Quantifying The Shortage of Mental Health Care in Venezuela Through Media Content Analysis

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QUANTIFYING THE SHORTAGE OF MENTAL HEALTH CARE IN VENEZUELA THROUGH MEDIA CONTENT ANALYSIS

by

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B.S. University of Florida, 2017

A thesis submitted in partial fulfillment of the requirements
for the degree of Bachelor of Science
in the Department of Health Sciences
in the College of Health Professions and Sciences
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ABSTRACT

The aim of this thesis was to assess the gaps and deficits in the mental health care staffing and related prescription drug or therapeutic intervention availability in Venezuela using media content analysis. This thesis also assessed the measures suggested by Venezuelan medical professionals for addressing the population’s needs for mental health services amid the nation’s crisis. The shortage of mental health care in Venezuela was assessed because various stressors, including life events, chronic stressors, and daily hassles, are substantially less than optimal among Venezuelans. The mental health consequences of these factors, along with the detrimental psychosocial demands commonly faced by Venezuelans, was explored within this study. Such an investigation is critical in light of the poor prioritization of intangible mental health care within the already inadequate health care system existing in Venezuela. The used media content included newspapers and periodicals published in Venezuela and foreign newspapers covering the medical crisis in Venezuela, published or posted interviews with Venezuelan medical personnel describing the health care crisis, social media posts involving requests for or availability of medicine and services, and social media posts of videos or images as visual testimony of the crisis. Coder reliability was assessed, and descriptive and inferential statistical tests were implemented for deductive analysis of the study’s results and to find possible answers to the presented research questions.

Key words: Venezuela, mental health, medical shortage, medical crisis, media content analysis, matrix method
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INTRODUCTION

Venezuela’s History

Brief Period of Prosperity

The South American country of Venezuela has a turbulent history marked by monarchies, dictatorships, and presidencies. The *Punto Fijo* regime established in 1958 made the petroleum state responsible for the management, employment, and implementation of the nation’s social welfare (Daguerre, 2011). Between 1973 and 1983, Venezuela relished in a brief economic boom, resulting from high international oil prices that granted the country’s petroleum industry success (Tarver & Frederick, 2005). The substantial revenue from petroleum sales was then harnessed by the Venezuelan government when it nationalized the petroleum industry in 1976 (Tarver & Frederick, 2005). The following administrations relied on these revenues to fund policies and initiatives. For example, during its 1974-1979 term, President Carlos Andrés Perez’s administration allocated more than 53 billion U.S. dollars (USD) for advancements in infrastructure, agriculture, and public health (Tarver & Frederick, 2005). The governments presiding over this oil-produced prosperity came close to fulfilling universal health care. However, such funding for public health was not continued by the later presidencies of the 20th century. This left the health care system to become both inaccessible to various rural and other otherwise disadvantaged populations and insufficient in terms of available services and performance by the 1990s (Wilpert, 2007).
Venezuela’s government system is a federal presidential republic—like the United States (Sawe, 2017). The health care system is a tripartite one, with a public, social insurance, and a private sector (Hartmann, 2016). Venezuela’s health care system came to depend heavily on federal funding, which was mostly granted from the export earnings accumulated by the nationalized industries (Daguerre, 2011). The petroleum industry contributed an exponentially increasing amount of these earnings, rising from 68.7% of the export revenue in 1998 to 96% by 2016. In turn, the Venezuelan government used this oil revenue for 40% to 45% of the nation’s budget (Hetland, 2016). After international oil prices dropped in the 1980s, health care was included in the social programs that endured cuts in real per capita funding, which decreased from 2,069 Venezuelan bolivar, or VEB, in 1987 to 1,099 VEB in 1994 (Coker, 1999; Daguerre, 2011). Both values are based on 1984 Venezuelan currency, when 1 VEB averaged 0.00802 USD (Coker, 1999; fxtop.com, 2019). This meant the end of the Punto Fijo regime model in Venezuela (Daguerre, 2011). Politicians decided to replace it with a compensatory social assistance model, meant to alleviate the effects of freshly introduced neo-liberal economic policies on the more financially precarious populations through conditional cash transfer programs (Daguerre, 2011).

By 1989, there had been a major decline in the quality of public health services, owing to the central government holding a major exterior debt, being heavily reliant on oil revenues, and having used up the occupationally-fragmented and class-stratified redistributive social welfare model of the 1960s and 1970s (Daguerre, 2011; Daryanani, 2017). The cuts that were made on public health care spending were so extensive that public hospitals became unable to provide
reliable medical care. Shortages of basic medical supplies plagued patients with the burden of purchasing their own gauze and surgical gloves, among other essential supplies (Coker, 1999). The situation further exacerbated with the departure of medical professionals who were frustrated by these inadequacies. Doctors employed under the public sector who still presided in the country in 1996 expressed their grievances for these poor conditions and their low wages in a strike that reached 27,000-strong in December of that year (Coker, 1999).

**Previous Accomplishments in Venezuelan Mental Health Care**

A widely recognized health care initiative from the early 1990s was the hosting of the Caracas Conference and the signing of the Caracas Declaration on the Modernization of Mental Health Legislation in 1990. As a result of the Conference, Venezuela enacted Resolution No. 1223 of October 15, 1992 and the Regulation for Psychiatric Establishments of Long Stay (Bolis, 2002). The goal of these pieces of legislation and the Conference was to advocate for human and civil rights of people living with mental illness as well as redefining health care models that structured primary psychiatric care in South American and Caribbean countries (Alarcon & Aguilar-Gaxiola, 2000; Bolis, 2002). Regardless, the Venezuelan government of the early 1990s left these movements largely unfunded, which was consistent with their decreased public health spending (Briggs & Mantini-Briggs, 2009; Daryanani, 2017; FitchSolutions, 2018).
How Health Disparities Propelled the Entrance of Hugo Chávez

The decline in Venezuelan health care quality and access during the late 20th century was addressed by the campaign promises of Hugo Chávez. He was a former lieutenant who mounted a coup attempt against Carlos Andrés Perez, who had been serving his second presidential term when he became infamous for orchestrating the deadly oppression of street protesters during the 1989 Caracazo (Suhr, 2016; Tarver & Frederick, 2005). After being imprisoned for his failed coup attempt against the Pérez administration, he was pardoned by the successor of Pérez, the second-time president Rafael Caldera (Tarver & Frederick, 2005). Chávez proceeded to run for presidency and was elected in 1998, pledging to restore the legitimacy of the government and reverse the social and economic plights that were left to accumulate and fester in the prior decades (Daguerre, 2011; Tarver & Frederick, 2005). Once well established in office, Chávez began executing the presidential power he had expanded in his rewrite of the constitution (Suhr, 2016; Wilpert, 2007). Chávez was able to achieve this by winning a 1998 mandate for the political system’s complete reformation, followed by a successful 1999 referendum allowing for the formation of a constitutional assembly with elected pro-Chávez members. This new constitution, which was approved in December of 1999, was pivotal to Venezuela’s history because it completely changed the roles and operations of government institutions involved in the central government’s execution of power (Wilpert, 2007). Within this constitution, he declared that access to health care was a constitutional right, that the privatization of public health care services was forbidden, and that the government would assume regulation of the preexisting private health care system. Additionally, he granted Petróleos de Venezuela, S.A. (PdVSA), the national oil company, influence in social and economic development and allocated
large sums of federal funding to his 2003 national health care provision program, *Misión Barrio Adentro* (Fraser & Willer, 2016; Hartmann, 2016; Suhr, 2016).

Chávez’s Universal Health Care Policies

*Misión Barrio Adentro*

*Misión Barrio Adentro* was paid for largely by the central government budget and by PdVSA, which Chávez had nationalized a year prior to the presidential decree. This and other social initiatives were indeed utilized to sustain popular support amid the startled response from the public and government at Chávez’s forceful industry takeover (Suhr, 2016). The program involved the importation of Cuban health care providers to support newly built medical centers in the deep urban and otherwise underserved regions of Venezuela. The locations for these community health care centers were chosen by considering the density of slum dwellings as identifiers for distinctly poverty-stricken areas (Daguerre, 2011). Chavez agreed to provide the Cuban medical professionals with food, lodging, and domestic transportation and to send Cuba 53,000 barrels of petroleum a day if Cuban President Fidel Castro paid for the professionals’ salaries and family support (Fraser & Willer, 2016). This reliance on Cuban providers was intended to be temporary while Venezuelan medical students completed an accelerated medical program designed for their participation in the social initiative (Jones, 2008). A major accomplishment of *Misión Barrio Adentro* included its contribution to the increase in the percentage of the GDP spent on social programs from 8.8% in 1990 and 1991 to 11.7% in 2004.
and 2005. To illustrate the financial allocation, 6% of the GDP was dedicated for public spending on Chavez’s Misiónes in 2006 (Daguerre, 2011).

*Nationalization of Pharmaceutical Providers, Changes in Currency Exchange System, Reliance on Imports, and Departure of International Pharmaceutical Companies*

In addition to taking ownership of PdVSA in order to have mass funding at his disposal, Chávez furthered his radical approach to health care provision by nationalizing various pharmaceutical manufacturers. The intent was to provide medicines at a more affordable price. However, the industry became overrun by mismanagement and was unable to supply the country with most of the essential drugs. This drove the medical industry to rely heavily on imports to meet the population’s medicinal needs (Casey, 2016; Fraser & Willer, 2016; Suhr, 2016). Payments of international imports of both finished medicinal products and chemicals used to domestically synthesize drugs were delayed by the complicated differential business-related currency exchange rates implemented by the Chávez administration, further diminishing the drug supply and therefore worsening the health care situation (Casey, 2016; Fraser & Willer, 2016). Because of the inability to properly operate these newly nationalized drug manufacturing industries, more and more medicines were imported instead of domestically produced. The inconsistent payments and accruing international debt deterred international businesses and diminished the number of pharmaceutical companies willing to sell to Venezuela over time (Casey, 2016; Daryanani, 2017; FitchSolutions, 2018; Fraser & Willer, 2016).
Flaws in Chávez’s Health Care System

Regardless of the Chávez administration attempts to make health care access more inclusive, the public health sector remained insufficient and thus relied on contract services from the private sector. This exacerbated the fragmentation of the health care system and left much of the rural population still without adequate or accessible health care. Furthermore, those who did not identify with the left-wing ideology of the Chávez administration were likely to avoid seeking services provided by Misión Barrio Adentro (Hartmann, 2016). This and the extensive focus on providing services mainly to low-income individuals eroded the universality of Venezuela’s health care policy that was guaranteed in the 1999 rewrite of the Constitution (Daguerre, 2011). Lastly, placing the health care system under the control of the central government without passing legislation to formalize this role led to a worsening in inefficiency, corruption, and quality of medical services (Fraser & Willer, 2016).

The Shortfalls of Misión Barrio Adentro

Although Misión Barrio Adentro managed to temporarily extend health care access to previously under or unserved populations, it exhibited many inadequacies (The Lancet, 2018). Mental health care did not appear to be highly prioritized (Briggs & Mantini-Briggs, 2009). Also, more than 4,000 of the Cuban health care providers were relocated to Bolivia and, thus, returned the doctor-to-population ratio closer to the baseline status (Jones, 2008). Additionally, the curriculum that the participating Venezuelan medical students learned from was not accredited (Correa S, 2017; Daryanani, 2017). This and the lack of further required credentials for Cuban
health care providers other than proof of their Cuban nationality greatly undermined the credibility of the medical care that people were receiving from these outreach medical centers. Meanwhile, Venezuelan medical counterparts were incentivized to emigrate owing to the inadequacies in personal and job security, gross underpayment due to exponential inflation unchanged by the purely masking nature of currency replacement systems, and threats from hospital managers to accept such circumstances enabled by unstable contracts (Correa S, 2017).

Furthermore, the construction was significantly behind schedule five years into the project, with less than half of the establishments built by their deadline and about a third of them being left unstaffed (Jones, 2008). Perhaps the most detrimental effect that the program had on the health care of the nation was that it was executed as a parallel system to the preexisting public health infrastructure (Daguerre, 2011; Daryanani, 2017; Fraser & Willer, 2016). Much of the funding from the central government that was intended for public health was redirected towards Misión Barrio Adentro and not to the preestablished public medical institutions (Daryanani, 2017; Fraser & Willer, 2016). Approximately $126.5 million (US) of PdVSA and central government reserves were used to fund the construction of the primary care facilities (Jones, 2008). The neglect of the public health care sector contributed to a substantial departure of public sector doctors owing to the worsening working conditions (Correa S, 2017).

Additionally, the government health spending on the private health care sector decreased from 73% in 1997 to 55.1% in 2008. Therefore, these institutions also suffered a decline in resources and performance. This was of concern because, as aforementioned, the public health care sector has relied considerably on the private health care sector for certain referral services (Hartmann, 2016).
*Misión Barrio Adentro* was unable to complete its universalist aims, establish itself as a consistent and stable system, or remain functioning during the health care crisis of more recent years (Daguerre, 2011; Jones, 2008). This social reform, just as others introduced during Chávez’s presidential terms, proved to be merely a short-term solution to poverty, health disparities, and the wavering support from the majority lower-income groups. It is important to emphasize that this health care initiative was fully implemented only after Chavez was faced with a recall referendum following the failed coup attempt against him in 2002 and the subsequent decline in living standards through the rest of that year and into 2003 (Daguerre, 2011; Fraser & Willer, 2016). *Misión Barrio Adentro* was characterized by the same undermining features as the other Missions initiated by the Chávez administration and traditional policies preceding Chavez’s presidential terms: extreme dependence on oil revenues, poor political and institutional accountability, extremely fluctuating funding, and “short-term opportunistic behavior” (Karl, 1997, as cited in (Daguerre, 2011) pp.116-60). Even so, Chávez’s successor, Nicolás Maduro, pledged to continue the implementation of Chávez’s policies and reforms (Stevens, 2017).

**Nicolás Maduro’s Attempt to Continue Chávez’s Agenda**

Nicolás Maduro was facing the start of the worst recession that the Western Hemisphere would come to witness when he came into power. Shortly before his death, Hugo Chávez urged the Venezuelan populace to vote Nicolás Maduro in as his successor. Maduro’s loyalty convinced Chávez that he was the candidate who was most likely to maintain the changes that Chávez and his allies had introduced to the country. Although Chávez was correct in his
assumption, Maduro had to bear the brunt of the economic collapse that resulted from a major
dip in international oil prices and the devaluation of Chávez’s currency replacement, the “strong”
bolivar, after unprecedented inflation (Stevens, 2017; Suhr, 2016). Maduro lacked the abundance
of financial resources, the military background, and the charisma needed to sustain the mass
popularity that Chávez had possessed among the civilians and the powerful Venezuelan military.
Moreover, Maduro’s takeover of all three branches of government, blunt expression of his
distrust towards the U.S., and his adamant rejection of international humanitarian aid further
isolated his administration in the global scene and polarized the political climate in Venezuela
(Stevens, 2017).

Recent Conflicts Pertaining to Venezuela

Since the onset of this year, Maduro has dealt with a newfound surge of disapproval by
both domestic and international entities, largely due to the emergence of Juan Guaidó into the
political scene and Maduro’s continued rejection of international humanitarian aid. Juan Guaidó
is a Venezuelan politician of the government-opposition party, who on the 23rd of January, 2019,
cited the Venezuelan Constitution’s Articles 233, 333, and 350 when he swore himself in as
interim president (Avendaño, 2019; Noticias Financieras, 2019). He claimed that the
Constitution grants the voted president of the National Assembly the right to temporarily act as
the nation’s president in the face of forceful usurpation of the executive branch (Avendaño,
2019). He and the majority of Venezuelans considered Maduro’s questionable re-election to
encompass these required conditions for Guaidó’s proclamation (Asia News Monitor, 2019).
However, experts have concluded different interpretations of the Venezuelan Constitution’s
articles in question, and these statements are still largely debated in the international scene, with the most notable recognizer of Guaidó’s interim presidency being the United States (Asia News Monitor, 2019; Mery & Kraul, 2019; Noticias Financieras, 2019).

As a consequence of these political developments, the U.S. collaborated with Canada and several European and Latin-American nations to attempt to provide humanitarian aid to Venezuela (Mery & Kraul, 2019). These efforts were met with violent rejection by the Venezuelan armed forces, resulting in civilian deaths and dangerous border tensions between Venezuela and its neighboring countries (Long, 2019; Mery & Kraul, 2019). The aftermath of these current events has been a worsening of international political strain, an even deeper decline of the quality of life in Venezuela marked by political uncertainty, and the further loss of support for Maduro and his regime.

