HEALTH AT THE MARGINS:

Distress and Illness after the 2005 Mudslide in

Santiago Atitlán, Guatemala

By

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AN UNDERGRADUATE THESIS

in

Anthropology

Submitted to the
Department of Anthropology
University of Pennsylvania

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2009

Figure 1
Health at the Margins

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ABSTRACT

The prolonged crisis recovery following the 2005 Guatemalan mudslide has embedded nearly 3 thousand Tz'utujil Maya *damnificados,* or victims, in a landscape of crisis and sustained structural asymmetry. In the impoverished village of Panabaj on the periphery of Santiago Atitlán, mudslide victims have lived in a makeshift relief camp for over three years since the disaster claimed approximately one thousand lives. This thesis, drawing upon 10 weeks of ethnographic fieldwork and 51 interviews, examines a) the social and economic stressors within the mudslide relief camp, b) the experience of distress among mudslide survivors, c) the shortcomings of medical and psychosocial interventions in relation to distress, and d) the belated relocation of mudslide survivors to a housing project and its effects on their health.

The mudslide and its aftermath have been internalized and expressed via a constellation of chronic somatizations that are categorized as *nervios.* Furthermore, health-seeking itineraries indicate that distress is increasingly medicalized throughout the community. Moreover, the relocation of survivors to government housing resettlement presents the real possibility that full recovery is illusory. Therefore, while Santiago Atitlán's community health leaders have recently organized a fledgling Mental Health Network, they have only begun to grapple with issues of chronic distress and the prolonged crisis recovery.

DEDICATION

Dedicado
a la memoria de las personas que han perdido la vida el 5 de octubre de 2005

y para
los sobrevivientes de Panabaj: que encuentren la salud, la paz y la felicidad
a pesar de las dificultades que se les atraviesen en el camino

ACKNOWLEDGEMENTS

The fieldwork for this thesis was funded by the Guatemala Health Initiative's Penn Hewlett Award for Innovation in International Offerings, and by the University Scholars Program at the University of Pennsylvania.

For their outstanding mentorship and kindness throughout my undergraduate years, I am grateful to Dr. Fran Barg, my thesis advisor, and to Dr. Claudia Valeggia.

Additionally, I thank Dr. Juan, Francisca, Chonita, Edwin, Dalila, Margarita and Doña Luz for helping to make this research feasible and unforgettable. My heartfelt appreciation goes to the warm and comedic Sapalú family, my Santiago Atitlán family: *gracias por todo y los extraño.* To *mis compañeras*, my fellow Guatemala Health Initiative student researchers, for all of our adventures. And to Tiago, *meu bem*, for all of your encouragement and affection.

Above all, I thank my parents for their love and support, and for the innumerable things they have taught me. *Los quiero mucho.*

INTRODUCTION

Theoretical Underpinnings

The village of Panabaj is located on the outskirts of Santiago Atitlán, a town of nearly 30,000 Tz'utujil Maya in the western highlands of Guatemala. Panabaj is indeed a place saturated with political, economic, and health concerns: it is a site of "compounding marginalities,"[1] or a borderland where peoples' everyday reality is structured by a violent and traumatic past. Conducting fieldwork in the Tzanchaj relief camp in 2008, nearly three years after a mudslide had devastated Panabaj and claimed over 1,000 lives, my inquiry has focused on the quiet brutality[2] that afflicts the survivors of the disaster. I have also worked to document their agonizing wait to be relocated to a housing resettlement from the makeshift shelters of the mudslide relief camp, located directly below the looming Volcano Tolimón from which the mudslides cascaded. Years into the aftermath, the men and women of the relief camp tend to express their experience of chronic distress via somatization. With under-implemented psychosocial support and the rapid medicalization of somatic expressions, the mudslide survivors are mired in an everyday, harsh reality of prolonged crisis recovery.

This thesis examines questions of distress, illness and marginality. To prime my analysis, the following section introduces several broad theoretical ideas that will guide my investigation of the social origins of illness among the mudslide survivors, as well as the ways in which subjectivity has been shaped by distress.

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[1] Byron Good et al, eds., *Postcolonial Disorders* (Berkeley: University of California Press, 2008), 3.
[2] Paul. Farmer, *Pathologies of Power* (Berkeley: University of California Press, 2003), xvi.

Critical Medical Anthropology

In his seminal article "Sociosomatics: The Contributions of Anthropology to Psychosomatic Medicine," Arthur Kleinman highlights the significant paradigm shift that took place upon the inception of the critical medical approach.[3] As anthropologists began to focus their investigations on the inextricable bond between illness and society, they began to witness how medical knowledge is a "socially-informed product of particular historical and cultural contexts."[4] Critical Medical Anthropology challenges us to understand disease as more than biological entities. Interrelating health and the economy, politics, and cultural norms and beliefs, medical anthropology "speaks of, and speaks from within, the complex intersection of social institutions and the bodies and selves of individuals."[5] Beyond the organic, pathological underpinnings of disease, Critical Medical Anthropology aims to illustrate the ways in which "political power and access to resources"[6] underlie determinants of health, as well as how various sectors of society are benefited – and jeopardized – by social, economic and health disparities. Illness not only has social consequences, but also social roots. Furthermore, while experiences such as poverty and violence significantly structure people's everyday realities, biomedicine has served to turn individuals into 'patients' that are "depersonalized sites of isolatable,

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[3] Arthur Kleinman and Anne E. Becker, "'Sociosomatics': The Contributions of Anthropology to Psychosomatic Medicine," *Psychosomatic Medicine* 60, no. 4 (1998).
[4] Soheir A. Morsy, "Political Economy in Medical Anthropology, in *Medical Anthropology Contemporary Theory and Method*, eds. Carolyn F Sargeant and Thomas M Johnson, (Westport: Praeger, 1996), 25.
[5] Lorna A. Rhodes, "Studying Biomedicine as a Cultural System," in *Medical Anthropology Contemporary Theory and Method*, eds. Carolyn F. Sargeant and Thomas M. Johnson (Westport: Praeger, 1996), 179.
[6] Peter J. Brown, Marcia C. Inhorn, and Daniel J Smith, "Disease, ecology and human behavior," in *Medical Anthropology Contemporary Theory and Method*, eds. Carolyn F Sargeant and Thomas M Johnson, (Westport: Praeger, 1996), 123.

treatable diseases." [7] This thesis employs a Critical Medical Anthropology approach in order to understand people as social beings who are embedded in complex networks of individual and collective experience.

Structural Violence

Paul Farmer uses the term *structural violence* to identify those major institutional forces that shape people's lives, and, in particular, their health. According to Farmer, classical anthropological scholarship has erroneously "misdiagnosed" poverty as a facet of cultural difference, neglecting to explore the larger macro-forces contributing to a population's situation, which include "extreme and relative poverty, social inequalities ranging from racism to gender inequality, and the more spectacular forms of violence that are uncontestedly human rights abuses."[8] Farmer views structural inequity as inherently violent, as it takes on a "pathogenic role"[9] that undermines a community, "generat[ing] a kind of quiet brutality."[10] Beyond reporting on the historically-given and economically-driven processes that conspire to constrain individual agency, it is moreover the task of the ethnographer to analyze the "meanings of suffering on people's everyday lives...how racism, cultural imperialism, marginalization, exploitation, and powerlessness shape people's identities."[11] Thus, following Farmer's prescription for ethnography, this thesis aims to "direct our focus to the total context of people's lives – to the wider 'social roots

[7] Merrill Singer and Hans Baer, eds., *Critical Medical Anthropology* (New York: Baywood, 1995), 73.
[8] Paul. Farmer, *Pathologies of Power* (Berkeley: University of California Press, 2003), 8.
[9] Ibid, 20.
[10] Ibid, vxi.
[11] Ibid, 264.

of disease – and particularly to the deleterious elements in... societies of violence, inequity, and marginalization."[12]

Subjectivity

Recent meditations on *subjectivity* have illuminated this concept as a powerful means of examining "the complex ways in which people's inner states reflect lived experience within everyday worlds, as well as within temporary spaces and transitions – moments of crisis and states of exception."[13] While theorists within Critical Medical Anthropology have often struggled to adequately link the psychological and social dimensions of an individual's life — the "most intimate forms of everyday experience"[14] — subjectivity emerges as a strategy of "belonging simultaneously to large-scale events and to familial and political-economic networks."[15] Whereas biomedicine is criticized for its reliance on mind and body dualism, lacking a vocabulary to relate mind, body, and society[16] and failing to "conceptualize a 'mindful' causation of somatic states,"[17] subjectivity has come to the fore as a means of connecting mind and body, as well as providing analytic tools to bring renewed attention to violence, hierarchies and other means of subjecting the subject.[18] Stemming from a series of workshops at Harvard University's Department of Social Medicine, Arthur Kleinman, João Biehl and Byron Good's recent volume *Subjectivity* (2007) claims that "'the body' has reemerged in

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[12] Ibid.
[13] João Biehl, Byron Good, and Arthur Kleinman, eds., *Subjectivity* (Berkeley: University of California Press, 2007), 5.
[14] Byron Good et al, eds., *Postcolonial Disorders* (Berkeley: University of California Press, 2008), 2-3.
[15] João Biehl et al, 30.
[16] Margaret Lock and Nancy Scheper-Hughes, "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology," *Medical Anthropology Quarterly* 1, no. 1 (1987): 48.
[17] Ibid, 47.
[18] Byron Good et al, eds., *Postcolonial Disorders* (Berkeley: University of California Press, 2008), 2.

anthropological analysis…as a privileged heuristic to historical and social processes." [19] The body is seen to mediate "medico-scientific formations, political economy, and social networks" as well as "psychological interiority." [20] Ethnographies of the body have since underscored somatic processes as central to our understanding of how distress, violence and political economy are mapped onto individual bodies and social collectivities. Thus, at its core, this thesis strives to understand how the body speaks to the lived experience of the survivors of the 2005 mudslide in Santiago Atitlán, as well as how the body is subjected to political, social and economic violence and power, and how inequality is manifested in the body.

Marginalization

Writing "at the margin," Arthur Kleinman contends that ethnography, belonging to the "no-man's-land" between science and the humanities,[21] is a powerful tool for "representing pluralism, reflexivity, and uncertainty…to resist the positivism, the reductionism, and the naturalism that biomedicine and, regrettably, wider society privilege." [22] Just as all of the anthropologists cited above have conducted fieldwork in "borderlands," or in contexts of "contradiction and disorder," [23] my fieldwork has taken me to what Paul Farmer would term "a community on the edge." [24] Drawing up the work of these and other anthropologists, I intend for this thesis to reflect my "descent into 'the

[19] Biehl, 8.
[20] Ibid.
[21] Arthur Kleinman, *Writing at the Margin: Discourse Between Anthropology and Medicine* (Berkeley: University of California Press, 1995), 193.
[22] Ibid, 195.
[23] Byron Good et al, eds., *Postcolonial Disorders* (Berkeley: University of California Press, 2008), 22.
[24] Paul. Farmer, *Infections and Inequalities: The Modern Plagues* (Berkeley: University of California Press, 1999), 19.

ordinary" [25] among the mudslide survivors in Panabaj. Since the mudslide disaster happened three years ago, very little has been written regarding the experience of the mudslide survivors and their suffering has grown increasingly invisible. This thesis aims to combine theory with the immediacy of the mudslide survivors' lives and struggles during the prolonged disaster aftermath. While anthropologists have been criticized for transforming people and profound human experience into "remote abstractions, discursive forms, or subject positions,"[26] I strive to stay true to the research conducted in 2008. "The important thing about the anthropologist's findings," Clifford Geertz wrote, "is his complex specificity, his circumstantiality." [27]

Thesis Outline

Chapter I, A Landscape of Distress, provides an introduction to Santiago Atitlán, located in the peripheries of Guatemala and marked with the legacy of trauma and crisis. After contextualizing the mudslide event, this chapter presents an overview of the major stressors that structure life inside the mudslide relief camp for the mudslide survivors.

Chapter II, The Body Bears Witness, begins with an exploration of the somatic expressions of mudslide survivors. This chapter then traces the itineraries of health-seeking that mudslide survivors pursue in order to "treat" the somatization of distress. Furthermore, this chapter not only considers the ways in which somatization is

[25] Veena Das, *Life and Words: Violence and the Descent into the Ordinary* (Berkeley: University of California Press, 2007), 5.

[26] Biehl et al, 13.
[27] Clifford Geertz, *The Interpretation of Cultures* (New York: Basic Books, 1973), 23.

medicalized, but also how such medicalization shapes doctor-patient relationships in Santiago Atitlán's various healthcare facilities and also spurs mudslide survivors to look toward self-medication as a more satisfying management of distress and uncertainty.

Chapter III, Reexamining Priorities: the Rise of the Red de Salud Mental, considers the recent history of psychosocial intervention in both the mudslide relief camp and throughout Santiago Atitlán. The purpose of this chapter is to probe what 'mental health' means in the Tz'utujil Maya community, how psychosocial programs have succeeded and failed to meet the needs of the community, and what role the nascent Mental Health Network is creating for itself in this context. Finally, this chapter points toward a delineation of future psychosocial interventions for more effectively utilized mental health service in Santiago Atitlán.

Finally, **Chapter IV**, (Dis)Integration: Relocation and the Possibility of Recovery, delves into the organizing that has taken place among the mudslide survivors in order to direct the housing resettlement project. Analyzing this mobilization as a mode of resisting unaccountable local and state governments, this chapter also traces the subsequent 'community' division over the issue of relocation. Furthermore, this chapter assesses mudslide survivors' expectations of their future lives in Chuk'muk, and ends with the perspectives of the first residents of the newly-opened relocation settlement.

METHODS

From June until mid-August 2008, I was one of ten Penn student researchers participating in the Penn-Hewlett Guatemala Health Initiative's ethnographic inquiry into the healthcare beliefs and practices of the Tz'utujil Maya population of Santiago Atitlán, Guatemala. The Guatemala Health Initiative (GHI), a multidisciplinary research, education, and service program consisting of student and faculty researchers from Penn's Schools of Medicine and Nursing, and the Department of Anthropology, seeks to develop community-based health programs in the Western Highlands of Guatemala. Like many other Mayan indigenous communities in the region, Santiago Atitlán suffers extremely high rates of maternal and infant mortality, presenting a dramatic challenge for public health officials. While this health issue was the main focus of GHI's research in Summer 2008, my individual research task aimed to explore mental health in this community. As GHI had only begun to touch upon the complexity of this issue across the Santiago Atitlán population, my fieldwork aimed to provide an in-depth portrayal of the lived experience of the victims of the 2005 Hurricane Stan mudslide.

