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Mi casa sin mí parada no es casa: Conceptualizations of functioning and functional impairment in rural Chiapas, Mexico

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ABSTRACT

In mental healthcare, functional impairment is an essential element in diagnosing and monitoring the severity of mental disorders. However, current clinical practices do not account for how context and culture might shape conceptions of functional impairment, given the demonstrated influence of cultural context on mental health, particularly in Mexico. We interviewed 16 members of a rural community in Chiapas, Mexico to understand how they understood functioning and how functioning is impacted by distress. We analyzed the data using thematic analysis with a critical lens. With regards to conceptions of functioning, participants described that to function was to work (*nuestra vida es el trabajo*), to satisfy the family's needs (*poder satisfacer las necesidades de la familia*), and to be at ease (*estar a gusto*). When participants, many of whom had been diagnosed with depressive and/or anxiety disorders, were distressed, they explained that their work (*oficio*) and family (*familia*) were impacted. All of the themes were influenced by the importance of family, economic oppression, and gender roles. The results demonstrate that mental healthcare providers must account for cultural context in psychological distress and functional impairment.

1. Introduction

The past 30 years have seen increased attention to global mental health, as the global health community has begun to explore how diseases impact quality of life (Whiteford et al., 2013). This increased attention to wellbeing is particularly relevant to mental disorders, given their disabling nature, which includes missed days from work or increased social isolation (Institute for Health Metrics and Evaluation, 2021). Mental disorders therefore represent a significant proportion of the global disease burden when this burden includes functional impairment and not just mortality (Ferrari et al., 2013; Institute for Health Metrics and Evaluation, 2021; Murray et al., 2006; Prince et al., 2007; Whiteford et al., 2013).

This greater attention to functioning can be seen in efforts to evaluate the effectiveness of interventions, which many researchers, including *The Lancet* Commission on Global Mental Health (Patel et al., 2018), now believe should assess improvements in functioning in addition to changes in symptomatology (e.g., Araya et al., 2003; Chatterjee et al., 2014; Sangraula et al., 2018). Evaluations of functional impairment typically take into consideration how the experience of the disorder affects work, social life, and other daily activities (American Psychiatric Association, 2013; Üstün et al., 2010). Individuals who experience considerable functional impairment are typically rated as having more severe disorders (e.g., American Psychiatric Association, 2013).

Although useful, the dominant clinical framework for assessing functioning has important limitations, as it does not account for how context and culture might shape conceptions of mental health and functional impairment (Cardemil et al., 2015; Tann, 2005). Indeed, much of what is known in global health clinical practice about functioning, and mental health more broadly, is based on a narrow range of cultures[1] (Fox and Prilleltensky, 1997; Sciolla, 2007), and often does not include cultures in LMICs (Patel et al., 2018). As such, mental health providers who do not recognize that experiences of mental health and

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[1] Culture is typically conceptualized as shared beliefs and traditions among a group of people. However, culture can also encapsulate structural factors such as economic and political context (Kleinman and Benson, 2006). We therefore use the terms "culture" and "cultural context" to refer to these contextual factors, as well.

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functional impairment are contextually-shaped, and miss the impact of privilege and oppression on functioning and distress, could provide lower quality of care. Increasingly, global health researchers, drawing from the work of medical anthropologists and social psychiatrists, have begun to note the limitations of this approach. However, many gaps remain in our understanding of particular settings and how context might exert influence in those settings. In this article, we contribute to this growing body by examining how culture and context might shape conceptions of functional impairment and mental health in Chiapas, Mexico. By way of background, we first review relevant literature from medical anthropology and social psychiatry, as well as psychometric work on functional impairment in global mental health.

1.1. *Cultural context, mental health, and functioning*

Medical anthropologists and social psychiatrists have long recognized that cultural context influences health and functioning. Medical anthropologists have drawn a distinction between disease as a biomedical condition and illness as a culturally-informed experience of being unwell (e.g., Finkler, 1994; Kleinman, 1981). In some cases, these fields have viewed illnesses, including psychological distress, as completely culturally-bound, such as in some idioms of distress (e.g., Yahalom, 2019; Montesi, 2018). Other perspectives conceptualize mental illness as having some aspects that are universal as well as other aspects that are more culturally-specific (e.g., neurasthenia, Kleinman, 1982; Reyes-Foster, 2013; Weller et al., 2008). For example, some researchers have described *nervios* in Mexican and other Latin American contexts as a discrete illness, in which a person feels preoccupied and has somatic symptoms, as well as a broader indicator of stress and depressive disorders (Weller et al., 2008). In each case, anthropologists and social psychiatrists have argued that the causes and manifestations of mental illness are contextual and not just biological.

In Mexico, the context of this study, there has been considerable research exploring contextual influences on illness and mental health, including religion, gender, and familism. Reyes-Foster (2013), for example, explored how Yucatec Mayan communities may view demonic possession as the cause of suicide attempts. Similarly, Finkler (1994) worked with low-income women in Mexico City and argued that higher levels of morbidity found in women compared to men could be explained by difficulties encountered by women on a daily basis, such as domestic violence, gendered expectations, poverty, and other contextual factors. Finkler (1994) thus draws a direct connection from context to functional impairment that is specific to women. According to Duncan (2017), familism is also important as both psychological suffering and healing may often be understood on a more communal level in various contexts in Mexico, as compared to US or western psychiatry which typically conceptualizes psychological distress more individualistically (Duncan, 2017). These studies push back against the dominant clinical view and provide evidence showing how culture and context shape experiences of mental health and functioning.

