have more knowledge about the problem and more confidence. The psychologist mentions that most patients don't know what the consult with her is about and many people only come once, because she won't give medication, only help in lifestyle changes. In the therapies it helps a lot to work with registers at home to relate the somatic problem to the life problems. The general doctors could also give some psychoeducation about simple problems she thinks. One general doctor does psychoeducation. She dialogues with the patients about how to activate the social network as a distraction, or to find someone confidential to talk about their problems. *"Or we talk about what things he or she likes to do and then I give that as homework. This combined with fluoxetine works very well and it can have a*

very positive impact on the life of the patient." Another doctor says he feels anxiety to give advises to the patients. For example he feels like telling a patient to better get divorced, but doesn't know if that is right.

The difficulty with the pharmacological treatment is that it takes time to see a positive effect and there is only good adherence if the patient understands what is happening, which is more difficult in Tzeltal patients because of the language barrier. The psychiatrist mentions that the idea of the patients of the medical treatment is quite magic; that with "pox" (Tzeltal for medication) things will be solved. This is also represented in the adherence to treatment; when there is improvement many patients stop taking medication. In the consults he takes the time to explain that the somatic part of the body is connected to the mental part.

Impact on life

The practitioners mention that the worse situation is when the family locks the patients up, usually schizophrenic or psychotic depressive patients. This usually happens because the family doesn't know anymore what to do with the person and has not found effective help. Often aggressiveness is the principle reason to come to this decision and sometimes they are even put in chains. Every year the psychiatrist sees a couple of those patients. Now he is treating a man who had been locked up for six years. After one month of treatment the family released him and after four months of treatment he started to interact again with the family. His mother feels very guilty of having had her son locked up for a lot of time, but they didn't know that there exists a treatment for his condition. A doctor mentions: *"Anxiety and depression, I think these people have to live with that, because it looks like they don't identify their conditions as something treatable, I don't know how many women are feeling sad every day, I think many".*

An important parameter of impact of treatment is the capability to work again, in the house or on the land. The improvement is also visible on the facial expression; "*patients can endure noises again, and don't feel too annoyed anymore*", comments one medical doctor. The benefit of a psychiatric treatment is bigger than psychological therapy according to the psychologist, because the medication confirms the condition of the patient. If a patient has to take medication to be cured, the disease is real and the social stigma of the condition becomes less. One medical doctor mentions that he knows several medical doctors who don't believe in psychiatry and less in this social context. However, he does see its effect, because he has seen the changes in the patients although it takes some time.

3.3 Similarities and differences in illness experiences of patients and perceptions of the practitioners.

In this section the patient narratives and practitioner's perceptions are compared and discussed. Issues are defined for strengthening of sociocultural understanding and communication during the clinical encounter with mental health patients.

Somatic expression of suffering

Both by patients and practitioners the problem is mentioned that doctors apply wrong diagnosis to mental health problems; like typhoid fever, gastritis, and high cholesterol. According to the practitioners one of the reasons for this is the difficulty to establish a mental disease diagnosis, because the Tzeltal patients rarely make the connection between bodily symptoms and adverse life events they live. However, from the patient narratives it became clear that mental suffering and somatic expressions are embedded in social situations and can be understood as a way of coping with social and other contextual situations. A possible other explanation might be the origin in the lack of body-mind connection in western biomedicine itself; that the medical approach doesn't allow obtaining more knowledge of the social life and psychological processes of the patients. The patient narratives gave insight in social explanations of the afflictions of the patients and that symptoms can be seen as a language of social life. Practitioners often speak in terms of risk factors and with this mind-set are inhibited to reach the necessary depth of understanding of their patients. A third explanation for the expression of mental suffering through bodily symptoms was expressed in the FGD; patients don't express their social problems to the medical doctor. Patients who suffer susto or nervios are being applied costumbre or go to healers; the medical doctor treats the bodily symptoms. Patients don't inform medical doctors easily about costumbre and alternative healers, because medicine is considered as a separate field of knowledge. However, if practitioner's would have a more open attitude towards patient's expression of suffering, as discussed above concerning conversive crisis and alternative healing, patient's would disclose easier and more integrative approaches and effective attention could be reached. Therefore, it is necessary to abandon the dichotomy of mind and body. Evaluation of a patient must be based on the patient's self-reported perceptions that include his somatic experiences as well as his emotional changes. In this approach concepts like somatization in which the dichotomy persists are not useful and a more integral approach to body and mind should be established when evaluating the patient's condition. A shift has to take place in medicine to see the body as part of a symbol system on individual and social level.