Constructing a Field Site

In 2005, my freshman year at Penn, I had read about the "Guatemalan mudslide" in the newspaper and attended several events on campus to fundraise for the victims. I could not have imagined that in a few short years I would spend 2.5 months immersed in a study of the prolonged aftermath of this disaster. When I arrived in Santiago Atitlán in

2008, my first challenge was to grapple with how I would approach the social impact and cultural meaning of this event in the lives of the mudslide victims, and to where and to whom I would go to gather this information. As I began sketching the complex individual, social, and political transformations of this question over the course of 10 weeks of immersion, a "field site" within Santiago Atitlán emerged. Participant-observation took me to Santiago Atitlán's various health institutions: the Centro de Salud is the Guatemalan Ministry of Health's free local clinic; the Hospitalito is a small-scale nongovernmental hospital facility staffed by both Guatemalan and international health practitioners and funded through international partnerships; the Puesto de Salud is a free health outpost located within the mudslide relief camp; various community *farmacias*, or pharmacies, offer health guidance and deliver injections; and additional community spaces, such as the headquarters of the volunteer firefighters and the local branch of the Guatemalan Red Cross, were meeting and workshop spaces for the Red de Salud Mental, or Mental Health Network. Every day I moved among these spaces, conversing with patients and health practitioners, being invited into nurse's stations and social work offices, sitting in waiting areas with community members, etc. Building experience upon experience, the scope of my research was shaped and reshaped daily. As my research objectives became clearer, data collection continued to precede hypothesis formulations so as to not limit my study to a single perspective of the community and its health. Russell Bernard comments that "the value of participant observation is that it opens things up and makes it possible to collect all kinds of data." [28] Rayna Rapp encapsulates the benefit of this methodology in her own work: "I set out with one set of research

[28] Russell H. Bernard, *Research Methods in Anthropology* (New York: AltaMira Press, 2006), 354.

questions, and was forced to enlarge and transform them as people educated me on the complexity of the issues as they perceived them." [29]

Interviewing

The use of semi-structured interviews empowered research interviewees to articulate their own definitions, judgments, and viewpoints by giving free reign to subjective information. In-depth interviews probed for demographic information including age, sex, education, occupation, marital status, and living situation, followed by elicitations of interviewee's perceptions of life prior to and following the mudslide, their health experience, the medical attention they sought or received after the mudslide and in the recent past, as well as their expectations of how life may or has already changed via relocation to the Chuk'muk government housing settlement.

A combination of convenience and snowball sampling was used to recruit interviewees. Beyond numerous unstructured, or open, interviews, 51 semi-structured interviews were conducted with adults, 18 years of age of older. Twenty Tz'utujil Maya females, 10 female healthcare personnel of either indigenous or ladino backgrounds, and 1 American female, who had been heavily involved in the mudslide recovery process, were interviewed. Fifteen Mayan males and 5 male healthcare personnel of ladino backgrounds were interviewed. Interviews with healthcare personnel took place at their respective healthcare institution in a private location, such as an empty consultation room or a social worker's office, while the rest of the interviews were conducted in participants' homes. While the majority of interviewees were living in the Tzanchaj

[29] Rayna Rapp, *Testing the Fetus*: The Social Impact of Amniocentesis in America (New York: Routledge, 1999), 2.

mudslide camp at the time of interviews, 5 interviewees were residents of cantón Panabaj, one of seven cantones, or divisions, of the town of Santiago Atitlán, that was primarily affected by the mudslide. Additionally, 8 interviewees were new residents of Chuk'muk, the site of the new housing settlement for mudslide survivors. All interviews were conducted by the researcher, and interviews were conducted in both Spanish and Tz'utujil. Many older and rural women speak little or no Spanish in addition to their first language, Tz'utujil. Therefore, interview questions and answers, when necessary, were translated to and from Tz'utujil by local translators who were hired for the duration of the GHI's project. A translator was present for every interview in case certain questions in Spanish needed further explication in Tz'utujil depending on the interviewee's Spanish capacity. Therefore, the interviewing process was as follows: a translator would accompany me to the home of the interviewee, I would provide introductions and obtain informed consent in Spanish, and this would be translated into Tz'utujil for the interviewee, if needed. Likewise, during interviews, I would give a prompt in Spanish, it would be translated into Tz'utujil, and the interviewee's response would be translated back into Spanish before continuing to the next part of the interview.

The interview process, particularly appropriate for eliciting genuine thoughtful reflections on sensitive issues, reflected Marshall and Rossman's claim that

> Typically, qualitative in-depth interviews are much more like conversations than formal events with predetermined response categories. The researcher explores a few general topics to help uncover the participant's perspective, but otherwise respects how the participant frames and structures responses – the participant's perspective on the

> phenomenon of interest should unfold as the participant views it, not as the researcher views it. [30]

Interviews lasted from a half hour to over 1.5 hours. Throughout interviewing, I aimed to triangulate my inquiries by obtaining multiple perspectives on topics from, for example, psychosocial workers, biomedical clinicians, mudslide survivors, local government officials, NGO leadership and Santiago Atitlán residents, etc, to increase the validity of research findings and conclusions.

Ethical Considerations

In a context of trauma and emotional stress, informed consent and sensitivity toward the mudslide survivors were of the utmost importance. Prior to arriving in Guatemala, the Guatemala Health Initiative faculty provided a week-long, intensive training workshop before traveling to the field, during which the importance of informed consent was underscored, and the researchers discussed signs of discomfort, fatigue and distress in interviewees in order to know when to terminate interviews so as to ensure each participant's safety. I also completed the online CITI training course in human subject research for the social sciences, and, prior to the start of research, the Penn-Hewlett Guatemala Health Initiative's research protocol was approved by the Philadelphia Institutional Review Board in 2008.

Given that most of the adults in the population are illiterate, handouts and brochures were not used to obtain consent. Prior to the start of research participation, the study was explained to interviewees verbally with the assistance of trained local

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[30] Gretchen B. Mashall and Catherine Rossman, *Designing Qualitative Research* (London: Sage, 1995), 80.

translators. During the course of interviewing, I heavily emphasized that participation was completely voluntary; participants could terminate their interviews at any time, and it was not required of them to discuss personal or uncomfortable information. Furthermore, participants did not receive remuneration beyond small tokens of appreciation for their participation such as various food items; thus, no direct benefits were foreseen in this study.

A note on photography: In one of my first interviews, a woman expressed her frustration with tourists and journalists who visited Panabaj "to take photographs, make promises, and change nothing." To avoid disrespecting the residents of the mudslide camp, I requested permission prior to taking photographs in the field, and I limited my photography to those individuals with whom I had developed a rapport.

Grounded Theory Analysis

After receiving consent from participants, interviews were audio-recorded. I transcribed these recordings over the course of July – December 2008. While I conducted interviews – or immediately following interviews – I took down fieldnotes with pertinent information regarding the interviewee, the content of the interview, as well as my impressions of the interview. I later replaced all names with an assigned pseudonym to preserve the anonymity and confidentiality of each research participant. During transcription, I translated all interviews from Spanish into English, with significant portions of interviews transcribed verbatim into Spanish, and then translated into English. It follows that throughout the text of this thesis, exemplary quotations provided in both Spanish and English represent the exact words of the interviewee. Quotations provided in

English without accompanying Spanish represent the translator's translation of what was said.

For this research, I employed the grounded theory approach to analysis, which involved: "(1) identifying categories and concepts that emerge from text; and (2) linking the concepts into substantive and formal theories." [31] This inductive method is especially useful for trying to discover patterns of behavior and thought across a particular group of people. Interview transcripts and fieldnotes were entered into a QSR NVIVO 8 database for coding and analysis. First, primary codes were generated from *emic* categories of places, people and objects encountered during fieldwork, as well as local terms and idiom. Second-level analytical codes, or themes, were then derived from the text, using the relationships among codes to build upon and contradict theoretical models.

[31] Bernard, 492.

Figure 2
Santiago Atitlán, Guatemala
(BBC News)

I

A Landscape of Distress

Santiago Atitlán, Guatemala

Linda Green, an anthropologist who has conducted ethnographic fieldwork in an indigenous village just north of Santiago Atitlán, writes, "Most Mayans live in grinding poverty, without the most basic social services, potable water, sanitation facilities, health services, adequate housing, or education."[32] In the western Highlands of Guatemala, 87 percent of the population lives in poverty, with 67 percent of the poor living in extreme poverty; that is, the monthly family income is not adequate to meet the costs of procuring basic food.[33] Moreover, half of Maya children under age five are chronically malnourished – the third highest rate, globally –, over half of the active labor force is either unemployed or underemployed, and illiteracy is extremely high, with 73 percent of men and 91 percent of women illiterate.[34] In this chapter, I introduce Santiago Atitlán and explore the effects of a prolonged crisis recovery following the 2005 Guatemalan mudslide in the peripheral village of Panabaj. The mudslide and its aftermath have embedded nearly 3 thousand *damnificados*, or victims, in a landscape of crisis, and survivors must cope with social and economic stressors that reinforce pre-existing inequities.

Santiago Atitlán, a Tz'utujil Maya indigenous town of approximately 37,000 inhabitants, is located in the Department of Sololá, in the western highlands of

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[32] Linda Green, *Fear as a Way of Life* (New York: Columbia University Press, 1999), 26.
[33] Pan American Health Organization, *Health Conditions in the Americas*, no. 549 (II) (Washington: PAHO, 1994).
[34] Linda Green, 26.

Guatemala. Santiago Atitlán is situated on the southwestern shore of Lake Atitlán, which is surrounded by various indigenous villages where Mayan culture – predominantly that of the Tz'utujil and Kaqchikel ethnicities – is still prominent today. Mayan languages, for example, are spoken either exclusively or alongside Spanish, and vibrant traditional dress, such as intricately embroidered *huipil* blouses and *traje* pants, is still widely worn. Tourism brings thousands of visitors through the Lake Atitlán region annually, supporting a variety of small businesses, such as restaurants and shops. Due to this influx of foreigners, women's work, beyond domestic duties, includes making and selling beaded crafts, woven textiles and embroidered clothing in the center of town, either to supplement their husbands' income or as the sole household wage-earner. While the local economy has begun to open itself to national and international markets, an average male's income consists of subsistence wages as a *campesino*, or field hand, at a local *cafetal*, or coffee plantation, as well as other sources of menial labor. The wealth that is injected into Santiago Atitlán's economy via tourism is limited to the center of town and concentrated in the hands of a few elite families. The vast majority of Santiago Atitlán, however, endures more humble circumstances.

Beyond its distinct cultural and economic milieu, Santiago Atitlán is haunted by the ghastly specter of the Guatemalan Civil War, *el conflicto armado*. The longest civil war in Latin American history, lasting from 1960-1996, *el conflicto armado* consisted of state-sponsored violence and homicide, targeting numerous indigenous towns, including those situated on Lake Atitlán. It is estimated that over 100,000 Guatemalans were murdered and at least 38,000 people disappeared throughout the conflict. Moreover, over 400 rural villages were destroyed and the Guatemalan army's scorched earth policy

forced hundreds of thousands to flee, either to other parts of Guatemala or to nearby nations, such as Mexico and Honduras.[35] The war, which reached its peak of brutality in 1980–1983, was in every sense a 'dirty war.' Throughout the civil war, Mayan people were universally presumed to be supporters of the guerilla insurgents that fought against the Guatemalan government. The conflict penetrated Mayan communities to the core, pitting families and communities against each other and instilling chronic fear and distrust at every level.[36] In December 1990, a group of 13 unarmed civilian protesters, including 5 children, was massacred by the Guatemalan army as they approached the center of town in a demonstration against military repression. Today this tragic event is commemorated by a small collection of monuments called the *Parque de Paz*, or the Peace Park, which is located on the outskirts of town, halfway between Panabaj and Santiago's *centro*, its town square. The extent to which the violence infiltrated peoples' lives is moreover manifested in the traumatic fragments that are woven into narratives of self, family, community and government. One Atiteco man, Diego, 66, emphasized that the military violence and repression primarily affected the impoverished villages living on the margins of Santiago Atitlán, where an army base was located:

> "Recuerdo que sufrimos…estuvieron los miembros del Ejército, que nos causaron mucho dolor y tristeza. Muchos de mis paisanos fueron secuestrados y asesinados por el Ejército"

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[35] : Susanne Jonas, *The Battle for Guatemala: Rebels, Death Squads, and U.S. Power*, Boulder, CO: Westview Press, 1991, 70.

[36] Patricia Foxen, "Cacophony of Voices: A K'iche' Mayan Narrative of Remembrance and Forgetting," *Transcultural Psychaiatry* 37, no. 3 (2000).

> [I remember how we suffered. There were members of the Army that caused us so much pain and sadness. Many of my fellow countrymen were kidnapped and assassinated by the Army]. [37]

While peace accords were signed between the Guatemalan government and the National Guatemalan Revolutionary Unity (URNG) in December 1996, in effect ending 36 years of civil war, the "poisonous knowledge" of violence[38] continues to inform Atitecos' relationship to the Guatemalan government and military.

In 2005, a traumatic event shaped a new layer of collective trauma among the periphery population of Santiago Atitlán. Hurricane Stan, a storm passing over Central America in the first week of October, brought relentless rain to the region, and ultimately caused a massive mudslide in the early hours of the morning on October 5. In eight minutes, one million cubic meters of land, rocks and trees dislodged from the slopes of Volcán Toliman, one of three dormant volcanoes surrounding Santiago Atitlán. Many survivors still recall the night of the mudslide with vivid terror. While the rest of her family – nearly 20 individuals – drowned in the mudslide, Carmen "drowns in memory" upon remembering the disaster: "Me recuerdo de cuando bajó la corriente…Murió la familia entera" [I remember when the torrents fell…My entire family died]. Additionally, *Memorias de Panabaj* beings with a poignant portrayal of the night of the mudslide:

> "Son las tres de la manana...la mayor parte de la población está tratando de escapar en medio de las corrientes cuando la fuerza del agua empieza a desatar toda su furia...caen piedras y árboles, las casas empiezan a venirse abajo, los gritos de las personas atrapadas, la

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[37] ADECCAP. *Memorias de Panabaj. Proyect de Memoria Colectiva.* 58.

[38] Veena Das, *Life and Words: Violence and the Descent into the Ordinary* (Berkeley: University of California Press, 2007), 63.

> desesperación de sacar a los familiares debajo de los escombros...el infierno sigue durante mas de dos horas...la oscuridad es total"
>
> [At three in the morning, most of the population is trying to escape amongst the torrents when the currents of the water begin to release all its fury; rocks and trees fall, the houses begin to collapse, trapped people shout, the desperation to free relatives covered in rubble...the hell continues for more than 2 hours...the darkness is total].[39]

The mudslide, as an event of traumatic rupture, constituted a crisis of imagination among the individuals caught up in its profound upheaval. A common refrain punctuating the survivors' mudslide narratives emphasizes that such an event was absolutely unthinkable. "Nunca podíamos imaginar lo que iba pasar" [We never could have imagined what happened].[40] In the immediate aftermath of the disaster, Carlos only remembered chaos and confusion: "No sentía nada, estaba siempre mareado, como un borracho" [I couldn't feel anything, I was always dizzy, like a drunk].[41] Similarly, Dolores recalled being stunned and frozen, unable to think clearly about the disaster happening around her: "No sentía si estaba viva, mi corazón estaba muerto, mi pensamiento también. No sentía nada" [I couldn't feel if I was alive, my heart was dead, my mind also. I didn't feel anything]. Héctor, a middle-aged man who lost several members of his family, felt painfully alone as the chaos of the emergency efforts happened around him: "Estaba solo…no tenía padre ni madre que me consolían, me quedaba totalmente huérfano" [I was alone…I didn't have a father or mother to console me, I was totally orphaned].[42]

The village of Panabaj was almost entirely blanketed in mud, burying an estimated

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[39] ADECCAP. *Memorias de Panabaj Proyecto de Memoria Colectiva.*
[40] Ibid. 17.
[41] Ibid. 18.
[42] Ibid.21.