The Collapse of Venezuela’s Infrastructure

Much of the mismanagement and corruption that is responsible for the deterioration of Venezuela’s infrastructure occurred after Maduro granted military officers business and diplomatic posts. As much as a third of all cabinet minister posts and an even greater proportion of deputy minister posts were granted to military figures. Maduro’s intent was to gain and solidify approval by the Venezuelan military, which had inheritably entrusted the late, ex-military Chavez to a considerably higher degree. Placing these officials in these state and business seats, for which they were largely unqualified and unprepared, produced an inefficiency that further corroded the management of the country (Suhr, 2016). In addition to the nepotism present behind the political decisions of both the Chávez and Maduro administrations,
there was also a lack of executive supervision in state affairs. The consequence has been a worsening of embezzlement and corruption among politicians in Venezuela (Suhr, 2016).

During Chavez’s first term in 2003, he mandated regulations on the Venezuelan currency system, including fixing the exchange rate, which resulted in the emergence of an unofficial black-market exchange rate between the Venezuelan bolivar and the U.S. dollar (Hetland, 2016; Suhr, 2016). This rate has been exploding ever since Maduro took office. In 2015, It was reported to be up to 150 times greater than the rate established by the central government (Hetland, 2016). The devaluation of the Venezuelan currency is furthered by the incentive to resell dollars obtained through the Venezuelan government, purposed for business or individual use, on the black market for up to 15,000% profit (Hetland, 2016). Both private and corporate entities that benefit in receiving foreign currency at the official exchange rate must first be regarded as a close advocate of the government by openly expressing their political support, especially through political rallies and publicized statements (Daryanani, 2017).

This devaluation of the Venezuelan currency has caused the nation’s inflation rates to rapidly become the highest in the world, bearing down on businesses and employees alike and leaving masses unemployed. In 2008, Chávez had replaced the traditional bolivar currency with the “strong” bolivar, which simply took off three zeroes from denominations (Rueda, 2008). The intention was to stave off the effects of inflation and make transactions easier, however a more recent currency replacement shows the futility of such an economic change. Maduro mirrored Chávez’s strategy in 2018 by replacing the “strong” bolivar with the “sovereign” bolivar, removing five more zeroes from the Venezuelan currency’s denominator (Al Jazeera, 2018).
Those who managed to remain employed during recent years were assured a minimum monthly wage that was valued at less than a carton of eggs. The minimum wage in 2017 was between 12 and 33 U.S. dollars per month (Daryanani, 2017; Stevens, 2017). Domestic production declined, and imports dwindled as the country became barely able to continue paying for shipments. Hetland (2016) claimed that in 2014, the Venezuelan economy contracted by 4% and that inflation reached 62.2%. During the following year, the economy was estimated to have contracted by 10% and inflation was approximated at 200%. The inflation proceeded to increase by 500% between 2015 and 2016 (Stevens, 2017). The International Monetary Fund calculated Venezuela’s inflation rate to have reached 13,860% in April of 2018 (Osorio, 2018).

The Venezuelan government became exponentially less capable of handling the nation’s economy. This was largely due to the constantly increasing state spending and inefficiency, the repeated use of PdVSA’s revenue to cover government expenses, and the excessive printing of currency and utilization of gold reserves (Suhr, 2016). Global figures including China, Russia, and Cuba agreed to oil shipments as payment for their goods and services. They also provided the Venezuelan government with substantial loans, which the Maduro administration recently defaulted.

Each passing year less and less was available to the public. Basic commodities were the first to become scarce, followed by more essential foods and medicine. Electric outages increased in frequency, partly due to large amounts of Venezuelan petroleum being exported rather than withheld for domestic usage. Oil was calculated to comprise 96% of Venezuela’s total exports in 2015 (Suhr, 2016). Crumbling infrastructure meant that water supply was cut down throughout all major Venezuelan cities. Finally, supply of food and medicine became so
diminished that a large part of the population had visibly lost weight and thousands began to die from otherwise easily preventable diseases and illnesses. The main food items that Venezuelans ate in 2014 were processed, simple carbohydrates and low-quality fats. These typically consisted of bread, corn flour, and margarine (Fraser & Willer, 2016). This poor diet is likely responsible for the average of 8-kilogram weight loss among adults (Daryanani, 2017).

For some potentially fatal ailments, the only cure has been to purchase medicine available only outside of the country. It became more common to see Venezuelans visiting other countries with the intent of purchasing various medications, including insulin, high blood pressure medications, essential antibiotics, analgesics, and anti-psychotics (Daryanani, 2017). However, pre-established limitations on foreign purchases imposed by the government hinders the ability for traveling Venezuelans to bring enough foreign currency while abroad. The maximum of 2,500 U.S. dollars for travel per year puts a very finite limit on the kinds and the amount of medications that Venezuelans could acquire while outside of the country. Furthermore, paperwork for these travel funds have been so extensively delayed, that international travel has been rendered impossible for many Venezuelans (Daryanani, 2017).

Concerns gave way to frustrations as the leading drivers to the diaspora of medical professionals furthered the medical deficit in the country. Diseases that Venezuelans have needlessly died from include diabetes, cancer, depressive disorders, cardiovascular disease, various systemic infections, maternal and birth complications, and malnutrition. Markedly, some of these diseases are chronic in nature. This may be a consequence of inadequate chronic condition management resulting from people rationing out any medications they are able to acquire, mistakenly believing that the treatment is still effective if they do so (Fraser, 2017).
Of great medical concern are the elevated maternal and infant mortality rates and the robust return of various tropical diseases such as malaria and chikungunya (Fraser & Willer, 2016). In 2017, the vice-president of the Venezuelan Medical Federation claimed that 242,976 cases of malaria occurred in 2016 (Correa S, 2017). Maternal mortality rate climbed from 56 per 100,000 in 2007, which was calculated following Chavez’s re-election, to 112 per 100,000 in 2016. The rate had been rising during Chavez’s second term, but the statistic became exponentially worse under the Maduro administration (Fraser & Willer, 2016). Moreover, infant mortality rate was up by 18% during the first half of 2016 compared to the rate in 2015 (Fraser & Willer, 2016). These rates are in addition to the Health Ministry of Venezuela’s ceasing of publishing epidemiology bulletins amid the surge of chikungunya cases in 2015 (Fraser & Willer, 2016). However, the unofficial rates were very similar to the Health Ministry’s delayed Epidemiological Bulletin, which described malaria cases and maternal and infant mortality rates. Notably, the Health Minister of the time was dismissed for having authorized the publication of the bulletin (Daryanani, 2017; Fraser, 2017). The severity of the maternal and infant mortality rates is compounded by the rise in teenage pregnancies in Venezuela, which is likely due to insufficient reproductive health care access (Osorio, 2018). Such a health care disaster is not entirely new to Venezuela, where the central government has a history of failing to protect its citizens from social risks worsened by economic crises (Daguerre, 2011). However, such suffering resulting from the current unprecedented crisis will create reverberations in Venezuelans’ physical as well as mental health outcomes for generations to come.
Connection between Stress and Physical Health

Research has established a strong association between chronic or untreated physical illness and mental health consequences. Additionally, connections between social determinants and health as well as psychosocial implications and physical illness have also been identified. Biological pathways have been described in a social context to reveal how these social and psychological factors produce health outcomes. Particularly, the fight-or-flight response has been deemed the major mediator of these pathways. There is a general agreement that this autonomic response is beneficial in instances of acute stress rather than chronic stress. Researchers have argued that prolonged exposure to the biochemical products and by-products of the stress response is detrimental to one’s physical health, owing to either over-pronounced or desensitized responses to stress-response mediators. Bodily functions that have exhibited changes according to prolonged psychobiological stress responses include neuroendocrine, autonomic metabolism, and immune responses (Marmot & Wilkinson, 2005).

Psychosocial stressors and resilience and vulnerability factors are what determine these psychosocial stress responses. These stressors include life events, chronic stressors, and daily hassles, all of which are characteristically less than optimal among Venezuelans. The coping responses, personalities, and social support systems that Venezuelans possess encompass the resilience and vulnerability factors (Marmot & Wilkinson, 2005). The mental health consequences of these factors along with the detrimental psychosocial demands commonly faced by Venezuelans will be explored within this study. Such an investigation is critical in light of poor prioritization of intangible mental health care within the already inadequate health care
The precarious state of Venezuela’s health care system is partly due to the inconsistencies within the fragmented system comprised of different facilities intended for either those who are insured, uninsured, in the military, or seeking private sector services (Daryanani, 2017; Fraser & Willer, 2016). To the detriment of the majority low-income Venezuelan population, the health care system has become largely privatized, which greatly conflicts with the supposed socialistic views of the Maduro administration (Fraser & Willer, 2016).

The current health care crisis that Venezuela has arrived at is the product of multiple and chronic social, political, and economic issues. Directly involved are the underfunding of the health care sector, the implementation of inappropriate health policies, and the macroeconomic issues of currency devaluation and meager domestic production (Bello, Damas, Marco, & Castro, 2017). Another contributing economic factor is the proliferation of the black market for the sale of goods, such as essential medicine, that has acted as an obstacle for the central and state governments to implement decommodification reforms (Hetland, 2016).

Drug providers in Venezuela have a diminishing ability to pay for imports since their currency becomes devalued while they wait for payment delays to be processed. These delays occur because drug providers are required to request permission from the central government to purchase foreign currency. Because these payment delays have become typical among Venezuelan drug purchasers, foreign companies now demand immediate payment for their
products. The purchasing power of Venezuelan drug providers is further undermined by the commissions they may have to pay to intermediaries. Domestic production of pharmaceuticals is hindered by similar problems associated with importing chemicals needed to synthesize drugs (Fraser & Willer, 2016). The associated increased manufacturing costs without the corresponding increase in retail price, owing to the fixed price caps set by the government, meant that drug manufacturers struggled to remain in business (Suhr, 2016).

In 2016, the monthly salary of a doctor or college professor was between $30 and $50 (Fraser & Willer, 2016). Because of these inadequate wages and other adverse working conditions, a substantial flow of doctors have emigrated from Venezuela, while graduate and residency programs receive a dwindling amount of applications each passing year (Fraser & Willer, 2016). The Venezuelan Medical Federation places the number of doctors who have emigrated “in recent years” at 16,000 (Correa S, 2017). Moreover, medical students and other health care professionals have faced violence in the past by security forces during their attempts to treat injured protesting civilians, neutral bystanders, or wounded security officials (Bello et al., 2017). All of these factors contribute to the diaspora of medical professionals from Venezuela.

According to an unofficial report made by a physician group in the Central University of Venezuela, almost 70% of public hospitals claimed to have experienced interruptions in water service in 2016. This is a drastic increase from the 39% of public hospitals that reported the same a year prior (Fraser & Willer, 2016). Additionally, the general shortage of food brought about a major deficiency in dietary supplies for hospitals. In 2016, hospitals self-reported that 7% of them were able to feed their patients at an appropriate frequency and quality, 17% claimed that family members had to provide the patients with their dietary needs, 12% stated they were giving
at most two meals a day to their patients, and more than 50% reported to provide three daily meals which lacked the ability to be modified for specific diets and varied considerably in quality and quantity.

Some of the sectors most severely damaged by the nation’s crisis are the public and private health care sectors. Because the Venezuelan government’s health ministry ceased to regularly publish national health data, some researchers and former health ministers have taken up the responsibility of quantifying the conditions of the nation’s health care system. They combined leaked official records with university surveys in their studies. On August 23rd, 2016, they found that 65 of the 86 hospitals surveyed considered medical supplies to be scarce, an increase from 55% during 2014. Additionally, 81% of these hospitals claimed a shortage in medical and surgical materials, compared to 57% of them in 2014. These hospitals represented 38 Venezuelan cities. Furthermore, the doctor who directed the study was also employed by a private hospital, where an alleged 80% of his patients are unable to obtain their medicine regardless of their ability to pay. The study concluded that less than 10% of the public sector’s emergency rooms, operating rooms, and adult intensive care units were completely operating, that 13% of adult intensive care units and 17% of operating rooms were not functioning at all, and that all other institutions claimed to have intermittent problems (Fraser & Willer, 2016). The result is people waiting for months, perhaps within a hospital, to receive critical surgeries (Stevens, 2017).

Of the supplies claimed to be in shortage include gloves, sutures, anesthesia, chemotherapy drugs, and laboratory diagnostic testing equipment including specific blood tests and X-ray, tomography, ultrasound, and magnetic resonance supplies (Correa S, 2017; Fraser &
Willer, 2016; Stevens, 2017). The Venezuelan Institute of Palliative Care voiced its alarm at the widespread medical shortage through a letter in 2017 expressing that doctors no longer had the ability to relieve their patients from unnecessary pain owing to the unavailability of every analgesic type (Fraser, 2017). The shortages have stagnated hospitals to the point that they must regularly refuse patients (Stevens, 2017). Since the hospitals are unable to afford stocking themselves with the few supplies that can be found, vendors have begun circulating hospital halls selling basic medical supplies to people waiting to be treated (Daryanani, 2017). This has made health care costs that are directly imposed on patients or their families extremely expensive. A bottle of saline solution on the unofficial market can sell for as high as 200 U.S. dollars (Stevens, 2017). To boot, there is an inpatient bed shortage evident in the decrease from 48,000 beds for the 24 million country’s inhabitants in 1998 to 19,000 beds for the expanded population of 30 million in June of 2017 (Correa S, 2017).

Mental Health Care Supply Crisis

Currently Available Statistics and Outlook

Mental health care is one of the most visibly affected areas of Venezuela’s health care, alongside oncological and HIV treatments (Bello et al., 2017). A medication deficit of over 85% was claimed to be present in June of 2018 by the president of the College of Pharmacists of Venezuela’s Aragua state. As such, the reported pharmaceutical market outlook in Venezuela was poor, with projected improvements of the nation’s market conditions being extremely limited and the deconsolidation of Venezuelan operations in addition to suspension of trade by
international pharmaceutical companies to continue (FitchSolutions, 2018). The only three pharmaceutical companies that the report described that still manufactured central nervous system disorder treatments were Laboratorios Elmor, Pfizer, and Sanofi (FitchSolutions, 2018).

The Need for Mental Health Care in Venezuela

Current Projections Concerning Depressive Diseases

A Venezuela pharmaceuticals and health care report for the fourth quarter of 2018 stated that neuropsychiatric conditions will be the most contributing to Venezuela’s chronic disease burden for the following 15 years, since the number of disability-adjusted life years lost (DALY) is projected to rise from 961,503 years in 2014 to 1,060,001 years in 2030. The report placed the greatest contribution to these neuropsychiatric-related DALYs on depression. The other top causes for the increase in DALYs were Alzheimer’s disease and dementia. In the year 2000, it was estimated that the global top three causes of disease burden would be heart disease, depression, and road traffic accidents by 2020 (Alarcon & Aguilar-Gaxiola, 2000).

Elevated Suicide Rates

Compared to the global suicide rate of 10.5 per 100,000 in 2016, the suicide rate of the western Venezuelan state of Merida was 19 per 100,000 in 2017 (Rosati, 2018). This contrasts tragically with the progress in the mental health training, promotion, primary prevention, and coverage that were being accomplished in the region during the mid-1990s (Alarcon & Aguilar-Gaxiola, 2000). The current suicide statistic was calculated by The Venezuelan Violence
Observatory, a Venezuelan-based NGO, by analyzing press clippings and police and hospital registries. In the nation’s capital of Caracas, at least 131 suicides occurred between June and July of 2018. The extrapolated 786 suicides in Caracas during 2018 were equivalent to Venezuela’s National Statistics Institute’s last reliable national rate of 788 from 2012. Advocacy and rights groups Convite and Cecodap stated that suicide rates rose 67% in 2017 among the Venezuelan elderly and 18% in 2017 among the Venezuelan youth since the previous year. All of this was shadowed by the lack of a suicide hotline in Venezuela in 2018 (Rosati, 2018).

Shortage in Psychiatric Medications

*The New York Times* published an article in 2016 stating that 85% of psychiatric medicines were unavailable by October of that year. The article claimed to have cited Venezuela’s top pharmaceutical trade group (Casey, 2016). Additionally, the extent of the shortages in anti-depressant and anti-anxiety medicines were not approximated in Rosati’s article (2016), but the personal accounts within it described people failing to find enough or any of these drugs for themselves or their loved ones who critically needed them.