Medical or popular naming

From the patient and practitioners interviews it became clear that mental health patients who are receiving treatment normally don't know their medical diagnosis. There was difference in opinion among the practitioners concerning the importance of the patients knowing the medical name of the mental problem. Some practitioners manage the prototypic names like susto and espanto, which are diseases caused by traumatic events (dangerous animals, falling, drowning, anxiety to die, etc.) During a consult observation the psychiatrist comments: "*What you feel in your stomach comes from your head. You are not diseased of triglycerides and laboratory studies won't show what you have. It's the nerves that cause your problem".* Others mention the medical diagnosis and some try to explain what happens in the brain. In the interviews it is mentioned that mental health promotion and prevention is important, in order for people to recognize their mental suffering and to know that allopathic medicine can treat these afflictions as well. Extreme conditions of locking up a person who has gone mad can be prevented if medical terms for mental health conditions and it's treatment are part of the lay information of people and their coping strategies.

Medication or medicalization

About the place of medication in treatment of mental problems there were different opinions. In the FGD and some interviews practitioners mentioned that first all somatic causes need to be excluded before thinking in a mental problem. Since medication is long term and often expensive, first therapy should be applied and if this is not effective medication can be considered. Other practitioners consider that therapy often is not possible because follow up cannot be frequent. The psychiatrist commented that medication however helps to improve mental well-being and therefore give opportunities to improve daily life and affront problems. The psychologist mentions that the medicalization that exists in society affects her practice. Often people are not interested in therapy and want medicine that improves their condition. The interviewed patients report a positive effect of medication and improvement of their daily life. However, a returning issue in the practitioner's interviews is that many doctors don't believe in psychiatry in this context, because of the medicalization of socio-economic living conditions in the communities. In order to unify criterias for treatments it is needed to reach consensus between the different practitioners in the indications for treatment of mental problems.

Open or closed questions

From the medical doctor interviews and observations it became clear that the medical doctor often has to deal with a certain degree of anxiety in him or herself to reach a diagnose in limited time, with information from translations which are difficult to interpret. This condition inhibits a more open and holistic approach to the patient that can lead to integrative evaluation of the problem the patient presents on individual level and in his or her social life. The following example of a patient interrogation demonstrates this: *Doctor: "I'm going to ask you some quick questions in order to know you better: Do you have allergies?" Patient: "They have given me a medication for spots that I got, but I got nose bleeding". Doctor: "Were you operated once?" Patient: "No" Doctor: "Do you take medication?" Patient shows a bag full of medications and comments: "I have many body pains". Doctor: "Has something happened in your life?" Patient hesitates in answering. Doctor: "Now I will revise you."* Standard medical anamnesis inhibits a holistic interview style in which a patient has more opportunity to express about his problem. The approach of the psychiatrist that was observed was to start with an open question and to let the patient and his family speak first about all the concerns they have and then give concrete explanations and advices. The psychologist would ask many, sometimes confronting questions, in order to explore the problem in debt. Uncomfortable situations were not avoided. She would give instructions for registering emotions and problematic situations at home, to be commented in the following consult. She also focussed a lot on explaining the relation between body and mind. For the mental patient encounter an approach with more open questions leads to better understanding and confidence in the doctor-patient relationship.

Chapter 4: Conclusions and recommendations

Since mental health problems take sixth place in most frequent diagnostics of HSC outpatient clinic, a considerate part of medical care is concerning these conditions. Therefore it is important to continuously evaluate and improve mental health care in the outpatient clinic of HSC. In this research the focus was on the communication between patient and practitioner, because this is an essential element for achieving effective and sociocultural acceptable mental health care. By interviewing patients and practitioners, it became clear that patient illness experiences have to be evaluated as integral part of the patient's social context. The practitioner's interviews also provided interesting information of their perception of mental health problems in the patient population, as well as elements for consideration of their medical practice and the mental health project of HSC. In this section specific conclusions from findings are defined and recommendations for implementation in the HSC mental health project are formulated according to priority for the objective of this research.