1.2. *Measures of functional impairment in low-and middle-income countries*

Despite these strides in anthropological research, the dominant, clinical body of literature on functional impairment has mostly ignored the impact of culture. In the Diagnostic and Statistical Manual of Mental Disorders, for example, many disorders include a criterion that focuses on functional impairment, noting that symptoms must “cause clinically significant distress or impairment in social, occupational, or other important areas of functioning” (American Psychiatric Association, 2013), with no consideration of culture or context. On a global scale, the World Health Organization completed a series of studies in the 1990s to validate disability (i.e., functional impairment) instruments worldwide (e.g., Ormel et al., 1994; Üstün, 1994; VonKorff et al., 1996) and concluded that existing, standardized disability questionnaires can be reliable and valid in global health research (VonKorff et al., 1996). These studies, which have been foundational to global mental health’s understanding of functional impairment, leave out the possibility that cultural variability across sites might shape functioning in unique ways.

More recently, however, researchers within global mental health have begun to question the assumption that functional impairment is always experienced in the same way and have begun developing measures of functioning that take into consideration the connection between mental health and cultural context (e.g., Bolton and Tang, 2002; Üstün et al., 2010). For example, the World Health Organization Disability Assessment Schedule (WHODAS 2.0) was designed as a culturally sensitive measure that could be implemented across LMICs to assess functional impairment (Üstün et al., 2010; Habtamu et al., 2017; Risal et al., 2021). In developing the WHODAS 2.0, an international research team generated a number of novel items that assessed functioning in domains like cognition, life activities, and community participation. The team also performed a cross-cultural applicability study to validate the measure (Üstün et al., 2010). While an improvement on previous approaches, the WHODAS 2.0 is still a standardized measure that is intended to be used in any global context.

Other researchers, recognizing that most existing measures were created in western cultures, have created measures for specific non-western contexts (Applied Mental Health Research Group, 2013; Padmavathi et al., 1995). For example, Bolton and Tang (2002) created a contextually-specific measurement of functional impairment in various cultures in LMICs by choosing activities relevant to a specific context, including division of activities along binary gender roles. Other contextually-specific approaches to assessment of functional impairment have been conducted in LMICs for severe mental disorders (Habtamu et al., 2016, 2017), as well as common mental disorders (Figge et al., 2020; Kaiser et al., 2013).

1.3. *The current study*

Despite this recent increase in attention to cultural and contextual influences on functioning, there remain many gaps in this work. In particular, most of this work has been conducted in contexts within Africa (e.g., Bolton et al., 2004; Habtamu et al., 2015; Habtamu et al., 2016) and Asia (e.g., Poudyal et al., 2009; Kane et al., 2018). Similar research is needed in other contexts, such as Latin America, where we found limited studies (e.g., Kaiser et al., 2013). As such, this study focuses specifically on rural Mexico. While anthropologists have explored some similar concepts to functioning and mental health in Mexico (e.g., Duncan, 2017; Finkler, 1994; Reyes-Foster, 2013), more research is needed to explore how functional impairment is understood in Mexico in order to inform competent mental health care. For example, most of the empirical literature even in non-western contexts conceptualizes the highest level of impairment as being unable to complete activities of daily life (e.g., Bolton and Tang, 2002; Bolton et al., 2004; Habtamu et al., 2016). Clinicians in rural Chiapas, Mexico, where this study takes place, however, had previously observed that patients in the mental health program often continued to care for their homes and families even when they were experiencing depression or anxiety. An exploratory, qualitative study could help to shed light on how functional impairment is experienced in unique ways in this setting.

This study examined how individuals in Chiapas understand functional impairment. In particular, we explored how participants conceptualize functioning and functional impairment, as well as the relationship between mental health and functional impairment.

2. Materials and methods

2.1. *Setting*

This study took place in Chiapas, Mexico and was conducted in collaboration with *Compañeros En Salud* (CES), the Mexican sister branch of the global health organization, Partners In Health. CES operates public primary-care clinics in ten communities and collaborates with one government hospital in the Sierra Madre region of Chiapas. The study location provided an ideal setting for this study for several reasons. The vast majority of psychological research is conducted in the United States (Arnett, 2009), and so rural Chiapas provides a context that is different in many ways. In particular, the people of this region have faced a long history of marginalization and economic oppression that has left Chiapas as one of Mexico's poorest states (Consejo Nacional de Evaluación de la Política de Desarrollo Social, 2020). Most families in the community where this study took place depend on the coffee harvest for their income. Across the centuries, the United States and European countries have owned much of the farming land and trading power, such as through the North American Free Trade Agreement (NAFTA), while Mexican laborers, particularly from indigenous groups, have been exploited in the coffee fields (Alba Vega, 2003; Henderson, 2019; París Pombo, 2006). It is estimated that coffee farmers, who complete intensive labor to produce the crop, receive only 5% of the profits (González, 2018).

