A Cross-Cultural Analysis of Clinical Depression: Rural Coastal Highlands of Guatemala

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A Cross-Cultural Analysis of Clinical Depression: Rural Coastal Highlands of Guatemala

Carroll College
Helena, MT

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Senior Honors Thesis
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cultivating my interests and encouraging me to persevere.
Abstract

In the summer of 2007, I was given the opportunity to spend three months living at the mission of the Catholic Diocese of Helena, Montana, in Santo Tomas, Guatemala, whose Mayan people are dramatically marked by a socio-political history of radical violence, instability, and poverty. The purpose of the thesis was to conduct research on Mayan psychological health in conjunction with the mission’s Clinica Maxeña, the main provider of basic health services to this area. As a result of qualitative and quantitative data gathered during this time, this thesis will attempt to describe the culturally specific understanding of depression in Guatemala, and demonstrate how this understanding can benefit the discussion of the etiology and treatment of depression.

The Mayans demonstrate an astute understanding of psychological health characterized by a worldview radically different from our own. In particular, the Mayan view on psychological health cannot be easily compartmentalized due to its holistic view of the human person.

In addition to a qualitative approach, the Beck Depression Inventory (BDI-II) was administered. Results showed that BDI-II scores of 49 Guatemalans were significantly higher than means of a published psychometric comparison of a normal group in Canada. Thirty-five percent of the Guatemalans’ scores were categorized as “severe,” and no one reported receiving psychological services.

Herbal treatments for mood disorders are available through a Mayan medicinal-plant clinic. Almost all treatment options for depression also treat for anxiety. The psychosocial experience of the Mayan people and the nature of Mayan treatments for depression strongly support the HPA axis theory on depression.
Introduction

In the summer of 2007, I was given the opportunity to spend three months living at the mission of the Catholic Diocese of Helena, Montana, in Santo Tomás la Unión, Guatemala, whose Mayan people are dramatically marked by a socio-political history of radical violence, instability, and poverty. The purpose was to conduct research on Mayan psychological health in conjunction with the mission’s Clínica Maxeña, the main provider of basic health services to this area. As a result of qualitative and quantitative data gathered during this time, this thesis will attempt to describe the culturally specific understanding of depression in Guatemala, and demonstrate how this understanding can benefit the discussion of the etiology and treatment of depression.
Background

I'd always see my mother cry...I was afraid of life and asked myself, what will it be like when I'm grown up. My name is Rigoberta Menchú. It's hard for me to remember everything that's happened to me in my life since there have been many very bad times but, yes, moments of joy as well. The important thing is that what has happened to me has happened to many other people too: My story is the story of all poor Guatemalans. My personal experience is the reality of a whole people.

-Rigoberta Menchú (1983)

Rigoberta Menchú is the most well-known international advocate for the Mayan people and has become an icon of the struggles of the Guatemalan people for peace. In her book that gained her the Nobel Prize, I, Rigoberta Menchú, she discusses at length the trauma that befell her family under the control of the Guatemalan dictatorship. Her story provides readers with a paradigmatic sense of the violence and domination Mayan Indians experienced in Guatemala and reveals how the Mayan experience created a heuristic of loss of hope and dignity at a cultural level.

In a report by the Transcultural Mental Health Institute (1998), scientists give a report explaining the psychology of liberation in Guatemala and other Latin America countries. The authors state that “most modern Latin American wars can be understood in terms of class interests and conflicts over unequal distribution of resources” (Comas-
Díaz, Lykes, & Alarcón, p. 778). The authors report that the death and disappearance of loved ones throughout the crisis became a normal part of psychosocial reality for the Mayans (Comas-Díaz et al., 1998).

The historical situation is complex, but Greg Grandin in his book titled *The blood of Guatemala*, states that “Faced with an unprecedented challenge to their authority, the state, the military, and the oligarchy, supported by the United States, identified Indians as the collective enemy and launched a wave of repression that the United Nations – administered Truth Commission has characterized as genocide” (p. 233). Between the years of 1960 and 1996 Guatemala suffered a Civil War that resulted in the genocide of an estimated 200,000 people in over 600 massacres and the displacement of over one million others. It is estimated that 83% of the murders were Mayan people.

In 1944 Jorge Ubico, reigning dictator in Guatemala from 1931-1944, was overthrown by the Guatemalan people. This pro-democracy act marked the first time in Guatemalan history that the people were given the right to vote in a free election. In his term that lasted from 1945-1951, Juan José Arévalo Bermejo, the new president, began reforms that gave the majority lower class new hope. In 1951 the presidency smoothly transitioned to Jacobo Arbenz Guzmán who continued the reforms started by Arévalo. The reform Arbenz is famous for is the Agrarian Reform Law, which reallocated the unequal distribution of land. It is estimated that during this time 2% of the population controlled 72% of the land. Arbenz himself in this reform handed over some 1,200 acres. The reform was successful in that it is estimated to have helped 100,000 farmers, but it was detrimental in the end because it instigated his overthrow. For many reasons, including the reforms and the threat to the United Fruit Company, Arbenz was
overthrown by a U.S. military coup. With the support of Army Colonel Monzón, Arbenz was replaced by Carlos Castillo. This new dictatorship effectively started a Civil War that would proceed to last for 36 years aided by subsequent military abusers such as José Efrain Ríos Montt. On March 10, 1999, the Clinton administration actually issued a formal apology to Guatemala for the human rights abuses committed and for the role the United States played in the 36-year-long Civil War.

This era of violence affected every corner of Guatemala, and the atrocities of this time have become permanently fixed in the Guatemalan paradigm. Simply put, the history and culture of Guatemala in the last half century, and especially of the Mayan ethnic group, cannot begin to be understood apart from the reality of systematic and extensive violence and the resulting socio-cultural, political, economic, and psychological damage to the Mayan people.

(Left) "The soldiers tortured small children and adults in the CPR of Santa Clara in Chajul – 1987."
-Catalina Ixcoy Tiu

(Right) "The sad history of the 95 massacred in 'Estrella Polar.' All were finished off by domestic and wild animals."
-Maria Canay Terraza
Photos courtesy of Romelia Gonzales, from the book: *Threads breaking the silence: Stories of the women of the CPR-Sierra from the Civil War in Guatemala* (2005).
The Mission

Set amidst this longstanding history is a clinic established by the Catholic Diocese of Helena in 1964, just north of the city Mazatenango, Guatemala. Over the past forty years the mission has developed a clinic, called the Clínica Maxeña, which provides people of the community basic health services using both Western medicine and traditional Mayan medicine.

There are three main aspects of the clinic. The central service of the clinic is based in Santo Tomás la Unión and is equipped to provide basic health services and preventive education to people of the region. From this founding branch, an additional outreach service funded by the European Union travels to secluded communities and administers basic health services such as vaccines, childcare, and medicines for common ailments. The third branch of the clinic, just ten years old, is called the Medicinal Plant Project, and with their garden of 102 plants, they offer a more traditional naturopathic and traditionally holistic Mayan treatment. The Medicinal Plant Clinic is the only branch of the clinic that offers treatment for mood disorders.