1. This research gave some insights in the way patients live their mental sufferings and the way this symbolizes the individuals in their social worlds. It became clear that mental afflictions and their bodily representations can be interpreted as a thorough language of social life. The multiplicity of causes patients mention for their affliction is related to the uncertainty with which they experience life itself and the distrust of values of the other and moral norms in society. It is obvious that in a clinical encounter there is no time to explore illness narratives, but activities should be established in order for practitioners to achieve more cultural understanding and thereby be able to obtain major patient insight and confidentiality in the doctor-patient relationship. A shift must take place from verticality and hegemonic attitude towards open questions, sociocultural interest and more time for the patient. The first one can be achieved by applying Arthur Kleinmann's 7 explanatory model (EM) questions (Box 1) in the clinical encounters with patients with mental health problems, but also for other health problems. (42)

What do you call this problem?
What do you believe is the cause of this problem?
What course do you expect it to take?
What do you think this problem does inside your body?
How does it affect your body and your mind?
What do you most fear about this condition?
What do you most fear about the treatment?

Box 1: Explanatory model questions of Arthur Kleinmann
Kleinman A, Benson P. Anthropology in the clinic: The problem of cultural competency and how to fix it. PLoS Med 2006;3(10):1673-1676

If there is no time for all questions, at least one open question has to be applied that concerns what matters most in the experience of illness and treatment for the patients. This can help the practitioner to make improved patient specific treatment decisions. (42). Also, it would be important that medical doctors experience patient's narratives to obtain more knowledge of their social world. This can be realized by using the MINI as interview structure and the psychological framework CSMI for analysis, as demonstrated in Annex 4. As became clear from the results of the patient interviews, the CSMI is a model that can improve understanding of illness experiences and coping strategies of individual patients. The use of this model in clinical case evaluations can help practitioners to understand the patient's reasoning and sense making. The weight of social inequities and the norms and values of the communities on the emotional wellbeing, illness representation and decision making in health seeking behaviour of patients can be visualized and understood better by its use.

2. Erroneous diagnostics for mental problems are frequent and lead to ineffective care, medicalization and unnecessary costs. Gastritis, high cholesterol and typhoid fever are frequent diagnosis in mental health patients. The main reason mentioned by the practitioners is the somatic presentation of mental health problems, because of the division that patients make between allopathic and traditional healing. Also the biomedical approach of the doctor doesn't allow exploring the mental and social wellbeing of the patients. Apart from an open interview approach in the clinical encounter and illness narrative experiences, medical doctors need to receive more training in mental health problems, in order to make it part of general medical practice and not only an optional diagnostics of exclusion. Practical trainings that include clinical cases, facilitated by the psychiatrist and psychologist of the hospital are of vital importance to reach evidence-based consensus in diagnostics and treatment of mental problems. The WHO mhGAP guide (43) can be used as a basis and clinical guidelines specified to HSC have to be developed in order to embed the trainings and serve as practical guide during the clinical encounter.

3. From the practitioner interviews and focus group discussion it resulted that the diagnostic scales PHQ-9 and GAD-7, tools that are being used in HSC, are not easy to apply. Cultural understanding is needed in order to be able to formulate the questions of the tools well, to give clear instructions for translations to Tzeltal to the translator and to understand and evaluate in an adequate manner the answers of the patients. Part of the mental health training programme therefore needs to be cultural responsible application of these diagnostic scales. In clinical case sessions, the questions and answers of the corresponding scale need to be discussed. It also has to be kept in mind that the scales are not decisive for diagnosis, but a guide that helps to

orient general doctors in mental health problems. Annex 5 gives an example of issues for interpretation of the PHQ9.