Another important cultural factor in this area is the influence of gender roles. In Chiapas, like in most of the world, men usually take on the role of earning and controlling the family income, while women are tasked with maintaining the home and taking care of the children (Aguerrebere et al., 2021; Brunt, 1992). These gender role expectations are reinforced by sociopolitical forces, such as government conditional cash-transfer programs. In these programs, women are tasked with meeting certain conditions on behalf of their family, such as school and clinic attendance, in exchange for monetary support (Ehsan and De Silva, 2015). Land-owning men in rural Mexico, on the other hand, tend to have more representation in *ejidos*, local forms of government, and more sociopolitical power within their communities (Brunt, 1992). In addition, many women in this region face intimate partner violence, as do 50% of women nationwide (Instituto Nacional de Estadística y Geografía, 2018). Many of CES's female patients who have depression report having experienced domestic violence (Aguerrebere et al., 2021), and globally experiencing domestic violence is associated with having a mental disorder (Howard et al., 2010; Terrazas-Carrillo et al., 2016). In indigenous communities in Chiapas, women have organized to fight for their social and economic rights, such as the right to live without domestic and political violence (Speed et al., 2006). However, women in the region where CES works, whose ancestors were stripped of their indigenous heritage and customs through a violent nationalization campaign in the early 20th century, have often been isolated from these movements (Hernández-Castillo, 2001). In this area, work and social expectations are often based on gender (Aguerrebere et al., 2021).

Against this background of systemic oppression, there are large gaps in access to healthcare in the rural regions, particularly mental health care (Heinze et al., 2016). Given the dearth of specialty services in the state, CES has adopted a task sharing model that consists of training and supervising community health workers, doctors, and nurses in various mental health screenings and interventions. With this model, CES has begun to build a mental health care system in a previously neglected region (Aranda and Rodríguez-Cuevas, 2021). The greater attention of healthcare providers to mental health in Chiapas had led to the informal recognition that many patients did not exhibit functional impairment as expected; for example, mental health patients often continued to care for their family and their homes. Thus, the providers wanted to better understand the relationship between psychological distress and impairment.

2.2. Study design

In this study, we use qualitative interview methodology as it is a common approach for describing and analyzing the experiences of participants (Creswell, 2013), and we wanted to capture the under-researched experience of functioning and impairment. A semi-structured interview guide can be found in the appendix. The guide was developed initially by the first and fifth author and later refined by the fourth author and a paid local research assistant to ensure that the wording was contextually appropriate. As recommended by Bolton and Tang (2002), we asked participants about their daily activities when healthy. We probed in various areas of functioning, based on the WHODAS 2.0, as well as questions physicians used at the local clinic to informally assess functioning (sleep, appetite, relationships, and work).

2.3. Recruitment and data collection

Sixteen participants were recruited through the clinic and general community by the first author and a paid research assistant from the community. The clinic sample was generated through purposive sampling by targeting patients who had been diagnosed with depressive and anxious disorders. To ensure confidentiality, clinic patients were informed of the study by the clinic physician and community health workers and then contacted the first author if interested in participating. Participants from the general population, who may or may not have experienced depressive or anxiety disorders, were recruited using convenience sampling, in order to better understand how the community as a whole viewed mental health and functional impairment. The first author collaborated with the research assistant to make community-wide announcements, as well as recruit door-to-door. All participants had to be 18 years or older.

The data were collected between July and August 2019. Following the informed consent procedure, participants were interviewed in Spanish by the first author, either in their homes or in a private clinic room, based on their preference. The semi-structured interview lasted 30 to 90-min and focused on functioning and functional impairment, distress, and the relationship between the two, as well as factors that might impact this relationship.

2.4. Analytical strategy

We used reflexive thematic analysis (TA) to analyze the interviews (Braun et al., 2018; Braun and Clarke, 2013), which allowed us to apply a critical lens (e.g., Fox and Prilleltensky, 1997; Ponterotto, 2005) to the data. Critical research, and the related branch of liberation psychology, have a long history in Latin America, and thus influenced our approach to interpreting the data (Fox and Prilleltensky, 1997; Martín-Baró, 2006). Critical researchers focus on power relations and believe that there is no one reality in the data, but rather multiple meanings that could be gathered and filtered through the perspectives of the researchers (Ponterotto, 2005). Sexism to one set of researchers, for example, could be interpreted by others as traditional family values or a pragmatic division of labor (e.g., Borland, 1991). Through this critical lens, we interpret the data with an eye to systems of privilege, power, and oppression.

Braun and Clarke (2013) describe six steps to conducting TA: data familiarization, initial coding, theme creation, theme review, theme definition and naming, and reporting results. All interviews were transcribed in Spanish by a paid research assistant and then checked for quality by the first and third authors, who also reviewed the field notes and discussed initial patterns during the first step, data familiarization. For the second step, initial coding, each member of the research team (the first three authors) coded the interviews separately and then met to discuss their codes. The first author kept the master code list, and the team refined and enriched the initial codebook. Coding remained mostly descriptive at this point, and any interpretations or ideas for themes were noted in memos, along with areas where the authors' understanding of the data differed. The team met regularly to review the first half ($n = 8$) of the transcripts. Subsequently, as there were fewer new codes, the first author coded the last half on her own with the codebook established by the group. For the third step, theme creation, the research team then reviewed all quotes for each code, as well as memos, and organized the data into themes. Fourth, the first author met with the local research assistant to review the initial themes, to ascertain the extent to which the themes were reflective of and translatable to members of her community. Transcripts were also reviewed for evidence contrary to themes in order to enrich and expand them, as suggested by Morrow (2005), and to determine if there were any key sections related to the research questions that had not been included under a theme (Nowell et al., 2017). In the fifth step, the team reviewed the themes to finalize names and labels for each one. In the sixth and last step, report writing, the team aimed to report the results focused on the research questions, power relations, and the experiences of the participants.