The recent experience of the Guatemalan people presents a wealth of psychosocial factors that would lead one to expect a high incidence of mood disorders. This expectation was the impetus for my interest in the psychological health of the Mayan people. However, it was clear that any investigation into mood disorders in Guatemala must consider the culture and history of the Mayan people as intrinsic to that inquiry. Therefore, I proceeded by way of naturalistic inquiry toward a holistic understanding of mood disorders in Guatemala.
In this thesis my goal is to impart how understanding the Mayan view of mood disorders can benefit the overall discussion of the etiology and treatment of depression. The results of this inquiry must lead one to either question the cross-cultural validity of the Beck Depression Inventory (BDI-II) or to consider the psychosocial foundations of depression to be meaningful for a generalized etiology of this disorder.
Methods

"The task of the naturalistic researcher interacts with the languages and meanings of human beings" (Eriandson, Harris, Skipper, & Allen, 1993, p. 4).

Upon arriving in Guatemala I discovered that between the arena of modern psychological discourse and the people of the Guatemalan highlands the two do not even share a common word for what we describe as depression. This left me groping for a way to study something that cannot even be discussed using common terminology. This is when I abandoned a strictly empirical methodological approach and sought an approach that would allow me to analyze qualitative as well as quantitative data. Doing justice to the question of mood disorders in another culture demanded a more holistic methodology.

The basis of this approach is that the goal of research is to holistically analyze a question or hypothesis. The philosophical assumption underlying my research methods is that all aspects of reality are interrelated and that to isolate a single aspect from the context of the whole cripples its meaning. There are many unique ways in which Guatemalans experience depression, and therefore they cannot but understand depression in a unique way. In research methodology it is primarily important to not isolate one aspect of the experience of depression in Guatemala. In order to create a deep and rich understanding of the reality, the many diverse aspects of Mayan experience must be taken into account.

There are many important aspects of research methodology that follow from this approach. A holistic approach in no way precludes rigorous observation and quantitative data. It merely seeks to situate this data in the context of a larger understanding of the culture and situation so that the data can be made meaningful through a broader
understanding of the research question. Divorcing data points, whether qualitative or quantitative, from each other and from their context can serve to only limit their meaning. A holistic approach allows the questions raised by contextual data such as culture, history, and geography to draw out deeper implications than could be discovered through isolated analysis. Although this type of approach seeks to be sensitive to a particular context, it is not irrelevant to a generalized discussion. Rather, it asserts the vital importance of discovering shared elements between differing constructions of reality. A holistic approach is capable of placing conclusions from diverse situations into meaningful dialogue without merely reducing those situations to a falsely equated context. The holistic approach allowed me to reach a meaningful understanding of the phenomenon of depression among the Mayan people, which can be applied to a generalized discussion.

Gathering data did not begin with the experiences I had in Guatemala. Stable data on the history of the people was collected before and during my trip so as to more fully understand the situation at hand and to understand the look and feel of depression in Guatemala. The historical context I gained in a few key readings was paramount in my view of the culture. Especially noteworthy readings are: *Guatemala: Never again!* is a part of REMHI, Recovery of Historical Memory Project, launched by the Archdiocese of Guatemala. The historical memory project was compiled with 5,000 testimonies from people who lived through the Civil War. This project is especially important to the Mayan consciousness because it endowed the people with a means to communicate to the world the abuses they suffered, and in being heard a small piece of justice was granted to an immeasurable injustice, and the people could then begin to seek reconciliation.
Threads breaking the silence: Stories of the women of the CPR-Sierra from the Civil War in Guatemala is another noteworthy read. Threads breaking the silence similarly provides a history as well as a place for people's personal accounts and pictures of the weavings done that express a certain memory from the war. The historical data I acquired through this research is very important to the project not only to provide a deeper understanding of the cultural context of depression in the Mayan people, but also because it highlights psychosocial factors which need to be considered as possibly significant to the prevalence of mood disorders.

In order to explore the local understanding of mental health, it was important that I spend three months living in Santo Tomás la Unión, Guatemala. My goal in doing this was to become a member of the community, taking in the rich context of the situation. I spent my first month there just observing and tagging along wherever I could and asking questions whenever I got the chance. During this time I kept a log of many of my observations that would help direct my research. I also used this time to practice my Spanish and build rapport within the community.

Once I built an affinity within the community and the clinic, I began conducting formal interviews with doctors and nurses. I conducted interviews with the directors of all three of the clinic's branches, as well as with nurses with whom I came in contact with.

The Beck Depression Inventory (BDI-II), (Appendix A), was selected as the method by which to measure depression as it has been demmed a valid and reliable measure of depression based on the criteria in the Diagnostic and Stastical Manual of Mental Disorders (DSM-IV). The BDI-II builds on 35 years of psychometric data on depression.
The format of the BDI-II consists of 21 questions and asks the participant to respond 0-3 on the Likert scale. Scores range from 0-63. The total score interpretation can be viewed in Appendix B.

Using the BDI-II in Spanish as a tool to assess depression, 50 randomly selected people were asked to respond to the questionnaire. The sample is not comprised of quantity; however, the sample is purposive in that samples were taken from about 25 different communities in the region, providing a wide range of responses. Participants from such a wide range of places were accessible to me because I traveled with the outreach team of the clinic to many different communities.

In the actual process of approaching people, it was necessary for me to establish a level of trust since I stuck out as an American. So, first I introduced myself as a student working in conjunction with the clinic. I informed the participants that they were being asked to participate in a study on the psychological health of members of the community in order to gain an understanding of how the clinic can better serve the needs of the community. In general, I read the test aloud; however, if the participant had adequate literacy skills, he or she was allowed to complete the test alone. I asked the participant to choose Spanish or Quiché as the language of choice for the questions. I hired an educated translator whom I trained for the purpose of translating aloud the BDI-II (Spanish translation) into Quiché when necessary. As a note of explanation, Quiché is primarily a spoken and not written language, so it would be nearly impossible to have a written version of the BDI-II in Quiché.

Once I had gathered this data, I used statistical analysis to compare the data to a normal group. The goal in the entire process of gathering data was to bring together
multiple perspectives to better understand the whole and to situate the questions at hand. Understanding the difference in representations of depression in another culture requires the employment of qualitative methodology along with the use of quantitative data.
Results

My results consist of three parts: First, the results I collected from the Beck Depression Inventory-II; second, a qualitative report summarizing interviews with participants and their understanding of depression in Guatemala; and finally, qualitative research done at the Medicinal Plant Clinic demonstrating how the understanding of depression in that area is manifested in the analysis and treatment of depression at the Clinic.

Quantitative Data

Forty-nine surveys were completed. The average age of the sample is 36. The sample contains 40 female responses (82%), and 9 male responses (18%). Six people who responded are Ladinos (not indigenous), and the remaining 43 respondents are indigenous Mayan.