4. From the patient interviews it became clear that concrete and practical advises are useful and probable to be followed up. The psychiatrist, psychologist and one medical doctor who participated in this research do some kind of psycho-education. Other practitioners expressed the need to learn more about how to apply psycho-education. There is no consensus among the practitioners about psycho-education and the majority of the interviewed doctors didn't mention to be applying psycho-educational advises. A probable explanation for this is that in the medical career there is no training concerning this theme. A strategy that can be recommended is Problem Management Plus (PM+) of WHO, a low-intensity psychological intervention for adults in communities that are exposed to adversity. (44) "Low-intensity" means that the delivery requires a less intense level of specialist human resource use. The term adversity is used to describe circumstances like hardships due to chronic poverty, long-term humanitarian emergencies or displacements. PM+ is useful for a range of emotional problems. It does not involve diagnosing mental disorders, even though it is likely to help people with mood and anxiety disorders. It can be applied to improve aspects of mental health and psychosocial well being no matter how severe people's problems are. It involves managing stress, managing problems, get going and keep doing, strengthening social support and staying well.

5. In order to be able to indicate in a detailed manner the need to start medication or to proceed with therapy, meetings between psychologist and psychiatrist as well as their supervision of medical doctors is necessary. In the decision making not only medical facts are of importance, but also feasibility of therapy because of travelling distance or patient's treatment expectations for example.

6. A frequent returning issue in both patient as well as practitioner interviews was the lack of knowledge of patients about mental health and mental problems. This was represented in the narratives by social stigma of mental disease and large health seeking pathways as well as medicalization of somatic symptoms. Therefore, mental health promotion and prevention of mental disease, as well as education concerning the most prevalent mental diseases would help patients to recognize conditions and possible solutions. These educational activities must take place as integral part of the clinical encounters and of a fieldwork project in the communities concerning health promotion, prevention and primary health care. However, it is important that the promotion and prevention of mental health in biomedical terms is treated alongside the cultural side of mental suffering.

7. The narratives gave new insights and an opportunity to improved understanding of the complexity of the patient illness experiences. The results of the interviews with both patients and practitioners, as well as the comparison, gave important input for improvement of the mental health care in HSC. Illness narratives as well as practitioner's perceptions of patient's experiences thus can be an important source of information for improvement of care. It is important to gain knowledge of the patient's view as well as the biomedical view in order to define elements to improve patient care. This research only took place with patients of HSC. However, in future research it is necessary to interview people from the communities, alternative healers, as well as medical doctors of other institutions, in order to achieve a broader scope of the way mental illnesses are being lived and treated in the Tzeltales and the wider indigenous population.

Implementation plan

In order to realize the above-mentioned recommendations in the mental health project of HSC, the following implementation plan is proposed.

Training program medical doctors	Periodicity
1. Clinical sessions facilitated by the psychiatrist: In these meetings mental health patients who are receiving follow up by the medical doctors and psychologist are evaluated, with a focus on application of diagnostic scales, and use of the clinical guidelines of the hospital, as well as treatment decisions 2. Clinical sessions facilitated by the psychologist: The objective of these sessions is to train the medical doctors in psycho-education for the patients. (PM+) 3. Clinical sessions concerning patient narratives: A medical doctor interviews a mental health patient by using the MINI questions. The narrative is analysed with the CSMI and the medical doctor presents the narrative and the analysis in the clinical session	Each type of clinical session on a monthly basis (3 mental health sessions a month)

4. Individual evaluation of interculturality with medical doctors In these meetings the use of the EM questions, the use of the diagnostic scales as well as the use of the clinical guidelines of HSC in the clinical encounters are evaluated in individual meetings between the medical doctor and medical coordinator of the hospital.	Individual evaluations every 6 months
5. Community mental health promotion and prevention Community health workers are trained in mental health promotion and recognition of principally depression and anxiety problems.	As an integrative part of the existing community health worker training program, minimal 2 mental health trainings of 2 days a year in every region

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Annex 1: EZLN

In Chiapas, a southern state of Mexico, due to conditions of extreme poverty, discrimination and repression faced by indigenous population groups since the Spanish conquest, dissatisfaction and revolutionary fervour has long been present. In January 1994, the emergence of the Zapatista Army of National Liberation (EZLN) resulted in massive international pressure and solidarity and slowed down neoliberal authoritarian reforms. The rights of the indigenous population were put in the centre of the public agenda. A dialogue between government and EZLN was started, but the resulting San Andres accords were never put into practice by the government. A long non-violent struggle of the Zapatistas and other social organizations followed to demand the rights for the indigenous population. In 2003 the Zapatistas started to build their own autonomous political, social and cultural system as a reaction to the non-response of the government. The government however, since that time has been applying strategies to control the rural indigenous population through a low intensity armed conflict, by politically dividing communities through presence of paramilitaries and militaries and through social assistance programs. (1,2) In this way the government aims to suffocate the independent farmer organizations, in order to be able to proceed with neoliberal reforms. (3)

The autonomous Zapatista organization according to its ideology is organized "from down to up", in order to prevent domination from the ones who are leading the organization and to create autonomy on local as well as regional level. (4) This means that on community level people are working in different collective charges, that can be running the collective store, or be health- or education promoter. Charges change over time, so members of the organization often work in different areas over time.