1,400 people beneath the displaced earth and rubble. Upwards of 3,000 people were missing, and thousands were left homeless and destitute. While local and transnational organizations soon descended upon the disaster site in the following days to provide basic necessities to survivors and to exhume the bodies of the dead mired beneath, Santiago Atitlán was outraged by the Guatemalan government's belated response. By mid-morning on October 5, Santiago Atitlán's local Hospitalito, the staff of the Centro de Salud, and the volunteer firefighter brigade created an emergency coalition. Furthermore, the Guatemalan Red Cross, Save the Children and Doctor's Without Borders had rapidly assembled. Additionally, a team of Cuban doctors sent by Fidel Castro attended the wounded and sick, while organizations from Honduras and Canada purified water and secured food for the victims. However, four days had passed before the then-President Oscar Berger visited Panabaj, and nearly a week went by before federal aid was mobilized.[43] Moreover, when the military arrived with trucks and aircraft, the Panabaj survivors refused their entry into the community, as the trauma of the mudslide harkened back to the scars of the oppressive force of the military during the civil war. Due to the six to twelve-meter drifts of mud that had accumulated over the village, rescue attempts were deemed futile as there was little hope of finding survivors. Furthermore, exhumations posed serious health risks to rescue workers. Only several days after the mudslide hit, the mayor of Santiago declared Panabaj a "mass grave."

In the immediate aftermath, numerous survivors found shelter in local churches or attempted to stay with relatives in the *casco urbano*, the center of town. Within several

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[43] "Guatemala villages 'mass graves.'" *BBC News*, 10 October 2005. Available online: <http://news.bbc.co.uk/2/hi/americas/4324038.stm> and Frank Jack Daniel, "Anger at Slow Aid to Guatemala Mudslide Village," *Reuters*, 10 October 2005. Available online: <http://www.planetark.com/dailynewsstory.cfm/newsid/32898/story.htm>

weeks of the disaster, however, the Tzanchaj mudslide relief camp had been constructed, and 700 families took refuge in the 290 shelters in the camp. The marks of the transnational organizations responsible for the camp persist: Oxfam's logo is prominently displayed on each aluminum-sided latrine, the European Union's stars are painted onto water tanks, and the crude wooden frames and canvas walls of the makeshift shelters proudly state, "USAID: A gift from the people of the United States of America." Beyond receiving a 9x9 meter shelter, typically shared among 5 individuals, each family was to receive a monthly ration of maize, corn soy blend, beans, and vegetable oil from the World Food Programme.

Despite the rapid response of humanitarian aid, the Guatemalan mudslide was soon eclipsed by the Pakistan earthquake, which occurred on October 8, 2005 and impacted approximately 8 million people. Furthermore, taking place on the coattails of the Asian tsunami, it is possible that the disaster response in Santiago Atitlán was impacted by a phenomenon known as "donor fatigue." Many resources – as well as compassion and empathy – had already been expended on the tsunami disaster. Furthermore, as the recovery process in Panabaj transitioned from an acute emergency to a prolonged recovery, international donor agencies shifted to newer, more urgent emergency situations, transferring their resources and the media's gaze from Panabaj to other parts of the world.

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The remainder of this chapter analyzes the actual everyday experience of mudslide

survivors in a landscape of burgeoning uncertainty. In response to the displacement of the mudslide survivors into the liminal mudslide relief camp following the disaster, the following section probes the everyday stressors that were discussed across interviews. With few resources to rebuild their lives, the mudslide survivors have not moved beyond a survival existence. Commonly described as *una lucha*, a fight or struggle, their everyday experiences provide an entry point into understanding the sustained trauma of the mudslide.

Figure 3
The Tzanchaj Mudslide Relief Camp

Fieldnotes *July 6, 2008*

It is a hot morning in the Tzanchaj mudslide camp, and the intensely green Volcán Toliman looms ahead. The brown, treeless channel running down the volcano, carved out by the mudslide three years ago, is still visible at a distance. Entering the camp, I pass several women working with beads at small tables close to the ground, draping textiles over their heads to shade their eyes from the intensity of the sun. A reggaeton beat thumps through the canvas walls of a corner shelter. Smoke hovers in the air, and children scream and scramble down the dirt path. Candelaria greets me and holds back the canvas doorway to her shelter so that I can enter. She crouches on the dirt floor and her two young children sit in a wooden bunk bed nearly. Candelaria is 23 years old and has 2 children. Her husband sells firewood. Six people have lived in her shelter for almost 3 years…

The Loss of Home

The mudslide survivors idealize their lives in Panabaj prior to the mudslide. In an interdependent society, social relationships are highly valued. In the mudslide survivors' recollections, Panabaj was considered safe, always well lit, and a symbol of neighborly communion. "Estábamos todo juntos: compartíamos y bromeábamos…todo era tranquilo" [We were all together: we shared, we joked…everything was tranquil]. However, life in the relief camp is very different. One of the largest impacts to interviewees was surely the loss of home, as it undermined the physical and social center of family. Typically, families in Panabaj shared a compound of several houses with their extended family: women would complete domestic chores and weave together while the men worked as day laborers, traveling together to and from the fields. Instead of these collective *terrenos,* or land plots, the mudslide survivors moved into the "narrow" and "insubstantial" emergency shelters, with barely enough space for the nuclear family. Candelaria, a thirty-year-old woman, recalled the crowdedness of the relief camp with the influx of refugee families when it was first opened. "If you had 5 or 6 people in your family, you would get half of an *albergue,* the 9 x 9 meter shelter, while those families with 9 or more surviving members would receive an entire shelter for themselves," she explained. The shelters were quickly denounced as being in *mala condición,* or in pitiful condition. Candelaria explained that wind whipped through the camp causing the wooden frame of the shelter to shudder. Moreover, cold drafts penetrated tears in the canvas walls, and the ceilings leaked when there was heavy rain. Due to the discomfort of the cramped relief camp quarters, some families moved into the center of town and took on impossible loans to cover the monthly payment of 300-500 quetzales for a housing rental. Candelaria's family, however, decided to return to their mud-covered houses in Panabaj,

attempting to remove the mud, rocks and trees in the hopes of rebuilding on the same land.

This attachment to former land and homes elevated the importance of ownership among the residents of the mudslide camp. Interviewees equated proprietorship with agency, feeling dehumanized and impotent due to their lack of ownership. A young man, Salvador, offered the following maxim: "Estar en casa propia es vida; vivir en el albergue es una esclavitud" [To be in your own house is life; to live in this shelter is slavery]. He longed to *ser dueño,* or to be owner, of a plot of land, just as his father had been. Furthermore, those living in the Tzanchaj camp are constantly reminded of the threat of a mudslide, as they are situated beneath Volcán Toliman. Living in the physical location of the disaster prevents their thoughts from straying far from the mudslide event. "Seguimos vivendo al pie del deslave" [We continue living at the foot of the mudslide], remarked José. While a great trench was dug into the base of the volcano in the months after the mudslide to create a channel that would absorb mud torrents in the event of another mudslide, José doubts that the trench is anything more than false security: "This entire camp is unsafe," he said, resenting that his family is being kept in a place of danger. "When we don't have to live here anymore, we won't live in fear."

Economic Vulnerability

Like many interviewees, Juana, the mother of 6 children, is preoccupied with whether she and her husband can support their family in the wake of the mudslide. As a *campesino*, or field hand at a local coffee plantation, her husband barely earns enough to feed their family on 20-25 quetzales daily, which purchases very basic meals, such as

cornmeal porridge and corn tortillas. Nicolas, a young father, explained that while he had little money saved prior to the mudslide, he always relied on the availability of day labor wages. However, in recent months there had been a significant increase in job competition, making it more difficult for him to find available work as an unskilled laborer.

For widows, the economic struggle is particularly dire. Josepha, 25, the mother of two young children, spends her days beading keychains to sell to tourists. Since her husband died in the mudslide, Josepha has found life to be *peligrosa*, or dangerous. Although she is committed to supporting her family, she has very few options to do so. Beaded crafts, textiles and embroidery – all time-intensive and intricate labor – saturate the local market, driving down the wages that women receive. Josepha, earning about 100 quetzales monthly, or approximately $12, began to restrict her food intake so that her children would have more to eat. Very quickly, she began losing weight and feeling weak. Although Josepha had heard rumors that widows received 24,000 to 50,000 quetzales in the months following the mudslide from various organizations, she lamented that she received no such support. “This is what I worry about every day: being able to buy corn, sugar, food,” she said, but her endurance is fading: “Ya no tengo ganas de aguatarlo” [I don’t have the will to bear this], she concluded.

Sanitation

Pedro, a middle-aged man, summarized his experience in the survivor’s camp as “great suffering” in terms of the lack of hygiene among the mudslide survivors. “There’s filth, there’s so many fleas and bedbugs in the night… It is impossible to clean these

houses well from the dirt floors and the latrines have a horrible stench." Pointing to a mountain of refuse on the edge of the cornfield across from his row of shelters, Pedro burns his family's garbage or dumps it into Lake Atitlán because the government has stopped sending municipal workers into the mudslide camp to collect it. As the trash piles grow larger, his family gets ill more often. Similarly, Juana is made physically ill every time that she uses the latrine. Each *fila* of 10 shelters, or approximately 100 individuals, shares a single shower and privy. Juana reported that, while some people clean after themselves, many do not: "You bathe in others' filth." She echoed many others when she said that she felt "trapped" by not being able to do the simplest human activities with dignity.

Violence and Substances

Violence is a conspicuous part of everyday life in the mudslide camps, as intra-familial violence is universally acknowledged, and sexual abuse is said to target teenage females. However, even in such close quarters, neighbors admit to passively standing by in the face of violence, watching from the other side of the street, or listening from the other side of a thin, canvas wall. Many interviewees agreed that emotions of despair, misery and frustration have detached from the mudslide event and have been redirected toward other mudslide survivors. Chonita, for example, remarked that the relief camp environment had changed many residents: "Tienen diferentes caracteres" [they have different characters]. Children relish in fighting, teens shout and listen to loud music until dawn, and grown men become angered with one another, nearly coming to blows.

Chonita wished that there were stronger walls between the shelters in order to isolate her family from a violent environment.

Similarly, alcoholism has pervaded the community as an escape from the harsh realities of the relief camp. Francisco regretted his dependency on alcohol, but knew no other way to get by in the relief camp. “When I lived in Panabaj, I never consumed liquor. But now almost daily my wife buys me a bottle and I drink it to sleep without problems,” he stated. Alcoholism has left a permanent mark on struggling families. Sara, a middle-aged woman living in the mudslide camp, was abandoned by her husband who took a bus to Guatemala City one morning and never returned. Pained by this desertion, her teenage son also began to drink excessively, carousing with young men who neither work nor attend school. He often steals his mother’s limited funds to purchase beer. Concepción reported spending barely 10 quetzales a day on food. Despite the many difficulties of the relief camp, what has truly “destroyed” Concepción is her son’s unfortunate transformation. Several times she repeated, “No hay paz, ni tranquilidad” [There is no peace, nor tranquility].

Communal Mistrust

Scholars debate whether or not the consequences of crisis are categorically detrimental to a community. For example, Austin and Godleski contend that, after large-scale disaster, survivors develop a profound identification with one another. Drawing solace and strength from the experience of collective trauma, survivors form a “trauma membrane”[44] between themselves and the outside world. They are able to share the

[44] Linda S. Austin and Linda S. Godleski, “Therapeutic Approaches for Survivors of Disaster,” *Psychiatric Clinics of North America* 22, no. 4 (December 1999): 898.

burden of the crisis in their daily lives with the rest of the community and benefit from the "courage and altruism" of each other.[45] Contrary to their notion of the "trauma membrane," however, the tragic mudslide event compromised taken-for-granted social relationships and breached attachments of family, friendship and community. The initial imperative to help one's neighbors in the Santiago Atitlán community dissipated over time. While mudslide survivors cherished the initial "compromiso de apoyar en cualquier forma" [promise to support in whatever way], this mode of reciprocity soon deteriorated. Many mudslide survivors were initially invited to stay with relatives in the *centro*, but after about one month, relatives' generosity waned. Exceeding people's capacity for charity, the mudslide survivors moved into the relief camp, abandoning their trust in extended networks of family and friends as fallbacks for support. In this same vein, Judith Hermann underscores that "in trauma…sustaining bonds among individuals, their families and communities are destroyed."[46]

Furthermore, Linda Green argues that contradictions of suffering often emerge "[wherein] community opportunism may win out over cooperation, leading to further internal violence."[47] Within the mudslide camp, one factor that has contributed to community breakdown is the perceived exploitation of humanitarian aid by some mudslide survivors. "No podemos tener confianza en nuestros vecinos" [We can't trust our neighbors], one interviewee, Pedro, told me. He claimed that many of the mudslide survivors had become *ladrones*, or thieves, who enter other family's shelters when they go to work or to town in order to steal food donations. Additionally, residents of the mudslide camp accuse other survivors of hoarding donations and rushing at the delivery

[45] Ibid.
[46] Linda Green, 119
[47] Ibid, 13.

trucks to apprehend more than their fair share of the sacks of basic grains. “Eso no es la forma correcta de actuar. Deberíamos de estar agradecidos y tener respeto” [This is not the right way to act. We should be thankful and have respect]. Salvador, however, claimed that it was necessary to take advantage of “todo que viene en donación” [every donation that comes]. He sells excess bags of Incaparina, a protein-enriched dietary supplement provided by the World Food Programme, and ground corn at the weekly market for a small profit in order to buy other food items. Salvador firmly defended his actions, saying that it was critical to his survival. With no other networks of support, and with humanitarian assistance waning, he was unapologetic for this dubious modus operandi.

Stigma

Adding to communal mistrust and deterioration is a pernicious narrative that has developed in the wider population of Santiago Atitlán. The mudslide is commonly construed to be an act of divine condemnation for “Panabaj’s sins and thievery.” In one of the most intensely evangelized sites worldwide – with over forty Evangelical congregations, let alone Catholic churches – this narrative has taken hold of the community. While one interviewee strongly resisted such an explanation for his misery, saying “Dios nunca castiga a nadie” [God never punishes anyone], other mudslide victims have speculated whether they are, indeed, to blame for their own suffering. “Tal vez todo eso es una prueba, tal vez nosotros hicimos cosas malas ante los ojos de Dios” [Perhaps this is a test; perhaps we have done bad things before the eyes of God], Juana considered. Comparing the mudslide to the Biblical flood, she considered, “si no

hacemos lo correcto, podría pasar lo mismo" [if we don't do what is right, another mudslide will come].

To craft such a narrative, the legacy of the *conflicto armado* in Santiago Atitlán has been invoked to explain the 'sins' of the Panabaj community. A story has circulated saying that Santiago's peripheral villages, including Panabaj, are populated with former guerilla fighters with stashes of weapons. Concepción, a middle-aged woman living in the Centro, for example, said it was rumored after the mudslide that large quantities of weapons were found floating in the lake, washed from the homes of the "bad people" of Panabaj. Additionally, there are many portrayals of Panabaj villagers as a threat due to their poverty and desperation. Residents of peripheral *cantones* of Santiago are historically impoverished, while many families living in the center of town enjoy a much more comfortable lifestyle. Several interviewees accused the mudslide survivors of coming to the *centro* to rob and even murder the more wealthy classes.

Whether or not these caricatures hold any weight, negative images of the mudslide survivors have galvanized anxieties and sparked debate over whether or not the mudslide survivors deserve continuing aid. Instead, the relief camp inhabitants should be expected to start lifting themselves from their poverty and debased ways. Angelica, a middle-aged woman living in the Centro, commented, "It is time for the people to stop waiting for help and work on themselves." Those who live in the Tzanchaj albergues should "lift themselves out of the way their lives are…the filth; they don't work. They could work and support their families if they tried." Angelica, among others, believes that the survivors' sustained poverty stems from laziness rather than inadequate government or humanitarian support: "People do not neglect their homes and abandon their children

because they are sad, but because they are not even trying," she commented. Angelica shared a parable of work that resonated with many other urban women's comparison of themselves to the mudslide survivors:

> "There are two women. One woman does not have any education, but she works on her embroidery every day. She cares for her children, she works all morning and afternoon, she saves her money so that she can buy food for her family, goes into town when she needs to in order to purchase food and medicines, and she cleans her home. The other woman dwells on all of the things that she doesn't have. She didn't go to school, doesn't work diligently, she can't feed her children, she stops organizing her home and washing clothing, and instead she complains and says that she is too weak and sad to fix this. She never searches for work, but she didn't try everything that she should have tried."