The BDI-II manual provides a depression level interpretation for the test scores (Appendix B). In accordance with the manual correlates, responses show that 35% of the Guatemalan sample display “severe” depression, 35% display “moderate” depression, 14% display “mild” depression, and 16% display “minimal” depression. In short, only 16% of the population sample demonstrates normal results on the BDI-II. These results are represented to the left in Figure 1.
Beck, Steer, & Brown, the authors of the BDI-II manual, conducted studies to investigate the psychometric characteristics of the test measurement. I compared my sample in Guatemala to those studies done by the authors of the BDI-II manual in order to compare my sample to a source that the test makers have deemed as a measure of reliability and validity. The first group my sample is compared to is a college student sample, which is the comparative normal group. The second group my sample is compared to are psychiatric outpatients who completed the BDI-II as a standard intake battery of psychological tests (1996, p.14). Overall test score means are 24.7 (moderate) for the Guatemalan sample, 22.5 (moderate) for the psychiatric outpatients, and 12.6 (minimal) for the college student sample (fig. 2).
A t-test was employed to test for significance between responses in Guatemala and the comparative normal college student population group in Canada. The results show significance beyond the .01 level in a one tailed test. \( t(40) = 5.10, p = 4.25 \times 10^{-6} \). A t-test comparing the Guatemalan sample to the psychiatric outpatients shows no significant difference. \( t(40) = 0.91, p = 0.19 \). These results demonstrate that there is a closer resemblance of the Guatemalan sample to the psychiatric outpatients than there is to the comparative normal group.

The BDI-II allows the person to respond on a Likert scale 0-3 in 21 different categories (Appendix A). Fig. 3 is a comparison of the difference in subgroup means between the three different population samples.

Figure 3.
When represented schematically (figure 3), the data shows that the college student sample and the psychiatric outpatients follow the same pattern at different degrees, demonstrating the validity of the test. The Guatemalan sample, however, has a much different and markedly unpredictable subgroup response.

Similar to Fig. 3 above, Fig. 4 below is a rank order of the symptom subgroups. This table shows the subgroups in order of mean score for each symptom. The table notes the differences in the highest mean symptoms between the cultures.

<table>
<thead>
<tr>
<th></th>
<th>Guatemalans</th>
<th>College Students</th>
<th>Psychiatric Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Crying</td>
<td>Changes in Sleeping Pattern</td>
<td>Changes in Sleeping Pattern</td>
</tr>
<tr>
<td>2</td>
<td>Changes in Sleeping Pattern</td>
<td>Concentration Difficulty</td>
<td>Self-Dislike *</td>
</tr>
<tr>
<td>3</td>
<td>Agitation</td>
<td>Tiredness or fatigue</td>
<td>Concentration Difficulty</td>
</tr>
<tr>
<td>4</td>
<td>Changes in Appetite</td>
<td>Changes in Appetite</td>
<td>Loss of Energy</td>
</tr>
<tr>
<td>5</td>
<td>Sadness</td>
<td>Irritability</td>
<td>Tiredness or Fatigue</td>
</tr>
<tr>
<td>6</td>
<td>Loss of Interest in Sex</td>
<td>Loss of Energy</td>
<td>Loss of Pleasure</td>
</tr>
<tr>
<td>7</td>
<td>Loss of Pleasure</td>
<td>Agitation</td>
<td>Self-Criticalness *</td>
</tr>
<tr>
<td>8</td>
<td>Loss of Energy</td>
<td>Pessimism</td>
<td>Loss of Interest</td>
</tr>
<tr>
<td>9</td>
<td>Tiredness or Fatigue</td>
<td>Self-Dislike</td>
<td>Indecisiveness</td>
</tr>
<tr>
<td>10</td>
<td>Self-Criticalness *</td>
<td>Self-Criticalness</td>
<td>Crying</td>
</tr>
<tr>
<td>11</td>
<td>Loss of Interest</td>
<td>Past Failure</td>
<td>Irritability</td>
</tr>
<tr>
<td>12</td>
<td>Pessimism</td>
<td>Guilty Feelings</td>
<td>Pessimism</td>
</tr>
<tr>
<td>13</td>
<td>Concentration Difficulty</td>
<td>Loss of Interest</td>
<td>Agitation</td>
</tr>
<tr>
<td>14</td>
<td>Punishment Feelings *</td>
<td>Loss of Pleasure</td>
<td>Past Failure *</td>
</tr>
<tr>
<td>15</td>
<td>Guilty Feelings *</td>
<td>Crying</td>
<td>Changes in Appetite</td>
</tr>
<tr>
<td>16</td>
<td>Past Failure *</td>
<td>Sadness</td>
<td>Sadness</td>
</tr>
<tr>
<td>17</td>
<td>Irritability</td>
<td>Indecisiveness</td>
<td>Loss of Interest in Sex</td>
</tr>
<tr>
<td>18</td>
<td>Self-Dislike *</td>
<td>Worthlessness</td>
<td>Guilty Feelings *</td>
</tr>
<tr>
<td>19</td>
<td>Indecisiveness</td>
<td>Punishment Feelings</td>
<td>Worthlessness *</td>
</tr>
<tr>
<td>20</td>
<td>Suicidal Thoughts or Wishes*</td>
<td>Suicidal Thoughts or Wishes</td>
<td>Punishment Feelings *</td>
</tr>
<tr>
<td>21</td>
<td>Worthlessness *</td>
<td>Loss of Interest in Sex</td>
<td>Suicidal Thoughts or Wishes*</td>
</tr>
</tbody>
</table>

Figure 4
Qualitative Report

Before arriving in Guatemala I had assumed that researching the prevalence and treatment of depression in the highlands of Guatemala would be a relatively clear cut endeavor. I discovered how wrong an assumption that was because I immediately learned that the Mayans experience depression in a way that fits only with their reality. I had to first explore this overall Mayan reality before I could begin to understand depression, or tristeza (sadness), as the highland area terms it, from the local standpoint.

The Mayan culture tends to see depression less as a disorder and more as a common symptom of life, which they call tristeza. To understand depression, it is important to first address the Mayan understanding of suffering and sadness. As discussed earlier in the background section, the Mayans have been a part of a seriously oppressive history that has become a part of their being. Even for those who did not directly experience the war, the aftermath of violence affects them through poverty, political oppression, and the oral tradition of what happened to loved ones.

In an interview, a nurse who works at the clinic discussed her perception of the psychological state of the people. She described the lasting effects of the Civil War, as well as the reality of oppression that the Mayans still endure. Currently, she explained, there is a shortage of men due to the fact that many Guatemalans are constantly trying to escape into the United States (Anon, personal communication, 2007). In getting to know families I met in the region, I learned that people sell their land to hire a “coyote,” who is an expert in smuggling people across the border. The men do this in hopes that they will make it across the border and then make enough money to send back to their families in Guatemala. Most of the men either die in the journey or are deported back to their village
in Guatemala. The nurse expressed her sentiments that this causes much emotional damage to the community.

To gain a better understanding of factors that contributed to the emotional damage of those I was interviewing, each participant was given the opportunity to express a reason(s) for his or her feelings of sadness at the time of the interview. Below is a consolidated table briefly summarizing these autobiographical reports.