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Annex 2: McGill Illness Narrative Interview

Generic Version for Disease, Illness or Symptom Danielle Groleau, Allan Young, & Laurence J. Kirmayer ©2006 Spanish translation by Irene Hofmeijer (2009), then corrected by Consuelo Errazuriz and Fannie Martel (2010) (55)

Introduction:

Section 1: Initial Narrative
This first part is unstructured and aims to collect an illness narrative organized by chronological continuity of events. If the participant is using a disease label, prototype or explanatory model, it is noted, but the basic questions are repeated to encourage participants to tell their story in their own words.

Section 2: Prototypes
In order to elicit narratives that reveal prototypical experiences of self and others, the questions in this section are more structured. The importance of prototypes differs between participants, depending if this type of reasoning has predominance over rational or causal ways of reasoning. The questions refer to self-prototypical experiences of participants or others (family, social, media) concerning their health behaviour, and the degree to which participants use these experiences to explain their health problem.

Section 3: Explanatory Models
This section aims to elicit explanatory model narratives of the interviewees' health problem, produced by a causal type of reasoning, according to a local idiom of distress, perceived causal attributions, bodily aspects (how the health problem affects the body, the social context of the health problem and how the explanatory model is connected to the participant's health problem experience.

Section 4: Help Seeking and Service Utilization
This is a narrative of the participants' experience with health services (medical doctor or/and healer), possible hospitalization, and the response to received treatment, including a rationalization of compliance with treatment recommendations and satisfaction with received care.

Section 5: Impact of Illness
This section aims to explore the impact of the health problem on the participant's life in general and his/her perception of how the illness has led to changes in identity, roles and functioning since the onset. Ways of coping, social supports and other supports are interviewed.

Section 1. INITIAL ILLNESS NARRATIVE

1. When did you experience your health problem or difficulties (HP) for the first time? [*Substitute respondent's terms for 'HP' in this and subsequent questions.*] [*Let the narrative go on as long as possible, with only simple prompting by asking*, 'What happened then? And then?']

2. We would like to know more about your experience. Could you tell us when you realized you had this (HP)?

3. Can you tell us what happened when you had your (HP)?

4. Did something else happen? [*Repeat as needed to draw out contiguous experiences and events.*]

5. If you went to see a helper or healer of any kind, tell us about your visit and what happened afterwards.

6. If you went to see a doctor, tell us about your visit to the doctor/hospitalization and about what happened afterwards.

6.1 Did you have any tests or treatments for your (HP)? [*The relevance of this question depends on the type of health problem.*]

Section 2. PROTOTYPE NARRATIVE

7. In the past, have you ever had a health problem that you consider similar to your current (HP)? [If answer to #7 is Yes, then ask Q.8]

8. In what way is that past health problem similar to or different from your current (HP)?

9. Did a person in your family ever experience a health problem similar to yours? [If answer to #9 is Yes, then ask Q.10]

10. In what ways do you consider your (HP) to be similar to or different from this other person's health problem?

11. Did a person in your social environment (friends or work) experience a health problem similar to yours? [If answer to #11 is Yes, then ask Q.12]

12. In what ways do you consider your (HP) to be similar to or different from this other person's health problem?

13. Have you ever seen, read or heard on television, radio, in a

magazine, a book or on the Internet of a person who had the same health problem as you? [If answer to #13 is Yes, then ask Q.14]

14. In what ways is that person's problem similar to or different from yours?

Section 3. EXPLANATORY MODEL NARRATIVE

15. Do you have another term or expression that describes your (HP)?

16. According to you, what caused your (HP)? [List primary cause(s).]

17. Are there any other causes that you think played a role? [List secondary causes.]

18. Why did your (HP) start when it did?

19. What happened inside your body that could explain your (HP)?

20. Is there something happening in your family, at work or in your social life that could explain your health problem? [If answer to #19 is Yes, then ask Q.20] 20. Can you tell me how that explains your health problem?