According to Angelica, if humanitarian aid organizations had stayed longer, it would not have changed the way in which the mudslide survivors are taking advantage of national and international handouts.

Similarly, Juan, another resident of the *casco urbano*, or town's center, feels that the mudslide survivors overlook the extent to which they were impoverished prior to the mudslide. From his perspective, the mudslide victims not only sentimentalize the tranquility and comfort of their lives prior to the disaster, but they also exaggerate the belongings and wealth that were washed away by the mud torrents in order to exploit the aid that was later brought to the region. "Their grave poverty did not start with the mudslide," he said, arguing that many of the inhabitants of Panabaj that were hit hardest by the mudslide were intensely poor squatters. Thus, he claims that while the survivors use the disaster as the sole explanation for their current poverty, they are not being honest about the circumstances of their prior lives.

Trauma and the Everyday

This chapter has illustrated how the acute emergency of the mudslide has transformed into an everyday landscape that is riddled with uncertainty and distress. When a visitor approaches the Tzanchaj relief camp, they will first notice a large sign at the front of the camp that reads, "Construcción de los Albergues Temporales para Familias Damnificadas" [Construction of Temporary Shelters for the Victimized Families]. When I first entered the relief camp and heard several residents refer to themselves as *damnificados*, I was wary to use this term, myself, as it could easily be construed as a subjugating and essentializing label. While *damnificado* translates from Spanish as 'victim,' the residents of the relief camp indicate that the term is moreover suffused with notions of the abandonment, poverty, and, above all, uncertainty of living in the mudslide camp. Although the relief camp was deemed 'temporary,' the mudslide survivors have struggled to come to terms with the indefinite extension of crisis. Their victimhood is perpetuated by the harshness of life within the camp. Similarly, Raphael argues that post-disaster refugee camps dislocate victims and heighten the emotions and circumstances that leave people in a state of constant desperation.[48]

In the remainder of this thesis, I analyze the role of uncertainty and distress as the *damnificados* grapple with healthcare-seeking, a dearth of psychosocial support, and a prolonged housing resettlement process. In the following chapter, The Body Bears Witness, I consider the ways in which the mudslide survivors aim to overcome the brutality of the everyday, with biomedicine as a means of creating certainty out of

[48] Beverly Raphael, When Disaster Strikes: How Individuals and Communities Cope with Catastrophe (New York: Basic Books, 1986), 131.

precariousness.

Figure 4
Inside the Relief Camp

Figure 5
Nicolasa Weaving

II

The Body Bears Witness

Somatization as an Idiom of Distress

The experience of distress among the mudslide survivors has been internalized and embodied as persistent *somatization*. This chapter explores distress, an "elastic category" [49] that intertwines "mind, body, and social body," [50] through the ways in which mudslide survivors have converted their trauma into physical, bodily complaints – most of which are without medically identifiable origins. Anthropologists concerned with the embodiment of distress have gravitated to pain in order to understand how the body mediates individuals' understandings of relationships and institutions. This chapter presents the predominant symptoms from which the mudslide survivors suffer when they etiologically anchor their condition in the mudslide and its aftereffects. As in many indigenous and non-indigenous settings throughout the Central American region, the mudslide survivors bundle these symptoms into an illness called *nervios.* With no precise equivalent in Western psychiatry, *nervios* is a culturally sanctioned idiom of distress that frames a heterogeneous complex of symptoms that include, among the mudslide survivors, intense and frequent migraine, insomnia, loss of appetite, and intrusive memory.

Arthur Kleinman notes that "in many non-Western societies, *somatization*, or the presentation of personal and interpersonal distress…has been shown to be the

[49] Nancy Scheper-Hughes, 177.
[50] Ibid, 169.

predominant expression of difficulties in living." [51] In the case of the mudslide survivors, I argue that somatic expressions, as an idiom of distress, 'speak' in a form of cultural critique. To be clear, the mudslide survivors are surely not the only people in Santiago Atitlán to somatize via *nervios.* Throughout the town's population, the causes of *nervios* can be quite diverse, often stemming from family relationships, exposure to violence, and money problems. Beyond my fieldwork within the mudslide relief camp, I spoke with, for example, a divorced woman who experienced bouts of intense migraine as well as an unemployed man with chronic pain in his extremities. Both individuals located their pain within the category of *nervios*. However, in the following section, I draw on the commentary provided by individuals who have rooted their somatic expressions in the aftermath of the mudslide.

While *nervios* is often considered to be episodic and short-lived, this chapter contends with *somatization* as a reflection of the chronicity of "personal conflicts, community upheaval and social control through bodily experience."[52] Moreover, the remainder of this chapter considers somatization not only as an idiom of distress, but also as a strategy for medical help-seeking. Nancy Scheper-Hughes' descriptive ethnography *Death Without Weeping* has greatly impacted this approach. Exploring *nervoso* as the idiom by which *os pobres*, or the poor, expressed "scarcity and violence" and their "existential precariousness"[53] in Alto de Cruzeiro, Brazil, Scheper-Hughes examines how the community, only recently incorporated into the biomedical health care system, responds to the *medicalization* of their needs. The *nervos* idiom is "appropriated by medicine and transformed into a biomedical disease...requiring medication...that alienates

[51] Arthur Kleinman, *Writing at the Margin: Discourse Between Anthropology and Medicine* (Berkeley: University of California Press, 1995), 51.
[52] Ibid, 159.
[53] Nancy Scheper-Hughes, 194.

mind from body and that conceals the social relations of sickness."[54] Similarly, in Santiago Atitlán, *nervios* confounds the biomedical model, as mudslide survivors increasingly seek medical attention for their symptoms. Thus, doctors wrestle with the ways in which pain medication, tranquilizers and psychotropics should be administered in the case of somatizing mudslide survivors.

The Phenomenology of Distress

In the following section, I provide several vignettes in order to represent the most commonly reported symptoms with etiologies traced to the mudslide and its aftermath. While I briefly consider the ways in which the sufferers succumb or resist these symptoms, subsequent sections will provide an in-depth analysis of health-seeking itineraries and coping-strategies among chronically somatizing mudslide survivors.

Pain

"There are women who actually died from the sadness of losing their families," Juan, a 19 year-old living with his family in a mudslide camp *albergue*, commented. Emphasizing the physicality of their mourning – that it pervaded their bodies and utterly debilitated them – Juan's insight resonates with the stories of several women whose grief transformed into somatized pain. After Katerina's husband died in the mudslide, she began to feel a constant pain in her head: " 'What's going to happen to my children?' I thought about this, over and over…that they don't have a father. Who is going to give me money to take care of the children?" Similarly, Lucia, who lost numerous family members in the disaster, continues to suffer as much in the present as she did in the days

[54] Ibid, 169

following the mudslide. Her intense *dolor de cabeza*, or headache, happens "every day, all day," bringing sharp pains to her eyes. "El dolor es constante" [The pain is constant]. Likewise, in response to her daughters' deaths, Rosario began to have difficulties swallowing as an inexplicable and severe pain developed in her stomach, as well as her neck and back. "It is the heavy sadness that causes it," she said, "una gran tristeza" [a great sadness]. This pain has debilitated her at least three times a week since the mudslide.

Fear

Many of the mudslide survivors live in a perpetually altered state of response to stress, and they often claim to be "frozen" by anxiety, in that they are unable to overcome threatening thoughts and images in their minds. Beyond severe migraines, Nicolasa's sleep has been riddled with nightmares. Due to chronic insomnia, she eats poorly and her body is wasting. Nicolasa admitted to a fear of leaving her house, and she has stopped going to the marketplace and visiting the other women in her family. When it begins to steadily rain, she clutches her children, shaking. She cannot leave the house, she said, because another mudslide may occur, and her children will be swept away without her. Similarly, Micaela's children often shriek and cry, refusing to eat and running away from the mudslide camp when there are heavy rains. As they were very young at the time of the mudslide, they vaguely remember the event. However, the chaotic night when Micaela and her family fled from the mud torrents has marked them indelibly. They wake up suddenly at night and are "frozen," Micaela told me, with tears in their eyes. During the day, they have grown increasingly rebellious and Micaela is unable to discipline

them. Fatigued and weak, Micaela accepts their behavior. “No puedo aguantarlo” [I can’t bear it], she sighed. She resents her neighbors who accuse her of being incapable of caring for her children.

“Excess Memory” and Intrusive Thoughts

Coping with the loss of her sisters, Elena often experiences *golpes a la cabeza*, or the feeling that she has been hit in the head repeatedly from “thinking too much” about the traumatic past. Suffering from what she described as being akin to nausea and disorientation, it is difficult for her to stand upright, and she sometimes loses feeling in her legs, altogether. Filled with horrific memories of the mudslide, along with pleasant memories of her sisters, Elena feels that the *fuerza en la cabeza*, or the strength in her head, has been drained, and that she is incapable of preventing these memories from returning. She lamented that she has spent so many hours a day *luchando*, or struggling, with this problem instead of working on domestic chores or weaving. Similarly, Pablo, a teenager and high school student, reacted in disbelief at the profound disturbance the mudslide and its aftermath have perpetuated in his life. He considered the years after the mudslide to be “lost years.” Losing his motivation to study, Juan stopped attending school and his grades drastically fell. Feeling “out of control”, he has several episodes of sweating and dizziness throughout the week. “Me vuelvo loco de tanto pensar” [I am crazy from too much thinking], he explained. ““I start thinking of many, many things, very rapidly, rapidly. I can’t focus at all. Aquí se sufre mucho” [Here, one suffers a lot].

Distress as Contagion

Several mudslide survivors indicated that somatization behaves like a contagious illness, passed from one person to the next if not repressed or avoided. David, a young man who grew up in the center of Santiago Atitlán, volunteered with his father on a rescue team after the mudslide. Working to uncover a house utterly choked with mud where an entire family had been buried together in a single room, David and his father were profoundly affected when they exhumed the victims' bodies to find that the mother of the family was still clinging to an infant in her arms. Afterward, David's father had frequent nightmares about the infant, and he was unable to master disturbing images of the baby. Whenever he described such nightmares to his son, 'the infant memory' was passed to David, so that the following night David, instead, would be haunted by this memory. As a result, both father and son developed a tacit agreement to never discuss the event or its impact on them. In a similar vein, Nicolasa, a mudslide survivor living in the relief camp, explained that it is important that a person suffering from *nervios* does not visit others. "You should never talk about your *nervios* with anyone else, because they will start to experience it, too," she warned. This imperative reflects just one mechanism by which social alienation is propagated among the distressed survivors of the mudslide. For example, whenever Concepción thinks about her teenage son, her migraines return. Although she would like to visit some of her friends when she is feeling this way, she argued that they, too, have their own memories to contend with. It would be unfair to "give them her worries" by talking about her loss and pain.

Gendered Distress

According to Talcott Parson's enduring theory of the 'sick role,' sickness provides sufferers with an exemption from the obligations of daily life.[55] A person is not held accountable for their illness and is relieved of their usual activities until they have recovered. In this view, *nervios* may be seen as a coping strategy by which people temporarily free themselves from demands and expectations placed upon them. A sick person withdraws from society until they are restored from illness to health. In the vignettes already provided, it is clear that many women have assumed a sick role after the mudslide. In fact, it may be argued that life in the mudslide camp, as being-out-of-place and a state of exception, is, in itself, the 'sick role' of the entire community of mudslide survivors.

While every one of the females I interviewed within the mudslide camp was experiencing persistent *nervios* in one shape or form, several of the male interviewees seemed to avoid questions regarding *nervios,* discussing the symptoms that their wives suffered rather than speaking about their own experience of distress. Studies of trauma victims in various contexts have shown remarkable differences between males and females in distress-related behavior, in terms of both the experience and the report of effects. Numerous researchers in Latin America have reported that *nervios* is more common among women than men, and they conjecture that women in traditional societies with a strict gender role differentiation are more burdened with responsibilities and obligations in contexts of poverty and scarcity, and thus are encumbered with the brunt of

[55] Talcott Parsons , *The Social System*, Toronto, Ontario: Collier Macmillan Canada, Ltd, 1951.

the distress of living under such conditions.[56] Carol Wool and Arthur Barsky, furthermore, offer several explanations for more frequent somatization in women than in men: women are more willing to admit to discomfort than men, women more readily seek medical attention than men, and men and women have "innate differences…in their threshold, tolerance and sensitivity" to bodily symptoms.[57]

While it is likely that across the population of mudslide survivors one would find a discrepancy in the numbers of males and females that experience *nervios*, my research does not indicate that there is an "innate difference" between men and women in their "threshold" for distress. Instead, cultural codes of *machismo* seem to be at play and contribute to the underreporting of somatization among men. For example, Juan, a middle-aged resident of the mudslide camp, insisted that he could talk about his distress solely his wife. As a *señor del pueblo*, or a man of the community, Juan said that he does not talk to other men about their feelings regarding the mudslide: "No puedo preguntar a ellos eso" [I can't ask them about this], he claimed. Additionally, men are afforded a more constrained sick role. Their refusal to work is deemed more culturally deviant than that of a woman due to the fact that a man must leave the house each day in order to work, whereas the women of the mudslide camp are domestically situated. Juan suspects that many of the men he works with in the fields have not "moved past" the mudslide. He reports that it is common for men who were physically injured during the mudslide to invoke these wounds in order to justify their underemployment, to excuse their fatigue or apathy, or to justify their absence from work on various days. "Tampoco puedo trabajar

[56] Nelly Salgado de Snyder et al, "The Prevalence of Nervios and Associated Symptomatology Among Inhabitants of Mexican Rural Communities," *Culture, Medicine & Psychiatry* 24, no. 4 (2000).
[57] Carol Wool and Arthur Barsky, "Do women somatize more than men? Gender differences in somatization," *Psychosomatics* 35, no. 5 (1994): 448.

por las heridas que tengo en la espalda y la cabeza" [Neither can I work due to wounds on my back and head], Juan said, but he said that it was not an option for him to stop going to work.

Medicalizing "Dis-ease"

While Talcott Parson's formulation of the 'sick role' excuses a sick person from daily duties, it is simultaneously incumbent upon that individual to seek help in order to make a speedy recovery. Upon the extensive backdrop of biomedical intervention that Santiago Atitlán has experienced in the past several decades, mudslide survivors have begun to seek medical assistance in order to cope with their distress. Medicalization refers to the way in which medical jurisdiction has expanded to encompass many problems previously not defined as medical issues.[58] Among the mudslide survivors, distress is being transformed into a medical condition as a result of medicalization. However, while Scheper-Hughes assigns the full responsibility for medicalization to the medical institutions in the town of Bom Jesus, Brazil, my fieldwork among the mudslide survivors in Santiago Atitlán indicates that the locus of initiating the medicalization of distress resides in the mudslide survivors, themselves, who desire the means to put an end to their bodily pain. Scheper-Hughes argues that, in medicalizing hunger, the doctors in Northeast Brazil drew upon the Cartesian dualism of the western medical model to "alienate mind from body and conceal the social relations of sickness."[59] However, my

[58] Simon J. Williams and Calnan, Michae, "The "limits" of medicalisation?: modern medicine and the lay populace in "late" modernity," *Social Science & Medicine* 42, no. 12 (1996): 1609.
[59] Nancy Scheper-Hughes, 169.

experience in Santiago Atitlán shows that medicalizing can also progress "from below" as the mudslide survivors, who have no other means to cope with distress, construe somatized pain as disease that requires medical treatment.