<table>
<thead>
<tr>
<th>Autobiographical report</th>
<th>Occurrence</th>
<th>Severity of depression in category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family Problems</td>
<td>30% of responses</td>
<td><img src="chart1.png" alt="Pie chart" /></td>
</tr>
<tr>
<td>• Marriage problems</td>
<td></td>
<td>Family Problems</td>
</tr>
<tr>
<td>• Family away (unspecified reason)</td>
<td></td>
<td>minimal: 0%</td>
</tr>
<tr>
<td>• Child related (i.e. jail, alcoholic, sick, disobedient)</td>
<td></td>
<td>mild: 12%</td>
</tr>
<tr>
<td>• Unspecified</td>
<td></td>
<td>severe: 41%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>moderate: 41%</td>
</tr>
<tr>
<td>2. Death of family or loved ones</td>
<td>21% of responses</td>
<td><img src="chart2.png" alt="Pie chart" /></td>
</tr>
<tr>
<td>• Economic related death (i.e. immigration, could not pay for doctor)</td>
<td></td>
<td>minimal: 6%</td>
</tr>
<tr>
<td>• Unspecified</td>
<td></td>
<td>mild: 8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>severe: 33%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>moderate: 33%</td>
</tr>
<tr>
<td>3. Illness/Injury</td>
<td>19% of responses</td>
<td><img src="chart3.png" alt="Pie chart" /></td>
</tr>
<tr>
<td></td>
<td></td>
<td>minimal: 10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>mild: 18%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>severe: 30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>moderate: 45%</td>
</tr>
<tr>
<td>4. Immigration related</td>
<td>7% of responses</td>
<td><img src="chart4.png" alt="Pie chart" /></td>
</tr>
<tr>
<td></td>
<td></td>
<td>minimal: 25%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>mild: 20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>severe: 5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>moderate: 50%</td>
</tr>
</tbody>
</table>
5. Heartache (i.e. unspecified)  5% of responses

6. Susto*  4% of responses

7. Unspecified  14% of responses

Figure 5
*Susto is a culturally specific illness unique to the Latin American culture that means someone has suffered from a fright or a trauma (Director of Medicinal Plant Clinic, personal communication, 2007).

This self-report analysis is not an attempt to provide an etiology for the depression, but rather these reports from the interviews are intended to provide some insight into the psychosocial context of the test respondents. In gathering data I tried to identify critical incidents, those specific events that either “highlight normal operation or contrast sharply” (Erlandson et al., 1993, p. 105). In my research, critical incidents were the things people talked about, shown above, in relation to their feelings of sadness.

These interviews suggested to me that suffering and sadness are seen by the Mayans as an inextricable part of life. Every person I interviewed said that they felt sad and gave many reasons for that sadness. I gained a sense that Mayans expect sadness as a part of their lives. In our culture there is a perception that suffering is not a necessary part of life,
but rather it is a disordered experience that can be eliminated from one’s life through certain choices. But the Mayans do not see that there is a choice: suffering does not result from your choices but rather is something that happens to you and is beyond your control. The Mayans see suffering as a given part of every life, but this is not to say that they are a dejected or disheartened culture, in fact it seems to be quite the opposite. Because Mayans accept suffering as an unavoidable aspect of their lives, they are adept at coping with suffering, especially through their faith and close-knit communities.

Further questions in the interviews with the participants were aimed at identifying the treatment aspect of depression or tristeza. Each person was asked if he or she has ever received mental healthcare, and all denied any formal treatment. But when I asked how they cope with the feelings, many people expressed ways of coping that could be described as strategies in psychotherapy. Many people discussed hope and faith in God and finding fulfillment in life through spirituality. Others explained that they have social relationships within communities that keep them going every day. My experience was that as a result of these things, one would be hard-pressed to find a socially isolated person amidst this way of being in relationship in every aspect of one’s life.
Mayan Medicinal Plants for Mood Disorders

God said, “See, I have given you every plant yielding seed that is upon the face of all the earth, and every tree with seed in its fruit; you shall have them for food.”

Genesis 1:29

Every year the Clínica Maxeña celebrates the Jornada Mundial del Enfermo, or the World Day of the Sick. This day, instituted in May of 1992 by Pope John Paul II, is a time to reflect on and discuss the complex problems associated with health. In a talk given to the Clinica Maxeña on the fifteenth World Day of the Sick, the bishop of the region discussed the topic of the year: Fragility and health: Horizons of hope. In his talk, he outlined how the fragility of the human person can be seen physically, intellectually, morally, and spiritually. He discussed how only in treating all of these aspects of the human person in our hospitals can we be “gente de salud,” or people of health (Bishop of the region, name unverifiable May 23, 2007).
This talk epitomized the mission of the Medicinal Plant Clinic, which is to treat the whole human person. In an attempt to understand this different approach to medicine and this different way of viewing depression in Guatemala, I conducted many interviews with the director of the Medicinal Plant Project on the treatment of mood disorders.

I could barely get beyond my first question before the director was quoting Genesis. He explained that the plant project’s philosophy is that God gave men all the plants on the earth for our use and that man can be healed with those plants without ever needing any other form of medication. With approximately 102 plants that are grown at the mission, the director believes that they can treat most ailments.

The director also explained some of the ways that the idea of treating the whole person is put into practice at the Medicinal Plant Clinic. When a patient comes in for a visit, the clinic educates on topics such as eating the right foods, getting the right nutrients, detoxifying the body, building the immune system, and rejuvenating the circulation system through exercise. Beyond these basic principles of health, the director also stressed the importance of counseling the patient if s/he is in distress and making sure that the patient has a support system in his or her home community so that nobody is isolated. Ensuring that the patient has a social support system in the home community becomes especially important when the patient is diagnosed with a mood disorder.

The main examination technique utilized at the Medicinal Plant Clinic is called the “bio-energy exam.” In this assessment scenario, there are two doctors present, both trained in the bio-energy technique, who determine through the energy in the patient’s body which plant is appropriate for the particular patient. First the patient explains the symptoms that s/he is experiencing. The examiner then brings forth an array of plants
that are known to treat the symptoms the patient has. Then, using a thin rod similar to a pencil but nearer to 20cm in length, the examiner places the tool’s end firmly against a bio-energy point. There are several bio-energy points on the body as can be seen in the diagram below. The most common bio-energy point utilized is the “timo,” which is the soft spot near the base of the collar bone.

Diagnostic Points of the Bioenergy Exam

Next, plants are placed one by one and in combinations in one of the patient’s hands until one plant, or combination of plants, is found by the examiner to have the right energy. This energy is determined by how easily the examiner’s free hand opens when plants are placed in the patient’s hands. This is illustrated below.
When the hand is said to open freely, as shown above left, the body has accepted the plant. When the hand does not open freely, as shown above right, the body denies the plant.

This approach is obviously far outside the mainstream biomedical model’s approach to treating illness and is clearly something that is not to be immediately understood empirically or scientifically. However, one point to take away from this approach is that it treats each person who walks into the clinic as a unique patient with different medicinal needs. Even if different patients have the same symptoms, each person has a unique energy and background that must be assessed and discussed before prescribing medicine.

The holistic scheme of Mayan wellness governs the approach to mood disorders, as they are treated in an identical way to any other illness as outlined above. The director explained that the clinic sees only a few people a year who come specifically for a health concern solely related to mood. More often, he said, people come for other health problems, and in the initial inventory the examiner determines that there is an underlying psychological health disturbance that needs to be treated.