It is also important to reflect on trustworthiness, or how reliable the results are in qualitative work based on constructs like transparency (Braun and Clarke, 2013; Morrow, 2005; Nowell et al., 2017). We ensured trustworthiness through team meetings in which we discussed codes, created a plan for our data collection and analysis, documented each step including the use of a codebook and memos, and participated in a simplified version of member checking by reviewing the results with a research assistant from the community (Morrow, 2005).

2.5. Ethics

This study was approved by the Clark University Institutional Review Board, as well as the Ministry of Health of the state of Chiapas, Mexico.

2.6. Reflexivity

From a critical perspective, it is important to discuss the positionalities of the authors, as researcher identities shape the interpretation of the data (Ponterotto, 2005). Overall, all of the authors are clinicians and/or researchers working to address inadequate mental health delivery, as well as the role of context and culture in mental health. The first author is a white, cisgender woman of European-American heritage, raised in a high-income family in New England, who is a native English speaker and fluent in Spanish. The second author is a Latino, cisgender man raised in a low-income/working-class family in Mexico who is a native Spanish speaker and fluent in English. The third author is a white, cisgender Latina woman, from a middle-class family in Honduras, who is a native Spanish speaker and fluent in English. The fourth author is a white, cisgender Mexican woman, raised in a middle-class family in Mexico City, who is a native Spanish speaker and fluent in English. The final author is a Latino, cisgender man born in Chile and raised in a middle-class family in the U.S. He is bilingual in Spanish and English.

3. Results

We interviewed 16 adults from a rural community. Sociodemographic characteristics can be found in Table 1. Only two participants had not personally experienced some sort of psychological distress, while the rest of the participants had either been diagnosed with or screened positive for an anxiety or depressive disorder, or described signs of similar types of psychological distress during the interview, such as *nervios* (Lewis-Fernández et al., 2002).

We identified several themes that explicate how participants conceptualized functioning and how they viewed the connection between functioning and mental health.[2] Each theme was shaped by the participants' context, particularly *familismo*, gender roles, and economic oppression. *Familismo* is a Latinx cultural value that centers the importance and interdependence of family (Campos et al., 2014). In our study, gender roles encapsulate a gendered division of labor (along a gender binary), as well as sexism faced by women. Economic oppression is reflected in the longstanding poverty this region has faced as a result of structural violence (Farmer, 2009), such as companies outside of Chiapas determining the price structures for coffee in the region (González, 2018).

Table 1
Sociodemographic characteristics of study participants (n = 16).

Variable	N (%) or mean (SD)
Gender	
Women	11 (68.75)
Men	5 (31.25)
Age	37 (16.22)
Highest level of education	
No education	3 (18.75)
At least some primary school	7 (43.75)
At least some secondary school	2 (12.50)
At least some high school	3 (18.75)
At least some college	1 (6.25)
Occupation[a]	
Homemaker	11 (68.75)
Coffee farmer	3 (18.75)
Other	4 (25.00)
Economic status	
Not enough money for basic expenses	5 (31.25)
Enough money for basic expenses but not other things	8 (50.00)
Enough money for basic expenses and other things	3 (18.75)
Current or history of anxiety or depressive disorders	
Yes	10 (62.50)
Potentially (e.g. described symptoms or *nervios*)	4 (25.00)
No	2 (12.50)

Note. SD = standard deviation.

[a] Occupation does not add up to 100% because some participants reported more than one occupation.

The themes were especially shaped by the reports of the women's experiences, as we were able to recruit more women in general, as well as more women with a history of mental disorders. In addition, the men who participated in this study tended to provide less rich information about psychological distress and its impact on functioning. Nevertheless, we note discrepancies and similarities between men and women through a lens of gender and power.

3.1. Conceptualizations of functioning

We identified three themes that captured participant experiences of what functioning means to them. In general, participants noted that to function in this context is more than just being free of depression or anxiety; it is to work (*nuestra vida es el trabajo*), to provide for one's family (*poder satisfacer las necesidades de la familia*), and to be at ease (*estar a gusto*). From a critical perspective, these themes highlight the influence of cultural context on functioning in day-to-day life. In this section, there was a balance between women's and men's voices, with almost all men and women endorsing each theme.

3.1.1. Nuestra vida es el trabajo (our life is our work)

Almost all participants expressed that functioning was inextricably linked to work. Límbano (single man who lived with and supported his mother and extended family, 52 y.o.) described the lives of those in his community as focused on work when asked about his day-to-day schedule: "*Pensando en el trabajo, al trabajo.* ***Nuestra vida de nosotros es el trabajo****.* [Thinking about work, going to work. Our life is our work.]" The pervasiveness of this view of good functioning was likely connected to the family's survival in the context of rural economic oppression. Ernestina (married woman, 35 y.o.) explained, for example, how life is for the poor:

> *Si no barro mi casa, va a estar bien sucia. Si no lavo la ropa, se va a amontonar … y si no hacemos comida no comemos … Se tiene que hacer buena vida, uno de pobre, pues no tenemos para más. Los ricos pues meten*

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[2] We selected direct quotes from participants in Spanish as theme names in order to center the participants' experiences and not alter the original meaning of the phrases. We translated the quotes to facilitate understanding of the themes, and we used pseudonyms to protect the participants' confidentiality.