In the remainder of this chapter, I will examine the cultural parameters underlying health-seeking related to distress among the mudslide survivors. Although biomedicine is increasingly understood as a means to bring the body and mind under control[60] and sought after as a defense against pain, bodily vulnerability, and an unpredictable environment, medicine has played a very limited role in aiding the mudslide survivors in their distress.

Health-Seeking Itineraries and Legitimizing Pain

Pain can be overwhelming to the person experiencing it, but barely perceptible to everyone else. Thus, health-care seeking may be undertaken to legitimize and validate pain via the intersubjective experience between doctors and patients.[61] In Santiago Atitlán's healthcare settings, there is an implicitly hierarchical agreement between doctors and patients, characterized by an asymmetry of knowledge, competence, and power. The community looks to physicians as authority figures that will recognize their pain, legitimize their suffering, and target their symptoms with medication. However, pursuing medical attention for distress is not yet a hardened cultural practice in Santiago Atitlán. While somatizing mudslide survivors commonly approached doctors regarding their bodily pain at the time I was conducting fieldwork in 2008, it was made clear that

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[60] Vibeke Steffen, Richard Jenkins, and Hanne Jessen, *Managing Uncertainty: Ethnographic Studies of Illness, Risk and the Struggle for Control* (Odder (Denmark): Narayana Press, 2005), 15.
[61] Mark Nichter, "The Mission Within Madness: Self-Initiated Medicalization as Expression of Agency," in *Pragmatic Women and Body Politics*, eds. Lock, Margaret M. and Patricia Alice Kaufert (Cambridge: Cambridge University Press, 1998), 328.

such a response was not as culturally permissible only several years earlier. Before the mudslide, Chonita, 22, explained that it was unacceptable for her to see a doctor for severe migraines that left her incapacitated. Her father had died, and her mother did not want to “face the fact” of having an invalid in the family, so she advocated against seeing the doctor and making Chonita’s symptoms known publicly. Instead, Chonita attempted to continue her daily duties, such as beading, weaving and making tortillas, despite spending considerable time each day cowering in pain. In the aftermath of the mudslide, however, a doctor examined Chonita when she complained about her migraines.

Therefore, one possible origin of medical health-seeking for somatized distress is found in the immediate aftermath of the disaster. Directly after the mudslide took place, survivors were taken to Santiago Atitlán’s various healthcare settings where wounds were stitched, broken bones were set, and shards of rock and earth were cleaned from skin, ears, eyes and noses. Shuttles rushed medical traumas to the Sololá regional hospital for operations that the small-scale *Hospitalito* facility could not perform. Doctors and nurses from the community — and even foreign physicians arriving independently or with NGOs — visited the community churches where hundreds took shelter after the storm. Those who began to somatize migraines, pain, gastritis, nausea, etc, in these moments warranted the attention of medical personnel. The community’s biomedical staff was entirely dedicated to the survivors and began to address various bodily manifestations that originated in the traumatic rupture of the mudslide. In the following days, weeks and months, when urgent medical emergencies had been resolved but somatic repercussions of the trauma persisted, many mudslide survivors continued to seek medical help for their somatized distress.

There are several limitations to health-seeking in Santiago Atitlán. The cost of seeking heath care can hinder a family from medical assistance, especially among Santiago Atitlán's poorest residents. Although consultations are free at the Centro de Salud and cost a nominal fee at the Hospitalito for those patients with as few resources as the mudslide survivors, a *tuk-tuk* taxi to and from the center of town can cost between 5 and 10 quetzales, or about $.60 - $1.20. Many residents of the relief camp rarely go into town due to even this minimal cost. Therefore, the cost of many medicines is prohibitive for mudslide survivors, as well. The Centro de Salud only carries certain medicine that it provides without a fee, while all other medications must be purchased at local *farmacias*, or pharmacies. Additionally, waiting at the clinic to see a doctor is uncomfortable and can take up half a day. Even before the doctors and nurses arrive in the morning, a queue has formed in the waiting areas of the Centro de Salud and the Hospitalito, and it may take several hours to be seen by the doctor or nurse, as no specific appointments are scheduled.

Moreover, those who have sought medical attention for their somatizations have met disappointing outcomes. In several cases, interviewees questioned doctors' ability. "When will a doctor come who can help us?" Rosario asked. In her view, the doctor was either incompetent or utterly dismissive of her pain. He turned her away with an ineffectual packet of aspirin for migraines that have lasted for over three years. Micaela's doctor visit resulted in "una decepción" [a disappointment]. Similarly, María, 50, recalled feeling intimidated by the nurses when she first went to the Centro de Salud for her insomnia. It was a year after the mudslide, and her head and heart began to hurt because she was unable to sleep. Maria reported that she felt "very uncomfortable" and was

"treated poorly" by the Centro de Salud nurses who ignored her in the waiting room for many hours despite her pain. Finally, when the doctor examined her, he recommended a medicine that the Centro de Salud did not offer for free, and that she would have to purchase in a *farmacia.* Maria bought the box of pills for 25 quetzales, or $3, and took the medicine for several weeks, although she claimed that it had a negligible effect on her insomnia and pain. Furthermore, if she were to continue taking the medicine, she would not be able to afford food. "The doctor gives you the slip of paper [with the name of the medicine], but what are you going to do? With what money?"

From the medical practitioners' perspective, somatization is a salient source of frustration. Chronic pain, for example, "challenges the central tenet of biomedical epistemology: namely, that there is objective knowledge, knowable apart from subjective experience."[62] Dr. Salvador, a ladino physician at the Hospitalito, estimated that 65 to 70 percent of the consultations at the Hospitalito contain a psychosomatic dimension. Physicians tend to relegate *nervios* to secondary importance, however, and Dr. Salvador claims that the effects of *nervios* are underestimated. Many physicians, like Dr. Salvador, claim that, with limited resources and training, there is very little that they can do for somatizing patients. When a patient begins to discuss interpersonal conflict or the stress of unemployment, Dr. Salvador regrettably has limited time to discuss these underlying factors with patients.

> "Problems like migraines…severe stress and anguish: unfortunately, here [at the Hospitalito] we are only doctors and do not have psychological training. There is very little time to talk at any depth about these issues with a patient…there are many, many patients, already, who face a long

[62] Mary-Jo DelVecchio Good et al, eds., *Pain as Human Experience: An Anthropological Perspective* (Berkeley: University of California Press, 1992), 6.

> wait to see a doctor…Typically all we can do is turn them away. There are more urgent cases to attend to."

While Dr. Salvador only recently moved to Santiago Atitlán, Dr. Chávez, the physician at the Puesto de Salud health outpost located in the mudslide relief camp, was born in San Lucas, a town only several miles from Santiago Atitlán. Raised in poverty and a native Tz'utujil-speaker, Dr. Chávez is a walking hybridization of Tz'utujil Maya and biomedical culture. After training as a physician in Cuba, Dr. Chávez returned to the Western Highlands of Guatemala in April 2008. Closely identifying with the people of Panabaj, having been raised on the opposite shore of Lake Atitlán, he feels as though he has been failing the community: the packets of acetaminophen he gives to patients are ineffectual and the vitamins he distributes "aren't addressing the problem." Even with a full understanding of *nervios*, he claims that his "hands are tied:" the mudslide survivors do not need medication, but social programs to lift them out of misery. "I can't provide that," he told me.

The pharmacy at the Hospitalito is well stocked with a diversity of palliatives and psychotropic drugs; however, Dr. Salvador is wary of prescribing potent pharmaceuticals to the mudslide survivors. "In order to take these medications, it requires a higher level of education; otherwise, people may mismanage or abuse the medicine, bringing even more problems upon themselves." In the past, he has prescribed 5 mg of Valium for a course of 15-20 days to several patients dealing with anxiety and insomnia. While he had considered this to be a low enough dosage that these patients would not build a tolerance or become dependent, many patients began to cling to the drug. When the Valium masked his symptoms, one of the patients deemed it "the good medicine" and was

angered when Dr. Salvador refused to refill his prescription. Dr. Salvador presumed that the man was able to find Valium at one of the local *farmacias* where the purchase of the drug may not need a prescription. Afterwards, Dr. Salvador decided not to endorse the sedative, and instead prescribed placebo sugar pills in all but a few dire cases.

Thus, in their attempt to receive medical assistance for somatic expressions of distress, the already socially marginal mudslide survivors become "problem patients" at the borderland of biomedicine that is not able to give them relief. Not only are the mudslide survivors left feeling disillusioned by the futility of their health-seeking, but, as somatizing patients, they undermine health practitioners' sense of "fighting the good fight," [63] as in the case of Dr. Chávez, or are simply deemed a nuisance by others.

Technologies of (the) Self - Medication

Because doctors are unable to adequately respond to the distress that the mudslide survivors communicate via the body, many somatizers have taken a drastic detour in their health seeking and self-medication has become a phenomenon in the community. Eliminating the doctor as middleman, many mudslide survivors have come to rely on pharmacists at local *farmacias* to provide advice regarding medications and then to provide drugs, saving their customers the time of a doctor's visit followed by a pharmacy run. At the numerous *farmacias* throughout Santiago Atitlán, many types of medication that would normally require a prescription in the United States are *venta libre*, or over-the-counter. As I talked with several pharmacists throughout Santiago Atitlán, it became apparent that there are varying degrees of flexibility in terms of *venta libre* restrictions on prescription-only drugs depending on the *farmacia* and pharmacist that one approaches.

[63] Mark Nichter, 328.

While no pharmacist would admit to selling prescription drugs *venta libre*, many accused their competitors of doing so, as making a sale is a powerful incentive for bending the rules. One pharmacist insisted that, while he strictly abided by the *venta libre* restrictions, other pharmacists continue to sell antipsychotic drugs, such as Haloperidol Decanoate intramuscular injections (intended for acute delirium and psychosis) and tranquilizers such as Valium and Halción, without a prescription. Beyond the issue of restricted drugs, herbal sedatives and neurotropic vitamins (primarily B1, B6 and B12) are popular purchases in *farmacias*. Brand names like Neurobión 25,000, Nervidoce and Neurofortan, all megadose B-complex injections, claim to have an analgesic and regenerative effect on nerves at high enough dosages. These injections have increasingly found a niche market among somatizers.

In Santiago Atitlán, one dominant factor that contributes to the increasing popularity of neurotropic injections is an overwhelming "faith" or "trust" in injections. Within Santiago Atitlán, recent health interventions have equated injections with necessity and efficacy. Vaccinations for measles and rubella, for example, are compulsory and highly managed by health practitioners in the community. Furthermore, the Depo-provera birth control *injectable* is rapidly replacing birth control pills as the primary form of family planning. There has been a strong push among health practitioners to transition to injections as they help women monitor their next dosage rather than contending with improper usage of pills. Injections are, moreover, endowed with a palpable 'charisma': they are widely regarded throughout Santiago Atitlán as potent and direct ways to "attack" illness. One interviewee, for example, considered a painful injection to be the most desirable way of getting medicine because she associated

the pain of the injection with more healing power. In this way, injections have been elevated above other forms of medicine due to its tangible expression of healing.

The transition from physician-seeking to self-medication among mudslide survivors can be read as a mode of resistance to biomedical hegemony as somatizers withdraw from the institutionalized medical realm and enter into liminal spaces of medical and social practice. Appropriating the symbolic power of physicians — the syringe[64] — discontented 'patients' reconfigure biomedical powerplay by challenging the roles and authorities in the knowledge structure called Medicine. Thus, self-medicators challenge the idea of the doctor as an oracle who has sole access to the knowledge base of Medicine. Perhaps out of frustration with the negligible results of medical treatment, many somatizers seek a direct access to the resources of medicine, thereby claiming control over their own bodies. A consequence of this is that, through self-medication, the mudslide survivors have begun to empiricize the body; that is, they hold their own experiments, hypotheses and attempted explanations for their cure. One interviewee, Nino, told me about his wife's use of mega-dose B-complex injections. Sharing the results of her injection-use with other women and with the pharmacists, I would argue that her self-medication works toward creating an alternative body of knowledge, separate from the restricted knowledge that physicians possess. Experimenting with different brands and with varying vitamin dosages, her self-medication is thus an empirical exploration of the self. Self-medication can therefore be viewed as a drive toward achieving knowledge *through the body* as an antidote to the stressors that are also experienced through the body, via somatization.

[64] World Health Organization, Injection Practices in the Developing World - Results and Recommendations from Field Studies in Uganda and Indonesia. Available online: <http://www.who.int/medicinedocs/en/d/Js2232e/2.html>

The use of vitamin B-6 injections also represents a fascinating return to "natural remedies." *Curanderos*, or healers, have largely been rendered obsolete in Santiago Atitlán by the powerful hold of biomedicine throughout the community. Several "herbalists" have commodified their healing arts into consumer-driven spectacles in the streets of the weekly market, creating and advertising their top-selling "natural remedies" – typically fruit and vegetable purees. Even in a more isolated region of the Western Highlands, Linda Green remarks that the Mayan women knew very little regarding locally available medicinal plants and herbs, and they rarely used them. "'There are plants in the mountains that our mothers and grandmothers used. I don't know much about them; I only remember a few'"[65] commented one woman named Margarita. Similarly, among the mudslide survivors, natural remedies, such as herbal teas or infusions, are rarely used to cope with pain.[66] Therefore, is the burgeoning use of B-complex injections viewed as medicine or vitamin? As treatment or prevention? Somatizers may ultimately cling to the injection as it embodies both the biomedical and the natural as a hybrid remedy representing the best of both biomedical and non-biomedical worlds.

Therefore, while injection-use is growing with pharmacists both administering injections and selling syringes, needles and injectable medicines, it remains questionable whether these injections physiologically affect users, or whether the benefit is solely psychological. Vitamin B-12, like iron, is needed for the production of red blood cells; it is also required for a health nervous system. B-vitamin deficiencies can cause numbness,

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[65] Linda Green, *Fear as a Way of Life* (New York: Columbia University Press, 1999), 120.

[66] Only one interviewee used a natural remedy for somatic symptoms. For her migraines, the woman prepared a little *ceniza*, or ash, and *un carbón de fuego*, a fire coal, putting it into water to make *água de ruda*, or ruda water, from the ruda plant.

tingling sensations in extremities, confusion, depression, and an abnormal sense of balance.[67] However, the 500 mg megadose injections, containing at least 5 times the established upper tolerable daily intake level vitamin B-6, may, in fact, be a risk to somatizers. Studies have shown that excess vitamin B-6 can result in nerve damage.[68] Furthermore, while very little is known regarding the physiological basis of a vitamin B abuse-induced dependency, one study has shown that individuals self-medicating with vitamin B6 dramatically increased the frequency and quantity of their usage over time as their desire for stress-relief and energy caused a psychological dependence.[69] Notwithstanding, megadose neurotropic vitamins may have a placebo effect that enables somatizers to manage their distress. However, it also indicates a frightening openness to habitualizing *injectables*, which could prove disastrous if vitamins were replaced with more potent substances. With improper usage, drug and injection abuse as "maladaptive coping strategies"[70] may loom on the horizon. Moreover, as lay injectionists in other contexts in the third world were often not aware of the need to sterilize their needles, and received little or no training at all in Western medical techniques,[71] there is the potential for dangerous repercussions to stem from self-medicating.