Since the word depression is not used in the region I was in, there are no treatments specific to this illness. In order to understand which plants are used for depression I listed
the 21 symptoms of depression used in the BDI-II and asked the director of the Medicinal Plant Clinic which plants are used to treat for those symptoms. He responded that there are 14 plants used to treat three main illnesses with characteristics of depression: susto, espanto, and tristeza. Susto is a culturally specific illness unique to the Latin American culture that means someone has suffered from a fright or a trauma. According to the director of the Medicinal Plant Clinic, susto is characterized by trembling, acting in a strange way, not being able to sleep, yelling or screaming, and headache. Susto is usually accompanied by anxiety or nervousness. Espanto is another culturally specific illness that can encompass a wide array of symptoms and is often described interchangeably with susto, but the director describes that espanto is when a person experiences a soul-loss. Finally, tristeza, as described earlier, is an illness that means sadness.

Following is a list of the 14 plants the director told me are used to treat the symptoms of depression as described in the DSM-IV. These plants all treat for illnesses related to depression symptoms, though some are described as being used for susto in particular. Because of the way the Medicinal Plant Clinic treats illness, somebody who suffers a trauma may be given a different plant than someone with the same symptoms who did not suffer from a trauma. Each description lists the illnesses that the plant is used for, including illnesses besides those listed above. The description includes medicinal purposes the Mayans have identified beyond treating illnesses linked to mood. In addition, each description lists any research found in the mainstream medicinal plant references on the uses of that plant in relation to mood disorders.
1. Basil

Common name Spanish: Albahaca

Scientific name: Ocimum basilicum

In the treatment of mood disorders the Medicinal Plant Clinic reports using Basil as a treatment for tristeza, as well as susto. Other Mayan uses include treatment of bacterias, ojeado (evil eye), menstrual problems, vaginal infections, diarrhea, and throat irritation.

According to the Encyclopedia of medicinal plants, basil has a sedative effect and has been found to treat nervous irritability, depression, anxiety, and insomnia (Chevallier, 1996, p. 238).

The Physician's desk reference for herbal medicine (PDR) suggests that while there are no proven uses, the oils in basil have been used to treat depression (2004, p. 65).

2. Carnation

Common name Spanish: Clavel

Scientific name: Dianthus caryophyllus

The Mayan Medicinal Clinic reports using clavel as a treatment for the symptoms of tristeza. There are no listings for the uses of carnations in relation to the symptoms of mood disorders in any mainstream western reference books.
3. Egyptian Rue

Common name Spanish: Ruda
Common name Quiché: Rura
Scientific name: *Ruta chalepensis*

In the treatment of mood disorders, the medicinal plant clinic reports using Egyptian Rue as a treatment for sadness as well as *susto*.

Additionally, the Mayans use Egyptian Rue as an intestinal anti-parasitic, a repellent, to replenish nutrients, to treat colitis caused by anger, *ojead*, and a relaxant. There are no listings for the medicinal uses of *ruda* in relation to mood disorders in any mainstream western encyclopedias.

4. Guinea henweed, guinea henleaf, gully root

Common name Spanish: Apacin

Scientific name: *Petiveria alliacea*

The Medicinal Plant Clinic reports using *apacin* for symptoms of *susto* and *espanto*. *Apacin* is also used for rheumatism, sinus infections, and convulsions.

There are no listings for the medicinal uses of *apacin* in relation to mood disorders in any mainstream western encyclopedias.
5. Ixbut (no common name in English)

Common name Quiché: Ixbut

Scientific name: *Euphorbia lancifolia*

The Medicinal Plant Clinic reports using Ixbut for *susto* symptoms. There are no listings for the medicinal uses of Ixbut in relation to mood disorders in any mainstream western encyclopedias.

6. Lemon Grass

Common name Spanish: Te de Limon

Scientific name: *Cymbopogon citrates*

The Medicinal Plant Clinic uses lemon grass as a treatment for *tristeza* to calm and relax the person. Lemon grass is either taken as a tea, or for another tranquil effect, the patient may often be bathed in the sweetly scented lemongrass allowing the aroma and saturation of the plant to relax them. The Mayans also use lemongrass for high blood pressure, fever, and cold.

The *Encyclopedia of medicinal plants* reports that lemon grass is usually taken as a soothing tea, especially to relax the muscles (particularly of the gut) (Chevallier, 1996, p.196).

In the *PDR* lemon grass is listed as a treatment recommended by aroma therapists to relieve stiffness and for a calming effect. The studies on lemon grass have shown to be inconclusive. While some studies have reported that lemon grass does not improve sleep
or anxiety, other studies report a hypotensive result from this plant. Further studies have found lemon grass to have an anti-inflammatory effect different from aspirin and related drugs (2004, p. 506).

7. Lemon tree

Common name Spanish: Arbol de limon

Scientific name: *Citrus limon*

The Medicinal Plant Clinic states that many different parts of the lemon can be used in different ways to calm nervousness and relax the body. Lemons can also be used for cold, headache, gas, rheumatism, dysentery, and kidney stones.

The *Encyclopedia of medicinal plants* states that in Spanish popular medicine, there have been so many uses that entire books have been written about it. The encyclopedia states that in general lemon is helpful in maintaining overall health (Chevallier, 1996, p. 81).

The *PDR* states that along with many rumored but unproven uses of lemon, it is known to be a source of vitamin C and effective as an anti-inflammatory (2004, p. 501).

8. Linden or Lime Tree

Common name Spanish: Tilo

Scientific name: *Tilia spp.*

In the treatment of mood disorders the Mayan clinic reports using *Tilo* for *tristeza.* It is used for its relaxant properties.
According to the *Encyclopedia of medicinal plants* Linden works as a sedative remedy by relieving tension and stress, calms the mind, and allows for easy sleep. The encyclopedia reports that it is an excellent remedy for stress and panic and specifically treats nervous palpitations. Linden is also commonly used to lower high blood pressure especially when emotional factors are involved (Chevallier, 1996, p. 275).

The *PDR* reports that the silver linden flower has a possible anxiolytic sedative effect. The flavonoid compounds in the flower are said to be responsible for this anti-stress effect (2004, p. 521).

9. Marigold

Common name Spanish: Flor de muerto

Common name Quiché: K’exwach

Scientific name: *Tagetes erecta* (African Marigold), *Tagetes patula* (French marigold), or *Calendula officinalis* (marigold)

In the treatment of mood disorders the Medicinal Plant Clinic reports using marigold for *tristeza, susto*, and *espanto*. Other ailments for which the Mayans use marigold include internal gas, a de-parasitic, clearing up skin blemishes, and *ojeados*.

According to the *PDR*, calendula’s colorful flowers were thought to lift the spirits and encourage cheerfulness. The *PDR* lists marigolds as having therapeutic properties, one of them being its use for various inflammatory conditions (2004, p. 545)
10. Orange

Common name Spanish: Naranja

Scientific name: *Citrus spp.*

The Mayan Medicinal Clinic reports using *la naranja* as a treatment for the symptoms of *susto, espanto,* and *tristeza.*

The *PDR* suggests that the Bitter Orange (*Citrus aurantium*) has medicinal uses as a neurostimulant, though that is not confirmed. Other uses are for nervous complaints, as a sedative for nervous tension and sleeplessness, as well as for a loss of appetite (2004, p. 88).