High-Stress Environment

There are intense sources of stress that have come to be considered typical of life in Venezuela. These mostly involve stressors that are domestic, political, and economic in nature. Domestic causes of stress that are frequently discussed are a sense of insecurity in one’s home regardless of the time during the day, the precarious health of oneself and loved ones owing to
unavailable health care, limited dietary choices resulting from widespread shortages, and the obligation to spend extended periods of time at home due to public insecurity and the associated lack of recreational opportunities in the community. Additionally, a sense of loneliness has become prevalent among Venezuelans who experience the departure of their loved ones to other countries (Rosati, 2018).

Political sources of stress arise from governmental inefficiency, undesirable political electoral results and actions, isolation resulting from poor education and censored media, awareness of the extreme bias or other flaws of available information, recurrence of dramatic policy changes (especially in the form of currency replacement), and the absence of formally implemented regulations, controls, or systematic processes by the central or state governments.

The economy is a potent source of stress for Venezuelans because of severe delays in services, long entrance and check-out lines, high cost of life, volatile economy, shortages of goods and services, poor customer services and workplace professionalism due to lack of incentive among the employed, and the lack of productivity and commercial activity after dusk due to the lack of safety.

People need to stand in long lines whenever they look for groceries, which vary widely in price depending on whether they are provided directly through the fixed price government system or the unofficial black market (Daryanani, 2017; Suhr, 2016). An increasing amount of the available food is sold in the black market because people make a higher income reselling goods in the black market than if they were employed in a legitimate manner (Suhr, 2016). Venezuelans endure tremendous amounts of stress when trying to purchase groceries and other basic goods because of these factors.
Another lamented symptom of the shortages in basic goods is the widespread incidence of store looting. It is a product of desperation to begin with, and it leaves chaos and destruction in its wake. Over time, looting became increasingly frequent (Suhr, 2016). The mere sight of looted stores is a cause for distress, and the economic consequences of closed shops can be very detrimental.

Knowing that people have died from simple knee scrapes because of the absence of basic antibiotics may possibly be producing a general sense of anxiety among some Venezuelans (Stevens, 2017). Furthermore, the constant uncertainty throughout various aspects of daily life, such as driving, commuting, family affairs, and civil rights, produces a considerable amount of stress for most Venezuelans. Driving can be such a stressful activity since risky driving behavior is extremely common, neglect of road systems by the government has produced horrendous road conditions, and there exists a high incidence of crime perpetrated on the road. Venezuelans’ perseverance and ability to improvise to meet basic needs is tested on a daily basis, and a sense of learned helplessness is a major contributor to the perceived depression among Venezuelans.

Furthermore, theft and violent crime have climbed, likely exacerbated by the scarcity of food rations (Stevens, 2017). Compounding this is an extreme prevalence of impunity on Venezuela’s streets; only 5% of violent crimes are investigated (Daryanani, 2017).

Venezuelans share the traumatic experience of witnessing the rapid deterioration of their country and the preventable suffering and deaths of those they know. Moreover, they experience either directly or indirectly the high rate of homicide within the Venezuela, which has been placed among the highest in the world (Garzon & Muggah, 2017). The effects of this prevalence of violence on mental health, particularly anxiety and post-traumatic stress disorders, have not
been quantified yet (Belfort & González, 2005). However, it is observable that the high risk of violence has fed unhealthy and self-destructive recreational activities at home because they are deemed safer than leaving the house for alternative activities.

*Long Term Impacts on the Populace*

Venezuelan youth are particularly vulnerable to the damaging experiences associated with being a child raised and growing up in a deteriorating country. Alarming in the context of the conditions that the Venezuelan youth endure, researchers have found relationships between an adult’s nutrition while they were a child and their subsequent mental health developments as an adult. Adult mental illness onset possessed a correlation with poor childhood nutritional status (Marmot & Wilkinson, 2005).

The nutritionist who led the development and health area of the Development Studies Center at the Central University of Venezuela in 2016 warned of long-term effects of the malnutrition that has been gripping an increasing breadth of the nation’s population (Fraser & Willer, 2016). This nutritional crisis is responsible for the 25% rise in absenteeism among the public-school student population, owing to these schools no longer being able to provide meals for their students (Osorio, 2018). Furthermore, the rise in infant mortality rate may be reflecting this poorer nutritional status among children combined with the lack of vaccination, which characterizes the inadequate pediatric health care in Venezuela (Fraser, 2017).

Worsening the life course of young Venezuelans, university-level education has been prolonged if not completely stalled for many college students. This is a product of frequent professor strikes that mean to communicate the need to hire more staff and to increase professor
wages amid the economic crisis. The most substantial source of insecurity for Venezuelan young adults is the difficulty to find and maintain available or sufficiently paying jobs, especially after considering that employers also struggle with the nation’s hyperinflation rate. It was estimated that in 2013, a family of four would need 4 to 5 minimum-wage jobs to support their family (Suhr, 2016). This drives a major portion of the young adult population in Venezuela to emigrate in the hopes of finding better socioeconomic conditions. Lastly, this lack of economic security has also driven up the suicide rate.

Abysmal Conditions in Psychiatric Hospitals

The deterioration of psychiatric hospitals is blatant through their decreased capacity to house long-term patients. According to Venezuela’s Health Ministry, the public psychiatric hospitals were able to hold 23,630 patients in 2013, which is drastically different from the reported 5,558 long-term psychiatric patients being treated in 2015. Another major manifestation of the decline in psychiatric services is the psychiatric hospital of El Peñón, which was only able to house two patients in 2016 despite of their capacity for 40 due to inadequate food supplies (Casey, 2016).

In El Pampero Hospital, another psychiatric hospital, crippling limitations are evident in that it had no working psychiatrist for at least two years after 2014 and that it received running water for only a few hours a day by the year 2016. Additionally, its scant food supply caused many of its patients to become malnourished and grossly underweight. The medical staff resorted to rationing the inadequate supply of sedatives, tranquilizers, and medication that was left. These rations were not enough to relieve the patients of their symptoms; thus, the medical staff had no
other alternative but to physically restrain or isolate psychotic patients (Kohut & Casey, 2016; Stevens, 2017). Suicidal patients have been stripped of their clothing in order to prevent their use for self-harm. El Pampero Hospital, like many other public hospitals, exhibited extremely poor sanitary conditions, with patients lacking basic toiletries and cleaning supplies being low in stock (Kohut & Casey, 2016).

**Poor Implementation of Mental Health Policies**

In light of all of the aforementioned shortages in resources for mental health care, it is highly notable that previously available resources were not properly allocated for following through of mental health care legislation passed in the early 1990s. The enactments of the previously described Resolution No. 1223 of October 15, 1992 and the Regulation for Psychiatric Establishments of Long Stay produced only temporary improvements in mental health care access and quality. Some of the advancements that have now since regressed include better coordination within the mental health sector, more organized mental health plans, increased multisectoral participation in health plans and programs, marginally better patient participation within these multisectoral collaborations, the provision of mental health care through primary health care services, and improved procedures of voluntary, involuntary, and compulsory admission into mental health institutions (Bolis, 2002).

Regardless, the priority placed on and the resources provided to mental health care has always been below optimal (Bolis, 2002). The major challenge faced by Venezuela’s health care system has been and continues to be predominantly implementational in nature, since pivotal legislature already exists. However, future legislation must be developed to ensure an adequate
mental health sector, particularly concerning the areas of shifting demographics and their respective mental health demands, the scant financial resources allocated to the public sector, the facilitation of civil society advocacy, and the accountability of the judicial system (Bolis, 2002).

Research Questions

The exact extent of the shortage in mental health care services in Venezuela has not been thoroughly quantified. Perhaps the last time that an appropriate amount of attention was dedicated to the mental health care sector of Venezuela was contemporary to the hosting of the Regional Conference for the Restructuring of Psychiatric Care in Latin America within the Local Health Systems Model in Caracas, in which the Caracas Declaration of 1990 was signed. This is largely due to the Venezuelan government failing to publish regular health care statistics in addition to the censoring of their country’s media outlets (Daryanani, 2017), although media remains the most available source of up-to-date information. Using a media content analysis, this study addressed the following research questions:

What are the deficits or gaps in mental health care staffing, psychiatry-related prescription drug, therapeutic intervention, and mental health institution availability in Venezuela?

What measures are suggested by Venezuelan mental health experts and professionals for addressing the population’s need for mental health services amid the nation’s crisis?

The mental health care services that were investigated included those offered in hospital inpatient, residential, and outpatient settings. The specific hospital inpatient services included were the availability of public psychiatric hospitals and general hospital psychiatric units.
Residential mental health settings included were psychiatric residential centers, alcohol and drug rehabilitation facilities, and nursing homes with psychiatric consultation services. Finally, outpatient mental health services explored were comprised of partial hospitalization programs, intensive outpatient programs, outpatient clinics, community mental health centers, private practice practitioner offices, and tele-psychiatric and tele-mental health services. These outpatient settings may have involved family therapy, group therapy, individual therapy, educational sessions, individual counseling, medication management, and psychological support via telephone, online chat, or videoconferencing. This mental health service list and subsequent descriptions were provided in North Texas Help’s webpage, “Types of Mental Health Treatment Settings and Levels of Care” (North Texas Help, 2019).

Deficits in mental health care included the lack of available prescription mental health medications among pharmacies, lack of state funding towards the mental health care sector, closure of mental health care institutions, crowding of mental health care institutions, squalid conditions in mental health care institutions, the inability for institutions to provide appropriate or timely medication or therapy to mental health patients, the inability of institutions to provide basic necessities such as food and clean water to mental health patients, the under-staffing of mental health care institutions, and the absence of available mental health care services across entire towns, cities, states, or regions.

This study was confined to researching conditions within Venezuela and accounts from Venezuelans still presiding in Venezuela and those who have emigrated to other countries since the nation’s crisis began in 2013. Both major Venezuelan cities and more rural regions were investigated, and their respective mental health care conditions before and after the onset of
the crisis were considered. This was due to the differential access and quality of mental health care services that results from distinct levels of available resources in accordance to region demographics.
METHODS

Media Content Analysis

This method was used to approximate the severity of the shortages in mental health services and medications through the analysis of interrelated themes within the obtained media. These themes were comprised of specific words, phrases, and content forms (Dallimore, McLaughlin, Williams, & Noyes, 2019).

Relevant Content

The media content sought were newspapers and periodicals published in Venezuela and foreign newspapers covering the medical crisis in Venezuela, published or posted interviews with Venezuelan medical personnel describing the health care crisis, social media posts involving requests for or availability of medicine and services, and social media posts of videos or images as visual testimony of the crisis. Venezuelan newspapers that are digitally accessible were referenced, including the newspaper 2001, El Impulso, and La Hora. Much of the aforementioned newspapers were listed in The Europa World Year Book: Kazakhstan-Zimbabwe, 2004 (Taylor & Francis, 2004).

Social media posts made by these newspaper businesses were also considered, because Venezuelans have had to rely on these posts rather than printed publications in the face of printing shortages and censorship attempts by the central government. The types of social media posts compiled were articles, videos, photographs, blogs, and individual statements. Social
networking sites that were searched for data included Twitter, Instagram, Facebook, Reddit, and YouTube.

Additionally, alternative sources of news coverage, which included XLSemanal, VIVOplay, VPItv, El Pitazo, Efecto Cocuyo, TVVenezuela Noticias, Informe 21, La Patilla Agencia Carabobeña de Noticias, and NTN24 Venezuela were also data sources since Venezuelans have also relied on these foreign-run and online Venezuelan news outlets to remain informed. This is because there has been a considerable amount of censoring in the media which began after certain journalists who voiced overly critical opinions on the Venezuelan government were threatened and/or attacked (Suhr, 2016). In addition to these Venezuelan news outlet sources, the study’s results were drawn from publications from the following foreign news sources: The National Public Radio, The New York Times, Miami Herald, BBC News, Global News, Guardian News, Al-Jazeera International, Sky News, and Reuters. During the search for foreign news media, less prominent news sources such as El Imparcial de Oaxaca, Editora Peru, Psyciencia, South China Morning Post, France 24, and La Hora, Ecuador, were identified as insightful sources of information about Venezuela’s mental health crisis. Any accessory media that were not previously listed, but were identified as considerably relevant, were also included in the aggregation of media content.

Videos of people being interviewed during street protests were also searched since these may contain first-hand accounts of Venezuelans’ struggles in maintaining their and their loved ones’ mental health. These videos were acquired from the social media sites mentioned previously. The media content pertained only to the time period between the beginning of January and the end of November of 2019. The frequency of these corresponding types of media being
published over that given time were also calculated. Much of the decisions behind these content elements were taken into account (Dallimore et al., 2019; Daniel Riffe, 2007).

*Sampling*

The sample of media content were from sources that were either published online or made available online between the months of January and November of 2019. A total of 51 media articles were included in the study. The search terms = “Venezuela” AND “mental health” OR “psychiatry” OR “anxiety” OR “depression” were used to find the sources (Dallimore et al., 2019). These search terms were replicated in Spanish in Latin American research databases to find media content published and posted in Spanish. Periodicals were sought from CQ Researcher Plus Archive, Florida Digital Newspaper Library (University of Florida), New York Times (Nexis Uni), News & Newspapers (University of Central Florida Libraries), Nexis Uni, U.S. Major Dailies (ProQuest), U.S. Southeast Newsstream (ProQuest), Alternative Press Index (EBSCOhost), AP Images (EBSCOhost), Business Source Premier – Country Reports (EBSCOhost), Ethnic NewsWatch (ProQuest), Facts on File, ABI/INFORM Complete (ProQuest), Academic Search Premier (EBSCOhost), CINAHL Plus with Full Text (EBSCOhost), ERIC (EBSCOhost), JSTOR, MEDLINE (EBSCOhost), PsycInfo (EBSCOhost), Web of Science (Thomas Reuters), and Google search engine with applied terms to limit to newspapers. These databases were chosen because they index a multitude of newspapers and periodicals. News outlets from countries besides Venezuela that were included in the media search were The National Public Radio, The New York Times, Miami Herald, BBC News, Global News, Guardian News, and Reuters. NTN24 and VPItv specifically cater to a Venezuelan
audience, especially those who are living abroad. User-generated comments were also considered and analyzed for professional populations and general population opinions.

There was an emphasis on audio and video sources since Venezuela’s government has not been publishing regular or reliable statistics on the country’s health care system or public health for approximately the past decade (Daryanani, 2017). Therefore, very limited primary or quantitative data shed light on the true nature of the medical shortages and the repercussions that they have on Venezuela’s population (Daguerre, 2011). This is a challenge shared by any researcher intending to study the aspects of Venezuela’s crisis that are censored by the Venezuelan government. The time period of January to November of 2019 was selected owing to the significant wave of media coverage concerning Venezuelan National Assembly member Juan Guaidó’s attempt to secure interim presidency in addition to the recognition and support of his position by the U.S. government. Furthermore, the efforts to bring in humanitarian aid into Venezuela by the U.S. and others in the international community and the threats and violence that armed Venezuelan forces have inflicted upon involved or protesting civilians has also caught the attention of the public eye.

In order to extract latent themes from the compiled data, manually developed, computer-based content dictionaries were employed in the study’s analysis (Bernard & Ryan, 2010). From these identified themes, matrices were formed using text management software NVivo, which has text management and analysis features that process both English and Spanish.
**Analysis Design**

Selected media were imported into NVivo v. 12 (QSR International Pty Ltd.; Melbourne, Australia) for quantitative media content analysis. This program enabled analysis of dense text and multimedia information (McNiff, 2016). Themes were determined through a combination of a priori and a posteriori means. First, the a priori themes were delineated before the media was read based on pre-existing knowledge and understanding of Venezuela’s mental health care crisis. Then, new themes or subthemes were raised from trends identified during the reading of literature and from fresh understanding of the factors involved in Venezuela’s mental health care crisis (Bernard & Ryan, 2010).

The following attributes were extracted from the media pieces included in the study: source, media format, month of publication, Venezuelan or foreign city and state, mental health condition(s) discussed, and media content (Dallimore et al., 2019). A mock table listing these attributes is given in Table 1.