> *criada, meten una muchacha, y ellos no hacen nada. Porque tiene pues de cómo. Nosotros de pobre, no llegamos a eso. Tenemos que trabajar.* [If I don't sweep my house, it will be very messy. If I don't do the laundry, it will pile up … if we don't make the food, we don't eat … You have to make a good life, one who is poor, well, we don't have any other option. The rich can hire a maid, they can hire a housekeeper, and they don't do anything. Because, well, they have the means. We poor folks, we don't have that option. We have to work.]

Ernestina explicitly drew a contrast between her experiences and those with more economic resources. The salience of this difference was evident for many participants who explained that their life was their work because they could not access less time-consuming, higher paying vocations. Of note, some women expressed having fewer educational opportunities than men, reflecting the power differentials that result from gender inequity. Participants seemed to take pride in the hope that their labor would lead to more opportunities for their children someday, however. Despite the recognition of the role of gender inequity and economic oppression, participants were proud of their commitment to work and the connection to functioning.

3.1.2. *Poder satisfacer las necesidades de la familia (to be able to meet the family's needs)*

All of the participants explained that functioning was closely connected to their ability to meet their family's material and emotional needs. This theme clearly connects to the value of familism. For example, Celia (married woman, 29 y.o.) described how being healthy, or functioning, meant that one is able to satisfy one's family's needs:

> *Pienso que ser sana es … **poder satisfacer las necesidades de la familia** en tiempo y forma. Porque cuando nos enfermamos de cualquier forma, por ejemplo, física o emocional, el cuerpo no se siente bien. No hay energías para realizar las actividades, no hay ganas, no se puede.* [I think that to be healthy is … to be able to satisfy the family's needs in good time and in an appropriate manner. Because when we get sick in any way, for example, physically or emotionally, the body doesn't feel well. There is no energy to do our activities, there is no motivation, you can't do it.]

Additionally, this theme connects to gender roles, as the family's functioning often rested on women's less valued, unpaid labor (e.g., emotional work in the family, household maintenance, caregiver burden) and men's paid labor (e.g., in the coffee fields). The women generally held less power and reported that they were expected to work in many domains with little to no respite, as part of being a good mother and wife. They were often expected to base their decisions around their husbands (e.g., expectation to live with in-laws). In addition to keeping the home running on the family-level, several participants, particularly women, also discussed functioning as providing opportunities for their children, such as supporting both daughters and sons in their education.

3.1.3. *Estar a gusto (to be at ease)*

Almost all participants also described ideal functioning as being at ease and content (*estar a gusto*) in all activities. Javier (single man, 28 y. o.), for example, shared that functioning means to be at ease in his work and leisure: "*Sano … es estar bien con mis hermanos, estar en el trabajo a gusto, de ver televisión, estar en el teléfono* … [Healthy … it's to be well with my siblings, to be at work at ease, to watch television, to be on my phone …]" Participants also described how functioning entailed enjoying rest and work, compared to going through the motions of work or being preoccupied when trying to rest. Often, women reported trying to find moments to be free of emotional labor by watching a short television show to escape from the day-to-day worries, while men were able to be at ease by resting completely. Other women did not even have this opportunity so reported trying to be at ease in their work, such as Guadalupe (married woman, 41 y.o.), who stated:

> "*Estar bien yo digo que es cuando uno se levanta contento, pues,* sin *ningún dolor. Uno está animada para hacer el oficio, con la fuerza de hacerlo.* [To be well I think is when one wakes up happy, without any pain. One is motivated to work, with the strength to do it.]"

3.2. *Connection between mental health and functioning*

Our next section involved the relationship between functional impairment and mental health in the cultural context of rural Chiapas. There were two domains that participants reported as primarily impacted by mental health: work (*oficio*) and family (*familia*), with several themes under each domain. As with the previous section, men's experiences are reflected in some themes more than others, and these themes demonstrated the importance of cultural context on functioning.

3.2.1. *Oficio*

Under *oficio*, we identified two themes: work as an obligation (*la obligación es de hacer el oficio*) and without motivation to work (sin *ganas de quehacer*).

3.2.2. *La obligación es de hacer el oficio (work as an obligation)*

Almost all participants expressed that work was an obligation (*la obligación es de hacer el oficio*) that often needed to be completed in spite of distress. Ernestina (married woman, 35 y.o.) explained that she had to have food ready for her husband and other coffee farmers when they came back from work, no matter how she was feeling emotionally:

> *O a veces hay días que no da ganas de hacerlo nada, a veces está uno ahí, pero la **obligación es de hacerlo** pues. ¿Si vienen la gente del trabajo y no encuentran nada?* [Or sometimes there are days when I don't feel motivated to do anything, sometimes I'm like that, but it's an obligation. What if the people come back from work and don't find anything?]