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[67] Institute of Medicine, Food and Nutrition Board, Dietary Reference Intakes: Thiamin, riboflavin, niacin, vitamin B6, folate, vitamin B12, pantothenic acid, biotin, and choline (Washington: National Academy Press, 1998).
[68] Jacques Selhub et al, "Association between Plasma Homocysteine Concentrations and Extracranial Carotid-Artery Stenosis," *New England Journal of Medicine* 332, no. 5 (1995): 141.
[69] Institute of Medicine, Food and Nutrition Board, Dietary Reference Intakes: Thiamin, riboflavin, niacin, vitamin B6, folate, vitamin B12, pantothenic acid, biotin, and choline (Washington: National Academy Press, 1998).
[70] Nancy Scheper-Hughes, *Death Without Weeping: The Violence of Everyday Life in Brazil* (Berkeley: University of California Press, 1992), 129.
[71] World Health Organization, *Injection Practices in the Developing World - Results and Recommendations from Field Studies in Uganda and Indonesia*. Available online: <http://www.who.int/medicinedocs/en/d/Js2232e/2.html>

Conclusions: "Medical Attention"

Throughout this chapter, I have considered somatic manifestation to be a mode of expression that references discontent and emotional disturbance. Moreover, I have analyzed the ways in which embodied distress brings mudslide survivors into a power dynamic with physicians who may or may not recognize their pain as treatable. While rejecting biomedicine as a means of addressing distress has been somatizers' common response to dissatisfying medical experiences, an increasing dependency on medical attention has also been noted. For example, one afternoon while I was shadowing Dr. Salvador in the Hospitalito, a woman was brought into the emergency room at the Hospitalito with severe migraines. Dr. Salvador recognized the woman as having been to the Hospitalito on multiple prior occasions. She faced many issues at home, he told me, including a lot of stress and problems with her children. "She needs help and attention to work through these issues…but not here at the Hospitalito," he commented. "We will care for her here, but she will continue to return and use time and resources until some other support takes our place." Similarly, on another occasion, Dr. Chávez escorted a woman from the relief camp to the Hospitalito, where she required an emergency operation. When she emerged from the procedure, Dr. Chávez described her as "helpless." He said that the woman had asked the doctors for permission to stay in the Hospitalito for a week to enjoy the kindness of other people, and to feel important. "We need to tread very carefully with this type of patient…people who like the attention return and return and return. There are *many.*…"

Thus, becoming a 'patient,' for some, is a desirable subjectivity, pitting the trend toward self-medication against what Mary-Jo DelVecchio Good might call a drive toward

the *biotechnical embrace.* In a complex "political economy of hope,"[72] DelVecchio Good considers the *biotechnical embrace* to be an irrational clinging to medicine's possibilities for comfort. While this chapter has illustrated the ways in which many mudslide survivors come to resist biomedicine for its frustrating rejection and alienation, it has also rendered the biomedical sphere desirable in its power to legitimate and bestow attention.

To conclude, such circumstances point to a paradoxical mis-utilitization of the available health resources in Santiago Atitlán. In the case of somatized distress, biomedical health care intervention is not what the distressed survivors need. Thus, individuals who somatize have rejected biomedical support outright, or – consciously or not – have adapted their symptoms to be in alignment with ways of getting medical atention. There are several ramifications to this feedback loop. As the survivors' health care education about the clinic increases in breadth and sophistication, there is the possibility that public health resources in Santiago Atitlán will be overdrawn. Increased dependence on mis-matched treatment modalities by those who have differing and unmet needs impinges upon the healthcare access of those whose needs can be properly served by what is currently available. The medicalization of distress then, is a powerful current running against the mudslide survivors' ability to achieve recovery. Clearly, what is needed at this point is an emphasis on psychosocial support, as many doctors have already indicated. In the following chapter, I explore the vast potential of psychosocial efforts for the mudslide survivors, and consider what is needed to overcome the shortcomings of mental health intervention in Santiago Atitlán.

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[72] Mary- Jo DelVecchio Good, "The Biotechnical Embrace and the Medical Imaginary," in *Subjectivity: Ethnographic Investigations*, eds. J. Biehl, B. Good. and A. Kleinman, University of California Press, 2007, 346.

Figure 6
A meeting with the Mental Health Network

III

Reexamining Priorities:

The Rise of the *Red de Salud Mental,* Santiago Atitlán

Approximately one year following the mudslide event, Dr. Chicajau, the Director of Santiago Atitlán's Centro de Salud, named *salud mental*, or mental health, as the community's second priority. That is to say, second to the Centro de Salud's goal to tackle the high level of maternal mortality, Dr. Chicajau recognized mental health to be the community's most pressing health issue. "I am fairly certain that this is the only municipality in the entire country that has named mental health as its second highest concern," he told me in one of several meetings. In his view, mental ill-health is not only an individual problem, but is moreover a community-wide issue that unravels the *tejido social*, or social fabric, of Santiago Atitlán:

> "After the mudslide, there was a sustained rise in, and a high level of, community-wide concerns…so that individual problems translated to interpersonal conflicts and violence, which have spiraled into interfamilial problems that affect education, nutrition and care for children and teenagers who are, in turn, not prepared to live responsible adult lives at their full potential."

By acknowledging mental health as a top health priority, Dr. Chicajau aimed to bolster his requests to the Guatemalan Ministry of Health for increased psychosocial support, resources, and educational materials in Santiago Atitlán. However, despite Dr. Chicajau's attempt to increase psychosocial resources in Santiago Atitlán, the limited interventions that are already in place throughout the community have been, so far, underutilized.

The first half of this thesis has taken stock of distress and the response to distress in the aftermath of disaster at the level of the individual. This chapter, however, transitions to the community-level infrastructure that has been implemented to aid the mudslide survivors as they attempt to manage their ongoing grief and distress. This chapter begins with a brief 'history' of psychosocial intervention in Santiago Atitlán since the mudslide. By piecing together the memories of mudslide survivors and health practitioners regarding psychosocial efforts in Panabaj from 2005-2008, this chapter analyzes the extent and impact of social support following the mudslide. Furthermore, I draw upon in-depth interviews with the current practitioners of psychology and social work in Santiago Atitlán to assess the efficacy of psychosocial interventions today. Additionally, this chapter concerns the birth of the *Red de Salud Mental*, or Santiago Atitlán's first Mental Health Network. The group formed only several months before my arrival in Guatemala, and I became a member of the fledgling *red* during my time in Santiago Atitlán, ultimately presenting several of my research findings for the Mental Health Network leaders and other community health leaders during a *convocatoria*, or meeting, in Santiago Atitlán in August 2008 (see Appendix A).

The Psychosocial Past

Dr. Jorge, a *ladino* psychologist trained in Guatemala City, came to the Western Highlands of Guatemala for the first time in 2003 as part of a psychological research and action team that offered psychosocial support to families during the exhumations of mass graves after the Guatemalan Civil War. In February 2008, Jorge was sent by the Equipo de Estudios Comunitarios y Acción Psicosocial, a nongovernmental research center in

Guatemala City, to initiate a study on intrafamilial violence in Santiago Atitlán. In Jorge's view, psychosocial programming in the past operated as philanthropic endeavors that he also characterized as paternalistic. Rather than "sincerely attempting a health intervention or therapy," Jorge claimed that social support teams revolved around "hand-outs" that increased peoples' dependency:

> "The community always adapts to opportunities – that is to say, it is opportunistic. There was the mudslide. 50 different institutions came: international organizations, as well as national organizations, a pile of people…They didn't teach anyone how to work with the resources they have. There was an excess of resources, and many families didn't have to find work as long as donations were supporting them."

In this way, Jorge argued that social programs had maintained people, rather than giving them skills to support themselves. Furthermore, of the numerous organizations that descended upon the mudslide disaster scene – UNICEF, Oxfam, and other transnational organizations – few stayed in Santiago Atitlán for more than a month.

While Teresa, also a *ladino* psychologist from Guatemala City, did not work in Santiago Atitlán until recently, several of her colleagues at the Regional Health Ministry in Sololá were part of a team of 10 psychologists that were sent to Panabaj in the immediate aftermath of the mudslide. Teresa, the sole clinical psychologist in Santiago Atitlán, faults the Ministry of Health and the psychologists for underutilizing themselves as resources in the mudslide aftermath. She explained that psychosocial teams targeted only certain individuals, such as widows and those who had lost upwards of 20 relatives in the disaster. "While everyone lost someone, there was a very specific population that received support," she said, underscoring that the psychosocial teams could have

employed additional collective therapy techniques, rather than an individualized approach, in order to reach more of the mudslide victims. Only one of the mudslide survivors I interviewed was visited by psychologists after the mudslide event. However, Teresa insists that more people were "supported" by the psychosocial team than the community reports. The teams "went on visits to talk with people, to listen to them, to ask them how they are doing… That is what they had the resources to do. It's difficult to have anything tangible, which is what the community was accustomed to responding to." Stemming from this comment, one of the larger issues with which this chapter contends is what types of "social support" are culturally meaningful or culturally alien to the mudslide survivors. Here, Teresa underscores that psychosocial interventions have provided "specific types" of support that the community perhaps did not expect or desire.

The Rise of the Red de Salud

One of the underlying reasons for the underutilization of Santiago Atitlán's current, albeit limited, mental health infrastructure stems from the loose confederation of health resources throughout the town. While a system of psychological referral technically exists among the health institutions, not every facility is accustomed to recommending patients to Teresa, the clinical psychologist. Dr. Chávez, physician at the Puesto de Salud in the Tzanchaj mudslide relief camp, for instance, had never recommended that a patient follow-up with the psychologist. Furthermore, many doctors and nurses throughout Santiago Atitlán were unsure of how often (once a week) and when (Tuesday afternoons) Teresa actually offered psychological consultations. Teresa noted that it was only recently that a new social worker at the Hospitalito began to refer

patients with complaints of sexual abuse or intrafamilial violence to a follow-up with her. She estimated that two cases were referred to her daily at the Hospitalito; however, rarely did any patients follow through.

Despite elevating mental health to second priority, Dr. Chicajau said that there has been very little response to his call for more psychosocial resources – "both monetary and human." With the aim to consolidate the resources that come into the community in order to expand mental health projects, "It would be key for us to have more broad support programs, such as a radio program regarding community health and educational programs. This would be prevention for mental health." One main barrier to bringing psychosocial resources to Santiago Atitlán is not only that the Sololá Ministry of Health has severely limited the number job positions for psychologists, but also that few psychologists want to work outside of Guatemala City. Dr. Chicajau has not only requested a permanent clinical psychologist in Santiago Atitlán to have "someone…here 5 days a week" as Teresa is only employed one day week, but he also sees the need for a full-time psychologist to teach other community healthcare providers psychosocial support theories and techniques, as they currently receive little to no training in this area.

With the goal of tackling these issues, Santiago Atitlán's Red de Salud Mental, or Mental Health Network, was initiated by Dr. Jorge during the first week of February 2008. While the psychologists who came to Santiago Atitlán after the mudslide had previously attempted to organize such a coalition, their short-lived involvement in the community contributed to organizational inertia and the early network quickly dissolved. The Network was formed primarily with the goal to communicate across Santiago Atitlán's healthcare institutions and social organizations in order to collaborate on

community-wide projects. Under Dr. Jorge's leadership, the Red de Salud Mental organizational board consists of two *ladino* social workers at the Ministerio Público, Teresa, the clinical psychologist, and several Atiteca women who are social workers at the Centro de Salud. Bringing together these various contacts in weekly meetings, Jorge's overarching objective has been to highlight and unify mental health messages and protocols across the community's health infrastructure, and involve local organizations and health practitioners in workshops that work to raise awareness about mental health among these community leaders.

During the course of my fieldwork in Santiago Atitlán, the Red de Salud Mental conducted two mental health workshops with community nurses and the volunteer firefighter squad. With the aim of forging mental health collaboration, the first workshop, held in late June, focused on intrafamilial violence and its effects on mental health, while the second workshop took place in July and dealt with the mental effects of disasters. Filled with *dinámicas*, or games, and role-playing activities, the workshops were not only engaging, but ultimately left both groups of participants feeling more knowledgeable about the "challenges to well-being" in the community. However successful, Dr. Jorge expressed his concern that the leadership of the workshops came almost entirely from the *ladino* leadership of the Mental Health Network, while the Atiteca social workers, who are most familiar with the community and will be rooted there for far longer than the psychologists, took on a more passive role. "These projects almost entirely stem from my partnership with Teresa. This is the problem. We come and go, and when I leave, it will be the duty of the upcoming Network leaders to continue our efforts." In fact, when Dr. Jorge was called to a new research site in late July, the Red de Salud Mental took an

indefinite hiatus from organizing projects. Sara, the Centro de Salud social worker to whom Dr. Jorge had bequeathed the Network, lamented that organizing was time-consuming, and that all of the Network members were only part-time social workers with their own families to care for. “There will be more psychologists and social workers from Guatemala City to continue these projects,” she concluded.

This attitude is a particular loss for the Santiago Atitlán community, as the Atiteca social workers have the potential, as cultural-insiders, to ensure that psychosocial interventions have fully taken the community’s needs into account. Both Teresa and Dr. Jorge described Santiago’s social workers as having the potential to provide critical reinforcement to clinical efforts in the community. “The social workers can facilitate organization, and help people meet their needs and navigate the structure of support, so that we can help the community overcome its grief and resolve emotional issues. Their work is fundamental,” Teresa commented. For example, Victoria, the social worker at the Hospitalito, consults with patients regarding their economic options when they are receiving treatment in order to determine what percentage of the costs of treatment - whether it is 65% of the hospital costs, or even 5 – 10%, they can afford. Victoria views her work as complementary to that of the psychologist: “*Mi trabajo es conocer el mundo de las personas*” [My work is to understand the patients’ world], she commented. Victoria is particularly popular and vocal. She encourages patients to abide by the treatments that doctors have prescribed, and to follow through with Teresa when they have been referred.

However, social workers continue to be underutilized resources and unempowered agents within the community. On the various days that I spent with the

Atiteca social workers at the Centro de Salud, they spent the majority of their time in a backroom of the health clinic, often making decorations for the elementary school children in the relief camp or gossiping. While the weekly programs these women bring to the children of Tzanchaj are significant, as no other extracurricular programs are offered to entertain young children in the mudslide camp, their place in the backroom of the Centro de Salud is moreover symbolic of their lack of visibility and utilization in Santiago's healthcare system. With little psychosocial training, the social workers have not been prepared or motivated to initiate new projects without the supervision of transient psychologists, like Dr. Jorge, or Dr. Chicajau, the Director of the Centro de Salud.

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In the remainder of this chapter, I aim to consider in what ways future psychosocial interventions in Santiago Atitlán may meet or perhaps modify the community's expectations of "support." Firstly, I share several impressions of 'psychology' among the mudslide survivors in order to contend with the ways in which psychosocial support must either work from within the medical model or defy the medical model altogether in order to satisfy the community's needs.