11. Passionflower

Common name Spanish: Granadilla

Scientific name: *Passiflora incarnata*

The Mayan Medicinal Clinic reports using granadilla for symptoms of *tristeza.*

The *Encyclopedia of Medicinal Plants* reports that this plant is valued as a sedative and for its tranquilizing properties, which have long been used in Central and North America, especially for insomnia and hysteria. Research has shown that the plant does affect the central nervous system, but the cause of this sedative, tranquilizing, and sleep-inducing effect has not been identified. The sedative effect is widely acknowledged to be used for anxiety, tension, irritability, insomnia and to reduce many states of nervous over-activity and panic (Chevallier, 1996, p. 117).

According to the *PDR,* the glycosides in passionflower have been shown to act as a hypotensive. The *PDR* expressed similar uses for nervousness and insomnia. The
authors state that passion flower is used internally for depressive states of hysteria, general nervous agitation, and insomnia (2004, p. 622).

12. Peppermint

Common name Spanish: Chicle leñoso, Menta leñoso, and Menta

Scientific name: *Mentha piperita* (Labiatae)

The Medicinal Plant Clinic reports using *menta* as a treatment for *tristeza, susto*, and *espanto*. In particular, the clinic reports that *menta* is a relaxant especially for nervousness that can be used for those people having sleeping difficulties.

The *PDR* states that peppermint has a mild sedative effect, which in studies has shown to be effective in relieving headaches, muscles spasms, and other pain (2004, p. 628).

13. Rosemary

Common name Spanish: Romero

Scientific name: *Rosmarinus officinalis*

The Medicinal Plant Clinic reports using *romero* for symptoms of *susto* and *espanto*.

In the *Encyclopedia of Medicinal Plants* rosemary is stated to have a longstanding reputation as an “invigorating herb, imparting a zest for life” (Chevallier, 1996, p. 125). According to this
Encyclopedia, research has shown that rosemary is a stimulant and also has an anti-inflammatory effect. The herb is suggested to be a circulatory stimulant that is a “warming herb” supposed to stimulate circulation of blood to the head. Rosemary is also proposed to be a restorative herb, capable of helping the body recover from long-term stress and chronic illness. Lastly, rosemary is thought to have an uplifting capacity especially for those who are not actually ill but who are stressed and “failing to thrive.” The encyclopedia pronounces its value as an herb that raises the spirits and is useful for mild to moderate depression (Chevallier, 1996, p. 125).

The PDR states that rosemary has been used traditionally in folk medicine for many things including states of exhaustion (2004, p. 690).

14. Willow leaf groundsel or Barkley’s Ragwort

Common name Spanish: Chilka

Scientific name: Senecio salignus

The Medicinal Plant Clinic uses chilka for susto, espanto, and ojeado. There are no listings in mainstream western encyclopedias for the medicinal uses of chilka in relation to mood disorders.
Discussion

There are several conclusions that could be drawn from the results of the BDI-II study regarding the validity and significance of the application of this test. Choosing between these possible conclusions demands considering the total meaning of both quantitative and qualitative data.

One assumption that could be drawn from the results of this thesis is that the BDI-II may not be an accurate measure of depression in the Mayan culture, based on the obvious difficulties in cross-cultural analysis. The fact that 84% of the sample showed higher than normal depression levels suggests the possibility that the BDI-II is inaccurate. Only 16% of the population was in the normal range of depression, which is much lower than would be expected from a random sample of a population.

The unusually high results of the BDI-II elicit a discussion on the way in which an illness may be uniquely defined and affected by a particular culture. The results of the BDI-II demonstrate the difference in cultural understandings of depression. Figure 3 shows how the Guatemalan sample is irregular in subgroup means as compared to the college student normal group and the psychiatric outpatients, which is important in questioning the validity of the BDI-II in Guatemala. Both the normal group and the outpatients demonstrate validity in subgroup scores, but this is not the case in the Guatemalan sample whose subgroup means are highly abnormal in comparison. (see figure 3 results). Figure 4 analyzes the highest mean responses of the 21 subgroup symptoms, and it shows that the Guatemalans report severity of different symptoms than the psychiatric outpatients. While this may not say much as depression tends to vary by person, it is noteworthy that the symptom rank differs a great deal. Further research into
the culture such as the qualitative observations I recorded can help to explain the meaning of the variations in symptoms reported by the Mayan people.

The results extrapolated from the BDI-II indicate that these people experience depression in a different way. Suffering is such an every day experience of life for the Mayan people that on a diagnostic tool such as this, questions about sadness, loss of hope, and loss of pleasure may not accurately diagnose for depression. Though they may be a people with many joys and much peacefulness in life, on a test they may still respond with increased reports of depressive symptoms. Therefore we could conclude that the results of the BDI-II are meaningful in spite of the cultural limits of the test's validity, and can actually point out the differences in cultural understandings of depression.

Although the BDI-II may not be as accurate a measure of depression in a cross-cultural context as it is intra-culturally, there is still a degree to which the results can be compared to a normal group. It is a fair conclusion to make that it measures a deep sadness of some sort in the Mayan culture because it is not as if the participants did not understand what crying means or what loss of pleasure means. The subjects still reported the symptoms and the medicinal plant clinic treats for symptoms, recognizing a group of symptoms similar to those of a disorder. The results of the BDI-II indicate not only cross-cultural differences in the experience of depression but also similarities, which can serve as the ground of meaningful comparison between the sample taken and normal groups.

Upon accepting the essential validity of the results, the discussion turns to the question of the significance of the results. In the discussion it is important first to recognize the possibility of methodological error that may skew the soundness of the
conclusions. One way this study could have been more accurate is if there were equal numbers of men and women participants. Due to cultural conditions, this was not obtainable. Men were usually out working in the fields during the day, and this was the time of day my interviews were conducted. Additional methodological errors could have resulted from the potential inadequacy of 49 persons as a sample size for BDI-II data. The language barrier represents another possible methodological error. While most of the people I interviewed spoke Spanish, many also preferred their native language of Quiché. I trained an educated person who could translate from Quiché to Spanish for me, but the complications of double translation are obviously confounding variables.

Beyond the questionable validity of the BDI-II data and the possible skewed results due to error in methodology, there is still lasting significance. Based on the culture and based on the results beyond the BDI-II, there is still important discussion that is not based in a scientific 1:1 comparison. It does not seem that the BDI-II can be used as a perfect objective comparison between groups because it would be unrealistic to say that 84% of Guatemalans suffer from depression as opposed to only 12% of men and 20% of women in North America who are estimated to suffer from depression at some point in their lifetime (Kessler, 2003, p. 3096). However, as a subjective holistic observation, it does seem that there is a higher prevalence of depression in Guatemala. This is supported not only in the statistical data but in observation as well.