Participants emphasized how their commitment to work was not impacted by mental health because they did not have the option to stop working. This obligation was shaped by misogyny, gender roles, and economic oppression. Similar to Ernestina, Araceli (married woman, 41 y.o.), described how much her household depends on her work, even when she is struggling with her mental health, stating that even though people perceive women to be weaker than men, she disagrees because "*Mi casa* sin *mí parada no es casa* [My home without me standing is not a home]." Men appeared to experience the impact of distress on their occupational functioning differently. The men in the study seemed to view work as an obligation but also had the option to stop working when they were distressed, if only for a short period of time. Ricardo (married man, 22 y.o.) articulated the potential (and sexist) consequences of women not completing the housework, however:

> *Llegar y todo sucio la casa, pues nosotros estamos acostumbrados que esté limpio. Pues si lo dejaran de hacer pues se miraría muy feo ¿no? … Y pues eso dejan la esposa y buscan otra* (risa). [To get home and have the house all dirty, well we are used to it being clean. So if they were to stop doing the housework, well it would look really bad, right? A reason to leave your wife and look for another (laughs).]

3.2.3. *Sin ganas de quehacer (without motivation to work)*

Since participants viewed work as an obligation, the experience of work seemed to be impacted by mental health more than whether or not participants worked at all. The majority of participants who had experienced a mental illness described how they did not have the energy or desire to complete their work. For example, Amada (married woman, 21 y.o.), described how she had low energy while she was forced to work while depressed:

> *A veces amanezco **sin ganas de quehacer** … como que no quisiera yo levantarme. Quisiera estar todo el día dormida … Pues, me levanto*

> *porque si no me levanto más peor. Empiezan a decir … que parezco una patrona, una reina, que no quiero hacer nada.* [Sometimes I wake up without energy to do my work … like I don't want to get up. Like I want to sleep all day … Well, I get up because if I don't get up it's even worse. They start to tell me … that I am acting like a boss, like a queen, like I don't want to do anything.]

While most women in the study completed their work while distressed, as they did not have the freedom to stop working, many of them reported decreased quality of work. Many women completed their work while feeling restless or did not feel fulfilled by the work, for example.

Another way that participants, mostly women, navigated working with low energy was to leave some tasks "for another day" ["*para el otro día*" (Ernestina, married woman, 35 y.o.)] and only complete the essential tasks, such as cooking but not cleaning. In this context, a seemingly ordinary coping strategy (i.e., leaving something for the next day) may signal a great deal of distress, as it goes against the expectations of women and of working to survive. The amount of work completed seemed to depend not on the severity of a mental disorder, but rather on the availability of social resources; women who could leave the work for the next day tended to have children, particularly daughters, who were old enough to help with the housework (demonstrating the interdependence of family, or familism) or to experience less sexism by having husbands who would not threaten their physical or marital security if they did not complete the housework. Men in the study did not mention this lack of energy as much, though again this could be because we sampled fewer men with mental disorders.

3.3. Familia (family)

Family was the second major domain in which functioning was impacted by mental health. Under family, we identified three themes to demonstrate how family relationships were impacted by psychological distress: I shut myself in (*me encerraba*), I get angry (*me enojo mucho*), and in despair for my family (*desesperada por mi familia*).

3.3.1. Me encerraba (I shut myself in)

About half of participants described shutting themselves in their rooms and/or homes away from others when in distress, or "*me encerraba*" (Elizabeth, married woman, 26 y.o., history of depression). Men and women shut themselves out of different social activities, such as men avoiding sporting events, demonstrating the salience of gender roles in this context. Women such as Maribel (married, 29 y.o.) would shut themselves away from family and visitors when they were depressed:

> *No quería salir. Y si veía alguien que estaba en la puerta, si estaba tocando, yo gateaba dentro de mi casa para que nadie vea que estoy adentro.* [I didn't want to leave. And if I saw that someone was at the door, if they were knocking on the door, I would crawl around my house so that they wouldn't see that I was inside.]

It is important to consider that shutting oneself in would be a form of functional impairment that could limit their ability to meet the family's needs, a main pillar of functioning expressed by participants.

3.3.2. Uno se enoja mucho (I get angry a lot)

Many women and some men reported how they would get angry while distressed, feeling more irritable and/or acting more aggressively towards their family. While irritability is also a symptom of depression and anxiety, participants described it as a form of functional impairment because it impacted relationships. This anger impaired participants' ability to function within their families. Rosa (married woman, 36 y.o.) described how she and her husband fought more when she was depressed:

> *… Más el carácter, **se enoja uno mucho** … De solo cuando a veces, me dicen algo, a veces me enojo, o me pregunta mi esposo su comida, a veces ya ni atenderlo. Es lo que me pasa a mí.* [… One tends to get angry a lot … Even just when sometimes they say something to me, sometimes I get angry, or my husband asks me for his food, sometimes I don't even pay attention to him. That is what happens to me.]

These arguments often led to participants feeling even more separated from their families. Conflict could be escalated as family members grew frustrated when participants were distressed. Flori (married woman, 21 y.o.), for example, described how she felt separated from her husband when she developed depression for a second time:

> *Me dolía demasiado la cabeza … incluso hasta a veces ya no quería ni tener relaciones con mi esposo … discutíamos … lo único que quería era que él me abrazara y que.. me diera ánimos.* [I'm not sure where that strength came from, because at that time … I had terrible headaches … to the point that sometimes I didn't want to have sex with my husband anymore … we would argue … the only thing that I wanted was for him to hug me and … give me encouragement.]