Throughout Santiago Atitlán – and especially among the mudslide survivors – there is little understanding of 'mental health' and 'psychology.' In the vast majority of responses to questions pertaining to 'psychology,' interviewees immediately inserted it into a medical model of diagnosis and treatment. For example, like many people, Ana, a

middle-aged mudslide survivor, had never before heard of the term ‘psychologist.’ “No one talks about this kind of doctor,” she said. While Ana did not know what to expect from ‘the psychologist doctor,’ as she termed it, she hoped that “he would find the right medicines for her mother…whatever she needs – pills and injections or something else.” Like many interviewees, Ana assumed that a psychologist would cure a patient in the same way that a biomedical doctor would. Furthermore, there is general confusion as to what symptoms fall under the jurisdiction of the ‘psychologist.’ “Quiero aprender como de no recordar. ¿Este médico puede hacer esto?” [I want to learn how to not remember. Can this doctor do this?] Juan, a resident of the mudslide camp, asked me. Similarly, Diego, a young man living in the mudslide camp, told me that he had seen psychologists on Guatemalan *telenovelas*, or television soap operas; however, he could not conceive of how “laying on a psychologist’s couch” would help him overcome the things he had seen during the mudslide event. The psychologists can listen to him talk and cry, he said, but what is he supposed to do after that? Therefore, even from the perspective of someone with more exposure to psychology – albeit a pop culture representation – the salient question remains as to whether or not the ‘therapy’ he has seen on television would be culturally appropriate in his community.

These impressions of psychology are, moreover, apparent from Teresa’s interaction with mudslide survivors in her consultations as clinical psychologist in the Centro de Salud. The following vignette of Cruz, an alcoholic, encapsulates many of the common-held presumptions regarding psychosocial support Teresa has encountered among the mudslide survivors. One afternoon when I was shadowing Teresa in the Centro de Salud, a middle-aged man, Cruz, arrived for a consultation. After being treated

for severe hemorrhoids on several occasions over the past several months by Dr. Chicajau, Cruz admitted that he had been drunk nearly every day for a month. Wanting to decrease his excessive consumption of alcohol to avoid aggravating the hemorrhoids, Cruz agreed to meet with Teresa upon Dr. Chicajau's urging. During the consultation, Cruz openly talked about the pain and stress that characterized his daily life. Knifed by thieves as a young man, he always had trouble finding employment due to his illiteracy and dependence on alcohol. After Cruz's wife died several years ago, his son worked to support him until he left Santiago Atitlán for Guatemala City. Moreover, Cruz's father has grown increasingly deranged in his old age, and tends to leave the house and wander at night. After the session, which lasted approximately forty minutes, Teresa remarked how typical it was that Cruz had misunderstood the purpose of the consultation. Assuming that the psychologist was a medical doctor, Cruz was very narrowly focused on obtaining a medicine, like the steroid cream and suppositories Dr. Chicajau had provided, to cure him of alcoholism. Teresa had asked him to continue to attend sessions with her weekly, but Cruz did not seem amenable to the idea.

Thus, the issue of how to adapt a clinical psychologist program to the population of Santiago Atitlán is a critical hurdle for Dr. Chicajau and the Red de Salud Mental. The notion of 'the psychologist' must somehow be differentiated from that of a medical doctor. Furthermore, there is the concern that stigma may play a role is deterring people from seeking a consultation with a psychologist.

Alternatively, several mental health researchers have contended that many communities worldwide need to change their approach to well-being from "service-led"

interventions to "user-led" programs.[62] That is to say, while Dr. Chicajau has urged the Ministry of Health for a full-time clinical psychologist for the Centro de Salud, it is also critical for him to consider the ways in which clinic-based treatment for distress is culturally alien to the mudslide survivors. Miller and Rasco argue that "clinic-based mental health services are neither especially efficient for reaching large numbers of distressed refugees, nor culturally well-matched to the worldviews of those they are intended to serve."[63] Rather, they advocate that group therapy via community projects would reduce isolation among the members of a community. Furthermore, new projects could lend meaning and structure to people's lives, build new skills that would help people find employment, and cultivate collaboration that would work to mend breached social ties within the community.[64] Furthermore, rooting mental health interventions in community settings rather than the health clinic more actively integrates the mudslide survivors into the process of shaping their health, rather than reproducing the hierarchical doctor-patient relationship in psychologist-mudslide survivor interactions.

Thus, this chapter points to Santiago Atitlán's ongoing negotiation with ways in which the community can provide psychosocial resources to the mudslide survivors in order to overcome not only the trauma of the past, but the stressors they face daily. While, as one mudslide survivor told me, "health" is often construed as matters of "inyecciones y enfermedades" [injections and sickness], the Red de Salud Mental has the potential to explode this biomedical understanding of health and instead emphasize the ways in which "well-being," as a more holistic understanding of health, may be achieved.

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[62] C. Watters, "Emerging Paradigms in the Mental Health Care of Refugees," *Social Science and Medicine* 52, no. 11 (2001): 1710.
[63] Kenneth E Miller and Lisa M. Rasco, *Mental Health of Refugees: Ecological Approaches to Healing and Adaptation* (Mahwah: Lawrence Erlbaum, 2004), 32.
[64] Ibid, 33.

It should be the main priority of the Mental Health Network to facilitate the realization and understanding that lasting health derives not from simply treating the wounds of the past, but rather from the initiatives taken to build bridges into the future.

Figure 7
A family living in Chuk'muk I

Figure 8
Chuk'muk I

IV

(Dis)Integration:

Relocation and the Possibility of Recovery

This chapter aims to construct a second 'recent history' of the prolonged resettlement process with which the mudslide survivors have contended for almost three years, as they have awaited relocation from the mudslide relief camp to a government-sponsored housing project on the opposite outskirts of Santiago Atitlán. Within the mudslide relief camp, the relocation is a frequent topic of conversation. The Chuk'muk settlement will provide sturdy, brick homes, with cement porches and small, grassy backyards. While Chuk'muk is imagined as a utopic solution to the conditions endured within the mudslide camp, the community has simultaneously been divided via the politics of relocation. Subsequent, competing discourses regarding the desirability of leaving Panabaj have also emerged. In this chapter, I begin by presenting the various factors that have shaped mudslide survivors' opinions regarding relocation from the relief camp. Secondly, by having the opportunity to interview some of the first residents of the Chuk'muk I settlement, I probe the ways in which the resettlement process has generated false hope. While it seems unthinkable that those living in miserable conditions would reject the opportunity to relocate, Chuk'muk is not the promise of liberation that many residents of the mudslide camp desire. Rather, the relocation constitutes yet another node in the rhizome of distress that furthers the disintegration of interpersonal relationships and sense of community among the mudslide survivors.

A History of Relocation

In June 2006, a General Assembly took place in Panabaj, organized by the Asociación de Desarrollo Comunitario del Cantón Panabaj (ADECCAP), a grassroots organization that was borne out of the local emergency team that organized in the days following the mudslide. Bringing together its residents as well as those of the *cantónes* of Tzanchaj and Ch'ool (the liminal territory between Panabaj and Tzanchaj), ADECCAP intended to announce a comprehensive resettlement plan. Over one year after the mudslide, there had already been numerous challenges to a rebuilding effort that would remove the mudslide survivors from the misery of the relief camp.

Just prior to the meeting, a government land assessment has designated all of the territory within three peripheral *cantónes* of Santiago Atitlán as "high risk." While the mudslide victims had demanded that a risk assessment take place prior to the commencement of the housing rebuilding effort, Guatemalan government officials instead began spending the rebuilding funds to construct houses behind the relief camp, at the base of Volcán Tolimón, from which the mudslide cascaded the night of October 5, 2005. The construction was halted, however, when the entire lot, along with numerous properties in the *cantónes* of Pachichaj, Panul and Ch'ool, was condemned by the Coordinadora Nacional para la Reducción de Desastres (CONRED), a national emergency organization. When the government's hasty rebuilding plan was forced to terminate in May 2006, the half-constructed, concrete edifices served as a ghastly monument to wasted funds due to poor planning.

With the mudslide camp evacuated four times in 2006 due to heavy rains, the residents of the relief camp were eager for a revitalized effort to move them from

Tzanchaj. Therefore, in July 2006, ADECCAP announced its new plan that would construct a housing settlement on the Chuk'muk land plot. The plan, however, divided the mudslide camp along two organizational axes. While 339 families chose ADECCAP as their representative and continued to press for a resettlement site in Chuk'muk – "the safe location" - 300 additional families thought it best to use the governmental and international funding to rebuild the Panabaj community where they had lived their entire lives. "Iría mucho mejor regresar a nuestro propio sitio, donde vivíamos antes. Ahí podíamos construir nuevamente nuestra casa…estar tranquilo" [It was going to be better to return to our own site, where we lived before. There we would rebuild our house…to be peaceful], Juan, a middle-aged interviewee said. The Comité de Reconstrucción formed to represent these families' interests. As a result, the community was not only divided, but families had diverged, as well. Francisco, the ADECCAP president, explained that "la division ha afectado a la Comunidad y ha atrasado el trabajo de reconstrucción" [the division has affected the community and delayed the reconstruction work]. Concepción, an elderly widow, recalls how frustrating it was not to be in agreement with the rest of her family, and imagines that her family will be divided when the mudslide camp is dissolved after Chuk'muk fully opens: "Tengo division con mis familiares, porque ellos están inscritos con el Comité de Tzanchaj y yo estoy con ADECCAP. Me imagino que ellos se van a quedar en Panabaj. Yo no puedo quedarme ahí" [I have division with my relatives, because they are inscribed with the Comité while I am with ADECCAP. I imagine that they will stay in Panabaj, but I can't stay here].

However, Chuk'muk will not only be the new home to the mudslide survivors, but to numerous families that previously lived within the three *cantónes* that CONRED

designated as *alto riesgo*, or high risk - a total of 1800 households in total. Originally, ADECCAP had negotiated a plan in which resettlement would take place in two phases: first, the 737 families from Panabaj and Tzanchaj that were directly affected by the mudslide would be relocated, while in the second phase, 600 families from the remainder of the high risk zone would be moved. However, in time, this plan was abandoned. Instead, the entire *alto riego* zone was divided into three groups, and a lawyer from the center of town had been chosen to run *un sorteo*, or a drawing, in order to decide the order in which three waves of people would be resettled into the Chuk'muk projects. Chuk'muk I, which has already been constructed and recently populated with approximately 30 families in Spring 2008, has a total of 211 families, while Chuk'muk II is slated to house an additional 300 families. Furthermore, there are plans to build a Chuk'muk III and IV.

Resistance to relocation among those living in the mudslide camp stems from two conditions. Firstly, rather than basing relocation on an algorithm that would privilege those in the most precarious situation – the mudslide survivors still living in the relief camp – the lottery system erased the vulnerability differential that significantly distinguishes the mudslide survivors' experience of distress from those who were not directly affected by the mudslide, but must move due to impending risk. Secondly, while it was originally promised that the resettlement project housing would serve as a form of compensation for the mudslide survivors, the houses in Chuk'muk are no longer entirely cost-free to the mudslide survivors.

Dolores, a relief camp resident and treasurer *El Comité* reports that each homeowner must pay the *mano de obra*, or construction labor, for their own house. Each

edifice costs 42,000 quetzales in total, or approximately $5,200, with government agencies contributing 15,000 quetzales to each house, and other institutions, including Save the Children, Mercy Corps, and Oxfam, providing the remainder. Families have been assigned *terrenos* or landplots in Chuk'muk, and must pay for construction when the building materials arrive. "These houses are not presents from the government," Dolores commented, "and the people in the relief camp must somehow save resources when they have none." Dolores, herself, has struggled to slowly save money in order to pay for the labor to secure a house in Chuk'muk. Although she embroiders *huipiles*, it is nearly impossible to put money away, she said, and she estimated that it will be at least several months before her family has firmed up the status of their relocation to Chuk'muk.

While the distance from Chuk'muk to Tzanchaj is less than ten kilometers – the rough equivalent of a bumpy fifteen-minute *tuk-tuk* ride from Santiago Atitlán's outermost margin to margin – this short distance encompasses a world of difference for the mudslide survivors. To many, Chuk'muk is not only considered a place of safety, taking them out of the *zona de alto riesgo*, or the high risk zone, but it is also construed as "a dream," and "a light" that will remedy the mudslide camp misery. Many interviewees imagined the numerous ways in which their lives would transform after resettlement: "My husband will stop drinking," "my bones will no longer shake at night," "my children will obey" …

One of the most anticipated benefits of resettling in Chuk'muk centers upon the collective experience of the mudslide survivors. Several interviewees expected that Chuk'muk would not only reinvent individuals and families, but the community as well.

Tensions stemming from tight living quarters, alcohol abuse, and garbage inundation, for example, would no longer be concerns in Chuk'muk, where the houses have thick walls and clean surroundings. Furthermore, within the three macro-waves of relocation to the various Chuk'muk projects, people have been given the choice of organizing *grupos* of relatives and friends to relocate and live with within Chuk'muk. Thus, while the residents have no control over *when* their group would be able to move, other fears have been allayed by permitting the mudslide survivors to fashion their own neighborhood and perhaps rebuild social networks that fell into disarray when the mudslide relief camp *filas*, or rows, were haphazardly assigned. Dolores explained to me that there are 8 families in her *grupo*, consisting of her parents, siblings, cousins, as well as four families that are her friends. Currently, all of these families are scattered across the mudslide camp.

However, the issue of entitlement has soured many mudslide survivors' hopes for a tranquil and unified Chuk'muk community. Juan, a middle-aged man, asserted that the traumatic experience of the mudslide should have given him priority status when it came time to assign people to the waves of relocation. "*Yo soy verdadero damnificado*" [I am a true victim], he claimed, in contrast to the many families in other *cantónes* that were made eligible or Chuk'muk housing due to the land condemnation. To Juan, it is *una traición*, or a betrayal, that less-affected families are receiving tantamount assistance from the government. Indignantly he said, "It is madness…there are people already in Chuk'muk right now who never lost a relative, a friend, their house. We are here [in the mudslide camp]." Similarly, Nicolasa accused these families of taking advantage of the

relocation process. "Now they have their houses in Chuk'muk *and* their other houses in the area of *alto riesgo*. We don't have anything…"

The View from the Other Side

As the protracted Chuk'muk relocation began to take place in 2008, high hopes have been replaced with numerous pragmatic concerns. Firstly, the cost of living in Chuk'muk will be elevated at the same time that employment opportunities will be held constant, if not decreased due to the distance of the settlement from the *cafetales* where the *campesinos* typically labor. Furthermore, at an increased distance from the center of town, Chuk'muk signifies additional transportation costs. Micaela realized that when her family moves to Chuk'muk, she will have to find extra money to send her son to school. Currently, there are no schools in Chuk'muk, and Micaela speculated that many children may stop attending their schools in the center of town and, even further, in Tzanchaj, if their parents cannot afford paying $2 daily for *tuk tuk* taxis to school. She doubts that the municipality will provide a free service to transport the students. In this same vein, people are preoccupied with not having enough money to *iniciar*, or initiate, their new lives in Chuk'muk with their limited resources. While the relocation provides them the opportunity to *construir nuevamente*, or rebuild again, people are frustrated that they will live in new, but empty, houses.

While there is a great deal of speculation as to what changes the relocation will bring to the lives of the mudslide survivors, the first residents of Chuk'muk point to the possibility that life beyond the mudslide relief camp will be nothing more than a reiteration of the stressors that have already undermined individual and collective

wellbeing in *los albergues.* Andres, a middle-aged man who recently settled into Chuk'muk I with his family, cannot find a job. "Aquí, no podemos hacer nada diferente" [There's nothing we can do differently here], he said. Additionally, Lucia complains that the people of Chuk'muk, located on the periphery of Santiago Atitlán, are ignored by the municipality. The municipality must fill the community's water tanks daily for there to be an adequate supply; however, there have been days when the water has run dry.