The natural question becomes why depression is so prevalent. As a holistic understanding of depression in Guatemala, my results seem to suggest that higher rates of mood disorders are intimately linked to psychosocial factors and ethnicity.
The link between anxiety and depression has long been established. In the *International encyclopedia of psychiatry, psychology, psychoanalysis, and neurology* published in 1977, the author states in regards to anti-anxiety drugs that, “Since many psychoneurotic patients are very anxious and only moderately depressed, it would be reasonable to assume that they might respond to drugs in this group that would be effective against depression by eliminating the anxiety” (Van Nostrand Reinhold Company, p. 58). Furthermore, in subsequent explanations about psychotherapy and the use of other drugs, the author consistently refers to reducing anxiety and agitation.

Anxiety is a reaction to stress, which is generally described as a reaction to environmental cues. Therefore the link between depression and anxiety highlights the importance of psychosocial factors as an important element in the etiology of depression. The observation that many of the medicinal plants used by the Mayans to treat symptoms of depression also treat symptoms of anxiety supports this connection and further demonstrates the link between depression and psychosocial causes for the Mayan people.

The connection between psychosocial factors, stress, and depression is the subject of extensive empirical research. There are many theories on the physiological etiology of depression, but not very many emphasize the role that psychosocial factors and ethnicity may have. The most well known theory of the etiology of depression is called the monoamine deficiency hypothesis, which emphasizes the role that lower levels of neurotransmitters plays in those with depression. The monoamine deficiency hypothesis effectively ignores the role of psychosocial factors.

However, another theory of depression called the HPA axis theory suggests that depression may be closely linked to chronic elevated stress levels throughout life. The
HPA axis theory focuses on possible abnormalities that may occur in the Hypothalamic-Pituitary-Adrenal axis (HPA axis). This axis is what is activated in the stress response. These elevated stress levels are suggested to be most likely caused by a triggering childhood event or a poor psychosocial background.

In a brief explanation of the HPA axis, a stressful event reaches the amygdala, which sends the signal to the hypothalamus, which then triggers the release of corticotropin-releasing-hormone (CRH) from the hypothalamus. From there the CRH as chemical messenger alerts the anterior pituitary to release adrenocorticotropic hormone (ACTH). Finally the adrenal glands are stimulated by ACTH to release cortisol into the bloodstream. With the release of cortisol the brain is alerted to release more neurotransmitters. In a healthy person, the negative feedback loop of the HPA axis can then also alert the hippocampus to inhibit the release of CRH to inhibit excessive cortisol release (Freberg, 2006, p.469) It is important to understand this pathway in order to understand the relationship it may have to depression.

In a review article on the mechanisms of depression, Belmaker and Agam cite many studies discussing the link between depression and stress and possible psychosocial factors. According to Belmaker and Agam, numerous studies have shown that cortisol and CRH can be linked to patients with depression (as cited in Merali, Z. et al., 2004; MacMaster F.P. et al., 2006; & Burke H.M., Davis M.C., Otte C., & Mohr D.C, 2005). Even more attention-grabbing are the studies that have linked high levels of CRH with a history of physical or sexual abuse (as cited in Lee R., Geracioti T.D. Jr., Kasckow J.W., & Coccaro E.F, 2005). Moreover, in studies done on rats, tricyclic antidepressant treatments aimed at increasing monoamines have demonstrated a reversal of the
depressive symptoms (as cited in Bhansali P., Dunning J., Singer S.E., David L., & Schmauss C, 2007). It is apparent and well-researched that increasing monoamines has an affect on the hypothalamic-pituitary-cortisol system and can even reverse the effects of long-term stress (as cited in Holsboer F., 2000). While there are studies that assert that cortisol levels in the blood do not correlate with a diagnosis of depression (as cited in Burke, H.M. et al., 2005), there are compelling counter-suggestions, one being that the depression may not necessarily be due to high cortisol levels, but rather due to a chronic mild elevation in cortisol (Belmaker & Agam, 2008). The bottom line is that there is no clearly defined physiological relationship between stress and depression. (Belmaker & Agam, 2008).

Another major theory on depression is related to stress and the suppression of neurogenesis. High levels of glucocorticoids suppress neurogenesis, which occurs most prominently in the hippocampus. Interestingly enough, MRI's of patients with depression show a decreased hippocampus size (as cited in MacQueen G.M. et al, 2003), demonstrating a very likely link between stress and depression. Studies have shown that antidepressant medications counter suppression of neurogenesis, the creation of new neurons, caused by stress (as cited in Reagan L.P. et al., 2004).

Another piece of research that is particularly applicable to stress and depression, is related to a neurotrophic peptide called the brain-derived neurotrophic factor (BDNF). According to Belmaker and Agam, BDNF is a neuropeptide important for axonal growth, neuronal survival, and synaptic plasticity. Studies have demonstrated that levels of BDNF are affected by stress and cortisol (as cited in Kozlovsky N. et al., 2007; Angelucci F., Brenè S., & Mathé A.A., 2005). In a study done on patients who
committed suicide, researchers found that BDNF was reduced in their hippocampus (as cited in Karege F., Vaudan G., Schwald M., Perroud N., & La Harpe R., 2005). Additionally, just as with the neurogenesis and the HPA axis system, the use of antidepressants modulates the suppressed levels of BDNF and other growth factors (as cited in Karege F. et al., 2005; Chen B., Dowlatshahi D., MacQueen G.M., Wang J.F., & Young L.T., 2001).

One additional theory related to stress and depression is the inflammation theory. In his book *The instinct to heal*, Dr. David Servan-Schreiber states that stress causes an inflammatory reaction and since a long period of stress usually precedes depression, it may be that depressive symptoms are directly caused by stress-related inflammation. (2004, p. 137).

My research strongly supports the correlation between stress and depression. The Mayan psychosocial reality is one of pervasive violence and instability, the BDI-II test demonstrated an elevated level of depression among this culture, and Mayan treatments for the symptoms of depression are characterized by also treating for anxiety and stress related symptoms, as well as the inflammation response. The psychosocial reality of Guatemala is the clearest explanation for the elevated levels of depression, which I documented both qualitatively and quantitatively. Together, these results suggest a link between psychosocial factors and depression, which points toward theories of depression that correlate stress and depression. Such theories not only are supported by my results, but also strengthen the credibility of those results. Based on my results, it seems that there is a strong link between depression and stress which demonstrates the need for further research into this connection.
Conclusion

This thesis has described the culturally specific understanding of depression in Guatemala, and demonstrated how this understanding can benefit the discussion of the etiology and treatment of depression. The elevated prevalence of depression directs us to recognize that psychosocial factors play a leading role in the etiology of depression in Guatemala. The holistic view of the human person exemplified in Mayan treatment of mood disorders reveals the necessity to consider all aspects of the person when treating depression.

The reality of depression in Guatemala is important not only for a discussion on the etiology of mood disorders, but provokes us to acknowledge the deeper realities of conditions of life for people in developing nations, the profuse effects of violence, and the concrete results of foreign policy. An understanding of depression as a result of psychosocial factors has implications outside the realm of psychology, the DSM-IV and the treatment of symptoms. The etiology and treatment of depression must base their conclusions on more than an analysis of symptoms, and modern psychology must engage depression as a holistic reality.
“A problem cannot be solved on the level of consciousness from which it was created.”