Flori's account of when she would get angry demonstrates how irritability impacts the family system, which is likely more burdensome in a place where familism is woven through the social fabric.

3.3.3. Desesperada por mi familia (In despair for my family)

Many participants were in despair for their families and concerned about the impact of their mental health on their family's wellbeing, again connected to one of the pillars of functioning in this context, to meet the family's needs. Araceli's (married woman, 41 y.o.) concern about the emotional toll her depression had on her family represents this theme well. After describing the extra work her family had to complete around the house while she was depressed, she said:

> *… yo **desesperada por mis hijos y mi marido**. Ellos me miraban que me iba a sentar a la cama, ay, no se me borra la cara de mis hijos. "Mami, levántate. Mami, ya no estés aquí. Mami, le pidamos a Dios." Ya todo lo tenía grabado en mi mente. Era desesperado [desesperante] para mi familia.* [… I was in despair for my children and my husband. They would look at me when I would go to sit on my bed, oh I can't get my children's faces out of my head … "Mommy, get up. Mommy, don't stay here. Mommy, we pray to God." Now I have everything recorded in my mind. It was desperate for my family.]

This form of experiencing functional impairment was particularly gendered, as all of the participants who endorsed this theme were women. Hugo (married man, 22 y.o.), when probed, briefly discussed how his family felt when he was distressed. He simply noted that "they become sad" ("*se ponen tristes*"), in contrast to Araceli's elaborate description of feeling "in despair" ("*desesperada*"). This theme was influenced by economic oppression, as well, because family members may take on even more work in a context where survival depends on work, such as Araceli's family. As with the other themes, the impact of mental health on family functioning may be particularly distressing in a context where familism is highly valued, and functioning is viewed at the family level, not the individual level.

4. Discussion

In this study, we explored conceptualizations of functioning and functional impairment in participants living in Chiapas, Mexico from a critical perspective. In general, participants described that to function was to work, to meet the family's needs, and to be at ease. Psychological distress impacted functioning in two main domains: work and family relationships. Participants expressed how work was an obligation that had to be completed for survival, whether participants completed their work themselves or were able to have a family member help them. Most participants described a lack of energy and/or doing only the essential tasks when they were distressed. Participants also shared that family relationships were greatly impacted when their mental health suffered.

They reported isolating themselves, growing irritated easily, and/or being consumed with concern about the impact of their mental health on their family. In this setting, cultural context was woven throughout these themes, particularly economic oppression, gender role expectations, and familism.

Our findings support the notion that cultural context influences how functional impairment is manifested. This message, in alignment with the work of medical anthropologists and social psychiatrists, challenges assumptions that experiences of functional impairment are uniform across populations (e.g., Ormel et al., 1994; Üstün, 1994; VonKorff et al., 1996). While there are methods to adapt functioning scales based on context, most of the most frequently used measures were created in and for high-income countries (Bolton and Tang, 2002). These common measures of functional impairment/disability do consider functional impairment in the "social and occupational" spheres (American Psychiatric Association, 2013), similar to our themes under work and family, but they do not account for how culture shapes impairment. Results from our study critique and expand upon two implicit pieces of this clinical functioning literature, role functioning and individualism. While we argue that functioning is specific to each context, questioning role functioning and individualism may be a good starting point for understanding functional impairment in cultural contexts where functioning has not been investigated.

Findings from this study raise questions about when and where to consider role functioning, or one's ability to complete work (Berger et al., 2016; Ormel et al., 1994). Research in western countries often focuses on how mental disorders impact productivity, with outcomes such as missed days of work or number of participants who leave the workforce and acquire disability benefits (e.g., Frey et al., 2020; Mittendorfer-Rutz et al., 2014; Riihimäki et al., 2015). Even measures designed in non-western contexts conceptualize the highest level of impairment as not being able to complete a task at all (e.g., Bolton and Tang, 2002). Our results suggest that this emphasis on role functioning may not be as useful in contexts such as rural Chiapas, where not working is often not an option, especially for women. In our study, many of the women reported continuing to do the housework despite being depressed because "*mi casa* sin *mí parada no es casa*" ["my home without me standing is not a home"]. These women would often rely on family members to help around the house when they felt depressed, and their level of role functioning thus depended more on available social support rather than the severity of their disorder. The focus on role functioning in other contexts seems reflective of functioning in a capitalistic environment (e.g., the goal is to improve functioning to increase worker productivity), whereas most participants in our study were functioning to survive, be at ease, and contribute to their families.