21. Have you considered that you might have *[INTRODUCE POPULAR SYMPTOM OR ILLNESS LABEL]*?

22. What does *[POPULAR LABEL]* mean to you?

23. What usually happens to people who have *[POPULAR LABEL]?*

24. What is the best treatment for people who have *[POPULAR LABEL]?*

25. How do other people react to someone who has *[POPULAR LABEL]?*

26. Who do you know who has had *[POPULAR LABEL]*?

27. In what ways is your (HP) similar to or different from that person's health problem?

28. Is your (HP) somehow linked or related to specific events that occurred in your life?

29. Can you tell me more about those events and how they are linked to your (HP)?

Section 4. SERVICES AND RESPONSE TO TREATMENT

30. During your visit to the doctor (healer) for your HP, what did your doctor (healer) tell you that your problem was?

31. Did your doctor (healer) give you any treatment, medicine or recommendations to follow? [List all]

32. How are you dealing with each of these recommendations? [*Repeat Q. 33 to Q. 36 as needed for every recommendation, medicine and treatment listed.*]

33. Are you able to follow that treatment (or recommendation or medicine)?

34. What made that treatment work well?

35. What made that treatment difficult to follow or work poorly?

36. What treatments did you expect to receive for your (HP) that you did not receive?

37. What other therapy, treatment, help or care have you sought out?

38. What other therapy, treatment, help or care would you like to receive?

Section 5. IMPACT ON LIFE

39. How has your (HP) changed the way you live?

40. How has your (HP) changed the way you feel or think about yourself?

41. How has your (HP) changed the way you look at life in general?

42. How has your (HP) changed the way that others look at you?

43. What has helped you through this period in your life?

44. How have your family or friends helped you through this difficult period of your life?

45. How has your spiritual life, faith or religious practice helped you go through this difficult period of your life?

46. Is there anything else you would like to add?

Annex 3: Informed consent forms

Consent Form for patient participants of the study on illness experiences of mental health patients of Tzeltal origin in Chiapas, Mexico

I, Heleen Kruip, investigator of the mental health care study, would like to inform you about this study and ask you if you agree to participate in answering some questions about your illness history and your opinion of the care you are receiving, in a personal interview.

The aim of the study is to know how to improve the care for mental health patients at Hospital San Carlos. Therefore, the disease experience of patients and their family is very important. With the results of the study we will make recommendations to the health workers of Hospital San Carlos on how to improve the care for mental health patients. You will also be informed about the results.

You do not have to participate in this study if you don't want to. If you decide to participate you can quit at any moment. You are not obligated to answer any of the questions if you don't want to. There won't be any effect on you or your family if you decide to quit.

What you tell to me will be private and confidential and the participation is completely anonymous and will take place in a private room away from the public. Your name will only be written down on this form and it will be saved separately from the information you give during the interview. The interview will be recorded. Documents and recordings will be saved in a locked place and stored on the computer of the investigator with a password. All recordings and notes will be destroyed within 5 years after the research ends. Only the investigator will have access. This study is independent from the ministry of health and they have no access to this information.

Talking about the experience of your disease history might be painful for you. If you find it necessary, the psychiatrist or psychologist of the hospital can provide you guidance after the interview.

If you decide to participate, it will be important that your answers are honest, so that we can really get useful information from this study that can help to improve mental health care. The interview will take between one hour and

one and a half hour.

Are you willing to participate? Yes/No

Patient's name.....fingerprint.....

Family member's name.....finger print.....

Signature of interviewer.....date…….

Contact details interviewer: Heleen Kruip tel. 9671306475

Consent Form for practitioner participants of the study on illness experiences of mental health patients of Tzeltal origin in Chiapas, Mexico

I, Heleen Kruip, investigator of the mental health care study, would like to inform you about this study and ask you if you agree to participate in an interview.