<table>
<thead>
<tr>
<th>Title</th>
<th>Media Source</th>
<th>Media Format</th>
<th>Month</th>
<th>City, State</th>
<th>Mental Health Condition</th>
<th>Content</th>
</tr>
</thead>
</table>

*Note. Schematic was based on example provided in (Bernard & Ryan, 2010).*
**Coding Protocol**

The coding book parameters and procedures for theme classification were established a priori, while any additions or modifications of themes or subthemes were made a posteriori. These modifications to the coding scheme were produced from text-frequency analysis in addition to the researcher’s judgement based on what was read in the available literature. Incidence of specific words or phrases in the data were manually coded into themes for relation to medical personnel or medical supply, content intent (medical request, health care availability, personal statements, documentation or broadcasting of conditions), and mental health condition (anxiety, depression, psychosis, other) (Dallimore et al., 2019). These variables were pretested on a few randomly selected media pieces. Any inconsistencies that came up were addressed to optimize coder reliability (Bernard & Ryan, 2010).
Figure 1: Theme nodes under mental health care insufficiency
These nodes were used to determine the extent of the mental health care shortage by assigning files to relevant indicators of shortage and of increasing demand.
Figure 2: Theme nodes under evidence of excessive mental strain
These nodes were used to determine the possible factors behind the worsening of the mental health of the Venezuelan population.

Reliability Procedure

Coder reliability was assessed through NVivo’s coding comparison feature after a sample of 15% of the data was randomly selected and then presented to a second individual for re-coding. The second coder had an intermediate Spanish reading capability, was of similar cultural
background of the first coder as a Venezuelan immigrant, and had previous experience in qualitative research in socioeconomic topics. This test was meant to identify any potential “theme drift,” in which disparate themes are perceived from the same sample of data. If a significant lack of consistency were calculated, then slippage in the coders’ understanding or application of the coding protocol would be deemed a significant possibility (Daniel Riffe, 2007). Inter-rater reliability through percentage of cross-agreement across coders, and kappa coefficient were calculated in order to determine coding reliability (Bernard & Ryan, 2010; Dallimore et al., 2019). Jacob Cohen developed the Kappa coefficient standards for determining agreement within nominal scales (Cohen, 1960).

Analysis with Matrix Method

The Matrix Method involved relating different themes together into theoretical models (Bernard & Ryan, 2010). This was executed with NVivo. First, a case-by-variable matrix was formed from the amassed texts and pre-established codes (Bernard & Ryan, 2010). Afterward, descriptive and inferential statistical tests available in NVivo were implemented for deductive analysis of the study’s results and to find possible answers to the presented research questions (Dallimore et al., 2019). These tests consisted of queries for text search, word frequency, content coding, compound coding, and group coding. These queries enabled an array of data analysis, which included finding the frequency of a word, phrase, or concept, identifying relationships between coded content and selected nodes and/or attributes, or a combination of aforementioned analyses to search for more co-existing relationships between the data and themes. Maps and charts were also generated through NVivo, including hierarchy charts of the nodes coded across
the media files. These demonstrated the prevalence of themes across the data through proportional and overlapping boxes. Microsoft Excel’s feature of map creation was also utilized to visually present the Venezuelan states that were mentioned in the collected data. Owing to the qualitative nature of the study, much of the identification of relationships depended on researcher’s judgement. This was imperative for a “big picture” to be established from the media content, as opposed to the “little snippets” that the NVivo analysis of the accumulated media content provided.
RESULTS

Media Content Table

Table 2

*The Matrix Method Table with the Accumulated Data*

<table>
<thead>
<tr>
<th>Title</th>
<th>Media Source</th>
<th>Media Format</th>
<th>Month</th>
<th>City, State</th>
<th>Mental Health Topic</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>America is more stressed than Venezuela, Gallup poll shows</td>
<td>Newsweek</td>
<td>Webpage</td>
<td>April</td>
<td>New York City, U.S.A.</td>
<td>Chronic Stress</td>
<td>Compares results from international stress poll</td>
</tr>
<tr>
<td>Asesoría Psicológica en Carabobo</td>
<td>Reddit</td>
<td>Reddit post</td>
<td>June</td>
<td>Carabobo, Carabobo</td>
<td>N/A</td>
<td>Request for clinical psychologist services</td>
</tr>
<tr>
<td>Asi me siento aqui lejos de Venezuela</td>
<td>Reddit</td>
<td>Reddit post</td>
<td>November</td>
<td>International</td>
<td>Anxiety, Depression</td>
<td>Venezuelan emigrant expresses mental health issues</td>
</tr>
<tr>
<td>Caos, ansiedad y desesperacion por apagon de mas de tres dias en Venezuela</td>
<td>Presencia</td>
<td>News Article</td>
<td>November</td>
<td>Caracas, Capital District</td>
<td>Anxiety</td>
<td>Describes Venezuelan crisis and effect on mental health</td>
</tr>
<tr>
<td>Como cuidar tu salud mental si vives en Venezuela</td>
<td>El Tuqueque Noticias</td>
<td>News Article</td>
<td>August</td>
<td>N/A</td>
<td>Anxiety, Depression, Suicide</td>
<td>Mental health problems in Venezuela and mental health advice</td>
</tr>
<tr>
<td>¿Cómo hacer para encontrar motivación en Venezuela?</td>
<td>Reddit</td>
<td>Reddit post</td>
<td>September</td>
<td>Rural</td>
<td>Depression</td>
<td>Venezuelan expresses mental health issues and asks for advice</td>
</tr>
<tr>
<td>Continuing blackouts in Venezuela are having adverse effects on the nation's children</td>
<td>Miami Herald</td>
<td>News Article</td>
<td>April</td>
<td>Maracaibo, Zulia</td>
<td>Anxiety, Behavioral Problems</td>
<td>Effect of electric outages on mental health in children</td>
</tr>
<tr>
<td>Crisis en Venezuela aumenta casos de depresion, ansiedad, and suicidios</td>
<td>El Imparcial de Oaxaca</td>
<td>News Article</td>
<td>May</td>
<td>Oaxaca, Mexico</td>
<td>Anxiety, Depression, Suicide</td>
<td>Describes mental health crisis</td>
</tr>
<tr>
<td>Title</td>
<td>Source</td>
<td>Type</td>
<td>Date</td>
<td>Location</td>
<td>Mental Health Conditions</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
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<td>--------</td>
<td>-------</td>
<td>----------</td>
<td>--------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Denuncian pretension de cerrar el hospital psiquiátrico el pampero en Barquisimeto</td>
<td>Vivoplay</td>
<td>Video</td>
<td>August</td>
<td>Barquisimeto, Lara</td>
<td>Psychosis, Schizophrenia</td>
<td>Response to psychiatric hospital possibly closing</td>
</tr>
<tr>
<td>Despair in Venezuela</td>
<td>American</td>
<td>Journal</td>
<td>January</td>
<td>Caracas, Capital District</td>
<td>Anxiety, Depression</td>
<td>Describes struggle of mental health professionals in Venezuela</td>
</tr>
<tr>
<td>Depresion y ansiedad estan afectando a migrantes venezolanos en Peru</td>
<td>Editora Peru</td>
<td>News</td>
<td>May</td>
<td>Lima, Peru</td>
<td>Depression, Anxiety, Suicide, Schizophrenia</td>
<td>Mental health of Venezuelan immigrants arriving in Peru is poor</td>
</tr>
<tr>
<td>Desde que salí de Venezuela no confío en las personas</td>
<td>Reddit</td>
<td>Reddit post</td>
<td>June</td>
<td>International</td>
<td>Post-Traumatic Stress, Anxiety</td>
<td>Video of Venezuelans crossing the border from Venezuela to Colombia</td>
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<td>Despair, anxiety, desperation of #venezuelans trying to cross the Venezuelan/Colombian border</td>
<td>Instagram</td>
<td>Video</td>
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<td>San Antonio del Táchira, Táchira</td>
<td>Anxiety</td>
<td>Video of Venezuelans crossing the border from Venezuela to Colombia</td>
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<td>El aumento del suicidio en Venezuela: otra consecuencia de la crisis</td>
<td>El Pitazo</td>
<td>News</td>
<td>September</td>
<td>Caracas, Capital District; Valles del Tuy, Miranda; Maturin, Monagas; Catia La Mar, Vargas; Maracaibo, Zulia; Valle de la Pascua, Guárico; Merida, Merida</td>
<td>Anxiety, Depression, Suicide, Schizophrenia</td>
<td>Describes state of mental health care across the country</td>
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<tr>
<td>El psiquiátrico de la muerte en Venezuela es real: imágenes aterradoras</td>
<td>El Pitazo</td>
<td>News</td>
<td>September</td>
<td>Caracas, Capital District</td>
<td>Psychosis, Schizophrenia</td>
<td>Shows the decrepit conditions of a mental health institution</td>
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<td>EXPresidente de la Sociedad de</td>
<td>El Pitazo</td>
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<td>August</td>
<td></td>
<td>N/A</td>
<td>Mental health professional</td>
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<td>Psiquiatría denuncia precariedad en centro médico</td>
<td>denouncing the mental health care situation</td>
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<td>The Federation of Psychologists of Venezuela announced they launched a national training and research program on suicide in Venezuela on the International Day for Suicide Prevention</td>
<td>Organization announces national training and research program on suicide</td>
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<td>A glimpse into a Venezuelan ward: Cockroaches, excrement and a drugs shortage</td>
<td>Shows the decrepit conditions of a mental health institution</td>
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<td>Hoy cumplo 27 y me invade la depresión por no haber alcanzado ninguna de mis metas</td>
<td>Reddit user describes their depression because of their living conditions in Venezuela</td>
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<td>Hablan los psicólogos: ¿Cómo sobrellevar la crisis en Venezuela?</td>
<td>Two clinical psychologists describe the mental health crisis</td>
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<td>La deprimente economía de Venezuela, literalmente.</td>
<td>A Venezuelan asked the Reddit community what they thought about the mental health crisis</td>
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<td>La poca salud mental del venezolano en peligro tras el mayor apagón de la historia de Venezuela</td>
<td>Effect of electric outages on mental health across country</td>
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<td>La salud mental de niños y adolescentes esta amenazada por crisis humanitaria compleja en el país</td>
<td>Describes how the country’s crisis is affecting the</td>
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<td>La salud mental en Venezuela</td>
<td>Psyciencia</td>
<td>News Article</td>
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<td>Parana, Entre Rios, Argentina</td>
<td>General Mental Health, Behavioral Problems</td>
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<td>Llevar la salud mental dentro de una Venezuela en crisis</td>
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<td>Migracion venezolana: la sombra de la depresion cruza fronteras</td>
<td>La Hora</td>
<td>News Article</td>
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<td>Ecuador</td>
<td>Anxiety, Depression, Suicide</td>
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<tr>
<td>Para tomar en cuenta: recomendaciones para manejar la ansiedad en</td>
<td>Caraota Digital</td>
<td>Webpage</td>
<td>March</td>
<td>Caracas, Capital District</td>
<td>Anxiety</td>
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<td>Venezuela</td>
<td>Federacion de Psicologos de Venezuela</td>
<td>Webpage</td>
<td>March</td>
<td>N/A</td>
<td>Depression, Anxiety, Suicide</td>
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<tr>
<td>Recomendaciones a tener en cuenta en la actual situacion pais</td>
<td>El Pitazo</td>
<td>Webpage</td>
<td>March</td>
<td>San Cristobal, Táchira</td>
<td>Anxiety, Chronic Stress</td>
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<tr>
<td>Recomendaciones para preservar la salud mental en tiempos de crisis</td>
<td>El Pitazo</td>
<td>Webpage</td>
<td>March</td>
<td>Caracas, Capital District</td>
<td>Anxiety, Depression, Suicide</td>
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<td>ofreció Futuro Visible</td>
<td>YouTube</td>
<td>Video</td>
<td>July</td>
<td>Barquisimeto, Lara</td>
<td>Chronic Stress</td>
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<td>Regiones - Gisela Galeno - miércoles 17 de julio de 2019</td>
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<td>YouTube</td>
<td>July</td>
<td>Caracas, Capital District</td>
<td>Anxiety, Depression, Suicide</td>
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<td>Reparten volantes en Barquisimeto sobre cómo cuidar la salud</td>
<td>El Pitazo</td>
<td>News Article</td>
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<td>Barquisimeto, Lara</td>
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<td>mental</td>
<td>Reddit</td>
<td>Reddit post</td>
<td>May</td>
<td>Caracas, Capital District</td>
<td>Anxiety, Depression, Suicide</td>
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mental health of children and adolescents

Describes the factors that could adversely affect Venezuelans' mental health

Describes the mental health care crisis

Describes the mental health of Venezuelan migrants in Ecuador and Peru

Gives advice on mental health

Gives advice on mental health

Describes an initiative to give mental health advice

A clinical psychologist is interviewed about the mental health crisis

Describes an initiative to give mental health advice

A Venezuelan asked the Reddit community what they
<p>| Situación del país afecta la salud mental de los venezolanos | Vivoplay Video January Caracas, Capital District Depression | A psychiatrist is interviewed on the mental health crisis |
|-------------------------------------------------------------|---------------------------------------------------------------|
| Solicitud de Apoyo Psicológico (Fase: Atención Remota) | Federacion de Psicologos de Venezuela Webpage March N/A General Mental Health | An organization requests international assistance with an emergency call line |
| Testimonio: “Uno construye casas grandes para que luego se le caigan encima” | YouTube Video May Caracas, Capital District Anxiety, Depression, Suicide | Describes the mental health crisis and mentions elderly mental health |
| This week the Congress of the Venezuelan Society of Psychiatry will be held. Growing up, learning, cooperating among all is necessary, to work as professionals in the &quot;Mental Health Reconstruction in Venezuela.&quot; | Twitter post October Caracas, Capital District Anxiety, Depression, Addiction | Announces a dialogue on the mental health crisis |
| Today on International Mental Health Day, we meet our allies @enlauca and @COFAVIC on our first day of Psychosocial Intervention course in contexts of human rights violations and Psychological First Aid by phone. | Twitter post October N/A Anxiety, Depression, Suicide | Announces a new mental health emergency call line |
| VE Venezuela mental health institutions struggle in economic crisis | YouTube Video March Peribeca, Táchira; San Cristobal, Táchira Psychosis, Schizophrenia | Closure of psychiatric hospital and decrepit conditions of |</p>
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<thead>
<tr>
<th>Title</th>
<th>Column 1</th>
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<tbody>
<tr>
<td>Venezuela Bans Lines Outside of Bakeries that Spread “Anxiety”</td>
<td>Panam Post</td>
<td>News Article</td>
<td>August</td>
<td>Miami, U.S.A.</td>
<td>Anxiety</td>
<td>Describes the ban on lines outside of bakeries intended to improve mental health</td>
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<td>Venezuela crisis watched by China immigrants who fled chaos with anxiety – and hope</td>
<td>South China Morning Post</td>
<td>Video</td>
<td>January</td>
<td>Hong Kong, China</td>
<td>Anxiety</td>
<td>Describes the emotional impact on Chinese-Venezuelans who have had to emigrate</td>
</tr>
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<td>Venezuela Deprimida (I Parte): La crisis de salud mental en Venezuela</td>
<td>YouTube</td>
<td>Video</td>
<td>September</td>
<td>Caracas, Capital District</td>
<td>Anxiety, Depression, Suicide</td>
<td>Psychiatrist describes the mental health crisis</td>
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<td>Venezuela Deprimida (II Parte): ¿Cómo salir de la depresión?</td>
<td>YouTube</td>
<td>Video</td>
<td>September</td>
<td>Caracas, Capital District</td>
<td>Anxiety, Depression, Suicide</td>
<td>Psychiatrist describes the mental health crisis</td>
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<tr>
<td>Venezuela faces spiraling mental health crisis</td>
<td>France 24</td>
<td>Video</td>
<td>March</td>
<td>Paris, France</td>
<td>Anxiety, Depression, Suicide</td>
<td>Describes mental health crisis</td>
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<tr>
<td>VENEZUELA: ANARE: GHOST TOWN FOR THE MENTALLY ILL</td>
<td>YouTube</td>
<td>Video</td>
<td>July, 2015</td>
<td>Anare, Vargas</td>
<td>Psychosis, Schizophrenia</td>
<td>Describes the decrepit conditions of a mental health institution</td>
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<tr>
<td>Venezuela: sin madurar ley de salud mental</td>
<td>Blogger</td>
<td>Blog</td>
<td>April</td>
<td>N/A</td>
<td>Mental Health Policy</td>
<td>Describes initiative at Colombian border to give mental health care to Venezuelan migrants</td>
</tr>
<tr>
<td>Venezuelan migrants to get regional vaccination cards under 10-nation pact</td>
<td>Reuters</td>
<td>News Article</td>
<td>August</td>
<td>Cucuta, Colombia</td>
<td>Mental Health Policy</td>
<td>Shows Venezuelan migrants</td>
</tr>
<tr>
<td>Venezuelans salsa dance to cope with economic crisis</td>
<td>YouTube</td>
<td>Video</td>
<td>May</td>
<td>Caracas, Capital District</td>
<td>Chronic Stress</td>
<td>Shows Venezuelans salsa dancing to cope with stress</td>
</tr>
<tr>
<td>Visualizing the happiest country on every continent</td>
<td>Visual Capitalist Pictograph</td>
<td>April</td>
<td>Vancouver, Canada</td>
<td>Happiness Levels</td>
<td>Shows the happiness levels of the countries in the world, including Venezuela, with responsible factors</td>
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<td>“When I lived in Venezuela I developed depression and anxiety since I was 16, of course due to many reasons, but mostly because I wasn't able to accept myself as trans. Latin countries are still really misogynist and intolerant regarding LGBT+ people.”</td>
<td>Instagram post</td>
<td>July</td>
<td>N/A</td>
<td>Anxiety, Depression</td>
<td>Describes mental health struggles of LGBTQ Venezuelan migrant</td>
<td></td>
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<tr>
<td>Why a Venezuelan girl wants her dad to send money so she can buy a helicopter</td>
<td>National Public Radio News Article</td>
<td>March</td>
<td>Maracaibo, Zulia</td>
<td>Depression, Behavioral Problems</td>
<td>Describes effect that migratory separation has on mental health of Venezuelan children</td>
<td></td>
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<tr>
<td>Zulia - Codhez: 36% familias zulianas presentan ansiedad y depresión - VPltv</td>
<td>YouTube Video</td>
<td>November</td>
<td>Maracaibo, Zulia</td>
<td>Anxiety, Depression, Chronic Stress</td>
<td>Describes effect of caring for malnourished children on Venezuelan mothers' mental health</td>
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</tbody>
</table>

Table of all media content selected for data analysis. Includes title, media source, media format, month of publication, state and city in Venezuela referred to within the media, mental health conditions discussed in the media, and short summary of media content.
Figure 3: Number of files coded under each month
Line graph showing the trends on published media content relevant to Venezuela’s mental health care crisis. The time range of considered media content was from January 2019 to November 2019.