This study also raises questions about the individualistic perspective in functioning research and clinical practice. This idea is addressed in some culturally-specific measures that include functioning at the community level (e.g., Bolton et al., 2004; Habtamu et al., 2016), but is notably absent in the dominant clinical literature. In western psychology and psychiatry, disorders are understood to originate within an individual, such as from cognitive distortions, and are treated most often through one-to-one interventions (Azétsop and Rennie, 2010; Bleakley, 2020; Frey et al., 2020; Fox and Prilleltensky, 1997; Sciolla, 2007). Critical and liberation psychologists have historically argued that conceptualization and treatment of suffering at this individual-level may not work in the context of oppression, because the roots of the problems are social (e.g., Fox and Prilleltensky, 1997; Martín-Baró, 2006). Our findings, for example, highlighted the impact of economic oppression and sexism on how people functioned or had difficulty functioning. Most clinical instruments that evaluate impairment come from the tradition of medical individualism, though. Research in western cultures also primarily focuses on the experience of impairment on an individual level, such as through lowered self-esteem (Cotter et al., 2019) or identity change (Fauske et al., 2015). In non-western contexts, however, people may view themselves as interdependent, wherein the self is dependent upon others and vice versa, known at a cultural level as collectivism (Markus and Kitayama, 1991). Similarly, Erich Fromm (1964), a German researcher who conducted extensive work in Mexico in the 20th century, theorized that psychological wellbeing comes from feeling connected to others, similar to our themes around family. With many of our participants, for example, a clinician might evaluate someone as "functioning" because they complete their housework, when in reality they are severely distressed but value meeting the needs of their family and/or feel pressured to fulfill specific gender roles. In many studies in Mexico, a country made of diverse cultures many of which value familism, researchers measure family functioning rather than individual functioning (e.g., Pérez and Martínez, 2016; Saavedra-González et al., 2016), which could be beneficial in other collectivistic contexts, as well.

In addition, results from the study were notable in what was not included in participant conceptualizations. Indeed, there were several domains in cross-cultural measures, particularly the WHODAS 2.0, that were not mentioned or were expressed differently in our study. In particular, participants did not comment on if and how their understanding/communication or mobility were impacted, two of the six domains in the WHODAS 2.0 (Üstün et al., 2010). Also absent from participant conceptualizations were mention of pleasurable activities, such as community activities or getting along with friends. Unlike in the WHODAS 2.0, life in this context seems to revolve around working and supporting one's family. While parts of those domains are covered in the WHODAS 2.0 and other similar measures (Üstün et al., 2010), both the salience and quality were different in our study.

While the specific findings of our study may only apply to rural Chiapas, as we argue that functioning is context-specific, we hope that the broad messages will illustrate how cultural context impacts functioning generally and that specific findings could be relevant in unique ways to other under-researched contexts, such as the need to look beyond role functioning and individualistic assessments of functioning.

4.1. *Strengths and limitations*

This study has several strengths and limitations. There were fewer men than women in the sample, particularly men with a known mental health history. As such, our analysis was more influenced by the data provided by the women, and we may not have captured fully the experiences of men in this community. Additionally, while we try to draw attention to culture and context, working from a psychological and mental health framework automatically medicalizes distress in a way that may have limited how participants discussed their experiences, though we tried to keep questions open-ended.

In terms of strengths, we hope that our critical, qualitative approach centers the participants and their views of functioning, calling attention to where mainstream conceptualizations of functioning fall short. The focus on an under-researched group, particularly women in low-income countries, using rigorous qualitative methods is also a strength. As far as we know, the cultural lens of this study is unique in functioning research in Mexico, and we hope that it will have both theoretical and practical, clinical implications.

5. Conclusion

This study explored the experiences of functioning and functional impairment in a sample of participants from Chiapas. The results demonstrate that accounting for cultural context is *imperative* to understanding how functioning is impacted by distress. Global mental health and psychological interventions that neglect to explore how family or community, gender roles, economic oppression, or other pieces of cultural context operate will not be effective in contexts where individuals see themselves as part of a larger collective and are impacted by structural violence at a systemic level. Clinicians and researchers could benefit from replacing or complementing such assessments with open-ended questions about the patient's environment. For example, for our participants, functioning was not just about whether or not someone could complete their work (because often it was an obligation), but whether or not they were "at ease" in the kitchen or felt like they were contributing to their family's wellbeing while working. With a cultural lens for functional impairment, clinicians could more accurately diagnose and monitor psychological distress, mental health services could more adequately address service user's context, and those living with mental disorders could feel more centered and heard in their care.

Additionally, in rural Chiapas, spaces should be created for women to be at ease. Despite the participants' desire to be "at ease," there seems to be a shortage of spaces for people, especially women, to rest or to socialize outside their homes, which has been found to further impair women's mental health in this context (Aguerrebere, 2018). Importantly, as feminists have argued, leisure is linked to power, and thus, spaces to be "at ease" could serve as contexts for further oppression, if structures remain unchanged, as well as resistance and empowerment in the context of gender oppression (Henderson, 1990). Mental health professionals must also advocate for equitable policies, such as fair pay or domestic violence prevention, given that inequality is clearly shaping distress and functioning. In general, effective and equitable mental health care in this context must recognize that feeling "desperate for my family [*desesperada por mi familia*]," as the participant Araceli said, is perhaps more important to unlocking the impact of psychological suffering on a patient than fitting diagnostic criteria for functional impairment.

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CRediT authorship contribution statement

Sarah Joy Hartman: Conceptualization, Methodology, Formal analysis, Investigation, Writing – original draft, Writing – review & editing, Project administration, Funding acquisition. **Néstor Noyola:** Methodology, Formal analysis, Writing – review & editing. **Viena Murillo:** Formal analysis, Writing – review & editing. **Fátima Rodríguez Cuevas:** Conceptualization, Writing – review & editing. **Esteban V. Cardemil:** Conceptualization, Methodology, Writing – review & editing, Supervision.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

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