The aim of to study is to know more about illness experiences of mental health patients of Hospital San Carlos. Therefore, your knowledge of and opinion about patient illness experiences is very important. The results of the study will be discussed with the medical team and recommendations for improvement for mental health care will be formulated.

You do not have to participate in this study if you don't want to. If you decide to participate you can quit at any moment. You are not obligated to answer any of the questions if you don't want to. There won't be any effect on you or your family if you decide to quit.

What you tell to me will be private and confidential and the participation is completely anonymous and will take place in a private room away from the public. Your name will only be written down on this form and it will be saved separately from the information you give during the interview. The interview will be recorded. Documents and recordings will be saved in a locked place and stored on the computer of the investigator with a password. All

recordings and notes will be destroyed within 5 years after the research ends. Only the investigator will have access. This study is independent from the ministry of health and they have no access to this information.

If you decide to participate, it will be important that your answers are honest, so that we can really get useful information from this study that can help to improve mental health care. It is important that you are willing participate in an interview of about one hour, in order to get all the necessary information.

Are you willing to participate? Yes/No

Respondent's name.....signature.....

Signature of interviewer.....date.....

Contact details interviewer: Heleen Kruip tel. 9671306475

Annex 4: CSMI application

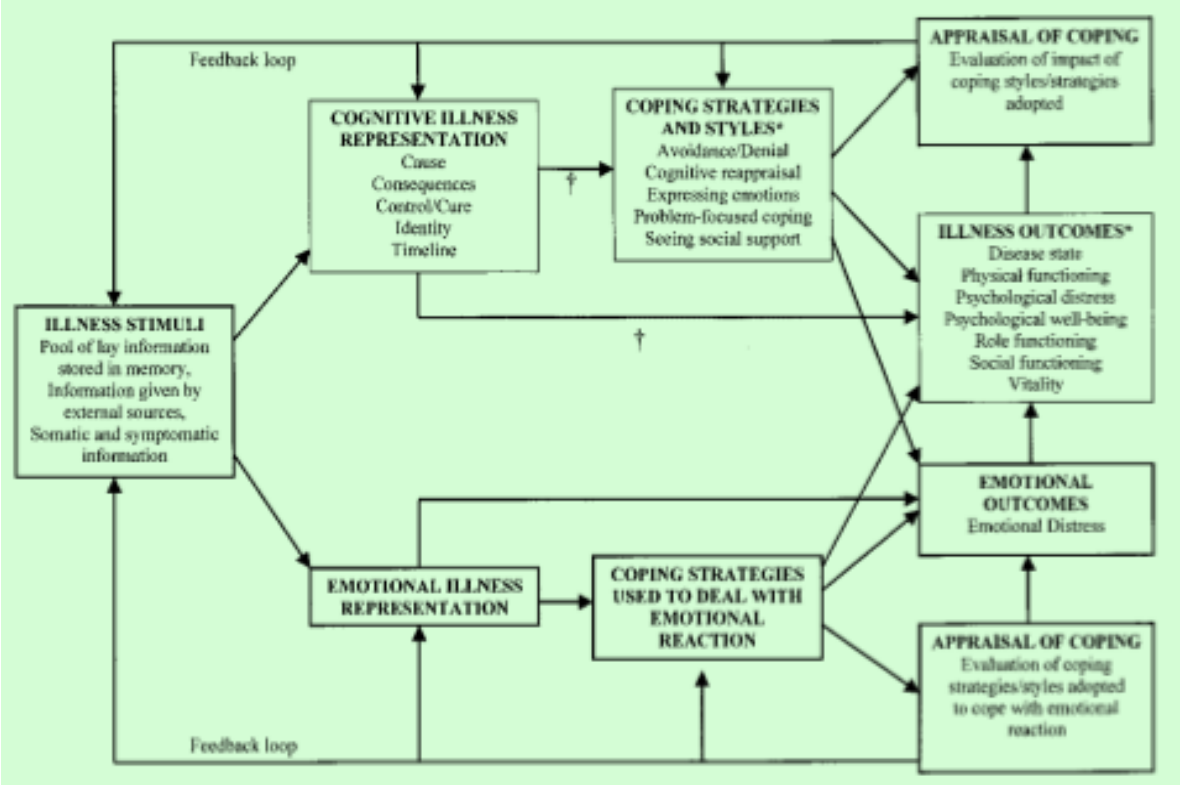

Figure 1. Common Sense Model of Illness
Diefenbach MA, Leventhal H. The Common-Sense Model of Illness Representation: Theoretical and Practical Considerations. Journal of Social Distress and the Homeless 1996;5(1):11-38