Figure 4: Number of files coded under Venezuelan states

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Map of the states of Venezuela presenting the number of files that pertained to each state. Some files referred to more than one state, while others did not refer to any.

Figure 5: Top 14 key words within aggregated data
Bar graph depicting the most frequent words of interest across all the data. The words “parent” and “children” were of particular interest, since the current mental health issues affecting Venezuela’s children will likely have consequences for generations to come.

Figure 6: Files with the highest text match for “mental health” and “salud mental”
Bar graph showing the four files that had the highest amount of pertinence to mental health. The Spanish term for mental health (salud mental) was also queried.

Figure 7: Number of files coded under different mental health topics
Bar graph delineating the number of files that were coded under certain mental health conditions or topics. Some files referred to multiple conditions or topics.

Figure 8: Number of files coded under different media sources
Bar graph showing the most popular media sources that produced media referring to the mental health crisis in Venezuela. The least popular media were excluded from the graph.

Figure 9: Number of files coded under media formats
Bar graph presenting which media formats portrayed the data. Videos included both YouTube videos and independently uploaded videos on websites.
Figure 10: Hierarchy chart of all nodes coded across the data
Hierarchy chart generated in NVivo demonstrating the prevalence of nodes that were coded throughout all of the media content.
The last major query result was that of the coding comparison. It was used to determine inter-rater reliability through Kappa coefficient and percent agreement between the first and second coders of this study. The Kappa coefficient was 0.96, while the percentage agreement was 93.45%. Jacob Cohen, who developed the standards for Kappa coefficient interpretations for finding agreement within nominal scales, determined that a Kappa coefficient of less than zero indicated no agreement, between 0.01 and 0.20 was between none and slight agreement, between 0.21 and 0.40 was fair agreement, between 0.41 and 0.60 was moderate agreement, between 0.61 and 0.80 was substantial agreement, and between 0.81 and 1.00 was almost perfect agreement. He also considered a percent agreement of at least 80% as the accepted minimum (Cohen, 1960).
Factors that Worsened Venezuelans’ Mental Health

To understand the extent of the mental health care deficit in Venezuela, it is important to identify the factors that may be worsening the mental health of the Venezuelan population. In turn, these factors increase the demand for mental health care, which worsens the deficit by overburdening the available mental health services.

The article “El Aumento del Suicidio en Venezuela: Otra Consecuencia de la Crisis” by El Pitazo (2019) provided extensive insight behind the factors of the Venezuelan crisis that may be responsible for the manifestation of negative mental health symptoms among the Venezuelan people. The factors that the article blamed for the increase in suicides are the medication shortages, economic crisis, depression and loneliness after loved ones emigrate, the deterioration of the public health sector, chronic frustration and sadness, and lack of therapeutic services caused by the emigration of psychiatrists and clinical psychologists. The article also mentioned that people commit suicide to avoid becoming a burden to others during the nation’s socioeconomic and humanitarian crisis (Rodriguez, 2019).

Other factors that are claimed to perpetrate the worsening of Venezuelan mental health are the shortages of gas, physical currency, food, and potable water. Many people do not have food reserves that last more than two days, and many others have had to resort to non-potable natural water sources for drinking water (Arepa Digital, 2019; imgabyandre, 2019).
Economic Factors

Peoples’ mental health is also being tested by the drops in salary and the relentless hyperinflation. (El Imparcial de Oaxaca, 2019; Godula, 2019). Psychologist professors’ salaries have been reduced to practically nothing, with a professor claiming to work four jobs just to be able to meet basic necessities (Clay, 2019). Venezuelans on Reddit have posted about having to work freelance trades without prior formal education on the trade and subsequently experiencing feelings of burnout and mental exhaustion. To make things worse, these people stated that they could not afford to continue scheduling consultations with available mental health professionals. They recognized that their poor mental health will likely have further negative consequences in the future, but that they do not have enough time or money to treat it (HectorCore, 2019).

Cultural Factors

The article continues by mentioning the trivialization of suicide and the avoidance of honest dialogue about personal emotions by Venezuelans and how these two factors undermine suicide prevention efforts in the country (Rodriguez, 2019). Families have avoided reporting suicides, which further worsens suicide prevention (El Imparcial de Oaxaca, 2019). The president of the Venezuelan Society of Psychiatry, Dr. Miguel Angel de Lima, explained that Venezuelans tend to seek help for their psychiatric issues as last resort, which increases the urgency of expanding prevention efforts (Gomez, 2019).

Venezuelans on Reddit described various cultural characteristics that they declared are prevalent in Venezuela and partially responsible for the mental health crisis in the country.
Reddit users proclaimed that the negative behavior and attitudes of Venezuelans resulting from their collective frustration worsens mental health by generating socially toxic environments. They complained of the pervasiveness of gossip and arguments between people, as well as the unforgiving social environments in high schools and universities towards those living with mental illness (HectorCore, 2019; imgabyandre, 2019).

The protection of mental health in Venezuela is further undermined by the general intolerance towards mental health issues by the Venezuelan culture, according to some Venezuelans active on Reddit. These users illustrated a society in which mental health is dismissed as relevant to only psychosis and schizophrenia and considered as a measure of one’s personal weakness. The Reddit users proclaimed that Venezuelans consider themselves to have adequate mental health as long as they have not “gone crazy.” Various people generated posts admitting to current or previous major depressive disorders and described a very hostile social environment, in which people did not recognize clinical depression as different from being too sad, sensitive, lazy, or mentally weak. Altogether, Venezuelans on Reddit acknowledge these cultural attributes as considerable obstacles to improving mental health care in Venezuela (imgabyandre, 2019).

Venezuelan Reddit users also suspect that apathy and lack of esteem in a considerable portion of the population in the face of economic or political dilemmas are a result of “social engineering” by the Venezuelan government. Overall, Reddit users expressed uncertainty and pessimism about the country’s political climate and how its portrayed by the international media (HectorCore, 2019).
Venezuelans on Reddit also emphasized that their people tend to have distrust towards clinical psychologists and psychiatrists owing to a bad reputation gained after historical malpractice cases during the 20th century. They noted that a significant amount of the remaining mental health professionals in the country practice psychoanalysis, which they find scientifically questionable (imgabyandre, 2019).

Factors Identified by Mental Health Professionals

Venezuelan mental health professionals who have been treating the increasing number of Venezuelans enduring mental health consequences have identified specific factors that they believe are contributing to this increasing prevalence of symptoms. The president of the Federation of Psychologists of Venezuela, psychologist Juan Carlos Canga Linares, blamed the shortages of basic necessities and the sociopolitical conflict for the worsening of frustration, fear, and despair among Venezuelans. Another psychologist who has been generating “emotional maps” as part of her qualitative research on the populations of Caracas and 10 other major Venezuelan cities since 2015 has determined a high prevalence of negative emotions, such as sadness, fear, and anger, among these populations (Clay, 2019). The psychiatrist Dr. Maria Isabel Parada alleged that Venezuelans have become very polarized and argue a lot between each other, going as far as breaking people off from their lives in the midst of the country’s crisis. The psychiatrist explained that this behavior generates a significant amount of stress for these people and therefore increase their likelihood of developing mental health sequelae (Diario 2001, 2019c). Among the factors that mental health professionals have determined are physical barriers to accessing mental health care, which includes the absence of available transportation for
traveling to mental health consultations (Diario 2001, 2019c). Another barrier is the frequent failure of telephone and cellular signals in the country, which disrupts emergency mental health assistance call lines (Televen Tv, 2019).

**Vulnerable Populations**

There are several groups in Venezuela who are particularly susceptible to developing mental health illness. Those living in poverty were noted as some of the most vulnerable to developing these problems (Rodriguez, 2019). Among other vulnerable groups include people with pre-existing mental health illness, victims of political violence, women, and children.

*People with pre-existing mental health illness*

People who rely on regular medication for treating their mental health conditions suffer greatly from the national mental health care deficit. A blog claimed that between 70% and 85% of those with mental health illness in the Americas do not have access to mental health care (Medina, 2019).

*Victims of political violence*

Victims of state violence are subdued by kidnappings, torture, mistreatment, and public shootings. Those who survive or bear witness to these acts are exposed to experiences that can cause grave psychological effects (Clay, 2019). In addition, Venezuelans have become depressed after knowing of preventable deaths resulting from the Venezuelan government's negligence toward infrastructure (HectorCore, 2019).
Women in Venezuela

Women living in Venezuela have been victims of unwanted pregnancies due to lack of available contraceptives, which has increased cases of anxiety, panic disorders, depression, interpersonal violence, and substance abuse among women (Clay, 2019; Godula, 2019). Women have also been rationed less food than other family members, suffering worse levels of malnutrition in comparison (Clay, 2019).

Children in Venezuela

The nation’s crisis is devastating the life expectancy of Venezuelan’s population, particularly of the youth (Rodriguez, 2019). Some children’s mental health is worsening because of their parents having to leave them in Venezuela to find jobs in other countries. These children report feeling insecure, sad, angry, and abandoned after their parents’ departures (Clay, 2019; Godula, 2019). The anger that Venezuelan children feel is apparent from personal accounts such as when an 8-year-old girl made her hang-man game phrase be “I hate Maduro” (Alex, 2019a). 849,000 children experienced at least one parent leave the country for work in 2018. Many Venezuelans leave their children behind when they cannot afford to travel as a whole family (Alex, 2019b). At least 28% of those who emigrated reported leaving behind at least one child. Mental health illnesses among children are also suspected to be a result of malnutrition, lack of education, and lack of options for recreational activities. Children are skipping on classes because of food shortages, lack of public transportation, and again, because of the absence of their parents or guardians. The attendance rate for pre-kindergarten dropped to 33% by the third
period of 2019. The general school attendance rate was 72% in the Caracas-Vargas sectors, 70% in the nation’s eastern regions, and between 79.2% and 76.5% in Miranda state (Alex, 2019a).

Extensive power outages have also had a detrimental effect on the psyche of Venezuelan children, especially in the most tropic regions of the country. In Maracaibo, children have been resorting to sleeping outside to avoid the excessive heat retained in their house at night. This has been very uncomfortable and even dangerous to them, as children are subjected to constant mosquito bites and occasionally bites from poisonous insects such as centipedes. Furthermore, the recurrence of electricity blackouts has exposed children to the sounds of people screaming as they became victims of ransacking and other forms of violence (Alex, 2019a).

Aggravating the situation for Venezuelan youth are teachers and social workers who are not prepared to be sensible to this youth’s emotional needs and the failure of technology such as electric power and communication signals, which are necessary for keeping children in contact with their parents (Alex, 2019b). Additionally, children may be reluctant to reunite with their parents abroad if it means leaving behind the rest of their family and friends (Alex, 2019b). There has also been a reemergence of deadly and crippling infectious diseases that plague among the young (La Patilla, 2019). Some children are subjected to violence by their severely frustrated parents, who struggle to financially maintain their families (Clay, 2019). Finally, it must be noted that parents caring for young children are just as much subjected to mental health strains as their own children (La Patilla, 2019).
Mass Migration of Venezuelans

A major stressor shared by Venezuelans is the departure of loved ones searching for better quality of life in another country. The most modest statistic on how many Venezuelans have left their country since the crisis began to take root around 2014 is 2.3 million people (Rodriguez, 2019). However, other sources cite a number as high as 3 million people who have emigrated (El Imparcial de Oaxaca, 2019). Another source placed the number at 1.9 million people since 2015, with 5,000 Venezuelans emigrating every day (Clay, 2019). The United Nations Office for Coordination of Humanitarian Affairs reported 3 million Venezuelan refugees as of November, 2018 (Alex, 2019b). According to the United Nations High Commissioner for Refugees, the total number of Venezuelans who have emigrated will reach 4 million by the end of 2019 (La Hora, 2019). The process of migration is typically a physically and emotionally strenuous ordeal for these people. A strong demonstration of this are the chaotic and dangerous conditions at the Simon Bolivar International Bridge on the Colombia-Venezuela border, which has been blockaded by shipping containers by the Venezuelan government (alfiehurtado, 2019). The stress of migration is compounded by the emigrants’ fears of failing in their new country and having to return to the deteriorating conditions of Venezuela (Rodriguez, 2019).

Electrical Outages

Mass electrical outages, especially the one that occurred in the beginning of March of 2019, elicited strong negative responses, such as anxiety and despair, in the general population. These responses were greatly aggravated by the unknown number of deaths of newborn children
and critical care patients in hospitals, outbreak of protests, acts of violence toward civilians by state police and armed militia, and ransacking of commercial districts (Arepa Digital, 2019; Presencia.MX, 2019).

*Prevalence of Negative Information*

Many Venezuelans have fallen into a habit of “nearly compulsive consumption” of endless local and national bad news (Redaccion El Tuqueque Noticias, 2019).

*Increase in Mental Health Problems*

According to a blog, the Federation of Psychologists of Venezuela stated that 70% of Venezuelans are living with some form of mental health disorder (Medina, 2019). Gisela Galeno, a clinical psychologist who represents this organization, declared that cases of depression, anxiety, and suicide are on the rise in Venezuela. She blamed the aforementioned violent political crisis that has engulfed the country (Televen Tv, 2019). The frequency of these mental health conditions, in addition to a few others such as psychosis, behavioral problems in children, and self-destructive behavior, were delineated in various media content.

*Increase in Suicides*

*Suicide statistics*

The Venezuelan Observatory for Violence reported 19 per 100,000 inhabitants suicide rate in the state of Merida, which is only surpassed by 20 other countries in the world
(Rodriguez, 2019). This rate is quadruple the rate from the year 2005, when the rate was between 4 and 5 per 100,000 inhabitants (El Imparcial de Oaxaca, 2019; Rodriguez, 2019). However, De Lima has stated that the statistic from the Venezuelan Observatory for Violence is unofficial and cannot be confirmed without official data from the government, which has neglected to produce official suicide statistics for seven years (Gomez, 2019). Even so, it is still claimed that the suicide rate has tripled in just the past 4 years, with the most affected groups being despaired young and elderly (El Imparcial de Oaxaca, 2019; Televen Tv, 2019).