-Albert Einstein
Appendix A: BDI-II Spanish
Instrucciones: Este cuestionario consiste en 21 grupos de frases. Lea con cuidado cada grupo de frases y luego seleccione una frase en cada grupo que mejor describa la manera en que usted se ha sentido durante las últimas dos semanas, incluyendo el día de hoy. Encierre en un círculo el número al lado de cada frase que usted escoja. Si hay varias frases dentro de un grupo que parecen aplicarse a su situación con la misma relevancia, encierre en un círculo el número más alto de ese grupo. Asegúrese de no escoger más de una frase por cada grupo de frases, incluyendo el número 16 (Cambios en el Patrón de Sueño) o el número 18 (Cambios de Apetito).

1. Tristeza
   0 No me siento triste.
   1 Me siento triste la mayor parte del tiempo.
   2 Estoy triste todo el tiempo.
   3 Me siento tan triste e infeliz que no puedo soportarlo.

2. Pesimismo
   0 No me siento desanimado(a) acerca del futuro.
   1 Me siento más desanimado(a) acerca de mi futuro que de costumbre.
   2 No espero que las cosas me salgan bien.
   3 Siento que mi futuro no tiene esperanza y que las cosas solamente van a empeorar.

3. Fracaso
   0 No me siento como un fracaso.
   1 He fracasado más de lo que debería.
   2 Mirando a mi pasado, veo muchos fracasos.
   3 Siento que como persona, soy un fracaso total.

4. Falta de Placer
   0 Obtengo tanto placer como antes de las cosas que disfruto.
   1 No disfruto de las cosas tanto como antes.
   2 Obtengo muy poco placer de las cosas que solía disfrutar.
   3 No puedo obtener ningún placer de las cosas que antes disfrutaba.

5. Sentimientos de Culpa
   0 No me siento particularmente culpable.
   1 Me siento culpable por muchas cosas que he hecho o debería haber hecho y no las hice.
   2 Me siento bastante culpable la mayor parte del tiempo.
   3 Me siento culpable todo el tiempo.

6. Sentimientos de Castigo
   0 No siento que estoy siendo castigado(a) por la vida.
   1 Siento que quizá esté siendo castigado(a) por la vida.
   2 Espero ser castigado(a) por la vida.
   3 Siento que estoy siendo castigado(a) por la vida.

7. Auto-Desprecio
   0 Me siento igual que siempre acerca de mi persona.
   1 He perdido la confianza en mí mismo(a).
   2 Me siento decepcionado(a) conmigo mismo(a).
   3 No me gusta quien soy.

8. Auto-Crítica
   0 No me critico o me culpo a mí mismo(a) más que de costumbre.
   1 Me critico a mí mismo(a) más de lo que solía hacerlo.
   2 Me critico a mí mismo(a) por todos mis defectos.
   3 Me culpo a mí mismo(a) por todo lo malo que sucede.

9. Pensamientos o Deseos Suicidas
   0 No tengo ningún pensamiento de matarme.
   1 He tenido pensamientos de matarme, pero no lo haría.
   2 Quisiera matarme.
   3 Me mataría si tuviera la oportunidad.

10. Llanto
    0 No lloro más de lo que solía llorar.
    1 Lloro más de lo que solía llorar.
    2 Lloro por cualquier cosa.
    3 Siento que aunque quiero llorar, no puedo.
11. **Agitación**
   0 No estoy más inquieto(a) o tenso(a) que de costumbre.
   1 Me siento más inquieto(a) o tenso(a) que de costumbre.
   2 Estoy tan inquieto(a) o agitado(a) que me es difícil quedarme quieto.
   3 Estoy tan inquieto(a) o agitado(a) que tengo que estar moviéndome constantemente o haciendo algo.

12. **Falta de Interés**
   0 No he perdido el interés en otras personas o actividades.
   1 Ahora estoy menos interesado(a) en otras personas o actividades que antes.
   2 He perdido mucho interés en otras personas o actividades.
   3 Se me hace difícil tratar de interesarme en cualquier cosa.

13. **Indecisión**
   0 Tomo mis decisiones tan bien como siempre.
   1 Se me hace más difícil tomar decisiones que de costumbre.
   2 Ahora tengo mucha más dificultad en tomar decisiones que de costumbre.
   3 Tengo dificultad en tomar cualquier decisión.

14. **Falta de Valor Personal**
   0 No siento que soy inservible.
   1 No me considero que sea tan valioso y útil como antes.
   2 Me siento inservible en comparación con otras personas.
   3 Me siento completamente inservible.

15. **Falta de Energía**
   0 Tengo tanta energía como siempre.
   1 Tengo menos energía de la que solía tener.
   2 No tengo suficiente energía para hacer muchas cosas.
   3 No tengo suficiente energía para hacer nada.

16. **Cambios en el Patrón de Sueño**
   0 No he experimentado ningún cambio en mi patrón de sueño.
   1a Duermo algo más que de costumbre.
   1b Duermo algo menos que de costumbre.
   2a Duermo mucho más que de costumbre.
   2b Duermo mucho menos que de costumbre.
   3a Duermo todo el día.
   3b Despierto 1-2 horas más temprano y no puedo volver a dormir.

17. **Irritabilidad**
   0 No estoy más irritado(a) que de costumbre.
   1 Estoy más irritado(a) que de costumbre.
   2 Estoy mucho más irritado(a) que de costumbre.
   3 Estoy irritado(a) todo el tiempo.

18. **Cambios de Apetito**
   0 No he experimentado ningún cambio en mi apetito.
   1a Tengo un poco menos de apetito que de costumbre.
   1b Tengo un poco más de apetito que de costumbre.
   2a Tengo mucho menos apetito que de costumbre.
   2b Tengo mucho más apetito que de costumbre.
   3a No tengo nada de apetito.
   3b Tengo muchas ganas de comer todo el tiempo.

19. **Dificultades de Concentración**
   0 Me puedo concentrar tan bien como siempre.
   1 No me puedo concentrar tan bien como acostumbraba.
   2 Es difícil mantener mi mente en algo por mucho tiempo.
   3 Me doy cuenta que no puedo concentrarme en nada.

20. **Cansancio o Fatiga**
   0 No me canso o fatigo más que de costumbre.
   1 Me canso o fatigo más fácilmente que de costumbre.
   2 Estoy muy cansado(a) o fatigado(a) para hacer muchas de las cosas que antes hacía.
   3 Estoy muy cansado(a) o fatigado(a) para hacer la mayoría de las cosas que antes hacía.

21. **Falta de Interés en el Sexo**
   0 Recientemente no he notado ningún cambio en mi deseo sexual.
   1 Estoy menos interesado(a) en el sexo que antes.
   2 Ahora tengo mucho menos interés en el sexo que antes.
   3 He perdido el interés en el sexo por completo.
Appendix B: BDI-II Manual Score Interpretation

<table>
<thead>
<tr>
<th>Total Scores</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-13</td>
<td>minimal</td>
</tr>
<tr>
<td>14-19</td>
<td>mild</td>
</tr>
<tr>
<td>20-28</td>
<td>moderate</td>
</tr>
<tr>
<td>29-63</td>
<td>severe</td>
</tr>
</tbody>
</table>

References