Analysis of illness narrative of Feliciano:

Illness stimuli:
Patient 1 has seen people in the community get sick from one moment to the other. After his brother died his parents got sick as well. He started with an eye infection for which he couldn`t find cure quickly and then he started with pain of his chest and quick heart beating. The medical doctors would say he has high blood pressure or gastritis. After having seen many doctors he came with the psychiatrist who explained him that he suffers anxiety.

Cognitive illness representations:
He didn't know what would be the cause of his illness; he thought it was something wrong with the heart and that he might die. When the doctors would say he has gastritis he knew it was wrong diagnosis, because his heart was beating so fast. The psychologist wanted to talk with him about his life, but he thought that would not stop his fast heart beating. When he started to take medication for anxiety he started to get better and he started to relate

the fast heart beating to the things that happened to him; the dying of his brother, the disease of his parents, the fear of not having enough money to buy food when he was not able to work. It was in 2012 that he got ill from his eye, a couple of months later he arrived with the psychiatrist and started to take medication. When he got stomach pains because of the medication, he stopped it for a time and started to look for diagnosis for these pains, because one doctor said it could be a tumour. He went with a gastro-enterologist, who realized endoscopy and only diagnosed a small hiatal hernia that doesn't need treatment. He started to take different herbal teas for his stomach problem. A year later he returned with the psychiatrist, because he felt anxious again. Now he is under control for 4 years and he can work again. He keeps searching for and taking different herbs for his stomach pain.

Coping strategies and styles:
When his eye problem didn't get resolution even when searching in different places (Ocosingo, San Cristobal) with different doctors, he got very bad and thought he would die. He didn't relate his condition to the things that were happening. He thought severe Disease had gotten over him, like he had seen happening to family members and in the community.
Since he improved with the anxiety medication he is able to be responsible for himself again. He tries to be quiet, started working again little by little and keeps taking his medication. He doesn't go to meetings of his community, because often there is a lot of discussion and then his condition could become worse again. Many men of the community have gotten gastritis or high blood pressure. He doesn't play soccer, because he thinks his heart is weak and will start beating fast again. He searched also with many doctors for cure of the stomach problem, however at the end he accepted he would not find remedy by keeping searching and he started to try out teas. Because he started to relate his symptoms to the lived situations he got tranquilized. When he got very bad his wife came to accompany him and his father and that tranquilized him. He also mentions the church, that God will provide and there will always be food to survive, this idea has tranquilized him.

Emotional illness representation
The fear of dying because of the quick heart beating and the fear of having to spend all the money on medication and not have enough for food.

Coping strategies to deal with emotional reaction
There was a lot of help seeking with many doctors when he got his anxiety attacks. Every time his symptoms would not solve but increase, he would try another health facility.

Appraisal of coping
He realized it would not help him to keep looking for cure with different doctors or natural healers and that he would better stay with the psychiatrist. This has helped him to be calmer and in the last period he has started to work again, in the field and in woodcutting.

Emotional outcome
He feels he is under control now.

Illness outcome
He is not cured, but he can work again. He wonders if he will ever get cured, but he has to insist with the medications and keep working and listening to himself to stay calm. He would like to play a bit of guitar again and sing, but he can't because of his stomach. Now he can go alone to the hospital for his medical consult, before he always had to be accompanied, because he would think he could die on the way.

Appraisal of coping
He thinks that if he insists with his treatment and way of living, he can move on.

Annex 5: PHQ-9 issues for improved interpretation

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Beneath are written suggestions for better interpretation of the questions for the Tzeltal patients:

Question 2: "feeling without strength"
Question 5: "not feeling like eating or wanting to eat a lot"
Question 6: "Feeling that you cannot comply with your duties"
Question 7: "Not being able to finish what you're doing, like making tortillas or your work on the land"

More than half the days would be better asked like “more days with the problem than without” and since time perceptions is less exact it is important to insist in a clear answer until the interviewer is sure.