Thus, the hopeful rhetoric regarding life in Chuk'muk is quickly fading. While, as discussed earlier, many mudslide survivors emphasize the significance of owning *su propia casa*, or their own house, the completed Chuk'muk project represents a new challenge. When all of the mudslide survivors have resettled and the government has "fulfilled" its duty to the mudslide victims, will Chuk'muk become a new zone of displacement where joblessness, poverty, and illness persist? The celebration of the new housing settlements may eclipse the ongoing struggle of the utterly destitute that reside there.

La 'Comunidad'

In 1976, a monumental earthquake shook the Chimaltenango Department of Guatemala, also located in the Western Highlands, north of Santiago Atitlán. 27,000 people were dead and thousands more homeless and injured. Linda Green comments that, "as destructive as the earthquake was, it also had many widespread constructive effects…The damage it caused became a catalyst for economic opportunities, political organizing, and the rebuilding of a sense of cooperation and mutual support among many community members in the towns and villages of Chimaltenango…The cleavages and

fissures that existed in the communities were nullified,"[65] Doña Marcelina, one of Green's interviewees, responded, "The earthquake not only shook the earth, but shook us to organize to better our lives."[66]

Unlike the post-disaster scenario that Green describes above, the mudslide survivors' community mobilization has often been more destructive than constructive, and has solely organized around the issue of housing, rather than giving voice to the mudslide survivors' dire need for other forms of social support. In this final chapter, I have chronicled the community organization and division in relation to the agonizing relocation process that has perpetuated the mudslide survivors' struggle. On one hand, community-based organizations, such as ADECCAP, emerged out of chaos, discontent and resistance to the state's lack of accountability and obligation to its distressed citizens. However, the struggle over community representation and contending with competing plans of relocation instigated in-fighting and communal division. Once there was the hope of unity. As one interviewee put it, "Vamos a ser una comunidad, estemos unidos y valemos los unos por los otros, sin hacernos ningún daño" [We are going to be a community, united, valuing one another, without causing harm]. As the relocation process continues to take place in Santiago Atitlán today, such an outcome remains to be seen.

[65] Linda Green, *Fear as a Way of Life* (New York: Columbia University Press, 1999), 45.
[66] Ibid, 46.

Figure 9
Dressed in a huipil and falda with Francisca, my translator and friend

VI

Conclusions:

Health at the Margins

"¿Será que me voy a curar?"
[Will I be cured?]

– Nicolasa

In the aftermath of the mudslide, the physical landscape of Panabaj was forever changed, as was its political, economic, and social geography. Across the chapters of this thesis, I have been guided by several concepts within Critical Medical Anthropology – structural violence, subjectivity, medicalization, and the phenomenology of health and illness – in order to better understand the 2005 Guatemalan mudslide in Santiago Atitlán in terms of individual experience, as well as the macro-economic and political circumstances that have limited the agency of mudslide survivors and have impeded their recovery from disaster. Grappling with the fragmentation, contradiction, and, in many moments, sheer sadness of the mudslide survivors' lived experience, this thesis has ultimately employed an "experience-near" approach[67] in order to focus upon the transactions among the "three bodies" that critical medical anthropology has delineated: 1) *the individual body*, or lived experience; 2) *the social body*, or the body and society, interrelated; and 3) *the body politic*, or the body as regulated by

[67] Vibeke Steffen, Richard Jenkins, and Hanne Jessen, *Managing Uncertainty: Ethnographic Studies of Illness, Risk and the Struggle for Control* (Odder (Denmark): Narayana Press, 2005), 12.

social and political controls.[68] Chapter 1, A Landscape of Distress, has probed the *individual body*. My study of the mudslide relief camp has illustrated the microcosm of distress that the mudslide survivors inhabit. Chapter 2, The Body Bears Witness, has analyzed the *social body*. My examination of embodied distress has shown that, while mudslide survivors seek empathy from medical doctors, they are denied intersubjectivity. Finally, Chapters 3 and 4 have incorporated notions of *the body politic*. The nascent Mental Health Network continues to work toward psychosocial programming as an alternative to the medicalization of distress, while the birth of the Chuk'muk resettlement "community" points toward the continued political and economic subjugation of the mudslide survivors.

To conclude, this thesis has worked toward answering several overarching questions: What is *health* among the mudslide survivors? That is to say, when will "relief" take place, when will "recovery" be achieved, and when will "aftermath" have terminated? While, in many ways, health continues to be considered "the absence of disease," [69] the World Health Organization (WHO) has combated this narrow definition with a view of health as "the possession of complete physical, mental and social well-being."[70] Critical Medical Anthropology, however, challenges anthropologists to delve even deeper into issues of "access to and control over the basic material and nonmaterial resources that sustain and promote life at a high level of satisfaction."[71] Therefore, health, as an "elastic concept,"[72]

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[68] Margaret Lock and Nancy Scheper-Hughes, "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology," *Medical Anthropology Quarterly* 1, no. 1 (1987): 6.
[69] Beverly Raphael, When Disaster Strikes: How Individuals and Communities Cope with Catastrophe (New York: Basic Books, 1986), 56.
[70] World Health Organization, Injection Practices in the Developing World - Results and Recommendations from Field Studies in Uganda and Indonesia. Available online:
<http://www.who.int/medicinedocs/en/d/Js2232e/2.html>
[71] Ibid.
[72] Ibid.

should be understood in terms of the specificity of a socio-cultural context. For the survivors of the 2005 Guatemalan mudslide, the so-called "relief" of the "relief camp" and the so-called "recovery" of the "recovery process" have ultimately rendered the *damnificado,* or victimized subjectivity, a continuing way of being-in-the-world. The aftermath of the mudslide has become a trauma unto itself, and attempts to normalize the mudslide survivors' distress and to assume that trenchant adversity will cease once they have been relocated to Chuk'muk are founded in delusion. Nancy Scheper-Hughes urgently reminds us that "we cannot forget that whatever else illness is...it is also an act of refusal, an oblique form of protest."[73] Thus, the mudslide survivors' continuing distress serves as an indictment of the social roots of illness in Santiago Atitlán, and urgently calls our attention to the margins.

[73] Nancy Scheper-Hughes, *Death Without Weeping: The Violence of Everyday Life in Brazil* (Berkeley: University of California Press, 1992), 213.

Figure 10
Lake Atitlán, Guatemala

APPENDICES

A.

Summary of Research:

Drafted and Presented by Serena Stein to the Santiago Atitlán Centro de Salud Director and Healthcare Staff at the Centro de Salud Monthly Health Workshop, August 2008

INFORME FINAL DEL TRABAJO

PROYECTO DE SALUD MENTAL, TZANCHAJ Y CHUKMUK
SANTIAGO ATITLAN, DEPARTAMENTO DE SOLOLÁ,
GUATEMALA, JULIO 2008.

Introducción

En este proyecto preliminar, realizado durante el mes de julio de 2008, hemos entrevistado personas de Santiago Atitlán, quienes de alguna manera sufren o han sufrido los efectos del Huracán Stan en el año 2005. El objetivo de este proyecto fue tratar de entender mejor la problemática de salud mental de la población afectada. Para ello se entrevistaron a 50 personas del albergue, del cantón Panabaj y personas ya residentes en Chuk'muk I. En este trabajo, realizamos un estudio transversal cualitativo en donde intentamos resumir el objetivo inicialmente trazado. Queremos recalcar el carácter preliminar de esta investigación y poner una nota de advertencia en este sentido respecto a las conclusiones generales que se puedan rescatar de nuestros hallazgos.

Resumen de los hallazgos:

I. Comentarios sobre la vida en el albergue

- Las personas del albergue tienden a describir la vida antes de la tormenta como "tranquila". Esto contrasta con lo que actualmente perciben: el diario vivir se ha transformado en una preocupación y sobresalen los problemas de inseguridad – Los entrevistados comentan que "no hay una buena comunidad" - existe mucha delincuencia tanto dentro de la comunidad como intrafamiliar, mencionan que los niños son más agresivos, no respetan a sus padres, hay violaciones y agresiones hacia las jóvenes, y hay abuso de sustancias.
- Hemos recibido comentarios respecto al problema de la inestabilidad laboral: sólo consiguen trabajos temporarios, día a día.

- También comentan que las viviendas no son apropiadas: son estrechas, fueron construidas en un área de riesgo, son temporales, hay hacinamiento, hace frío durante la noche, a veces hay problemas con la electricidad.
- Esto se suma a los comentarios respecto al ambiente e higiene: Tienen que compartir letrinas, a veces están llenas y no limpias, hay bastante basura en las calles que no son recolectadas debidamente por parte de las autoridades, hay olor desagradable en el ambiente, hay bastante roedores y insectos y perros callejeros que amenazan a los niños.

Comentario:
Creemos que la autonomía es un tema muy importante entre los entrevistados, especialmente los del albergue en Tzanchaj. Las personas comentan que desean tener sus propias viviendas, cocinas y terreno: "ser dueño de y cuidar eso".

II. Expectativas hacia la comunidades de Chuk'muk

La gente parece tener altas expectativas hacia la vida en Chuk'muk. "Me parece un sueño," dice una mujer. Entre los beneficios de mudarse a Chuk'muk mencionan:

- Ser dueño del terreno y vivienda
- una casa bien construída
- no vivir en una área de riesgo
- el regreso a un estado de tranquilidad

Sin embargo, algunas personas nos comentaron que las altas expectativas hacia Chuk'muk son una ilusión porque los problemas sociales los seguirán todavía en el nuevo lugar. Respecto a esto mencionan:

- el costo adicional de transporte a la cabecera municipal, especialmente para los trabajadores y escolares
- la distancia entre Chuk'muk y los lugares del trabajo de sus respectivos terrenos de siembra
- la falta de conocimiento sobre el área de Chuk'muk,(por ejemplo, no saben donde pueden conseguir trabajo cerca, y la leña para cocinar)
- creen que los problemas sociales, como la violencia, la promiscuidad de los jóvenes, y el abuso de sustancias, van a continuar
- en Chuk'muk, no hay mas oportunidades de trabajo
- les faltan los recursos para equipar sus nuevas viviendas – por ejemplo, la cocina, la cama como eran sus hogares antes de la tormenta

Comentario:
Fue muy enfatizado entre los entrevistados su gran temor y preocupación respecto a que vayan a continuar los problemas sociales en Chuk'muk. Además, mencionaron la distancia entre su trabajo y el centro donde se venden artículos típicos, que también presenta el problema de la distancia y costo adicional entre Chuk'muk y el centro municipal para sacar turnos de consulta con la psicóloga en el Centro de Salud.

III. Pensamientos sobre la salud comunitaria y la experiencia de la salud

- Se recibieron comentarios respecto a los efectos crónicos sobre la salud física debido a la tormenta que incluyen enfermedades respiratorias, disminución de la agudeza visual y capacidad de oír, condiciones de piel, rehabilitación, dolor del cuerpo, la falta de sensibilidad en las extremidades del cuerpo.
- Mujeres, hombres y adolescentes hablaron de efectos crónicos y frecuentes (en muchos casos, no menos que 3 veces a la semana por casi tres años) de la tormenta, que incluyen *nervios*, migrañas, dolor de estómago, insomnio, pesadillas, disminución del apetito, miedo, preocupación, faltar interés en sus actividades y trabajo, y no quieren salir de casa.
- Se mencionaron también efectos emocionales:
  – Pérdidas: la familia, amigos, vecinos, la comunidad anterior, pertenencias y ganancias, que perdieron mucho tiempo y oportunidades mientras estaban recuperando
  – La permanencia de miedo, inseguridad y preocupación diaria
  – La tristeza crónica
  – La falta de apoyo, se sienten que han estado abandonados
  – Disgusto con el gobierno debido al proceso de construir y distribuir viviendas en Chuk'muk

Comentario:

Al hablar con personas sobre su salud mental y emocional, algunas personas empezaron a llorar muy fuerte. Creemos que esto ilustra el trauma no resuelto que persiste en las vidas de las víctimas. Es importante notar que esas emociones y problemas con los *nervios*, como dicen las personas, no dependen del género, la edad ni el lugar donde viven. Las memorias dolorosas y efectos traumáticos siguen afectando tanto a los hombres como las mujeres y tanto a las personas que viven en sus casas originales en Panabaj como aquellos que han vivido en Chuk'muk I por unos meses. Esas preocupaciones han afectado muchos aspectos de la vida de estas personas, como sus relaciones con miembros de su familia, y, además, han ido dañando sus relaciones comunitarias debido a sospechas de vecinos oportunistas que estén aprovechándose del proceso de entregar viviendas a la población. Adicionalmente, las personas reconocen que no tienen alta calidad de vida y que han sufrido mucho en los años después de la tormenta "sin apoyo adecuado," como ellos dicen.

V. Comentario sobre una intervención psicológica

- Durante las entrevistas, dedicamos una parte del tiempo a educar un poquito sobre la salud mental e intervenciones psicológicas.
- En general, la gente no ha oído hablar de un psicólogo y solamente una persona tuvo una experiencia con un psicólogo que visitó el albergue en los meses directamente después del deslave.
- Entre los entrevistados, hay quienes han tratado de buscar ayuda por problemas mentales como *nervios*, pero para tratar los síntomas físicos sin atención a los efectos psicológicos. Por eso, han buscado medicamentos, inyecciones en el Puesto de Salud, Prodesca y el Centro de Salud, y también, medicamentos, inyecciones y vitaminas en las farmacias del centro.

- Después de explicar el papel del psicólogo – como lo de la psicóloga que trabaja en el centro de Salud cada semana – los entrevistados dijeron que no sabían que había un psicólogo en Santiago, que tendrían mucho interés en recibir atención con este tipo de medico, y que desearían – aparte de los medicamentos – apoyo, acompañamiento, discutir sus vidas y problemas, y consejos con esa profesional.
- Expresaron su deseo de que el profesional visite a las personas en sus casas porque es difícil sacar un turno de consulta en el centro de salud – especialmente lo que dijeron hombres que trabajan todas las mañanas. Además, dijeron que es mejor que el psicólogo hable Tz'utujil o tenga un traductor que pueda hablar con ellos en su idioma.

Comentario:
Fue muy destacado entre los entrevistados la falta conocimiento sobre los servicios de salud, especialmente los de la psicóloga. Además, les falta mucha información sobre como pagar tratamientos y medicamentos con la asistencia de la trabajadora social en el hospitalito, si es necesario.

Conclusión

Este fue un trabajo preliminar y de carácter exploratorio, realizado con la intención de entender mejor la problemática de la gente afectada directamente por el Huracán Stan en lo referido a su salud mental y emocional. En este informe hemos presentado un resumen de los puntos que consideramos más importantes con la esperanza de que contribuyan a futuros delineamientos de políticas de salud pública en esta comunidad.

Resulta muy claro que todavía queda mucho por saber y por entender para tener un panorama más claro de la situación. Sin embargo, basado en las conversaciones que hemos tenido con miembros de la comunidad, creemos que es importante continuar ofreciendo prestaciones de servicios de salud mental (equipo de psicólogos) y divulgar dicho servicio en la comunidad. También destacamos la necesidad de reforzar una infraestructura de apoyo social, en especial en lo referido a transporte, combustible, ubicación de las escuelas y lugares de trabajo, de manera que la transición a Chuk' muk sea lo menos traumática posible para esta comunidad.

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B.

Tzanchaj Refugee Camp Demographics, Compiled by Dr. Juan Guarcas Batzibal,

Tzanchaj Albergue Puesto de Salud, July 2008

Población	Males	Females	Total
0<1	3	9	12
1<5	56	48	104
5 to 9	78	75	153
10 to 17	80	79	159
18 to 24	58	57	115
25 to 49	99	126	225
50 or more	44	45	89
Totals	418	439	857

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