*Nationwide incidences of suicides*

Numerous suicides in Venezuela have been attributed to the deteriorating conditions of the country, encompassing suicides motivated by extreme hunger, unplanned pregnancy, unavailability of anti-depressives, migratory family separations, and medical diagnoses that require expensive treatment. These suicides have occurred throughout the whole country, with cases recorded in the states of Miranda, Monagas, Vargas, Zulia, and Guárico (Rodriguez, 2019). One specific case was triggered by the tardiness of food from one of the government-endorsed food distribution committees. Anonymous sources in Monagas also reported seven suicides due to hunger in a 2-month period. Additionally, suicides occurring after victims received a cancer diagnosis have been disclosed. A suicide in Guárico state demonstrated the urgency of anti-depressive medication availability for those with pre-existing mental illness (Rodriguez, 2019).
Suicides among children and adolescents

A 2018 report from the children’s rights NGO Cecodap, Community Learning Center in English, stated that the humanitarian crisis has increased suicides among children and adolescents. The psychologist Abel Saraiba had counted 11 suicides among the youth in 2014 and 34 in 2017. The Psychological Attention Service under Cecodap in Caracas indicated that 50% of their family clients sought consultation because of internal conflict or the use of physical or humiliating punishment. Twenty-eight percent of these families reported mood changes, while 25% of children reported mood changes. Cecodap saw 516 consultations and 186 cases in December of 2018 and reported 5 children with suicide ideation and self-inflicted lacerations in the year of 2018 (La Patilla, 2019).

Suicide discussions on Reddit

Venezuelans on Reddit have noted an increase in suicides among their people both inside and outside of Venezuela. Venezuelan Reddit users have shared very personal stories, including the suicides of loved ones and their own suicide attempts or ideations (HectorCore, 2019; imgabyandre, 2019).

Increase in Anxiety and Depression

Much of the increase in suicide is a result of predisposing factors, such as the rise in the prevalence of depression and anxiety among the Venezuelan population (Redaccion El Tuqueque Noticias, 2019). According to psychiatrist Dr. Luis Madrid, who specializes in bipolar and depressive disorders, 80% of Venezuelans show signs of mild depression, especially within
adolescent and young adult age groups (Vivoplay.net, 2019b). Dr. Gilberto Aldana, a clinical psychologist from Vargas Hospital in Caracas, claimed that his two most common diagnoses are anxiety and depressive disorders, which he said were characteristic of the current Venezuelan population (Diario 2001, 2019a). Additionally, other mental health counseling personnel claimed that they are experiencing a spike in consultations for anxiety and depression across all socio-economic groups. They also reported an increase in consultations for stress disorders and mood disorders (El Imparcial de Oaxaca, 2019).

These trends are implicated to be consequences of the chronic stress experienced in daily Venezuelan life, which plagues both patients and medical staff alike (Clay, 2019). People increasingly witness public panic attacks, know of people with post-traumatic stress, and observe the development of anxiety and depression among children (Clay, 2019; Godula, 2019). It may come as no surprise that the pictograph by Visual Capitalist, using data from World Happiness Report 2019, placed Venezuela at 108th place in the world for country happiness score and as the least happy country in South America, with a happiness level of 4.7 out of 10 (Ghosh, 2019).

Anxiety, depression, and food insecurity among mothers

Anxiety and depression levels in mothers caring for malnourished children were studied at the University Hospital of Maracaibo Department of Nutrition and Development. Eight hundred families were surveyed on their perceived food security, depression level, and anxiety level. Ninety percent of the mothers were concerned about not meeting their family’s alimentary needs. Six out of 10 of the mothers were found to have moderate levels of depression. Almost fifty-seven percent of these mothers had 6 symptoms of severe anxiety, while only 13.3% exhibited no anxiety symptoms and 6-7% had no outward symptoms of depression (VPItv, 2019).
Anxiety and depression discussions on Reddit

In a discussion on Reddit about the mental health effects that Venezuelans are experiencing from their day-to-day life, a user told of a time when he or she was attempting to do exercise in a gym to alleviate their stress and were overwhelmed by a “depression attack” (HectorCore, 2019). This demonstrates how strong of a hold that depression has come to have on even proactive Venezuelans. Another Venezuelan Reddit user attributed their depression to their stalled college education, inability to own a home, and living “in a miserable country” (Samkiud, 2019).

Anxiety and depression among Venezuelan migrants

Testimonies from Venezuelan migrants about their mental health outside of Venezuela were abundant and worrisome. Those who have migrated to Peru and Ecuador have sought considerable assistance from clinical psychologists and psychiatrists for their mental health symptoms (La Hora, 2019). The Venezuelan Civil Association in Ecuador stated that they attend to 200 people for mental health in 6 months, stating that some clients merited therapy or psychiatric treatment.(La Hora, 2019). An interviewed Venezuelan psychopedagogist claimed to have seen 40 clients from Venezuela with depressive symptoms that have led to suicide attempts (La Hora, 2019).
A Reddit post shared a news article from a Peruvian news agency that described Venezuelan migrants arriving in Peru with symptoms of depression, anxiety, and, less frequently, suicide ideation and schizophrenia (Andina, 2019). This news article was bolstered by another Reddit post by a Venezuelan who had emigrated to Peru six months prior. It described their post-traumatic stress symptoms resulting from experiences pertaining to the insecurity that is rampant in Venezuela and how these symptoms were interfering with their daily life in Peru (throwawayacc222, 2019).

A Venezuelan who had emigrated to an unknown location expressed on Reddit the depression and anxiety that they had been experiencing since their departure from their country, friends, and family. They grieved the end of better times in Venezuela, and they recognized that moving back to Venezuela would not give them what they were nostalgic for (Drokny, 2019). Migrants such as this may have substantial difficulty in moving on and making the most out of their new lives in their new countries. Therefore, they suffer significantly from depression and anxiety long after leaving Venezuela.

A particular migrant group consists of Chinese-Venezuelans, who are descendants of people who originally immigrated to Venezuela from China for better economic opportunities and quality of life. Since the downfall of Venezuela, these Chinese-Venezuelans have had to move back to China while suffering substantial emotional and economic losses (Huifeng, 2019).

Anxiety and depression among children

Venezuelan children who have emigrated to other countries are also not liberated of their mental health ailments upon leaving their native nation’s crisis. A study by the foundation
Chamos Venezolanos in Ecuador found that in a sample of 100 minors, 27.8% exhibited signs of depression, with 2.8% severe level, 8.3% moderate level, and 16.7% mild level depression prevalence. 58.3% of these 100 children had anxiety disorder that resulted from the disruption of their education (La Hora, 2019). Another indication of the significant negative impact that Venezuelan children have endured is the development of violent tendencies and behavioral problems among some of them (La Hora, 2019).

On the other spectrum of migratory mourning are the children who are left behind in Venezuela by one or more parents as opposed to the aforementioned children who manage to emigrate from Venezuela with their parents. A 4-year-old girl, whose father had to move to Peru to provide financial support for his family, began attending free therapy consultations after developing severe feelings of abandonment. She was said to have accused him of not loving her for having left the country (Alex, 2019b).

Children who have at least one parent leave the country to find better employment typically have better physical health than children whose parents are still struggling to provide for their families in Venezuela. However, children with absent parents tend to develop more mood and behavioral problems, such as depression and hostility (Alex, 2019b). A psychologist who works at the Pediatric Specialties Hospital in Maracaibo stated that 3 out of 10 of her pediatric clients see her because of the mental impact they have undergone from having at least one of their parents leave the country (Alex, 2019b). This increasingly common experience among the youth has precipitated a number of mood issues, such as crying spells and sudden mood changes, and behavioral issues such as neglect of school work and personal hygiene, nail biting, pants wetting, and disobedience (Alex, 2019b). These negative manifestations are
compounded by the stress that encompasses life in Venezuela, especially electrical outages. Blackouts have been making children more “angry, afraid, frustrated, anxious, and short-tempered” (Alex, 2019a). The previously mentioned mood and behavioral problems that are arising in children due to their parent(s) leaving are in addition to regressive behaviors that electrical outages seem to exacerbate, such as thumb sucking, needing to sleep near others, and seemingly unwarranted crying (Alex, 2019a).

**Depression among elderly**

Just as many children are being left behind by their families, an overwhelming segment of the elderly Venezuelan population have been watching more and more of their remaining descendants leave the country. Elderly Venezuelans who are left behind by their families often suffer from depression and suicide ideation and fall into a state of absolute self-negligence (Diario 2001, 2019b). One elderly woman who saw two of her granddaughters emigrate suffered through five months of depression, during which she lost 26 kilograms (TVVenezuela, 2019).

**Relapse in Psychiatric Patients**

As explained in a previous section, patients with pre-existing severe mental illness are highly vulnerable to being affected by the mental health care shortages. The lack of anti-psychotic medications has caused psychosis to return in many psychiatric patients (Godula, 2019; Rodriguez, 2019).
Increase in Self-Destructive Behavior

Venezuelans have asked each other through Reddit on each other’s thoughts about the Venezuelan crisis and if it has affected their emotional health. There was a strong consensus noted from these Reddit posts that Venezuelans are indeed going through emotional trials and that different defense mechanisms have developed in their efforts of coping with their hostile environment. On one Reddit post, a user explained that the prevalent party culture may be such a method of coping that has resulted in unhealthy behavior, especially among the youth. On the same post, someone else stated that Venezuelans have had to adopt a form of “obligatory insanity” to be able to endure their situation (HectorCore, 2019).

Similarly destructive is the denial that one is experiencing mental health symptoms. Venezuelans on the aforementioned Reddit post alleged that many among their population denies having mental health issues because it is not generally accepted to be open about one’s mental health (HectorCore, 2019).

Increase in Physical Sequelae

A Venezuelan replied to a Reddit post about the detrimental mental effects of the country’s circumstances by stating that they had a resting blood pressure of 180/100 mmHg at 23 years of age as a result of the intense stress they experienced daily (HectorCore, 2019). On another Reddit post, a Venezuelan described experiencing severe gastrointestinal symptoms brought on by their chronic mental stress (imgabyandre, 2019).
Increase in Emergency Mental Health Call Line Use

The Federation of Psychologists of Venezuela run an emergency mental health assistance call line every Friday from 8:00 a.m. until 5:00 p.m. A representative from the organization reported an average of seven callers every Friday, which was a 60% increase from the previous year. They stated that the majority of callers are at least 25 to 30 years of age, and commonly seek assistance with their mood disorders such as depression and anxiety, and interpersonal conflicts. Male callers were said to be on the rise, which is a group that traditionally evades seeking professional mental health support (Televen Tv, 2019).

Stefania Aguzzi, a psychologist who runs a free mental health consultation hotline, said that levels of anxiety have reached chronic levels in those who she consults and fears that they will soon develop depression (Godula, 2019).

Shortage of Mental Health Personnel

The Dr. Domingo Luciani Hospital in Eulace self-reported an 80% decrease in psychiatry specialty personnel, stating that they have two of the eleven original psychiatrists, one of the original four or five clinical psychologists, and no psychiatry or psychology residents of the usually two or three working at their institutions as of September 2019. The hospital also reported a concurrent increase in arriving patients (Rodriguez, 2019).

At the Autonomous Institute University Hospital of the Andes, Ignacio Sandia is left to manage two headquarters and explained that the Psychiatric Service of Iahula has eight of the
original fourteen psychiatrists and three of the original five clinical psychologists servicing the primary health center of Merida, which sees 22,000 consultations per year (Rodriguez, 2019).

The Psychiatric Hospital of Caracas, the nation’s major psychiatric facility, has only five psychiatrists working until 6:00 p.m. and no maintenance staff (Caracas, 2019).

Academic mental health experts that would be contributing to the nation’s research on the conditions of mental health care are disappearing as both professors and students leave the country (Clay, 2019; Godula, 2019). This has caused research to stagnate and for universities to drop off the radar of the international academic community (Clay, 2019).

The psychiatric wing of San Cristobal's General Hospital, which is the only mental health institution left in the state of Táchira, has undergone a decrease in psychiatrist, nurse, and maintenance staff. The staff deficit is so severe that they only accept eight patients at a time. They previously had a capacity for sixty patients (Al Jazeera English, 2019).

The general consensus of mental health professionals was that many of their colleagues have left and that it has caused a deficit in mental health care staff (Alex, 2019b; Televen Tv, 2019). The only locations that offer free consultation for children are public hospitals and some organizations such as Cecodap, Profam, and Fundana (Alex, 2019b). The NGO Psychologists Without Borders operates in Caracas with 10 clinical psychologists and provides free and low-cost services to between 500 and 600 patients every month. As of September of 2019, they had a waitlist of around 50 patients (Diario 2001, 2019c).

The difficulty that Venezuelans face in accessing mental health consultation is reflected in their use of social media to locate available professionals. A Reddit user requested the Venezuelan Reddit community if they knew of any clinical psychologist in the city of Carabobo.
Unfortunately, no one had a straight answer. One replied with that the usual price of a visit is $5-$10 per hour, and another expressed their distrust toward the institutions and professionals remaining in the country and cautioned the individual (alvesrivas, 2019).

Of the information retrieved from the collected media content, evidence showcasing the shortage in mental health care personnel was among the least common data. Most indicators came from direct interviews with mental health care personnel.

**Shortage of Mental Health Medications**

The article by Rodriguez (2019) was the most insightful in determining the extent of the psychiatric medication shortage in Venezuela. According to Norma Barreno, an interviewed psychology researcher, there used to be three selective serotonin reuptake-inhibiting anti-depressives available for free five years ago in Venezuela through the Program for Medicines of High Cost of the Venezuelan Institute for Social Securities (Rodriguez, 2019). However, the only anti-depressive that is still available for free is sertraline through the call line 0800-SALUDYA and occasionally amitriptyline. These medications are imported from Cuba (Rodriguez, 2019).

The ex-president of the Venezuelan Society of Psychiatry, Dr. Wadalberto Rodriguez, claimed that of 70 compounds previously available for mental health treatment, only 4 remain in the country as of September, 2019 (Rodriguez, 2019).

The Dr. Domingo Luciani Hospital stated that five years ago, it had access to top of the line medications from the Social Security’s pharmacy. These included at least 5 anti-psychotic compounds, 2 or 3 latest-generation anti-depressive medications such as sertraline and
escitalopram, and 5 anti-psychotic medications: risperidone, quetiapine, olanzapine, aripiprazole, and ziprasidone. Nowadays, the only available anti-depressive is sertraline through the government’s inconsistent supply and the anti-psychotic quetiapine is only available at 300 mg. The only top-line anti-psychotic remaining, risperidone, is only available through private pharmacies and costs at least 300 sovereign bolivars (Rodriguez, 2019).

Norma Barreno, the aforementioned psychology researcher, claimed that there are barely any psychotropics such as benzodiazepines left in the country. She said that the call line 0800-SALUDYA used to have bromazepam, and that diazepam can occasionally be found in pharmacies (Rodriguez, 2019).

The Psychiatric Hospital of Caracas reported a lack of anti-depressives and anti-psychotic medications. An interviewee said that 20 packets of anxiolytics and sedatives with an expiration date of 2016 were being used as of August 2019, and that they have to ration the medication supplies the receive.

The nation’s pharmacological shortage is said to be at 90%, making it unfeasible for mental health patients to maintain their daily medication requirements (Gomez, 2019). Psychiatrist Dr. Robert Lespinasse, ex-president of the Psychiatric Society of Venezuela, backed the claim that there is a severe shortage of medication treatments for the severely mentally ill (El Pitazo, 2019). This extreme shortage has made families resort to the expensive black market for medication and has resulted in illness relapses among patients (Clay, 2019). Reddit users have expressed their involuntary cessation of anti-anxiety medications owing to the shortage and high cost of available medications (HectorCore, 2019). A Reddit user explained that medications for depression, anxiety, and bipolar disorders are largely unavailable and are as expensive as
medications for chronic diseases such as hypertension, diabetes, and cancer (imgabyandre, 2019).

Similar to information on the shortage of mental health personnel, evidence of the shortage of mental health medications was not as frequent as data pertaining to the factors responsible for the worsening of Venezuelans’ mental health and evidence of the increasing manifestations of mental health illness among the Venezuelan population. Half of the information obtained was from a single article, and a considerable portion of the rest of the data was general statements by social media users, mental health figures, and popularized news articles.

_Deterioration or Closure of Mental Health Care Institutions_

All of the media describing the conditions of mental health institutions in Venezuela described a state of deterioration and recent closures of various hospitals and centers around the country. This media highly consisted of interviews with current or former mental health staff from these institutions.

The Institute of Psychiatric Rehab in Peribeca, Táchira state, closed in May of 2018 due to complete lack of medicine and food for the mental health patients. It was once one of the most respected psychiatric institutions in Venezuela and had a capacity for 300 patients. The 50 patients that had remained were transferred to another institution in northern Venezuela prior to the institution’s closure. This closure meant there only be one mental health care institution left in the entire state of Táchira, the psychiatric wing of San Cristobal's General Hospital. A psychiatrist who formerly worked at the institution explained that half of the original 300
patients were released at the start of the nation’s crisis, when the government began cutting its budget for mental health care. The patients were reduced to 110, and between 45 and 55 patients subsequently died from starvation during the following years. The YouTube video covering this institute’s closure presented images of chronically malnourished former patients who weighed only 40 kilograms. Only 9 patients of the 50 who were transferred upon the closure were reported to still be alive. The interviewed psychiatrists did not agree with the central government’s sentiment that U.S. sanctions caused the strife of the public health services (Al Jazeera English, 2019).

A popularized news article described deplorable conditions in the Psychiatric Hospital of Caracas, which included an insignificant salary of $6/month for the staff, 20-month power outage in the largest hospital wing, absence of mattresses and sheets, shortage of patient rooms, and buildup of garbage, human excrement, and insects. The hospital houses only 36 patients out of their original capacity for 300. The staff who were interviewed stated that their hospital’s decrepit conditions were kept as a secret until July 2019 out of fear for retaliation by the government (Caracas, 2019). On that month, a video was published on YouTube presenting footage of the biohazardous conditions within the hospital and a local initiative to clean and disinfect the patients’ quarters (RPTV News, 2019).

In August 2019, the president of Lara state’s College of Medics, Rene Rivas, denounced the consideration of closing El Pampero Psychiatric Hospital in Barquisimeto. While he argued for the patients’ sake, a nurse who had worked there for the past 25 years scolded the lack of medical treatment for those patients. She emphasized that they will eventually die if they
continue to be left untreated (Vivoplay.net, 2019a). This hospital is the one mentioned in this study’s introduction subsection, the abysmal conditions in psychiatric hospitals.

Some mental health figures, including an ex-president of the Psychiatric Society of Venezuela, psychiatrist Dr. Robert Lespinasse, and clinical psychologist Gisela Galeno, asserted that the mental health hospitals of Venezuela were deteriorating, that the institutions suffered from a deficit in mental health care personnel, and that working conditions for the remaining professionals are grueling and are still worsening (El Pitazo, 2019; Televén Tv, 2019).

Two clinical psychologists from The Vargas Hospital in Caracas stated that the institution is still holding up regardless of diminishing resources and staff deficits. They claimed that they see between 80 and 90 new patients every Monday and that they have never closed down (Diario 2001, 2019a). However, a psychiatrist interviewed during the month prior said that Vargas Hospital was not able to take in more patients with advanced levels of suicidal ideation due to lack of psychiatrists and medications (Diario 2001, 2019c).

The last notable mental institution is the historical psychiatric colony in the town of Anare. The hospital was founded in 1945, and the community traditionally depended on the jobs generated by the psychiatric institution. By 2015, the hospital had deteriorated to the point where patients were released to roam freely through the streets in order to give them a chance to find food and water. The hospital’s manager blamed the government for not providing enough funding (AP Archive, 2015). However, there has not been any more news coverage on the conditions of this colony since 2015. This is of great concern and could imply that the psychiatric patients did not prosper. This media piece is the only one published outside of this study’s set temporal range of January 2019 to November 2019.
Neglect of Mental Health Care by the Venezuelan Government

The media recovered on the response of the Venezuelan government to the mental health crisis depicts a failure to act. The National Institute of Statistics ceased reporting on suicide rates in 2012 (Rodriguez, 2019). In October of 2019, the Health Ministry finally released the Annual Mortality Report of 2014, in which it stated that 569 deaths were due to self-inflicted lesions. This number is lower than the statistic in 2013 and is in fact the lowest of the past 19 years. The article that mentioned this report portrayed it with much skepticism (Rodriguez, 2019).

The Venezuelan Observatory for Violence collects data independently from local hospitals and morgues in order to generate unofficial statistics on the violence plaguing the country, including the rise in suicide rates (El Imparcial de Oaxaca, 2019).

The budget set by the Ministry of Health for the mental health sector is said to not rise above 5%, and the deterioration of psychiatric hospitals continues because the government does not attempt to contact these institutions (Gomez, 2019). In contrast, an ex-president of Psychiatry Society of Venezuela claimed that mental health care only gets 1% of the health care budget (El Pitazo, 2019). The Psychiatric Hospital of Caracas denied receiving any of the aid that the government received from the Red Cross, Russia, and China (Caracas, 2019).

In April of 2019, a blog detailed that there was less than a year left for the Venezuelan government to finalize the National Plan for Human Rights 2016-2019, in which is the Law for Mental Health. The blog explained that this law would advocate for the inclusion of mental health within primary care and general hospitals and would suggest organization of mental health care training (Medina, 2019).
The Venezuelan government has not taken any action in response to the rise in child and adolescent suicide incidences (La Patilla, 2019). Furthermore, the only perceived response by the Venezuelan government in regards to Venezuelans’ mental health has been to ban lines outside of bakeries because the government blames them of “causing anxiety” (Martin, 2019).

It is suspected that the lower frequency of media portraying the failure of the Venezuelan government in addressing the nation’s mental health crisis may be due to the fear of retaliation by the Venezuelan government for criticizing it. Those who are concerned for mental health in Venezuela tend to be within Venezuela, which may be due to the widespread human nature of avoiding the topic of mental health. Since these domestic sources are bearing witness to the mental health crisis, they are more likely to report on it than foreign sources. However, as previously mentioned, these media pieces are among the least common, very likely due to the oppressive behavior of the Venezuelan government.

**Recommendations by Mental Health Experts for Addressing Mental Health Crisis**

A major obstacle that the Venezuelan population faces in accessing mental health care is in fact their pronounced hesitation and skepticism towards seeking mental health care. A clinical psychologist from Vargas Hospital in Caracas said in an interview that the fear of seeing a clinical psychologist or psychiatrist must first be dismantled (Diario 2001, 2019a).

Within an article published by the American Psychology Association, there are suggestions for how psychologists around the globe can assist Venezuelan mental health professionals. These include sharing publications, access to conferences, and financial aid,
inviting Venezuelan psychologists to collaborate on research or teaching, collecting data from Venezuela, and contacting the Federation of Psychologists of Venezuela (Clay, 2019).

Three specialists, professor Norelbis Aguilar, Dr. Enriqueta Sileo, and psychologist Abel Saraiba, stated that the situation of Venezuelan children and adolescent mental health must be brought to light. They also emphasized the need for national statistics, the identification of the present health care capabilities, the generation of a plan for national school attendance, and establishing a national healthcare plan for children and their families. Furthermore, they recommended improving the conditions of mental health care by strengthening the education of mental health professionals with the context of humanitarian emergencies and prevention campaigns (La Patilla, 2019).

More suggestions for the sake of Venezuelan children suffering emotionally from being left behind by their parents includes preparing manuals for schoolteachers to help them be more sensitive towards these children’s emotional needs. This tactic was successfully employed in the Philippines, which also has a considerable population of children with parents working abroad (Alex, 2019b).

Mental health professionals working with Venezuelan migrant populations stressed the need to make the migration experience as positive as possible. They recommended playing Venezuelan music near Red Cross stations on national borders and to facilitate safe spaces for Venezuelan children to artistically express themselves. These mental health professionals also emphasized the importance of refocusing and encouraging Venezuelan migrants in their original goals. This is because the difficulties endured during migration may pull them away from meeting these aspirations (La Hora, 2019).
Mental health professionals in Venezuela, especially around the Caracas metropolitan area, have collaborated with each other to reduce the gap between the increased mental health care demand and the deficit in mental health care staff and medications. Some of these alliances were made between domestic organizations, while others have been made between Venezuelan and international entities.

The Federation of Psychologists of Venezuela launched both a one-day-a-week emergency call line operated by volunteer psychologists and a program of free consultations by volunteer psychologists (Clay, 2019; Televen Tv, 2019). They have requested assistance from the international mental health community in operating their free mental health telephone helpline (Federacion de Psicologos de Venezuela, 2019b). Psychologists Without Borders and psychologist Stephanie Aguzzi both also established free mental health consultation call lines (Godula, 2019; TVVenezuela, 2019).

The Federation of Psychologists of Venezuela have also published an online directory of mental health centers that offer free or low-cost services and reach out to the populace with mental health advice through television, radio, Twitter, and Instagram (Clay, 2019). Additionally, their website contains five flyers that detail various recommendations for the Venezuelan public regarding mental health. These include recommendations on how to live in Venezuela’s crisis, how to live with inflation and shortages while raising young children, and how to support one’s children amid the country’s crisis (Federacion de Psicologos de Venezuela, 2019a).
The Federation of Psychologists of Venezuela also established the Psychological Support Program with the Central University of Venezuela as an emergency initiative to provide psychological services through telephone, cellphone, and the internet. The blog author that mentioned this initiative did not seem to find it adequate to meet the mental health needs of the Venezuelan population (Medina, 2019). Also provided through the Psychological Support Program were two videos made from Psychologist First Responders which the blogger claimed were intended for mental health patients as coping resources (Medina, 2019). However, he may have been referring to the two videos intended for helping mental health care providers better serve the Venezuelan population (Federacion de Psicologos de Venezuela, 2019a).

On the International Day for Suicide Prevention, the Federation of Psychologists of Venezuela announced through a Twitter post that they had launched a national training and research program on suicide in Venezuela (Federacion de Psicologos de Venezuela, 2019a). A Twitter user reposted an announcement by the Federation of Psychologists of Venezuela about them meeting with allies on World Mental Health Day to give a Psychosocial Intervention course in the context of the human rights violations occurring in Venezuela and providing psychological first aid by phone (Fed de Psic de Vzla, 2019). Mental health organization that is active on Twitter is the Venezuelan Society of Psychiatry, which posted about its Congress discussion held in Caracas concerning the reconstruction of mental health care in Venezuela. Among the topics they discussed were panic disorders, depression, and alcohol and drug use (@francacaterina, 2019).

AVESA and Psychologists Without Borders are collaborating to eventually provide psychosocial support to low-income communities in Caracas (Clay, 2019). Another NGO,
Futuro Visible or Visible Future, worked with El Pitazo news outlet to have a public discussion with San Cristobal residents on how to manage one’s mental health during the country’s crisis.

Many Venezuelan psychologists who have emigrated still wish to help their colleagues from their new homes. One developed a virtual network for mothers in Venezuela to promote the wellbeing of families, offer strategies for promoting independent democracy, and provide online psychotherapy (Clay, 2019). A major international effort dedicated to the mental health of Venezuelan migrants was the pact between ten different nations to provide health care to Venezuelan migrants on the Colombian border, with mental health care being highly prioritized (Reuters, 2019).

Overall, the community of the remaining mental health professionals in Venezuela recognized the need for emergency initiatives and acted upon this demand by establishing various free or low-cost mental health consultation services, producing various sources of recommendations for both the Venezuelan populace and for mental health professionals treating them, holding dialogues about the mental health crisis present in the country, and reaching out to international mental health communities for assistance in executing their initiatives.

Advice for Maintaining Personal Mental Health in Venezuela

Because of the constant high-stress environment present in Venezuela, numerous lists of recommendations were made in hopes of helping Venezuelans alleviate their adverse mental health symptoms. These lists were made by concerned Venezuelan citizens, Venezuelan and foreign news outlets, and Venezuelan and foreign mental health experts.
El Pitazo recommended that Venezuelans have realistic migration plans (2019). El Tuqueque Noticias suggested spending time with loved ones, planning out finances to make purchases only once a week, sleeping between 6 and 8 hours per night, limiting news intake, taking in news as calmly and prudently as possible, making home cooked meal plans including plenty of fruits and vegetables, exercising at least three times a week, meditating, recognizing and controlling internal emotions, engaging in leisure activities, rejecting internal negative and aggressive attitudes, and seeking professional help when symptoms become chronic (Redaccion El Tuqueque Noticias, 2019).

The Caraota Digital published a news article detailing various recommendations and mentioning an Instagram account, @psiconfioo, that offers regular simple recommendations for managing anxiety in Venezuela’s environment. The article’s recommendations included seeking support from social relationships with other Venezuelans, verifying shared information before resending in order to prevent spreading false expectations, solving simple problems first, and spending time relaxing, practicing hobbies, and physically exercising (Caraota Digital, 2019).

The Federation of Psychologists of Venezuela reached out with coping strategies through radio, television, Twitter, and Instagram (Clay, 2019). A clinical psychologist from Vargas Hospital, Caracas, recommended physical exercise, a pinch of cocoa powder under the tongue in the morning before teeth brushing as a natural anti-depressive, bananas and vegetables rich in tryptophan, nature and park walks, and therapeutic help from specialists (Diario 2001, 2019a). Dr. Maria Isabel Parada, a psychiatrist from Psychologists Without Borders in Caracas, said that taking up a personal project, playing with kids, volunteering with an NGO, and speaking with physically separated family members at least every 3 days for 20-30 minutes can be very
uplifting, especially for elderly individuals (Diario 2001, 2019c). The last notable initiative by an organization to provide mental health recommendations for Venezuelans was the one by Civil Association 251 in Action, which handed out flyers at different bus stops in the city of Barquisimeto (Torres, 2019).

Among the ways that Venezuelans attempt to find emotional release in the middle of their nation’s crisis are going out to dance (CGTN America, 2019) and posting information about their personal crises on social media such as Reddit. A common occurrence on Reddit posts made by the online Venezuelan community is users sharing words of encouragement and occasionally making jokes of considerable dark humor about the nation’s socioeconomic and mental health disasters (HectorCore, 2019). These Venezuelans were typically substantially relieved to read that others thought similarly of the mental health crisis in Venezuela (imgabyandre, 2019).

One Reddit user expressed symptoms of migratory mourning since emigrating from Venezuela. Those who responded to the post told them to live in the present and to make the most out of their new life in their new home. They also recommended them to see a therapist and gave some stress management advice (Drokny, 2019).

Another Reddit user reached out for help with their post-traumatic stress symptoms they acquired while living in Venezuela. Those who replied told them to seek professional help after emphasizing that they had similar symptoms, as well (throawayacc222, 2019). Some Venezuelans on Reddit also empathized with and encouraged a user who had posted about major depressive symptoms caused by living in the socioeconomic crisis, telling them that they were not to blame for their situation and giving general mental health advise. They also made typical dark humor jokes about their nation’s crisis (Samkiud, 2019).
Other Venezuelans who use Reddit have expressed in other Reddit posts that mental health symptoms do not disappear and may even worsen upon leaving Venezuela. They strongly suggested addressing one’s mental health issues regardless of what country one is living in (MiniParticula, 2019).

It was apparent that Venezuelans had several support networks available to them through social, professional, and online means. The prevalence of these resources seemed to have increased within the past year, since there were not as many media content search results from prior years. The social platform that facilitated the most dialogue between Venezuelans concerning mental health was Reddit, and the organization most involved in providing recommendations for Venezuelans pertaining to their mental health was the Federation of Psychologists of Venezuela.
DISCUSSION

Implications for Mental Health Care Policy and Legislation in Venezuela

Media content obtained during the study heavily implied that the mental health care sector of Venezuela’s health care system is financially neglected by the central government. Media also stated that Venezuela’s central government has only accepted humanitarian aid from the Red Cross and international allies China and Russia and that this aid has not been received by mental health institutions. Most humanitarian aid and volunteer mental health services from Venezuela’s neighboring country, Colombia, is received once Venezuelans cross nation lines and enter Colombian territory. This is due to high tension between the nations’ governments and repeated refusals by the Venezuelan government to receive assistance from Colombia. Furthermore, the Venezuelan government has not accepted assistance from any other major advocate for mental health care, such as mental health subdivisions of the World Health Organization. Lastly, one blog briefly mentioned that mental health care legislation in Venezuela is incomplete and unimplemented. All of this information is in addition to the highly apparent mental health staff, medication, and institution deficit that was found during the media content analysis.

Mental Health Care Funding

Taking these findings into account, various recommendations exist for Venezuela’s civilian communities and local, state, and central governments to consider for rebuilding the nation’s mental health care system. The foremost issue that must be addressed is the gross
underfunding of the mental health care sector. One media source claimed that the Venezuelan government allocates 1% of its health care budget to mental health care, while another one stated that the allocation does not surpass 5% (El Pitazo, 2019; Gomez, 2019). In order for a low-income country to provide a scaled up, basic package of cost-effective mental health care interventions, their government must invest around $2 per capita towards these initiatives. This is roughly 3-4% of public expenditures on health or 2% of total health expenditures for an average country in Latin America (Mnookin, World Bank Group, & World Health Organization, 2016).

A report made by a collaboration between Seth Mnookin, the World Health Organization, and the World Bank Group from 2016 emphasized the use of investment from forming alliances between national governments and international development partners. This source of funding could be used to mend deficits in mental health care through cost-effective interventions. The report also offered a few inventive suggestions on how a low-income country could fund its mental health care system. Before listing these suggestions, this report emphasized that they were not a substitute for proper governance by the nation’s central and regional governments or for comprehensive development assistance (Mnookin et al., 2016). The suggestion that was most applicable to Venezuela’s infrastructural conditions was to utilize taxes on alcohol and other addictive substances, which are “disproportionally” consumed by those with mental health symptoms, to create a funding pool for the nation’s mental health care system (Mnookin et al., 2016). The other suggestion involved the utilization of airfare, which is not feasible in Venezuela because many countries have ceased direct flights between their airports and Venezuelan
airports. The next question would be what public policies are necessary for Venezuela to achieve affordable and cost-effective mental health care (Mnookin et al., 2016).

**Policies and Legislature**

The report by the World Health Organization continues by refocusing on productive governing for the sustainable development of mental health care systems through public policies, political mobilization, and effective use of domestic resources (Mnookin et al., 2016). The report’s results showed that many low-income countries like contemporary Venezuela had policies and laws that did not completely align with human rights protections, nor were they adequately implemented or properly involved people with mental disorders and their families (World Health Organization, 2015). In the 2014 Mental Health Atlas, the World Health Organization measured the prevalence of certain mental health policies and legislation across the globe to assess the advancement of mental health care systems that implemented human rights protections (World Health Organization, 2015). These policies included the following: policies that promote the transition towards community-based services, policies that refer specifically to the assertion of human rights of people with mental disorders, policies that promote services and supports for the inclusion and independence of people with mental disorders, policies that facilitate the use of recovery approaches by mental health providers, and policies that facilitate the involvement of people with mental disorders in decision-making (World Health Organization, 2015).

In addition to these policies, the 2014 Mental Health Atlas searched for the prevalence of these particular kinds of mental health care legislations: legislation promoting the
aforementioned transition towards community-based mental health services, legislation for the protection of legal rights of people with mental disorders, legislation for alternatives to forceful practice, legislation detailing procedures for people with mental disorders to file human rights complaints to independent agencies, and legislation that mandates regular inspections of mental health facilities by independent agencies for evaluation of human rights conditions (World Health Organization, 2015).

Regardless of all the prior discussion on the recovery and development of the mental health care sector in Venezuela, these actions would not produce sustained results if the primary and community health care systems are not functional, properly structured, and consistently funded (Mnookin et al., 2016). Even so, this discussion will continue with infrastructural recommendations for the mental health care system that will become more feasible once the primary and community health care systems are stabilized.

**Structuring a Comprehensive Mental Health Care System**

In order for mental health care to become effective in Venezuela, a comprehensive system involving the government, health care institutions, and communities must be established (Mnookin et al., 2016). Political momentum through a multi-sectorial consensus must be achieved for the implementation of mental health policies such as the ones previously mentioned (Mnookin et al., 2016). Political mobilization on the local level should be utilized to forge partnerships with service providers that have the potential to determine mental health outcomes. Some examples of services that play a role in the mental health of the people that they serve include early childhood education services, primary medical care, and home visiting programs.
for special populations (American Psychological Association, 2013). A strategy for creating effective mental health advocacy programs is to have influential entities within the political and commercial spheres collaborate to develop social programs that contain social, emotional, and mental health support components (American Psychological Association, 2013). Through these public initiatives and other policies, mental health policy makers must strive to expand public awareness of mental health issues, increase community engagement in addressing these issues, and structure care delivery systems to treat these issues. In this way, mental health services can be established and used by the Venezuelan population who urgently needs them (Mnookin et al., 2016).

Mental health care in Venezuela must be restructured to become integrated within other areas of health care, particularly primary, maternal, and pediatric health care (Mnookin et al., 2016). People access these other services more often, and the health conditions encompassed by these specialties have strong potential for influencing an individual’s mental health. By involving mental health services in those other areas, the confrontation of mental health concerns would become more likely and comprehensive. Medical training should emphasize strategies for encouraging the participation of professionals from sectors that are either traditionally or rarely involved in mental health provision. Sectors that should be targeted are those that would be able to contribute to the dissemination of science-based messages advocating the relevance of mental health in achieving desired societal outcomes (American Psychological Association, 2013). In addition to these collaborations between medical specialties, collaborative care coordinated between patients’ self-care efforts, clinical providers’ direct care management, and other
medical, mental health, and community-based assistance must be cultivated and preserved (Mnookin et al., 2016).

In addition to bolstering the health sector, other sectors of society should become involved in addressing mental health issues in the Venezuelan populace to assure an optimal mental health support network (Mnookin et al., 2016). Anti-stigma campaigns are critically needed in Venezuela, as the media content has shown that stigma against pursuing and receiving mental health care is a major obstacle for a successful mental health care system in Venezuela. School and workplace-based interventions are also in great need, as other media included in the study implied that significantly low tolerance towards mental health affairs exists in these environments in Venezuela. The last major service sector that is specifically relevant to Venezuela is the provision of humanitarian aid by both domestic and international sources. Humanitarian aid that involves health care provision would become much more effective through the implementation of mental health services, since periods of crises such as the one Venezuelans face generate spikes in mental health symptoms, as demonstrated in the retrieved media. Assimilating mental health and psychosocial support into humanitarian efforts made for the sake of the people living in Venezuela would prove powerful in alleviating mental health conditions that are felt across the country (Mnookin et al., 2016).

**International Intervention**

If the Venezuelan government is financially incapable of recovering and sustaining the nation’s mental health care system, then direct assistance from other countries or international health organizations is necessary to prevent complete collapse. Accepting help from international
mental health agencies would prove substantially beneficial, especially from the World Health Organization. The WHO has facilitated mental health care system development in various countries, including Belize, the Republic of Chile, and Venezuela’s neighboring country, Guyana (World Health Organization, 2019). Such initiatives have tackled key mental health care gaps by identifying major milestones accomplished by the target country, such as Venezuela’s signing of the Caracas Declaration on the Modernization of Mental Health Legislation in 1990, and building upon them (Department of Mental Health & Substance Abuse & WHO Geneva, 2009). Furthermore, these efforts by the WHO help nations form key partnerships between professionals within the target country, WHO officials stationed in the nation, WHO officials back at headquarters, and WHO officials in regional and sub-regional offices. The experts within these alliances identify essential next steps for the further development of the nation’s mental health care system, all the while keeping in mind the existing treatment gaps and contextual factors influencing the country’s mental health needs and services (Department of Mental Health & Substance Abuse & WHO Geneva, 2009).

Suggestions for Improving Mental Health Care Access and Equity for Vulnerable Populations in Venezuela

There were certain groups of people in Venezuela that were identified during the analysis of media as notably vulnerable to developing mental health conditions as consequences of their adverse environment. These groups included women, children, elderly, people with pre-existing mental health illness, and victims of political violence.
As previously mentioned, mental health care access for women in Venezuela would greatly expand if mental services were blended into women’s health services, especially during access to maternal health care (Breitinger, 2018). Not only are the instances when women access OB-GYN services one of the most common ways that women access health care systems, but reproductive health affairs are a source of many emotional concerns for women (Breitinger, 2018; U.S. Department of health and Human Services & Office on Women's Health, 2009). Women’s health care providers should take the opportunity to screen women, especially those who are pregnant or new mothers, for depression and other mental health disorders (APA Public Interest Government Relations Office, 2019; U.S. Department of health and Human Services & Office on Women's Health, 2009). Twenty percent of women with postpartum depression symptoms have thoughts of committing suicide (APA Public Interest Government Relations Office, 2019). As was seen in the media, some Venezuelan women who have fallen victim to unplanned pregnancies have experienced stress and depression so severe as to drive them to suicide. It is imperative to screen for risk factors such as depression to prevent such instances from occurring in the future, especially given the stark rise in unplanned pregnancies in Venezuela. On this note, family planning education initiatives that regard the lack of contraceptives and STI protection are also in great need.

Due to the severe prescription medication shortages gripping the Venezuelan health care system, emergency protocols should be developed and implemented to allow some form of health care to female mental health patients regardless of pregnancy status. Pregnant women with mental health symptoms often have to resort to only behavioral interventions that focus on
parent engagement and social support, since certain mental health medications are contraindicated during pregnancy (APA Public Interest Government Relations Office, 2019). These treatment plans can be applied to non-pregnant women in Venezuela, since the extensive medication shortage may merit such mental health treatment substitutes. Other emergency interventions that encompass humanitarian crisis management and disaster planning would benefit from considering gender issues and other manners in which women are affected in particular by these situations (U.S. Department of health and Human Services & Office on Women's Health, 2009). The nature in which the mental health of women are impacted by Venezuela’s crisis is distinct from the mechanisms that adversely influence the mental health of Venezuelan men.

Children

The media content presented a child and adolescent population that is substantially anxious and fearful owing to the uncertainties surrounding every aspect of life in Venezuela. Of particular concern were the manifestations of regressive behavior, social withdrawal, and uncooperative attitudes in children as common coping mechanisms. To combat the adverse effects that children feel from the rampant violence, insecurity, and failure of public services, a few recommendations are provided. First, Venezuelan adults must promote open dialogue with the children and adolescents about violence, fear, and personal safety (Mental Health America, 2019a). This is intended to relieve some feelings of fear and anxiety in the youth and to help the youth understand and come to terms with their country’s conditions. Care givers are advised to encourage children to express their concerns, validate the feelings that children express, speak
honestly about their own feelings, create and review safety plans with children, look for and recognize behavior that indicates unease in children, empower children to become involved in their communities’ anti-violence programs, help children improve their problem-solving and conflict resolution skills, and continue dialogue about violence and insecurity even after personal crises have passed (Mental Health America, 2019a). Lastly, finding activities that promote self-confidence and high self-esteem among children is important for positive mental health development (Mental Health America, 2019b). Such activities should provide caregivers with the opportunity to give praise, help set realistic goals, and offer honest opinions and words of encouragement to children (Mental Health America, 2019b).

When children’s anxieties and other mental health symptoms show signs of becoming chronic, families in Venezuela should be able to access mental health care services for their children. To improve availability of mental health services to Venezuelan families, primary care providers could undergo role changes and be granted the permission to provide and authorize services for common childhood and adolescence mental health conditions (American Academy of Child and Adolescent Psychiatry, 2009). Other resources that are vital to providing mental health care services to families with children include family network organizations, community-based psychiatric care, crisis outreach teams, special education services, family resource centers, support groups, and protection and advocacy groups (Mental Health America, 2019b). The remaining mental health professionals in Venezuela should reach out to allies to create and maintain these auxiliary services through extensive collaborations and outreach efforts.
Other Vulnerable Populations

The collected media content implicated that many of the elderly in Venezuela were mourning the departure of their younger family members and letting themselves physically and emotionally deteriorate in solitude. For the sake of their physical health, in-home medical provision may be necessary for those who have become socially withdrawn and unmotivated to seek medical care outside of their homes. To reduce the grip of migratory mourning, volunteer efforts can be organized to provide letter-writing services for the elderly to contact family members who have had to emigrate from the country. Letter sending can be used to bypass the inconsistencies in telephone, internet, and electrical services that would otherwise interrupt contact between loved ones.

For people with pre-existing mental health conditions, support groups may be imperative because of the inevitable lack of their medications. Prevention of institutionalization is highly suggested, because the acquired media displayed psychiatric hospitals either closing down or in horridly inhumane conditions. People who have been providing services in these dilapidated institutions may have to transition to in-home assistance for patients who are not a danger to others or themselves since their hospitals' conditions are catastrophic and may bring about an earlier death to some of the psychiatric patients.

For victims of political violence, volunteer mental health efforts could collaborate with the volunteer emergency and first aid services that frequently attend civilian protests to provide mental health contacts and references once patients have been stabilized. Additionally, they can visit these hospitals and provide contacts, references, and services to those admitted after falling victim to this sort of violence.
Applying Secondary Data Analysis in Future Research

There are some recommendations that can be made for future media content analyses intended for the assessment of the conditions in highly censored countries based on the insight gained from this study. One is to use the google search “"key words" site: URL” to find relevant media without having to resort to potentially costly social media mining software. This search method also helps with social media searches that would otherwise rely on hashtags, since some social media, such as Instagram, lack advanced search settings.

Additionally, either knowledge on the language or a translator for the language of the country under study is necessary. This is because direct translation software are extremely limited in detecting cultural nuances, especially frequently used idioms and phrases. There was a substantial use of Venezuelan idioms and phrases in this study’s data. These were detected by the single theme coder, who is both fluent in Spanish and has personal Venezuelan cultural background. If future qualitative studies involve theme coding, then initial coders who identify with the culture of the censored country being studied may be faced with difficulty in finding a second coder with similar cultural and linguistic background. It is important to note that this study’s results may have been different if the data had been coded by a researcher with less personal familiarity with the data's context.

For Venezuela, online news outlets or those that are operated from another country have proven to be extremely insightful, since they broadcast events that would be otherwise censored from the media. These sources may therefore be sought in media content analyses of other similarly censored countries. Printed newspapers and periodicals from Venezuela tended to be biased towards the Venezuelan government and were therefore excluded from the collected
media. This bias towards the government is consistent with these news printers being the primary recipients of consistent supplies of printing paper and ink. Outlets that are endorsed by the Venezuelan government often minimize aspects of the humanitarian crisis, because the Venezuelan government has been suspected of attempting to occlude the severity of the crisis from its citizens and international entities. Lastly, the social media platform that provided the most insight into Venezuelan civilians' personal experiences was Reddit. YouTube was the hub for most of the news video coverage. The third most attentive platforms were websites of these aforementioned Venezuelan news outlets. It is important to note that some of these Venezuelan news providers were exclusively on YouTube and lacked a website of their own.

Limitations

A major limitation identified within this media content analysis study is the censorship of social media in Venezuela. Various social media platforms periodically go offline in Venezuela, especially during periods of substantial civilian unrest such as when protests occur on a daily basis for weeks or months at a time. This equates to missing media content data being “lost” to censorship. In addition to the direct severing of social media access, social pressures to censor oneself on social media is prevalent. Particularly, authoritative figures in the workplace and law enforcement who are supporters of the central government threaten those who they have authority over to not share ideas, photos, or videos of the humanitarian, political, and economic crises in Venezuela. This also leads to concerned loved ones to advise against posting such material on social media for the sake of one’s safety. Overall, there are many obstacles to broadcasting the true conditions under which Venezuelans currently live.
Another major limitation is that the study was conducted by only one coder, who contacted a second coder to contribute only to the completion of an inter-rater reliability test. If the media content theme coding and qualitative analysis had been conducted by more than one researcher, then coding bias may have been considerably reduced.

The last major limitation was the inability to find opinions on the mental health care crisis in Venezuela by professionals other than psychiatrists, clinical psychologists, mental health nurses, psychology professors, and journalists. No professionals of other areas of expertise, such as pharmacists, economists, or politicians were found speaking about Venezuela’s mental health care system. The inclusion of opinions and testimonies from experts of these other sectors would have made this study’s results much more accurate in presenting what Venezuelan experts thought of the status of the mental health care crisis as a whole.

Conclusion

This media content analysis study was successful in shedding more light on the actual extent of the mental health care deficit in Venezuela. Media detailing the shortages in mental health care personnel and medications were found and utilized in the analysis. Additionally, media that portrayed the decay and loss of mental health facilities further showcased the increasing treatment gap for mental health patients in Venezuela. More media content pertaining to mental health in Venezuela was found than was expected, and much of the information was used to present corresponding symptom management and public policy recommendations made by mental health professionals in Venezuela and abroad. Lastly, implications for mental health care system structure, funding, and utilization were indicated. Further evaluation of Venezuela’s
mental health care system is necessary to pin-point action plans that are more tailored to the critical situation present in the country. If media coverage on Venezuela’s mental health crisis is sustained or continues to rise, a considerable amount of information will continue to be made available for future media content analyses.
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